

Task Force on Group Self-Insurance

*Report to Governor Paterson
and the New York State Legislature*

June 2010

Task Force on Group Self-Insurance Report to the Governor and the Legislature

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Chapter One - Executive Summary

A. BACKGROUND

Under current NYS law, employers who wish to self-insure for workers' compensation may either self-insure individually or join together and request approval to operate as a group self-insured trust (GSIT). The members of a GSIT proportionally share in any surplus which may have been generated by the trust (i.e., contributions for a given fiscal year which exceed expenses). Conversely, members are jointly and severally liable for any deficit which may occur when the contributions are inadequate to pay all of the GSIT's obligations for a given period.

Workers' Compensation Law (WCL) includes a provision which requires the Workers' Compensation Board (WCB) to assess all self-insured employers for all expenses incurred by the WCB relative to self-insured business. It has been the WCB's interpretation that this includes the WCB's administrative and regulatory costs and for the costs of any unmet obligations incurred by an insolvent individual or group self-insurer and that these costs are assessed pursuant to Section 50-5 of the WCL (50-5 assessment).

Prior to the 2006/07 fiscal year there had never been a group default in New York State. The 50-5 assessment was, as a result, only imposed for the administrative costs of running the self-insurance program and the defaults of several individual self-insurers. The total annual industry-wide assessment was below \$10 million.

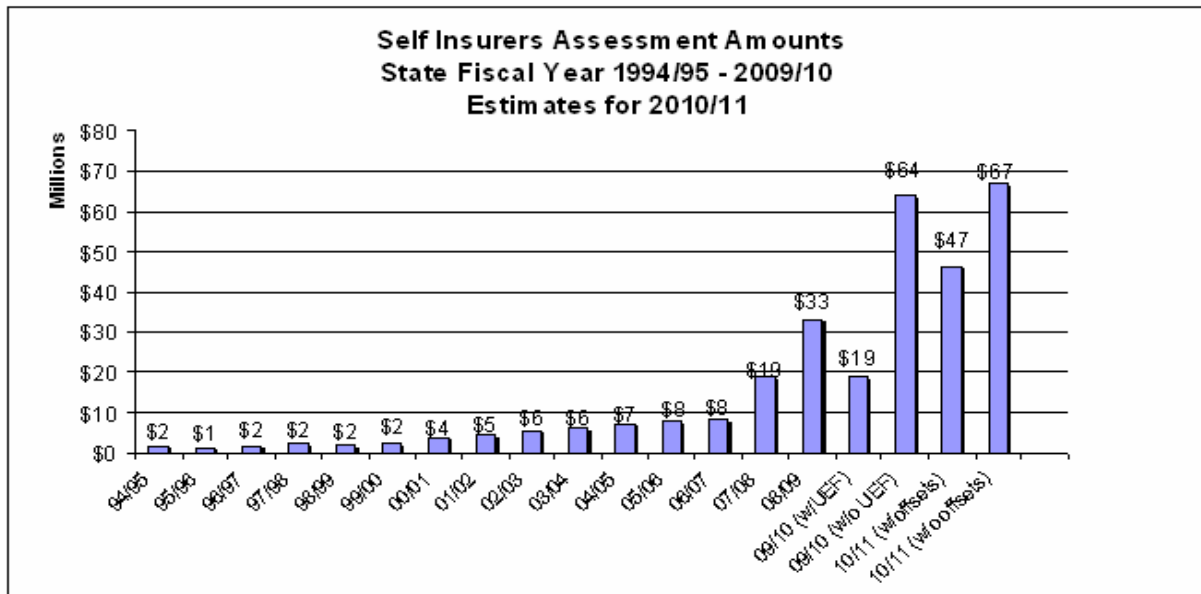
In 2006/07, for the first time in the history of the program, several groups were closed due to financial concerns; in 2007/08 those groups, plus several additional groups became insolvent. Due to a growing level of unfunded claims costs related to these insolvent groups, the 50-5 assessment for 2007/08 almost doubled. As additional groups defaulted, and as their projected level of unreserved claims has grown, this assessment has grown even higher.

The following chart depicts the change in the self-insurers' assessment from 1994/95 to levels projected for 2010/11. This assessment is made against all self-insurers based upon their proportionate share of indemnity payments made.¹

¹ The reform of 2007 changed the apportionment methodology for the self-insurers' assessment from security deposit held to pure premium. As a result of these changes, the group self-insurers were required to pay a larger share of the assessment as they have a larger proportionate share of pure premium than they have security deposits. The June 2008 legislation changed the methodology from pure premium to indemnity payments made and the split is now more evenly apportioned among both the individual and group self-insurers.

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Without the benefit of one time offsets which included borrowings from the Uninsured Employers Fund (UEF)², the assessment for 2009/10 would have been \$64 million. Due to the UEF borrowing, the actual assessment for 2009/10 was limited to approximately \$19 million. However, the 2010/11 assessment level has again seen significant increases and recent estimates have been set at \$47 million. This level reflects several one time funding offsets without which the assessment would be \$67 million. The future of this assessment has now been called into question by a decision of a New York Supreme Court Judge declaring it to be a violation of the United States Constitution’s “takings” clause in *Held v. New York State Workers Compensation Board* (“*Held*”) (Sup.Ct. Albany Cty. April 14, 2010).³

There are currently a total of 15 insolvent GSITs. Recent projections indicate that these groups have a combined deficit of \$498 million. It is important to note that this number reflects the completion of 7 out of 15 forensic reviews. Of those reviews, the trend indicates that the post forensic deficit is much larger than that originally stated by the groups. In fact, the total deficit for these 7 groups more than doubled from \$179 million to \$378 million post forensic. If this trend persists at this rate for the remaining 8 trusts whose forensics have yet to be completed, their deficit would increase from \$120 million to more than \$254 million; the total deficit for all 15 insolvent groups currently projected at \$498 million deficit would be over \$600 million.

² Legislation passed in 2008 authorized the WCB to borrow up to \$52 million from the UEF to defray the costs of the defaults of the group self-insured trusts, of which \$45 million was ultimately borrowed. The legislation provides for a repayment of \$3 million per year plus interest starting in SFY 2010-11.

³ A copy of the amended decision and the status of the *Held* lawsuit are included as Exhibit A. Also included is a list of the pending litigation related to various group trusts of which the WCB is aware.

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The majority of the assessment levels shown above for 2007/08 – 2010/11 is related to the cash flow needed to pay unfunded claims and benefits for these GSITs. The assessment levels will continue at similar or higher levels while these claims are being run-off unless efforts to collect funds owed by group members are more successful and/or other alternatives for funding the defaults are identified.

Currently, the total known funding shortfall or deficit is projected at \$498 million, of which 76% (\$379.1 million) is attributed to groups formerly administered by a single entity, Compensation Risk Managers (CRM); an additional \$30.6 million (6%) can be attributed to groups formerly administered by a second entity, Consolidated Risk Services (CRS). The forensic reports performed on a number of the insolvent groups documented a relationship between principals at CRM and CRS. As such, 82% of the outstanding deficits can be linked back to these common principals. The remaining 18% relates to four groups, which were each administered by different entities.

Joint and several liability among the members of a group trust was the intended security for the financial stability of the group self-insurance program in the event the GSIT's assets were insufficient. Collections from the employer members of the insolvent groups under joint and several continue to be pursued. However, as detailed later in this report, for a number of reasons including deficiencies in statute, delays and expense in pursuing joint and several recoveries⁴, this mechanism has failed to provide timely recovery of the joint and several obligations from the members of insolvent groups. Many former members of these insolvent groups have refused to pay WCB issued bills and some have challenged assessments through litigation. In fact, of the \$498 million total deficit billed to the employer members of the insolvent groups, only \$33.8 million has been collected to date (approximately 6.8%). This collection rate does not, however, include a significant number of commitments of funds via signed agreements, including agreements with members from the Healthcare Industry Trust of New York (HITNY) and the Manufacturing Self-Insurance Trust (MSIT) that will result in significant payments towards the liability of those GSITs.⁵

⁴ The expenses related to defaults include the cost of forensic reviews, administrative staff time and other litigation expenses associated with pursuing joint and several.

⁵ MSIT represents \$19.1 million of the total deficit. Of this amount the WCB has signed agreements from former members to pay \$14.2 million towards this liability. HITNY represents \$220.9 million of the total deficit. The WCB currently has an 18-month agreement with HITNY members to cover the monthly cash flow of the group which represents approximately \$27.4 million. The WCB also has agreements to pay from three other insolvent groups, a combination of which represents an additional \$22.6 million pledged. The total payments to date and remaining pledges equal \$82 million to offset the \$498 million deficit.

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In spite of the poor collection rates, claimants must continue to be paid the benefits to which they are entitled and receive timely medical care. The assessment made against all self-insurers has been the funding stream which guarantees those benefits until adequate collections are made from former group members of insolvent GSITs.

The impact of the assessments on the entire self-insurance community, the considerable amount of unfunded liabilities of the insolvent groups and the impact that joint and several liability has had on the employer members of the insolvent groups has called into question the group model and the long term viability of the group program and led to the creation of the Task Force.

B. TASK FORCE MANDATE

In order to understand the reasons for these defaults and assess the long term viability of the group model, legislation signed by Governor Paterson on June 30, 2008 created a Task Force on Group Self-Insurance.

As per the legislation members appointed to the Task Force include the following:

Joseph Pennisi, Task Force Chair (Through October 2009)	Designee of Chair, WCB
Mary Beth Woods, Task Force Chair (Appointed November 2009)	Designee of Chair, WCB
Bruce Topman	Designee of Superintendent of Insurance
Colleen Gardner	Commissioner of Labor
Art Wilcox	NYS AFL-CIO
Ken Pokalsky	Business Council
Steve Scotti	Individual Self-Insurer
Janice Johnson	Group Self-Insurer
Eric Frumin	Representative of WC Claimants
Harry Bronson	Nomination of Assembly
Alyssa Talanker	Appointment of Senate
Kate Powers	Appointment of Senate
Charles Fitz-Gerald	Without Limitation
Ciro Lupo	Without Limitation
Paul Magaril (member through February 2010)	Without Limitation

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The June 2008 legislation states that:

“The task force shall report to the Governor, the Speaker of the Assembly and the Temporary President of the Senate on or before February first, two thousand nine making recommendations concerning:

- 1. the prevention of future defaults by group self-insurers;*
- 2. regulation of group self-insurers and its impact and effectiveness;*
- 3. payment of claims insured by insolvent group self-insurers;*
- 4. the long term viability of group self-insurance; and*
- 5. such other topics related to group self-insurance as the task force may deem necessary.”*

The majority of the Task Force members were not appointed until well after the February 1, 2009 deadline for the report. Therefore, the deadline was not met. This report contains recommendations concerning each of the topics listed above and serves to address the legislative mandate.

C. METHODOLOGY

The Task Force met bi-weekly from April 2009 through March 2010, with the exception of a month in 2009, due to the appointment of a new Task Force Chair. A final meeting was held on May 27, 2010 to complete this report.

During the initial meetings it was resolved that the Task Force should go on record affirming the enforcement powers of the WCB and its Chair while the Task Force deliberations were conducted with regard to the collection efforts against members of insolvent trusts. A resolution of such was sent to Governor Paterson; the President Pro Tempore of the Senate; the Speaker of the Assembly; and the State Attorney General.

*A copy of that resolution is attached as **Exhibit B.***

During the course of the Task Force meetings, representatives of various stakeholders in the group self-insurance arena were asked to present information which they believed would assist the Task Force in developing its recommendations. Extensive documentation was also prepared by the WCB and reviewed by the Task Force members.

*A summary of the stakeholders that presented and the documentation reviewed is attached as **Exhibit C.***

*Attached as **Exhibit D** is a summary of the regulatory history of group self-insurance, including the proposed rules and regulations.*

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D. SCOPE

Pursuant to the legislative mandate of June 2008, the analysis and recommendations set forth in this report relate to group self-insurers. The scope of this report does not include the employers that self-insure for workers' compensation on an individual basis nor does it include other types of self-insurance such as disability benefits or political subdivisions that self-insure.

Pursuant to Section 50 of the WCL, groups that consist solely of State or local public entities are considered to be exempt from many of the annual report filings and the financial requirements applicable to private group trusts. This exemption is based upon the premise that the employer members of these public groups have taxing authority which supports the payment of their claims. As the public groups are not currently required to submit annual financial reports, they have been excluded from the analysis and summary information contained in this report. If similar instances of funding shortfalls or mismanagement are occurring in these types of groups it will cause financial distress among these public employers.

Therefore, the Task Force recommends that the New York State Office of the State Comptroller conduct audits of these entities to assure that abuses similar to those detected in the private group trust setting are not occurring.

There are five Roman Catholic Dioceses across the State that self-insure. These programs provide coverage for entities under the auspices of their particular diocese consisting primarily of churches, cemeteries, health care facilities and schools. Although these entities were admitted under the group self-insurance program, since their inception in the mid 1970's, they have operated in a hybrid individual/group manner. Specifically, unlike most group self-insurers that post a minimal security deposit, most of these programs have posted a larger security deposit, more typical of individual self-insurers.

The WCB has been working with each of the dioceses over the course of the past few years to determine which type of program, individual self-insurance or group, would be more appropriate for their particular circumstances. However, the WCB has not required each of the dioceses to definitively declare either option and fully meet all of the requirements of either the group or individual programs.

It is the recommendation of this Task Force that the WCB require each of the dioceses that self-insure to comply with all of the financial and programmatic requirements of self-insurance or obtain coverage via one of the other methods allowed under the WCL.

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E. SUMMARY OF FINDINGS AND RECOMMENDATIONS

Upon reviewing the extensive documentation and interviewing various stakeholders, the findings and recommendations of the Task Force are as follows:

1. Payment of Claims of Insolvent Groups

Collections from the employer members of the insolvent groups will continue to be pursued with the goal of satisfying, in full, the obligations of each insolvent trust. Ultimately, these collections will be used to pay the obligations of the insolvent trusts and to reduce the amount of future assessments made against the self-insurers, in the event *Held* is overturned and collection of such assessments resumes.

If the groups currently offering coverage were required to terminate or if more rigid financial standards were applied, the dramatic increase in the self-insurers' assessment resulting from the recent group defaults might be exacerbated by additional defaults. This potential certainly exists. There are a number of options which should be applied to mitigate these types of adverse consequences, including: improved funding levels for the active groups and/or those in run-off, earlier triggers for insolvency determination and posting of additional security deposits.

In addition, the Task Force is proposing a number of legislative and administrative enhancements which should increase the amounts collected and the timeliness of those collections, thus mitigating the impact that these defaults have on the remainder of the self-insurance community. A number of these elements have been included in an Article VII proposal (Part R of the General Government Article VII) contained in the 2010 Executive Budget.

The legislative enhancements will:

- Reaffirm the WCB's authority under Section 26 of the WCL to pursue judgments and provide other collection tools to the WCB in addition to traditional joint and several billings;
- Grant the WCB the authority to deem employers, in limited instances, who do not honor their joint and several obligations to be non-compliant with the coverage requirements of the WCL;
- Empower the WCB to pursue, in appropriate cases, all available actions such as stop-work-orders, debarment from public works and other penalties that are currently imposed on employers who do not have the required workers' compensation coverage;

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- Reaffirm the WCB's right as successor in interest to all the rights of the insolvent group trust;
- Reaffirm the WCB's right to immediate access to the records of the insolvent group trust and its advisor's records related to the trust including work products;
- Authorize the WCB to initiate joint and several lawsuits and other third party recoveries through retention of outside counsel, in addition to suits that may be brought by the Attorney General's Office; and
- Reform the State's assessment methodology for assessments other than the self-insurers' assessment by eliminating the GSIT category when distributing the initial indemnity liability among sectors. This option would result in the assessment liability being re-distributed to the remainder of the industry. The employers that participated in the group program would pay this liability with their new "carrier".

In addition to more timely collections of the joint and several liabilities of the employer members, the Task Force reviewed other tools which might limit the impact that insolvent groups have on the remainder of the self-insurance community.

The Task Force recommends:

- Legislation for Assumption of Workers' Compensation Liability Insurance Policy – An Assumption of Liability Policy, (ALP) will allow for the purchase of a policy to transfer the tail of workers' compensation claims and the risk of claims development to a carrier, absolving the self-insurance program from any further exposure. This alternative must be performed in a manner of assuring complete compliance with the WCB regulations and law, thus providing maximum protection for the claimant. In addition, the entity offering the ALP must make available liaison services for both the employees and the employers in the event there are issues that arise after transition. This option would be available to groups that are in run off and have adequate monies available to pay for the ALP as well as insolvent groups. The Task Force stresses that any such legislation should require a high level of financial participation by members of the insolvent group to ensure that a substantial portion of the deficit is covered by those members, thus mitigating the impact on the self-insurers' assessment. In addition, the Task Force recommends that the WCB consult with the individual and group advisory committees prior to the execution of any such transactions that impact the self-insurers' assessment.

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- WAMO Settlements – The Waiver Agreement Management Office (WAMO) was created as part of the Workers’ Compensation Reform Act of 2007. The Act allows a carrier, self-insurer, or the State Insurance Fund to be “paid” an amount equal to the value of claims in the Special Disability Fund in return for waiving future claims against the Fund. The WCB should explore the option, consistent with the terms of the legislation, for the insolvent group trusts to provide interim cash to pay claims or settlements pursuant to Section 32 of the WCL for cases accepted by the Special Disability Fund.

2. *Long Term Viability of the Group Program and Prevention of Future Defaults*

The Task Force deliberated on the future of groups and the long term viability of the group model. In doing so, the Task Force considered, among other things:

- What would be the financial viability of group trusts under the proposed WCB regulations, particularly the new funding requirements?
- Could the WCB effectively regulate the financial status of trusts, even with the newly proposed regulations?
- Do the current financial risks related to participation in a group trust outweigh the benefits, as defined by trust members?
- Is there sufficient confidence in the accuracy of financial and claims data for group trusts to assure effective WCB regulation and oversight?
- What coverage alternatives are available, or could be made available, to current trust participants that would reduce risks and retain benefits of trust membership?
- What are the risks of, and options for, closing down still active but under funded trusts?

Extensive documentation regarding the pros and cons of group self-insurance was reviewed, and various industry participants were asked to present information they deemed pertinent to this review. The benefits of group self-insurance were measured against the risks to employers and claimants.

According to group members and group administrators the benefits of group membership may include but are not limited to:

- Improved loss control services and outcomes;
- Aggressive return-to-work programs;
- Increased stability of rates;
- Enhanced coverage options for certain types of employers that have difficulty obtaining coverage in the commercial market; and
- Potential for dividends.

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Despite these asserted benefits, based on input from remaining active groups, serious concerns were raised regarding the future cost-competitiveness of groups given the new funding requirements. In contrast, the Task Force generally agreed that the rules and regulations are a minimum threshold but even the proposed requirements cannot ensure financial viability of the group self-insured trusts, particularly when such trusts are subject to manipulation by various parties associated with the trust. In addition, questions remain as to whether the WCB has or will have in the future sufficient and appropriate staff to provide effective oversight, especially with regard to financial, actuarial and claims management issues.

Based on evidence reviewed and extensive discussions, the Task Force has concluded that the inherent risks of group self-insurance, combined with the financial risks posed by insolvent groups, out-weigh the potential benefits.

The most notable flaws inherent to the group self-insurance program include the following:

- The joint and several liabilities can significantly impact the member employer's business operations and can have a serious impact on the employer's financial position, including their ability to borrow and acquire surety bonds, for years into the future.
- The amount of the assessment liability imposed by 50-5 fluctuates significantly and it is often required to be paid in a short time frame in order to meet the cash flow needs related to the unfunded liabilities of insolvent groups. Further, the future ability of the WCB to impose such assessments has been called into question by the *Held* decision.
- A significant level of trustee involvement and oversight is essential to ensure proper administration of the groups. This level of involvement for small business owners is overly burdensome and often not achievable.
- There is a conflict of interest that exists between the group administrator and the third party administrator particularly with regard to establishing accurate reserve estimates. Accurate reserves are the cornerstone of ensuring that a group remains healthy and able to meet its financial obligations. When manipulation of reserves is a product of such conflict of interest, effective regulation of the groups becomes nearly impossible. Gross understatement of the required reserves by the group's key advisors has been identified as a major reason for the downfall of a majority of failed group trusts.
- It is not cost beneficial, nor is it likely attainable, to provide the level of regulatory oversight needed to ensure that the group's maintain the necessary financial and operational standards to protect the employer members that participate in the group self-insurance program.

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- The information provided to and submitted by the independent consultants on behalf of the groups, including claims, actuarial and fiscal data is a key component to ensure that the group's funding position remains viable. It is difficult to ensure the veracity of the data in a cost beneficial manner.
- The excessive costs and time associated with pursuing litigation to enforce the joint and several provisions of the WCL further delay collection efforts.

The group model is built upon the joint and several liabilities of the employer members which likely outweigh the benefits that may be derived from belonging to a group. The Task Force finds that the group model imposes too much risk on the employers that participate in it and recommends that the group self-insurance program be terminated.

The Task Force recommends that efforts should be made to find acceptable alternatives to help the employers who are members of GSITs obtain alternative coverage, with appropriate arrangements for orderly transition and provisions for all appropriate benefits for claimants and uninterrupted coverage for employers.

3. Regulation of Group Self-Insurers (to the extent group self-insurance continues to exist)

As a result of the precarious position of the group program and the significant increase in the 50-5 assessment related to defaults, it is imperative that the WCB continue to pursue rules, regulations and prescribed reports which make an effort to address past deficiencies while the recommendations of the Task Force are under deliberation by the Governor and the Legislature.

Prior to the first meeting of the Task Force, the WCB drafted rules and regulations which would replace the current version (NYCRR Part 317) in its entirety. These rules and regulations have been reviewed, revised and are largely supported by the Task Force members and have been submitted to the Governor's Office of Regulatory Reform for pre-proposal review prior to formal promulgation.

The most notable enhancements included in the proposed rules and regulations include:

- Contribution year funding and reporting;
- Funding requirements which include a risk margin;
- Enhanced reporting; and
- More extensive independent examination of records and affairs of the group at least once every three years by service providers chosen by the WCB.

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At the same time, the Task Force recognizes that there are a number of fundamental components of the group model that are difficult to regulate even with the most stringent of regulatory environments. These challenges include:

- Appropriate reserving for claims;
- Adequate group oversight by trustees;
- Adequate WCB oversight;
- Prevention of misconduct by administrators;
- Enforcement and collection of joint and several; and
- Preparation, submission and evaluation of accurate actuarial and other financial reports.

These various challenges create an environment where it is difficult to identify mismanagement and potential fraud. In spite of the regulatory enhancements, Task Force members continue to have concerns that the group self-insurance model places participating employers, especially small employers, at significant financial risk. This is particularly true with respect to joint and several liability.

4. Other Topics Related to Group Self-Insurance

In addition to the specific topics to be reviewed by the Task Force per the legislation, there are two additional issues which were addressed. These issues are alternatives to group self-insurance for providing the required workers' compensation coverage and the overall impact of assessments on group trusts.

These topics were evaluated in the context of group self-insurance no longer being an option going forward.

Alternative Coverage: There are a number of alternatives that would provide employers with some degree of the benefits enjoyed with group self-insurance without exposing them to the risks discussed above. These alternatives may include but are not limited to:

- Safety group with the State Insurance Fund;
- Safety group with a carrier;
- Individual self-insurance;
- Selective self-insurance legislation that would allow for alternative coverage which might include "quasi-individual" self-insurance for a specific sector that exhibits a unique need and satisfies certain criteria.

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Assessments: The various assessments (other than the self-insurers' assessment) should be reformed by eliminating the GSIT category when distributing the initial indemnity liability among sectors. This option would result in the assessment liability being re-distributed to the remainder of the industry and the employers that had participated in the group program would pay this liability with their new "carrier" like all other employers.

F. CONCLUSION

It is the recommendation of the Task Force that legislation be prepared to terminate the group self-insurance program effective December 31, 2010. The Task Force strongly recommends that such legislation include alternative coverage options and be enacted sufficiently in advance so that all existing groups and their members have time to find alternative coverage which maintains the full benefits and rights of claimants.

In addition, in an attempt to mitigate the impact on all self-insured employers and to allow existing groups to better manage the run off, the following other legislative provisions should be included:

- Reaffirm the WCB's authority under Section 26 of the WCL to pursue judgments and provide other collection tools to the WCB in addition to traditional joint and several billings;
- Grant the WCB the authority to deem employers who do not honor their joint and several obligations non-compliant with the coverage requirements of the WCL;
- Empower the WCB to pursue all available actions such as stop-work-orders, debarment from public works and other penalties that are currently imposed on employers who do not have the required workers' compensation coverage;
- Reaffirm the WCB's right as successor in interest to all the rights of the insolvent group trust;
- Establish the WCB's right to immediate access to the records of the insolvent group trust and its advisor's records related to the trust including work product;
- Authorize the WCB to initiate joint and several lawsuits and other third party recoveries through retention of outside counsel, in addition to suits that may be brought by the Attorney General's Office;
- Reform the assessments (excluding the self-insurers' assessment) by eliminating the GSIT category when distributing the initial indemnity liability among sectors. This option would result in the assessment liability being re-distributed to the remainder of the industry and the employers that participated in the group program would pay this liability with their new "carrier".

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- Authorize assumption of workers compensation liability insurance policies to give GSITs the ability to manage or eliminate their tail of claims. This alternative must be performed in a manner which assures complete compliance with the WCB regulations and law, thus providing maximum protection for the claimant. In addition, the entity offering the assumption of liability policy must make available liaison services for both the employees and the employers in the event there are issues which arise after transition.

In the interim, while the recommendations of the Task Force are being considered by the Governor and the Legislature, the Task Force is recommending that the WCB take the following administrative actions:

- Upon finalization, implement the regulations to mitigate any additional deterioration of the group self-insurance program;
- Continue its independent reviews and remediation efforts with the GSITs to verify and strengthen their financial condition;
- Intervene earlier for under funded GSITs that may become insolvent to ensure timely collections under joint and several so there is minimal self-insurers' impact;
- Aggressively work with the under funded GSITs to increase the funding levels and, where possible, increase security deposits for under funded GSITs;
- Work with the Waiver Agreement Management Office to secure amounts owed from the Special Disability Fund to help offset the ongoing claims costs for accepted cases;
- Assist existing group members to obtain alternative coverage as needed; and
- Increase the number and type of staff at the WCB to ensure aggressive and adequate oversight of the group trust industry.

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Chapter Two – History of the Group Self-Insurance Program

A. BACKGROUND

Employers who elect to become self-insured for workers' compensation on either an individual or group basis must apply to and be approved by the Workers' Compensation Board (WCB). Self-insurers must maintain adequate funding so that the proper workers' compensation benefits are paid to injured workers.

A GSIT must establish and maintain a dedicated trust financed by the contributions of members for the exclusive purpose of paying for and otherwise administering workers compensation liabilities incurred by the members. GSITs are required to maintain acceptable assets in the trust which are at least 100% of total liabilities. Groups that fail to maintain the appropriate funding levels are deemed under funded and are subject to a number of sanctions aimed at restoring the GSIT's funding in a timely manner.

The WCB requires individual self-insurers to post security deposits which represent the ultimate workers' compensation liabilities of the employer. If an individual self-insurer defaults on their workers' compensation claims, the WCB uses the security deposit to pay claims. GSITs must also post security deposits with the WCB.

The first groups approved to operate were required to post a security deposit similar to those of the individual self-insurers. However, over time, there occurred a shift in the policy of the WCB related to the amount of security required of the groups. In lieu of a security deposit that was equal to the GSIT's ultimate liabilities, the focus was for each group self-insurer to maintain a trust which is dedicated to the payment of the workers' compensation obligations of the group members. The security deposit posted by most GSITs is minimal and equates to little more than a "risk margin" if the trust's liabilities develop higher than projected.

In addition to the dedicated trust fund, an underlying premise of group self-insurance is that the employer members who participated in a GSIT are jointly and severally liable for all of the GSIT's obligations incurred during their period of membership. A fully funded GSIT coupled with the joint and several liabilities of the employer members was intended to be the equivalent of the full security deposits posted by the individual self-insurers. GSITs must also maintain excess insurance coverage which protects the group from catastrophic losses on a per occurrence basis.

Members of GSITs in New York must be homogeneous. The homogeneity requirement is based on the assumption that employers in the same industry better understand the risk/exposure for which they are jointly and severally liable. The rules and regulations define homogeneity broadly as "employers that perform related activities in a given industry".

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Chapter Two – History of the Group Self-Insurance Program (continued)

The board of trustees of a GSIT is responsible for ensuring that the GSIT adheres to the WCL and all applicable rules and regulations. The trustees of the GSIT have fiduciary responsibilities to the members and, as such, must ensure that the group is being administered for the benefit of the employer members. The trustees must coordinate and oversee the services of any parties providing services to the group. This would include, for example, the group administrator, third party administrator, legal services, loss control, accounting, actuarial and investment management. The trustees must fulfill the duties outlined in the group self-insurer's trust document, bylaws, and participation agreement.

The group administrator is described as that entity responsible for assisting the GSIT in complying with the provisions of the WCL and the rules and regulations promulgated thereunder. With varying degrees of trustee oversight, the group administrator is typically delegated responsibility for the coordination of services including, but not limited to, insurance purchasing, loss control, legal, accounting and actuarial services.

In addition to the group administrator, each GSIT will also typically obtain the services of a third party administrator (TPA) or claims administrator. The TPA is the individual or entity licensed by the WCB, responsible for the administration and defense of workers' compensation claims of members of an authorized self-insurer.

GSITs are currently required to submit financial statements prepared in accordance with Generally Accepted Accounting Principles (GAAP) as well as an actuarial report and payroll information by classification code. As the definition of regulatory trust assets and liabilities differs from that under GAAP, a GSIT's regulatory funding position may differ, in some cases dramatically, from the financial statements prepared in accordance with GAAP.

A GSIT's regulatory funding level is generally less than its GAAP funding level. A GSIT's regulatory funding level only considers cash or liquid investments that are immediately available to pay claims. The most common adjustments made when determining regulatory funding are the exclusion of receivables including contributions receivable; exclusion of investments that exceed the limitations prescribed by the rules and regulations; pledged or collateralized assets; and adjustments related to the valuation of claims reserves.

The WCB performs an annual review of this data and determines the regulatory funding position of every active GSIT. A report is provided annually to each GSIT's trustees and upon request, to members. However, the details are not released to the general public as much of the specific financial and programmatic information has been considered proprietary to the GSIT.

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Chapter Two – History of the Group Self-Insurance Program (continued)

The WCB publishes limited information on each active GSIT which includes the following:

- group name;
- group origination date and fiscal year end;
- industry served;
- number of active members;
- name and contact information for the group/group administrator; and
- operating restrictions imposed (if any).

Additionally, as of January 2010, the WCB began to include the following:

- percentage of regulatory funding level; and
- amount of regulatory deficit (if applicable).

The rules and regulations currently governing group self-insurers (NYCRR Part 317) were enacted in January of 2001. Under these rules and regulations a group shall continue for such time as may be necessary to accomplish the purpose for which it was created as long as all requirements to maintain authorization continue to be met. A GSIT that is currently offering coverage for workers' compensation to its employer members is known as an "**active group**".

Upon termination of a GSIT's status as a self-insurer (either voluntarily or involuntarily), the GSIT will be considered to be "**inactive**". The GSIT will continue to administer the workers' compensation liabilities incurred during its period of existence, provided they demonstrate their ability to do so to the satisfaction of the WCB. The board of trustees of all inactive GSITs must designate the appropriate key advisors (e.g., group administrator, claims administrator, accountant, actuary, etc.). An inactive GSIT that is able to meet all of its obligations and maintain adequate cash reserves under the WCL is considered to be in "**run-off**".

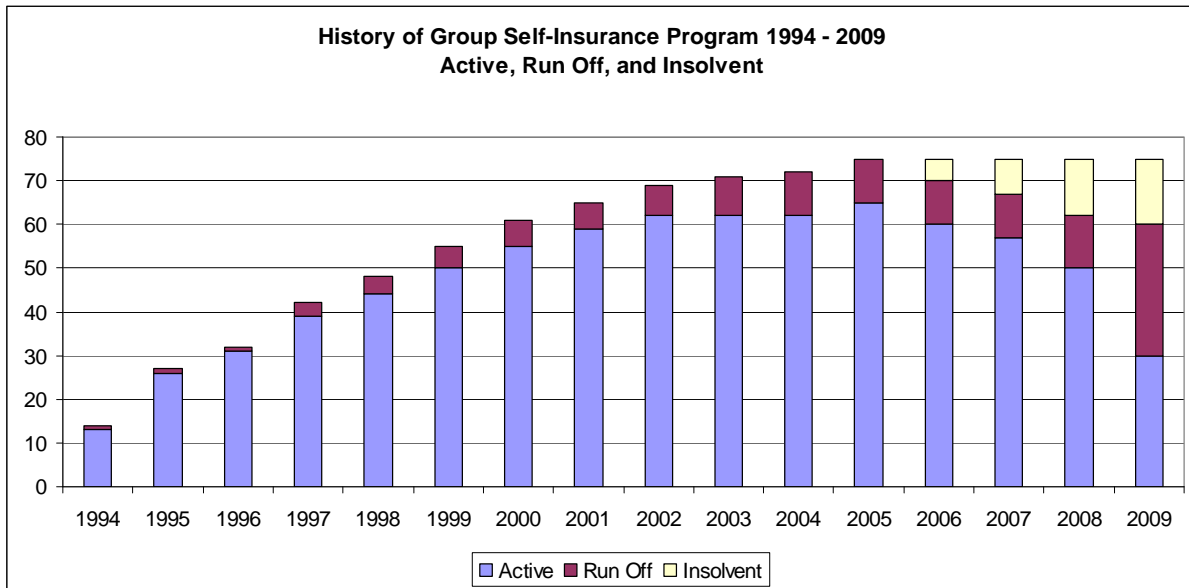
If a group is unable to pay its outstanding lawful obligations it is considered to be "**insolvent**". Insolvency is demonstrated when: i) the group is under funded; and ii) the sum of the group's available cash and investments is less than the total cost of all the group's liabilities that will be paid within the succeeding six months. Under NYCRR Part 317.20, a designation of insolvency allows the WCB to use the self-insurers' assessment, if necessary, to ensure the uninterrupted payment of benefits under the WCL.

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Chapter Two – History of the Group Self-Insurance Program (continued)

The information contained herein summarizes the operational information on file with the WCB as well as a review of the GAAP statements, actuarial reports and the determination of the regulatory funding position of every GSIT performed by the WCB annually.⁶ The information on the inactive GSITs includes those that closed due to funding shortfalls as well as GSITs that were adequately funded and closed on a voluntary basis.

The chart below depicts the dramatic shift in the number of each type of group from 1994 to 2009:



As shown on the chart above, the number of active GSITs increased steadily from 1994 reaching its peak in 2005 with 65 active groups. The first decrease in the overall number of active GSITs occurred from 2005 to 2006 with a reduction from 65 GSITs down to 60. That decline in the number of active GSITs has continued; as of the end of 2009 there were only 30 GSITs actively providing coverage.

Up until 2005, although there were a small number of inactive GSITs, none of them were deemed to be insolvent. As such, they were able to meet all of their obligations under the WCL and they had no impact on the self-insurers' assessment made against the entire industry.

⁶ Annual reports are not due to the WCB until 120 days after the close of the fiscal year. As such, most of the 2009 reports were not filed until May 2010. The information contained herein was based on the 2008 fiscal year filed in May of 2009.

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Chapter Two – History of the Group Self-Insurance Program (continued)

Since 2005, both the number of inactive GSITs and their financial status has changed dramatically. These changes can be traced, in part, back to the enactment of NYCRR Part 317 on January 31, 2001. At that time, it was determined that many of the provisions would be applied to the fiscal years that began on or after that effective date. Therefore, the first audited reports held to the new standards were for the fiscal year which ended on December 31, 2002. These reports were received by the WCB in May 2003, in accordance with the new filing deadlines. As a result, 2003 was the first time that the WCB was able to begin to measure each GSIT's compliance with the various programmatic and funding standards outlined in the 2001 rules and regulations.

Based upon those reviews, it became apparent that there were more than a dozen GSITs with significant funding issues. The WCB was concerned that some of those GSITs would never achieve fully funded status. Despite remediation efforts, in 2006 and 2007 several of these GSITs terminated coverage and were deemed to be insolvent.

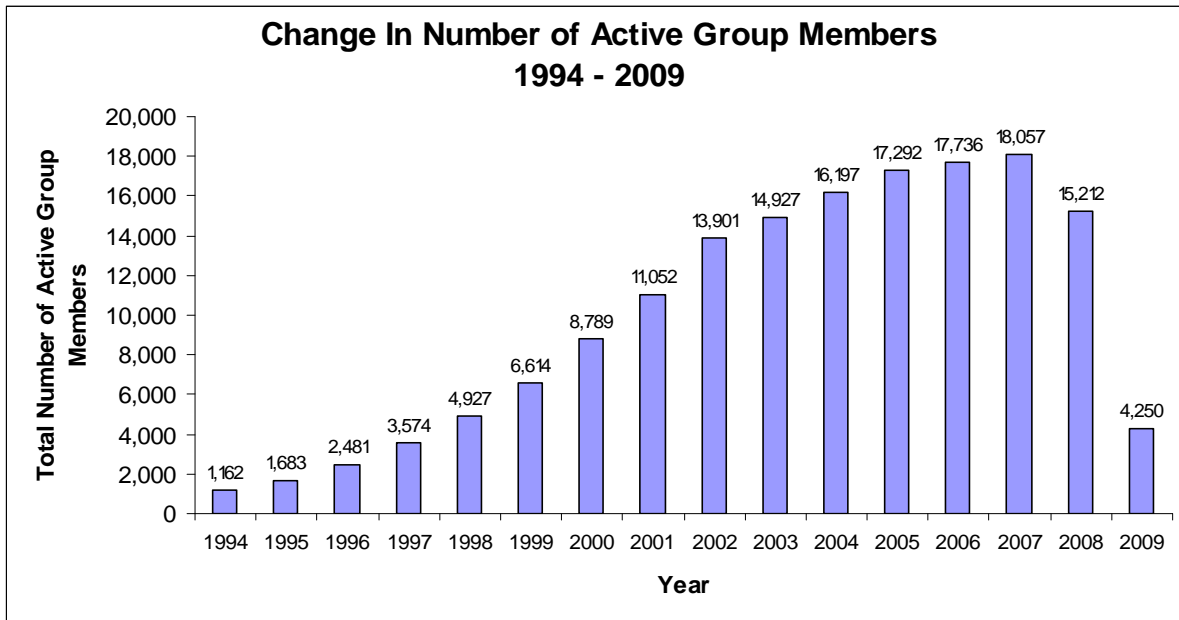
In 2007 and 2008, 7 GSITs administered by Compensation Risk Managers (CRM) defaulted unexpectedly. Unlike the insolvencies the WCB dealt with previously, prior to the default of these 8 groups, there was little to no indication in the financial and actuarial reports submitted that there was financial distress of the magnitude ultimately identified.

Finally, during 2009, an additional 20 groups ceased offering coverage. Of those, 19 closed voluntarily and are currently in run-off. Of these, 7 are under funded but have not defaulted on their workers' compensation obligations. They continue to be monitored by the WCB to ensure they are able to meet all of their ongoing obligations. The other GSIT that closed during 2009 was deemed to be insolvent and was terminated effective July 1, 2009. It is likely that additional GSITs may close voluntarily due to the current environment for group self-insurance. There may also be other groups that will be forced to close if their funding does not meet the minimum standards prescribed by the WCL.

With the decrease in the number of active GSITs, came a decrease in the number of employers actively participating in the group program, as shown here:

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Chapter Two – History of the Group Self-Insurance Program (continued)



Of the estimated 550,000 employers in the State of New York, the number of employers that obtained the required coverage from an active GSIT reached its peak in 2007 with more than 18,000 active members. As a result of the GSIT closings discussed above (both voluntary and involuntary), the number of active members reached a ten-year low as of the end of 2009 with only 4,250 employer members actively participating.

B. ACTIVE GSITs

A fundamental premise of GSITs in New York is that a group must be homogeneous since employers in the same industry better understand the risk/exposure for which they are jointly and severally liable. The rules and regulations define homogeneity broadly as “employers that perform related activities in a given industry”.

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Chapter Two – History of the Group Self-Insurance Program (continued)

The homogeneity of the 30 GSITs active as of the end of 2009 can be broken out as follows:

<i>Type of Group</i>	<i># of Active Groups</i>	<i># Active Members</i>
<i>Health and Social Service Sector</i>	<i>12</i>	<i>660</i>
<i>Contractors/Services to Contractors</i>	<i>3</i>	<i>1,300</i>
<i>Auto Service/Repair/Recovery</i>	<i>2</i>	<i>390</i>
<i>Retailers/Wholesalers</i>	<i>2</i>	<i>350</i>
<i>Transportation</i>	<i>2</i>	<i>200</i>
<i>Passenger Transportation</i>	<i>2</i>	<i>50</i>
<i>Eating and Drinking Establishments</i>	<i>1</i>	<i>270</i>
<i>Electrical Workers/Contractors</i>	<i>1</i>	<i>480</i>
<i>Gas/Petroleum/Fuel Oil Sales</i>	<i>1</i>	<i>90</i>
<i>Lumbermen</i>	<i>1</i>	<i>310</i>
<i>Manufacturing – Various Types</i>	<i>1</i>	<i>60</i>
<i>Printing</i>	<i>1</i>	<i>50</i>
<i>Schools/Colleges/Universities</i>	<i>1</i>	<i>40</i>
<i>Total</i>	<i>30 Groups</i>	<i>4,250 Members</i>

As of the end of 2009, there were 4,250 employer members actively participating in 30 active GSITs. Of these 30 GSITs, almost half (12 groups) consisted of employers in the health and social service field and had a total of 660 employer members for an average membership size of 55 members. There were 3 groups consisting of employers that are contractors or provide services to contractors; they had a total of 1,300 employer members. The remaining types had only 1 or 2 groups actively providing coverage as of the end of 2009, and the average size of these groups was about 150 employer members.

The following is a listing of the active GSITs, summarized by group administrator:

<i>Group Administrator</i>	<i>Group(s) Name</i>
<i>Arthur J. Gallagher Risk Mgmt Services</i>	<i>New York Bus Operators Comp Trust New York Operators Self-Insurance Trust</i>
<i>Cool Insurance Agency</i>	<i>NYAHSA Services, Inc. Self-Insurance Trust</i>
<i>FCS Administrators, Inc.</i>	<i>Automobile Dealers WC SI Trust Human Services Self-Insurance Trust Fund New York Choice Self-Insurance Trust Niagara Business Trust</i>
<i>First Niagara Risk Management, Inc.</i>	<i>New York State Motor Truck Association</i>

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Chapter Two – History of the Group Self-Insurance Program (continued)

<i>Group Administrator</i>	<i>Group(s) Name</i>
<i>Marsh USA, Inc.</i>	<i>New York College & University Risk Mgmt Western NY Hospital Risk Management Group</i>
<i>NCA Comp, Inc.</i>	<i>Contractors Self-Insurance Trust Fund PIA Manufacturers Self-Insurance Trust Fund</i>
<i>New York Compensation Managers</i>	<i>Automotive Service & Repair SI Trust NYSARC Workers' Compensation Trust Special Trades, Contracting and Construction</i>
<i>PMA Management Corp of New England</i>	<i>Hudson Health Care Workers' Comp Group</i>
<i>Program Risk Managers, Inc.</i>	<i>Community Residence Insurance Savings Plan ESTRA Self-Insurance Trust TEAM Transportation WC Trust</i>
<i>Reller Risk Management, LLC</i>	<i>Associated Builders & Contractors</i>
<i>EBS-RMSCO, Inc.</i>	<i>Beer Wholesalers Comp Trust of NY</i>
<i>SAFE, LLC</i>	<i>Healthcare of New York WC Trust</i>
<i>Self Funding, Inc.</i>	<i>Healthcare Underwriters Mutual Risk Mgmt</i>
<i>W.J. Cox Associates, Inc.</i>	<i>New York Lumbermen's Insurance Trust Fund</i>
<i>Self Administered</i>	<i>Baumann Self-Insurance Trust Electrical Employers SI Safety Plan McGuire Group Trust New York State Health Providers WC Trust Northeast Health WC Plan Via Health Workers' Compensation Trust</i>

In addition to the group administrator, each GSIT will also typically obtain the services of a third party administrator (TPA) or claims administrator. The TPA is the individual or entity licensed by the WCB, responsible for the administration and defense of workers' compensation claims. Of the 30 GSITs active as of the end of 2009, 16 were using a third party administrator that is either the same entity as their group administrator or is an affiliate, thus raising a possible conflict of interest. The TPAs for the remaining 14 GSITs are entities separate from the group administrator.

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The 2002 fiscal year was the first under the new funding/reporting standards prescribed by the rules and regulations that were enacted in 2001. As such, it is not surprising that this is the year when the most significant regulatory deficit was reported, with the GSITs showing a combined regulatory deficit totaling more than \$181 million. Since that time, the combined regulatory funding, as reported to the WCB, has substantially improved.⁷ As shown here, the overall combined 2008 regulatory surplus for the 30 GSITs active as of the end of 2009 is just under \$65 million:

Total Regulatory Assets	\$778,787,000
Total Regulatory Liabilities	<u>\$714,145,000</u>
Total Surplus	<u>\$ 64,644,000⁸</u>
Trust Equity Ratio	109%

In addition to the dollar amount of surplus or deficit which exists, the regulatory trust equity ratio (regulatory assets/regulatory liabilities) provides a measure of the program's solvency based upon assets versus liabilities. The combined regulatory trust equity ratio has improved substantially from 2002 – 2008, more than doubling from 53% in 2002 up to 109% in 2008.

The financial position of each GSIT must stand on its own. Therefore, while the combined regulatory funding and corresponding trust equity ratio summarized above provides some measure of the funding condition of the active program overall, the aggregated data nets together groups with surpluses against those with deficits. The trust equity ratio for each group provides a more meaningful indicator of the condition of each program from a regulatory perspective.

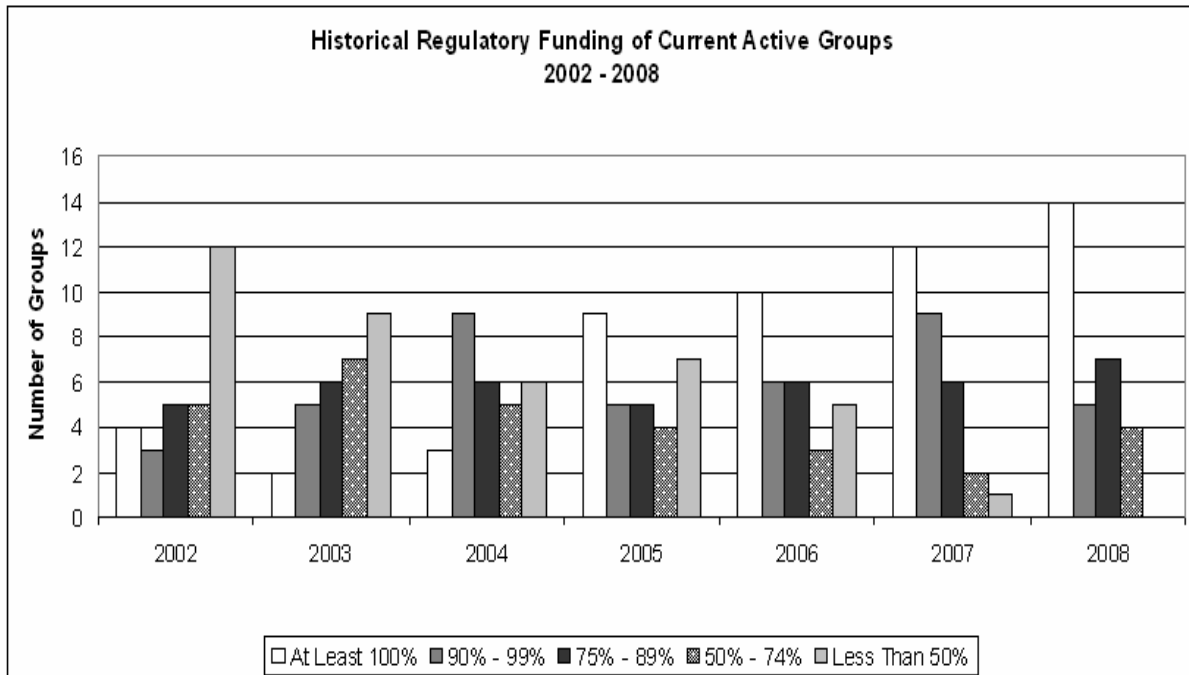
The historical regulatory trust equity ratios of the 30 GSITs active as of the end of 2009 can be broken out as follows:

⁷ Regulatory funding levels are determined based on financial statements and actuarial reports submitted by the trust.

⁸ It is important to note that one trust represents \$63.8 million of the surplus. Without this, the overall funding ratio would be slightly over 100%, with many of the groups still under funded.

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As shown, the funding levels of the 30 groups active as of the end of 2009 has improved since 2002. The number of groups that were at least 100% funded has changed from only 4 groups in 2002 up to 14 in 2008. In 2002, 12 of these groups were less than 50% funded; as of the end of 2008, no active group had regulatory funding of less than 50%.

Despite the increase in the number of GSITs that have achieved 100% funding, over one third of the GSITs active as of the end of 2009 are still funded at less than 90% as of 2008, including 4 that are less than 75% funded.

It is also important to note that the regulatory funding summarized here is based on the financial and actuarial reports as submitted and the annual review of these reports performed by the WCB. While those determinations may prove accurate, it is possible that the funding could change dramatically under the proposed funding and reporting structure going forward. For example, results of the forensic reviews on the insolvent GSITs required dramatic increases to the outstanding reserves. If similar restatements were needed for the 30 active GSITs, the funding levels summarized above could potentially be very different. Similar increases related to the accrual for WCB assessments may also prove necessary further affecting the funding levels shown.

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Chapter Two – History of the Group Self-Insurance Program (continued)

C. GSITs IN RUN-OFF

As of the end of 2009, there were 30 inactive GSITs that are deemed to be in run-off. Based upon the most recent information filed for these groups, it has been determined that each group is currently able to meet the necessary requirements and remain in the hands of their respective board of trustees who are responsible for appointing all appropriate key advisors including a group administrator to handle the day-to-day operations and a third party administrator to handle claims.⁹

If at anytime during the run-off the WCB determines that any of these GSITs will be unable to adequately administer the trust or if the trust has less than twelve months of cash to pay claims, the WCB will move to take over the administration of the GSIT including all aspects of its financial and programmatic operations.

The following is a listing of the 30 GSITs in run-off including the group name; effective and termination dates; number of years offering coverage; and total number of members while active.

⁹ The Preferred Manufacturers Insurance Trust Fund has been included with the groups considered to be in run-off since they are not insolvent; however, due to recent court rulings the WCB has assumed administration.

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Chapter Two – History of the Group Self-Insurance Program (continued)

Inactive Group Self Insurers In Run-Off (sorted alphabetically by group name)

Group Name	Effective Date	Termination Date	# of Years Offering Coverage	Total # Members	Status
<i>Building Exterior Services Trust of New York</i>	3/30/1994	5/12/2003	9	40	<i>Run-Off</i>
<i>Business Council WC Manufacturers Group SI Trust</i>	1/1/1996	1/1/2009	13	1,264	<i>Run-Off</i>
<i>Contractors Compensation Trust</i>	11/1/1999	1/1/2009	9	2,866	<i>Run-Off</i>
<i>Cooperative Association of Food Enterprises WC Trust</i>	6/13/1995	1/1/2009	14	3,986	<i>Run-Off</i>
<i>ElderWood Senior Care Self Insurance Trust</i>	11/1/2005	1/1/2009	3	14	<i>Run-Off</i>
<i>ELEC-Con Trust</i>	7/1/2001	1/1/2009	8	536	<i>Run-Off</i>
<i>Empire State Agricultural Compensation Trust</i>	12/31/1997	1/1/2009	11	1,801	<i>Run-Off</i>
<i>Empire State Education Trust</i>	6/30/2000	1/1/2009	9	112	<i>Run-Off</i>
<i>Empire State Hospitality Workers Compensation Trust</i>	3/1/1996	1/1/2009	13	731	<i>Run-Off</i>
<i>Empire State Transportation WC Trust</i>	1/1/1995	1/1/2009	14	935	<i>Run-Off</i>
<i>Excellus Companies Workers' Compensation Trust</i>	12/1/1995	9/1/2002	7	7	<i>Individual SI</i>
<i>First Automotive Services Trust</i>	1/1/2005	1/1/2009	4	1,018	<i>Run-Off</i>
<i>Gioia Insurance Trust Fund</i>	10/1/1991	12/31/2000	9	5	<i>Term Prior to 2001</i>
<i>Independent Grocers WC Self-Insurance Trust</i>	4/26/1996	7/1/2009	13	68	<i>Run-Off</i>
<i>Long Term Care Risk Management Group</i>	10/1/1992	12/31/2009	17	69	<i>Run-Off</i>
<i>Mercantile Self Insurance Trust</i>	10/1/1994	2/29/2008	13	575	<i>Run-Off</i>
<i>Metropolitan New York College & University WC Group</i>	7/1/1996	12/31/1999	4	11	<i>Merged</i>
<i>New York McDonalds Operators Workers' Comp Trust</i>	1/1/1999	1/1/2009	10	155	<i>Run-Off</i>
<i>New York Petroleum Association Compensation Trust</i>	7/1/2001	1/1/2009	8	228	<i>Run-Off</i>
<i>New York State Agricultural Compensation Trust</i>	1/1/1995	1/1/2004	9	183	<i>Merged</i>
<i>NY Transportation Workers' Compensation Trust</i>	12/1/2000	1/1/2009	8	1,374	<i>Run-Off</i>
<i>OLV Home Group</i>	4/1/1992	3/1/2003	11	4	<i>Individual SI</i>
<i>OHI Workers' Compensation Trust</i>	1/1/1998	12/31/2009	12	165	<i>Run-Off</i>
<i>Park Ridge Health System Workers' Comp Trust</i>	11/1/1995	11/1/1997	2	13	<i>Term Prior to 2001</i>
<i>Preferred Manufacturers Insurance Trust Fund</i>	1/1/1993	9/1/2009	17	211	<i>Run-Off</i>
<i>Rest Inn Safety Plan</i>	1/1/1971	4/1/1985	14	800	<i>Term Prior to 2001</i>
<i>Retailers of New York Workers Compensation Trust</i>	9/1/1997	1/1/2009	11	1,420	<i>Run-Off</i>
<i>Road and Bridge Construction Workers' Comp Trust</i>	8/20/1996	4/30/1998	2	12	<i>Term Prior to 2001</i>
<i>Selective Safety Trust</i>	10/1/1995	1/1/2009	13	161	<i>Run-Off</i>
<i>Sisters of St Francis Healthcare Group</i>	1/1/1994	7/25/1997	4	6	<i>Term Prior to 2001</i>
Averages			10	626	
Totals				18,770	

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These 30 GSITs were actively offering coverage for an average of 10 years. They provided coverage to more than 18,000 employers and had an average membership size of just over 600 members.

Of the 30 GSITs considered to be in run-off, 5 voluntarily terminated before the enactment of the 2001 rules and regulations; therefore, these GSITs are not required to submit annual financial and actuarial reports. However, as each of these GSITs has been inactive for a lengthy period, most, if not all, of the exposure related to their outstanding self-insured obligations has been addressed.

Two of the inactive GSITs merged with other active groups. In such cases, the surviving GSIT assumes the tail of liabilities of both as is allowed under NYCRR Part 317. One of the surviving GSITs, the Empire State Agricultural Compensation Trust voluntarily terminated coverage effective 1/2009. This group is responsible for the run-off of claims incurred by both the New York State Agricultural Compensation Trust and the Empire State Agricultural Compensation Trust. The other inactive group, the Metropolitan New York College and University WC Group merged with the New York College and University WC Risk Management Group which continues to offer coverage.

Two GSITs converted to individual self-insurance programs as it was determined that the employer members of these groups were more appropriately self-insured on an individual basis. These GSITs include: Excellus Companies Worker's Compensation Trust and OLV Homes Group. As individual self-insurers, these employers annually submit detailed claims information including amounts paid and reserved for all claims. The WCB reviews this information to determine the appropriate amount of security deposit that must be posted by these employers to be used by the WCB in the event the employers ever default on their self-insured obligations. Each of these employers brought their tail of claims incurred under their group programs into their individual self-insured programs and this is reflected in the amount of security they are required to post. As a result, there is no outstanding liability for the two as group self-insurers.

With the exclusion of the 5 that terminated prior to 2001, the 2 that merged with other GSITs, and 2 that converted to individual self-insurance, there are 21 remaining GSITs considered to be in run-off status. Each is required to submit regular cash flow reports to the WCB as well as annual financial and actuarial reports. This information is used by the WCB to ensure each GSIT's ongoing ability to meet all of their obligations under the WCL.

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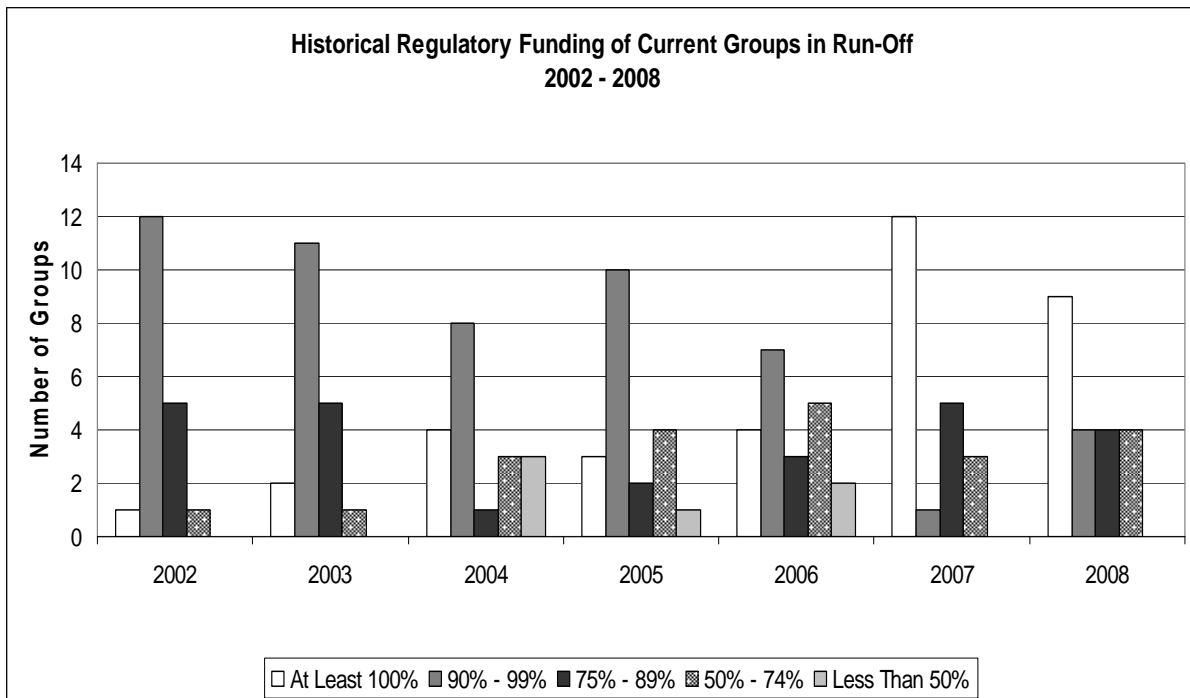
Chapter Two – History of the Group Self-Insurance Program (continued)

The overall combined 2008 funding levels for these 21 groups in run-off are as follows:

Total Regulatory Assets	\$416,539,000
Total Regulatory Liabilities	<u>\$430,078,000</u>
Total Deficit	<u>(\$ 13,539,000)</u>
Trust Equity Ratio	97%

The 21 GSITs in run-off have regulatory assets of \$417 million, just slightly lower than their regulatory liabilities of \$430 million and a trust equity ratio (regulatory assets/regulatory liabilities) of 97%.

As is the case with the active GSITs, the financial position of each inactive GSIT in run-off must stand on its own. Therefore, while the combined regulatory funding and corresponding trust equity ratios summarized above provide some measure of the funding condition of these GSITs overall, the aggregated data nets together groups with surpluses against those with deficits. The specific funding level of each group program provides a more meaningful indicator of the condition of these group programs in run-off from a regulatory perspective.



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Of the 21 GSITs in run-off, 9 have a funding level of at least 100% and another 4 have funding between 90% and 99%. Based upon the information filed with the WCB these inactive GSITs appear to be able to meet all of their obligations incurred during their various periods of providing active coverage.

As of the 2008 fiscal year end, these GSITs are as follows:

**Inactive Group Self Insurers In Run-Off - Regulatory Funding at Least 90%
(sorted alphabetically by group name)**

Group Name	Total # Members	Total Regulatory Assets	Total Regulatory Liabilities	Surplus (Deficit)	Trust Equity Ratio
<i>Building Exterior Services Trust of New York</i>	40	\$453,000	\$394,000	\$59,000	114.97%
<i>Business Council WC Manufacturers Group SI Trust</i>	1,264	\$50,799,000	\$49,868,000	\$931,000	101.87%
<i>Contractors Compensation Trust</i>	2,866	\$86,074,000	\$83,834,000	\$2,240,000	102.67%
<i>Cooperative Association of Food Enterprises WC Trust</i>	3,986	\$38,919,000	\$38,322,000	\$597,000	101.56%
<i>ElderWood Senior Care Self Insurance Trust</i>	14	\$6,576,000	\$5,525,000	\$1,051,000	119.02%
<i>Empire State Agricultural Compensation Trust</i>	1,801	\$22,795,000	\$19,178,000	\$3,617,000	118.86%
<i>Empire State Education Trust</i>	112	\$6,904,000	\$7,295,000	-\$391,000	94.64%
<i>Empire State Hospitality Workers Compensation Trust</i>	731	\$16,415,000	\$16,398,000	\$17,000	100.10%
<i>Empire State Transportation WC Trust</i>	935	\$47,129,000	\$45,733,000	\$1,396,000	103.05%
<i>First Automotive Services Trust</i>	1,018	\$6,387,000	\$6,698,000	-\$311,000	95.36%
<i>New York Petroleum Association Compensation Trust</i>	228	\$8,154,000	\$8,583,000	-\$429,000	95.00%
<i>NY Transportation Workers' Compensation Trust</i>	1,374	\$61,547,000	\$66,594,000	-\$5,047,000	92.42%
<i>Retailers of New York Workers Compensation Trust</i>	1,420	\$15,630,000	\$15,586,000	\$44,000	100.28%
Averages	1,215	\$28,291,000	\$27,229,000	\$1,062,000	103.90%
Totals	15,789	\$367,782,000	\$364,008,000	\$3,774,000	101.04%

These GSITs had more than 15,700 members while active. Their combined regulatory assets exceed their regulatory liabilities by a mere \$3.8 million.

There are 8 GSITs in run-off with funding levels less than 89%, including 4 with funding between 75% and 89% and 4 with funding below 75%.

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Chapter Two – History of the Group Self-Insurance Program (continued)

As of the 2008 fiscal year end, these GSITs are as follows:

**Inactive Group Self Insurers In Run-Off - Regulatory Funding Less Than 90%
(sorted alphabetically by group name)**

Group Name	Total # Members	Total Regulatory Assets	Total Regulatory Liabilities	Surplus (Deficit)	Trust Equity Ratio
<i>ELEC-Con Trust</i>	536	\$11,513,000	\$13,342,000	-\$1,829,000	86.29%
<i>Independent Grocers WC Self-Insurance Trust</i>	68	\$1,671,000	\$2,071,000	-\$400,000	80.69%
<i>Long Term Care Risk Management Group</i>	69	\$9,213,000	\$12,036,000	-\$2,823,000	76.55%
<i>Mercantile Self Insurance Trust</i>	575	\$6,397,000	\$10,739,000	-\$4,342,000	59.57%
<i>New York McDonalds Operators Workers' Comp Trust</i>	155	\$3,828,000	\$4,882,000	-\$1,054,000	78.41%
<i>OHI Workers' Compensation Trust</i>	165	\$2,382,000	\$3,340,000	-\$958,000	71.32%
<i>Preferred Manufacturers Insurance Trust Fund</i>	211	\$4,545,000	\$6,602,000	-\$2,057,000	68.84%
<i>Selective Safety Trust</i>	161	\$9,208,000	\$13,058,000	-\$3,850,000	70.52%
Averages	243	\$5,679,000	\$7,516,000	-\$1,837,000	75.56%
Totals	1,940	\$48,757,000	\$66,070,000	-\$17,313,000	73.80%

Collectively, these GSITs had more than 1,900 members. As of the end of 2008, these 8 GSITs had regulatory liabilities which exceeded their regulatory assets by roughly \$17 million.

These 8 GSITs are monitored closely by the WCB to ensure that they continue to fulfill all of the workers' compensation obligations incurred while active. If the funding for any of these groups falls below the current 12-month threshold, the WCB will move to take over administration.

D. INSOLVENT GSITs

As per NYCRR Part 317.20, upon failure on the part of a GSIT to properly administer all liabilities, the WCB will assume the administration and final distribution of the GSIT's assets and liabilities. These GSITs are considered to be in liquidation. Typically, the assumption of a liquidated GSIT is triggered by its poor funding position. However, the WCB will take over the administration of a GSIT if there is any concern about the ability of the GSIT to assure the uninterrupted payment of all benefits under the WCL. This may include a lack of trustees that are available to appoint the appropriate key advisors.

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Chapter Two – History of the Group Self-Insurance Program (continued)

As described above, if a GSIT is unable to pay its outstanding lawful obligations it is considered to be “*insolvent*”. Insolvency is demonstrated when: i) the group is under funded; and ii) the sum of the group’s available cash and acceptable investments is less than the total cost of all the group’s liabilities that will be paid within the succeeding six months.

The WCB will attempt to collect from the employer members of each insolvent GSIT pursuant to each member’s joint and several liability for the trust’s obligations, either with the benefit of a full forensic reconstruction of the GSIT’s operations or with interim bills based upon estimates until a forensic review can be completed.

The WCB’s first priority, however, is to ensure that every claimant receives the full benefits to which they are entitled regardless of the funding position of the GSIT that is liable for those benefits. The GSITs funding and the timing of the billings/collections under joint and several liability can be such that the insolvent group has insufficient funds for the WCB to make those payments on their behalf. In such cases, the WCL requires the WCB to issue an assessment to the entire private self-insurance community, both groups and individuals, in order to ensure the uninterrupted payment of all benefits. As noted, the ability to impose such assessments is currently at issue in the *Held* litigation.

Currently, 15 GSITs meet the criteria of insolvency. The most recent projections indicate that these 15 GSITs have a combined deficit of \$498 million. The GSITs that have been deemed to be insolvent are:

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Chapter Two – History of the Group Self-Insurance Program (continued)

**Insolvent Group Self Insurers
(sorted alphabetically by group name and rounded to the nearest 100,000th)**

Group Name	Administrator	# of Years Offering	Total # Members Assessed	Estimated Deficit	Forensic Completed/In Progress
<i>Builders Self insurance Trust</i>	<i>Marsh, USA, Inc.</i>	9	260	\$6,400,000	IP
<i>Elite Contractors Trust of New York</i>	<i>Compensation Risk Managers</i>	9	2,676	\$61,500,000	IP
<i>Health Care Providers Self-Insurance Trust</i>	<i>Program Risk Management, Inc.</i>	16	263	\$25,300,000	IP
<i>Healthcare Industry Trust of New York</i>	<i>Compensation Risk Managers</i>	8	319	\$220,900,000	C
<i>Manufacturing Industry WC SI Trust</i>	<i>Consolidated Risk Services</i>	8	89	\$9,900,000	C
<i>Manufacturing Self Insurance Trust</i>	<i>NY Compensation Managers, Inc.</i>	9	267	\$19,100,000	C
<i>New York Healthcare Facilities WC Trust</i>	<i>Hamilton Wharton Group, Inc.</i>	9	137	\$37,400,000	C
<i>New York State Cemeteries Trust</i>	<i>Compensation Risk Managers</i>	6	81	\$800,000	IP
<i>Provider Agency Trust for Human Services</i>	<i>Consolidated Risk Services</i>	9	42	\$17,100,000	C
<i>Public Entity Trust of New York</i>	<i>Compensation Risk Managers</i>	6	13	\$7,600,000	C
<i>Real Estate Management Trust of New York</i>	<i>Compensation Risk Managers</i>	7	125	\$2,200,000	IP
<i>Retail and Wholesale Industry WC SI Trust</i>	<i>Consolidated Risk Services</i>	8	69	\$3,600,000	IP
<i>Trade Industry WC Trust for Manufacturers</i>	<i>Compensation Risk Managers</i>	6	119	\$6,800,000	IP
<i>Transportation Industry WC Trust</i>	<i>Compensation Risk Managers</i>	7	517	\$13,400,000	IP
<i>Wholesale and Retail WC Trust of New York</i>	<i>Compensation Risk Managers</i>	9	688	\$65,900,000	C
Averages		8	378	\$33,200,000	
Totals			5665	\$497,900,000	

The insolvent GSITs were in existence for an average of 8 years and offered coverage to more than 5,600 employer members while active. The Healthcare Industry Trust of New York has the single largest deficit at \$220.9 million, followed by the Wholesale and Retail WC Trust of New York and the Elite Contractors Trust of New York with deficits of \$65.9 million and \$61.5 million, respectively.

It is important to note that the total projected deficit of \$498 million reflects the completion of 7 out of 15 forensic reviews. Of those reviews, the trend indicates that the post forensic deficit is much larger than that originally stated by the groups. In fact, as shown below, the total deficit for these 7 groups more than doubled from \$179 million to \$378 million post forensic:

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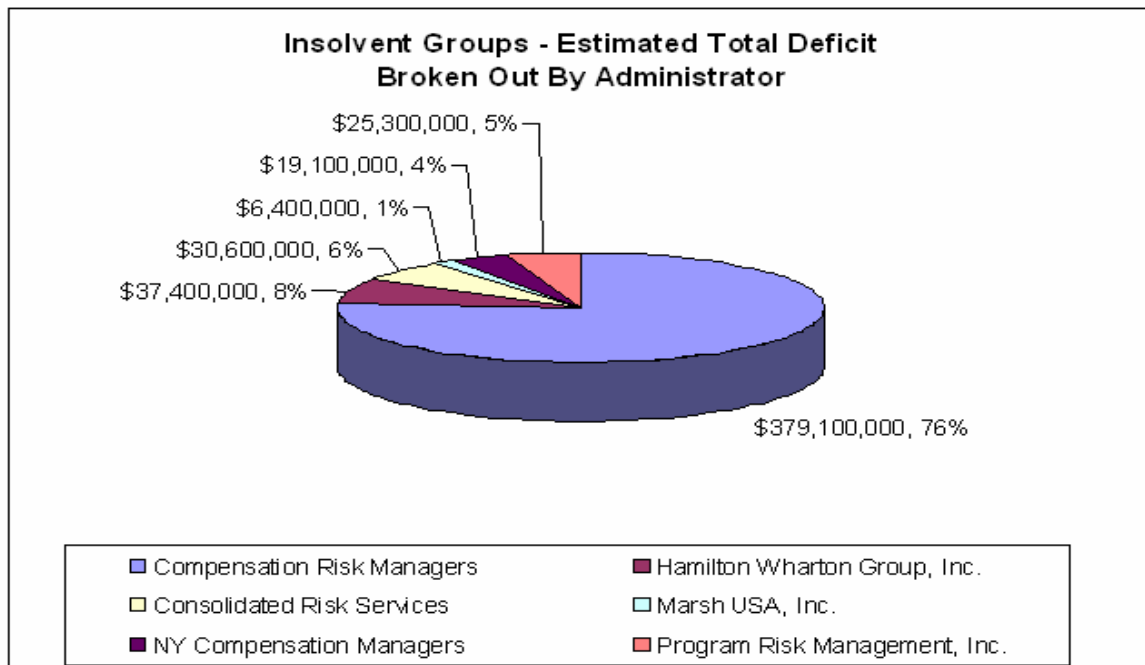
Chapter Two – History of the Group Self-Insurance Program (continued)

Insolvent Group Self-Insurers - Difference in Total Deficit Post Forensic Review

<u><i>Group Name</i></u>	<u><i>Regulatory Deficit at Termination</i></u>	<u><i>Final Forensic Deficit</i></u>	<u><i>Increase in Deficit Post Forensic</i></u>
<i>Healthcare Industry Trust of New York</i>	\$91,400,000	\$220,900,000	\$129,500,000
<i>Manufacturing Industry WC SI Trust</i>	\$6,900,000	\$9,900,000	\$3,000,000
<i>Manufacturing Self Insurance Trust</i>	\$16,900,000	\$19,100,000	\$2,200,000
<i>New York Healthcare Facilities WC Trust</i>	\$25,900,000	\$37,400,000	\$11,500,000
<i>Provider Agency Trust for Human Services</i>	\$16,100,000	\$17,100,000	\$1,000,000
<i>Public Entity Trust of New York</i>	\$2,300,000	\$7,600,000	\$5,300,000
<i>Wholesale and Retail WC Trust of New York</i>	\$19,100,000	\$65,900,000	\$46,800,000
Total	\$178,600,000	\$377,900,000	\$199,300,000

If the trend persists at this rate for the remaining 8 trusts whose forensics have yet to be completed, their deficit would increase from \$120 million to more than \$254 million; the total deficit for all 15 insolvent groups currently projected at \$498 million deficit would be over \$600 million.

The deficits shown above can be summarized by group administrator as follows:



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Of the 15 insolvent GSITs, 8 were all handled by the same group administrator, Compensation Risk Managers. Those 8 GSITs make up 76% of the total estimated deficit of all the insolvent GSITs. Of the 15 insolvent GSITs, 3 were handled by Consolidated Risk Services; those GSITs make up an additional 6% of the current total deficit amount.

The forensic reports performed on a number of the insolvent GSITs documented a relationship between principals at CRM and Consolidated Risk Services. Based upon the relationship documented in the forensic reports, 82% of the total estimated deficit amount for all of the 15 insolvent GSITs can be associated back to the same principals at CRM/CRS. The remaining 18% is associated with 4 GSITs all handled by different group administrators.

With the implementation of the new rules and regulations in 2001 it was expected that some GSITs would be unable to meet the new financial criteria. Several of the GSITs included above were identified as having significant funding issues soon after the standards contained in the rules and regulations currently in place were established. Despite remediation efforts, a number of these GSITs ultimately failed.

However, the bulk of the deficit shown is attributable to the CRM GSITs. In contrast to those noted above, none of the CRM GSITs were initially identified as significantly under funded. In fact, each of CRM's GSITs had funding levels in excess of 90% for virtually all fiscal periods. The GAAP financials that were submitted did not bring to light the severe funding issues until the 2006 financials were filed with the WCB in 2007.

**CRM Trusts
Historical GAAP Funding Levels**

<i>Group Name</i>	<i>Fiscal Year</i>					
	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>
Elite Contractors Trust of New York	109%	102%	102%	103%	94%	93% *
Real Estate Management Trust	96%	92%	96%	92%	52%	23%
Trade Industries WC Trust	90%	92%	91%	90%	45%	9%
Wholesale and Retail WC SI Trust	101%	95%	93%	95%	65%	34%
Transportation Industry WC SI Trust	101%	101%	102%	95%	74%	n/a **
Healthcare Industry Trust of New York	101%	93%	95%	85%	29%	8%
New York State Cemeteries Trust	n/a	100%	102%	103%	104%	66%
Public Entity Trust of New York	90%	96%	100%	56%	34%	2%

*Elite's 2007 financials were prepared by CRM. The 2008 trust equity ratio was reduced to 34% in 2008 once the reserves were restated.

**Financials not available

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The dramatic decrease in the funding position for the majority of these trusts, from 2005 to 2006, was the result of the failure of the GSITs administered by CRM to recognize adequate reserves which understated liabilities in the prior years. The total CRM trusts' GAAP assets reported to the WCB in 2005 and 2006 remained virtually unchanged at \$93 million and \$96 million, respectively. Contrarily, the total CRM trusts' GAAP liabilities reported in 2005 were \$101 million and increased to \$194 million in 2006.

As a result of these sudden and unexpected failures, the WCB hired consultants and ultimately conducted forensic reviews to determine the causes of the various insolvencies. Findings were as follows:

- Administrators played an extensive role in establishing and running GSIT operations resulting in numerous conflicts of interest such as:
 - Self serving contracts that benefited the administrator such as payment based on membership size not performance;
 - Execution of contracts with affiliate companies to redirect more money from the trust to the administrator;
 - Administrators having complete autonomy with regard to the underwriting and acceptance of members;
 - Significant growth in membership with unsubstantiated discounts which resulted in higher fees to the administrator;
 - Administrators paying themselves unreasonable brokerage fees for placing excess coverage even when placed with affiliates.

- The inherent structure of a GSIT requires trustees to take an active role. However, a group's board of trustees is made up primarily of employer members running their own businesses on a daily basis. Often times, trustees have little or no experience with workers' compensation that would enable them to identify concerns or raise questions about the data provided by the administrator. They often failed to fulfill their roles as trustees by, among other things:
 - Delegating complete authority to the administrator without adequate oversight with the expectation that the administrator would act in the best interest of the members;
 - Failing to properly screen prospective members of the GSIT for admission, and allowing continued membership for employers who did not meet minimum underwriting criteria;
 - Granting discounts or other preferential treatment to members that were not fiscally or administratively justified.

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- The trustee’s lack of involvement and, oftentimes, lack of knowledge about workers’ compensation, allowed the administrator to manipulate the data so that the GSIT appeared more funded. These types of manipulations included:
 - Suppressing claims reserves;
 - Recording questionable accounting transactions;
 - Using unsupported discount rates;
 - Failing to terminate chronic non-performing members;
 - Providing questionable data to actuaries and accountants when generating year end financial statements.

Due to the factors noted above, the deficits originally reported on the financial statements of a number of GSITs were substantially restated. For example, in the Healthcare Industry Trust of New York, the GAAP deficit in 2005 was reported to be approximately \$6 million. The post forensic review estimated deficit has grown to \$220.9 million.

Joint and several liability among the members of a GSIT was the intended security for the financial stability of the group self-insurance program in the event the GSITs assets were insufficient. Collections from the employer members of the insolvent GSITs continue to be pursued. However, this mechanism has failed to provide prompt recovery of expenses from the members of insolvent GSITs. The number of members who voluntarily pay their joint and several obligations is very low. For example, of the 137 former members of the New York Healthcare Facilities Trust which has a deficit of \$37 million, only 51 have agreed to pay any portion of their share of the deficit. As previously stated, of the \$498 million billed to date to the employer members of the insolvent GSITs, only \$33.8 million has been collected to date (approximately 6.8%).

In spite of the poor collection rates, claimants must continue to be paid the benefits to which they are entitled and receive timely medical care. The 50-5(g) assessment made against all self-insurers is the funding stream which guarantees those benefits, although the *Held* decision – if it is upheld – has called that funding stream into question. As GSITs defaulted, and as their projected level of unreserved claims has grown, this assessment was subject to significant increases. The assessments, if they are ultimately upheld by the courts, will continue at high levels while the claims are being run-off unless collection efforts are more successful and/or if other alternatives for funding the defaults are identified. Options available in the event that the 50-5(g) assessment is definitively struck down in the *Held* litigation are a subject beyond the scope of this report.

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Chapter Two – History of the Group Self-Insurance Program (continued)

The shortcomings identified by the forensic reviews, the magnitude of the insolvencies, the refusal of the majority of the members of insolvent GSITs to voluntarily pay bills representing their actual or estimated share of joint and several liability, the delay and inadequate rate of forced collection from those members, and the corresponding increase in the self-insurers' assessment needed to protect claimants have called into question the group model and the long term viability of the group program.

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Chapter Three – Funding Defaults

A. BACKGROUND

The WCB's first priority is to ensure that all claimants receive the full benefits to which they are entitled regardless of the funding position of the GSIT liable for those benefits. Ultimately, the goal is to satisfy in full the obligations of each insolvent GSIT via collections from the members while at the same time limiting the amount of future assessments made against the self-insurers.

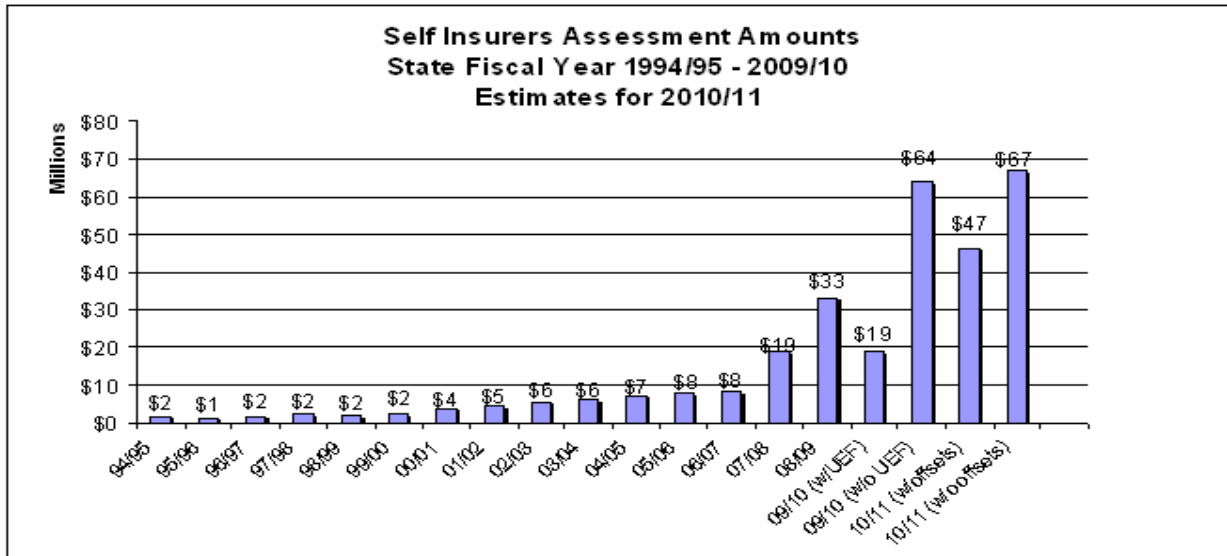
The recent defaults have shown that the funding and the timing of the billings/collections under joint and several can be such that the WCB cannot make those payments directly from the insolvent GSIT's funds. Of the \$498 million billed to date to the employer members of the insolvent GSITs, only \$33.8 million has been collected. This collection rate does not, however, include a significant number of commitments of funds via signed agreements, including agreements with members from the Healthcare Industry Trust of New York (HITNY) and the Manufacturing Self-Insurance Trust (MSIT) that will result in significant payments towards the liability of those GSITs.¹⁰ Nonetheless, the collection rate to date has required the WCB to issue an assessment to the entire private self-insurance community, both groups and individuals, in order to ensure the uninterrupted payment of all benefits while joint and several continues to be pursued.

The following chart depicts the change in the self-insurers' assessment from 1994/95 to levels projected for 2010/11.

¹⁰ MSIT represents \$19.1 million of the total deficit. Of this amount the WCB has signed agreements from former members to pay \$14.2 million towards this liability. HITNY represents \$220.9 million of the total deficit. The WCB currently has an 18-month agreement with HITNY members to cover the monthly cash flow of the group which represents approximately \$27.4 million. The WCB also has agreements to pay from three other insolvent groups, a combination of which represents an additional \$22.6 million pledged. The total payments and remaining pledged amounts equal \$82 million to offset the \$498 million deficit.

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Chapter Three – Funding Defaults (continued)



This assessment incorporates the costs of administering the self-insurance program, unmet obligations of individual self-insurers and unmet obligations of insolvent groups. This is assessed against all self-insured employers based upon their proportionate share of indemnity payments made.¹¹

The legislation passed in June of 2008 allowed the WCB to borrow up to \$52 million from the Uninsured Employers Fund (UEF) to offset the self-insurers’ assessment with a repayment schedule of \$3 million annually beginning in 2010. Prior to the 2007/08 fiscal year, the average self-insurers’ assessment was well below \$10 million. The assessment for 2007/08 almost doubled to just over \$19 million. This assessment has continued to see dramatic increases for 2008/09 when the final assessment was \$33 million. Without the benefit of the UEF borrowings, the assessment for 2009/10 would have exceeded \$60 million; because the WCB was able to transfer \$45 million from the UEF, the actual assessment for 2009-2010 was limited to approximately \$19 million.

¹¹ The reform of 2007 changed the apportionment methodology for the self-insurers’ assessment from security deposit held to pure premium. As a result of these changes, the group self-insurers were required to pay a larger share of the assessment as they have a larger proportionate share of pure premium than they have security deposits. The June 2008 legislation changed the methodology from pure premium to indemnity payments made and the split is now more evenly apportioned among both the individual and group self-insurers.

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Chapter Three – Funding Defaults (continued)

The self-insurers' assessment for SFY 2010/11 is estimated to be \$47 million. This level reflects several one-time funding offsets without which the assessment would be \$67 million. The offsets include 50-5 reimbursements which reflect collections from members of the defaulted GSITs, and other one time funding sources such as funding available from a legislative mandate for over collection of assessments. Legislation proposed in the 2010/11 Executive Budget would allow for additional UEF borrowing to further reduce these assessments.

The various collection efforts currently utilized by the WCB and their results to date were reviewed by the Task Force. As a result, the Task Force is proposing a number of enhancements applicable to the existing defaults which should increase the amounts collected and the timeliness of those collections, thus mitigating the impact on the remainder of the self-insurance community. Additionally, recommendations which may apply to any future defaults have also been identified.

B. PAYMENT OF CLAIMS – EXISTING DEFAULTS

The WCB currently utilizes a number of methods to collect from the employer members of an insolvent group. Ultimately, the collection efforts for every group will be based on a full forensic reconstruction of the group's funding position which includes an apportionment of the deficit among the employer members.

However, delays in the forensic reviews have forced the WCB to issue interim bills in a number of instances pending the completion of a full forensic review. These delays were due to the WCB's inability to obtain records from previous administrators and trust advisors; lack of cooperation by former members, trustees and/or advisors; delays in contracting with forensic auditors; and issues surrounding attorney-client privilege.

The various methods currently used to collect from the employer members of the insolvent groups, the group(s) that each method was applied to, and the collection rates for each, are summarized below.

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Chapter Three – Funding Defaults (continued)

Billings Based on Forensic Reviews – The WCB hires a forensic auditor to perform a full reconstruction of the failed group to determine the cause of the failure and every member’s proportionate share of the deficit. These reviews served as the basis for joint and several billings that were presented to every member. The deficit assessment is based upon an estimation of the amounts needed to discharge all liabilities of the group including the reasonable cost of liquidation such as claims administration costs, actuarial and accounting services and the value of future WCB assessments. The members are required to pay their pro-rata deficit over a period of time with interest, while preserving the WCB’s right to seek additional future payments from the member on a joint and several basis should this become necessary.

The amounts billed and collected from the groups for which the billing was based upon a full forensic review include the following:¹²

Billings Based on Forensic Reviews

<u>Trust Name</u>	<u>Number of Members Billed</u>	<u>Amount Assessed</u>	<u>Total Collected as of 5/17/10</u>	<u>% Collected to Date</u>
<i>Healthcare Industry Trust of New York</i>	319	\$220,900,000	\$7,921,000	3.59%
<i>Manufacturing Industry WC SI Trust</i>	89	\$9,900,000	\$2,553,900	25.80%
<i>New York Healthcare Facilities WC Trust</i>	137	\$37,400,000	\$5,871,200	15.70%
<i>Provider Agency Trust for Human Services</i>	42	\$17,100,000	\$9,451,400	55.27%
<i>Public Entity Trust of New York</i>	13	\$7,600,000	\$922,400	12.14%
<i>Wholesale and Retail WC Trust of New York</i>	688	\$65,900,000	\$2,365,600	3.59%
Totals	1288	\$358,800,000	\$29,085,500	8.11%

Lawsuits Based on Joint and Several History – With the first groups to default, the WCB conducted the forensic review, issued bills based on the forensic results, and referred to the New York State Attorney General’s Office (AG) the names of any former employers who refused to pay their obligations. For one group, Manufacturing Self-Insurance Trust, due to possible allegations of a statute of limitations defense, the WCB made a referral to the AG and commenced litigation prior to the forensic review to ensure that all future rights would be preserved. A summons with notice and then a complaint have been served in this matter. In the meantime, a forensic review was performed on this group and joint and several allocations were adjusted accordingly.

¹² HITNY represents \$220.9 million of the total deficit. The WCB currently has an 18-month agreement with HITNY members to cover the monthly cash flow of the group which represents approximately \$27.4 million. The WCB also has agreements to pay from three other insolvent groups, a combination of which represents an additional \$22.6 million pledged. The total payments and remaining pledges equal \$82 million to offset the \$498 million deficit.

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Chapter Three – Funding Defaults (continued)

Lawsuits Based on Joint and Several

<u>Trust Name</u>	<u>Number of Members Billed</u>	<u>Amount Assessed</u>	<u>Total Collected as of 5/17/10</u>	<u>% Collected to Date</u>
Manufacturing Self Insurance Trust	336	\$19,100,000	\$0	0.00%

Collections are \$0 due to WCB pursued litigation to enforce joint and several collections. Estimated billings were not issued due to concerns relative to the statute of limitations. As of May 2010, approximately 130 of the MSIT members entered into a settlement agreement with the WCB, under which they pledged \$14.2 million towards meeting the trust's liability going forward. Litigation is proceeding against the remaining trust members.

Estimated Deficiency Billing – On June 30, 2008, Governor Paterson signed legislation that contains several new provisions aimed at strengthening the self-insurance program in the State of New York. These provisions include a requirement that the WCB levy an assessment on the members of an insolvent group self-insurer within 120 days of the default.

The time constraints imposed by this legislation prohibit the completion of a forensic review prior to the initial billings. Therefore estimated bills are now sent within the 120-day legislative mandate pending completion of a full forensic review.

The WCB bills each of the members with cover letters accompanying invoices that restate their obligations to pay, including specific examples of the interest and collection fees that are accruing on their estimated billing amount. The assessment is based upon an estimation of the amounts needed to discharge all liabilities of the group including the reasonable cost of liquidation such as claims administration costs, actuarial and accounting services and the value of future WCB assessments. Full forensic reconstructions are performed on all such groups and the deficiency billings are adjusted, as necessary, upon completion of the forensic review.

The groups for which the forensic review has not yet been completed but estimated deficiency billings were done in accordance with the 2008 legislation include the following:

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Chapter Three – Funding Defaults (continued)

Interim Bills Based on Estimated Deficiencies Prior to Forensics

<u>Trust Name</u>	<u>Number of Members Billed</u>	<u>Amount Assessed</u>	<u>Total Collected as of 5/17/10</u>	<u>% Collected to Date</u>
<i>Builders Self Insurance Trust</i>	260	\$6,400,000	\$404,200	6.32%
<i>Elite Contractors Trust of New York</i>	2676	\$61,500,000	\$0	0.00%
<i>Health Care Providers Self Insurance Trust</i>	263	\$25,300,000	\$1,051,300	4.16%
<i>New York Cemeteries Trust of New York</i>	81	\$800,000	\$81,500	10.19%
<i>Real Estate Management Trust of New York</i>	125	\$2,200,000	\$109,400	4.97%
<i>Retail and Wholesale Industry WC SI Trust</i>	69	\$3,600,000	\$394,800	10.97%
<i>Trade Industries WC Trust for Manufacturers</i>	119	\$6,800,000	\$834,600	12.27%
<i>Transportation Industry WC Trust</i>	517	\$13,400,000	\$1,826,500	13.63%
Totals	4110	\$120,000,000	\$4,702,300	3.92%

The following summarizes the various collection efforts listed above:

Summary of Collections to Date

<u>Trust Name</u>	<u>Number of Members Billed</u>	<u>Amount Assessed</u>	<u>Total Collected as of 5/17/10</u>	<u>% Collected to Date</u>
Total All Groups	5734	\$497,900,000	\$33,787,800	6.79%

As noted above, the 6.8% does not reflect a significant number of agreements reached with members of HITNY or MSIT, nor does it reflect money which has been pledged by members of trusts pursuant to payment plans, but which is not yet due or received. The amounts pledged to date are estimated to be \$82 million. Nonetheless, the collection efforts to date have not been successful; of the \$498 million billed less than \$34 million has actually been collected. Despite the various methods used to collect under joint and several, the collection of the deficit amounts from the employer members of the insolvent groups has not been sufficient to meet the cash flow needs of each insolvent group.

In an attempt to mitigate the cash flow impact on the healthy self-insurers, the WCB has developed two other approaches to offer to the former members of these insolvent trusts to incite them to begin paying. Specifically:

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Tender Offer – Members of the insolvent trusts have been concerned with the unlimited exposure to their former group even if they begin making payments. Members of these trusts have indicated that they are willing to pay their share if they can be released from the joint and several provisions. Therefore, members of one of the insolvent trusts (MSIT) were offered the opportunity to be released from their joint and several obligations in return for paying 100 percent of their share of the estimated deficiency plus a supplemental amount for the release. The joint and several liabilities, however, would only be waived if a substantial portion of the members accepted the proposal. The remaining members will continue to be fully liable for the entire unpaid deficit under the joint and several provisions of the statute. On May 4, 2010 this offer resulted in an agreement with approximately 130 MSIT members to pay \$14.2 million towards the trust's liabilities.

Payments Based on Cash Flow – In some instances, members of these insolvent trusts believe that the ultimate costs of the trust may not develop as high as predicted by the WCB. They are willing to pay something but feel that the joint and several share of the ultimate costs are unreasonable and unaffordable. Therefore, in an attempt to allow more time to see how the ultimate claims develop, members of HITNY, an insolvent trust have been offered an opportunity to collectively pay an amount equal to the expected monthly claims and administrative costs for the trust over the next 18 months. These payments will be made by the former members in lieu of making a full payment on their joint and several obligations for a set period. This allows the members more time to see how the claims develop, while ensuring that for the period of the agreement they will not place any cash flow burden on the rest of the self-insurance community.

The Task Force has reviewed a number of enhancements which should increase the amounts collected and the timeliness of those collections. Some of these enhancements would require legislation, while others could be pursued by the WCB as administrative remedies. These tools should be used in addition to any and all of the collection efforts described above. The use of any one of these remedies should not preclude the WCB from the other remedies available. The collection tools include:

- Enhanced Joint and Several Tools – The WCB attempts to collect from the employer members of each insolvent group under their joint and several liability, either with the benefit of a full forensic reconstruction of the group's operations or with interim bills based upon estimates until a forensic review can be completed. There are a number of additional tools that, if available, are expected to expedite the collection efforts, including, but not limited to:

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- Reaffirm the WCB’s authority under Section 26 of the WCL to pursue judgments. The WCB could make use of the provisions pertaining to awards of compensation for defaulting employers as provided for under WCL Section 26. Currently, members of a GSIT remain liable for the payment of awards unless the award is paid by the employer or the GSIT. The WCL further provides that the WCB may file a certified copy of unpaid awards with an appropriate clerk of a supreme court, resulting in a judgment against the employer in the amount of the unpaid award.
- Empower the WCB to pursue all available actions such as stop-work-orders, debarment from public works and other penalties that are currently imposed on employers who do not have the required workers’ compensation coverage against members of GSITs who have clearly failed to meet their legal obligations.
- More Timely Completion of Forensic Reviews – The size and complexity of insolvent GSIT’s operations plays a large role in determining the length of time to complete a forensic accounting. This process has been consistently, and in some cases considerably, lengthened by the lack of cooperation received from former key advisors (who in some instances may have reason to be less than forthcoming in responding to data requests) of the now insolvent GSITs.

Many times the WCB’s initial requests for documents necessary to complete the forensic reviews, including work papers or work product, go ignored. In other instances requests are refused outright. In such circumstances the WCB is forced to resort to the issuance of a subpoena for the documents needed. Invariably, this causes the recipient of the subpoena to obtain an attorney to respond, further delaying the compliance time. Moreover, there are invariably “translation” issues that occur once the lines of communication move from accountants to attorneys. Each step in the process leads to inordinate delays.

Delays in the completion of the forensic reviews often lead to lower joint and several collection rates initially, as the employer members are not willing to pay based on interim estimated bills. They often opt to wait until the deficit amount and their proportionate share is confirmed via the forensic review.

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- Successor in Interest - It is suggested that if the WCB's role as successor in interest to the group trusts was explicitly stated, there would be less possibility that former administrators and/or their advisors (such as the group administrator, third party administrator, certified public accountant, actuary and/or legal counsel) would even attempt to argue that the current statutory language is a ground to refuse legitimate WCB requests for data. Furthermore, placing this language in the text of WCL would allow the WCB to make use of the catch all penalty provisions. This would undoubtedly lessen the lengthy forensic process, allow the WCB to issue final bills more timely, and improve the collection results.
- Litigation Resources – Authorize the WCB to initiate joint and several lawsuits and other third party recoveries through retention of outside counsel, in addition to suits that may be brought by the Attorney General's Office. The New York State Attorney General's Office acts as the WCB's attorney in litigation matters against members of an insolvent group. It is often difficult, particularly in the current economic environment, to ensure that the adequate number of staff is dedicated to this significant effort. It is recommended that the WCB have the ability to hire outside counsel, where necessary and appropriate, to conduct any legal actions which will expedite the collection efforts.

In addition to the enhanced collection tools discussed above, the Task Force reviewed other tools which might limit the impact that insolvent groups have on the remainder of the self-insurance community in the form of increased assessments.

These include:

- Assumption of Workers Compensation Liability Insurance Policy (ALP) - Currently, carriers can transfer claims that have been incurred under first dollar policies they have written to another carrier under certain circumstances. These transfers are clean and unconditional and once finalized it is as if those claims were always the responsibility of the assuming carrier. The claims are fully protected by the WC guaranty fund; if the assuming carrier ever defaults there is no recourse against the original carrier.

If the appropriate legislation were enacted, a policy could be purchased to transfer the tail of self-insured workers' compensation claims (including all future development) to a carrier, absolving the self-insurance program from any further exposure. The carriers would collect and pay into the guaranty fund all appropriate surcharges to ensure that should the carrier ever default the claims would be fully protected without recourse to the self-insurer. The net effect would be as if the claims were initially incurred by the carrier.

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This alternative must be performed in a manner that assures complete compliance with the WCB regulations and laws, thus providing maximum protection for the claimant. In addition, the entity offering the ALP must make available liaison services for both the employees and the employers in the event there are issues that arise after the transition.

Such an ALP option may not always be the most inexpensive manner in which to settle a book of claims. However, it does provide a fixed cost mechanism to move the long term exposure away from the employer members of a discontinued group (or the remainder of the self-insured community). A known fixed cost today will most likely be more appealing than an unknown cost for an unspecified timeframe.

- WAMO Settlements –The Waiver Agreement Management Office (WAMO) was created as part of the Workers’ Compensation Reform Act of 2007. The Act allows a carrier, self-insurer, or the State Insurance Fund to be “paid” an amount equal to the value of claims in the Special Disability Fund in return for waiving future claims against the Fund. The WCB should explore this administrative option in regard to GSITs, consistent with the terms of the legislation to pay claims and settlements related to claims that have been accepted by Special Funds for reimbursement.

C. PAYMENT OF CLAIMS – FUTURE DEFAULTS

If the group option was no longer available and the groups actively providing coverage were terminated, the same standards described above would be applied. Each group would be monitored on an ongoing basis as its claims while self-insured were run-off. Any group able to meet all of its obligations would stay in the control of its board of trustees. Any insolvent group that is unable to pay its outstanding obligations would be assumed by the WCB. If there were any threat that a claimant might go unpaid as a result of insolvency and if the final resolution of *Held* allows the WCB to do so, the WCB would use the self-insurers’ assessment as the funding stream to guarantee those benefits while the joint and several liability of the employer members of the insolvent group was being pursued.

There is some concern that if the groups currently offering coverage were required to terminate, the self-insurers’ assessment related to the recent group defaults would be exacerbated by additional defaults. This potential exists, particularly as ongoing assessment costs will have a negative impact on a trust’s cash flow. If these assessments continue to rise and there are no new revenues going into the trust, additional trusts could default.

In addition to the methods described above regarding the payment of claims for the existing defaults, there are a number of administrative options which may be applied to any future defaults which may occur.

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These include:

- Increased Funding Levels – Active Groups/Groups in Run-Off - First and foremost, the focus should be on increasing the funding levels of the active groups and those in run-off in an attempt to avoid insolvency and any future impact on the self-insurers' assessment. The proposed rules and regulations should address this effort with the increased funding levels, contribution year funding/reporting and required risk margins going forward.
- Posting Security Deposits - Individual self-insured employers are required to submit detailed claims information including amounts paid and reserved for all claims. The WCB uses this information to determine the appropriate amount of security deposit that must be posted by these employers to be used by the WCB in the event the employers ever default on their self-insured obligations. A similar process could be applied to the group self-insurers that are in run-off so that if they ever default on the obligations incurred while self-insured, the WCB could liquidate the deposit and ensure claims are paid without impact on the remainder of the self-insurance community.
- Earlier Triggers for Insolvency Determination – Under current regulations, a group that has less than six months of cash and investments available to pay the next year's worth of claims is deemed insolvent. At that point, the deficiencies are included in the self-insurers' assessment.

It has been the WCB's policy that a group that has less than twelve months worth of cash and acceptable investments will be taken over by the WCB. Often times, due to the lengthy and complicated process of transitioning a group's records and assets, by the time a group is transitioned to the WCB it already has less than six months worth of cash. The WCB is then left with no other option than to immediately begin to utilize the self-insurer's assessment while the joint and several billing and forensic reviews are initiated. The Task Force recommends that the trigger for the WCB's assumption of a group be increased to a minimum of 24 months. This would enable the transition to the WCB to be completed, the initial billings to be sent, and the forensic reviews to be initiated prior to exhaustion of the group's own assets. Therefore, the group's impact on the self-insurer's assessment (to the extent it may be imposed following a final resolution in *Held*), might be somewhat contained.

Changing the trigger point for the WCB assumption of a group will undoubtedly result in an increase in the number of groups being transitioned to the WCB. The trigger point should not be set unreasonably high so as to cause all of the groups to trigger WCB takeover. However, the current level of twelve months has proven to be insufficient when safeguarding the impact on the remainder of the self-insurance community.

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Chapter Four – Long Term Viability of the Group Model

A. BACKGROUND

The Task Force has debated and discussed the future of groups and the long term viability of the group model. Extensive documentation regarding the pros and cons of group self-insurance was reviewed and key stakeholders were asked to present information they deemed pertinent when performing this evaluation. The benefits of group self-insurance were measured against the risks for the various stakeholders including employers, claimants, and key advisors.

The following provides a summary of the positive and negative aspects of the group model which were considered when evaluating the long term viability of the program. Specific examples based upon the information reviewed for the active and insolvent groups have been included. Also provided is the final conclusion drawn as a result of this evaluation: that the group self-insurance program as it presently exists should be terminated.

B. BENEFITS OF GROUP SELF-INSURANCE

Per the International Association of Industrial Accident Boards and Commissions “if done correctly and regulated appropriately, group self-insured programs can provide a long term stable marketplace for its employer members. Though not always the least expensive program on the front end, through distributions of surplus to the members, prudent underwriting, active loss control and education of employer members, groups can level the cost to employers through the hard and soft market cycles when commercial carriers may be unable to or unwilling to write certain business risks.”

Other possible benefits of group self-insurance include:

- Employer Involvement - Conceptually, employers are likely to be more involved in their workers’ compensation exposure and focused on safety and loss prevention than they might be if simply paying a carrier premium. This should result in lower claims costs, improved return-to-work for employees, and increased stability of rates.
- Cost Savings - Employers involved in a group self-insurance program may benefit in terms of lower costs and potential dividends that they would not receive with a profit-driven carrier policy.
- Safety Training and Education - Groups allow for a more controlled focus on safety. The homogeneity requirement provides opportunities for more targeted safety programs. Safety inspections can be more effective with similar types of employers.
- Enhanced Coverage Option - Groups allow an alternative for certain types of employers that have difficulty obtaining coverage in the commercial market.

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- Competition - The option to self-insure as a group increases the competition in the workers' compensation market place and thus keeps rates more reasonable. In the absence of the group option, and without other alternatives made available, the type of employer that would typically join a group will only be able to obtain coverage from the State Insurance Fund (SIF) or a licensed carrier. Based upon presentations made by active members of existing groups, some carriers may be unwilling to write certain classes of payroll thus limiting the options even more.
- Claims Handling - Trustees/members can play a more active role in the handling of claims including more direct contact and communication with claims administrators. Caseload ratios can be lower than with the SIF or carriers.

C. RISKS OF GROUP SELF-INSURANCE

The proposed rules, regulations and supporting prescribed reports include rigid funding and reporting requirements as well as many other minimum requirements that must be met by every active group in order to continue to be authorized to self-insure. Although the proposed environment going forward makes an effort to address the past deficiencies and ensure the future viability of the program, there are a number of fundamental components of the group model that are difficult to regulate even with the most stringent of regulatory environments. There is still substantial cause for concern that the group self-insurance model continues to place all employers that participate in group self-insurance at significant risk.

The more notable challenges of group self-insurance include the following:

- Joint and Several Liability - The potential very large joint and several liability on group members for the group's obligations, coupled with the long term nature of workers' compensation claims poses a significant risk to group members. The ability of various parties associated with the trust to manipulate the operation of groups for their own benefit to the member's detriment can heighten this risk. Further, group members remain jointly and severally liable for claims long after the claims were actually incurred and/or long after their period of membership in the group may have ended. As a result, it is difficult for an employer to accurately weigh the risks and benefits of joining a group as opposed to other types of coverage allowed under the WCL.
- Financial Risk – Unlike a traditional insurance policy where the employer has a fixed annual premium, each employer participating in a group is at risk of additional costs regardless of its own loss experience.

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- Underlying Financial Stability - The joint and several model that had previously been viewed as the cornerstone to the financial stability of the group program has proven to be unreliable and unable to provide a timely mechanism for payment. As demonstrated previously, the majority of the members of the insolvent GSITs have so far refused to voluntarily pay bills representing their actual or estimated share of joint and several liability and forced collections from those members are delayed and generally inadequate to meet the obligations of the GSIT.
- Mismanagement - The management of much of a group's operations is often left to key advisors, primarily the group administrators. The weakness in this structure is that the bulk of the decision making is being done by individuals whose interests do not always align with those of the members. In fact, in the short term, these key advisors may actually stand to benefit by being overly optimistic with many of the operating decisions including developing rates, setting reserves, and issuing dividends. Various advisors are often paid based upon the size of the group. The healthier the group appears the more members join and the more compensation the key advisors receive. When the inadequate rates and reserves materialize the key advisors have not contracted to be jointly and severally liable for the shortfall. This was a significant issue that was highlighted in the forensic reviews conducted on the CRM trusts.
- Trustee Oversight - The foundation of the GSIT program is built upon the concept of small businesses in a similar line of work banding together and assuming joint and several liability for each others workers' compensation exposure, in an effort to lower their costs. Under the current group program, most of the time the only affiliation these employers have is their common membership in the group trust. While the board of trustees is predominantly made up of group members, with very limited exception, these employers are not insurance professionals. The board of trustees delegates much of the day-to-day operations of running the group to various key advisors including administrators, brokers, accountants and actuaries, and is therefore dependent on their acting in good faith in the interests of the trust members. In practice, however, such good faith has not always been present. For example, the CRM forensic reviews noted that the administrator contracted with its own affiliates for things such as medical bill reviews, brokerage commissions, and excess coverage, and charged the group additional fees often without the knowledge of the trustees.

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The proposed regulations attempt to further resolve this issue by, among other provisions, not allowing trustee authority to be delegated and by eliminating several inherent conflicts of interest. However, based on the recent forensic results, it is questionable whether the level of involvement and expertise needed from the trustees and employer members is realistic. Experience has shown that even when the board of trustees is very active and consists of attorneys, CPAs, and CFOs, they can still be misled. The trustees and members are primarily focused on running their own businesses on a daily basis and do not have the time or expertise needed to ensure that the group is run effectively.

Finally, given the possibility that legal action will be taken against former trustees of insolvent trusts, it will be extremely difficult to attract and maintain trustees.

- Reserving Subjectivity - Workers' compensation claims reserves include both indemnity and medical expenses that are expected to be paid out over many years. Given the variety and complexity involved in reserving, it would be difficult and/or administratively impossible to promulgate specific reserving standards for every conceivable set of circumstances that could then be applied consistently across every type of claims. The Board does not promulgate specific reserving guidelines, but providing a reasonable range is well within the parameters and expertise of the group's third party administrator. It should be noted however, that such guidelines for reserving do not exist for most lines of insurance. These regulatory difficulties are compounded by the fact that reserve totals are the starting point for the actuary when developing a group's ultimate liabilities. If the reserves are artificially suppressed, or assumptions are overly optimistic, the ultimate claims reserve will be understated. Even with more detailed reporting which includes specific information by claim year, it will take years for the actual costs of any specific claim or all claims for a given period to be accurately measured. As a result, the operating results for each year cannot be measured with absolute certainty until long after the coverage period has ended. Group members are indefinitely left exposed to those liabilities as they continue to develop.

The magnitude of this type of manipulation can be demonstrated by several of the CRM forensic reviews. For example, in the Health Care Industry Trust the forensic reviews noted that the claims reserves were substantially suppressed. The reserve estimates prepared by the trust's original actuary placed the trust's deficit at roughly \$6 million in 2005. The deficit has since grown to over \$200 million in 2009.

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- Regulatory Oversight - Given the level of involvement that can realistically be expected from trustees and/or employer members, the day-to-day oversight of the groups would then fall to the WCB (or some other regulatory body). However, the increased administrative costs, which would be incurred by the WCB to ensure that each group was being run effectively, would be cost prohibitive.

In addition, as it currently stands, these administrative costs would be shared among both the group and individual self-insurers. It does not seem equitable to require the individual self-insurers to bear a significant increase in costs related specifically to the appropriate regulation of groups. Conversely, if the assessment methodology were changed to assess group administrative costs only to the groups being regulated, these groups would not be able to bear the additional financial burden.

- Impact of Assessments – The difficulties inherent in group trust operations have been complicated further by the need to assess the healthy trusts, along with individual self-insurers, to provide for payment of claims while actions are taken to recover from members of insolvent group trusts. This complicates operation of financially viable healthy trusts. Further, the *Held* decision has, at present, called the WCB's authority to issue these assessments into question.

It appears as if the proposed rules and regulations and prescribed reports, despite the numerous enhancements, may not be able to prevent the issues described above in a cost beneficial manner. Essentially, the group trust program is reliant to a large degree on the good faith legal compliance of trustees, administrators, and key advisors.

Finally, the group community has expressed concern about its ability to meet the standards as proposed, which do not specifically address the challenges summarized above. A regulatory environment that would ensure complete compliance would potentially be so far-reaching and cost prohibitive as to negate any benefit that might be expected when establishing a group.

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D. FUTURE OF GROUPS

The Task Force has reviewed a number of options with regard to the future of the group program.

Initially, the Task Force contemplated whether or not the proposed rules and regulations were adequate. Specifically, groups would be required to increase funding levels, account for and fund the trust's operations on a contribution year specific basis and include a risk margin in their rates going forward. In addition, all groups would have to undergo an in-depth financial, actuarial and claims review so that the regulatory funding level could be accurately and independently measured. Groups that meet and maintain the new standards, including the requisite risk margin and contribution year funding/reporting, would have the ability to offer coverage going forward. Groups that are under funded would have to meet certain remedial benchmarks for increased funding and achieve full funding in a timely manner or face termination.

Based on input from remaining active groups, serious concerns were raised regarding the future cost-competitiveness of groups given the proposed requirements. Additionally, results of the forensic reviews became available which identified a number of key issues which led to the recent defaults, some of which by their very nature are difficult to regulate in the GSIT context. Most notably:

- Level of trustee oversight needed to ensure proper administration is difficult to maintain;
- The inherent conflicts of interest for trust administrators and TPAs, and the difficulty of regulating such conflicts which has contributed to the default of a number of groups; and
- The ability of parties associated with the trust to manipulate the operation of groups for their own benefit to the detriment of the members is difficult, if not impossible, to regulate.

The proposed rules and regulations, despite the numerous enhancements, have not gone far enough to prevent these issues. In addition, it is unlikely that the WCB has or will have in the future sufficient staff to provide effective oversight, regardless of the exhaustiveness of the rules and regulations.

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Consideration was also given to allowing groups to continue provided they could post a security deposit equal to the full value of their ultimate losses as determined by the WCB in a manner similar to the individual self-insurers. However, it has been the experience of the WCB that when requested to do so, it was typically not possible for the groups to post the required deposit. Unlike the larger individual self-insurers, the smaller employers that belong to a group do not have the financial resources needed to post and/or collateralize such a deposit.

It was ultimately determined that if these options were pursued it would not offer the members a guaranteed cost program and the members would still be exposed to long term joint and several liability. In addition, it is possible that the level of funding, reporting and oversight that would be necessary would cause the group model to no longer be cost beneficial. Finally, it is possible that the WCB would undertake an extensive and costly effort to establish such an environment only to discover that there are not employers/groups that are ready, willing or able to meet the standards established.

Based on all of the evidence reviewed and extensive discussions, the Task Force has concluded that the inherent risks of group self-insurance, combined with the financial risks posed by insolvent groups, far outweigh the potential benefits. The group model simply imposes too much risk on the employers that participate in it and should not be allowed to continue. Even with further enhancements the risks of the group model, built upon joint and several liability of employer members, outweigh the benefits which may be derived from group self-insurance.

The Task Force recommends that legislation be prepared to terminate the group self-insurance program effective December 31, 2010. All existing groups and their members should be given sufficient time to find alternative coverage which maintains the full benefits and rights of claimants.

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Chapter Five – Regulation of Group Self-Insurers

**A. 2008 LEGISLATION
DRAFT RULES AND REGULATIONS**

Legislation enacted in June 2008 reformed many of the financial, reporting and operational standards applicable to group self-insurers. In addition, the forensic reviews performed to date¹³ identified a number of issues which contributed to the group defaults. In response to the legislative changes and forensic findings, and prior to the first meeting of the Task Force, the WCB had drafted rules and regulations which would replace NYCRR Part 317 in its entirety.

These rules and regulations have been reviewed, revised and largely supported by the Task Force members and have been submitted to the Governor's Office of Regulatory Reform for pre-proposal review prior to formal promulgation.

The most notable enhancements in the final draft of the rules and regulations include the following:

- Contribution year funding and reporting.
- Funding requirements including a risk margin which will provide for a more conservative approach to projecting ultimate liabilities.
- Enhanced reporting including detailed prescribed reports and actuarial opinions to support the financial statements.
- Prohibitions on distributions to members.
- More extensive independent examination of records and affairs of the group at least once every three years by service providers chosen by the WCB.
- Timelier funding of deficits based upon contribution year specific operating results.
- Enhanced measures for maintaining group homogeneity.
- Separation of duty requirements for key agents.
- Creation of an advisory committee for group self-insurance.

In conjunction with the development of the new rules and regulations, the WCB is in the process of developing a comprehensive reporting package that every group would have to file annually. With the filing of these detailed prescribed reports, the funding position of every active group self-insurer would be measured in a more consistent, accurate and timely manner. Groups that fail to meet the minimum funding requirements would be required to submit a plan to immediately cure the default or would be subject to termination in as expeditious a manner as possible.

¹³ Forensic reports reviewed by the Task Force included the Manufacturing Self Insurance Trust and the Healthcare Industry Trust of New York.

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It is important to note that while the rules and regulations will go through the formal comment period, the proposed new standards have caused great concern in the group self-insurance community. Some members of the group community have expressed the position that the risk margin coupled with the contribution year specific funding/reporting requirements are too onerous and the enactment of the rules and regulations and supporting reports as proposed will result in an inability to “stay competitive”. Finally, others have expressed the position that the proposed funding standards are not necessary to assure financial solvency given the other new regulatory and reporting requirements.

At the same time, the Task Force recognizes that there are a number of fundamental components of the group model that are difficult to regulate even with the most stringent of regulatory environments. These challenges include:

- Appropriate reserving for claims;
- Adequate group oversight by trustees;
- Adequate WCB oversight;
- Prevention of misconduct by administrators;
- Enforcement and collection of joint and several liability; and
- Preparation, submission and evaluation of accurate actuarial and other financial reports.

These various challenges create an environment where it is difficult to identify mismanagement and potential fraud. In spite of the regulatory enhancements, Task Force members continue to have concerns that the group self-insurance model places participating employers, especially small employers, at significant financial risk. This is particularly true with respect to joint and several liability.

As a result of the challenges inherent to the group model, and while the recommendations of the Task Force are being considered by the Governor and the Legislature, the Task Force is recommending that:

- Upon finalization, the WCB should implement the regulations to mitigate any additional deterioration of the group self-insurance program;
- The WCB should continue its independent reviews and remediation efforts with the GSITs to verify and strengthen their financial condition;
- The WCB should work aggressively with the under funded GSITs to increase the funding levels and, where possible, increase security deposits for under funded GSITs; and
- The WCB should intervene earlier for under funded GSITs that may become insolvent to ensure timely collections so there is minimal impact on self-insurers.

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Chapter Five – Regulation of Group Self-Insurers (continued)

B. REGULATORY OVERSIGHT/STAFFING

The group self-insurance program was first established as an off-shoot of the individual self-insurance program. As such, it has always been under the regulatory purview of the WCB. Initially, very little distinction was made between the regulation of group and individual self-insurers. The first group self-insurers were required to submit the same annual reports as individual self-insurers and their security deposits were also comparable.

While the first groups approved to operate were required to post a security deposit similar to those of the individual self-insurers it was noted that the underlying premise of group self-insurance is that the employer members who participate in a GSIT are jointly and severally liable for all of the GSITs obligations incurred during their period of membership. A fully funded GSIT coupled with joint and several liabilities of the employer members was intended to be the equivalent of the full security deposits posted by the individual self-insurers. GSITs were also required to maintain excess insurance coverage which protects the group from catastrophic losses on a per occurrence basis.

Accordingly, in lieu of a security deposit that was equal to the GSIT's ultimate liability, in determining the amount of security required of the groups, the focus was for each group self-insurer to maintain a trust which was dedicated to the payment of the workers' compensation obligations of the group members. The security deposit posted by most GSITs was therefore reduced and was intended to reflect a "risk margin" if the trust's liabilities developed higher than projected.

Moreover, prior to the late 1990's, the group program was somewhat contained; there were not many groups and those that were active were smaller with more closely affiliated employer members. The concept of joint and several among the members had never been tested as none of these earlier groups had ever defaulted.

It was not until the size of the group program began to grow dramatically that a larger distinction started to evolve between group and individual self-insurance. However, in retrospect, the number and specialized knowledge of WCB staff were not sufficient to identify underlying issues with the groups' deficiencies as they developed and to proceed with remediation in enough time to significantly mitigate any further negative impact. This was exacerbated by the limited regulatory tools available to staff.

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Chapter Five – Regulation of Group Self-Insurers (continued)

Many correlations can be drawn between the larger group self-insurers that started to appear in the late 1990's and small traditional carriers or mutual companies. As a result, the Task Force discussed whether or not the regulation of groups should continue with the WCB or would be more appropriately housed with the State Insurance Department (SID).

After lengthy discussion, and given the magnitude of the issues recently experienced in the group self-insurance program and the potential for fraud and/or gross misconduct, proper regulation would be a challenge regardless of where the authority for that regulation was housed. Finally, in light of the recommendation to terminate, it was determined that the regulatory oversight of the run-off of the groups should remain with the WCB. The SID should, however, be consulted with respect to solvency.

*Task Force on Group Self-Insurance
Report to the Governor and the Legislature*

Chapter Six – Other Issues

A. BACKGROUND

In addition to the specific topics to be reviewed by the Task Force per the legislation, there were two additional issues which were discussed.

These issues are:

- What alternatives for providing the required workers' compensation coverage would be available to these smaller employers in the event the group trust program is terminated?
- What impact would there be on the WCB's assessments including, but not limited to, the self-insurers' assessment made against both individual and group self-insurers, if groups were no longer allowed?

Although these topics were evaluated in the context of group self-insurance no longer being an option going forward, these issues are relevant even if groups remain.

B. ALTERNATIVE COVERAGE OPTIONS

Under the WCL, employers must provide workers' compensation coverage to their employees and can do so in one of three ways: 1) by obtaining a policy from a licensed carrier; 2) by obtaining a policy from the State Insurance Fund (SIF); or 3) by becoming approved to self-insure.

The option to self-insure as a group was established as a means of allowing smaller employers to enjoy the benefits of self-insurance previously reserved for larger employers that were approved to self-insure on an individual basis. Primarily, these benefits include more active involvement with their claims and control over their workers' compensation costs.

There are a number of alternatives that would provide employers with some of those benefits without exposing them to the risks inherent to group self-insurance. These alternatives include:

*Task Force on Group Self-Insurance
Report to the Governor and the Legislature*

Chapter Six – Other Issues (continued)

Safety Group with the SIF – The SIF runs a number of safety groups that, like group self-insurance, offer loss sensitive insurance plans that enable employers in the same industry to pool their insurance premiums and spread risk among the employer members of the same group. Unlike group self-insurance, however, the safety groups offer a fully insured plan, which is supported by the full faith and credit of the SIF. Safety group members can receive dividends if the losses develop lower than expected (as can group trust members if a surplus exists). However, safety group plan members cannot be assessed under joint and several as can group trust members. Additionally, the safety groups offer many of the characteristics seen in effective group trusts including case management; safety and loss control; return-to-work programs; and anti-fraud activities.

It appears as if the SIF safety groups offer many of the positive aspects of group self-insurance without many of the negatives such as long term exposure to joint and several liability. However, there is not an existing safety group for every type of employer. In addition, certain employer members who have expressed a negative view of the service at the SIF and might be reluctant to return. Finally, it is likely that some of the existing members in the group trusts will not meet the underwriting standards of the SIF safety groups. As such, there are no guarantees that employers that currently belong to group trusts will want to move to a safety group or will necessarily be approved for membership in a safety group.

Safety Group with a Carrier – There are carriers that provide a product similar to the SIF safety groups whereby employers can obtain guaranteed cost coverage with the full protection of the workers' compensation guaranty fund. These policies are individually underwritten with an emphasis on common safety controls and risk management. Similar to the group model, employers must be homogeneous. Dividends are based upon actual losses but are at the sole discretion of the carrier.

Individual Self-Insurance – Typically, employers that participate in group self-insurance do so because they wish to self-insure but are unable to meet the criteria to self-insure on an individual basis. These criteria currently include meeting minimum financial net worth standards; the posting of a security deposit equal to the full value of the employer's outstanding workers' compensation claims; and obtaining excess insurance which protects against catastrophic loss. In certain limited circumstances, it is possible that a current group trust member may meet the various programmatic and fiscal criteria to become an individual self-insurer. An application for individual self-insurance should be encouraged from any such employer.

*Task Force on Group Self-Insurance
Report to the Governor and the Legislature*

Chapter Six – Other Issues (continued)

Selective Self-Insurance Option – Legislation has allowed certain types of employers (including the jockeys and black car operators) to support specific legislation that enables them to self-insure as a quasi group/individual. Similar legislation should be considered for a selective self-insurance option in limited circumstances for certain strongly affiliated groups of employers provided they meet a combination of mandatory and discretionary criteria.

The mandatory criteria for qualifying for this type of self-insurance should include the following:

- A. Participant employers represent 85% of the particular market; OR
- B. Participant employers are signatory to the same collective bargaining agreement;

AND:

- o Predominant payroll classification of the participants are confined to a limited number of payroll classes; and
- o Regulatory funding status for the former group containing such employers, as determined by the WCB, is funded for four out of the five previous years as confirmed by a WCB directed forensic review including, but not limited to payroll, financial, actuarial and claims review; and
- o Participant employers agree to adhere to the safety standards established for this particular set of employers.

Other criteria that should be considered in addition to those above are:

- o Participant employers utilize alternative dispute resolution that is part of the collective bargaining;
- o Participant employers represent a class of employers typically under-served in the traditional insurance market;
- o The group to which the employers belonged demonstrated success at reducing injury rates;
- o The group to which the employers belonged demonstrated a high retention rate of participating employers.

Unlike the current group self-insurers, the security deposit that would be required of these groups would be similar to that of the individual self-insurers. These deposits would fully secure all outstanding self-insured obligations (indemnity and medical) for the employer's cumulative period of self-insurance.

*Task Force on Group Self-Insurance
Report to the Governor and the Legislature*

Chapter Six – Other Issues (continued)

Like individual self-insurers, these groups would be required to annually submit detailed data, including claim specific reserve information as well as updated payroll and payment amounts. This information would be used to project the value of the fully developed outstanding indemnity and medical obligations. The security deposit requirements for these groups would then be based on that projection.

This alternative is only recommended in limited circumstances where a majority of the specific criteria listed above have been met.

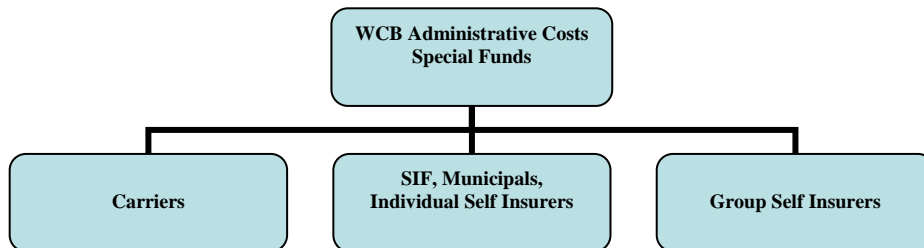
C. ASSESSMENTS

If the group option were no longer available or if the group self-insurer's tail of claims were transferred via an Assumption of Workers Compensation Liability Insurance Policy, the various sections of the WCL that drive the assessment methodology would need to be altered to recognize the fact that the group category shown below would no longer be feasible, particularly in light of the number of group defaults. These assessments cover WCB costs other than regulation of self-insurance, and employers in effect continue to pay these costs through their new "carrier."

Specifically:

Administrative and Special Fund Assessments – The WCB assesses its administrative and special fund costs to the entire industry, which includes carriers, the State Insurance Fund (SIF) and both the individual and group self-insurers. These assessments fall into two general categories: (1) administrative assessments which support the day-to-day operations of the WCB and interdepartmental programs at the Department of Labor and Health; and (2) special fund assessments which support programs administered by the WCB that make payments directly to claimants or reimburse carriers or self-insured employers/groups for payments that they have made to claimants in special categories.

These administrative assessments are broken into three distinct categories as follows:



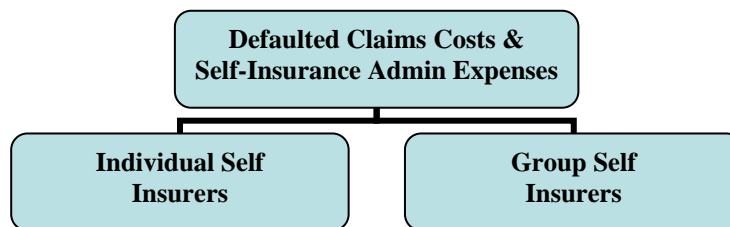
**Task Force on Group Self-Insurance
Report to the Governor and the Legislature**

Chapter Six – Other Issues (continued)

The possibility that there will be no more group self-insurers highlights a fundamental flaw in the assessment methodology. If unchanged, the assessment methodology would likely result in the remaining “healthy” groups experiencing a significant financial strain because of increased assessments due to a smaller and smaller number of groups which to allocate the costs. Theoretically this could cause a systemic failure of the group assessment system. Although current law addresses this problem by allowing for assessments against closed groups, this system could face collection difficulties in the even of a global group self-insurance collapse. This problem must be addressed in a fair and equitable manner in the context of closing of the group self-insurance program, by allowing for a backup or alternative assessment mechanism.

Alternative assessment mechanisms should recognize the fact that the employers that have left (or will leave) the group option will be obtaining their coverage by one of the other methods allowed under the WCL (carrier or SIF). The premium they will pay that carrier or the SIF will include a surcharge related to WCB assessments. While the carriers and SIF will pay a larger share of the overall assessments, they will be collecting more premium (and premium surcharges) as they will also have a larger share of the market with the competition of group trusts no longer available.

Self-Insurers’ Assessment pursuant to Section 50-5 of the WCL - The WCL includes a provision which requires the WCB to assess all self-insured employers for the costs of any unmet obligations incurred by a defaulted individual or group self-insurer as well as the costs of administering the self-insurance program. As noted, this provision has been found unconstitutional in the *Held* decision, and should that decision remain intact, its impact will need to be addressed.



When a group self-insurer defaults, this provision protects claimants in the event that the payments under joint and several liability are not received timely to guarantee the benefits. While collections under joint and several will ultimately be used to offset future assessments, in the interim, group defaults can and have had a significant impact on the self-insurers’ assessment levels.

*Task Force on Group Self-Insurance
Report to the Governor and the Legislature*

Chapter Six – Other Issues (continued)

As the cost and number of insolvent groups continues to rise, the number of individual and group self-insurers declines. The remaining “healthy” self-insurers, therefore, continue to face increasing assessment levels. Theoretically this could cause a systemic failure of the group assessment system.

In order to mitigate the impact that these defaults have had to the self-insurance community in the form of increased assessments, the Task Force has reviewed a number of enhancements which should increase the amounts collected and the timeliness of those collections. These tools are described in Chapter Three of this report and potentially include the enforcement of unpaid claims directly from the employers; findings of non-compliance for employers that do not pay under joint and several; more timely forensic reviews and billings; and the hiring of outside counsel where necessary and appropriate.

In addition to the enhanced collection tools, the Task Force reviewed other options which might limit the impact that insolvent groups have on the remainder of the self-insurance community in the form of increased assessments. These include ALPs and WAMO settlements.

Finally, if the groups currently offering coverage were required to terminate or if more rigid financial standards were applied, the significant increase in the self-insurers’ assessment resulting from the recent group defaults may be exacerbated by additional defaults. This potential exists. There are a number of options which should be applied to mitigate these types of adverse consequences, including: improved funding levels for the active groups and/or those in run-off; earlier triggers for insolvency determination and posting of additional security deposits.

***TASK FORCE ON
GROUP SELF-INSURANCE***

Summary of Litigation

Exhibit A

Report to the Governor and the Legislature

June 2010

*New York State Workers' Compensation Board
Summary of Litigation*

**Summary of Status
Held, et al v. Workers' Compensation Board and Zachary Weiss**

The following is the Workers' Compensation Board's (Board) summary of the events, as of May 21, 2010, concerning recent court activity relative to the constitutionality of various provisions of the Workers' Compensation Law (WCL).

On April 14, 2010 in *Held, et al v. Workers' Compensation Board and Zachary Weiss*, (Albany County Index No. 2957-08) (Held), Justice O'Connor found the provisions of WCL §50(5)(g) which authorizes the payments unconstitutional, enjoined the Board from issuing further WCL §50(5)(g) assessments and vacated the assessments levied by the Board under WCL §50(5)(g) from 2008 forward. However, the Held decision also found that the provisions of WCL §15(8), 151, and, to the extent implicated by reference, §25-a, are all constitutional provisions of the WCL and all assessments levied pursuant thereto are valid¹.

On May 6, 2010, the Board filed a notice of appeal from the court's decision in the Held DJ with the Appellate Division, Third Department. As a result of that filing, and pursuant to the provisions of CPLR §5519(a)(1), the plaintiffs in the Held were automatically stayed from attempting to enforce that portion of the Held DJ decision which vacated the assessments levied by the Board under WCL §50(5)(g) from 2008 forward. On May 19, 2010, the Appellate Division signed the Board's order to show cause, pursuant to the provisions of CPLR §5519(c), seeking a discretionary stay from that portion of the Held DJ decision which enjoined the Board from issuing further WCL §50(5)(g) assessments. In the event that the Appellate Division grants the Board's motion, the Board will be able to levy WCL §50(5)(g) assessments during the pendency of its appeal of the underlying Held DJ decision.

¹ On May 21, 2010, the court issued a second amended decision clarifying that the original decision granted the Board's motion for summary judgment on the constitutionality of WCL §§15(8), 151, and, to the extent implicated by reference, §25-a.

New York State Workers' Compensation Board
Summary of Litigation

Name	Date Filed	Subject Matter and Status
I. GROUP SELF-INSURANCE TRUSTS (GSIT)		
Held, et al. v. WCB	April 10, 2008	Article 78 challenging WCL § 50(5) assessments. By decision and order filed July 2, 2008, Board's authority to levy 50(5)(f) assessments upheld but insolvency needed to be better defined. Albany County Index No. 2957-08
Held, et al. v. WCB (Held Appeal)	May 28, 2008	Appeal of Article 78 to Appellate Division. Board argued lack of aggrievement. Appeal dismissed on grounds of lack of aggrievement. No appeal taken.
Held, et al. v. WCB (Held DJ)	April 10, 2008	Declaratory judgment challenging constitutionality of WCL assessments. By second amended decision and order filed 5/20/10, Court found 50(5)(g) to be an unconstitutional taking but granted WCB's SJ motion on 15(8), 25-a and 151. Albany County Index. No. 2943-08
Held, et al v. WCB (Held DJ Appeal)	Board filed NoA on May 6, 2010. Plaintiffs cross appeal on May 20, 2010	Appeal of Held DJ decision. Plaintiff's cross appeal. May 19, 2010, Board seeks discretionary stay from injunctive relief of Held DJ decision via OSC. Fully submitted on 5/28/10. Awaiting decision from AD3d.
Held, et al. v. WCB (Held II)	March 10, 2009	Article 78 challenging the 2007 fifth quarter, 2008 third and four quarters and 2009 first quarter WCL § 50(5) assessments [both (f) and (c)] and the Board's insolvency regulation. Fully submitted. Albany County Index. No. 1847-09
Nuara, et al. v. WCB	June 11, 2008	Article 78 by inactive trusts challenging the WCL assessments. By decision and order dated February 11, 2010, Board's authority to levy assessments on inactive GSITs upheld but invalidates assessments as against plaintiffs because Board's interpretation of "preceding year". Protective NoA filed 3/26/10. Albany County Index No. 5076-08
Aides at Home, et al. v. WCB	July 28, 2008	Article 78 seeking to enjoin the Board from enforcing Assessment Billing Package; raises regulatory negligence. Decision/Order/Judgment rendered 2/23/09, upholding Board's authority to enforce assessment billing package, dismisses regulatory negligence claim. Albany County Index No. 6389-08
Aides at Home, et al. v. WCB (Aides At Home Appeal)	Appeal perfected March 24, 2010	Appeal of above decision. Fully submitted, oral argument held on May 27, 2010 and awaiting decision.
Visiting Nurse Regional Health Care System, et al. v. WCB	July 31, 2008	Article 78 seeking to enjoin the Board from enforcing Assessment Billing Package; raises regulatory negligence. Vened in Westchester. Board filed Motion for change of Venue in addition to Answer. Motion granted and case transferred to Albany County. Fully submitted. Westchester County Index No. 16779/08.
Bezalel Nursing Home, et al. v. WCB	July 29, 2008	Article 78 seeking to enjoin the Board from enforcing Assessment Billing Package; raises regulatory negligence and seeks disclosure of documents. Case has been adjourned several times as document issue is negotiated in context of related collection action by Board (see WCB v. HCF members, below). Next appearance scheduled for August 9, 2010. Albany County Index No. 6413-08.

New York State Workers' Compensation Board
Summary of Litigation

Name	Date Filed	Subject Matter and Status
I. GROUP SELF-INSURANCE TRUSTS (GSIT) (Continued)		
Baden Street Settlement of Rochester, et al. v. WCB	August 11, 2008	Article 78 seeking to enjoin the Board from enforcing Assessment Billing Package; raises regulatory negligence. Answer filed. No oral argument scheduled at this time. Adjourned without date pending AD3rd's decision in Aides at Home. Albany County Index No. 6772-08
James Taylor Manufacturing, et al., v. WCB	August 11, 2008	Article 78 seeking to enjoin the Board from enforcing Assessment Billing Package; raises regulatory negligence. Mtg held with P's, explanation and documentation provided. Five of seven P's have agreed to withdraw papers and sign DACA. Remaining P's have until 6/4/10 to decide whether or not to file amended petition. Albany County Index No. 6780-08.
Cannon Industries, Inc., et al., v. WCB	August 7, 2008	Article 78 seeking to enjoin the Board from enforcing Assessment Billing Package; raises regulatory negligence. Answer filed. Oral argument scheduled for 6/18/10. Albany County Index No. 6739-08.
XTCB, Inc., f/d/a Tom Cat Bakery, Inc., Tribeca Ovens, Inc., and Brooklyn Brewery, Inc. v. WCB	May 15, 2009	Article 78 seeking to enjoin the Board from enforcing Interim Assessment Billing Package. Discontinued WOP by stipulation 7/16/09 pending final assessment from Board. Albany County Index No. 0789-09.
Century Mold Co., Inc. v. WCB	November 20, 2009	Article 78 seeking to enjoin the Board from enforcing Interim Assessment Billing Package. Discontinued WOP by stipulation 3/8/10 pending final assessment from Board. Albany County Index No. 9812-09.
RGB Management Corp., et al. v. CRM, Wholesale Retail Trust and SAFE, LLC	October 23, 2008	Action brought by members of WRWCT against CRM and also alleges that members not liable for deficit as they properly withdrew from Trust. By decision filed 3/25/10 action dismissed as causes of action held derivative and Plaintiff unable to show that Board not taking action in light of WCB action against CRM. Board MTD deemed moot as P's stipulated to drop CoA that is not liable. New York County Index. No. 603058/2008.
CRM v. WCB and HITNY	January 22, 2008	Interpleader action commenced by CRM seeking judicial approval to turn over HITNY documents and remaining funds to WCB. Funds and documents transferred pursuant to Order on Consent executed in April 2008. Dutchess County Index No. 2008/427.
CRM v. HITNY, et al. and WCB	October 3, 2008	Declaratory judgment challenging Board's ability to commence actions against CRM as de facto Trustees of insolvent Trusts and claiming CRM did no wrong. WCB and CRM execute tolling agreement that includes acknowledgement by CRM that WCB has standing to commence such action on behalf of insolvent GSITs. WCB files MTD on 5/18/09 for, inter alia, failure to name necessary parties and failure to state cause of action (non justiciable). Board's MTD granted on justiciability. Dutchess County Index No. 2008-7616
House of Good Shepherd v. WCB	March 26, 2008	Seeks an accounting from the Board and also names Board's TPA. Board's MTD granted on 9/4/09. Oneida County Index No. CA2007-000906.
WCB v. CRM, LLC, et al.	December 9, 2009	WCB's action against CRM and affiliates to recover cumulative deficit of all eight CRM GSITs. Parties enter standstill agreement effective 3/31/10 through 7/31/10. Albany Cty. Index No. 10288-09

New York State Workers' Compensation Board
Summary of Litigation

Name	Date Filed	Subject Matter and Status
II. RELATED CASES IN WHICH BOARD IS NOT NAMED PARTY		
Metal Goods Trust v. Advent Tool & Mold, Inc.	Notice of Appeal from Supreme Court decision filed on 3/14/08	Collection of joint and several liability of Trust against member. Board sought involvement on Amicus level because of trial level decision contrary to principles of J&S/Board regulations/WCL. AD affirmed Supreme Court. Erie County Index No. 2005-6418
Westchester Fire Insurance Company v. PETNY, Village of Kenmore, Village of Lancaster, et al.		Action commenced by provider of surety bond for PETNY against PETNY and members of PETNY to recoup monies paid to the Board when the bond was called. Multiple actions commenced in county in which former members are located as members are municipalities. Letter to Court advising the Board will not appear in this action (4/09).
Liberty Mutual Insurance Company v. WRWCT, Trustees, members of WRWCT.		Action commenced by provider of surety bond for WRWCT against WRWCT and members of WRWCT to recoup monies paid to the Board when the bond was called. Letter to Court advising the Board will not appear in this action (4/09). New York County Index No. 114950/08
FS Kids, LLC, et al. v. Compensation Risk Managers, LLC		WRWCT member suit v CRM. (Erie County Index No. I-2008/11268)
Armstrong Brands, Inc., et al. v. Compensation Risk Managers, LLC		TRADE member suit v. CRM. (Erie County Index No. I-2009/1537)
Arlen Senior Contracting of Central Islip, LLC, et al. v. Compensation Risk Managers, LLC		REMTNY member suit v. CRM. (Erie County Index No. I-2009/9212)
70 Sheldon, Inc., et al. v. Compensation Risk Managers, LLC		Transportation member suit v CRM. (Erie County Index No. I-2009/9742)
Healthcare Industry Trust of New York, et al. v. Compensation Risk Managers, LLC, et al.		HITNY member suit v CRM, actuary, accountant, brokers. (Albany County Index No. 5966-09)
Motherly Love Home Care Service Inc. v. Program risk Management, Inc.		Member sued HCP arguing that premium for coverage was improper as persons were independent contractors and not employees. HCP implead Trust per indemnity agreement. Trust agreed to indemnify HCP in exchange for dismissal of suit as against Trusts with prejudice. HCP wins SJ motion. Defendants appeal to AD 1st Dept. CAMP conference scheduled for 6/14/10. Suffolk County Index No. 11981/06.
Healthcare Acquisition Corp. d/b/a Allen Home Health Care, et al. v. Program Risk Management, Inc., et al.		Suit by three members of HCP against PRM, accountant and actuary alleging CRM type causes of action. Nassau County Index No. 008714-10.
III. COLLECTION CASES		
WCB v. MSIT members	January 18, 2008	Board's action to collect \$19 Million in pro rata and joint and several liability from members of MSIT. Board issues tender offer in March 2010. Tender offer accepted by over 135 members who pledge over \$14 Million. Board to discontinue against these members and continue litigation against remaining 35. Albany County Index No. L00010-08.
WCB v. PATH members	August 22, 2008	Board's action to collect \$19 Million in pro rata and joint and several liability from members of PATH. Albany County Index No. L-00095-08.
WCB v. HCF members	June 27, 2008	Board's action to collect \$34 Million in pro rata and joint and several liability from members of HCF. Board agreed to allow defendant's claims reviewer access to reserve information under NDA in facilitation of settlement. Access complete and awaiting final report from claims reviewer. Albany County Index No.L00076-08.

*New York State Workers' Compensation Board
Summary of Litigation*

Name	Date Filed	Subject Matter and Status
III. COLLECTION CASES (Continued)		
WCB v. NYMIT members	August 22, 2008	Board's action to collect \$10.6 Million in pro rata and joint and several liability from members of NYMIT. Albany County Index No. L-00098-08.
IV. OTHER INTERIM AGREEMENTS		
HITNY	February 9, 2010	WCB enters agreement with approximately 200 members of HITNY to pay sufficient funds to meet HITNY's obligations on ongoing basis so as to avoid WCL §50(5)(g) assessment for HITNY for FY 2010-11 while parties pursue settlement.

WILLIAM HELD, JR., as Chairman of Contractors Compensation Trust; ALFRED LAVKER, as Chairman of Cooperative Association of Food Enterprises Workers' Compensation Trust; JOHN S. KOGET, as Chairman of THE ELEC-CON TRUST; GERALD O. SILVER, as Chairman of Empire State Education Trust; JOSEPH SCARING, as Chairman of Empire State Hospitality Workers' Compensation Trust; GREGORY F. DeLORENZO, as Chairman of Empire State Transportation Workers' Compensation Trust; FLOYD HUNTZ, as Chairman of First Automotive Services Trust; JOHN SHERMAN, as Chairman of NYSARC Workers' Compensation Trust; JOHN D. MANISCALCO and THOMAS J. PETERS, as Co-Chairman of New York Petroleum Associations Compensation Trust; PAUL ROSS, as Chairman of New York McDonald's Operators Worker's Compensation Trust; JAMES R. PIETROPAOLI, as Chairman of NY Transportation Workers' Compensation Trust; JOHN MacDOUGALL, as Chairman of Retailers of New York Workers' Compensation Trust; and KENNETH MONTERA, as Chairman of The Selective Safety Trust,

Plaintiffs,

-against-

STATE OF NEW YORK WORKERS' COMPENSATION BOARD, and ZACHARY S. WEISS, as Chairman of the Workers' Compensation Board,

Defendants.

(Supreme Court, Albany County, All Purpose Term)

(Justice Kimberly A. O'Connor, Presiding)

**SECOND AMENDED¹
DECISION AND ORDER**

Index No.: 2943-08
RJI No.: 01-08-09274

¹ The Amended Decision and Order, issued May 5, 2010, is amended herein only to clarify the Court's determination regarding the provisions of the WCL challenged by the plaintiffs other than former WCL § 50(5)(f) and current WCL § 50(5)(g), as stated by this Court on the record during oral argument held on May 20, 2010. No other amendments to the Decision and Order have been made.

APPEARANCES:

PATTERSON BELKNAP WEBB
& TYLER LLP

Attorneys for Plaintiffs
(Stephen P. Younger and
Niraj J. Parekh, Esqs., of Counsel)
1133 Avenue of the Americas
New York, New York 10036

PHILLIPS LYTLE LLP
Attorneys for Plaintiffs²
(Kenneth A. Manning, and
Craig R. Bucki, Esqs., of Counsel)
One HSBC Center, Suite 3400
Buffalo, New York 14203-2887

PHILLIPS LYTLE LLP
Attorneys for Plaintiffs¹
(Kelly M. Lester, Esq., of Counsel)
Omni Plaza, 30 South Pearl Street
Albany, New York 12207

HON. ANDREW M. CUOMO
Attorney General of the State of New York
Attorney for Defendants
(Richard Lombardo, Assistant Attorney
General, of Counsel)
The Capitol
Albany, New York 12224

O'CONNOR, J.:

Plaintiffs commenced the instant declaratory judgment action (and a companion C.P.L.R. Article 78 proceeding) to challenge the authority of defendant New York State Workers' Compensation Board ("Board") to levy certain assessments against them pursuant to the Workers' Compensation Law ("WCL"). Plaintiffs have moved for an order, pursuant to CPLR 3212, granting

² Philips Lytle LLP is co-counsel for all plaintiffs except NYSARC Workers' Compensation Trust.

summary judgment in their favor for the relief demanded in the complaint. Defendants oppose the motion and have cross-moved, pursuant to CPLR 3212, for summary judgment dismissing the complaint. Oral argument was held on March 24, 2009, and post-argument submissions were received by the Court. The papers are fully submitted, and all issues have been briefed.

PROCEDURAL HISTORY

After this action was commenced and while plaintiffs' companion Article 78 proceeding was pending, the Legislature enacted new legislation amending the Workers' Compensation Law (*see* L. 2008, ch. 139). The new legislation was signed into law by the Governor on June 30, 2008. It includes amendments to provisions of the WCL § 50(3-a), WCL § 50(5)(c), and § 50(5)(f) as well as WCL § 15(8)(h)(4) and § 151(2)(b), which are at issue in this action (*see* L. 2008, ch. 139, § 1, § 3, § 7, & § 15).

On July 7, 2008, this Court issued a Decision/Order/Judgment in plaintiffs' Article 78 proceeding (*see Held v. Workers' Comp. Bd.* [Sup. Ct., Albany County, July 7, 2008, Index No. 2957-08]). While the Court determined, *inter alia*, that the language of WCL § 50(5)(f)² confers upon the Board the authority to assess all private self insurers, including GSITs, for the anticipated losses, liabilities, and expenses of defaulted GSITs³, the Court found that the Board had failed to

² The version of WCL § 50(5) that was in effect at the time of the challenged assessments included two subparagraphs "(f)." The second subparagraph (f) of WCL § 50(5), the provision at issue in this action and the companion Article 78 proceeding, was renumbered subparagraph (g) in the new legislation. All references to former WCL § 50(5)(f) herein are to second subparagraph (f).

³ The Court found that upon a plain reading of WCL § 50(5)(f) considered in light of the relevant legislative history, attendant regulations, and the provisions of § 50 as a whole, the Legislature's use of the term "private self-insured employer" evidenced its intent that such provision apply to all non-public self-insurers, including individual self-insured employers and GSITs. In that case, this Court discussed the use of the terms "private" and "employer" in the context of the self-insurance program and more specifically in WCL § 50, and found that those terms referred to both individual self-insurers and GSITs.

comply with the statutory prerequisites of that section prior to levying the challenged assessments against the plaintiffs.⁴ The Court, however, declined to rule on plaintiffs' challenges to the constitutionality of WCL § 50(5)(f) under federal and state due process and takings clauses, and under the federal contracts clause, finding that those questions are more appropriately addressed to the instant action.

On July 24, 2008, plaintiffs filed an amended complaint to include a challenge to the constitutionality of WCL § 50(5)(g), § 50(5)(c), § 50(3-a), § 15(8)(h)(4), and § 151(2)(b) as applied under the new legislation. On August 1, 2008, the Board amended, on an emergency basis, the rules and regulations pertaining to group self insurance to add a definition of "insolvent" (*see* 12 N.Y.C.R.R. § 317.20[a]). The amended regulation also added a new provision, which states that "[t]he Chair shall levy an assessment against all private group self-insurers, pursuant to Workers' Compensation Law section 50(5)(g), whenever he or she, or his or her designee, determines that workers' compensation benefits may be unpaid by reason of the default of an insolvent private group self-insurer as defined in [the regulation]" (12 N.Y.C.R.R. § 317.20[b]). Subsequent to its expiration as an emergency rule,⁵ the amended regulation was finalized, adopted, and became effective on November 5, 2008.

In 2009, the Legislature once again enacted legislation amending the Workers' Compensation Law (*see* L. 2009, ch. 56).⁶ The new legislation, however, is not at issue in this action.

⁴ The Court found that the defendants failed to demonstrate, and the record did not establish, that the defaulted GSITs were in fact insolvent and that the posted security held by the Board's chairman on behalf of the defaulted GSITs was about to become exhausted as required by the statute. As a result, the Court annulled and vacated the WCL § 50-5(f) assessments levied against the plaintiffs.

⁵ The emergency rule expired on October 29, 2008.

⁶ The new legislation includes an amendment to the provisions of WCL § 15(8)(h)(4).

FACTUAL BACKGROUND

Plaintiffs comprise thirteen individual groups of employers in related fields and industries that adopted a plan for self-insurance, pursuant to WCL § 50(3-a) and the promulgated rules and regulations, to provide coverage for the payment of workers' compensation benefits to their employees. Groups of employers, like plaintiffs, that have adopted a plan for self insurance under WCL § 50(3-a) are denominated group self-insured trusts ("GSIT"). To qualify to operate as a GSIT, there must exist "a homogeneity in the nature of the group members' business activities" (12 N.Y.C.R.R. § 317.2[1]; *see* 12 N.Y.C.R.R. § 317.3[a]; *see also* WCL § 50[3-a][1]). Furthermore, each employer-member of a GSIT must contractually agree to assume the workers' compensation liabilities of all employer-members within the group and to pay all workers' compensation obligations of each associated member (*see* former WCL § 50[3-a][2], WCL § 50[3-a][2][a], as amended; *see also* 12 N.Y.C.R.R. § 317.2[i]).

Specifically, each employer-member of a GSIT must agree to be jointly and severally responsible for the liabilities of the GSIT as a whole. As such, each individual group of employers seeking authorization to operate as a GSIT is required, as part of its application, to execute a trust agreement as well as a participation agreement "which must be shared with all prospective members of the group," contains "language prescribed by the [Board's] chair," and is "in a form approved by the chair" (12 N.Y.C.R.R. 317.4[5][i] & [ii]). In addition, the participation agreement "must be individually executed by each member of the group" and must "include an acknowledgment that the prospective member has been provided a copy of the trust agreement and has reviewed that agreement, specifically the provisions related to joint and several liability" (12 N.Y.C.R.R. 317.4[5][ii]).

An employer-member participating in a GSIT is not relieved from its liability for workers' compensation obligations prescribed by the WCL except upon payment by the GSIT or by the employer-member itself (*see* former WCL § 50[3-a][3], and as amended). In addition, insolvency or bankruptcy of an employer-member of the GSIT does not relieve the GSIT from the payment of workers' compensation liabilities that accrued during the employer's membership in the GSIT (*see id.*). To secure its obligation to pay workers' compensation claims under the WCL, each employer-member of a GSIT must provide the Board with "satisfactory" and "sufficient" proof of, *inter alia*, its financial ability to pay compensation for the employer-members in the industry covered by it, and to guarantee the payment and administration of all obligations arising under the Workers' Compensation Law (*see* former WCL § 50[3-a][2], WCL § 50[3-a][2][b], as amended; *see* 12 N.Y.C.R.R. § 317.3[d], § 317.5, § 317.6 & § 317.10). GSITs accomplish this by depositing with the Board's chairman securities or cash, or by filing irrevocable letters of credit and/or a surety bond in an amount determined by the Board's chair⁷ (*see* former WCL § 50[3-a][2], WCL § 50[3-a][2][b], as amended; 12 N.Y.C.R.R. § 317.5).

⁷ Prior the enactment of the 2008 legislation amending the WCL, WCL § 50(3-a)(2) provided that the security deposited with the Board would be "in an amount to be determined to secure [a GSIT's] liability to pay the compensation of each employer . . . in accordance with the provisions of paragraph d of subdivision 5 of [the WCL]." Pursuant to former WCL § 50(5)(d), the amount of the deposit of securities, letters of credit or cash, or the amount of a surety bond to be filed with the Board pursuant to WCL § 50(3-a) was to be jointly determined by the chairman of the Board and the superintendent of insurance. The 2008 amendments eliminated the provision that the amount would be determined in accordance with WCL § 50(5)(d). The 2008 legislation also eliminated the superintendent of insurance's involvement in determining the amount of security to be deposited with the Board as well as the language that the security amount was to be determined by the Board's chair as set forth in WCL § 50(5)(d). The regulations, however, maintain that the amount of security deposited is "as determined by the chair" (12 N.Y.C.R.R. 317.5). In addition, prior to the 2008 legislation, WCL § 50(5)(d) provided that Board's chairman "may . . . request the superintendent of insurance for such other assistance, and the superintendent of insurance is hereby authorized to render such assistance upon request of the chairman, as may be necessary to insure the financial ability of such groups to pay compensation for the employers in the industries covered by such plans." The 2008 legislation removed the language: "compensation for the employers in the industries covered by such plans," and replaced that language with: "all liabilities provided by this chapter."

Defendant Board is charged, *inter alia*, with administering the provisions of the WCL and its attendant rules and regulations pertaining to workers' compensation benefits. As a self-funded agency, the Board's administrative expenses are recouped through annual assessments on the participants in the workers' compensation system. The WCL authorizes the Board to levy monetary assessments against GSITs, including an assessment to finance the special disability fund (*see* WCL § 15[8][h][4]), and an assessment to cover the costs and expenses associated with administering the Workers' Compensation Law (*see* WCL § 151[2][b]) and the self-insurance program (*see* WCL § 50[5]).⁸ The WCL also confers upon the Board the authority to assess all private self-insurers, individual self-insurers and GSITs, for the anticipated losses, liabilities, and expenses of defaulted GSITs (*see* former WCL § 50[5][f], new WCL § 50[5][g]).

In February 2008, the Board's chairman sent plaintiffs a notice of assessment, demanding the first quarterly installment of the § 50(5) assessments, comprising both the § 50(5)(c) assessment and the § 50(5)(f) assessment.⁹ Plaintiffs disputed these assessments, but were advised that failure

⁸ Prior to the 2008 amendments to the WCL, assessments levied by the Board against GSITs, pursuant to WCL § 15(8)(h)(4), § 50(5), and § 151(2)(b), were determined using a "pure premium calculation" and allocated based upon a specific statutory formula. The "pure premium calculation" was defined in the prior WCL as:

the New York state annual payroll as of December thirty-first of the preceding year by class code for each employer member of a group self-insurer multiplied by the applicable rate for each class code as determined by the workers' compensation rating board in effect on December thirty-first of the preceding year (former WCL § 15[8][h][4] & § 151[2][b]; *see* former WCL § 50[5][c]).

The 2008 amendments maintained the "pure premium calculation" methodology for assessments imposed pursuant to WCL § 15(8)(h)(4) and § 151(2)(b) for healthy GSITs and GSITs that ceased to self-insure. However, the amendments redefined the "pure premium calculation" for § 15(8)(h)(4) assessments against healthy and terminated GSITs, and for § 151(2)(b) assessments levied against terminated GSITs. They also changed the assessment methodology from the "pure premium calculation" to indemnity payments for assessments levied pursuant § 50(5)(c) and § 50(5)(g).

⁹ In the Article 78 proceeding, plaintiffs made a motion to stay enforcement of the 2008 § 50(5) assessments levied against them pending the Court's determination of the petition. The parties agreed to a voluntary stay through the return date of the application. A temporary stay as to the enforcement of the portion of the assessments that had been imposed by the Board pursuant to former WCL § 50(5)(f) was granted by Decision and

to remit payment could result in the drawing of posted security or revocation of plaintiffs' authority to operate as a GSIT. The companion C.P.L.R. Article 78 proceeding and this action followed. Following the Court's July 7, 2008 Decision/Order/Judgment in the companion C.P.L.R. Article 78 proceeding, the Board annulled and vacated the challenged assessments. In August 2008, the Board levied an assessment against the plaintiffs pursuant to the provisions of WCL § 50(5)(g). Plaintiffs paid these assessments under protest.

DISCUSSION

Summary judgment is a drastic remedy which should only be granted when there clearly are no triable issues of fact (*see Andre v. Pomeroy*, 35 N.Y.2d 361, 364 [1974]). It is well settled that “the proponent of a summary judgment motion must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact” (*Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324 [1986]; *see Winegrad v. New York Univ. Med. Ctr.*, 64 N.Y.2d 851, 853 [1985]; *see also Bush v. St. Clare's Hosp.*, 82 N.Y.2d 738, 739 [1993]). The “[f]ailure to make such [a] showing requires denial of the motion, regardless of the sufficiency of the opposing papers” (*Winegrad v. New York Univ. Med. Ctr.*, 64 N.Y.2d at 853).

It is only when the moving party has established a right to judgment as a matter of law that the burden shifts to the party opposing the motion to establish, by admissible proof, the existence of a genuine issue of material fact (*see Zuckerman v. City of New York*, 49 N.Y.2d 557, 562 [1980]). The Court will then view the evidence in the light most favorable to the party opposing the motion, giving that party the benefit of every reasonable inference, and determine whether there is any triable

Order of this Court, dated May 2, 2008. Plaintiffs, however, were directed to pay the portion of the 2008 assessments levied pursuant to WCL § 50(5)(c)—the general administrative expenses—which were not in dispute and were not the subject of that proceeding. Plaintiffs paid their § 50(5)(c) general assessments in full.

issue of fact (*see Boston v. Dunham*, 274 A.D.2d 708, 709 [3d Dep't 2000][citing *Boyce v. Vazquez*, 249 A.D.2d 724, 726 (3d Dep't 1998)]).

Plaintiffs' challenge to the authority of the Board to assess healthy GSITs for the anticipated losses, liabilities, and expenses of unrelated, defaulted GSITs rests on the premise that the statutory and regulatory scheme governing New York's self-insurance system, and specifically those aspects of the Workers' Compensation Law and its attendant rules and regulations pertaining to group self-insured trusts, was designed around the principle that groups of employers in related fields and industries that adopt a plan for self-insurance, thereby becoming a group self-insured trust, agree and are responsible only for the workers' compensation obligations of the employer-members of that group self-insured trust, and not for the obligations of other unrelated group self-insured trusts. Plaintiffs argue that the assessments levied against them under former WCL § 50(5)(f) and pursuant to WCL § 50(5)(g) for the anticipated losses, liabilities, and expenses of unrelated, defaulted group self-insured trusts violate their federal and state constitutional rights to due process of law, violate the contracts clause of the United States Constitution, and effect a taking of their property without just compensation under the United States Constitution and the New York State Constitution.

Specifically, plaintiffs contend that the 2008 assessments levied against them pursuant to former WCL § 50(5)(f) violate their rights to due process of law under the United States Constitution and New York State Constitution because they were not provided with adequate notice of, and an opportunity to be heard with respect to, their potential liability for the unpaid workers' compensation and benefits owed by other GSITs under the WCL. Plaintiffs further argue that defendants' retroactive application of the provisions of new WCL § 50(5)(g), § 50(5)(c)(1), and § 50(3-a)(8) would violate their due process rights, in that the Board would be authorized to recalculate plaintiff's

2008 assessments to include massive liabilities that did not exist under the statutory structure in place when the Board was first required to calculate and issue those assessments. Plaintiffs also aver that new WCL § 50(5)(c), § 15(8)(h)(4), and § 151(2)(b) permit the Board to impose continuing liabilities and double assessments upon plaintiffs and their employer-members who choose to discontinue their membership in a GSIT.

Plaintiffs also argue that new WCL § 50(5)(g) and the Board's application of former WCL § 50(5)(f) violate the Contracts Clause of the United States Constitution because assessments for the anticipated workers' compensation obligations of GSITs in unrelated industries unreasonably and substantially impairs the contractual relationship between plaintiffs and their employer-members, in that it would be virtually impossible for plaintiffs, their employer-members, and trustees to accurately ascertain the enormous, unquantifiable risks posed by the default of an unknown and unknowable number of GSITs in a variety of unrelated industries and fields throughout the State of New York. In addition, plaintiffs argue that the imposition of assessments for liabilities and expenses of other GSITs would prevent healthy GSITs from satisfying the claims of the employees of their own employer-members, and could eventually put all GSITs out of business. Moreover, plaintiffs aver that such assessments are an unreasonable and inappropriate means to ensure that the workers' compensation claims made against members of defaulted GSITs are paid, as there are clearly more moderate courses available to recover the costs of the workers' compensation obligations of defaulted GSITs.

Finally, plaintiffs claim that the Board's assessments pursuant to former WCL § 50(5)(f) and new WCL § 50(5)(g) constitute a taking of plaintiffs' property without just compensation, further abridging their rights to due process of law. Plaintiffs maintain that because of the flagrant and

palpable inequality between the crushing burden imposed by assessments for the anticipated liabilities, losses, and expenses of defaulted GSITs and the minimal, if any, benefit plaintiffs will receive from the payment of those assessments, such assessments constitute an arbitrary taking of their trust fund property without compensation in violation of the takings clause of the Fifth Amendment to the United States Constitution and Article I, § 7 of the New York State Constitution.

The takings clause of the Fifth Amendment of the United States Constitution, made applicable to the States through the Fourteenth Amendment (*see Chicago, B. & Q.R. Co. v. Chicago*, 166 U.S. 226, 239 [1867]), provides: “nor shall private property be taken for public use, without just compensation” (U.S. CONST. AMEND. V). The New York State Constitution likewise guarantees that “[p]rivate property shall not be taken for public use without just compensation” (N.Y. CONST., art. I, § 7[a]). The purpose of the takings clause “is to prevent the government from ‘forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole’” (*Palazzolo v. Rhode Island*, 533 U.S. 606, 617-618 [2001][quoting *Armstrong v. United States*, 364 U.S. 40, 49 [1960]]). Although takings issues are more commonly presented when governmental interference with property can be characterized as a physical invasion than when interference arises from a public program which adjusts the benefits and burdens of economic life to promote the public good (*see Penn Central Transp. Co. v. City of New York*, 438 U.S. 104, 124 [1978]), “economic regulation . . . may nonetheless effect a taking” (*Eastern Enters. v. Apfel*, 524 U.S. 498, 523 [1998][citations omitted]).

Notably “legislative [a]cts adjusting the burdens and benefits of economic life come to the [c]ourt with a presumption of constitutionality” (*Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 15 [1976]). As such, “[a] party challenging governmental action as an unconstitutional taking bears

a substantial burden” (*Eastern Enters. v. Apfel*, 524 U.S. at 523 [citing *United States v. Sperry*, 493 U.S. 52, 60 [1989]]). Indeed “government regulation-by definition-involves the adjustment of rights for the public good” and “[o]ften this adjustment curtails some potential for the use or economic exploitation of private property” (*Andrus v. Allard*, 444 U.S. 51, 65 [1979]). Certainly, “not every destruction or injury to property by governmental action” or governmental interference with a property interest “has been held to be a ‘taking’ in the constitutional sense” (*Armstrong v. United States*, 364 U.S. at 48 [citation omitted]).

Whether a challenged law, which interferes with a property interest, has effected a regulatory taking involves an evaluation of the “justice and fairness” of the governmental action (*see Eastern Enters. v. Apfel*, *supra*, at 523; *see also Andrus v. Allard*, 444 U.S. at 66). While this inquiry involves no set formula and often relies “on *ad hoc*, factual inquiries into the circumstances of each particular case,” three factors are of “particular significance”: (1) the economic impact of the governmental action on the challenging party; (2) the extent to which governmental action has interfered with reasonable investment-backed expectations; and (3) the character of the governmental action (*Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 224-225 [1986]; *see Penn Central Transp. Co. v. City of New York*, 438 U.S. at 124).

Guided by these principles and applying the factors eschewed by the United States Supreme Court in reviewing a regulatory takings claim, the Court finds that assessing healthy group self-insured trusts for the workers’ compensation obligations of defaulted, unrelated group self-insured trusts unconstitutionally imposes significant liability on healthy GSITs, like plaintiffs, which was not anticipated when these trusts were formed and the extent of which is substantially disproportionate to plaintiffs’ past experience in New York’s self-insurance system. As such,

application of former WCL § 50(5)(f) and new WCL § 50(5)(g) to plaintiffs effects an unconstitutional taking of their private property without just compensation.

As to the severity of the economic impact, there is no doubt that assessments levied under former WCL § 50(5)(f) and pursuant to new WCL § 50(5)(g) place a substantial financial burden upon plaintiffs. Plaintiffs' employer-members are clearly deprived of any amount of money that they must pay to the Board to fulfill their statutory obligation (*see Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. at 222 [finding that an assessment for a pension withdrawal penalty “constitutes a real debt that the employer must satisfy, and . . . is not an obligation which can be considered insubstantial”]; *Eastern Enters. v. Apfel, supra*, at 529). Furthermore, failure to pay these assessments subjects plaintiffs to the imposition of monetary penalties and possible revocation of their authorization to operate as a GSIT (*see* 12 N.Y.C.R.R. § 317.21 & § 317.22; *see also Eastern Enters. v. Apfel, supra*).

Moreover, assessments imposed against plaintiffs under former WCL § 50(5)(f) and pursuant to WCL § 50(5)(g) “resemble[] a calculation made in a vacuum” (*Eastern Enters. v. Apfel, supra* [internal quotation marks and citation omitted]). There is no direct relationship between plaintiffs and the defaulted GSITs, whose workers' compensation losses, liabilities, and expenses plaintiffs are statutorily obligated to pay for, other than their similar status as group self-insured trusts formed under the same legislative scheme and subject to the same statutory and regulatory responsibilities. In addition, plaintiffs did not voluntarily agree to assume the workers' compensation obligations of unrelated GSITs, including insolvent and defaulted group self-insured trusts (*cf. Concrete Pipe & Products of California, Inc. v. Construction Laborers Pension Trust for Southern California*, 508 U.S. 602, 646 [1993]; *Connolly v. Pension Benefit Guaranty Corp., supra*, at 225).

The Court is unpersuaded by defendants' claim that recovery of funds from the employer-members of insolvent GSITs, which will drastically reduce the need for future assessments for these GSITs, and that monies collected from the defaulted GSITs, which will be credited against future assessments, somehow mitigate the economic impact placed upon plaintiffs by former WCL § 50(5)(f) and new WCL § 50(5)(g). The mere fact that the economic burden upon plaintiffs may be temporary and/or can be reduced by recoveries obtained from insolvent GSITs does not negate the impact or mean that the liability imposed by former § 50(5)(f) and new § 50(5)(g) assessments is not significant.

With respect to reasonable investment-backed expectations, the Court finds that plaintiffs could not have contemplated their liability for the anticipated losses, liabilities, and expenses of other unrelated, defaulted GSITs. The Court is mindful of its prior ruling in *Held v. Workers' Comp. Bd.*, which was recognized in *Nuara v. State of New York Workers' Comp. Bd.* (Sup. Ct., Albany County, February 11, 2010, Index No. 5076-08), that the Workers' Compensation Law confers upon the Board the authority to assess all private self-insured employers, and specifically healthy GSITs, for the workers' compensation obligations of unrelated, defaulted GSITs. The Court finds, however, that the authority conferred upon the Board under former WCL § 50(5)(f) and pursuant to new WCL § 50(5)(g), which exists in statute, is inconsistent with the overall legislative scheme pertaining to group self-insurance in New York State.

Under the statute governing group self-insurance, "employers" are defined to include "employers with related activity in a given industry" (WCL § 50[3-a][1]). GSITs that adopt a "plan" for self insurance "for the payment of compensation . . . to their employees" under the statute are required to "assume the liability of all the employers within the group and pay all compensation for

which the said employers are liable” (former § 50[3-a][2], WCL § 50(3-a)(2)(a), as amended). An employer participating in a group self-insurance plan is not relieved from its workers’ compensation liability under the statute, except upon payment by the group or by the employer-member itself (*see* former WCL § 50[3-a][3], and as amended). Likewise, the insolvency or bankruptcy of a participating employer-member does not relieve a GSIT from the payment of compensation for injuries or death sustained by an employee during the time the employer was a participating member of such GSIT (*see id.*).

Each GSIT is also required, pursuant to the statute, to furnish the Board with “satisfactory proof . . . of [its] financial ability to pay such compensation” for the employer-members “in the industry covered by it” (former WCL § 50[3-a][2], WCL § 50[3-a][2][b], as amended). GSITs meet this obligation by depositing with the Board’s chairman securities or cash, filing letters of credit, or posting a surety bond “in an amount to be determined to secure its liability to pay the compensation of each employer” in the industry covered by it (*id.*). Further, the statutory provision that sets forth a GSIT’s continuing obligation to secure its workers’ compensation liabilities following termination indicates that the Board’s chairman may retain a GSIT’s pledged and posted security or, in lieu thereof, accept a policy of insurance “for the additional purpose of securing such further and future contingent liability as may arise from prior injuries to workers and be incurred by reason of any change in condition of such workers warranting the board making subsequent awards for payment of additional compensation” (former WCL § 50[3-a][5], WCL § 50[3-a][7][a], as amended).

The promulgated rules and regulations¹⁰ pertaining to group self-insurers define a GSIT as “an association of employers performing related activities in a given industry that contractually agree, in accordance with Section 50(3-a) of the Workers’ Compensation Law, to assume the workers’ compensation liabilities of each associated member” (12 N.Y.R.R. § 317.2[i]). To establish a GSIT as a self-insured group, the regulations require “homogeneity” among the participating employer-members (*see* 12 N.Y.C.R.R. § 317.3[a]; *see also* 12 N.Y.C.R.R. § 317.2[1]; § 12 N.Y.C.R.R. § 317.4[a] & [b][1]). Furthermore, under the regulations “[a]ny group of employers seeking . . . authorization to operate as a group self-insurer in accordance with [WCL § 50](3-a)” is required to enter into a trust agreement and a participation agreement (12 N.Y.C.R.R. § 317.4[5]). Both agreements must “be shared with all prospective members of the group,” contain “language prescribed by the [Board’s] chair,” and be “in a form approved by the chair” (12 N.Y.C.R.R. 317.4[5][i] & [ii]). In addition, the participation agreement must “include an acknowledgment that the prospective member has been provided a copy of the trust agreement and has reviewed that agreement, specifically the provisions related to joint and several liability.”

As part of its application to operate as a group self-insurer, the regulations require a GSIT to acknowledge “its commitment . . . to pay to or on behalf of injured employees and to the dependents of deceased employees all compensation and medical benefits as required by the provisions of the Workers’ Compensation Law” (12 N.Y.C.R.R. § 317.4[7][i]). Further, consistent with its statutory obligation, a GSIT must demonstrate “sufficient aggregate financial strength and liquidity” and “adequate security . . . to guarantee the payment and administration of all obligations

¹⁰ The rules and regulations govern the application procedures for, and qualifications and responsibilities of, any group of employers seeking to become, or which have been approved to operate as, a group self-insurer in New York.

arising under the Workers' Compensation Law" (12 N.Y.C.R.R. § 317.3[d]). As such, a GSIT must "deposit with the [Board's] chair and maintain securities, cash, surety bond or irrevocable letters of credit, in a form and an amount determined by the chair" (12 N.Y.C.R.R. § 317.4[a][8][i]). The amount of the security deposited with the chair is based, in part, upon either "the combined annual payroll of the group members," or "the group self-insurer's retention as specified on the certificate of excess insurance . . . which limits the liability of a group on a specific per occurrence basis with respect to claims" (12 N.Y.C.R.R. § 317.5[a][1] & [2]). Moreover, the regulations require each GSIT's board of trustees to "establish written bylaws," which set forth, among other things, the rights and responsibilities of the GSIT's employer-members, "including acknowledgment of the joint and several liability assumed by each member of the group"(12 N.Y.C.R.R. § 317.12).

Applying the principles of statutory construction,¹¹ giving effect to the plain and ordinary meaning of the words used, the language of the WCL suggests an intent on the part of the Legislature to create a scheme of joint and several liability *only* among the employer-members in a particular GSIT, not among all GSITs. This is evidenced by the definition of "employers" used in the statute as well as the requirement that the employer-members of a GSIT must assume the workers' compensation obligations of "all employers within the group," and that fact that all employer-members of a GSIT remain responsible for the workers' compensation claims of a participating employer-member who becomes insolvent or bankrupt. Furthermore, the statute requires each GSIT

¹¹ "The governing rule of statutory construction is that courts are obliged to interpret a statute to effectuate the intent of the Legislature" (*People v. Finnegan*, 85 N.Y.2d 53, 58 [1995]). Since "the clearest indicator of legislative intent is the statutory text, the starting point in any case of interpretation must always be the language itself" (*Matter of Price Chopper Operating Co. v. New York State Liquor Auth.*, 52 A.D.3d 924, 925-926 [3d Dep't 2008][citing *Majewski v. Broadalbin-Perth Cent. Sch. Dist.*, 91 N.Y.2d 577, 583 [1998]; see also *Matter of Kern v. New York State Dept. of Civ. Serv.*, 288 A.D.2d 674, 676 [3d Dep't 2001]). Thus, "[w]here the statutory language is clear and unambiguous, the court should construe it so as to give effect to the plain meaning of the words used" (*Wise v. Jennings*, 290 A.D.2d 702, 703 [3d Dep't 2002] [quoting *Patrolmen's Benevolent Ass'n of City of New York v. City of New York*, 41 N.Y.2d 205, 208 (1976)] [internal quotations and citations omitted]).

to furnish and maintain adequate financial strength and resources to secure the compensation obligations of each employer-member of that GSIT, even after the GSIT terminates its status as a group-self-insurer. Moreover, the regulatory scheme governing group self-insured trusts supports such an interpretation.

Although former WCL § 50(5)(f) and new WCL § 50(5)(g) expressly confers authority on the Board to impose assessments against healthy GSITs for the anticipated losses, liabilities, and expenses of unrelated, defaulted GSITs and appear to support defendants' argument that the Legislature intended this to be the case, it is significant to this Court that such authority is set forth only in those provisions of the former law and the new statute. Reference to this liability is not made in any of the other provisions of the statute discussed above. The statute does not require GSITs to assume liability for the employer-members in all GSITs formed pursuant to WCL § 50(3-a). Further, a GSIT is not required to furnish proof of its financial ability to pay or to secure its obligation to pay the workers' compensation claims of the employees of all GSITs.

Also, the regulations pertaining to GSITs, which were adopted after the enactment of former WCL § 50(5)(f), specifically require a relatedness of business activities among employer-members of a GSIT and place particular emphasis on the joint and several responsibility of all employer-members of a GSIT for the workers' compensation obligations of each participating employer-member, in the participation agreement and as part of a GSIT's written bylaws. Although the regulations require a GSIT to secure the payment and administration of all of its obligations arising under the Workers' Compensation Law, these obligations were not expressly defined in the regulations, when the rules and regulations were promulgated, to include the anticipated losses,

liabilities, and expenses of unrelated GSITs.¹² This obligation was later included in regulations in response to this litigation.

Under these circumstances, the Court finds that the authority of the Board to assess healthy GSITs for the anticipated losses, liabilities, and expenses of unrelated, defaulted GSITs under former WCL § 50(5)(f) and pursuant to new WCL § 50(5)(g) is inconsistent with the overall legislative scheme governing group self-insurance in New York.

Moreover, enforcement of these provisions against healthy GSITs raise substantial questions of fairness (*see Eastern Enters. v. Apfel*, 524 U.S. 498, 534-536 [1998]). Defendants argue that plaintiffs have always been on notice that they could be subject to former WCL § 50(5)(f) and new WCL § 50(5)(g) given the express language in the statute vesting the Board with the authority to make assessments against healthy GSITs “to obtain interim funds needed to satisfy the workers’ compensation obligations of insolvent, private self-insured employers.” Defendants further aver that plaintiffs, “in fact assumed the liability for assessments issued pursuant to what was formerly WCL § 50(5)(f) when they executed the trusts and participation agreements.” These arguments, however, do not resolve what the Court has determined to be an inconsistency between the authority conferred under the law and the GSIT legislative scheme. Defendants also ignore the fact that the significant liability imposed by the statute “is not calibrated either to [plaintiffs’] past actions or to any agreement-implicit or otherwise-by the [plaintiffs]” to assume the workers’ compensation obligations of unrelated, defaulted GSITs (*Eastern Enters. v. Apfel*, 524 U.S. at 535; *see Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 230-231 [1986] [O’Connor, J., concurring] [for the

¹² The regulations define “[t]rust liabilities” to include “accrued Workers’ Compensation Board assessments” (12 N.Y.C.R.R. § 317.2[o]).

proposition that the imposition of liability without regard to the extent of an employer's actual responsibility could raise serious concerns under the takings clause]).

Prior to 2007, the Board had never exercised its authority under former WCL § 50(5)(f) to assess healthy GSITs for the anticipated losses, liabilities, and expense of defaulted GSITs. Also, when the rules and regulations were promulgated in 2001, implementing the provisions of the WCL pertaining to group self-insurance, the regulations did not address this aspect of liability in the context of the overall legislative scheme for GSITs. Therefore, plaintiffs could not have anticipated that they would be subject to these assessments.

Furthermore, contrary to defendants' assertions, plaintiffs' trust agreements, which contain "language prescribed by the [Board's] chair . . . in a form approved by the chair," provide only for joint and several liability among the employer-members within each particular trust (*see, e.g.*, Weiss Aff., Ex. G, Contractors Compensation Trust Agreement, at § 2.03 [providing that "[a]ll Participating Members shall and are deemed to be jointly and severally liable for all Workers' Compensation obligations incurred by the Trust"]). This concept of joint and several liability amongst only the employer-members of a particular GSIT is made manifest by the participation agreement, which was executed by each of the plaintiffs in the form drafted, promulgated, and prescribed by the Board and which states:

[i]n particular, the Employer understands, acknowledges and agrees that as a member of the Group Self Insured Trust, the Employer is jointly and severally liable for all obligations under the Workers' Compensation Law, of all Trust Members, during the Employer's period of membership.

While plaintiffs' employer-members contractually agreed to be jointly and severally liable for all obligations under the WCL, this agreement extends only to the obligations of their respective trusts and not to the anticipated losses, liabilities, and expenses of unrelated, defaulted trusts.

Moreover, the legislative scheme establishing GSITs is founded upon the fundamental principle that assembling a group of like employers engaged in a similar industry will enable those employers to appropriately assess the risk of injury to the workers employed by members of the group, and to, thus, provide adequate coverage for the workers' compensation claims relating to the injuries sustained by those workers in the course of their employment. Assessment of the risk for different industries will necessarily include the potential for more claims in those industries which engage in inherently more dangerous, injury-prone activities, and fewer claims in those industries in which injury is less frequent or significant. As such, the grouping of employers in like industries enables the GSITs to more accurately assess that risk. Employers will, therefore, be held responsible for payment of claims on a level commensurate with the level of risk of injury and dangerousness in their field. To construct a statutory and regulatory scheme that is based upon these principles, but then assess GSITs for workers' compensation claims and expenses relating to a field that was not part of their risk assessment, flies in the face of the scheme that was intended by the Legislature, and creates an unanticipated burden on those GSITs that are being assessed.

Finally, there is no question that the intent of the Legislature, in enacting former WCL § 50(5)(f), was to ensure that the claims of injured workers do not go unpaid due to the insolvency of private self-insurers obligated to pay such claims. Certainly, this type of interference with a property interest can be characterized as one which "arises from a public program that adjusts the benefits and burdens of economic life to promote the common good" (*Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. at 225). However, where, as here, the interference forces parties, like plaintiffs, to bear a burden that is substantial in amount and unrelated to any commitment they made, especially in light of the inconsistency between the Board's authority under former WCL § 50(5)(f) and new

WCL § 50(5)(g) and the legislative scheme which contemplates a group self-insurance system premised upon joint and several liability amongst group members only, “the governmental action implicates fundamental principles of fairness underlying the [t]akings [c]lause” (*Eastern Enters. v. Apfel, supra*, at 537).

CONCLUSION

On the specific facts of this case, the Court finds that the application of former WCL § 50(5)(f) and new WCL § 50(5)(g) to plaintiffs effects an unconstitutional taking. As such, plaintiffs are entitled to summary judgment in their favor, and defendants’ cross-motion for summary judgment must be denied.

The parties’ remaining arguments have been considered and found to be without merit, and/or have been rendered moot or academic in light of the foregoing determination.

Accordingly, it is hereby

ORDERED AND ADJUDGED, that plaintiffs’ motion for summary judgment is granted only to the extent that the application of former WCL § 50(5)(f) and new WCL § 50(5)(g) to plaintiffs effects an unconstitutional taking, but is otherwise denied; and it is further

DECLARED AND ADJUDGED, that the application of former WCL § 50(5)(f) and new WCL § 50(5)(g) to the plaintiffs is unconstitutional, as violative of the takings clause of the United States Constitution and the New York State Constitution; and it is further

ORDERED AND ADJUDGED, that the defendants are permanently enjoined from taking any action to enforce former WCL § 50(5)(f) and new WCL § 50(5)(g) to assess the plaintiffs for the anticipated losses, liabilities, and expenses of unrelated, defaulted group self-insured trusts; and it is further

ORDERED AND ADJUDGED, that the 2008 assessments levied by the Workers' Compensation Board against plaintiffs and any assessments levied by the Board against plaintiffs thereafter under former WCL § 50(5)(f) and pursuant to WCL § 50(5)(g) are annulled and vacated; and it is further

ORDERED AND ADJUDGED, that defendants' cross-motion for summary judgment is denied regarding the issues relating to former WCL § 50(5)(f) and WCL § 50(5)(g), and is otherwise granted; and it is further

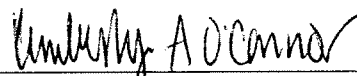
ORDERED AND ADJUDGED, that the Workers' Compensation Board shall take action consistent with this Decision and Order.

This memorandum constitutes the Decision and Order of the Court. The original Decision and Order is being forwarded to the attorneys for the plaintiffs. A copy of the Decision and Order together with all supporting papers on the motions are being forwarded to the Office of the Albany County Clerk for filing. The signing of this Decision and Order, and delivery of a copy of the same to the County Clerk, shall not constitute entry or filing under CPLR 2220. Counsel is not relieved from the applicable provisions of that rule relating to filing, entry, and notice of entry of the original Decision and Order.

SO ORDERED, ADJUDGED, AND DECLARED.

ENTER.

Dated: May 20, 2010
Albany, New York



HON. KIMBERLY A. O'CONNOR
Acting Supreme Court Justice

Papers Considered:

1. Notice of Motion, dated December 29, 2008;
2. Affidavit of Richard S. Flaherty, sworn to December 24, 2008;
3. Affirmation of Stephen P. Younger, Esq., dated December 29, 2008, with Exhibits 1-91 annexed;
4. Plaintiffs' Memorandum of Law, dated December 30, 2008;
5. Notice of Cross-Motion, dated February 6, 2009;
6. Affidavit of Kathleen Griffin, sworn to February 5, 2009, and Affidavit of Zachary S. Weiss, sworn to February 6, 2009, with Exhibits A-Z and AA-FF annexed;
7. Defendants' Memorandum of Law, dated February 6, 2009;
8. Affirmation of Stephen P. Younger, Esq., dated February 26, 2008 (*sic*);
9. Affidavit of Richard S. Flaherty, sworn to February 26, 2009, with Exhibits 1-11 annexed;
10. Plaintiffs' Reply Memorandum of Law, dated February 27, 2009;
11. Letter of Richard Lombardo, Assistant Attorney General, dated March 10, 2009, with enclosures;
12. Letter of Stephen P. Younger, Esq., dated March 18, 2009;
13. Affidavit of Mary Beth Woods, sworn to April 16, 2009; *and*
14. Letter of Stephen P. Younger, Esq., dated April 21, 2009, with Exhibit A annexed.

***TASK FORCE ON
GROUP SELF-INSURANCE***

Task Force Resolution

Exhibit B

Report to the Governor and the Legislature

June 2010

*New York State Workers' Compensation Board
Task Force Resolution*

**Resolution of the Task Force on Group Self-Insurance
Dated May 14, 2009**

Whereas, Chapter 138 of the Laws of 2008 established a Task Force on Group Self Insurance with a charge to make recommendations to the Governor, the Speaker of the Assembly and the Temporary President of the Senate on future defaults by, regulation of, and the long term viability of group self insurers on or before February 1, 2009; and

Whereas, appointments to this commission were not made until after February 1, 2009 and the first meeting was held on April 7, 2009; and

Whereas, Chapter 138 of the Laws of 2008 has bestowed many more powers on the Chairman of the Workers' Compensation Board and the Board itself; and

Whereas, many employers and employees have, in the past, depended on group trusts for coverage; and

Whereas, many lawsuits between the numerous aspects of group trusts have commenced or are commencing in the future; and

Whereas, trusts have had an extreme negative financial effect on many employers, both within group trusts and also all self insured employers; and

Whereas, there are still some group trusts that are extremely under funded, which, if left unchecked, could bring another blow to all self insured employers in the State of New York; and

Whereas, many questions are being asked of the Task Force concerning the administrator and other services of various groups, therefore be it

Resolved, that this Task Force go on record that, pending the release of the report, that the Workers' Compensation Board and its Chair should utilize all enforcement powers including those provided under Chapter 138 of the Laws of 2008, aggressively pursuing collection efforts, both pending and future against defaulted trusts.

Resolved, that a copy of this resolution be sent to the Governor, the Temporary President of the Senate, the Speaker of the Assembly and the Attorney General.

***TASK FORCE ON
GROUP SELF-INSURANCE***

***Listing of Stakeholders and
Documentation Reviewed***

Exhibit C

Report to the Governor and the Legislature

June 2010

*New York State Workers' Compensation Board
Listing of Stakeholders and Documentation Reviewed*

During the course of the Task Force meetings, representatives of various stakeholders in the group self insurance arena were asked to present information which they believed would assist the Task Force in developing its recommendations. Extensive documentation was also prepared by the WCB and presented to the Task Force members.

Those stakeholders included:

- WCB General Counsel;
- Bickmore Risk Services – Consultants engaged by the WCB to assist in the re-engineering of all aspects of both the individual and group self insurance programs;
- State Insurance Fund safety group manager;
- Representatives from the State Insurance Fund;
- Members/Trustees of group self insurers;
- Group Self Insurance Association of New York (GSIANY)
- Key agents of group self insurers.

Documentation prepared by the WCB and presented to the Task Force members includes:

- Baseline Report on Group Self Insurance – Provides a summary on the status of the group program including the financial and programmatic status of the active groups.
- Comparison of the Rules and Regulations Governing Group Self Insurers – Provides a summary of the evolution of the rules and regulations that have governed group self insurance including those in effect prior to 2001; updates enacted in January 2001; and rules and regulations proposed going forward.
- Handbook on Group Self Insurance – The WCB has been in the process of developing a handbook which would include all pertinent forms, reports, and circulars needed to fully implement the legislation passed in 2008 and the proposed rules and regulations. Samples of what the handbook would contain and the format that this information would be presented in were provided.
- Report on Inactive Group Self Insurers – This report provides information on the inactive groups including those that closed due to funding shortfalls as well as groups that were adequately funded and closed on a voluntary basis.
- Funding Defaults – Historical information on the level of the self insurer's assessment; distinguishes existing defaults from those which may occur in the future; and explores alternatives for funding each type of default.
- WCB Assessments – Provides a brief summary of the methodology used to assess group self insurers and includes a recommendation to change that methodology to one that “floats” to where the active coverage is written.
- Individual Self Insurance Alternative Funding Models – This is a copy of the report delivered to the Governor and the Legislature in December 2007 recommending the transition of the current silo approach of posting security deposits for the individual self insurers to a pooled approach.

Additional information prepared at the request of Task Force members during the course of the various meetings includes the following:

- Summary of 06/30/2008 legislative changes;

*New York State Workers' Compensation Board
Listing of Stakeholders and Documentation Reviewed*

- Summary of the status of various action items required under the legislation;
- Estimated and forensic assessments collection report;
- Defaulted group's cash flow estimates;
- Cash flow shortfalls of defaulted groups;
- Copy of forensic audit – defaulted group;
- Summary of the reasons for delays in forensic audits;
- Summary of administrator, accountant, actuary and third party administrator for active and inactive groups;
- Pros and cons of allowing group trusts to offer coverage;
- Pros and cons placing restrictions on group's key agents (group administrator, third party administrator, brokers);
- Draft report prepared by Bickmore Risk Services (BRS) in collaboration with the WCB making recommendations on the regulation of group self insurers;
- Summary of BRS recommendations and WCB response when developing the proposed rules and regulations;
- Summary of other states approach to regulating group self insurers;
- Pros and cons of WCB or State Insurance Department regulating group self insurers;
- Staffing history of the WCB's self insurance office;
- Summary of remediation plans currently in place for active groups that are under funded.

***TASK FORCE ON
GROUP SELF-INSURANCE***

***Comparison of the Rules and Regulations
Governing Group Self-Insurance***

Exhibit D

Report to the Governor and the Legislature

June 2010

*New York State Workers' Compensation Board
Comparison of the Rules and Regulations Governing Group Self-Insurance*

A. Background

The regulatory environment that group self insurers operate in has undergone dramatic transformation in the last two decades. Prior to January 2001, the legislation and supporting rules and regulations governing group self insurance trusts did not make a major distinction between the individual and group self insurance programs.

In January of 2001, rules and regulations (NYCRR Part 317) which distinguish groups from individual self insurers in terms of the annual reporting and financial requirements were enacted.

Legislation of June 2008 further reformed many of the financial, reporting and operational standards applicable to group self insurers. In response to those legislative changes rules and regulations which would replace NYCRR Part 317 in its entirety were drafted.

Despite the very fundamental questions about the group model under deliberation by the Task Force (including the long term viability of the program) current statute allows groups to exist. Additionally, the role of the Task Force is simply to make recommendations; Task Force findings are not legislatively binding. As such, it was agreed that the initial focus of the Task Force would be the review of the rules and regulations drafted by the WCB and the finalization of rules and regulations which would support the legislation passed in June of 2008 and, to the extent possible, prevent defaults like those recently experienced.

Based upon the review of the original WCB draft and input of the various Task Force members, comprehensive rules and regulations were finalized, submitted to the Governor's Office of Regulatory Reform (GORR) and are expected to be released for public comment. Once the formal comment period has ended, and in the absence of any legislative mandates to the contrary, the WCB will continue to move towards full implementation of the final version of the rules and regulations.

This document serves to summarize the evolution of the rules and regulations including the changes made from those in effect prior to 2001 from those being proposed if the group model is to continue going forward. In addition, the following are attached which provide more detail on this evolution:

Attachment A	Rules and Regulations in Effect Prior to January 2001
Attachment B	Rules and Regulations Enacted January 2001
Attachment C	Proposed Rules and Regulations 2010

*New York State Workers' Compensation Board
Comparison of the Rules and Regulations Governing Group Self-Insurance*

B. Rules and Regulations Prior to 2001

Prior to 2001 the rules and regulations governing group self insurance were relatively brief. Specifically, Section 315.6 stated that the rules and regulations which applied to individual self insurers shall be equally applicable in all respects to group self insurers. In addition, each group self insurer was required to submit a payroll report by classification code for each participating employer; a report in a format prescribed by the Chair indicating compensation and medical losses; a certified, independently audited financial statement of the group's assets and liabilities; and any and all agreements, contracts and other pertinent documents relating to the organization of the employers in the group. The security deposit requirements of earlier groups were similar to those of the individual self insurers, roughly equal to all of their outstanding workers' compensation indemnity and medical obligations.

Although group self insurers were required to submit annual financial statements, these statements were not supported by an actuarial report. In addition, this earlier version of the rules and regulations did not define what types of assets were acceptable and what should be included when measuring a group's liabilities. As a result, the financial statements submitted on behalf of each group often times did not offer an accurate representation of a group's funding position and ongoing ability to pay claims.

In the years prior to 2001, the limited regulatory authority available in the rules and regulations and the shortcomings in the reporting structure were not readily apparent as group self insurance did not play as large a role in the market as it eventually would. In fact, of the groups that currently offer coverage only two were established prior to the 1990's.

In the mid to late 1990's the option to self insure as a group began to play a larger role in the New York workers' compensation market. By the late 1990's there were 50 active groups providing coverage to more than 6,000 employer members. With the extraordinary growth in the group self insurance market it became apparent that it was necessary to expand the regulatory oversight of the groups and develop rules and regulations more specific to the group self insurance model.

C. Rules and Regulations Enacted 2001

In January of 2001, the WCB adopted extensive rules and regulations which govern the operations of group self insurers. These rules and regulations represented a substantial improvement over the previous version that did not recognize the vast difference between a group and an individual self insurer.

*New York State Workers' Compensation Board
Comparison of the Rules and Regulations Governing Group Self-Insurance*

The most notable enhancements included in the 2001 rules and regulations include the following:

- Funding requirement of assets which exceed liabilities.
- Definition of acceptable assets and liabilities.
- Annual filing of actuarial reports in addition to the GAAP financial statements previously required.
- Filing requirements for notification of membership changes.
- Terms and procedures applicable to under funded groups.
- Penalty provisions for violation of any provision and for late filings of reports.

These rules and regulations were enacted on January 31, 2001. It was determined that many of the provisions would be applied to fiscal years which began on or after that effective date. As the majority of the groups have a fiscal year which runs from January 1 – December 31, the fiscal year beginning January 1, 2002 was the first time period subject to the new regulatory standards. Thus, the first reports submitted pursuant to the new regulations were due to the WCB on May 1, 2003 for the fiscal year ended December 31, 2002. As a result, 2003 was the first time that the WCB was able to begin to measure each group's compliance with the various programmatic and funding standards outlined in the 2001 rules and regulations. Based upon a review of the annual reports submitted in 2003 significant funding issues were identified in a number of groups.

Despite remediation efforts, a number of these groups have since defaulted on their obligations under the WCL and been taken over by the WCB. Extensive forensic audits have been conducted to determine the reasons for the defaults and to apportion the deficit among the employer members.

In response to the group defaults, the results of the forensic audits, and other data available to the WCB after several reporting cycles under the 2001 regulatory structure, it became apparent that further enhancements to the governing statute and supporting rules and regulations were necessary.

***D. 2008 Legislation
Draft Rules and Regulations***

Legislation enacted in June 2008 required reform of many of the financial, reporting and operational standards applicable to group self insurers. In addition, the forensic audits performed to date identified a number of issues which contributed to the group defaults. In response to the legislative changes and forensic findings, and prior to the first meeting of the Task Force, the WCB had drafted rules and regulations which would replace NYCRR Part 317 in its entirety.

*New York State Workers' Compensation Board
Comparison of the Rules and Regulations Governing Group Self-Insurance*

Based upon the forensic reviews on defaulted groups, the draft rules and regulations make an attempt to remedy many of the issues which contributed to the group defaults. These issues include, but may not be limited to, the following:

- Claims Reserves
 - Conflict of interest between TPA and group administrator
 - Substantial under reserving of claims by TPA
 - Intentional manipulation of reserves by TPA/Group Administrator

- Trustees
 - Trustees failed to act in a fiduciary role
 - Trustee involvement inadequate
 - Inappropriate delegation of duties

- Administrators
 - Failure to act in the best interest of the trust
 - Failure to fulfill duties outlined in agreements
 - Lack of disclosure to trustees/members
 - Actions to obtain personal gain at the expense of group and its members
 - One-sided service agreements that favor administrator
 - Poor underwriting
 - Non-compliance with underwriting requirements
 - Remedial actions not effective

- Conflicts of Interest
 - Administrator's use of affiliate companies
 - Failure to disclose affiliates to trustees
 - Excessive use of affiliated case management companies
 - Placement of excess insurance with affiliate companies
 - Intentional billing costs of affiliates to claims files to avoid detection

- Professional improprieties on part of key agents
 - Lack of due diligence on part of actuary and/or accountant
 - Improper accounting/actuarial practices to meet funding thresholds

- Rates
 - Inadequate rates
 - Excessive discounts for certain members
 - Manipulation of experience mod factors

- Safety programs
 - Lack of formal programs
 - Inconsistent audits

The initial focus of the Task Force was the review of the rules and regulations drafted by the WCB and the finalization of rules and regulations which would support the legislation

*New York State Workers' Compensation Board
Comparison of the Rules and Regulations Governing Group Self-Insurance*

passed in June of 2008 and, to the extent possible, address many of the issues listed above. Based upon the review of the original WCB draft and input of the various Task Force members, comprehensive rules and regulations were finalized.

The most notable enhancements included in the final draft of the rules and regulations include the following:

- Contribution year funding and reporting.
- Funding requirements will include a risk margin which will provide for a more conservative approach to projecting ultimate liabilities.
- Enhanced reporting including detailed prescribed reports and actuarial opinions to support the financial statements.
- Prohibitions on distributions to members.
- Independent examination of records and affairs of the group at least once every three years.
- Timelier funding of deficits based upon contribution year specific operating results.
- Enhanced measures for maintaining group homogeneity.
- Licensing requirements for group administrators.
- Separation of duty requirements for key agents.
- Advisory committee for group self insurance.

In conjunction with the development of the new rules and regulations, the WCB is in the process of developing a comprehensive reporting package that every group would have to file annually. With the filing of these detailed prescribed reports, the funding position of every active group self insurer would be measured in a more consistent, accurate and timely manner. Groups that fail to meet the minimum funding requirements would be required to cure the default timely or will be subject to termination in as expeditious a manner as possible.

It is important to note that while the rules and regulations will go through the formal comment period, the proposed new standards have caused great concern in the group self insurance community. Some members of the group community have expressed the position that the risk margin coupled with the contribution year specific funding/reporting requirements are too onerous and the enactment of the rules and regulations and supporting reports as proposed will result in an inability to “stay competitive”.

E. Conclusion

The regulatory environment that group self insurers operate in has undergone dramatic transformation in the last two decades. The rules and regulations governing group self insurance have transformed from making very little distinction between the individual and group programs to rules and regulations which include very distinct annual reporting and financial requirements for every group.

*New York State Workers' Compensation Board
Comparison of the Rules and Regulations Governing Group Self-Insurance*

The legislation signed by Governor Paterson in June of 2008 reforms many of the financial, reporting and operational standards applicable to group self insurers. Rules and regulations which support that legislation have been finalized and submitted to the GORR.

The proposed rules and regulations include rigid funding and reporting requirements as well as many other minimum requirements that must be met by every active group in order to continue to be authorized to self insure. However, in spite of these regulatory enhancements, there is still cause for concern that the group self insurance model continues to place small employers that participate in group self insurance at significant risk particularly with respect to joint and several. In addition, there are a number of fundamental components of the group model that are difficult to regulate even with the most stringent of regulatory environments.

The more notable risks of group self insurance include the following:

- Joint and Several Liability - The unlimited joint and several liability on group members for the group's obligations coupled with the long term nature of workers' compensation claims. Members often times do not even understand the risk of joint and several; they are under the impression they bought a traditional policy. In addition, the ability of unscrupulous actors to manipulate the operation of groups for their own benefit to the member's detriment. These conflicting components result in group members being jointly and severally liable for claims long after the claims were actually incurred and/or long after their period of membership in the group may have ended. It is difficult, if not impossible, for an employer to accurately weigh the risks/benefits of joining a group as opposed to other types of coverage allowed under the WCL.
- Mismanagement – The management of much of a group's operations is often left to key agents including administrators, brokers, accountants and actuaries. However, these agents do not assume joint and several liabilities as do the employer members.

The weakness in this structure is that the bulk of the decision making is being done by individuals whose interests do not always align with those of the members. In fact, in the short term, these key agents may actually stand to benefit by being overly optimistic with much of the operating decisions including developing rates, setting reserves, and issuing dividends. These key agents are often paid based upon the size of the group. The healthier the group appears the more members join and the more compensation the key agents receive. When the inadequate rates and reserves materialize the key agents are not jointly and severally liable for the shortfall.

- Trustee Oversight – The foundation of groups is built upon the concept of small businesses in a similar line of work banding together and assuming joint and

*New York State Workers' Compensation Board
Comparison of the Rules and Regulations Governing Group Self-Insurance*

several for each others workers' compensation exposure in an effort to lower their costs. Under the current group program, most of the time the only affiliation these employers have is their common membership in the group trust. While the board of trustees is predominantly made up of group members, with very limited exception, these employers are not insurance professionals. The board of trustees is often focused on their own personal day-to-day operations of running their businesses and leaves much of the decision making to various key agents including administrators, brokers, accountants and actuaries, and is therefore dependent on their acting in good faith in the interests of the trust members.

The 2008 legislation limited groups to five hundred members. The proposed regulations attempt to further resolve this issue by, among other provisions, not allowing trustee authority to be delegated and by eliminating several inherent conflicts of interest.

However, based on the recent forensic results, it is questionable whether the level of involvement and expertise needed from the trustees and employer members is realistic. Experience has shown that even when the board of trustees is very active and consists of attorneys, CPAs, and CFOs, they can still be misled. The trustees/members are primarily focused on running their own businesses on a daily basis and do not have the time or expertise needed to ensure that the group is run effectively.

Finally, in light of the new requirements placed on the trustees and the likelihood that the WCB will be forced to take legal action against former trustees of defaulted trusts, it will be extremely difficult to attract and maintain trustees.

- Reserving Subjectivity – Workers' compensation claims reserves include both indemnity and medical expenses that are expected to be paid out over many years. Given the variety and complexity involved in reserving, it is impossible to promulgate specific reserving standards which can be applied consistently across all types of claims. These regulatory difficulties are compounded by the fact that reserve totals are the starting point for the actuary when developing a group's ultimate liabilities. If the reserves are artificially suppressed, or assumptions are overly optimistic, the ultimate claims reserve will be understated. Even with more detailed reporting which includes specifics by claim year, it will take years for the actual costs of any specific claim or all claims for a given period to be accurately measured. As a result, the true operating results for each year cannot be measured with any degree of specificity until long after the coverage period has ended. Group members are indefinitely left exposed to those liabilities as they continue to develop.

The new regulations and forms attempt to address this issue and will certainly mitigate the impact particularly the requirement to separate the group administrator and the TPA functions. However, recent audit reports suggest that there are many administrative costs being passed through as "direct" claims costs

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which would be difficult to detect by either the trustees or the WCB. The level of scrutiny needed to detect such practices would not be cost effective.

- Regulatory Oversight – Given the level of involvement that can realistically be expected from trustees and/or employer members, the oversight of the groups would then fall to the WCB (or some other regulatory body). However, the increased administrative costs, including increased staffing, that would be incurred by the WCB to ensure that each group was being run effectively, including reviewing the actions of accountants, auditors and actuaries, would be cost prohibitive.

In addition, as it currently stands, these administrative costs would be shared among both the group and individual self insurers. It does not seem equitable to require the individual self insurers to bear a significant increase in costs related specifically to the appropriate regulation of groups. Conversely, if the assessment methodology were changed to assess group administrative costs only to the groups being regulated, these groups would not be able to bear the additional financial burden.

- Impact of Assessments – The difficulties inherent in group trust operations have been complicated further by the need to assess the healthy trusts, along with individual self insurers, to provide for payment of claims while actions are taken to recover from members of defaulted group trusts. This greatly complicates operation of financially viable healthy trusts. In sum, the mismanagement of certain trusts has made it more difficult to construct a financially viable group program for all groups.

It appears as if the proposed rules and regulations and prescribed reports, despite the numerous enhancements, may still have certain aspects that have not gone far enough to prevent the issues described above in a cost beneficial manner. Essentially, the group trust program is reliant to a large degree on the good faith legal compliance of trustees and administrators. Conversely, the group community has expressed concern about their ability to meet the standards as proposed which do not specifically address the challenges summarized above. A regulatory environment that would ensure complete compliance would potentially be so far-reaching and cost prohibitive as to negate any benefit that might be expected when establishing a group.

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Comparison of the Rules and Regulations Governing Group Self-Insurance*

ATTACHMENT A – RULES AND REGULATIONS PRIOR TO 2001

*New York State Workers' Compensation Board
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Attachment A – Rules and Regulations Prior to 2001

§315.1 Application

- (a) Every employer desiring to become a self insurer shall make application in form prescribed by the chairman. This application shall contain:
- (1) a payroll report filed by classification code, for the five preceding annual fiscal periods;
 - (2) a report in a format determined by the chairman indicating compensation and medical losses (payments plus reserves), for a period up to 10 years prior to the date of application;
 - (3) the most recent, certified, independently audited financial statement of the employer and copy of form 10K, if any, filed by the employer with the Securities and Exchange Commission. A subsidiary company may submit the consolidated financial statement of the parent company in lieu of its own individual financial statement. In such event, however, the parent company must guarantee the liability of the subsidiary company under the Workers' Compensation Law, by filing with the chairman, an Agreement of Assumption and Guarantee in form approved by the chairman;
 - (4) a description of the safety organization maintained by the employer for the prevention of accidents; and
 - (5) a description of the business operations performed or to be performed by the employer.
- (b) If, upon examination of the certified, independently audited financial statement and other data submitted, the chairman is satisfied as to the ability of the employer to make current compensation payments and that the employer's tangible assets and profit and loss history make the payment of all obligations that may arise under the Workers' Compensation Law, reasonably certain, the application may be granted subject to the conditions herein provided. The chairman will notify the employer of approval or nonapproval of his or her application within 120 days.

Amended 315.1 on 9/20/82; amended 315.1(b) on 4/24/86.

§315.2 Agreement

The employer shall execute and file with the chairman an agreement, in prescribed form:

- (a) to pay to injured employees and to the dependents of the deceased employees, from time to time, all compensation as required by the provisions of the Workers' Compensation Law;
- (b) to deposit with the chair securities, and/or cash, and/or a surety bond, and/or irrevocable letters of credit, in form approved by the chair, in amounts or penal sum as hereinafter provided;
- (c) to pay annually such share of the expense of the administration and other expense or assessment as provided by the Workers' Compensation Law;
- (d) to permit the chairman's authorized representatives access to the premises of the employer for the purpose of examining operations and records pertaining to the employer's financial condition and status as a self-insurer under the Worker's Compensation Law;
- (e) that the chair may sell any part of the securities deposited, draw on the letters of credit or require the surety to pay forthwith to the chair all or any part of the penal sum of the bond, and from the proceeds of the securities, from such penal sum, from the amount drawn, or from the employer's deposit of cash pay any compensation obligations, expense, or assessments imposed by law when such employer may neglect or refuse to pay such obligations, expense, or assessments or within 30 days prior to the expiration date of any letters of credit when the employer shall have failed to renew or replace such letters or have substituted cash, securities or a surety bond; and

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(f) if the chairman shall so require, to pay any awards commuted under section 27 of the Workers' Compensation Law into the aggregate trust fund.

Amended 315.2 on 12/24/86; amended 315(b) on 3/29/89; amended 315.2(e) on 3/29/89.

§315.3 Securities, cash, surety bond and/or letters of credit

(a) The applicant shall deposit with the chairman securities of the kind specified in subdivisions 1, 2, 3, 4, 5, and paragraph (a) of subdivision 7 of section 235 of the New York State Banking Law. Such securities shall be registered in the name of "Chairman, Workers' Compensation Board, State of New York." Interest paid on securities on deposit will be regularly remitted to the self-insurer for whose account they are deposited, so long as such self-insurer complies with this Subchapter and the provisions of the Workers' Compensation Law, and is not in default in the payment of compensation or other obligation under the Workers' Compensation Law.

(b) A cash deposit may be deposited in lieu of securities, surety bond or letters of credit. Such cash deposit will be deposited in an interest-bearing account in the name of "Chair, Workers' Compensation Board, State of New York" and shall be in an account authorized by the Comptroller of the State of New York. Such cash deposit is to be by certified check. Interest paid on the cash deposit will be regularly remitted to the self-insurer for whose account it is deposited so long as such self-insurer complies with the provisions of the Workers' Compensation Law and is not in default in the payment of compensation or other obligation under the Workers' Compensation Law.

(c) Surety bonds accepted in lieu of securities, cash, or letters of credit shall be undertaken and enforced in the name of the "Chair, Workers' Compensation Board, State of New York" and shall be in form approved by the chair and issued by a company authorized by the Superintendent of Insurance to write business as a surety in the State of New York.

(d) to be acceptable, a letter of credit must comply with all requirements set forth in Regulation 133 of the New York State Insurance Department, codified as Part 79 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York, except that:

(1) the beneficiary shall be the Chair, Workers' Compensation Board, State of New York;

(2) the evergreen clause shall provide for at least 60 days written notice to the Chair of the Workers' Compensation Board prior to expiry date for nonrenewal.

(3) a bank, to be a qualified bank, may in lieu of a determination by the Securities Evaluation Office of the National Association of Insurance Commissioners for purposes of 11 NYCRR, section 79.1(e)(3), have either a long-term debt rating equal to Baa/BBB or better by Moody's or Standard & Poor's or the equivalent thereto from any other securities rating service, and/or a short-term debt rating of P2/A2 from Moody's or Standard & Poor's or the equivalent thereto from any other securities rating service;

(4) the letter of credit shall additionally provide that any legal proceedings with respect thereto be subject to the jurisdiction of the courts of the State of New York; and

(5) the form and content thereof shall be acceptable to the chair.

Amended 315.3 on 12/24/86; added 315.3(d) on 3/29/89.

§315.4 Periodic reports

(a) Reports shall be filed with the chairman, by each self-insurer as follows:

(1) the most recent certified, independently audited financial statement and copy of form 10K, if any, filed by the employer with the Securities and Exchange Commission, to be filed not later than three months after the close of the self-insurer's fiscal year. A

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subsidiary company may submit the consolidated financial statement of the parent company in lieu of its own individual financial statement. In such event, however, the parent company must guarantee the liability of the subsidiary company under the Workers' Compensation Law by filing with the chairman, an Agreement of Assumption and Guarantee in form approved by the chairman;

- (2) a payroll report filed by classification code, for the 12-month period ending March 31st of each year;
 - (3) a statement of all outstanding death and disability claims as of September 30th of each year, segregated by State fiscal year (April 1st through March 31st) of accident occurrence;
 - (4) a statement of compensation and medical losses incurred by the self-insurer for the 12-month period ending September 30th, analyzed by State Fiscal year of accident occurrence; and
 - (5) additional or more frequent reports or statements as may be required by the chairman.
- (b) The reports called for in paragraphs (a)(2), (3), and (4) of this section shall be filed no later than November 1st of each year.

Amended 315.4 on 12/21/66; added 315.4 on 10/01/82.

§315.5 Withdrawal of securities or cash; nonrenewal of letters of credit: termination of surety bond

- (a) Withdrawal of securities or cash; nonrenewal of letters of credit.
- (1) A self-insurer who has discontinued business in this State or who has arranged for the payment of its compensation claims by one of the other methods provided by law may apply to the chair for the return of the securities or cash deposited or permission not to renew the letters of credit. Such self-insurer shall file a sworn statement of:
- (i) all outstanding liabilities for compensation;
 - (ii) all pending claims for compensation; and
 - (iii) all accidents that have occurred during the period of two years prior to the date of application.
- (2) After the lapse of 26 months, if all claims have been finally adjudicated and fully paid either by the self-insurer directly or by payment into the aggregate trust fund as provided in section 27 of the Workers' Compensation Law, and all expenses and assessments required by law have been paid, the chair may accept a self-insurer's release policy as specified in subdivision 3 of section 50 of the Workers' Compensation Law in an amount to be determined by the chair. On acceptance of such policy, the securities or cash of the self-insurer on deposit with the chair shall be returned to the self-insurer or, the chair shall notify the self-insurer that the letters of credit need not be renewed.
- (b) Termination of surety bond. The chair, upon receipt of notice of termination of a surety bond filed by a self-insurer with the chair, may make demand upon the self-insurer to deposit with the chair, within 10 days after demand, securities or cash or file irrevocable letters of credit in an amount determined in accordance with sections 316.6, 316.2 and 316.3 of this Title. If the self-insurer fails to comply with such demand in the manner and sum and within the period required, the privilege of self-insurance may be terminated.

Amended 315.5 on 12/24/86; amended 315.5 on 3/29/89.

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§315.6 Group self-insurance

- (a) Sections 315.1 to 315.5, inclusive, as set forth in this Part, which apply to individual self-insurers, shall be equally applicable in all respects to group self-insurers as defined in subdivision 3-a of section 50 of the Workers' Compensation Law. In addition, each such group desiring to become a self-insurer shall submit to the chairman, with the application for self-insurance, the following:
- (1) a payroll report field by classification code, for each participating employer of the group for five preceding annual fiscal periods;
 - (2) a report in a format determined by the chairman indicating compensation and medical losses, both payments and reserves, incurred by each participating employer, for a period up to 10 years prior to the date of application;
 - (3) a certified, independently audited financial statement of the group's assets and liabilities; satisfactory proof of financial ability to pay compensation for the employers participating in the group plan; the group's reserves, its source and assurance of continuance; and
 - (4) any and all agreements, contracts and other pertinent documents relating to the organization of the employers in the group.
- (b) The periodic reports required to be filed in section 315.4 of this Part, shall be consolidated and submitted by the group self-insurer for its participating employers.
- (c) The group self-insurer shall, within 10 days, notify the chairman, on a prescribed form, of a new participating employer, together with the reports of the employer as required in paragraphs (a)(1) and (2) of this section.

Amended 315.6 on 12/14/66; amended 315.6 on 10/01/82.

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**TITLE 12 OF THE OFFICIAL COMPILATION OF CODES, RULES AND
REGULATIONS OF THE STATE OF NEW YORK**

**CHAPTER V - WORKERS' COMPENSATION
SUBCHAPTER B - SELF INSURERS
PART 317 – GROUP SELF-INSURANCE**

§317.1 Statement of Purpose

To establish application procedures, qualifications and responsibilities for any group of employers which desires to become, or which has been approved to operate as, a group self-insurer.

§317.2 Definitions

For purposes of these rules,

- (a) “American institution,” shall mean an institution created or existing under the laws of the United States of America or of any state, district or territory thereof.
- (b) “Board of trustees”, shall mean that body, identified in the trust agreement, which is responsible for all operations of the group self-insurer and which shall take all necessary action to protect the assets of the group self-insurer.
- (c) “Claims” shall mean, for purposes of financial reporting and determining trust liabilities, the present value of all workers’ compensation claims, including those incurred but not reported, and the expenses associated therewith which the group is obliged to settle and adjust. Such claims must be determined on an actuarial basis and may be discounted at a reasonable rate. The Board may reject discount rates considered to be unreasonable. Claims may be variously referred to as “claim reserves,” “loss reserves,” or “reserves for loss and loss adjustment expenses” in group self-insurers’ financial statements and actuarial reports.
- (d) “Claims administrator” or “Third Party Administrator” shall mean an individual or entity licensed by the Workers’ Compensation Board pursuant to subdivision (3-b) or (3-d) of section 50 of the Workers’ Compensation Law which is responsible for the administration and defense of workers’ compensation claims of members of an authorized group self-insurer.
- (e) “Contribution” shall mean the annual charge to individual members of a group self-insurer to cover its workers’ compensation liabilities and assessments.
- (f) “Excess insurance” shall mean insurance, purchased from an insurance company authorized by the superintendent of insurance, which reduces the exposure of the group self-insurer i) for workers’ compensation claims and ii) for employers’ liability. Such

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- excess insurance may be specific, aggregate or other insurance, singly or in combination, in amounts and form acceptable to the chair.
- (g) “Group administrator” shall mean an individual or entity that is responsible for ensuring compliance with the provisions of these rules and the coordination of outside services including but not limited to claims processing, loss control and legal, accounting and actuarial services.
 - (h) “Group member” or “employer” shall mean an individual employer that is participating in a group self insurance arrangement in accordance with subdivision (3-a) of section 50 of the Workers’ Compensation Law.
 - (i) “Group self-insurer,” “employer group,” “group,” or “self-insurance trust,” shall mean an association of employers performing related activities in a given industry that contractually agree, in accordance with section 50(3-a) of the Workers’ Compensation Law, to assume the workers’ compensation liabilities of each associated member.
 - (j) “Marketing materials” shall mean any financial statement, pamphlet, circular, graphic, form letter, sales literature, advertising or other communication, whether written, recorded, electronic or verbal, intended for or directed to current or prospective members of the group self insurer.
 - (k) “Municipal corporation,” shall mean a county, town, city, village, school district (except a school district in a city with a population of one hundred twenty-five thousand or more), board of cooperative educational services, fire district, a district corporation or a special improvement district governed by a separate board of commissioners.
 - (l) “Rated activities in a given industry,” described in section 317.3(a) of this Part, shall mean that there exists a homogeneity in the nature of the group members’ business activities.
 - (m) “Trust account” or “Trust fund” shall mean a trust account or fund, financed by the contributions of and assessments on members of a group self-insurer, for the exclusive purpose of paying for and otherwise administering workers’ compensation liabilities incurred by members of the group self-insurer.
 - (n) “Trust assets” shall mean cash and deposits in a bank or trust company insured under the provisions of the Federal Deposit Insurance Act or investments permitted pursuant to section 317.8(c) of this Part. For purposes of these rules, assets shall not include fixed assets nor shall they include the security posted by the group self-insurer under section 317.5 of this Part.
 - (o) “Trust liabilities” shall mean all claims, accrued Workers’ Compensation Board assessments, accrued expenses including administrative costs, costs of excess insurance policies, and other fixed costs, accounts payable, loans, bonds and notes payable, unearned contributions and all other trust obligations.

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- (p) “Qualified actuary” shall mean an individual who i) is a member in good standing of the Casualty Actuarial Society, ii) is a member in good standing of the American Academy of Actuaries who has been approved as qualified for signing casualty loss reserve opinions by the Casualty Practice Council of the American Academy of Actuaries, or iii) satisfies the requirements of section 95.5(d) of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York.
- (q) “Termination” shall mean (i) such action taken by a group self-insurer to remove a group member from participation in the group, or (ii) the cessation of a group’s status as a self-insurance trust.
- (r) “Withdrawal” shall mean such action taken by a group member to remove itself from a group self-insurer.

§317.3 Qualification to Operate as a Group Self-Insurer

To qualify as a group self-insurer and to maintain authorization to operate as a group self-insurer, the following requirements must be satisfied:

- (a) The group must include two or more employers that perform related activities in a given industry and that have been in business for a period of time which is acceptable to the chair. With the exception of groups consisting of municipal corporations, a group self-insurer must demonstrate the related nature of the group members’ business activities, to the satisfaction of the chair, by one or more of the following methods:
 - (1) all group members must be classified within the same or a related Standard Industrial Classification Code (SIC Code) Division Structure as published in the United States Department of Commerce’s Standard Industrial Classification Code Manual, or must share a predominant payroll classification;
 - (2) all group members must be members in good standing in an industry-specific trade association, which shall not have been established for the primary purpose of obtaining group self-insurance status and shall have been in existence for at least five years prior to applying for such status;
 - (3) through the furnishing of such other information as may be required by the chair in order to demonstrate the related nature of the participating employers’ business activities.
- (b) With the exception of groups consisting of municipal corporations, the group must have and maintain an aggregate net worth of members which is at least one million dollars (\$1,000,000), unless otherwise authorized by the chair. The net worth of any related or subsidiary companies which are not signatories to the trust agreement shall not be included in the calculation of aggregate net worth.

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- (c) With the exception of groups consisting of municipal corporations, the group must have and maintain a combined annual payroll of group members which, when multiplied by the current manual rates promulgated by the New York compensation insurance rating board, is at least five hundred thousand dollars (\$500,000), unless otherwise authorized by the chair. Such payroll shall only include amounts paid to workers in New York State who are covered by the self-insured group.
- (d) With the exception of groups consisting of municipal corporations, the group must demonstrate i) sufficient aggregate financial strength and liquidity as described in the capitalization requirements set forth in section 317.6 of this Part, ii) adequate security, as described in section 317.5 of this Part, and iii) adequate excess insurance, as described in section 317.10 of this Part, to guarantee the payment and administration of all obligations arising under the Workers' Compensation Law.
- (e) A group self-insurer that fails to satisfy the requirements set forth in this Subpart to maintain authorization to operate as a group may be subject to dissolution at the direction of the chair.

§317.4 Application Requirements for Authorization of New Employer Groups

- (a) Any group of employers seeking initial authorization to operate as a group self-insurer in accordance with subdivision (3-a) of section 50 of the Workers' Compensation Law shall satisfy the qualifications set forth in section 317.3 of this Part and shall submit an application to the chair as prescribed below. This application shall contain:
 - (1) a current payroll report filed by classification code for each participating employer of the employer group for the preceding annual fiscal period. Such payroll shall only include amounts paid to workers in New York State who are covered by the self-insured group;
 - (2) a description of the safety program, if any, proposed for the employer group;
 - (3) applications for participation duly executed by each employer participating in the group in a form prescribed by the chair;
 - (4) copies of the following items, certified by the group's board of trustees and group administrator:
 - (i) the bylaws of the group self-insurer which shall provide for all of the prescribed terms as set forth in section 317.12 of this Part;
 - (ii) a list of the names and addresses of all trustees, specifically identifying voting trustees. At least two-thirds of the voting trustees shall be officers, partners, members or employees of group members;

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- (iii) a list of the names and addresses of each of the officers, directors and general managers of the group administrator;
 - (iv) a description of the group's organization for the administration of claims as well as the duly executed contract between the board of trustees, the group administrator and the claims administrator;
 - (v) any duly executed contract between the board of trustees and either an attorney-at-law licensed to practice in New York State or a representative of self-insured employers licensed by the Workers' Compensation Board pursuant to subdivision (3-b) or (3-c) of section 50 of the Workers' Compensation Law, pertaining to the representation of group members before the Workers' Compensation Board;
- (5) with the exception of groups consisting exclusively of municipal corporations:
- (i) the trust agreement, with language prescribed by the chair and in a form approved by the chair, which must be shared with all prospective members of the group and which must be signed by each of the trustees of the group;
 - (ii) the participation agreement, with language prescribed by the chair and in a form approved by the chair, which must be shared with all prospective members of the group and which must be individually executed by each member of the group, and which shall include an acknowledgment that the prospective member has been provided a copy of the trust agreement and has reviewed that agreement, specifically the provisions related to joint and several liability, the methodology utilized to determine member contributions, the annual adjustment to contributions, and to membership terms.
- (6) documentation from the group administrator consisting of:
- (i) evidence of experience in the administration of group insurance or group self-insurance programs or other relevant experience such as that of an attorney-at-law, a certified public accountant, or a qualified actuary who has experience in providing professional services to such groups;
 - (ii) two professional references associated with recent group administration services or other relevant experience; and
 - (iii) if incorporated in New York, a certificate of incorporation or, if not incorporated or incorporated in a state other than New York, proof of an actual place of business in New York, within the meaning of section 308 of the Civil Practice Law and Rules.

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- (7) a properly executed application form as prescribed by the chair, whereby the group self-insurer acknowledges its commitment:
- (i) to pay to or on behalf of injured employees and to the dependents of deceased employees all compensation and medical benefits as required by the provisions of the Workers' Compensation Law;
 - (ii) to pay annually its proportionate share of the expense of administration or other expenses or assessments as provided by the Workers' Compensation Law;
 - (iii) to pay any awards commuted pursuant to section 27 of the Workers' Compensation Law into the aggregate trust fund, if required by the chair;
 - (iv) to permit the chair's authorized representatives access to the premises and to audit relevant records of the group administrator, the trustees of the employer group, and/or any individual member of the employer group for the purpose of examining operations and records;
 - (v) to notify the chair, in writing, within ten days of the election, resignation or removal of any member of the board of trustees;
 - (vi) to notify the chair, in writing, within ten days of the hiring of any new independent law firm, or third party administrator licensed by the Workers' Compensation Board pursuant to subdivision (3-b) or (3-d) of section 50 of the Workers' Compensation Law, to represent the group before the Board, and to file with the chair a properly executed and certified copy of the contract or service agreement;
 - (vii) to notify the chair, in writing, within ten days of the appointment of any new group administrator and to file with the chair a properly executed and certified copy of the contract or the service agreement, as well as documentation from the new group administrator as required by section 317.4(a) of this Part;
 - (viii) to produce full, truthful and timely reports as required by the chair in section 317.19 of this Part;
 - (ix) to notify the chair and all group members, in writing, within ten days of any alteration, modification or amendment to terms of the group's trust document, participation agreement or bylaws.
- (8) With the exception of groups consisting exclusively of municipal corporations, groups shall
- (i) deposit with the chair and maintain securities, cash, surety bond or irrevocable letters of credit, in a form and an amount as determined by the chair in accordance with section 317.5 of this Part;
 - (ii) maintain excess insurance as defined in section 317.2(f) of this Part;
 - (iii) have each group member execute a participation agreement as prescribed by this section.
- (b) Groups which do not consist exclusively of municipal corporations shall also be required to submit:

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- (1) a description of the nature of the group members' business activities and evidence that they perform related activities in a given industry in accordance with section 317.3(a) of this Part;
 - (2) an actuarial feasibility study directed and certified by an independent qualified actuary;
 - (3) a report identifying the projected rate of contribution and assessments to be paid by each member for the first year of the group's operation, and the manner in which such contributions and assessments were calculated. Such report shall be closely reviewed by the chair for purposes of determining the adequacy, consistency and rationality of the projected contributions.
- (c) If, upon examination of the application and supporting documentation, the chair is satisfied as to the ability of the employer group to make payment of all claims and to fulfill all other obligations, authorization to operate as a group self-insurer may be granted subject to the conditions set forth in this Part.

§317.5 Security

- (a) Group self-insurers shall deposit with the chair securities, cash, surety bonds and/or irrevocable letters of credit, in an aggregate amount as determined by the chair, but not less than:
 - (1) the combined annual payroll of the group members multiplied by the current manual rates promulgated by the New York compensation insurance rating board; or
 - (2) one and one-half times the group self-insurers' retention as specified on the certificate of excess insurance filed with the chair which limits the liability of a group on a specific, per occurrence basis with respect to claims; but
 - (3) in no event shall such security amount be less than the product of the statutory maximum weekly compensation rate for total disability multiplied by 52, multiplied by 30.
- (b) The amount of a group self-insurer's security will be reevaluated annually following the receipt and review of the annual financial and other reports required in section 317.19 of this Part, and such security deposits may be adjusted at the direction of the chair.
- (c) The group self-insurer's security deposit shall be in a form prescribed herein:
 - (1) The applicant shall deposit with the chair securities of the kind specified in subdivisions (1), (2), (3), (4) and (5), and paragraph (a) of subdivision (7), of section 235 of the Banking Law. Such securities shall be registered in the name of "Chair, Workers' Compensation Board, State of New York." Interest paid on securities on deposit will be regularly remitted to the group self-insurer for whose account they are deposited, so long as such group self-insurer complies with this Part and the provisions of the Workers' Compensation Law, and is not in default

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- in the payment of compensation, assessments or other obligation under the Workers' Compensation Law.
- (2) A cash deposit may be made in lieu of securities, surety bond or letters of credit. Such cash deposit will be deposited in an interest-bearing account in the name of "Chair, Workers' Compensation Board, State of New York" and shall be in an account authorized by the Comptroller of the State of New York. Such cash deposit is to be by certified check. Interest paid on the cash deposit will be regularly remitted to the group self-insurer for whose account it is deposited so long as such group self-insurer complies with the provisions of the Workers' Compensation Law and is not in default in the payment of compensation, assessments or other obligation under the Workers' Compensation Law.
- (3) Surety bonds accepted in lieu of securities, cash, or letters of credit shall be undertaken and enforced in the name of the "Chair, Workers' Compensation Board, State of New York" and shall be in form approved by the chair and issued by a company authorized by the superintendent of insurance to write business as a surety in the State of New York.
- (4) A letter of credit must comply with all requirements set forth in Regulation 133 of the New York State Insurance Department, codified as Part 79 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York, except that:
- (i) the beneficiary shall be the Chair, Workers' Compensation Board, State of New York;
 - (ii) the "evergreen clause" shall provide for at least sixty days written notice to the chair of the Workers' Compensation Board prior to the expiration date for non-renewal;
 - (iii) a bank, to be a qualified bank, may in lieu of a determination by the Securities Evaluation Office of the National Association of Insurance Commissioners for purposes of section 79.1(e)(3) of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York, have either a long-term debt rating equal to Baa/BBB or better by Moody's or Standard & Poor's or the equivalent thereto from any other securities rating service, and/or a short-term debt rating of P2/A2 from Moody's or Standard & Poor's or the equivalent thereto from any other securities rating service;
 - (iv) the letter of credit shall additionally provide that any legal proceedings with respect thereto be subject to the jurisdiction of the courts of the State of New York; and
 - (v) the form and content thereof shall be acceptable to the chair.

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- (d) The security held by the chair pursuant to paragraph (a) hereof shall not be included in the calculation of the group self-insurer's trust assets for purposes of determining the financial condition of the group.
- (e) The chair may draw upon any security deposits made pursuant to paragraph (a) hereof:
 - (i) to satisfy any claims, liabilities, obligations, expenses or assessments of a group self-insurer, or
 - (ii) when a group self-insurer shall have failed to renew or replace a letter(s) of credit within thirty days prior to the expiration date of such letters or to substitute its deposit with cash, securities or a surety bond of equal value. The chair will provide the group self-insurer with notice prior to drawing upon any security deposits.
- (f) Upon receipt of a notice of cancellation of a surety bond or non-renewal of letter(s) of credit filed by a group self-insurer with the chair, the chair may make demand upon the group self-insurer to deposit with the chair within ten days after demand securities or cash, or to file or reinstate irrevocable letters of credit, or post or reinstate a surety bond in an amount determined in accordance with subdivision (a) of this section. If the group self-insurer fails to comply with such demand in the manner and amount demanded, and within the time period required, the privilege of group self-insurance may be revoked.
- (g) If for any reason the status of a group self-insurer is terminated or revoked, the securities or surety bond on deposit shall remain in the custody of the chair, and the irrevocable letter of credit shall remain in force, for a period of at least twenty-six months. At the expiration of such time, or such further period as the chair may deem proper and warranted, the group self-insurer may apply to the chair for the return of the securities or cash deposited or permission not to renew the letters of credit. The chair may accept the group self-insurer's release policy as specified in paragraph (5) of subdivision (3-a) of section 50 of the Workers' Compensation Law in an amount to be determined by the chair and in a form approved by the superintendent of insurance. Upon acceptance of such policy, the securities or cash of the group self-insurer on deposit with the chair shall be returned to the group self-insurer, or the chair shall notify the group self-insurer that the letters of credit need not be renewed.
- (h) The provisions of this Subpart shall not apply to groups consisting exclusively of municipal corporations.

§317.6 Capitalization

- (a) Group self-insurers shall file evidence of capitalization in an amount approved by the chair as described herein. Groups shall prepare annual financial statements in accordance with Generally Accepted Accounting Principles (GAAP). However, only assets and liabilities as defined in section 317.2 of this Part will be considered when determining the group's financial condition.

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- (b) Group self-insurers are required to establish and maintain trust assets, as such term is defined in subdivision (n) of section 317.2 of this Part, in an amount which exceeds trust liabilities, as such term is defined in subdivision (o) of section 317.2 of this Part. Group self-insurers who fail to comply with this capitalization standard shall be deemed “under-funded” and shall immediately provide the chair with an acceptable plan of action as may be appropriate in order to make up the deficiency in a time prescribed by the chair. Such under-funded groups may also be subject to any or all of the provisions set forth in section 317.9 of this Part.
- (c) Upon authorization to operate as a group self-insurer, the group shall deposit into the trust an amount equal to a minimum of 40% of the initial security deposit held by the chair. Consistent with section 317.5(d) of this Part, the security held by the chair shall not be considered a trust asset and shall not be used to satisfy the financial obligations of a solvent trust. By the end of the first full reporting year, the group shall have deposited amounts sufficient to bring the trust assets to an amount which exceeds trust liabilities. These amounts shall be paid to the trust on a monthly, quarterly, or annual basis as required by the bylaws of the group.
- (d) The provisions of this Subpart shall not apply to groups consisting exclusively of municipal corporations.

§317.7 Contribution Rates

- (a) The contribution rates utilized by a group self-insurer shall not be inadequate, unfairly discriminatory, destructive of competition or detrimental to the solvency of the group.
- (b) If the chair has reasonable cause to believe that a group’s contribution rates do not conform to the requirements of subdivision (a) of this section, then he or she may require the submission of a report identifying the contributions paid by each of the group members for the preceding year, the projected contributions for each group member for the current fiscal year, and the manner in which such contributions were calculated.
- (c) Such report shall be closely reviewed by the chair for purposes of determining the adequacy of contributions as well as the consistency and rationality of the contribution calculations. In addition to other factors, the chair may consider generally accepted actuarial standards as well as the New York Compensation Insurance Rating Board’s manual rate premium standards in conducting its review of this report.
- (d) If, after such review, the group’s contribution rates are deemed to be inadequate, unfairly discriminatory, destructive of competition or detrimental to the solvency of the group, the chair may mandate the group’s adherence to the New York Compensation Insurance Rating Board’s rates and rate making procedures. Groups directed to adhere to the New York Compensation Insurance Rating Board’s rates may apply to the chair for discounts to such rates based upon past and prospective losses, investment income, and other relevant factors.

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§317.8 Integrity of the Group Self-Insurer's Trust Funds

Every effort shall be made by the group self-insurer, its trustees, its group administrator or other agent(s) to preserve the integrity, strength and liquidity of the group's funds so as to permit the timely and complete payment of all group claims and other liabilities. With the exception of groups consisting of municipal corporations, unless otherwise authorized by the chair, group self-insurers shall be subject to the following requirements with respect to trust funds:

- (a) The group self-insurer, its trustees, its group administrator or other agent(s) shall not utilize any of the trust funds collected from group members or earned by the trust for any purpose not directly related to the payment of claims, security deposits, assessments, penalties, reasonable costs of operation, fixed costs such as excess insurance, the payment of earnings or refunds to group members, or other trust obligations. The group self-insurer, its trustees, its group administrator or other agent(s) shall not borrow money from the trust fund or in the name of the trust and shall not permit any lending, issuance of debt instruments or other forms of obligations and encumbrances, nor shall the group self-insurer, its trustees, its group administrator or other agent(s) extend credit to a member for the payment of contributions or assessments. This restriction shall not preclude the group-self insurer from permitting fixed installment plans, not to exceed one year, for the payment of members' contributions or assessments.
- (b) The trust assets of the group self-insurer shall not be commingled with the assets of any member, nor shall the funds dedicated to the payment and administration of claims, assessments, and other costs arising under the Workers' Compensation Law, or to employer liability costs, be commingled with any other funds, such as those dedicated to pension and health benefits.
- (c) Subject to the limitations set forth in subdivision (d) of this section, a group self-insurer, its trustees, its group administrator or other agent(s) may invest any funds of the trust which are not necessary for the payment of short term obligations of the trust in the following:
 - (1) Government Obligations:
Obligations which are not in default as to principal or interest, which are valid and legally authorized, and which are issued or guaranteed by:
 - (i) the United States or by any agency or instrumentality thereof,
 - (ii) any state in the United States, or
 - (iii) any agency or instrumentality of any state in the United States, provided that such government obligations shall be by law payable, as to both principal and interest, from taxes levied or adequate special revenues pledged or otherwise appropriated.

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- (2) Obligations of American Institutions:
Obligations which are issued by any solvent American institution which are not in default as to principal or interest provided such obligations:
 - (i) are rated A or higher (or the equivalent thereto) by a securities rating agency recognized by the superintendent, or
 - (ii) have been given the highest quality designation by the Securities Valuation Office of the National Association of Insurance Commissioners.

- (3) Preferred Shares of American Institutions:
Preferred shares issued by a solvent American institution.

- (4) Equity interests:
Investments in common shares of any solvent American institution, if such equity interests are registered on a national securities exchange, as provided in the Securities Exchange Act of 1934, 15 U.S.C. §§ 78a-78kk or otherwise registered pursuant to said act and, if so otherwise registered, price quotations therefore are furnished through a nationwide automated quotations system approved by the National Association of Securities Dealers, Inc.

- (d) Investments of group self-insurers under subdivision (c) of this section shall be subject to the following limitations:
 - (1) No group self-insurer shall invest in the obligations or the preferred or common shares of any one American institution in an amount which exceeds five percent of total trust assets nor shall any group self-insurer invest in the obligations or the preferred or common shares of American institutions in an amount which exceeds twenty-five percent of total trust assets.
 - (2) No group self-insurer shall invest trust assets in investment securities or obligations of a group member or a group member's parent, subsidiary, or affiliate or any person or entity under contract with the group self-insurer.

- (e) A group self-insurer, its trustees, its group administrator or other agent(s) shall not distribute dividends or excess earnings if such distribution reduces total assets below total liabilities. Prior written notification shall be provided to the chair at least thirty days prior to the issuance of any such distribution.

§317.9 Terms and Procedures Applicable to Under-Funded Group Self-Insurers

- (a) Group self-insurers are required to maintain at all times sufficient trust assets within the trust fund to exceed claims and all other liabilities.

- (b) Group self-insurers whose assets do not exceed liabilities are deemed to be under-funded and may be subject at any time to any or all of the following provisions, at the discretion of the chair:

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- (1) the chair may call for a meeting with the group's board of trustees and/or group administrator to discuss the financial condition of the trust fund and to determine the appropriate course of action to restore the trust fund's financial stability in a timely manner;
 - (2) the chair may require an examination of the group self-insurer pursuant to section 317.4(a)(7)(iv) of this Part;
 - (3) the chair may require the submission of additional financial and/or actuarial documentation from the group self-insurer including, but not limited to, a report such as that described in section 317.7(b) of this Part;
 - (4) the chair may require a written plan from the group's board of trustees and/or group administrator in order to restore the trust fund's financial stability. Such written plan must be in a form and content acceptable to the chair including, but not limited to, a projected plan for member contributions for the next five years or such additional period of time as the chair may require;
 - (5) the chair may suspend the addition of any new members into the group and/or suspend the payment of any earnings on deposits or investments or assessments or any portion thereof until the group self-insurer is deemed to be adequately funded; or
 - (6) the chair may require additional security deposits to be held in accordance with section 317.5 of this Part;
 - (7) the group self-insurer may be required to immediately levy an assessment upon the group members or take such other action as may be appropriate in order to make up the deficiency.
- (c) If the chair determines that the financial stability of the under-funded trust fund cannot be restored in a timely and appropriate manner, the chair may revoke the group's self-insurance status.
- (d) The provisions of this Subpart shall not apply to groups consisting exclusively of municipal corporations.

§317.10 Excess Insurance

- (a) The group self-insurer shall also file certificate(s) evidencing that excess insurance, as defined in section 317.2(f) of the Part, has been obtained to reduce the exposure of the group self-insurer i) for workers' compensation claims, and ii) for employers' liability. Such excess insurance must be in a form approved by the superintendent of insurance and must be issued by a property and casualty company licensed by the superintendent of insurance to write excess insurance in New York with respect to workers' compensation insurance and employer's liability insurance as defined in paragraph (15) of subdivision

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of section 1113 of the Insurance Law. The retention levels for the excess insurance shall be in an amount acceptable to the chair.

- (b) The group self-insurer shall immediately notify the chair, in writing, of any change in its excess insurance.
- (c) The provisions of this Subpart shall not apply to groups consisting exclusively of municipal corporations.

§317.11 Blanket Fidelity Bond

Every group self-insurer shall be required to file with the chair evidence that it has obtained a Blanket Fidelity Bond providing coverage for theft, disappearance or destruction of money, securities, or other property, in an amount acceptable to the chair. Such Bond shall provide coverage for dishonest acts of the group administrator, or a trustee, employee or agent of the group, whether identified or not, while acting alone or in collusion with others, and shall name the group self-insurer as loss payee. Such Bond shall be maintained at all times during the existence of the group self-insurer.

§317.12 Bylaws

Each group self-insurer's board of trustees must also establish written bylaws which provide detailed information as to the operations and administration of the group self-insurer. Such bylaws shall address issues including but not limited to: qualifications for group membership; procedures for adding or terminating group members; rights and responsibilities of group members including acknowledgment of the joint and several liability assumed by each member of the group; group self-insurer's name, location, fiscal year; basis for establishing member contributions; underwriting considerations; meetings; safety programs, if any; disclosure of group self-insurer's books, reports, etc. to members; and procedures for amending bylaws.

§317.13 Notice Regarding Addition of New Member to Group Self-Insurer

A group self-insurer shall, within thirty days of the execution of a new group member's prescribed participation agreement, notify the chair on a prescribed form of such new group member and file i) an individual group member application and ii) a copy of the properly executed prescribed participation agreement. Coverage within the group will become effective upon execution of the group member application and participation agreement, except in the case of a withdrawal from policy coverage governed by subdivision (a) of Section 94 of the Workers' Compensation Law. In the event the Board subsequently rejects the application, the group must file a notice of termination, in accordance with section 317.14(a) of this Part, within thirty days after the notice of rejection.

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§317.14 Notice Regarding Termination or Withdrawal of Member From Group Self-Insurer

- (a) A group self-insurer's termination of a member shall not be effective until at least ten days after notice of such termination, on a prescribed form, has either been filed in the office of the chair or sent by certified or registered letter, return receipt requested, and also served in like manner upon the employer.
- (b) A group member shall not be eligible to withdraw from the group self-insurer and fulfill its future workers' compensation obligations through alternative coverage until it shall have provided the current group self-insurer with at least 30 days notice of its intent to terminate participation. Notice of termination shall also be provided to the chair by the group in accordance with subdivision (a) of this section.
- (c) If the termination or withdrawal of a member causes the group self-insurer to fail to satisfy the qualification requirements set forth in section 317.3 of this Part, related to net worth of group self-insurer and combined payroll, the group's board of trustees and/or group administrator shall, within 30 days of the notice of withdrawal or decision to terminate, advise the chair of its plan to bring the group self-insurer into compliance with the financial and other requirements in a timely and appropriate manner. If the group self-insurer fails to devise a plan which will bring it into compliance in a timely and appropriate manner, the chair may revoke its group self insurance status.
- (d) The group self-insurer shall make a good faith effort to maintain records on the whereabouts of group members which have been terminated or which have withdrawn from participation in the group.

§317.15 Changes in Legal Status of Group Members

Any group member which undergoes any changes in its legal status which results in the issuance of a new taxpayer identification number or unemployment insurance number shall be required to complete a new participation application and shall execute a new participation agreement. A group self-insurer shall, within ten days, notify the chair in writing of any such change and shall, at that time, file the new application and agreement.

§317.16 Merger

With the approval of the chair, two or more group self-insurers may merge into one of the constituent groups. The group self-insurer resulting from the merger of two or more group self-insurers shall assume, in full, all liabilities and obligations of the constituent groups.

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§317.17 Solicitation of New Members

Group administrators, trustees of the group, and insurance brokers and consultants shall make a good faith effort to fully disclose to prospective group members both the rights and responsibilities of participating in the group. No party shall make a material misrepresentation or omission of a material fact in connection with the solicitation of a prospective group member, or engage in any practices prohibited by section 2403 of the Insurance Law. No group shall pay commissions to or otherwise engage in marketing or sales relationships with insurance brokers who have had their licenses suspended or revoked by the Insurance Department. The trustees of a group shall require all brokers to comply with section 2120 of the Insurance Law.

317.18 Marketing Materials

- (a) All marketing materials disseminated or communicated by or on behalf of a group self-insurer, group administrator or trustee of a group shall be strictly factual in nature and shall be truthful and accurate in all respects, and shall not contain any statements which cannot be measured or verified, or which are in any way deceptive, misleading or coercive.
- (b) If the chair has reasonable cause to believe that any marketing materials disseminated or communicated by or on behalf of a group self-insurer, group administrator or trustee of a group do not conform to the requirements set forth in subdivision (a) of this section, then he or she may require that all marketing materials disseminated or communicated by or on behalf of such group self-insurer, group administrator or trustee of the group be submitted to the chair within thirty days. The chair may also direct the submission of additional information supporting such marketing materials.
- (c) If the chair determines that submitted marketing materials do not conform to subdivision (a) of this section, the chair may direct the group self-insurer, group administrator or trustee of a group to:
 - (i) immediately cease dissemination or communication of such materials;
 - (ii) provide the chair with the names and addresses of all entities to whom those materials were disseminated or communicated;
 - (iii) disseminate additional information clarifying or explaining such disapproved materials; or
 - (iv) file, until otherwise directed, all future marketing materials with the chair thirty days prior to their dissemination or communication.

§317.19 Periodic Reports to be Submitted by Group Self-Insurers

- (a) Group self-insurers, with the exception of groups consisting exclusively of municipal corporations, shall file the following reports, evidencing proper capitalization and integrity of trust funds, with the Workers' Compensation Board no later than one hundred and twenty days after the close of the fiscal year of the group:

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- (1) a financial summary report in a form prescribed by the chair;
 - (2) audited financial statements prepared in accordance with GAAP, for the preceding fiscal year, certified by an independent certified public accountant;
 - (3) an actuarial report certified by an independent qualified actuary verifying claims as defined in section 317.2(c) of this Part, and the method of calculating such claims, based upon accepted actuarial standards of practice;
 - (4) a payroll report filed by classification code for each group member and in aggregate for the preceding twelve month period and including the current total number of employers participating in the group as well as the current total number of employees for each employer; such payroll report should be accompanied by the final payroll audit of the group, as submitted to the group's excess insurance carrier.
- (b) The chair may engage an attorney, actuary, certified public accountant or other qualified person or organization other than a salaried employee of the board to conduct or assist in an examination of the annual reports submitted herein. In the event that such professional services are utilized, any costs incurred shall be borne and paid by the group self-insurer under examination.
- (c) Group self-insurers shall immediately report to the chair, in writing, any information which materially alters any of the facts presented in the periodic reports above or which indicates that the group is no longer in compliance with requirements set forth in these rules, particularly those set forth in section 317.6 of this Part.
- (d) Group self-insurers shall promptly file with the chair any amendments or updates to its agreements, contracts, bylaws and any other written documentation which must be submitted in accordance with these rules.
- (e) Group members within the construction classification, as defined in subdivision (2) of section 89 of the Workers' Compensation Law, shall be subject to the information submission requirements provided for under paragraph (6) of subdivision (a) of section 674 of the Tax Law and shall file with the Commissioner of Taxation the information described therein.
- (f) Group self-insurers shall also be required to file such additional reports as may be deemed necessary by the chair.

§317.20 Termination and Dissolution of the Group

The group shall continue for such time as may be necessary to accomplish the purpose for which it was created, and so long as all requirements to maintain authorization as set forth in this Part continue to be met. Upon termination of the group's status as a group self-insurer, the group will continue to administer the workers' compensation liabilities incurred by the group. Upon failure

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on the part of the group to properly administer such liabilities, the chair shall assume the administration and final distribution of the group's assets and liabilities.

§317.21 Revocation of Group Self-Insurer Status

A group which persistently or repeatedly or in any case willfully violates any provision or multiple provisions of this Part, or persistently or willfully fails to comply with any requirement set forth in this Part, may be subject, upon notice and an opportunity to be heard, to revocation of its authorization. In the alternative, the chair may direct the issuance of penalties pursuant to section 317.22 of this Part.

§317.22 Penalties

- (a) A group which violates any provision of this Part, or fails to comply with any requirement set forth in this Part, except failure to timely submit any report required by section 317.19 of this Part, may be subject, upon notice and an opportunity to be heard, to a civil penalty of up to \$2,500 for each violation or instance of non-compliance, payable by the group into the fund created by section 151 of the Workers' Compensation Law.
- (b) A group which fails to timely submit any report required by section 317.19 of this Part may be subject, upon notice and an opportunity to be heard, to a civil penalty of \$500 per day for each day during which it refuses or neglects to submit such report, payable by the group into the fund created by section 151 of the Workers' Compensation Law.

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ATTACHMENT C – PROPOSED RULES AND REGULATIONS

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Attachment C – Proposed Rules and Regulations 2010

§317.1 Statement of Purpose

This Part establishes application procedures, qualifications and responsibilities for any group of employers which desires to become, or which has been approved to operate as, a group self-insurer.

§317.2 Definitions

“Board of trustees” or “trustees” shall mean that body which shall act as the fiduciary for the benefit of the employer members and is ultimately responsible to ensure that the group self-insurer complies with the Workers’ Compensation Law of New York, the rules and regulations adopted thereto by the Chair, the coordination of any and all key agents, ensuring that all compensable claims are paid promptly and ensuring that all necessary precautions are taken to safeguard the assets of the group.

“By-Laws” shall mean the document that provides the specific operating parameters for the group self insurer and governs the policies and procedures to be followed by the group, its trustees and members. The by-laws must address all operational aspects of the group self insurer as specified by the Board.

“Cancellation” shall mean such action taken by a group member to voluntarily remove itself from a group self-insurer.

“Chair” shall mean the Chair of the Workers’ Compensation Board.

“Claim reserves,” “loss reserves,” or “expected claims liabilities” shall mean the liabilities reported by the group self-insurer relating to the value of all outstanding workers’ compensation claims. These liabilities shall include actuarially calculated claims costs including incurred but not reported. All such claims shall be developed to their ultimate value and include loss adjustment expenses and other expenses associated therewith which the group is obliged to pay, settle and adjust. Such claims liabilities shall be determined by a qualified actuary, in accordance with the standards provided in this Part.

“Claims administrator” or “third party administrator” shall mean an individual or entity licensed by the Workers’ Compensation Board pursuant to the Workers’ Compensation Law which is responsible for the administration and defense of workers’ compensation claims of members of an authorized self-insurer.

“Contribution” shall mean the payments made by individual employer members of a group self-insurer to cover its workers’ compensation liabilities and its share of the other costs and assessments necessary to operate the group self-insurer.

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“Declaration of trust” shall mean the document that formally establishes the group self insurer, states its intended purpose and governs the fundamental operating parameters of the group self-insurer. The trustees of the group must operate the trust in accordance with the declaration of trust.

“Excess insurance” shall mean insurance, purchased from an insurance company authorized by the Superintendent of Insurance, which reduces the exposure of the group self-insurer i) for workers’ compensation claims and ii) for employers’ liability. Such excess insurance may be specific, aggregate or other insurance, singly or in combination, in amounts and form acceptable to the Chair.

“Fully funded group self insurer” shall mean a group who maintains acceptable assets as described in this part of at least 100% of its liabilities as described in this part.

“Group administrator” shall mean an individual or entity licensed by the Workers’ Compensation Board pursuant to the Workers’ Compensation Law which is responsible for assisting the group self-insurer in complying with the provisions of the Workers’ Compensation Law and the rules and regulations promulgated thereunder, and for the coordination of services including, but not limited to, claims processing, insurance purchasing, loss control, legal, accounting and actuarial services.

“Group member,” “employer member,” “employer,” or “member” shall mean an individual employer that is participating in, or has participated in, a group self-insurance arrangement in accordance with subdivision (3-a) of section 50 of the Workers’ Compensation Law.

“Group self-insurer,” “employer group,” “group,” “group trust,” “self-insurance trust,” “group self-insured employer,” or “trust” shall mean an association of employers performing related activities in a given industry that contractually agree, in accordance with subdivision (3-a) of section 50 of the Workers’ Compensation Law, to be jointly and severally liable for the workers’ compensation liabilities of each associated member.

“Key Agent” shall mean any person, firm or corporation hired by the board of trustees to perform duties on behalf of the group self insurer. Such key agents include but are not limited to the group administrator, the claims administrator, or entities providing legal, loss control, independent medical examinations, accounting, insurance brokerage, investment management or actuarial services.

“Loss cost rate” shall mean the actuarial determined claims rate at the central estimate. It shall include provisions for loss and loss adjustment expense.

“Loss cost modifier” shall mean the loss rate deviation from the most recent loss costs approved by the superintendent of insurance.

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“Loss cost multiplier” shall mean additional rate charge above loss cost rate for all costs other than loss and loss adjustment expense. The costs reflected by the loss cost multiplier may include but are not limited to excess insurance, general administration, commission, placement fees, taxes, licenses, fees and assessments required by the Workers’ Compensation Law and paid to the Chair

“Marketing materials” shall mean any financial statement, pamphlet, circular, graphic, form letter, sales literature, advertising or other communication, whether written, recorded, electronic or verbal, intended for or directed to current or prospective members of a group self-insurer.

“Participation Agreement” shall mean the document that is signed by both the employer member of the group and the group administrator which establishes the member’s agreement to the responsibilities of being in a group self insurer including, but not limited to, joint and several liability.

“Policy year,” “program year,” “fiscal year,” or “fund year” shall mean the annual program year which period of time commencing at 12:01 a.m. on January 1 and ending at 12:00 a.m. on the following January 1 of each year.

“Qualified actuary” shall mean an individual who i) is an Associate or Fellow of the Casualty Actuarial Society; ii) meets the American Academy of Actuaries’ qualification standards for actuaries issuing statements of actuarial opinion in the United States; and iii) has not been barred by the Workers’ Compensation Board Chair from issuing actuarial opinions related to New York group self-insurers.

“Termination” shall mean i) such action taken by a group self-insurer to remove a group member from participation in the group, or ii) the cessation of a group self-insurer’s status as a self-insurance trust.

“Trust assets” shall mean cash and cash equivalents or investments permitted pursuant to this Part.

“Trust documentation” refers to the collective documents that govern the operation of the trust including the “declaration of trust”, “by-laws”, and “participation agreement”.

“Trust liabilities” shall mean all claims reserves including any applicable risk margin, assessments, accrued expenses including administrative costs, costs of excess insurance policies, and other fixed costs, accounts payable, loans, bonds payable, notes payable, unearned contributions and all other trust obligations pursuant to this Part.

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“Under funded group self insurer” shall mean any group self-insurer who fails to maintain acceptable assets as described in this part of at least 100% of its liabilities as described in this part. For the purposes of determining a group self insurer’s funding status each fund year must be monitored separately and in the aggregate.

“Withdrawal” shall mean such action taken by a group member to remove itself from a group self insurer.

§317.3 General Requirements to Operate as a Group Self-Insurer

(a) Minimum Requirements – To qualify as a group self-insurer and to maintain authorization to operate as a group self-insurer, the following minimum requirements must be satisfied:

1. A group self-insurer must demonstrate the related nature of the group members’ business activities, to the satisfaction of the Chair, as required in this Part.
2. The group must include at least four (4) members with an aggregate net worth of at least \$3,000,000 as evidenced by independently audited financial statements, reviewed financial statements, or copies of the member’s tax returns, or such other proof as the Chair may require, with a period end of not more than twelve (12) months from the date of submission, unless otherwise authorized by the Chair. The net worth of any related or subsidiary companies which are not signatories to the trust document shall not be included in the calculation of aggregate net worth.
3. The annual contributions to the group must exceed \$1,500,000 of which at least \$1,000,000 must be dedicated to paying solely for loss and allocated loss adjustment expense.
4. The group must include no more than five hundred (500) members, unless additional membership is approved in writing by the Chair on application by the group self-insurer. Approval of such application will be conditioned upon a finding that the group is fully funded as required in this Part and that the addition of new members or of additional contributions will not render the group under funded. The Chair may, in approving such application, establish such limits or conditions on future membership as necessary to ensure the solvency of the group. Any group self-insurer whose membership exceeded five hundred (500) members as of June 30, 2008 shall not be required to reduce its membership but shall not increase its membership except by the written approval of the Chair.
5. No more than thirty (30) percent of annual contribution can be attributable to one (1) member.
6. The group must demonstrate that it meets the requirements of this Part to guarantee the payment and administration of all obligations arising under

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the Workers' Compensation Law including but not limited to: sufficient financial strength and liquidity; adequate security deposit, as required; and adequate excess insurance. Failure to meet any or all of the requirements of this Part shall be sufficient grounds to terminate the group's privilege to operate as a self-insurer.

- (b) Failure to Meet Minimum Qualifications to Operate – The trustees and the group administrator shall immediately notify the Chair, in writing, if any event causes the group self-insurer to fail to satisfy the qualification requirements set forth in this section. Within thirty (30) days of this initial notice of the group self-insurer failing to satisfy the qualification requirements, the group board of trustees and the group administrator shall provide to the Chair its plan to bring the group self-insurer into compliance with the minimum requirements to operate as a group self-insurer. If the group self-insurer fails to notify the Chair, to submit a plan which will bring it into compliance, and meet the requirements of the plan submitted, the Chair may revoke the group's privilege to self-insure.

§317.4 Application Requirements for Authorization of New Employer Group

(a) Initial Application - Any group of employers seeking initial authorization to operate as a group self-insurer shall satisfy the minimum qualifications set forth in this Part and shall submit an application to the Chair as prescribed below. An application must be submitted at least one hundred twenty (120) days prior to the requested effective date and shall at a minimum contain:

1. An application for authorization to operate as a group self-insurer on a form prescribed by the Chair.
2. A payroll report for the preceding fiscal period filed by classification code for:
 - a. each participating group member; and
 - b. an aggregate payroll report for the group self-insurer.Such payroll report shall only include amounts paid to workers in New York State who will be covered by the self-insured group.
3. A report identifying the projected rate of contribution and assessments to be paid by each member for the first year of the group's operation, and the manner in which such contributions and assessments were calculated. At a minimum for the first three (3) years of a group's operations, the rates charged must be no less than the loss costs promulgated by the designated workers' compensation rate service organization adjusted for all reasonable expenses and experience modifications as described in this Part. Such report should be supported by an independent actuarial feasibility study directed and certified by an independent qualified actuary

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- and must include the business plan of the group self-insurer including expected rates of growth in the first five (5) years of the group's operation.
4. A description of the safety plan proposed for the employer group including the number of safety visits/audits required for members and the process through which the group will ensure adherence to the safety standards for its members. Such program must also include the process for terminating members who do not meet the standards imposed by the safety plan.
 5. A description of the underwriting standards of the group self-insurer including the homogeneity and experience modification parameters and any other relevant eligibility criteria.
 6. A properly executed application for participation for each employer member including a properly executed participation agreement acknowledging the responsibility of the member under joint and several liability in a form prescribed by the Chair.
 7. All documents governing the operation of the group self-insurer as described in this Part, certified by the group's board of trustees, which shall include but may not be limited to the declaration of trust, bylaws, participation agreement and contractual agreements between the group and the key agents.
 8. A list of the names and addresses of all trustees and properly executed trustee acknowledgement form prescribed by the Chair in accordance with this Part.
 9. A list of the names and addresses of all key agents, including but not limited to group administrator and third party administrator.
 10. An acknowledgement form prescribed by the Chair and properly executed by the group's trustees whereby they, on behalf of the group, acknowledge their commitment to ensure the following but not limited to:
 - a. To pay to or on behalf of all injured employees and to the dependents of deceased employees all compensation and medical benefits as required by the provision of the Workers' Compensation Law.
 - b. To pay annually its proportionate share of the expense of administration or other expenses or assessments as provided by the Workers' Compensation Law.
 - c. To pay any awards commuted pursuant to section 27 of the Workers' Compensation Law into the Aggregate Trust Fund, if required by the Chair.
 - d. To establish and maintain the group trust fund pursuant to this Part.
 - e. To comply with all provisions of this Part including but not limited to those related to minimum funding, reporting, examination of group records, excess insurance, membership, and governing documentation.

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If, upon examination of the application and supporting documentation, the Chair is satisfied as to the ability of the employer group to make payment of all claims and to fulfill all other obligations, authorization to operate as a group self-insurer may be granted subject to the conditions set forth in this Part.

(b) Merger of Two or More Groups – With the approval of the Chair, two (2) or more group self-insurers may merge into one (1) of the constituent groups. Approval will be conditioned upon the Chair's determination that the group self-insurer resulting from the merger of two (2) or more group self-insurers meets all of the requirements of this Part including the limitations on the number of group members. The group self-insurer resulting from the merger shall assume, in full, all liabilities and obligations of the constituent groups.

§317.5 Trustees

(a) Identification of Trustees – Each group self-insurer in its application for self-insurance shall set forth the names and addresses of each of its trustees on a form prescribed by the Chair. Notice of any change in trustees shall be filed with the Chair, on a prescribed form, within ten (10) days thereof. The names and addresses of each of the trustees shall be made available to both the active and inactive employer members of the group self-insurer upon request.

(b) Minimum Trustee Requirements – All trustees must meet the minimum requirements set by the Chair including, but not limited to, the following:

1. All trustees shall be residents of the State of New York or officers or directors of corporations authorized to do business in the State of New York.
2. At least 2/3 of the trustees shall be employees, officers, owners or directors of active or inactive group members.
3. No person who is an employee, officer, owner, director or relative of the group administrator or the claims administrator or any other key agent of the group self-insurer or any person who is an employee, officer, owner, director or relative of a subsidiary, affiliate, or parent company to the group administrator or the claims administrator or any of the key agents may serve as a voting, non voting, or ex-officio member of the board of trustees of a group self-insurer.
4. All trustees must acknowledge their fiduciary responsibility by executing documentation prescribed by the Chair.
5. All trustees will be required to meet with a designee of the Chair to complete an orientation developed and provided by the WCB of his/her responsibilities as a trustee.

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6. All trustees are expected to attend the trustee meetings and any meetings held with the WCB unless sufficient grounds for absence are documented.
7. All trustees must maintain the appropriate level, type, and form of Directors and Officers insurance as prescribed by the Chair.

(c) Trustee Responsibilities – The board of trustees is responsible to ensure that the group self-insurer complies with the Workers' Compensation Laws of New York, the rules and regulations adopted thereto by the Chair, and the coordination of any and all key agents, as well as, the requirements contained in the group declaration of trust, bylaws and participation agreement of the group self-insurer. The group self-insurer's board of trustees shall ensure that all compensable claims are paid promptly and shall take all necessary precautions to safeguard the assets of the group. Trustee responsibilities must include, but not be limited to, the following:

1. All trustees shall act as the fiduciary for the benefit of employer members of the group self-insurer and shall carry out their authority and responsibilities under the declaration of trust and bylaws independent of any authority and responsibilities they may possess or exercise as an employee, officer or director of a member.
2. Maintain oversight responsibility for all monies collected or disbursed by the group self-insurer. Funds not needed for current obligations may be invested by the board of trustees or designee in accordance with this Part.
3. Engage a licensed group administrator to carry out the policies of the board of trustees and provide day-to-day management of the group self-insurer. The board of trustees shall enter a written agreement with the group administrator which shall include, but not be limited to, a description of the duties, responsibilities and compensation to be paid annually to the group administrator for all duties performed. The written agreement shall be subject to the approval of the Chair. The group administrator must possess a current license issued by the Chair as required by this Part.
4. Engage a licensed third party claims administrator to provide the group with the necessary workers' compensation claims handling. The board of trustees shall enter into a written agreement with the claims administrator which shall include, but not be limited to, a description of the duties, responsibilities and compensation to be paid annually to the claims administrator for all duties performed. The written agreement shall be subject to the approval of the Chair. The claims administrator must possess a current license issued by the Chair as required by this Part.
5. Engage an independent, certified public accountant to audit the financial accounts and records of the group immediately after the December 31 close of each fiscal year and prepare the financial reports required by this

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- Part. The board of trustees shall have the sole authority to select and appoint the independent, certified public accountant.
6. Engage an independent, qualified actuary to prepare the actuarial report and accompanying opinion required by this Part and the contribution rate analysis required by this Part. The board of trustees shall have the sole authority to select and appoint the independent, qualified actuary.
 7. The board of trustees is authorized to engage the services of an independent legal counsel to represent and advise the board on legal matters and concerns that may arise.
 8. The board of trustees shall maintain the integrity of the group's investments according to this Part and the declaration of trust and bylaws of the group self-insurer.
 9. The board of trustees shall review and authorize the chair of the board of trustees to sign and submit all the periodic reports made to the WCB on behalf of the group self-insurer.
 10. The board of trustees shall not extend credit to individual group members. This restriction shall not preclude fixed installment plans, not to exceed one (1) year, for the payment of members' contributions.
 11. The board of trustees shall not borrow any monies from the group self-insurer or other parties except in the ordinary course of business and without first advising the Chair in writing of the nature and purpose of the loan and obtaining prior written approval of the Chair.
 12. The board of trustees shall elect, at a minimum, a chair, secretary and treasurer whose responsibilities shall be reflected in the group's declaration of trust and bylaws.
 13. The board of trustees shall hold, at a minimum, four meetings per year, one of which must be held in person. The trustees, at their option may elect to hold the remaining or any additional meetings via telephone or video conference.
 14. There shall be written minutes of all trustee meetings which must be certified by the chair and/or secretary of the board of trustees and a copy of the certified meeting minutes of each meeting of trustees shall be filed annually with the Chair.
 15. The board of trustees shall take the necessary actions to ensure that the group self-insurer complies with the Workers' Compensation Law of New York, the rules and regulations adopted thereto by the Chair, and coordination of any and all service providers, as well as, the requirements contained in the group bylaws, the declaration of trust, and participation agreement of the group self-insurer.
 16. In contracting with the group administrator, third party administrator or other key agents, the trustees shall ensure that no conflict of interest exists between the interests of the group self-insurer and those of the key agents. In the event that fiscal authority is contracted to any key agent, the trustees

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shall ensure that adequate division of responsibility exists and that satisfactory internal fiscal controls are established and documented to safeguard the fund's assets. Such documentation will be subject to inspection by the Chair.

17. The board of trustees shall at least annually hold a membership meeting to which all group members and the Chair or his/her designee are invited to attend with at least sixty (60) days advance written notice of the meeting to all current members. At this annual membership meeting, the group administrator shall present a summary of the administrator's annual written report to all members; the board of trustees shall provide a financial summary of the group's financial condition and summarize the trust assets available to pay claims; and the claims administrator shall summarize the claims liabilities of the group self-insurer.
18. The board of trustees will vote on the admission of new members into the group and ensure that new members are admitted in accordance with the group's governing documents, underwriting standards and homogeneity requirements. The board of trustees is prohibited from delegating the authority to add new members to the group to any of its key agents.

(d) Standard of Care for Trustees – All trustees must discharge his or her duties with the standard of care described herein:

1. Each member of the board of trustees shall discharge his or her duties with the ordinary care under the circumstances then prevailing that a prudent person in a like capacity and familiar with such matters would use. Each trustee, by accepting his or her appointment, acknowledges the responsibility of the trustee to the group self-insurer and its beneficiaries in the administration of the group self-insurer, and the obligation of the trustee to administer the group self-insurer in accordance with applicable law, including but not limited to regulations set forth in this Part, or successor rules or regulations thereto.
2. A trustee who has voting status and who is present at a meeting of the board of trustees when action is taken shall be presumed to have concurred in the action unless his or her dissent thereto shall be entered in the minutes of the meeting, or unless he or she shall submit written dissent to the person acting as the chair of the board of trustees. Such right to dissent shall not apply to a trustee who voted in favor of such action.
3. A trustee shall be accountable according to the duty of care prescribed in the group self-insurer's governing documents for all acts or omissions of the group self-insurer during the tenure of his or her term of office and, similarly, a trustee shall not be accountable for any acts or omissions of the group self-insurer before or after the tenure of his or her term of office.

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(e) Number and Terms of Trustees – The group must establish a minimum and maximum number of trustees and detail the number of meetings to be held annually pursuant to its trust document and approved by the Chair. The group self-insurer is required to maintain the minimum number of trustees as provided in the group's declaration of trust and bylaws. However, at no time can the number of trustees be less than three (3). Failure to maintain the minimum number of trustees may subject the group to termination of its self-insured status. Trustees must be elected by the membership in accordance with the group's declaration of trust and bylaws. The group must stagger trustee terms, provide definitive renewable terms for all trustees, and establish a process for filling trustee vacancies pursuant to its declaration of trust and bylaws. Vacancies on the board of trustees must be filled in accordance with the group self-insurer's governing documents or within six (6) months, whichever is sooner.

(f) Trustee Compensation – Trustees shall be entitled to receive compensation for any reasonable expenses incurred while discharging their official duties as trustees of the group trust if authorized by the trust document and approved by the board of trustees and to the extent considered ordinary and reasonable for the undertaking of their duties. Any additional considerations for compensation should be governed pursuant to the group's bylaws in accordance with this Part.

§317.6 Key Agents

(a) Group Administrator - Each group self-insurer shall have secured the services of a licensed group administrator to be responsible for assisting the group self-insurer in complying with the provisions of the Workers' Compensation Law and the rules and regulations promulgated thereunder, and for coordinating services, including but not limited to general administration and management of the group's affairs, determination and collection of annual contributions and deficit assessments, loss control, independent medical examinations, claims processing, legal, accounting and bookkeeping services. Nothing in this section shall relieve the trustees from any fiduciary obligation they hold to the other members of such group self-insurer.

1. Identification of Group Administrator –Each group self-insurer in its application for self-insurance shall set forth the name and address of its group administrator on a form prescribed by the Chair. Notice of any change in the group administrator shall be filed with the Chair, on a prescribed form, at least thirty (30) days prior to the proposed effective date of the proposed change in the group administrator, or may accompany the agreement with the new administrator submitted to the Chair as required in paragraph two (2) of this subdivision.

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2. Contractual Agreements – Each group self-insurer shall submit to the Chair copies of any agreement or contract with an entity that serves or will serve as its group administrator at least thirty (30) days prior to becoming effective, and the effectiveness of such contract shall be conditioned on the absence of an objection by the WCB during the thirty (30) day period. Contracts that shall be subject to such objection shall include any contract in violation of regulation or policy promulgated by the WCB, and any contract that does not provide reasonable cancellation or renewal terms, including any contract that requires an affirmative act by the trustees of the group self-insurer to prevent automatic renewal, or that does not permit cancellation for negligence, violation of law, contains terms in excess of five (5) years, or other good cause. If such agreement or contract is submitted to the WCB it shall be deemed to have been approved unless it has been objected to by the WCB within the thirty (30) day period discussed above. Nothing herein shall waive any applicable provision of the Workers' Compensation Law and the rules and regulations promulgated thereunder and any person or entity's responsibilities for compliance with any applicable laws, rules and regulations. The submission of such contract or agreement to the WCB by the group self-insurer and group administrator shall include a certification that such contract or agreement complies with all applicable laws, rules and regulations.

No such agreement or contract shall be submitted to the WCB by the group self-insurer unless the group administrator with whom the agreement or contract is with has any and all required licenses to perform the services contemplated by the agreement or contract and by submitting such agreement or contract to the WCB for review, the group self-insurer and group administrator will be deemed to have certified that all required licenses are in effect. In addition, in order to meet the requirements of this section, the contractual agreement shall be accompanied by a compensation disclosure which includes: (1) a restatement of the current contractual agreement language between the group self-insurer and the group administrator; (2) an indication of the total amount of compensation received by the group administrator from the group during the fund year and the dates of such fund year period; (3) a breakdown of the total amount by each provision of the compensation agreements; and (4) if the group administrator provides services in addition to those as a group administrator, lists of such other services, including but not limited to claims administration and insurance brokerage, and the corresponding compensation received by the administrator for such services.

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- (b) Third Party Administrator - Each group self-insurer shall have secured the services of a licensed third party administrator to be responsible for claims processing and payment, excess insurance reporting and collection, legal and medical service payments. Nothing in this section shall relieve the trustees from any fiduciary obligation they hold to the other members of such group self-insurer.
1. Identification of Third Party Administrator –Each group self-insurer in its application for self-insurance shall set forth the name and address of its third party administrator on a form prescribed by the Chair. Notice of any change in the third party administrator shall be filed with the Chair, on a prescribed form, within thirty (30) days prior to the proposed effective date of the change in claims administrator or may accompany the agreement with the new third party administrator submitted to the Chair as required in paragraph two (2) of this subdivision.
 2. Contractual Agreements – Each group self-insurer shall submit to the Chair copies of any agreement or contract with an entity that serves or will serve as its third party administrator at least thirty (30) days prior to becoming effective, and the effectiveness of such contract shall be conditioned on the absence of an objection by the WCB during the thirty (30) day period. Contracts that shall be subject to such objection shall include any contract in violation of regulation or policy promulgated by the WCB, including any contract with terms in excess of five (5) years, and any contract that does not provide reasonable cancellation or renewal terms, including any contract that requires an affirmative act by the trustees of the group self-insurer to prevent automatic renewal, or that does not permit cancellation for negligence, violation of law, or other good cause. If such agreement or contract is submitted to the WCB, it shall be deemed to have been approved unless it has been objected to by the WCB within the thirty (30) day period discussed above. Nothing herein shall waive any applicable provision of the Workers' Compensation Law and the rules and regulations promulgated thereunder and any person or entity's responsibilities for compliance with any applicable laws, rules and regulations. The submission of such contract or agreement to the WCB by the group self-insurer and the third party administrator shall include a certification that such contract or agreement complies with all applicable laws, rules and regulations.

No such agreement or contract shall be submitted to the WCB by the group self-insurer unless the third party administrator with whom the agreement or contract is with has any and all required licenses to perform the services contemplated by the agreement or contract, and by submitting such agreement or contract to the WCB for review, the group self-insurer

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and third party administrator will be deemed to have certified that all required licenses are in effect.

- (c) Other Key Agents - Each group self-insurer shall have secured the services of key agents, as necessary, qualified in complying with the provisions of the Workers' Compensation Law and the rules and regulations promulgated thereunder, including, but not limited to legal, loss control, independent medical examinations, accounting, insurance brokerage, investment management, and actuarial services. Nothing in this section shall relieve the trustees from any fiduciary obligation they hold to the other members of such group self-insurer.
1. Identification of Key Agents –Each group self-insurer in its application for self-insurance shall set forth the name and address of its key agents on a form prescribed by the Chair. Notice of any change in the key agents shall be filed with the Chair, on a prescribed form, within thirty (30) days prior to the proposed effective date of the change in the key agents or may accompany the agreement with the new key agent submitted to the Chair as required in paragraph two (2) of this subdivision.
 2. Agreements – Each group self-insurer shall submit to the Chair copies of any agreement, contract or engagement letter with an entity that serves or will serve as a key agent of the group self-insurer at least thirty (30) days prior to becoming effective, and the effectiveness of such agreement, contract or engagement letter shall be conditioned on the absence of an objection by the WCB during the thirty (30) day period. Agreements that shall be subject to such objection shall include any agreement that does not provide reasonable cancellation or renewal terms, including any agreement that requires an affirmative act by the trustees of the group self-insurer to prevent automatic renewal, or that does not permit cancellation for negligence, violation of law, or other good cause, contains terms in excess of five (5) years and any other agreement in violation of law or regulation. No such agreement shall be submitted to the WCB by the group self-insurer unless the key agent with whom the agreement is with has any and all required licenses to perform the services contemplated by the agreement. If such agreement is submitted to the WCB it shall be deemed to have been approved unless it has been objected to by the WCB within the thirty (30) day period discussed above. Nothing herein shall waive any applicable provision of the Workers' Compensation Law and the rules and regulations promulgated thereunder and any person or entity's responsibilities for compliance with any applicable laws, rules and regulations. The submission of such agreement to the WCB by the group self-insurer and any other key agent shall include a certification that such agreement complies with all applicable laws, rules and regulations.

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3. The group self-insurer must disclose all related party relationships or affiliations of and between all of its key agents to the WCB. Such disclosure must be included with the group self-insurer's annual financial reporting requirements outlined in Section 317.20.
4. Licensing Requirements – No person, firm or corporation shall carry out the tasks of a key agent on behalf of a group self-insurer unless such person holds a license for the specific duties or responsibilities to be performed that require such a license. Proof of such license shall be filed with the Chair upon request.

§317.7 Conflicts of Interest

Any key agent shall be considered to have a possible conflict of interest if (1) the key agent has an existing or potential financial or other interest which impairs or appears to impair his/her ability to exercise independent and unbiased judgment in the discharge of his/her responsibilities to the group trust; (2) such key agent is aware that a member of his/her family, or any organization in which such key agent's family member is an officer, director, employee, member, partner, trustee or controlling stockholder has an existing or potential financial or other interest which impairs or appears to impair the key agent's ability to exercise independent judgment in the discharge of his/her duties to the group trust; or (3) the key agent receives a financial or other material benefit through inappropriate use of knowledge or information confidential to the group trust.

- (a) Any company that serves as a key agent of a group self-insurer, including the group administrator, claims administrator, insurance broker, any company conducting independent medical examinations, actuary or certified public accountant, is prohibited from serving as any other key agent and from having a direct or indirect management or financial interest in any other key agent of the group for same group self-insurer.
- (b) Any owner, officer, director or employee of a company that serves as a key agent of a group self-insurer, including the group administrator, claims administrator, insurance broker, any company conducting independent medical examinations, actuary or certified public accountant is prohibited from serving as an officer, director or employee of any other key agent of the group.
- (c) Any employer member, including any of its employees, officers, or directors, is prohibited from serving in any key agent capacity of the group self-insurer of which it is a current or former member.
- (d) No officer or director of, or person holding five (5) percent or more ownership interest in a group administrator shall within two (2) years of serving in such capacity or holding such ownership interest, serve in any capacity or hold any ownership interest in a workers' compensation carrier that provides or solicits

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the provision of compensation under this title for any employer that is or was a member of such group self-insurer.

- (e) No officer or director of, or person holding five (5) percent or more ownership interest in a group administrator shall, within two (2) years serve in such capacity or hold such ownership interest in a carrier that provides or solicits excess coverage for any group self-insurer administered by such administrator.

§317.8 Governing Documents

The administration of a group self-insurer shall, in addition to the Workers' Compensation Law and the rules and regulations enacted pursuant thereto, be governed by a declaration of trust, the bylaws and the participation agreement executed by each participating member. In addition to the declaration of trust, bylaws and participation agreement, any and all agreements, contracts and other pertinent documents relating to the organization of the members in the group self-insurer shall be filed with the Chair. No other documents, unless approved and filed with the Chair will govern the operations of the group self-insurer.

(a) Declaration of Trust and Bylaws – The declaration of trust and bylaws govern the operations of the group self-insurer and must contain language prescribed by the Chair and be in a form approved by the Chair. The declaration of trust and bylaws must be shared with all members of the group self-insurer and must include, at a minimum, the following:

1. Declaration and purpose of group self-insured trust to include duration and termination of trust, definitions, fund year, jurisdiction, governing documents, agreement and undertaking.
2. Trustees to include responsibilities, number of, election, terms, voting, requirements for quorum, meetings, vacancies (resignation/removal) and compensation.
3. Participating members to include joint & several liability, homogeneity, contributions, payroll audits, disputes, terms of participation, procedures for adding or terminating members, rights and responsibilities of members, withdrawal or termination of membership, underwriting considerations, member meetings, member voting, disclosure of group self-insurer's books, reports to members, and procedures for amending governing documents and related opt-out periods.
4. Professional services to include group administration, accounting, claims administration, insurance brokerage, independent accountant, actuary, and legal and investment advisor.

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5. Fiscal matters to include excess insurance, errors & omissions/fidelity coverage, integrity of group self-insurer's trust fund, regulatory funding, contribution rates, deficit assessments, investment standards, declaration and payment of dividends and prohibited transactions.
6. Group records and reporting to include reports to members, reports to the WCB and marketing.

(b) Participation Agreement – Each group self-insurer must establish a participation agreement with language prescribed by the Chair and in a form approved by the Chair. Each prospective member must properly execute a participation agreement for the group which acknowledges that the member:

1. Agrees to assume and discharge, jointly and severally, any liability of the group self-insurer incurred during their period of membership.
2. Understands its responsibility under joint and several liability including, but not limited to, the requirement to properly fund the trust and pay contributions and assessments as required, including those for unpaid claims or any other liability of the group incurred during its period of membership.
3. Understands that, by joining a group, it has not purchased an insurance policy, but is participating in group self-insurance and, as such, it shall not be relieved from any liability for workers' compensation for its individual claims incurred during its period of membership in the group unless payment is made by the group self-insurer. The member must also acknowledge that it understands that joining the group does not provide for a guaranteed cost program
4. Has received a copy of the group's declaration of trust and bylaws and agrees to all the provisions set forth therein.
5. All existing and new group members must execute and submit to the Board a prescribed participation agreement which acknowledges its responsibilities in the group outlined in this section.

(c) Amendments to Governing Documents – The trustees shall amend the declaration of trust, the bylaws, the participation agreement, and other governing documents to comply with the laws of the State of New York, the Rules and Regulations of the Chair as adopted or amended hereafter in a manner outlined in such documents. Any such amendments must be filed with the Chair at least thirty (30) days prior to becoming effective and the effectiveness of such amendment shall be conditioned on the absence of any objection by the WCB during the thirty (30) day period. Any such amendments must be submitted for consideration by the Chair in a prescribed format. Any such amendments must be sent to the participating trust members upon WCB approval of the amendment at which time any member must be given the opportunity to withdraw its membership in the trust without penalty as of the date the amendment becomes effective.

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(d) Compliance – Any group self-insurer whose documentation does not comply with the standards set forth in this section and/or whose documents have not been filed with the WCB as required herein shall immediately submit to the WCB a plan which ensures compliance by January 1, 2010. Failure to submit documentation as described herein shall be cause for termination of the group self-insurer's privilege to self-insure.

§317.9 Homogeneity

A group self-insurer shall demonstrate and maintain the related nature of the group members' business activities, to the satisfaction of the Chair. The primary factor used by the Chair when making a determination regarding homogeneity will be the qualifying payroll of the group members. Upon submission of a member's application to the group, the WCB will determine a member is homogeneous if more than eighty (80) percent of the member's payroll is in one (1) or more of the payroll classifications determined, by the WCB, as qualified for a particular industry and further specified in the group self-insurer's governing documents. For the purposes of determining homogeneity, payroll associated with the standard exception codes, as determined by the WCB, will be excluded from the calculation of qualifying payroll of a member.

The following definitions shall apply for purposes of determining homogeneity:

- a) "Qualifying payroll" shall be defined as the total payroll of a group which contains the acceptable payroll classes for a group as determined by the WCB as acceptable in a group for a particular industry. The list of qualifying payroll class codes may be amended by the WCB.
- b) "Standard exception codes" shall be defined as those payroll class codes which are excluded from the calculation of qualifying payroll as determined by the WCB.
- c) "Acceptable payroll classification code" is that, which has been determined by the WCB, allowable for a group to utilize in defining its homogeneity standard.

The following will govern the application of the homogeneity standard by the WCB:

- (a) List of Acceptable Payroll Classification Codes – The Chair will establish and maintain a list of acceptable payroll classification codes for each of the major industries for which group self-insurance trusts exist. The Chair may amend the list of acceptable codes for an industry or provide for additional industries, as necessary, at its sole discretion. New groups in organization may request the Chair to establish payroll classifications for the industry to be served by the new group self-insurer if no such payroll classification exists.

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(b) Group Self-Insurer's Standard of Homogeneity – Each group self-insurer must establish its homogeneity standard based upon its particular industry and the corresponding list of acceptable payroll classification codes established by the WCB. Each group self-insurer's governing documents must identify the industry and corresponding payroll classification codes that define the group's homogeneity. A group's standard of homogeneity must be filed with and approved by the Chair. The Chair will review the group's proposed homogeneity to ensure it complies with the rules established herewith, the group's governing documents and includes a reasonable number of payroll class codes. The Chair reserves the right to limit the number of payroll class codes that a group may use if it so determines that the group's homogeneity standard is not consistent with the group's intended purpose.

(c) Amendment of Acceptable Payroll Classification Codes – The trustees of a group self-insurer may amend the qualifying codes for the group self-insurer as provided for in the governing documents of the group self-insurer. Any such amendments must be submitted to the Chair sixty (60) days prior to the effective date and will be effective upon the Chair's written approval. Such amendments can only be made once annually in conjunction with the renewal of the group members' participation. Current group members must be notified of any such change and given the opportunity to cancel their participation from the group self-insurer prior to the effective date of the amended codes without penalty. Any member who cancels coverage must provide the group with the notification required in this Part. Notice of such cancellation shall also be provided to the Chair by the group in accordance with this Part.

(d) Annual Verification of Group's Homogeneity – The Board will review the group's payroll by classification code and by member annually in conjunction with the group's reporting requirements as outlined in this Part. Following the review, any member whose payroll does not conform to the established homogeneity standard must be terminated prior to the group's next renewal date. Notice of termination of participation shall be filed in the office of the Chair or sent by certified or registered letter, return receipt requested, and also served in like manner upon the member.

(e) Common Ownership – In addition to the methods for determining homogeneity described above, commonly owned businesses of participating members may also be considered for membership provided: (1) the group self-insurer's governing documents do not otherwise limit or prohibit such participation; (2) the majority owner(s) of the applicants and of the active member are the same party; (3) that no more than twenty (20) percent of the combined annual payroll of the applicant and the active member fails to meet the homogeneity standard of the group self-insurer. Failure to continue to meet the homogeneity and ownership standards described herein will be cause for termination of the employer members and notice of termination of participation shall then be filed in the office of the Chair or sent by certified or registered letter, return receipt requested, and also served in like manner upon the members. Employers admitted under the common

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ownership provision will not be considered for the purposes of determining the number of employer members of the group.

(f) Other Information – The Chair may require the group self-insurer to furnish other information in order to demonstrate the related nature of the group members' business activities particularly if the group limits its membership factors other than the industry covered, such as a geographic area. Factors which may be considered, by the Chair, when establishing homogeneity standards include, but are not limited to, the amount of payroll covered by each employer member and the length of time each employer has been in business or the classification code of each employer.

§317.10 Member Responsibilities

Every member of a group self-insurer must comply with all responsibilities outlined in the group's governing documents. Members shall provide the group administrator with accurate contact information during their period of active participation as a member of the group and after their participation in the group ends. Provision of this accurate contact information shall be the responsibility of the member. Such contact information shall include, but not be limited to, their legal name and all other names used, legal status and their mailing address for the receipt of all correspondence, including, but not limited to, billing, collections and other related documents. Members shall not cancel their prior workers' compensation coverage until their participation in the group self-insurer has been approved and coverage becomes effective.

(a) Liability of Member for Compensation

1. Each member of a group self-insurer shall be responsible, jointly and severally, for all liabilities of the group self-insurer provided for by the Workers' Compensation Law and the rules and regulations enacted pursuant thereto occurring during its respective period of membership, and such liability shall attach to any recipient of a conveyance of assets made in violation of section 273 of the debtor and creditor law.
2. A member's participation in a group self-insurer shall not relieve it of its liability for compensation prescribed by the Workers' Compensation Law and the rules and regulations enacted pursuant thereto except by the payment thereof by the group self-insurer or by itself.

(b) Liability of Group Self-Insurer for Compensation of Members' Employees

1. As between the employee and the group self-insurer, notice to or knowledge of the occurrence of the injury on the part of the member shall be deemed notice or knowledge, as applicable, on the part of the group self-insurer.

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2. A group self-insurer shall in all things be bound by and subject to the orders, findings, decisions or awards rendered against the participating member for the payment of compensation under the Workers' Compensation Law and the rules and regulations enacted pursuant thereto.
3. The insolvency or bankruptcy of a participating member shall not relieve the group self-insurer from the payment of compensation for injuries or death sustained by an employee during the time the member was a participant in such group self-insurance.
4. Termination of a participating member shall not relieve the group self-insurer from the payment of compensation for injuries or death sustained by an employee during the time the member was a participant in such group self-insurer.

(c) Changes in Legal Status of Group Members – Any member which undergoes any changes in its legal status including those that result in the issuance of a new taxpayer identification number shall be required to complete a new member application and prescribed participation agreement wherein the member acknowledges their joint and several obligation for their period of membership. A group self-insurer shall, within ten (10) days, notify the Chair in writing of any such change and shall, at that time, file the new application and participation agreement. Failure to do so may result in a rejection of the new application and penalties for noncompliance.

(d) Penalties Against Members for Noncompliance – If at any time a member of a group self-insurer intentionally or materially understates or conceals payroll, or intentionally and materially misrepresents or conceals employee duties or if the employer intentionally or materially misstates payroll or claims information for the purposes of determining employer contributions, such employer shall be deemed to have failed to secure compensation and shall be subject to sanctions applicable under section 52 of the Workers' Compensation Law in addition to any other sanctions available under the law.

§317.11 Membership

(a) Addition of New Member to Group Self-Insurer – Group self insurers must notify the Chair of a new group self-insurer member. Such notification shall be submitted on a prescribed notice of application and acknowledgement for participation in a group self-insurer and/or member application form.

The notice of application must be submitted for a prospective member to reserve the group's right to add such member at least twenty (20) days prior to binding coverage for that member. The notice of application also includes the member's acknowledgement of its rights and responsibilities to the group including joint and several liability. The notice of application will be valid for sixty (60) days from the date it was received by the Board.

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If a member chooses to bind coverage within the sixty (60) day timeframe, he/she must properly execute the member application and prescribed member participation agreement.

(b) **Involuntary Termination of Member from Group Self-Insurer**

1. Notice of termination of a participating member for any reason by the group self-insurer shall not be effective until at least ten (10) days after notice of such termination, on a prescribed form, has been served (a) by presentation in the office of the Chair or mailed by certified or registered letter, return receipt requested, and (b) also served in like manner upon the member being terminated.
2. Notice of termination of a participating member, for any reason, other than non-payment of contributions by the group self-insurer shall not be effective until at least 30 (thirty) days after the notice of such termination, on a prescribed form, has been served.
3. A group self-insurer may rescind the involuntary termination of a member within thirty (30) days of the date of termination on a form prescribed by the Chair.
4. A member's termination by the group self-insurer shall not be rescinded by the group self-insurer more than three (3) times.
5. Any employer whose membership in a group self-insurer is terminated after a period of membership of less than four (4) years in such group self-insurer shall be precluded from obtaining prospective coverage from any group self-insurer for a period of at least three (3) years from the effective date of termination.

(c) **Cancellation of Member from Group Self-Insurer** – Any employer member participating in a group self-insurer shall not be eligible to cancel such membership from the group self-insurer and fulfill its workers' compensation obligations through alternative coverage until it shall have provided the current group self-insurer with at least forty-five (45) days notice of its intent to terminate participation.

(d) **Member Information** – The group administrator shall maintain current records on the contact information and current address of all group members including those which have been terminated or which have cancelled their participation in the group. Such contact information shall include, but not be limited to, their legal name and all other names used, legal status and their mailing address for the receipt of all correspondence from the State, including, but not limited to, billings, collections and other related documents.

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§317.12 Contribution Year Funding

A group self-insurer must maintain a dedicated trust fund that meets the funding requirements outlined in this Part. The integrity of the trust fund must be achieved, foremost, by the collection of adequate member contributions for each fund year. The contribution rates utilized by a group self-insurer shall not be inadequate, unfairly discriminatory, destructive of competition or detrimental to the solvency of the group self-insurer.

The overall annual contributions collected from all members in a fund year must support the expected claims liability and all other related expenses of the group applicable to the contribution fund year including the WCB's assessments. The group self-insurer shall continue to monitor the adequacy of the rates charged and the overall expenses for each fund year as the claims continue to develop. Any deficiencies noted in the rates charged for a given year should be allocated back to the employer members who participated in the group self-insurer for that fiscal year.

Interest income shall be apportioned to each contribution year based on a methodology established by the board of trustees. Such methodology shall be reviewed by the independent accountant and actuary to determine if discounting of rates and reserves is appropriate.

(a) **Fund Year** – Every group self-insurer must have a fund year that runs from January 1 through December 31. Group self-insurers that do not have a fund year that coincides with the calendar year as of the effective date of this Part must submit to the Chair a plan to convert their fund year and policy year to a calendar year basis as soon as practicable, but no later than January 1, 2011.

(b) **Rate Plan** – Group self-insurers must file a rating plan with the WCB, as soon as practicable but no later than sixty (60) days prior to the start of the fund year. Such rating plan shall become effective if deemed to be reasonable to the WCB. Such rating plan must be in a form prescribed by the Chair, and must be supported by an actuarial rate study prepared by an independent, qualified actuary as defined in this Part. The rate study must clearly identify the actuary's indicated loss cost rate, the loss cost multiplier and any other components as required in a form prescribed by the Chair. Assumptions must include all operational and administrative expenses, WCB assessments, applicable risk margins, and any deviations from the rating board's loss costs,. The rates may reflect the time value of money related to projected cash flows. The rate plan submitted by the group self-insurer must include a breakdown of the various rate components, including but not limited to:

1. Group loss costs (i.e., pure premium rate) in aggregate and by payroll classification at the expected level determined by the actuary.

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2. Additional costs for:
 - a. a risk margin prescribed by the Chair;
 - b. excess insurance;
 - c. general administration;
 - d. claims administration;
 - e. commissions, placement fees and related acquisition expenses;
 - f. taxes, licenses, fees and WCB assessments;
 - g. assessments to members related to deficits, if applicable.
3. Deviation percentage from a workers' compensation rate service organization by payroll classification code.

The rating plan must apply consistently to all members, and must provide for a common renewal date for all group self-insurer members. The rates filed can be adjusted based on an experience modification factor calculated for every member in accordance with the experience rating plan promulgated by a workers' compensation rate service organization or other entity designated by the Chair. Experience modification formulas must be applied consistently to all members and no losses or payroll should be judgmentally excluded. Additional rate adjustments based on safety must be supported by the rate plan and are subject to the approval of the Chair. No limitations, retention plans or caps shall be applied to the payroll of an employer member when establishing contribution rates other than those specifically authorized by the rating agency as part of the experience modification calculation.

Such rate plan will be reviewed by the Chair for the purposes of determining the adequacy of the contributions as well as the consistency and rationality of the contribution calculations. The Chair will notify the group if at any time it is determined that the rates are not actuarially supported or detrimental to the solvency of the group self insurer.

Alternatively, as deemed appropriate, the Chair may designate a workers' compensation rate service organization or other entity to calculate rating factors on behalf of a group self-insurer at the group self-insurer's expense. Rating factors may include, but are limited to, loss cost rates and experience modification factors. If the Chair designates a workers' compensation rate service organization or other entity to calculate rating factors on behalf of a group self-insurer, then the group self-insurer shall submit to the designated rate service organization or other entity any information necessary for the designated rate service organization or other entity to calculate the rating factors.

Group self-insurers shall be required to demonstrate that the rates charged and collected from employer members are consistent with those filed in the rate plan.

(c) Operating Results - The group self-insurer shall continue to report to the Chair, on a prescribed form, the operating results of each fund year including updated paid and

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incurred loss projections as well as incurred but not reported claims and all associated claim administration expenses. Any surpluses identified in the contributions collected for a given fund year may be distributed back to the employer members who participated in the group self-insurer for the fund year for which the surplus has been identified. However, such distributions must meet the requirements outlined in the group's governing documents and in this Part. Any fund year deficits must be billed back and collected from the employer members who participated in the group self-insurer for the fund year for which the deficit has been identified. Any deficits identified for any fiscal years prior to January 1, 2009, must be billed and collected no later than January 1, 2014. Deficits that exist for fiscal years after January 1, 2009, must be billed and collected as soon as practicable, but no later than December 31 of the fiscal year following the fiscal year in which the deficit occurred or no later than December 31 of the fiscal year following the fiscal year in which the deficit was identified, whichever is sooner. The surpluses in a given year shall not be used to offset any deficits identified for other plan years except as provided in this part.

(d) Payment of Contributions – The rates charged an employer member must be reported to the Chair, on a form prescribed by the Chair, upon acceptance of an employer member into a group self-insurer, and annually thereafter for every year that member maintains membership in the group self-insurer. Group self-insurers must collect from members amounts adequate to support the expected claims liabilities plus a risk margin as prescribed by the Chair and all other related expenses of the group for the entire fund year including the WCB's assessments. Contributions must be collected from the members on a schedule that assures that full annual contributions are collected no less than sixty (60) days prior to the end of the fiscal year. Nothing in this section shall prohibit the offering of payment plans to members provided that all contributions are fully collected within the timeframes described herein.

(e) Credits to Contributions - An employer member of a group self-insurer shall be eligible for a credit against their contributions if such credit is authorized by the Chair and in accordance with limitations set by the Chair, if such employer has implemented one or more of the following programs that comply with all of the requirements set forth by regulations promulgated by the Commissioner of Labor: (1) a Safety Incentive program; (2) a Drug Alcohol Prevention Program; and (3) a Return to Work Program.

An employer member of a group self-insurer must apply to the Department of Labor for such credit by June 30th. Such credit must also be identified and contemplated as part of the group's rating plan prepared by the independent actuary.

(f) Inadequate Rates – Rates charged and collected from every employer member may be subject to an independent review, as per this Part, at the sole discretion of the Chair. The group self-insurer shall annually submit a report identifying the contributions paid by each of the members for the preceding fiscal year, the projected contributions for each group self-insurer member for the current fiscal year, the manner in which such

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contributions were calculated, or any other information deemed necessary to establish the adequacy of the group self-insurer's rates. Such report shall be closely reviewed by the Chair for purposes of determining the adequacy of contributions as well as the consistency and rationality of the contributions calculations. If, after review by the Chair, the group self-insurer's contribution rates are deemed to be inadequate, unfairly discriminatory, destructive of competition and/or detrimental to the solvency of the group self-insurer, the Chair may mandate that the group self-insurer modify such rates as the Chair directs. Rates will be considered inadequate if they are insufficient, together with the investment income attributable to them, to sustain loss reserves and expenses in the class of business to which they apply.

(g) Penalties – In addition to any other remedy available the group self-insurer's failure to adhere to the rating structure filed with the WCB shall also constitute good cause for termination of the group status as a self-insurer.

§317.13 Funding Requirements

Group self-insurers must maintain a regulatory funding position with acceptable assets, as described in this Part, of at least one hundred (100) percent of its total liabilities, as described in this Part, including the claims reserve presented in the actuarial opinion on unpaid claims estimates with a twenty percent (20) risk margin prescribed by the Chair, and all other liabilities as described in this Part submitted by the group self-insurer. For the purposes of determining a group self insurer's regulatory funding position, each fund year must be monitored separately and in the aggregate.

Group self-insurers who fail to comply with this regulatory funding position standard for specific fund years and/or in the aggregate shall be deemed under funded and shall be subject to any or all of the provisions set forth in this Part. The regulatory funding requirements must be achieved, foremost, by the collection of adequate member contributions.

§317.14 Group Self-Insurer Assets

(a) Integrity of Group Self-Insurer Assets – Every effort shall be made by the group self-insurer, its trustees, its group administrator, the claims administrator, or other key agent(s) to preserve the integrity, strength and liquidity of the group self-insurer's assets so as to permit the timely and complete payment of all group claims and other liabilities.

The group self-insurer, its trustees, group administrator, claims administrator, or other key agent(s) shall not utilize any of the assets of the group collected from group members or earned by the group self-insurer for any purpose not directly related to the payment of claims, security deposits, assessments, penalties, reasonable costs of operation, fixed

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costs such as excess insurance, the payment of earnings or refunds to group members, or other trust obligations.

The group self-insurer, its trustees, its group administrator, claims administrator, or other key agent(s) shall not borrow money from the trust fund or in the name of the trust and shall not permit any lending, issuance of debt instruments or other forms of obligations and encumbrances, nor shall the group self-insurer, its trustees, its group administrator, claims administrator, or other key agent(s) extend credit to a member for the payment of contributions or assessments. This restriction shall not preclude the group self-insurer from permitting fixed installment plans, provided that such payment plans ensure the collections of contributions in accordance with this Part.

The trust assets of the group self-insurer shall not be commingled with the assets of any member, nor shall the funds dedicated to the payment and administration of claims, assessments, and other costs arising under the Workers' Compensation Law, or to employer liability costs, be commingled with any other funds, such as those dedicated to pension and health benefits. Funds of the group trust shall not be commingled with the funds or assets of any group member or any other group self-insurer, nor shall funds of the group trust be commingled with funds or assets of the group administrator, third party claims administrator, or any other key agent, vendor or service provider.

When measuring a group self-insurer's assets for purposes of determining its regulatory funding position, only the assets described below will be admitted including cash and cash equivalents; certain accounts receivable; excess insurance receivable; excess insurance recoverable; certain investments; and prepaid excess insurance and excess insurance costs. All other assets will be nonadmitted. The determination of assets which are admitted will be made at the sole discretion of the Chair.

(b) Cash and Cash Equivalents – Cash is defined as deposits and savings accounts in financial institutions limited to those with offices or branches of the financial institutions located in the State of New York. Should the amount deposited in any single account exceed the federally insured amount for any one (1) account, the financial institution shall also meet the credit rating requirements of "A" or higher (or the equivalent thereto) by a list of the nationally recognized statistical ratings organization and recognized by the SEC.

Cash equivalents are short-term, highly liquid investments that are readily convertible to cash and investments with original maturities of three (3) months or less. Nonadmitted cash and cash equivalents are any amounts that are in any manner restricted or utilized as collateral.

(c) Interest Receivable – Interest due to the group self insurer presented on the year end financial statements will be admitted.

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(d) Special Fund Reimbursement – Any special fund reimbursements due to the group from the Workers' Compensation Board will be admitted, provided the group is able to provide sufficient documentation that the claims are qualified for such reimbursements.

(e) Excess Insurance Receivable – Excess insurance receivables representing amounts due from excess carriers for payments made by the group trust in excess of the self-insured retention associated with such excess carrier's policies shall be deemed admitted assets if the underlying carriers maintain minimum financial ratings determined by the Chair and the carrier provides verification of acceptance of the claim on a form prescribed by the Chair, and the amount due from the carrier is less than six (6) months overdue.

(f) Excess Insurance Recoverable – Excess insurance recoverable representing the amount of incurred claims that have exceeded the self-insured retention on excess insurance policies, but for which the cumulative payments on such claims have not exceeded such self-insured retention shall be separately reported as an admitted asset. Such amounts shall only be deemed admitted if supported by an actuarial report submitted by the group self-insurer in accordance with this Part and will be allowed provided that the underlying excess carrier maintains minimum financial ratings determined by the WCB.

(g) Investment Standards – The board of trustees of a group self-insurer may invest excess funds not immediately needed for the payment of group liabilities. In order to protect the assets of the group self-insurer, provide the necessary liquidity to meet the obligations of the group self-insurer, and minimize the risk of loss of principal, a group self-insurer may invest in any of the following, subject to the limitations set forth in this section:

1. Federal Government Obligations – United States Treasury obligations or obligations which are not in default as to principal or interest, which are valid and legally authorized, and which are issued or guaranteed by the United States or by any agency or instrumentality thereof.
2. Non-Federal Government Obligations;
 - a. any state in the United States;
 - b. any agency or instrumentality of any state in the United States, provided that such government obligations shall be by law payable, as to both principal and interest, from taxes levied or adequate special revenues pledged or otherwise appropriated.
 - c. Bonds, notes, warrants, or other evidence of indebtedness of any local agency or State agency within the United States of America, including bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by the State or local

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- agency, or by the department, board, agency, or authority of the State or local agency, provided the credit worthiness of the security meets the credit rating requirements of this section
- d. Any mutual funds which invest in one hundred (100) percent U.S. federal, state or local government agency obligations or cash.
3. Domestic and Foreign Corporate obligations and investments in common and preferred stock:
- a. Prime Bankers' Acceptances of the fifty (50) largest global banks.
 - b. Commercial Paper
 - c. Medium-term notes, defined as all corporate and depository institution debt securities issued by corporations organized and operating within the United States or by depository institutions licensed by the United States or any state and operating within the United States.
 - d. Common stock issued by any solvent institution that is traded on a national stock exchange registered by the Securities and Exchange Commission;
 - e. Preferred stock issued by any solvent institution that is traded on a national stock exchange registered by the Securities and Exchange Commission;
 - f. Mutual funds invested in 100 percent of investments as defined above or cash.
4. Limitations on Investments – Investments of group self-insurers shall be subject to the following limitations based on the investment portfolio. Investment portfolio means the aggregate market value of all holdings in permitted investments, cash, and cash equivalents.
- a. Maximum Maturities
 - 1. Commercial paper shall have a maximum maturity of two hundred seventy (270) days or less.
 - 2. Medium term notes shall have a maximum remaining maturity of five (5) years or less at the time of purchase.
 - 3. The weighted average duration of the trust investment portfolio must not exceed the weighted average duration of the trust liabilities.
 - b. Credit Rating – All investment ratings shall be obtained from a nationally recognized statistical ratings organization and recognized by the SEC.
 - 1. Investments in any government obligation shall have a credit rating of “AAA”.
 - 2. Commercial Paper rated “A1”/ “P1”/ “F1”
 - 3. Medium-term notes shall be rated “AAA”

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4. Mutual Funds must maintain the highest rating as set by a nationally recognized statistical rating organization.
 - c. Maximum Investments per category
 1. Corporate obligations and investments in common and preferred stock shall not exceed ten (10) percent of the total investment portfolio.
 2. With the exception of U.S. federal government obligations, no investment in any one institution shall exceed more than five (5) percent of the total investment portfolio.
 3. Investments other than U.S. federal government obligations, total investments cannot exceed thirty (30) percent of the total investment portfolio.
 4. Investments in obligations, common or preferred stocks of foreign entities, shall be limited to five (5) percent of the Trust portfolio.
 - d. Other Limitations:
 1. No group self-insurer shall invest trust assets in investment securities or obligations of a group member or a group member's parent, subsidiary, or affiliate or any person or entity under contract with the group self-insurer as a service provider.
 2. No group self-insurer, whether through its registered investment advisor or not, shall participate in “short selling” (a sale of a security not owned by the seller; a technique used to take advantage of an anticipated decline in price or to protect a profit), or in “margin transactions” (purchase of a security on credit after a margin has been deposited).
 3. No group self-insurer shall invest trust assets in reverse repurchase agreements.
 4. No group self-insurer shall invest trust assets in collateralized mortgage obligations (CMOs).
5. Compliance – Any group self-insurer that has investments which do not comply with the regulations set forth herein as of the adoption of these regulations, will have until December 31, 2009, to re-balance the group self-insurer’s portfolio in order to come into compliance with the standards set forth herein. Any new investments must comply with the requirements of this section at the time of purchase.
- (h) Prepaid Expenses – Only prepaid excess insurance and reinsurance costs will be deemed admitted assets. All other prepaid expenses will be considered nonadmitted.
- (i) Nonadmitted Assets – Any other assets held by the group self-insurer will be nonadmitted when measuring a group self insurer for the purposes of determining its regulatory funding including, but not limited to: contributions receivable, fixed assets and

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accounts receivable. The security deposit(s) held by the Chair pursuant to this Part shall not be included in the calculation of the group self-insurer's trust assets for purposes of determining its regulatory funding position. Similarly, any trust assets pledged as collateral for the security deposit(s) held by the Chair shall not be included in the calculation of the group self-insurer's trust assets for the purposes of determining its regulatory funding position.

§317.15 Group Self-Insurer Liabilities

(a) Reserve for Claims – Group self-insurers are required to establish and maintain actuarially sound loss reserves which shall comply with the standards provided herein. Claims reserves maintained by the group self-insurer must be supported by the actuarial report filed by the group on an annual basis as described in this Part and shall include a twenty percent risk margin established by the Chair. The reserve for claims must be recorded on a gross basis at the full incurred value regardless of potential for excess insurance recoveries. A group may elect to discount reserves, provided the discount rate utilized is reflective of the group self-insurer's funding position, is supported by the actual earning capacity of the group self-insurer, and meets any and all standards promulgated by the Chair. For contribution years prior to January 1, 2010 reserves shall be set at no less than the actuary's expected reserve level with any appropriate adjustments for discounting. For contributions years beginning January 1, 2010 a risk margin as established by the Chair will be applied to the actuarial loss reserves for the determination of regulatory funding.

(c) Dividends Payable – If the conditions as described in this Part for making payment of distributions have been met, the amount eligible for payment will be considered a liability for purposes of reviewing the group trust funding level under this Part. Any remaining distributions or dividends that are declared and recorded as liabilities of the group trust and that are not eligible for payment shall not be considered for purposes of evaluating the funding level of the group trust. However, any such distribution or dividend payable must be in compliance with this Part.

(d) Other Liabilities – Any other obligations of the group trust including, but not limited to, assessments, deferred revenue, accrued expenses, accounts payable, loans and notes payable shall be included as liabilities of the group self-insurer when determining the regulatory funding as described in this Part.

§317.16 Distribution to Members

(a) Conditions on Making Distributions – If deemed fully funded for a fiscal year as per the standards set forth in this Part, a group self-insurer may declare and accrue dividend liabilities from the operating activities of a contribution year indicating a surplus

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above any risk margin that may be required by the Chair. However, a group self-insurer shall not begin making distributions for that contribution year until the following conditions have been met:

1. At least twenty-four (24) months must have elapsed since the close of the fiscal year for which distributions are being paid.
2. The fiscal year for which distributions are to be paid must be fully funded as defined in this Part and as reported as per this Part.
3. The payment of such distributions shall not reduce trust assets below trust liabilities, as calculated in accordance with this Part.
4. The payment of such distributions must be from surplus funds and shall not include any funds restricted for any other use or purpose.
5. The group must provide written notice of the distribution to the WCB at least sixty (60) days in advance of the actual distribution. Such notification will be a form prescribed by the Chair and include a description of the allocation methodology with detail by member. Accompanying the notification will be a signed certification by the chair of the board of trustees and the group administrator stating that the proposed distribution meets each and every requirement contained in this Part.
6. The payment of such distributions shall be paid to members who participated in the group self-insurer during the year for which the distributions apply regardless of their current membership status.

(b) Payment Schedule – If the conditions outlined in (a) have been met, the group self-insurer may make distributions. The distribution for each fiscal year shall be recalculated based upon the most recent reports filed with the WCB in accordance with this Part. The total amounts paid for each contribution year shall not exceed those in accordance with the following schedule:

1. First year [twenty-four (24) months after the end of the fiscal year] up to twenty-five (25) percent of the distribution amount may be paid;
2. Second year [thirty-six (36) months after the end of the fiscal year] up to thirty-three (33) percent of the distribution amount may be paid;
3. Third year [forty-eight (48) months after the end of the fiscal year] up to fifty (50) percent of the distribution amount may be paid; and
4. Fourth year [sixty (60) months after the end of the fiscal year] up to one hundred (100) percent of the distribution amount may be paid.

(c) Offsetting Deficits – Deficits identified for a specific fund year may be offset by distributions paid in accordance with this section for specific employer members, provided the member participated in the group self-insurer for the fund years during which both the deficit and distribution apply. Distributions for those members that do not have offsetting deficits must be paid directly to the member.

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(d) Penalties – In addition to any other remedies available at law or in equity, any distributions paid by a group self-insurer not in accordance with the standards set forth above may be cause for termination of a group's privilege to self-insure and/or the group administrator's license to administer group self-insurers.

§317.17 Insurance

(a) Fidelity Coverage – Every group self-insurer shall be required to file with the Chair evidence that it has obtained a blanket fidelity bond or fidelity insurance policy providing coverage for the theft, disappearance or destruction of money, securities, or other property, as deemed necessary by, and in a form acceptable to, the Chair.

(b) Professional Liability Coverage – Every group self-insurer shall be required to file with the Chair evidence that its key agents have obtained professional liability insurance coverage for errors and acts of omission in an amount, type, and form acceptable to the Chair. Proof of adequate professional liability coverage for errors and acts of omission shall be required to be provided for the board of trustees of each group self-insurer from the group administrator, the claims administrator, the independent accountant, the insurance brokers, and independent actuary. In addition, the group self-insurer itself shall provide evidence of such coverage on behalf of the board of trustees and any employees or other key agents of the group self-insurer. The group self-insurer shall be named as the loss payee on each such professional liability policy with the State of New York named as an additional insured. If coverage is written on a claims-made policy, each policy shall include policy language or an endorsement providing an extended discovery period of not less than two (2) years from the time work under the current contract with the group self-insurer is completed. The board of trustees and the group administrator shall maintain a copy of each such required professional liability policy for review/audit by the Chair.

(c) Changes – The policies or contracts described herein shall not be cancelable except upon at least sixty (60) days written notice by certified or registered letter, return receipt requested, to the group self-insurer, and served in like manner upon the Chair. The group self-insurer shall immediately notify the Chair, in writing, in a form prescribed by the Chair, of any change in the fidelity or professional liability coverage.

§317.18 Excess Insurance

The group self-insurer shall also file certificate(s), in a form prescribed by the Chair, evidencing that the group self-insurer maintains specific excess insurance which reduces the exposure of the group self-insurer for workers' compensation claims and for employers' liability. No contract or policy of excess insurance shall be deemed acceptable unless such certificate includes an affirmation that the policy issued is in

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compliance with this Part. Such excess insurance must be in a form approved by the Superintendent of Insurance and must be issued by a property and casualty company licensed by the Superintendent of Insurance to write excess insurance in the State of New York with respect to workers' compensation insurance and employer's liability insurance as defined in paragraph (15) of subdivision (a) of section 1113 of the Insurance Law.

(a) Retention Levels – Maximum retention levels of the group self-insurer for the specific excess insurance will be set at the discretion of the Chair. Factors considered when establishing the maximum retention levels will include, but need not be limited to, the financial position of the group; the overall size of the group self-insurer including annual contribution levels; and the availability and pricing of such coverage.

(b) Upper Limits – The specific excess insurance policy(s) under this Part shall provide the group with coverage up to the statutory limits. Exceptions will be granted in the sole discretion of the Chair.

(c) Carrier Ratings – The Chair will set minimum financial ratings of excess insurance carriers that must be met for the excess insurance certificate to be deemed acceptable. Such ratings will be re-evaluated at the discretion of the Chair, but no less than annually.

(d) Limits – No more than one (1) group may be covered by any contract or policy of excess insurance and the named insured shall be the group self-insurer, with the State of New York named as an additional insured. The excess insurance must provide coverage equally to all members of the group self-insurer, with no exceptions as to payroll classification. The insolvency of the group self-insurer shall not relieve the excess insurer(s) of their duties and liabilities under the policy.

(e) Changes – The policy or contract shall not be cancelable except upon at least sixty (60) days written notice by certified or registered letter, return receipt requested, to the group self-insurer, and served in like manner upon the Chair. The group self-insurer shall immediately notify the Chair, in writing, in a form prescribed by the Chair, of any change in its excess insurance.

(f) Related Party Transactions – All of the parties to the placement of a specific excess insurance policy under this Part shall maintain a level of independence such that the best interests of the group self-insurer have been met. All fees and commissions related to the placement of such coverage must be fully disclosed to the trustees and to the WCB in compliance with the reporting requirements set forth in this Part.

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§317.19 Security Deposits

(a) Minimum Deposit – Group self-insurers shall deposit with the Chair securities, cash, surety bonds and/or irrevocable letters of credit, in an aggregate amount as determined by the Chair. Factors considered when determining the minimum deposit amount include:

1. The combined annual payroll of the group members multiplied by the current loss costs promulgated by a workers' compensation rate service organization; or
2. One and one-half times the group self-insurers' retention as specified on the certificate of excess insurance filed with the Chair which limits the liability of a group on a specific, per occurrence basis with respect to claims;
3. The product of the statutory maximum weekly compensation rate for total disability multiplied by fifty-two (52), multiplied by thirty (30).
4. The group's current regulatory funding position.

(b) Annual Evaluation – The amount of a group self-insurer's security deposit(s) will be re-evaluated annually following the receipt and review of the annual financial and other reports required by this Part. Such security deposit(s) may be adjusted at the direction of the Chair. The group self-insurer's funding position and size will be the considered when determining the adequacy of the security on deposit with the Chair.

(c) Form of Deposit – The group self-insurer's security deposit shall be in a form prescribed herein:

1. The applicant shall deposit with the Chair securities of the kind specified in subdivisions (1), (2), (3), (4) and (5), and paragraph (a) of subdivision (7), of section 235 of the Banking Law and shall have an aggregate market value at least equal to an amount determined in accordance with subdivisions (a) and (b) of this section. Such securities shall be registered in the name of "Chair, Workers' Compensation Board, State of New York." Interest paid on securities on deposit will be regularly remitted to the group self-insurer for whose account they are deposited, so long as such group self-insurer complies with this Part and the provisions of the Workers' Compensation Law, and is not in default in the payment of compensation, assessments or other obligation under the Workers' Compensation Law.
2. A cash deposit may be made in lieu of securities, surety bond or letters of credit. Such cash deposit will be deposited in an interest-bearing account in the name of "Chair, Workers' Compensation Board, State of New York" and shall be in an account authorized by the Comptroller of the State of New York. Such cash deposit is to be by certified check or wire transfer. Interest paid on the cash deposit will be regularly remitted to the group self-insurer for whose account it is deposited so long as such group self-

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insurer complies with this Part and the provisions of the Workers' Compensation Law, and is not in default in the payment of compensation, assessments or other obligation under the Workers' Compensation Law.

3. Surety bonds accepted in lieu of securities, cash, or letters of credit shall be undertaken and enforced in the name of the "Chair, Workers' Compensation Board, State of New York" and shall be in a form approved by the Chair and issued by a company authorized by the superintendent of insurance to write business as a surety in the State of New York. A surety company, to be a qualified surety company, must meet the minimum financial ratings established by the Chair.
4. A letter of credit must comply with all requirements set forth in Regulation 133 of the New York State Insurance Department, codified as Part 79 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York, provided that:
 - (i) the beneficiary shall be the Chair, Workers' Compensation Board, State of New York;
 - (ii) the letter of credit shall provide for at least sixty (60) days written notice to the Chair of the Workers' Compensation Board prior to the expiration date for nonrenewal;
 - (iii) a bank, to be a qualified bank, may in lieu of a determination by the Securities Evaluation Office of the National Association of Insurance Commissioners for purposes of section 79.1(e)(3) of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York, have either a long-term debt rating equal to Baa/BBB or better by Moody's or Standard & Poor's or the equivalent thereto from any other securities rating service, and/or a short-term debt rating of P2/A2 from Moody's or Standard & Poor's or the equivalent thereto from any other securities rating service;
 - (iv) the letter of credit shall additionally provide that any legal proceedings with respect thereto be subject to the jurisdiction of the courts of the State of New York;
 - (v) the form and content thereof shall be acceptable to the Chair; and
 - (vi) the bank issuing the letter of credit may not be a member of the group self-insurer or the parent of a member of the group.

(d) Exclusion from Assets – The security deposit(s) held by the Chair pursuant to this Part shall not be included in the calculation of the group self-insurer's trust assets for purposes of determining the financial condition of the group, except as provided in this Part. Similarly, any trust assets pledged as collateral for the security deposit(s) held by the Chair shall not be included in the calculation of the group self-insurer's trust assets for the purposes of determining the financial condition of the group or to determine if total assets exceed total liabilities for the purpose of making distributions to group members per this Part.

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(e) Drawing on Deposit – The Chair may draw upon any security deposit(s) made pursuant to this Part:

1. If the group self-insurer fails to satisfy any claims, liabilities, obligations, expenses or assessments of the group self-insurer;
2. If the group self-insurer becomes insolvent or is deemed to be insolvent by the Chair; or
3. When a group self-insurer fails to renew or replace a letter(s) of credit within thirty (30) days prior to the expiration date of such letters or to substitute its deposit with cash, securities or a surety bond of equal value.

(f) Cancellation of Security Deposit – Upon receipt of a notice of cancellation of a surety bond or expiration of letter(s) of credit filed by a group self-insurer with the Chair, the Chair may make demand upon the group self-insurer to deposit with the Chair within thirty (30) days prior to the cancellation date of said surety bond or thirty (30) days prior to the expiration date of said letter(s) of credit, securities or cash or to file or reinstate letter(s) of credit or post or reinstate a surety bond in an amount determined in accordance with subdivision (a) and (b) of this section. If the group self-insurer fails to comply with such demand in the manner and amount demanded, and within the time period required, the privilege of group self-insurance may be revoked.

(g) Failure to File Security Deposit – A group self-insurer who fails to file or maintain the security deposit required by the Chair will be deemed to have failed to secure compensation for the amount not deposited and shall be liable for all penalties and other available remedies for such failure.

(h) Termination of the Group Self-Insurer – If for any reason the status of a group self-insurer is terminated or revoked, the cash, securities or surety bond on deposit shall remain in the custody of the Chair, and the irrevocable letter of credit shall remain in force, for a period of time determined by the Chair.

§317.20 Reporting Requirements

Group self-insurers shall file reports, no less than annually, evidencing proper regulatory funding and integrity of trust funds as well as continued compliance with the various other requirements set forth in this Part. Such reports will include forms prescribed by the Chair and must be filed with the Chair no later than one hundred twenty (120) days after the close of the fund year of the group self-insurer or in accordance with schedules promulgated by the Chair.

(a) Prescribed Reports – Every group self-insurer must file, no less than annually, reports in a form prescribed by the Chair which demonstrate the group's compliance with the minimum requirements set forth in this Part. Such prescribed reports must be certified by the board of trustees and be supported by the audited financial statements and

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the actuarial opinion described herein. Such report will include, but not be limited to, a funding year analysis which details the payroll, contributions, dividends, and expenses associated with each specific funding year including updated paid and incurred loss projections. The form and content of such report will be in the sole discretion of the Chair.

(b) Audited Financial Statements – Every group self-insurer must file, no less than annually, certified and independently audited comparative financial statements prepared in accordance with Generally Accepted Accounting Principles (GAAP). Such reports shall include exhibits prescribed by the Chair indicating specific amounts collected as group member contributions and earned from investments, as well as specific amounts for the year reported for various administrative costs, including but not limited to the following:

1. fees and commissions paid to the group administrator;
2. fees paid to the third party administrator;
3. commissions paid to brokers;
4. premium paid for excess insurance;
5. other expenses.

The financial statements should also include an attestation as to the group self-insurer's conformance with the standards set forth in this Part, a summary of any significant accounting policies and reconciliation between the reserves projected in the actuarial report described herein and those presented on the financial statements.

(c) Actuarial Opinion – Each group self-insurer shall submit, no less than annually, an actuarial report and accompanying opinion prepared and signed by a qualified actuary, as that term is defined in this Part, pertaining to its claims liabilities as described in this Part. At a minimum this report shall:

1. contain sufficient documentation including disclosure of key assumptions and deviations from industry standards for actuarial peer review;
2. be in compliance with the Actuarial Standards Board's Actuarial Standards of Practice;
3. be based on claims information valued as of the group self-insurer's program year end;
4. be submitted to the WCB in complete written format within one hundred twenty (120) days after the end of the group self-insurer's program year; and
6. be made available to all members of the group self-insurer upon request.

The contents of the report shall include projections of ultimate loss and loss adjustment expense. These shall be displayed as follows:

1. at the expected or actuarial central estimate as defined by the Actuarial Standards Board's Actuarial Standards of Practice;
2. separately for each fund year and in aggregate;

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3. gross and net of insurance recoverable;
4. on an undiscounted basis and on a discounted rate, providing that the annual discount rate is supported by the actual earnings capacity of the group self insurer.
5. with a risk margin prescribed by the Chair.

The actuarial opinion shall contain any additional forms prescribed by the Chair.

(d) Additional Reports – Every group self-insurer shall also be required to file such additional reports as may be deemed necessary by the Chair to ensure continued compliance with the requirements set forth in this Part. Such reports may include information by member and program year, including contributions, dividends, and assessments. Detailed information regarding excess insurance and security may also be required.

(e) Reports to Members – A group administrator shall provide an annual written report to all members of the group self-insurer with a copy to the WCB in a form prescribed by the Chair. Such report shall include, but may not be limited to the following:

1. the name of the group administrator;
2. the names and business affiliation of the trustees;
3. the results of the most recent financial audit including the funding position of each contribution year;
4. the percentage of total liabilities held by the self-insurer in unrestricted cash and investments permitted per this Part;
5. the number and amount of rate deviations provided to members during the prior year and whether the recipient of any such deviation was a trustee; and
6. disclosure related to the joint and several liability implications for each member.
7. All audits and actuarial reports and opinions shall be made available to members upon request. In addition, each group shall hold an annual membership meeting as set forth in this Part.

(f) Changes in Information Reported – Group self-insurers shall immediately report to the Chair, in writing, any information which materially alters any of the facts presented in the periodic reports described herein or which indicates that the group is no longer in compliance with requirements set forth in these rules, particularly those set forth in this Part.

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§317.21 External Report

The Chair shall make available to the public, on its website and in writing upon request, any information deemed appropriate, including but not limited to:

- (a) the identity of all group self-insurers that have provided workers' compensation under this subdivision in the prior three (3) years;
- (b) the group administrator of each such group self-insurer;
- (c) the financial condition of all such group self-insurers as determined by the WCB in the last financial audit; and
- (d) the WCB's regulatory definition of assets and liabilities.

In addition to the information listed above, the Chair shall make available any other such information as the Chair may deem appropriate, but which shall not include any confidential or proprietary information. The WCB may also direct the disclosure of any nonproprietary information regarding any group self-insurer, including whether a member is a member thereof, to any claimant upon showing of need.

§317.22 Marketing Materials/Solicitation of Members

(a) Standards for Marketing Materials – All marketing materials disseminated or communicated by or on behalf of a group self-insurer shall be strictly factual in nature and shall be truthful and accurate in all respects, and shall not contain any statements which are in any way deceptive, misleading or coercive. The board of trustees, group administrator, insurance brokers, consultants, or any other agent acting on behalf of the group self-insurer shall make a good faith effort to fully disclose to prospective group members both the rights and responsibilities of participating in the group. No party shall make a material misrepresentation or omission of a material fact in connection with the solicitation of a prospective group member. No group self-insurer shall pay commissions to or otherwise engage in marketing or sales relationships with insurance brokers who have had their licenses suspended or revoked by the Insurance Department. The board of trustees shall require all brokers to comply with section 2120 of the Insurance Law. All marketing materials must properly disclose the responsibilities of a group member under joint and several liability including the provisions outlined in Section 317.8(b)(1),(2), and (3).

(b) Misleading or Inaccurate Marketing Materials – Copies of all marketing materials used by or on behalf of a group self-insurer must be presented to the Chair for the purposes of ensuring compliance with this Part. The Chair may also direct the submission of additional information supporting such marketing materials. If the Chair has cause to believe that any marketing materials disseminated or communicated by or on behalf of a group self-insurer do not conform to the requirements of this Part, then the Chair may require that the group:

1. Immediately cease dissemination or communication of such materials.

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2. Provide the Chair with the names and addresses of all entities to whom those materials were disseminated or communicated.
3. Disseminate additional information clarifying or explaining such disapproved materials.

The Chair may further require the group self-insurer to file, until otherwise directed, all future marketing materials with the Chair prior to their dissemination or communication.

§317.23 Examination of the Records and Affairs of the Group Self-Insurer

(a) Access to Records – The Chair or the Chair's designee shall have free access to all records of the group self-insurer for purpose of verification and to all the claim files, books and papers relating to the group's business and to the books and paper's of the group's key agents including, but not limited to the group administrator and third party administrator. The Chair or the Chair's designee may summon and examine under oath any person who the Chair or the Chair's designee believes has knowledge or information of the affairs, claims, transactions or circumstances being examined or investigated. All records of the group self-insurer shall be maintained and labeled in a manner that allows for document retrieval and access by the Chair or the Chair's designee and in accordance with any directives issued by the Chair with regard to such document maintenance and labeling.

(b) Independent Examinations – The Chair shall evaluate, no less than once every three (3) years, a group self-insurer's compliance with the financial and regulatory requirements for self-insurance, its claims handling, operations and business practices. The Chair may engage any qualified person or organization to assist with such evaluation and any costs incurred by the Chair shall be borne by the group under examination. Failure to submit to such independent review or to pay such costs, upon demand of the Chair, shall be sufficient grounds to terminate coverage of the group self-insurer. Such reviews may be performed more frequently at the sole discretion of the Chair. Any and all reports which result from such review will be shared with the trustees of the group self-insurer under review as well as the employer members, upon request.

(c) Reports Prepared by Independent Party – The Chair may require reports to be prepared by an independent accountant, actuary or other consultant, selected by the WCB or, at the Chair's discretion, by the group self-insurer from a list which shall be pre-approved by the Chair to determine whether the group self-insurer meets the financial criteria for self-insurance. All actuaries so selected shall be qualified actuaries as defined in this Part, and shall be fellow or associates of the Casualty Actuarial Society.

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§317.24 Terms and Procedures Applicable to Under Funded Groups

(a) Sanctions – A group self-insurer must annually provide proof of trust assets permitted by regulation of the Chair of at least one hundred (100) percent of the total liabilities, including the expected claims liabilities calculated with a risk margin prescribed by the Chair for fiscal years beginning on or after January 1, 2010, presented in the actuarial opinion on liabilities submitted by the group self-insurer. Any group self-insurer whose admitted assets are not at least one hundred (100) percent of total liabilities shall be deemed under funded. Under funded group self-insurers may be subject at any time to any or all of the following sanctions, at the discretion of the Chair:

1. The group must submit a plan for achieving fully funded status in a timely manner which may include a deficit assessment on members of such group self-insurer which shall be subject to approval or modification by the Chair.
2. The details of such plan may be documented in a consent agreement executed by the board of trustees and provided to employer members upon request. If deficit assessments to members are deemed a necessary part of the plan, they must be done in accordance with (b) of this section.
3. The Chair may condition its continued authorization to act as a group self-insurer on the appointment of an outside monitor selected by the Chair, at the group self-insurer's expense.
4. The Chair shall impose such limitations on admission of new members or offering of discounts on under funded group self-insurers to ensure that such group self-insurer shall become fully funded. At a minimum, no group whose regulatory funding is below seventy-five (75) percent may admit new members.
5. The Chair shall require the submission of additional financial and/or actuarial documentation from the group self-insurer.
6. The Chair shall require additional security deposits to be held in accordance with this Part for those groups deemed less than seventy-five (75) percent funded on a regulatory basis to be held in accordance with this Part. Such additional deposits shall be based on the level of under funding as determined by the WCB.
7. The Chair shall require notification to the employer members of the group self-insurer regarding the group's financial position and remediation plan.
8. The Chair shall engage qualified experts to conduct an independent examination pursuant to section 317.23, to evaluate the financial integrity and funding status of the group self-insurer whose regulatory funding level is below 50 percent, which shall pay for the costs of the examination. The Chair may engage experts for those trusts above 50 percent as deemed necessary.
9. The Chair may require any other actions deemed necessary and appropriate, in the sole discretion of the Chair, to restore the group self-insurer's financial stability.

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(b) Deficit Assessments – If the contribution year funding required as per this Part shows a deficit in a given prior fiscal year of operation, the board of trustees shall develop, approve and submit a written plan to the Chair detailing how that deficit will be addressed by the group self-insurer in as timely a manner as possible. Any deficits identified for a given fund year must be billed back and collected from the employer members who participated in the group self-insurer for the fund year for which the deficiency has been identified as outlined in the approved plan. Any deficiencies identified for any fiscal years prior to January 1, 2009, must be billed and collected no later than January 1, 2014. Deficits that exist for fiscal years after January 1, 2009, must be billed and collected as soon as practicable, but no later than December 31 of the fiscal year following the fiscal year in which the deficit occurred or no later than December 31 of the fiscal year following the fiscal year in which the deficit was identified, whichever is sooner. Failure to bill and collect the deficits noted will be cause to terminate the group's privilege to self-insure.

(c) Failure to Restore Financial Integrity – Effective January 1, 2014, any group self-insurer that fails to show it is fully funded in accordance with this Part shall have one (1) year to cure the deficiency. If such deficiency is not cured within one (1) year, the group self-insurer shall be given six (6) months to terminate its coverage.

§317.25 Termination of a Group Self-Insurer

(a) Voluntary Termination of a Group Self-Insurer – The group shall continue for such time as may be necessary to accomplish the purpose for which it was created, and so long as all requirements to maintain authorization as set forth in this Part continue to be met. The Chair must be notified of a voluntary termination by a group of its status as a self-insurer at least ninety (90) days prior to the effective date of termination. Notification must be served, in like manner upon all active and inactive members of the group. Upon the termination date of the group's status as a self-insurer, the group shall continue to ensure the proper administration of the liabilities incurred by the group during its period of existence. Such terminated group self-insurer must continue to submit periodic reporting as described in this Part, and must continue to meet the funding requirements as described in this Part.

(b) Involuntary Termination of Group Self-Insurer – A group which persistently or repeatedly or in any case willfully violates any provision or multiple provisions of the Workers' Compensation Law, the rules and regulations enacted pursuant thereto, or any other applicable laws, rules and regulations, or persistently or willfully fails to comply with any requirement set forth in the Workers' Compensation Law, the rules and regulations enacted pursuant thereto, or any other applicable laws, rules and regulations, may be subject to termination of its authorization to operate as a group self-insurer. The Chair must notify the group self-insurer of such termination at least one hundred twenty (120) days prior to the effective date of termination. Notification must then be served, by

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the group self-insurer, in a like manner upon all active and inactive members of the group at least ninety (90) days prior to the effective date of termination. Upon termination of the group's status as a self-insurer, the group will continue to ensure the proper administration of the liabilities incurred by the group during its period of existence. Such revoked group self-insurer must continue to submit periodic reporting as described in this Part, and must continue to meet the funding requirements as described in this Part. The notification requirements herein may be waived, at any time, at the discretion of the Chair.

317.26 Dissolution of a Terminated Group Self-Insurer

Upon termination of a group's status as a self-insurer, the group shall continue to ensure the proper administration of the liabilities incurred by the group during its period of existence.

- (a) Group Self-Insurer in Runoff – Any group self-insurer who voluntarily or involuntarily terminated coverage, demonstrates the ability to pay its outstanding lawful obligation under the Workers' Compensation Law as they mature in the regular course of business, and maintains an active Board of Trustees, will be deemed to be a group self-insurer in runoff. For a Group in Runoff, the Board of Trustees is responsible for the final distribution of the group's assets and liabilities. A Group-Self-Insurer in runoff is required to consistently demonstrate the ability to properly administer the liabilities remaining in the Group.

In addition to the required financial, actuarial and cash flow reporting, a Group Self-insurer in Run-Off may be subject at any time to any or all of the following sanctions, at the discretion of the Chair:

1. The group must submit a plan for achieving fully funded status in a timely manner, which may include a deficit assessment on employer members who participated in the group self-insurer during its period of existence.
2. The Chair may appoint an outside monitor selected by the Chair, at the group self-insurer's expense.
3. The Chair may require an examination of the group self-insurer pursuant to this Part.
4. The Chair may require the submission of additional financial and/or actuarial documentation from the group self-insurer.
5. The Chair may require additional security deposits to be held in accordance with this Part.

If the group in runoff fails or is anticipated to fail to properly administer its workers' compensation liabilities, the Chair may assume such administration

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and take whatever steps deemed appropriate to ensure the proper administration of the group's liabilities including but not limited to taking possession of management records, assets and liabilities.

- (b) Group Self-Insurer in Liquidation – Any terminated group self-insurer who has failed or it is anticipated to fail to properly administer workers compensation liabilities will be deemed a group self-insurer in liquidation. For a Group in Liquidation, the Chair assumes the administration of the Trust and is responsible for the final distribution of the group's assets and liabilities.

The following may constitute evidence of a failure to properly administer workers' compensation liabilities: i) evidence of the group self-insurer's willful failure to comply with any provision of the Workers' Compensation Law or the regulations of the WCB; ii) the failure or neglect of the group self-insurer to adhere to any of the terms of any agreement between the WCB and the group self-insurer concerning the terms and conditions of the group self-insurer's continued administration of its liabilities post termination of the group self-insurer's status as a self-insurer; iii) insufficient assets to pay its outstanding lawful obligations under the Workers' Compensation Law as they mature in regular course of business; or iv) such other good cause as may be determined by the Chair or his or her designee.

Any group self-insurer who does not have sufficient trust assets to pay its outstanding lawful obligations under the Workers' Compensation Law as they mature in the regular course of business will be considered insolvent. The Trust will be deemed to be insolvent if it is shown that i) the group self-insurer is underfunded as defined in the Workers' Compensation Law section 50(3-a); and (ii) the sum of the self-insurer's assets, as defined by section 317.2 of this Part, plus the available security deposit held by the Chair pursuant to Workers' Compensation Law section 50 (3-a) and section 317.5 of this Part, is less than the total cost of all of the self-insurers anticipated workers' compensation trust liabilities, as defined by section 317.2 of the Part, that will accrue within the succeeding six months.

Under the Workers' Compensation Law, the Chair shall levy an assessment on the members of the insolvent group self-insurer within one hundred twenty (120) days of such insolvency for such an amount he or she determines to be necessary to discharge all liabilities of the group self-insurer, including the reasonable cost of liquidation such as claims administration costs, actuarial and accounting services, and the value of future assessments on members of such group self-insurer. The Chair may impose subsequent deficit assessments, or return funds to members, to adjust the monies collected to reflect the time of participation and percent of group self-insurer liabilities for such time. Notwithstanding any such action by the Chair, each member of the group self-insurer shall remain jointly and severally responsible for all liabilities provided by this chapter including but

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not limited to outstanding and estimated future liabilities and assessments. Nothing in this paragraph shall prevent the Chair from offering payment plans or settling claims against members of any group self-insurer as necessary to facilitate collection.