

**WORKERS' COMPENSATION
IN NEW YORK STATE:
STATE OF THE SYSTEM
2006**

By: Robert E. Grey

Grey & Grey, LLP
360 Main Street
Farmingdale, New York 11735
(516) 249-1342

277 Broadway – Suite 400
New York, New York 10007
(212) 964-1342

118-21 Queens Boulevard – Suite 618
Forest Hills, New York 11375
(718) 268-5300

RGrey@GreyAndGrey.com

TABLE OF CONTENTS

	<u>Page</u>
Summary	iii
I. Introduction	1
A. Background	1
B. Problems With the Workers’ Compensation System	1
C. The Purpose of This Paper	2
II. Injured Workers.....	2
A. Wage Replacement Benefits	2
B. Medical Treatment	7
C. Access to Benefits	9
III. Employers and Insurers	12
A. Employers	12
B. Insurers	17
IV. The Workers’ Compensation Board	23
V. Legislative Proposal	32
A. Wage Replacement Benefits	32
B. Medical Care and Treatment	33
C. Definitional Change and Rehabilitation	35
D. Administrative Reform	36
E. Insurers and Self-Insurance	40
F. Safety	44
G. World Trade Center Claims	44
VI. Conclusion	46

SUMMARY

A. Introduction.

This paper is divided into five sections. The first section is a brief introduction to the general issues in the New York workers' compensation system. The introduction identifies the four basic constituencies of the system as workers, employers, insurance carriers, and the state Workers' Compensation Board. The following three sections are devoted to an in-depth analysis of the issues and concerns of each constituency, and the fifth section is a proposal for legislative reform.

B. Injured Workers.

Injured workers have three essential issues: wage replacement benefits, medical treatment, and access to benefits. With regard to wage replacement benefits, increases in both the minimum and maximum rate are required. With regard to medical treatment, increased worker control and diminished bureaucratic delay are essential, as well as improvement in the delivery of health care in situations where there is a controversy or lack of insurance. In the area of access to benefits, increased worker education (with employer co-operation) is needed, as is improvement in the administrative procedures of the state agency.

C. Employers.

Employers have two concerns: reduction of costs (insurance premium and assessments) and delivery of benefits. The primary source of employer costs is insurance premium. Insurance premium is calculated based on various factors including payroll. The ability of some employers to reduce the visibility of their payroll while not reducing the actual insurable risk has resulted in the transfer of costs from those employers to

others and keeps insurance premiums artificially high. In order to deal with this issue action must be taken to ensure that premium is fairly charged to all employers based on their actual payroll and actual risk.

The concerns of employers are intertwined with insurance issues because New York is a mandatory insurance state, and therefore employer issues are considered together with insurer issues in Section III.

D. Insurance Carriers.

Insurers are concerned primarily with profitability. The paper discusses in detail the fact that claims have declined about 45% in the past fifteen years, accompanied by a decline in indemnity payments to workers. It is reported by the insurers that these savings have been offset by an increase in medical costs. However, over the past ten years, insurance premiums in New York have declined over 30%, although this decline is offset to an unknown extent by an increase in assessments. Reported insurer profit during this time period average in excess of 9% per year. There is currently no reliable information available on the amount of premium collected by insurers, the amounts paid out in indemnity and medical benefits to injured workers, the extent of insurer administrative costs, the nature of insurer profits (underwriting profits, where premium collected exceeds payments made or investment profit based on income from invested reserves), or the extent to which profits have been diverted to other areas, such as reserve strengthening. The source of almost all available insurer data is the Compensation Insurance Rating Board (CIRB), which is controlled by the insurers and is the vehicle through which rate increases are requested from the state Insurance Department.

The absence of reliable data regarding the insurers makes it impossible to judge the validity of insurer claims of high claims-driven costs or the fairness of the premium charged. Bid-rigging investigations by the New York State Attorney General, the Legislative Position paper of the Professional Insurance Agents of New York (PIANY), and the state Insurance Department's rejection of the insurer's request for a rate increase have all raised issues regarding the credibility of insurer data.

E. The Workers' Compensation Board.

The state Workers' Compensation Board has instituted a number of procedures intended to streamline the processing of claims by the Board and to reduce the agency's administrative burden. These procedures include the non-indexing of some claims, the use of "informal" resolution procedures such as decisions issued on paper and "conciliation" hearings, and the administrative closure of cases with "no further action" status. It is questionable whether the use of these procedures has in fact streamlined the processing of claims or reduced the agency's administrative burden. Both empirical and statistical information suggests that the effect of these procedures has in fact been to reduce worker access to benefits (the mission of the agency being to the contrary) and to prolong the actual final resolution of individual claims.

F. Legislative Reform.

The following are the legislative reform proposals made in this paper:

1. Increase the maximum wage replacement benefit to two-thirds of the state average weekly wage.
2. Index the maximum wage replacement benefit to increases in the state average weekly wage.

3. Increase the minimum wage replacement benefit to one-quarter of the maximum benefit rate.
4. Increase authorization limits for diagnostic testing and surgical procedures.
5. Limit treatment modalities such as physical therapy and chiropractic manipulation.
6. Require payment of medical bills by private insurance carriers where the claim or compensability of a particular treatment is contested.
7. Streamline existing procedures for reimbursement of private insurers from workers' compensation carriers when the compensability of treatment or diagnostic testing is established.
8. Provide for attorneys fees in cases involving medical treatment so that workers can secure representation.
9. Define penalties and medical and transportation reimbursement as payments of compensation subject to statutory time limits for payment and penalty.
10. Establish fee schedules for prescription medication and durable medical goods.
11. Permit workers' compensation insurers to negotiate for discounts with prescription medication and durable medical goods providers.
12. Define total disability as the inability of the worker to perform his job or any restricted or light duty job offered to him by the employer.
13. Expedite the finalization of claims by abandoning timelines for the permanency findings in favor of maximum medical improvement.

14. Expand the use of vocational assessment and retraining programs.
15. Increase the amounts of existing statutory penalties, make their use mandatory instead of discretionary, and target conduct such as the frivolous controversy of cases.
16. Reduce time periods for employer and insurer compliance and filing through the expansion of existing electronic filing programs.
17. Make statutory and regulatory changes aimed at reducing adjournments and lack of preparedness, including preclusion of cross-examination in the absence of contradictory evidence.
18. Render certain WCL Judge decisions non-appealable.
19. Impose time limits within which decisions must be made.
20. Replace the CIRB with an independent entity empowered to investigate insurer income, expense, and profits.
21. Require insurers or the Board to confirm employer entities, payroll, employee classifications and loss history to ensure correct premium charges.
22. Increase regulation and oversight over self-insured employers and self-insurance trusts.
23. Consider making the New York State Insurance Fund the exclusive workers' compensation insurer in the state.
24. Expand the use of existing workplace safety programs and institute additional workplace safety programs, while providing employers incentives for their use.
25. Expand the scope of WCL Section 8-A concerning World Trade Center claims.

I. INTRODUCTION.

A. Background.

Each year, more than 140,000 New York workers develop work-related injuries or illnesses.¹ Almost all are covered by the New York State Workers' Compensation Law.²

The purpose of New York's workers' compensation law (and similar laws in other states) is to provide wage replacement benefits and medical coverage for injured workers while shielding employers from lawsuits.³ Because the law is social legislation, it is intended to be interpreted broadly for the protection of workers.⁴

B. Problems with the Workers' Compensation System.

According to the Center for Justice & Democracy, "the workers' compensation system has been rife with problems almost since its inception."⁵ In New York, current problems involve 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. All four constituencies – workers, employers, insurers and the Board – seek changes that will address their particular issues. The question is whether all of these issues can be addressed in a way that will benefit all parties.

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.

C. The Purpose of This Paper.

This paper will consider the four constituencies of the workers' system and the issues surrounding each of them. The purpose of this analysis is to bring clarity to the overall picture and to outline a plan that will achieve three critical objectives. Those objectives are to (1) increase benefits for injured workers, (2) reduce medical costs for insurers, and (3) reduce costs for employers.

Sections II through IV of this paper will discuss the issues involving each constituent group, with brief consideration of available solutions. Section V will offer a comprehensive proposal for overall reform of the system.

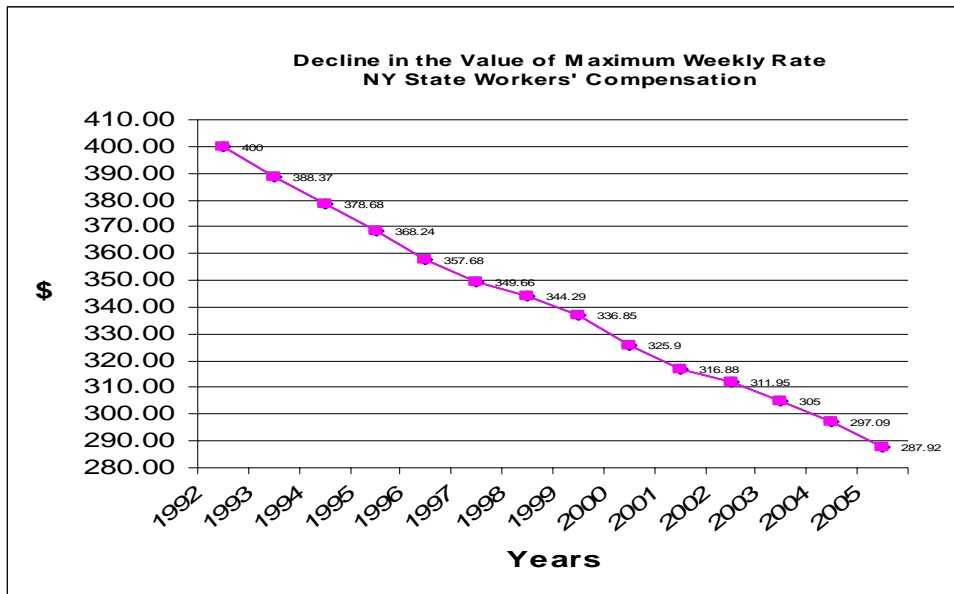
II. INJURED WORKERS.

A. Wage Replacement Benefits.

The most critical issue for injured workers is the amount of workers' compensation benefits for wage loss. The original intent of the Legislature was that the maximum workers' compensation benefit rate should be two-thirds of the state average weekly wage. Unfortunately, the benefit rate was not indexed to changes in the state average weekly wage. As wages rose due to inflation and other economic factors, workers' compensation benefits became increasingly inadequate as a means of support for injured workers and their families.

Due to the chronic decline in value of workers' compensation benefits, the Legislature has raised the maximum rate from time to time. However, each time the Legislature re-visits the issue of an appropriate maximum benefit rate, tangential issues are drawn into the discussion which make it increasingly difficult to craft acceptable legislation.

The last increase in the maximum benefit rate occurred in 1990, when it was raised from \$300 per week to \$400 per week over a three year period ending in 1992.⁶ At that time, however, the \$400 per week was less than 50% of the state average weekly wage.⁷ Further, measured in 1992 dollars, \$400 per week is now worth less than \$288 (see chart below). Today, the state average weekly wage in New York is approximately \$960⁸, which means that honoring the principles of the original Workers' Compensation Law would require a maximum compensation rate of \$640 per week.

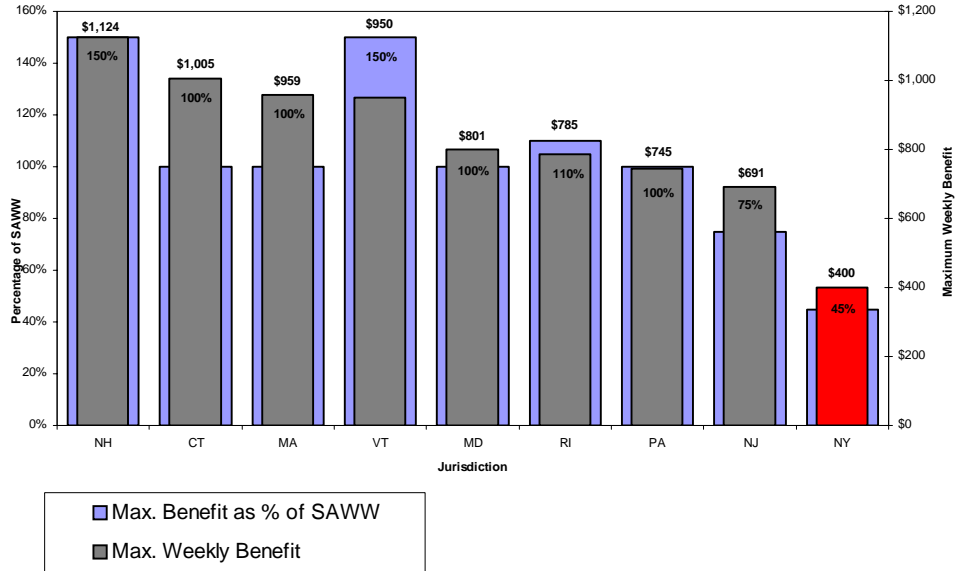


There is no question that New York's benefit rate has failed to keep pace with the benefits available to injured workers in other states in the region. The chart below is instructive in this regard.

⁶ WCL Section 15.

⁷ Source: Bureau of Labor Statistics, United States Department of Labor.

⁸ Id.



As demonstrated in the chart, the maximum weekly wage benefit in the region ranges from a low of \$691 in New Jersey to a high of \$1,124 in New Hampshire. The average of these state maximum benefit rates is \$882.50, more than double the New York maximum of \$400 per week. In addition, in every state except New Jersey the benefit rate is at least 100% of the state average weekly wage. New Jersey’s benefit rate is 75% of the state average weekly wage, far higher than New York’s 45%. It is simply inexcusable and unacceptable that injured workers in New York receive less than half as much as injured workers in other states in the region.

A corollary problem to the inadequacy of the maximum benefit rate is the inadequacy of the minimum benefit rate. The current minimum benefit rate is only \$40 per week, up from \$30 per week prior to 1990.⁹

It must be recognized that as presently constructed, the workers’ compensation system is adversarial. Few workers receive the maximum benefit rate unchallenged by

⁹ WCL Section 15.

the insurance carrier. If a worker is disabled for more than a few weeks, it is typical for the carrier to have the worker examined by an “independent medical examiner” (“IME”). The IME process, its name aside, is not one in which the worker is evaluated by a neutral physician. Rather, it is one in which the worker is examined by a physician who typically performs hundreds (sometimes thousands) of examinations annually for insurance carriers or “IME companies” for defense purposes. The outcome of such an examination is almost invariably one in which the defense doctor reports that the worker is less disabled than reported by his or her treating doctor. The insurer then uses the report to reduce the worker’s benefits.¹⁰

It is the use of these IME reports that makes the minimum rate important. If an IME reports a “mild partial disability,” the insurer will typically reduce the worker’s benefit rate to one-sixth of his or her average weekly wage.¹¹ For a worker who earns \$600 per week, this is a reduction to \$100 per week. For a worker who earns \$400 per week, it is a reduction to \$66.67 per week.

Many workers who are found by IMEs to have “mild” (or “moderate” or “marked”) disabilities are in fact unable to return to their occupation. As a result, the current minimum rate creates enormous hardship for tens of thousands of injured workers. Most have difficulty affording food and shelter even when receiving the maximum rate, which is itself roughly equivalent to the poverty line for a family of

¹⁰ Insurer abuse of the IME process was addressed by the Legislature with the enactment of WCL Section 137. The continued substantial involvement of “IME companies” in the process of producing and transmitting IME reports has, however, diluted the beneficial results that the statute was intended to achieve.

¹¹ WCL Section 15.

four.¹² That the law permits reductions to third-world income levels of \$100 per week or less is essentially a license for injured workers to be literally “starved back to work.”

Some have suggested that permanent disability benefits should be limited in duration, or “capped.” Most versions of “cap” proposals suggest a sliding scale, where those who are “more disabled” are paid for longer periods of time and those who are “less disabled” are paid for shorter periods of time, but with all benefits ending at some point. These proposals are misguided on many levels.

First, there is no logical, legal or social justification for terminating the benefits of a permanently disabled worker. If the worker has permanently lost the ability to earn a living, it stands to reason that the worker should be paid for as long as that loss of earning capacity continues. Any contrary rule simply shifts the “cost” of the injured worker from the employer and carrier where it properly belongs onto the worker himself, his family, charity, and ultimately the New York State taxpayer, who funds welfare.

Second, all of the “sliding scale” proposals suggest that the period of payments should depend on the “degree of disability.” As discussed in Section V of this paper, “degree of disability” is an artificial concept involving medical impairment, which is only tangentially related to an injured person’s ability to work. An accountant with a broken arm and a construction worker with the same broken arm have the same “degree of disability,” but while the accountant may have little or no loss of earning capacity the construction worker’s livelihood depends on the use of his arms. Limiting payments based on “degree of disability” is therefore irrational and unjustifiable. The 90 year

¹² 2005 HHS Poverty Guidelines, United States Department of Health and Human Services (poverty line for a family of four in the continuous 48 states and the District of Columbia is \$19,350, compared to \$400 per week maximum workers compensation rate equal to \$20,800 per year).

history of the law requiring payment of benefits for as long as the disability continues should be honored.

In summary, any review and reform of the workers' compensation system must include increases in both the maximum and the minimum workers' compensation benefit rates in order to address the issues faced by injured workers, but should not involve any limitation of awards for permanent disability.

B. Medical Treatment.

Injured workers report substantial difficulty and delay in obtaining medical diagnosis and treatment for work-related injuries. Workers are permitted to seek treatment only from doctors who are "coded" by the New York State Workers' Compensation Board.¹³ 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.¹⁴ 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.

In addition, workers are confronted with excessive and unnecessary delays in obtaining approval for treatment and diagnostic testing. The law does not allow a worker to obtain a medical test, device or treatment costing more than \$500 without advance

¹³ WCL Section 13 et. seq..

¹⁴ Id.

approval of the insurer.¹⁵ However, many common diagnostic tests (such as MRI or EMG testing) cost more than \$500, as do virtually all surgical treatments (even on the limited workers' compensation medical fee schedule).

The law does require an insurer to either authorize the requested test or treatment or to deny authorization based on a conflicting medical opinion within 30 days of the date of the request.¹⁶ As discussed above regarding wage replacement benefits, however, it is all too easy and common for an insurer to obtain a conflicting medical opinion. Further, in cases where the insurer simply fails to act, the worker is still unable to obtain the needed test or treatment in a timely fashion. Few diagnostic centers or surgeons will accept the statement that "authorization exists as a matter of law due to insurer inaction" as sufficient assurance of payment. And while the Workers' Compensation Board has instituted a procedure known as the "MD-1 procedure" to provide written authorization, that procedure has the effect of extending the statutory 30-day provision to ninety days or more.¹⁷

On the whole, the existing provisions of the Workers' Compensation Law are inadequate to allow injured workers to receive medical treatment in a timely fashion. These delays prolong the period of worker disability, increase the degree of permanent injury, and on the whole drive up insurer costs.

Therefore, the process for diagnosis and medical treatment of injured workers must be significantly expedited through statutory and regulatory change.

¹⁵ WCL Section 13-a(5).

¹⁶ Id.

¹⁷ 12 NYCRR 325-1.4 et. seq.

C. Access to Benefits.

Any amendment of the law that increases benefits for workers will be reduced to irrelevance if worker ability to access those benefits is not improved. Workers are largely uninformed and misinformed about the nature and availability of workers' compensation benefits. As presently constructed, the law places no obligation on the employer to inform workers about their rights in the event of on-the-job injury. Instead, the employer need only inform the Board and its insurance carrier, leaving the worker to fend for himself.

A dozen years ago, this situation was not nearly as problematic as it is today. At that time, upon receiving an employer's accident report, a medical report, or any other document that might indicate the existence of a claim, the Workers' Compensation Board would create a file (index) and begin to hold a series of hearings that would continue until the claim reached a natural conclusion. Over the past decade, however, the Board has adopted a number of regulatory and administrative policies that, taken together, have substantially reduced worker access to benefits. The statistical effect of these policies is discussed in detail in Section IV of this paper, but is appropriate to discuss their general effect on worker claims at this juncture.

The Board's reaction to receipt of paperwork that might indicate the existence of a claim is a threshold issue to be addressed. Over the years, the Board's criteria for indexing have become increasingly refined. The result is that rather than being a receptacle for claims, the Board has become more of a filtering agent. Employer incident reports (C-2 forms) no longer automatically prompt indexing, but instead are held until a medical report is also filed. The same is true for medical reports that are received but are

not connected with either an employer's incident report or a claimant's claim. Even claims filed by workers (C-3 forms) are not automatically indexed. Documents that are considered unsuitable or inadequate for indexing are apparently maintained by the Board in a "no claims" status, with no notification sent to the injured worker.

In the declining number of claims that are indexed, the Board's current procedures create further obstacles to receipt of benefits for injured workers. Rather than automatically scheduling a hearing at which a claim can be assessed and the worker can be advised by an administrative law judge (ALJ), the Board now attempts to resolve claims without hearings wherever possible. This is done through the use of decisions made by non-ALJ (and generally non-lawyer) Board employees based on file reviews, known as "administrative" or "proposed" decisions. In essence, if a Board employee thinks that the nature of the injury, pre-accident salary (average weekly wage) and period of lost time can be determined from documents filed with the Board, a decision is issued making the supposedly correct findings. These decisions also invariably state that "no further action is contemplated by the Board at this time," thus administratively closing the case.

Not surprisingly, these administrative and proposed decisions are rife with inaccuracies. They are issued on the assumption that all relevant documents and information are on file with the Board; to practitioners across the state, this is a laughable proposition. When workers were called to the Board for hearings, an ALJ could assess the worker's understanding of the issues in his or her case and could tailor an explanation that was meaningful to the worker. The "one-size-fits-all" approach of administrative and proposed decisions renders them confusing and meaningless to many workers for

many reasons, weeding out those with language barriers and those of limited legal sophistication. Lastly, these decisions administratively close thousands of cases in which workers are entitled to further benefits without providing a meaningful explanation to the worker of what those benefits might be.

The Board's use of administrative closings is not limited to the administrative and proposed decision process. Even claims that appear for hearings are routinely marked "no further action" by the Board's ALJs despite the fact that further action will almost certainly be required. Prime examples of such inappropriate administrative closings are cases where surgery is authorized and those where the worker has produced medical evidence of permanency and the carrier has requested an opportunity to respond. Although there is little question that a further hearing will be required in these cases, the Board typically marks these cases "no further action" and requires the worker to affirmatively request a hearing in order to move the claim forward to its natural conclusion.

Practitioners who request hearings in "no further action" cases are often met with resistance from the Board. Requests are denied on the grounds that evidence has not been submitted, that the evidence submitted is inadequate, that not enough time has elapsed (even in cases where the worker is out of work and receiving no payments), or are simply ignored with unfortunate regularity.

All of these procedures operate to deny or limit worker access to benefits. Most have been accomplished administratively or through regulation without statutory change, however, statutory change is apparently needed to reverse the process.

Another area in need of both statutory and regulatory change involves uninsured employers. Although the Board has made progress in identifying uninsured employers, there are still an excessive number of claims in which the employer is found to have defied the legal requirement to carry workers' compensation insurance. Some of these employers improperly claim to be sole proprietors, reporting employees as "independent contractors" in order to avoid paying for insurance; others simply "run naked" and hope to avoid detection. Cases in which the employer is uninsured typically involve long delays (in some cases a year or longer) during which neither the worker nor his doctors are paid.

III. EMPLOYERS AND INSURANCE CARRIERS.

The issues involving employers and insurers are related on a number of levels. In some ways, the interests of employers and carriers are identical, and in others they are diametrically opposed. To understand the workers' compensation system, it is essential to deconstruct the relationship between employers and carriers, particularly in light of a campaign by insurance interests to portray employers and carriers as wholly united in interest. Nothing could be further from the truth, and the failure of many employers to grasp this concept has hindered past efforts to achieve meaningful reform.

A. Employers.

Most employers have two objectives when it comes to workers' compensation. They want low insurance costs, and they want their employees to be able to access and receive benefits in the event of work-related injury or illness. In pursuit of these objectives, employers must choose between buying insurance from a private carrier,

using the New York State Insurance Fund, self-insuring, or joining a self-insurance trust. Most municipalities and municipal entities self-insure, as do some large private businesses. The State Insurance Fund serves as the insurer of last resort, and is required by law to provide a policy to any employer that is capable of paying premium. However, many private employers who have a choice obtaining insurance from a for-profit insurer opt instead to use the State Insurance Fund. Self-insurance trusts are occasionally used by employers in particular industry groups, such as construction or health care.

In general, the twin objectives of most employers are consistent with the interests of self-insurance, self-insurance trusts, and the State Insurance Fund. However, many employers (perhaps due to lack of information, effective marketing, or the bundling of insurance products) opt to purchase insurance from private, for-profit insurance carriers. The interests of these carriers diverge from employer interests in several significant ways. First, the for-profit nature of the private carriers puts upward pressure on their prices (insurance premiums). This is obviously contrary to the interest of the employer in keeping the employer's costs low. Second, while an employer often has an interest in the well-being of an injured employee, the insurer has no such concern other than to minimize its expense in the handling of the claim for benefits.

The divergence of the interests of employers and insurance carriers continues in the area of premium fraud. 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,¹⁸ paying workers “off the books” or failing to reveal that they have any employees.

All of these devices (in addition to 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.

The natural response to this issue should be for insurers to conduct premium audits and other investigation of their insureds in order to be certain that premium is being properly charged. In fact, this is commonly done by the State Insurance Fund. However, such audit and investigation is rarely (if ever) undertaken by private insurers. This is because competitive forces preclude them from alienating insureds and potential insureds by pursuing premium dollars that are siphoned out of the system, particularly where they can replace those dollars by simply raising premium for employers in general.

Further evidence of the differences between employers and private insurers in the area of workers’ compensation can be found in the legislative position paper of the Professional Insurance Agents of New York (“PIANY”).¹⁹ The members of PIANY are

¹⁸ WCL Section 50.

¹⁹ Legislative Position; Professional Insurance Agents of New York State Inc. available at www.piaonline.org/GIA/NY/position_workerscomp.pdf

in a unique position to understand the competing agendas of employers and insurers as they serve as intermediaries between the two, and their legislative position paper is therefore of special importance.

One of PIANY's first observations is the fact that "New York provides little or no incentive for the use of recognized, successful workplace safety programs." While the existence of such programs would greatly benefit workers and employers, they would provide less benefit to insurers, which would presumably be obligated to offer discounts to employers taking advantage of such programs and to pass on any claim savings to employers through reduction of premium.

PIANY further observed that "when a claim does occur, New York's workers' compensation coverage performs unfavorably in its delivery of benefits when compared with other regulated insurance products."²⁰ Further, "the expense associated with the delivery of benefits is significantly greater than that for similar regulated insurance products such as health, life, disability or accident policies."²¹

The insurance agents complain, however, that they cannot get a true picture of whether employers are being charged premium fairly compared with other states, noting 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

²⁰ Id.

²¹ Id.

evidence that there has always not been effective enforcement of accuracy in industry reporting.”²²

The agents bring a unique perspective to the question of whether insurers fairly charge employers. As discussed above,

insurers are required to audit employers’ operations to ensure the employer is paying the full premium indicated for its operations. ... Regarding over-charges, there are also problems that can impact individual employers. These problems can involve not only misclassification of operations but also miscalculation of experience mods.

Unwarranted increases in an employer’s experience mod can be a function of improper reserving practices by the insurer, in which the total costs of incidents and claims involving that employer are projected by the insurer at higher levels than the facts of these cases ultimately support. Collection of surcharges based on experience mods can serve as a perverse incentive for insurers to set claim reserves high, then lower them after these claims no longer factor into the experience lookback period for purposes of calculating surcharges.

An entire consulting specialty is devoted to detecting insurers’ overcharges; but these consultants tend to be employed only by larger employers where the potential savings clearly justify the cost of obtaining this type of expertise. Smaller employers tend to remain unaware of these mistakes and may actually be overpaying. Again, how can the state ensure employers are not overcharged?”²³

The lack of credibility of certain private insurers has also given employers reason to question the propriety of premium charges. “In a recent investigation, 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

²² Id.

²³ Id.

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?"²⁴

Employers are entitled to know that insurers are collecting premium fairly and that they are collecting all of the premium that is due from all employers, rather than using some employers to subsidize others (or simply raising rates across the board instead of targeting miscreant employers). In addition, employers are entitled to know how private insurance carriers perform vis-à-vis one another and as compared to the State Insurance Fund. That data is currently unavailable, leaving employers at a disadvantage in choosing a workers' compensation insurer. Therefore, an essential component of any solution to the issue of workers' compensation costs is a resolution of the dissonance between the interests of employers and private insurers.

B. Insurers.

The insurance industry takes the position that workers' compensation costs are too high, meaning the insurers feel that the amount of premium collected is insufficient to cover their claim costs (medical and indemnity) and administrative costs (staffing and litigation expense) while still permitting a reasonable profit. As a result, the insurers seek a reduction in claim costs by cutting or capping worker benefits. Certain employer groups have joined the insurers in this campaign based on the promise of lower premiums associated with lower costs.

²⁴ Id.

As discussed above, it is highly questionable whether the private insurance industry is in fact collecting all available premium from all employers. Presumably, effective collection procedures would in and of themselves reduce premium rates. In addition, all available data belies insurer claims that high claim costs are driving premiums and that insurer profits are “inadequate.”

The primary source for industry data is the National Council of Compensation Insurers (NCCI), which recently issued its 2006 report.²⁵ It should be noted that this report is not specific to New York, although much of the information in the report does in fact correlate with available New York data.

NCCI reports that 2005 “was another year of significant accomplishments for the workers compensation insurance industry. In 2005 all of the major financial performance measures for the line experienced significant improvement.”²⁶ As a result, NCCI stated that its “short-term view of the line is optimistic.”²⁷ In addition, NCCI noted that “the workers’ compensation calendar year combined ratio stands at 102% for 2005, a five-point improvement from 2004 – and the best result since 1997. The accident year combined ratios remain in the low 90s for both 2004 and 2005, nearly a 50-point improvement from 1999!”²⁸ Furthermore, “claim frequency continued its decade-long decline in 2005. The moderation in indemnity claim cost increases that we have observed in recent years also continued.”²⁹ To the extent that the combined ratio in

²⁵ “2006 State of the Line: Analysis of Workers’ Compensation Results,” www.NCCI.com

²⁶ 2006 State of the Line: Analysis of Workers’ Compensation Results, NCCI.

²⁷ Id.

²⁸ Id.

²⁹ Id.

workers' compensation insurance "lagged overall industry results," NCCI attributed the shortfall to "some much-needed reserve strengthening."³⁰

Even given the diversion of profit to strengthen reserves, in 2005 "the investment gain associated with workers' compensation insurance [was] up a point to about 12%. This is still down dramatically from the late 1990s, when interest rates were higher and the stock market produced large gains. However, it has begun to creep up a bit the last two years after bottoming out at 10.4% in 2003."

Contrary to insurer allegations of increased claim costs, the truth is that the increased profitability of workers' compensation insurance is attributable to the reduction in the frequency of claims and the cost of those claims.

NCCI estimates that the change in the average cost of workers' compensation indemnity claims rose a modest 2% in 2005. This continues a moderation in the increase in indemnity claims costs that we have seen since 2002. ... For several years we have observed that the frequency of smaller claims has been dropping more rapidly than larger claims. This phenomenon would tend to raise the rate of change in the 'average' claim size two to three points per year. However, as you will see shortly, it appears that beginning in about 2003 the more rapid drop in the frequency of small claims in relation to other claims ceased. This may explain some of the moderation in the rate of change in the growth of indemnity claims in recent years. Recent experience is showing that indemnity claim cost changes are much more in line with average wage changes. Given that benefits are a function of wages, we would expect this pattern in workers' compensation systems that are stable.³¹

Further, "based on a preliminary analysis of data in NCCI states, the frequency of lost-time claims declined another 4.5% in 2005. This continues the patter that has persisted

³⁰ Id.

³¹ Id.

since the early 1990s. The cumulative decline in frequency is in excess of 45% over that time period.”³²

As a result of these trends, “the workers compensation insurance industry had another excellent year on an accident year basis. NCCI estimates the combined ratios for both 2004 and 2005 accident years to be about 90%, the best results in recent memory. This is a 50-point improvement since the 140% peak in 1999. It is the third consecutive year of accident year underwriting profits for the line.”³³

Many of the statements in the NCCI report are consistent with information available from other sources. Most significantly, there is substantial corroboration of the NCCI report of a 45% decline in claims over the past decade, a decline in the number of claims involving lost time from work, a greater decline in the frequency of small claims than large claims, and a decrease in overall payment of indemnity. As admitted by NCCI, all of these factors have substantially improved the financial position of insurers to the point that many have an underwriting profit (more premium collected than claims paid out) in addition to an investment profit.

More specifically, the NCCI statement that “claim frequency continued its decade-long decline” exactly matches the Workers’ Compensation Board’s data (discussed in Section IV) showing a fifteen-year decline in claims indexed. The statement that the frequency of small claims is declining at a greater rate than large claims may also be read as being consistent with the administrative barriers to claim filing, claim prosecution, and claim resolution discussed in Section II. C. and in greater detail in Section IV below.

³² Id.

³³ Id.

The NCCI report regarding the reduction in lost time claims and indemnity payments is also consistent with the research of other sources. At least one authority has estimated that indemnity claims resulting in cash benefits paid to workers declined by over 36% from 1988 through 1997³⁴ and another has estimated that from 1988 – 1997, indemnity claims made by workers declined by over 32%.³⁵

Some additional insight into insurer costs and profits was provided on July 17, 2006, when the New York State Insurance Department disapproved a filing by the Compensation Insurance Rating Board (“CIRB”) for a rate increase for private insurers.³⁶ The Insurance Department points out that the CIRB is licensed under Insurance Law Section 2313 and that all workers’ compensation insurers must report statistics to it. The CIRB then compiles and evaluates the data (from the insurers’ self-report) and proposes rate changes for approval by the Department of Insurance. If the rate increase sought exceeds 2%, a public hearing is required.³⁷

On this occasion, 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.³⁸ It also observed that according to the insurer’s own

³⁴ Burton, et. al., Workers’ Compensation Benefits Continue to Decline, 10 Workers’ Compensation Monitor, 1,7 (July/August 1997).

³⁵ Ballantyne, Workers’ Compensation Research Institute, Revisiting Workers’ Compensation in New York: Administrative Inventory, Jan. 2002, p. 127; table 5.8 at p. 84.

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.

³⁷ Id.

³⁸ 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]

submission, loss experience for 2004 decreased 4% and for 2005 it decreased an additional 2.3%.³⁹

The Insurance Department further commented that workers' compensation carriers are not intended to have "underwriting profit" in which premium collected exceeds claims paid. The target number in that regard is 0%, and insurers are expected to profit solely through "investment return." The Superintendent further states that "this target provision appears to have worked well in enabling insurers to earn a reasonable return on capital."⁴⁰ This may be compared to the NCCI data, which demonstrated that workers' compensation insurers generally are earning not only an underwriting profit of about 10% in 2004 and 2005 but also an investment profit in excess of 12%.

The Insurance Department's analyzed the profitability numbers of workers' compensation insurers (again, based on their self-report) over the ten years from 1994-2004, observing that "New York has been able to maintain a competitive and healthy market, with profitability in a reasonable range." Indeed, 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%.⁴¹

It will therefore be seen that there is a substantial discrepancy between the claims of private insurers regarding their claim costs and profit margins and the existing data (to the extent that it can be verified). However, it is difficult to arrive at a meaningful policy

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."

³⁹ Id.

⁴⁰ Id.

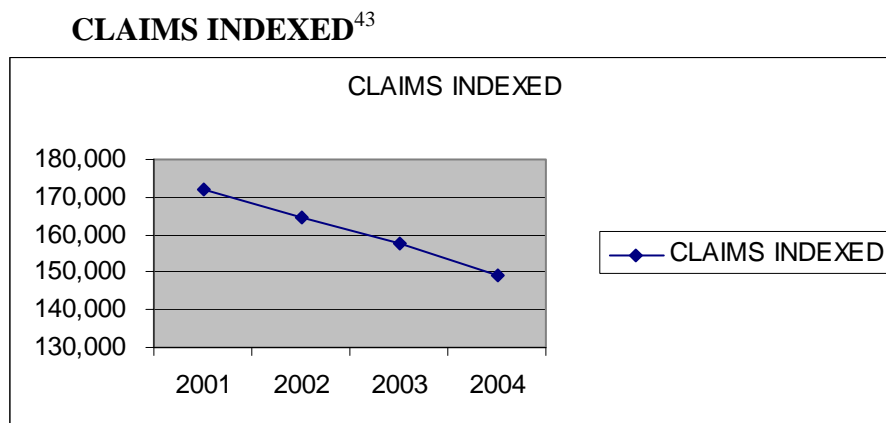
⁴¹ Id.

prescription in the absence of independently verifiable data regarding the financial condition of private insurers. The most that can be said at this juncture is that it appears that the private workers' compensation insurance market is both healthy and profitable, and that claims and claim costs have declined substantially over the past decade.

IV. THE WORKERS' COMPENSATION BOARD.

As discussed previously regarding access to benefits of injured workers, there have been numerous administrative changes made by the Workers' Compensation Board. These changes have had a significant impact on patterns in workers' compensation claims, which is perhaps not surprising given the Board's place as the exclusive adjudicatory agency for these claims. The Board's own statistics provide a clear picture of the situation.

As illustrated in the chart below, the number of claims indexed by the Board has declined each year, going from 172,098 in 2001 to 149,034 in 2004.⁴² This represents a decline in claims filed of 13.5%.



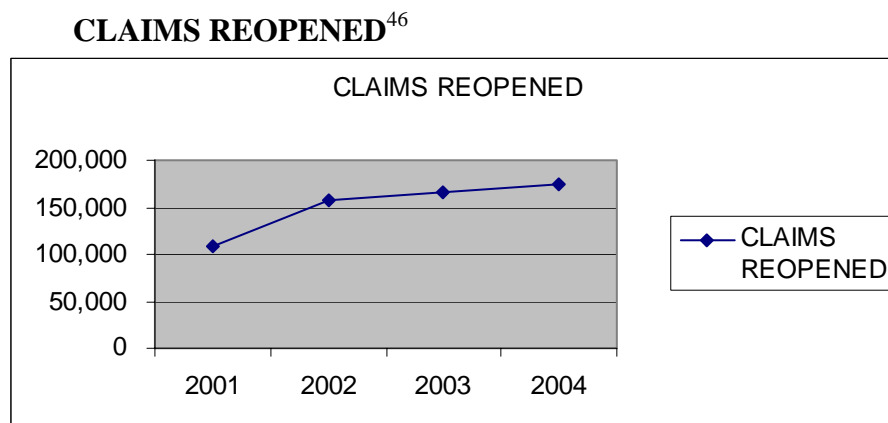
⁴² Summary Annual Reports of the Workers' Compensation Board, 2000 through 2004.

⁴³ Id.

As discussed above, the Workers' Compensation Board has administratively replaced true closures with the inaccurate terminology "no further action is contemplated by the Board at this time." Despite the fact that it uses cases marked "no further action" in its statistics for "resolved" cases, however, the Board acknowledges that "no further action" is not synonymous with "closed."

NFA, or "no further action," is often incorrectly associated with the words "case closed." NFA simply means that the Judge has resolved all presently ripe issues before him/her. The case will not be scheduled on the calendar for another hearing until other issues become ripe and the parties request further Board intervention.⁴⁴

A measure of the lack of "resolution" achieved through the "no further action" finding can be found in reviewing the Board's data on reopened cases. As shown in the charts below, the number of claims reopened increased from 108,510 in 2001 to 173,812 in 2004.⁴⁵ This is, of course, a trend exactly opposite to the number of claims indexed. It will also be noted that the Board reopened more cases in 2004 than it indexed in any of the previous four years, and for the past three years it has reopened more claims than it has indexed.

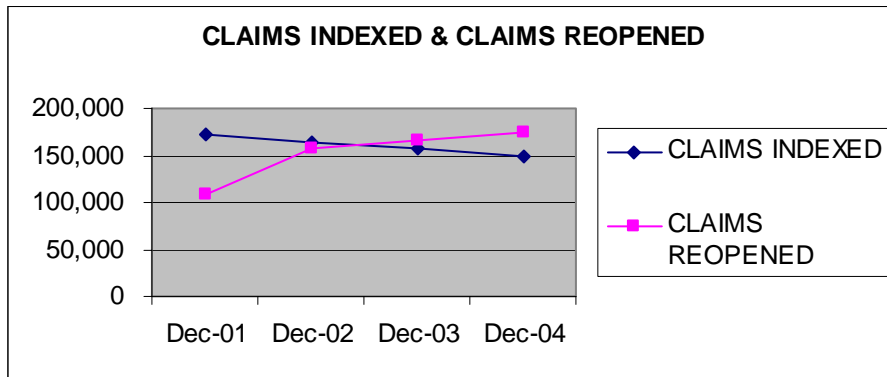


⁴⁴ New York State Workers' Compensation Board Annual Report, 2001, page 11.

⁴⁵ Summary Annual Reports of the Workers' Compensation Board, 2000 through 2004.

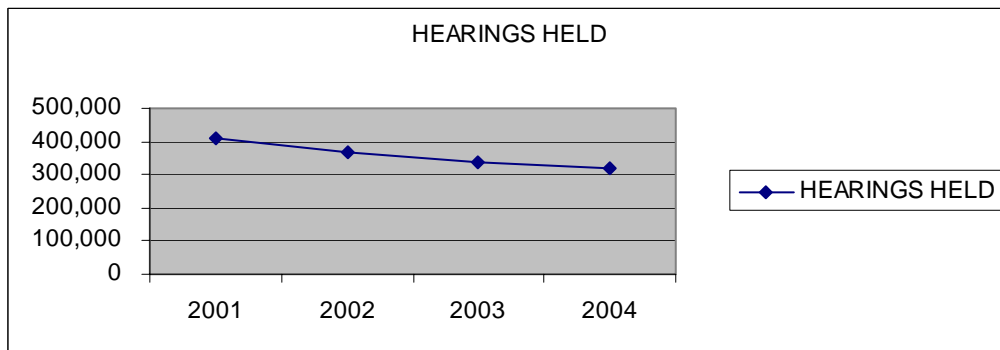
⁴⁶ Id.

CLAIMS INDEXED VS. CLAIMS REOPENED⁴⁷



The Board claims that hearings will be scheduled when issues are “ripe.” It would appear, however, that fewer issues are “ripe” for hearings each year, as the number of hearings held by the Board has declined from 407,983 in 2001 to 319,751 in 2004.⁴⁸

HEARINGS HELD⁴⁹



There appear to be two primary reasons behind the significant decline in the number of hearings held by the Board. The first and most obvious is the decline in claims being filed. This may be attributed in part to increasing frustration by injured workers with the benefits afforded by workers’ compensation and the speed (or lack thereof) with which those benefits are delivered. Another major factor is the procedure

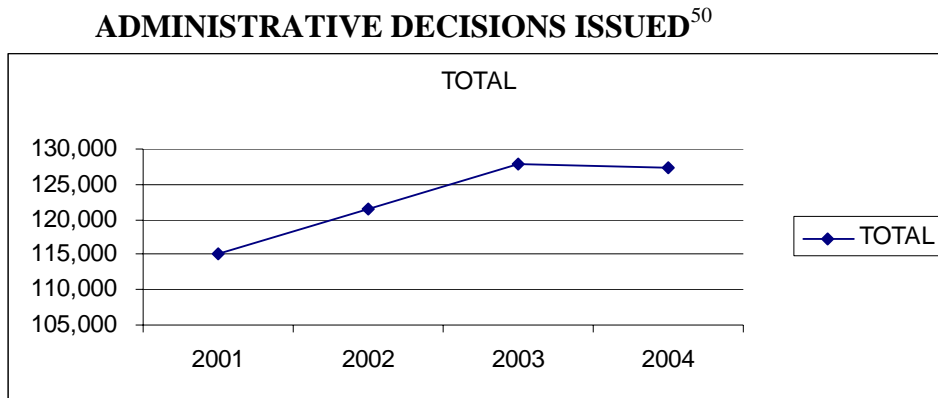
⁴⁷ Id.

⁴⁸ Id.

⁴⁹ Id.

utilized by the Board itself, particularly the use of “Administrative” and “Proposed” decisions.

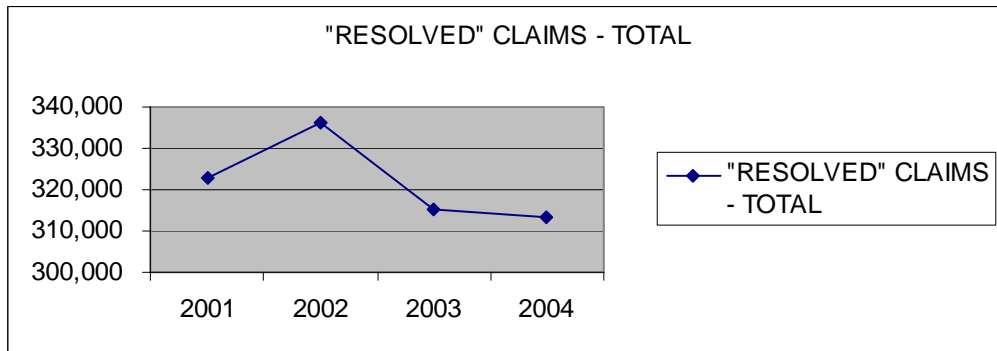
The chart below outlines the total number of Administrative Decisions issued by the Board from 2001 through 2004. The contrast between the sharp decline in the number of hearings shown in the chart above and the steady increase in the number of Administrative Decisions issued as shown in the chart below is apparent.



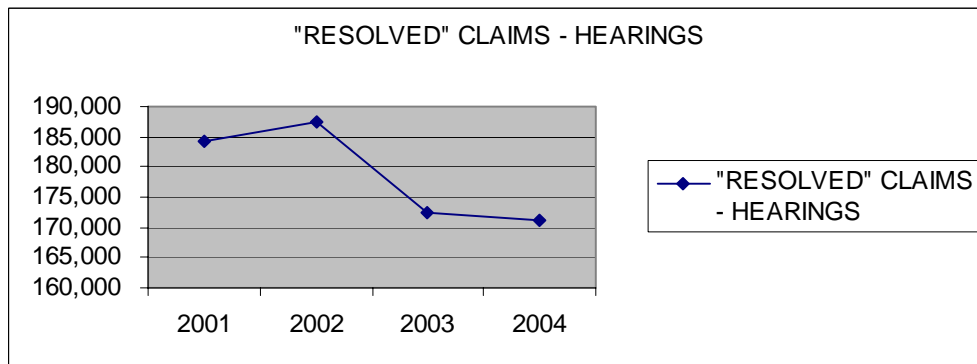
As seen above, the Board’s use of Administrative and Proposed Decisions has increased in rough proportion to the decrease in hearings, at which injured workers are often advised of their rights by WCL Judges. As seen in the charts below, the overall number of claims “resolved” by the Board decreased for three consecutive years. While the decrease in “resolution” through hearings has generally mirrored the decrease in overall “resolutions,” the number of claims “resolved” through Administrative Decisions actually increased in 2004, and the number of claims “resolved” through Proposed Decisions has changed only minimally over the past four years.

⁵⁰ Id.

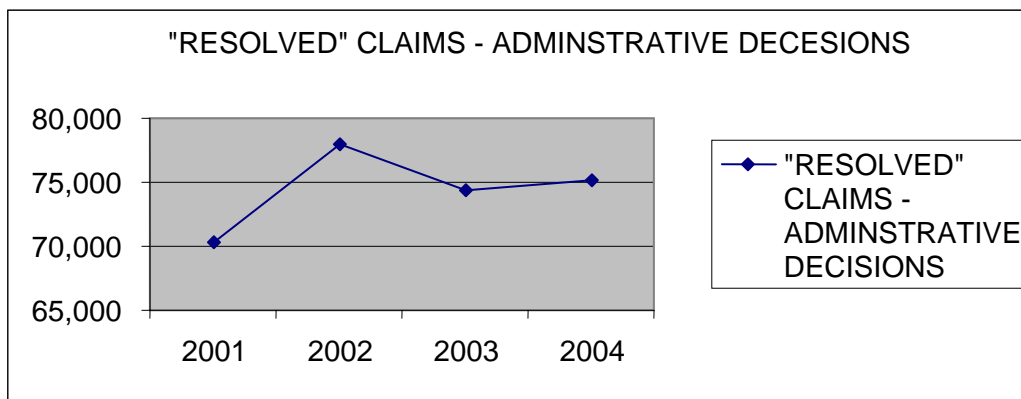
“RESOLVED” CLAIMS – TOTAL⁵¹



“RESOLVED” CLAIMS – HEARINGS⁵²



“RESOLVED” CLAIMS – ADMINISTRATIVE DECISIONS⁵³

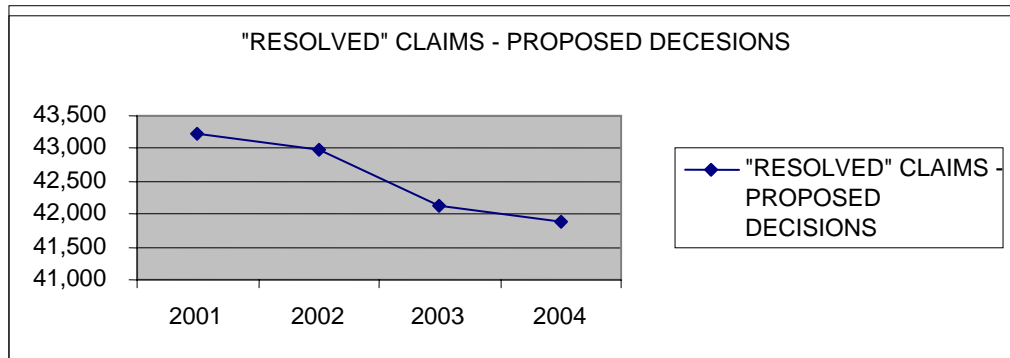


⁵¹ Id.

⁵² Id.

⁵³ Id.

“RESOLVED” CLAIMS – PROPOSED DECISIONS⁵⁴



In summary, the number of claims “resolved” at hearings declined from 57% of the total number of “resolutions” in 2001 to 55% in 2004, while the number of claims “resolved” through Administrative Decisions increased from 22% of the overall total in 2001 to 24% of the overall total in 2004. Claims resolved through Proposed Decision have consistently remained at 13% of the overall total, while settlements have accounted for only 3% and resolution at pre-hearing conferences of contested cases has held steady at 5%.

All of the trends identified for the years 2001 through 2004 continued at approximately the same rates of increase and decline in 2005.⁵⁵

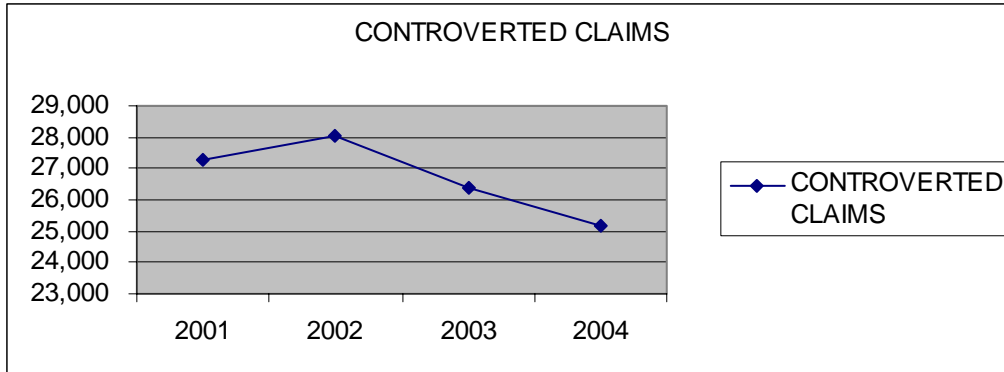
As observed earlier in this paper, New York’s workers’ compensation system is largely adversarial, with a high percentage of claims contested by insurers. Unfortunately, it would appear that the law in its present form, at least as interpreted by the Board, provides extremely limited disincentives for insurers to contest claims. While the controversy rate does not tell the entire story (many issues arise and are litigated even in “uncontroverted” claims), it is instructive.

⁵⁴ Id.

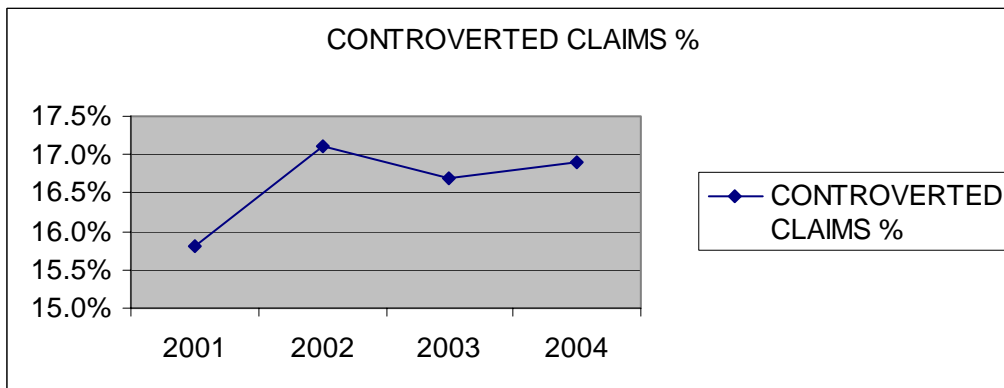
⁵⁵ Summary Annual Report of the New York State Workers’ Compensation Board, 2005.

As seen in the charts below, roughly 17% of claims are contested on “basic issues” each year.

NUMBER OF CONTESTED CLAIMS⁵⁶



CONTESTED CLAIMS AS A PERCENTAGE OF INDEXED CLAIMS⁵⁷

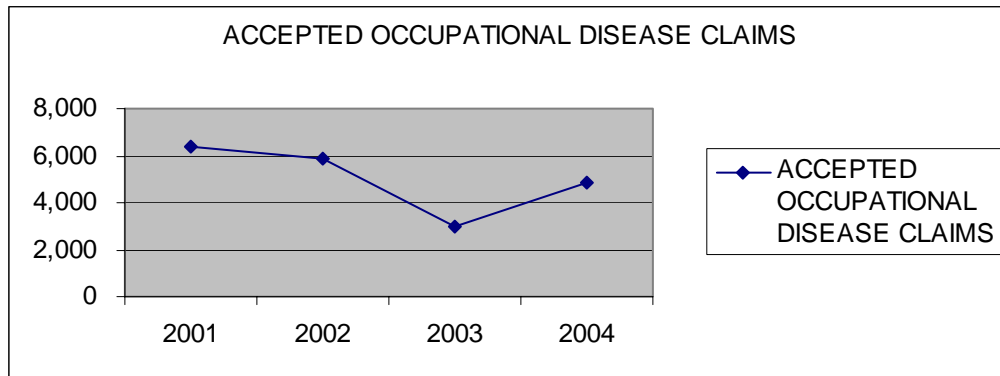


Although the overall number of controverted cases has been fairly consistent as a percentage of total claims filed, the chart below shows that the number of uncontested occupational disease claims fell sharply from 2001 through 2003 before rebounding slightly in 2004. Since there is no evidence that significantly fewer occupational disease claims are being filed (and anecdotal evidence regarding repetitive stress injuries would suggest the contrary), it would appear that occupational disease claims are being increasingly contested by employers and insurance carriers.

⁵⁶ Summary Annual Reports of the Workers’ Compensation Board, 2000 through 2004.

⁵⁷ Id.

ACCEPTED OCCUPATIONAL DISEASE CLAIMS⁵⁸



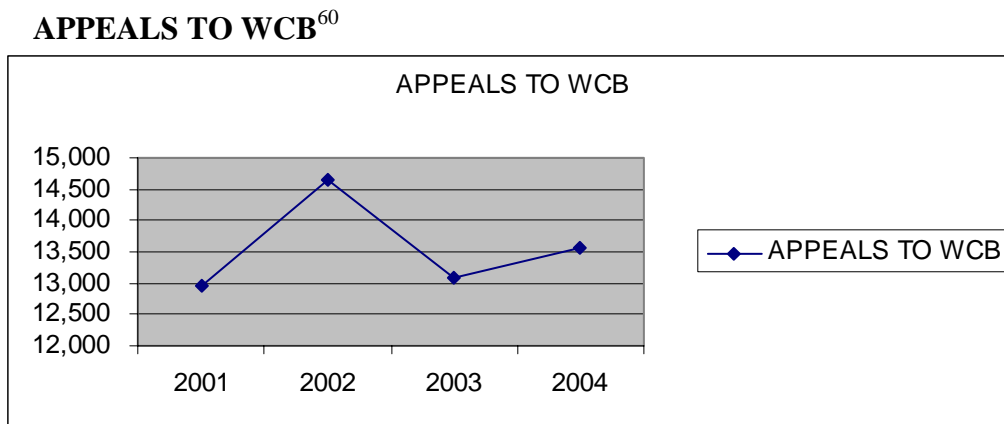
PIANY has questioned whether the Workers' Compensation Board does enough to discourage controversies. "Workers' compensation is designed as a 'no-fault' system. But, compared to (for example) New York's no-fault insurance benefits for auto accident victims, workers' compensation benefits must be wrested from the system rather than being made readily available under the presumption of eligibility that a no-fault system should embody. ... Some estimate that over half of workers' compensation claims in New York are challenged, even though only about 5 percent of these challenges ultimately are upheld by the Workers' Compensation Board. The question is, why are so many claims controverted, when the insurer ultimately will end up paying?"⁵⁹

In the workers' compensation system, the natural consequence of a controversy is an appeal. Just as current administrative procedures do little to discourage insurers from controverting claims, they do little to discourage appeals when (as often occurs) the claim is established or a finding is made in favor of the injured worker. In understanding this data, it must be pointed out that while a case is on appeal, the insurer is free to make payment (or more often, refuse to make any payment) as it sees fit.

⁵⁸ Id.

⁵⁹ Legislative Position; Professional Insurance Agents of New York State Inc. available at www.piaonline.org/GIA/NY/position_workerscomp.pdf

The chart below shows the number of appeals filed in the years 2001 through 2004. It is to be noted that although the number of hearings has decreased by about 25%, the number of appeal has generally increased, meaning that a greater percentage of WCL Judge decisions are being appealed.



The increasing number of appeals to the Board from WCL Judge decisions appears to have translated into an increasing number of appeals from the Board's decisions to the Appellate Division of the Supreme Court. Although the Board has not provided any data regarding Notices of Appeal filed in 2001, and has provided only partial data for 2004, 821 Notices of Appeal from the Board's decisions were filed to the Appellate Division in 2002 and that figure increased by over 20% to 1,030 in 2003.⁶¹

The Workers' Compensation Board data outlined above makes it clear that the Board's current administrative procedures are inadequate to ensure the sort of speedy claim resolution that was the original intent behind the Workers' Compensation Law. In many ways, the Board's ability to achieve the objectives of the law is limited by the lack of statutory authority. As discussed in Section V below, both statutory and regulatory

⁶⁰ Summary Annual Reports of the Workers' Compensation Board, 2000 through 2004.

⁶¹ Id.

changes are needed to provide the Board with the tools it needs to discourage frivolous controversies and to expedite the resolution of claims.

V. LEGISLATIVE PROPOSAL.

A. Wage Replacement Benefits.

The situation involving the weekly wage replacement benefit is nothing short of a crisis. In keeping with the historic compromise of workers' compensation law, the maximum weekly wage benefit should be two-thirds of the state average weekly wage. Currently, this would require an increase in the maximum weekly benefit to \$640.

In order to prevent the unnecessary repetition of a backsliding and inadequate weekly wage replacement benefit, the maximum benefit rate must be indexed and should automatically increase based on increases in the state's average weekly wage as determined by the Labor Department.

Because workers' compensation benefit rates are tied to accident dates, many workers with long term disabilities still receive benefits today based on maximum rates well below the poverty line. These workers should be provided cost of living adjustments so that they do not become dependent on charity or public assistance. This principle should also be applied going forward to new claims.

In addition, the minimum rate should be raised to no less than one-quarter of the statutory maximum rate. Under current law, that would raise the minimum rate from \$40 per week to \$100 per week; with a raise in the maximum rate from \$400 to \$640 the minimum rate would rise to \$160 per week.

As discussed in Section II, however, the payment of workers' compensation benefits for permanent disability should not be subjected to time limitation or "cap." There is no reason why a worker who is permanently disabled from an on-the-job injury should not be paid for as long as the disability lasts. The cost of supporting a worker who is injured on the job should not be transferred from the employer or the employer's workers' compensation insurance company onto the worker, the worker's family, or the welfare system. In addition, capping or scheduling benefits based on "degree of disability" or medical impairment would result in unfair and disparate treatment of workers without regard to their age, education, vocational background, language skills, and other factors that are relevant to their ability to be gainfully employed.

B. Medical Care and Treatment.

Because of the current adversarial nature of the workers' compensation system and the inefficient procedures used by the Board in this area, diagnostic testing and surgical treatment are often delayed for months, prolonging the period of disability and increasing the level of permanency for injured workers. The paradoxical end result is that as insurers exert more control over medical treatment, their administrative and indemnity costs rise. The solution is to afford injured workers more control over their medical treatment, while providing certain safeguards for insurers.

The dollar limit for pre-authorization for diagnostic testing and surgical treatment should be substantially raised from \$500 to \$2,500. This would exclude courses of physical therapy and chiropractic treatment, which are discussed below.

Limitations should be imposed on chiropractic and physical therapy. There should be standardization in the amount of such treatment that may be approved based on diagnosis, diagnostic test results, and surgery. By way of example, a diagnosis of lumbar derangement or lumbar sprain/strain would call for a maximum of 36 such treatments. A subsequent finding of a herniated or bulging disc would permit an additional course of therapy. Authorization for a surgical procedure would include additional authorization for pre- and post-surgical therapy. The Board would retain discretion to authorize additional physical therapy or chiropractic treatment in any given case upon a showing of medical necessity. However, standardization should reduce overall insurer costs for medical care, as will other changes outlined below.

Private health insurance carriers should be obligated to pay for medical care that is being contested by a workers' compensation insurer or in a controverted case. Existing procedures for reimbursement of such health insurers should be streamlined.

Many injured workers are currently unable to secure legal representation in cases involving medical treatment disputes due to the inability of workers' compensation attorneys to be paid in such cases. The Board should be authorized to award legal fees in such cases payable by the insurance carrier or self-insured employer. In addition to enabling injured workers to obtain representation and thus medical care, it may also result in a reduction in controversy in such cases.

Fee schedules must be established for prescription medications and durable medical goods. Insurers should be permitted to make direct payment for such goods and medications in order to take advantage of their bulk negotiating and purchasing power

and reduce costs. Provision must also be made for speedy reimbursement to the injured worker in the event that the insurer fails or refuses to make such payment directly.

C. Definitional Changes and Rehabilitation.

The central premise of wage replacement is that an injured worker has lost earning capacity, the ability to earn money from work, due to injury. Despite the existing statutory reference to earning capacity, for many years the Workers' Compensation Board has set benefit levels based on "disability," which is a purely medical concept with limited connection to a worker's ability to earn a living. The Board's concept of "total disability" requires an inability to earn any income at any occupation, even on a part-time basis. As a practical matter, it is illogical and unreasonable to require a worker who is temporarily disabled from his job, yet who retains the physical capacity to do other work, to retrain himself for other work or to leave his or her employment of many years to seek a temporary job. Many employers prohibit workers from doing so without forfeiting their existing employment. Under the existing system, however, workers are obligated to do exactly that or, more likely, face a sharp reduction in weekly benefits. The solution to this unjust situation is to tie benefit rates for temporary disability more closely to a worker's earning capacity in his or her field of employment.

Where a worker is temporarily disabled, he should be entitled to receive his maximum benefit rate as long as he is unable to perform all of the usual and customary duties of his employment or any light or modified duty assignment reasonably offered by the employer based on restrictions given by the worker's physician.

The existing two-year guideline for assessment of permanent (non-schedule) disability should be abandoned, and should be replaced with a standard tied to the achievement of maximum medical improvement. Arrival at a point of maximum medical improvement should not, however, cut off a worker's entitlement to palliative medical care.

Upon determination of maximum medical improvement, if the worker is unable to return to his or her former employment, he or she should be required to participate in vocational assessment and retraining programs provided by the Board. The evaluation of the Board's rehabilitation or vocational unit should be admissible, but not solely determinative, of the worker's residual earning capacity in cases of permanent disability.

D. Administrative Reform.

There are a number of fundamental flaws in the existing administration of the workers' compensation system. First, enforcement of existing statutory and regulatory provisions intended to reduce controversy, limit issues, and streamline the claim process is, at best, sporadic. Second, the existing statutory and regulatory provisions are inadequate to discourage the wholesale controversion and delay of claims, and in fact tend to reward such behavior. And third, in many instances the existing statutory and regulatory provisions are actually counter-productive and increase insurer costs. Whether regulatory reform does or does not occur, statutory change is required to limit the Board's discretion in these matters.

The Workers' Compensation Law includes many penalty provisions. There are penalties for failing to make voluntary payment of compensation in uncontroverted

claims, for failing to make timely payment of awards, for failing to be prepared for a hearing, for filing a frivolous appeal, and so on. Unfortunately, many of these penalties are of such small amounts (often \$100 and at most \$300) that they provide little incentive for insurers to conform their behavior to the statute, they are viewed as no more than annoyances by many WCL Judges, and attorneys for injured workers are compelled to advise their clients that requesting such penalties may cause the worker more resistance to the claim in the future than the penalty would be worth. Many insurers, and one large self-insured employer in particular, habitually disregard the statutory requirements, apparently having calculated that the savings from such disregard far outweigh the costs of the existing penalties, even if they were actually imposed, which seldom occurs. A substantial increase in the amounts of all existing penalties (a portion of which could be made payable to the Board, thereby defraying assessments to some extent) would be invaluable in discouraging such frivolous conduct. A specific area in which additional penalties would be warranted would be the area of controverted cases. Permitting the Board to award legal fees payable by the carrier in such cases would likely reduce frivolous controversies. Another area in which unwarranted delay could be avoided would be to define penalties and “medical and transportation” reimbursement as payments of compensation, thus making them subject to the statutory time frames for payment and making non-payment or late payment subject to penalties. This would avoid the long delays workers often suffer while waiting to have out-of-pocket expenses reimbursed, an area presently subject to no time limits or penalties.

In addition to calculating that penalties are an inadequate deterrent, many insurers and self-insured employers profit from the delays associated with the Board’s failure to

process claims in speedy fashion. These delays are due partly to the Board's inefficiency in processing claims and partly to inadequacies in the statute. Many, if not all of the time provisions in the Workers' Compensation Law were established with the concept of allowing time for mail. In the present day, given the Board's extensive use of electronic communication, these time limits are unnecessary and outdated. The time limitations within which employers and carriers must respond to Board notices and furnish documents can and should be dramatically reduced. Insurers are well aware that if a claim is denied or payments are reduced that it may take an injured worker two months or more to obtain a hearing date from the Board, and that by requesting adjournments or raising issues at the hearing payment of full benefits may be delayed for many more months. The Board must be obligated to schedule hearings within a reasonable time frame (possibly 30 days) after the request of a party together with documentation supporting that request. Conduct at the hearing is discussed below.

Insurers are well aware that they need not be prepared for the first hearing on any given issue. Despite the fact that the Board often issues notices of reopening and notices of hearing advising the insurer of the issue to be considered, it is routine for the Board to grant adjournments "to investigate" or "to obtain a consultant's report" despite the fact that a prudent and reasonable insurer could easily have done so prior to the hearing. These routine adjournments (often for 60 or 90 days, after which the worker must request a hearing and wait another 60 or 90 days) result in months of unnecessary delays. One cause of these delays is the Board's position (with some support from the Appellate Division) that the statute affords an insurer an unfettered right to cross-examine a treating physician on his or her report, even in the absence of evidence to the contrary and despite

the statutory presumption in favor of the physician's report. In order to rectify this situation, the Board must be prohibited from granting an adjournment to an insurer unless the insurer can establish that it did not or should not have had knowledge of the issue at least 30 days before the hearing. The duration of any adjournments granted due to an insurer's lack of pre-hearing notice should be accordingly limited. For issues of which the carrier had notice more than 30 days before the hearing, the insurer should be required to either produce contrary evidence at the hearing in support of a request for cross-examination or submit an offer of proof at least seven days before the hearing as to why cross-examination is warranted.

The party that is unsuccessful at a hearing has recourse to the Board's appeal procedures. Although the Board has made substantial progress in reducing the time it takes in deciding appeals, many cases on appeal still await a decision six months or more after the date of the WCL Judge decision. More must be done to limit the number of appeals taken and the time it takes to process them. One area that might be addressed is to render WCL Judge determinations of tentative or temporary rates non-appealable. In many instances, WCL Judges are confronted with a conflict in medical opinion, and set an appropriate rate as a "tentative" rate pending litigation. There is little or no incentive for insurers not to appeal these determinations, as the insurer is permitted to pay at the lower rate for months pending the appeal and the litigation. Rendering these decisions non-appealable would reduce the workload of the Board's Office of Appeals and the speedier processing of claims would alleviate any possible prejudice to the insurer.

A corollary to the Board's difficulty in deciding appeals in a timely fashion is the inability of some WCL Judges to issue reserved decisions in a reasonable time. Such

decisions should be required to be filed within 60 days of the date on which decision is reserved (either at a hearing or upon submission of papers by the parties).

The Workers' Compensation Board presently construes the statute as requiring an injured worker to produce medical proof of disability every 45 days in order to certify continuing entitlement to wage replacement benefits. This rule compels injured workers to see doctors or chiropractors for appointments that are not medically necessary, generating needless medical bills that are paid by insurers. The "45-day rule" is also problematic for many physicians, who prefer to see patients at intervals of medical necessity instead of legal necessity. Therefore, the "45-day rule" should be replaced with a requirement that the treating physician must provide a prognosis of disability, and that the disability is presumed to continue (in the absence of contrary evidence) during the period of that prognosis, with the prognosis to be updated or revised at each medical appointment. Such a rule would end medically unnecessary office visits, reducing costs for insurers while restoring rationality to courses of medical treatment.

E. Insurers and Self-Insurance.

Much has been made of the role of claimant fraud in the workers' compensation system. In New York, evidence continues to accumulate that the true scope of claimant fraud is a microscopic fraction of insurer propaganda on the subject. According to the Center for Justice and Democracy, in

the early 1990s, insurance companies mounted an organized campaign to shift the financial burden of workers' compensation claims back to the injured worker. They did this by trumpeting up distorted rhetoric around the idea of "fraudulent" workers' compensation claims, greatly exaggerating the extent of the problem in order to

have such assumptions become part of the public consciousness.

For example, according to a Los Angeles Times article, “[a]t the height of anti-fraud fever in California, then-Gov. Pete Wilson ... asserted without proof that 30% of all claims were fraudulent. At the same time, California’s Department of Insurance estimated that worker fraud only accounted for about three-tenths of one percent of claims. Most studies have shown that only about 1 percent of claims are fraudulent.”⁶²

The same difference between insurance propaganda and reality exists in New York. Most practitioners estimate that claimant fraud exists in less than one percent of workers’ compensation claims, even as insurer and employer groups claim much higher figures. In 1996, however, the Legislature amended the Workers’ Compensation Law to include tougher anti-fraud provisions and to require insurers to create special anti-fraud units known as Special Investigation Units (SIUs).⁶³

Ten years after the creation of these SIUs and after new emphasis was placed on bringing fraud prosecutions against injured workers, however, the State Insurance Department found little evidence of claimant fraud, observing that the total savings to all insurers combined was less than \$2 million annually from 1997 through 2003 and that one typical insurer had 320 fraud referrals out of 31,000 claims processed covering 40,000 policies written – about one-tenth of one percent.

Meanwhile, the New York State Attorney General was pursuing prosecutions against insurers and insurance agencies related to bid-rigging (thus artificially raising prices for employers) and defrauding state workers’ compensation funds of billions of dollars. On February 9, 2006, the office of the Attorney General announced that

⁶² Workers’ Compensation: A Cautionary Tale, Center for Justice & Democracy 2006.

⁶³ WCL Section 114.

insurance company American International Group (AIG) had agreed to pay \$1.6 billion to settle charges related to fraud, bid-rigging, and improper accounting. \$344 million of that sum was earmarked for “states harmed by AIG's practices between 1986 and 1995 involving workers' compensation funds.”⁶⁴ On March 27, 2006 it announced that insurance company Zurich Financial Services had agreed to pay \$153 million to settle charges related to bid-rigging.⁶⁵ The Zurich settlement brought the sums recovered by the attorney general from insurance carriers and their executives to \$2.6 billion.

Lost in the overheated discussion of claimant fraud is the issue of potential vast and widespread premium fraud by insurers. There is presently no reliable information available as to the amount of premium collected and benefits paid by workers' compensation insurers. As discussed earlier, insurers are required to self-report their data to the Compensation Insurance Rating Board (CIRB), which is itself controlled by the insurers. The CIRB is then the entity that submits rate requests to the State Insurance Department, which must evaluate those requests without independent confirmation or verification of the data submitted. The insurers have reported profits in the area of 9% per year in the past decade, although many observers have concluded that the actual figure is considerably higher. Meanwhile, the insurers contend that New York is a prohibitively expensive state in which to do business, even as the competition for business among these insurers has substantially reduced the market share of the State Insurance Fund.

In fairness to employers, an independent audit of the New York workers' compensation market is needed. If it is concluded that the insurers have been

⁶⁴ Press Release, Office of the Attorney General, 2/9/06.

⁶⁵ Press Release, Office of the Attorney General, 3/27/06.

systematically overcharging employers or that the insurers are incapable of writing premiums that are competitive with the State Insurance Fund, consideration should be given to prohibiting private workers' compensation insurance in the state and the creation of a monolithic State Insurance Fund, as exists in a number of other states.

If private insurance is permitted to continue to exist, then rigorous annual auditing and reporting must be required so that accurate information can be obtained as to the income and expense of insurers to be used in the rate-setting process. In addition, such insurers should be authorized to sell supplemental workers' compensation insurance benefits so that high wage earners may purchase additional coverage.

Additional scrutiny must also be given to self-insurers, including municipalities. Practitioners in the field and injured workers report that many self-insured employers are more antagonistic to claims and claimants than insurers, yet there has been no report of any State action against any self-insured employer. The Board must be directed to collect and maintain data on the claims behavior of self-insurers, and authorization must be provided for the revocation of the self-insurance license of any self-insurer (including municipalities) coupled with a requirement that such self-insurer obtain coverage with the State Insurance Fund.

Employers must also be evaluated to ensure that all payroll that might be subject to a claim for workers' compensation benefits is reported and made subject to premium. The ability of some employers to avoid premium charges by reducing payroll visibility or misclassifying employees results in the unfair shifting of the burden to other employers and raises costs for all employers. Either private insurers must be required to conduct payroll and premium audits or another entity must be empowered to do so.

F. Safety.

Existing programs regarding safety awareness, safety incentives, and premium reduction through participation in such programs should be substantially expanded. These programs benefit all parties in the workers' compensation system, yet are insufficiently emphasized and inadequate incentives are provided for their use. A combination of premium discounts, tax incentives, and other measures should be employed to encourage employers to emphasize workplace safety, thus reducing the rate of injury and illness and associated workers' compensation claim costs.

G. World Trade Center Claims.

While the Workers' Compensation Law was recently amended to provide some coverage for World Trade Center claims, that coverage is limited. At present, only "rescue, recovery and clean-up" workers are covered, and then only those who comply with an onerous "registration" requirement. Thousands of office workers in lower Manhattan who had little alternative but to return to the area after 9/11 in order to earn a living are not covered by the law.

It is suggested that the registration period should be extended or (preferably) eliminated. It serves primarily as a trap for the unwary, and secondarily to intimidate workers (primarily immigrant groups) through the "sworn statement" requirement and notice to the employer.

Another issue exists regarding primarily immigrant clean-up workers in lower Manhattan who are unable to identify their employer. Many such workers are able to identify their work locations. The general liability insurer of the owner of the building

identified by the worker liable for payment of compensation. Because the building owner should be able to identify the employer, the insurer should be permitted to identify the employer and seek reimbursement in a manner consistent with existing WCL Section 25(1)(f).

The fact that Article 8-A permits the filing of workers' compensation claims does not guarantee the success of such claims. Given the accumulating medical data, including the report of the World Trade Center Medical Monitoring Program and the City of New York Department of Health Guidelines identifying certain medical conditions known to be associated with World Trade Center exposure, it seems reasonable to afford workers afflicted with such medical problems the benefit of some limited presumptions consistent with the existing presumptions in public employee pension laws.

VI. CONCLUSION.

We hope that this White Paper has provided a useful outline of the present state of the New York workers' compensation system and the means by which it may be improved.

Dated: New York, New York
December 1, 2006

Robert E. Grey

Grey & Grey, LLP
360 Main Street
Farmingdale, New York 11735
(516) 249-1342

277 Broadway – Suite 400
New York, New York 10007
(212) 964-1342

118-21 Queens Boulevard – Suite 618
Forest Hills, New York 11375
(718) 268-5300

RGrey@GreyAndGrey.com