OLIVER WYMAN

Consulting Actuaries

A REVIEW OF CURRENT WORKERS COMPENSATION COSTS IN NEW YORK

Scott J. Lefkowitz, FCAS, MAAA, FCA

November, 2015

MARSH & McLENNAN COMPANIES

CONTENTS

For additional information on the contents of this article, contact Oliver Wyman Actuarial Consulting, Inc.

Scott J. Lefkowitz, FCAS, MAAA, FCA
Oliver Wyman Actuarial Consulting, Inc.
48 South Service Road Suite 310
Melville, NY 11747
631-577-0548
scott.lefkowitz@oliverwyman.com

Scott J. Lefkowitz leads the Melville, NY office of Oliver Wyman Actuarial Consulting. He is a Fellow of the Casualty Actuarial Society, a Member of the American Academy of Actuaries, and a Fellow of the Conference of Consulting Actuaries. With over 28 years of experience in the insurance and risk management industry, Mr. Lefkowitz has provided consulting services to a wide variety of clients on all aspects of property/casualty risk exposure. Mr. Lefkowitz is an expert as respects workers compensation exposures, and currently researches workers compensation costs in a number of jurisdictions.

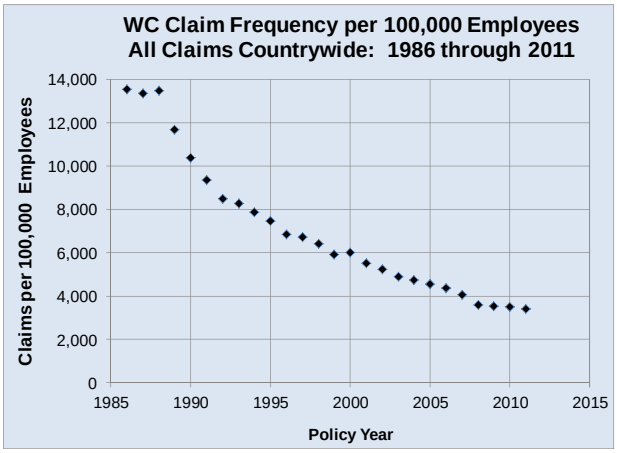
Introduction

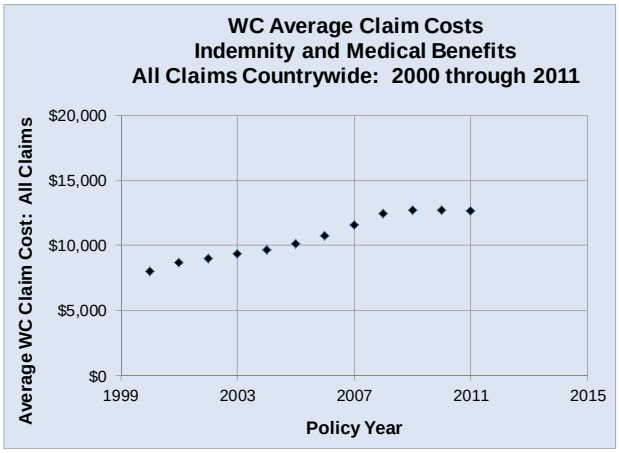
The cost and frequency of workers compensation (WC) claims vary greatly between the different states. Each individual state, or jurisdiction, has its own WC benefit structure, administrative system, and governing statutes. Compensation rates, maximum and minimum weekly benefits, automatic adjustments to maximum and minimum benefits, system utilization, industry mix, administrative efficiency, constraints on medical care, and general cost of living levels all vary, potentially significantly, by jurisdiction, and represent a sample cross section of items that directly impact claim incidence and costs within each individual jurisdiction.[1]

Countrywide WC claim frequency has generally been decreasing since the early 1990s. The observed long-term decline is common across all jurisdictions and industries. Reasons include implementation of loss prevention programs (ergonomics and safety programs), other workplace changes that act to reduce claim potential (automation, cordless tools), loss control programs (return to work), and aging of the population (as age increases, claims become less frequent but more costly).

The average claim cost, or severity, of WC claims naturally increases over time. Wage inflation has a direct impact on the cost of indemnity (wage replacement) benefits, while increases in the cost of medical services and pharmaceuticals have a highly leveraged impact on the cost of WC claims, where medical care is generally more complex and costly than services associated with general health care.[2]

Countrywide WC claim frequencies and average claim costs are displayed below:





Actual metrics and their specific behavior over time vary widely by jurisdiction.

[1] For example, in Vermont, the maximum and minimum weekly benefits for WC claims is 150% and 50% of the state average weekly wage (SAWW), currently $798 (2014). Total disability benefits are paid for the duration of disability, or life, and claimants receive an annual cost of living adjustment. In Mississippi, the maximum weekly benefit is 100% of the SAWW, and the minimum is fixed at $25. The SAWW is $695.35 (2014). The maximum duration for all claims is 450 weeks (9 years) with no cost of living adjustments. This illustrates differences in benefit structure as well as overall cost of living (the SAWW in VT is ~15% greater) between the two jurisdictions.

[2] In the early 1990s, the portion of WC benefit costs associated with medical services was approximately 40% of total benefit costs. Currently, that value is roughly 60%. This increase is a direct result of the greater cost inflation affecting medical benefits, relative to payroll inflation which impacts indemnity benefits.

This paper examines and discusses metrics specific to the State of New York (NY). NY is a unique jurisdiction, in that following a period of accelerating WC costs (benefits[3]; claim related expenses[4]; and assessments[5]) in NY from 2000 to 2007, the state enacted legislation in 2007 with the expectation of materially reducing costs. Rather than reducing costs, the 2007 legislation ultimately led to higher costs that now greatly exceed pre-legislation levels. During the period from 2006 (the year prior to the legislation) through 2012[6]:

- The incidence of lost time[7] (LT) claims in NY decreased by a modest 7%. The countrywide incidence of LT claims declined by 19% during the same period of time.
- The average benefit cost of a LT claim in NY increased by ***48%***. The average countrywide benefit cost of a LT claim increased by 12% during the same period of time. Note that current forecasts place the average benefit cost of a LT claim in NY at approximately $100,000 in 2016. This is prior to consideration of claim related expenses and NY State assessments.
- The average cost of claim related expenses in NY increased 41% from $5,153 per claim in 2006 to $7,266 per claim in 2012. Countrywide, the cost of claim related expenses increased by 34%, from $4,278 in 2006 to $5,732 in 2012. Though the percentage increase in NY claim related expenses during this period was only marginally greater than countrywide metrics, the absolute cost of claim related expenses has been and remains materially greater in NY.
- Collected assessments in NY required to provide for the cost of claims in state managed claim related funds (15-8 and 25-A, discussed later in this paper) increased from approximately $600 million in 2007 to approximately $950 million in 2013.

Oliver Wyman's analysis indicates that current costs in NY are among the highest in the United States.

[3] Benefit costs include the cost of indemnity (wage replacement) benefits and the cost of medical treatment.

[4] Claim related expenses refer to allocated loss adjustment expenses, also called defense and cost containment expenses. In general, these include expense costs attributable to individual claims, the primary component of which is legal fees.

[5] Assessments are surcharges paid to the Workers Compensation Board to fund various WC programs in NY. These programs are the Special Disability Fund (15-8), the Reopened Case Fund (25-A), the cost of running the Workers Compensation Board and other programs (151 and IDP), and the self-insurer's assessment (50-5). Only private (excluding public entities such as counties and municipalities) self-insured employers and groups pay the 50-5 assessment.

[6] The most recently available insurance industry data for NY is from 2012. The most recently available countrywide insurance industry data is available from 2011. 2012 countrywide industry metrics are forecasts.

[7] LT claims involve lost work time and therefore include the cost of wage replacement benefits. LT claims include temporary disability claims, permanent partial disability claims, permanent total disability claims, and fatalities. Medical only claims (MO) are generally minor, low cost claims requiring short-term medical treatment with little or no lost work time and therefore no wage replacement benefits. Oliver Wyman estimates that the average benefit cost of a NY LT claim in 2016 will be over $100,000 while the average expected cost of an MO claim in NY will be approximately $1,900 in 2016.

The purpose of this paper is to:

- briefly review the 2007 legislation;
- explain why both claim costs and assessments have increased since 2007 in the context of current and historical claim incidence rates and claim costs;
- benchmark claim frequency, claim costs, and overall costs against other states and countrywide metrics;
- discuss NY's relative WC cost ranking compared to other states; and
- discuss potential future cost levels.

Data used in this paper is from the NY Compensation Insurance Rating Bureau (NYCIRB), the National Council on Compensation Insurance (NCCI), and other miscellaneous sources of insurance industry information.

The NYCIRB is the WC data collecting organization in NY whose members include insurance carriers writing WC in NY, is licensed by the state, and analyzes collected WC claims data generated by all insurance companies doing business in the state. The NYCIRB uses this data to calculate loss costs[8] and other rating values for all employee WC classifications.

The NCCI is the WC data collecting organization in 36 jurisdictions. The NCCI is licensed in states such as Florida, Virginia, the District of Columbia, Mississippi, etc. The role of the NCCI is identical to the role of the NYCIRB. The NCCI analyzes collected WC claims data generated by all insurance companies doing business in a specific state where the NCCI is licensed to do business. The NCCI uses this data to calculate premium rates (or loss costs, depending on the jurisdiction) and other rating values for all employee classifications. The NCCI is the largest WC data collecting organization. CA, DE, MA, MI, MN, NY, NJ, PA, and WI all have their own independent data collecting organizations. IN and NC do as well, however the NCCI provides statistical services to the local organizations in those jurisdictions. Jurisdictions with exclusive state mandated WC insurance funds manage their own data and include ND, OH, WA, and WY.

Countrywide data used in this paper is based on NCCI data, which includes combined data only from those states in which the NCCI operates. States with exclusive WC insurance funds are excluded because data is generally unavailable. States with independent data collecting organizations listed in the paragraph above, except NY and CA, are excluded because testing showed that the impact of data from these states on countrywide metrics would be minimal. NY and CA are excluded because material law changes over the past decade have caused material changes to metric behavior which will distort general countrywide trends. Other reasons for excluding NY and CA are the sheer size of these jurisdictions (which will heavily weight countrywide averages) as well as cost and other unique attributes of these two states.

[8] Loss cost refers to the expected cost of benefits and claim expense per $100 payroll. Insurance companies subsequently factor in provisions for overhead, other expenses, and profit to generate a final premium rate. Loss costs are a direct measure of claim costs. Premium rates will generally increase (or decrease) by the same percentage change as loss costs, assuming no change to insurance company expense provisions. Some states, such as New Jersey, require the responsible WC data collecting organization to file the entire premium rate, rather than just the loss cost of insurance premium.

Summary of the 2007 Legislation

Legislation enacted in 2007 included the following five key components:

1. **Increase to the maximum and minimum weekly benefits.**
   The maximum and minimum wage replacement benefits had been $400 and $40 per week since 1992. The legislation implemented a transition to a maximum benefit equal to 2/3rds of the state average weekly wage (SAWW) effective July 1, 2010, updated annually from that point forward. The current maximum weekly benefit in NY is $844.29 effective July 1, 2015, more than double the $400 in effect prior to the law change. The minimum weekly benefit increased to a fixed amount of $100 per week effective July 1, 2007, and was subsequently increased to $150 effective May 1, 2013.

2. **Elimination of lifetime permanent partial disability (PPD) awards.**
   The primary cost driver in NY had been non-scheduled[9] PPD claims. Indemnity benefits for non-scheduled PPD claims accounted for **40% of total** WC (medical and indemnity) benefit costs in NY. Prior to the legislation, benefits paid for non-scheduled PPD claims were for the duration of the disability, which in most circumstances translated into lifetime disability awards. The legislation capped the duration for all but the most serious non-scheduled PPD awards to a maximum of 525 weeks from the date of impairment classification.

3. **The Special Disability Fund (SDF or 15-8) was closed to new claims.**
   The SDF mechanism reimburses employers for a portion or all of the benefit[10] cost of qualifying claims. Assessments provide funding for the SDF. SDF assessment costs increased materially from 2001 to 2006. The 2007 legislation closed the SDF to claims with dates of loss on or after July 1, 2007.

4. **The Aggregate Trust Fund (ATF) was expanded to include PPD claims.**
   Prior to July 1, 2007, the ATF required an insurance carrier[11] to deposit the present value of future indemnity benefits for permanent *total* disability (PTD) claims and death claims. The deposit was avoided if the claim was settled within 6 months of disability classification. If the deposit occurred, the ATF attempted to settle the claim as well, but at lower settlement amounts than carriers with the ATF retaining the difference. The ATF requirement was not a material issue because PTD claims and fatalities represented a small portion of system benefit costs (~5%). The legislation expanded the ATF requirement to include PPD claims, which represent the bulk of WC costs in NY. The ATF mechanism generally favors claimants, though claimants and insurance carriers both benefit by avoiding an ATF deposit.

5. **Implementation of Medical Treatment Guidelines.**
   The 2007 law provided for the implementation of medical treatment guidelines. The cost impact of this element of the 2007 law change was not estimated at the time the legislation was passed. Implementation of the guidelines began in 2010.

---

[9] Scheduled permanent partial disability claims provide for a specified number of weeks of benefits for loss of use of certain body parts, such as fingers, hand, leg, foot, etc. Non-scheduled claims would include back, neck, and injuries to body parts not otherwise listed on the published schedule.

[10] Administration of claims approved for SDF relief remains the responsibility of the carrier or self-insured employer. The SDF reimburses employers for a portion or all of the benefit cost of these claims. Claim related expenses, such as defense, surveillance, court, or administration related costs, remain the financial responsibility of the carrier or self-insured employer.

[11] The ATF requirement applies only to private insurance carriers. It does not apply to self-insured employers nor does it apply to the NY State Insurance Fund.

The material cost increases associated with the increases to the maximum weekly benefit were expected to be more than offset by the material cost decreases associated with eliminating lifetime PPD awards, resulting in a substantial net cost savings[12]. Expansion of the Aggregate Trust Fund to include PPD claims was expected to modestly increase costs, though the impact was not quantified. Medical guidelines were not implemented until 2010. With implementation, the consensus is that they are helping control costs.

Closing the SDF to new claims was expected to stabilize funding and therefore assessment costs. In the short term, moderate cost increases were expected because insurers and self-insured employers would have to fund the full cost of claims that are no longer SDF eligible ***and*** pay for assessments required to fund claims in the SDF until all such claims are closed. In theory, over the longer term, decreasing assessments (as required SDF funding declines to zero) will exactly offset costs shifted back to insurers and self-insured employers. However, a realistic assumption that insurers and self-insured employers will manage claims for which they retain full financial responsibility much more efficiently leads to expectations of a net savings over the long term.

In response to the legislation and based on these expectations, WC loss costs were decreased by 18.4% effective October 1, 2007, with an additional reduction of 6.4% implemented effective October 1, 2008.

Initial expectations were overly optimistic. Since 2007, WC costs in NY have increased to levels ***greater*** than the cost level prior to the 2007 legislation. The following chart shows that as of October 1, 2015, WC costs in NY are expected to be almost ***20% greater*** than costs prior to the 2007 legislation.

Approved Lost Cost Changes by Effective Date in New York

Effective Date	Approved Change	Cumulative Change		
10/1/2007	-18.4%	-18.4%		
10/1/2008	-6.4%	-23.6%		
10/1/2009	4.5%	-20.2%		
10/1/2010	7.7%	-14.0%		
10/1/2011	9.1%	-6.2%		
10/1/2012	0.0%	-6.2%	Filed Increase was +11.5%	
10/1/2013	9.5%	2.7%	Filed Increase was +16.9%	
10/1/2014	0.0%	2.7%	Filed Increase was +6.8%	Actuarial Indication was +17.4%
10/1/2015	5.9%	**8.8%**	Filed Increase was +6.9%	Actuarial Indication was +15.8%
10/1/2007 to 10/1/2015		**18.9%**	← Cumulative Change from 10/1/07 Based on 10/1/15 Actuarial Indication	
10/1/2008 to 10/1/2015		**45.7%**	← Cumulative Change from 10/1/08 Based on 10/1/15 Actuarial Indication	

Loss Cost: Indemnity + Medical + Loss Adjustment Expense

Note that since 2012, the NY Department of Financial Services has routinely disapproved the filed increases to loss costs in NY. The "20% greater than" statement is based on the actuarial indication in the most recent loss cost application, not what was approved by the state.

[12] Other elements of the legislation were expected to increase (ATF expansion) or decrease (Medical Treatment Guidelines) costs. The change to the maximum and minimum weekly benefits and the elimination of lifetime PPD awards were the elements expected to have the greatest impact on costs.

Consequences of the 2007 Legislation

1. The increases to the maximum weekly benefit had a much greater impact on cost than originally anticipated due to increased utilization.

The chart on the following page is based on data published by the NYCIRB in 2014. The column labeled "All PPD and TTD>52 Weeks" in the chart had been labeled as PPD in the published 2014 data. In 2014, claims defined PPD claims reflected the following definition:[13]

- Any permanent injury that does not involve permanent total disability.
- Any temporary[14] injury that satisfies any one of the following criteria:
  - The duration of disability benefits exceeds or is expected to exceed one full year. No loss is to be reported as temporary total if the duration of total disability exceeds or is expected to exceed 52 weeks.
  - A lump sum settlement is made or, in the judgment of the carrier, will be required to settle future benefits.
  - The extent of the liability for future payments cannot be determined.

Claims with TTD durations in excess of 52 weeks were included because a claimant on TTD in excess of a year will likely have a residual permanent partial impairment and will therefore likely be classified as a PPD claim. With this definition, the chart clearly illustrates two items:

- Beginning in 2005, the percentage of LT claims identified as either PPD or TTD claims with durations in excess of 52 weeks began to marginally increase.
- Subsequent to the 2007 legislation that percentage of LT claims identified as either PPD or TTD claims with durations in excess of 52 weeks began to materially increase, from 48% in 2007 to 59% in 2011.

These increases are likely due to an increase in the portion of claims with TTD durations greater than a year[15] and represent a manifestation of the greater willingness of claimants to extend the period of temporary total disability prior to assignment of an impairment rating or scheduled loss of use award. Claimants are more willing to remain on total disability given that weekly benefit payments, rather than being capped at $400 per week, are capped at over $800 per week.

---

[13] This statement is based on preliminary information provided by the NYCIRB.

[14] With LT claims, there is generally a period of total disability preceding the point in time when a final assessment of disability is made. During this period of total disability, the claim is classified as a temporary total disability (TTD) claim. In cases where there is no permanent impairment, the claimant will return to work with no additional income benefits, and the claim is closed as a TTD case. In cases where there is permanent, but partial, disability, the claim is reclassified as PPD once the final assessment of permanent impairment is made. In the rare circumstances where the claimant is permanently and totally disabled, the claim is classified as a permanent total disability (PTD) claim.

[15] The NYCIRB, on a preliminary basis, explained that recently published *2015 data* likely reflects a change in definition of PPD for reporting purposes. The PPD definition in the 2015 data is as follows:

A permanent partial loss is defined as any permanent injury that does not involve permanent total disability.

The 2015 data for policy year 2011 shows a large decrease to the number of PPD claims, and a large increase to the number of TTD claims. Similar shifts were observed for older policy years, though the shifts decreased and eventually disappeared as policy years became older. These observations are the basis of the assertion that the increasing percentages observed in the 2014 data are primarily due to an increasing number of claims with TTD durations in excess of 52 weeks, as well as claims with uncertain duration and claims that have had, or are expected to have, settlements.

NEW YORK CLAIM FREQUENCY
per 100,000 workers
2014 Published NYCIRB Data

Policy Year	Total Lost Time	All PPD and TTD>52 Weeks	All PPD and TTD>52 Weeks Percentage
2001	1,219	494	41%
2002	1,142	456	40%
2003	1,108	440	40%
2004	1,030	419	41%
2005	988	416	42%
2006	953	425	45%
2007	939	451	48%
2008	927	489	53%
2009	926	509	55%
2010	943	537	57%
2011	941	552	59%

While some claims will close with no permanent partial benefits (these claims remain categorized as TTD), many claims currently classified as TTD will ultimately become permanent partial disability claims. For these claims, the period of time on total disability prior to receiving an impairment rating or scheduled loss of use award is referred to as the "healing period." Other evidence of extended healing periods since the 2007 legislation comes from the NY Workers Compensation Board. According to the Board, the average time to disability rating in NY has increased from 4.8 years (prior to the 2007 law change) to 6.4 years (based on data measured in 2013). Note that PPD duration limits on non-scheduled PPD claims implemented by the 2007 legislation do not include the healing period. The duration "clock" does not start until an impairment rating is received. In many respects, the lack of a maximum duration on the healing period is a fundamental defect in NY state WC statutes. The additional cost of extended healing periods is not limited to benefit payments. There is additional utilization of medical services to justify remaining on temporary total disability, as well as the frictional cost of legal involvement and hearings. The magnitude of the impact of the increase to healing periods since 2007 is illustrated by simply considering a $600 per week benefit paid for an additional 52 weeks, which adds over $30,000 to the cost of a claim, prior to consideration of unnecessary medical costs and other frictional costs.

Expansion of the Aggregate Trust Fund (ATF) to include PPD claims may be acting to delay impairment ratings as well. Note that if a claim is not settled within six months of establishing an impairment rating, a cash deposit into the ATF equal to the present value of benefits due is required. Claimant attorneys may use the threat of an ATF deposit to gain greater leverage in settlement negotiations and to secure larger settlements than otherwise might have been obtained.

On the other hand, it should be noted that the ATF also motivates claimants to settle, given that once a deposit into the ATF is made, the ATF generally will act to settle claims at materially lower values than might have been offered by the carrier. Discussions with claims administrators indicate that while the ATF deposit rule pressures both parties, the leverage favors claimants[16].

2. The cost of LT claims, rather than decreasing subsequent to the law change, increased substantially.

Lost Time Claim Severity
New York Compared to NCCI Countrywide Values

Policy Year	New York State Indemnity	New York State Medical	New York State Total	NCCI Countrywide Indemnity	NCCI Countrywide Medical	NCCI Countrywide Total
2001	28,193	15,099	43,293	17,263	19,237	36,500
2002	30,091	16,711	46,802	17,886	18,773	36,659
2003	30,574	17,839	48,414	17,589	19,452	37,041
2004	31,633	18,458	50,091	17,886	20,939	38,825
2005	32,182	20,517	52,698	18,699	22,052	40,751
2006	33,694	21,801	55,495	19,759	23,017	42,776
2007	35,546	25,044	60,590	21,259	24,432	45,691
2008	39,334	26,641	65,975	22,358	25,386	47,744
2009	40,448	28,477	68,925	21,645	25,963	47,608
2010	43,701	28,660	72,362	21,561	25,749	47,310
2011	47,493	30,641	78,134	21,185	26,265	47,450
2012	49,682	32,189	81,871	**21,403**	**26,903**	**48,306**
2001 to 2006:	20%	44%	28%	14%	20%	16%
2006 to 2012:	47%	48%	48%	8%	17%	13%

***NCCI 2012 values are forecasts because 2012 data is not yet available.**

The chart above compares LT claim costs in NY to countrywide data, and shows that on a countrywide basis, LT claim costs increased 16% from 2001 to 2006. In NY, LT claim costs increased 28% during the same time period. The increase is primarily due to medical costs, but indemnity costs increased as well. Note that the largest increase to LT claim costs during this period occurred in the 2004 to 2006 time period, which coincides with the start of the increase in the portion of claims that are PPD or TTD with extended durations, illustrated by the chart in the prior section. It was this increase, as well as the increase to assessments, that ultimately lead to the 2007 legislation. Unfortunately, the result of the legislation is clear from the table above. From 2006 through 2012, LT claim costs in NY increased by almost 50%, while countrywide LT claim costs increased 13% during the same period. The

[16] The ATF rule applies only to employers insured by private carriers. It does NOT apply to self-insured employers nor does it apply to employers insured by the State Insurance Fund. Conversations with Oliver Wyman clients that are insured with large deductible insurance policies indicate that the ATF is a cost driver. However, both self-insured and insured clients of Oliver Wyman have experienced similar material cost increases since the 2007 legislation. Therefore, while the expansion of the ATF to include PPD claims has likely contributed to cost increases, it is not clear whether this contribution is material in the context of other issues, such as delays to impairment ratings originating from claimants and overall system utilization.

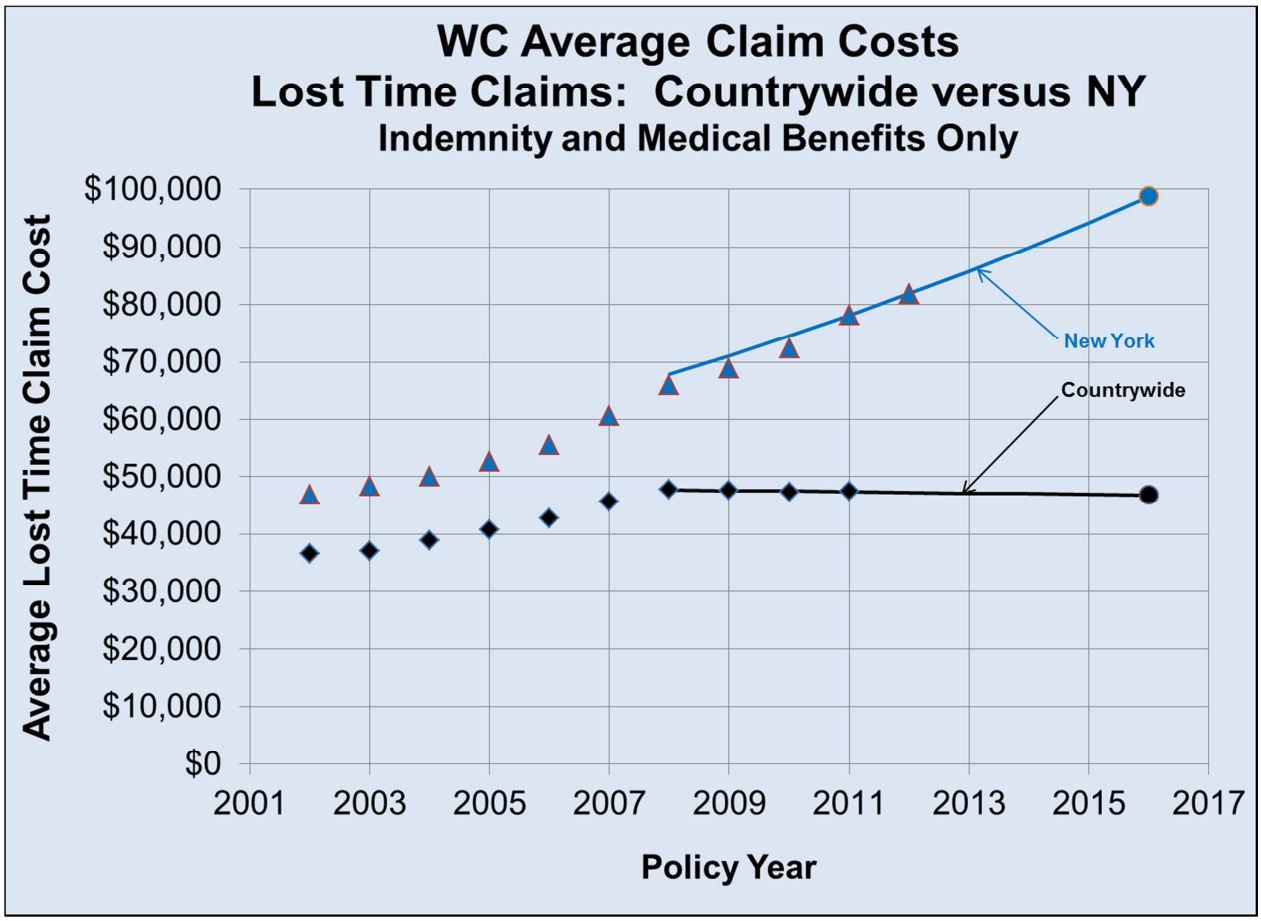
increase to LT claim costs in NY was driven by the extension of time on total disability prior to receiving an impairment rating, as well as extraordinarily high PPD awards relative to costs in other states.

3. Medical Treatment Guidelines

The Workers Compensation Board implemented initial guidelines in 2010, and implementation continues through today. Conversations with Oliver Wyman clients indicate that the guidelines may favorably impact costs over the longer term.

The overall impact of the 2007 legislation has been to materially increase WC costs. Additionally, there had been concern regarding the viability of the 525 week limit on the duration of PPD claims. The law allows for claimants with an 80% or more loss of earnings capacity to apply for hardship lifetime permanent total disability awards. Claims professionals have expressed concerns that a greater proportion of claimants than anticipated by the 2007 law will, near the end of their claim, apply and receive hardship status. While this is still a concern, research has shown that the number of claims with impairment ratings in excess of 80% at this point in time is extraordinarily small. If this remains the case, the impact of this provision of the legislation will be small.

The graph below illustrates historical and expected future indemnity and medical benefit costs for LT claims in NY and for countrywide data. The chart below *does not include* the impact of claim related expenses and assessments, which are material cost components in NY.



Assessments

There are five primary programs funded by assessments:

15-8	Special Disability Fund
25-A	Reopened Case Fund
50-5	Self-Insurer Assessment
IDP	Interdepartmental Expenses
151	Workers Compensation Board Administration

Descriptions of each assessment follow:

IDP and 151

IDP and 151 provide for administration costs of the Workers Compensation Board and other occupational health and safety programs in NY. Collected assessments for IDP had been approximately $60 million from 2007 to 2013. Collected assessments for 151 have ranged between $175 million to $210 million.

15-8 Special Disability Fund

The Special Disability Fund (15-8) is the second injury fund. The assessment for 15-8 (closed to claims with dates of loss on or after July 1, 2007 by the 2007 legislation) increased from approximately $500 million in the time period of the 2007 legislation to over $600 million in 2010. Initial expectations at the time of the 2007 legislation were that required funding would remain at or near levels at that time, and slowly decrease as claims closed over time. Instead, required assessment funding has remained near or over $600 million since 2010. Projected 2016 assessment funding is $630 million. Required funding is expected to remain near this level in the immediate future, and then decrease over time until all claims in the fund close. This will occur over a 40+ year time horizon.

25-A Reopened Case Fund

The Reopened Case Fund (25-A) generally provides for the cost of claims where there has been no wage replacement benefit paid for a least three years, and at least seven years have passed since the date of loss. Assessments had been generally $100 million to $200 million prior to 2007. In 2010 assessments were near $250 million, $323 million in 2011, and $314 million in 2013. Two material issues emerged with the 25-A subsequent to the 2007 legislation. First, there was much greater utilization of 25-A. This is reflected in the increase in assessments from roughly $150 million per year in the time period of the 2007 legislation, to $314 million in 2013. It is possible that the increase in utilization was partially due to publicity surrounding the closure of 15-8 by the 2007 legislation, but this is speculation. The second, more material issue, is that prior to the 2007 legislation, non-scheduled PPD claims often resulted in lifetime disability awards with weekly benefit payments. These claims could not be placed into 25-A because they would not meet the key prerequisite that a minimum of three years pass between the date of the last wage replacement benefit and entry into 25-A due to lifetime indemnity payments. Elimination of lifetime disability awards for all but the most serious of PPD claims effectively created a large pool of claims that, after sufficient time had passed, potentially would meet the requirements for entry into 25-A for the purpose of funding injury related medical benefits. Because of this issue, as well as the large increase in assessments,

25-A was closed to all new claims regardless as to date of loss[17] effective January 1, 2014. Required future funding is expected to remain at or near the projected $200 million required for 2016 for the immediate future, and then decrease over time until all claims close. As with 15-8, this is expected to occur over a 40+ year time horizon.

50-5 Self-Insurers

This assessment provides for administration of the self-insurance market in NY and funding of benefit payments due to claims insured by insolvent self-insured employers and group trusts[18]. Cash revenue required to fund 50-5 increased from $8.4 million in 2006 to over $27 million in 2013. A much smaller number of employers fund the larger cash requirement because of the closure of most group trusts since 2006. The impact is a materially greater cash burden on remaining self-insured employers.

Legislation enacted in 2013, in addition[19] to closing 25-A, simplified the extraordinarily complex manner by which assessments were levied. The legislation created a single unified assessment for 15-8, 25-A, 151, and IDP. Additionally, the legislation created a single assessment base for all employers, and relieved self-insured employers of the need to maintain a balance sheet accrual for future assessment payments[20]. In 2014, the assessment percentage was 13.8% of standard premium for insured employers, or 13.8% of the standard premium equivalent[21] for self-insured employers. The 13.8% charge funded only 15-8, IDP, and 151 in 2014. The total assessment percentage was 13.2% in 2015, which funded 25-A, 15-8, IDP, and 151. The projected 2016 assessment rate is 12.9%, funding all four assessments.

[17] Arguments had been made that rather than closing 25-A to *all* new claims as of January 1, 2014, 25-A should have been closed to claims with dates of loss on or after January 1, 2014, given that published loss costs in NY anticipated utilization of 25-A, and closing 25-A to all claims potentially created an element of unfairness given that premium charges based on published loss costs anticipated utilization of 25-A. On the other hand, the 2007 legislation created a potentially much greater utilization of 25-A not captured in historical data and not considered at the time the legislation was passed. More pragmatically, without closure to all claims at this time, assessments required to fund 25-A potentially could have risen to current levels associated with 15-8, essentially replacing one assessment problem (15-8) with another (25-A).

[18] In the mid-2000s, there were approximately 70 active self-insured groups. As of June 30, 2015, there are 3 active trusts left. A large number of these groups became insolvent, many involving litigation.

[19] The 2013 legislation also increased the minimum weekly benefit from $100 to $150 per week.

[20] Prior to the 2013 legislation, insured employers paid an annual assessment based on their premium charge. The insurer collected the assessment charge and then paid the state. Self-insured employers, however, paid an assessment charge based on prior year indemnity payments (a simplification of an extraordinarily complex process). This meant that a self-insurer, even if it closed the self-insurance program, would still be obligated to pay assessments until all claims in the program closed. Therefore, self-insured employers had to maintain a balance sheet accrual for future assessments associated with future indemnity payments on prior claims. The 2013 legislation changed the assessment base for self-insured employers from indemnity payments to a standard premium equivalent, eliminating the need for a balance sheet accrual. The state now assesses self-insured employers in the same manner as insured employers for the 15-8, 15-A, IDP, and 151 assessments. However, the 50-5 assessment for self-insurers still uses indemnity payments as an assessment base. Therefore, a balance sheet accrual is still required for this single assessment.

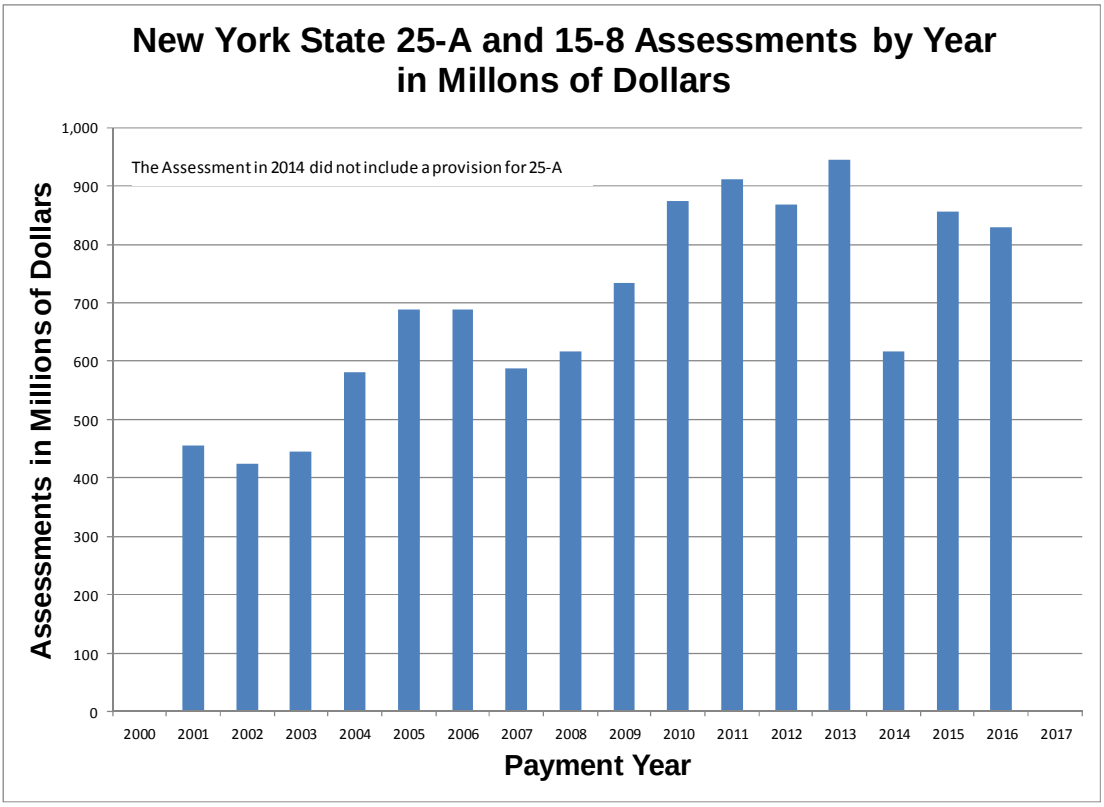
[21] The standard premium equivalent is equal to payroll (in units of $100) by employee classification multiplied by the appropriate manual loss cost published by the NY Compensation Insurance Rating Bureau. The justification for this approach is loss costs understate standard premium because loss costs do not include insurance company expenses and profit that are included in premium rates used by insurance carriers. On the other hand, the calculation does not give self-insured employers the benefit of the experience modification factor, which would act to reduce standard premium given that self-insured employers generally have better than average loss experience.

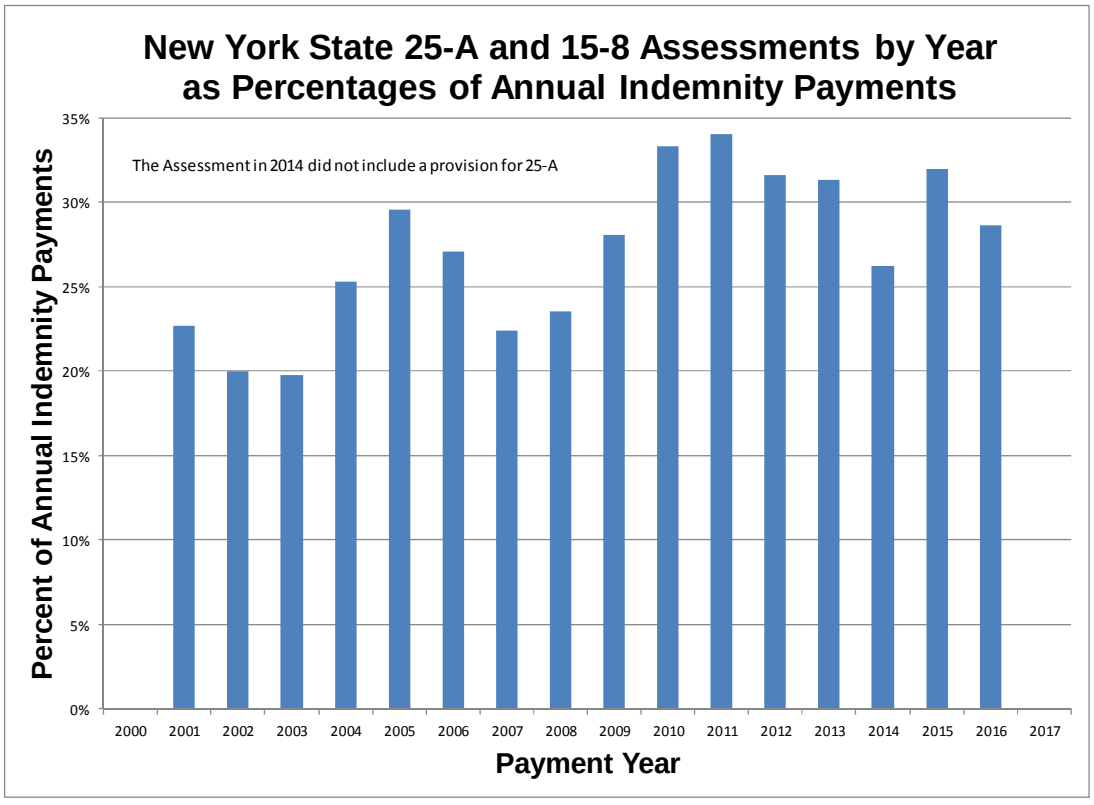
Self-Insurers still fund 50-5, though the magnitude of required funding has declined. The assessment process for 50-5 is complex. Using 2014 as an example, for assessments paid in 2014, the assessment base is indemnity payments made by the self-insured entity from April 1, 2014 through March 30, 2015. The assessment percentage is the required cash need for 2014, divided by total self-insured indemnity payments from April 1, 2014 through March 31, 2015. There are four quarterly assessments in 2014, which reflect estimates of both the 50-5 cash need as well as the indemnity payments made by the specific self-insured entity during the specified measurement period, and a total estimate of indemnity payments by all self-insured entities during the specified measurement period. Estimates of all quantities are refined with each additional quarterly assessment. There will be a fifth and final assessment "true-up" in early 2016 that reflects actual indemnity payments made from April 1, 2014 through March 31, 2015 and the actual cash requirement of 50-5 during 2014. Self-insurers must maintain an accrual for expected future assessments based on estimates of the unpaid indemnity benefits of self-insured claims. Note that the assessment base is unlimited indemnity payments, so excess insurance protection has no impact on a specific self-insured's assessment base.

While the 2013 law change greatly simplified the assessment process, it did not, nor could it really, impact the magnitude of the assessment requirement. Assessments will continue at or near current levels until claim payments generated by 25-A and 15-8 begin to decline as claims close. The graphs on the following pages show actual assessment dollar collections[22] by year and assessment dollar collections as a percentage of indemnity payments[23], by year.

[22] The data displayed in this graph is a combination of actual dollar figures provided directly by the NY Workers Compensation Board or taken from annual Board reports, as well as estimates by Oliver Wyman based on data from various sources.

[23] Prior to the 2013 law change, assessments for insured employers were based on standard premium, while assessments for self-insured employers were based on indemnity payments. The graph puts all assessments on an estimated common assessment base for comparison purposes.


New York State 25-A and 15-8 Assessments by Year
in Millons of Dollars
The Assessment in 2014 did not include a provision for 25-A
Assessments in Millions of Dollars
1,000
900
800
700
600
500
400
300
200
100
0
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017
Payment Year


New York State 25-A and 15-8 Assessments by Year
as Percentages of Annual Indemnity Payments
The Assessment in 2014 did not include a provision for 25-A
Percent of Annual Indemnity Payments
35%
30%
25%
20%
15%
10%
5%
0%
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017
Payment Year

Total Cost Ranking

The cost of WC insurance varies widely among jurisdictions for the reasons stated in the introduction to this paper. Complicating the issue is the variation of industries between different states. The impact of this latter item is easily seen if the majority of payroll in one state is in the logging industry, and the majority of payroll in another state is in financial services. A comparison of the average WC cost relative to payroll between these two states does not have meaning, given how hazardous the logging industry is relative to the financial services industry. This concern is easily addressed by using a common distribution of payroll by WC employee classification for all states to measure cost. The ranking was calculated by obtaining the cost of benefits and claim related expenses by WC employee classifications by jurisdiction[24], and then averaging this information by jurisdiction using the assumed payroll distribution. The result of this exercise shows that NY is currently the second most expensive jurisdiction in the United States.

Average Cost of Indemnity Benefits, Medical Benefits, and Claim Related Expense per $100 Payroll
Oliver Wyman Quarter 4 2015 Study

RANK	STATE	Average Cost per $100 payroll
1	CA	2.47
2	**NY**	**2.36**
3	NJ	2.24
4	DE	1.97
5	CT	1.97
6	AK	1.68
7	MT	1.65
8	IL	1.57
9	LA	1.43
10	VT	1.43

The ranking reflects the actual cost of medical benefits, indemnity benefits, and claim related expenses, without consideration of insurance company related expenses, profit, taxes, and

[24] This approach was used where the NCCI is the licensed statistical agency or in jurisdictions with other statistical agencies that use methods to develop premium rates similar to, if not identical to, the NCCI. However, there are jurisdictions where different and less precise approaches were used due to variation in available information as well as the methods by which WC premium rates are determined and charged. Of note is Washington, which is a monopolistic fund state where WC insurance is available only from the state-sponsored agency (Department of Labor and Industries). The method by which premium rates are developed and charged in WA is fundamentally different from approaches used in other states. WA provides a substantial discount to employers in the state to reflect investment income, amongt other items. Removal of the discount results in average cost per $100 payroll of approximately $2.80, which would make WA the most expensive jurisdiction. However, this measurement is not on a common payroll basis, and it is not clear what impact using a common payroll to measure the average cost would have on the WA value. As such, WA was excluded from this measurement.

investment income offsets.[25] The ranking is therefore a true measure of the cost of benefits and claim related expense by jurisdiction.

The Oregon Department of Business and Consumer Services published a biennial study in 2014 that ranks each state according to total WC costs. The Oregon study considers the total net cost of WC insurance, and therefore includes, in addition to benefit costs and claim related expenses, insurer related expenses, profit, taxes, assessments, investment income offset, as well as competitive adjustments and discounts provided by insurers to certain employers. Additionally, the Oregon Study is based on a distribution of payroll specific to Oregon. The general ranking of the Oliver Wyman study is quite similar, but not precisely the same, as the Oregon study. The ten most costly states from the Oregon study[26] are presented below:

Average WC Premium Cost
Oregon Department of Business and Consumer Services
2014 Biennial Study

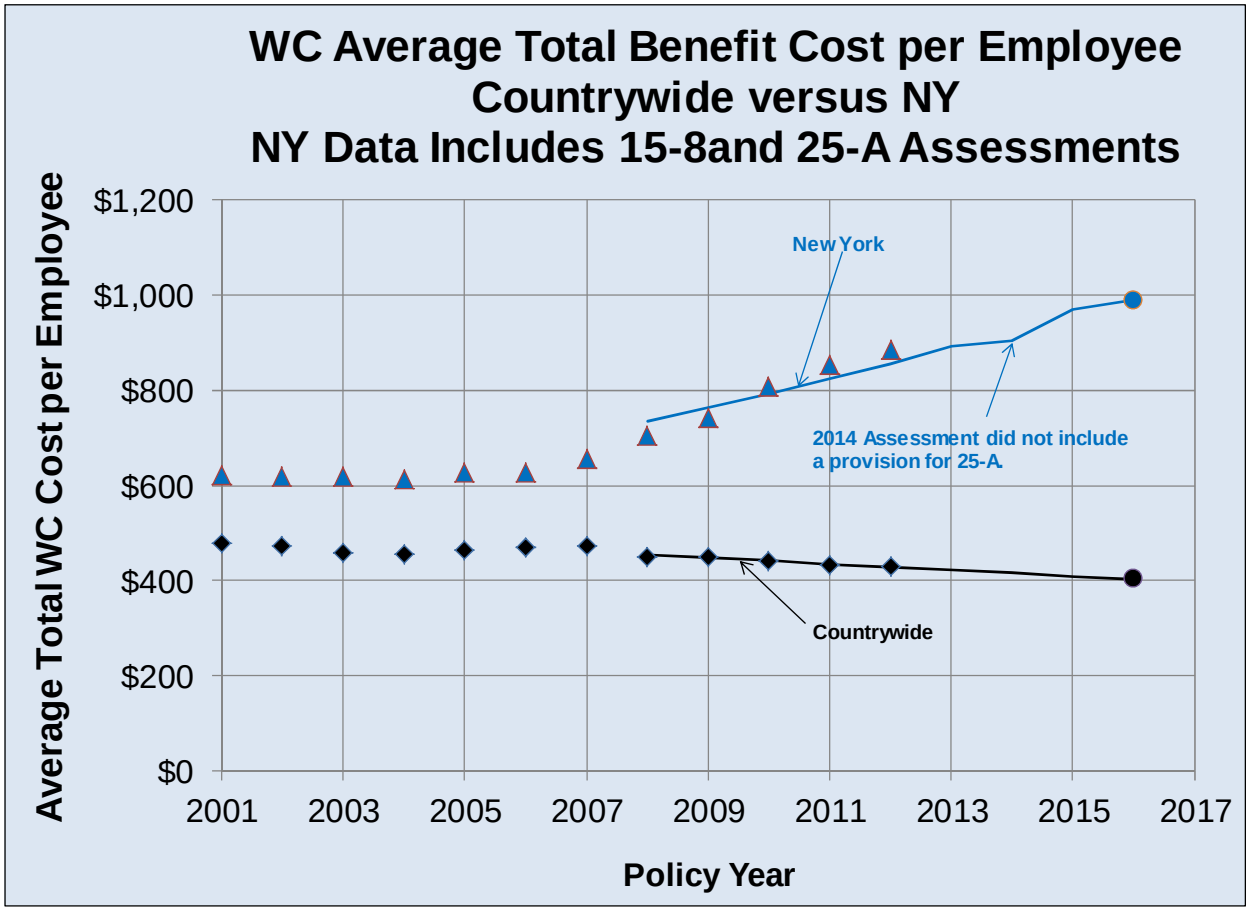
RANK	STATE	Average Cost per $100 payroll
1	CA	3.48
2	CT	2.87
3	NJ	2.82
4	**NY**	**2.75**
5	AK	2.68
6	OK	2.55
7	IL	2.35
8	VT	2.33
9	DE	2.31
10	LA	2.23

Note that the Oregon Study is based on loss costs that were effective in NY during 2014, and therefore does not reflect the increase to loss costs approved effective October 1, 2015, nor does the Oregon Study reflect adjustments implemented to bring published loss costs to the actuarially indicated level.

[25] The cost of benefits and claim related expense is the starting point from which WC premium rates are calculated. Insurance company expenses, commissions, profit, taxes, and other fees are added to the cost of benefits and claim related expenses to develop premium rates. Additionally, insurers will earn investment income on financial reserves established to fund claim payments. Insurers will often reflect anticipated investment income to set premium rates. None of these items are considered in this ranking. However, the ranking developed by the Oregon Department of Business and Consumer Services (see text) does.

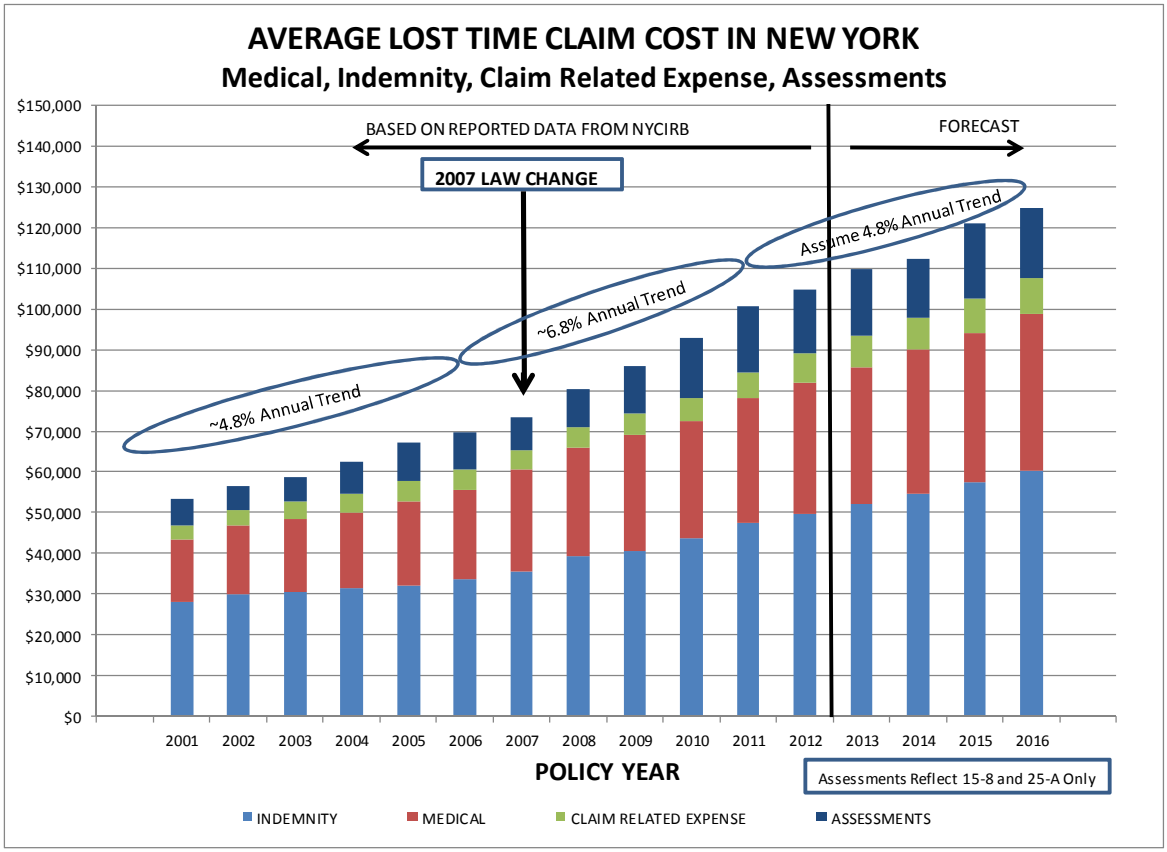
[26] Washington State would be the most noticeable difference between the Oliver Wyman and Oregon studies. WA has a large discount for investment income and a very low administrative expense provision in published premium rates. These two items are reflected in the Oregon ranking but would not be reflected in the Oliver Wyman ranking. WA is excluded from the Oliver Wyman ranking because as of the time of the publication of this paper because an an analysis of the WC classifications in WA has not yet been completed.

The following graph illustrates the average total WC cost per employee in NY relative to countrywide values. The distinguishing characteristic is that while average costs per employee in NY had been substantially greater (~40%) than countrywide values prior to 2007, average costs in NY were more than twice Countywide values by 2012. Average costs in NY are projected to be 2.5 times as great as countrywide values in 2016. The observed increase to NY costs per employee subsequent to 2007 are a direct result of the 2007 legislation, which was implemented as reform legislation with the intent of reducing WC costs in NY.



Closing Comments

The following graph displays the components of LT claim costs in NY from 2001 through 2016. Values subsequent to 2012 are forecasts given that insurance industry data is currently available only through 2012. The assessment components include provisions only for the Special Disability Fund (15-8) and the Reopened Case Fund (25-A), as these represent the cost of claims that have been shifted from insurers or self-insured employers to the respective funds, and therefore represent a component of claim costs.



The chart shows that the average cost of a LT claim in NY during 2016 is expected to approach $125,000. Comparable countrywide values are expected to be less than half this amount.

For additional information on the contents of this article, contact Oliver Wyman Actuarial Consulting, Inc.

Scott J. Lefkowitz, FCAS, MAAA, FCA
Oliver Wyman Actuarial Consulting, Inc.
48 South Service Road Suite 310
Melville, NY 11747
631-577-0548
scott.lefkowitz@oliverwyman.com

OLIVER WYMAN

Consulting Actuaries

Oliver Wyman Actuarial Consulting, Inc.
48 South Service Road
Suite 310
Melville, NY 11747
631-577-0548

www.oliverwyman.com/actuaries