

**Report to the Governor, the Speaker of the Assembly, and the Majority  
Leader of the Senate from the Superintendent of Insurance Respecting  
the Compensation Insurance Rating Board, and Rate-Making, Pursuant  
to the 2007 Workers' Compensation Reform Act,  
Section 308(g) of the Insurance Law**

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## **I. EXECUTIVE SUMMARY**

On March 13, 2007, Governor Spitzer signed into law a series of reforms to the Labor, Insurance, and Workers' Compensation Laws (the "Reform Act"). This Report is submitted by the Superintendent of the Insurance Department (the "Superintendent") pursuant to Section 308(g) of the Insurance Law, which provides:

The Superintendent shall report to the governor, the speaker of the assembly, and the majority leader of the senate on or before September first, two thousand seven on ...[matters related to the Compensation Insurance Rating Board.] Such report shall address, among such matters that the Superintendent may deem relevant to the Compensation Insurance Rating Board including: (1) the manner in which the Compensation Insurance Rating Board has performed those tasks delegated to it by statute or regulation; (2) whether any of those tasks would more appropriately be performed by any other entity, including any government agency; and (3) the rate-making process for workers' compensation insurance.

During the development of the 2007 reforms, the Compensation Insurance Rating Board ("CIRB") changed its savings estimates mid-way through the legislative negotiations. This and other historical issues brought into question whether CIRB should continue in its current role as the exclusively statutorily delineated rate service organization ("RSO"). This report answers the question in the broader context of an evaluation of the rate-making process for workers' compensation insurance in New York State. While the Superintendent found key limitations in CIRB's performance, the importance of industry-wide data collection to the rate-making process and the absence of a strong alternative data collection organization led to the conclusion that a restructured rating board should continue to function in a much more limited role.

The beginning of this Report provides an executive summary, background information about the statutory framework for workers' compensation insurance, the current workers' compensation insurance rate-making process, and the role of CIRB in the rate-making process as the State's RSO. The remainder of this

Report (1) examines CIRB's functions and evaluates its performance as a data collector and RSO; (2) assesses the current administered approach to workers' compensation insurance rates; (3) provides recommendations for changing the rate-making process; and (4) presents recommendations relating to collection and analysis of industry-wide workers' compensation data.

In reaching its conclusions, the Department consulted with numerous parties involved in the workers' compensation system, including a representative from organized labor, private insurance carriers, the State Insurance Fund ("SIF"), private sector actuaries, business representatives, rating boards in several states, insurance regulators in several states, individuals involved in the passage of the Reform Act, and members of the Department and its actuaries.

#### **A. The Importance of Industry-wide Data Collection and Analysis**

The explicit language of the 2007 Reform Act has precluded CIRB, and indeed any workers' compensation RSO, from filing rates or statistical information with the Department after February 1, 2008. In addition, as of January 1, 2008, no RSO, with respect to workers' compensation insurance, may "exchange" statistical information with insurers or other RSOs. Read together, these new provisions appear to remove the legal authority for CIRB, or any other licensed workers' compensation insurance RSO, to collect data from insurance carriers and SIF and to act on behalf of carriers by filing rates, rating plans, or other statistical information for workers' compensation insurance. In addition, CIRB has been legislatively removed from carrying out a number of other important statutory obligations.

The health and stability of the workers' compensation insurance market is predicated upon the ability of the Department, SIF, private insurance carriers, and self-insureds to evaluate the cost of workers' compensation risks accurately. The ability of the Department and carriers to measure risk accurately depends upon the collection, aggregation, and actuarial analysis of a large amount of relevant workers' compensation data. The only way to accumulate a sufficient quantity of data is for the data to be collected on an industry-wide basis. An inability to collect and analyze industry-wide data will make it impossible for many large and small insurance carriers and SIF to reliably set premium rates. This uncertainty will lead to carriers charging excessive or

inadequate rates for workers' compensation insurance, a decrease in the number of private insurance carriers willing to offer workers' compensation insurance in New York State, barriers to entry to the workers' compensation insurance market, a reduction in competition, and an increase in the potential for carrier insolvencies. In order that the market can continue to operate in an efficient, fair, and stable manner, there must be an entity responsible for collecting and analyzing the necessary workers' compensation data.

#### **B. CIRB's Functions and an Evaluation of its Performance**

As New York's sole workers' compensation RSO for over 90 years, CIRB has sought to supply the necessary data collection and actuarial analysis that enable premiums to be established at the appropriate level. In addition, CIRB provides underwriting services, such as policy audits and employer inspections that allow the market to function efficiently.

CIRB has performed its data collection functions in a satisfactory manner by employing industry standard quality control measures, taking a proactive role in correcting data that contains minor, non-substantive errors, and continually upgrading its data facilities and quality control measures. At the direction of the Department, CIRB has made significant improvements to its data quality systems over the past ten years.

CIRB has also performed underwriting services reliably. CIRB has maintained classifications and addressed employer classification concerns, and its policy form analysis is an important process that helps ensure that employers pay correct premiums. However, the Department is concerned about the low number of full premium verification audits that CIRB performs, especially given the fact that a large percentage of audits in 2006 resulted in an adjustment to the policyholder's premium. Overall, although there are areas that could be improved, namely the rigor of data collection and the number of audits performed each year, CIRB has performed the tasks detailed above in an efficient and reliable manner.

However, CIRB's yearly rate filings with the Department have raised concerns. The Department believes that in certain years, CIRB has submitted revisions that can be viewed as strategic starting points for rate negotiations with the Department, as opposed to impartial analysis based solely upon actuarial calculations. Moreover, CIRB's

performance in attempting to calculate the savings as a result of the Reform Act exhibited clear and significant shortcomings.

**C. The Current Administered-Pricing Approach to Rate-Making Should be Changed**

Currently, New York employs an “administered-pricing” approach to private insurance carrier rate regulation for workers’ compensation insurance. CIRB collects a significant amount of data from SIF and private insurance carriers. It then aggregates and actuarially analyzes the data in an attempt to forecast the overall workers’ compensation costs for New York for the following year. These forecasted costs are comprised of (1) the expected costs arising from the indemnity and medical benefits to be provided to injured workers; (2) an added industry average expense factor to cover the general costs of doing business; and (3) other factors such as medical and indemnity cost trends. When CIRB files for this overall rate change, it must be approved by the Department. The Department often does not immediately approve CIRB’s rate request, but rather directs CIRB to re-file at a level that is less favorable to insurance carriers. CIRB then calculates the rates that are paid by each of over 600 employer classifications, based on their risk levels and historical losses. With few exceptions, all employers are charged these “manual rates” by private insurance carriers.

A review of the current administered-pricing approach leads to the conclusion that it should be abandoned for a number of reasons. First, administered pricing precludes sufficient price competition, which the Department believes will benefit employers through lower premiums. Second, because the rates are approved by a committee of insurers, an appearance of collusion inevitably results and serves to undermine the legitimacy of the rate-making process. Third, the current rate-making approach protects inefficient insurance carriers from competition with more efficient competitors and leads to super-competitive profits for some insurance carriers. This occurs because the manual rate calculation includes an industry-wide average expense load factor, which leads to manual rates that insulate some high-cost carriers from price competition and disproportionately rewards low cost carriers that are more efficient than the industry average. Finally, because CIRB’s rate filings are currently made on behalf of all workers’ compensation insurance carriers, they have at times been viewed as a starting

point for collective negotiations with the Department. The appropriate role for an RSO, however, is to come up with its best estimate of the rate that would meet carriers' costs, not to seek to bargain with the Department to a particular end point.

The current approach to rate-making should be changed in favor of a more competitive and transparent process, based upon aggregate industry "Loss Costs." These published figures will reflect industry-wide losses and directly related expenses. Rates, subject to Department approval, will be determined using carrier-specific "Loss Cost Multipliers" that are filed by each carrier and reflect each carrier's individual underwriting skill and expense structure. This approach is currently used by a majority of states.

A rate-making process based upon loss costs and company specific Loss Cost Multipliers will be a major improvement over the current process for several key reasons. First, moving to a loss cost system removes the ability of an RSO to file fully developed rate indications, because each carrier will be responsible for its own filings. This will eliminate the potential for and appearance of collusion in the rate-making process. Second, a loss cost system will provide more price competition by insurance carriers for an employer's business through the filing of multiple Loss Cost Multipliers. Third, having private insurance carriers file their own expense information prevents low-expense carriers from receiving a windfall because of an industry-wide expense load factor in the administered rates. In addition, less efficient carriers will need to become more efficient in order to remain competitive. Although, under a loss cost system, CIRB will no longer file industry-wide rates on behalf of insurance carriers with the Department, the collection and actuarial analysis of industry-wide workers' compensation data will still be essential to a functioning workers' compensation insurance market.

#### **D. Recommendations for Industry-Wide Data Collection and Other Statutory Functions**

The absence of accurate industry-wide claims data is likely to destabilize the workers' compensation insurance market. The Insurance Law should be amended to remove the sunsets on the filing of statistical information, loss costs, and related data with the Department and on the exchange of workers' compensation data. Furthermore, CIRB has specific statutory responsibilities that need to be discharged in order to fund many

important government functions, effectuate legislative mandates, and administer numerous premium discount programs. For example, the Workers' Compensation Board derives a portion of its operating budget from assessments calculated by CIRB, and CIRB is responsible for determining discounts for downstate construction employers under the New York Construction Employment Payroll Limitation Program. A workable legislative solution would be to allow the Superintendent to designate the entity that would serve as the Workers' Compensation Rating Board. By designating CIRB in the short term, the Department would enable these functions to continue without interruption.

The two organizations, other than CIRB, that could serve as an RSO and undertake the necessary data collection and underwriting services are the Department and the National Council on Compensation Insurance ("NCCI"). As a practical matter, it would be nearly impossible for the Department to put in place the required technological and personnel resources necessary to perform CIRB's functions by February 1, 2008, the date of the legislative sunset for CIRB and other RSOs in workers' compensation insurance. NCCI provides classification relativities, experience modifications, loss costs, and in certain cases, advisory or manual rates for a number of states. In the short term, it would be extremely difficult to make an orderly transition from CIRB to NCCI by February 1, 2008. Because rate revisions and calculations of loss costs require many years of historical data, much of this possibly proprietary data already collected by CIRB would need to either be collected again or transferred to NCCI. Given the time constraints and other issues, the Department does not believe that NCCI can more appropriately perform CIRB's duties at this time.

In the short term, a restructured CIRB is the best, and indeed only, available resource to collect and analyze industry-wide data for the submission of loss costs to the Department. If the law is amended to allow for the continued operation of an RSO in the workers' compensation market, significant changes to CIRB's corporate governance structure will be required to allow for public representation on CIRB's Board of Directors, as well as increased transparency and oversight by the Department. These public members, along with Department and SIF, should constitute a majority of the Board. Despite its shortcomings in recent rate revisions and in benefit scoring during the

recent reforms, the Department believes that CIRB can continue to respond to the specific needs of the New York workers' compensation system.

In the absence of the legal authority for an RSO to operate within the workers' compensation market, the Department will be compelled to retain the services of a data collection organization ("DCO"). In the short term, CIRB is the only viable DCO. As such, the Department would bring CIRB directly under its supervision as an outside service provider. The difference between this scenario and the recommendation that CIRB be authorized to continue to act as an RSO is that, as a DCO, CIRB will be acting on the behalf of the Department and not on behalf of the insurance carriers. While it may be possible to develop a workable solution based upon retaining CIRB as a DCO, this solution is less desirable than an amendment to the Insurance Law for a number of reasons, including: (1) the Department has concerns that the DCO approach would require the devotion of considerable existing Department resources; (2) insurance carriers may have concerns that the use of a DCO by the Department to collect and analyze data in order to promulgate loss costs create a potential conflict of interest; and, (3) there are legal concerns that the retention of CIRB as a vendor to perform these actuarial tasks may expose the State to litigation.

In the long term, the Department will continue to examine how CIRB performs its duties and whether an orderly transition of CIRB's duties either to another independent RSO or to the Department or another government entity is warranted.

## **II. STATUTORY AND ADMINISTRATIVE BACKGROUND**

Article 23 of the Insurance Law provides the legal framework for the rate-making process, specifies the basic filing requirements imposed upon carriers in support of a rate filing, and authorizes the delegation of workers' compensation rate filing obligations by carriers to a licensed RSO.

New York law requires prior approval by the Superintendent of the rates in workers' compensation.<sup>1</sup> The Superintendent can deny a rate request if he finds the

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<sup>1</sup> Section 2305(b)(1) of the Insurance Law specifically provides that rates and rating plans for workers' compensation insurance must be filed with the Superintendent and shall not become effective unless either the filing is approved or a certain amount of time has elapsed without the filing being disapproved.

requested rate excessive, inadequate, unfairly discriminatory, destructive of competition, or detrimental to the solvency of insurers. In making rates, consideration should be given to, among other things, past and prospective loss and expense experience.<sup>2</sup> The information that may be furnished in support of a rate filing includes: (1) the experience or judgment of the insurer or RSO making the rate; (2) its interpretation of any statistical data it relies upon; (3) the experience of other insurers or RSOs; and (4) any other relevant factors.<sup>3</sup> Rate filings do not need to be made on a carrier-by-carrier basis. Instead, an insurer or group of insurers is authorized to delegate its rate filing obligations by giving notice to the Superintendent that it uses rates and rate information prepared by a designated RSO,<sup>4</sup> and in fact, this is the way that New York's workers' compensation insurance system has operated since 1914.

All RSOs that file rates must be licensed by the Superintendent.<sup>5</sup> CIRB, an unincorporated non-profit association, was formed in 1914 for the purpose of becoming the RSO for carriers issuing workers' compensation insurance policies in New York. In 1914, CIRB applied for and obtained the license from the Department to do so. In this capacity, CIRB collects data, described in more detail below, from the private insurance carriers and SIF that is necessary to support the rates and rating plans that it files with the Department.

The 2007 Reform Act has placed limitations on the ability of CIRB, or indeed any workers' compensation RSO, to file rates with the Department. The Reform Act added subsection (s) to Section 2313 of the Insurance Law, which provides:

Notwithstanding any other provision of this article, no rate service organization may file rates, rating plans or other statistical information for workers' compensation insurance after February first, two thousand and eight.

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<sup>2</sup> Insurance Law §2304(a).

<sup>3</sup> Insurance Law §2304(b).

<sup>4</sup> Insurance Law §2306. Section 2313 of the Insurance Law defines an RSO as "a person or any other entity which makes or files rates as permitted by this article, or which assists insurers in rate making or filing by collecting, compiling and furnishing loss or expense statistics, or by recommending rates or rate information, or which inspects, test appliances, formulates rules or establishes standards, as such activities relate to rate making or administration of rates."

<sup>5</sup> Insurance Law §2313(b).

Accordingly, as of February 1, 2008, CIRB, the current RSO for workers' compensation carriers, may not participate in the rate-making process. In addition, Section 2316 of the Insurance Law, the provision concerning prohibition of anti-competitive behavior by RSOs and insurance carriers, was amended. Under the amendment, as of January 1, 2008, no RSO with respect to workers' compensation insurance may "exchange" statistical information with insurers or other RSOs.<sup>6</sup> Read together, these new provisions appear to remove the legal authority for CIRB, or any other licensed workers' compensation insurance RSO, to collect data from insurance carriers and SIF and to act on behalf of carriers by filing rates, rating plans, or other statistical information for workers' compensation insurance. While individual insurers are still authorized, and even required, to file workers' compensation rates, they will no longer have the ability to accurately price insurance due the absence of aggregate loss data.

### **III. THE RATE-SETTING PROCESS: ADMINISTERED PRICING AND MANUAL RATES**

In 1913, New York State passed one of the nation's first comprehensive workers' compensation laws. The New York Workers' Compensation Law (the "WC Law") requires employers to provide health and indemnity benefits to injured workers covered by the statute. In order to ensure that the mandated benefits are available, employers are required, with few exceptions, to obtain workers' compensation insurance. Employers can obtain the required coverage, either through a private insurance carrier, SIF, or through self-insurance.<sup>7</sup> In 2006, 38% of accepted claims were covered by private insurance carriers, 26% were covered by SIF, and 35% were covered through self-insurance or self-insured trusts.<sup>8</sup>

Workers' compensation premiums are set through a highly complex process that involves (1) a specialized collection of industry-wide data by CIRB, (2) CIRB's actuarial analysis of the industry-wide data, (3) CIRB's filing of proposed manual rates based upon

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<sup>6</sup> Amended Section 2316(a)(2) of the Insurance Law.

<sup>7</sup> SIF is not a private insurance carrier. Rather, it is a non-profit agency of New York State.

<sup>8</sup> Claims data is from the Workers' Compensation Board. 1% of accepted claims were not covered by insurance.

its analysis, and (4) the Department’s review and approval of manual rates.<sup>9</sup> In the rate-making process, the interplay between CIRB, insurance carriers, and the Department operates as follows:

- CIRB collects specific workers’ compensation data from private insurance carriers and SIF, which it uses to accumulate a large enough universe of relevant historical data for meaningful actuarial analysis;<sup>10</sup>
- CIRB actuarially analyzes the historical data that it collects so that it can forecast future workers’ compensation costs;
- When CIRB files proposed rates with the Department for approval, it submits an overall indicated rate change;
- Based on the Department’s approved rate change, CIRB calculates the average rate per \$100 of payroll charged to each of the 600 employer classifications.<sup>11</sup> These rates are called the “manual rates,” and are the basis for virtually all premiums charged for workers’ compensation policies in New York;
- Insurance carriers write policies for employers in New York. When a carrier writes a policy for an employer, the employer is assigned the classification code that most accurately describes it;
- Insurance carriers send each policy issued to CIRB, where it is put through an automated review process to ensure that all information it contains is correct, including the correct classification code;
- Insurance carriers collect detailed data on each policyholder and the premiums and losses associated with each policy;

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<sup>9</sup> The manual rates are the starting point in determining the level of premium charged by insurance carriers, as additional approved rating plans and pricing programs exist which may increase or decrease the amount of the premium.

<sup>10</sup> It is important to note that CIRB does not collect any data from self-insured employers or self-insured trusts (collectively, “self-insureds”). In New York State, self-insureds comprise roughly one-third of the total workers’ compensation insurance market. This means that CIRB’s data is drawn from two-thirds of the market.

<sup>11</sup> The Insurance Law specifically authorizes the grouping of risks by classification. Section 2304(c) provides that risks may be “grouped by classification for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions or both.” Insurance Law §2304 (c).

- Each private insurance carrier and SIF, in support of the annual rate filings made by CIRB, submits three types of data to CIRB:
  - Unit Statistical Data: Data on a policy-by-policy and claim-by-claim basis detailing employer and claim characteristics, and losses associated with each policy and claim;
  - Aggregate Financial Data: Data on an insurance carrier-wide basis that includes net premium collected, total medical and indemnity losses paid and outstanding, and claim counts;
  - Expense Data: Data on each insurance carrier’s expenses, including overhead such as rent, marketing, and administrative costs;
- In recognition of the fact that each employer within a classification may have a unique risk profile, CIRB “experience rates” each employer that pays a standard premium of \$5,000 or more. CIRB’s collection and analysis of Unit Statistical Data makes the experience rating of individual employers possible;
- CIRB uses Aggregate Financial Data and Expense Data to calculate the overall rate change in each yearly filing; and
- The Department approves, rejects, or requests modifications in the overall rate level and/or rating plans filed by CIRB after reviewing and evaluating the data that CIRB submits in their support.

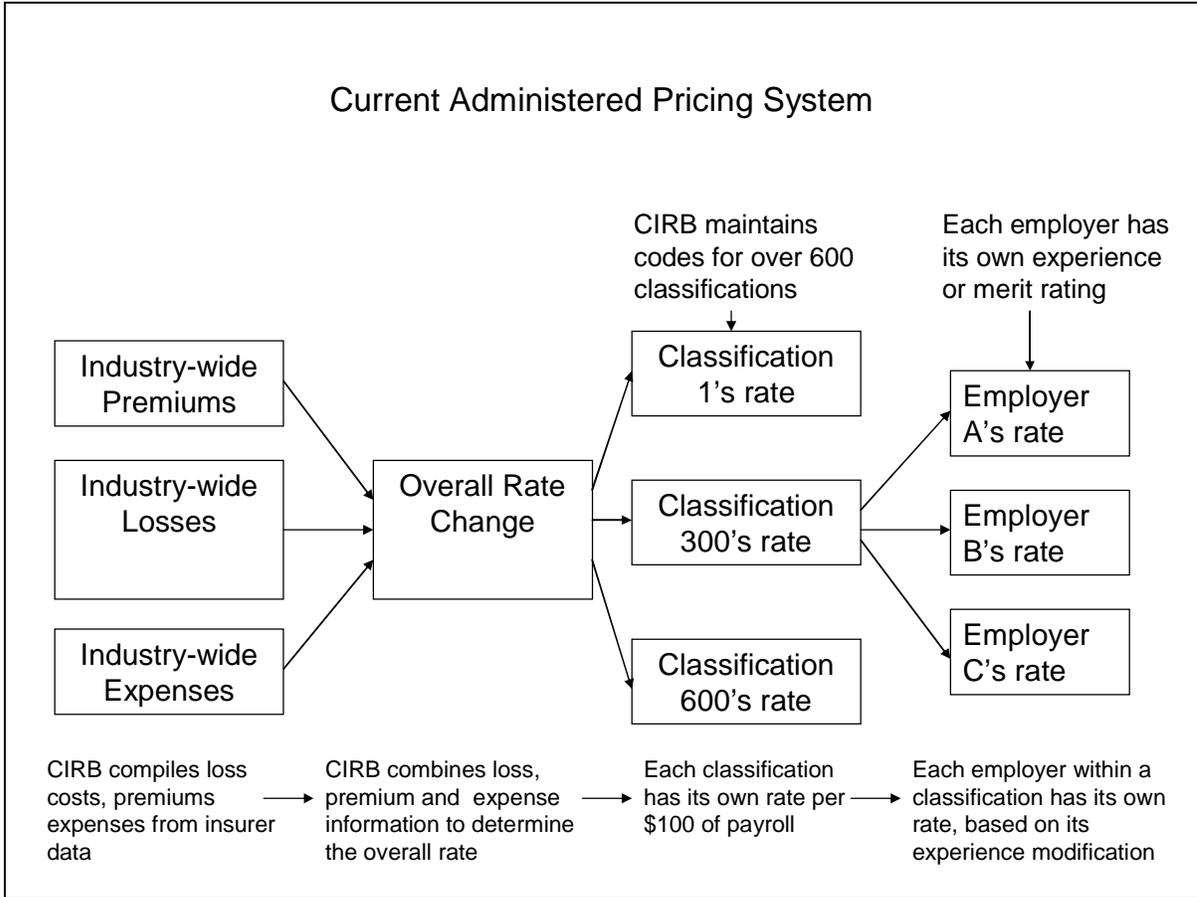
At the end of this process, the Department’s goal is to ensure that actual premium collected is sufficient to (1) fund the expected medical and indemnity benefits to be paid to injured workers covered by the WC Law; (2) cover the expected costs of adjusting a particular claim, such as attorney’s fees and medical examinations; and, (3) cover the general costs of doing business, such as commissions to agents, overhead expenses, salaries, premium taxes, and underwriting expenses.<sup>12</sup> To accurately forecast the amount of premium that needs to be collected today to cover future costs and expenses, large

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<sup>12</sup> Thus, in a given policy year, premiums are supposed to meet all claims costs associated with the policies written in that year, regardless of when the claims are ultimately resolved. For example, if a claim is filed in 2000 on a policy issued in 2000, but payments are still being made to the injured worker in 2008, the premium collected in 2000 must be sufficient to cover the medical and indemnity payments through 2008 as well as all of the costs incurred in servicing the claim, and the projected payments for the remaining life of the claim.

amounts of credible historical workers' compensation data are required. The following diagram illustrates the current administered rate-making process.

**Figure 1: The Current Administered Pricing System**



**IV. CIRB'S PERFORMANCE OF THE TASKS DELEGATED TO IT BY STATUTE AND REGULATION**

CIRB's functions fall into three general categories: (1) electronic collection of industry-wide data; (2) actuarial analysis of the data collected in order to file a proposed rate level change with the Department; and (3) general underwriting services. In order to evaluate CIRB's performance, the Department reviewed the results of its prior exams of CIRB and consulted with its own actuaries, with carriers of different sizes and product mix that currently write workers' compensation insurance in New York, with a

representative from organized labor, with business representatives, and with numerous workers' compensation regulators in other states.<sup>13</sup>

CIRB employs approximately one hundred forty full-time employees, and has five main departments: Executive, Information Technology and Operations, Actuarial Services, Underwriting & Field Services, and Finance & Administration. It has three oversight committees:

(1) The Governing Committee is comprised of delegates from six private insurance carriers and SIF. The Governing Committee acts as CIRB's Board of Directors and is responsible for overall policy and personnel decisions;

(2) The Rates Committee is made up of delegates from nine private insurance carriers and SIF, but also has two public members, one of which is a representative of organized labor and the other who represents employers. The Rates Committee approves CIRB's yearly rate filing before it is filed with the Department. It also hears protests from employers that believe they are misclassified and approves changes in employer classifications; and

(3) The Actuarial Committee has the same structure as the Rates Committee, but without public members. It is responsible for reviewing the methodology and data collection processes used to develop rates. Appropriately, the committee members are generally associates or fellows of the Casualty Actuary Society.

#### **A. The Collection of Industry-Wide Data by CIRB**

Each insurance company that writes workers' compensation policies in New York is required to report a significant number of data fields to CIRB. These fall into three basic categories: Aggregate Financial Data, claim specific data called Unit Statistical Plan ("Unit Stat") data, and general carrier Expense Data.<sup>14</sup>

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<sup>13</sup> The Department conducted extensive consultations with regulators from the states of California, Illinois, Maine, Maryland, Michigan, Nebraska, New Jersey, and Pennsylvania.

<sup>14</sup> As stated previously, all of the data collected by CIRB is ultimately used to calculate the proposed manual rates, classification relativities, employer experience modifications and merit ratings. More importantly, it is the centralization or "pooling" of the data that puts CIRB in a position to conduct the required actuarial analysis to calculate these figures.

Aggregate Financial Data is gathered from each company and includes company-wide standard premium, net premium after discounts and credits to policyholders, overall indemnity and medical losses paid, losses incurred but not reported, claim counts, case reserves, and the value of adjustments for safety and specialty programs.<sup>15</sup>

CIRB collects Aggregate Financial Data from each private insurance carrier and SIF on a policy year<sup>16</sup> and accident year<sup>17</sup> basis. Policy year data is considered the most accurate, but it takes two years to collect. For example, policy year 2006 data is collected from the first day of the policy year period until the day the last policy written that year expires. Consequently, data for policy year 2006 is not fully available until 2008. Accident year data covers the accidents that occur in a particular calendar year. Accident year data can be especially useful when analyzing benefit changes and economic fluctuations within the marketplace.

The second type of data that insurance carriers and SIF are required to submit to CIRB is Unit Stat Data,<sup>18</sup> which consists of detailed claims information reported on a policy-by-policy basis. Unit Stat Data includes employer payroll, premium amount, and specific loss information by type of injury and the employer's classification. The information for each policy is measured eighteen months after the policy is written, and then at yearly intervals. Unit Stat Data are the only data detailed enough to create classification relativities and experience and merit ratings for specific employers.

The third category of data collected by CIRB is general Expense Data. As the name suggests, Expense Data relates to a carrier's taxes, commissions, general overhead,

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<sup>15</sup> A full description of the variables required by CIRB and submission procedures for the Financial, Unit Stat, and Special Data calls can be found at [http://www.nycirb.org/2007/depts/actuary/dr1\\_06.pdf](http://www.nycirb.org/2007/depts/actuary/dr1_06.pdf).

<sup>16</sup> Policy year data includes all premiums and losses for policies written during a specific time period. For example, policy year 2006 data would include premiums earned for all policies written between January 1, 2006 and December 31, 2006, and all losses associated with those same policies.

<sup>17</sup> Accident year data includes all premiums earned during a specific year and the losses incurred for accidents that occurred during that year, regardless of when the policy was written. For instance, 2006 accident year data would include all premiums collected in 2006 and the losses incurred for all accidents that occurred during 2006.

<sup>18</sup> This data is submitted pursuant to The Unit Stat Plan, which was reviewed and approved by the Superintendent prior to its implementation. Moreover, all editions or amendments to the Unit Stat Plan have been reviewed and approved by the Superintendent.

and administrative and underwriting costs. The Expense Data is used by CIRB to determine average carrier expenses, which are incorporated into the manual rates.<sup>19</sup>

CIRB requires insurance carriers and SIF to submit the Aggregate Financial, Unit Stat and Expense Data electronically.<sup>20</sup> After the data is submitted, CIRB employs a number of automated quality checks, or “edits,” to ensure data quality and consistency. Any discrepancies are examined and resolved.

Unit Stat Data are examined for accuracy, and are put through approximately 1,400 edits. These data are particularly voluminous in a state as large and diverse as New York. In 2006, CIRB processed over 650,000 reports containing the required Unit Stat Data (“Unit Reports”). Each Unit Report is subject to an automated quality check by CIRB and about 20% required correction. Incorrect data entries are first reviewed by CIRB’s staff. If the problem is simple, CIRB’s staff will often make a correction without requiring the carrier to resubmit the data. If a discrepancy cannot be resolved through a manual review, the insurance carrier is contacted and asked to resolve the problem and to resubmit corrected data.

In order to ensure that insurance carriers submit data in time for CIRB to perform the calculations necessary for the annual rate filing, late and incorrect reporting is penalized financially. To calculate a penalty, CIRB employs a formula that takes into account how late the data was submitted, the carrier’s market share, errors in the submitted data, and the level of responsiveness to CIRB’s inquiries. In 2006, CIRB collected \$108,938 in penalties for incorrect or late Aggregate Financial Data and \$68,000 in penalties for problems related to Unit Stat Data.<sup>21</sup>

## **B. Evaluation of CIRB’s Data Collection Efforts and Quality Control**

CIRB has performed its data collection responsibilities adequately, and the data are reliable. CIRB employs generally accepted techniques to collect and screen data.

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<sup>19</sup> Expense Data does not include costs directly related to workers’ compensation claims (*i.e.*, benefits paid, reserves, lawyer’s fees, medical examiner fees). These direct expenses are included in the loss portion of the manual rate revision.

<sup>20</sup> CIRB is a member of the American Cooperative Council on Compensation Technology (“ACCCT”) and the Compensation Data Exchange (“CDX”), and works with other DCOs and statistical agents to ensure that data submissions conform to accepted standards and formats.

<sup>21</sup> Unpublished communications from CIRB.

Some carriers believe that CIRB should invest more resources and expertise in maintaining state-of-the-art data facilities and analysis capabilities. However, many believed that CIRB has served the market well. Both Department and private actuaries expressed confidence in the completeness, integrity and accuracy of New York State workers' compensation data.

Carriers expressed a wide range of opinions about CIRB's data collection processes. While some carriers praised CIRB's systems and willingness to work with carriers, others described the data submission process and edits as more onerous than the systems used by other independent rating boards and NCCI, the organization that serves as an RSO or DCO for thirty-nine states. There was no general consensus among carriers on this particular issue.

A concern was raised that CIRB's data quality control measures are more lax than those of other organizations. The Department has found no strong basis for this concern. First, CIRB employs data quality control measures that are nearly identical to the quality control measures employed by other RSOs and DCOs. Second, CIRB's proactive approach to correcting data that contains minor, non-substantive errors may have given carriers the faulty impression that CIRB's quality control measures are more lax because data submissions are not immediately rejected and returned to the carriers for correction.

There are certain editing procedures that CIRB does not apply that other rating boards do. Currently, CIRB does not apply edits that go beyond simple arithmetic calculations. Some RSOs perform edits that involve cross-checking over multiple years of data and actuarial forecasting. CIRB is in the process of developing these edits and has plans to implement them by 2008.

The Department examines CIRB approximately every three years. Previous exams of CIRB by the Department provide further support for the conclusions concerning CIRB's performance in data collection and quality control. During one exam, the Department's examiners randomly selected policies from three insurance carriers and compared CIRB's Unit Stat Data with the carriers' own records for those policies. The Department's examiners found no discrepancies or irregularities, other than rounding errors, between the Unit Stat Data and the data provided by the companies to CIRB. In addition, the examiners found that the Aggregate Financial Data from the three previous

years was consistent with the data from the companies' own financial records. Finally, the Department found that over the past ten years, CIRB has made significant improvements to its data quality systems.<sup>22</sup>

**C. The Current Rate-Making Approach and CIRB's Role in the Rate-Making Process**

New York currently employs an administered-pricing approach to private carrier rate regulation for workers' compensation. The first step in the process is the calculation of the overall rate level change. The second step is the establishment of the manual rates for approximately 600 employer classification codes. In most cases, the manual rates are the starting point in arriving at the final premium that is billed by an insurance carrier to an individual policyholder. Numerous rating plans and pricing programs exist that can, and in most cases must, be used by the insurance carriers to adjust the manual rate either upward or downward. These programs have either been approved by the Department or mandated by statute. CIRB, as the licensed RSO for workers' compensation carriers, is involved in many of the rating plans and pricing programs that affect the premium amounts charged to policyholders.

**1. CIRB's Calculation of Proposed Manual Rates and the Submission of the Proposed Manual Rates to the Superintendent for Prior Approval**

As an RSO for workers' compensation insurance carriers, CIRB must support its filings with appropriate data.<sup>23</sup> To do so, CIRB collects the Aggregate Financial, Unit Stat, and Expense Data described in previous sections from each private insurance carrier and SIF. CIRB then aggregates the individual insurer data to calculate "loss costs." Loss costs generally include all incurred medical and indemnity losses and allocated loss adjustments expenses ("ALAE").<sup>24</sup> ALAE are those expenses that are directly related to the servicing of the claim, including independent medical examiners and attorneys' fees.

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<sup>22</sup> In 1994, the State commissioned a report by the actuarial firm of Milliman and Robertson and by Arthur Anderson. The report recommended a number of changes for improving the quality of the data CIRB collected. In an exam, the Department found that CIRB had implemented most of these recommendations, and that the remaining recommendations were low-priorities.

<sup>23</sup> Insurance Law §§ 2304, 2305, 2306.

<sup>24</sup> Incurred losses are the sum of paid losses, reserves, and losses incurred but not reported.

Put somewhat differently, loss costs do not include general overhead expenses, profit, taxes, licensing fees, or commissions. Loss costs are based upon historical aggregate losses and ALAE, adjusted through actuarial development to their ultimate value.<sup>25</sup> Each classification has its own average loss cost, because each class of employers has a different risk level that leads to different levels of losses. CIRB calculates the proportional differences in losses between classifications, which are referred to as “classification relativities.” CIRB’s classification relativities are filed with the Department as a part of its annual filing.

In calculating the manual rates, CIRB adjusts the loss costs upward by applying an industry average expense load factor, which includes general overhead and underwriting expenses. This expense load factor is based on industry-wide average expenses, calculated from the data submitted by the private insurance carriers and SIF.<sup>26</sup>

Based on the loss costs, expense load factor, and other factors like trend, CIRB calculates an overall rate change indication, which it files with the Department. The Superintendent must approve the rates before they can be used by insurance carriers.<sup>27</sup> The Superintendent is empowered to reject the proposed manual rates if the rates are excessive, inadequate, unfairly discriminatory, destructive of competition, or detrimental to the solvency of insurers.<sup>28</sup>

## **2. Moving Beyond the Manual Rates – Application of Various Approved Rating Plans and Pricing Programs**

New York’s administered-pricing approach includes a number of rating plans and pricing programs that either allow or mandate private insurance carriers to depart from the manual rates. CIRB is directly involved in many of these programs as the RSO. Of these programs, experience and merit rating are of the utmost importance in rate-making

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<sup>25</sup> Actuaries use “Loss Development Factors” to bring the present value of a claim up to its total expected value over its entire life. Loss Development Factors are, in essence, multipliers that use historical data to predict how much a claim will cost over time.

<sup>26</sup> Under the current rate-making process, the Department does not allow CIRB to include a profit provision in its expense load factor. Instead, insurance carriers earn a profit through investment income earned on the premium float—premiums are collected now but the associated claim losses are paid out in the future.

<sup>27</sup> Insurance Law §2305(b).

<sup>28</sup> Insurance Law §2303.

and facilitate the implementation of various workplace safety programs, which are described below. The experience and merit rating programs are mandatory and are important public policy tools to improve workplace safety in the State.

**(a) Experience Rating**

The current Experience Rating Plan, proposed by CIRB and approved by the Superintendent in 2006, applies to all New York employers that would otherwise pay a workers' compensation standard premium greater than or equal to \$5,000 under the applicable manual rates.<sup>29</sup> CIRB calculates an experience modification by comparing a specific employer's losses over the past three years to the losses of all employers within the same employer classification. An experience rated employer's workers' compensation premium is calculated by multiplying the applicable manual rate by the experience modification.

Experience rating provides a strong economic incentive for employers to create safer working environments. The table below provides an example of how injury records and the resulting experience modifications can dramatically alter premium levels, here by 73%.

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<sup>29</sup> Generally, the standard premium is the premium determined on the basis of the manual rate, any experience or merit rating, credits under the New York Construction Classification Premium Adjustment Program, and credits or debits under the workplace safety programs.

**Figure 2: Experience Modification Example**

Impact of Experience Modifications on Premiums	
Company A with a Poor Safety Record	Company B with a Good Safety Record
<p><b>Company A</b>, a manufacturer of plumbing supplies (Classification Code 3188), has a payroll of \$100,000 and a pre-modified workers' compensation manual rate of \$7.30 per \$100 of payroll. <b>Company A</b> has a poor safety record resulting in an experience modification factor of 1.6. <b>Company A's</b> workers' compensation rate computes as follows:</p> <ol style="list-style-type: none"> <li>1. Payroll (\$100,000) multiplied by the manual rate (\$7.30) divided by 100 equals the manual rate premium of \$7,300.</li> <li>2. Manual rate premium (\$7,300) multiplied by the experience modification (1.6) equals the standard premium of <b>\$11,680</b>.</li> </ol>	<p><b>Company B</b>, also manufacturer of plumbing supplies, has the same pre-modified workers' compensation manual rate of \$7.30 per \$100 of payroll and has the same total payroll as <b>Company A</b>. Because of its good safety record, <b>Company B's</b> experience modification factor is 0.94. Their workers' compensation rate computes as follows:</p> <ol style="list-style-type: none"> <li>1. Payroll (\$100,000) multiplied by the manual rate (\$7.30) divided by 100 equals the manual rate premium of \$7,300.</li> <li>2. Manual rate premium (\$7,300) multiplied by the experience modification (0.94) equals the standard premium of <b>\$6,862</b>.</li> </ol>
<p><i>In this example, <b>Company A's</b> workers' compensation insurance premium is 73% higher than <b>Company B's</b> premium.</i></p>	

In addition to providing an economic incentive to create safer workplaces, experience modifications are an integral part of the Compulsory Workplace Safety and Loss Prevention Plan, and the Voluntary Safety, Drug, and Alcohol Prevention Plan, and Return to Work Program.

Section 134 of the WC Law provides for the establishment of a “compulsory workplace safety and loss prevention program for all employers whose most recent annual payroll is in excess of [\$800,000] and whose most recent *experience rating exceeds the level of 1.2*.”<sup>30</sup> Such an employer, after receiving written notice from the Department of Labor (DOL), must arrange for and undergo a “workplace safety and loss prevention consultation and written evaluation.”<sup>31</sup> A failure by the employer to

<sup>30</sup> WC Law §134(1) (emphasis added).

<sup>31</sup> WC Law §134(2).

implement recommended remedial action within the time prescribed by the statute will result in the imposition of a premium surcharge of 5% by the employer's insurer.<sup>32</sup>

Prior to the Reform Act, CIRB had the obligation of notifying employers who were subject to the mandatory workplace safety program. This approach dovetailed with the fact that CIRB calculated the experience modifications and could identify those employers with a payroll in excess of \$800,000. It is unclear how the DOL will be able to maintain this program in the absence of an organization that computes experience ratings.

Experience rating also triggers statutory voluntary safety programs. Under the Reform Act, employers will be eligible for a credit to their workers' compensation premiums if they (1) pay an annual workers' compensation premium of at least \$5,000; (2) maintain an *experience rating of under 1.30*; and (3) implement a safety incentive program, a drug and alcohol prevention program, or a return to work program.

Absent an amendment to the Insurance Law, CIRB will not be able to calculate experience ratings after February 1, 2008. Thus, the Voluntary Safety, Drug and Alcohol Prevention, and Return to Work Programs will no longer be functional if CIRB, or any other RSO, is precluded from collecting Aggregate Financial and Unit Stat data and filing experience modifications with the Department.<sup>33</sup>

### **(b) Merit Rating**

Most of the employers that do not meet the requirements necessary to be experience rated will be merit rated pursuant to a special rule contained within the Experience Rating Plan. Under merit rating, the manual rate for an employer is adjusted by a factor that is based on the number of claims that the employer has had in the three most recent years for which loss data is available. CIRB currently performs the calculations necessary to merit rate employers through the analysis of Unit Stat Data. The schedule below applies to companies subject to the merit rating criteria:

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<sup>32</sup> WC Law §134(3).

<sup>33</sup> No regulations have been promulgated yet concerning the premium credit or credits that will be made available to employers that participate in these voluntary Safety, Drug and Alcohol Prevention, and Return to Work Programs. The Superintendent, in cooperation with the Commissioner of Labor, is currently studying the issues involved.

**Figure 3: Merit Rating Schedule**

Number of claims in the three most recent years	Applicable credit or debit
0	8% credit
1	0
2	4% debit
3 or more	8% debit

Merit rating, like experience rating, leads to savings for those companies that maintain safe workplaces, and penalizes employers with poor safety records. For example, Company X, a farm supply dealer (Classification Code 8199) with \$100,000 in payroll that has not had a single claim in the three most recent years, will be assigned a merit rating credit of eight percent. This merit rating credit will be applied to the unadjusted manual rate of \$4,000 to arrive at a merit rated premium of \$3,680 (\$4,000 minus \$320, or eight percent). If that same employer had three claims filed in the most recent three years, its final premium would be \$4,320, which is roughly 17% higher than the premium paid by the employer with no claims.

In addition to calculating experience modifications and merit ratings, CIRB plays a crucial role by storing data about an employer's historical loss experience, even if the employer has switched insurance carriers. Without this function, an employer that has had bad loss experience in a given year could simply switch to a new insurance carrier with no knowledge of the employer's prior losses.

This would cause two significant problems. First, it would create a public safety and public health problem by seriously reducing the safety incentives that the experience modification system provides, since bad loss experience would not be incorporated into irresponsible employers' rates. Second, it would make it extremely difficult for insurance carriers to accurately gauge and, consequently, price risk.

**(c) Premium Discount by Size of Policy Program**

Under the Premium Discount Program, private insurance carriers, recognizing the fact that the expenses associated with writing a workers' compensation policy do not increase as quickly as the dollar amount of the premium increases, are required to give a premium discount to employers that meet the requirements of the program. The premium discount is a per policy credit and is calculated based upon the policy standard premium.

Pursuant to the criteria set forth in the approved program, CIRB publishes graduated premium discount tables for stock and non-stock carriers. The following chart provides a general overview of the approximate premium discounts currently in effect:

<i>Standard Premium</i>	Stock Carrier	Non-Stock Carrier
First \$5,000	0.0%	0.0%
Next \$95,000	10.9%	3.5%
Next \$400,000	12.6%	5.0%
Over \$500,000	14.4%	7.0%

**(d) Small Deductible Plans**

In accordance with Section 50(3-e) of the WC Law, certain deductibles must be offered to all employers whose estimated annual premium at policy inception is \$12,000 or more. In response to this statutory requirement, CIRB filed a small deductible plan with the Department for the Superintendent’s approval. Under the approved small deductible plan, the carrier pays all amounts applicable to each workers’ compensation claim, and the employer then is required to reimburse the carrier up to the agreed upon deductible amount for each occurrence. Deductibles are offered in the amounts of \$100, \$200, \$300, \$400, \$500, \$1,000, \$1,500, \$2,000, \$2,500, and \$5,000. A premium credit is given to those employers that participate in the small deductible plan. The size of the credit depends upon the amount of the chosen deductible and the policyholder’s classification code or hazard group. CIRB currently reviews the actuarial soundness of the hazard groups. The below chart details the amount of the credits that can be obtained through a policyholder’s participation in the small deductible plan:

Deductible	Percentage Premium Reduction By Hazard Group			
	I	II	III	IV
\$100	0.4%	0.3%	0.2%	0.1%
\$200	0.7%	0.5%	0.3%	0.2%
\$300	1.0%	0.7%	0.4%	0.2%
\$400	1.3%	0.8%	0.6%	0.3%

\$500	1.5%	1.0%	0.7%	0.4%
\$1,000	2.7%	1.8%	1.2%	0.7%
\$1,500	3.7%	2.5%	1.7%	0.9%
\$2,000	4.5%	3.1%	2.1%	1.2%
\$2,500	5.3%	3.7%	2.5%	1.4%
\$5,000	8.7%	6.1%	4.3%	2.5%

**(e) New York Construction Classification Premium Adjustment Program**

The New York Construction Classification Premium Adjustment Program (the “NYCCPAP”) provides for a premium credit for up to one year for some employers involved in the construction industry. The NYCCPAP, proposed by CIRB and approved by the Department in 1993, was established to rectify the potential inequity caused by the large disparity between high wage and low wage employers in the construction industry. Under the NYCCPAP, experience rated employers in the construction industry may be eligible to receive a premium discount where their employees earn an average hourly rate of \$15.50 or more in one or more of the construction-related classification codes. Approximately 3,700 construction employers participate in the NYCCPAP and obtain, on average, a fifteen percent discount off the otherwise applicable manual rate.

**(f) New York Construction Employment Payroll Limitation Program**

Another pricing program that affects the construction industry is the Construction Employment Payroll Limitation Program (“CEPLP”). CEPLP came into effect as the result of legislation passed in 1998. Under this pricing program, the cost of workers’ compensation insurance is adjusted through the use of caps on the amount of payroll that can be used to calculate the manual rates. The payroll limitations are tied to three established geographic territories to recognize differences in salaries in different parts of the State. The CEPLP legislation specifically charged CIRB with the responsibility of determining the proper premium adjustments – surcharges or territorial differentials – to apply to specific employers based upon the employer’s location, payroll, and industry wide wage data from the Department of Labor. It is unclear whether CIRB can continue performing this function under the Reform Act.

**(g) Retrospective Rating Plans**

The retrospective rating plan or “RRP” is an optional rating plan that requires the agreement of both the employer and the carrier prior to its application. Under the RRP, a policyholder’s final premium is calculated after the policy expires. The final premium is based on the policyholder’s actual loss experience for that policy period. However, a policyholder’s premium is confined to a pre-established range, regardless of the amount of losses during the policy year. The minimum and maximum limits of the range are agreed upon by the carrier and policyholder at the inception of the policy. Upon expiration of a retrospective policy, the policyholder’s losses and other policy information are used to calculate a “retro” premium. A comparison is then made between the “retro” premium and the premium the policyholder paid at the inception of the policy. The policyholder will owe the carrier additional premium if the “retro” premium is greater than the original premium. If, on the other hand, the “retro” premium is smaller than the original premium, the policyholder is entitled to a refund of the difference.

Retrospective rating is not an appropriate rating plan for a large number of employers. In fact, retrospective rating is only appropriate for those businesses that are willing to invest in risk management programs to lower their losses, have the financial ability to absorb additional cost if losses are worst than expected, and have the ability to reasonably predict losses and loss patterns. It is for these reasons that the RRP is eligible to only those employers with an estimated standard premium of at least \$25,000, in combination with premiums for general liability, commercial auto, hospital professional liability, glass and crime lines of insurance. To be retrospectively rated for three consecutive years, an employer’s estimated premium for three years must be at least \$75,000.

Retrospective rating adds to the level of price competition in the marketplace by allowing carriers to negotiate over the range within which employers will be responsible for losses during the course of a policy year and, in the process, affect the amount of the premium to be charged at the outset of the policy. However, the amount of price competition that results from the ability to price a policy in this fashion is limited, especially given the fact that the number of eligible employers is relatively small.

### **(h) Dividend Plans**

Similar to manual rate deviations, dividend plans are carrier initiated plans (as opposed to those plans filed on behalf of carriers through CIRB) that must be pre-approved by the Superintendent. Carriers have created various types of dividend plans – flat plans, variable plans, retention plans, safety group plans – all of which provide for the possibility of eligible policyholders receiving a portion of the paid premium back from the carrier. The amount received is based upon the actual loss experience of the insured (or insureds in the case of a safety group) versus what the expected loss experience was when the premium was originally calculated by the carrier.<sup>34</sup> Dividend plans, no matter the type, set forth the eligibility criteria upon which an employer may participate in the dividend plan. All employers meeting the eligibility criteria must be offered the option to participate in the plan. In other words, carriers are prohibited from offering dividend plans to a discrete number of policyholders out of a larger group of potential policyholders that meet the requirements of the approved dividend plan.

Dividend plans create a back-end incentive to encourage employers to develop and maintain safe workplaces. The level of competition created through the use of dividend plans is limited for two primary reasons. First, dividend plans do not allow the carriers to compete on price on the “front-end” of the policy. Second, the amount of the dividend, to the extent that it materializes, is almost exclusively the result of the loss experience of the policyholders participating in the dividend plan. In essence, carriers can compete on the possible amount of the dividend but can not guarantee that one, of any size, will actually be paid.

### **(i) Large Deductible Plans**

Large deductible plans are crafted by individual insurance companies and submitted to the Department for approval by the Superintendent. Policies written pursuant to an approved large deductible plan require that the insured pay the first part of a covered loss, up to the level of the deductible. Insureds must pay all losses under the deductible for each claim filed. The size of the deductible is agreed upon at the time the

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<sup>34</sup> Dividend plans are prohibited from guaranteeing the payment of a dividend. Moreover, dividends must be declared by the Board of Directors of the insurance carrier and paid out of earned surplus.

policy is written, and all large deductible plans require that a letter of credit be obtained by the insured in an amount equal to the expected losses under the deductible. All insureds with a standard premium of \$200,000 are authorized to enter into large deductible plans. These independently filed programs are offered to larger employers and typically contain deductible amounts of \$100,000 and higher. The details of these programs are unique to each carrier and are contained in the carrier filings that are submitted to the Department.

#### **(j) Drug Free Workplace Programs**

Individual carriers have developed “drug free workplace” programs that provide, upon approval of the Superintendent, for a reduction in an employer’s premium. The approved drug free workplace programs have the following basic employer eligibility requirements: (1) the employer must have a detailed written substance abuse policy; (2) the employer must provide training to supervisors about the company’s program; (3) the employer must provide its employees with drug and alcohol abuse education; (4) the employer must provide its employees with access to an employee assistance program (“EAP”); and, (5) the employer must institute a system to identify substance abuse through a drug and alcohol testing program.

If an employer implements an approved drug free workplace program offered by its workers’ compensation carrier it can earn a five percent credit against the applicable manual rate. All of the drug free workplace programs currently approved by the Superintendent offer the same premium credit of five percent. Thus, to the extent a carrier has an approved plan to offer its policyholder and the policyholder elects to participate, the policyholder will be limited to a manual rate discount of five percent.

Similar to many of the other rating plans and programs, the drug free workplace program was not created with the goal of increasing price competition. Rather, the program was created with the goal of increasing safety and lowering accident rates in the workplace.

#### **(k) Independent Rating Plans**

In theory, a private carrier could file with the Superintendent an entirely new rating plan that is independent of the manual rates and all other rating plans and programs

that have been submitted by CIRB to the Superintendent. No carrier has ever filed its own Independent Rating Plan with the Department because no single carrier has enough credible data to support such a filing. The lack of any Independent Rating plans illustrates the industries' need for the collection of data on an industry-wide basis.

#### **D. CIRB's Performance as an RSO**

CIRB's overall performance as the State's RSO has been satisfactory with regard to: (1) fundamental actuarial analysis; (2) the calculation of experience modifications and merit rating debits or credits; and (3) yearly classification relativity calculations.

CIRB has failed to meet the Department's performance expectations in the area of benefit scoring and has, at times, given the impression that its filed rate revisions were not entirely the result of objective actuarial analysis.

##### **1. CIRB's Performance with Regard to its Manual Rate Filings**

Each year, as part of its rate filing, CIRB employs a number of actuarial techniques and assumptions to predict expected losses and expenses in the upcoming period. Among the factors that CIRB considers are past incurred losses, past paid losses, loss development rates, macroeconomic conditions, the rate of medical cost inflation and the rate of wage growth.

In its review of CIRB's filings, the Department has not agreed with all of the assumptions that CIRB has made or has taken issue with certain techniques. For example, starting in 2004, the Department insisted that CIRB include the experience of Large Deductible policies in the database it uses to calculate the manual rates.<sup>35</sup> The Department believes that the inclusion of this data provides a more complete picture of system losses. Based on these differences in actuarial opinion, the Department has often refused to approve a requested rate change in whole, but rather directs CIRB to re-file with a different rate.

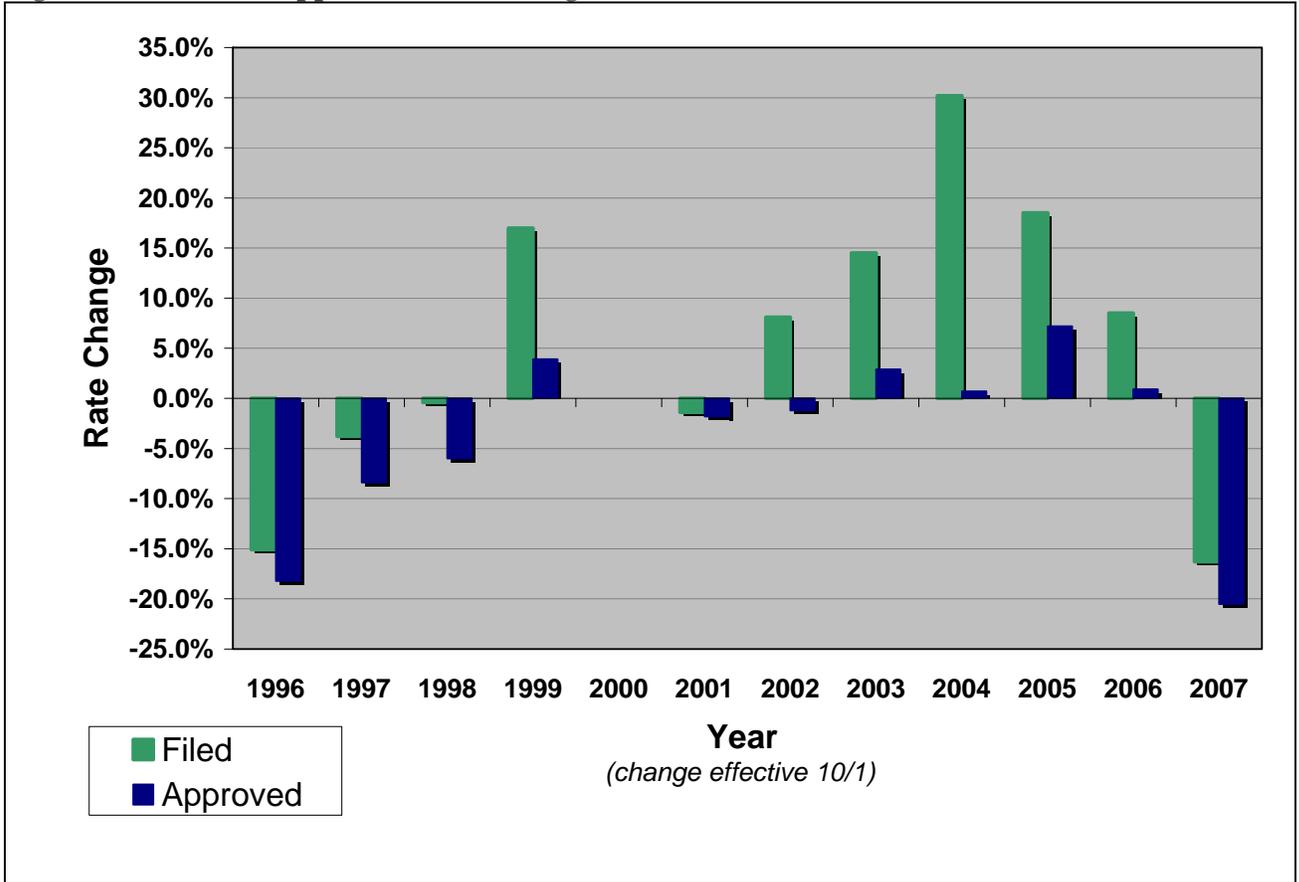
The following chart shows the rate changes that CIRB has requested and those that have been approved by the Department. Clearly, over the past ten years, the

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<sup>35</sup> The inclusion of large deductible plan losses requires that the carriers report losses that may have been borne by employers under the deductible. Large deductible plans can be an effective means to control costs by causing the insured to retain more risk. This will tend to reduce costs under large deductible plans relative to full risk plans.

Department has approved lower rates than CIRB has requested. It is the Department's opinion that these disagreements have, for the most part, resulted from substantive differences in opinion.

**Figure 4: Filed and Approved Rate Changes**



The goal of each rate filing is to provide adequate premium to meet the losses and expenses for claims that arise under the upcoming year's policies. As noted above, the Department targets zero industry-wide underwriting profit when reviewing CIRB's rate filings. Hence, the Department approves rates that result in an expected combined loss and expense ratio of 1.0.<sup>36</sup> This means that every premium dollar that a carrier collects should be paid out in full, either for losses, loss adjustment expenses, or general expenses. If the industry has a combined ratio of less than one for a given year, it means that approved rates generated premiums that were greater than the losses and expenses,

<sup>36</sup> The combined loss and expense ratio = (Losses+Loss Adjustment Expenses+General Expenses)/Standard Premium.

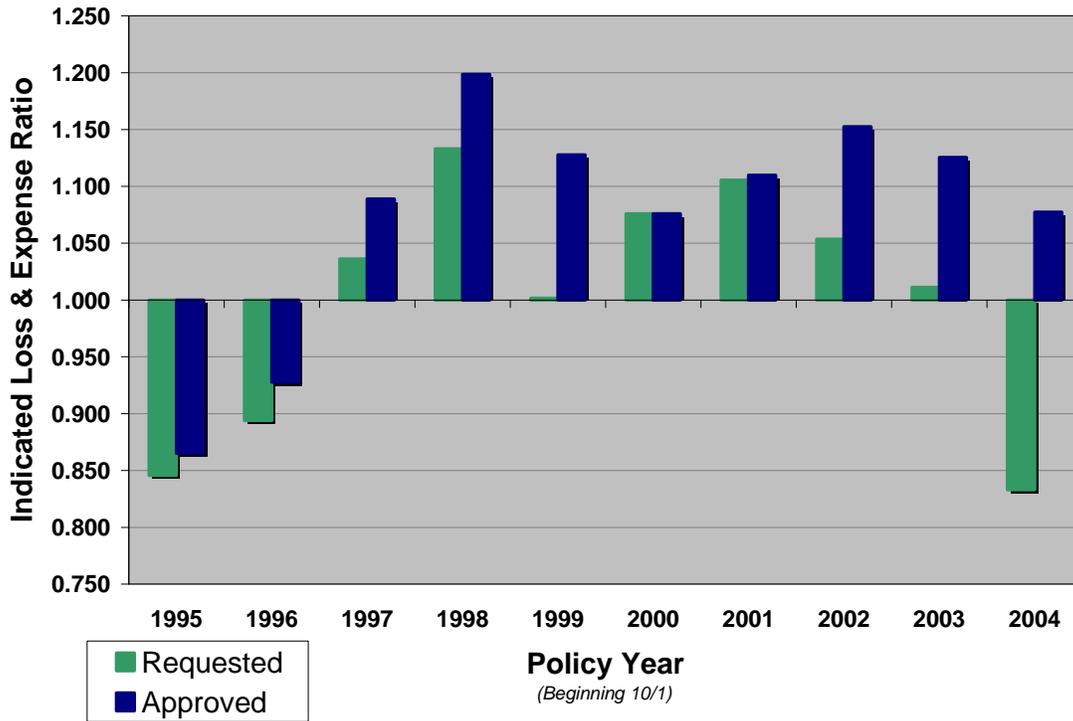
and that carriers earned an underwriting profit during that year. Conversely, a combined ratio of greater than 1.0 implies that the approved rates generated premiums that were less than the incurred losses and expenses. In this instance, it is not generally the case that the industry is unprofitable, because the industry is able to earn investment income on premium dollars that are available to cover slow-developing future losses that have not yet been paid.

One way to evaluate CIRB's rate filing accuracy is to retrospectively evaluate the difference between the actual combined loss and expense ratios and the target of 1.0. It is important to note that no actuarial organization, including CIRB, could be expected to predict future losses and expenses with 100% accuracy. However, if CIRB consistently requested rate changes that would have resulted in combined loss and expense ratios lower than 1.0, its actuarial judgment and impartiality could be called into question. On the other hand, if the Department consistently approved rate changes that resulted in a combined loss and expense ratio of greater than 1.0, it would not be carrying out its obligation under statute to ensure that rates are adequate and not detrimental to the solvency of insurers. The following chart shows indicated loss and expense ratios for policy years 1995-2004 based on the rate changes that CIRB requested and the rate changes that the Department approved. The ratios are calculated using historical data on loss development and premium collected, as observed in the years subsequent to a filing. The "Requested" bars show the combined ratio based on observed losses and the level of premium that would have been collected had the Department approved CIRB's requested rate change. The "Approved" bars, on the other hand, show the combined ratio based on observed losses and the level of premium that was collected based on the Department's approved rate change.<sup>37</sup>

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<sup>37</sup> The data examined do not include the experience of SIF or Large Deductible plans. It is important to note that these charts, too, are subject to actuarial assumptions, namely that: (1) policies are written uniformly over the year, and (2) losses occur uniformly over the year.

**Figure 5: Indicated Loss & Expense Ratios Based on Filed and Approved Rates**



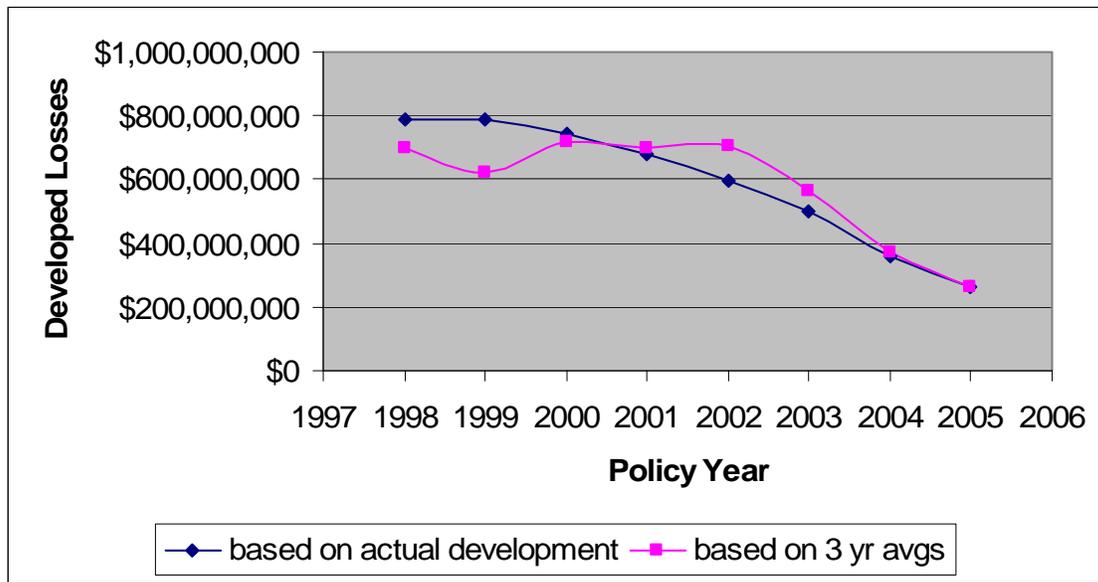
The chart shows that both CIRB’s filed rates and the rates approved by the Department resulted in an underwriting profit in 1995 and 1996, and an underwriting loss between 1997 and 2003. It appears that in certain years the Department’s approved rates kept the combined ratio closer to 1.0 than it would have been based on CIRB’s requests. By the same token, private carriers experienced underwriting losses from 1997 to 2003 and CIRB’s requests for rate increases during that time period were not unreasonable. The low ratio that would have been realized in the policy year beginning October 1, 2004 based on CIRB’s 30.2% rate increase request in 2004 is troubling, but can be explained in part by the fact that the loss experience during that year was surprisingly good compared to the previous few years. In 2006, CIRB requested a rate increase of 7.5%, but the Department rejected the rate filing, which resulted in a 0% change. While complete data is not available for that year, CIRB’s 2007 rate filing indicated a decrease in losses. This is a preliminary indication that CIRB’s 7.5% rate request was unnecessary. The Department believes that in certain years, CIRB has submitted revisions that can be

viewed as starting points for negotiations with the Department as opposed to being solely based upon actuarial calculations.

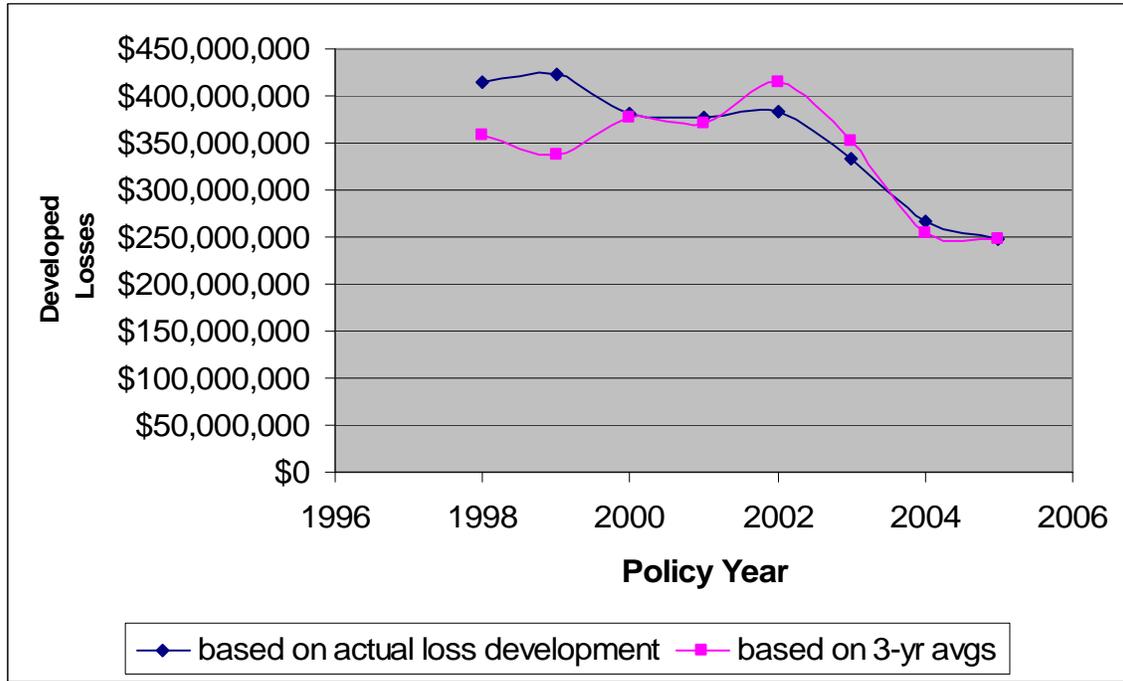
Overall, the chart illustrates the cyclical nature of the insurance market and the difficulty of accurately predicting the exact premium needed to cover losses and expenses. On numerous occasions, both CIRB and the Department have advanced revisions that resulted in combined ratios above and below 1.0. CIRB, for its part, has not systematically filed rates that would have resulted in carrier profit.

Another way to evaluate the actuarial techniques and assumptions that CIRB employs is to examine its calculated loss development factors (“LDFs”). LDFs capture the fact that claims develop over time and that the losses incurred in the first year of a claim’s life will not account for all of the losses ultimately incurred. Typically, ultimate losses are two to three times the losses incurred in the first year. CIRB predicts the upcoming year’s losses by multiplying an average of the most recently available accident year and policy year losses by a three year average of the most recent LDFs. The following two charts show, respectively, the developed medical and indemnity losses that CIRB predicted in its filings based on its three year average LDFs versus the actual developed losses that were observed.

**Figure 6: Developed Indemnity Losses Based on Actual Development vs. CIRB’s Calculated 3 Year Average LDFs**



**Figure 7: Developed Medical Losses Based on Actual Development vs. CIRB's Calculated 3 Year Average LDFs**



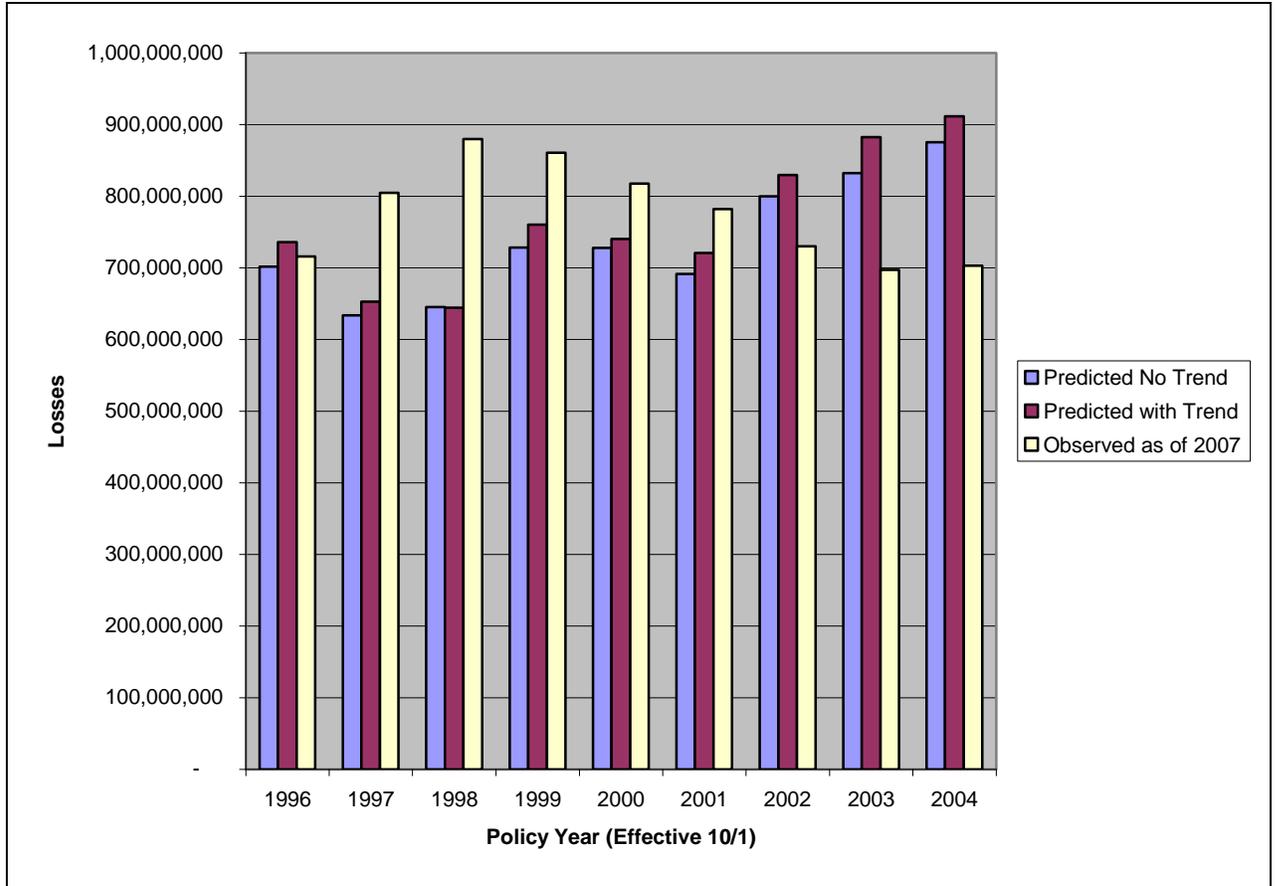
The charts show that CIRB's predicted loss development is very similar to development that ultimately materialized.<sup>38</sup>

A third way to evaluate CIRB's ability to predict losses is to examine the pure medical and indemnity losses that CIRB's rate filing indicated in a given year versus what is observed to have actually happened in that year. In order to calculate the overall rate change indication for a given policy year, CIRB takes the average of the most recently available policy year's and accident year's developed loss data, then applies both a medical and indemnity "trend" factor on top of the developed losses. This trend is meant to account for factors not present historically, such as an increase in the rate of medical inflation. For example, to calculate policy year 2004's indication, CIRB averages developed losses from policy year 2002 and accident year 2003, then applies a calculated trend. The following two charts show CIRB's predicted indemnity and

<sup>38</sup> It is important to note that the later years' "actual" LDF's are only the result of a few years of observed data.

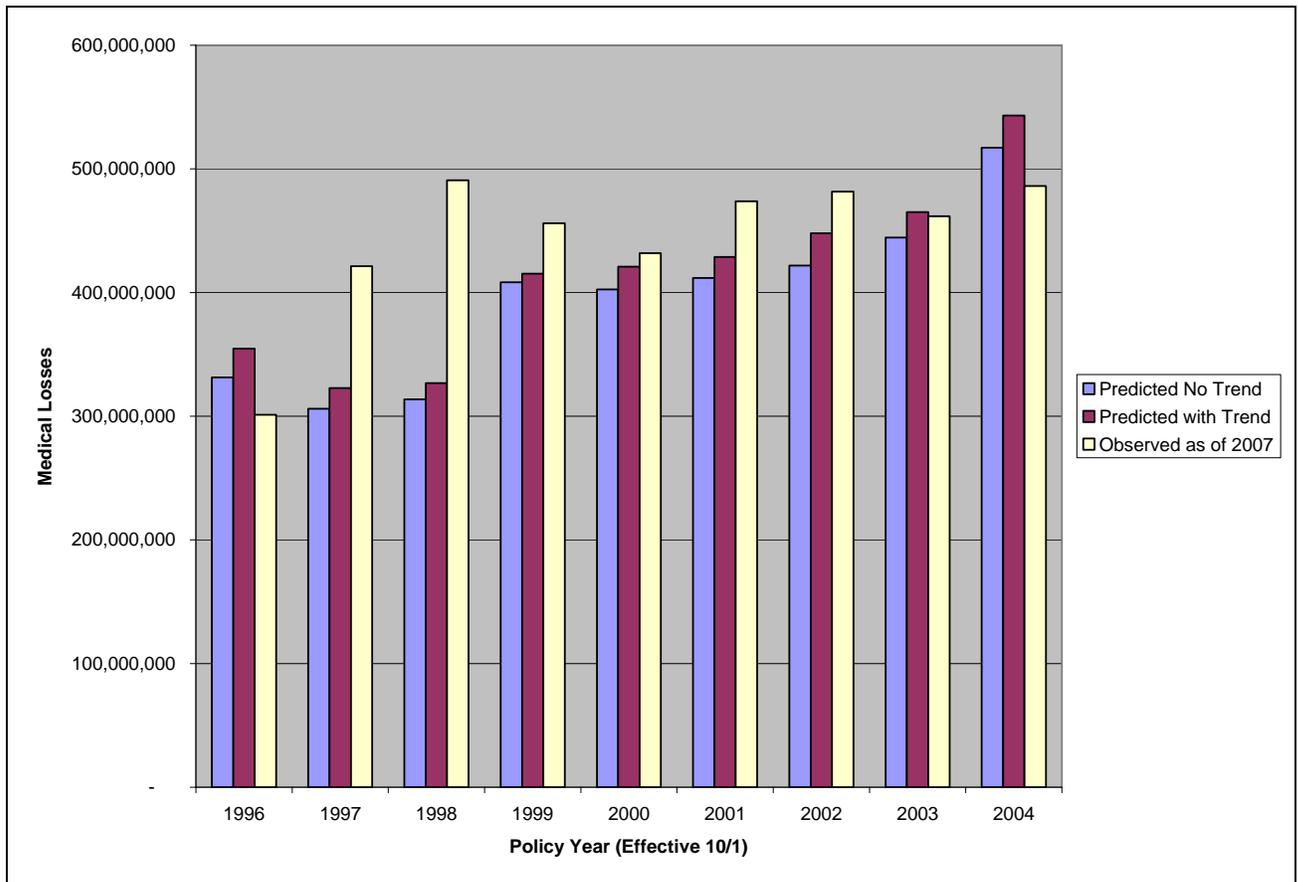
medical losses for policy years 1996 through 2004, both with and without trend, and the indemnity and medical losses that were actually observed during those policy years.<sup>39</sup>

**Figure 8: Predicted versus Observed Indemnity Losses**



<sup>39</sup> The observed losses are calculated using data from CIRB's filings, through 2007. Clearly, more is known about the development of losses in earlier years than in recent years.

**Figure 9: Predicted versus Observed Medical Losses**



These charts show the inevitable lag in predicting losses. Because CIRB, and every actuarial organization, relies upon historical data in its calculations, phenomena observed in recent years will be incorporated into a current rate filing. Since 1999, CIRB's medical loss predictions have been more accurate than its indemnity predictions. This is not surprising in light of the well documented persistent increases in the costs of healthcare in New York and the nation as a whole. In general, the Department has viewed CIRB's indemnity trend estimates with some skepticism. While modest recent increases in average wages tend to increase indemnity payments, changes in the industry mix in New York State have contributed to consistent declines in accident frequency. Based on these charts, it appears had the Department allowed the full indemnity trend factor in recent years, the resulting rate would have tended to exceed actual losses.

Overall, it appears that CIRB has, in most instances, performed adequately in predicting losses. As discussed above, CIRB's data collection system is considered accurate and complete. Since the data form the basis for the loss estimates, it is

reassuring that these estimates have been reasonably accurate. The Department believes that in most years, CIRB's rate filings have been made in good faith; however, the Department notes that there have been occasions over the last twelve years where CIRB's filings could have resulted in excessive rates.

## **2. CIRB's Calculation of Experience and Merit Ratings**

Overall, CIRB's calculations of experience modifications and merit ratings are done in an actuarially sound manner. Moreover, carriers were generally appreciative of the timeliness of CIRB's experience modification calculations. It is important that the modifications and merit rating factors be available before a policy expires, so that insurance carriers can have an accurate picture of the loss history of the employer when it chooses whether to renew the policy or compete for the employer's business.

However, the Department and certain carriers are concerned that, while experience modifications are designed to have an average of 1.0, the average experience modification in New York is actually between 0.80 and 0.90. As a result, the safety programs described above that are "pegged" to a specific experience rating are not implemented as widely as may have been intended, with fewer employers being subject to mandatory programs and fewer eligible for the voluntary programs.

Although experience rating remains a strong safety incentive because unsafe employers still pay proportionately more than safe ones, such a low average experience modification reduces the number of employers subject to safety programs mandated by the legislature. For example, the Compulsory Workplace Safety and Loss Prevention Program is mandatory for employers with experience modifications of 1.2 or greater. Out of the roughly 80,000 experience rated employers in New York, fewer than 3,000 of them have experience modifications of greater than 1.2. In fact, over 66,000 employers have experience modifications of less than 1.0, and only about 13,000 employers have experience modifications of greater than 1.0. This imbalance should be addressed immediately so that the full effects of the safety programs that are triggered by high experience modifications can be implemented to the extent that the legislature intended.

### **3. CIRB's Actuarial Performance with Regard to the Maintenance of Classification Relativities**

As set forth above, each employer that purchases workers' compensation insurance in New York is classified according to the nature of its business, and each classification pays a different average rate per \$100 of payroll. Classification relativities are important to ensure that more dangerous employment bears its fair share of system costs. CIRB uses standard actuarial techniques in calculating the relativities and the Department has found no problems with CIRB's application of the actuarial methods applied.

### **4. CIRB's "Scoring" of Changes in Benefits is Lacking**

CIRB's strengths do not lie in calculating the savings due to benefit changes. In both the 1996 and 2007 reforms, CIRB changed its savings estimates mid-way through the legislative negotiations. This aroused the suspicion of numerous stakeholders that CIRB was intentionally underestimating the rate impact of reform proposals.

In particular, CIRB produced an inaccurate underestimate of the savings under the Reform Act by using an incorrect formula to calculate the costs associated with increased weekly indemnity benefits. The Department believes that this was an honest but basic mistake, which if it had not been caught could have reduced the impact of the reform legislation on premium paid by employers.

Furthermore, during the extensive consultations that CIRB had with the Department before the July, 2007 rate filing, it became apparent that CIRB needed expert help in calculating the effects of benefit changes. CIRB addressed this by hiring an actuarial consulting firm to conduct its own analysis and interact with the Department.

It is clear that scoring benefit changes is not one of CIRB's core competencies. In the future, either CIRB should improve its abilities in this area or the State should look for an alternate body to perform this task.

### **E. Underwriting Services Performed by CIRB**

CIRB performs underwriting services that maintain the employer classification system and ensure that policy forms are accurate. Maintaining a list of over 600 classifications and properly classifying employers is vital to the efficiency of the workers' compensation insurance market. Misclassification of employers can result in

incorrect rates for a particular job category, and can lead to inequitable cross-subsidization among classes to guaranty adequate premium for the industry as a whole.

CIRB reviews classifications on an annual basis to determine whether new classifications need to be created as industries change and safety innovations are introduced, and whether existing classifications should be eliminated because their business operations have become obsolete. CIRB does this through studies of payroll, loss data, and inspection reports. CIRB also looks to the changes NCCI and other rating organizations makes to their classification systems to analyze whether the same changes should be made to New York's classifications.

In order to ensure that employers are properly classified, CIRB conducts thousands of inspections per year and reclassifies those businesses it finds to be misclassified. Scheduled Routine Inspections are conducted for experience rated employers, while Test Inspections are conducted at random for non-experience rated (smaller) employers. In 2006, approximately fourteen percent of both Routine and Test Inspections resulted in class changes for employers. This is roughly in line with the percentage of class changes that result from NCCI's routine inspections.<sup>40</sup>

CIRB also reviews all policies written in New York for accuracy. It ensures that the policy is properly written and contains the correct classification code, experience modification or merit rating factor, and rate for the employer. The vast majority of these policies are received electronically, and CIRB staff members manually enter those received in hard copy into CIRB's database. Once in electronic form, each policy is put through a number of automated edits to ensure accuracy and completeness. If a policy fails the edit process, it is reviewed by CIRB staff and the carrier is notified if a mistake is discovered. Out of over 500,000 policies received by CIRB in 2006, 136,685 required manual review. CIRB fines carriers both for submitting hard copies of policies and for submitting policies with errors. CIRB collected \$181,083 in fines for hard copies and \$213,000 in fines for errors in policies. The fines for policy errors are part of CIRB's "Criticism Fine" program, which has been implemented over the last two to three years.<sup>41</sup>

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<sup>40</sup> Interview with NCCI representatives on 8/7/2007.

<sup>41</sup> Unpublished Communications from CIRB.

CIRB's Field Services Department performs physical inspections and conducts audits of randomly selected employers for the Premium Verification Program. In the audit process, an inspector can request a physical audit and review payroll, premiums charged, classification of the employer, and a number of other factors that are required to verify correct policies. CIRB conducted roughly 2,000 physical audits in 2006, and 37.2% of the employers audited required an adjustment to their premium. In 2005, CIRB found that the corrected premium was on average 3.0% higher than premium charged by the carriers. On the other hand, in 2006 CIRB found that corrected the premium was 2.2% lower than the premium charged by the carriers.<sup>42</sup>

#### **F. Evaluation of the Underwriting Services Performed By CIRB**

CIRB has performed well in maintaining classifications and addressing employer classification concerns. CIRB has been sensitive to New York's unique mix of jobs and industries by creating a number of New York-specific classifications that do not exist elsewhere in the country. However, some insurance carriers remarked that CIRB should maintain classifications more closely aligned with NCCI's classifications to allow for interstate efficiencies. This would be especially useful for national employers with similar operations in several states.

CIRB's policy analysis is an important way to ensure that employers pay correct premium. CIRB's Criticism Fine program, which fines for errors in policies submitted by insurance carriers, is a good step towards ensuring that employers are charged correct premium. This program should continue to be developed as a part of the policy analysis program.

While CIRB conducts thousands of Routine and Test Inspections per year, the Department is concerned about the low number – fewer than 2,000 – of full premium verification audits that CIRB performs, especially given the fact that 37% of audits in 2006 resulted in an adjustment to the policyholder's premium. This high adjustment rate implies that both carriers and CIRB should do more to ensure that an employer is being charged the correct amount of premium. It also may point to market conduct issues that should be reported to the Department. Although CIRB's corrected premium

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<sup>42</sup> New York Compensation Insurance Rating Board 2006 Annual Report.

determinations averaged only 2.2% lower than what the carriers had calculated in 2006, this amounts to tens of millions of dollars when applied to the entire system. It is important to note, however, that CIRB has little control or influence over whether and how an insurance carrier audits the employers it insures. In this regard, CIRB may benefit from added Department involvement in its enforcement activities.

**G. Overall Evaluation of CIRB's Data Collection and Underwriting Services**

Although there are areas that could be improved, namely the rigor of data collection and number of audits performed each year, CIRB has performed the tasks detailed above in an efficient and reliable manner. The Department believes that CIRB has performed these necessary functions for the workers' compensation insurance industry well, taken the responsibilities delegated to it by statute and regulation seriously, and has strived to be responsive to both the carrier community and the Department.

**V. RECOMMENDATIONS CONCERNING CHANGING THE RATE-MAKING APPROACH**

While the Department is persuaded that CIRB is an effective data gathering organization, CIRB's rate filings have been uneven at times and the subject of frequent criticism by the Department and stakeholders. For this, and other key reasons, a change to the current rate-making process is both warranted and feasible.

**A. Key Reasons Supporting the Need to Change New York's Approach to Rate-Making**

New York's administered pricing approach to rate-making should be changed for several key reasons. First, the current administered pricing precludes sufficient price competition, which the Department believes will benefit employers through lower premiums. While most existing rating programs modify the rates for certain employers based on specific loss histories and risk characteristics, they do not provide real avenues for premium price competition among private insurance carriers and between private insurance carriers and SIF. This is because all discounts, credits and plan designs are determined by statute or subject to approval by the Superintendent. While an employer can receive a discount off of its base manual rate for good experience or by adopting

safety programs, the same discount will be offered by every carrier.<sup>43</sup> Only a select few of the rating plans and pricing programs inject price competition into the workers' compensation insurance market, most notably, the Large Risk Rating Option and manual rate deviations.

The Large Risk Rating Option ("LRRO") allows premium to be negotiated between insurance carriers and large employers. This reflects the Department's determination that very large employers are in a good position to negotiate their own rates. The LRRO is available to all employers with a standard premium in excess of \$500,000 for workers' compensation insurance or in combination with premiums for general liability, commercial auto, hospital professional liability, glass and crime lines of insurance. Although the LRRO provides a significant amount of price competition, it is only available to a small group of very large employers.

New York State law also authorizes individual private insurance carriers to deviate from the approved manual rates by a fixed percentage, provided certain criteria are met. To deviate from the manual rates, a private carrier must submit a rate deviation filing to the Department for the Superintendent's approval. The filing must contain data showing that the proposed deviation from the manual rates is supported by the individual carrier's expenses or the actual losses of its own book of business. If the carrier's expenses or its policyholders' loss experience justifies a lower premium, the carrier's application for a deviation will be approved by the Superintendent, and the "deviated company" will be authorized to price all of its policies at that approved deviated rate.<sup>44</sup> A private insurance carrier must have one deviated rate that must be applied uniformly to all workers' compensation policyholders of that insurer, regardless of classification code. In other words, each and every employer that is insured by a carrier with an approved ten percent downward deviation will receive a ten percent discount off of the manual rate for

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<sup>43</sup> The rating plans and pricing programs that clearly fall into this category include Experience Rating, Merit Rating, Premium Discount by Size of Policy Program, Small deductible plan, NYCCPAP, CEPLP, Compulsory Workplace Safety and Loss Prevention program, Drug free workplace programs, and Voluntary Safety, Drug and Alcohol Prevention, and Return to Work Programs.

<sup>44</sup> Beginning in 1995, the Department also began approving "competitive deviations," which allow the support for a deviation to be based on market competition factors. However, carriers need to file actuarial data justifying the deviation on a going forward basis.

its classification, subject to the application of the employer's experience modification. Current regulations do not allow for deviations that vary by classification code.

This competitive regime has led many insurance carriers to operate two or three subsidiaries within New York State, most of which also offer many other lines of insurance, in addition to workers' compensation. Insurance carriers maintain multiple subsidiaries with approved deviations in an effort to offer their underwriters a menu of possible percentage deviations within the corporate group. As of February 1, 2007 there were approximately 112 currently active companies with approved deviated rates. The Department has, with very few exceptions, only allowed minus 5%, minus 10%, and minus 15% deviations. Only approximately 35 companies currently have minus 15% deviations, approximately 50 companies have 10% deviations, and approximately 15 companies have 5% deviations approved.

Manual rate deviations inject a limited amount of price competition into the workers' compensation market by providing individual carriers with the ability to price risk somewhat differently at a policy's inception. One private carrier might be able to offer an employer a ten percent discount off the applicable manual rate by issuing the policy through its ten percent "deviated company." Another private carrier may only be willing to offer a five percent discount off the manual rate. Nevertheless, competition through the use of "deviated companies" is limited by the fact that New York has approved (with very few exceptions) only a few deviated rates, and that no upward deviations have been approved. Thus, private insurance carriers are not permitted to deviate down from the manual rate more than fifteen percent, and, in any event, can only offer a few discount options. Allowing deviations from the manual rate is, at best, a limited method for promoting price competition within the workers' compensation insurance market.

A new rate-making approach should be instituted that permits more price competition while still guarding against irresponsible underwriting. This should result in reduced premiums and more affordable workers' compensation insurance throughout the State.

The second reason to abandon administered rating is to gain more transparency and simplicity in the rate-making approach. Manual rates are set through a highly

complex and somewhat opaque process. Because the rates are recommended by a committee of insurers, an appearance of collusion inevitably results and can undermine the legitimacy of the rate-making process. In fact, the lack of transparency in the process has created the suspicion that the manual rates are not the product of sound actuarial analysis. A new approach to rate-making should be implemented that increases the level of transparency and decreases the level of suspicion that the rates charged by private insurance carriers are not the result of sound actuarial judgment.

Third, the current rate-making approach tends to (1) protect some inefficient insurance carriers from competition with more efficient competitors, and (2) lead to potentially super-competitive profits for efficient insurance carriers. This occurs because the manual rate calculation includes an industry-wide average expense load factor. This leads to the approval of manual rates that insulate inefficient carriers, whose expenses are higher than the industry average, from having to become more efficient. On the other hand, the more efficient carriers may be able to earn a “profit” from the manual rates because their level of overhead is below the average expense incorporated into the manual rates. A new approach to rate-making should be instituted that both compels carriers to become more efficient and prevents the most efficient carriers from receiving any windfalls.

Fourth, the Department currently does not approve filings by private insurance carriers for deviations above the manual rates. This pricing restriction prevents private insurance carriers from underwriting risks that are not adequately covered by the risk’s applicable manual rate. The Department believes that allowing more competition for high risk employers will lead to a healthier workers’ compensation insurance market in New York.

Finally, as mentioned above, CIRB’s rate filings are currently made on behalf of all workers’ compensation insurance carriers and have occasionally been viewed as a starting point for collective negotiations with the Department. A new rate-making process where individual carriers file their own rates with the Department should be implemented to eliminate the potential for a coordinated effort to elevate rates above a pure actuarial indication.

## **B. New York Should Adopt a Loss Cost Approach to Rate-Making**

New York should replace its current administered approach to rate-making with a system based upon loss costs and carrier-specific loss cost multipliers. Since 1980, the overwhelming majority of states have moved to loss cost approaches for setting rates for workers' compensation. Approximately thirty-six states currently base rate-making on loss costs, while only eight operate under an administered-pricing approach.<sup>45</sup>

Under a loss cost approach, a DCO or an RSO collects much of the same data currently being collected by CIRB for the purpose of calculating the expected loss costs for each employer classification. The expected loss costs are then presented to the regulatory authority for approval or publication. It is then incumbent upon individual private insurance carriers to file what are referred to as Loss Cost Multipliers ("LCMs"). LCMs are multipliers that reflect a private insurance carrier's own loss experience as well as its own expenses.

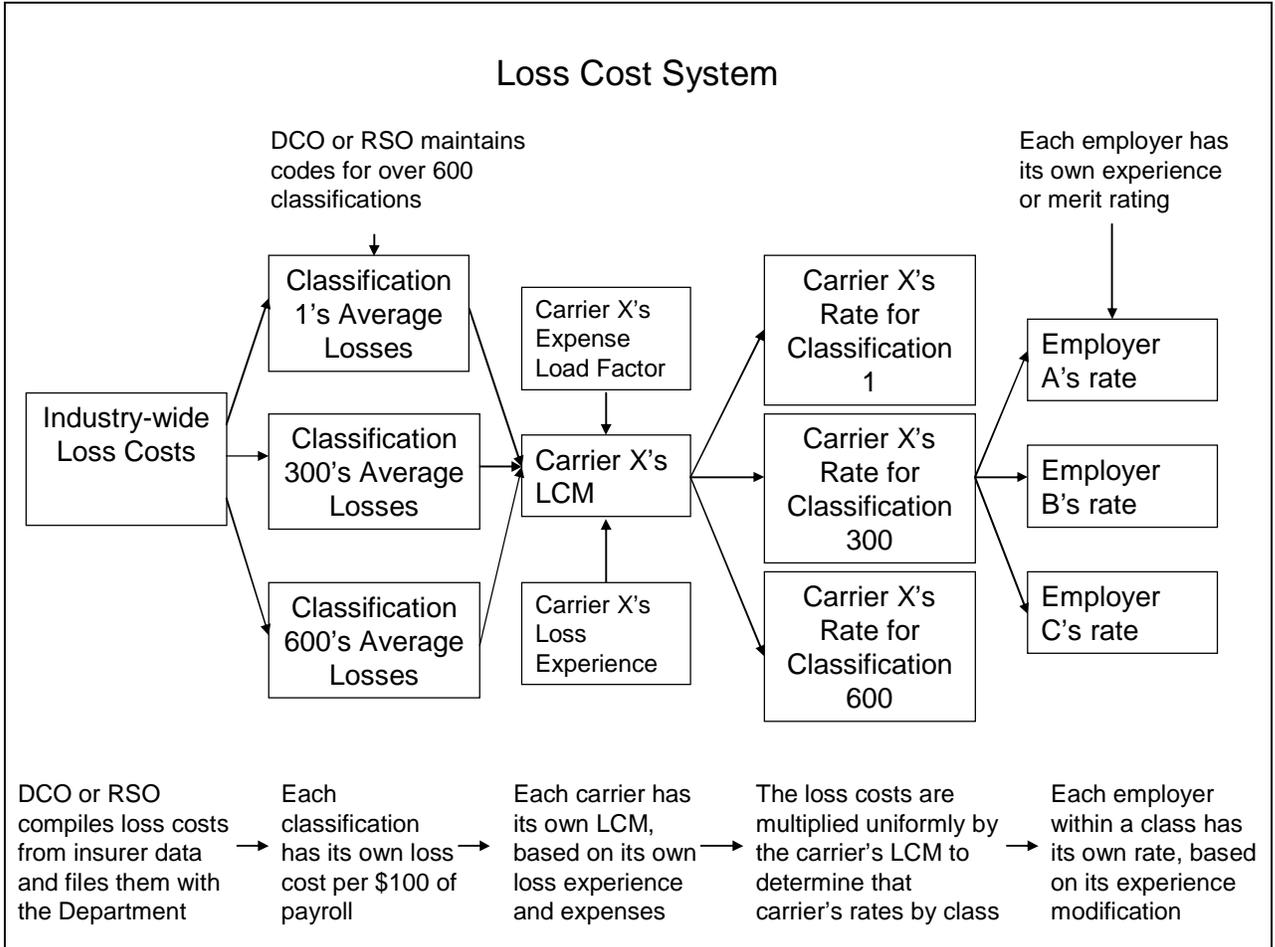
Private insurance carriers can establish multiple subsidiaries or member companies with different LCMs, which will give them the flexibility to write policies at different pricing points, depending upon the risks. In CIRB's 2007 rate filing, losses are roughly seventy-five percent of the manual rate, while expenses are roughly twenty-five percent. Under a loss cost system, a carrier that has loss experience that is ten percent better than average and expenses ten percent lower than average would file an LCM that results in rates that are ten percent lower than what the manual rates would have been. An insurance carrier could offer its good risks policies from this subsidiary company, which provides a percent discount off of what would have been the industry-wide manual rate in an administered pricing system. On the other hand, a private insurance carrier could establish a subsidiary carrier that writes for worse than average risks. In this case, the carrier could file a significantly higher LCM. This LCM would permit that carrier to deviate above what would have been the manual rate – allowing it to issue a policy to an employer that it believes poses a higher than average risk within the applicable classification code. Under this system, employers are still subject to experience and merit rating, in much the same way as under an administered pricing approach. The

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<sup>45</sup> States that operate under an administered-pricing approach are: Arizona, Florida, Idaho, Iowa, Massachusetts, New Jersey, New York, and Wisconsin.

following diagram illustrates the basic components of a loss cost approach to rate-making:

**Figure 10: The Loss Cost Approach to Rate-Making**



Numerous benefits should flow from a shift to a loss cost rate-making approach. First, a loss cost system will provide more price competition by insurance carriers for an employer's business through the availability of multiple companies authorized to offer policies at reduced rates. At the same time, by maintaining and making available the loss costs by classification, the system will not create any barriers to entry to the workers' compensation market. Second, having private insurance carriers file their own Expense Data eliminates the situation described above where more efficient carriers receive a windfall because of an industry-wide expense load factor in the administered rates. Third, less efficient carriers will need to become more efficient if they want to remain

competitive. Fourth, a loss cost system will be much more transparent than an administered rate system. Fifth, the loss cost approach reduces the potential for, or appearance of, collusion amongst insurers in the rate-setting process. Sixth, allowing a range of loss cost multipliers that are both higher and lower than what the manual rates would have been should increase competition between private insurance carriers and SIF, which is currently the only carrier allowed this kind of pricing freedom.

Finally, it is the Department's belief that the competition for good risks will intensify under a loss cost system. This increased competition which will encourage employers to undertake safety improvements to qualify for low rates.

While more competition will be injected into New York's workers' compensation insurance marketplace with a move to loss costs, the Department will remain in a strong position to monitor and approve the rates being charged by the private insurance carriers. Both industry-wide loss costs and individual carrier LCMs will be subject to the appropriate level of scrutiny by the Department. Moreover, the Department plans to maintain prior approval over all filings and to increase testing for solvency during the transition to loss costs to guard against irresponsible or predatory rate filings on the part of the insurance carriers. The Department will also remain in a position to monitor the integrity of the financial data provided by insurance carriers to support their rates and will monitor the statistical data collected and used by the DCO or RSO to develop loss costs, classification relativities, and experience modifications.

## **VI. RECOMMENDATIONS CONCERNING DATA COLLECTION AND OTHER STATUTORY FUNCTIONS**

An organization – whether a statistical agent assisting the Department, or an RSO acting on behalf of carriers – must be authorized to collect and analyze industry-wide workers' compensation data. The absence of accurate industry-wide claims data will lead to a disastrous situation for workers' compensation insurance carriers, SIF, and employers. The lack of an organization that collects and examines Aggregate Financial, Unit Stat, and Expense Data will have significant negative effects on insurance company solvency, insurance availability, and competition. Foreclosing the ability of an entity to collect industry-wide data and to calculate loss costs, classification relativities, and experience modifications would be an unprecedented move in the wrong direction and

isolate the New York workers' compensation insurance market from the rest of the country. Currently, all states require this type of information, and a healthy, stable and efficient New York workers' compensation insurance market requires it. Under such a system, all but a small group of very large, national carriers will lose the ability to accurately price risk. Thus, an insurance carrier trying to compete for business in the market without a credible actuarial basis to price a policy may do one of two things, misjudge the risk and price too low, leading to an inadequate premium to cover losses, or price too high, in recognition of the uncertainty of the risk. In essence, carriers will be pricing "blind" to the true cost potential of a risk. There will be a significantly higher probability that one or more carriers will price their policies in such a way as to drive themselves into insolvency.

SIF and most, if not all, private carriers will find it impossible to calculate the complete set of classification relativities and experience modifications. There are over 600 classification codes in New York State, and without detailed claims data on a large number of employers within every class, there is no way to reliably compare classes against one another or employers within classes against their peers. Currently, over 200 insurance companies write workers' compensation insurance in New York. Many of the smaller companies play an important role in the system by targeting small employers or specializing in a specific class or region not served by larger insurers. If these companies do not have access to the types of classification relativities and experience modifications currently provided by CIRB, they will almost certainly be forced to stop writing workers' compensation insurance in New York State. The result will be a decrease in competition as large insurance companies buy smaller companies' books of business and increase their market share.

In addition, only carriers that write a critical mass of policies — those with a large percentage of market share — may be able to accurately price risk, and even then only in the classifications in which they write a sufficient amount of policies. Private insurance carriers of all sizes will exit the New York market because they would rather stop writing insurance than be in a position of writing policies based upon inadequate data. Employers may find it increasingly difficult to obtain workers' compensation insurance

from private carriers, and some employers throughout the State may face higher premiums.

Finally, the lack of experience modifications will preclude the implementation of safety programs mandated by statute that are triggered by high experience modifications. The absence of experience rating will also eliminate one of the most effective economic incentives for employers to improve safety.

**A. Recommendation that the Statute Be Amended to Allow for RSOs and Data Exchange**

Based on the market disruptions that will arise without centralized data collection and analysis, the Insurance Law should be amended to authorize workers' compensation RSOs to collect data from insurers in the workers' compensation insurance market and file statistical information, loss costs, and related data with the Department. Although administered rate-making through a centralized body may serve to limit competition, data gathering by an industry association within reasonable limits has a well-established pro-competitive impact.<sup>46</sup> The move to a loss cost system will remove centralized, collaborative rate-making and will inject competition into the workers' compensation insurance market. The proposed restructuring of CIRB, as described below, will address any remaining concerns regarding collusive behavior.

**B. Entities that Could Serve as New York's Rate Service Organization**

The Department considered other entities that could collect and analyze Unit Stat, Aggregate Financial, and Expense Data from insurance carriers and SIF, and calculate experience modifications, classification relativities, and loss costs. The two organizations, other than CIRB, that could provide the necessary data collection and underwriting services are the Department and NCCI.

**1. The Department Collects and Analyzes Industry Wide Claims Data and Publishes Rates**

One of the options considered was to have the Department perform CIRB's current functions. The Department is already responsible for regulating the industry and receives yearly financial filings from all insurance carriers. In addition, under the

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<sup>46</sup> *Antitrust Guidelines for Collaborations Among Competitors*. Federal Trade Commission and the U.S. Department of Justice. April 2000.

Department's recommended rate-making approach, the Department will be responsible for reviewing all of the LCM filings made by individual insurance carriers. However, numerous practical and substantive reasons counsel against bringing the industry data gathering and analysis functions into the Department, especially in the short term.

As a practical matter, it would be nearly impossible for the Department to put in place the required technological and personnel resources necessary to perform CIRB's functions by the February 1, 2008 legislative sunset for CIRB and other RSOs in workers' compensation insurance. CIRB employs approximately 140 people, has an operating budget of \$11 million per year, and has been functioning as New York's RSO for over 90 years. The Department cannot develop the necessary data systems or expertise in the short amount of time before CIRB's role as New York's RSO sunsets.

A number of insurance carriers and career professionals within the Department voiced serious concerns over the Department performing the data collection and analysis functions currently performed by CIRB. In their view, having the Department collect and analyze data for the purpose of publishing loss costs removes appropriate checks and balances from the system. In addition, many of the insurance carriers were concerned that the levels of efficiency and responsiveness would be reduced if the Department, rather than CIRB, were to perform the data collection, analysis, and experience and merit rating functions.

## **2. NCCI as the Licensed New York's RSO**

Although the Department is impressed with its services and its professionalism, both the Department and a number of insurance carriers have reservations about transferring CIRB's duties to NCCI, which acts as an RSO or DCO in thirty-nine states.

NCCI provides classification relativities, experience modifications, loss costs, and in certain states, advisory or manual rates. NCCI also plays an important role in determining rates for multi-state employers. While CIRB collects Unit Stat Data for New York State based employers, NCCI collects that information on a multi-state basis and compiles all of the various states' information into experience modifications for large nationwide companies. In these respects, NCCI already collects and processes the same types of data as CIRB. Indeed, most carriers that submit data to NCCI also submit New

York State data, which is used to calculate experience modifications for national employers.

The amendment to the Insurance Law barring “exchanges of data” and filing of rates by RSOs would be applicable to NCCI. Absent a statutory amendment, NCCI will not be an available option as of February 1, 2008. In any event, the Department does not consider NCCI a preferred option.

In the short term, it would be difficult to make an orderly transition from CIRB to NCCI by February 1, 2008. CIRB has over 90 years of expertise in New York’s workers’ compensation market and the specific data and data collection systems needed to keep New York’s market running smoothly. Because rate revisions and calculations of loss costs require many years of historical data, much of the data already collected by CIRB would need to either be collected again or transferred to NCCI. Given the time constraints, CIRB’s expertise, and CIRB’s satisfactory performance as an RSO, the Department does not believe that NCCI can more appropriately perform CIRB’s duties at this time.<sup>47</sup>

### **3. A Restructured CIRB as New York’s RSO**

In the short term, a restructured CIRB is the best, and indeed only, available resource to collect and analyze industry-wide data for the submission of loss costs to the Department under the new rate-making approach described above. Despite its shortcomings in recent rate revisions, the Department believes that CIRB can continue to effectively respond to the specific needs of the New York workers’ compensation system.

Both large multi-state and small regional carriers are currently able to sit on CIRB’s Governing and Rates Committees. SIF also has a permanent seat on these committees, and representatives from organized labor and employers have permanent seats on the Rates Committee. A switch away from a New York-specific RSO, assuming legislative authority to have an RSO in workers’ compensation, could preclude both the SIF and many small carriers from playing an active role in the governance of New York’s RSO, as they would be competing with carriers from other states for these positions. In

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<sup>47</sup> It is important to note that there are numerous statutory programs that reference the functions of a lawful workers’ compensation rating board. As described in section (C) below, prior to the Reform Act, the legislation specifically referred to CIRB, a New York based not-for-profit company. In order to transfer these functions to NCCI, the Legislature would have to name NCCI, a for-profit corporation headquartered in Boca Raton, Florida, in these statutory provisions.

addition, New York labor and business interests may lose their voices. It is perhaps for these reasons that many large states – including California, Pennsylvania, Massachusetts, and Wisconsin – have chosen to maintain their own single-state RSOs.

If the law is amended to allow for the continued operation of an RSO in the workers' compensation market, significant changes to CIRB's corporate governance structure and increased oversight by the Department will be required. Changes to CIRB's governance structure should be made to ensure that it is truly an independent rating board that represents the best interests of the employers of New York State, injured workers, insurance carriers, and the Department.

CIRB's Governing Committee is currently comprised of private insurance carriers and SIF. The Department recommends that this structure be altered to allow for significantly more Departmental participation and public input. Representatives from organized labor and New York State employers, the Department, and an independent member who is an associate or fellow of the Casualty Actuary Society should have permanent seats on the committee. These additional members and the permanent representative from SIF should constitute a majority of the Governing Committee. In order to further establish the credibility of the new structure, the Superintendent or another independent individual should be the chair of the Governing Committee. This same broader representation should also be instituted for the Actuarial Committee. Funding for CIRB would continue to be provided by the private insurance carriers and SIF, and CIRB would file loss costs to the Department, over which the Department will have prior approval. This corporate restructuring would be coupled with new Department regulations establishing a loss cost rate-making approach. These changes will ensure that rates in New York State are competitive.

Moreover, the changes in CIRB's governance and the more active role of the Department in the data collection will limit the potential for collusion among the private carriers. With the increase in Departmental oversight, the Superintendent will be in a position to guide the agenda and overall policy of CIRB to be consistent with the interests of the insurance carriers, employers, labor, and the public. Thus, CIRB should continue to collect the required industry data as an RSO and file statistical information, loss costs, and related data with the Department. This will also allow CIRB to continue to maintain

classifications, calculate experience modifications, and perform other necessary underwriting services that enable the market to function efficiently.

**C. Recommendation to Address the Absence of a Rating Board from Other Statutory Provisions After February 1, 2008**

There are several other negative ramifications that will flow from the lack of a lawful replacement for CIRB after February 1, 2008. The workers' compensation system is infused with statutorily mandated programs, funding mechanisms, and legal requirements that are currently linked to CIRB. After February 1, 2008, all of CIRB's statutorily mandated duties are to be carried out by a "Workers' Compensation Rating Board" as is designated by law. Should no such entity be designated, many workers' compensation programs will no longer function.

For example, Section 50(3-e) of the WC Law mandated that CIRB develop discounts on small deductible plans that are offered to employers whose estimated annual premium at policy inception is \$12,000 or more. CIRB currently maintains the hazard groups and classifications that determine the size of the policyholder's credit. Another example is the CEPLP. Under this program, the cost of workers' compensation insurance is adjusted by capping insured payroll. The caps result in significant savings for construction employers in high payroll territories. The CEPLP legislation specifically charged CIRB with the responsibility of determining the proper premium adjustments.

In addition, until February 1, 2008, CIRB is charged with calculating assessments for the Special Disability Fund, the Reopened Cases Fund, and part of the operating budget for the Workers' Compensation Board. The statutorily imposed pricing restrictions on SIF will also be affected by the sunset of the provisions containing CIRB. Pursuant to Section 2339(d) of the Insurance Law, SIF is precluded from charging an employer any rate in excess of the rate promulgated by CIRB which "does not constitute a fair and reasonable differential charge giving due regard to the nature and hazards of his business or operations."<sup>48</sup>

After February 1, 2008, there is no practical way that these essential functions can be accomplished without legislation. A workable legislative solution would be to allow

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<sup>48</sup> Numerous other examples exist that raise the same or similar issues, including the NYCCPAP and the Safety Investment Program under Section 135 of the WC Law.

the Superintendent to designate the entity that would serve as the Workers' Compensation Rating Board. By designating CIRB in the short term, the Department would enable these functions to continue without interruption. Over the long term, the Department and policymakers would retain the ability to continually evaluate the performance of the designated entity, and make any changes that are warranted.

**D. The Retention of a Data Collection Organization to Assist the Department with the Promulgation of Loss Costs**

In the event RSOs are not permitted for workers' compensation, the Department is exploring the possibility of retaining CIRB as a DCO to perform the needed data collection and analysis functions. Again, this should be done to avoid the market upheaval that would result from the absence of industry-wide loss cost data. As a DCO, CIRB will not file statistical information with the Department. Rather, the Department will bring CIRB directly under its supervision as an outside service provider. The Department will mandate by regulation that carriers regularly report Aggregate Financial, Unit Stat, and Expense Data to CIRB, and CIRB will then analyze that data. The difference between this proposal and the recommendation that CIRB continue to act as the RSO is that it will be acting *on the behalf of the Department* and not on behalf of the insurance carriers. Private insurance carriers and SIF will continue to fund CIRB's activities through assessments by the Department.

While it may be possible to develop a workable solution based upon retaining CIRB as its DCO, this solution is less desirable than an amendment to the Insurance Law, which would allow CIRB to continue operating as the State's licensed RSO in the workers' compensation market. The drawbacks to retaining CIRB as the State's statistical agent are: (1) insurance carriers are concerned that the use of a DCO by the Department to collect and analyze data in order to promulgate loss costs creates a potential conflict of interest; (2) the Department is concerned that the DCO approach would require the devotion of considerable existing Department resources; and, (3) the retention of a vendor to perform these actuarial tasks may expose the State to litigation.

## **VII. CONCLUSION**

Data collection and analysis are vital to the health of New York's workers' compensation insurance market. Without an organization to calculate loss costs, classification relativities, and experience modifications, tremendous market upheaval will occur. As such, the Legislature should amend Article 23 of the Insurance Law to allow the use of an RSO and the exchange of data in workers' compensation insurance. A re-authorization of RSOs in workers' compensation insurance will be coupled with a significant change to the rate-making process and a re-structuring of CIRB's corporate governance. Additionally, CIRB's authority to perform other statutory functions should be preserved in the short term so that numerous pricing plans and programs and assessment calculations continue without interruption. To achieve this, the Department should be allowed to designate the entity that would serve as the Workers' Compensation Rating Board.

The Department recommends a change in the rate-making system from an administered pricing approach to a loss cost approach. This will inject transparency and competition into the market by allowing carriers to file their own LCMs, rather than relying upon the manual rates currently submitted by CIRB.

Given that CIRB has performed many of its functions satisfactorily and that no other entity could more appropriately perform CIRB's duties in the short term, CIRB should continue to be New York's workers' compensation RSO. However, in order to ensure that CIRB's data collection and actuarial processes are both of the highest quality and transparent to the public, CIRB's Governing Committee needs to be significantly restructured. In the long term, the Department will continue to examine how CIRB performs its duties and whether an orderly transition of CIRB's duties either to another independent RSO or to the Department or another government entity is warranted.