



ANALYSIS OF PROPOSED BILLS TO REFORM THE WORKERS COMPENSATION SYSTEM

Part O of Senate Bill 2605 / Assembly 3005, which is part of the proposed budget bill introduced by Governor Cuomo proposes to reform several elements of the workers compensation system. Subsequently, the Senate introduced S2605C which is similar to the original bill, and the assembly introduced A3005C which has several sections either omitted, added, or revised from the original Governor’s budget bill.

Please note, that the New York Compensation Insurance Rating Board (NYCIRB) takes no position in favor or against any section of the proposed bills. It is the responsibility of the NYCIRB to analyze and comment on the possible cost impacts of the bill.

The NYCIRB estimates that Part O of the original Governor’s Budget Bill (S2605/A3005), will result in an increase of between 4.4% and 5.3% in future workers compensation loss costs. In addition, the NYCIRB estimates that the closure of the Reopened Case Fund will result in an unfunded liability for private carriers and the State Insurance Fund of between \$1.1 Billion and \$1.6 Billion. The increase in loss costs, however, will be largely offset by a reduced Reopened Case Fund assessment. Combined with the anticipated long term savings from the elimination of the Aggregate Trust Fund, which cannot be quantified at this time, this bill is expected to result in overall net savings in employers’ costs. While S2605C is expected to result in the same impact as the original Governor’s Budget Bill, A3005C is expected to result in an overall increase of 0.3% in loss costs, due to the increase in the minimum weekly benefits.

Several sections of the proposed bills may result in significant cost impact and are described below, followed by an actuarial analysis for each section. Other sections are expected to result in minimal cost impact or have not been evaluated. Those sections are listed in the Appendix attached to this pricing analysis.

Reopened Case Fund

Section 25-A of the workers compensation law allows for certain claims to be transferred over to a fund known as the “Fund for Reopened Cases.” Claims become eligible to be transferred to the fund if at least seven years passed from the date of injury, and if at least three years have passed since the date of the last indemnity payment. Section 13 of the bill indicates that no claims shall be accepted by the fund on or after January 1, 2014. According to the bill, assessments to keep the amount of assets of the fund at the minimum statutory level shall be levied on all employers as part of a single assessment as prescribed in a new proposed section 151 of the workers compensation law (described below), and that the amount of such assessment will be determined by the Chair of the Workers’ Compensation Board. Note that the Assembly Bill A3005C does not propose to close the fund to new cases.

Actuarial Analysis



Because of lack of exact information on incurred losses by the Fund by Accident Year, the calculation below utilizes historical assessment amounts by calendar year as a proxy. In addition, the analysis provided below applies to the original Governor's Budget Bill, and to S2605C, but not to A3005C which does not propose to close the Fund to new cases.

1. Prospective Impact

The proposed bill would shift costs of the future reopened cases from the fund to the carriers. In the absence of specific data by accident year, the analysis used historical assessment amounts and related them to historical losses derived from financial data. The historical assessments allocated to the private carriers and the SIF from 2003 to 2011 has been over \$141M. This included years with assessment as low as under \$70M, and years with projected assessments of as much as over \$240M. After accounting for disbursements from the Fund in accordance with the volunteer firefighters and volunteer ambulance workers laws, and for payments of supplemental benefits as described in Subdivision 9 of Section 25-a of the statute, an average assessment amount of \$120M was used in the calculation. This average assessment amount is divided by average total historical losses for the years in which the reopened cases originally came from. The average annual losses from the private carriers and the SIF for policy years years 1996 through 2006 are approximately 2.67B. The direct impact is therefore 4.5% ($=(\$120M/\$2.67B)-1$). The actual impact could be higher or lower. Some argue that some savings may be generated because the carrier would now retain control of these claims, and any extra cost that may have been incurred to make a claim eligible to the provisions of 25-A would be eliminated. In addition, some of the frictional costs associated with determining whether claims are eligible for the fund may be eliminated, mitigating some of the increase in the loss costs. Thus, the final impact could possibly be as much as 10% less than the direct impact determined above. On the other hand, assessments in recent years have grown significantly, and the direct impact calculated above included no trend factors. In addition, carriers may incur additional expenses associated with the reopened cases on top of the actual loss amounts. This could potentially result in an impact of as much as 10% above the indicated direct impact. We conclude therefore, that the final impact on loss costs as a result of this change may be in the range of 10% above or below the direct impact of 4.5%, resulting in a projected increase in loss cost of 4.1% to 5.0%.

2. Retrospective Impact (Unfunded Liability)

The unfunded liability results from claims on current and past policies which were closed, may be reopened in the future, and would have been subject to the provisions of Section 25-A. For example, a policy from 2007 could have had a claim that is now closed, and the last payment on which was in 2012. If this claim reopens in, for example, 2016, it could have been deferred to the Reopened Case Fund, but since the bill provides for the Fund's closure, this claim would remain the responsibility of the carrier. However, the premium charged for this policy did not incorporate that possibility, and assumed such costs would be borne by the Fund. Therefore, there is an unfunded liability which will have to be paid by the carriers (i.e. a retrospective cost impact). To estimate the magnitude of this liability, it was assumed that for the private carriers and the SIF, the annual assessment amount of \$120M as derived above serve as a proxy for the payments needed to pay for such claims each year in the future. Then, since at least seven years must have passed since the date of accident, payments made in 2014 will be



made on claims occurring in 2006 and earlier, i.e. on policies that have expired, and the cost for which is unfunded. Only in the year 2022 payments will begin to be made on claims occurring in 2014 that were accounted for in the prospective impact described above. However, at that point, the majority of payments would still be made on claims occurring on policies that have expired. A maturity distribution of claims entering the Fund each year was assumed based on carrier information received by the Rating Board. For example, it was assumed that, in a particular year, 25% of claims transferred to the fund are at 8 years since occurrence, 20% are at 9 years since occurrence, etc., up to 1% of claims at 26 years since occurrence. The total unfunded liability is the sum of future payments of these claims that have not been transferred to the fund, and with accident date prior to 2014. Varying the maturity distribution assumption, and assuming loss trend of 0% to 2%, it is estimated that the unfunded liability is between \$1.1B and \$1.6B.

3. The Reopened Case Fund Assessment

The Reopened Case Fund is “Pre Funded” and the assessment is currently needed to “replenish” the assets of the fund to the minimum statutory level. That level is essentially the value of all total claim liabilities of the Fund plus 10%. If the reserves on claims currently in the Fund are inadequate, and future development on these liabilities will exceed 10%, then future assessments may be necessary to enable the Fund to meet its statutory liabilities. Since new claims will not be part of the assessment, it is expected to be lower than the current assessment of 4.9% of Standard Premium.

Aggregate Trust Fund

Prior to 2007, the Aggregate Trust Fund (ATF) was used to ensure payments to claimants by ordering carriers to make the full present value of fatal and permanent total claims into the fund. The 2007 reform expanded the mandatory ATF provision to non-scheduled permanent partial disability: Section 14 of the bill prohibits the WCB from directing mandatory deposits into the ATF, effectively closing it. The bill emphasizes that orders of payment made prior to the enactment of the bill must be complied with, and that non-compliance may be subject to a penalty of 20% of the ATF deposit amount to injured workers and \$50 to the state. This section is proposed to become effective 30 days after enactment of bill. This section is omitted in Assembly Bill A3005C, and thus the actuarial analysis below does not apply to it.

Actuarial Analysis

Although the ATF mandatory deposit provision was expanded in 2007 to include non-scheduled permanent partial claims, actual payment orders into the fund for these claims are believed to have been kept at a minimal level. However, this change may have put upward pressure on costs that partially contributed to worsening experience and the need for loss cost increases. In the pricing of the 2007 reform no explicit impact was included to reflect the expansion of the Fund. We propose, therefore, that with the closing of the Fund, no explicit cost impact should be included in the derivation of loss costs. We note, though, that the elimination of the ATF is likely to result in overall net savings in employers’ costs. However, due to the lack of significant ATF activity and minimal information to



support quantification of this change, any such savings will flow through future experience and be reflected in future loss cost filings. Note that the State Insurance Fund (SIF), representing approximately 40% of the insured market, is not subject to this provision of the statute. Any savings that may be generated by this section, will therefore not apply to the 40% of the market insured by the SIF.

Minimum Weekly Benefit

The current minimum weekly benefit for Permanent Partial, Permanent Total and Temporary injuries is \$100. Section 7-a of the bill would increase the minimum weekly benefit for these types of injury to \$150.00 per week, for injuries occurring on or after May 1, 2013. This Section is included in the Governor's original budget bill, as well as in both Senate 2605C and Assembly 3005C.

Actuarial Analysis

The determination of the loss cost impact resulting from this proposal is based on a universally accepted actuarial methodology developed by actuary Barney Fratello in a paper entitled *The Workers Compensation Injury Table and Standard Wage Distribution Table – Their Development and Use in Workers Compensation Insurance Ratemaking*, published by the Casualty Actuarial Society. This publication, or portions thereof, has been used for over fifty years by actuaries in all jurisdictions to price the effects of changes in the weekly benefit that are either proposed or enacted by their respective state legislatures. The incorporation of a state's current statutory minimum weekly benefit, the proposed minimum weekly benefit, the state's average weekly wage and the 2010 'Standard Actuarial Wage Distribution Table' enable an actuary to produce an accurate estimate of the benefit cost when changes to the minimum are proposed or enacted.

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

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

The methodology is performed separately for each injury type [death, permanent total, permanent partial major (>22,000 per claim), permanent partial minor (<22,000 per claim) and temporary] to recognize any variation in the minimum, as a percent of wage, that is provided for by statute. Recognition has also been given to the lower wage levels of PPD claimants and the manner of determining benefits that is used by the Workers' Compensation Board (WCB) for PPD cases. This is consistent with the calculation performed in the annual loss cost filings.



Once the indicated changes are determined by injury type, these changes are applied to a distribution of incurred losses by injury type in order to obtain the estimated change in total indemnity costs. In this analysis, a five-year distribution of losses by injury type has been used to provide additional stability. The resultant indicated indemnity change is then weighted with the distribution of indemnity and medical losses based on 2010 policy year financial data to obtain an overall change.

The increase in the minimum weekly benefit is expected to result in a 0.3% increase in total workers compensation claim costs. This impact applies to all three of the proposed bills.

Assessment process

Section 22 of the bill repeals the current assessment process and provide for a new process (Section 151 of the workers compensation law) by effectively combing the assessments for the Special Disability Fund (Section 15-8), Self Insured Bond Financing (Section 50-C), the Reopened Case Fund (Section 25-A), the Disability Benefit Fund (Section 214), and the expenses of the WCB into a single assessment, to be collected directly from employers. The combined assessment may also include an amount needed to finance the Aggregate Trust Fund, if necessary. Also, employers affected by the Group Self Insurance default may be subject to an additional assessment of up to 30% of premiums. The assessment rate will be determined by the Chair of the WCB. According to the bill, until a process is established to collect assessments directly from employers, carriers would be responsible for collecting the assessments on behalf of the WCB and remitting collected assessment directly to the WCB, and may be subject to penalties if they knew or should have known of data misrepresentation by an employer. Another provision as part of this section (omitted in S2605C) includes transfer of funds from the State Insurance Fund to the State's general fund.

In addition, this section would require all data in possession of the Rating Board to be made available to the WCB and the Department of Financial Services upon request. S2605C is also providing for protection of such data.

Actuarial Analysis

This provision is not expected to result in any direct impact on the loss costs. However, some administrative cost savings may result, which could possibly put a downward pressure on the overall assessment amount. On the other hand, additional assessments as per the new Section 50-C, and additional costs that may be necessary to support any Aggregate Trust Fund deficiency may put upward pressure on future assessments.

In addition, significant costs may be incurred by the Rating Board (and its member carriers) and the Workers' Compensation Board to support any transfer of data in accordance with the last provision of this section.

Summary

As the closing of the Reopened Case Fund is expected to result in an increase in loss costs of 4.1% to 5.0%, (which will be largely offset because of reduced Reopened Case Fund assessment), and the increase in minimum weekly benefit are expected to result in an



additional loss cost increase of 0.3%, the NYCIRB estimates that the original Governor's Budget Bill, will result in an increase of between 4.4% and 5.3% in future loss costs. Combined with anticipated long term savings from the elimination of the Aggregate Trust Fund, this bill is expected to result in overall net savings in employers' costs. In addition, the NYCIRB estimates that the closure of the Reopened Case Fund will result in an unfunded liability for private carriers and the State Insurance Fund of between \$1.1 Billion and \$1.6 Billion. This unfunded liability will not affect future loss cost level calculation.

The overall cost impact of the S2605C, given the similarity to the original Governor's Budget Bill, is expected to be the same as the impact of the original bill as indicated above. The cost impact of A3005C is estimated to be an increase of 0.3% due to the increase in minimum weekly benefits.

In addition to the sections of the bills described above, other section of the bills have either not been evaluated or are expected to result in minimal or no impact. These sections are described in the attached Appendix.

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Appendix

The intent of this appendix is to provide a brief, general description of the different sections of the proposed reform from the Governors bill, and to identify which sections have been omitted, revised or modified in the subsequent bills. These sections are either expected to result in a minimal cost impact or have not been evaluated by the Rating Board. For more details on each section, please refer to the actual proposed legislation.

Section Description

1. Repeals definition of Special Funds Conservation Committee **(Omitted in the A3005C)**
2. Chiropractic Practice Committee: change from 1 Physician and 2 Chiropractors to 3 chiropractors.
3. Psychology Practice Committee: change from 2 Psychologist to 3 Psychologists.
4. Medical Bill Disputes:
 - Introduces a Single Arbitrator Process in Lieu of an arbitration committee, in disputes involving bills of less than one thousand dollars (or greater than \$1000 if requested by provider). The arbitrator will be a medical provide-selected by the chair of the same practice area as the medical services in dispute.
 - Introduces a Single Arbitrator Process for hospital bills less than \$1,000.00.
5. Introduces Single Arbitrator Process for podiatry care disputed bills under \$1000.00.
6. Introduces Single Arbitrator Process for chiropractic services disputed bills for amounts under \$1000.00.
7. Introduces Single Arbitrator Process for Psychological services disputed bills under \$1000.00.
8. Special Disability Fund
 - Eliminates SDF Claim filing fee (No Impact since fund closed for new claims)
 - Effective 1/1/14 assessment would be levied on “Affected Employers” and the amount will be part of a unified assessment as per the revised section 151 of the law.
 - WCB may audit employers (in addition to carriers, self insureds and the SIF)
9. Allows the chair to appoint an attorney to represent and defend the S.D.F. in lieu of representative.
10. Appeals: Current: Application for review by the full board may be made if the decision by board panel is not unanimous. (Except if dissent is for referral to specialist)
Proposed: Application for review by the full board can be made even in case of Unanimous Decision.
 - If not Unanimous decision (other than referral to specialist) full board shall review.
 - If unanimous (or only dissent was to refer to specialist) chair and/or full board have discretion to review.

(A3005C: the application for the full board review can be to raise arguments as to deficiencies in the board panel review.)

This section to become effective 90 days after bill is enacted.
11. **Governor’s Budget Bill and S2605C:** Provides that the “Standard of review” in appeals of an arbitrator decision in an alternative dispute resolution” procedure shall be the same as for any appeal of a workers comp case.
A3005C: Provides for recording of all hearings by a stenographer

12. Specifies board may modify/rescind decisions based on appeals only if an appeal is in accordance with the S-23 of the WC Law.
16. Remove reference to SFCC from Section 32.
17. Allows the possibility of newly formed self insured groups to deposit securities in a trust, as an alternative to the current requirement of providing securities to the WCB.
18. Converts the "Group self Insurer Default Offset Fund" to "Self Insurer Offset Fund.", to pay unmet claims on any self insurer.
19. Revises the penalty for failing to obtain insurance from \$2000 to "Up to \$2000" for each 10 day period. (The alternative penalty of 2 times the payroll remains unchanged).
20. –Revises the restrictions on investments of the State Insurance Fund.
–allows for the supply or reserve funds of the SIF to be loaned, and for securities of investments to be sold subject to the approval of the superintendent.
–Prohibits investments on the SIF that are against public policy.
21. Eliminates a section relating to the administrative expenses of the SIF.
23. Cancellation of Insurance Contracts Section: includes language for cancellation due to non-payment of assessment.
24. Same as 23. Applies to cancellation of SIF.
25. Repeals requirement for location of WCB offices. There is no longer a requirement to maintain an office in Albany. **A3005C completely repeals this section from the statute.**
26. Repeals the current assessment process for the special fund for disability benefits, and combines the assessment as described in section 151.
27. Administrative expenses for disability benefits law will be combined into the new assessment process as described in Section 151
28. Update language in Volunteer Firefighter Benefits law to be in accordance with the domestic relation law ("spouse" in lieu of "husband"/"wife" etc)
29. Assessments to administer the Volunteer Firefighter Benefits Law are to be combined into the total assessment as per section 151.
30. Update language in Volunteer Ambulance Workers Benefits law to be in accordance with the domestic relation law ("spouse" in lieu of "husband"/"wife" etc)
31. Assessment to administer the Volunteer Ambulance Workers Benefits Law are to be combined into the total assessment as per section 151.
32. New section authorizing chair to issue bonds to finance self insurers offset fund.
33. Chair may request transfer of bond proceeds for purpose outlined in the bond financing agreement.
34. Adding section 50-C to the law relating to self insured bond financing.
35. Revising the "public authorities" law as relates to self insured board financing.
36. Revising the "public officers" law to define "Employee" to include members of the board and officers and employees it dormitory authority for the purposes as "Public Authorities law".
37. Effective date.