

**WORKERS' COMPENSATION
IN NEW YORK STATE:
STATE OF THE SYSTEM
2008**

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INTRODUCTION

Due to its length, we have divided this paper into two parts. Part One consists of four sections: the executive summary, a discussion of issues in the workers' compensation system, our recommendations, and a conclusion. Part Two is an extensive appendix intended to serve as a reference source on a number of issues.

In Part One, the executive summary (Section I) may be read independently. It summarizes problems in the workers' compensation system and offers a brief tour of the various governmental responses (primarily through legislation and task force reports). Reference is made to the portions of Section II where these problems are discussed more fully, as well as to sections of the Appendix that include a full treatment of the particular governmental response. The executive summary also includes a list of our recommended solutions.

Section II provides a full discussion of each of the major issues confronting workers, employers and insurers in New York's workers' compensation system. Reference is again made to the portions of the Appendix which relate to each of these issues.

Section III contains a summary of our recommendations for possible resolution of these systemic problems.

The issues discussed in Part One have been addressed through legislation and the reports of various Task Forces. Some of the Task Force reports address a single issue; others touch on multiple issues. Part Two consists of an Appendix divided into eight sections which address the Task Force reports and other governmental responses to the issues in the system. These sections may be read either independently or as a whole.

We hope that Part One will be useful in understanding the nature and the causes of the problems that prevent the New York workers' compensation system from achieving its intended goals, and that Part Two will serve as a reference point for intensive analysis of particular governmental responses to these issues.

PART ONE

I. EXECUTIVE SUMMARY

A. The Purpose of this Paper.

Each year, more than 125,000 New York workers suffer a work-related injury or illness.¹ Almost all are covered by the New York State Workers' Compensation Law.²

The original intent of New York's workers' compensation law was to provide speedy and adequate wage replacement benefits and medical coverage for injured workers while permitting employers to purchase insurance against the cost of occupational injury and illness.³ In essence, workers surrendered their right to sue employers for personal injury in exchange for employer assurance that certain limited benefits would be provided in a timely fashion and without controversy. Because the law is social legislation, it is intended to be interpreted broadly for the protection of workers.⁴

Over time, this basic "bargain" was increasingly eviscerated as the value of the benefits provided by law were eroded by inflationary pressures, employers increasingly came to view workers' compensation as a "cost" of business to be reduced like other commodities, and insurer pursuit of increased profit margins contributed heavily to adversarial behavior and litigation within the system.⁵

¹ Summary Annual Reports 2000 through 2005, New York State Workers' Compensation Board.

² New York State Workers' Compensation Law, Sections 2, 3, 11.

³ New York State Workers' Compensation Law, Section 11; Cifolo v. General Electric Company, 305 N.Y. 209, 215; 112 N.E.2d 197 (1953).

⁴ Verschleiser v. Joseph Stern & Son, 229 N.Y. 192,199; 128 N.E. 126 (1920); see also DiDonato v. Rosenberg, 263 N.Y. 486, 488; 189 N.E. 560 (1934) ("the Workmen's Compensation Law is to be liberally construed to serve the social need underlying it").

⁵ Workers' Compensation: A Cautionary Tale, Center for Justice & Democracy, 2006.

On March 13, 2007, legislation was enacted that made a number of significant changes to the Workers' Compensation Law.⁶ In connection with the legislation, a number of Task Forces were created to study and report on additional legislation and potential regulatory and administrative reforms of the workers' compensation system.⁷ By the end of March, 2008, most of the Task Forces had issued reports regarding their respective study areas.⁸

The purpose of this paper is to (1) identify problems in the workers' compensation system; (2) review the changes made by the 2007 legislation; (3) predict the effects of the legislation; (4) review and analyze the reports of the various Task Forces; (5) identify and discuss current workers' compensation issues beyond the scope of the Task Forces; and (6) make recommendations for alteration and implementation of the statutory changes and the recommendations of the Task Forces.

⁶ 2007 New York Workers' Compensation Reform Act, 3/13/07.

⁷ Id.

⁸ Report to the Governor from the Superintendent of Insurance Summarizing Workers' Compensation Data and Recommending Improvements in Data Collection and Development of a Research Structure for Public Policy, NYS Insurance Department, available at http://www.ins.state.ny.us/wc/wc_index.htm; Report of the Commissioner on Return to Work, NYS Dept. of Labor, available at http://www.labor.state.ny.us/agencyinfo/ReturntoWorkReportMarch12_2008.shtm; Recommended Workers' Compensation Streamlined Docket Regulations, NYS Insurance Dept, available at http://www.ins.state.ny.us/wc/wc_index.htm; Individual Self-Insurance Alternative Funding Models, NYS Workers' Compensation Board, available at <http://www.wcb.state.ny.us/content/main/PressRe/2007/NewFundingModelForSIClaims.jsp>; Knee Injury Medical Treatment Guidelines, NYS Insurance Department, available at http://www.ins.state.ny.us/wc/wc_index.htm; Low Back Injury Medical Treatment Guidelines, NYS Insurance Department, available at http://www.ins.state.ny.us/wc/wc_index.htm; Shoulder Injury Medical Treatment Guidelines, NYS Insurance Department, available at http://www.ins.state.ny.us/wc/wc_index.htm; Cervical Spine Injury Medical Treatment Guidelines, NYS Insurance Department, available at http://www.ins.state.ny.us/wc/wc_index.htm; General Principles: Medical Treatment Guidelines, NYS Insurance Department, available at http://www.ins.state.ny.us/wc/wc_index.htm; Medical Treatment Guidelines Education Plan, NYS Insurance Department, available at http://www.ins.state.ny.us/wc/wc_index.htm.

B. Background.

This paper is a sequel to Workers' Compensation: State of the System, 2006 (hereinafter "the 2006 White Paper"), which was prepared to inform the discussion which led to the 2007 legislation.⁹ The 2006 White Paper identified the principal problems in the New York workers' compensation system as "the amount of benefits injured workers receive, delays in medical treatment, cost to employers, lack of transparency regarding insurance carrier financial information, and the state Workers' Compensation Board's administrative procedures."¹⁰ The paper made a number of recommendations for the resolution of these problems.

For injured workers, the 2006 White Paper suggested "increasing the maximum and minimum benefit rates; indexing benefit rates so that they rise as State wages rise; raising authorization limits to expedite medical care; and legislative and regulatory change to improve access to benefits."¹¹

For employers, the 2006 White Paper suggested "enforcement against dishonest employers, restoring payroll dollars to the workers' compensation system upon which premium can be charged and ensuring that premium charges are based on actual employment information ... [and] [e]nhanced transparency of insurer data (through independent verification of insurer information) regarding claims, expenses, and profits [which would permit] an informed comparison of insurer performance."¹²

For insurance carriers, the 2006 White Paper suggested a "transfer [of] the functions of the [New York Compensation Insurance Rating Board] to an independent

⁹ Workers' Compensation: State of the System, 2006, NYCOSH/Robert E. Grey, available at [http://www.nyworkerscompensationalliance.org/WorkersCompensationWhitePaper3_06\[1\].d06\(1\).pdf](http://www.nyworkerscompensationalliance.org/WorkersCompensationWhitePaper3_06[1].d06(1).pdf).

¹⁰ Id. at page 4.

¹¹ Id. at p. 5.

¹² Id. at p. 6.

entity (possibly the Insurance Department) with authority to investigate, audit, and verify insurer claims,” or in the “alternative ... exclude private insurers from the workers’ compensation insurance market in favor of the State Insurance Fund.”¹³

For the Workers’ Compensation Board, the 2006 White Paper suggested “the reduction of barriers to worker benefits and the modification or abandonment of archaic rules and regulations. The latter includes excessive time periods for authorization of medical testing or treatment, periodic production of medical evidence to support continued benefit awards, and administrative procedures that encourage litigation.”¹⁴

Many of suggestions contained in the 2006 White Paper were taken up in the 2007 legislation, and others are presently the subject of the Task Force reports. However, both the legislation and the Task Force reports also went beyond (and in some cases contradicted) the recommendations of the 2006 White Paper.

C. Issues in the Workers’ Compensation System.

Many of the issues in the workers’ compensation system that were identified in the 2006 White Paper still exist. In some instances this is because the bulk of the effects of the 2007 legislation and the recommendations of the various Task Forces have yet to take effect. In others it is because the issues have not yet been addressed through legislation, regulation, or administration. In a few instances the legislation and recommendations of the Task Forces are likely to exacerbate existing problems.

¹³ Id. at p. 7.

¹⁴ Id. at p. 8.

1. Availability and Accuracy of Data.

Several Task Force reports have identified a significant problem in the lack of availability and accuracy of data about the performance of the workers' compensation system.¹⁵ Unfortunately, in some instances this has not prevented the Task Forces from making recommendations based on plainly flawed information, rather than deferring comment until data collection and analysis issues have been resolved. This issue is discussed in Section II.A. and is also considered in Appendix V.

2. Access to Benefits.

Access to benefits remains a significant issue that has been given scant attention. The issue was absent from the 2007 legislation, was considered to a minimal extent by the Streamlined Docket Task Force, and as yet has not been addressed administratively by the Workers' Compensation Board (hereinafter "the WCB"). This issue is discussed in Section II.B. and Appendices II and VI.

3. Wage Replacement Benefits.

The issue of the adequacy of wage replacement benefits was a primary focus of the 2007 legislation.¹⁶ The legislative solution to this issue was to increase the maximum weekly benefit rate and to ultimately index that rate to the New York State average weekly wage. This solution will provide some benefit to a small percentage of high wage

¹⁵ See, e.g., Report to the Governor from the Superintendent of Insurance Summarizing Workers' Compensation Data and Recommending Improvements in Data Collection and Development of a Research Structure for Public Policy, NYS Insurance Department, available at http://www.ins.state.ny.us/wc/wc_index.htm.

¹⁶ NYS Governor's Office Press Release: Workers' Compensation Rates to Drop by Record 20.5%, July 11, 2007, available at <http://www.ny.gov/governor/press/0711071.html>.

workers for short periods of temporary disability. However, the increase in the maximum benefit rate was tied to the implementation of time limitations (“caps”) on permanent partial disability benefits. Rather than increasing worker benefits, the net effect of these changes was to reduce benefit payments by approximately \$700 million annually.¹⁷

These issues are discussed in Section II.C. and Appendices I and V.

4. Medical Treatment.

Medical treatment issues were the subject both of the 2007 legislation and of the Medical Guidelines Task Force, which has issued a partial report.¹⁸ The thrust of the statutory changes was to streamline the approval process for medical treatment in exchange for increased employer and carrier control over the treatment process. The Medical Guidelines Task Force report addresses certain treatment issues but does not address revision of the WCB’s Medical Guidelines, which could directly impact the amount of benefits injured workers receive. These issues are discussed in Section II.D. and Appendix III.

5. Return to Work Policy.

Return to work policy is connected to a number of other workers’ compensation issues. In addition to being central to the mission of workers’ compensation programs, it can affect medical treatment and wage replacement issues, as well as the nature, scope,

¹⁷ Summary 2007 Rate Revision Pre-Filing, New York Compensation Insurance Rating Board, June 26, 2007.

¹⁸ Knee Injury Medical Treatment Guidelines, NYS Insurance Department; Low Back Injury Medical Treatment Guidelines, NYS Insurance Department; Shoulder Injury Medical Treatment Guidelines, NYS Insurance Department; Cervical Spine Injury Medical Treatment Guidelines, NYS Insurance Department; General Principles: Medical Treatment Guidelines, NYS Insurance Department; Medical Treatment Guidelines Education Plan, NYS Insurance Department. All are available at http://www.ins.state.ny.us/wc/wc_index.htm

cost and payor of vocational rehabilitation programs. These tasks were delegated to the Department of Labor by the 2007 legislation, and the Department issued a report from the Return to Work Task Force.¹⁹ The report recommends a number of incremental changes of policy and procedure in this area, and identifies other areas for further consideration, legislation and regulation. These issues are discussed in Section II.E. and Appendix IV.

6. Employer Fraud.

Employer fraud was a significant focus of the 2007 legislation, and is one of the areas that have been implemented most quickly by the WCB. In essence, the 2007 legislation increased civil and criminal penalties for the failure to maintain workers' compensation insurance, equated under-reporting of payroll and misclassification of employees with uninsured status, and provided the WCB and other agencies with additional tools and resources to identify and prosecute violators. These issues are discussed in Section II.F..

7. Reduction of Employer Costs.

Reduction of the cost to employers of workers' compensation insurance was perhaps the single most important factor in the enactment of the 2007 legislation.²⁰ Virtually every aspect of the legislation was designed to effectuate this outcome. The reports and recommendations of many of the Task Forces continue to be addressed to the

¹⁹ Report of the Commissioner on Return to Work, NYS Dept. of Labor, available at http://www.labor.state.ny.us/agencyinfo/ReturntoWorkReportMarch12_2008.shtm.

²⁰ NYS Governor's Office Press Release: Workers' Compensation Rates to Drop by Record 20.5%, July 11, 2007, available at <http://www.ny.gov/governor/press/0711071.html>.

further reduction of employer costs. These issues are discussed in Section II.G. and Appendix V.

8. Self-Insurers.

The 2007 legislation also directed the WCB to review and report on self-insurance issues, both for individual self-insurers and for self-insurance trusts. The WCB issued a report recommending a change from the “silo” approach to self-insurance in which each employer is required to post security for payment of its claims to a “pooled” approach, in which the security posted by all self-insured employers is pooled to provide payment in the event of default by one.²¹ Although certain information is currently available, the WCB has not yet issued a formal report regarding the issue of self-insured trusts. These issues are discussed in Section II.H..

D. The 2007 Legislation.

The 2007 legislation significantly altered New York’s workers’ compensation system. The stated intent of the legislation was to improve benefit amounts and reduce systemic obstacles for injured workers while cutting overall costs for employers.²² Changes were made in the amount of benefits, the time periods for eligibility, the availability of medical care, delivery of medical services, and certain technical procedural areas. A detailed discussion of the legislation may be found Appendix I. A summary appears below.

²¹ Individual Self-Insurance Alternative Funding Models, NYS Workers’ Compensation Board, available at <http://www.wcb.state.ny.us/content/main/PressRe/2007/NewFundingModelForSIClaims.jsp>.

²² NYS Governor’s Office Press Release: Workers’ Compensation Rates to Drop by Record 20.5%, July 11, 2007 available at <http://www.ny.gov/governor/press/0711071.html>.

In the area of benefits, the legislation attempted to address the fact that the statutory maximum benefit rate was inadequate by increasing the maximum rate incrementally from \$400 per week (where it remained from July 1, 1992 to July 1, 2007) to \$600 per week (as of July 1, 2009), and then indexing the maximum rate to the New York State average weekly wage as determined by the Commissioner of Labor effective July 1, 2010.²³ This increase in the statutory maximum benefit was tied to a schedule of time limits on benefit payments for permanent partial disability, which previously were not subject to time limitation. It has been estimated that the net effect of the rate raise and the time limitations is a savings to employers (alternatively viewed as a reduction in benefits) of approximately \$700 million per year.²⁴ To date, there has been no change in WCB procedures that determine a worker's "degree of disability" or "loss of earning capacity," which in turn affect the amount of weekly benefits the worker actually receives – which in most instances is less than the statutory maximum rate.

In the area of medical treatment, the legislation increased the pre-authorization threshold for specialized treatment or diagnostic testing from \$500 to \$1,000, while giving employers and carriers control over the facilities to be used by injured workers. The legislation also called for the establishment of a list of "best medical practices," a list of "pre-authorized procedures," and fee schedules for prescription medication and durable medical goods.²⁵ Implementation was left to the WCB and the Medical Guidelines Task Force, which thus far have only partially addressed the legislative mandate.

²³ Workers' Compensation Law Section 15.

²⁴ Summary 2007 Rate Revision Pre-Filing. New York Compensation Insurance Rating Board, June 26, 2007; NYS Governor's Office Press Release: Workers' Compensation Rates to Drop by Record 20.5%. July 11, 2007, available at <http://www.ny.gov/governor/press/0711071.html>.

²⁵ 2007 New York Workers' Compensation Reform Act Sections 25-30, 72, 3/13/07

In the area of employer fraud, the WCB was directed (in co-operation with other State agencies) to identify employers that (1) fail to secure insurance; (2) understate payroll; and (3) misclassify employees. Criminal and civil penalties were increased, with a two-tier system depending on whether the employer has more than five employees.²⁶

The primary purpose of the statutory amendments regarding employer fraud was to recapture insurance premium that previously escaped through the underreporting of payroll and the misclassification of employees. Other effects of these amendments are to level the competitive playing field for legitimate employers and to improve worksite safety.

The legislation also made a large number of secondary changes to the Workers' Compensation Law, including achieving the "sunset" of the Second Injury Fund (the Special Funds WCL Section 15(8) Fund).²⁷

E. The Streamlined Docket Task Force.

The issue of "controverted claims," in which the employer or carrier contest the worker's basic entitlement to benefits on grounds such as "no jurisdiction," "untimely notice to the employer," "no accident arising out of and in the course of employment," was identified as an area of particular concern. This led to the creation of the Streamlined Docket Task Force (known generally as "the Rocket Docket"), which was charged with identifying a means of reducing controversies and expediting the resolution of controverted claims. The report of this Task Force and the proposed forms that

²⁶ 2007 New York Workers' Compensation Reform Act Sections 1, 7-24, 3/13/07.

²⁷ 2007 New York Workers' Compensation Reform Act Sections 1, 75-79, 3/13/07.

resulted from its suggestions are discussed at length in Appendix II. A summary of that discussion appears below.

The report of the Streamlined Docket Task Force²⁸ identified three interconnected areas for administrative and regulatory reform. The ultimate recommendation of the Task Force was that the WCB adopt a highly expedited schedule for litigation of controverted accident claims in which the worker has an attorney, which are approximately 30% of all controverted claims.

Due to the fact that this expedited schedule begins to run from the date the WCB “indexes” a claim, the Task Force further recommended that the WCB decline to “index” claims until all necessary documents were filed, thus attempting to ensure that the parties would have some form of “discovery” before being subject to the expedited procedures.

Finally, due to the perceived inadequacy of existing WCB forms, the Task Force recommended the creation and adoption of new forms providing more detailed information about the claim.

The report of the Streamlined Docket Task Force and the new forms proposed by the WCB in response to the report have generated significant controversy and present practical and legal issues for all parties in the workers’ compensation system.

F. The Medical Guidelines Task Force.

Medical treatment issues are the foundation of all workers’ compensation systems. Absent a work-related injury or illness resulting in the need for medical treatment and/or causing a loss of earning capacity, there is no need for workers’

²⁸ Recommended Workers’ Compensation Streamlined Docket Regulations, NYS Insurance Dept., available at http://www.ins.state.ny.us/wc/wc_index.htm.

compensation. As a result, medical guidelines for diagnosis and treatment are a critical element of workers' compensation programs, as is the relationship between medical impairment, loss of earning capacity (a medical-vocational issue) and benefit awards. A more detailed discussion of the report and remaining issues facing the Medical Guidelines appears in Appendix III. A summary appears below.

Thus far, the Medical Guidelines Task Force has issued a partial report addressing best treatment guidelines for injury to the four body parts seen as the most significant "cost drivers" for employers and carriers.²⁹

The Task Force has not issued a report regarding revisions to the WCB Medical Guidelines, which are used by the WCB to assess "degree of disability" and "schedule loss of use." Degree of disability is the primary component in the WCB's assessment of an injured worker's loss of earning capacity, which in turn determines the amount of the worker's weekly benefit for replacement of lost wages. Schedule loss of use awards are the amount of compensation provided for permanent injury to extremities, vision loss, and hearing loss.

At one point, the Task Force contracted with Dr. Christopher Brigham, editor of the Sixth Edition of the American Medical Association Guidelines ("the AMA Guidelines") to "translate" the AMA Guidelines for use in New York.³⁰ Due to the wide divergence between the principles of the AMA Guidelines and existing New York law

²⁹ Knee Injury Medical Treatment Guidelines, NYS Insurance Department; Low Back Injury Medical Treatment Guidelines, NYS Insurance Department; Shoulder Injury Medical Treatment Guidelines, NYS Insurance Department; Cervical Spine Injury Medical Treatment Guidelines, NYS Insurance Department; General Principles: Medical Treatment Guidelines, NYS Insurance Department; Medical Treatment Guidelines Education Plan, NYS Insurance Department. All are available at http://www.ins.state.ny.us/wc/wc_index.htm

³⁰ Unions vs. Injury Expert, New York Times March 10, 2008 (available at <http://www.nytimes.com/2008/03/10/nyregion/>); AMA Guidelines Loom in N.Y. Debate, Workcomp Central, 10/30/07.

and practice, this approach was highly controversial. As a result, existing guidelines for “degree of disability” and “schedule loss” evaluation remain in effect.

G. The Return to Work Task Force.

While the Streamlined Docket Task Force issued a complete report, and the Medical Guidelines Task Force issued a partial report covering only the material on which the participants were in agreement, the Return to Work Task Force issued a report making recommendations on subjects in which agreement could be reached and identifying areas in which agreement could not be reached, as well as the reasons for disagreement.³¹ As a result, the Return to Work Task Force report is of value both as a group of current recommendations and as a template for further legislative and administrative consideration. A complete discussion of the report of the Return to Work Task Force appears in Appendix IV. A summary appears below.

The Task Force recognized that an essential element of the 2007 legislation was the use of vocational factors in benefit determinations, and that this was tied to the availability and efficacy of vocational rehabilitation evaluations and programs. As a result, the Task Force recommended (1) development of return-to-work educational programs for employers; (2) requirement of formal return-to-work policy by employers of more than 25 workers; (3) re-design of WCB forms regarding vocational information; (4) education of physicians in occupational health issues; (5) WCB-paid vocational rehabilitation evaluation of all claimants who reach maximum medical improvement and have not returned to work; (6) development of incentive programs for hiring disabled

³¹ Report of the Commissioner on Return to Work, NYS Dept. of Labor, available at http://www.labor.state.ny.us/agencyinfo/ReturntoWorkReportMarch12_2008.shtm.

workers; (7) payment of attorneys in “medical only” cases; (8) WCB review of cases to ensure proper awards for reduced earnings; and (9) data collection on return to work rates.

The Task Force was unable to reach agreement on whether many of these programs should be mandatory, the extent of the programs, how to implement the statutory “safety net” and funding issues. The primary reason for the lack of agreement appears to have been the unwillingness of employers and carriers to incur up-front costs in exchange for long-term savings. Absent resolution of these problems, the existing recommendations of the Task Force are unlikely to have a significant impact on benefits for injured workers or on return to work rates.

H. The Insurance Department Report.

The New York State Insurance Department (hereinafter “the Insurance Department”) played a significant role both in the 2007 legislative process and in producing the subsequent Task Force Reports. In addition to generating the Streamlined Docket report and its involvement with CIRB and self-insurance issues, the Insurance Department has issued a report involving workers’ compensation data and claim trends.³² This report, a pivotal document touching on almost every issue in the workers’ compensation system, is discussed in depth in Appendix V.

The Insurance Department report focuses on the “costs” of workers’ compensation, which are composed primarily of benefits paid to injured workers and

³² Report to the Governor from the Superintendent of Insurance Summarizing Workers’ Compensation Data and Recommending Improvements in Data Collection and Development of a Research Structure for Public Policy, NYS Insurance Department., available at http://www.ins.state.ny.us/wc/wc_index.htm.

treating physicians. The report concludes that “average cost per claim” is rising and that there are significant “frictional costs” largely due to controverted cases and claimant attorney fees. The report suggests that further data be collected about claimants, administrative judges, employers and insurance carriers, claimant attorneys and treating physicians, while excluding defense attorneys and “independent medical examiners” (hereinafter “IMEs”) from evaluation.

There are a number of reasons to question the utility of the Insurance Department report, not least of which is the fact that the report suggests that accurate data be collected before final conclusions can be reached – and then proceeds to arrive at conclusions in the absence of reliable data. The Insurance Department instead uses data obtained from the CIRB and the WCB, which is unreliable for a variety of reasons. Finally, whether “average cost per claim” is a relevant basis for analysis is debatable, as overall costs can decline significantly even as average costs per claim increase. There is substantial evidence that overall costs in New York have remained stable or declined in the past ten to fifteen years.

I. Workers’ Compensation Board Procedures.

The impact of the Workers’ Compensation Law (including the 2007 legislative changes) is largely dependent on how it is administered by the WCB. As an administrative agency, the WCB has tremendous latitude in deciding how to process claims and award benefits. The manner in which the WCB exercises its discretion has a direct impact on worker benefits.

The WCB currently limits worker access to benefits through two procedures: non-hearing determinations and the use of “no further action” status. Non-hearing determinations often result in the closure of claims without awarding all available benefits to the injured worker, especially those who are unrepresented. The WCB’s use of the “no further action” designation to remove cases from its docket of active claims transfers the obligation to the injured worker to repeatedly take affirmative action to pursue benefits. In addition, this designation obscures the distinction between claims that have been truly resolved and those that are temporarily inactive, preventing a meaningful analysis of many workers’ compensation issues.

WCB procedures are discussed at length in Appendix VI, as well as in many of the other sections of the Appendix. Their impact permeates most of the issues considered in Section II, especially access to and amount of benefits.

J. Immigrant Worker Issues.

Immigrant workers with workers’ compensation claims are confronted with language, cultural, and practical issues that affect not only their ability to access benefits but also the amount of benefits that they receive and their ability to make use of those benefits. These problems were compounded by the decision in Ramroop v. Flexo-Craft Printing, Inc.,³³ in which the WCB denied a particular type of workers’ compensation benefit to a severely injured worker based on that worker’s immigration status. Workers’ Compensation Law Section 17 prohibits the WCB from using immigration status in awarding benefits, and although the WCB found another technical basis for denying benefits in this case, immigration status was the ultimate basis of the WCB’s decision.

³³ Ramroop v. Flexo-Craft Printing, Inc., 41 A.D.2d 1035 (3rd Dept. 2007).

This decision was upheld by the Appellate Division based solely on immigration status, and the case is on appeal to the Court of Appeals.

The use of immigration status to deny workers' compensation benefits is not only contrary to the letter and the spirit of the Workers' Compensation Law, it is contrary to public policy and would reward employers for safety and health violations. These issues are discussed in Appendix VII.

K. World Trade Center Issues.

On August 13, 2006, Article 8-A was added to the Workers' Compensation Law.³⁴ This amendment permitted World Trade Center ("WTC") responders to file a registration form, thus preserving their ability to claim benefits at a later date should they become ill due to WTC exposures. The law was also intended to liberalize the time period in which WTC responders are required to file claims. In general, the law was meant to ease their path to claiming and receiving benefits.

In practice, Article 8-A has become a resource used by employers and carriers to contest workers' compensation claims of WTC responders. The defenses usually advanced are (1) the claim is time-barred despite the new law; (2) the condition is not "latent" and thus not covered by the law; and/or (3) the responder's medical problem is not "causally related" to his or her WTC exposure.

The particular issues of WTC responders in the workers' compensation system and proposed remedies are discussed in Appendix VIII.

³⁴ Workers' Compensation Law Section 161 et. seq.

L. Recommendations.

This paper makes the following recommendations:

Availability and Accuracy of Data

1. Create a New York Workers' Compensation Research Institute ("NYWCRI") within the Cornell University School of Industrial and Labor Relations.
2. Continue the process of eliminating the CIRB not only as a rate-making entity but also as a primary repository of information about workers' compensation. Transfer the rate-making function to the Insurance Department. Transfer the data collection function to the NYWCRI, with insurers, self-insurers, and the WCB to report data directly to NYWCRI.
3. Require the WCB to distinguish between claims that are fully resolved and those that are temporarily inactive.
4. Require the WCB to collect and report data regarding workers' compensation defense costs, including (a) defense attorney costs by carrier and employer; (b) IME costs by carrier and employer; (c) claims controverted by carrier and employer; and (d) outcome data by carrier and employer.
5. Require the WCB to collect and report data regarding IMEs, including the results of IME examinations by IME and by IME vendor.
6. Require the WCB to collect and report data regarding actual claim costs for medical and indemnity by type of injury and type of award.

7. Require the WCB to collect outcome data in controverted claims.

Access to Benefits

8. Eliminate non-hearing determinations by the WCB.
9. Require the WCB to translate forms and informational literature into additional foreign languages.
10. Eliminate WCB use of “no further action” status for claims that have not been fully resolved.
11. Provide for carrier payment of claimant attorney fees in cases involving medical treatment only.
12. Require carrier payment of claimant attorney fees in controverted cases.

Wage Replacement Benefits

13. Index the statutory minimum benefit to 25% of the statutory maximum benefit.
14. Re-define “total disability” as the inability to engage in one’s former work or any suitable light-duty position made available by the employer or through the vocational rehabilitation process.
15. Establish a statutory presumption that a worker who has stopped work due to the compensable injury is entitled to an award of benefits for loss of earning capacity attributable to the injury.
16. Provide cost of living increases for workers’ compensation benefits to offset the effects of inflation.

17. Amend the 2007 legislation to make the \$500 maximum benefit rate effective March 13, 2007 instead of July 1, 2007.
18. Eliminate the time limitations on benefits for permanently partially disabled workers.

Medical Treatment Issues

19. Clarify the 2007 legislation to establish that diagnostic tests performed at facilities selected by the employer or carrier are limited to radiological tests with films to be copied for the injured worker and/or his physician. Provide for repeat testing if films resulting for the first test are of poor quality.
20. Establish a limited radius as the geographic area in which diagnostic test facilities selected by the employer or carrier must be located in relation to the claimant's residence. Consider a different radius upstate and downstate.
21. Require workers' compensation carriers to reimburse non-workers' compensation payors for medical expenses they pay at 125% of the amount of the bills paid.
22. Eliminate the requirement that the injured worker must have a C-4 form every 45 days as a condition of continued benefits payments.

Return to Work Policy

23. Adopt and implement the recommendations of the Return to Work Task Force.
24. Establish a statewide employer education program administered by the WCB and funded by assessments on insurers and self-insurers to promote the advancement and implementation of return to work programs.
25. Establish funding for vocational rehabilitation services through assessments on employers and self-insurers in the absence of other federal and state funding.
26. Incentivize employers to establish and utilize return to work programs by deeming injured workers totally disabled if not returned to work by the employer or through the vocational rehabilitation process.
27. Exclude time spent in the vocational rehabilitation process from the time limits on permanent partial disability for accidents occurring after March 13, 2007.

Workers' Compensation Board Procedures

28. Impose time limits for decisions by administrative law judges and the WCB Office of Appeals.
29. Eliminate depositions of medical witnesses.
30. Clarify WCB regulations to establish that IMEs must personally mail their reports to all parties in the same time and using the same manner.

31. Increase the amounts of existing statutory penalties, make their use mandatory instead of discretionary, and target conduct such as the frivolous controversy of cases.
32. Reduce time periods for employer and insurer compliance and filing while expanding existing electronic filing programs.
33. Make statutory and regulatory changes aimed at reducing adjournments and lack of preparedness, including preclusion of cross-examination in the absence of contradictory evidence.
34. Render certain WCL Judge decisions non-appealable.

Claims Involving Immigrant Workers

35. Amend WCL Section 17 to clarify that the WCB may not use immigration status for any purpose in the determination of a claim or any part thereof.
36. Translate WCB forms and instructions into multiple languages.
37. Make translation services used by WCB available to injured workers.

World Trade Center Claims

38. Amend Article 8-A to prohibit the WCB from establishing a date of disablement more than 2 years prior to the date a claim is filed.
39. Amend Article 8-A to establish a list of medical conditions presumed to be causally related to WTC exposure.

40. Amend Article 8-A to define “latent condition” to include (but not be limited to) to the list of medical conditions presumed to be causally related to WTC exposure.

Employer Fraud

41. Provide the WCB with additional staff to enforce existing law regarding employer obligations.
42. Establish a searchable database allowing private individuals to verify an employer’s workers’ compensation insurance status and the number of employees reported by the employer as covered under the policy.

Premium Costs

43. Consider making the New York State Insurance Fund the exclusive workers’ compensation insurer in the state.

Self-Insurance Issues

44. Adopt the WCB recommendation to change self-insurance from a “silo” approach to a “pooled” approach.
45. Require self-insurers to re-qualify for self-insured status annually.
46. Make self-insurers and the State Insurance Fund subject to Aggregate Trust Fund payments in cases of permanent partial disability.

II. ISSUES IN THE WORKERS' COMPENSATION SYSTEM.

This section will identify some of the basic issues involved in workers' compensation policy, including (1) availability and accuracy of data; (2) access to benefits; (3) adequacy of wage replacement benefits; (4) medical treatment issues; (5) return to work policy; (6) employer fraud; (7) premium costs; and (8) self-insurance issues. Many of these issues are interrelated. The Appendix highlights how these issues were addressed by the 2007 legislation and the reports of the various Task Forces, as well as their impact on specific matters such as the claims of immigrant workers and WTC responders.

A. Availability and Accuracy of Data

There is a critical lack of accurate and reliable data regarding New York's workers' compensation system. There is presently no single entity or agency that is charged with collecting and analyzing workers' compensation claims, and the reliability of data reported by the existing entities is often undermined by their self-interest. The two primary entities that presently possess or collect data about the system are the CIRB and the WCB. In each instance, the data reported by these entities is suspect.

1. The CIRB.

One of the most complete sources of claim data is the CIRB, which receives information from insurers regarding their claim costs. The CIRB then compiles and analyzes this data for rate-making purposes. Unfortunately, there are a number of

significant problems with the accuracy of the data previously reported by CIRB. These problems are considered at length in Appendix V, but are outlined below.

First, CIRB receives data only from private insurers and the State Insurance Fund, which together amount to about two-thirds of the market in New York.³⁵ The self-insured sector of the market (the other one-third) did not report data to CIRB (or to any other source), and thus a significant amount of data was lost.

Second, CIRB does not effectively audit or verify the accuracy of the information it receives from insurers. As a result, the reliability of CIRB data was subject to severe criticism. One such instance occurred in July, 2006, when the Insurance Department disapproved the CIRB's filing for a significant rate increase.³⁶ At that time, the Insurance Department reviewed the history of rate changes going back to 1995, observing that there has been "an overall average rate decrease of 30%" over that time span, but that insurers continued "to earn a reasonable return on capital."³⁷ The Insurance Department pointed out that with the exception of 2001 (due to the September 11th attacks), from 1997 through 2004 the average return on net worth for New York workers' compensation insurers was 9.4%.³⁸ The discrepancy between the CIRB's claims and substantial

³⁵ Report to the Governor from the Superintendent of Insurance Summarizing Workers' Compensation Data and Recommending Improvements in Data Collection and Development of a Research Structure for Public Policy, NYS Insurance Department, at pp. 21-22, available at http://www.ins.state.ny.us/wc/wc_index.htm.

³⁶ In the Matter of Workers' Compensation Insurance Rate Application of the New York Compensation Insurance Rating Board, Opinion and Decision of New York State Insurance Department, 7/17/06, available at http://www.ins.state.ny.us/wc/wc_index.htm.

³⁷ Id. According to the New York State Workers' Compensation Board's 2001 Summary Annual Report there was a 39.1% reduction in the manual rates for workers' compensation benefits from 1995 through 2001. Further, in a press release, the Superintendent of the Insurance Department stated that a "detailed analysis of the [CIRB] application demonstrated that an increase is not warranted. ... The statistical data that was submitted as part of the rating board's application, and the testimony received at the public hearing, indicate the workers' compensation insurance market in New York remains quite profitable."

³⁸ Id.

contradictory data led the Insurance Department to reject the application for a rate increase in its entirety.

Third, the manner in which CIRB collected data is not always compatible with relevant workers' compensation practice. A prime example is the CIRB's claim about the cost of permanent partial disability claims, which was a fundamental basis of the 2007 legislation time-limiting permanent partial disability benefits. Prior to the enactment of the legislation, the method by which the CIRB calculated the cost of permanent partial disability awards was not generally available. The March, 2008 report of the Insurance Department revealed this methodology for the first time, and provided an outstanding illustration of its lack of reliability.

The Insurance Department revealed for the first time that the CIRB does not actually distinguish between schedule loss of use awards (which are finite awards for permanent injury to extremities) and permanent partial disability awards. "Instead, CIRB splits PPD into major and minor categories. Separating PPD data as scheduled and non-scheduled is critical information."³⁹ The Insurance Department further revealed that the CIRB's determination of whether a "PPD" claim was "major" or "minor" depended on whether the carrier's reserves on the claim were more or less than \$22,000.⁴⁰ It must be noted that a worker earning \$600 per week would be entitled to an award of \$22,000 or more with schedule loss awards totaling 17.5% of an arm, 20% of a leg, 22.5% of a hand or 27.5% of a foot. It is therefore apparent that counting all "major PPD" claims as permanent partial disabilities in fact included a vast number of schedule loss awards, thus resulting in an incalculable overestimation of the cost of permanent partial disabilities.

³⁹ Insurance Department Report at p. 22.

⁴⁰ Id. at p. 22, footnote 24.

Perhaps even worse than the CIRB's inclusion of schedule loss awards in its estimation of PPD costs is that fact that, according to the Insurance Department, none of the CIRB's "data" was based on actual claim costs. Instead, "the CIRB classifies the data as it is projected by the payor, i.e., when an insurer projects that a [temporary disability] case will become a PPD case, it reserves the case as a PPD and forwards the case data to CIRB as a PPD."⁴¹ In other words, CIRB reports the number and type of PPD cases not based on the actual result of any particular claim, but rather based on the carrier's "projection" of the claim, which projection is directly tied to the carrier's need or desire to set reserves aside. The CIRB made no effort to evaluate the extent to which these "projections" related to actual costs. The accuracy of carrier "projections" is affected by many factors, not least of which is the impact of Section 32 settlements. The Insurance Department found that 78% of the cases resolved by Section 32 settlement between 2000 and 2006 did not involve permanency.⁴² It is highly likely that a large percentage of these 12,645 claims were matters in which the carrier "projected," but never actually paid, benefits for permanent partial disability.

As a result of these and other factors, the 2007 legislation prohibited the CIRB from functioning as a rate-making entity, and directed the Insurance Department to report on a means of transferring this function.⁴³ Although the Insurance Department has proposed a means of achieving this goal, it does not ameliorate the issue of inaccurate data collection by the CIRB.

⁴¹ Id. at p. 29, emphasis added.

⁴² Id. at p. 103.

⁴³ 2007 New York Workers' Compensation Reform Act Section 57, 3/13/07.

2. The WCB.

The WCB is also a primary source of data about the workers' compensation system. Unfortunately, the utility of WCB data is also impaired for a number of reasons.

First, the WCB's ability to collect data is limited by technical issues. The WCB has claimed that it is unable to provide claim information on a "by employer" basis on the grounds that employer names are recorded by the WCB as "text" and not "data." By way of example, claims against the New York City Transit Authority are supposedly recorded by the WCB based on the worker's identification of the employer on the C-3 claim form. This could be "NYCTA," "NYC Transit Authority," "New York City Transit Authority," "New York City TA," or other variations.⁴⁴ By contrast, insurers and claimant attorneys are assigned "codes" by the WCB that permits data collection for those entities. Until Employer Identification Numbers (EINs) are required on employer C-2 forms (or the WCB assigns codes to employers as it does to carriers and claimant attorneys), there is apparently no way for the WCB to track or report claim data by employer.

Second, the utility of WCB data is limited by the fact that the agency does not collect medical cost information and that its collection of indemnity data appears to have been haphazard until recently. As a result, the WCB is unable to provide a clear picture of claims by type, the amount of benefits paid, or other critical information.

Third, certain WCB procedures actually obscure crucial information about worker experience in the system. Until approximately the year 2000, the WCB identified the result of a hearing in one of three ways: "adjourned" (no substantive action taken); "continued" (substantive action taken but the claim is not fully resolved); and "closed"

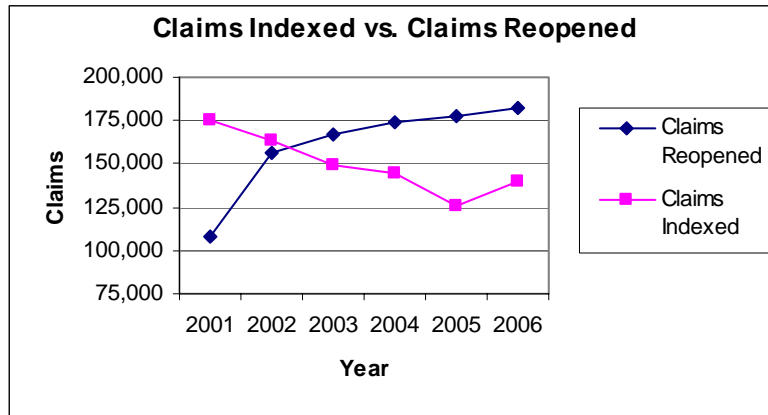
⁴⁴ Of course, the Transit Authority is self-insured and the WCB could identify claims against this employer by carrier code. It is used for illustrative purposes only because of the variety of ways its name may be recorded on a C-3.

(case fully resolved). Under this system the status and progress of all claims could (potentially) be easily identified, as well as the average amount of time it took for a claim to be fully resolved. Unfortunately, when this system was in use the WCB lacked the technical ability to track this data.

In 2000, around the same time it implemented modern information technology systems, the WCB eliminated the use of the word “closed,” instead substituting the phrase “no further action is contemplated by the Board at this time” (hereinafter “NFA”). WCL Judges, who were always encouraged to close as many cases as possible in order to build the WCB’s statistics of “resolved” claims, were instructed to aggressively use the new “NFA” procedure wherever possible. As a result, claims in all stages of the process are now simply marked “NFA,” and no distinction is drawn between claims that are fully resolved and those that have simply been “taken off of the calendar” only to be imminently reopened for further action. Thus, despite its technological advance, the WCB is unable to provide any accurate information regarding how many cases are actually fully resolved as opposed to how many cases have simply been made temporarily administratively inactive. For the same reason, the WCB is unable to provide a meaningful answer to the question of how long it takes the average claim to become “fully resolved.”

The chart below illustrates the rise in the number of cases reopened by the WCB each year from 2001 through 2006 as compared to the number of claims indexed by the WCB in each of those years. It will immediately be observed that the number of claims reopened surpassed the number of claims indexed beginning in 2003. The trend line for

claims reopened is directly attributable to the WCB's use of the NFA procedure and clearly demonstrates the unreliability of WCB data regarding "resolved claims."



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Another WCB initiative that affects both statistics and the actual delivery of benefits is the use of non-hearing determinations. These decisions are largely comprised of boilerplate language that is unintelligible to most injured workers, and almost invariably conclude with an "NFA" finding.⁴⁶

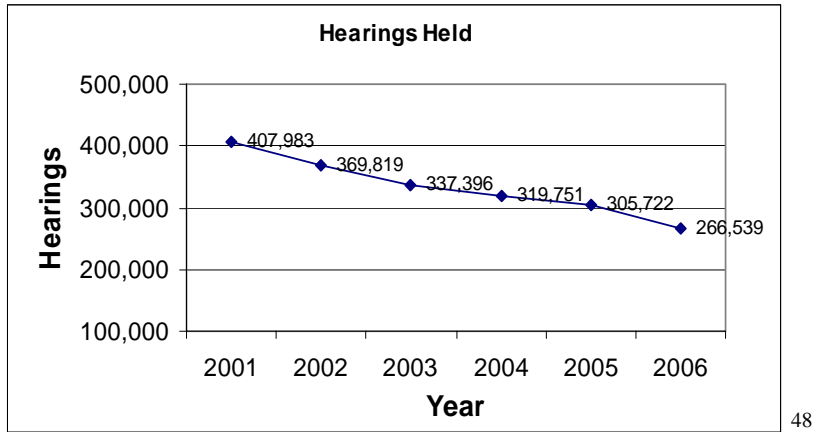
The use of non-hearing determinations results in the forfeiture of wage replacement and/or schedule loss awards by many injured workers. As a result, the claims of these workers are often mischaracterized as "medical only" or "temporary disability" instead of as claims involving permanency. The Insurance Department has noted an increase in attorney involvement in supposedly "medical only" claims from 25% in 2000 to 36% in 2006.⁴⁷ It is likely that this increase in representation is tracking increased misidentification by the WCB of schedule loss claims as "medical only" claims, in part due to the use of non-hearing determinations.

⁴⁵ Source, Workers' Compensation Board Summary Annual Reports 2001 – 2006.

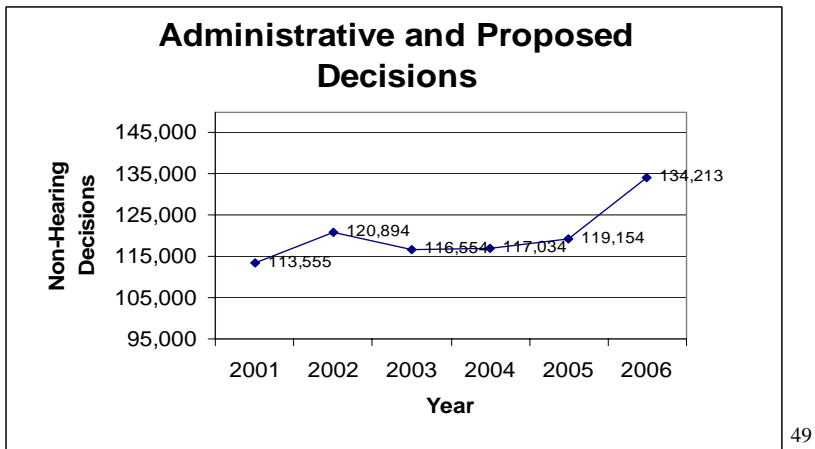
⁴⁶ It is to be noted that these decisions are issued only in English, making it even less likely that they will be understood by non-English speaking workers.

⁴⁷ Insurance Department Report at p. 91.

The charts below demonstrate the WCB's decreasing use of hearings in favor of non-hearing determinations.



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Fourth, while the WCB does collect certain information regarding controverted claims (primarily the type of claim, whether the worker is represented, and the length of time it takes to “resolve” the controversy), the WCB does not collect or report outcome data, either in the aggregate or by employer or carrier. As a result, the WCB is unable to identify whether certain employers or carriers are more likely to contest claims than others, whether certain types of claims are more prone to controversy, the rate at which

⁴⁸ Source, Workers' Compensation Board Summary Annual Reports 2001 – 2006.

⁴⁹ Id.

any type of claim is decided in favor of one party or another, or the impact of attorney representation on worker benefits either in contested claims or in general.

It is therefore apparent that the data collected by the WCB is of limited value in evaluating the actual performance of and costs associated with the workers' compensation system.

3. Complicating Factors and Other Agencies.

A complicating factor in using CIRB and WCB data is the fact that the systems used by these entities are fundamentally incompatible.⁵⁰ As a result, the accuracy of the information collected and reported by one cannot be cross-checked by reference to that of the other.

Some additional information relevant to the workers' compensation system is collected by the Department of Labor in connection with vocational rehabilitation and unemployment programs, as well as with regard to employer information. However, to date only a minimal attempt has been made to integrate this data with other available information and to assemble the patchwork of statistics into a usable whole.

“Frictional costs” associated with adversarial behavior and litigation within the workers' compensation system have been identified as an area of concern.⁵¹ However, there is little information available about the cause of the “friction.” The Insurance Department has identified and reported on the fees earned by attorneys representing workers before the WCB.⁵² To the extent that claimant attorney fees are even relevant to the discussion, it is probable that they are simply a symptom of adversarial behavior, not

⁵⁰ Insurance Department Report at pp. 21-23.

⁵¹ Id. at p. 4.

⁵² Id. at p. 92.

a cause. In addition, the WCB's failure to collect outcome data or to categorize and quantify benefit data prevents a comparison of benefits received by represented workers to benefits received by unrepresented workers. The collection of such data is likely to more than justify fees paid to claimant attorneys, particularly in view of the institutionalized barriers to access to benefits discussed in Section II.B..

Those familiar with the system have suggested that the root causes of the so-called friction are not claimant attorneys, but rather are (1) IME reports used by employers and carriers to limit benefit payments and (2) defense-inspired litigation. There is presently no means of identifying the number of exams performed by each IME or IME vendor, the cost of these exams, their outcome, the association between individual IMEs and IME vendors, and the association between certain IMEs or vendors and certain employers or carriers. There is likewise no present means of identifying the association between defense firms and carriers, defense costs, or the relationship between defense costs and claim outcomes. Without this type of information, it is impossible to determine the causes of systemic friction with any degree of reliability.

4. Recommendations.

As a result of the data collection issues identified above, we make the following recommendations:

1. Create a New York Workers' Compensation Research Institute ("NYWCRI") within the Cornell University School of Industrial and Labor Relations.

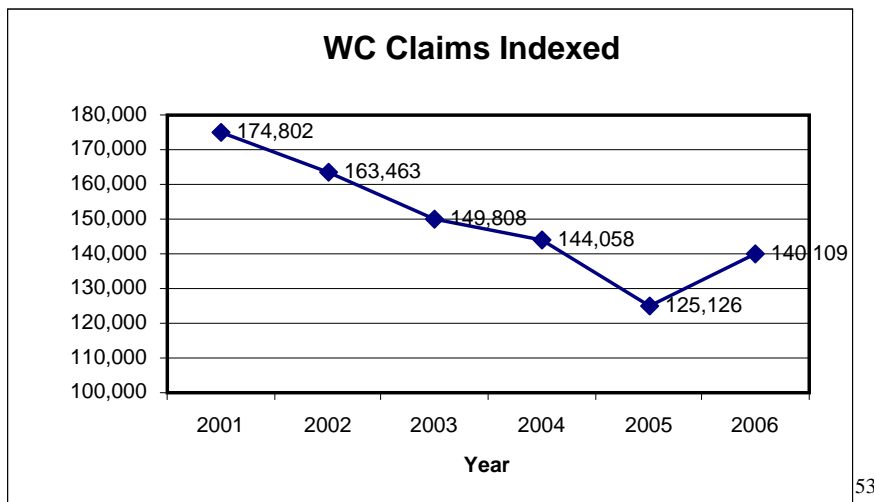
2. Continue the process of eliminating the CIRB not only as a rate-making entity but also as a primary repository of information about workers' compensation. Transfer the rate-making function to the Insurance Department. Transfer the data collection function to the NYWCRI, with insurers, self-insurers, and the WCB to report data directly to NYWCRI.
3. Require the WCB to distinguish between claims that are fully resolved and those that are temporarily inactive.
4. Require the WCB to collect and report data regarding workers' compensation defense costs, including (a) defense attorney costs by carrier and employer; (b) IME costs by carrier and employer; (c) claims controverted by carrier and employer; and (d) outcome data by carrier and employer.
5. Require the WCB to collect and report data regarding IMEs, including the results of IME examinations by IME and by IME vendor.
6. Require the WCB to collect and report data regarding actual claim costs for medical and indemnity by type of injury and type of award.
7. Require the WCB to collect outcome data in controverted claims.

B. Access to Benefits

Even given the limited available data, it is clear that injured workers are having significant and increasing difficulty in accessing benefits through the workers' compensation system. The primary obstacles to access to benefits are (1) inability to file claims; (2) non-hearing determinations and the use of "no further action" status; and (3) inability to obtain representation in medical only" and controverted claims.

1. Inability to File Claims.

The chart below shows the number of claims "indexed" by the WCB from 2001 through 2006.



The WCB's statistics regarding indexed claims are illustrative of worker difficulty in accessing benefits. In 2003 the WCB, which is supposed to receive notification of all workers' compensation claims, indexed 149,808 claims. In the same year the CIRB – which only receives data from two-thirds of the market – was aware of 154,598 claims.⁵⁴ Working from CIRB figures, the Insurance Department concluded that there were about

⁵³ Source: WCB Summary Annual Reports 2001-2006.

⁵⁴ Insurance Department Report at p. 24

206,079 reportable workers' compensation events in 2003.⁵⁵ It thus appears that the WCB "indexed" barely 70% of the on-the-job accidents reported by employers.⁵⁶

While the WCB's failure to receive reports of or index a significant percentage of workers' compensation claims is further evidence of data collection problems, it also points to worker difficulty with access to benefits. It appears that in the year 2003 over 50,000 workers were injured on the job, yet had no contact with the state agency primarily responsible for ensuring their timely and adequate receipt of benefits. Assuming that 2003 was a representative sample (and there is no reason to think that it is not), over a quarter million workers have been shut out of the system in the past 5 years.

2. Non-Hearing Determinations and NFA.

The WCB's use of non-hearing determinations and NFA procedure discussed above have a significant impact on access to benefits for those workers who do find their way into the system. As previously mentioned, the use of non-hearing determinations often prevents workers from obtaining all of the benefits they may be due. In effect, non-hearing determinations relieve the WCB of the "burden" of contacting and advising injured workers about their rights in a meaningful way. These decisions are issued without regard to the injured worker's language, literacy, or intellectual capacity, all of which could be easily identified by an administrative law judge if a hearing was held. The use of NFA procedure in these decisions, as well as throughout the hearing process, also relieves the WCB of its obligation to manage the claim to ensure worker receipt of

⁵⁵ Id.

⁵⁶ 2003 Summary Annual Report, New York State Workers' Compensation Board.

benefits. Instead, this burden is transferred to the injured worker, or more likely to his or her attorney.

According to the Insurance Department, from 2000 through 2006 there was virtually no change in the average number of hearings held for unrepresented claimants – the figure diminished only slightly from 1.7 hearings per case to 1.6 hearings per case.⁵⁷ Meanwhile, in the same time frame, hearings for represented claimants dropped from 4.7 per case in 2000 to 2.7 per case in 2006.⁵⁸ These statistics demonstrate that in a period of six years, the WCB effectively transferred the work associated with two hearings per case – over 40% of the total work – from “on-calendar” resolution at the WCB to “off-calendar” work by the injured worker’s attorney. It is reasonable to conclude that the number of hearings for unrepresented workers remains low because unrepresented workers are either unable to effectively pursue their claims in the face of the WCB’s NFA procedure or because they become represented after appearing *pro se* at one or two hearings. In either event, it is obvious that the WCB’s use of NFA procedure has had a detrimental effect on the ability of injured workers to access benefits.

3. “Medical Only” and Controverted Claims.

Despite the complexity of the workers’ compensation system, only a small percentage of injured workers with “medical only” claims are able to secure representation. The primary (perhaps sole) reason for this circumstance is that the Workers’ Compensation Law only permits a claimant’s attorney to receive a fee as a lien on “compensation,” which does not include medical benefits. This rule impacts both

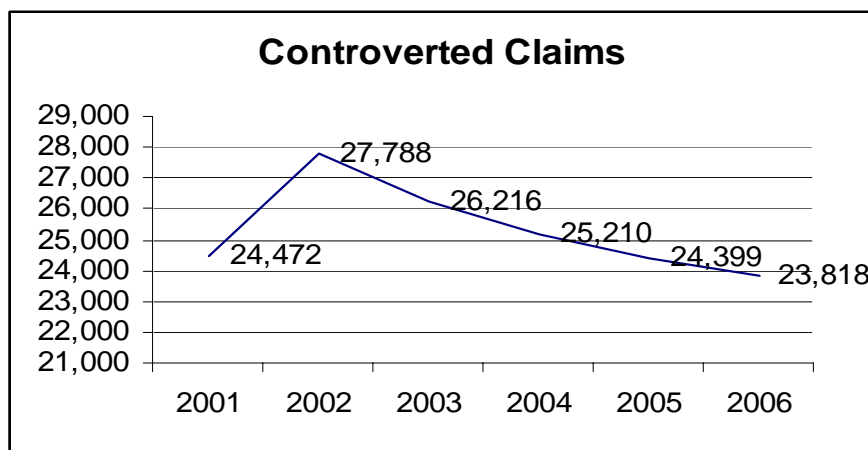
⁵⁷ Insurance Department Report at p. 77

⁵⁸ Id.

injured workers and health care providers, whose ability to be paid for their services is dependent on the worker's success in establishing his or her claim.

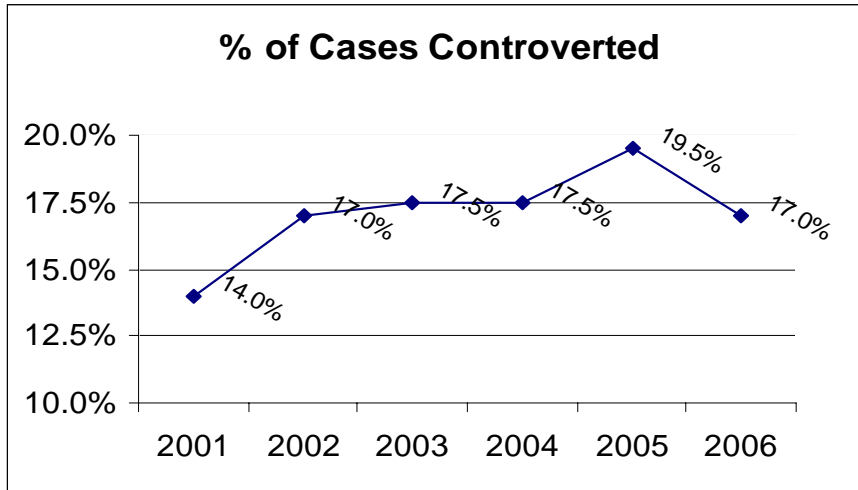
As previously noted, the WCB either does not collect or has not reported outcome data on the experience of unrepresented individuals versus represented individuals in the system. As a result, it is difficult to quantify the precise impact of lack of representation on worker benefits. However, the observation of those familiar with the workers' compensation system is that workers who are not represented by an attorney are far less likely to obtain benefits than those who have assistance of counsel. It therefore appears that the inability of "medical only" claimants to obtain representation presents a significant obstacle to access to benefits.

A similar situation exists in the area of controverted claims. It must be observed that the system includes virtually no meaningful disincentives for employers and insurers to contest claims. The charts below show trends involving controverted claims both in raw numbers and as a percentage of all claims.



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⁵⁹ Source, Workers' Compensation Board Summary Annual Reports 2001 – 2006.



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It is apparent that controverted claims are a significant issue in the workers' compensation system. While the Streamlined Docket Task Force has recommended methods for WCB processing of controverted claims, its recommendations are not directed at the reduction of controversy in the first instance. Assuming that employer and carrier denial of benefits present a barrier to access to benefits, the system must include meaningful disincentives to controvert claims absent good cause.

4. Recommendations.

In view of the problems with worker access to benefits, we make the following recommendations:

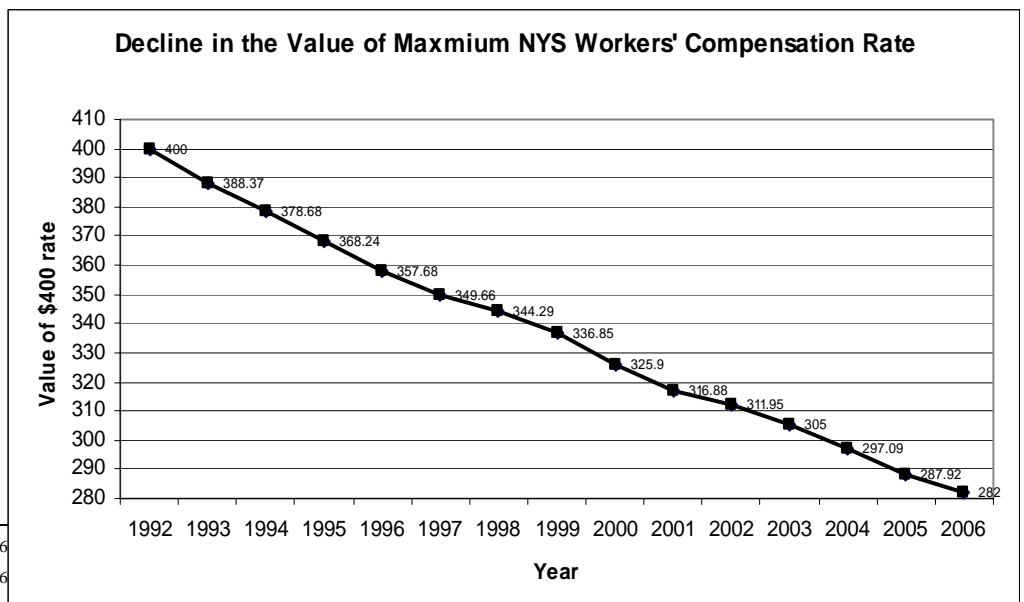
1. Eliminate non-hearing determinations by the WCB.
2. Require the WCB to translate forms and informational literature into additional foreign languages.
3. Eliminate WCB use of "no further action" status for claims that have not been fully resolved.

⁶⁰ Source, Workers' Compensation Board Summary Annual Reports 2001 – 2006.

4. Provide for carrier payment of claimant attorney fees in cases involving medical treatment only.
5. Require carrier payment of claimant attorney fees in controverted cases.

C. Wage Replacement Benefits

The Workers' Compensation Law provides that if a worker is totally disabled, the weekly benefit is two-thirds of his or her pre-accident average weekly wage.⁶¹ However, the benefit is limited to the maximum rate in effect on the date of the accident.⁶² For accidents that occurred on or after July 1, 1992 and before July 1, 2007 the maximum weekly benefit was \$400 and the minimum benefit was \$40 per week.⁶³ As shown on the chart below, the failure to increase the maximum weekly benefit rate from 1992 through 2007 and the absence of any "cost of living" provision in the Workers' Compensation Law resulted in a severe decline in the real-dollar value of workers' compensation benefits.



⁶³ Id.

As a result of the 2007 legislation, for accidents occurring on or after July 1, 2007 and before July 1, 2008 the maximum benefit is \$500 per week. For accidents occurring on or after July 1, 2008 and before July 1, 2009 the maximum benefit will be \$550 per week. For accidents occurring on or after July 1, 2009 and before July 1, 2010 the maximum benefit will be \$600/week. Accidents occurring on or after July 1, 2010 will have a maximum rate equal to two-thirds of the State average weekly wage as determined by the Commissioner of Labor. The minimum benefit rate was also raised to \$100 per week for accidents occurring on or after July 1, 2007.⁶⁴

1. Workers Affected by the Maximum Rate.

The number of injured workers who will benefit from the increased maximum rates is subject to debate. The fact that the maximum rate is tied to the “State average weekly wage” as of July 1, 2010 calls attention to the difference between average and median figures. According the State cross-industry estimates of the United States Department of Labor, Bureau of Labor Statistics, as of May, 2006 the average wage in New York State was \$45,820, or approximately \$880 per week.⁶⁵ However, the median wage was only \$35,170, which is about \$675 per week.⁶⁶ When the “State average weekly wage” figure is inserted into the distribution of New York wages in the chart below, it appears that the State average weekly wage actually corresponds to the 63rd percentile of wage earners.

⁶⁴ WCL Section 15

⁶⁵ United States Department of Labor, Bureau of Labor Statistics, State Cross-Industry Estimates, available at http://www.bls.gov/oes/oes_dl.htm.

⁶⁶ Id.

<u>Percentile</u>	<u>Annual Wage</u>	<u>Weekly Wage (approx.)</u>
10 th	\$16,420	\$300
25 th	\$22,500	\$425
50 th	\$35,170	\$675
63rd⁶⁷	\$45,820	\$880
75 th	\$56,650	\$1,075
90 th	\$88,260	\$1,700 ⁶⁸

As demonstrated on the chart, nearly 50% of New York's workers receive no benefit from increasing the maximum rate beyond \$400 per week, and another 13% will not be entitled to the new maximum rate when it is indexed to the State average weekly wage. Only the top 37% of wage-earners will be eligible for that rate.

In addition, the group of high-wage earners that may be entitled to the maximum rate as of July 1, 2010 is presumably less likely to suffer work-related injury and to need workers' compensation benefits. In 2006, 45% of the claims for workers' compensation benefits were filed by workers earning less than \$600 per week, while 55% were filed by those earning more.⁶⁹ Although the WCB does not provide data about the distribution of claims by wage in excess of \$600, higher wages are generally associated with less hazardous occupations, and it may be assumed that there is a negative correlation between higher wages and incidence of workers' compensation claims. As a result, the bottom 50% of workers (who received no benefit from the increase in the maximum rate) are more likely to need workers' compensation benefits, whereas the top 37% (who will be eligible for the new maximum rates in 2010) are unlikely to file claims.

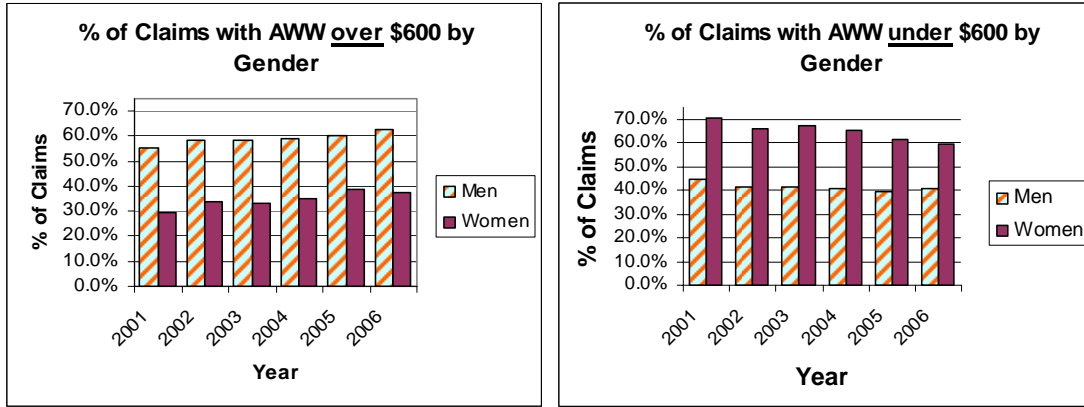
It should also be noted that the correlation between average weekly wage and occupational injury varies according to gender. The charts below show that most women

⁶⁷ Estimated.

⁶⁸ United States Department of Labor, Bureau of Labor Statistics, State Cross-Industry Estimates, available at http://www.bls.gov/oes/oes_dl.htm.

⁶⁹ WCB 2006 Summary Annual Report, Appendix XIV.

who file workers' compensation claims earn less than \$600 per week, whereas most men who file earn more. As a result, the increase in the maximum benefit rate has a disproportionate impact based on gender, benefiting male workers far more than women.



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2. The Maximum Rate and Total Disability Benefits.

For workers who are temporarily totally disabled, increasing the maximum benefit rate greatly benefits high-wage workers, while having no impact on benefits paid to workers who earn \$600 per week (\$31,200 per year) or less. The chart below compares the change in the total disability rate for a worker earning \$1,200 per week as compared to a worker earning \$600 per week, depending on the date of accident.

Accident between:	\$1,200/week worker	\$600/week worker
7/1/92 – 6/30/07:	\$400	\$400
7/1/07 – 6/30/08	\$500	\$400
7/1/08 – 6/30/09	\$550	\$400
7/1/09 – 6/30/10	\$600	\$400
7/1/10 - ??????	\$660 ⁷¹	\$400

It is apparent that increasing the maximum benefit rate has a significant positive impact for high wage workers who are temporarily totally disabled, and that it has no effect at all on workers who earn \$600 per week or less.

⁷⁰ Source: WCB Summary Annual Reports, 2001- 2006.

⁷¹ This figure assumes a state average weekly wage of \$990 in 2010.

3. The Maximum Rate and Partial Disability Benefits.

Most workers do not receive benefits for total disability for an extended period of time. If the worker is out of work for more than six weeks, the employer or carrier almost invariably obtains an IME. The overwhelming majority of IME reports state that the worker is not totally disabled, and often report some degree of “partial disability.” The WCB divides “partial disability” into “degrees,” often in the categories of “mild” (25% to 49% disabled) “moderate” (50% - 74% disabled) and “marked” (75% to 99% disabled).

A worker who is less than totally disabled is not entitled to payment of two-thirds of his or her pre-accident wage. A “marked partial” disability of 75% entitles the worker to one-half of the average weekly wage, a “moderate partial” disability of 50% entitles the worker to one-third of the average weekly wage, and a “mild partial” disability entitles the worker to one-sixth of the average weekly wage. The effect of these calculations on benefit payments to the workers from our previous example is shown on the chart below:

<u>Accident between:</u>	<u>\$1,200/week worker</u>	<u>\$600/week worker</u>
	<u>Marked / Moderate / Mild</u>	<u>Marked / Moderate / Mild</u>
7/1/92 – 6/30/07:	\$400 / \$400 / \$200	\$300 / \$200 / \$100
7/1/07 – 6/30/08	\$500 / \$400 / \$200	\$300 / \$200 / \$100
7/1/08 – 6/30/09	\$550 / \$400 / \$200	\$300 / \$200 / \$100
7/1/09 – 6/30/10	\$600 / \$400 / \$200	\$300 / \$200 / \$100
7/1/10 - ??????	\$600 ⁷² / \$400 / \$200	\$300 / \$200 / \$100

As in the case of temporary total disability, the increase in the maximum rate has no impact on benefits due to the worker who earns \$600 per week. The chart also demonstrates that the increase in the maximum rate has no impact on benefits due the worker who earns \$1,200 per week for “mild” or “moderate” partial disability. When the

⁷² This assumes a State average weekly wage in 2010 of \$990.

maximum rate reaches \$600 per week, further increases also have no impact on the benefits due this worker for “marked” partial disability.

As a result, the maximum rates are meaningful only if made available to injured workers. This can be achieved by reinforcing the relevance of earning capacity (in lieu of “disability” or “impairment”) as the standard for receipt of benefits and by reducing the viability of technical legal arguments such as “voluntary withdrawal from the labor market.”

4. The Minimum Rate.

The 2007 legislation increased the minimum benefit rate from \$40 per week to \$100 per week. Based on the wage distribution chart on page 43, this has a significant positive impact on the bottom 10% of wage earners, who earn \$300 per week or less, and also has a favorable impact on the next 15%, who earn less than \$425 per week. For accidents occurring before July 1, 2007, a worker earning \$300 per week could face a benefit reduction to \$50 per week if an IME reported a “mild partial” disability; a worker earning \$420 per week could be reduced to \$70. For accidents after July 1, 2007, the establishment of a minimum rate of \$100 is of great assistance to this group of wage-earners.

Unfortunately, the 2007 legislation did not “index” the minimum rate either to the State average weekly wage or to the maximum rate. As a result, it is anticipated that the minimum rate will suffer the same loss of value over time as occurred with the maximum rate from 1992 to 2007.⁷³

⁷³ See chart on p. 42.

5. Past Accidents and Future Inflation.

In addition, the 2007 legislation did not provide any mechanism for “cost of living” or other increases in workers’ compensation benefits over time. A worker’s benefit rate is fixed based on the date of accident and his or her earnings in the year before that accident. Thereafter, no adjustment is made for the effects of inflation. A worker who was found to be permanently disabled in 1992 at a maximum rate of \$400 per week found that in 2006 those benefits were worth \$282. The same thing will occur to future workers who are entitled to the new maximum benefit rates. The use of the term “indexing” is misleading in this regard. Only the maximum rate, which depends on accident date, is “indexed;” benefits are not.

6. Time Limits on Permanent Partial Disability Awards.

For accidents that occurred before March 13, 2007, workers who were found to be permanently partially disabled were entitled to payment for the full duration of their disability. The 2007 legislation imposed time limits (caps) on permanent partial disability benefits for accidents occurring on or after March 13, 2007.⁷⁴ The length of time that a permanently disabled worker may be paid depends on the worker’s “degree of disability” or “loss of earning capacity,” and varies from four to ten years.⁷⁵ A “safety net” was provided for workers who are more than 80% disabled and who do not return to work.⁷⁶

Several issues are presented by these time limitations. First, although the time limitations apply to accidents occurring on or after March 13, 2007 the increased

⁷⁴ 2007 New York Workers’ Compensation Reform Act, Section 4, 3/13/07

⁷⁵ Id.

⁷⁶ 2007 New York Workers’ Compensation Reform Act, Section 5, 3/13/07

maximum rates apply to accidents occurring on or after July 1, 2007. If the imposition of time limitations on permanent partial disability benefits was intended to counterbalance the increase in maximum rates, it would seem reasonable for both to have the same effective date. As presently structured, however, workers who are involved in accidents or who become disabled due to occupational disease between March 13, 2007 and June 30, 2007 are subject to the caps on permanent partial disability without benefiting from the increase in the maximum rates. This is patently inequitable.

Second, the Insurance Department has reported that most permanently partially disabled workers do not in fact return to work, and that the WCB's conclusion about "degree of disability" bears no correlation to such a worker's probability of returning to work.⁷⁷ Further, the Department of Labor has reported that existing vocational rehabilitation programs are wholly inadequate.⁷⁸ Given this information, it appears that the "safety net" provided by the statute will be of little benefit. As a result, it is likely that many permanently partially disabled workers will have their benefits terminated as a result of the 2007 legislation.

Third, new information has revealed that the data used to justify the implementation of time limitations on permanent partial disability benefits is unreliable. This issue was discussed in Section II.A. and is considered further in Appendix V.

Fourth, it has been estimated that while increasing the maximum benefit rate will increase costs to employers and carriers by \$164 million per year, the imposition of time limits on permanent partial disability benefits creates a savings to employers and carriers of \$822 million per year, resulting in a net loss of benefits to injured workers of \$658

⁷⁷ Insurance Department Report at pp. 95-101.

⁷⁸ Report of the Commissioner on Return to Work, NYS Dept. of Labor, available at http://www.labor.state.ny.us/agencyinfo/ReturntoWorkReportMarch12_2008.shtm

million per year.⁷⁹ It is clear that if time-limiting permanent partial disability benefits was intended to counterbalance the increase in the maximum benefit rate, “balance” was not achieved.

7. Recommendations.

In view of the foregoing discussion, we make the following recommendations:

1. Index the statutory minimum benefit to 25% of the statutory maximum benefit.
2. Re-define “total disability” as the inability to engage in one’s former work or any suitable light-duty position made available by the employer or through the vocational rehabilitation process.
3. Establish a statutory presumption that a worker who has stopped work due to the compensable injury is entitled to an award of benefits for loss of earning capacity attributable to the injury.
4. Provide cost of living increases for workers’ compensation benefits to offset the effects of inflation.
5. Amend the effective date of the \$500 maximum rate from July 1, 2007 to March 13, 2007.
6. Eliminate the time limitations on benefits for permanently partially disabled workers.

⁷⁹ Summary 2007 Rate Revision Pre-Filing. New York Compensation Insurance Rating Board, June 26, 2007.

D. Medical Treatment Issues

Wage replacement benefits and medical treatment are the two primary benefits provided by workers' compensation programs. Injured workers have long reported substantial difficulty and delay in obtaining medical diagnosis and treatment for work-related injuries. According to the 2006 White Paper, "workers are permitted to seek treatment only from doctors who are 'coded' by the New York State Workers' Compensation Board. These doctors are highly regulated by the workers' compensation system, are required to file specific forms at specific intervals, are burdened with requests for information additional to the required forms from insurers, must provide office appointments that are not medically necessary in order to preserve patient's wage loss benefits, and are subject to a fee schedule that does not adequately compensate them. As a result, workers are often unable to obtain the services of superior physicians, who seek to avoid the overwhelming bureaucracy and low fees associated with workers' compensation claims."⁸⁰

The 2007 legislation included provisions directed at addressing some of the issues associated with the approval process for treatment and diagnostic testing. Thorough consideration is given to these provisions in Appendix I. The pre-authorization limit was raised from \$500 to \$1,000, permitting a larger number of routine diagnostic tests to be performed without prior approval.⁸¹ However, injured workers are now required to use a diagnostic test facility or network designated by the employer or carrier for performance of these tests.⁸² Employers and carriers are also now permitted to designate the pharmacy

⁸⁰ Workers' Compensation: State of the System 2006 at p. 17, NYCOSH/Grey, available at [http://www.nyworkerscompensationalliance.org/WorkersCompensationWhitePaper3_06\[1\].d06\(1\).pdf](http://www.nyworkerscompensationalliance.org/WorkersCompensationWhitePaper3_06[1].d06(1).pdf).

⁸¹ 2007 New York Workers' Compensation Reform Act, Section 28, 3/13/07.

⁸² 2007 New York Workers' Compensation Reform Act, Section 29, 3/13/07.

to be used by the injured worker for prescription medication, and generic medication is to be provided unless the treating physician specifically directs the use of a brand-name medication.⁸³ It has been estimated that these changes will result in a cost savings to employers of approximately \$292 million.⁸⁴

The 2007 legislation left a number of issues unaddressed, delegating the resolution of some to the WCB and some to the Medical Guidelines Task Force. These issues include the promulgation of a list of “pre-authorized procedures,” “best medical practices,” the extent of the geographic area within which the carrier may require a claimant to use a carrier-designated diagnostic test facility or pharmacy, the nature of the diagnostic tests covered by the statute, and whether the carrier’s diagnostic test facility is required to provide copies of the test results to the injured worker and his or her treating physician. A few of these issues have been considered by the Medical Guidelines Task Force and are discussed in Appendix III. Most have yet to be addressed.

Recommendations.

1. Clarify the 2007 legislation to establish that diagnostic tests to be performed at facilities selected by the employer or carrier are limited to radiological tests and that films must be provided to the injured worker or his physician free of charge. Provide for repeat testing if films resulting for the first test are of poor quality.

⁸³ 2007 New York Workers’ Compensation Reform Act, Sections 26-27, 3/13/07.

⁸⁴ Summary 2007 Rate Revision Pre-Filing. New York Compensation Insurance Rating Board, June 26, 2007.

2. Establish a limited radius as the geographic area in which diagnostic test facilities selected by the employer or carrier must be located in relation to the claimant's residence. Consider a different radius upstate and downstate.
3. Require workers' compensation carriers to reimburse non-workers' compensation payors for medical expenses paid by such payors at 125% of the amount of the bills paid.
4. Eliminate the requirement that the injured worker must have a C-4 form every 45 days as a condition of continued benefits payments.

E. Return to Work Policy

In addition to providing wage replacement benefits and medical treatment, a goal of workers' compensation programs is to provide vocational rehabilitation and a path to return to work for workers who suffer occupational injury and illness. Although certain sections of the Workers' Compensation Law reference vocational rehabilitation,⁸⁵ and although the WCB does perform some limited vocational screening through its Rehabilitation Unit, the WCB does not perform full vocational assessments or retraining. Instead, workers who express an interest in vocational rehabilitation are referred by the WCB to one or more programs administered by the Department of Labor.

In some instances, employers and carriers seek to become involved in the rehabilitation process. Unfortunately, the utility and trustworthiness of these efforts are undermined by the frequent desire of employers and carriers to use vocational information to seek reduction of benefit payments.

⁸⁵ See, e.g., WCL Section 15(3)(v).

The Return to Work Task Force headed by the Department of Labor addressed many of the issues surrounding vocational rehabilitation with regard to workers' compensation.⁸⁶ The report of this Task Force is addressed at length in Appendix IV. The Task Force recommended (1) development of return-to-work educational programs for employers; (2) requirement of formal return-to-work policy by employers of more than 25 workers; (3) re-design of WCB forms regarding vocational information; (4) education of physicians in occupational health issues; (5) WCB-paid vocational rehabilitation evaluation of all claimants who reach maximum medical improvement and have not returned to work; (6) development of incentive programs for hiring disabled workers; (7) payment of attorneys in "medical only" cases; (8) WCB review of cases to ensure proper awards for reduced earnings; and (9) data collection on return to work rates.

The efficacy of these recommendations is obviously dependent on their application, implementation and funding. By way of example, the contents of mandatory employer return-to-work policies will determine whether these policies are anything more than a token effort. Similarly, vocational rehabilitation "evaluation" is only the first step of the actual rehabilitation process, but the Task Force makes no recommendations regarding the scope of or funding for a full rehabilitation process.

From a workers' compensation standpoint, questions exist as to the impact of time spent in vocational rehabilitation on earning capacity, as well as the effect of a failure to rehabilitate on entitlement to benefits. The Workers' Compensation Law as it existed prior to the 2007 legislation included a financial incentive for partially disabled workers

⁸⁶ Report of the Commissioner on Return to Work, NYS Dept. of Labor, available at http://www.labor.state.ny.us/agencyinfo/ReturntoWorkReportMarch12_2008.shtm.

to return to work. If a partially disabled worker returns to work at earnings less than his or her pre-accident salary,⁸⁷ WCL Section 15(5-a) requires the WCB to award benefits based on the worker's actual earnings, rather than based upon the "degree of disability." In many instances, the injured worker was able to obtain an increase in the compensation rate as a result of returning to work (in addition to which the worker had the income earned from working).

However, as indicated by the Insurance Department, most permanently partially disabled workers do not return to work. Given that they have been found by the WCB to have some earning capacity, it would be desirable to provide them with incentives (or at the very least not to penalize them) for engaging in vocational rehabilitation. One such incentive would be to exclude time spent in vocational rehabilitation from the number of weeks the worker is entitled to permanent partial disability benefits, in essence deeming time spent in vocational rehabilitation to be a period of "temporary disability" in which it is unknown whether the worker can be successfully retrained and reemployed.

Further, if the vocational rehabilitation process does not succeed in retraining or reemploying the injured worker, then the worker presumably has no earning capacity. Under these circumstances, the WCB should be obligated to rescind its classification of the worker as permanently partially disabled and to declare the worker totally industrially disabled.⁸⁸ Such "reclassification" is permitted under existing law and falls squarely within the WCB's continuing jurisdiction over workers' compensation claims.⁸⁹

⁸⁷ "Reduced earnings" is the workers' compensation term for this situation.

⁸⁸ The concept of "total industrial disability" is that while the worker may be less than totally disabled from a medical standpoint, when vocational factors are taken into consideration the worker is unemployable. See e.g. Guan v. CPC Home Attendant Program, 2008 NY Slip Op 2933; 2008 N.Y. App. Div. LEXIS 2872 (3rd Dept. April 3, 2008); Forte v. City & Suburban, 292 A.D.2d 738; 739 N.Y.S.2d 761 (3rd Dept. 2002).

⁸⁹ WCL Sections 15, 123.

Furthermore, reclassifying non-retrainable permanently partially disabled workers as totally industrially disabled ameliorates the harsh effect of the time limitations on permanent partial disability benefits (which do not apply to totally disabled workers), and effectively expands the “safety net” created by the 2007 legislation to capture precisely the group of workers it was intended to protect.

We therefore make the following recommendations regarding return to work policy:

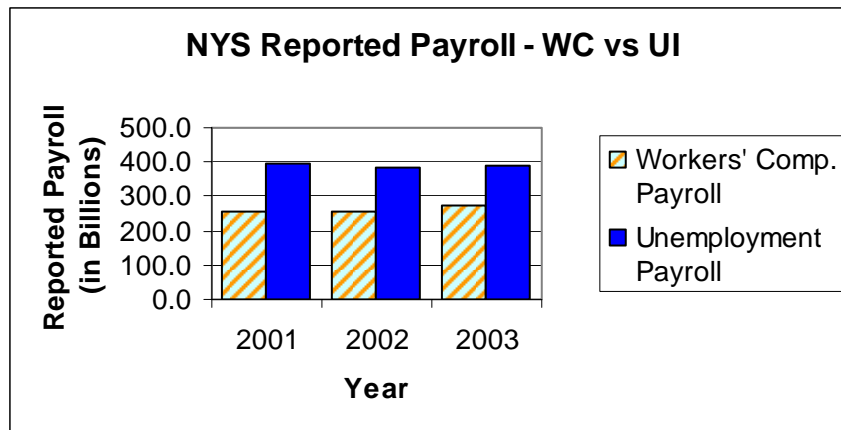
1. Adopt and implement the recommendations of the Return to Work Task Force.
2. Establish a statewide employer education program administered by the WCB and funded by assessments on insurers and self-insurers to promote the advancement and implementation of return to work programs.
3. Establish funding for vocational rehabilitation services through assessments on insurers and self-insurers in the absence of other federal and state funding.
4. Incentivize employers to establish and utilize return to work programs by deeming injured workers totally disabled if not returned to work by the employer or through the vocational rehabilitation process.
5. Exclude time spent in the vocational rehabilitation process from the time limits on permanent partial disability for accidents occurring after March 13, 2007.

F. Employer Fraud

It has become apparent that employer fraud imposes a significant cost on the workers' compensation system. This issue was addressed at length in the 2006 White Paper.

In some industries, premium fraud by employers is pervasive, and drives up costs for legitimate business. To understand premium fraud, one must understand that the three major criteria for assessing premium are (1) the nature of the business; (2) payroll; and (3) loss history (prior claims). Among the devices used by dishonest employers are misclassification of employees from a higher-risk job title into a lower-risk job title, use of multiple corporate entities with transfer of employees from the books of one entity to another in order to reduce payroll visibility or loss history, and the mischaracterization or misreporting of employees as independent contractors. In addition to these subterfuges, some employers simply defy the legal requirement that they carry insurance, paying workers "off the books" or failing to reveal that they have any employees.

The landmark study on the issue of employer avoidance of insurance premiums is the January 25, 2007 report of the Fiscal Policy Institute entitled "New York State Workers' Compensation: How Big is the Shortfall?" The authors of the report concluded that "employer non-compliance with the state's workers' compensation program is a growing problem in New York. Many companies fail to provide this coverage for their workers. This ... [increases] the premium costs for other employers." In order to assess the scope of the problem, the Fiscal Policy Institute obtained data from the New York Compensation Insurance Rating Board ... regarding workers' compensation payroll data reported from 2001 through 2003. It then obtained data from the New York State Department of Labor for the same period of time concerning reported unemployment insurance payroll. Using the gross numbers, reported payroll for unemployment insurance was approximately \$120 billion per year higher than reported payroll for workers' compensation. The Fiscal Policy Institute then adjusted the data to account for differences between the systems, and having made all possible pro-employer adjustments, concluded that the differential was close to \$80 billion per year.



The Fiscal Policy Institute concluded that employer under-reporting of payroll of approximately \$80 billion per year amounted to underpayment of \$500 million to \$1 billion in workers' compensation insurance premium per year – a cost shifted from dishonest employers onto honest employers.

The Fiscal Policy Institute further concluded that there has been a massive effort by New York employers to claim that their workers are independent contractors as opposed to employees (thus avoiding payment of workers' compensation insurance premium). Indeed, the Institute observed that the rise in "self-employment" mirrors almost precisely a decline in wage and salary employment.

All of the devices enumerated by the Fiscal Policy Institute and others (including certain bookkeeping devices legally used by large employers to minimize payroll) have the effect of removing payroll dollars from the system that should be subject to premium, while insurer risk and exposure remains the same. As a result, employers that honestly report their business and payroll are placed in the position of subsidizing dishonest employers.⁹⁰

The 2007 legislation addressed some of these issues. Misclassification and under-reporting of payroll were added to the statute as violations equal to the failure to carry insurance, which existed previously as a civil and criminal offense. The civil and criminal penalties for these failures were increased, with the potential for felony convictions in the case of employers of more than five employees who are repeat offenders, as well as debarment from bidding on public contracts. A definition of "substantially owned affiliated entity" was added in order to address individuals who re-incorporate in order to perpetrate this type of fraud or in an effort to avoid punishment.

⁹⁰ 2006 White Paper at pp. 23-25.

In order to enable the WCB to proactively address these issues, the agency was provided with subpoena power, the authority to enter and inspect workplaces, and the authority to issue stop-work orders. It has been estimated that these tools may achieve fraud savings of \$48 million, far short of the Fiscal Policy Institute estimate of the size of these types of fraud.⁹¹

Of course, these statutory tools are only of value to the extent that they are utilized by the WCB, which depends in part on the number and type of staff available to the WCB in this area. It has been observed that employers who engage in these types of proscribed activity often do so to obtain an advantage over their competitors. As a result, law-abiding employers and their employees have an interest in assisting the WCB in identifying and pursuing violators. However, the WCB does not currently provide these employers and employees with the tools to easily identify and report potential offenses. It has also been observed that employers who do not comply with workers' compensation requirements also tend to have poor worksite safety practices. Enforcement of workers' compensation obligations therefore has a positive impact on worksite safety.

The New York State Joint Enforcement Task Force on Worker Misclassification issued a report in February, 2008 in which it stated that it found 2,100 workers misclassified by 117 employers in a four-month period.⁹² During the same period of time, the Unemployment Insurance Division estimated that over 35,000 workers were misclassified.⁹³ The Task Force also reported \$19.4 million in unreported wages, on

⁹¹ Summary 2007 Rate Revision Pre-Filing, New York Compensation Insurance Rating Board, June 26, 2007. See also Fedex Home Delivery, 2006 NY Wrk. Comp. 30401455; 2006 NY Wrk. Comp. LEXIS 10289; Working Life (High and Low), NY Times April 20, 2008, available at www.nytimes.com/2008/04/20/business/20work.html.

⁹² Report of the Joint Enforcement Task Force on Employee Misclassification, NYS Department of Labor, available at <http://www.labor.state.ny.us/agencyinfo/MisclassificationofWorkers.shtm>.

⁹³ Id.

which employers avoided both workers' compensation premium charges and federal, state, and local taxes.⁹⁴ Given the massive amount of employer fraud that was uncovered in a short period of time with limited use of the new statutory and regulatory tools, it is clear that this is an area that requires substantial additional attention.

As a result, we make the following recommendations:

1. Provide the WCB with additional staff to enforce existing law regarding employer obligations.
2. Establish a searchable database allowing private individuals to verify an employer's workers' compensation insurance status and the number of employees reported by the employer as covered under the policy.

G. Premium Costs

Whether workers' compensation insurance premiums are "too high" is more a philosophical question than a practical one. If few benefits are provided, premiums should be lower; if the system provides greater benefits, then presumably premiums will rise. The real issue is whether premiums are set correctly (or efficiently) once a decision has been made about the benefits to be provided by the system.

One means of judging whether premium levels are appropriate is by comparison to other states. For a number of reasons, however, it has been difficult to obtain this comparison of New York workers' compensation insurance premium rates. Raw comparison of premium rates either as a whole or by industry group can be misleading due to differences in wages, benefits, insurance systems, and methods of calculation

⁹⁴ Id.

among states. The Professional Insurance Agents of New York (“PIANY”) has stated that “New York increasingly has become difficult to compare to other states because of its peculiar rate-setting procedure. Questions have arisen from several quarters about the methodology and the figures used. Parties intent on comparing New York’s cost structure to other states’ frequently are frustrated by a lack of apples-to-apples figures and a sense that the process is unnecessarily complicated and obfuscated, as well as by evidence that there has always not been effective enforcement of accuracy in industry reporting.”⁹⁵

However, reported insurer profits – at least to the extent that they can be verified – may be one measure of whether premiums are being charged correctly in relation to the benefits provided by the system. Verification, of course, is the key. PIANY noted that “New York and other states found that AIG had systematically underreported figures upon which its liability for assessments was based. A settlement reached with this carrier in February, 2006 included a provision that AIG was to pay \$343.5 million, divided among multiple states ... Some observers question whether the amount should have been higher. More important, AIG’s underpayments came to light only because it came under investigation for other reasons. How adequate is state oversight of insurers’ reporting of figures on which their assessments are based, and are all insurers accurately reporting their true figures?”⁹⁶

Some information about the insurance environment in New York can be gleaned from a review of the reports of the National Council of Compensation Insurers (“NCCI”), which obtains data from 37 states (not including New York). In its 2006 annual report,

⁹⁵ Legislative Position; Professional Insurance Agents of New York State Inc. available at www.piaonline.org/GIA/NY/position_workerscomp.pdf.

⁹⁶ Id.

NCCI noted a number of claim trends favorable to insurers, including a continued decline in claims.⁹⁷ As a result, insurers were able to engage in “some much-needed reserve strengthening” and still manage an investment gain associated with workers’ compensation insurance of about 12%.⁹⁸

Additional information about the financial state of workers’ compensation insurers was made available by the Insurance Department in connection with its rejection of the CIRB’s application for a workers’ compensation premium rate increase in 2006. At that time the Insurance Department reviewed the history of rate changes going back to 1995, observing that there has been “an overall average rate decrease of 30%” over that time span.⁹⁹ The Insurance Department stated that workers’ compensation insurers should not have “underwriting profit” in which premium collected exceeds claims paid, and instead are expected to profit solely through “investment return.” Using this standard, the Insurance Department concluded that “New York has been able to maintain a competitive and healthy market, with profitability in a reasonable range.”¹⁰⁰

Notwithstanding the accumulated evidence that insurers were significantly profitable and that premiums for employers were steadily declining, the 2007 legislation was designed to effectuate further premium reductions for employers. It has been estimated that the net effect of the 2007 legislative changes is a reduction in insurance premium of approximately 20%, which amounts to a \$1 billion annual savings to employers.¹⁰¹ The legislation also attempted to abolish the CIRB as the rate-making

⁹⁷ “2006 State of the Line: Analysis of Workers’ Compensation Results,” www.NCCI.com

⁹⁸ Id.

⁹⁹ In the Matter of Workers’ Compensation Insurance Rate Application of the New York Compensation Insurance Rating Board, Opinion and Decision of New York State Insurance Department, 7/17/06, available at http://www.ins.state.ny.us/wc/wc_index.htm.

¹⁰⁰ Id.

¹⁰¹ Summary 2007 Rate Revision Pre-Filing, New York Compensation Insurance Rating Board, June 26,

agency in an effort to create greater transparency of insurance company data and to perhaps permit a more accurate assessment of the profitability of these insurers.¹⁰²

As stated in the 2006 White Paper, it continues to be our feeling that the profit motive of private insurers is counterproductive to the efficient delivery of benefits to injured workers at the most efficient cost to employers. Simply put, there is little reason to credit information supplied by insurers or by the CIRB, which they previously controlled, and the insurers' profit motive builds an unnecessary cost into the system.

We therefore make the following recommendation:

1. Consider making the New York State Insurance Fund the exclusive workers' compensation insurer in the state.

H. Self-Insurance Issues

Not all employers purchase insurance from a private insurance company or the State Insurance Fund; many are self-insured either individually or as part of a group (typically as a member of a "self-insurance trust").

A common issue involving group self-insurance trusts and individual self-insurers is whether they are able to provide adequate security for payment of existing and potential workers' compensation claims. This issue is particularly acute with regard to group self-insurance trusts. The WCB recently terminated 20 group self-insurance trusts covering 4,407 employers with current annual claims costs in excess of \$78 million.¹⁰³ The reason for the terminations was "funding shortfalls," meaning that the WCB felt

2007; NYS Governor's Office Press Release: Workers' Compensation Rates to Drop by Record 20.5%, July 11, 2007, available at <http://www.ny.gov/governor/press/0711071.html>.

¹⁰² 2007 New York Workers' Compensation Reform Act, Section 57, 3/13/07.

¹⁰³ New York State Workers' Compensation Board Summary of Terminated Group Self-Insured Trusts.

there was a significant possibility that the self-insurance trusts would be unable to meet their financial obligations to injured workers.¹⁰⁴ The trusts involved covered a broad range of industry groups including manufacturing, healthcare, transportation, retail sales, construction, and education.¹⁰⁵

The administration of group self-insurance trusts is of equal concern. On April 15, 2008 the WCB notified one third-party administrator, CRM Holdings, Ltd., that it would schedule administrative proceedings towards the revocation of CRM's license to act as a third-party administrator.¹⁰⁶ The Board cited CRM for (1) repeated failure to pay injured workers in a timely fashion; (2) repeated failure to file proper forms with the WCB; (3) repeatedly engaging in dilatory conduct; (4) failing to list a client in its license application as required; (5) failing to provide information to that same client; (6) routinely failing to set adequate reserves; (7) failing to cooperate with a WCB audit; and (8) providing false information in connection with that audit.¹⁰⁷ There is presently no information available regarding whether these types of failures are limited to CRM or whether they are endemic to third-party administrators for group self-insurance trusts (or individual self-insurers).

The 2007 legislation directed the WCB to evaluate and report on the status of individual self-insurers.¹⁰⁸ In response, the WCB issued a report in which it recommended a change from the current "silo" approach to self-insurance to a "pooled"

¹⁰⁴ Id.

¹⁰⁵ Id.

¹⁰⁶ Compensation Risk Managers, LLC Receives Notice of Administrative Action by New York Workers' Compensation Board, CRM Holdings, Ltd. Press Release, 4/17/08.

¹⁰⁷ Letter from WCB to CRM dated April 15, 2008.

¹⁰⁸ 2007 New York Workers' Compensation Reform Act, Section 64, 3/13/07.

approach.¹⁰⁹ The WCB reported that (excluding political subdivisions) there are “150 parent companies approved to self-insure on an individual basis ... [plus] 285 subsidiary corporations ... for a total of 435. ... Collectively, the self-insured employers have approximately 525,000 New York employees.”¹¹⁰ These employers have posted security deposits of \$1.8 billion.¹¹¹

The “silo” approach current used requires each self-insurer to obtain WCB approval to self-insure, and to post a security deposit upon approval, which is then updated annually.¹¹² If claims against it are not paid by the employer, then the security deposit is used by the WCB to pay the claims. However, once self-insurance status is granted it is not revoked based on changes in the employer’s financial condition, but only if the employer fails to pay its obligations or post adequate security.¹¹³ In addition, self-insurers are not required to re-apply or re-qualify on a periodic basis. If all of the current 150 self-insurers were required to re-qualify for self-insurance status, 10 of them (6.67%) would fail to qualify.¹¹⁴

The WCB has concluded that the fundamental deficiency in the “silo” approach is that each employer’s deposit can only be used to pay claims against that employer. As a result, some employers have substantial security deposits that are unlikely to be used, and the security deposits of other employers may be inadequate.¹¹⁵

In view of these issues, the WCB suggested a shift from the “silo” approach to a “pooled” approach. As part of this shift, “only those employers that meet certain

¹⁰⁹ Individual Self-Insurance Alternative Funding Models, NYS Workers’ Compensation Board 12/07, available at <http://www.wcb.state.ny.us/content/main/PressRe/2007/NewFundingModelForSIClaims.jsp>.

¹¹⁰ Id. at p. 1.

¹¹¹ Id.

¹¹² Id.

¹¹³ Id. at p. 13.

¹¹⁴ Id. at p. 16.

¹¹⁵ Id. at pp. 14-15.

minimum creditworthiness standards would be permitted to continue to self-insure as part of the pool.”¹¹⁶ The security deposits of these employers would then be “pooled” to “guarantee the payment of claims in the event of default” by one pool member.¹¹⁷

While moving to the “pooled” approach resolves some of the issues that exist in the “silo” approach, problems remain. The WCB has recommended that a credit rating of “B2” be deemed adequate for participation in the pool.¹¹⁸ This would eliminate 9 current self-insurers, one short of the 10 that would currently fail to qualify for self-insurance status if compelled to re-qualify.¹¹⁹ Requiring a credit rating of “B1” would eliminate 18 self-insurers, and it appears that the WCB has opted to recommend the inclusion of one financially questionable self-insurer (thus posing a risk to the pooled security) instead of excluding 8 marginally sound self-insurers.¹²⁰ In addition, the WCB has not recommended that self-insurers be required to periodically re-qualify. It is therefore unclear whether a self-insurer whose credit rating fell below the minimum level for qualification would be disqualified from participation in the pool.

In view of these issues, we make the following recommendations:

1. Adopt the WCB recommendation to change self-insurance from a “silo” approach to a “pooled” approach.
2. Require self-insurers to re-qualify for self-insured status annually.
3. Make self-insurers and the State Insurance Fund subject to Aggregate Trust Fund payments in cases of permanent partial disability.

¹¹⁶ Id. at p. 22.

¹¹⁷ Id. at p. 2.

¹¹⁸ Id. at p. 25.

¹¹⁹ Id.

¹²⁰ Id.

III. RECOMMENDATIONS.

This paper makes the following recommendations:

Availability and Accuracy of Data

1. Create a New York Workers' Compensation Research Institute ("NYWCRI") within the Cornell University School of Industrial and Labor Relations.
2. Continue the process of eliminating the CIRB not only as a rate-making entity but also as a primary repository of information about workers' compensation data. Transfer the rate-making function to the Insurance Department. Transfer the data collection function to the NYWCRI, with insurers, self-insurers, and the WCB to report data directly to NYWCRI.
3. Require the WCB to distinguish between claims that are fully resolved and those that are temporarily inactive.
4. Require the WCB to collect and report data regarding workers' compensation defense costs, including (a) defense attorney costs by carrier and employer; (b) IME costs by carrier and employer; (c) claims controverted by carrier and employer; and (d) outcome data by carrier and employer.
5. Require the WCB to collect and report data regarding IMEs, including the results of IME examinations by IME and by IME vendor.
6. Require the WCB to collect and report data regarding actual claim costs for medical and indemnity by type of injury and type of award.

7. Require the WCB to collect outcome data in controverted claims.

Access to Benefits

8. Eliminate non-hearing determinations by the WCB.
9. Require the WCB to translate forms and informational literature into additional foreign languages.
10. Eliminate WCB use of “no further action” status for claims that have not been fully resolved.
11. Provide for carrier payment of claimant attorney fees in cases involving medical treatment only.
12. Require carrier payment of claimant attorney fees in controverted cases.

Wage Replacement Benefits

13. Index the statutory minimum benefit to 25% of the statutory maximum benefit.
14. Re-define “total disability” as the inability to engage in one’s former work or any suitable light-duty position made available by the employer or through the vocational rehabilitation process.
15. Establish a statutory presumption that a worker who has stopped work due to the compensable injury is entitled to an award of benefits for loss of earning capacity attributable to the injury.
16. Provide cost of living increases for workers’ compensation benefits to offset the effects of inflation.

17. Amend the 2007 legislation to make the \$500 maximum benefit rate effective March 13, 2007 instead of July 1, 2007.
18. Eliminate the time limitations on benefits for permanently partially disabled workers.

Medical Treatment Issues

19. Clarify the 2007 legislation to establish that diagnostic tests to be performed at facilities selected by the employer or carrier are limited to radiological tests and that films must be provided to the injured worker or his physician free of charge. Provide for repeat testing if films resulting for the first test are of poor quality.
20. Establish a limited radius as the geographic area in which diagnostic test facilities selected by the employer or carrier must be located in relation to the claimant's residence. Consider a different radius upstate and downstate.
21. Require workers' compensation carriers to reimburse non-workers' compensation payors for medical expenses paid by such payors at 125% of the amount of the bills paid.
22. Eliminate the requirement that the injured worker must have a C-4 form every 45 days as a condition of continued benefits payments.

Return to Work Policy

23. Adopt and implement the recommendations of the Return to Work Task Force.
24. Establish a statewide employer education program administered by the WCB and funded by assessments on insurers and self-insurers to promote the advancement and implementation of return to work programs.
25. Establish funding for vocational rehabilitation services through assessments on employers and self-insurers in the absence of other federal and state funding.
26. Incentivize employers to establish and utilize return to work programs by deeming injured workers totally disabled if not returned to work by the employer or through the vocational rehabilitation process.
27. Exclude time spent in the vocational rehabilitation process from the time limits on permanent partial disability for accidents occurring after March 13, 2007.

Workers' Compensation Board Procedures

28. Impose time limits for decisions by administrative law judges and the WCB Office of Appeals.
29. Eliminate depositions of medical witnesses.
30. Clarify WCB regulations to establish that IMEs and not IME vendors must mail IME reports to all parties in the same time and using the same manner.

31. Increase the amounts of existing statutory penalties, make their use mandatory instead of discretionary, and target conduct such as the frivolous controversy of cases.
32. Reduce time periods for employer and insurer compliance and filing through the expansion of existing electronic filing programs.
33. Make statutory and regulatory changes aimed at reducing adjournments and lack of preparedness, including preclusion of cross-examination in the absence of contradictory evidence.
34. Render certain WCL Judge decisions non-appealable.

Claims Involving Immigrant Workers

35. Amend WCL Section 17 to clarify that the WCB may not use immigration status for any purpose in the determination of any claim or any part thereof.
36. Translate WCB forms and instructions into multiple languages.
37. Make translation services used by WCB available to injured workers.

World Trade Center Claims

38. Amend Article 8-A to prohibit the WCB from establishing a date of disablement more than 2 years prior to the date a claim is filed.
39. Amend Article 8-A to establish a list of medical conditions presumed to be causally related to WTC exposure.

40. Amend Article 8-A to define “latent condition” to include (but not be limited to) to list of medical conditions presumed to be causally related to WTC exposure.

Employer Fraud

41. Provide the WCB with additional staff to enforce existing law regarding employer obligations.
42. Establish a searchable database allowing private individuals to verify an employer’s workers’ compensation insurance status and the number of employees reported by the employer as covered under the policy.

Premium Costs

43. Consider making the New York State Insurance Fund the exclusive workers’ compensation insurer in the state.

Self-Insurance Issues

44. Adopt the WCB recommendation to change self-insurance from a “silo” approach to a “pooled” approach.
45. Require self-insurers to re-qualify for self-insured status annually.
46. Make self-insurers and the State Insurance Fund subject to Aggregate Trust Fund payments in cases of permanent partial disability.

IV. CONCLUSION.

Part One of this paper has outlined the purpose and status of current governmental action regarding the workers' compensation system (Section I), the underlying issues (Section II), and our recommendations for favorable resolution of these issues (Section III). A complete analysis of the data, legislation, and Task Force reports that provide the foundation for the foregoing commentary may be found in Part Two.

PART TWO - APPENDIX

I. THE 2007 LEGISLATION.

On March 13, 2007, Governor Eliot Spitzer signed a bill that included 82 separate sections and affected provisions of the Workers' Compensation Law, Labor Law, Tax Law, Public Authorities Law, and Public Officers Law. The bill, known as the 2007 New York Workers' Compensation Reform Act, has been referred to in this paper as the 2007 legislation.

The purpose of the 2007 legislation was to make significant changes in the workers' compensation system, and its avowed intent was to improve benefit amounts and reduce systemic obstacles for injured workers while cutting overall costs for employers.¹²¹ Changes were made in the amount of benefits, the time periods for eligibility, the availability of medical care, delivery of medical services, and certain technical procedural areas.

Although the legislation is now over one year old, it remains impossible to predict with certainty all of the ways that these statutory changes will affect New York's workers, employers, and insurance carriers. In part this is because all of the results of the statutory changes cannot be anticipated until they begin to be applied in practice. Additionally, the workers' compensation system is an administrative system in which the actions and decisions of the WCB have a significant impact on the amount of benefits available and the speed with which they are delivered.

¹²¹ NYS Governor's Office Press Release: Workers' Compensation Rates to Drop by Record 20.5%, July 11, 2007 available at <http://www.ny.gov/governor/press/0711071.html>.

There are four major areas that were affected by the 2007 legislation: benefits, medical care, procedural changes, and employer anti-fraud measures.

A. Benefits.

1. Rate Changes.

The statutory changes in benefits directly impact injured workers and are projected to result in the most significant reduction in employer costs. At the outset, the legislation amended WCL Section 15(6)(a) to increase the maximum benefit rate from \$400 to \$500 for accidents occurring on or after July 1, 2007 but before July 1, 2008; \$550 for accidents occurring on or after July 1, 2008 but before July 1, 2009, and \$600 for accidents occurring on or after July 1, 2009 but before July 1, 2010. As of July 1, 2010 the maximum rate will be set at two-thirds of the New York State average weekly wage (as defined in new WCL Section 2(16)), to be adjusted annually thereafter. These new benefit rates apply to both injury and death claims.

The minimum benefit rate was also increased from \$40 to \$100 as of July 1, 2007.

It has been estimated increasing the maximum and minimum benefit rates will result in additional annual costs to employers and carriers of \$164 million.¹²² Increasing the maximum benefit rate is, on its face, beneficial for injured workers. Those who earn more than \$600 per week have long suffered economic harm by the \$400 per week maximum benefit. In addition, increases in the maximum benefit rate have historically occurred at intervals of a decade or more, eroding the value of the maximum benefit rate for workers injured later in the cycle compared to those injured shortly after a benefit

¹²² Summary 2007 Rate Revision Pre-Filing. New York Compensation Insurance Rating Board, June 26, 2007.

increase. Therefore, the creation of a link between the maximum workers' compensation benefit and the state average weekly wage, with automatic annual increases in the benefit rate as the state weekly wage rises, is a significant accomplishment for high-wage workers.

On the other hand, the increase in the maximum benefit rate is of no value to those workers who earn less than \$600 per week. The continuation of the requirement that the workers' compensation benefit rate be two-thirds of the worker's average weekly wage means that although the statutory maximum benefit rate is higher, these workers remain unable to receive more than the current \$400 per week maximum.

Also, the increase in the benefit rate does not benefit existing claimants, nor does indexing provide any ongoing benefit once a claim has been established. The sponsor's memorandum in connection with the legislative change states that "by indexing wages, claimants are assured that their benefits will not suffer real-dollar benefit reductions due to inflation."¹²³ This is simply not correct. An injured worker's maximum compensation benefit rate is fixed as of the date of the accident (or date of disablement in claims for occupational disease). Notwithstanding the indexing of the statutory maximum benefit rate to increases in the state average weekly wage as of July 1, 2010 for future accidents, once a worker is injured his or her individual benefit rate is tied to the date of accident and does not rise over time. Therefore, those receiving compensation benefits will continue to suffer "real-dollar benefit reductions due to inflation."

It must also be observed that historically, few workers have received the statutory maximum benefit rate for an extended period of time. In practice, employers and insurers

¹²³ Sponsor's Memo to 2007 New York Workers' Compensation Reform Act, 3/13/07 by Assemblyman Sheldon Silver, Speaker of the Assembly.

generally obtain and rely upon “independent medical examination” (IME) reports which minimize an injured worker’s level of disability or loss of earning capacity. Since a worker’s benefit rate depends on both his average weekly wage and his level of disability, a reduction in the level of disability often results in a reduction in the worker’s benefit rate. Therefore, unless the use or impact of IMEs is reduced, the benefit of increasing the maximum rate will be short lived for many injured workers. The increase in the minimum benefit rate from \$40 to \$100 may mitigate some of the harsher effects of the use of IMEs, especially for low wage workers who did not benefit from increasing the maximum rate. However, unlike the maximum rate, the minimum rate is not indexed. If this is not the subject of future legislative correction, the \$100 minimum rate will ultimately fall into the same irrelevance as the \$40 rate it replaces.

There are other ways in which the value of the maximum benefit is diminished. Social Security Disability benefits, No-Fault benefits, Long Term Disability benefits, and some contractual and pension benefits may offset or reduce their payments based on the receipt of workers’ compensation benefits. In these instances, receiving a greater workers’ compensation benefit simply means that the injured worker receives a lower payment from the other source. Other than an occasional tax benefit from receiving workers’ compensation instead of the secondary benefit, greater workers’ compensation amounts may not benefit some workers at all.

Some of the money that workers will receive as a result of increasing the maximum benefit rate will also be repaid by some workers to the insurance carriers at a later date. By way of example, WCL Section 29(1-a) provides that in motor vehicle accident cases, a workers’ compensation carrier has no lien against a claimant’s recovery

from a third party to the extent that the benefits paid by the carrier are equivalent to benefits that would have been payable under the No-Fault law.

The current monthly maximum benefit under the No-Fault Law is \$2,000 per month. As a result, workers' compensation payments within the first three years of the accident or \$50,000 could never constitute a lien on a personal injury action because the \$400 per week maximum rate was only \$1,733.33 per month, which is less than the monthly No-Fault amount. When the compensation rate rises to \$500 per week, however, the monthly rate will be \$2,166.67, of which \$166.67 will be lienable. At \$550 per week the monthly benefit rate will be \$2,383.33, of which \$383.33 will be lienable. At \$600 per week the monthly benefit rate will be \$2,600, of which \$600 per will be lienable. This issue will be further exacerbated as the maximum benefit rate increases annually after July 1, 2010.

Similarly, WCL Section 29 gives the workers' compensation carrier a lien for workers' compensation benefits paid against a worker's personal injury action against a third party. As a result, increasing the maximum benefit rate serves to increase the compensation carrier's lien against a worker's third-party lawsuit.

In summary, increasing the maximum benefit rates will have a significant positive effect on temporary disability payments for high-wage workers. However, some of those effects will be offset by the nature of the system and by related benefit issues. The increase in the maximum rate provides no benefit to workers earning less than \$600 per week. However, all workers are negatively impacted by the time limitations on permanent partial disability awards discussed below.

2. Time Limits on Permanent Partial Disability.

As a counterpart to the increase in the maximum benefit rates, WCL Section 15(3)(w) was amended to provide various time limits for receipt of permanent partial disability benefits. The length of time that permanent partial disability benefits are payable depends on the extent to which the worker's "degree of disability" (or "loss of earning capacity"). The time limitations are shown on the table below:

<u>Degree of Disability</u>	=	<u>Weeks of benefits</u>
96-99%	=	525 weeks.
91-95%	=	500 weeks.
86-90%	=	475 weeks.
81-85%	=	450 weeks.
76-80%	=	425 weeks.
71-75%	=	400 weeks.
61-70%	=	375 weeks.
51-60%	=	350 weeks.
41-50%	=	300 weeks.
31-40%	=	275 weeks.
16-30%	=	250 weeks.
1-15%	=	225 weeks.

In an apparent effort to soften some of the harshness of these time limitations, new WCL Section 35 was entitled "Safety Net." This statute includes four separate requirements. First, the Commissioner of Labor was required to issue a report by December 1, 2007 "making recommendations as to how to assure that workers categorized by the WCB as permanently partially disabled return to gainful employment to the greatest extent practicable." An advisory council was created to assist the Commissioner in this project, which resulted in the report of the Return to Work Task Force discussed in Appendix IV. Second, existing case law permitting workers with partial disabilities from a medical standpoint to claim a total disability based on industrial factors was codified and preserved. Third, an "extreme hardship" provision was included

permitting workers who are more than 80% disabled to apply to the WCB for an extension or waiver of the applicable time limitation, or for re-classification as totally disabled. Fourth, the Commissioner of Labor, the WCB, and the Superintendent of Insurance were required to track the status of permanently partially disabled claimants and to report annually on their status beginning December 1, 2008.

It has been estimated that these provisions result in an annual savings to employers and carriers of \$822 million, \$658 million more than the additional cost associated with increasing the maximum rates.¹²⁴

The 2007 legislation imposes a schedule of time limits for permanent disability awards under which those workers who are more disabled can receive benefits for a longer period of time (up to ten years) and those who are less disabled are entitled to a shorter benefit period (as little as four years). Typically, those with greater degrees of disability will also receive a higher benefit rate, while those with lesser degrees of disability will receive a lower benefit rate. Thus, the time limitation provision establishes a “double bonus” for the more disabled (higher rate and longer period) and conversely a “double penalty” for the less disabled (lower rate and shorter period).

In the near term, the benefit changes and their dates will affect the prosecution of claims for occupational disease. Where the date of disablement might fall between March 13, 2007 and July 1, 2007, it is plainly better for the claimant if the date of disablement is set prior to March 13, 2007. There is no rate advantage for dates of disablement between March 13, 2007 and July 1, 2007, and such claims are subject to the time limitations on permanent partial disability claims. If, however, potential dates of

¹²⁴ Summary 2007 Rate Revision Pre-Filing. New York Compensation Insurance Rating Board, June 26, 2007.

disablement could be after July 1, 2007 or before March 13, 2007 consideration will have to be given to whether the claimant benefits more from a higher rate or from the absence of a time limitation on permanent partial disability benefits. The claimant's average weekly wage and the nature of the claim require consideration, because a claimant with an average weekly wage of \$600 or less would not benefit from the availability of a higher rate, while a claimant with a claim that is likely schedulable is not affected by the time limitations on permanent partial disability.

After March 13, 2009, when it will no longer be possible to file a timely claim with an uncapped date of disablement prior to March 13, 2007, it will generally be preferable to establish later dates of disablement to take advantage of higher benefit rates.

It must also be observed that these new time limitations apply only to periods of permanent partial disability under the specific section of the law that covers these awards. It would seem clear that the periods of time in which a worker is temporarily totally or temporarily partially disabled after the accident do not count towards the time limitations, and that the weeks of permanent partial disability are in addition to weeks payable for temporary disability. It may also be assumed that weeks of temporary total disability during the period of permanent partial disability (if, for example a permanently partially disabled worker has surgery and is temporarily totally disabled following the surgery) are not to be counted as part of the available weeks. Arguably, a worker who has used all available weeks of permanent partial disability benefits and is "capped out" would still be entitled to awards for periods of temporary total or temporary partial disability after the expiration of the time limit.

It is not entirely clear whether the worker can only use the permanent partial disability benefits consecutively in the weeks following classification as permanently partially disabled or whether the worker may use them at any time until the number of weeks are reached. If, for example, a worker with a permanent partial disability at a 50% disability level returns to work at no reduction in earnings 100 weeks after classification, does he retain the remaining 200 weeks of permanent partial disability benefits for future use should his condition recur at a later date? Since the statute does not provide that the permanent partial disability weeks must run consecutively, this is presumably the case.

Apportionment between or among multiple cases is also likely to be problematic. If the worker has an accident prior to March 13, 2007 that is not subject to the time limitations, and a later accident that is, what is the result if the benefit rate is subsequently apportioned between or among the cases? Similarly, if the claimant has two cases, both after March 13, 2007, and is found to be permanently partially disabled as a result of both accidents, is the claimant entitled to separate permanent partial disability benefit periods in each claim, or one period divided between the cases? Clearly there are many questions that cannot be answered at this time, and the answers to which may not be discernable for some time to come.

The effective date of the time limitation provisions means that workers who are injured between March 13, 2007 and June 30, 2007 are subject to the new time limitations without benefiting from any increase in the maximum rate, which applies only to accidents that occur after July 1, 2007.

3. Degree of Disability and the “Safety Net.”

The schedule of time limitations provides for different benefit periods depending on levels of disability in increments as small as 4%. The largest increment is 15%. Historically, the WCB has defined partial disability the broad categories of mild (25% - 49%), moderate (50% - 74%) and marked (75% - 99%). While the parties in the system have always been free to settle on compensation rates anywhere within the spectrum of disability from 25% to 99%, the current Workers’ Compensation Board Medical Guidelines do not provide guidance beyond the three broad categories. Further, as a matter of practice WCL Judges and the WCB rarely establish compensation rates for disabilities other than at the 25%, 50% and 75% plateaus (although on occasion a “mild to moderate” rate of 37.5% or a “moderate to marked” rate of 62.5% is fixed).

Clearly the establishment of incremental levels of disability contemplates a substantial revision of the Workers’ Compensation Board Medical Guidelines. Beyond that revision, physicians, lawyers, and WCL Judges will have to become familiar with the distinction between, for example, a 71% - 75% disability and a 76% - 80% disability. While training will presumably be readily available for WCL Judges, and while lawyers should be self-motivated to become familiar with these fine distinctions, it may be difficult to disseminate the necessary information to the medical profession and to encourage some to become re-educated. Failure to educate treating physicians will likely result in reduction in worker benefits, particularly given the probability that IMEs will be trained quickly by insurance carriers and IME companies.

Some of the “degrees of disability” described in the new statute appear to conflict with existing legal provisions. The two lowest categories of degree of disability are 1% -

15% (225 weeks) and 16% to 30% (250 weeks). While this clearly contemplates that some injured workers could be found to have degrees of disability less than 25%, such a finding is expressly prohibited by existing WCL Section 15(5-a), which provides that if a worker is partially disabled and not working, the WCB is prohibited from finding a wage earning capacity in excess of 75%, which conversely means that the WCB may not find a degree of disability less than 25%.

The codification of existing law regarding industrial total disability does not create any rights or obligations that did not previously exist. However, the express addition of this provision to the statute can be read as a signal to the WCB and the WCL Judges that greater focus should be placed on an injured worker's earning capacity (taking into consideration his or her age, education, work experience, language barriers, intellect, and the realities of the competitive workforce). If this is true, then it would appear that industrial total disability claims are to be substantially expanded. It has long been true that the statute refers to earning capacity as opposed to disability, and it has long been true that except on the outside margins the WCB has been unwilling to concern itself with the more complicated concept of earning capacity where the simple concept of disability was available to be used. The statutory amendments go out of their way to incorporate industrial total disability into black letter law, and the Commissioner of Labor is in many ways given a direct role in the operations of the WCB. It is entirely possible that as a matter of practice permanently partially disabled claimants will be evaluated by the Department of Labor and if found to be untrainable or if they cannot successfully re-employed they will be found industrially totally disabled by the WCB. Alternatively, it may become commonplace for injured workers to retain vocational

rehabilitation experts to assist in proving industrial total disability. Depending on the cost of these consultations, it may be worthwhile for a claimant with a significant permanent partial disability to invest in such an expert to try to turn a time-limited benefit into a permanent one.

The impact of the “extreme hardship” provision is difficult to foresee. It is likely that the apparent move to liberalize the use of industrial total disability will encompass many of those who have a greater than 80% disability, leaving a limited class eligible to use this provision. Historically, few claimants have been found greater than 75% disabled yet less than totally disabled. It remains to be seen how this will be affected by the anticipated new Medical Guidelines. A possible subject for future legislative change would be the extension of this “extreme hardship” provision to claimants with lower degrees of disability.

The safety net provisions also require the Commissioner of Labor to track and report on the status of permanently partially disabled workers. This is an important provision, as it will be a partial indicator of how many workers are successfully retrained, how many become subject to time limitations, and how many are covered by the industrial disability and extreme hardship provisions. However, the use of these reports will be limited by the elimination of claimants from the system through settlements, as discussed below. There does not appear to be any mechanism for tracking the status of workers who elect to settle their cases, and thus the reliability of the data obtained through the tracking portion of the safety net statute will be limited.

4. Settlements.

The imposition of time limits on permanent partial disability is likely to result in an increased motivation for injured workers to seek final settlements of their claims before their benefit weeks are terminated by operation of law. In an apparent effort to provide these workers with some leverage in obtaining settlements, WCL Section 27(2) was amended to provide that awards made after July 1, 2007 for permanent partial disability must be reduced to present value and paid by the carrier into the Aggregate Trust Fund (“ATF”).¹²⁵ WCL Section 27(8) was also amended to provide that where the ATF enters into a Section 32 settlement agreement, no portion of the unused deposit is returned to the carrier.

WCL Section 32, the legal provision that provides for final settlements, was amended to specifically authorize the Special Funds and the ATF to enter into settlement agreements. Employers and insurers are obligated to make a Section 32 settlement offer to the injured worker two years after the claim is indexed or six months after classification as permanently partially disabled, whichever is later.¹²⁶ In death claims the offer must be made within 6 months of the date entitlement is established for all beneficiaries. The offer must explain how it is divided among wage replacement benefits, medical expenses, and attorneys fees, and must be accompanied by a statement of rights.

The issue of settlements is directly connected to the time limitation of permanent partial disability benefits. Workers who are permanently partially disabled and who are

¹²⁵ This provision applies only to private insurers, and does not include the State Insurance Fund or self-insured employers.

¹²⁶ Unlike the provision requiring deposit into the ATF, this provision was not limited to private insurers but applies equally to the State Insurance Fund and self-insured employers.

not eligible for either the extreme hardship exception or the industrial total disability exception are left with only three options: return to work, receive benefits to the end of their applicable time limitation, or settle. Many permanently partially disabled workers are unable to return to work for a variety of reasons, yet are not totally disabled. For these workers, the only remaining options are to settle or be paid weekly for their available time limit.

The statutory amendments thus incentivize permanently partially disabled workers to settle their claims instead of simply waiting for their benefits to end. There is an effort to balance this by requiring all workers' compensation carriers – private insurers, the state insurance fund, and self-insured employers – to “offer each claimant the opportunity” to settle. The statute further attempts to ensure that such settlement offers will be fair by removing some insurers' leverage in negotiating settlements. It does so by requiring the insurer to pay the present value of the future compensation award into the ATF if it fails to settle with the claimant, permitting the ATF to settle the claim, and depriving the insurer of any refund if the ATF settles with the claimant. It also gives the Insurance Department a measure of control by permitting it to set the “industry standard rate” for interest, thus permitting it to adjust the present value calculations (increasing or decreasing the amount of the required ATF deposit). However, the portion of the amendments regarding mandatory ATF deposits apply only to private insurers, and do not cover the State Insurance Fund or self-insured employers.¹²⁷ It is not apparent that the amendments include any mechanism to require fair settlement offers by the State Insurance Fund or self-insured employers. While this

¹²⁷ Legislation has been introduced in an effort to rectify this situation, but has not gained significant traction to date. See S06325.

can be justified to a certain extent in the case of the State Insurance Fund given that it is the alter ego of the ATF, it is unclear whether the WCB can or will use its power to regulate self-insurers to require adequate settlement offers in the absence of a mandatory ATF deposit provision.

The amendments also attempt to create settlements of existing cases in connection with the elimination of the Special Funds 15(8) (Second Injury) Fund. Existing case law has established that the Special Funds has no direct rights or obligations with regard to the injured worker in Second Injury Fund matters, and that the Fund exists solely to reimburse employers and carriers where appropriate. The amendments change this to permit the Special Funds to directly settle cases in which it is liable to reimburse the employer or carrier. Further, the employer or carrier's consent is not required, and they are simply to be given notice of the Special Funds' action to settle the case. The amendments appear to assume that the Special Funds has either full liability or no liability in any given case. In practice, however, this is not always true. It is commonplace for a worker to have multiple cases among which liability is apportioned and the Special Funds is liable in some, but not all. In these cases, it is unlikely that the worker will settle only a portion of the claim (on the Special Funds case or cases). Further, in some instances there is only one claim with "partial reimbursement" from the Special Funds to the carrier. It is unclear whether the Special Funds will be permitted to proceed without the consent of the carrier in these instances.

A waiver management office was established at the WCB to process these settlements, and the retention of third party administrators to effectuate settlements is authorized. Most workers who have existing permanent partial disability claims in which

the Special Funds' liability has been established have already been informed about the possibility of settlement. Therefore, unless the settlement offers made by the Special Funds improve upon previous offers made by carriers (which have always tried to settle such cases to reduce administrative and benefit costs), it is unlikely that a significant percentage of these cases will actually be settled.

Notwithstanding the ultimate resolution of many of these technical matters, it is anticipated that the limitation of claims for permanent partial disability, in combination with the requirement of settlement offers in all such cases and mandatory ATF deposits in some of them, will result in a substantial increase in Section 32 settlements.

B. Medical Care and Treatment.

The 2007 legislation made a number of changes to the statutory framework concerning the delivery of medical care to injured workers. Some of these changes will have a direct and substantial impact in and of themselves. However, many of the expected changes in the delivery of medical care are clearly intended to be accomplished through regulation, little of which has occurred thus far.

1. Devices and prescription medication.

WCL Section 13(a) was amended to specifically add dental treatment and prosthetic devices to medical treatment covered under the law. The WCB is further directed to establish fee schedules for medical, dental, surgical, optometric services, crutches, nurse and hospital service, medicine, eyeglasses, false teeth, artificial eyes, orthotics, prosthetic devices, and functional assistive and adaptive devices and apparatus.

A new WCL Section 13(i) was added requiring employers and carriers to either pay pharmacy bills (or reimburse the claimant) within 45 days after submission unless the case is controverted or the prescription is not causally related, in which event they must provide a written explanation and pay any undisputed portion. Violation of the time limitation renders the carrier subject to interest at the CPLR rate, and each failure to comply is a separate violation. Carriers are authorized to contract directly with pharmacies and to require claimants to use the carrier's pharmacy (or mail order service if the pharmacy is not reasonably located for the claimant).

New WCL Section 13(o) directed the WCB to establish a pharmaceutical fee schedule, to be modified annually on April 1. Pharmacies are also required to fill prescriptions using generic drugs unless there is a specific direction to the contrary from the treating physician.

2. Diagnostic testing.

WCL Section 13-a(5) was amended to raise the pre-authorization limit for diagnostic testing and treatment from \$500 to \$1,000. The WCB was also directed to issue and maintain a list of pre-authorized procedures. However, WCL Section 13-a(7) was also added, permitting carriers to contract with a network to perform diagnostic tests, x-ray, MRI and other radiological tests and to require the claimant to use a facility within the carrier's network provided that it is a reasonable distance from the claimant and it is not an emergency. Prior to requiring the claimant to use the carrier's network, the carrier must provide the claimant with a statement of rights. Where the test costs in excess of \$1,000, the carrier is required to notify the claimant and the treating physician, who are

permitted to select the facility within the carrier's network.¹²⁸ Results of tests are to be sent to the treating physician "immediately upon completion."

3. Discussion.

Taken together, these statutory amendments give the WCB a greater degree of control over the details of medical treatment, while placing employers and carriers in charge of the delivery of that treatment. Thus far, the WCB has only issued new dental and prescription medication fee schedules. Carriers have begun to form relationships with networks to provide diagnostic tests and pharmaceuticals. It appears that the primary element in those relationships is low price, but many fear that a secondary motive for insurers will be the opportunity to exert influence over the reports of diagnostic tests.

One issue presented by carrier choice of pharmacy and diagnostic test facilities is the "reasonable distance" requirement. WCB regulations currently define a reasonable distance (for IME examinations) as the county in which the claimant resides or an adjoining county; this would seem to be an unreasonable distance for a pharmacy.

When the WCB's promulgates a list of pre-authorized procedures it should be a positive development for injured workers. Historically, workers have had difficulty obtaining diagnostic tests that cost less than the pre-authorization amount due to the unwillingness of diagnostic test facilities to provide service without prior assurance of payment. Presumably the list of pre-authorized procedures will be connected to an

¹²⁸ Note that in some instances there is a difference between the fee schedule amount for a procedure and its cost; certain diagnostic testing networks perform tests at a lower cost than the fee schedule. In this area, the law is based on cost, not the fee schedule.

administrative means of issuing prompt authorization, relieving this chronic systemic problem.

More problematic are the provisions that give insurers control over the delivery of diagnostic tests. It remains unclear whether the statute is limited to the delivery of radiological tests such as CT-scans, MRIs, and X-rays or whether it applies to all diagnostic tests. It would be contrary to past practice and the state of the law in other fields for insurers to be permitted to select doctors or facilities to perform invasive diagnostic testing on injured workers. Further, the results of tests that do not produce films are capable of interpretation by the physician performing the test. Where insurers are in a contractual relationship with the facility or physician providing the test, the potential for insurer influence over the reported results of tests is troublesome. Further, while the statute requires the carrier to provide the “results” of tests to the treating physician, it is unclear whether the “results” include the radiologist’s report or the actual films. Again, given the potential for insurer influence over reported test results, it would be preferable if this provision were defined to specify that the actual films must be provided.

As mentioned above, much of the impact of these statutory amendments will depend on the regulations and schedules yet to be issued by the WCB.

C. Procedural Changes.

The WCB is of course free to make procedural changes at any time, either through the regulatory process or simply through the manner in which it administers the statute. It is, however, constrained in some instances by the express language of the

statute, which places certain limits on the WCB's ability to effect substantive change through regulation. The 2007 legislation included a variety of statutory changes that may affect permissible WCB procedure.

The legislation added a new WCL Section 114-a(3) providing that if a claim or appeal is prosecuted "without reasonable ground" the WCB may assess costs against a party and may assess reasonable attorneys fees against an attorney, which may not be reimbursed by the client (party). Such costs and fees are payable to the WCB. Both the language and location of this provision are of interest. On its face, the statute amounts to authorization for the WCB to impose sanctions on either attorneys or parties for the prosecution of claims that lack "reasonable ground." This is, in and of itself, consistent with sanction procedures that are available to state and federal judges in civil actions. Whether the use of this provision by the WCB has a chilling effect on the prosecution of new and novel legal theories, or is restricted to a punitive role in restraining egregious conduct remains to be seen. The location of this provision in the anti-fraud statute, WCL Section 114-a raises an additional question regarding its use. It is possible that by virtue of being so located, the applicability of the new subdivision will be restricted to allegations of fraud. If this is indeed the case, then the statute will be used almost exclusively as a deterrent to employers, carriers and their attorneys raising frivolous or groundless fraud allegations against injured workers.

WCL Section 134 was amended to direct the Commissioner of Labor to implement regulations for safety, drug and alcohol prevention, and return to work incentives.

WCL Section 13-n was amended to provide for a \$10,000 penalty, revocation of registration, and referral to the Attorney General for alteration of IME reports.

WCL Section 10(4) was amended to expressly disqualify claimants from benefits during periods in which they are incarcerated due to a felony conviction. Such claimants are also expressly permitted to apply to the WCB for reinstatement of benefits upon release from incarceration. This amendment is of interest for what it does not cover. It has long been accepted that incarceration following conviction for either a misdemeanor or a felony (but not a petty offense) disqualifies a claimant for receipt of benefits for the period of incarceration. The apparent intent of the statutory amendment was to codify existing case law, but by restriction the amendment to felony convictions, it may be argued that misdemeanor incarceration is no longer a disqualifying event.

WCL Section 13-d was amended to provide for the removal of physicians for misconduct or incompetence, and to require the co-ordination of WCB action in this regard with the Department of Health.

WCL Section 25 was amended to reduce the time of the pre-hearing conference in controverted cases from 60 days to 45 days, but to add the requirement that a medical report must be submitted. The time in which a case may be transferred to the expedited hearing part was reduced from two hearings to one. The reduction in time for pre-hearing conferences in contested cases is directly connected to the Streamlined Docket initiative discussed in Appendix II. The addition of the requirement for submission of a medical report may be troublesome in a limited category of cases depending on how it is enforced by the WCB. Existing case law has established that where the claimant's claim rests upon the presumptions of WCL Section 21 (primarily unwitnessed death claims), no

medical report is required in the first instance. Should the WCB enforce the amended statutory requirement in such cases, it could have the effect of denying hearings in such cases.

Several areas of the 2007 legislation were directed towards the transfer of the CIRB's function as a rate-making agency. This was subsequently accomplished through legislation changing the governance of the CIRB.¹²⁹

D. Employer Fraud.

The 2007 legislation increased existing penalties for failure to secure workers' compensation insurance, created new penalties and remedies, and expanded the scope of conduct subject to penalty and prosecution.

WCL Section 2(17) now defines a "substantially owned affiliated entity" as "the parent company of the person, any subsidiary of the person, or any entity in which the parent of the person owns more than fifty percent of the voting stock, or any entity in which one or more the top five shareholders of the person individually or collectively also owns a controlling share of the voting stock, or an entity which exhibits any other indicia of control over the person or over which the person exhibits control, regardless of whether or not the controlling person or parties have any identifiable or documented ownership interest."

WCL Section 52 was amended to provide that failure to obtain compensation, misstatement of payroll, or misclassification of employees for an employer of 5 or fewer employees is a misdemeanor punishable by a fine of \$1,000 to \$5,000 for each 12 months in which the violation exists. For employers of more than 5 employees, violation is a

¹²⁹ Chapter 11 of the Laws of 2008; see also A09817.

class E felony punishable by a fine of \$5,000 to \$50,000. A second violation within a five year period is a class D felony punishable by a fine of \$10,000 to \$50,000.

Corporate officers who take reasonable steps to secure insurance are afforded an affirmative defense to criminal prosecution. The civil penalty for any violation of this section is \$1,000 for each ten-day period. Employers who are found to have intentionally and materially under-stated or concealed payroll or who have materially misrepresented or concealed employee duties to avoid proper classification for calculation of premium payments are deemed to have failed to secure compensation and are made subject to the criminal and civil provisions of the statute.

WCL Section 131 was amended to require that employer payroll records include the job classification of employees and the employer's accident history. Failure to maintain or provide this information is a misdemeanor subject to fine of \$5,000 to \$10,000. A second violation within a 10 year period is a class E felony punishable by a fine of \$10,000 to \$25,000. A civil penalty of \$1,000 is imposed for each 10 day period in which the employer is in violation.

WCL Section 114(4) was amended and WCL Section 114(5) was added so that violations of WCL Sections 52 and 131 can now be charged together with violations of WCL Section 114. A second offense within 10 years or a violation involving two or more claimants has become a class D felony.

WCL Section 141 was amended and WCL Section 141-a was added to authorize the chair of the WCB to issue stop work orders and to (a) enter and inspect any place of business at any reasonable time for the purpose of investigating employer compliance; (b) examine and copy business records; (c) administer oaths and affirmations; and (d) issue

and serve subpoenas for the attendance of witnesses or production of business records. Employers who have failed to secure workers' compensation insurance or pay penalties are deemed an immediate serious danger to public health and safety and the chair is authorized to serve stop-work orders.

Furthermore, the 2007 legislation added a new WCL Section 141-b providing that any employer that has been subject to a final assessment of civil fines or penalties or a stop-work order, or has been convicted of a misdemeanor, and any substantially owned affiliated entity, shall be ineligible to bid on any public work contract or subcontract for one year. The debarment period for employers that have been convicted of a felony is five years.

Taken together, these statutory amendments made the pursuit of employer fraud an integral part of the WCB's mission. To date, with certain exceptions, the issue of employer failure to maintain insurance has largely come to the WCB's attention only in the context of uninsured employer claims. The WCB is now directed to co-ordinate with various other state agencies to identify and pursue employer fraud.

The clear intent of this portion of the legislation was to recapture insurance premium that has escaped through the underreporting of payroll and the misclassification of employees, and to greatly expand the arsenal of tools available to accomplish that goal. As with all provisions of the Workers' Compensation Law and similar administrative statutes, the effectiveness of these amendments depends on the will and skill of the agency in their use.

II. THE STREAMLINED DOCKET TASK FORCE.

On June 1, 2007 the Insurance Department issued its “Recommended Workers’ Compensation Streamlined Docket Regulations,” which are commonly referred to as the “Rocket Docket.”¹³⁰ The report of the Streamlined Docket Task Force identified three inter-connected areas for administrative and regulatory reform, and its ultimate recommendation was that the WCB adopt a highly expedited schedule for litigation of controverted accident claims in which the worker has an attorney, which are approximately 30% of all controverted claims.¹³¹

Due to the fact that this expedited schedule begins to run from the date the WCB “indexes” a claim, the Task Force further recommended that the WCB decline to “index” claims until all necessary documents were filed, thus attempting to ensure that the parties would have some form of “discovery” before being subject to the expedited procedures.

Finally, due to the perceived inadequacy of existing WCB forms, the Task Force recommended the creation and adoption of new forms providing more detailed information about the claim.

In the actual process, these issues arise in the opposite order, beginning with the forms (which start the process), continuing with the action taken by the WCB in response to those forms (indexing), and concluding with procedure in controverted claims.

¹³⁰ Recommended Workers’ Compensation Streamlined Docket Regulations, NYS Insurance Dept, 6/1/07, available at http://www.ins.state.ny.us/wc/wc_index.htm

¹³¹ Id., see also Report to the Governor from the Superintendent of Insurance Summarizing Workers’ Compensation Data and Recommending Improvements in Data Collection and Development of a Research Structure for Public Policy, NYS Insurance Department, available at http://www.ins.state.ny.us/wc/wc_index.htm

A. WCB Forms.

The forms which most commonly begin the workers' compensation process are the C-2 Employer's Report of Injury/Illness, the C-3 Claim for Compensation and the C-4 Attending Doctor's Report. As part of the Streamlined Docket initiative, the WCB has proposed a re-design of each of these forms.¹³²

The existing versions of these forms are each one page, as they have been since originally adopted. The revisions originally proposed by the WCB substantially expanded the information required on the forms, and consequently the number of pages. However, the WCB has accepted input from participants in the workers' compensation process and as a result the current proposed version (issued November 29, 2007) requires only brief commentary.

1. The C-2 Form.

The proposed C-2 form would benefit from two corrections. The form refers to compensation other than wages, but identifies only lodging or tips. There is substantial legal precedent for the specific inclusion of meals in this category, and perhaps the addition of the words "or other non-monetary compensation" would be wise. With regard to the location of the accident, the form asks "Was this location where the employee normally worked?" It should be modified to read "Was this a location ..." in recognition of the fact that many workers have multiple work locations. This would also improve the grammar of the sentence.

¹³² The WCB Forms Task Force is the entity that formally issued the proposed new forms.

2. The C-3 Form.

The only obvious issue presented by the proposed C-3 form is the inclusion of an inquiry about prior injuries. The Second Injury (15(8)) Fund was abolished as part of the 2007 legislation, thus obviating the need for any generalized inquiry into past medical conditions. In addition, there are innumerable cases holding that it is inappropriate for the Workers' Compensation Board to apportion workers' compensation benefits between a prior non-compensable injury and a work-related accident.¹³³

Thus, there does not appear to be any reason for an inquiry into the issue of prior injuries other than to create a basis for controversy on the issue of causal relationship. This would seem to be contrary to the purpose of the statute, which is the speedy and non-controversial compensation of injured workers, and also to the mission of the Streamlined Docket Task Force. In addition, should an injured worker fail to properly understand or respond to this question, the worker's entitlement to benefits may later be jeopardized by a fraud allegation raised by the employer or carrier.

3. The C-3.3 Form

The WCB has proposed a new "limited medical release" which has no counterpart in previous workers' compensation practice. While there is some benefit to be obtained

¹³³ See, e.g., Johnson v. Feinberg-Smith Associates, Inc., 2003 N.Y. App. Div. LEXIS 5518 (3rd Dept. 2003); Bruno v. Kelly Temp Servs., 301 A.D.2d 730, 753 N.Y.S.2d 550, 2003 N.Y. App. Div. LEXIS 11 (3rd Dept. 2003); Krebs v. Town of Ithaca, 293 A.D.2d 883, 741 N.Y.S.2d 303, 2002 N.Y. App. Div. LEXIS 3808 (3rd Dept. 2002); Bruno v. Kelly Temp. Serv., 301 A.D.2d 730, 753 N.Y.S.2d 550, 2003 N.Y. App. Div. LEXIS 11 (3rd Dept. 2003); Hogan v. Hilltop Manor of Niskayuna, 303 A.D.2d 822, 756 N.Y.S.2d 344, 2003 N.Y. App. Div. LEXIS 2202 (3rd Dept. 2003); Montana v. Orion Bus Industries, 303 A.D.2d 820, 756 N.Y.S.2d 346, 2003 N.Y. App. Div. LEXIS 2182 (3rd Dept. 2003); Johnson v. Feinberg-Smith Assoc., 305 A.D.2d 826, 759 N.Y.S.2d 592, 2003 N.Y. App. Div. LEXIS 5518 (3rd Dept. 2003); Nye v. IBM Corp., 2 A.D.3d 1164, 768 N.Y.S.2d 706, 2003 N.Y. App. Div. LEXIS 13917 (3rd Dept. 2003); Peck v. Village of Gouverneur, 790 N.Y.S.2d. 246, 2005 N.Y. App. Div. LEXIS 1468 (3rd Dept. 2005).

from having a standardized workers' compensation medical release form, it should not be made part of the C-3 form. In addition, there are several stylistic and practical issues raised by the form in its present state.

The inclusion of the medical release form would appear to be tied to the C-3 inquiry into prior injuries. If that inquiry is deleted, then there is no justification for the inclusion of this release as part of the C-3 form.

The proposed form requires the health care provider to provide the employer, the compensation carrier, and the claimant's attorney or representative with medical records related to the workers' compensation claim and any prior conditions that were "similar" or "related" to those that are part of the claim. The release also permits (but does not require) the health care provider to discuss these conditions with the same group of recipients.

This presents both practical and legal issues for injured workers and health care providers, and potentially for employers as well.

First, it is apparently left to the discretion of the health care provider whether any prior condition is "similar" or "related" and thus whether those documents should be provided. If this authorization is directed to a worker's primary care physician (as may be expected in many cases), in order to comply with the authorization the provider would be required to comb through the patient's entire chart, identify conditions that might (in the provider's opinion) be "related" or "similar," redact the excess material, and then provide only that material which is covered by the authorization. There is no existing system of which we are aware that would permit independent review or analysis (or even provide any guidance to providers) about what is or is not "related" or "similar."

Second, the tremendous burden that this authorization imposes on providers has apparently been overlooked. As observed above, in many instances a line-by-line review of a patient's chart, with associated editing, redacting, and copying, would be required to comply with the requirements of the authorization. We wonder what mechanism is to be established to compensate providers for the countless hours of additional review that would be required. Indeed, we suspect that it is far more likely that most providers will simply copy the entire patient chart and forward it to the requesting party, regardless of whether the medical issues discussed in the chart are "related" or "similar." This would have the effect of providing the employer or carrier (or claimant's attorney) with unnecessary and irrelevant (not to mention privileged) medical information. It would also leave the provider subject to a civil action by the patient for unauthorized disclosure of privileged material. This latter eventuality is insufficiently emphasized in the existing form.

Third, the inclusion of the C-3.3 form as part of the C-3 and its generalized use will create substantial delay in the processing of workers' compensation claims. It is to be expected that carrier action on claims, payment of benefits, and authorization and payment for medical treatment will be delayed while carriers await receipt of medical records. Those who regularly request medical records are aware that it often takes more than a month before records are received in response to a generalized request. The review and editing process that will be required of providers under the proposed form can be expected to (at least) double that estimate.

4. Forms C-4 and C-4.2.

There is no question that the C-4 and C-4.2 forms provide far more detailed information than is available on the existing C-4/48 forms. While this additional information may be of benefit to the Board and to employers or carriers, it will clearly come at the expense of additional time spent by health care providers. One way in which this could be addressed would be to increase the workers' compensation fee schedule to account for the extra time and effort that will be required of providers.

B. Indexing.

In most cases, the WCB requires the production of “prima facie medical evidence” (“PFME”) before permitting the injured worker to pursue his or her claim. Practitioners have long understood that PFME is a medical report with a history of the occupational event (accident or occupational work history), a diagnosis of a medical condition, and an opinion that the history was probable cause of the medical condition. Despite the usual requirement that PFME be produced to pursue the claim, however, the WCB has never required the submission of PFME as a condition of indexing a claim in the first place. Simply put, there is no area of law in which the party making a claim is required to prove his or her claim before it is filed, which would be the effect of requiring PFME as a condition precedent to indexing.

The Streamlined Docket report makes precisely that proposal, stating that the WCB should not index a claim until it receives a C-2 or a C-3, plus a limited medical release, plus PFME. The report proposes a definition of PFME as “a medical report by an attending medical provider that gives a history of the accident or occupational disease,

a diagnosis, and a statement as to whether the injury is causally related to the accident or occupational disease.”¹³⁴ The potential issue here is the WCB’s definition of “attending,” not to mention the question of why a report is not “prima facie” if it meets all of the legal requirements yet is not from an “attending” doctor. At a minimum, the regulation should refer to a medical report by an “attending or examining” medical provider. Some injured workers do not have an “attending” doctor beyond the emergency room. Under the existing regulation, they would never be able to submit prima facie medical evidence to prosecute their claims, because the only medical reports would be the emergency room record (not a C-4) and possibly a report from an “examining” (but not “attending”) doctor.

Further, in many death cases there is neither an attending nor an examining medical provider, but simply a review of records. In short, the restriction of the source of prima facie medical evidence to “attending medical providers” is contrary to existing law¹³⁵ and may serve to deny substantive and procedural rights to injured workers. As is pointed out by the regulation itself, a medical report is “prima facie medical evidence” if it includes a history of the accident, a diagnosis, and a statement as to causal relationship. The source of the report would seem to be irrelevant to its character, although certainly it may play a role in the weight it is accorded by a WCL Judge – for which no regulation is required.

¹³⁴ Proposed regulation 12 NYCRR 300.1(a)(6).

¹³⁵ See, e.g., Hicks v. Hudson Valley Community College, 34 A.D.3d 1039; 825 N.Y.S.2d 287 (3rd Dept. 2006); Lumia v. City of New York; 21 A.D.3d 600; 799 N.Y.S.2d 644 (3rd Dept. 2005), Holmes v. Kelly Farm & Garden, Inc., 1 A.D.3d 743; 766 N.Y.S.2d 651 (3rd Dept. 2003); Barrington v. Hudson Valley Fruit Juice, Inc., 297 A.D.2d 886; 747 N.Y.S.2d 613 (3rd Dept. 2002).

Therefore, the words “by an attending medical provider” should be deleted from the proposed regulation. In the alternative, the regulation should be amended to read “by an attending or examining medical provider.”

Historically, if the WCB did not receive documents deemed sufficient for indexing, the documents were maintained in a “no claims” file, from which they could be retrieved if “indexable” documents were later received. As a result, there was no lack of clarity about whether a claim had been filed: it was either indexed, or it wasn’t.

The Streamlined Docket report seems to call for abolishing the “no claims” procedure and replacing it with a new procedure requiring “the assignment of a case number and creation of case file” upon receipt of “non-indexable” documents, which “is not the indexing of a claim for purposes of any time periods set forth in the Workers’ Compensation Law.”¹³⁶ The regulation further states that time periods in the law do not run from “the assignment of a case number,” but only from “indexing.”¹³⁷

While the abolition of “no claims” status is desirable, the creation of a halfway state implicating “time periods” raises questions as to exactly which “time periods” are referenced. This is further complicated by the fact that the proposed regulations require the WCB to follow up with the injured worker for two years after receipt of non-indexable documents, which is the period of the statute of limitations for claim filing. This creates the implication that even if a C-3 form is submitted by the worker (a claim for compensation), his or her claim is not “filed” for time limitations purposes until it is “indexed” by the WCB.¹³⁸

¹³⁶ Proposed regulation 12 NYCRR 300.37

¹³⁷ Id.

¹³⁸ Proposed regulation 300.37(b)(3)(v).

One positive aspect of the proposed indexing regulations is its requirement that employers provide injured workers with a “claimant information packet” advising the worker what is required to file a claim. This requirement does not presently exist and presents a barrier to access to benefits for many workers.

C. Controverted Claims.

The stated purpose of the Streamlined Docket Task Force was to develop a means of expediting the resolution of controverted workers’ compensation claims. Existing law requires the employer or carrier to file a C-7 form within 25 days after the date the Board’s notice of indexing is mailed. The Task Force proposes many new requirements, including that the C-7 form (1) must provide a factual basis for the controversy and for any defenses; (2) must contain a written certification signed by the carrier or its attorney; (3) must provide the names and telephone numbers of any potential carrier witnesses; and (4) must list all documents that the carrier may use in defending the claim.¹³⁹

The report suggests that the carrier be permitted to petition the Board “for a broader release” than the limited release the claimant is required to file as a condition of indexing. However, such a petition is only to be “granted upon a showing of relevance.”¹⁴⁰

If the carrier’s C-7 contends that the claimant’s medical report is not prima facie medical evidence, “the Board shall determine the issue within five days of receipt of the notice of controversy” and the determination shall not be appealable by the carrier. If the

¹³⁹ Proposed regulation 12 NYCRR 300.38.

¹⁴⁰ Id.

medical report is found not be prima facie medical evidence, the claimant is to be afforded an opportunity to submit additional medical reports.¹⁴¹

Within 10 days after the Board receives a C-7 form, the Board is to issue a notice (1) setting a pre-hearing conference for a date within 45 days of the date the C-7 form was received, (2) directing the parties to file pre-hearing conference statements, (3) directing that an IME reports are to be served “at or before” the pre-hearing conference (and that failure to do so shall operate as the waiver of an IME on the issue of causal relationship), and (4) calling for a trial on the same day as the pre-hearing conference.¹⁴²

Pre-hearing conference statements are to be filed “electronically” with the Board and served on the other parties 14 days before the pre-hearing conference. The statement “shall include” (1) a summary of the claim, (2) “the theory of the case”, (3) an “offer of proof” for each defense, (4) a list of lay witnesses with names, addresses, and a summary of their testimony, (5) a list of medical witnesses to be cross-examined, (6) the names of any additional necessary parties, (7) a statement that all discovery has been completed, and (8) a certification that the party “has conferred in a good faith effort to settle or otherwise resolve the case.”¹⁴³

Parties are required to attach to their pre-hearing conference statements copies of all documents they intend to use that are not already part of the Board’s file. If the carrier fails to comply with the pre-hearing conference statement rules, it may be precluded from submitting evidence or witnesses. If a claimant’s attorney fails to comply, he or she is subject to a “mandatory, substantial reduction” in fee.¹⁴⁴

¹⁴¹ Id.

¹⁴² Id.

¹⁴³ Id.

¹⁴⁴ Id.

At the pre-hearing conference, the WCL Judge or conciliator is to ensure that all required forms and information have been filed, “find a waiver of any defense for which the offer of proof” is insufficient, require the parties to identify their witnesses and those doctors they wish to cross-examine, and decide whether the medical witnesses are to testify at the Board or by deposition.¹⁴⁵

If medical witnesses are to testify at the Board, their testimony date shall be no more than 40 days after the pre-hearing conference. They may testify by telephone, are to be subpoenaed by the carrier, and are to be notified by the Board.¹⁴⁶

If medical witnesses are to be cross-examined by deposition, the depositions are to be taken within 25 days of the pre-hearing conference, and transcripts are to be filed within 10 days thereafter.¹⁴⁷

If the claimant fails to appear for a pre-hearing conference, the case will be closed for failure to prosecute and can be reopened when the claimant is prepared to proceed. If a carrier fails to appear, “the workers’ compensation law judge will render a decision based upon the evidence contained in the Board file.”¹⁴⁸

Cases that are not resolved at the pre-hearing conference are to proceed immediately to trial (that day) and any witnesses who do not appear are to be precluded absent “extraordinary circumstances.” Where medical testimony is required, there is to be no direct examination and the physician’s report is to constitute his or her “direct examination.” Only cross-examination and “re-direct” examination is to be permitted. If a carrier’s IME does not appear, his testimony will be precluded. If a treating doctor does

¹⁴⁵ Id.

¹⁴⁶ Id.

¹⁴⁷ Id.

¹⁴⁸ Id.

not appear, his testimony is to be taken by deposition “as soon as practicable.” The WCL Judge is to make a decision from the bench immediately after the testimony is complete.¹⁴⁹

It will be observed that the Task Force proposes to do away with direct examination of physicians, instead directing that the physician’s report is to constitute his or her direct testimony. While this is an unusual concept, it could be effective if all of the medical evidence and reports are to be considered. However, because the Task Force also proposes restricting a treating physician’s “direct testimony” to the answers to the questions on a C-4 form, this puts injured workers at a disadvantage compared to insurance company IMEs, who are free to submit multi-page narrative reports containing a wealth of information and commentary/

On balance, however, the proposed controverted case regulations should be favorable to claimants who are capably represented. However, the highly compressed time frame and substantial additional burdens on counsel create the possibility that those who are represented by smaller or less technologically advanced law firms may suffer.

III. THE MEDICAL GUIDELINES TASK FORCE.

The Medical Guidelines Task Force is required to address a number of issues resulting from the 2007 legislation and associated processes. These issues include identifying best medical practices (for which no authorization will be required), treatment guidelines (from which the best medical practices will be drawn), and disability or impairment guidelines that must be tied to WCB determinations of wage earning capacity and to vocational evaluation and rehabilitation programs.

¹⁴⁹ Id.

A. Medical Treatment Guidelines.

Thus far, the Medical Guidelines Task Force has issued a partial report addressing treatment guidelines for treatment of injury to neck, back, shoulder and knee, which are the four body parts seen as the most significant “cost drivers” for employers and carriers.¹⁵⁰ According to the Insurance Department, treatment costs for these four body parts “account for nearly 60% of total medical costs in New York’s system.”¹⁵¹

1. Medical Costs.

Overall, the Insurance Department has stated that medical costs in New York rose from 34% of all benefit costs in 1994 to 38% of all benefit costs in 2003.¹⁵² It may be observed, however, that this does not necessarily mean that medical costs were increasing; it could be equally consistent with decreasing indemnity costs. However, the Insurance Department also alleges that “the medical costs of claims by workers out more than seven days grew substantially faster than the rate of medical inflation each year from 1997 to 2002.”¹⁵³ Again, no explanation is provided as to why a different period (1997-2002) from the period used earlier (1994-2003) was selected, nor are specific figures provided.

It must also be observed that medical costs in New York’s workers’ compensation system are subject to a fixed fee schedule, and thus increased medical costs cannot arise from the rising cost of any individual treatment modality.¹⁵⁴ As a result, the Insurance

¹⁵⁰ New York State Insurance Department News Release, “Insurance Department Issues Draft Workers’ Compensation Medical Treatment Guidelines,” December 3, 2007, available at http://www.ins.state.ny.us/wc/wc_index.htm.

¹⁵¹ Id.

¹⁵² Id.

¹⁵³ Id.

¹⁵⁴ Letter from Eric Dinallo, Superintendent of Insurance, to Zachary Weiss, Chair of the WCB, dated

Department attributes the increase in medical costs to increased “utilization,” which it proposes to correct through the use of medical treatment guidelines.¹⁵⁵ However, the Insurance Department concedes that “New York has been a moderate cost state in comparison to other states” and that “New York had the 5th lowest medical costs per permanent partial disability case, and the 9th lowest medical costs per total temporary disability case.”¹⁵⁶ It is difficult to reconcile this information.

In a letter from the Superintendent of Insurance to the Chair of the WCB, the Insurance Department identifies the source of its data as the CIRB.¹⁵⁷ The lack of reliability of CIRB data is discussed in Section II.A. and will be considered again in Appendix V. Regardless of the accuracy of this data, it provides the basis for the Insurance Department’s production of proposed medical treatment guidelines for use by the WCB.

2. Treatment Guidelines.

The Medical Guidelines Task Force begins its report with the proposition that “evidence-based guidelines” are essential to prevent both “excessive utilization” and denial of medical care “simply to reduce costs.”¹⁵⁸ It goes on to note that there is no standard of “utilization” used by all employers and carriers, which results in inequality of treatment and “adds to frictional costs.”¹⁵⁹ The proposed answer to this perceived problem is “standardization.”

December 3, 2007.

¹⁵⁵ Id.

¹⁵⁶ Id.

¹⁵⁷ Id.

¹⁵⁸ Id.

¹⁵⁹ Id.

In lieu of using an existing set of guidelines from another state or medical organization, the Task Force opted to select a preferred guideline for each body part, with the ultimate goal of collecting the individual guidelines into a cohesive whole.¹⁶⁰ The result was the production of a 50 page document addressing knee injuries,¹⁶¹ a 53 page document addressing low back injuries,¹⁶² a 63 page document addressing shoulder injuries,¹⁶³ and a 54 page document addressing neck injuries.¹⁶⁴ The accumulated 220 pages of medical treatment guidelines were accompanied by a statement of general principles¹⁶⁵ and an education plan.¹⁶⁶

The general principles are largely geared to measurements of functional progress and return to work, and pain relief is significantly de-emphasized. The first principle (entitled “medical care”) states that treatment “should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work.”¹⁶⁷ Palliative treatment (generally including pain relief) is “viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.”¹⁶⁸ Active therapy is to include “functional application in vocational or

¹⁶⁰ Id.

¹⁶¹ Knee Injury Medical Treatment Guidelines proposed by the State of New York Insurance Department to the Workers’ Compensation Board, available at http://www.ins.state.ny.us/wc/wc_index.htm.

¹⁶² Low Back Injury Medical Treatment Guidelines proposed by the State of New York Insurance Department to the Workers’ Compensation Board, available at http://www.ins.state.ny.us/wc/wc_index.htm.

¹⁶³ Shoulder Injury Medical Treatment Guidelines proposed by the State of New York Insurance Department to the Workers’ Compensation Board, available at http://www.ins.state.ny.us/wc/wc_index.htm.

¹⁶⁴ Cervical Spine Injury Medical Treatment Guidelines proposed by the State of New York Insurance Department to the Workers’ Compensation Board, available at http://www.ins.state.ny.us/wc/wc_index.htm.

¹⁶⁵ General Principles: Medical Treatment Guidelines proposed by the State of New York Insurance Department to the Workers’ Compensation Board, available at http://www.ins.state.ny.us/wc/wc_index.htm.

¹⁶⁶ Medical Treatment Guidelines Education Plan, available at http://www.ins.state.ny.us/wc/wc_index.htm.

¹⁶⁷ General Principles, Medical Treatment Guidelines at p. 1

¹⁶⁸ Id.

community settings,” and surgery “should be within the context of expected functional outcome and not solely for the purpose of pain relief.”¹⁶⁹ Specific provision is made for the use of “functional capacity evaluations” and “job site evaluations.”¹⁷⁰

The Task Force recognized that its approach to medical care is dramatically different from past and present practice, and that the hypothetical benefits of its recommended approach “will be more fully realized if all of the key players in the workers’ compensation system obtain adequate training on how to use the treatment guidelines and have sufficient incentive to continue applying them.”¹⁷¹ It therefore recommends training of WCB personnel, health care providers, and employer and carrier personnel.¹⁷² The Medical Treatment Guidelines Education Plan includes detailed suggestions as to how this training could be implemented.

3. Discussion.

There are several issues associated with the adoption of the sort of standardized medical treatment guidelines recommended by the Task Force. First, while standardization may result in all patients with similar injuries receiving similar treatment, that is not necessarily in the best interest of every patient. It is well known that individuals respond differently to injury based on a host of factors including age, general medical condition, genetic predisposition, and psychological make-up. If standardized guidelines do not permit sufficient flexibility to account for these differences, some patients may receive less than optimal care.

¹⁶⁹ Id. at p. 2.

¹⁷⁰ Id. at pp. 3-4.

¹⁷¹ Medical Treatment Guidelines Education Plan at p. 2.

¹⁷² Id.

A related issue is whether the guidelines are to serve as a “floor” for minimum acceptable treatment, beyond which authorization may be sought for additional services in any given case, or as a “ceiling,” beyond which no treatment may be authorized. Employers and carriers would presumably argue for the latter, while injured workers and treating physicians require the former.

The focus of the guidelines is also problematic. Certainly rehabilitation and return to work are essential goals following an occupational injury or illness. However, it is unacceptable to deny an injured worker surgery for the purpose of pain relief even if there are no “functional gains” to be made as a result of the procedure.

Although there can be no doubt that the Medical Guidelines Task Force worked diligently to produce the treatment guidelines, general principles, and education plan, a sense remains that the documents are less the product of informed medical judgment than they are the result of political negotiation and compromise between the medical needs of injured workers and the financial desires of employers and carriers.

B. Impairment Guidelines.

The Task Force has not issued a report regarding revisions to the Workers’ Compensation Board Medical Guidelines, which are used by the WCB to assess “degree of disability” and “schedule loss of use.” Degree of disability is the primary component in the WCB’s assessment of an injured worker’s loss of earning capacity, which in turn determines the amount of the worker’s weekly benefit for replacement of lost wages. Schedule loss of use awards are the amount of compensation provided for permanent injury to extremities, vision loss, and hearing loss.

At one point, the Task Force contracted with Dr. Christopher Brigham, editor of the Sixth Edition of the American Medical Association Guidelines (“the AMA Guidelines”) to “translate” the AMA Guidelines for use in New York.¹⁷³ Due to the wide divergence between the principles of the AMA Guidelines and existing New York law and practice, this approach was highly controversial. It was also controversial “because Dr. Brigham, who has offices in Maine, California and Hawaii, is ... one of the country’s leading advisers to companies locked in legal disputes with workers over disability payments.”¹⁷⁴

The AMA Guidelines (and similar “impairment rating systems”) focus on medical impairment, as opposed to the effect of the injury on the worker’s earning capacity. This conflicts with the legal principles underlying New York’s workers’ compensation law, which focuses on loss of earning capacity.¹⁷⁵ The Chair of the WCB has stated that “New York is a wage state. It is not an impairment state. ... Ultimately ... New York has to make a decision about wage loss.”¹⁷⁶ This approach cannot be reconciled with the AMA Guidelines, which do not take into consideration factors such as age, education, occupation and vocational history. Furthermore, the AMA Guidelines include provisions for reduction of awards based on pre-existing medical conditions, regardless of whether those conditions affected the worker’s ability to do his or her job before the occupational injury. In New York, the WCB and the courts have consistently rejected apportionment

¹⁷³ Unions vs. Injury Expert, New York Times March 10, 2008 (available at <http://www.nytimes.com/2008/03/10/nyregion/>)

¹⁷⁴ Id.

¹⁷⁵ WCL Sections 15(7), 37; see also DiFabio v. Albany Co. Dept. of Social Serv.s, 162 A.D.2d 775, 557 N.Y.S.2d 688 (3rd Dept. 1990); Henderson v. Capitol Davis Joint Venture, 98 A.D.2d 894, 470 N.Y.S.2d 852 (1983).

¹⁷⁶ AMA Guidelines Loom in N.Y. Debate, Workcomp Central, 10/30/07.

to pre-existing conditions that did not cause “a disability in the compensation sense,” that is, did not affect the worker’s ability to function on the job.¹⁷⁷

It is therefore clear that importing the AMA Guidelines, or any similar “objective, impairment-based system,” into the New York workers’ compensation system would be inconsistent with the core principle of the system, which is the determination of loss of earning capacity. Moreover, there is no evidence that the existing WCB Medical Guidelines have been inadequate to assist the WCB in evaluating the medical issues of “degree of disability” and “schedule loss.” To the extent that the WCB has failed to address the impact of degree of disability on wage earning capacity, that situation is due more to the failure to consider non-medical factors (vocational issues) than to any inherent flaw in the existing guidelines.

We therefore make the following recommendations:

1. Clarify the 2007 legislation to establish that diagnostic tests to be performed at facilities selected by the employer or carrier are limited to radiological tests and that films must be provided to the injured worker or his physician free of charge. Provide for repeat testing if films resulting for the first test are of poor quality.

¹⁷⁷ See, e.g., Johnson v. Feinberg-Smith Associates, Inc., 2003 N.Y. App. Div. LEXIS 5518 (3rd Dept. 2003); Bruno v. Kelly Temp Servs., 301 A.D.2d 730, 753 N.Y.S.2d 550, 2003 N.Y. App. Div. LEXIS 11 (3rd Dept. 2003); Krebs v. Town of Ithaca, 293 A.D.2d 883, 741 N.Y.S.2d 303, 2002 N.Y. App. Div. LEXIS 3808 (3rd Dept. 2002); Bruno v. Kelly Temp. Serv., 301 A.D.2d 730, 753 N.Y.S.2d 550, 2003 N.Y. App. Div. LEXIS 11 (3rd Dept. 2003); Hogan v. Hilltop Manor of Niskayuna, 303 A.D.2d 822, 756 N.Y.S.2d 344, 2003 N.Y. App. Div. LEXIS 2202 (3rd Dept. 2003); Montana v. Orion Bus Industries, 303 A.D.2d 820, 756 N.Y.S.2d 346, 2003 N.Y. App. Div. LEXIS 2182 (3rd Dept. 2003); Johnson v. Feinberg-Smith Assoc., 305 A.D.2d 826, 759 N.Y.S.2d 592, 2003 N.Y. App. Div. LEXIS 5518 (3rd Dept. 2003); Nye v. IBM Corp., 2 A.D.3d 1164, 768 N.Y.S.2d 706, 2003 N.Y. App. Div. LEXIS 13917 (3rd Dept. 2003); Peck v. Village of Gouverneur, 790 N.Y.S.2d. 246, 2005 N.Y. App. Div. LEXIS 1468 (3rd Dept. 2005).

2. Establish a limited radius as the geographic area in which diagnostic test facilities selected by the employer or carrier must be located in relation to the claimant's residence. Consider a different radius upstate and downstate.
3. Require workers' compensation carriers to reimburse non-workers' compensation payors for medical expenses paid by such payors at 125% of the amount of the bills paid.
4. Eliminate the requirement that the injured worker must have a C-4 form every 45 days as a condition of continued benefits payments.

IV. THE RETURN TO WORK TASK FORCE.

The Return to Work Task Force attempted to address precisely the issues that would not be addressed by implementation of the AMA Guidelines: the vocational capacity and potential for rehabilitation of injured workers. This Task Force was charged with reviewing and recommending vocational rehabilitation and return to work programs as well as the co-ordination of these programs with workers' compensation benefits. It issued a report making recommendations on subjects in which agreement could be reached as well as identifying areas in which agreement could not be reached and the reasons for disagreement.¹⁷⁸ Time and again the reason for "disagreement" was the unwillingness of employers and carriers to fund programs that would result in small up-front costs but long-term savings, as well as significantly improve the lot of injured workers.

¹⁷⁸ Report of the Commissioner on Return to Work, NYS Department of Labor, March, 2008, available at http://www.labor.state.ny.us/agencyinfo/ReturntoWorkReportMarch12_2008.shtm.

The Task Force recognized that an essential element of the 2007 legislation was the use of vocational factors in benefit determinations, and that this was tied to the availability and efficacy of vocational rehabilitation evaluations and programs. As a result, the Task Force recommended (1) development of return-to-work educational programs for employers; (2) requirement of formal return-to-work policy by employers of more than 25 workers; (3) re-design of WCB forms regarding vocational information; (4) education of physicians in occupational health issues; (5) WCB-paid vocational rehabilitation evaluation of all claimants who reach maximum medical improvement and have not returned to work; (6) development of incentive programs for hiring disabled workers; (7) payment of attorneys in “medical only” cases; (8) WCB review of cases to ensure proper awards for reduced earnings; and (9) data collection on return to work rates.¹⁷⁹

The Task Force indicated that in addition to providing wage replacement benefits and medical treatment, a goal of workers’ compensation programs is to provide vocational rehabilitation and a path to return to work for workers who suffer occupational injury and illness.¹⁸⁰ Although certain sections of the Workers’ Compensation Law reference vocational rehabilitation,¹⁸¹ and although the WCB does perform some limited vocational screening through its Rehabilitation Unit, the WCB does not perform full vocational assessments or retraining. Instead, workers who express an interest in vocational rehabilitation are referred by the WCB to one or more programs administered by the Department of Labor.

¹⁷⁹ Id.

¹⁸⁰ Id. at p. 15.

¹⁸¹ See, e.g., Workers’ Compensation Law Section 15(3)(v).

In some instances, employers and carriers seek to become involved in the rehabilitation process. Unfortunately, the utility and trustworthiness of these efforts are undermined by the frequent desire of employers and carriers to use vocational information to seek reduction of benefit payments.

The Task Force reported that return to work rates for permanently partially disabled claimants were consistently and significantly lower than those who were temporarily totally disabled.¹⁸² As a result, the Task force made more than 50 recommendations in various categories primarily intended to improve return to work rates for permanently partially disabled workers. Unfortunately, many of these recommendations are diluted “compromise” recommendations that are far less likely to achieve meaningful results than if they were fully implemented and funded.

The Task Force found that “return to work interventions are effective in reducing the duration of work disability” and that “every dollar spent by employers on accident prevention and return to work yields savings.”¹⁸³ However, “some Council members” opposed mandating return to work programs on the grounds that it might “impose a burden” on employers.¹⁸⁴ As a result, the Task Force was only able to reach consensus on a recommendation that employers of more than 25 employees should have a “written, formal, consistent return to work policy.”¹⁸⁵

¹⁸² Report of the Commissioner on Return to Work at p. 17. It must be noted that all workers who experience only a period of temporary total disability by definition then return to work, so it necessarily follows that the return to work rates of permanently partially disabled workers will be lower if less than all of them do not return to work. As a result, it is difficult to evaluate the significance of this statement in the Report unless the goal is to return all permanently partially disabled workers to work (which while a worthy goal does not seem feasible).

¹⁸³ Id. at p. 21.

¹⁸⁴ Id. at p. 22.

¹⁸⁵ Id.

The Task Force found that employer education was critical to the success of return to work programs, but again was unable reach a consensus on whether such education should be mandatory or voluntary due to the opposition of “some Council members.”¹⁸⁶ As a result, the Task Force was limited to deferring a recommendation on this issue while it attempts to “seek consensus from stakeholders.”¹⁸⁷ Similarly, the Task Force found that “the negative effects of workplace disability are reduced or mitigated for those who participate in vocational rehabilitation, but was faced with certain members who “expressed concern over cost,” among other issues.¹⁸⁸ In the end, “while all Council members agreed on the value of rehabilitation in certain cases, no agreement could be reached on who should bear the costs for providing the assessment and the vocational rehabilitation services.”¹⁸⁹ The same result was reached in the area of providing employers with incentives for establishing return to work programs: “The Council members could not agree on how such programs should be funded.”¹⁹⁰

From a workers’ compensation standpoint, questions exist as to the impact of time spent in vocational rehabilitation on earning capacity, as well as the effect of a failure to rehabilitate on entitlement to benefits. The Workers’ Compensation Law as it existed prior to the 2007 legislation included a financial incentive for partially disabled workers to return to work. If a partially disabled worker returns to work at earnings less than his or her pre-accident salary,¹⁹¹ WCL Section 15(5-a) requires the WCB to award benefits based on the worker’s actual earnings, rather than based upon the “degree of disability.”

¹⁸⁶ *Id.* at pp. 27-28.

¹⁸⁷ *Id.* at p. 28.

¹⁸⁸ *Id.* at p. 36.

¹⁸⁹ *Id.* at p. 40.

¹⁹⁰ *Id.* at p. 48.

¹⁹¹ “Reduced earnings” is the workers’ compensation term for this situation.

In many instances, the injured worker was able to obtain an increase in the compensation rate as a result of returning to work (in addition to which the worker had the income earned from working). To ensure that workers who return to work at reduced earnings are properly compensated, the Task Force called upon the WCB to “implement process changes that will improve transparency and consistency on issues such as ‘reduced earnings awards.’”¹⁹²

However, as indicated by the Insurance Department, most permanently partially disabled workers do not return to work. Given that they have been found by the WCB to have some earning capacity, it would be desirable to provide them with incentives (or at the very least not to penalize them) for engaging in vocational rehabilitation. One such incentive would be to exclude time spent in vocational rehabilitation from the number of weeks the worker is entitled to permanent partial disability benefits, in essence deeming time spent in vocational rehabilitation to be a period of “temporary disability” in which it is unknown whether the worker can be successfully retrained and reemployed. However, the Return to Work Task Force was unable to “reach agreement” on this issue.¹⁹³

Further, if the vocational rehabilitation process does not succeed in retraining or reemploying the injured worker, then the worker presumably has no earning capacity. Under these circumstances, the WCB should be obligated to rescind its classification of the worker as permanently partially disabled and to declare the worker totally industrially disabled.¹⁹⁴ Such “reclassification” is permitted under existing law and falls squarely

¹⁹² Report of the Commissioner on Return to Work at p. 57.

¹⁹³ Id. at pp. 40-41.

¹⁹⁴ The concept of “total industrial disability” is that while the worker may be less than totally disabled from a medical standpoint, when vocational factors are taken into consideration the worker is unemployable.

within the WCB's continuing jurisdiction over workers' compensation claims.¹⁹⁵ Furthermore, reclassifying non-retrainable permanently partially disabled workers as totally industrially disabled ameliorates the harsh effect of the time limitations on permanent partial disability benefits (which do not apply to totally disabled workers), and effectively expands the "safety net" created by the 2007 legislation to capture precisely the group of workers it was intended to protect. When this issue was raised in the Return to Work Task Force, it was opposed by "some Council members" on the grounds that it would detract from the "PPD caps, which they thought was key to assuring long-term cost savings under the 2007 reform legislation ... while acknowledging that the 2007 legislation specifically incorporate[ed] existing case law on" total industrial disability.¹⁹⁶ As a result, the Department of Labor was again left to further "analyze" the data before making a recommendation.

The Return to Work Task Force also considered the impact of representation on worker benefits, medical care, rehabilitation, and return to work. Because a claimant's attorney cannot be paid in a "medical only" case, a lower proportion of claimants with medical only cases are represented than in cases involving indemnity payments.¹⁹⁷ Because failure to authorize treatment may ultimately impact on the return to work process, and because there appear to be significant issues with "carriers not complying with orders to pay [for] medical care, and the inability to penalize carriers for noncompliance," the Task Force recommended that provisions be made for payment of claimant attorneys in "medical only" cases.¹⁹⁸

¹⁹⁵ Workers' Compensation Law Sections 15, 123.

¹⁹⁶ Report of the Commissioner on Return to Work, at p. 50.

¹⁹⁷ Id. at p. 55.

¹⁹⁸ Id. at p. 56.

In considering the treatment and recovery process, the Task Force observed that in 2006 the WCB held more than 21,000 hearings on medical treatment issues, while “the odds for return to full employment drop to 50% after six months of absence from work.”¹⁹⁹ Conversely, “injured workers who return to their at-injury employer in a safe and timely manner sustain the best long-term employment and wage earning capacity.”²⁰⁰ The Task Force further hypothesized that “in the medical community, return to work is not traditionally viewed as a conventional health outcome,” but that “physician education should improve return to work outcomes.”²⁰¹ As a result, the Return to Work Task Force coordinated its activities in this area with those of the Medical Guidelines Task Force and the WCB Forms Task Force (an outgrowth of the Streamlined Docket Task Force), in the end making a group of recommendations regarding physician education in the area of occupational medicine and workers’ compensation reporting.²⁰² This appears to have been one of the few areas in which this Task Force was not hampered by an inability to reach “consensus” based on employer and carrier “concerns” about cost.

We therefore make the following recommendations regarding return to work programs with relation to the workers’ compensation system:

1. Adopt and implement the recommendations of the Return to Work Task Force.
2. Establish a statewide employer education program administered by the WCB and funded by assessments on insurers and self-insurers

¹⁹⁹ Id. at p. 32.

²⁰⁰ Id. at p. 45.

²⁰¹ Id. at pp. 32-33.

²⁰² Id. at p. 34-35.

to promote the advancement and implementation of return to work programs.

3. Establish funding for vocational rehabilitation services through assessments on employers and self-insurers in the absence of other federal and state funding.
4. Incentivize employers to establish and utilize return to work programs by deeming injured workers totally disabled if not returned to work by the employer or through the vocational rehabilitation process.
5. Exclude time spent in the vocational rehabilitation process from the time limits on permanent partial disability for accidents occurring after March 13, 2007.

V. THE INSURANCE DEPARTMENT REPORT

On March 3, 2008 the Superintendent of Insurance transmitted a Report to Governor Eliot Spitzer discussing certain workers' compensation data and making certain recommendations. This paper comments on the methodology, conclusions, and recommendations of the Report. Some different conclusions are drawn and alternative recommendations are made herein.

A. The Methodology of the Report.

The methodology used in the preparation of the Superintendent's report is troublesome. At the outset, the report states that the Insurance Department "consulted

numerous parties involved in the workers' compensation system, including representatives from organized labor, private insurance carriers, the State Insurance Fund, the Workers' Compensation Board and representatives of other state's workers' compensation systems."²⁰³ Notably absent from this list were injured workers, attorneys (either claimant or defense), physicians (either treating physicians or so-called "independent medical examiners" (IMEs), or non-organized labor worker rights organizations. The Department's list of consultants seems to have ensured that the Department would receive "the big picture" unadorned by practical advice from those who are engaged in the system on a day to day basis. This lack of practical advice shows, for example, in the Report's inability to correctly spell "carpal tunnel syndrome."²⁰⁴ Another example appears in the Report's statement that from 2004 through 2006 54% of injured workers received the maximum weekly benefit rate of \$400 and that the "distribution" was \$334.90.²⁰⁵ The Report fails, however, to identify for what period of time any claimant actually received these figures. The experience of those who are familiar with the practice of workers' compensation is that while many claimants may initially receive a high benefit rate, it is quickly reduced through carrier use of IMEs.

Second, the Report identifies the trend of "costs per claim growing significantly" as a crucial finding.²⁰⁶ Much of the balance of the report is then addressed to consideration of why "costs per claim" are growing, and finding a means to reverse this trend. As discussed below in subsection A.1., however, the issue of "costs per claim" is

²⁰³ Report to the Governor from the Superintendent of Insurance Summarizing Workers' Compensation Data and Recommending Improvements in Data Collection and Development of a Research Structure for Public Policy, March, 2008, available at http://www.ins.state.ny.us/wc/wc_index.htm, p. 4.

²⁰⁴ Id. at p. 47.

²⁰⁵ Id. at p. 37; see also Report, p. 96.

²⁰⁶ Report at page 4.

in fact almost irrelevant, and any action taken towards addressing this issue will in fact amount to a further unwarranted reduction in benefits for injured workers. The fact is that overall workers' compensation costs – the relevant issue – are not rising. If prior statements by the Governor and the Insurance Department are accurate, overall workers' compensation costs should actually fall by over \$1 billion per year (three-quarters of which is attributable to capping permanent partial disabilities) as a result of the 2007 statutory amendments.

Third, the Report is based largely on unreliable or unverifiable data which has been produced by entities with a vested self-interest in the process – the CIRB and the WCB. The specific issues created by the use of CIRB and WCB data are discussed below in subsections A.2. and A.3..

1. The Use of “Costs Per Claim” as a Basis for Analysis is Incorrect.

The Superintendent's Report focuses primarily on the “costs” of workers' compensation and methods by which these “costs” may be reduced, particularly on a “per claim” basis. Without explanation or substantiation, the Report states that “to evaluate system performance in terms of costs it is important to examine cost per claim rather than total system costs.”²⁰⁷ To the contrary, we would suggest that the selection of “cost per claim” as the analytical starting point fundamentally undermines the utility of the Report. The essential purpose of the workers' compensation system is to deliver timely and adequate compensation to workers who are injured on the job. Employers are afforded a number of options to secure payment of benefits, including the purchase of a private insurance policy, obtaining coverage from the New York State Insurance Fund, and self-

²⁰⁷ Id. at p. 85.

insurance. However, as long as there are work-related injuries, the complete elimination of “cost” is impossible. In the context of existing work-related injuries, the reduction of “costs” really translates into the reduction of benefits for injured workers.

In addition, focusing on “costs per claim” reflects a lack of comprehension of certain trends in New York State workers’ compensation claims, and in the end distorts the result by leading to a conclusion that is the diametric opposite of reality.

The Report identifies the most significant trend in workers’ compensation claims, which is the fact that the frequency of “small claims” is decreasing rapidly.²⁰⁸ We note that neither NCCI nor the Superintendent provide an explanation of this trend, which we would suggest is attributable to the fact that increasing barriers to workers’ compensation benefits “disincentivize” workers with apparently minor claims to file for benefits, thus effectuating a cost transfer to private health insurers and union health and welfare funds. Regardless of the cause, however, the decreasing frequency of “small claims” results in an increase in average “per claim” costs, but does not result in an increase in total costs. Consider the following hypothetical illustration:

<u>Scenario A</u>		<u>Scenario B</u>	
10 claims = \$1,000	Total Cost = \$10,000	3 claims = \$1,000	Total Cost = \$3,000
5 claims = \$5,000	Total Cost = \$25,000	5 claims = \$5,000	Total Cost = \$25,000
4 claims = \$10,000	Total Cost = \$40,000	4 claims = \$10,000	Total Cost = \$40,000
1 claim = \$25,000	Total Cost = \$25,000	1 claim = \$25,000	Total Cost = \$25,000
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	Total = \$100,000		Total = \$93,000
	Average = \$5,000		Average = \$7,153.85

²⁰⁸ 2006 State of the Line: Analysis of Workers’ Compensation Results, NCCI, Report at p. 24.

In Scenario A, the carrier has a total of 20 claims, evenly distributed among small claims (\$1,000 in our example) and non-small claims (\$5,000 and up in our example). Although the total cost to the carrier of the claims is \$100,000, the average cost is only \$5,000 due to predominance of small claims in the sample.

In Scenario B, the frequency of small claims has declined 70%, while the frequency and cost of all other claims has remained identical. The carrier's "per claim" cost has jumped over 40% from \$5,000 to \$7,153.85, yet its total cost has declined 7% from \$100,000 to \$93,000.

It will therefore be seen that while the decline in "small claims" causes the appearance of a skyrocketing "cost per claim" in the remaining claims, in fact it does not prove that the costs of any individual claim have increased. Further, the superficial (and illusory) increase in "costs per claim" may in fact be associated with declining overall costs to workers' compensation carriers.

We also question the Report's consistent use of "average" figures as opposed to "median" figures. In many instances, there is a significant divergence between the average of a group and its median (the point at which half are above and half are below).²⁰⁹ Averages may be easily skewed by outliers at the high or low end of a range; medians are less susceptible to such variability.

2. Reliance on CIRB Data is Misplaced.

Much of the Superintendent's Report relies upon data obtained from the New York Compensation Insurance Rating Board (CIRB). The CIRB is, of course, essentially

²⁰⁹ By way of example, the median wage in New York in 2006 was \$35,170, while the average wage was \$45,820 (see page 42).

a wholly owned entity of the private insurance industry, and exists (or to date has existed) for the purpose of submitting proposals for increases in insurance rates.²¹⁰ Up until the present time there has been no entity with the ability to independently verify the data or the submissions of the CIRB. It goes without saying that it has been in the interest of the CIRB to submit rate increase proposals that would maximize insurance industry profits. Reference may be made to the Opinion and Decision of the Insurance Department of July 17, 2006, when an application for a rate increase filed by CIRB was disallowed.²¹¹ At that point in time the Insurance Department made clear its distrust of the accuracy and reliability of the data submitted by CIRB, which is now accepted wholesale and without significant criticism.

The unreliability of the CIRB was considered so pervasive that the March, 2007 Workers' Compensation Reform Act eliminated the CIRB in its present form, and the Insurance Department was instructed to offer a plan for the creation of a new rate-making agency.²¹² This has subsequently been carried out by legislation requiring new governance of the CIRB as a transition measure to its elimination, which is mentioned in passing in the Report itself.²¹³

In addition, as noted in the Report, the "CIRB data does not include any information from the self-insured portion of the marketplace, which is [one-third] of the market."²¹⁴ The Report attempts to compensate for this deficiency by simply adding one-

²¹⁰ Insurance Law Section 2313; see also Workers' Compensation: State of the System 2006, NYCOSH/Robert Grey, available at [http://www.nyworkerscompensationalliance.org/WorkersCompensationWhitePaper3_06f11.d06\(1\).pdf](http://www.nyworkerscompensationalliance.org/WorkersCompensationWhitePaper3_06f11.d06(1).pdf).

²¹¹ In the Matter of Workers' Compensation Insurance Rate Application of the New York Compensation Insurance Rating Board, Opinion and Decision of New York State Insurance Department, 7/17/06, available at http://www.ins.state.ny.us/wc/wc_index.htm.

²¹² Insurance Law § 308.

²¹³ Insurance Department Report at p. 18; see also Chapter 11 of the Laws of 2008.

²¹⁴ Id. at p. 22.

third to its various assumptions. By way of example, at one point the report takes the 154,598 claims reported by CIRB for 2003 and arbitrarily adds one-third, thus arriving at an assumption that there were 206,079 claims in 2003.²¹⁵ Had the Superintendent simply looked at the WCB data for 2003 (included in the next subsection) it would have known that there were only 149,808 claims indexed by the WCB that year. Clearly there is a significant variation between the data reported by CIRB and the data reported by the WCB, as the WCB, which covers the entire marketplace, indexed fewer claims than reported by the CIRB, which covers only two-thirds of the marketplace. It is unclear whether this particular deficiency rests with the WCB or the CIRB (it seems likely that the WCB is failing to “index” a large number of claims), but clearly there is a significant question regarding the accuracy of the data. The Report provides a partial explanation of this discrepancy, noting that that CIRB recorded 97,949 “medical-only” claims whereas the WCB recorded only 27,817,²¹⁶ but clearly further research is required before any satisfactory conclusions can be drawn.

Yet another limitation on the utility of the CIRB data is that it was culled from the 2003 policy year.²¹⁷ While the Superintendent offers a number of valid reasons (mainly related to claim maturity issues) for the selection of the 2003 policy year, that does not change the fact that conclusions and recommendations are being drawn for the present based on data regarding claims from 5 years ago. A brief review of the charts included in the next subsection regarding claim trends will immediately reveal that claim data in 2006 (the last publicly available year due to the WCB’s failure to produce a 2007 Summary Annual Report to date) is substantially different from 2003 data. Given the

²¹⁵ Id. at p. 24.

²¹⁶ Id. at p. 25.

²¹⁷ Id. at p. 23.

pattern shown on the charts through 2006, it is fair to assume the 2008 data is even more divergent from 2003 than was the 2006 data.

Given the fact that the veracity of the CIRB has been deemed so poor as to justify its elimination, and further given the age of the CIRB data used in the Report, the fact that it consists largely of “projections” instead of facts, and the substantial variation between the CIRB data and the WCB data, we question whether a Report built largely on unverified, self-reported data from the CIRB can itself be credible.

3. WCB Data is of Limited Value.

The other data source used by the Insurance Department in the preparation of the Report is information obtained from the Workers’ Compensation Board (WCB). While some of the WCB data is consistent, verifiable, and reliable, other WCB data is of dubious value. This is particularly true in the identification of “medical only” and “resolved” claims.

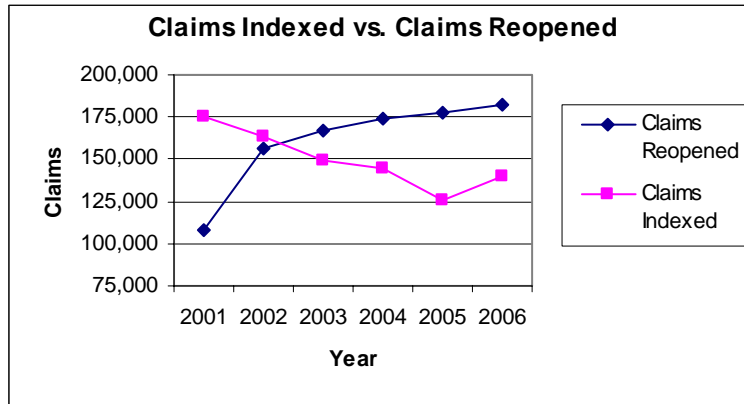
Until approximately the year 2000, the WCB identified the result of a hearing in one of three ways: “adjourned” (no substantive action taken); “continued” (substantive action taken but the claim is not fully resolved); and “closed” (case fully resolved). Under this system the status and progress of all claims could be easily identified, as well as the average amount of time it took for a claim to be fully resolved.

In 2000, the WCB eliminated the use of the word “closed,” instead substituting the phrase “no further action is contemplated by the Board at this time” (“NFA”). WCL Judges, who were always encouraged to close as many cases as possible in order to build the WCB’s statistics of “resolved” claims, were now encouraged to aggressively use the

new “NFA” procedure wherever possible. As a result, claims in all stages of the process are now simply marked “NFA,” with no distinction being drawn between claims that are fully resolved and those that have simply been “taken off of the calendar” only to later be reopened for further action. As a result, the WCB is unable to provide any accurate information regarding how many cases are actually fully resolved as opposed to how many cases have simply been made temporarily administratively inactive. Similarly, the WCB is unable to provide a meaningful answer to the question of how long it takes the average claim to become “fully resolved.” The Report recognizes this issue (at least to some extent), observing that 43% of controverted claims are marked “resolved” at the pre-hearing conference due simply to the non-appearance of the claimant.²¹⁸ Obviously these are not true “resolutions” because such claims can be (and frequently are) reopened.

The chart below illustrates the rise in the number of cases reopened by the WCB each year from 2001 through 2006 as compared to the number of claims indexed by the WCB in each of those years. It will immediately be observed that the number of claims reopened surpassed the number of claims indexed beginning in 2003. The trend line for claims reopened is directly attributable to the WCB’s use of the NFA procedure and clearly demonstrates the unreliability of WCB data regarding “resolved claims.” It also casts further doubt on the utility of using the year 2003 as a benchmark given the radical difference in trend after 2003 as opposed to the trend prior to 2003.

²¹⁸ Report at p. 68.



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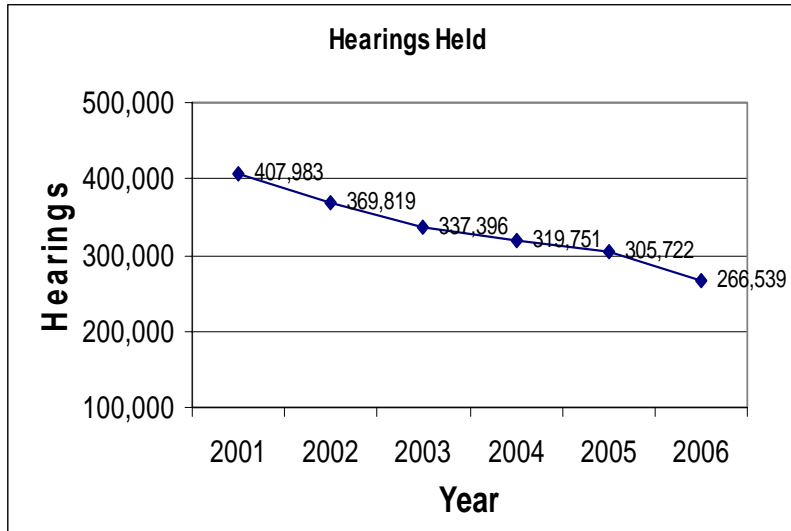
Another WCB initiative that affects both statistics and the actual delivery of benefits is the use of administrative and proposed decisions. These decisions are typically issued without the benefit of a hearing, and are largely comprised of boilerplate language that is unintelligible to most injured workers.²²⁰ Furthermore, these decisions almost invariably conclude with an “NFA” finding.

The practical effect of administrative and proposed decisions is to deny schedule loss awards (referred to as “PPD-SL” in the Superintendent’s Report) to many injured workers. Some of these claims involve no lost time beyond the statutory waiting period, permitting them to be identified as “medical only” claims. Others involve a limited period of lost time, permitting them to be identified as temporary disability (“TTD”) claims. However, in many instances the injured worker has a potential entitlement to a schedule loss award, but will not receive that award unless the worker takes affirmative action to pursue the claim before the WCB.²²¹ The charts below show the WCB’s increased use of administrative and proposed decisions even as the WCB schedules fewer hearings each year.

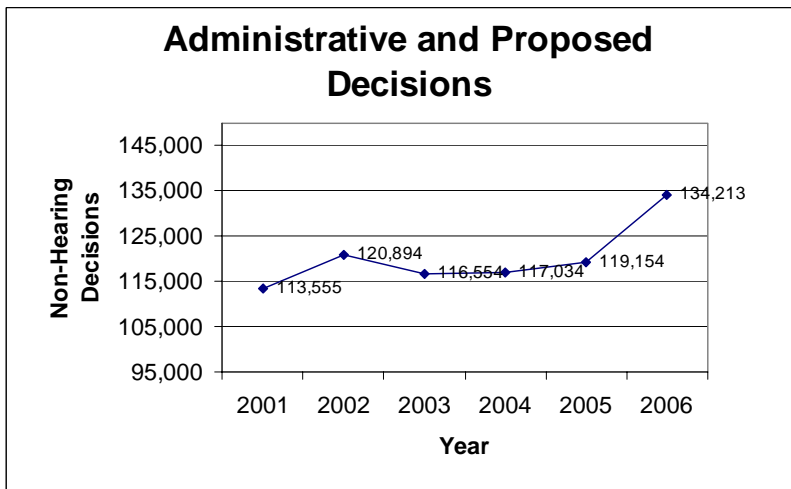
²¹⁹ Source, Workers’ Compensation Board Summary Annual Reports 2001 – 2006.

²²⁰ It is to be noted that these decisions are issued only in English, making it even less likely that they will be understood by non-English speaking workers.

²²¹ See Appendix VI.



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As a result of the WCB’s trend towards the use of administrative and proposed decisions, it cannot be determined how many claims are incorrectly categorized as “medical only” or “TTD” when the injured worker might have received additional benefits in the form of a schedule loss award had the worker had the benefit of legal advice or proper treatment by the WCB. Indeed, the Report notes (but professes that it cannot explain) an increase in attorney representation in allegedly “medical only” claims

²²² Source, Workers’ Compensation Board Summary Annual Reports 2001 – 2006.

²²³ Id.

from 25% to 36% from 2000 through 2006.²²⁴ Since claimant workers' compensation attorneys cannot currently receive a fee in a case involving medical treatment only, we would suggest that the increase in representation is tracking an increase in the misidentification by the WCB of schedule loss claims as "medical only" claims, which itself tracks the use of the administrative and proposed decision process to improperly categorize claims as "resolved" and "medical only" when in fact they are neither truly resolved nor medical only.

It is also worth observing that the WCB's shift away from a hearing-based system has not only had the effect of denying benefits to many injured workers, it has also transferred much of the work previously performed by the WCB to the claimant attorneys. Although the Report considers claimant attorney's fees at various points, it does not consider the extraordinary transfer of work and responsibility to these attorneys that has occurred as a result of the WCB's use of "NFA" procedures, administrative decisions, and proposed decisions. The Report establishes that this transfer of responsibility has increased over time. From 2000 through 2006 unrepresented claimants averaged 1.7 per case, while hearings for represented claimants dropped from 4.7 per case in 2000 to 2.7 per case in 2006.²²⁵ Those with experience in the system would suggest that unrepresented claimants have fewer hearings because they are unable to effectively pursue their claims in an adversarial system, whereas hearings for represented claimants have declined due to the WCB's refusal to schedule hearings where it is able to transfer the burden to the claimant's attorney.

²²⁴ Report at p. 91.

²²⁵ Report at p. 77.

Furthermore, the Report establishes that there is little value to the use of the conciliation process as compared to the hearing process in terms of claim resolution. From 2000 through 2006, the average time to “resolution” through conciliation was 120 days, compared to 133 days through the hearing process.²²⁶ Even the administrative decision process took 88 days,²²⁷ which is again of dubious benefit compared to the hearing process, especially when the loss of benefits created by the process is taken into account.

4. Conclusions Regarding the Methodology of the Report.

We would therefore suggest that the methodology employed in the Superintendent’s report is highly suspect. The selection of “average per claim cost” as a benchmark, and its identification as a problem to be solved, taints almost every other aspect of the Report. The simple fact is that the Report provides no evidence that the costs of individual claims are rising, or even that the aggregate costs of claims are rising. As demonstrated in subsection A.1. the “average per claim cost” can easily appear to skyrocket even as there is no change at all in the cost of individual claims and as the total cost of claims is actually declining.

Furthermore, the twin sources selected by the Superintendent for the provision of data, CIRB and the WCB, are both unreliable, although for different reasons. By excluding individuals with practical experience in the system from the preparation of the Report, the Superintendent neglected the inclusion of a valuable check on the information

²²⁶ Id.

²²⁷ Id.

provided by these agencies – whether it passes “the smell test” or is contradicted by anecdotal evidence.

The fact that using a flawed methodology is likely to produce a flawed conclusion need not be discussed at length. Having identified some of the methodological issues, however, we now turn to the Report’s use of the substantially inaccurate data it received.

B. Conclusions of the Report.

The Report reaches a number of conclusions about the New York State workers’ compensation system. Some of these conclusions may be justified, some remain unproven, and others are a product of the inaccurate data and faulty methodology discussed in Section A.

The primary conclusions reached by the report are that (1) costs per claim are rising; (2) New York’s indemnity cost are higher and its medical costs lower than the national average as a percentage of total payments; (3) “the driving forces behind rising costs are PPD NSL claims” (permanently partially disabled workers who could be paid for an indefinite period of time prior to the March 2007 amendments); (4) Section 32 settlements are associated with lower-wage workers and higher legal fees, but not with improved prospects for return to work; (5) there are many controverted cases and they are not resolved speedily; and (6) there are significant delays in the delivery of benefits. We will address each of these conclusions in subsections B.1. through B.6..

1. Costs Per Claim are Rising.

The fallacy of evaluating the workers' compensation system based on "costs per claim" has been discussed in Section A.1..

This is graphically demonstrated in the Report, however, which claims that the "average cost per indemnity claim" has increased from \$18,240 in 1997 to \$28,117 in 2003.²²⁸ Of course, this rising "average" cost has occurred during the same interval in which overall claims have been decreasing, and in particular during a period in which the rate of decline of "small" claims is dramatically greater than the rate of decline in all other claims. As a result, the so-called increase in "average cost per indemnity claim" is really a mirage created by the use of mathematical averages. In other words, there is no proof that a worker who is found to have a permanent partial disability today "costs" more than a worker who was so classified five years ago (or, for that matter, 15 years ago).

Indeed, given the fact that the maximum workers' compensation rate did not change for fifteen years from 1992 to 2007, and further given the fact that medical costs are governed by a fee schedule that has not undergone any significant modification, common sense would dictate that there has been no change in the "cost" of a permanent partial disability claim over the years. Rather, the fiction of the "rising cost of the average claim" is predicated on the fact that a much higher percentage of the remaining claim pool (which has been in a state of steady decline for many years) is serious injury claims, and thus their "average" is higher than it was when a large number of smaller claims were also part of the pool. Overall, however, there is no evidence that costs to employers or carriers have dramatically increased.

²²⁸ Report at p. 26.

The Report itself concedes that aggregate cost figures tend to rebut the “average cost per claim” theory: “Total indemnity costs ... look like they have been leveling off from 2000 to 2003 after growing significantly in the prior years.”²²⁹ The report correctly attributes this to the fact that overall claims are declining, yet fails to draw the connection between the fact that overall claims are declining because of the rapid decline in “small” claims and the increase in “average claim cost.” Not only does the report show that total indemnity costs have leveled off, it specifically shows that total PPD costs did not increase substantially between 2000 and 2003.²³⁰ The Report also provides data regarding the “average cost” of the “average PPD” from 2000 through 2003, and we find that the increase was about 5% (from \$149,521 to \$157,749 – about \$8,200).²³¹ However, almost two-thirds of that increase occurred between 2000 and 2001. We would again note here that no data is provided from 2003 through 2007, and the utility of five-year old data given the claim trends discussed herein is questionable. In any event, even if the data is accepted “as is,” an increase in cost of less than 1% per year since 2001 hardly seems significant.

In an attempt to buttress its argument that PPD costs are rising relative to temporary disability costs, the Report uses data regarding “the average indemnity cost per claim at 30 months of development” for PPD and TTD claims.²³² It is not surprising that after 30 months PPD costs are substantially higher than TTD costs, simply because the Workers’ Compensation Board Medical Guidelines call for a classification of PPD two

²²⁹ Report at p. 31.

²³⁰ Id. at p. 33.

²³¹ Id. at p. 36.

²³² Id.

years after an accident.²³³ Few claimants are still receiving awards for “temporary” disability two and a half years after the accident.

The report provides still additional data that contradicts its contention that costs are rising. Based on CIRB data, the report includes a table for the years 2000 and 2003 showing the number of claims filed for injuries to the back, neck, knee and shoulder, the total medical expense for those claims, and the average medical expense per claim.²³⁴ The table demonstrates that the number of back injury claims fell by over one-third from 2000 to 2003, while claims in the other categories remained fairly constant. However, both the total and the average medical expense declined in every category from 2000 to 2003. For back injuries, it fell by over 45%. Given this data, it is hard to understand the Report’s contention that costs are rising.

2. New York’s Indemnity Costs are High and Medical Costs are Low.

The Report states that “the average indemnity cost per claim of \$32,040 is almost twice the national average of \$18,996.”²³⁵ However, the Report does not indicate what the total indemnity cost is for each state, nor the number of claims filed for each state either in the aggregate or as a percentage of the workforce. As a result, it is difficult to assess whether this “cost per claim” is meaningful in any way. Further, even assuming that New York’s indemnity costs are unreasonably high (which again has not been proven), this is offset by the fact that New York has the 11th lowest medical fee schedule in the country, and the second lowest for physical medicine services such as physical

²³³ Workers’ Compensation Board Medical Guidelines, NYS Workers’ Compensation Board, 2006.

²³⁴ Id. at p. 57.

²³⁵ Report at p. 6.

therapy and chiropractic treatment.²³⁶ Given that the report states that medical expenses account for 42% of total workers' compensation costs, with indemnity accounting for 52%, it would seem that on balance New York's low medical expenses and allegedly high indemnity costs should result in about average overall costs.²³⁷ However, the Report makes no comment about how New York's overall costs relate to regional or national averages.

3. Non-Schedule Loss Permanent Partial Disability Claims are Driving Costs.

The Report provides a number of statements regarding the alleged costs of permanent partial disability claims (called PPD NSL claims in the Report). Many of these statements are consistent with press releases and other material distributed by the Business Council and other employer and carrier organizations prior to the March, 2007 amendments. A closer examination of the specific information in the Report reveals the questionable validity of these claims.

First, the Report states that "PPD NSL claims are estimated to represent 83% of PPD costs and 74% of total indemnity costs."²³⁸ In other words, of all workers' compensation indemnity benefits paid, almost three-quarters of the money allegedly goes to injured workers who have been declared permanently partially disabled. In addition, the amount of money paid to permanently partially disabled claimants is supposedly almost five times as much (83% to 17%) than the amount of money paid in schedule loss cases (called PPD SL claims in the Report).

²³⁶ Id.

²³⁷ Id.

²³⁸ Id. at p. 4.

On the very next page of the Report, however, we are informed that “the costs of PPD NSL can not be easily tracked and they are the driving factor behind medical and indemnity claim costs.”²³⁹ One wonders how it is possible to state unequivocally that PPD NSL costs are “the driving factor behind medical and indemnity claim costs,” to report the precise percentage of not only total indemnity but also of all permanent disability benefits these claims comprise, and to simultaneously report that they “can not be easily tracked.” Even more surprisingly, the Report later informs us that a deficiency in the information it obtained from the CIRB is “that CIRB does not separate out PPD SL and NSL claims. Instead, CIRB splits PPD into major and minor categories. Separating PPD data as scheduled and non-scheduled is critical information.”²⁴⁰

Further, the Report eventually reveals that the cases reported as PPDs by the CIRB are not even necessarily found to be such by the WCB. Rather, “the CIRB classifies the data as it is projected by the payor, i.e., when an insurer projects that a TTD case will become a PPD case, it reserves the case as a PPD and forwards the case data to CIRB as a PPD.”²⁴¹ In other words, CIRB reports the number and type of PPD cases not based on the actual result of any particular claim, but rather based on the carrier’s “projection” of the claim, which projection is directly tied to the carrier’s need or desire to set reserves aside. No effort is made to evaluate the extent to which these “projections” relate to the eventual reality of a claim.

As a result, the entire theory of the Report – that PPD cases are an overwhelming percentage of the costs in the workers’ compensation system- is completely undermined. Quite simply there is no basis to suppose that the claims reported as PPDs by the CIRB

²³⁹ Id. at p. 5.

²⁴⁰ Report at p. 22.

²⁴¹ Id. at p. 29, emphasis added.

are in fact PPD claims. To accept the validity of the CIRB data, one would have to assume that (1) carriers are infallibly correct in their “projection” of claims that involve permanency (which would mean that they never under-reserve or over-reserve such claims); (2) all “major” PPD cases are PPD NSLs and all “minor” PPD cases are PPD SLs; and (3) the CIRB is correctly sorting the “major” and “minor” PPD claims to provide an accurate estimate of their costs.

This is plainly absurd. There is no evidence that carriers “project” permanency in claims with even remote accuracy. There is no evidence on the question of how many cases involving “major” and “minor” permanency are schedule losses or PPD NSLs. In a footnote, the Report states that the CIRB categorizes “PPD” claims as major or minor based solely on whether the carrier has set reserves anticipating a cost of more or less than \$22,000.²⁴² Assuming a claim with an average weekly wage of \$600 or more, schedule loss awards totaling 17.5% of an arm, 20% of a leg, 22.5% of a hand or 27.5% of a foot all exceed \$22,000. Thus, it is highly likely that a vast number of “PPD SL” cases have been incorrectly counted as “PPD NSL” cases by the CIRB in its campaign to overstate the cost of PPDs for the purpose of securing caps on these awards.

In addition, there is no evidence of the impact of Section 32 settlements on these projections. On this point, the Report finds that 78% of the cases resolved by Section 32 settlement between 2000 and 2006 did not involve permanency.²⁴³ It is likely that a large percentage of these claims (involving a total of 12,645 cases) were matters in which the carrier “projected” permanency but was able to settle the claim before that finding occurred (thus avoiding the “projected” future payments). Just as in the case of including

²⁴² Id. at p. 22, footnote 24.

²⁴³ Id. at p. 103.

many schedule loss cases in the “cost of PPD NSL” figures, the failure to subtract cases in which the carrier “bought out” its PPD liability prior to classification renders the CIRB’s estimate of the number of PPD NSLs and their cost a work of fiction.

Even if some of the Report’s assumptions regarding the number of PPD claims are credited, the Report concedes that the number of these claims has been steadily diminishing, consistent with the trend of fewer claims overall.²⁴⁴ At most, the Report establishes that PPD claims are decreasing less rapidly than claims for temporary disability.²⁴⁵ Of course, this in no way supports the contention that PPD claims are “driving costs” – it simply means that their costs are not declining as rapidly as some would like.

Further, if its figures are to be credited at all, the Report establishes that the number of PPD NSL claims is a miniscule percentage of all claims. The Report claims that cases involving indemnity payments are only 36.6% of all claims.²⁴⁶ It further states that claims involving permanency are only 34.1% of all indemnity claims.²⁴⁷ This would mean that claims involving permanency are 12.48% of all claims (34.1% of 36.6 = 12.48). Finally, the Report claims that PPD NSL claims are 14.4% of all claims involving permanency.²⁴⁸ This yields the conclusion that PPD NSL claims are 1.8% of all claims (14.4% of 12.48 = 1.8). Using the figures of claims indexed by the WCB (which appear to be substantially lower than all claims given the fact that the CIRB numbers cover only two-thirds of the marketplace and are still higher than the WCB’s

²⁴⁴ Report at p. 28.

²⁴⁵ Id.

²⁴⁶ Id. at p. 25

²⁴⁷ Id. at p. 27.

²⁴⁸ Id. at p. 30.

figures), there would have been about 3,150 workers in 2001 who went on to be PPD NSLs, and only 2,150 in 2005 – a decline of over 30%.

Given the small and apparently declining number of injured workers who are found to be permanently partially disabled, it is highly unlikely that this tiny group of claims accounts for the overwhelming percentage of indemnity costs or that it is this group that is “driving costs.” In addition, the entire discussion of the “high cost” of PPD NSL’s overlooks a fundamental issue involved in these cases: other than permanent total disability and death claims (which make up an even more miniscule percentage of all claims), workers who are permanently partially disabled are the most seriously injured and disabled claimants in the system. Thus, it should make sense (and should not offend anyone’s sense of justice) that these workers receive a significant portion of the limited benefits available under the law.

Furthermore, any skepticism regarding the validity of permanent partial disability claims is (or should be) dispelled by the Report, which states that while “there has been an on-going belief that older workers file more claims to ‘supplement’ their retirement ... the data appears to disprove that theory.”²⁴⁹

4. Section 32 Settlements.

The Report devotes some consideration to the impact of Section 32 settlements, in which the injured worker may stipulate to a resolution of some or all of the issues in the claim. The Report assumes (as does the WCB) that all Section 32 settlements are a full and final resolution of all issues in the claim. While this may be generally true, it is far

²⁴⁹ Id. at p. 44.

from universally true. Again, this is an area in which the Report suffered from the absence of participation by those with practical experience in the system.

The Report reaches three major conclusions regarding Section 32 settlements. First, low wage-earners are more likely to arrive at a Section 32 settlement of their claim than high wage-earners.²⁵⁰ Second, PPD NSL claimants who resolve their claim by way of a Section 32 settlement do not tend to return to work post-settlement at a higher rate than PPD NSL claimants who do not settle.²⁵¹ And third, claimant attorney fees average about 12% in connection with a Section 32 settlement, compared to about 5% in other types of claims.²⁵² The Report offers no explanation for these findings, other than to note that they disprove the theory that claimants wait to settle their cases before returning to work.²⁵³

Those who have experience in the system can provide a number of explanations for the conclusions drawn by the Report, as well as some additional conclusions that are implicit in the Report but are not spelled out.

With regard to the fact that low wage-earners are more likely to settle their claims than high wage-earners, it is likely that this is a result of the fact that high wage-earners have a greater ability to withstand carrier resistance to their claims for a longer period of time, and thus have less need to settle their claims in order to avoid financial ruin. To the contrary, many low wage-earners are simply starved out of the system. When employed, many of these individuals live paycheck to paycheck. While they may be able to continue for a short time while receiving awards for temporary total disability, the

²⁵⁰ Report at p. 5.

²⁵¹ *Id.* at p. 104.

²⁵² *Id.* at p. 90-92.

²⁵³ *Id.* at p. 104.

inevitable reduction or suspension of benefits based on IME reports, followed by prolonged litigation (none of which is addressed by the Rocket Docket) leaves them victims of the system. Even if they are ultimately “successful” in their claims, they are left with little alternative but to settle and hope for the best.

The fact that claimants who arrive at Section 32 settlements do not tend to return to work is also unsurprising. The Report posits a similar theory about PPD NSL claimants – that they wait to be “classified” before returning to work – and disproves that as well.²⁵⁴ The simple fact is that most injured workers who have permanent partial disabilities are in fact unemployable, and the fact that they do not return to work following “classification” or settlement only provides further proof of that fact. Under the circumstances, it is deplorable that the benefits paid to this category of worker are identified as “costs” to be “reduced” for the purposes of “system efficiency” instead of recognizing that payment of these benefits is precisely the reason that the workers’ compensation system exists. “The statute was enacted for humanitarian purposes, framed, in the words of Chief Judge Cardozo, to insure that injured employees might ‘be saved from becoming one of the derelicts of society, fragment of human wreckage.’”²⁵⁵ The report makes the case that workers who are permanently partially disabled who do return to work generally earn less than half of their pre-injury wages.²⁵⁶ Under the circumstances it would appear that the system does a poor job of carrying out the humanitarian purposes for which it was enacted.

The Report also fails to recognize the additional work performed and responsibility undertaken by claimant attorneys in connection with Section 32

²⁵⁴ Id. at p. 98.

²⁵⁵ Richardson v. Fiedler Roofing, Inc., 67 N.Y.2d 246, 502 N.Y.S.2d 125, 493 N.E.2d 228 (1986).

²⁵⁶ Report at p. 100-101.

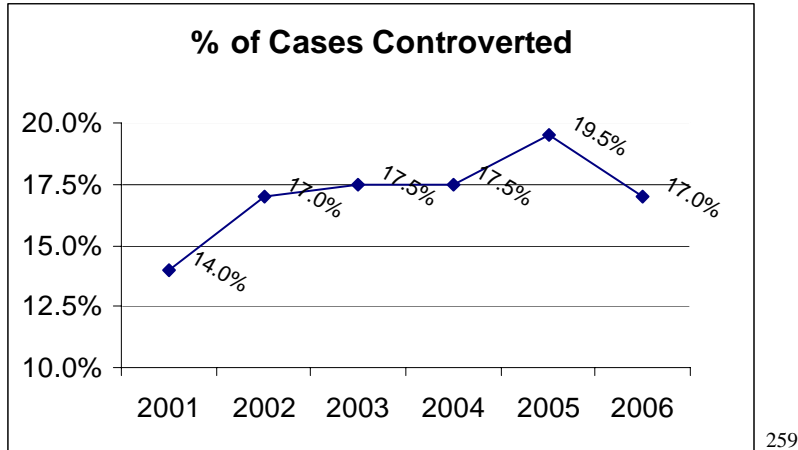
settlements, as well as the fact that – contrary to the Report’s conclusion – the legal fee in connection with the Section 32 settlement is often not additional to a fee associated with classification as a permanent partial disability. The Report indicates that between 2000 and 2006 only one-fifth of all Section 32 settlements involved workers who have been found permanently partially disabled.²⁵⁷ Therefore in 80% of the cases that were resolved by way of a Section 32 settlement, the attorney did not receive a fee associated with a PPD classification, and very likely received only nominal fees for appearing at hearings. Furthermore, the Report makes no comment about the fact that claimant attorneys’ fees are based on compensation awarded, and that while the amount of compensation awarded has remained unchanged for 15 years the expenses and obligations of these attorneys have steadily increased. In addition, these expenses and obligations have been systematically increased by the Board through the use of NFA procedures, administrative decisions, proposed decisions, and depositions, among other initiatives. This situation was discussed in Section A.3..

5. Controverted Cases.

The Report identifies controverted cases as a significant problem in the workers’ compensation system, and makes reference to the proposed Streamlined Docket (known generally as “the Rocket Docket”) as a vehicle to resolve this alleged problem. The Report claims that the percentage of claims that are controverted has been rising, from 15% in 2000 to 17% in 2005.²⁵⁸ The actual statistics are revealed in the chart below.

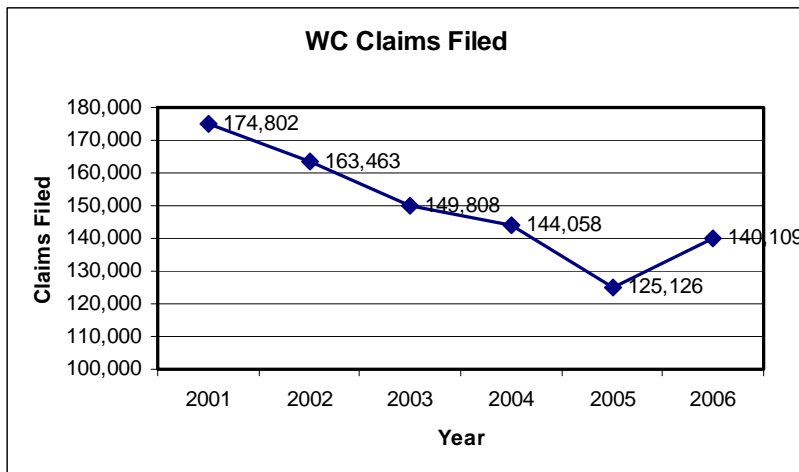
²⁵⁷ Id. at p. 103.

²⁵⁸ Id. at p. 5.



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However, the percentage of claims controverted must be considered with reference to the decline in the number of claims filed, which is depicted on the chart below.

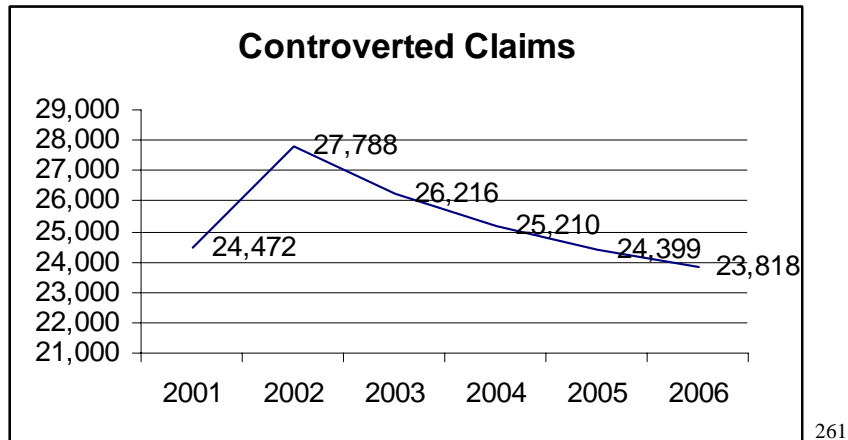


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When the percentage of controverted claims is compared to the number of claims filed, we find that the raw number of claims controverted is actually in decline. It may be presumed that the spike in controversies in 2002 was due to claims filed secondary to the events of September 11th, 2001, although this would require additional verification from the WCB.

²⁵⁹ Source, Workers' Compensation Board Summary Annual Reports 2001 – 2006.

²⁶⁰ Id.



As the Report fails to observe the steadily declining number of controverted cases since 2002, it does not offer any hypothesis as to the cause. We would suggest that the explanation is similar to the explanation for the decline in “small claims”: workers who have claims that are likely to be contested have been conditioned to accept defeat and delay, and are therefore increasingly less likely to file in the first place.

This is identified in the Report as the “frictional cost” associated with the defense of claims, and the Report notes that “one indicator of high frictional costs in New York State is the relatively high percentage of claims using independent medical examinations (“IME”).” The report goes on to state that carriers in New York use IMEs at more than twice the rate of 13 other states studied by the Workers’ Compensation Research Institute (WCRI).²⁶² This is discussed further in subsection B.6..

Turning to the comments that the Report does make about controverted cases, it concludes that it took an average of 348 days in 2000 to resolve a controverted case, and that this figure had declined by over 30% to 240 days in 2004.²⁶³ The Report identifies neither the factors that contribute to these delays, nor the steps that caused such a

²⁶¹ Source, Workers’ Compensation Board Summary Annual Reports 2001 – 2006.

²⁶² Report at p. 5.

²⁶³ Id.

significant reduction in the time required for resolution. In addition, the numbers used by the Report are averages, which means that one or more categories of especially complex claims that require longer resolution times may significantly affect these figures. The median figures are not provided.

The Report does divide controverted cases into occupational disease and accident claims, and finds that only 7.7% of accident claims are controverted compared to 46.7% of occupational disease claims. Further, between 2000 and 2006 it took an average of 246 days to establish occupational disease claims, and only 156 days for accident claims.²⁶⁴ It would therefore appear that the generalized statement regarding the length of time it takes to resolve controverted claims requires further analysis so that a distinction is made between extraordinarily complex claims and more typical claims. Further, the Report only provides the average length of time for resolution of each type of claims between 2000 and 2006; not the trend during this period. If the trend is the same as the overall trend from 2000 to 2004 discussed above, it is reasonable to assume that controverted accident claims currently take far less than 156 days to resolve. Absent further data, however, it is difficult to assess whether there is in fact any need for the implementation of the “Rocket Docket.” We would also observe that the fundamental principle underlying the Rocket Docket is that providing “payors at an early stage in the process with more information” should reduce controversies.²⁶⁵ Those with practical experience in the system question the validity of this assumption, which rests upon the proposition that employers and carriers generally controvert claims for “good faith” reasons such as lack of information. This is discussed further in subsection B.6..

²⁶⁴ Report at p. 47

²⁶⁵ Id. at p. 66

The Report also attempts to consider the outcome of controverted cases, but again is hampered by the lack of reliability of WCB data. Nearly half of all controverted cases are established in favor of the injured worker.²⁶⁶ However, this does not mean that the other half are resolved against the injured worker – the WCB simply does not provide data on the nature of the non-established controverted claims. Many are simply not prosecuted. In addition, no information is provided on the results of controverted claims in which the claimant has an attorney as compared to those in which the claimant is unrepresented.

In addition, the Report recognizes that “there are equally significant delays in providing timely benefits to claimants with non-controverted claims.”²⁶⁷ Given this statement, one wonders whether it might not be more prudent to consider the overall performance of the WCB in adjudicating claims instead of focusing solely on the issue of controverted claims, which appear to be declining in any event. The Report specifically addresses delays in authorization for medical treatment, and points out that the WCB has failed to provide any data regarding use of the MD-1 procedure and the associated delays.²⁶⁸

6. Delays in Delivery of Benefits.

The Report observes that New York is below the median of states studied in length of time from date of injury to first indemnity payment, length of time from

²⁶⁶ Id. at p. 74

²⁶⁷ Id. at p. 7

²⁶⁸ Id. at p. 65. Workers’ Compensation Law § 13-a(5) requires a carrier to either authorize a specialized test request in excess of the statutory authorization amount (now \$1,000) or to obtain an IME and deny authorization based on the IME report within 30 days. As a matter of practicality, a worker who has neither an authorization nor a denial is unable to obtain such treatment. As a result, the WCB has implemented an “MD-1” procedure which obligates the treating physician to file additional forms and which has the effect of extending the statutory period of 30 days to 90 days or more.

accident to employer notice to carrier, length of time from employee notice to employer to employer notice to carrier, and length of time from notice to carrier to first indemnity payment.²⁶⁹ However, the Report fails to identify any causes for this phenomenon.

The Report further addresses significant delays in authorization for medical care and in payment to health care providers, again without identifying any of the causes of this situation.²⁷⁰

The Report's failure to identify or address the causes of delay in delivery of benefits is consistent with the Report's theory that more complete disclosure in controverted cases would reduce the number of controversies. We suggest that the Superintendent's lack of familiarity with the workers' compensation system has resulted in a naïve view of the root cause of these problems. Those experienced in the system would suggest that claims are controverted, payments are delayed, and health care providers are not paid as part of a generalized effort to reduce the number of claims filed, to limit the prosecution of those claims which are filed, and to minimize the amount of benefits paid in those claims that are filed and prosecuted. The effectiveness of these tactics can be seen in the steady decline in claims filed, and particularly in the reduction of "small" claims (when the worker concludes that the "hassle" of the system is "not worth it") and controverted claims (when the worker doesn't file on the assumption that he or she "will lose anyway").

The Report makes some effort to identify the defense costs associated with workers' compensation claims. It concludes that "New York State's costs per claim are in line with other states but the utilization of medical-legal consultants is much higher,

²⁶⁹ Report at p. 51.

²⁷⁰ Id. at p. 55-64.

thus generating higher adjudication costs.”²⁷¹ The Report estimates that 25.5% of claims have IME reports within the first year, 37.2% of claims have IME reports within the first 3 years, and 37.3% of claims have IME reports within the first 5 years.²⁷² It is unknown where the data that provided these conclusions was drawn from, but the consensus among practitioners is that close to 100% of claims have IME reports within the first 6 months, and that most claims extending one year or longer have multiple IME reports. As there are a limited number of IME vendors registered with the WCB, one means of obtaining more accurate information might be to obtain figures from these vendors of the number of IMEs performed each year, and to compare those figures to the number of claims filed or the number of hearings.

Similarly, the Report makes an effort to identify defense attorney expenses “for claims with defense attorney expenses greater than \$500.” The Report concludes that only 2.5% of claims have such costs within the first year (average cost \$1,031), 12.2% have such costs within the first 3 years (average cost \$1,352), and 13.6% have such costs within the first 5 years (average cost \$1,401).²⁷³ Again, these figures do not remotely correlate with reality of actual practice in the workers’ compensation system. Applying simple arithmetic to these figures to arrive at the supposed “total defense costs” in the system and then dividing that total by the number of workers’ compensation defense attorneys in New York State would result in a conclusion that all such attorneys (and every member of their staff) are employed at a figure substantially less than minimum wage.

²⁷¹ Id. at p. 94.

²⁷² Id.

²⁷³ Id. at p. 95.

In short, the Report fails to assess the true causes of delay in benefit delivery, and its conclusions regarding the nature and extent of defense costs appears to be completely divorced from reality. As these factors are inextricably intertwined, a more rigorous analysis of this issue is needed.

C. Recommendations.

The Report makes a number of recommendations to obtain additional information about the “performance of major players in the claim administration system.”²⁷⁴ Many of these recommendations are sound and should be adopted. In fact, given the breadth and scope of the recommendations for the collection of further data, it is apparent that the Superintendent lacked an adequate basis upon which to develop the methodology or to arrive at the conclusions that are contained in the Report. We would suggest that instead of starting with a theory (average costs per claim are too high and must be reduced) and then developing a methodology and arriving at conclusions designed to support that theory, the Superintendent should have simply identified the areas in which sufficient data was not available and made recommendations for the collection of that data. In its present form, the Report puts the cart (methodology and conclusions) before the horse (factual information upon which to arrive at a methodology and a conclusion).

The Report divides its recommendations into “measurements” for carriers (called “payors” in the Report), judges, treating health care providers, claimant attorneys, and employers.²⁷⁵ There are a number of glaring omissions from this list. As demonstrated in the charts included in subsection A.3., the WCB holds fewer hearings each year (a

²⁷⁴ Report at p. 106.

²⁷⁵ Id.

35% reduction from 2001 to 2006), and increasingly substitutes non-hearing administrative action for hearings. As a result, in order to assess the activity and efficiency of the WCB, the performance of the entire agency – not just judges – must be measured.

Similarly, the Report includes claimant attorneys and treating doctors in the list of “players” to be measured, but excludes defense attorneys and IMEs. Even if the highly doubtful information contained in the Report regarding defense attorney and IME costs is credited, it cannot be said that they are so insignificant as to be unworthy of measurement. If our proposition (that defense attorneys and IMEs are the single greatest sources of delay and controversy in claims) is accepted, then these are the groups for whom measurement and evaluation is most important.

1. Payors.

The Report proposes that carriers be measured in 8 categories: (1) average number of days from date of injury to first indemnity payment; (2) percentage of indemnity claims in which payment is made within 21 days; (3) average number of days from submission of bill to payment; (4) number and percentage of claims which are controverted and then not established; (5) average number of days from date of controversion to resolution; (6) number and percentage of medical bills that are disputed; (7) number and percentage of medical bills resolved in favor of payor; and (8) number and percent of request for pre-authorization approval for medical care that are disputed, and the percent of the disputes that are resolved in favor of the payor.²⁷⁶

²⁷⁶ Report at p. 107.

These categories can and should be refined and supplemented. With regard to the number and percentage of claims which are controverted and then not established, the Report has already noted that “not established” does not equate to “disallowed.” Therefore, the data on controverted claims should include claims established, claims disallowed, claims not resolved on the merits, and claims not pursued.

With regard to the use of the pre-authorization procedure, the critical component is not whether the dispute is resolved in favor of the payor (they almost never are) but rather the length of time it takes to resolve such disputes. As discussed in Appendix VI, although the statutory time period for carrier response to a pre-authorization request is 30 days, routine carrier disregard of the law has compelled the WCB to institute the MD-1 procedure, which has the effect of extending the statutory 30 day period to 90 days or more.

None of the proposed carrier measurements are concerned with actual carrier behavior in the processing of either controverted or non-controverted claims. Although the Report notes that significant delays exist even in non-controverted claims, the recommendations for carrier measurements include nothing that would address this issue.

Carrier behavior in the defense of claims (both controverted and “accepted”) can best be measured with reference to defense attorney costs and the use of IMEs. As noted above, it is felt that both of these factors are extraordinarily minimized in the Report. Therefore, the following additional measurements should be made of carriers:

- (1) Number and percentage of claims in which there are defense attorney costs.

- (2) The total defense attorney costs, as well as the average and median defense attorney cost per claim.
- (3) The number and percentage of claims in which IMEs are used.
- (4) The total number of IME reports obtained, the total cost of those reports, and the average and median numbers of IME reports per claim.

We understand that it may not currently be possible for either the WCB or the Insurance Department to directly collect and measure data on defense attorney fees in the same way that the Report suggests that claimant attorney fees be tracked. However, it may indeed be possible to require the submission of defense attorney billing to the WCB either by statutory amendment or by simple regulation, in which event these “costs” could be tracked in the same manner as the proposed tracking of claimant attorney fees. This would prove either the Report’s hypothesis that defense attorney costs are minimal, or our hypothesis that these costs are extraordinary (and growing at a rapid pace due to the continued decline in hearings for represented individuals and the Board’s transfer of responsibility to attorneys for the parties).

We would also suggest that the performance of IME companies and individual IMEs should be monitored. It is generally accepted that IMEs are used by carriers for the purpose of obtaining leverage in litigation, as opposed to obtaining an honest opinion about the injured worker’s disability and need for treatment. The validity of this proposition can easily be tested by tracking:

- (1) The number of IME reports generated by each IME company and each IME.

- (2) The total and average cost of the IME reports generated by each IME company and each IME.
- (3) The number and percentage of reports from each IME company and each IME that:
 - (a) find no disability
 - (b) find each “degree” of partial disability (mild, moderate, marked)
 - (c) find a total disability
 - (d) authorize some medical care
 - (e) authorize no medical care.

This data should then be cross-referenced to carriers to determine whether certain carriers tend to use certain IMEs and IME companies more often and whether the use of such IMEs and IME companies correlates to the carrier’s claim controversy rate and defense attorney costs.

2. Judges

The report suggests seven categories of measurement for WCL Judges, including (1) number of cases adjudicated; (2) number and percentage of decisions appealed; (3) number and percentage of decisions affirmed on appeal; (4) number and percentage of claims that have adjournments; (5) average number of adjournments per claims that have adjournments; (6) for claims that have adjournments, average number of days between hearings; and (7) number and percentage of claims in which the judge applied the medical guidelines in deciding the medical dispute.²⁷⁷

²⁷⁷ Report at p. 108.

The first three of these categories are worthwhile and may well be productive of significant information. We would suggest that these categories should be supplemented to identify the number and percentage of cases in which the judge and the Office of Appeals decide in favor of the worker and the carrier.

The remainder of the categories, however, are essentially meaningless in current workers' compensation practice. As discussed in Section A.3., the Board's use of "no further action" has virtually eliminated "adjournments" (at least to the extent that they cannot be identified). Rather than "adjourn" a case, a WCL Judge will almost invariably mark a file "no further action," thus ensuring that it will be counted as a "resolution" and not an "adjournment." This can only be corrected by removing the impetus for WCL Judges to build statistics through false "resolutions" and by restoring the former categories of "adjourned," "continued" and "closed" (or "no further action") to permit proper measurement of the progress of claims through the system.

In addition, we do not accept as a premise the concept that adjournments or continuances are inherently unwarranted or worthy of condemnation. A workers' compensation claim follows the medical progress of the injured worker, and as a result there are of necessity times in the claim where adjournments or continuances are warranted.

Limiting the WCB measurements to judges also fails to consider the WCB's overall treatment of claims. We have hypothesized that a significant number of claims are closed by administrative decisions and marked "no further action," resulting in inappropriate categorization of these claims as "medical only." Likewise, the charts show that "claims reopened" have been rising even as hearings have declined. Finally,

we have pointed out that use of the “no further action” procedure makes it impossible to tell how long it truly takes a case to arrive at a true “final resolution” after being indexed.

These situations can be remedied by eliminating the administrative decision and “no further action” processes, which would allow the collection of the missing data. [We also observe that the Report demonstrates no advantage to the conciliation process over the regular hearing process, and thus it too should be eliminated.]

Absent the elimination of these processes, however, certain data should be obtained to determine the extent to which benefits to injured workers are being delayed and denied. In the case of administrative decisions, data should be obtained identifying the nature of the injury established by administrative decision. This would permit some analysis of the extent to which schedule loss injuries are being addressed by administrative decision. All WCB determinations, whether by administrative decision, proposed decision, or hearing determination, that result in a conclusion of “no further action” should be tracked to determine how long the claim remains inactive before an application is made to reopen the claim. This could be easily accomplished simply by following the filing of RFA-1 and RFA-2 applications in cases marked NFA. Suggested intervals would be 3 months, 6 months, and 1 year. One might assume that if no application to reopen was filed within 1 year of an NFA finding, the resolution was a true closure, whereas if the application is filed within 3 or 6 months of the NFA finding the “resolution” was illusory.

3. Health Care Providers, Claimant Attorneys, and Employers.

The recommendations for data collection regarding these participants in the process generally seem reasonable.

With regard to claimant attorneys, however, the collection of data in some categories may lead to erroneous conclusions. We assume, for example, that the interest in “average settlement award for Section 32 settlements” and “average legal fees per claim” is intended to determine whether a particular law firm is “good” or “bad,” or whether the firm is “overcharging.” We would caution that all claimant attorneys do not represent the same homogenous population. Like injured workers, claimant attorneys are distributed geographically throughout the state. Data shows that the average weekly wage of workers in many upstate locations is significantly lower than those downstate (indeed the State of New York pays “location pay” to its employees with this in mind). In addition, the nature of employment in upstate areas is, on the whole, significantly different from the distribution of employments in the metropolitan area. As a result, it may well be that upstate attorneys have lower fees than downstate attorneys.

Even within the same geographic area, different attorneys have different “niches” in practice. Some represent primarily low-wage earners, others represent a higher percentage of high-wage earners. Some are more willing to accept representation in complex claims than others. Not only do these issues factor into the amount of attorney fees, they also play a role in the average number of adjournments and the length of those adjournments. In many instances, the fact that a claim requires a number of hearings before reaching a final resolution is simply a sign that the attorney is aggressively pursuing the claim on behalf of the claimant, which is of course to be encouraged.

We note here that there is no reason why the same measurements that are applied to claimant attorneys cannot and should not be applied to defense attorneys for the purpose of identifying not only more litigious carriers (who contribute significantly to “frictional” costs) but also more litigious defense firms. It is the empirical observation of many in the workers’ compensation system that while the interest of the claimant’s attorney is generally perfectly aligned with that of the claimant (the speediest and most beneficial resolution with a minimum of “friction”), there is a far lower degree of identification of interest between the carrier’s attorney (who is paid for litigation) and the carrier (which may often benefit from resolution).

D. Conclusion.

The Report makes a number of valuable recommendations for the collection of data about the workers’ compensation system. In addition, we agree with the Report’s suggestion that this data collection should be performed by a university institute.²⁷⁸

It is unfortunate that the Report chose to pose a hypothesis, develop a methodology designed to support that hypothesis, and to arrive at conclusions without awaiting the data that it suggests should be collected. As outlined in this paper, the hypothesis of “average per claim cost” is erroneous, the methodology used to support that hypothesis is severely flawed due largely to the unreliability of existing data sources, and as a result the Report’s conclusions are either incorrect or so tainted by the process as to be unreliable.

We therefore suggest that the Report’s recommendations be adopted together with the following recommendations:

²⁷⁸ We would suggest the Cornell University School of Industrial and Labor Relations.

1. Collect and report data on controverted claims that are:
 - (a) established;
 - (b) disallowed;
 - (c) not resolved on the merits;
 - (d) not pursued.
2. Measure the number and percentage of claims in which there are defense attorney costs.
3. Measure the total defense attorney costs, as well as the average and median defense attorney cost per claim.
4. Measure the number and percentage of claims in which IMEs are used.
5. Measure the total number of IME reports obtained, the total cost of those reports, and the average and median numbers of IME reports per claim.
6. Measure the number of IME reports generated by each IME company and each IME.
7. Measure the total and average cost of the IME reports generated by each IME company and each IME.
8. Measure the number and percentage of reports from each IME company and each IME that:
 - (a) find no disability
 - (b) find each “degree” of partial disability (mild, moderate, marked)

- (c) find a total disability
 - (d) authorize some medical care
 - (e) authorize no medical care.
9. Measure the length of time cases marked “NFA” remain inactive before an application to reopen is filed.

VI. WORKERS’ COMPENSATION BOARD PROCEDURES.

As the principal agency associated with administering the Workers’ Compensation Law, the procedures of the WCB have been discussed throughout this paper. The purpose of this Appendix is to summarize and organize those procedures in a coherent fashion.

The WCB carries out a wide variety of functions in the workers’ compensation system, which may be organized generally in line with the claim process. First, the WCB “indexes” claims, meaning that it decides what documents are sufficient to constitute a claim under the law. Second, if the employer controverts the claim, the WCB is charged with deciding the controversy, thus making a decision whether the claim is valid or covered under the law. Third, if the claim is uncontroverted or if the WCB decides in favor of the worker, it must decide the basic issues in the case: the nature of the injuries, the worker’s pre-accident wage, the period and extent of any temporary disability from work. Fourth, the WCB must resolve post-establishment disputes about the basic issues as well as issues regarding ongoing medical treatment, wage loss, and permanency.

As a result of its responsibility to carry out these core tasks, the WCB also reviews the conduct of employers, insurers, and self-insurers. As a necessary

consequence, it comes into possession of substantial data regarding workers' compensation claims.

A. Indexing.

The indexing of a claim for workers' compensation is a threshold matter. If the WCB does not index a claim, then it has effectively made a determination that the documents or information it has received do not conceivably state a claim under the law. At this stage of the process no hearing is held and no due process is extended to the worker, so it is critical for the WCB to properly exercise its discretion in indexing claims. This is particularly true in view of the fact that the law requires an injured worker to file a claim within two years of the date of the accident (or date of disablement in occupational disease cases) or suffer the loss of all benefits.²⁷⁹

The WCB has long promulgated the C-3 form (Employee's Claim for Compensation) as its preferred claim filing document. There is no question that the WCB is empowered to issue regulations and forms in carrying out its statutory responsibilities.²⁸⁰ However, the statute itself does not require a worker to file a C-3 form; it simply requires the worker to make a "claim," which is nowhere defined in the law.²⁸¹ To the contrary, the courts have long held that it is not necessary for a worker to file a C-3 form in order to make a claim:

The failure to file a C-3 form does not necessarily preclude claimant from entitlement to workers' compensation benefits. The question to be resolved is whether either of the forms filed with the Board were sufficient to provide it with the facts of the injury and from which it might be

²⁷⁹ Workers' Compensation Law Section 28.

²⁸⁰ Workers' Compensation Law Section 117

²⁸¹ Workers' Compensation Law Section 28.

reasonably inferred that a claim for compensation was being made. The fact that claimant intended to make a claim for compensation when filing the C-2 form is not sufficient to satisfy the requirements of the Workers' Compensation Law. That report made no claim and none was reasonably to be inferred therefrom. However, the same cannot be said of the C-4 report filed by claimant's chiropractor. The statement contained therein, that claimant believed that she was not entitled to benefits unless she lost time from work and that she did indeed lose time from work, may be reasonably inferred to be a claim on her behalf for workers' compensation benefits, and the fact that such claim is made in the attending doctor's report is no bar to her recovery.²⁸²

If adopted, the proposals of the Streamlined Docket Task Force regarding indexing would contradict the long-established principle that the law does not require the use of a C-3 form to file a claim for workers' compensation benefits. The Streamlined Docket Task Force suggests that the WCB should not index a claim unless it receives (1) a C-2 or a C-3 form plus (2) a C-4 form plus (3) a C-3.3 limited release form.²⁸³ Under existing law, none of these documents is required for claim filing, let alone a combination of several forms. It is possible that the Task Force was led astray by a number of cases which hold that the WCB's receipt of a C-2 and C-4 form amounts to the filing of a claim even in the absence of a C-3 form. However, the point of this line of cases is to liberalize the rules for claim filing, not to constrict them. It is noteworthy that the court in the Boone case quoted above observed that either the C-2 form or the C-4 form might, standing alone, constitute a claim, and in that case the C-4 form alone was found adequate.

²⁸² Boone v. Rigaud, 176 A.D.2d 378; 574 N.Y.S.2d 86 (3rd Dept 1991) see also Kaplan v. Kaplan Knitting Mills, Inc., 248 N.Y. 10 (1928); McCutcheon v. Public Serv. Dept., 290 A.D.2d 679; 735 N.Y.S.2d 658 (3rd Dept. 2002); Stengel v. Great Atlantic & Pacific Tea Co., 14 A.D.2d 949; 221 N.Y.S.2d 157 (3rd Dept. 1961).

²⁸³ See Appendix II.

It may be observed that the Insurance Department report has called the WCB's current indexing procedures into question. For the year 2003, the Insurance Department estimated that there were over 200,000 reportable workers' compensation claims in New York State, while the WCB indexed fewer than 150,000 cases.²⁸⁴ This statistic raises a serious issue about whether the WCB's current indexing procedures are adequate to ensure workers access to the system and are awarded proper benefits. Further complication of the indexing procedures would further exacerbate what already appears to be a substantial problem.

We therefore suggest that the recommendations of the Streamlined Docket Task Force regarding claim indexing should not be adopted, and that any administrative steps taken in that direction by the WCB would be inappropriate.

B. Controverted Cases.

Once a claim is indexed by the WCB, the employer or carrier is obligated to respond to the claim either by accepting or controverting the claim. The issue of controverted claims has become an area of substantial focus, particularly by the Streamlined Docket Task Force.

It has been observed that about 17% of all indexed claims are controverted.²⁸⁵ Both the Streamlined Docket Task Force and the Insurance Department have focused on the length of time takes to resolve controverted cases, using average resolution times as their benchmark.²⁸⁶ Although expediting the resolution of controverted claims is

²⁸⁴ See Appendix V.

²⁸⁵ See page A-76.

²⁸⁶ See Appendices II, V.

certainly a worthy goal, current procedures and the proposed initiatives fail to take a number of factors into account.

The first issue revolves around the use of the term “resolution.” As discussed elsewhere in this paper and in Section C below, the WCB currently defines a “resolved” claim as one that has no hearings scheduled. However, there are many claims with no hearings scheduled that are far from “resolved” in the sense of having had a final determination of the issues on the merits, and they are constantly being reopened for further proceedings (going from “resolved” to “unresolved” with a keystroke on a WCB computer).²⁸⁷

The second issue is that even when used accurately in the sense of the claim having been decided, the term “resolved” offers no insight into the nature of the decision. A controverted claim could be “resolved” through the claimant’s inability to secure medical evidence, through a decision in favor of one party or the other, or settled under WCL Section 32 without a decision at all. The absence of such outcome data prevents an understanding of the full scope of the issues associated with controverted claims.

Third, it is not enlightening to consider all controverted claims as a group. It is well known that a greater frequency of controversy and longer time frame for resolution is associated with occupational disease claims than accident claims.²⁸⁸ Therefore, considering the overall controversy rate without dividing it into occupational disease vs. accident claims, or considering average time to “resolution” without the same division, leads to an inaccurate picture of the situation.

²⁸⁷ See chart on page A-60.

²⁸⁸ Insurance Department Report at p. 47

This has been partially addressed by attempting to segregate controverted claims by accidents and occupational diseases.²⁸⁹ This simple division does not, however, bring significant clarity to the picture. There is a significant divergence within occupational disease claims between “dust disease” cases such as asbestosis and “garden variety” occupational disease claims like carpal tunnel syndrome. Similarly, there is a significant divergence in accident claims between those that are controverted on straightforward issues like notice or jurisdiction and those that are controverted on more complex issues such as causal relationship. The more complex cases in each group tend to take far longer to resolve than the “simple” cases, driving up the average time to resolution.

Thus, even within the broad categories of occupational disease and accident, the use of averages is not particularly useful in identifying the number of claims that are both problematic and can be usefully expedited. It is entirely possible that if full and complete data were available in this area it would reveal that the complex claims and a relatively small number of the “simple” cases are skewing the statistics, and that the implementation of expedited procedures would in fact be of little overall benefit.²⁹⁰

Fourth, as discussed in Section D, the fact that a claim is not “controverted” does not mean that the worker will face no obstacles in obtaining benefits. Focusing on the fact that 17% of claims are “controverted” creates the erroneous impression that injured workers receive full benefits and medical treatment without resistance in the other 83% of claims. Of course, nothing could be further from the truth, and on balance it is likely that the “friction” encountered by injured workers in “accepted” cases far outweighs the difficulty caused by controverted claims.

²⁸⁹ Id.

²⁹⁰ It should be noted that the Insurance Department Report estimated that the Streamlined Docket initiative would affect about 30% of all controverted cases.

C. Basic Issue Determination.

If the claim is not controverted by the employer or carrier, or if the controversy has been decided in favor of the injured worker, then the claim is “established.” The WCB must then determine (1) the nature of the injuries that were caused by the accident; (2) the worker’s pre-accident wage; (3) how long the worker was out of work; (4) the worker’s “degree of disability” during the period of lost time; and (5) what the worker was paid while out, and by whom.

Prior to the year 2000, the WCB held a hearing in every case before making a determination on these issues. The injured worker, whether represented or not, would be called to appear before an administrative law judge, who would review the file, question the worker and the carrier, and make appropriate findings and awards. This process permitted the judge to assess the worker’s ability to comprehend his or her rights, to advise the worker of the right to counsel where indicated, to personally verify the accuracy of the documents that had been submitted by the carrier, and to inform the worker of other or further benefits that might be available in the claim.

The WCB subsequently abandoned the hearing process in favor of non-hearing determinations known as “administrative” or “proposed” decisions. If the WCB receives sufficient documentation to identify the answers to the issues mentioned above, a non-judicial WCB employee prepares a decision notice which is then mailed to the worker and the carrier.²⁹¹ These decisions make all of the same findings that were formerly made by administrative law judges, and the parties are provided 30 days to file an “objection.” If no objection is received, the decision becomes final.

²⁹¹ If the necessary documents are not received, the WCB will typically make multiple requests for the documents instead of scheduling a hearing. See the chart on page A-61 for data on the increased use of these decisions by the WCB.

All of the benefits of the hearing process are lost through this process. The file is reviewed by a claims examiner instead of by a law judge, and as a result the findings are often wrong. No assessment is made of the worker's ability to comprehend his or her rights, and indeed the forms are issued in English even where it is clear from the documents on file that the worker speaks another language. The accuracy of the documents submitted by the employer and carrier is taken for granted, despite the fact that none of those forms are required to be verified, notarized, or accompanied by supporting evidence. Most egregiously, no real effort is made to inform the worker of other or further benefits that might be available in the claim.

In addition, virtually all administrative and proposed decisions conclude with the designation "no further action is contemplated by the Board at this time" ("NFA"). Although incomprehensible to the injured worker, this language means that the WCB has categorized the claim as "resolved" and has removed it from its inventory of pending claims. The result is that thousands of injured workers with injuries that would entitle them to further benefits are not informed that their cases have been closed without a hearing and that to obtain those benefits they must take affirmative action to obtain evidence and request a hearing.

D. Post-Establishment Disputes.

Those workers who do understand the system (generally those who are represented by counsel) face significant delays even if their cases are not technically "controverted." As noted above, after indexing the WCB will often issue a non-hearing determination closing the case. The burden is thus shifted to the worker to affirmatively

request a hearing to obtain benefits. In a case involving a potential schedule loss of use award for permanent injury to an extremity, this requires the injured worker to obtain a specific medical report from a treating physician based on the WCB Medical Guidelines and to submit the report to the WCB with a particular form requesting “further action.” The WCB will then “reopen” the claim and schedule a hearing.²⁹² At the hearing, the administrative law judge will often direct the employer or carrier to produce an IME report within 60 or 90 days, and again mark the claim “no further action.” The burden is shifted back to the injured worker to wait for either the IME to occur or the time to expire and to again apply to the WCB to reopen the case.

The use of the “NFA” procedure not only places the heavy burden of prosecution on the shoulders of the injured worker, it prevents the WCB from providing reliable figures about the number of true “resolutions” and the length of time it takes to arrive at a true resolution. In the example above, the case would be marked “NFA” and thus deemed “resolved” at least three times – and we have used arguably the least complicated type of claim as our example.

A more typical scenario is that after accepting the claim and paying a limited period of benefits, the employer or carrier directs the worker to be examined by an IME, who reports that the worker is partially disabled (or not disabled at all) and that the worker requires less medical treatment than has been recommended by the treating physician. The carrier then reduces the worker’s benefit payments and declines to authorize medical care, sending a notice to the health care provider that the bills will not be paid.

²⁹² Practitioners report significant difficulty in persuading the WCB to reopen cases and schedule hearings in response to their requests for further action.

In this situation, the worker must again ask the WCB to schedule a hearing. Depending on how recently the claim was indexed, the identity of the employer or carrier, and the WCB hearing point to which the claim is assigned, the hearing may occur from six weeks to six months after the date of the request. In the interim, the worker receives only the payments and medical care that the carrier is willing to pay voluntarily.

When a hearing is scheduled, the administrative law judge may attempt to broker a compromise between the report of the IME and the reports of the treating physicians. If no compromise can be reached, the matter is typically scheduled for medical testimony, often to be taken by depositions “off calendar.” What this means is that the judge will place the WCB file into “NFA” status and direct the parties to take the testimony of the doctors on their own time, outside the hearing process, with transcripts and closing arguments to be submitted for review by the judge.

Not only does the deposition process deprive the administrative law judge of the opportunity to assess the credibility of the doctors as they testify, it creates inordinate delay for workers and expense for insurers. When depositions are directed, insurers must pay for subpoenas, court reporters, legal fees, and medical testimony. It is not unusual for a deposition to cost \$2,500 or more when all costs are considered. Meanwhile, the parties are usually given four months to complete the depositions, after which it is often several additional months before a decision is issued by the WCB. Further, the unsuccessful party will often appeal, delaying a final decision for many more months.

It is not unusual for this entire process to take a year or more before benefits are finally awarded. In the interim, the injured worker continues to receive only those payments and medical treatment that are agreeable to the employer and carrier. The

procedure may repeat several times in the course of any particular claim, with devastating effects on the health and welfare of injured workers.

There is no statistical information on the effect of these types of post-establishment disputes. These claims are not “controverted” claims, and thus they would be wholly unaffected by any of the procedures recommended by the Streamlined Docket Task Force. There is also no reliable data available about the cost of depositions to insurers, which would include the cost of the original IME exam, defense attorney appearance at the hearing, the cost of arranging depositions with physicians and the claimant’s attorney, subpoena fees, appearance fees to the doctors, defense attorney fees for the deposition, amounts paid to court reporters for transcripts, and defense attorney fees for submission of written summations at the conclusion of the depositions. These are obviously very significant “frictional” costs that are wholly invisible. They are highly profitable for defense attorneys, who benefit from litigation regardless of the outcome. Further, there is no data available about the relationship between these costs and the outcome of claims.

Even where monetary benefits are not at issue, WCB procedures result in significant delays in the medical treatment of injured workers. Prior to July 11, 2007, a physician was required to obtain pre-authorization from the workers’ compensation carrier for specialized tests or treatment that cost in excess of \$500.²⁹³ The law gave the carrier 30 days from its receipt of the request for authorization to either (1) approve the test or (2) obtain an IME examination and deny authorization based on the IME report.²⁹⁴

²⁹³ Workers’ Compensation Law Section 13-a(5)

²⁹⁴ Id.

As a practical matter, however, if the carrier simply disregarded its obligation under the law, the worker was unable to obtain the treatment, because diagnostic test facilities would not perform tests without advance authorization. As a result, when the 30 day time period expired the worker was left to request a hearing, which often took the WCB several months to schedule.

The WCB attempted to solve this problem by issuing the “MD-1” form and establishing an “MD-1 procedure” to accompany the form. The essence of the procedure was that if the 30 day period expired without a carrier response, the treating physician was to fill out an MD-1 form advising the WCB of the situation. The WCB would then give the carrier an additional 30 days to respond, and would issue an authorization if the carrier did not respond (thus extending the statutory 30 day time frame by at least another 30 days). If the carrier did respond (with an MD-2 form) then the WCB would evaluate the response and either schedule a hearing or reject the carrier position and issue an authorization (which would usually occur about 60 days beyond the original 30 day time frame – 90 days after the date of the request).

As a result of the 2007 legislation, the \$500 pre-authorization limit was raised to \$1,000.²⁹⁵ However, injured workers are now obligated to have their diagnostic testing done at facilities selected by the carrier. Although the increased authorization limit theoretically eliminates the requirement to obtain pre-approval for a greater number of common diagnostic tests, it remains unclear whether workers will actually be able to obtain the tests at carrier-selected facilities without active participation by the carrier. If they are not, then the inadequate MD-1 procedure will continue to come into play and will continue to create delays in the medical treatment process.

²⁹⁵ Id.

E. Conclusion.

Overall, it appears that the procedures of the WCB are not conducive to the collection of accurate data, full access to benefits by injured workers, receipt of benefits by workers, the efficient resolution of claims, or the discouragement of defense-inspired systemic friction. We therefore make the following recommendations:

1. Require the WCB to distinguish between claims that are fully resolved and those that are temporarily inactive.
2. Require the WCB to collect and report data regarding workers' compensation defense costs, including (a) defense attorney costs by carrier and employer; (b) IME costs by carrier and employer; (c) claims controverted by carrier and employer; and (d) outcome data by carrier and employer.
3. Require the WCB to collect and report data regarding IMEs, including the results of IME examinations by IME and by IME vendor.
4. Require the WCB to collect and report data regarding actual claim costs for medical and indemnity by type of injury and type of award.
5. Require the WCB to collect outcome data in controverted claims.
6. Eliminate non-hearing determinations by the WCB.
7. Require the WCB to translate forms and informational literature into additional foreign languages.
8. Eliminate WCB use of "no further action" status for claims that have not been fully resolved.

9. Provide for carrier payment of claimant attorney fees in cases involving medical treatment only.
10. Require carrier payment of claimant attorney fees in controverted cases.
11. Impose time limits for decisions by administrative law judges and the WCB Office of Appeals.
12. Eliminate depositions of medical witnesses.
13. Clarify WCB regulations to establish that IMEs and not IME vendors must mail IME reports to all parties in the same time and using the same manner.
14. Increase the amounts of existing statutory penalties, make their use mandatory instead of discretionary, and target conduct such as the frivolous controversy of cases.
15. Reduce time periods for employer and insurer compliance and filing through the expansion of existing electronic filing programs.
16. Make statutory and regulatory changes aimed at reducing adjournments and lack of preparedness, including preclusion of cross-examination in the absence of contradictory evidence.
17. Render certain WCL Judge decisions non-appealable.

VII. CLAIMS INVOLVING IMMIGRANT WORKERS.

All of the issues faced by workers in general when interacting with the workers' compensation system are exacerbated when the injured worker is an immigrant. The primary obstacle is the language barrier. All WCB forms are issued in English. In some

instances, the instructions that accompany the forms are available in Spanish translation, but even where the instructions are translated the form itself is not. There are no translations into other foreign languages that are common in several areas of the State, including Russian, Polish, and Chinese.

The language issues faced by immigrant workers are not limited to their interaction with the WCB, but extend to their ability to communicate with attorneys and health care providers in the system. Although the WCB has translation services available by telephone for the use of administrative law judges when holding hearings, these services are not made available to injured workers either at the WCB or elsewhere. As a result, many immigrant workers find themselves unable to communicate effectively with their own lawyers and doctors.

Immigrant workers also face cultural issues that impede their ability to access or receive benefits. Many come from countries in which the employer or governmental obligation to secure a worker's benefits is the norm. These workers expect that in the event of a work-related injury the employer will file all necessary paperwork and that the appropriate governmental agency (the WCB) will assure their receipt of benefits. This is substantially different from the New York workers' compensation system, in which the employer is not required to inform the worker of their independent obligation to file a claim, and in which the WCB has shed its responsibility to seek out and inform injured workers of their rights in favor of a far more passive adjudicatory role.

The language and cultural barriers faced by immigrant workers were compounded by the decision in Ramroop v. Flexo-Craft,²⁹⁶ in which the WCB denied a particular type of workers' compensation benefits to a severely injured worker based on that worker's

²⁹⁶ Ramroop v. Flexo-Craft Printing, Inc., 41 A.D.2d 1035 (3rd Dept. 2007).

immigration status. Workers' Compensation Law Section 15(3)(v) provides that if a worker has a "schedule loss of use" of 50% or more of a major member (hand, foot, arm, or leg) the worker may be entitled to certain "additional compensation" in the form of weekly payments if he or she continues to have lost earnings "due solely" to the compensable injury.²⁹⁷ This compensation is payable only if the worker has participated "in a board approved rehabilitation program" or has "been determined not to be a feasible candidate for rehabilitation."²⁹⁸

In Ramroop, the Board denied benefits based on the workers' alleged lack of participation in rehabilitation (the State agency declined to assist the worker due to his immigration status) and based on its conclusion that his loss of earning capacity was due in part to his immigration status (thus failing to meet the "due solely" requirement).²⁹⁹ This decision was affirmed by the Appellate Division based solely on the worker's immigration status.³⁰⁰

Workers' Compensation Law Section 17 prohibits the WCB from using immigration status in awarding benefits. In addition, the Court of Appeals has held that immigration status does not preclude an injured worker from receiving wage replacement benefits.³⁰¹ Thus, the use of immigration status to deny workers' compensation benefits is not only contrary to the letter and the spirit of the Workers' Compensation Law, it is contrary to public policy and would reward employers for safety and health violations.

In view of these issues, we make the following recommendations:

²⁹⁷ Workers' Compensation Law Section 15(3)(v).

²⁹⁸ Id.

²⁹⁹ Flexo-Craft Printing, Inc., 0953 0499, 2005 WL 3087787.

³⁰⁰ Ramroop v. Flexo-Craft Printing, Inc., 41 A.D.2d 1035 (3rd Dept. 2007).

³⁰¹ Balbuena v. Cassino Contracting Corp., 6 N.Y.2d 338 (2006).

1. Amend WCL Section 17 to clarify that the WCB may not use immigration status for any purpose in the determination of any claim or any part thereof.
2. Translate WCB forms and instructions into multiple languages.
3. Make translation services used by WCB available to injured workers.

VIII. WORLD TRADE CENTER CLAIMS.

There have been reports of widespread problems with claims brought under Workers' Compensation Law Article 8-A. Article 8-A was added to the Workers' Compensation Law on August 13, 2006.³⁰² The law permitted those involved in WTC rescue, recovery, and cleanup to file a registration form (WTC-12). Those who registered were then permitted to file claims for "latent conditions" resulting from their WTC exposure, and the Workers' Compensation Board ("WCB") was directed to apply the presumably more liberal "occupational disease" standard to measuring the timeliness of their claims in lieu of the "accident" standard applied by the WCB before the statute was enacted.³⁰³

A. Primary Legal Obstacles to WTC Claims under WCL Article 8-A.

1. The Statute of Limitations.

The intended "liberalization" of the statute of limitations by using occupational disease time frames has not achieved its intended purpose. Article 8-A uses the "date of

³⁰² Workers' Compensation Law Section 161 et seq.

³⁰³ Id.

disablement” as the starting point from which the statute of limitations is measured. The WCB has discretion in setting a date of disablement, and may use (among other dates) first medical treatment or first lost time.³⁰⁴ Because the WCB has latitude in this, and because in any given case some possible dates of disablement may fall more than 2 years before the date the claim was filed, this has caused employers and carriers to controvert almost every claim on statute of limitations grounds. The employer/carrier position is generally that they must raise the statute of limitations because the WCB may fix a date of disablement either more or less than 2 years before the claim was filed, and earlier dates may time-bar the claim.

Obviously what has occurred is that the use of the date of disablement standard has built controversy into every claim.

In response to this problem, we propose prohibiting the WCB from fixing a date of disablement more than 2 years before the date the claim is filed. This would remove the statute of limitations as a defense to claims brought under Article 8-A.

It is anticipated that employers and carriers will oppose this proposal on the grounds that “there must be a statute of limitations” in order to prevent claims being filed years in the future at which point the employer or carrier will be prejudiced by an inability to investigate and defend the claim.

While this argument seems credible at first blush, in fact it is specious. Claimants under Article 8-A are obligated to file a WTC-12 registration before 8/13/08, and the employers are notified of those registrations when they are filed. The WTC-12 is a sworn statement in which the claimant must identify when, where, and in whose employ the

³⁰⁴ See, e.g., Cummings v. Tenneco Chemicals Division, American Plastics, 53 A.D.2d 944; 385 N.Y.S.2d 419 (3rd Dept. 1976).

worker was engaged in rescue, recovery or cleanup. This “registration” requirement does not apply to any other workers’ compensation claim. As a result of this process, by August 13, 2008 employers will be aware of the entire universe of individuals who may file claims in the future, their activities at the site, and the nature and extent of their exposure. Therefore, any claim filed later cannot come as a surprise to the employer or carrier, nor will the employer’s ability to investigate be impaired. Indeed, it appears that the point of the registration requirement was precisely to limit potential claims and to provide notice and an opportunity to investigate to employers for all possible claimants.

2. “Latent Condition.”

The term “latent condition” was not defined in Article 8-A or elsewhere. Clearly this term was intended to exclude traumatic injury claims that could and should have been filed timely from coverage under the statute, and to include the various respiratory and other non-traumatic medical conditions that are known to be associated with WTC exposure. Unfortunately, employers and carriers are now using the term “latent condition” to contest exactly the sort of conditions that were intended to be covered. If the worker coughed or sneezed, or had an episode of sinusitis or rhinitis while at the WTC site, many employers and carriers are taking the position that the condition was not “latent” because symptoms manifested at the time and therefore Article 8-A does not apply. This is plainly unacceptable. Simply because a worker had limited symptoms while they were engaged in responder activities does not mean that they knew or should have known that they would later have a chronic problem. Thus, even if the temporary symptoms were not “latent,” the chronicity of the problem certainly is.

We therefore propose that the list of conditions to be covered by the presumption (discussed below) be specifically identified as “latent conditions” to eliminate this problem.

3. The Need for a Statutory Presumption.

Even where the statute of limitations and “latent condition” issues are overcome, many cases are contested and litigated on the issue of whether the worker’s medical problem is causally related to the WTC exposure. A statutory presumption of causal relationship would ease the path to compensability for these claims.

There are several places in the statute where a presumption could logically be located. We propose including the presumptions in WCL Section 47, which contains certain specific presumptions for certain occupational diseases. Section 47 references Section 3(2), where there is a list of occupations and a corresponding list of diseases presumed to be causally related. It would work equally well to make “WTC rescue recovery or cleanup worker” an “occupation” in Column A of Section 3(2) and the list of diseases the matching group in Column B. Alternatively a presumption could be added to Section 21. However, as indicated, we suggest that presumptions be added to the law as an amendment to Section 47.

B. Supporting Data.

In order to supplement our empirical experience and the anecdotal evidence we have received, we reviewed approximately 200 reported Workers’ Compensation Board Panel decisions in WTC claims, of which 55 involved claims brought under Article 8-A.

These opinions constitute the bulk of the reported decisions reported on this subject. It should be observed, however, that many Board Panel decisions are not reported, and therefore the decisions discussed below should be viewed as representative of a larger whole, rather than as the entirety of the decisions rendered by the WCB under Article 8-A.

1. Summary of Data.

The chart below shows the frequency with which each type of defense was raised in the Article 8-A cases, as well as the average time required to arrive at a final determination. In considering the data, it must be remembered that at least one defense was raised in all of the reported claims.

Totals For Each Category:

Sample Size:	55 Cases
Latent Condition:	17 Cases (31%)
Time Limitation:	48 Cases (87%)
Causal Relationship:	25 Cases (45%)
Avg. Time to Resolution:	30.27 Months

It is apparent that the statute of limitations is the most common defense raised by employers (87% of claims) and that the issues of causal relationship (45% of claims) and latent condition (31%) are also common. Perhaps most significant, however, is the fact that it took these workers an average of over two and a half years to obtain a final decision in their claims.

The chart below shows the frequency with which the typical defenses were raised in combination.

Combinations of Types of Cases:

Latent and Time Limited:	10 Cases (18%)
Latent and Causal:	1 Case (2%)
Time Limited and Causal:	17 Cases (31%)
Latent, Time Limited and Causal:	3 Cases (5%)

It appears from this information that employers and carriers raised and pursued multiple defenses in 31 of the 55 claims reviewed (56%), with the most common combination being the statute of limitations and causal relationship defenses.

After ruling on these defenses, the WCB found in favor of the worker in 38 cases (69%), in favor of the employer or carrier in 5 cases (9%) and directed further proceedings in 8 cases (15%). In 4 cases (7%) some parts of the worker's claim were established while others were disallowed.

C. Statutory Amendments.

In light of the foregoing data, we submit the following specific proposals for amendment of Article 8-A and other provisions of the Workers' Compensation Law.

1. Presumptions.

Amend Section 47 of the Workers' Compensation Law to read as follows:³⁰⁵

Presumption as to the cause of disease.

If the employee, at or immediately before the date of disablement, was employed in any process mentioned in the second column of the schedule of diseases in subdivision two of section three of this chapter, and his or her disease is the disease in the first column of such schedule set opposite the description of the process, the disease presumptively shall be deemed to have been due to the nature of that employment. Any exposure to the hazards of compressed air after July first, nineteen hundred forty-six shall be presumed, in the absence of substantial evidence to the contrary, to be injurious exposure. Any exposure to the hazards of harmful dust in this state for a period of sixty days after September first, nineteen hundred thirty-five, shall be presumed, in the absence of substantial evidence to the contrary, to be an injurious exposure. With respect to any state or local correction officer as defined in subdivision twenty-five of section 2.10 of the criminal procedure law, safety and security officer employed by the office of mental health, security hospital treatment assistant employed by the office of mental health, any uniformed court officer or court clerk of the unified court system having the powers of peace officer, the court reporter or the court interpreter, an exposure to the blood or

³⁰⁵ Text in *bold italics* is new statutory language.

bodily fluid of an individual, incarcerated, confined or otherwise, during the course of his or her employment that is reported in writing to such correction officer's, safety and security officer's, security hospital treatment assistant's, uniformed court officer's, court clerk's, court reporter's or court interpreter's employer within twenty-four hours of such exposure, shall be presumed, in the absence of substantial evidence to the contrary, to be an injurious exposure if, subsequent to such exposure, such correction officer, safety and security officer, security hospital treatment assistant, uniformed court officer, court clerk, court reporter or court interpreter is diagnosed with a blood-borne disease, including, but not limited to hepatitis C. *Any participant in World Trade Center rescue, recovery or cleanup operations as defined in WCL Section 161(1) who was exposed to the hazards of harmful dust at the World Trade Center site as defined in WCL Section 161(2) within the 48 hours after the airplane came into contact with the first tower, or for a total of 40 hours between 9/11/01 and 9/12/02, shall be presumed, in the absence of substantial evidence to the contrary, to have suffered an injurious exposure. It shall be further presumed, in the absence of substantial evidence to the contrary, that the following medical conditions are causally related to such injurious exposure: (a) diseases of the upper respiratory tract and mucosae, including conditions such as conjunctivitis, rhinitis, sinusitis, pharyngitis, laryngitis, vocal cord disease, upper airway hyper-reactivity and tracheo-bronchitis, or a combination of such conditions; (b) diseases of the lower respiratory tract, including but not limited to bronchitis, asthma, reactive airway dysfunction syndrome, and different types of pneumonitis, such as hypersensitivity, granulomatous, or eosinophilic; (c) diseases of the gastroesophageal tract, including esophagitis and reflux disease, either acute or chronic, caused by exposure or aggravated by exposure; (d) diseases of the psychological axis, including post-traumatic stress disorder, anxiety, depression, or any combination of such conditions; (e) diseases of the skin such as contact dermatitis or burns, either acute or chronic in nature, infectious, irritant, allergic, idiopathic or non-specific reactive in nature, caused by exposure or aggravated by exposure; or (f) new onset diseases resulting from exposure as such diseases occur in the future, including cancer, chronic obstructive pulmonary disease, asbestos-related disease, heavy metal poisoning, musculoskeletal disease, and chronic psychological disease.*

2. Statute of Limitations.

Amend Section 164 of the Workers' Compensation Law to read as follows:

Disablement of a participant in World Trade Center rescue, recovery and clean-up operations treated as an accident. The date of disablement of a participant in World Trade Center rescue, recovery and clean-up operations resulting from a qualifying condition that is causally related to such participant shall be treated as the happening of an accident within the meaning of this chapter and the procedure and practice provided in this chapter shall apply to all proceedings under this article, except where otherwise specifically provided herein. *In no event, however, shall the Board establish a date of disablement more than two years prior the date on which the claim was filed in a proceeding under this article.*

3. Definition of Latent Condition.

Amend Section 161 of the Workers' Compensation Law to read as follows:

Definitions. Whenever used in this article:

1. "Participant in World Trade Center rescue, recovery, or cleanup operations" means any (a) employee who within the course of employment, or (b) volunteer upon presentation to the board of evidence satisfactory to the board that he or she:

(i) participated in the rescue, recovery, or cleanup operations at the World Trade Center site between September eleventh, two thousand one and September twelfth, two thousand two; or

(ii) worked at the Fresh Kills Land Fill in New York city between September eleventh, two thousand one and September twelfth, two thousand two, or

(iii) worked at the New York city morgue or the temporary morgue on pier locations on the west side of Manhattan between September eleventh, two thousand one and September twelfth, two thousand two, or

(iv) worked on the barges between the west side of Manhattan and the Fresh Kills Land Fill in New York city between September eleventh, two thousand one and September twelfth, two thousand two.

2. "World Trade Center site" means anywhere below a line starting from the Hudson River and Canal Street; east on Canal Street to Pike Street; south on Pike Street to the East River; and extending to the lower tip of Manhattan.

3. "Qualifying condition" means any latent disease or condition resulting from a hazardous exposure during participation in World Trade Center rescue, recovery or clean-up operations. ***"Latent disease or condition" shall include all of the conditions presumed to result from injurious exposure to harmful dust from the World Trade Center identified in Section 47 of this chapter.***

4. "Disablement" shall have the same meaning as defined in section thirty-seven of this chapter and determined by the board in the same manner as provided in section forty-two of this chapter.

4. Application of New Law to Previously Disallowed Claims.

Amend Section 165 of the Workers' Compensation Law is amended to read as follows:

Reopening of disallowed claims.

The board, upon receiving a statement duly filed as required under section one hundred sixty-two of this article, from a participant in World Trade Center rescue,

recovery and clean-up operations for a qualifying condition that was disallowed as barred by section eighteen or section twenty-eight of this chapter shall reopen and redetermine such claim in accordance with the provisions of this article, provided that no such previously disallowed claim for a qualifying condition shall be determined to have a date of disablement that would bar the claim under section eighteen or section twenty-eight of this chapter. *Upon the effective date of the amendment to section one hundred sixty four of this article regarding permissible dates of disablement in claims brought under this article, the board shall reopen and redetermine such claim in accordance with the provisions of section one hundred sixty four as amended.*