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THE INSURANCE NEWSLETTER

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Changes in Experience Modifications

Most buyers of workers compensation insurance understand that their premiums are adjusted up or down by an experience modification, either a credit or debit factor applied to base premiums to reflect better or worse than average claims history. The size threshold at which these factors apply varies from state to state, but for most jurisdictions it's safe to assume that any workers compensation policy developing over $10,000 in annual premium will be subject to experience modification.

The National Council on Compensation Insurance (NCCI) is an organization that currently acts as the licensed rating and statistical organization in 34 states and promulgates experience modifications for eligible workers compensation policyholders in those states. The modification formula used by the NCCI has remained substantially the same for over two decades, but that's about to change, in ways that will affect you. The NCCI is rolling out changes to the experience modification formula that will take effect with modifications effective on January 1, 2013 and thereafter. Since most of the other sixteen states that have their own independent rating bureaus tend to follow NCCI's lead, we can expect widespread adoption of these or similar changes countrywide.

So what are the changes? Without venturing too far into the theory and arcana of experience modifications, it's still important to have a basic understanding of how the formula attempts to differentiate between frequency and severity in calculating an experience modification.

Let's start with a simple example. Account A has one claim for $50,000; account B has ten claims of $5,000 each, totaling the same $50,000. Which is the poorer workers compensation risk?

Well, accidents do happen; that's the reason we have insurance. And accidents can be serious, so large claims are certainly possible; it's a matter of luck. But one accident is not a trend, or an indication of a poor risk. Multiple accidents, even small ones, are another story. They are an indication of an underlying problem. Luck comes into play here, too, in that all the claims in this example were small, but the odds that a serious claim will happen in account B are ten times greater than in account A. The experience modification formula attempts to reflect these differences.

An experience modification calculation is nothing more than a comparison of actual claims experience to expected experience. Expected losses are determined by multiplying an expected loss rate to payroll, in exactly the same way a workers compensation premium is calculated. The expected loss rate is directly related to the basic premium rate for each classification, and generally runs around 33-35% of the premium rate. This relationship is important. Certain WC classifications have higher rates than others, reflecting the higher hazards of the jobs involved. These higher rated classifications will also have a higher expected loss rate, meaning more actual claims can be incurred before the experience modification is adversely affected. Conversely, a lower rated classification has room for fewer claims before the modification is affected.

Actual losses affect experience modifications in two ways. So called primary losses go into the formula at full value. Excess losses are discounted. Under the current experience modification formula, all claims

$5,000 and under are considered primary losses and go into the formula at full value. For larger claims the first $5,000 of each claim goes into the formula as primary loss, but amounts over that are considered excess loss, and are discounted.

Back to our account examples, account A has one claim for $50,000; $5,000 goes into the experience calculation at full value, but $45,000 is considered excess loss and is discounted. Account B has all small claims, so all claims go in the formula at full value, no discounting. Result: for the same total claims experience account B with ten claims will have a higher experience modification than account A with just one large claim.

Here is where the pending change comes in. The split point of $5,000 to mark where primary loss ends and excess loss begins has remained unchanged in the NCCI formula for over twenty years. Starting with experience modifications effective January 1, 2013 the NCCI will increase that split point to $10,000. A year later it goes up to $13,500 and a year after that to $15,000, where it will then be indexed for inflation and increase yearly after that. Result: more of each large claim is considered primary loss, with its more direct impact on your experience modification.

What does all this mean for you? NCCI has done reams of research on the affect of these changes, and reports that, in general, workers compensation insurance buyers with credit experience modifications will see larger credits, while insurance buyers with debit experience modifications will see larger debits. For most, the changes will be small, with, by NCCI estimation, 74% of all modifications showing changes (in either direction) of five points or less. They estimate 6.5% of all modifications will change five to ten points, and only 7% will change by ten points or more.

Claims information for experience rating purposes is valued six months after a policy expires. You'll most likely be reading this around the beginning of July, so the claims that will be going into January 1, 2013 experience modifications under this new formula are already valued and reported.

These changes have been in the works for a number of years, but they come at a time when the insurance market has noticeably tightened for workers compensation in particular. How a more difficult market intersects with the forthcoming changes in the modification formula is something we can't predict at this time, but we're keeping our eyes on it for you.

Personal Injury or Bodily Injury

We are often asked to review the insurance terms in contracts, leases and such. It's quite common for these documents to specify that parties carry certain types of insurance, and liability insurance is almost always mentioned. The attorneys who draft these contracts may be good lawyers, but they are frequently guilty of serious goofs in the wording they use in defining insurance requirements.

One common mistake is to include a requirement for insurance covering "Personal Injury", when in fact what they really want is insurance covering "Bodily Injury". To a layman they might sound the same, but they have very different and distinct meanings in a liability insurance policy.

The standard commercial general liability (CGL) policy that almost every business has covers claims for bodily injury. Bodily injury means tangible physical injury (blood, bruises, broken bones) or death. Some policies may extend to cover mental or emotional injury, but normally such coverage attaches only when such injury is claimed as a consequence of a bodily injury claim (so called physical-mental claims). Claims solely for non tangible psychiatric injuries that arise from purely psychiatric causes, such as stress, anxiety, and fear only (known as mental-mental claims) won't be covered as bodily injury.

Now let's assume CGL policy is a standard Insurance Services Office (ISO) form. This policy has a separate section that provides, in addition to bodily injury coverage, coverage for "personal injury" claims. This section defines "Personal and advertising injury" to mean injury, including consequential "bodily injury", arising out of one or more of the following offenses:

a. False arrest, detention or imprisonment;

b. Malicious prosecution;

c. The wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord or lessor;

d. Oral or written publication, in any manner, of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services;

e. Oral or written publication, in any manner, of material that violates a person's right of privacy;

f. The use of another's advertising idea in your "advertisement"; or

g. Infringing upon another's copyright, trade dress or slogan in your "advertisement".

As you can see, none of these covered personal injury offenses arise from tangible injury. That's the key distinction between bodily injury and personal injury... tangible versus nontangible injury.

Personal injury coverage in the GL policy is valuable extra protection most policyholders don't know much about. Of course, there are some pertinent exclusions to consider as well. There is generally no personal injury coverage for intentional acts that could knowingly lead to a claim. There is also no coverage for claims "arising out of oral or written publication of material, if done by or at the direction of an insured with knowledge of its falsity." So if the insured knew that her comments were false and this knowledge of falsity could be substantiated, the insurer would likely have a good reason to deny coverage. Bloggers beware; judges often enforce these personal injury exclusions.

Going back to the original point, though, personal injury and bodily injury are clearly not the same thing. When reviewing or negotiating leases or contracts, beware of requirements for insurance for "personal injury" when it's clear that what is really wanted is bodily injury coverage.

Fire Legal Liability

Speaking of contracts, and leases in particular, there is another important provision that should always be included in a lease, but which is often overlooked.

Simple scenario: you rent space in a building. The landlord buys insurance on the building, while you insure your stock, contents and other property in the building. A fire starts, damaging both the building and your contents.

Both insurance companies (yours and the landlords) accept the claim, investigate, and cut checks in payment to their respective policyholders. The landlord repairs the building, you replace your contents, and life goes on.

Then you get a letter from the landlord's insurance company. It turns out their investigation revealed that the fire started when one of your employees was smoking in the men's room and threw a butt into the trash can, which ignited. They say it was your fault the fire started, and they want to be reimbursed for the money they paid for the landlord's claim.

You turn this over to your insurance company and think nothing more about it until you get another letter, from them. They politely decline to pay the landlord's insurance company for you because 1) the building was not insured on your property policy (you already knew that) and 2) they direct your attention to a part of your general liability policy that says that the policy will not pay for property damage to "Property you own, rent, or occupy...". That, of course describes your leased space, including the men's room where the fire started. You are left holding the bag.

What the landlord's insurance company is doing is exercising their right of subrogation. Subrogation is the assignment to an insurer after payment of a loss of the rights of the insured to recover the amount of the loss from the party legally liable for it. In other words, while the landlord could have sued you for the damage to his building he chose instead to file a claim and be paid by his own insurance company. The right to sue didn't go away, though, it was simply transferred to the insurance company who paid the claim, who then exercised it.

How could you avoid this unpleasant situation? There is insurance to cover this, but the best answer in this case does not involve buying more insurance. If your lease was properly written it would include a mutual waiver of subrogation. With this you and the landlord would both agree in advance to waive, or give up, subrogation rights for yourself and your insurance company in the event of a property loss like this. What that means is that each insurance company pays their respective claim to their policyholder, and closes their file.

Normally insurance companies will write provisions in their policies prohibiting policyholders from doing anything that will compromise any rights the insurance company might have. Most property policies make an exception to that rule in the case of subrogation rights as described here, as long as you waive them in a document like a lease, as here, and do it before the loss occurs. For those policies that might not have this provision, underwriters will normally add it at little or (usually) no cost.

A well written lease will always contain a mutual waiver of subrogation clause somewhere, and you should always try to have that included. It's a benefit to both landlord and tenant and there should be no resistance to it on either side.

There is one thing that's worse than not having a mutual waiver of subrogation in your lease; that would be having a one way waiver, in the other party's favor. With that he, or his insurance company, can sue you, but you, or your insurance company, can't sue him if the loss was his fault. That's the worst of all worlds for you and yet, surprisingly, we still see it from time to time.

If you look at your lease and it's lacking the mutual waiver there is an insurance solution we can help you with, but your first effort should be to get the lease modified with a waiver of subrogation. Only if that fails would you need to consider an insurance solution.

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