TESTIMONY OF THE NEW YORK WORKERS' COMPENSATION ALLIANCE AND THE NEW YORK COMMITTEE FOR OCCUPATIONAL SAFETY AND HEALTH TO THE NEW YORK DEPARTMENT OF FINANCIAL SERVICES REGARDING THE 2016 WORKERS' COMPENSATION RATE FILING REQUEST OF THE COMPENSATION INSURANCE RATING BOARD

By: Robert E. Grey
Chair, Workers' Compensation Alliance
Treasurer, New York Committee for
Occupational Safety and Health

I. NYCOSH AND THE WCA.

The Workers' Compensation Alliance ("WCA") is a political action committee that advocates for the interests of injured workers in New York's workers' compensation system.[1] The New York Committee for Occupational Safety and Health (NYCOSH) is a non-profit coalition of labor unions and individuals dedicated to ensuring that every worker has a safe and healthful job.[2] Its membership includes more than 175 local unions and over 300 individual workers, physicians, lawyers and other health and safety activists. The WCA and NYCOSH submit this testimony in opposition to the rate filing request of the Compensation Insurance Rating Board ("CIRB").

II. SUMMARY OF THE NYCIRB LOSS COST FILING.

The New York Compensation Insurance Rating Board (NYCIRB) has submitted a Loss Cost Filing for October 1, 2016 seeking an increase of 9.3%.[3] NYCIRB asserts that

[1] http://www..nyworkerscompensationalliance.org
[2] http://www.nycosh.org
[3] NYCIRB R.C. 2412, 6/15/16; loss cost filing available at: http://www.nycirb.org/2007/depts/actuary/LC_Filing_10_1_16.pdf

based on a review of policy years 2013 and 2014, "permanent partial indemnity costs account for 86.56% of total indemnity costs," with two-thirds of those being non-schedule permanent partial disabilities [PPD] and the balance being schedule loss [SLU] cases.[4] NYCIRB thus concludes that PPDs account for 57.7% of all indemnity costs, while SLUs account for 28.8% of all indemnity costs.[5] Benefits for temporary disability would therefore be only 13.5% of all indemnity costs. NYCIRB also notes that while 60% of workers' compensation claims are for "medical only," those claims account for only 4% of the costs in the system.[6]

NYCIRB arrives at a loss adjustment factor for indemnity costs related to PPD and SLU claims of 0.93.[7] The overall loss adjustment factor for the filing is 1.093.[8] It therefore appears that NYCIRB claims that increases in permanent disability costs account for 85% of its rate filing (0.93/1.093 = .85).

We believe that NYCIRB's rate filing is based on inaccurate and incomplete information about claim trends in the workers' compensation system. NYCIRB's filing is based on the experience alleged for two policy years, 2013 and 2014. A more accurate and complete depiction of trends in the system through 2015 can be found in Workers' Compensation in New York State: State of the System, 2016, which is attached to this testimony as Exhibit A.

This testimony will highlight the areas in which NYCIRB's rate filing is internally inconsistent and contradicted by other available data; the current profitability

[4] NYCIRB 2016 Loss Cost Filing at p. 3.
[5] Id.
[6] Id. at p. 5.
[7] Id. at p. 4
[8] NYCIRB 2016 Loss Cost Filing, Exhibit A.

of insurers underwriting workers' compensation policies; the impact of third-party settlements; and NYCIRB's role in the process.

III. NYCIRB'S RATE FILING IS BASED ON INACCURATE INFORMATION ABOUT TRENDS IN THE WORKERS' COMPENSATION SYSTEM.

NYCIRB's assertions about the cost of PPD and SLU cases is not supported by the available data about these claims. Contrary to NYCIRB's projections, we believe that (1) the overall number of PPD classifications will decline in the next 12 – 24 months as the Board continues to resolve the remaining cases that were not classified between 2007 and 2012; (2) the time span from date of accident to date of classification will continue to decrease as the backlogged classifications are removed from the system; (3) an increasing percentage of PPD cases will be resolved by Section 32 settlements; and (4) cost increases due to SLU claims are small, incremental, and limited to cases that currently account for only 8% of indemnity costs.

A. Permanent Partial Disability Cases.

With regard to PPD claims, the table below was provided by the Workers' Compensation Board (the Board) in response to a FOIL request and shows the number of PPD classifications in each year from 2011 through 2015.

Number of Classifications of Permanency and Loss of Wage Earning Capacity with Accident Date on or After 3/13/07

		Duly Filed Year					
		2011	2012	2013	2014	2015	**Grand Total**
Classification	Duly Filed Month	Total Resolution Count	Total Resolution Count	Total Resolution Count	Total Resolution Count	Total Resolution Count	Total Resolution Count
NON SCHEDULE LOSS	JAN	103	124	219	469	376	**1,291**
	FEB	108	172	233	461	336	**1,310**
	MAR	132	167	262	483	398	**1,442**
	APR	128	140	253	403	397	**1,321**
	MAY	174	156	287	444	418	**1,479**
	JUN	144	165	292	421	347	**1,369**
	JUL	146	159	320	393	271	**1,289**
	AUG	128	193	364	373	223	**1,281**
	SEP	166	126	378	411	286	**1,367**
	OCT	151	181	503	403	305	**1,543**
	NOV	140	158	479	356	345	**1,478**
	DEC	193	216	465	378	320	**1,572**
Grand Total		**1,713**	**1,957**	**4,055**	**4,995**	**4,022**	**16,742**

There was a significant reduction in the number of PPD classification following the 2007 reforms. This was due to a number of factors, including insurer concern about the requirement of mandatory deposits into the Aggregate Trust Fund (ATF) and uncertainty among litigants about the impact of the renewed emphasis on loss of wage earning capacity. This is reflected in the data for 2011 and 2012, in which PPD classifications averaged 1,835 per year.

In 2012, however, the Board published guidelines for the determination of permanent disability and loss of wage earning capacity.[9] Thereafter, in 2013 the Board

[9] Guidelines for Determining Permanent Impairment and Loss of Wage Earning Capacity, 2012, available at http://www.wcb.ny.gov/content/main/hcpp/ImpairmentGuidelines/2012ImpairmentGuide.pdf

issued a directive intended to expedite permanency determinations to apply the caps to disabled workers.[10]

The impact of the issuance of the 2012 Guidelines and the Board's 2013 initiative appears in the number of classifications for 2013 and 2014, which increased 2.5 times to 4,525 per year. The figure then declined almost 20% between 2014 and 2015 from 4,995 to 4,022. This indicates that the Board's 2013 initiative has made significant progress in resolving the number of claims that were not classified between 2007 and 2013. The rate of classifications in 2015 likely reflects some portion of the previously delayed PPD cases, but the lower number indicates that the inventory of such cases has diminished.

This data therefore demonstrates that the number of classifications will continue to decrease in the next 12 to 24 months as the Board continues to eliminate any backlog of PPD cases. The time frame from date of injury to date of classification will be similarly reduced as the Board's classification efforts target progressively more recent claims. This is also demonstrated by the low indemnity cost NYCIRB reports for temporary disability benefits, which are only 13.5% of all costs and is reflective of the relatively short periods of temporary disability paid prior to PPD classification or SLU closure.

B. Settlements.

It is also important to note that a significant portion of PPD cases result in settlements, which occur at a savings to the insurer. The table below is based on data provided by the Board regarding settlements by private stock insurers.

[10] WCB Subject Number 046-548, available at http://www.wcb.ny.gov/content/main/SubjectNos/sn046_548.jsp

Number of Claims Involving Private Insurers with Section 32 Settlements

		Duly Filed Year					
		2011	2012	2013	2014	2015	**Grand Total**
Insurer - Carrier Type	Duly Filed Month	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count
PRIVATE	JAN	429	567	569	737	545	**2,847**
	FEB	377	532	488	574	491	**2,462**
	MAR	524	546	532	575	547	**2,724**
	APR	447	522	591	601	550	**2,711**
	MAY	411	685	671	542	414	**2,723**
	JUN	599	575	644	473	95	**2,386**
	JUL	431	641	660	577	218	**2,527**
	AUG	505	614	709	474	265	**2,567**
	SEP	564	532	638	544	378	**2,656**
	OCT	486	508	711	608	314	**2,627**
	NOV	599	532	690	734	447	**3,002**
	DEC	481	538	885	661	409	**2,974**
Grand Total		**5,853**	**6,792**	**7,788**	**7,100**	**4,673**	**32,206**

The State Insurance Fund settles claims at a much lower rate that the private insurance industry, and public self-insurers lag still further behind as shown the on the following two tables:

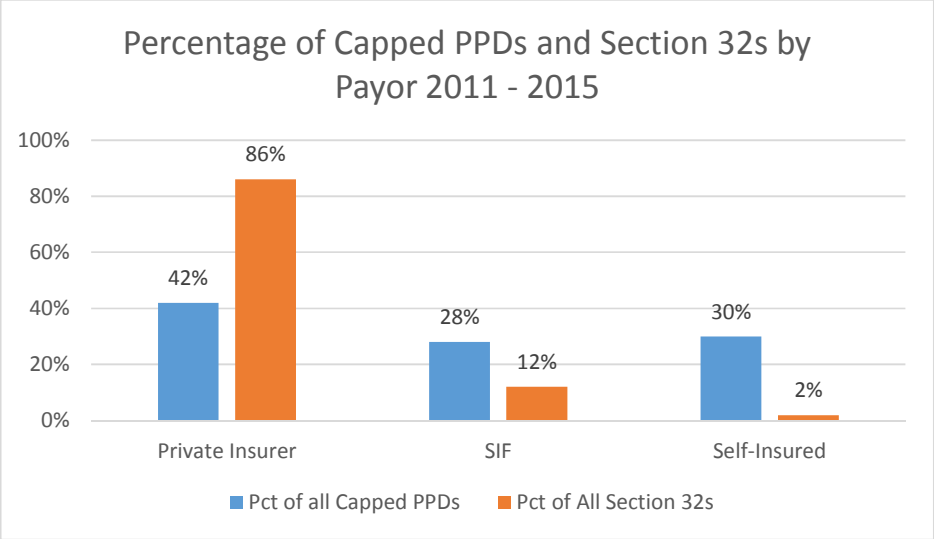
Number of Claims Involving the State Insurance Fund
Classified PPD Non Scheduled Loss with Section 32 Settlements

			Duly Filed Year					
			2011	2012	2013	2014	2015	**Grand Total**
Insurer – Name	Claim Injury Type	Duly Filed Month	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count
STATE INSURANCE FUND	PPD NSL	JAN	39	56	50	48	69	**262**
		FEB	30	53	44	46	49	**222**
		MAR	37	55	66	53	48	**259**
		APR	37	30	77	61	52	**257**
		MAY	45	76	78	58	52	**309**
		JUN	52	66	64	50	10	**242**
		JUL	54	64	66	72	31	**287**
		AUG	50	50	55	33	23	**211**
		SEP	51	39	52	51	44	**237**
		OCT	50	34	54	60	40	**238**
		NOV	37	48	65	65	41	**256**
		DEC	52	38	56	63	62	**271**
Grand Total			**534**	**609**	**727**	**660**	**521**	**3,051**

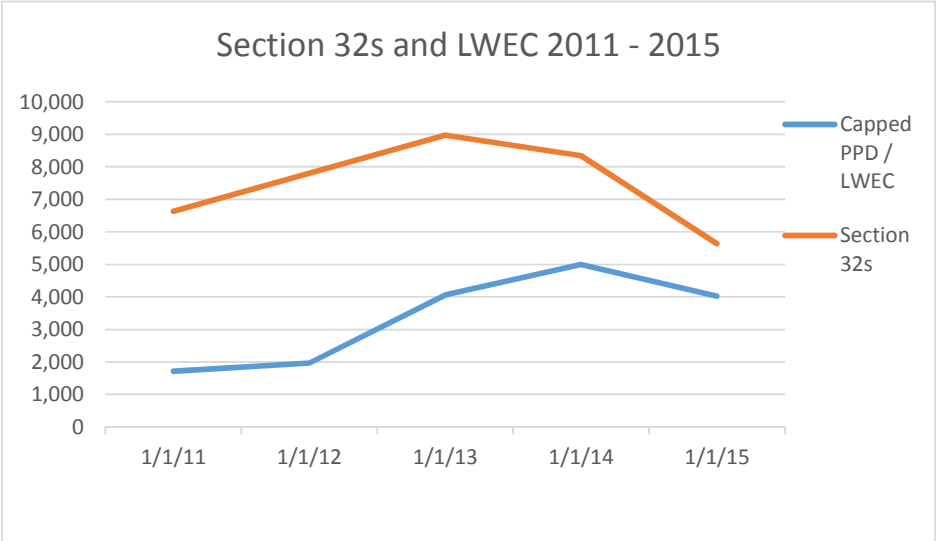
Number of Claims Involving Public Self Insurers
Classified PPD Non Scheduled Loss with Section 32 Settlements

			Duly Filed Year					
			2011	2012	2013	2014	2015	**Grand Total**
Insurer - Name	Case Type	Duly Filed Month	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count
SELF PUBLIC	PPD NSL	JAN	5	6	6	11	15	**43**
		FEB	12	8	10	7	11	**48**
		MAR	7	12	10	11	14	**54**
		APR	7	13	14	17	16	**67**
		MAY	5	4	7	13	8	**37**
		JUN	5	6	7	7	6	**31**
		JUL	8	9	3	17	4	**41**
		AUG	6	3	11	4	12	**36**
		SEP	8	11	7	11	9	**46**
		OCT	4	4	13	21	19	**61**
		NOV	9	6	8	11	8	**42**
		DEC	6	11	12	12	18	**59**
Grand Total			**82**	**93**	**108**	**142**	**140**	**565**

In total, private insurers account for 42% of permanent disability classifications, but 86% of all settlements. Claims involving the State Insurance Fund account for 28% of classifications, but 12% of all settlements, while claims involving private insurers account for 30% of all classifications but only 2% of all settlements. This is shown on the chart below.



It is also noteworthy that the rate of settlements follows an increasingly similar trend to the rate of PPD classifications, as shown on the chart below:



In summary, the data shows that (1) the overall number of PPD classifications will decline in the next 12 – 24 months as the Board continues to resolve the remaining cases that were not classified between 2007 and 2012; (2) the time span from date of accident to date of classification will continue to decrease as the backlogged classifications are removed from the system; and (3) an increasing percentage of PPD cases will be resolved by Section 32 settlements.

All of these factors can be expected to reduce claim costs associated with PPD cases in future years.

C. Schedule Loss of Use.

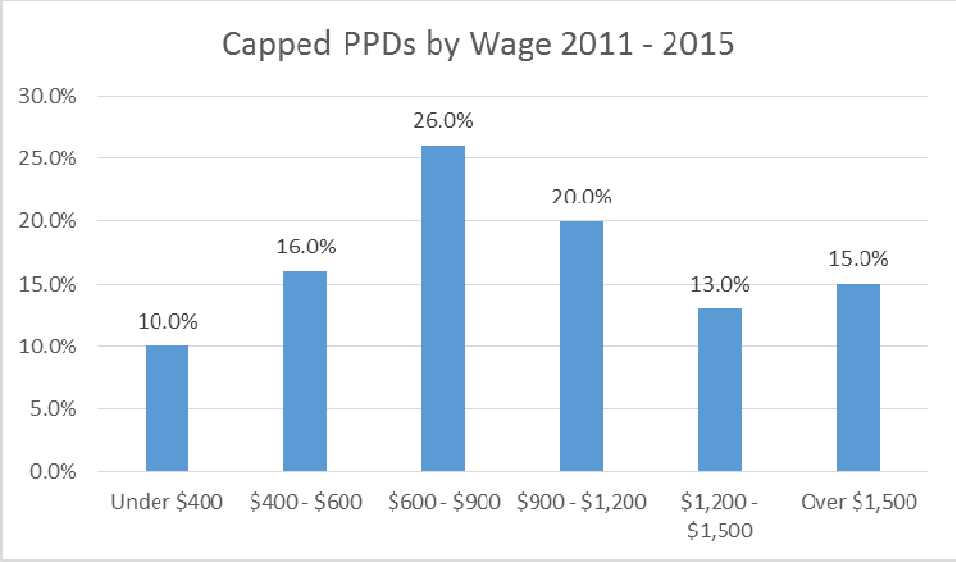
According to NYCIRB's submission, SLU cases only account for 28.8% of all indemnity costs. Moreover, there is no credible evidence that payments in these cases have increased except to the extent accounted for by increases in the maximum weekly benefit rate. In the past several years those increases have been incremental and have affected a diminishing percentage of workers.

The table below shows the wage distribution of injured workers in 2015 as reported by the Board. It is followed by a chart drawn from the same data.

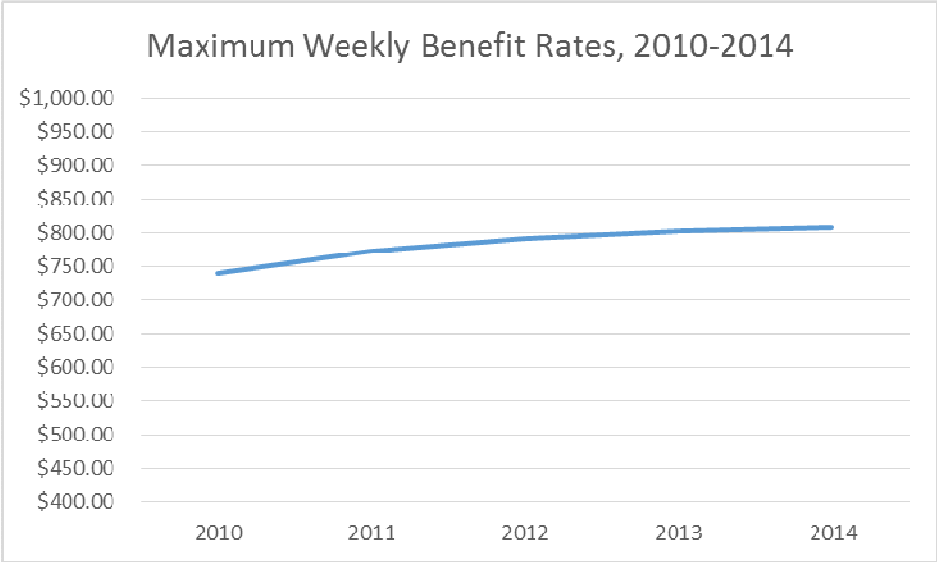
Number of Claims with Accident Date on or After 3/13/07 Classified PPD by Average Weekly Wage

	Claimant - Average Weekly Wage Group								
	$0 - $150	$150.01 - $400	$400.01 - $600	$600.01 - $900	$900.01 - $1200	$1200.01 - $1500	$1500.01 and up	U	**Grand Total**
PPD Class. Date (Year)	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count
2011	124	2,224	3,910	6,349	4,217	2,612	2,545	86	**22,067**
2012	120	2,557	4,096	6,634	4,880	3,241	3,277	49	**24,854**
2013	133	2,910	4,649	7,166	5,510	3,768	4,069	45	**28,250**
2014	119	3,001	4,724	7,329	5,874	3,915	4,765	34	**29,761**
2015	89	2,924	4,792	7,447	6,215	4,338	5,944	26	**31,775**
Grand Total	**585**	**13,616**	**22,171**	**34,925**	**26,696**	**17,874**	**20,600**	**240**	**136,707**

Claim count includes cases classified as PPD schedule loss of use and PPD non schedule



The amount of a schedule loss award depends on the rate of compensation, which in turn is based on the injured workers' wage. The graph below shows the changes in the maximum weekly benefit rate from 2010 through 2014. It is evident from this graph that there have been minimal and incremental changes in the maximum benefit rate over the past five years.



Because the value of schedule loss awards depends on the worker's average weekly wage, these awards have not increased for low wage workers since 1992. As shown above, 26% of injured workers fall into this category. Another 26% earn between $600 and $900 per week, which means that they have received no benefit from increases in the maximum weekly rate since 2009, when it rose to $600 per week.

Increases in the maximum weekly benefit rate provided additional SLU benefits to the 20% of workers who earn between $900 and $1,200 between 2009 and 2014. However, as the maximum benefit rate increases, a diminishing percentage of injured workers receive greater benefits. Since 2014, further increases in the maximum benefit rate have only impacted the remaining 28% of injured workers who earn more than $1,200 per week.

It therefore appears that further increases in the maximum weekly benefit rate, with concomitant impact on schedule loss awards, will affect (at most) 28% of the SLU cases that make up 28.8% of indemnity costs. In sum, this means that going forward, only about 8% of present indemnity costs are subject to potential increases as the

maximum weekly benefit rate rises.[11] Those increases will, of course, be small, incremental, and affect a diminishing portion of the workforce.

IV. THE RATE FILING DOES NOT TAKE INTO ACCOUNT LIEN RECOVERIES AND CREDITS BY WORKERS' COMPENSATION CARRIERS.

The issue of workers' compensation insurer recoveries due to their lien and credit rights when an injured worker pursues a third-party lawsuit is entirely absent from NYCIRB's submission.

There are generally two types of third-party cases: motor vehicle, and non-motor vehicle. The latter category includes construction accidents, trip and fall, product liability, etc. This group of non-motor vehicle lawsuits can then be subdivided into cases where the workers' compensation carrier is only involved because of its lien interest, and those in which it is an active participant.

Prior to 1996, if the injured worker sued a third-party, the third party could "implead" the employer if the employer had either (1) active negligence or (2) a contract requiring the employer to indemnify the third-party. These claims were permitted by the decision in Dole v. Dow Chemical. If the claim was that the employer was actively negligent, then the workers' compensation carrier had to defend and indemnify the employer in the lawsuit under the 1B provision of the workers' compensation policy. However, if the claim was that the employer was responsible because of a contractual indemnification provision, the employer's general liability insurance company provided

[11] If SLU cases are 28.8% of all indemnity costs as asserted by NYCIRB, and only 28% of workers earn more than $1,200 per week as shown by the Board's data, then only 8% of current indemnity costs (28.8 x .28) would be subject to further increases as a result of increased maximum benefit rates. This means that if the maximum weekly benefit rose 10%, it would have a 0.8% impact on indemnity (8 x .10 – 0.8).

the defense and indemnity. Defendants in lawsuits often made both claims against the employer, which resulted in complexities of insurance defense litigation.

In 1996, Workers' Compensation Law § 11 was amended to end the Dole v. Dow Chemical authorization for a defendant in a lawsuit to implead the plaintiff's employer except in cases where the plaintiff had a grave injury as defined by statute or where there is a contractual indemnification provision.[12] Therefore, there are now the following four typical situations for non-motor vehicle cases (using a construction accident as the model):

1. The plaintiff is a carpenter. He falls off of a scaffold and is injured. He sues the general contractor, which insured by AIG. The contract between the plaintiff's employer and the general contractor requires the employer to indemnify the general contractor for any injuries to its employees. The employer has a workers' compensation policy with the SIF and a general liability policy with Liberty Mutual. When the plaintiff sues the general contractor, the general contractor in turn sues the employer under the contractual indemnification provision. In that claim, Liberty Mutual (the employer's general liability carrier) will defend the employer and pay any part of the award or settlement against the employer.

2. On the same facts as above, the plaintiff also has a "grave injury" as defined by the statute. On these facts, SIF and Liberty will share in the defense and indemnity of the employer.

3. On the same facts as above, there is either no written contract between the plaintiff's employer and the general contractor, or there is a contract that doesn't include

[12] New York Workers' Compensation Law § 11.

an indemnification provision. On these facts, the general contractor cannot bring the employer into the case at all.

4. On the same facts as above, there is no contractual indemnification provision, but the plaintiff has a "grave injury." In this situation, the general contractor can sue the employer and the employer's workers' compensation insurance company will be responsible to defend the employer and pay any part of the judgement or settlement against the employer.

When the lawsuit settles or ends in a verdict, the compensation carrier has three rights: (1) to consent to the settlement (if the third-party case is compromised); (2) to recover a lien for past payments of indemnity and medical and (3) to take credit against future compensation and medical expenses for whatever the plaintiff received as his or her net recovery from the lawsuit.

The plaintiff has the right to require the compensation carrier to contribute its "equitable share" of the litigation expense on the theory that if part of the plaintiff's recovery is going to benefit the compensation carrier (through the lien and the credit), the compensation carrier should pay its fair share of the litigation expense.

Let's assume that (1) at the time of the third-party settlement the workers' compensation carrier's lien (for indemnity and medical paid up to that date) is $150,000; (2) the plaintiff has been found to have a permanent partial disability entitling him to $300 per week for 300 weeks into the future at the time of the third-party settlement, which is $90,000 in total future payments, (3) the third-party settlement is $300,000, and (4) the third-party litigation expense is $100,000.

On these facts, the compensation carrier's lien would be reduced from $150,000 to $100,000 as a result of its liability toward the third-party litigation expense pursuant to Workers' Compensation Law § 29. This results in the initial distribution of the third-party settlement as follows:

$300,000 settlement
- $100,000 litigation expenses (third-party lawyer fee and expenses)

$200,000
- $100,000 paid to compensation carrier

$100,000 to plaintiff

However, in addition to recovering $100,000 of the $150,000 it had paid out in the past, the compensation carrier is also entitled to take credit going forward for the $100,000 the plaintiff received from the lawsuit. That credit remains subject to its obligation to pay its equitable share of the litigation expense. The carrier has so far "paid" $50,000 of that expense by reducing its lien, so it has a maximum exposure going forward of another $50,000 (which would bring its contribution up to the full $100,000 third-party litigation expense).

As a matter of practice, what now happens is that instead of paying the plaintiff $300 per week going forward in workers' compensation (for the sake of this example we assume the ongoing medical expenses are zero), the compensation carrier will pay $100 per week and take credit for the net third-party recovery against the other $200 per week. What this means is that for the remaining 300 weeks of the compensation award, instead of getting $90,000, the plaintiff gets $30,000, while the compensation carrier takes credit for the third-party settlement against the other $60,000.

In order to determine how much compensation carriers benefit from the injured workers' third-party recovery, the remaining inquiry for the non-motor vehicle cases is who pays what part of the settlement. There are many possible variations of how responsibility can be divided among the defendant's insurance company, the employer's general liability insurance company, and the employer's workers' compensation insurance company. Going back to our examples above, and using one set of hypothetical distributions:

1. Where the plaintiff sues the general contractor, the general contractor impleads the employer because of a contractual indemnification provision and there is no grave injury, the general contractor's insurance company (AIG in this example) and the employer's general liability insurer (Liberty in this example) pay the entire third-party settlement or judgment. Let's assume that the settlement or judgement is divided evenly between them and that SIF is the employer's workers' compensation carrier. This is what happens:

   a. SIF pays $150,000 in compensation and medical, and faces a future liability of $90,000.

   b. AIG and Liberty pay $150,000 each to settle the third-party lawsuit for $300,000.

   c. The plaintiff gets $100,000 from his lawsuit.

   d. SIF gets back $100,000 of its past payment of $150,000.

   e. The plaintiff gets $30,000 of his future benefits.

   f. SIF is relieved of responsibility for paying $60,000 of its $90,000 future liability.

   g. The gross exposure to the SIF (before factoring in the third-party settlement) is $240,000 ($150,000 paid in the past, plus $90,000 due in the future). The net cost to the SIF after the third-party

settlement is $80,000 (it gets back $100,000, reducing its net past cost to $50,000, and only pays out an additional $30,000 into the future, for a total actual expenditure of $80,000).

2. Where the plaintiff sues the general contractor and the general contractor in turn sues the employer based on both (1) contractual indemnification and (2) grave injury let's assume that the general contractor and the employer share liability equally and that the employer's general liability carrier and workers' compensation carrier in turn share the employer's liability equally, so that AIG pays 50% and Liberty and SIF pay 25% each:

a. The parties agree that the lawsuit has a settlement value of $300,000.

b. SIF pays $150,000 in compensation and medical, and faces a future liability of $90,000.

c. AIG pays $150,000 and Liberty pays $75,000 towards the settlement of the third-party lawsuit for $300,000.

d. SIF waives $75,000 of its lien to account for its share of the value of the third-party settlement. This brings its lien down from $150,000 to $75,000. SIF then waives a third of that amount to account for its share of the third-party litigation expense, bringing its recoverable lien down to $50,000.

e. The plaintiff gets $100,000 from his lawsuit (225,000 paid by AIG and Liberty in settlement minus $75,000 attorney fee = $150,000, minus $50,000 paid to SIF for lien recovery = $100,000)

f. SIF gets back $50,000 of its past payment of $150,000.

g. The plaintiff gets $30,000 of his future benefits.

h. SIF is relieved of responsibility for paying $60,000 of its $90,000 future liability.

i. The gross exposure to the SIF (before factoring in the third-party settlement) is $240,000 ($150,000 paid in the past, plus $90,000 due in the future). The net cost to the SIF after the third-party

settlement is $130,000 (it gets back $50,000, reducing its net past cost to $100,000, and only pays out an additional $30,000 into the future, for a total actual expenditure of $80,000).

3. Where the plaintiff sues the general contractor and the employer is not brought into the case (because there is no contractual indemnification provision and no grave injury), then the distribution is exactly the same as example 1 above, except that instead of AIG and Liberty paying $150,000 each, AIG pays the full $300,000. This once again reduces the compensation carrier's actual payment to $80,000, or one-third of its exposure of $240,000.

4. Where the plaintiff sues the general contractor and the employer is brought into the case because of a grave injury, with no contractual indemnification provision, the distribution is as follows (assuming that the employer and the general contractor divide the responsibility equally):

a. The parties agree that the case has a settlement value of $300,000.

b. AIG pays $150,000 towards the settlement.

c. SIF waives its $150,000 lien.

d. SIF waives $50,000 of its future credit (because waiving its lien only contributed $100,000 in value to the settlement because it was only entitled to get $100,000 of it back).

e. The plaintiff has a net third-party recovery of $100,000 ($150,000 paid by AIG minus $50,000 attorney fee).

f. SIF pays the first $50,000 of its future liability.

g. SIF then pays $13,333.33 of its remaining $40,000 in future liability.

h. The gross exposure to the SIF (without the third-party settlement) is $240,000. The net cost to the SIF after the settlement is $213,333.33 (it saves $26,666.67 in payment of future liability).

In every scenario (even the grave injury situation), the existence of a third-party lawsuit reduces the compensation carrier's net claim cost, in some instances very significantly. Again, the examples above are only one set of potential distributions and there are innumerable other permutations.

The motor vehicle situation is slightly different. In the motor vehicle situation, the compensation carrier does not have a lien against a lawsuit to the extent its payments are equivalent to No-Fault (which is very loosely defined as the first three years or $50,000 in wage loss and medical bills). This is because the No-Fault carrier would not have had a lien against the lawsuit recovery if it had paid the bills.

However, in vehicular cases the insurer that pays No-Fault benefits is entitled to an "inter-company loss transfer (or ICLT) against the insurer for the vehicle that was "at fault." If the workers' compensation carrier is paying in lieu of the No-Fault carrier, it is similarly entitled to an ICLT. Thus, if the injured worker is not at fault and the compensation carrier pays workers' compensation benefits in lieu of No-Fault, it can recover its payments (again, only to the extent that they were equivalent to No-Fault) from the insurance company for the other vehicle.

Once the compensation carrier's payments exceed "basic economic loss" under the No-Fault law (i.e., they involve payment of more than $2,000 per month which is frequently the case now given increased workers' compensation benefit rates, they involve payment of lost wages more than 3 years post-accident, or they involve any payments made beyond a total of $50,000 for medical and indemnity), then the compensation carrier has a lien against the third-party action for those payments.

The employer is rarely if ever brought into third-party actions arising out of motor vehicle accidents, but let's consider the following four examples:

1. Plaintiff who earns $600 per week is involved in a motor vehicle accident while working. The plaintiff is not at fault for the accident. She is out of work for six months, gets workers' compensation benefits at the rate of $400 per week ($10,400) and has medical expenses of $6,000. She later settles a third-party lawsuit against the other vehicle for $50,000.

In this situation, the compensation carrier has no lien against the plaintiff's third-party recovery for the $16,400 it paid in compensation and medical because it is all equivalent to No-Fault benefits. However, it can recover that $16,400 from the insurance company for the other vehicle under an ICLT.

Therefore, the compensation carrier's net expense in this example is zero.

The distribution of the $50,000 settlement is $33,333.33 to the plaintiff and $16,666.67 to her attorney. Bear in mind that if a compensation claim is asserted in the future beyond the three year/$50,000 mark then the compensation carrier retains the right to take credit for the plaintiff's net third-party recovery.

2. Plaintiff earns $1,200 per week and is involved in a motor vehicle accident while working. The plaintiff is not at fault for the accident. She is out of work for six months, gets workers' compensation benefits at the rate of $800 per week ($20,800) and has medical expenses of $6,000. She later settles a third-party lawsuit against the other vehicle for $50,000.

In this situation, the compensation carrier has a lien against the plaintiff's third-party recovery for part of the $26,800 it paid in compensation and medical. Although all

of the money was paid within three years or $50,000, the $800 per week compensation rate was equal to $3,466.67 per month, which is $1,466.67 more than the monthly No-Fault maximum. It therefore has a lien of $8,800.02 ($1,466.67 x 6 months), and it is entitled to recover two-thirds of that amount from the plaintiff, or $5,866.68.

The distribution of the money from the third-party lawsuit here is as follows:

$50,000 settlement
- $16,666.67 litigation expense

$33,333.33
- $5,866.68 paid to compensation carrier

$27,466.65

In addition to recovering $5,866.68 of the $8,800.02 of its payments that exceeded basic economic loss from the plaintiff, the compensation carrier can also recover the $18,000 ($2,000 per month for 6 months plus $6,000 in medical) that it paid in benefits equivalent to basic economic loss from the insurance company for the other vehicle under an ICLT.

Therefore, the compensation carrier's net expense in this example is $2,933.32 because out of its total payments of $26,800 it can recover $18,000 from the other insurer and $5,866.68 from the plaintiff, leaving a net cost of $2,933.32.

Bear in mind that if a compensation claim is asserted in the future beyond the three year/$50,000 mark then the compensation carrier retains the right to take credit for the plaintiff's net third-party recovery.

3. Plaintiff is involved in a motor vehicle accident while working. The plaintiff is not at fault for the accident and is permanently disabled. The third-party action settles for $300,000. Let's assume that (1) at the time of the third-party settlement

the workers' compensation carrier's lien (for indemnity and medical paid up to that date) is $150,000; (2) the plaintiff has been found to have a permanent partial disability entitling him to $300 per week for 300 weeks into the future at the time of the third-party settlement, which is $90,000 in total future payments, (3) the third-party settlement is $300,000, and (4) the third-party litigation expense is $100,000.

In this situation, the compensation carrier's lien is immediately reduced from $150,000 to $100,000 because the compensation carrier does not have a lien for the $50,000 it paid in lieu of No-Fault benefits. The remaining $100,000 is then reduced by one-third to $66,666.67.

The third-party settlement is then distributed as follows:

$300,000
- $100,000 litigation expense

$200,000
- $66,666.67 payment to compensation carrier

$133,333.33 to plaintiff

In addition to getting back $66,666.67 of the $150,000 it had paid out in the past, the compensation carrier is also entitled to take credit going forward for the $133,333.33 the plaintiff received from the lawsuit. As in our earlier examples, the compensation carrier will pay $100 per week and take credit for his net third-party recovery against the other $200 per week. This means is that for the remaining 300 weeks of his compensation award, instead of getting $90,000, the plaintiff gets $30,000, while the compensation carrier takes credit for the third-party settlement against the other $60,000.

Moreover, because the plaintiff was not at fault for the accident, the compensation carrier can also recover the $50,000 that was taken off the top of its lien from the insurer for the other vehicle as an ICLT.

Therefore, in this example the compensation carrier's total exposure was $240,000 ($150,000 paid in past benefits and $90,000 future liability). However its net cost is $63,333.33 because it gets back (1) $50,000 from the other insurer and (2) $66,666.67 from the plaintiff, plus it is also relieved of $60,000 of its future liability. This is a total savings to the compensation carrier of $176,666.67, leaving it with a net cost of $63,333.33.

4. If we use the same facts as Scenario 3 above, except that the plaintiff is at fault for the accident, then the only thing that changes is that the compensation carrier does not get an ICLT. The third-party distribution remains the same, and the net result is that the compensation carrier's net cost is $113,333.33 (against an initial $240,000 liability) instead of $63,333.33.

Thus, the invariable impact of a third-party settlement is a reduction in the workers' compensation carrier's net cost as compared to the claim cost. This reduction is the result of a combination of lien recovery, credit for the plaintiff's net third-party settlement, and inter-company loss transfer. Even in cases where the employer's workers' compensation carrier is involved directly in the third-party lawsuit because of a grave injury, there are still often savings to the compensation carrier as a result of the lawsuit. In other cases, as shown above, the savings to the compensation carrier can be very significant.

Consideration of these issues is entirely absent from NYCIRB's loss cost filing, although they clearly have a significant impact on net workers' compensation costs, insurer profit margins, and the justification (or lack thereof) for an increase in premium charges to employers.

V. THE RATE FILING IS INCONSISTENT WITH CURRENT INSURER PROFIT LEVELS.

There is no evidence that current premium levels render the workers' compensation insurance market unprofitable for insurers.

A summary of the State Insurance Fund's financial results from 2011 through 2015 is attached as Exhibit B. According to the document, after showing underwriting losses from 2011 through 2013, SIF has had significant underwriting profits in 2014 and 2015. It is a long-established principle of DFS (and previously the NYS Insurance Department) that the target number for underwriting profit in workers' compensation insurance is zero. In addition to SIF's underwriting profits, the document shows significant surplus, reserves and assets.

While we recognize that there are slightly different economics for private insurers as compared to the SIF, the figures reported by SIF call into question the validity of NYCIRB's request for a 9.3% increase in employer premiums. It seems likely that private insurers, like the SIF are currently producing underwriting profits that would mitigate against any increase in premiums.

The SIF data is consistent with reports from NCCI that there was a six point drop in combined ratio in 2015 to a nationwide average of 94%.[13]

There is therefore no evidence that current premium levels are inadequate. To the contrary, the available information tends to show that – at current premium rates – workers' compensation is highly profitable for insurers. As discussed above, future trends are likely to reduce, rather than increase, claim costs, and there is thus no justification for a 9.3% increase in lost costs as requested by NYCIRB.

VI. NYCIRB'S ROLE IN THE RATE SETTING PROCESS SHOULD BE REVIEWED AND RECONSIDERED.

It remains the position of WCA and NYCOSH, as set forth in prior testimony to DFS and previously the Insurance Department in connection with loss cost filings, that NYCIRB should be removed from the rate setting process. In 2007 NYCIRB's role was made subject to a five year "sunset" provision. That provision was renewed in 2012, and will therefore require reconsideration in the near future.

We believe that NYCIRB's constituency – even after the addition of public members in 2007 – continues to preclude it from functioning as an objective, impartial and trustworthy source of claim data and rate-setting information. The portion of our 2013 testimony regarding this issue is attached as Exhibit C.

[13] 2016 NCCI State of the Line, available at https://www.ncci.com/Articles/Documents/II_AIS-2016-SOL-Presentation.pdf

VII. CONCLUSION.

The WCA and NYCOSH submit that CIRB's application for a 9.3% increase in loss costs should be rejected for the reasons set forth above.

Dated: June 20, 2016
New York, New York

Respectfully submitted,

Robert E. Grey
Chair, WCA
Treasurer, NYCOSH

WORKERS' COMPENSATION IN NEW YORK STATE: STATE OF THE SYSTEM 2016

By: Robert E. Grey
Grey & Grey, LLP

Dated: June 17, 2016

NASSAU*
360 Main Street
Farmingdale, NY 11735
(516) 249-1342
*Direct all mail to Nassau office.

SUFFOLK
646 Main Street
Port Jefferson, NY 11777
(631) 249-1342

QUEENS
118-35 Queens Boulevard
Suite 1505
Forest Hills, NY 11375
(718) 268-5300

MANHATTAN
115 Broadway
Suite 403
New York, NY 10006
(212) 964-1342

BRONX
305 East 149th Street
Second Floor
Bronx, NY 10451
(718) 268-5300

WESTCHESTER
203 East Post Road
Suite E
White Plains, NY 10601
(914) 984-2292

TABLE OF CONTENTS

Page

Introduction …… 1

I. Executive Summary …… 3

A. Background …..…… 3

B. Claim Filing….…….. 5

C. Administration …….. 6

D. Medical Treatment Guidelines …….. 9

E. Wage Replacement Benefits ……. 10

F. Permanency …… 11

G. Conclusion ……. 14

II. Background …… 18

A. The 2007 Legislation ……. 18

B. Administrative and Regulatory Changes ……... 19

III. Claim Filing …… 21

A. Claims by Injured Workers …… 21

B. Language Access …….. 23

IV. Administration …….. 26

A. Assembly and Indexing …… 26

B. Administrative and Proposed Decisions …….. 29

V. Medical Treatment Guidelines ……. 41

VI. Wage Replacement Benefits …… 43

VII. Permanency …….. 46

A. Schedule Loss of Use ……. 47

B. Permanent Partial Disability and Loss of Wage Earning Capacity …… 48

C. Settlements and the Aggregate Trust Fund …… 57

Conclusion …….……. 65

Exhibit A: FOIL 16-119 …….. A-1

Exhibit B: Workers' Compensation 2016: The Aftermath Of the 2007 Reforms for Injured Workers and The Impact of the Business Council Agenda …… B-1

Exhibit C: The Truth About the Business Council's Plan To Once Again Slash Compensation for Permanent Injury: A Continued Assault on Low Wage Workers …….. C-1

INTRODUCTION

This paper will review current data about how the New York State workers' compensation system is functioning. The system has undergone significant changes in the past two decades as the result of legislative and administrative action.

The paper includes information from the past five years, to the extent it was provided by the New York State Workers' Compensation Board. There were, however, many issues about which the Board declined to provide data. Five broad areas are evaluated: (1) claim filing; (2) administration by the state Workers' Compensation Board; (3) medical treatment; (4) wage loss; and (5) permanency.

The paper finds that workers face increasing obstacles in accessing benefits due to a variety of Board procedures and that these procedures have a disproportionate impact on workers who are not fluent in English. It also finds that while the 2007 reform legislation increased temporary disability and schedule loss awards for high-wage workers, it did not do so for low-wage workers. The 2007 legislation also caused an unprecedented escalation in uncompensated wage loss for permanently disabled workers throughout the wage spectrum. It appears that there is now widespread settlement of permanent disability claims by private insurers due to the new set of financial incentives created by the legislation. This pattern does not, however, extend to claims in which the responsible payor is the State Insurance Fund or a self-insured employer.

This is the fourth in a series of papers about the state of the system. Workers' Compensation: State of the System, 2006 ("the 2006 White Paper"), was written to contribute to the discussion leading to the 2007 legislation.[1] The 2006 White Paper

[1] Workers' Compensation: State of the System, 2006, Robert E. Grey, available at http://greyandgrey.com/White%20Papers/White%20Paper%202006.pdf

identified the main 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."[2] The paper made a number of recommendations to resolve these problems.

Workers' Compensation: State of the System, 2008 ("the 2008 White Paper") reviewed the 2007 legislation and the Task Forces that were created to implement the statutory changes.[3] The 2008 White Paper identified continuing problems in the system and made recommendations about modifying and implementing the legislation and the suggestions of the Task Forces.

Workers' Compensation: State of the System, 2014 ("the 2014 White Paper") discussed the impact of the various Task Forces reports and addressed areas in which the system had improved, stagnated, and deteriorated in achieving its core mission of delivering compensation and medical benefits to injured workers.[4]

Readers of this paper may wish to refer to the earlier papers for further data and additional perspective on the development of trends in the workers' compensation system over the past two decades.

---

[2] Id. at page 4.

[3] Workers' Compensation: State of the System, 2008, Robert E. Grey, available at http://www.greyandgrey.com/White%20Papers/White%20Paper%202008.pdf

[4] Workers' Compensation: State of the System, 2014, Robert E. Grey, available at http://www.nyworkerscompensationalliance.org/STATE%20OF%20THE%20SYSTEM%202014%20-%20Release.pdf

I. EXECUTIVE SUMMARY

A. Background.

Every year, tens of thousands of New York workers are injured at work or suffer from occupational illness.[5] Almost all are covered by the New York State Workers' Compensation Law.[6]

The law was meant to provide speedy and adequate wage replacement benefits and medical coverage for injured workers. Employers are required to buy insurance against the cost of occupational injury and illness.[7] Workers gave up their right to sue employers for personal injury in exchange for the employer's promise that compensation benefits would be provided in a timely fashion and without controversy. The law is social legislation, intended to be interpreted broadly for the protection of workers.[8]

Over the past two decades, the basic "bargain" has been broken. From 1992 to 2007 the value of compensation benefits was eroded by inflation. Employers have increasingly viewed workers' compensation as a "cost" to be reduced, while insurers have aggressively pursued increased profits in the field.[9] Meanwhile, a series of administrative initiatives has prevented workers from accessing their benefits as the Workers' Compensation Board's ("the Board's") mission shifted from protecting injured workers to "protecting the rights of workers and employers."[10]

---

[5] Summary Annual Reports 2000 through 2005, New York State Workers' Compensation Board.

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

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

[8] 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").

[9] Workers' Compensation: A Cautionary Tale, Center for Justice & Democracy, 2006.

[10] The Board's current mission statement reads: "The New York State Workers' Compensation Board protects the rights of employees and employers by ensuring the proper delivery of benefits to those who are injured

Against this background, the 2007 legislation made a number of significant changes to the Workers' Compensation Law.[11] 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.[12] These Task Forces later issued reports about contested cases,[13] Medical Treatment Guidelines,[14] Return to Work,[15] and Medical Impairment and Loss of Wage Earning Capacity.[16] The impact of the reports, many of which were implemented (with the notable exception of the Return to Work document) was considered in the 2008 and 2014 White Papers and will not be extensively reviewed again here.

The impact of various statutory and regulatory changes has been significantly accelerated by the Board's administrative actions, which have taken place largely without legislative or public scrutiny. In early 2016, requests were made to the Board pursuant to the Freedom of Information Law ("FOIL") for information about the impact of the various reforms and its administrative actions.[17] The Board initially denied the entirety of the request, but on appeal agreed to provide a response. The Board eventually provided a partial response, but declined to answer a number of inquiries. Correspondence related to the FOIL requests is attached as Exhibit A.

---

or ill, and by promoting compliance with the law;" http://www.Wcb.ny.gov/content/main/TheBoard/mission.jsp

[11] 2007 New York Workers' Compensation Reform Act, 3/13/07.

[12] Id.

[13] Recommended Workers' Compensation Streamlined Docket Regulations, NYS Insurance Dept., available at http://www.dfs.ny.gov/insurance/press_docs/p070604b.pdf

[14] 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.wcb.ny.gov/content/main/hcpp/MedicalTreatmentGuidelines/MTGOverview.jsp

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

[16] Disability Duration Guidelines, September, 2010; http://www.dfs.ny.gov/insurance/wc/wc-guidelines.pdf

[17] The request was initially labeled FOIL 16-19 by the Workers' Compensation Board. On appeal of the Board's initial denial, the Board re-labeled the request FOIL 16-119.

This paper is based on the data provided by the Board pursuant to the FOIL request, as well as other information made available by the Board and other sources. The data (and in some instances the Board's refusal to provide information) highlights significant concerns about the ability of injured workers to access benefits, limitations on medical treatment, the inadequacy of wage replacement benefits, and the lack of appropriate compensation for permanent disability. The findings in each of these areas are discussed below.

B. <u>Claim Filing.</u>

The Board's response to the FOIL request indicates that claims filed by injured workers increased about 33% from 161,581 in 2011 to 215,687 in 2015.[18]

It appears, however, that workers who do not speak English experience significant difficulty in filing claims and interacting with the Board. For example, in 2015 the Board received only 620 claims on its foreign-language forms out of 215,687, which is a rate of 0.3%. Similarly, the Board provided interpretation of only 1,444 documents out of the hundreds of thousands it received, which would (like the figure for claim forms) be a fraction of 1%.[19] 1,405 of the 1,444 documents (97%) translated by the Board were in Spanish; only 39 were in other languages. The low number of translation requests seems emblematic of the difficulties faced by non-English speakers who are injured on the job.

While the Board did provide 21,133 interpretation calls in 2015, that figure is only about 4% of the estimated 522,995 calls it processed. By contrast, according to Governor

[18] The figures regarding the number of claims filed may be inaccurate due to the potential filing of multiple claim forms in a single case and the fact that the Board's response to the FOIL request included a variety of forms that are not claim forms in its figures. Regardless of the actual number of forms filed, however, it is clear that there was a significant increase in the number of claims filed from 2011 to 2015.

[19] It is estimated that the Board receives and scans more than 1 million documents each year.

Cuomo's October, 2011 Executive Order to improve access to state services for non-English speakers, 2.5 million of the state's population of 19 million (13%) do not speak English.[20]

The Board refused to respond to inquiries about whether it issues its claim assembly documents or notices of decision in any languages other than English, but stakeholders report that it does not.

C. Administration.

In 2008, the Board departed from its long-established policy of "indexing" a case upon receipt of a claim, and adopted a two-step process in which cases are "assembled" upon receipt of a form, but not "indexed" until the file includes both a claim form and a medical report.[21] The significance of this change is that an employer or carrier is not legally required to respond to a claim until it is formally indexed. The Board's "assembly" of the case gives the injured worker a case number, but does not require the employer or carrier to take any action.

Between 2011 and 2013 the Board assembled an average of 123,975 claims per year. This figure jumped to 165,441 in 2014 before declining to 142,830 in 2015. In every year, however, the number of cases assembled by the Board was significantly lower than the number of claims filed, with an average difference of 26%. There is no ready explanation for the Board's assembly of far fewer cases than the number of claims filed. Moreover, in 2015 it appears that claims filed increased while the number of cases assembled declined.

---

[20] http://www.governor.ny.gov/news/governor-cuomo-issues-executive-order-improve-access-state-services-non-english-speakers-0; https://en.m.wikipedia.org/wiki/Demographics_of_New_York

[21] WCB Subject Number 046-254, available at http://www.wcb.ny.gov/content/main/SubjectNos/sn046_254.jsp

The Board declined to provide data about how many assembled cases were later indexed, or to indicate how many cases met its criteria to do so but were not indexed.

Once a case is indexed and accepted by the employer or carrier, the Board is obligated to issue a decision establishing the nature of the injury, the worker's pre-accident wage, and the period and extent of the worker's disability. However, in 2016 the Board indicated that it would no longer issue any type of decision in cases in which there was no time lost from work.[22]

In cases involving lost time where the employer or carrier accept responsibility, the Board attempts to "resolve" the claim without holding a hearing, and instead issues either an Administrative or a Proposed Decision, apparently depending on the extent of the lost time. Between 2011 and 2015 the Board issued 390,923 Administrative Decisions and 507,697 Proposed Decisions, thus "resolving" about 900,000 cases without a hearing.

The Board declined to provide information about how many Administrative Decisions involved claims for lost time in excess of one week or potential schedule loss of use awards, although the Board's statutory authority to issue Administrative Decisions is limited to cases that involve less than a week of lost time. The Board also declined to provide information about how many Proposed Decisions were issued as the result of conciliation meetings that are required by law, how many involved awards in excess of fifty-two weeks (the limit of the Board's legal authority to issue a Proposed Decision), how many were issued at the request of a worker, employer or carrier, and how many objections it received to Proposed Decisions.

[22] WCB Subject Number 046-777, available at http://www.wcb.ny.gov/content/main/SubjectNos/sn046_777.jsp

It is clear, however, that the Board has made increasing use of Administrative and Proposed Decisions to reduce the number of hearings, and by 2015 the Board reported that it was "resolving" half of the claims before it by "administrative processes" instead of at hearings.

The Board's reliance on administrative processes has resulted in increasing requests for it to reopen cases and to schedule hearings. From 2012 through 2015, requests for hearings by attorneys for injured workers rose from 131,177 to 167,575, an increase of over 20%. In the same time frame, hearing requests from unrepresented workers declined 97% from 1,241 to 169, once again demonstrating the increasing difficulty of workers in accessing benefits from the system. Another measure of the challenge workers face in pursuing claims without legal representation is that in 2012 they filed slightly less than 1% of hearing requests; by 2015 that figure had dropped to one-tenth of 1%.

There are numerous anecdotal reports that the Board responds far more promptly to hearing requests from insurers than from injured workers and their attorneys. The Board declined to provide information regarding the number of instances in which injured workers or their attorneys were required to file multiple requests before being granted a hearing. The Board also declined to provide information regarding the time frame in which it responded to requests from attorneys as compared to requests by insurers.

The Board did, however, provide data showing that insurers filed far fewer hearing requests than injured workers or attorneys, with the number remaining stable at an average of 84,830 per year even as requests from injured workers and attorney rose sharply. As a result, in 2012 insurers filed about two-thirds as many hearing requests as injured workers; by 2015 the ratio had declined to 48%. It may be inferred from this data that the Board responded promptly to requests from insurers, while requiring injured workers and their

attorneys to file multiple requests before receiving a reply. If accurate, this would confirm the accuracy of the anecdotal evidence about the Board's response to hearing requests by the respective parties.

The ultimate outcome of the Board's use of non-hearing resolutions, as well as its routine closure of cases with a "no further action" designation when hearings are scheduled, is that it now reopens more cases every year than it assembles. In four out of five years from 2011 through 2015, the Board reopened about 100,000 more claims than it indexed.[23]

D. Medical Treatment Guidelines.

The Board's Medical Treatment Guidelines (MTG) were discussed at length in the 2014 White Paper. In response to the FOIL request, however, the Board provided new data that provides additional insight into its application of the MTG.

According to the Board, in 2015 it received 272,396 requests to depart from its MTG ("variances"). The Board rejected 25,413 of those variances (9%) without awaiting action by the employer or carrier. Carriers voluntarily granted 85,922, or 31.5% of the variance requests that they processed.[24] Carriers denied another 47,896, or 17.5% of the variance requests. The Board did not provide data regarding its processing of the remaining 113,708, or 41% of the variances. It did report that only 10,238 variances received hearings by Workers' Compensation Law Judges (WCL Judges), of which 3,416, or one-third, were granted.

Overall, therefore, it appears that the Board receives several hundred thousand variances each year. Virtually all of these requests for medical treatment are processed

[23] The exception was 2014, when an unexplained increase in claims filed reduced the gap to 60,000.
[24] The Board provided data about the number of variances filed and rejected for 2015; the remainder of the data it provided covered the period from April of 2015 through March of 2016.

administratively, and through those processes about one-third are granted and the other two-thirds are denied.

E. Wage Replacement Benefits.

An examination of the impact of the 2007 statutory reforms on the amount of benefits paid to disabled workers and the extent of their wages that are not replaced by those benefits resulted in eight significant conclusions.[25] These findings include:

(1) The 2007 reforms did not increase benefits for low-wage workers who had temporary disabilities or injuries that resulted in schedule loss awards;

(2) Permanent partial disability benefits for these workers were slashed by 70% or more, creating huge savings for insurers at a huge cost to the most vulnerable part of the working population;

(3) The 2007 reforms did increase benefits for high wage workers for periods of temporary disability and for schedule loss, in some instances doubling these awards;[26]

(4) The 2007 reforms decimated permanent partial disability benefits for high-wage workers to the same extent – 70% - as for low-wage workers. However, the application of the PPD caps to high-wage workers created even larger dollar savings in unpaid benefits;

(5) The 2007 reforms did not affect uncompensated wage loss for low-wage workers with temporary disabilities, nor did it increase their benefits from schedule loss awards;

---

[25] Workers' Compensation 2016: The Aftermath Of The 2007 Reforms For Injured Workers And The Impact Of The Business Council Agenda, Grey, is attached to this paper as Exhibit B and is also available at: http://www.nyworkerscompensationalliance.org/uploads/file/Wage%20Loss%20and%20WC%20-Release.pdf

[26] According to wage distribution data published by the Workers' Compensation Board, about a quarter of all injured workers would fall into this category.

(6) While the 2007 reforms did reduce uncompensated wage loss for high wage workers in cases of temporary disability, these workers still suffer from significant uncompensated wage loss as the result of on-the-job injury;

(7) The 2007 reforms eliminated uncompensated wage loss for high wage workers in some schedule loss cases, providing them with the same benefit (in percentage terms) as low-wage workers; and

(8) Before the 2007 reforms workers suffered uncompensated wage loss of 67% or more in cases of permanent partial disability. As a result of the 2007 reforms, this figure rose to 90%, meaning that the workers' compensation system now replaces less than 10% of the wages lost by a permanently disabled worker.

F. Permanency.

The subject of permanent disability involves three distinct issues: schedule loss of use awards, permanent partial disability awards, and settlements.

With regard to schedule loss awards, the data shows that they have not increased for low wage workers since 1992.[27] Those who earn $600 per week or less – about a quarter of all injured workers – receive the same benefits for an injury today as they did twenty-four years ago. When inflation is taken into account, their awards today are worth forty percent less than their value in 1992.

With the exception of a three year period from 2007-2009, schedule loss awards have also been stagnant for workers who earn between $600 per week and $900 per week –

[27] The Truth About the Business Council's Plan to Once Again Slash Compensation for Permanent Injury: A Continued Assault on Low Wage Workers, Grey, is attached to this paper as Exhibit C.

another twenty-five percent of the injured worker population. For these workers, too, the value of their awards continues to lag inflation by about twelve percent.

Overall, schedule loss awards fail to adequately compensate three-quarters of injured workers as compared to inflation. On the opposite end of the spectrum, the awards fail to adequately compensate high wage earners for their actual wage loss.

With regard to permanent partial disability awards, the 2007 legislation imposed time limits, or caps, on these payments. In 2012, the Board issued Guidelines for Determining Permanent Impairment and Loss of Wage Earning Capacity (LWEC Guidelines), and in May of 2013 it announced that it intended to expedite permanency determinations to apply the caps to disabled workers.[28] In response to the FOIL request, the Board declined to provide information about how many hearings it had scheduled as a result of this initiative, how many had been requested by insurers, or how many had been scheduled by the Board on its own motion.

The Board did report, however, that classifications of permanent disability almost tripled from 1,173 in 2011 to 4,995 in 2014 before declining to 4,022 in 2015. It declined to provide any information about how many of those classifications involved loss of wage earning capacity greater than eighty percent, which would entitle the injured worker to consideration for the statutory safety net and potential relief from termination of benefits as a result of the caps. It also declined to provide any information about the distribution of its awards in the various cap segments running from four to ten years of benefits. In addition, the Board declined to provide information about how many workers have suffered benefit termination as a result of the caps, how many safety net hearings it has held, how many

[28] WCB Subject Number 046-548, available at http://www.wcb.ny.gov/content/main/SubjectNos/sn046_548.jsp

workers have been found eligible for the safety nets, or what policies (if any) it has developed to evaluate safety net eligibility.

The Board did provide data about the distribution of classifications among private insurers (42%), the State Insurance Fund (28%) and self-insured employers (30%). It also provided data showing that 35% of permanently disabled workers are women, while 65% are men. The Board reported that more than 60% of all permanently disabled workers are between the ages of 40 and 59, with a quarter younger than 40 and 12% over 60. The Board's data showed that 26% of injured workers earn less than $600 per week, and more than half earn less than $900 per week.

The Board was unable to provide meaningful information about the nature of the injuries that result in findings of permanent partial disability, reporting that almost 60% of the classifications involved an "unknown" injury classification. Similarly, the Board declined to provide information about the English-language fluency, ethnicity, pre-accident employment, post-injury work status or receipt of Social Security Disability benefits by permanently disabled workers.

Many cases involving classifications of permanent partial disability result in settlements. The 2007 legislation included a requirement that private insurers make settlement offers in such cases, and that they deposit the present value of the future payments into the Aggregate Trust Fund (ATF) if the case did not settle. The Board declined to provide information about how many mandatory settlement offers were made by private insurers, how many ATF deposits were calculated, directed or paid, or what enforcement action (if any) it has taken.

The Board did report that there was a 25% increase in the number of settlements by private insurers from 2011 through 2013, followed by a slight (9%) decline in 2014 and a

steep (35%) decline in 2015. Settlements by the State Insurance Fund largely followed the same trajectory as the figures for private insurers, but during the same time frame, the relatively small number of settlements by public self-insurers increased each year from 2011 through 2014, and remained stable in 2015.

Overall, analysis of the Board's data shows that from 2011 through 2015, claims involving private insurers account for 42% of permanent disability classifications, but 86% of all settlements. Claims involving the State Insurance Fund account for 28% of classifications, but 12% of all settlements, while claims involving public self-insurers account for 30% of all classifications but only 2% of all settlements. Analysis also shows that in 2011 the ratio of settlements to classifications was 26%, which nearly tripled to 71% by 2015.

The data regarding classification and settlement appears to indicate that the Board's efforts to expedite permanency classifications significantly reduced, if not eliminated, any "backlog" in such cases by the end of 2014. Moreover, the data appears to indicate that the statutory requirement for ATF deposits and the Board's initiatives have significantly increased the rate of settlement in cases involving permanent partial disability.

G. <u>Conclusions and Recommendations.</u>

Evaluation of the data leads to eight conclusions about systemic problems. Recommendations are offered regarding each issue identified.

1. It appears that workers are generally able to file claims, although the Board's inclusion of extraneous forms in its FOIL response precludes an accurate assessment of how many individual claims are being filed. It is clear from the data, however, that workers who are not fluent in English face significant obstacles in claim filing.

Recommendation: The Board should review its compliance with the Governor's Executive Order regarding language access. Printed and electronic forms should be more readily accessible in multiple languages. Outreach efforts to immigrant communities and worker centers should be significantly expanded to increase the visibility and accessibility of the workers' compensation system to workers who are not fluent in English.

2. The Board's division of its file creation process into "assembly" and "indexing" sows confusion among injured workers and delays insurer response to claims. It seems likely that the Board is simply not indexing many of the claims that are filed, notwithstanding its regulation to the contrary. This defers the insurer's obligation to accept or contest claims. An additional issue is presented by the Board's issuance of these complex notices in English, without regard to the injured worker's language or literacy issues.

Recommendation: All claims should be indexed immediately upon receipt of a claim or employer's report of injury and the filing of a medical report. The language used on a Notice of Indexing should be simplified, and the information about rights and benefits under the law should be expanded. Notices should be issued in the language spoken by the injured worker as indicated on his or her claim form.

3. The Board's use of Administrative and Proposed Decisions is instrumental in denying benefits to injured workers. These documents do not provide adequate information to injured workers either about the benefits being awarded or their entitlement to further benefits. They also suffer from the same deficiency as Notices of Assembly and Indexing, in that they use complex language and are issued only in English. This has a significant impact on access to benefits by workers with language or literacy issues. These issues are exacerbated by the Board's recently adopted policy to issue no decision at all in certain

cases and its apparent disregard of the statutory requirement that it schedule conciliation meetings prior to issuing Proposed Decisions.

Recommendation: The use of Administrative and Proposed Decisions should be discontinued. Injured workers should be afforded a hearing before a WCL Judge in every case so that information about their rights and available benefits can be communicated to them in a meaningful fashion and in an appropriate language.

4. The Medical Treatment Guidelines have resulted in a flood of variance requests, creating an enormous administrative burden for health care providers, employers, carriers, attorneys and the Board, while causing the widespread delay and denial of medical care.

Recommendation: The use of the Medical Treatment Guidelines should be restricted to the purpose outlined in the law, which is to "pre-approve" medical care. The MTG should not be used to pre-determine or pre-deny the need for treatment, which is governed by existing statutory provisions. This interpretation of the law would eliminate the extensive bureaucratic procedure created by the current regulations, and would enable workers to receive needed treatment while preserving the ability of employers and carriers to contest medical bills.

5. Despite increases in the maximum weekly benefit rate and periodic one-time increases in the minimum benefit rate, wage replacement benefits remain inadequate. Workers who are injured on the job suffer from significant uncompensated wage loss due to the inadequacy of workers' compensation benefits, especially in cases of permanent partial disability under the caps.

Recommendation: The minimum benefit rate should be set at 25% of the maximum benefit rate. This will reduce uncompensated wage loss for low wage workers.

6. Schedule loss of use awards have not increased since 1992 for workers who earn less than $600 per week, and have not increased since 2009 for workers who earn less than $900 per week. From July of 2015, the value of schedule loss awards will only improve for the 25% of workers who earn more than $1,200 per week. Meanwhile, payments for time lost from work are deducted from these awards. This includes wage payments that are returned to employers out of the injured worker's award.

Recommendation: Schedule loss awards should be payable additional to wage loss benefits, as is currently the case under the Longshore and Harbor Workers Compensation Act and in many other states.

7. The PPD caps have slashed payments to injured workers by 70% or more. The impact of this was intended to be assessed by the issuance of an annual Safety Net Report to consider the impact of the PPD caps on return to work. Regrettably, the Safety Net Report has not been publicly issued since 2008, the recommendations of the Return to Work Task Force have never been implemented, and the Board declined to provide any information on its policies or implementation of the statutory safety net provision.

Recommendation: The Safety Net Reports for the years 2009 through 2015 should be issued. The recommendations of the Return To Work Task Force should be implemented. The threshold for safety net eligibility should be reduced to 50% loss of wage earning capacity, and the Board should issue meaningful guidelines for safety net eligibility as suggested in the 2014 White Paper.

8. The number of settlements under Workers' Compensation Law § 32 is increasing for private carriers, especially as a percentage of PPD claims. This creates savings for insurers as injured workers settle their claims out of economic necessity created by the PPD caps. However, this trend does not apply equally to the State Insurance Fund

and self-insured employers, who settle relatively few claims. This is likely due to their exemption from liability to the Aggregate Trust Fund.

Recommendation: The Board should enforce the statutory requirement for employers and carriers to make mandatory settlement offers. The Aggregate Trust Fund deposit requirement should be expanded to the State Insurance Fund and to self-insured employers.

II. BACKGROUND.

Workers' compensation benefit rates stagnated from 1992 until 2007. The maximum weekly benefit rate during that time period was $400 per week, which resulted in significant uncompensated wage loss for high wage workers for periods of both temporary and permanent disability.

Efforts by labor to improve wage replacement benefits after 1992 were met with demands by the business community for the imposition of time limits, or caps, on awards for permanent partial disability. It was repeatedly asserted that this small group of claims was responsible for an overwhelming majority of the costs of the system. Labor's refusal to accept caps on awards for permanent disability and business's refusal to accede to any increase in the maximum weekly benefit rate resulted in a fifteen year stalemate.

A. The 2007 Legislation.

The centerpiece of the 2007 reform legislation was a compromise in which permanent disability benefits were capped, and the maximum weekly benefit rate was increased in steps and ultimately tied to the state average weekly wage for automatic future

increases. It was understood at the time that benefits for temporary disability and schedule loss would rise significantly for high wage workers, in exchange for which employers would achieve large savings from the cap on permanent partial disability claims that had allegedly driven most of the costs in the system.

There were many subsidiary components to the 2007 reforms. Business was promised additional savings through control of diagnostic testing and prescription medication. Workers were promised that their permanent disability awards would be calculated fairly by a renewed emphasis on loss of wage earning capacity, and that their claims would be settled fairly by the requirement of deposits into the Aggregate Trust Fund. Workers were also promised that their medical treatment would be expedited, with corresponding savings to employers by reduction of frictional costs associated with the authorization process.

B. Administrative and Regulatory Changes.

The implementation of these statutory changes was left to the Insurance Department and the Workers' Compensation Board, which created a number of task forces to propose administrative and regulatory action. These task forces ultimately recommended new guidelines for medical treatment and disability determination, as well as revision of the Board's processes to reduce the number of controverted claims and to expedite the resolution of those cases. Another task force issued a comprehensive report about rehabilitation and return to work, but its suggestions were not implemented.

From 2008 through 2012, the Board dramatically expanded the size, number and complexity of the claim forms for workers, medical reports for health care providers, and incident reports for employers. It later adopted electronic data filing which remains in the

early stages of development. The Board also changed the format of its case numbers, created new forms and processes for its assembly and indexing of claims, and issued new regulations covering these topics.

At the same time it created dozens of new forms and administrative processes with many technical requirements, the Board increasingly shifted its method of adjudication from hearings to the issuance of non-hearing decisions. More recently, the Board has stated that it will not issue any decisions at all in certain types of case.

The outcome of these administrative and regulatory initiatives has been a vast increase in the complexity of the system from the perspective of injured workers, health care providers, and representatives for both workers and employers. The workers' compensation system has never been less visible or more difficult to access for injured workers. The burden falls most heavily upon immigrant and low wage workers, who receive complex legal documents written in English and are not afforded hearings at which a Workers' Compensation Law Judge (WCL Judge) could offer a clearer explanation of their rights.

This paper discusses data provided by the Workers' Compensation Board and other sources in the context of the impact of statutory, regulatory, and administrative changes on access to benefits by injured workers.

III. CLAIM FILING.

An injured worker is generally required to give notice of the accident to his or her employer within 30 days, and also to file a claim with the Board within two years.[29] For workers to access benefits, it is essential for them to be given meaningful information about the legal requirement to file a claim. It is equally essential that the claim filing process be tailored to the appropriate language and literacy levels.

The form used to file a claim with the Board is a C-3.0 form. Although the form was formerly one page, as a result of the Board's post-2007 administrative and regulatory changes it is now two pages and must be accompanied by a medical release if the worker has a prior injury or illness that is similar to the work-related injury.[30]

This section reviews the data provided by the Board regarding claim filing generally. It also includes information about claim filing and system access by workers who do not speak English. The data appears to demonstrate that while workers generally continue to file claims, those who are not fluent in English file at much lower rates.

A. Claims by Injured Workers.

The Board's response to the FOIL request appears to indicate that claims filed by injured workers increased steadily between 2011 and 2015. Overall, claims filed increased by about 33% from 161,581 in 2011 to 215,687 in 2015.[31]

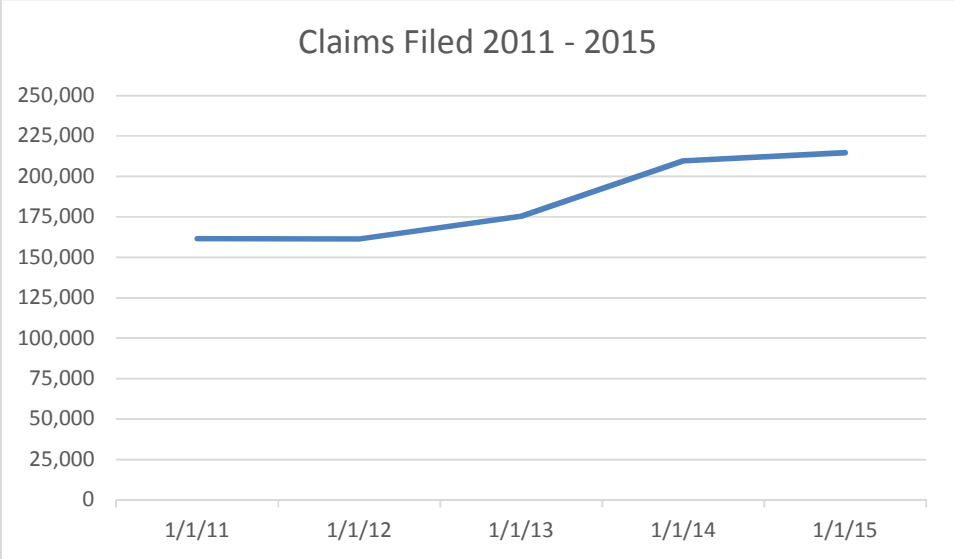
---

[29] New York State Workers' Compensation Law §§ 18, 28.
[30] 12 NYCRR § 300.37
[31] The figures regarding the number of claims filed may be inaccurate due to the potential filing of multiple claim forms in a single case and the fact that the Board's response to the FOIL request included a variety of forms that are not claim forms in its figures. Regardless of the actual number of forms filed, however, it is clear that there was a significant increase in the number of claims filed from 2011 to 2015.

Number of C-3 Forms Received[32]

		Received (Year)					
		2011	2012	2013	2014	2015	**Grand Total**
Form ID	Received (Month)	Total Form Count	Total Form Count	Total Form Count	Total Form Count	Total Form Count	Total Form Count
C-3	JAN	12,446	13,177	13,790	15,064	15,962	**70,439**
	FEB	13,227	13,747	13,512	14,444	17,376	**72,306**
	MAR	15,876	14,629	15,515	18,771	21,275	**86,066**
	APR	13,864	13,518	14,955	17,335	19,149	**78,821**
	MAY	13,024	14,297	15,210	16,844	16,837	**76,212**
	JUN	13,341	13,580	13,778	17,188	18,454	**76,341**
	JUL	12,760	13,650	14,896	18,901	18,269	**78,476**
	AUG	14,064	14,433	15,217	18,289	18,259	**80,262**
	SEP	12,918	11,866	14,367	19,042	17,173	**75,366**
	OCT	13,608	14,339	16,028	20,495	18,056	**82,526**
	NOV	13,633	12,290	14,626	16,322	16,451	**73,322**
	DEC	12,820	11,873	13,503	17,019	17,426	**72,641**
Grand Total		**161,581**	**161,399**	**175,397**	**209,714**	**214,687**	**922,778**

Form count includes forms C-3, C-3.0, C-3.0C, C-3.0H, C-3.0R, C-3.0S, C-3.1, C-3.3, C-3.3C, C-3.3P, C-3.3S, C-3C, C-3K, C-3P, C-3S, EC-3, EC-3.3X and EC-3T.



[32] This table and other similar tables in this paper are part of the Board's response to FOIL 16-119; the following graph and all other line graphs and bar charts in this paper were created based on the data provided by the Board in response to the FOIL as well as other available information (except as otherwise indicated).

B. Language Access.

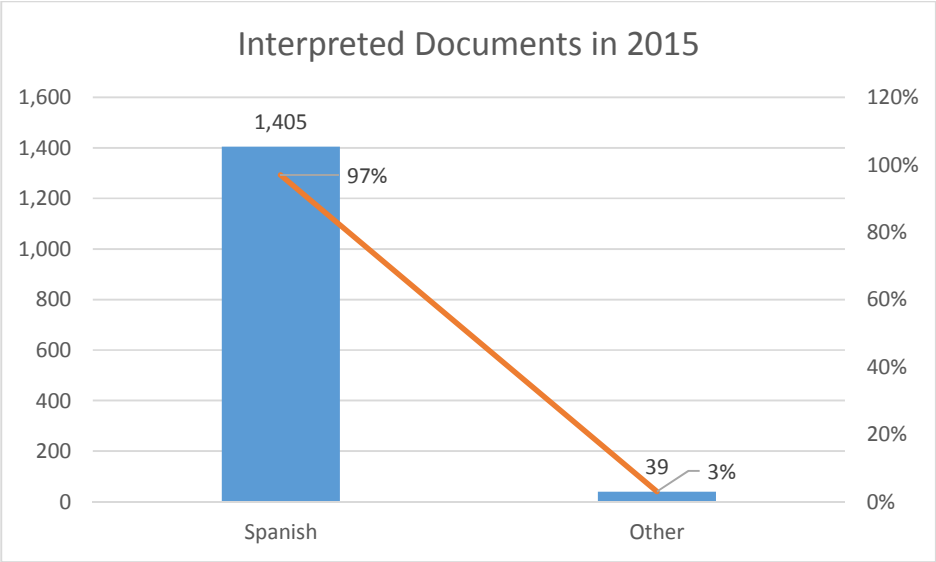
It appears, however, that workers who do not speak English experience significant difficulty in filing claims and in interacting with the Board. For example, in 2015 the Board received only 620 claims on its foreign-language forms out of 215,687 claims filed, a rate of 0.3%. Similarly, the Board provided interpretation of only 1,444 documents out of the hundreds of thousands it received, of which 1,405 (97%) were in Spanish and only 39 were in other languages. The low number of translation requests seems emblematic of the difficulties faced by non-English speakers who are injured on the job.[33]

Language Translation

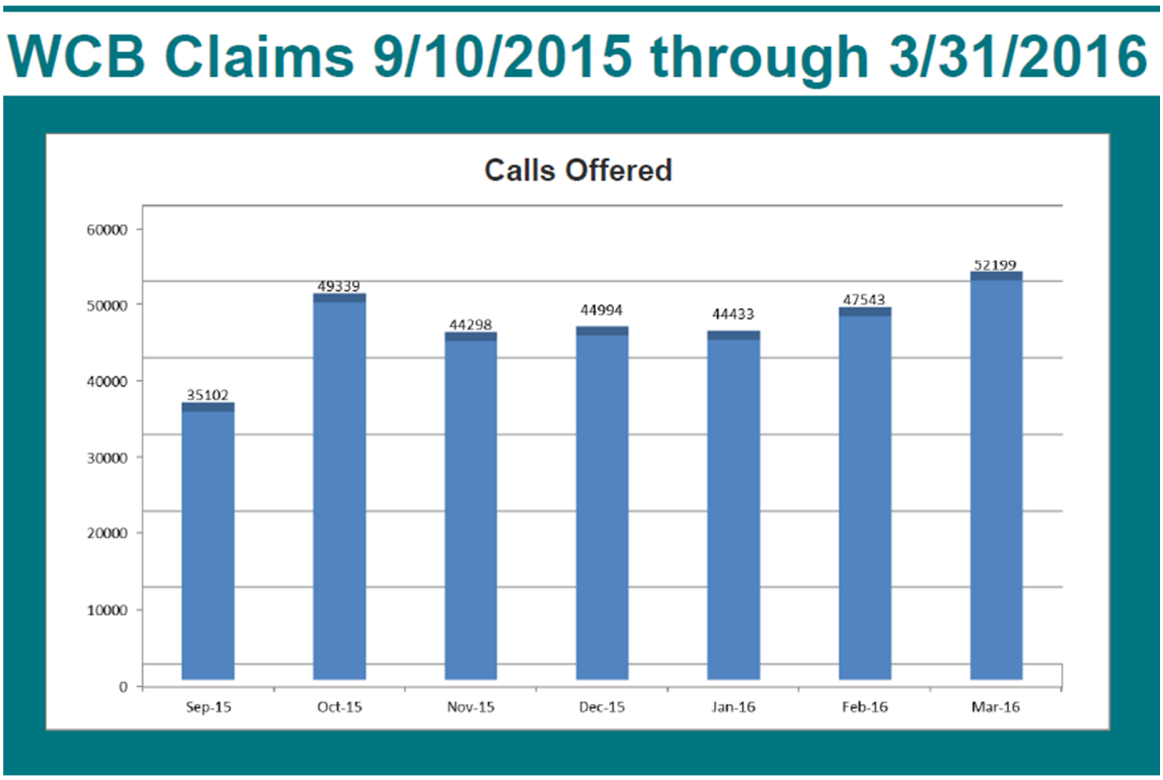
FORM ID	Count
Employee Claim (C-3.0 Chinese)	2
Employee Claim (C-3.0 Russian)	1
Limited Release of Health Information (HIPAA) (C-3.3 Spanish)	60
Limited Release of Health Information (HIPPA) (C-3.3SS)	1
Employee Claim (C-3 Chinese)	9
Employee Claim (C-3 Polish)	1
Employee Claim (C-3 Russian)	1
Employee Claim (C-3 Spanish)	604
Claim for Compensation in Death Case (C-62 Korean)	1
Claim for Compensation in Death case (C-62 Spanish)	1
Claimant's Authorization to Disclose Workers' Compensation Records (OC-110A Chinese)	2
Claimant's Authorization to Disclose Workers' Compensation Records (OC-110A Spanish)	727
Loss of Wage Earning Capacity Vocational Data Form (VDF-1)	11
Loss of Wage Earning Capacity Vocational Data Form (VDF-1 Chinese)	1
Loss of Wage Earning Capacity Vocational Data Form (VDF-1 Polish)	1
Loss of Wage Earning Capacity Vocational Data Form (VDF-1 Spanish)	14
Political Subdivision's Report of Injury to Volunteer Firefighter (VDF-2 Spanish)	1
Registration of Participation in World Trade Center Rescue, Recovery and/or Cleanup Operations: Sworn Statement Pursuant to WCL §162 (WTC-12)	1
Miscellaneous Correspondence	5
Total	1,444

- The WCB QA staff is responsible for processing requests for written translations on incoming foreign language documents. There was a total of 1,444 requests for English translations in 2015.
- There were 21,133 (302,968 minutes) telephone interpretation calls placed by WCB staff to assist incoming callers or to assist claimants during adjudication hearings/meetings.

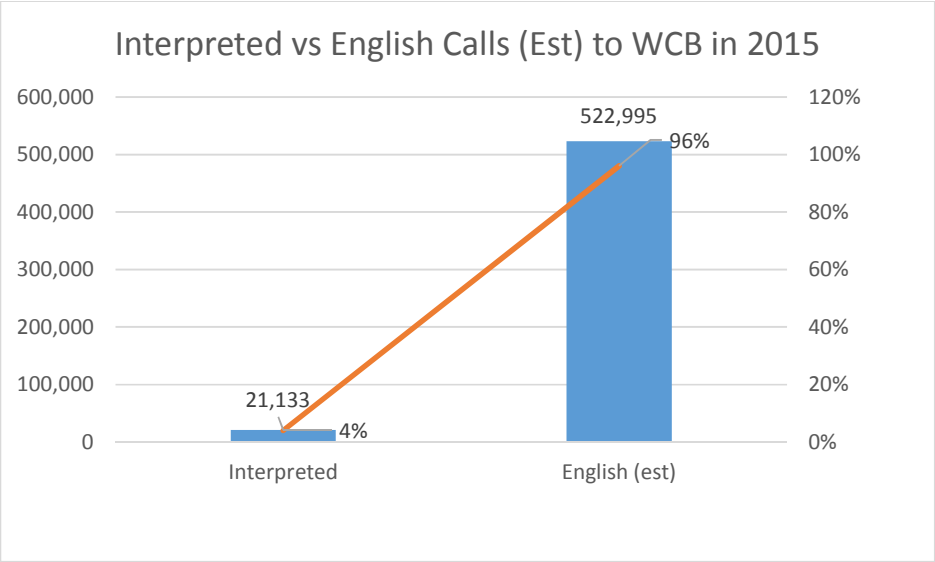
[33] The graphic was provided by the Board in a powerpoint presentation to its Advisory Council, Spring 2016.



While the Board did provide 21,133 interpretation calls in 2015, that figure is only about 4% of the estimated 522,995 calls it processed.[34]



[34] Id.



This figure can be placed in context by comparison to the estimate that over 13% of New York residents do not speak English. According to Governor Cuomo's October, 2011 Executive Order to improve access to state services for non-English speakers, 2.5 million of the state's population of 19 million do not speak English.[35] It therefore appears that in the area of claim filing the Board interacts with workers who are not fluent in English at a rate of 2% compared to their population share, and by telephone the rate is about 30%.[36]

The Board refused to respond to inquiries about whether it issues its claim assembly documents or notices of decision in any languages other than English, but stakeholders report that it does not. The absence of language-appropriate communication after a claim is filed further exacerbates the access issues faced by immigrant workers.

It therefore appears that the Board's forms and procedure have a significant deterrent impact on claim filing and claim prosecution by workers who are not fluent in English.

[35] http://www.governor.ny.gov/news/governor-cuomo-issues-executive-order-improve-access-state-services-non-english-speakers-0; https://en.m.wikipedia.org/wiki/Demographics_of_New_York

[36] 0.3% of claim forms vs 13% population is 2%; 4% of interpreted calls vs 13% population is 30%.

IV. ADMINISTRATION.

After a claim is filed, the Board is obligated to respond by creating a case file, assigning a case number, and taking administrative action to ensure that benefits are properly paid. An essential part of this process is meaningful communication to the injured worker about his or her rights. It is equally essential that the system afford the worker an opportunity to be heard and to pursue a meaningful remedy when benefits are diminished or denied by the employer or carrier.

The Board's administrative processes have become increasingly technical and complicated. As a result, workers are increasingly unfamiliar with their rights in the system. Their right to a hearing is routinely denied, and they are not provided with adequate remedies.

This section will review the Board's procedure for the creation of case files and the impact of its methods of claim determination on worker access to the system.

A. Assembly and Indexing.

In 2008, the Board departed from its traditional approach of "indexing" a case upon receipt of a claim, and adopted a two-step process in which cases are "assembled" upon receipt of a form, but not "indexed" until the file includes both a claim form and a medical report.[37] The significance of this change is that an employer or carrier is not legally required to respond to a claim until it is formally indexed.[38] Thus the "assembly" of the case gives the injured worker a case number, but does not require the employer or carrier to take any action.

---

[37] WCB Subject Number 046-254, available at http://www.wcb.ny.gov/content/main/SubjectNos/sn046_254.jsp

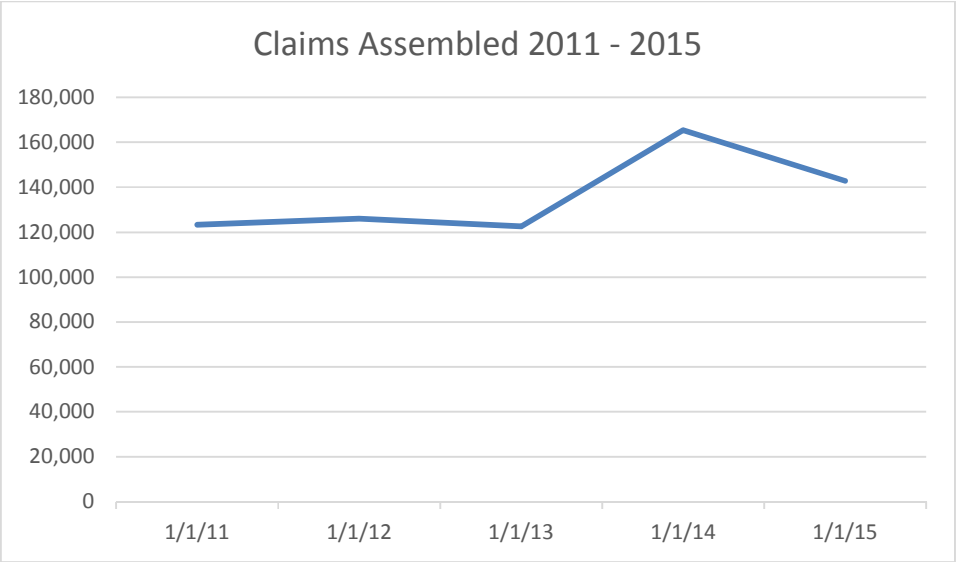
[38] See, e.g., New York Workers' Compensation Law § 25(2)(b).

Between 2011 and 2013 the Board assembled an average of 123,975 claims per year. This figure jumped to 165,441 in 2014 before declining to 142,830 in 2015. It appears that the significant increase in claims assembled in 2014 was a result of the Board's transition to electronic filing (EDI). The impact of this transition may also account for the elevated number of claims assembled in 2015 as compared to the pre-2014 trend. The spike in claims filed appears in the table below in March of 2014, and the figures in almost every subsequent month are greater than in the preceding months.

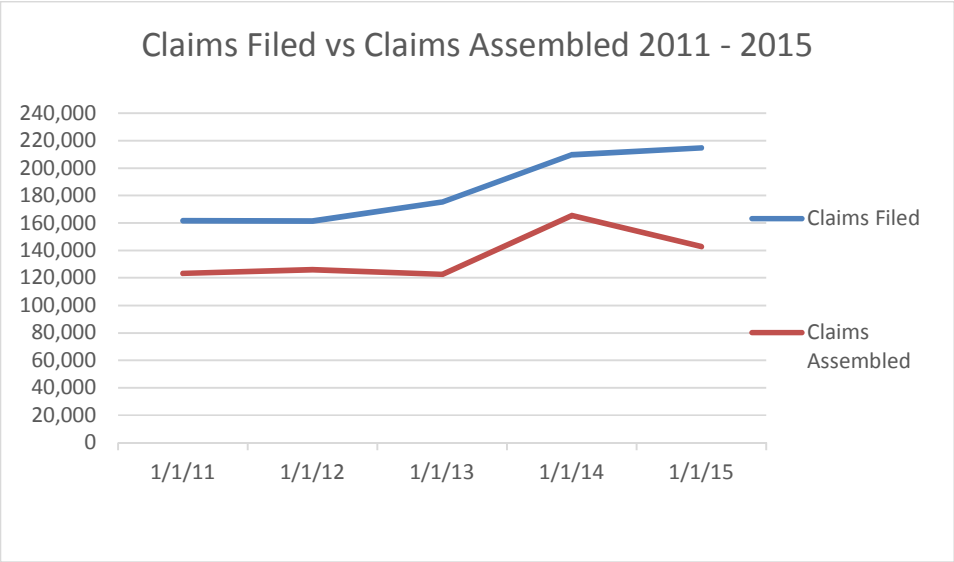
Number of Claims Assembled

	Claim Assembled (Year)					
	2011	2012	2013	2014	2015	**Grand Total**
Claim Assembled (Month)	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count
JAN	9,456	10,339	10,356	10,034	10,754	**50,939**
FEB	8,744	10,441	10,261	8,851	11,307	**49,604**
MAR	11,452	11,884	10,789	20,047	12,879	**67,051**
APR	10,844	10,806	12,311	14,306	12,331	**60,598**
MAY	9,763	11,738	11,005	12,797	11,167	**56,470**
JUN	9,645	11,165	8,095	16,599	12,639	**58,143**
JUL	9,430	10,707	10,493	11,880	13,185	**55,695**
AUG	11,191	11,091	9,797	16,631	11,914	**60,624**
SEP	10,535	10,034	10,204	14,108	11,256	**56,137**
OCT	10,769	9,441	10,879	15,020	11,731	**57,840**
NOV	11,391	9,782	8,932	12,544	12,041	**54,690**
DEC	10,025	8,636	9,493	12,624	11,626	**52,404**
Grand Total	**123,245**	**126,064**	**122,615**	**165,441**	**142,830**	**680,195**

The implementation of Electronic Data Interchange (EDI) by all carriers in April 2014 enables the Board to auto-assemble claims upon receipt of the First Report of Injury (FROI). Now, 94% of assembled claims are auto-assembled. When the carrier learns of the disability event (workplace injury), it must file a FROI with the Board. The higher number of assembled cases after 2013 reflects the effectiveness of EDI, which in turn supports the Board's efforts to monitor and ensure compliance with filing and payment obligations.



Even including the increase in claims assembled in 2014 and 2015, the Board assembled significantly fewer cases than the number of claims filed in every year from 2011 through 2015, with an average difference of 26%.



There is no ready explanation for the Board's assembly of far fewer cases than the number of claims filed. Moreover, in 2015 it appears that claims filed increased while the number of cases assembled declined.

The Board declined to provide data about how many assembled cases were later indexed, or to indicate how many cases met its criteria to do so but were not indexed. We note that its regulations require it to index every case in which its file contains a medical report and either an employee's claim or an employer's report of accident.[39] Anecdotal reports, which would appear to be confirmed by the Board's refusal to provide information, indicate that as a matter of administration the Board has opted to disregard its regulatory requirements if the claim is voluntarily accepted by the employer or carrier. This has the effect of providing employers and carriers with extended periods of time in which to respond to employee claims, potentially delaying the filing of notices of controversy and delaying claim resolution and payment of benefits.

B. Administrative and Proposed Decisions.

Once a case is indexed, the Board is obligated to issue a decision establishing the nature of the injury, the worker's pre-accident wage, and the period and extent of the worker's disability. However, in 2016 the Board indicated that it would no longer issue any type of decision in cases in which there was no time lost from work.[40] Although the Board may or may not be within its legal rights in this regard, the lack of a formal decision notice further decreases the Board's communication to and protection of the injured worker, and creates ambiguity about whether the worker's injuries are "established" for purposes of medical treatment and billing.

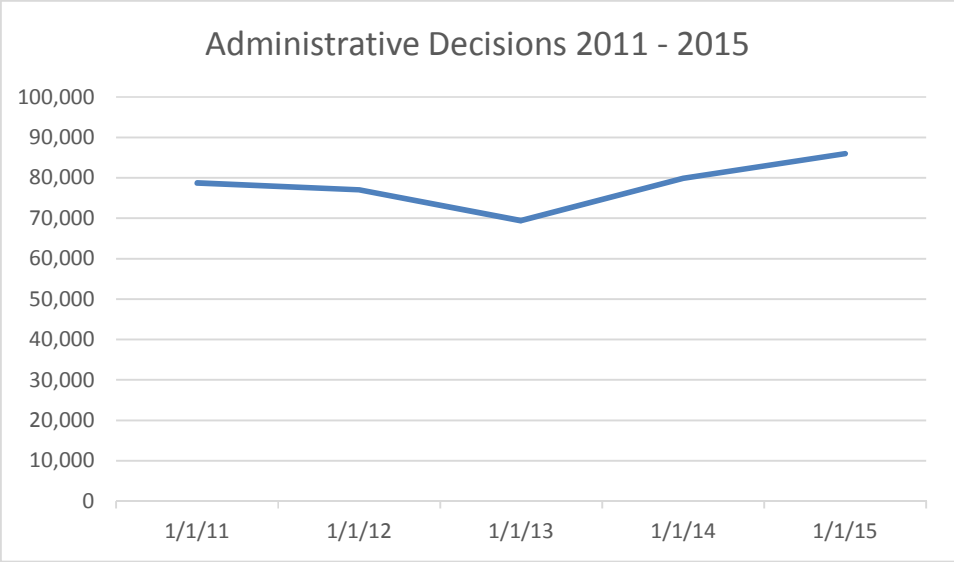
In cases involving lost time where the employer or carrier accept responsibility, the Board attempts to "resolve" the claim without holding a hearing, and instead issues either an

[39] 12 NYCRR § 300.37.
[40] WCB Subject Number 046-777, available at http://www.wcb.ny.gov/content/main/SubjectNos/sn046_777.jsp

Administrative or a Proposed Decision, apparently depending on the extent of the lost time. Between 2011 and 2015 the Board issued 390,923 Administrative Decisions and 507,697 Proposed Decisions, thus "resolving" about 900,000 cases without a hearing.

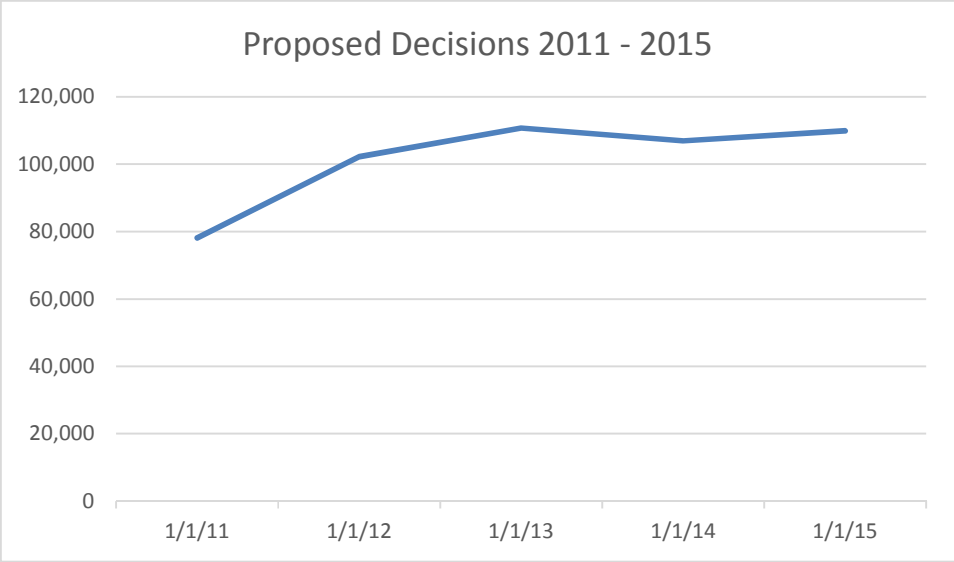
Number of Administrative Decisions Filed

	Administrative Determination (Year)					
	2011	2012	2013	2014	2015	**Grand Total**
Administrative Determination (Month)	Total ADs	Total ADs	Total ADs	Total ADs	Total ADs	Total ADs
JAN	6,247	6,330	6,562	7,195	5,655	**31,989**
FEB	5,377	6,371	5,372	5,268	5,687	**28,075**
MAR	6,229	8,486	5,872	5,781	7,888	**34,256**
APR	5,689	6,577	6,449	6,284	8,340	**33,339**
MAY	5,871	6,471	5,992	6,665	8,552	**33,551**
JUN	6,724	5,613	5,180	6,871	6,798	**31,186**
JUL	8,143	5,149	5,760	7,241	4,957	**31,250**
AUG	8,000	6,225	6,096	6,862	5,677	**32,860**
SEP	6,184	5,659	5,245	7,126	6,846	**31,060**
OCT	5,727	6,915	5,921	7,036	7,731	**33,330**
NOV	6,398	6,144	5,173	6,231	7,160	**31,106**
DEC	8,093	7,089	5,781	7,299	10,659	**38,921**
Grand Total	**78,682**	**77,029**	**69,403**	**79,859**	**85,950**	**390,923**



Number of Proposed Decisions Filed

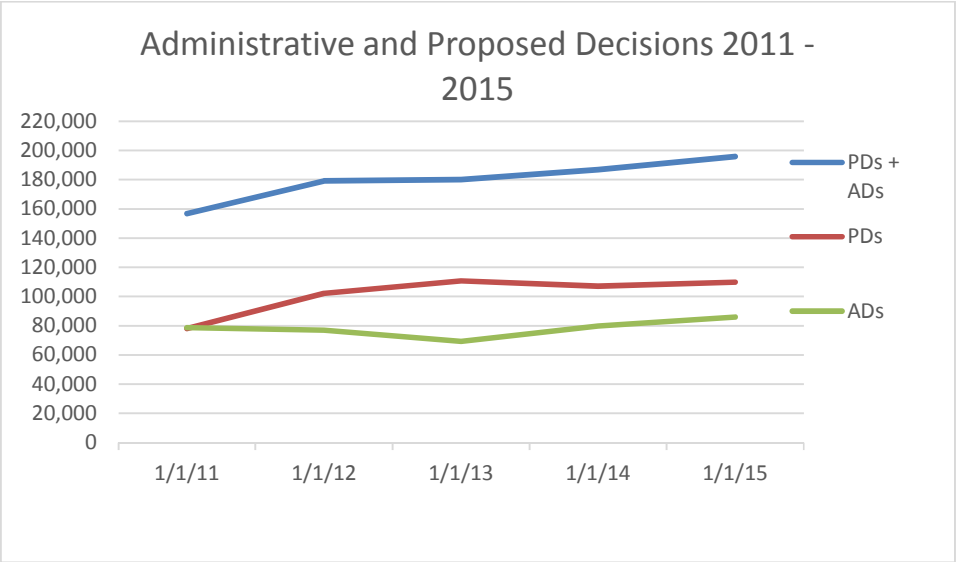
	Proposed Decision (Year)					
	2011	2012	2013	2014	2015	**Grand Total**
Proposed Decision (Month)	Total Proposed Decisions	Total Proposed Decisions	Total Proposed Decisions	Total Proposed Decisions	Total Proposed Decisions	Total Proposed Decisions
JAN	4,691	8,326	9,980	9,090	9,121	**41,208**
FEB	4,301	9,873	9,441	8,207	8,606	**40,428**
MAR	6,662	9,727	9,218	9,029	9,457	**44,093**
APR	5,862	8,134	9,490	9,548	9,663	**42,697**
MAY	6,945	8,988	10,050	9,845	8,565	**44,393**
JUN	7,137	9,453	8,725	9,312	8,186	**42,813**
JUL	5,790	9,033	8,529	8,518	8,479	**40,349**
AUG	7,658	9,100	9,313	6,345	9,018	**41,434**
SEP	7,377	7,124	8,610	9,350	9,369	**41,830**
OCT	7,237	8,085	10,464	9,628	10,312	**45,726**
NOV	7,214	6,127	8,499	8,626	8,803	**39,269**
DEC	7,188	8,271	8,417	9,475	10,106	**43,457**
Grand Total	**78,062**	**102,241**	**110,736**	**106,973**	**109,685**	**507,697**



The data indicates that while the number of Administrative Decisions remained relatively constant from 2011 through 2013, there was a sharp increase in the number of Proposed Decisions in March of 2011. This may reflect an unannounced policy change by the Board, or it may reflect the Board's use of Proposed Decisions to address issues created

by its promulgation of the Medical Treatment Guidelines in December, 2010. After March of 2011, however, the number of Proposed Decisions increased steadily through 2013 before leveling off in 2014.

At that point there was a sharp increase in the number of Administrative Decisions issued. Once again, this may reflect an unannounced policy or process change by the Board. The individual and aggregate numbers of the Administrative and Proposed Decisions issued between 2011 and 2015 are shown on the chart below, which demonstrates a progressive increase in the Board's use of non-hearing determinations to "resolve" claims.



The Board declined to provide information about how many Administrative Decisions involved claims for lost time in excess of one week or potential schedule loss of use awards, although the Board's statutory authority to issue Administrative Decisions is limited to cases that involve less than a week of lost time. The Board also declined to provide information about how many Proposed Decisions were issued as the result of conciliation meetings that are required by law, how many involved awards in excess of fifty-two weeks (the limit of the Board's legal authority to issue a Proposed Decision), how

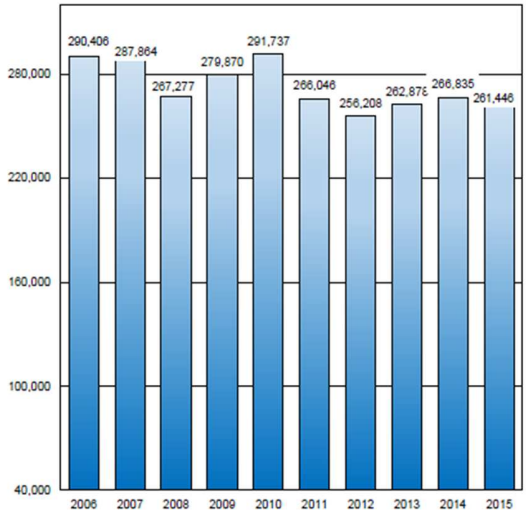
many were issued at the request of a worker, employer or carrier, and how many objections it received to Proposed Decisions.[41]

It is clear, however, that the Board has made increasing use of Administrative and Proposed Decisions to reduce the number of hearings, and by 2015 the Board reported that it was "resolving" half of the claims before it by "administrative processes."

The graphic below indicates that the Board held fewer hearings in every year from 2011 through 2015 than it held in any year from 2006 through 2010.

Number of Hearings Held from 2006 to 2015

Year	Total Hearings Held	Claims Pending at Year End	Ratio of Hearings Held to Claims Pending
2006	290,406	122,860	2.4
2007	287,864	116,392	2.5
2008	267,277	96,058	2.8
2009	279,870	90,315	3.1
2010	291,737	85,286	3.4
2011	266,046	99,995	2.7
2012	256,208	103,955	2.5
2013	262,878	110,208	2.4
2014	266,835	142,422	1.9
2015	261,446	164,972	1.6

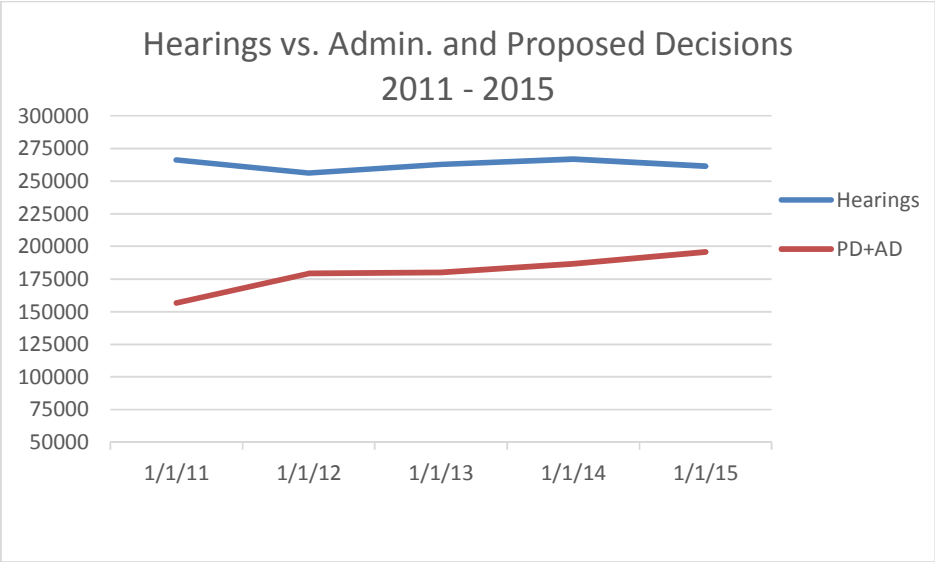


The number of hearings excludes commissioner hearings, board panel reviews and waiver agreements.

The number of claims pending reflects all cases assembled and currently open.

The hearing statistics from 2011 through 2015 can then be compared to the number of Administrative and Proposed Decisions issued from 2011 through 2015. The results are shown on the chart below.

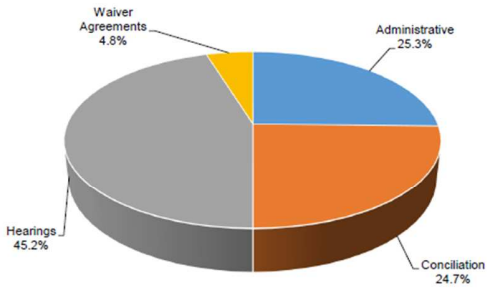
[41] New York Workers' Compensation Law § 25(2-b).



The Board has provided data regarding its use of various processes in 2015, and the graphic it published indicates that it "resolved" half of the claims before it without scheduling a hearing at which the injured worker could be present and participate.

Claim Resolution by Board Processes in 2015

Claim Resolution	Number of Resolutions	Percentage of Resolutions
Informal	177,220	50.0%
Administrative	89,794	25.3%
Conciliation	87,426	24.7%
Formal	177,206	50.0%
Hearings	160,291	45.2%
Waiver Agreements	16,915	4.8%
Total	354,426	100.0%



"Administrative" includes Administrative Determinations, Administrative Closures and Cancellations (A claim is cancelled if it is determined to be a duplicate).

"Conciliation" provides an informal and prompt resolution of the claim based upon the cooperation of both parties: the injured worker and the insurance carrier/self-insured employer.

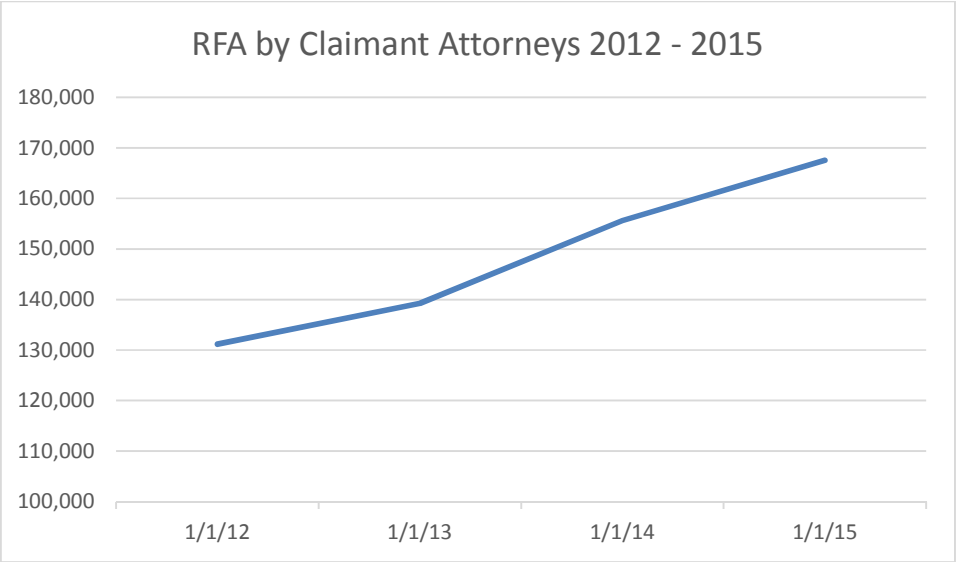
A claim resolved by the "Hearing" process is one for which a judge had determined that no further action by the Board was necessary at the conclusion of the hearing, this includes Pre-Hearing Conferences. A Pre-Hearing Conference provides a mechanism for the identification of issues and relevant evidence and to permit parties of interest an opportunity to assess their case and to resolve outstanding issues prior to scheduling a hearing regarding those issues.

The Board's reliance on administrative processes has resulted in increasing requests for it to reopen cases and to schedule hearings. Prior to August of 2011, either an injured worker or an attorney could file an RFA-1 form, while attorneys also made use of another form, the RFA-1LC. In August of 2011, however, the Board required attorneys to limit their use to form RFA-1LC, while injured workers continued to use the RFA-1 form. As a result, it is impossible to determine how many hearing requests were filed by injured workers and attorneys, respectively, in 2011.

From 2012 through 2015, however, hearings requests by attorneys can be differentiated from those filed by injured workers. During that time period, requests from attorneys for injured workers rose from 131,177 to 167,575, an increase of over 20%.

Number of RFA-1LC Forms Received

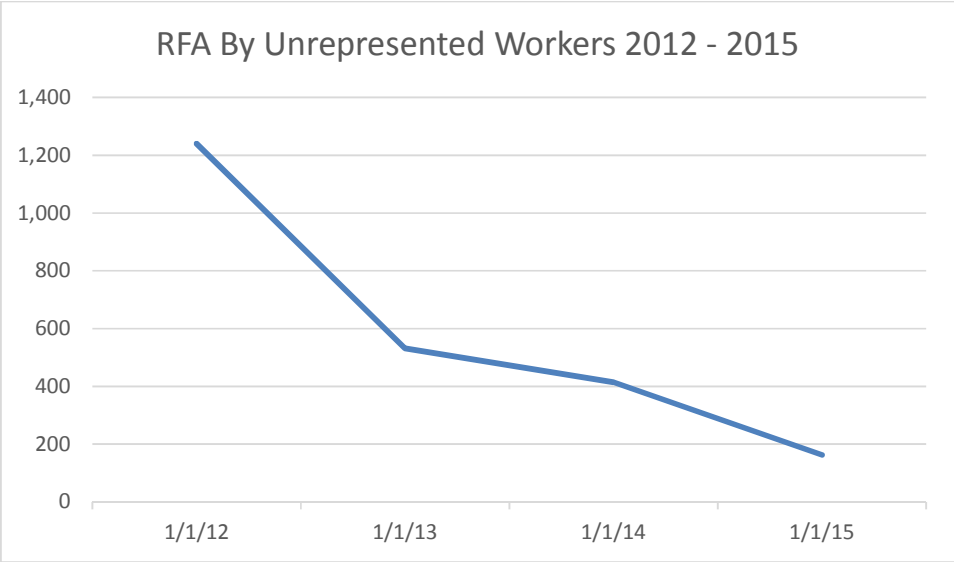
		Received (Year)					
		2011	2012	2013	2014	2015	**Grand Total**
Form ID	Received (Month)	Total Form Count	Total Form Count	Total Form Count	Total Form Count	Total Form Count	Total Form Count
RFA-1LC	JAN	2,017	10,251	11,499	12,014	12,645	**48,426**
	FEB	2,783	11,061	10,864	10,477	12,320	**47,505**
	MAR	4,331	12,647	12,355	12,735	14,393	**56,461**
	APR	4,328	10,899	12,210	13,173	14,299	**54,909**
	MAY	4,660	11,380	12,539	12,899	13,501	**54,979**
	JUN	6,797	11,130	10,695	13,152	14,893	**56,667**
	JUL	6,987	10,822	11,547	14,262	14,685	**58,303**
	AUG	8,878	12,102	11,912	13,360	14,246	**60,498**
	SEP	9,701	10,110	10,670	13,820	13,809	**58,110**
	OCT	10,164	11,099	12,738	14,334	14,523	**62,858**
	NOV	10,428	9,948	11,277	12,122	13,606	**57,381**
	DEC	10,418	9,728	10,964	13,303	14,655	**59,068**
Grand Total		**81,492**	**131,177**	**139,270**	**155,651**	**167,575**	**675,165**



During the same time frame from 2012 through 2015, hearing requests from unrepresented workers declined 97% from 1,241 to 169. This again demonstrates the increasing difficulty of workers in accessing benefits from the system. Another measure of the challenge workers face in pursuing claims without legal representation is that in 2012 they filed slightly less than 1% of hearing requests; by 2015 that figure had dropped to one-tenth of 1%.

Number of RFA-1 Forms Received

		Received (Year)					
		2011	2012	2013	2014	2015	**Grand Total**
Form ID	Received (Month)	Total Form Count	Total Form Count	Total Form Count	Total Form Count	Total Form Count	Total Form Count
RFA-1	JAN	6,469	165	50	39	15	**6,738**
	FEB	5,560	160	49	30	10	**5,809**
	MAR	6,863	128	41	27	35	**7,094**
	APR	6,566	99	54	35	16	**6,770**
	MAY	5,469	90	39	75	12	**5,685**
	JUN	4,254	170	51	28	17	**4,520**
	JUL	3,267	102	28	43	15	**3,455**
	AUG	1,967	82	38	20	5	**2,112**
	SEP	717	96	49	17	14	**893**
	OCT	262	67	54	25	12	**420**
	NOV	282	43	52	15	12	**404**
	DEC	205	39	27	60	6	**337**
Grand Total		**41,881**	**1,241**	**532**	**414**	**169**	**44,237**



There are numerous anecdotal reports that the Board responds far more promptly to hearing requests from insurers than from injured workers and their attorneys. The Board declined to provide information regarding the number of instances in which injured workers

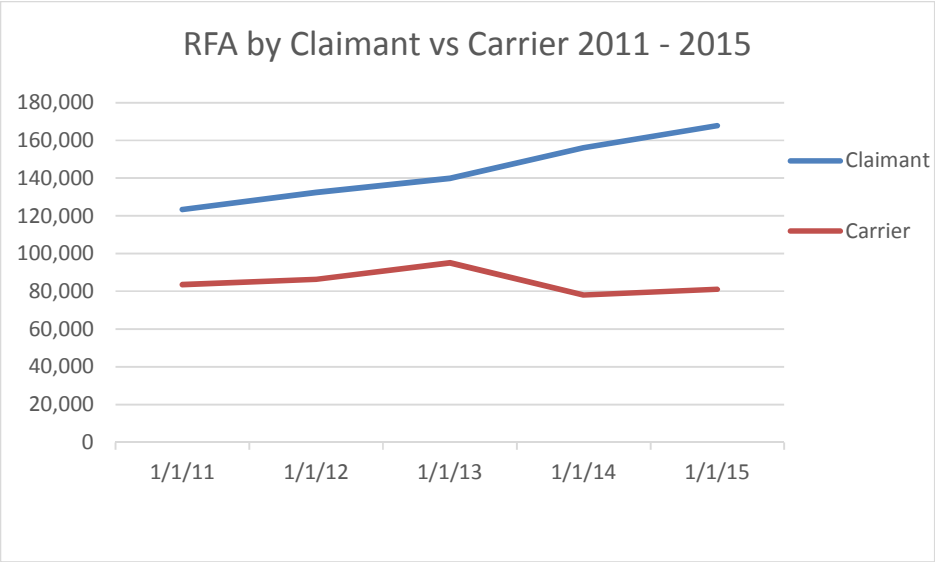
or their attorneys were required to file multiple requests before being granted a hearing. The Board also declined to provide information regarding the time frame in which it responded to requests from attorneys as compared to requests by insurers.

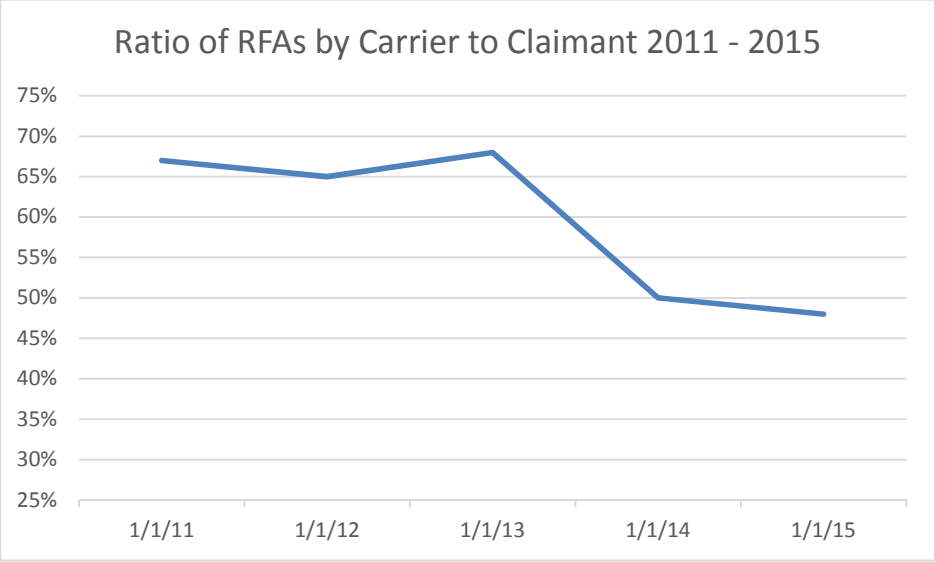
The Board did, however, provide data showing that insurers filed far fewer hearing requests than injured workers or attorneys, with the number remaining stable at an average of 84,830 per year even as requests from injured workers and attorney rose sharply.

Number of RFA-2 Forms Received

		Received (Year)					
		2011	2012	2013	2014	2015	**Grand Total**
Form ID	Received (Month)	Total Form Count	Total Form Count	Total Form Count	Total Form Count	Total Form Count	Total Form Count
RFA-2	JAN	6,889	6,767	7,506	6,750	6,206	**34,118**
	FEB	6,597	6,928	7,080	5,846	6,110	**32,561**
	MAR	8,009	7,717	8,107	6,676	7,074	**37,583**
	APR	7,582	7,270	7,579	6,431	7,041	**35,903**
	MAY	7,081	7,597	8,465	6,294	6,403	**35,840**
	JUN	7,120	7,520	7,673	6,460	6,953	**35,726**
	JUL	6,880	7,005	7,560	6,542	6,516	**34,503**
	AUG	7,099	8,123	7,826	6,447	6,667	**36,162**
	SEP	6,670	6,958	7,279	6,853	6,860	**34,620**
	OCT	6,748	7,593	8,427	7,408	7,445	**37,621**
	NOV	6,445	6,588	8,255	5,933	6,704	**33,925**
	DEC	6,432	6,296	9,397	6,399	7,062	**35,586**
Grand Total		**83,552**	**86,362**	**95,154**	**78,039**	**81,041**	**424,148**

As a result, in 2012 insurers filed about two-thirds as many hearing requests as injured workers; by 2015 the ratio had declined to 48%.



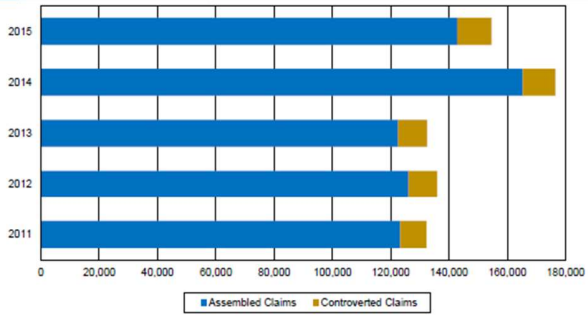


It may be inferred from this data that the Board responded promptly to requests from insurers, while requiring injured workers and their attorneys to file multiple requests before receiving a reply. If accurate, this would confirm the accuracy of the anecdotal evidence about the Board's response to hearing requests by the respective parties.

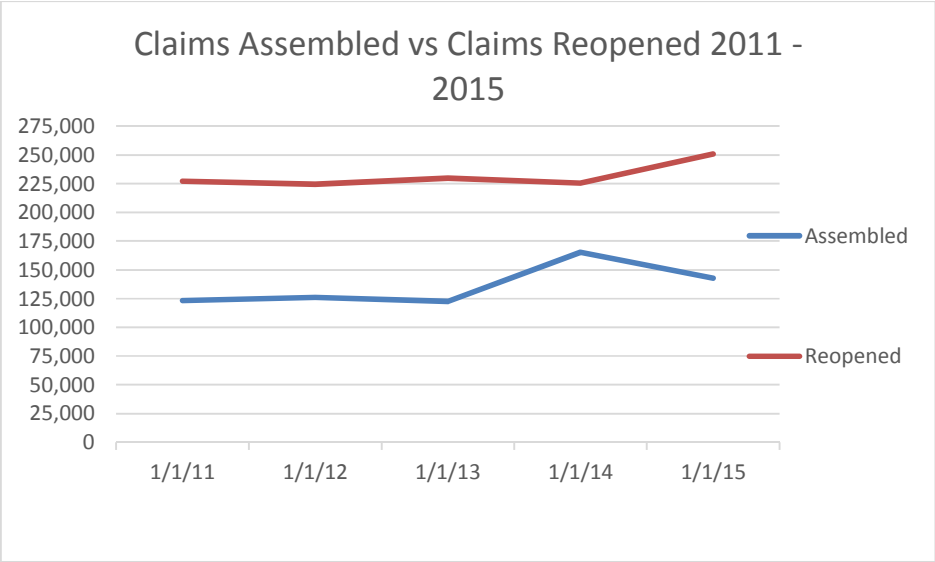
The ultimate outcome of the Board's use of non-hearing resolutions, as well as its routine closure of cases with a "no further action" designation when hearings are scheduled, is that it now reopens more cases every year than it assembles. In four out of five years from 2011 through 2015, the Board reopened about 100,000 more claims than it indexed.[42]

Claims Assembled and Controverted from 2011 to 2015

Year	Reopened Claims	Assembled Claims	Controverted Claims	Percent Controverted
2011	227,030	123,245	9,008	7.3%
2012	224,412	126,064	9,838	7.8%
2013	229,897	122,615	9,850	8.0%
2014	225,450	165,304	11,175	6.8%
2015	250,804	142,830	11,743	8.2%



A controverted claim is one for which the Board has received:
1) "Notice That Right To Compensation Is Controverted" indicating that the Carrier disputes the claim, and
2) qualifying medical documentation.
The implementation of Electronic Data Interchange (EDI) by all carriers in April 2014 enables the Board to auto-assemble claims upon receipt of the First Report of Injury (FROI). Currently 94% of assembled claims are auto-assembled. When the carrier learns of the disability event (workplace injury), it must file a FROI with the Board. The higher number of assembled cases after 2013 reflects the effectiveness of EDI, which in turn supports the Board's efforts to monitor and ensure compliance with filing and payment obligations.



[42] The exception was 2014, when an unexplained increase in claims filed reduced the gap to 60,000.

V. MEDICAL TREATMENT GUIDELINES.

The Board's Medical Treatment Guidelines (MTG) were discussed at length in the 2014 White Paper. In response to the FOIL request, however, the Board provided new data that provides additional insight into its application of the MTG. It remains clear that the MTG result in the denial of hundreds of thousands of medical treatment requests each year. Although this results in savings to employers and carriers in the cost of care, this is substantially offset by the administrative costs associated with the MTG process.

According to the Board, in 2015 it received 272,396 requests to depart from its MTG ("variances"). The Board rejected 25,413 of those variances (9%) without awaiting action by the employer or carrier. Carriers voluntarily granted 85,922, or 31.5% of the variance requests that they processed.[43]

Number of MG-2 Variance Requests Granted

Form ID	Received (Year/Month)	Total Form Count
MG-2G	APR- 2015	6,985
	MAY- 2015	6,721
	JUN- 2015	7,081
	JUL- 2015	7,418
	AUG- 2015	6,680
	SEP- 2015	6,648
	OCT- 2015	7,062
	NOV- 2015	6,987
	DEC- 2015	6,908
	JAN- 2016	7,346
	FEB- 2016	7,589
	MAR- 2016	8,497
Grand Total		**85,922**

Carriers denied another 47,896, or 17.5% of the variance requests.

[43] The Board provided data about the number of variances filed and rejected for 2015; the remainder of the data it provided covered the period from April of 2015 through March of 2016.

Number of MG-2 Variance Requests Denied

Form ID	Received (Year/Month)	Total Form Count
MG-2D	APR- 2015	3,846
	MAY- 2015	4,201
	JUN- 2015	3,364
	JUL- 2015	4,113
	AUG- 2015	3,865
	SEP- 2015	3,327
	OCT- 2015	4,112
	NOV- 2015	3,902
	DEC- 2015	4,086
	JAN- 2016	3,383
	FEB- 2016	4,752
	MAR- 2016	4,945
Grand Total		**47,896**

Count of denied variance requests does not include MG-2s that were denied and had a request for review.

The Board did not provide data regarding its processing of the remaining 113,708, or 41% of the variances. It did report that only 10,238 variances received hearings by Workers' Compensation Law Judges (WCL Judges), of which 3,416, or one-third, were granted.

Number of Variance Requests That Have Received Hearings Before WCL Judges

Form ID	Received (Year/Month)	Total Form Count
MG-2	APR- 2015	862
	MAY- 2015	849
	JUN- 2015	860
	JUL- 2015	918
	AUG- 2015	751
	SEP- 2015	773
	OCT- 2015	923
	NOV- 2015	854
	DEC- 2015	857
	JAN- 2016	726
	FEB- 2016	892
	MAR- 2016	973
Grand Total		**10,238**

Number of Variance Requests That Have Been Granted by WCL Judges

Form ID	Received (Year/Month)	Total Form Count
MG-2	APR- 2015	275
	MAY- 2015	240
	JUN- 2015	287
	JUL- 2015	287
	AUG- 2015	251
	SEP- 2015	272
	OCT- 2015	310
	NOV- 2015	289
	DEC- 2015	302
	JAN- 2016	265
	FEB- 2016	292
	MAR- 2016	346
Grand Total		**3,416**

Overall, therefore, it appears that the Board receives several hundred thousand variances each year, which are processed at substantial administrative cost to employers, carriers, the Board, health care providers, and attorneys for injured workers. Virtually all of these requests for medical treatment are processed administratively, and through those processes about one-third are granted and the other two-thirds are denied.

VI. WAGE REPLACEMENT BENEFITS,

A full discussion of the inadequacy of wage replacement benefits can be found in Exhibit B, Workers' Compensation 2016: The Aftermath of the 2007 Reforms For Injured Workers. That examination of the impact of the 2007 statutory reforms on the amount of benefits paid to disabled workers and on lost wages that are not compensated by the system resulted in eight significant conclusions.

First, the 2007 reforms did not increase benefits for low-wage workers who had temporary disabilities or injuries that resulted in schedule loss awards. Workers' compensation benefits are based in large part on the worker's pre-accident wage, and the most a worker can receive is two-thirds of that figure.[44] Therefore, workers who earn $600 per week or less did not benefit from increases in the statutory benefit rate, but are instead limited to the same $400 maximum weekly benefit that existed before the 2007 reform for both temporary and permanent disability awards.

Second, permanent partial disability benefits for these workers were slashed by 70% or more, creating huge savings for insurers at a huge cost to the most vulnerable part of the working population. This resulted from the change in permanent disability benefits from permanent to temporary (four to ten years), despite the continuance of the disability.

Third, the 2007 reforms did increase benefits for high wage workers for periods of temporary disability and for schedule loss, in some instances doubling these awards.[45] Unlike low-wage workers, those who earned more than $600 per week received higher weekly benefit rates for periods of temporary disability and for schedule loss to the extent supported by their wages.

Fourth, the 2007 reforms decimated permanent partial disability benefits for high-wage workers to the same extent – 70% - as for low-wage workers. However, the application of the PPD caps to high-wage workers created even larger dollar savings in unpaid benefits. Again, this is because the weekly benefit rate payable to a permanently partially disabled worker is a function of wages. A worker who earns $600 per week who is

[44] New York Workers' Compensation Law § 25. It must be noted that most workers do not receive compensation for total disability for extended periods of time, but are frequently paid at much lower benefit rates for partial disability.

[45] According to wage distribution data published by the Workers' Compensation Board, about a quarter of all injured workers would fall into this category.

moderately disabled may be paid $200 per week in compensation benefits, while a worker who earns $1,200 per week with a moderate disability receives $400 per week. Thus, the application of caps to permanent disability awards generated larger savings for insurers in the claims of high wage workers than low-wage workers, because the non-payable weeks would have involved a higher benefit rate.

Fifth, the 2007 reforms did not affect uncompensated wage loss for low-wage workers with temporary disabilities, nor did it increase their benefits from schedule loss awards. Because low-wage workers do not earn enough to benefit from the increased maximum rates their compensation for temporary disability and schedule loss were unaffected, and thus their uncompensated wage loss (the lost salary and benefits not covered by workers' compensation) are similarly unchanged.

Sixth, while the 2007 reforms did reduce uncompensated wage loss for high wage workers in cases of temporary disability, these workers still suffer from significant uncompensated wage loss as the result of on-the-job injury. Although high-wage workers received more weekly compensation benefits for lost wages after the 2007 reforms, the statutory benefit does not replace all lost wages. In addition, high-wage workers frequently have other employment benefits that are not taken into account by the workers' compensation system, but which contribute to their uncompensated wage loss after an injury.

Seventh, the 2007 reforms eliminated uncompensated wage loss for high wage workers in some schedule loss cases, providing them with the same benefit (in percentage terms) as low-wage workers. Although weekly compensation payments for temporary disability result in uncompensated wage loss, this is sometimes recovered by workers in cases where schedule loss awards are entered. Prior to the 2007 reform, low wage workers

recovered a higher percentage of their uncompensated wage loss by virtue of these awards than high wage workers. This was ameliorated to some extent by the 2007 reforms, which reduced uncompensated wage loss for high wage workers with schedule loss awards because the value of those awards was increased.

Eighth, before the 2007 reforms workers suffered uncompensated wage loss of 67% or more in cases of permanent partial disability. As a result of the 2007 reforms, this figure rose to 90%, meaning that the workers' compensation system now replaces less than 10% of the wages lost by a permanently disabled worker. The increase in uncompensated wage loss corresponds to the decreased portion of wage replacement benefits provided by the workers' compensation system for permanent partial disability.

Overall, the 2007 reforms reduced uncompensated wage loss for high wage workers with short term disabilities or schedule loss injuries, while dramatically increasing the extent of uncompensated wage loss for workers throughout the wage spectrum who suffer from permanent partial disabilities.

VII. PERMANENCY,

The subject of permanent disability involves three distinct issues: schedule loss of use awards, permanent partial disability awards, and settlements. As discussed previously, awards for permanent partial disability were capped by the 2007 legislation in response to the assertion of business that these claims were responsible for the bulk of the costs in the system. With that "reform" in place, the business-side discussion has now shifted to schedule loss awards. Each are discussed below.

A. Schedule Loss of Use.

An increase in schedule loss awards for high wage workers was an anticipated and negotiated consequence of the 2007 reform legislation. An injured worker's award for schedule loss – the permanent loss or loss of function of a limb, often involving fracture, surgery, amputation, or joint replacement – is based on the extent of the loss, the worker's pre-accident wage, and the date of accident.[46] Thus, an increase in the value of these awards for high-wage workers was built into the increased maximum benefit rates that were provided in 2007 in exchange for the caps on permanent partial disability.

There is no record of either business or labor expressing any concern with the methods by which schedule loss awards are calculated as recently as 2012. In January of that year, without objection by either group, the Board issued new guidelines for the determination of permanency and loss of wage earning capacity. These guidelines renewed and reissued the criteria for evaluating schedule loss of use.

The data shows that schedule loss awards have not increased for low wage workers since 1992. Those who earn $600 per week or less – about a quarter of all injured workers – receive the same benefits for an injury today as they did twenty-four years ago. When inflation is taken into account, their awards today are worth forty percent less than their value in 1992.

With the exception of a three year period from 2007-2009, schedule loss awards have also been stagnant for workers who earn between $600 per week and $900 per week – another twenty-five percent of the injured worker population.[47] For these workers, too, the value of their awards continues to lag inflation by about twelve percent.

---

[46] New York Workers' Compensation Law § 15(3).

[47] The 2007 reforms increased the maximum weekly rate from $400 to $600 between 2007 and 2009, thus increasing benefits for workers who earned between $600 and $900 per week..

Overall, schedule loss awards fail to adequately compensate three-quarters of injured workers as compared to inflation. On the opposite end of the spectrum, the awards fail to adequately compensate high wage earners for their actual wage loss.

Additional data and a full discussion of the issues involving schedule loss of use can be found in Exhibit C, The Truth About the Business Council's Plan to Once Again Slash Compensation for Permanent Injury: A Continued Assault on Low Wage Workers.

B. Permanent Partial Disability and Loss of Wage Earning Capacity.

The 2007 legislation imposed time limits, or caps, on permanent partial disability benefits. In 2012, the Board issued Guidelines for Determining Permanent Impairment and Loss of Wage Earning Capacity (LWEC Guidelines), and in May of 2013 it announced that it intended to expedite permanency determinations to apply the caps to disabled workers.[48]

The Board's directive was issued in response to complaints by insurers that it had been too slow to classify workers and apply the caps. These complaints were largely disingenuous in that the Board had expressed no reluctance to classify injured workers at any time after the 2007 reform. Rather, the delay in classification was the result of insurers' inexplicable reluctance to obtain permanency reports and request hearings on the issue before the Board. This continues in some instances up to the present day.

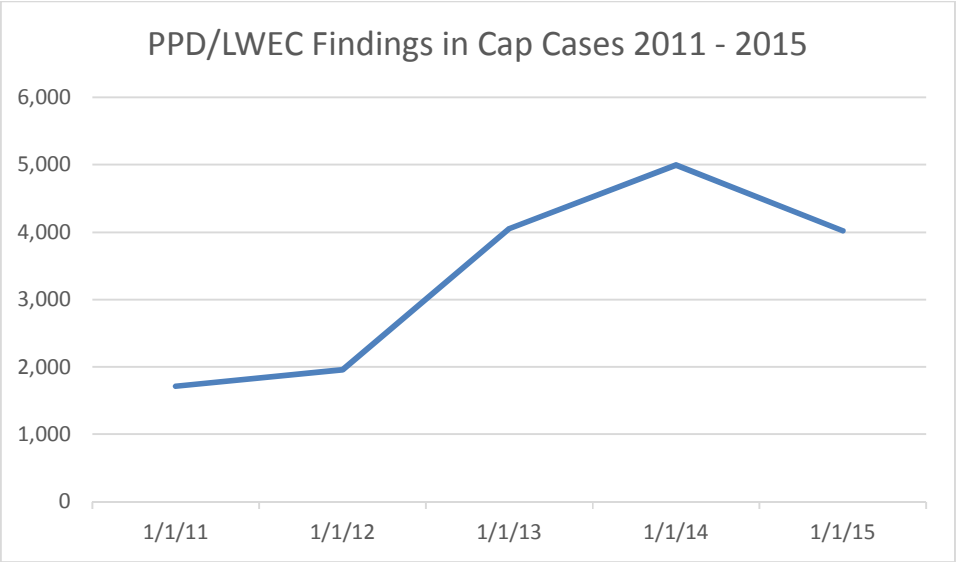
In response to the FOIL request, the Board declined to provide information about how many hearings it had scheduled as a result of its initiative, how many had been requested by insurers, or how many had been scheduled by the Board on its own motion.

[48] WCB Subject Number 046-548, available at http://www.wcb.ny.gov/content/main/SubjectNos/sn046_548.jsp

The Board did report, however, that classifications of permanent disability almost tripled from 1,173 in 2011 to 4,995 in 2014 before declining to 4,022 in 2015. Given that there were 3,670 classifications in 2011-12, an average of 1,835 per year, as compared to 13,072 from 2013 through 2015, an average of 4,357 per year, it seems likely that the Board's effort to expedite implementation of the caps has been highly successful. Moreover, the slight decline in classifications from 2014 to 2015 seems to indicate that any inventory of "delayed classifications" is being depleted. As a result, employer and carrier savings from the caps will increase in future years.

Number of Classifications of Permanency and Loss of Wage Earning Capacity with Accident Date on or After 3/13/07

		Duly Filed Year					
		2011	2012	2013	2014	2015	**Grand Total**
Classification	Duly Filed Month	Total Resolution Count	Total Resolution Count	Total Resolution Count	Total Resolution Count	Total Resolution Count	Total Resolution Count
NON SCHEDULE LOSS	JAN	103	124	219	469	376	**1,291**
	FEB	108	172	233	461	336	**1,310**
	MAR	132	167	262	483	398	**1,442**
	APR	128	140	253	403	397	**1,321**
	MAY	174	156	287	444	418	**1,479**
	JUN	144	165	292	421	347	**1,369**
	JUL	146	159	320	393	271	**1,289**
	AUG	128	193	364	373	223	**1,281**
	SEP	166	126	378	411	286	**1,367**
	OCT	151	181	503	403	305	**1,543**
	NOV	140	158	479	356	345	**1,478**
	DEC	193	216	465	378	320	**1,572**
Grand Total		**1,713**	**1,957**	**4,055**	**4,995**	**4,022**	**16,742**



Although the 2007 legislation imposed caps on permanent partial disability benefits, it also created "safety nets" for those who were found to have more than an eighty percent loss of wage earning capacity.[49] In addition, the Department of Labor was directed to issue annual "safety net reports" with data about the number of injured workers who were subject to benefit termination due to the caps, the return to work status of permanently disabled workers, the status of applications for relief from the caps by virtue of the statutory safety net, and other important data. Regrettably, the Department of Labor has not publicly released this report since 2008.

In responding to the FOIL request, the Board declined to provide any information about how many classifications involved loss of wage earning capacity greater than eighty percent. It also declined to provide any information about the distribution of its awards in the various cap segments running from four to ten years of benefits. In addition, the Board declined to provide information about how many workers have suffered benefit termination

[49] New York Workers' Compensation Law § 35.

as a result of the caps, how many safety net hearings it has held, how many workers have been found eligible for the safety nets, or what policies (if any) it has developed to evaluate safety net eligibility.

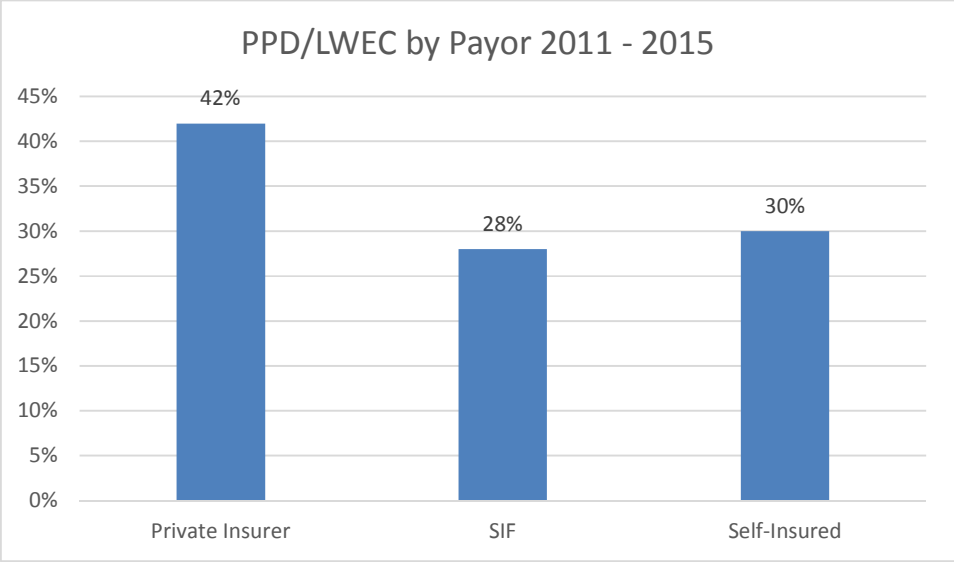
The Board did provide data about the distribution of classifications among private insurers (42%), the State Insurance Fund (28%) and self-insured employers (30%).

Number of Claims with Accident Date on or After 3/13/07 Classified PPD by Liable Payor

	Insurer- Carrier Type			
	PRIVATE	SIF	SELF	**Grand Total**
PPD Classification Date (Year)	Claim Count	Claim Count	Claim Count	Claim Count
2011	9,107	5,765	6,985	**21,857**
2012	10,499	6,533	7,674	**24,706**
2013	11,786	7,850	8,481	**28,117**
2014	12,479	8,375	8,725	**29,579**
2015	12,961	9,101	9,433	**31,495**
Grand Total	**56,832**	**37,624**	**41,298**	**135,754**

Claim count includes cases classified as PPD schedule loss of use and PPD non schedule loss.

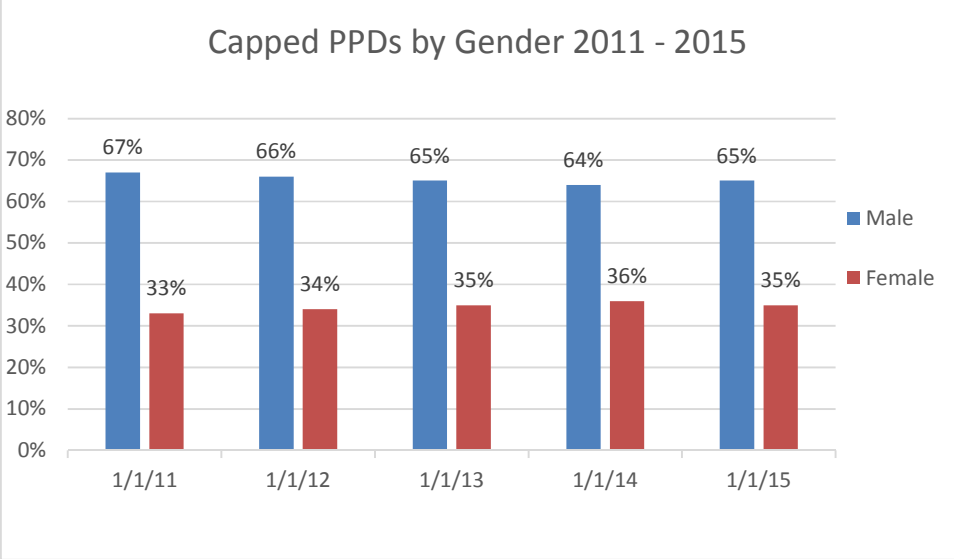
Self-Insurers includes both private and public self-insurers.



It also provided data showing that 35% of permanently disabled workers are women, while 65% are men.

Number of Claims with Accident Date on or After 3/13/07 Classified PPD by Gender

	Claimant- Gender			
	F	M	U	**Grand Total**
PPD Classification Date (Year)	Claim Count	Claim Count	Claim Count	Claim Count
2011	7,245	14,237	585	**22,067**
2012	8,527	15,935	392	**24,854**
2013	10,002	17,965	283	**28,250**
2014	10,659	18,985	117	**29,761**
2015	11,267	20,446	62	**31,775**
Grand Total	**47,700**	**87,568**	**1439**	**136,707**

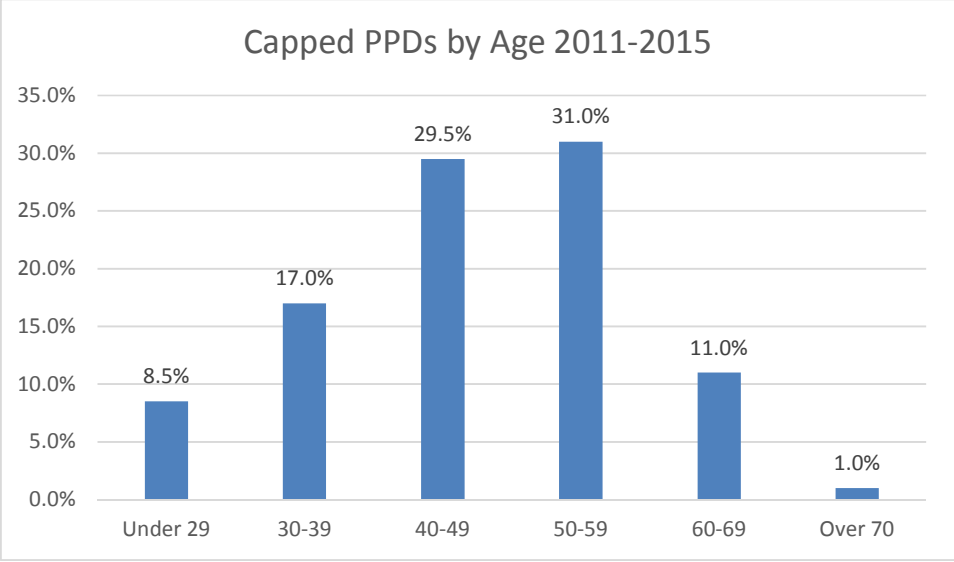


The Board reported that more than 60% of all permanently disabled workers are between the ages of 40 and 59, with a quarter younger than 40 and 12% over 60.

Number of Claims with Accident Date on or After 3/13/07 Classified PPD by Age at Injury

	Claimant- Age at Injury Group									
	0-17	18-29	30-39	40-49	50-59	60-69	70-79	80+	U	**Grand Total**
PPD Class. Date (Year)	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count
2011	20	2,003	3,796	6,785	6,599	2,426	250	48	140	**22,067**
2012	24	2,128	4,277	7,544	7,594	2,810	314	42	121	**24,854**
2013	17	2,475	4,717	8,404	8,832	3,141	362	38	264	**28,250**
2014	25	2,428	4,967	8,820	9,314	3,249	391	44	523	**29,761**
2015	15	2,627	5,512	8,944	10,238	3,607	422	44	366	**31,775**
Grand Total	**101**	**11,661**	**23,269**	**40,497**	**42,577**	**15,233**	**1,739**	**216**	**1,414**	**136,707**

Claim count includes cases classified as PPD schedule loss of use and PPD non schedule

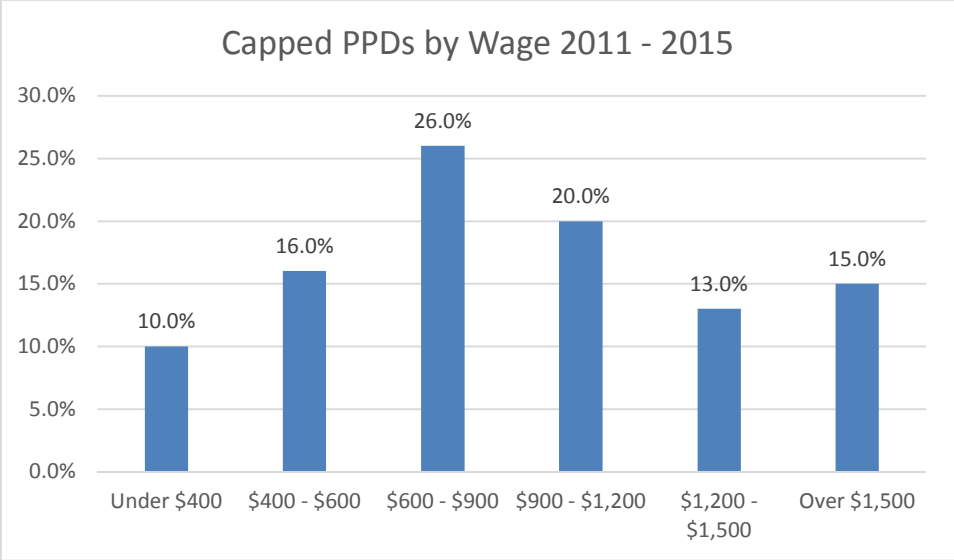


The Board's data showed that 26% of injured workers earn less than $600 per week, and more than half earn less than $900 per week. Fewer than 28% earn wages high enough to receive benefits at the current statutory maximum weekly rate.

Number of Claims with Accident Date on or After 3/13/07 Classified PPD by Average Weekly Wage

	Claimant - Average Weekly Wage Group								
	$0 - $150	$150.01 - $400	$400.01 - $600	$600.01 - $900	$900.01 - $1200	$1200.01 - $1500	$1500.01 and up	U	**Grand Total**
PPD Class. Date (Year)	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count
2011	124	2,224	3,910	6,349	4,217	2,612	2,545	86	**22,067**
2012	120	2,557	4,096	6,634	4,880	3,241	3,277	49	**24,854**
2013	133	2,910	4,649	7,166	5,510	3,768	4,069	45	**28,250**
2014	119	3,001	4,724	7,329	5,874	3,915	4,765	34	**29,761**
2015	89	2,924	4,792	7,447	6,215	4,338	5,944	26	**31,775**
Grand Total	**585**	**13,616**	**22,171**	**34,925**	**26,696**	**17,874**	**20,600**	**240**	**136,707**

Claim count includes cases classified as PPD schedule loss of use and PPD non schedule



The Board was unable to provide meaningful information about the nature of the injuries that result in findings of permanent partial disability, reporting that almost 60% of the classifications involved an "unknown" injury classification.[50]

[50] The data provided by the Board in response to this inquiry aggregated schedule loss and non-schedule loss permanent partial disability claims, but in either event the table provided by the Board makes it clear that it is not in possession of meaningful data regarding the nature of injuries in the majority of cases.

Number of Claims with Accident Date on or After 3/13/07 Classified PPD by Nature of Injury

	PPD Class. Date (Year)					
	2011	2012	2013	2014	2015	**Grand Total**
WCIO - Nature Injury Class Desc	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count
AIDS	-	-	-	-	3	**3**
All Other Cumulative Injury, NOC	16	26	53	218	413	**726**
All Other Occupational Disease Injury, NOC	15	26	67	160	204	**472**
All Other Specific Injuries, NOC	116	188	445	1,388	1,755	**3,892**
Amputation	4	5	31	100	127	**267**
Angina Pectoris	-	-	-	1	2	**3**
Asbestosis	-	-	-	1	1	**2**
Asphyxiation	-	-	-	1	2	**3**
Burn	2	4	17	79	95	**197**
Cancer	-	-	-	1	3	**4**
Carpal Tunnel Syndrome	31	55	128	534	722	**1,470**
Concussion	4	5	15	43	66	**133**
Contagious Disease	-	-	1	-	-	**1**
Contusion	127	179	540	2,386	3,807	**7,039**
Crushing	5	13	31	164	257	**470**
Dermatitis	1	-	-	3	13	**17**
Dislocation	25	58	229	597	590	**1,499**
Dust Disease, NOC	-	-	1	1	1	**3**
Electric Shock	1	1	6	17	23	**48**
Foreign Body	1	1	8	27	50	**87**
Fracture	83	142	402	1,724	2,351	**4,702**
Freezing	-	-	-	2	2	**4**
Hearing Loss Or Impairment	10	14	72	204	294	**594**
Heat Prostration	-	-	-	-	2	**2**
Hernia	2	1	13	34	51	**101**
Infection	1	1	6	19	20	**47**
Inflammation	45	68	184	611	694	**1,602**
Laceration	21	27	125	707	1,002	**1,882**
Loss Of Hearing	1	5	14	82	109	**211**

	PPD Class. Date (Year)					
	2011	2012	2013	2014	2015	**Grand Total**
WCIO - Nature Injury Class Desc	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count
Mental Disorder	-	-	1	6	1	**8**
Mental Stress	1	-	5	7	17	**30**
Multiple Injuries Including Both Physical And Psychological	3	5	17	29	34	**88**
Multiple Physical Injuries Only	44	82	203	715	888	**1,932**
Myocardial Infarction	1	2	3	3	3	**12**
No Physical Injury	2	3	12	34	44	**95**
Poisoning - Chemical, (Other Than Metals)	1	-	1	-	4	**6**
Poisoning - General	-	1	1	-	1	**3**
Puncture	4	4	11	77	106	**202**
Radiation	-	-	-	1	-	**1**
Respiratory Disorders	5	4	6	6	26	**47**
Rupture	28	37	124	354	422	**965**
Severance	7	11	13	79	64	**174**
Silicosis	-	-	-	1	-	**1**
Sprain Or Tear	220	318	856	3,225	4,429	**9,048**
Strain Or Tear	364	555	1,667	6,187	8,807	**17,580**
Syncope	-	-	1	5	5	**11**
Unknown	20,875	23,012	22,935	9,917	4,255	**80,994**
Vascular	1	-	3	3	2	**9**
VDT - Related Diseases	-	-	-	1	1	**2**
Vision Loss	-	1	3	7	7	**18**
Grand Total	**22,067**	**24,854**	**28,250**	**29,761**	**31,775**	**136,707**

Claim count includes cases classified as PPD schedule loss of use and PPD non schedule

Similarly, the Board declined to provide information about the English-language fluency, ethnicity, pre-accident employment, post-injury work status or receipt of Social Security Disability benefits by permanently disabled workers.

Overall, it is clear that the Board is implementing the permanent partial disability caps with increased efficiency, and that this will result in significant savings for employers

and carriers. It is also clear that the PPD caps impact workers of all ages, genders, and wage levels. However, absent a response from the Board to the relevant FOIL questions or the issuance of the statutorily mandated safety net report by the Department of Labor, it is impossible to determine the extent to which injured workers have been subjected to benefit termination, whether they have been able to access the statutory safety nets, or the relevant information regarding return to work or eligibility for Social Security disability benefits.

C. Settlements and the Aggregate Trust Fund.

Many cases involving classifications of permanent partial disability result in settlements, and the 2007 legislation included a requirement that private insurers deposit the present value of the future payments into the Aggregate Trust Fund (ATF) if the case did not settle.[51] This provision ensured that workers whose permanently disability benefits were subject to the caps would receive a fair settlement offer if their employer was covered by a private insurer.

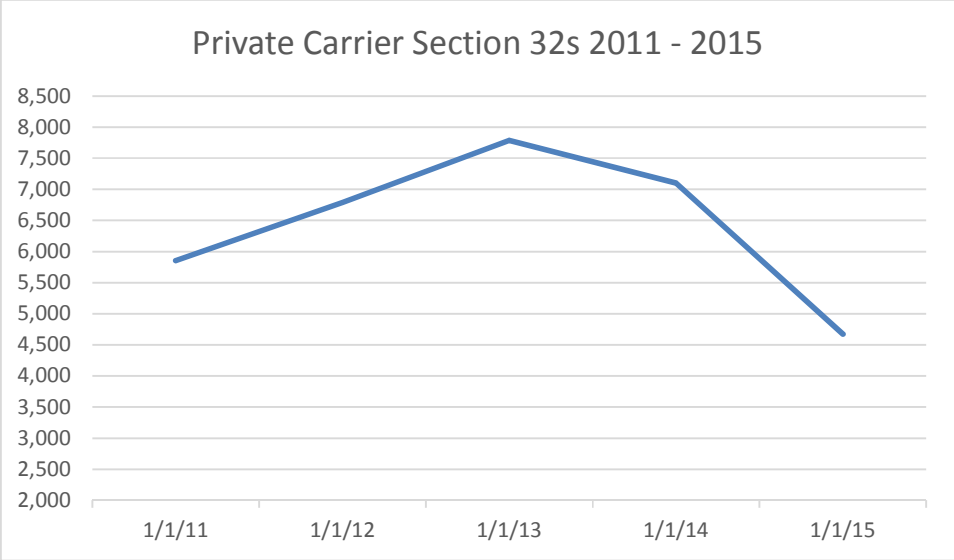
The Board declined to provide information about how many mandatory settlement offers were made by private insurers, how many ATF deposits were calculated, directed or paid, or what enforcement actions (if any) it has taken to ensure compliance with the law.

The Board did report that there was a 25% increase in the number of settlements by private insurers from 2011 through 2013, followed by a slight (9%) decline in 2014 and a steep (35%) decline in 2015.

[51] New York Workers' Compensation Law § 27.

Number of Claims Involving Private Insurers with Section 32 Settlements

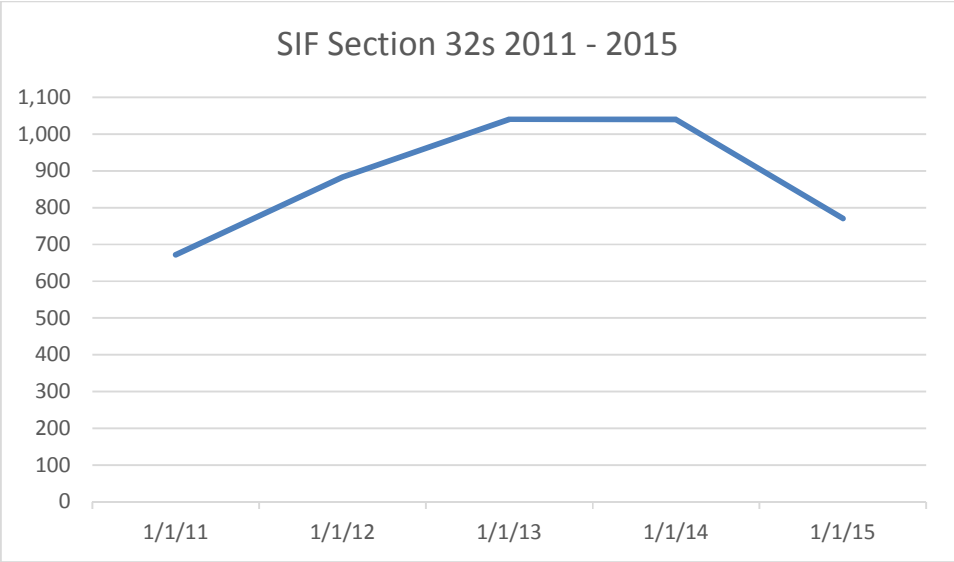
		Duly Filed Year					
		2011	2012	2013	2014	2015	**Grand Total**
Insurer - Carrier Type	Duly Filed Month	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count
PRIVATE	JAN	429	567	569	737	545	**2,847**
	FEB	377	532	488	574	491	**2,462**
	MAR	524	546	532	575	547	**2,724**
	APR	447	522	591	601	550	**2,711**
	MAY	411	685	671	542	414	**2,723**
	JUN	599	575	644	473	95	**2,386**
	JUL	431	641	660	577	218	**2,527**
	AUG	505	614	709	474	265	**2,567**
	SEP	564	532	638	544	378	**2,656**
	OCT	486	508	711	608	314	**2,627**
	NOV	599	532	690	734	447	**3,002**
	DEC	481	538	885	661	409	**2,974**
Grand Total		**5,853**	**6,792**	**7,788**	**7,100**	**4,673**	**32,206**



Settlements by the State Insurance Fund largely followed the same trajectory as the figures for private insurers, but during the same time frame the relatively small number of settlements by public self-insurers increased each year from 2011 through 2014, and remained stable in 2015.

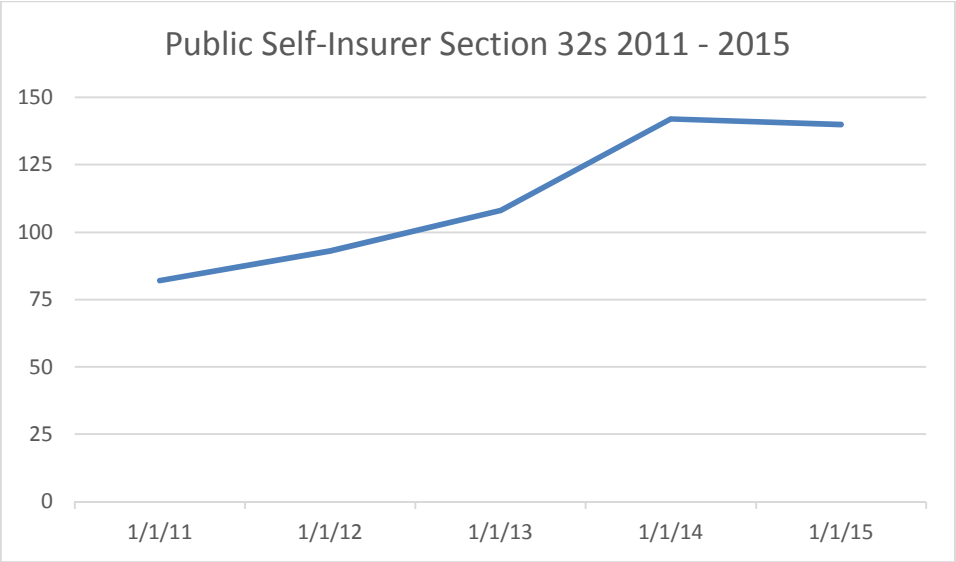
Number of Claims Involving the State Insurance Fund
Classified PPD Non Scheduled Loss with Section 32 Settlements

			Duly Filed Year					
			2011	2012	2013	2014	2015	**Grand Total**
Insurer – Name	Claim Injury Type	Duly Filed Month	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count
STATE INSURANCE FUND	PPD NSL	JAN	39	56	50	48	69	**262**
		FEB	30	53	44	46	49	**222**
		MAR	37	55	66	53	48	**259**
		APR	37	30	77	61	52	**257**
		MAY	45	76	78	58	52	**309**
		JUN	52	66	64	50	10	**242**
		JUL	54	64	66	72	31	**287**
		AUG	50	50	55	33	23	**211**
		SEP	51	39	52	51	44	**237**
		OCT	50	34	54	60	40	**238**
		NOV	37	48	65	65	41	**256**
		DEC	52	38	56	63	62	**271**
Grand Total			**534**	**609**	**727**	**660**	**521**	**3,051**

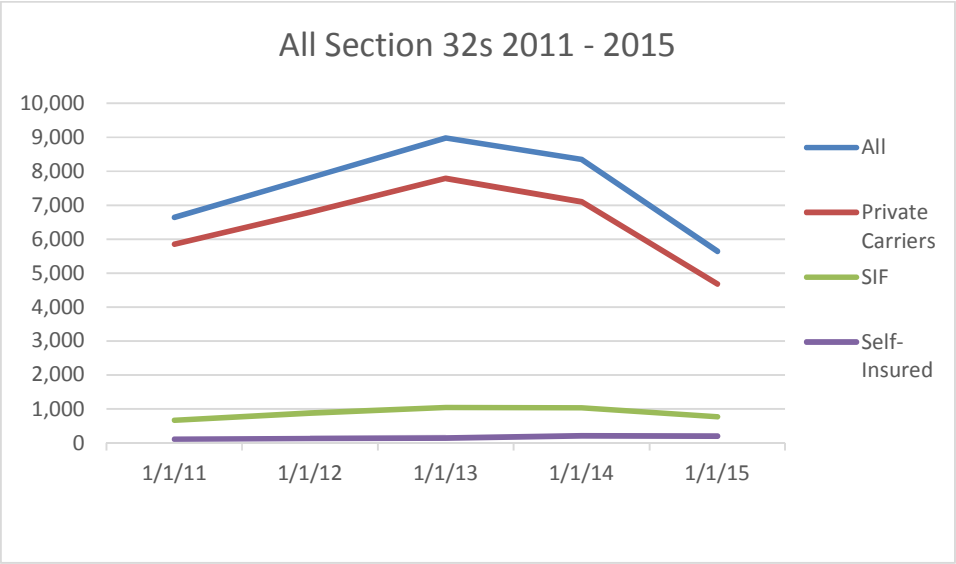


Number of Claims Involving Public Self Insurers
Classified PPD Non Scheduled Loss with Section 32 Settlements

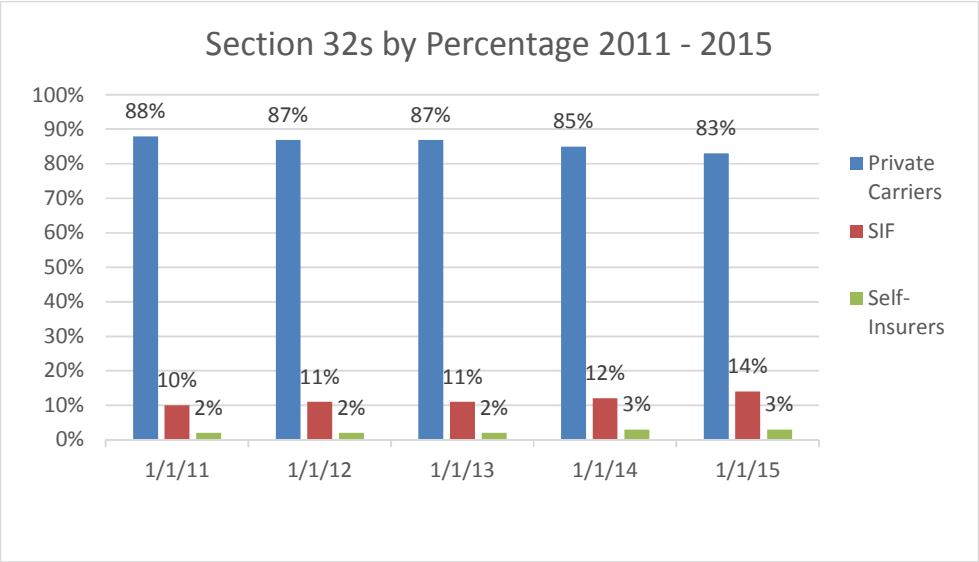
			Duly Filed Year					
			2011	2012	2013	2014	2015	**Grand Total**
Insurer - Name	Case Type	Duly Filed Month	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count	Claim Count
SELF PUBLIC	PPD NSL	JAN	5	6	6	11	15	**43**
		FEB	12	8	10	7	11	**48**
		MAR	7	12	10	11	14	**54**
		APR	7	13	14	17	16	**67**
		MAY	5	4	7	13	8	**37**
		JUN	5	6	7	7	6	**31**
		JUL	8	9	3	17	4	**41**
		AUG	6	3	11	4	12	**36**
		SEP	8	11	7	11	9	**46**
		OCT	4	4	13	21	19	**61**
		NOV	9	6	8	11	8	**42**
		DEC	6	11	12	12	18	**59**
Grand Total			**82**	**93**	**108**	**142**	**140**	**565**



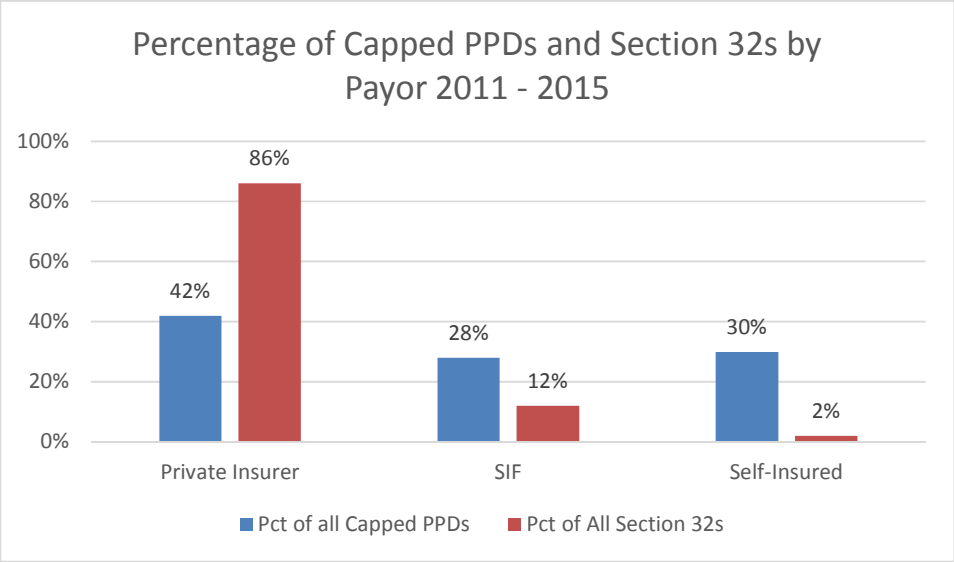
A comparison of the number of settlements across each of these three groups (private insurer, State Insurance Fund, and public self-insurer) appears on the graph below, together with the aggregate number of settlements.



As the data and the graph make clear, the overwhelming majority of settlements involve private insurers. This is shown again on the chart below, which depicts the percentage of settlements by each payor type.

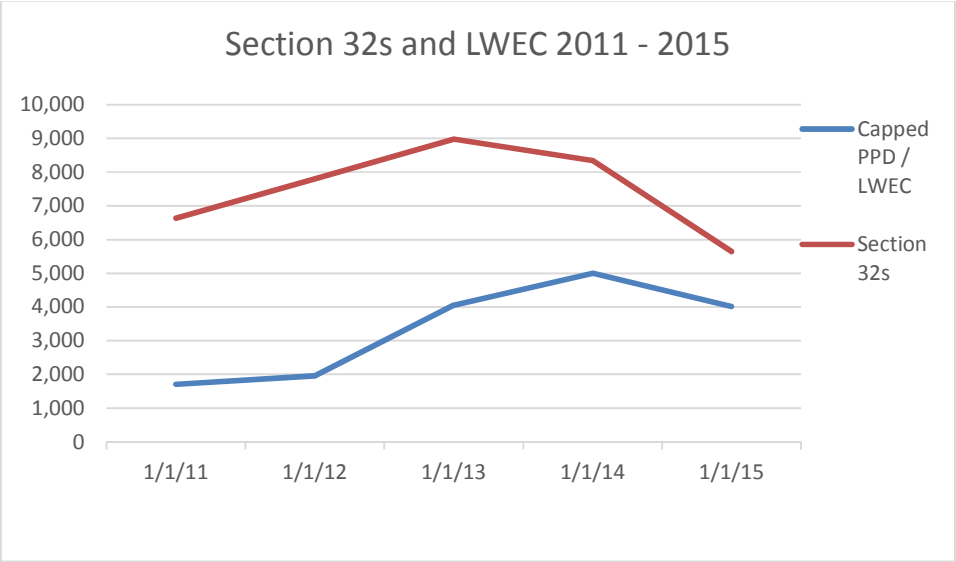


Overall, analysis of the Board's data shows that from 2011 through 2015, claims involving private insurers account for 42% of permanent disability classifications, but 86% of all settlements. Claims involving the State Insurance Fund account for 28% of classifications, but 12% of all settlements, while claims involving private insurers account for 30% of all classifications but only 2% of all settlements.

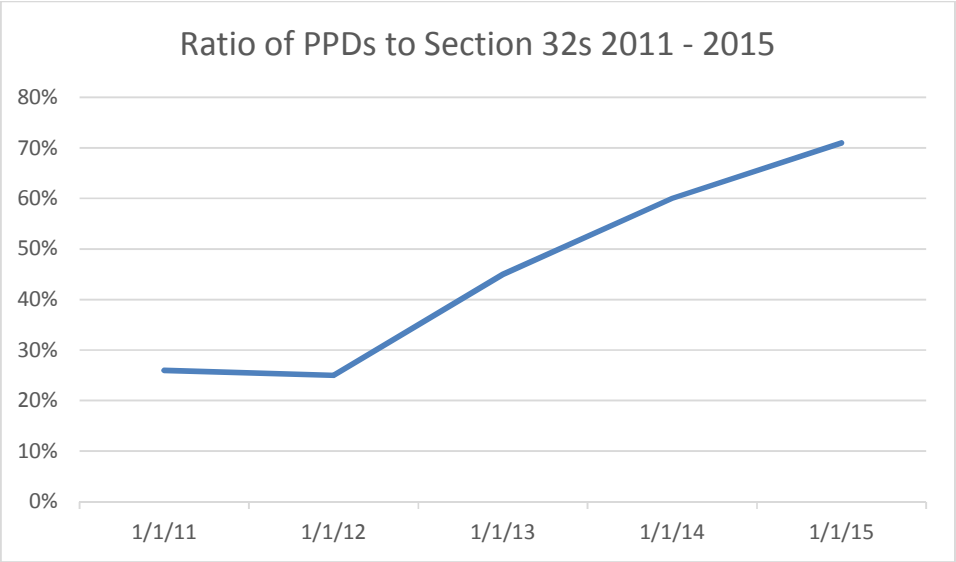


It may be concluded from these statistics that private insurers settle permanent partial disability claims efficiently, perhaps due to their potential liability to the ATF. The State Insurance Fund is far less efficient in arriving at final claims settlement, which is consistent with anecdotal evidence that its offers are routinely substandard as compared to the sum of capped weekly benefits. Public self-insurers are the least efficient of all, which is likely due to budgetary and political considerations that detract from fiscally responsible claims handling.

Overall, it appears that the 2007 reforms has significantly increased the percentage of claims that result in final settlement. Analysis also shows that in 2011 the ratio of settlements to classifications was 26%, which nearly tripled to 71% by 2015.



This increase is clearly attributable to the imposition of caps on permanent partial disability and the increase in classifications. This can be seen both by the converging shape of the trendlines on the graph above for classifications and settlements and by the ratio of settlements to classifications shown on the graph below.



The data regarding classification and settlement appears to indicate that the Board's efforts to expedite permanency classifications significantly reduced, if not eliminated, any "backlog" in such cases by the end of 2014. Moreover, the data appears to indicate that the statutory requirement for ATF deposits and the Board's initiatives have significantly increased the rate of settlement in cases involving permanent partial disability.

VII. CONCLUSION.

Taken as a whole, it appears that workers face significant obstacles in applying for and receiving workers' compensation benefits for lost wages and medical care. In particular, workers who are not fluent in English seem to have little ability to access benefits. While the 2007 legislation provided some increase in temporary disability and schedule loss awards for high-wage workers, it did not do so for low-wage workers. Meanwhile, workers throughout the wage spectrum suffer enormous uncompensated wage loss due to the inadequacy of permanent disability benefits. This dynamic has resulted in the widespread settlement of permanent disability claims by private insurers, but not by the State Insurance Fund or self-insured employers.

Dated: June 17, 2016
Farmingdale, New York

By: _____
Robert E. Grey
Grey & Grey, LLP

EXHIBIT A

FOIL 16-19 TO THE WORKERS' COMPENSATION BOARD

Section 1: ATF

Pursuant to New York's Freedom of Information Act, we hereby request production of the following information about permanent partial disability claims for each year from 2011 through 2015.

1. How many mandatory settlement offers have been made by employers and carriers pursuant to Workers' Compensation Law Section 32, by month and by year?

2. How many cases involving private insurers have resulted in classifications of permanent partial disability, by month and by year?

3. In how many cases involving private insurers have deposits into the Aggregate Trust Fund been directed in cases involving permanent partial disability, permanent total disability, and death, by case type, by month and by year?

4. How many decisions has the Workers' Compensation Board issued calculating the dollar amounts of Aggregate Trust Fund deposits in cases involving permanent partial disability, permanent total disability, and death, by case type, by month and by year?

5. How many Aggregate Trust Fund deposits have been made by private insurers upon direction of the Workers' Compensation Board in cases involving permanent partial disability, permanent total disability, and death, by case type, by month and by year?

6. What enforcement action, if any, has been taken by the Workers' Compensation Board with regard to unpaid Aggregate Trust Fund deposits?

7. How many claims involving private insurers have resulted in settlements pursuant to Workers' Compensation Law Section 32, by month and by year?

8. How many claims involving self-insured public employers have resulted in settlements pursuant to Workers' Compensation Law Section 32, in cases involving permanent partial disability, permanent total disability, and death, by case type, by month and by year?

9. How many claims involving the State Insurance Fund have resulted in settlements pursuant to Workers' Compensation Law Section 32, in cases involving permanent partial disability, permanent total disability, and death, by case type, by month and by year?

10. How many claims involving the Aggregate Trust Fund have resulted in settlements pursuant to Workers' Compensation Law Section 32, in cases involving permanent partial disability, permanent total disability, and death, by case type, by month and by year?

11. How many claims involving WAMO have resulted in settlements pursuant to Workers' Compensation Law Section 32, in cases involving permanent partial disability, permanent total disability, and death, by case type, by month and by year?

Section 2: Proposed Decisions

1. How many Proposed Decisions have been filed each month and in total each year?

2. How many Proposed Decisions are issued following a conciliation meeting at which the parties are present, by month and year?

3. How many Proposed Decisions are issued at the request of injured workers or their representatives, by month and year?

4. How many Proposed Decisions are issued at the request of employers or carriers, by month and year?

5. How many objections does the Workers' Compensation Board receive from injured workers or their representatives to Proposed Decisions, by month and year?

6. How many objections does the Workers' Compensation Board receive from employers or carriers to Proposed Decisions, by month and year?

7. How many Amended Proposed Decisions are issued in response to objections to Proposed Decisions received by the Workers' Compensation Board, by month and year?

8. How many hearings are scheduled in response to objections to Proposed Decisions received by the Workers' Compensation Board, by month and year?

9. How many Proposed Decisions determined the nature of the work-related injury, by month and year?

10. How many Proposed Decisions involve awards for more than fifty-two weeks of workers' compensation benefits, by month and year?

11. How many Proposed Decisions involving awards for more than fifty-two weeks of workers' compensation benefits were "schedule loss" cases, by month and year?

12. How many Proposed Decisions involved C-8.1 issues, by month and year?

Section 3: LWEC

1. How many hearings have been scheduled on the issue of permanency and/or loss of wage earning capacity, by month and by year?

2. How many hearings on the issue of permanency and/or loss of wage earning capacity have been scheduled at the request of employers or insurance carriers, by month and by year?

3. How many hearings on the issue of permanency and/or loss of wage earning capacity have been scheduled at the request of injured workers or their representatives, by month and by year?

4. How many hearings have been scheduled on the issue of permanency and/or loss of wage earning capacity on the Workers' Compensation Board's motion, without the request of a party, by month and by year?

5. How many classifications of permanency and loss of wage earning capacity have been made by the Workers' Compensation Board in cases with accident dates on or after March 13, 2007, by month and year?

6. How many injured workers with accident dates on or after March 13, 2007 has the Workers' Compensation Board determined to be permanently totally disabled, by month and by year?

7. How many injured workers with accident dates on or after March 13, 2007 has the Workers' Compensation Board determined to have a loss of wage earning capacity in excess of 80%, by month and by year?

8. How many Board Panel decisions have reversed or modified WCL Judge decisions finding injured workers to have a loss of wage earning capacity in excess of 80%, by month and by year?

9. How many wage earning capacity determinations has the Workers' Compensation Board made in each segment of the duration caps contained in Workers' Compensation Law Section 15(3)(w), by month and by year?

10. To the extent Workers' Compensation Board is in possession of data or information regarding the gender of permanently partially disabled workers with accident dates after March 13, 2007 who have been classified permanently partially disabled, kindly provide that data in the form maintained by the Board for any monthly or yearly period.

11. To the extent Workers' Compensation Board is in possession of data or information regarding the age of permanently partially disabled workers with accident dates after March 13, 2007 who have been classified permanently partially disabled, kindly provide that data in the form maintained by the Board for any monthly or yearly period.

12. To the extent Workers' Compensation Board is in possession of data or information regarding the English-language fluency of permanently partially disabled workers with accident dates after March 13, 2007 who have been classified permanently partially disabled, kindly provide that data in the form maintained by the Board for any monthly or yearly period.

13. To the extent Workers' Compensation Board is in possession of data or information regarding the ethnicity of permanently partially disabled workers with accident dates after

March 13, 2007 who have been classified permanently partially disabled, kindly provide that data in the form maintained by the Board for any monthly or yearly period.

14. To the extent Workers' Compensation Board is in possession of data or information regarding the nature of the pre-accident employment of permanently partially disabled workers with accident dates after March 13, 2007 who have been classified permanently partially disabled, kindly provide that data in the form maintained by the Board for any monthly or yearly period.

15. To the extent Workers' Compensation Board is in possession of data or information regarding the nature of the injuries of permanently partially disabled workers with accident dates after March 13, 2007 who have been classified permanently partially disabled, kindly provide that data in the form maintained by the Board for any monthly or yearly period.

16. To the extent Workers' Compensation Board is in possession of data or information regarding the average weekly wages of permanently partially disabled workers with accident dates after March 13, 2007 who have been classified permanently partially disabled, kindly provide that data in the form maintained by the Board for any monthly or yearly period.

17. To the extent Workers' Compensation Board is in possession of data or information regarding the liable payors (self-insured employers, private insurers, State Insurance Fund) of permanently partially disabled workers with accident dates after March 13, 2007 who have been classified permanently partially disabled, kindly provide that data in the form maintained by the Board for any monthly or yearly period.

18. To the extent Workers' Compensation Board is in possession of data or information regarding the work status of permanently partially disabled workers with accident dates after March 13, 2007 who have been classified permanently partially disabled, kindly provide that data in the form maintained by the Board for any monthly or yearly period.

19. To the extent Workers' Compensation Board is in possession of data or information regarding the receipt of Social Security Disability benefits by permanently partially disabled workers with accident dates after March 13, 2007 who have been classified permanently partially disabled, kindly provide that data in the form maintained by the Board for any monthly or yearly period.

20. How many permanently partially disabled workers with accident dates after March 13, 2007 have reached the end of their duration caps, resulting in benefit termination, by month and by year?

21. How many hearings have been held by the Workers' Compensation Board on the issue of a permanently partially disabled worker's entitlement to further benefits pursuant to Workers' Compensation Law § 35, by month and year?

22. How many permanently partially disabled workers with dates of accident after March 13, 2007 have been found eligible for further benefits pursuant to Workers' Compensation Law § 35, by month and year?

23. What standards, if any, have been promulgated by the Workers' Compensation Board regarding the requirements for safety net eligibility pursuant to Workers' Compensation Law § 35?

24. Please provide copies of all reports produced as required by Workers' Compensation Law § 35.

Section 4: Indexing

1. How many cases have been assembled each month and in total each year?

2. How many cases have been indexed each month and in total each year?

3. How many cases have been assembled and have (1) a C-2/FROI-00 or a C-3 and (2) a C-4.0 in the file but have not been indexed, by month and in total each year?

4. How many C-3 forms have been received by the Workers' Compensation Board, by month and in total each year?

5. How many C-3 forms indicate that the injured worker does not speak English, by month and in total each year?

6. How many notices of case assembly are issued in a language other than English?

7. How many notices of indexing are issued in a language other than English?

8. How many Administrative Decisions are issued in a language other than English?

9. How many Proposed Decisions are issued in a language other than English?

Section 5: Request for Further Action

1. How many RFA-1 and RFA-1LC forms have been filed each month and in total each year?

2. What is the average time between the date the Workers' Compensation Board receives an RFA-1 or RFA-1LC form and its response in each month and each year?

3. In how many cases does the Workers' Compensation Board receive multiple RFA-1 or RFA-1LC forms before responding in each month and each year?

4. In how many cases does the Workers' Compensation Board respond to an RFA-1 or RFA-1LC by scheduling a hearing in each month and each year?

5. What is the average time between the date the Workers' Compensation Board receives an RFA-1 or RFA-1LC form and the date of the hearing when a hearing is scheduled in response to the RFA-1 or RFA-1LC form, in each year?

6. How many RFA-2 forms have been filed each month and in total each year?

7. What is the average time between the date the Workers' Compensation Board receives an RFA-2 form and its response in each month and each year?

8. In how many cases does the Workers' Compensation Board receive multiple RFA-2 forms before responding in each month and each year?

9. In how many cases does the Workers' Compensation Board respond to an RFA-2 by scheduling a hearing in each month and each year?

10. What is the average time between the date the Workers' Compensation Board receives an RFA-2 form and the date of the hearing when a hearing is scheduled in response to the RFA-2 form, in each year?

Section 6: Medical Treatment Guidelines

1. How many MG-2 forms have been filed each month and in total each year?

2. How many MG-2 forms have been rejected by the Workers' Compensation Board prior to a response by the employer or carrier in each month and in total each year?

3. How many MG-2 variance requests have been granted by employers and carriers in each month and in total each year?

4. How many MG-2 variance requests have been denied by employers and carriers in each month and in total each year?

5. How many denials of MG-2 variance requests have been submitted to the Workers' Compensation Board's Medical Director's Office for determination in each month and in total each year?

6. How many MG-2 variance requests have been granted by the Workers' Compensation Board's Medical Director's Office each month and in total each year?

7. How many MG-2 variance requests have received hearings before WCL Judges in each month and in total each year?

8. How many MG-2 variance requests have been granted by WCL Judges in each month and in total each year?

Section 7: Administrative Decisions

1. How many Administrative Decisions have been filed each month and in total each year?

2. How many Administrative Decisions involve disability less than the waiting period, by month and year?

3. How many Administrative Decisions involve injuries that may be amenable to schedule loss determination, by month and year?

4. How many objections does the Workers Compensation Board receive from employers or carriers to Administrative Decisions, by month and year?

5. How many objections does the Workers' Compensation Board receive from injured workers or their representatives to Administrative Decisions, by month and year?

6. How many Amended Administrative Decisions are issued in response to objections to Administrative Decisions received by the Workers' Compensation Board, by month and year?

7. How many hearings are scheduled in response to objections to Administrative Decisions received by the Workers' Compensation Board, by month and year?

WORKERS' COMPENSATION BOARD RESPONSE TO FOIL 16-19

From: Cremo, Patrick (WCB) [mailto:Patrick.Cremo@wcb.ny.gov]
Sent: Friday, March 11, 2016 4:13 PM
To: IWBA Office
Cc: wcb.sm.Office.of.General.Counsel
Subject: FOIL No. 16-19

Dear Ms. McGrath:

Please accept the following in response to your February 4, 2016, Freedom of Information Law (FOIL) request, which was received by the Workers' Compensation Board's (Board's) Office of General Counsel on the same date by electronic mail. You seek a multitude of Board records pursuant to your request, relating to permanent partial disability claims, hearing requests, proposed decisions, the Medical Treatment Guidelines, administrative decisions and clams assembled, between 2011 and 2015.

Please be advised that the Board does not possess or maintain any existing records that are responsive to your request. The Board has determined, upon consultation with the New York State Office of Information Technology Services, that records responsive to your FOIL request cannot be retrieved without engaging in an extensive and involved programming effort. The Board is not required to engage in such a unreasonable effort when retrieving or extracting data from its computer storage systems (*see* Public Officers Law [POL] § 89[3][a]; Comm on Open Govt FOIL-AO-19021 [2013]). As such, your February 4, 2016 FOIL request is hereby denied.

According to the Committee on Open Government, "these provisions, read in conjunction with the descriptions of fees for actual costs . . . permit an agency to refuse to provide records that would require an unreasonable effort to prepare a record" (*see* Comm on Open Govt FOIL-AO-17606 [2009]); *Matter of Weslowski v Vanderhoef*, 98 AD3d 1123 [2d Dept 2012]).

To the extent that you deem any portion of this response to your FOIL request to be a denial, it may be appealed pursuant to POL § 89(4) to the Board's Executive Director at 328 State Street, Room 438, Schenectady, New York 12305.

In all future correspondence relating to this request, please refer to the above FOIL Number. Thank you.

Patrick J. Cremo
Associate Attorney & Records Access Officer

NYS Workers' Compensation Board
328 State Street, Schenectady, NY 12305
(518) 486-9564 | (518) 402-0113 FAX | patrick.cremo@wcb.ny.gov
http://www.WCB.NY.Gov

APPEAL OF DENIAL OF FOIL 16-19

Ms. MaryBeth Woods
Executive Director
New York State Workers' Compensation Board
328 State Street - Room 438
Schenectady, New York 12305

Dear Executive Director Woods:

We hereby appeal the Workers' Compensation Board's denial of FOIL No. 16-19. Copies of the various FOIL requests and the Board's denial are attached for your reference.

The denial states "that the Board does not possess or maintain any existing records that are responsive" to the FOIL requests. However, the response appears to indicate that the data is in fact in the Board's possession, but that it supposedly "cannot be retrieved without engaging in an extensive and involved programming effort."

To the contrary, we believe that the information in question is readily available to the Board.

We are attaching a copy of the Board's response to FOIL 12-16, in which it provided a response to a substantially similar FOIL request regarding the Medical Treatment Guidelines.

We are also attaching the cover page and the Executive Summary of the Board's 2014 Annual Report, which appears to include reports and data that are very similar to the information we requested about Proposed Decisions, Administrative Decisions, assembly, indexing, and hearings.

Moreover, we are attaching the 2010 "Annual Safety Net Report of the Commissioner," which was prepared "in conjunction with" the Board and which includes data and reports that address our request about permanent partial disability cases.

It therefore appears that all of the information we requested is readily available to the Board.

We recognize that the information we have requested is maintained in electronic form in the Board's computer systems (or in computer systems accessible by the Board). However, the fact that data is stored electronically does not relieve the Board of its obligation to respond to our request. Pursuant to Public Officers Law Section 89(3), "[a]ny programming necessary to retrieve a record maintained by a person … shall not be deemed to be the preparation or creation of a new record." The Board's denial offers no proof that anything beyond the "simple manipulation of a computer necessary to transfer existing records" would be required. In this regard, we would respectfully refer you to the Court of Appeals decision in Data Tree, LLC v. Romaine, 9 N.Y.3d 454, 849 N.Y.S.2d 489, 880 N.E.2d 10 (2007) (which generated the amendment to Public Officers Law Section 89(3)) and the decision of the Appellate Division, First Department in New York Comm. For Occupational

Safety & Health v. Bloomberg, 72 A.D.3d 153, 892 N.Y.S.2d 377 (1st Dept. 2010). A copy of the latter case, which was decided after the statutory amendment, is attached for your convenience.

We are also attaching a copy of the decision in Weslowski v. Vanderhoef, 98 A.D.3d 1123, 951 N.Y.S.2d 538 (2nd Dept. 2011) which was cited by the Board's Records Officer. You will observe that the Weslowski court held that "[t]he Legislature has declared that "government is the public's business and that the public, individually and collectively and represented by a free press, should have access to the records of government in accordance with the provisions of this article." It upheld the principle that the agency is required to produce information based on electronic data, and noted that the statute "prohibit[s] an agency from denying a request because it was too voluminous or burdensome." The agency in Weslowski was in fact directed by the court to respond to the FOIL petitioner's request.

We therefore appeal the Records Officer's denial of FOIL 16-19 and request that the Board produce data and information responsive to our requests.

WORKERS' COMPENSATION BOARD DECISION ON APPEAL OF FOIL 16-19

NEW YORK STATE OF OPPORTUNITY. | Workers' Compensation Board

ANDREW M. CUOMO
Governor

ROBERT E. BELOTEN
Chair

April 4, 2016

RECEIVED APR 10 2016

Angelina McGrath
IWBA Administrator
1450 Western Avenue, Suite 101
Albany, New York 12203

Re: Appeal of FOIL No. 16-19

Dear Ms. McGrath:

This letter is in response to your March 22, 2016, appeal, which was received by the Workers' Compensation Board's (Board's) Executive Offices on March 22, 2016. You appeal the March 11, 2016, determination of Board Records Access Officer (RAO) Patrick J. Cremo, to deny your February 4, 2016, request (Board FOIL Number 16-19) made under the Freedom of Information Law (FOIL) because "the records responsive to your FOIL request cannot be retrieved without engaging in an extensive and involved programming effort."

FOIL Request:

Your February 4, 2016, FOIL request sought the production of numerous records relating to permanent partial disability claims, hearing requests, proposed decisions, the Medical Treatment Guidelines, administrative decisions, and claims assembled, between 2011 and 2015.

Attached please find a copy of your February 4, 2016, FOIL request.

In RAO Cremo's March 11, 2016, response to your February 4, 2016, FOIL request, he determined that, "the Board does not possess or maintain any existing records that are responsive to your request and the Board has determined, upon consultation with the New York State Office of Information Technology Services, that records responsive to your FOIL request cannot be retrieved without engaging in an extensive and involved programming effort."

Attached please find a copy of RAO Cremo's March 11, 2016, correspondence in response to your February 4, 2016, FOIL request.

Executive Appeal:

In your March 22, 2016, correspondence, you appeal the denial of your February 4, 2016, FOIL request, arguing that you, "believe that the information in question is readily available to the Board." You also referenced the Board's response to FOIL 12-16, the Board's 2014 Annual Report, and the Department of Labor's 2010 "Annual Safety Net Report of the Commissioner," as all containing data similar to what you have requested.

Attached please find a copy of your March 22, 2016, FOIL appeal.

Executive Appeal Determination:

Public Officers Law (POL) § 89(3) provides that, "[w]hen an agency has the ability to retrieve or extract a record or data maintained in a computer storage system with reasonable effort, it shall be required to do so." I have reviewed your request and I believe that the Board has records available that are responsive to your FOIL request, which can be retrieved with "reasonable effort." I am returning your request to RAO Cremo to perform a search for the records that you have requested.

Conclusion:

Your FOIL request was not properly denied, I am directing RAO Cremo to perform a search for the requested records, and to issue a response to you within 20 business days.

Sincerely,

Mary Beth Woods

Mary Beth Woods
Executive Director

Enclosures

cc: Robert J. Freeman, Committee on Open Government
Patrick J. Cremo, RAO/WCB

WORKERS' COMPENSATION BOARD RESPONSE TO FOIL 16-119

From: Cremo, Patrick (WCB) [mailto:Patrick.Cremo@wcb.ny.gov]
Sent: Friday, May 27, 2016 12:52 PM
To: IWBA Office
Cc: wcb.sm.Office.of.General.Counsel
Subject: FOIL No. 16-119

Dear Ms. McGrath:

Please accept the following in response to your February 4, 2016 Freedom of Information Law (FOIL) request, which was remanded to this office by the Workers' Compensation Board's (Board's) Executive Director Mary Beth Woods on April 4, 2016.

Attached please find records responsive to your request number one (ATF) (parts 2, 7, 8 and 9); request number two (Proposed Decisions) (part 1); request number three (LWEC) (parts 5, 6, 10, 11, 15, 16 and 17); request number four (Indexing) (parts 1 and 4); request number five (RFAs)(parts 1 and 6); request number six (MTGs) (parts 1, 2, 3, 4, 7 and 8) and request number seven (ADs) (parts 1, 4 and 5).

With respect to the remaining portions of your FOIL request, please be advised that the Board does not possess or maintain any existing records that are responsive. The Board has determined, upon consultation with the New York State Office of Information Technology Services, that records responsive to the remaining portions of your FOIL request cannot be retrieved without engaging in an extensive and involved programming effort. The Board is not required to engage in such a unreasonable effort when retrieving or extracting data from its computer storage systems (*see* Public Officers Law [POL] § 89[3][a]; Comm on Open Govt FOIL-AO-19021 [2013]). According to the Committee on Open Government, "these provisions, read in conjunction with the descriptions of fees for actual costs . . . permit an agency to refuse to provide records that would require an unreasonable effort to prepare a record" (*see* Comm on Open Govt FOIL-AO-17606 [2009]); *Matter of Weslowski v Vanderhoef*, 98 AD3d 1123 [2d Dept 2012]).

To the extent that you deem any portion of this response to your FOIL request to be a denial, it may be appealed pursuant to Public Officers Law (POL) § 89(4) to the Board's Executive Director at 328 State Street, Room 438, Schenectady, New York 12305.

In all future correspondence relating to this request, please refer to the above FOIL Number. Thank you.

Patrick J. Cremo
Associate Attorney & Records Access Officer

NYS Workers' Compensation Board
328 State Street, Schenectady, NY 12305
(518) 486-9564 | (518) 402-0113 FAX | patrick.cremo@wcb.ny.gov
http://www.WCB.NY.Gov

EXHIBIT B

WORKERS' COMPENSATION 2016: THE AFTERMATH OF THE 2007 REFORMS FOR INJURED WORKERS AND THE IMPACT OF THE BUSINESS COUNCIL AGENDA

I. INTRODUCTION

Juana is a patient care aide at a large hospital. With overtime, she earns about $600 per week. Fred is a laborer in the heavy construction field who earns about $1,200 per week. In this paper, we will look at how the 2007 workers' compensation reforms affected the benefits they receive from the system – and how much of their lost wages are never replaced.

There are three basic types of workers' compensation benefit: temporary disability (when a worker is out of work for a limited period of time), "schedule loss" (where the worker suffers permanent damage to a limb, or has permanent vision or hearing loss), and "permanent partial disability" (where the worker is permanently disabled from his or her old job, but theoretically might be able to do something else.[52]

In 2007, the Workers' Compensation Law was changed in two fundamental ways. In one, the maximum weekly benefit rate was increased in stages from $400 per week to two-thirds of the "state average weekly wage," adjusted annually. As of July 1, 2014 this resulted in a new maximum benefit rate of $808.65 per week. However, an injured worker's benefit rate is limited to two-thirds of their own "average weekly wage." As a result, a worker who earns $600 per week or less did not see their workers' compensation benefits rise for any type of disability, whether temporary, permanent, or schedule loss.

[52] There are also permanent total disability and death benefits. There are a limited number of these types of claims, and as a result they are not considered in this paper.

The other significant change made in 2007 was that permanent partial disability benefits for injured workers were time-limited, or "capped." For the first time, instead of being paid permanently for a permanent disability, workers were limited to payment of between four and ten years for permanent disability. This change was made based on the Business Council's arguments about the "high cost of permanent partial disability claims," and its allegation that imposing time limits on permanent disability benefits would save employers billions of dollars.[53]

The 2016 Executive Budget has proposed another round of benefit reductions and new limitations on the processes workers use to obtain benefits from the workers' compensation system. In looking at these proposals, it is useful to see how the 2007 changes affected both low-wage workers like Juana and high-wage workers like Fred.

II. CHANGES IN WORKERS' COMPENSATION BENEFITS: 2006 VS 2014

Scenario 1: Temporary Disability Benefits. In October, 2006, Juana injures her back while lifting a patient. She misses ten weeks from work, and is paid workers' compensation benefits at $400 per week – two-thirds of her "average weekly wage" of $600 per week. If she suffered the same injury in October of 2014, her compensation benefits would be exactly the same. Even though the maximum weekly benefit rate rose to $808.65 per week, Juana's wages aren't high enough for her to receive any more than the old maximum rate of $400 per week.

[53] See, e.g., , http://www.wcb.ny.gov/content/main/TheBoard/Post2007Reform.pdf

Scenario 2: Schedule Loss of Use Benefits. In October, 2006, a door closes on Juana's hand as she is pushing a cart into a patient's room. She misses ten weeks from work, and is later found to have a 10% "schedule loss of use" of the hand due to a fracture. Her award for the injury is calculated based on her weekly workers' compensation benefit rate, and is worth a total of $9,760. However, the $4,000 in compensation benefits she was paid for time out of work ($400 per week for ten weeks) are deducted from her award. Juana also lost another $2,000 in wages that were not covered by workers' compensation, because her salary was $600 per week and compensation only paid her $400 per week. In the end, Juana gets $3,760 for her broken hand.

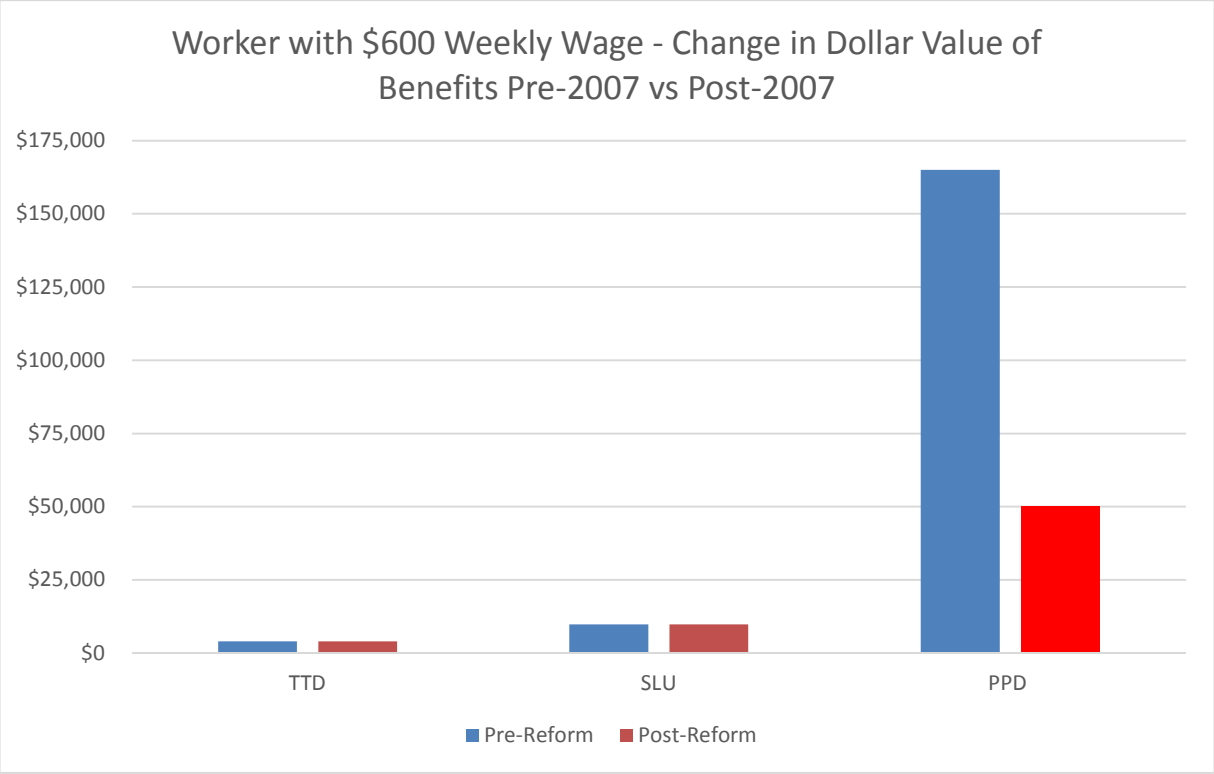
Once again, Juana's benefits in 2014 would be exactly the same as they were in 2006. Her award for schedule loss of use, like her award for temporary disability, is based on her average weekly wage. Because she does not earn enough to benefit from the increase in the maximum rates, her benefits for schedule loss were not improved by the 2007 reforms.

Scenario 3: Permanent Partial Disability Benefits. In October, 2006, Juana is assaulted by a patient and suffers multiple injuries. She is permanently disabled from her job as a patient care aide, and the Workers' Compensation Board decides that she has a "moderate permanent partial disability." This finding entitles her to only $200 per week in compensation benefits – one-third of her average weekly wage of $600. However, she is entitled to receive these benefits for as long as she remains disabled. If Juana is 45 years old at the time of the accident, these permanent disability benefits are worth about $165,000.

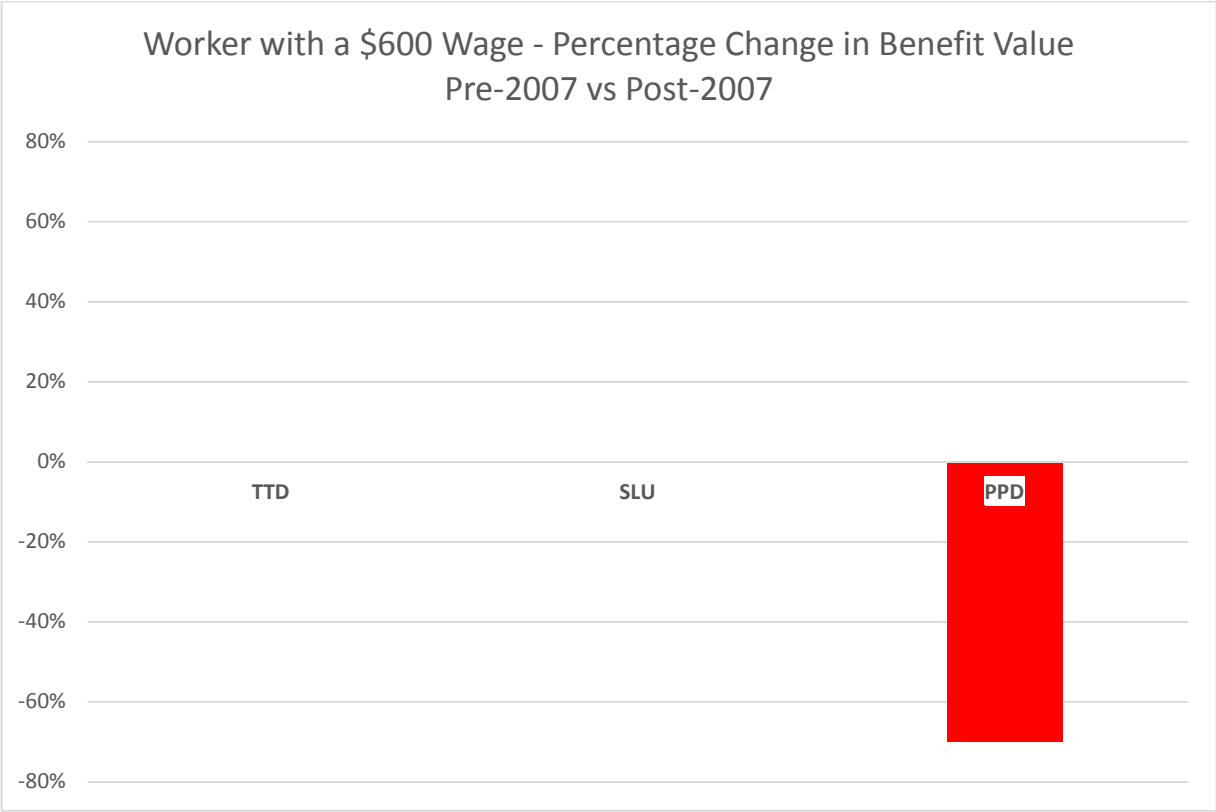
If Juana suffered the same injury in 2014, she would be entitled to the same $200 weekly compensation rate. However, because of the caps on permanent partial disability benefits (the "PPD caps"), she will only be paid for 300 weeks. Her permanent partial

disability benefits are now worth only $50,000 – less than 2 years' wages - even if she is never able to return to work.[54]

Summary: The 2007 reforms did not improve Juana's compensation benefits for temporary disability or for schedule loss, but they reduced her compensation for permanent disability by 70%, from $165,000 to $50,000. This is shown on the charts below.



[54] The figure shown is the present value of $200 per week for 300 weeks, using a discount rate of 5%. The same present value formula was used to arrive at the value of uncapped permanent partial disability benefits in the preceding paragraph.



Scenario 4: Temporary Disability Benefits. In October, 2006, Fred injures his back while lifting some cinderblocks and misses ten weeks from work. Although two-thirds of his "average weekly wage" of $1,200 per week would be $800 per week, his benefits are limited to the maximum statutory rate of $400 per week. As a result, Fred is paid a total of $4,000, while losing another $8,000 in wages. If Fred suffered the same injury in October of 2014, his compensation benefits would now be $800 per week as a result of the 2007 reforms. He now receives $8,000 in compensation, and loses $4,000 in wages. Unlike Juana, whose benefits for temporary disability remained the same despite the 2007 reforms, Fred's compensation for this type of disability has increased, while the amount of his uncompensated wage loss has decreased.

Scenario 5: Schedule Loss of Use Benefits. In October, 2006, a brick falls on Fred's hand and breaks two bones. He misses ten weeks from work, and is later found to

have a 10% "schedule loss of use" of the hand. His award for the injury is calculated based on the maximum weekly workers' compensation benefit rate of $400 per week, and is worth a total $9,760. However, the $4,000 in compensation benefits he was paid for time out of work ($400 per week for ten weeks) is deducted from his award. Fred also lost another $8,000 in wages that were not covered by workers' compensation, because his salary was $1,200 per week and compensation only paid him $400. In the end, even after receiving an award for "schedule loss," Fred loses $2,240 as a result of his injury.

If Fred's accident occurred in 2014, the result would be different. His award for schedule loss of use would now be paid at $800 per week, and would be worth $19,520, instead of $9,760. Payments for his time out of work would again be deducted, which would now be $8,000 instead of $4,000. Even after taking into account his $4,000 in uncompensated wage loss, Fred still receives $7,520 for his injury – as opposed to losing $2,240.

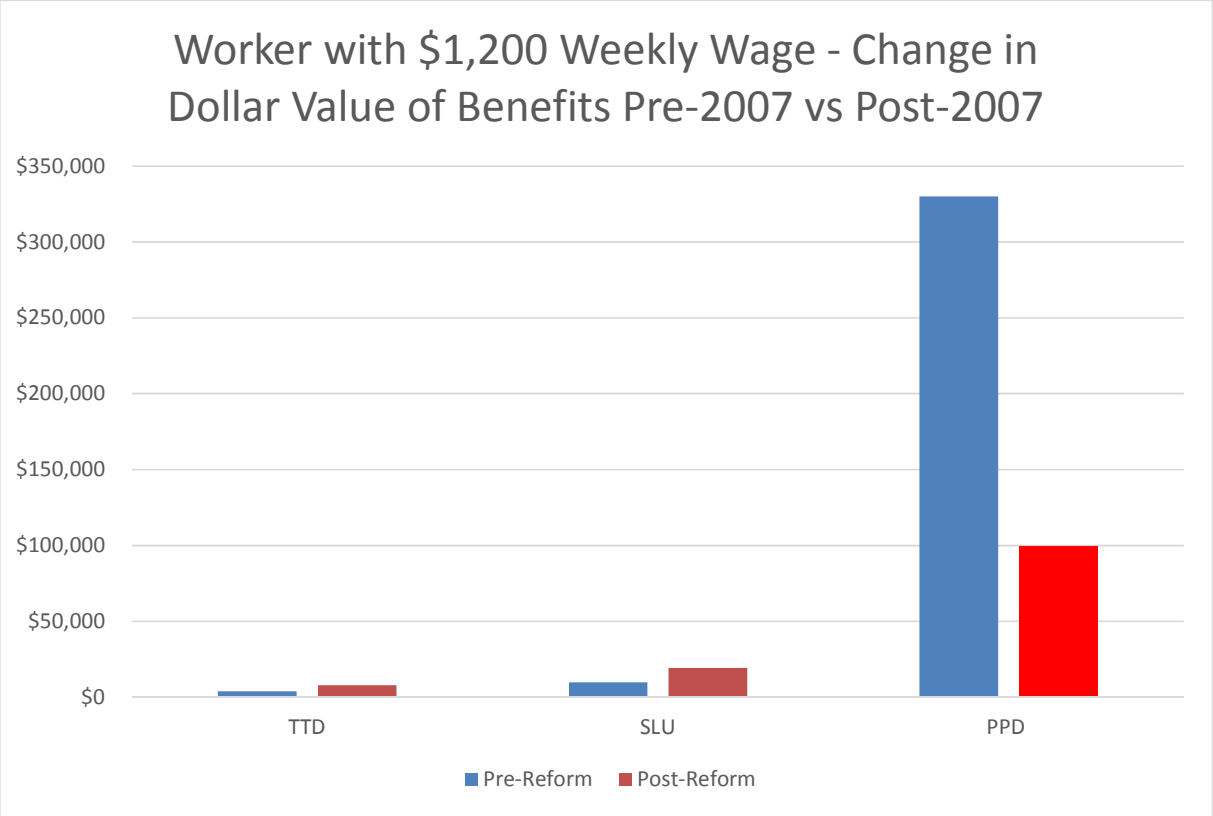
Scenario 6: Permanent Partial Disability Benefits. In October, 2006, Fred slips on some debris at a work site and suffers multiple injuries. He is permanently disabled from his job as a construction worker, and the Workers' Compensation Board decides that he has a "moderate permanent partial disability." This finding entitles him to $400 per week in compensation benefits – one-third of his average weekly wage of $1,200. However, he is entitled to receive these benefits for as long as she remains disabled. If Fred is 45 years old at the time of the accident, these permanent disability benefits are worth about $330,000.[55]

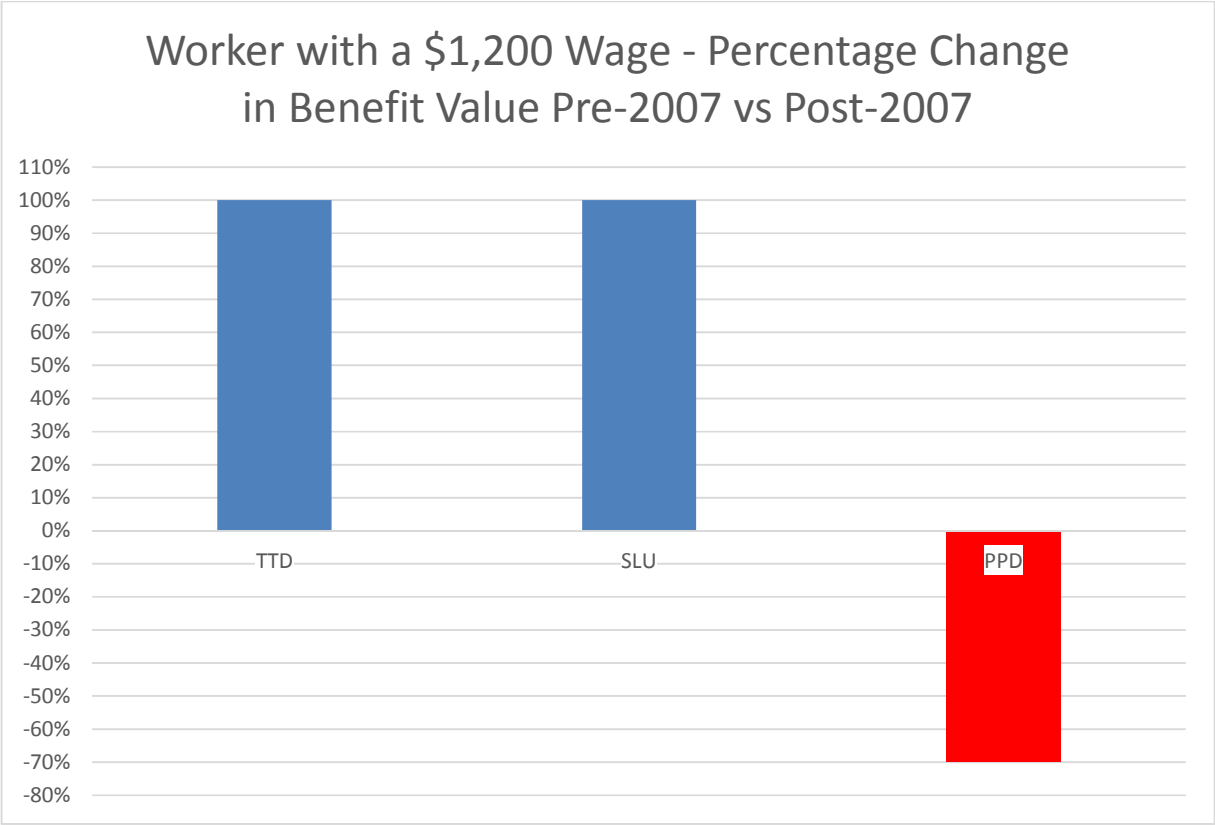
If Fred suffered the same injury in 2014, he would be entitled to the same $400 weekly compensation rate. However, because of the PPD caps he will only be paid for 300

[55] The same present value calculations are used here as in in Scenario 3, above.

weeks. His permanent partial disability benefits are now worth only $100,000 – less than two years' wages - even if he is never able to return to work.

Summary: The 2007 reforms improved Fred's compensation benefits for temporary disability and for schedule loss, but reduced his compensation for permanent disability by 70%, from $330,000 to $100,000. This is shown on the charts below.





<u>Impact of the 2007 Reforms on Compensation Benefits</u>.

The examples above illustrate four important facts about the impact of the 2007 reforms on workers' compensation benefits.

First, the 2007 reforms did not increase benefits for low-wage workers who had temporary disabilities or injuries that resulted in schedule loss awards.

Second, permanent partial disability benefits for these workers were slashed by 70% or more, creating huge savings for insurers at a huge cost to the most vulnerable part of the working population.

Third, the 2007 reforms did increase benefits for high wage workers for periods of temporary disability and for schedule loss, in some instances doubling these awards.[56]

[56] According to wage distribution data published by the Workers' Compensation Board, less than 15% of all injured workers would fall into this category.

Fourth, the 2007 reforms decimated permanent partial disability benefits for high-wage workers to the same extent – 70% - as for low-wage workers. However, the application of the PPD caps to high-wage workers created even larger dollar savings in unpaid benefits.

III. THE UNCOMPENSATED WAGE LOSS OF INJURED WORKERS

The benefit reductions that resulted from the 2007 reform legislation are only part of the cost of on-the-job injury to a worker. In almost every instance, workers lose wages and benefits that they never recover. The examples below illustrate how the 2007 legislation affected uncompensated wage loss for Juana and Fred.

Scenario 7: Temporary Disability Benefits. In Scenario 1, we saw that if Juana misses ten weeks from work, she is paid $400 per week regardless of whether she was injured before or after the 2007 reform legislation. In either case, she loses $6,000 in wages ($600 per week for ten weeks) and is only paid $4,000 ($400 per week). Her uncompensated wage loss, therefore, is $2,000, or 33% of her pre-accident wages.[57]

It must be noted that these calculations assume that Juana is paid for "temporary total disability" for her entire period of lost time. In practice, this is rarely the case. Employer use of so-called "independent medical examiners" routinely results in the reduction of weekly workers' compensation payments to injured workers, and a corresponding increase in uncompensated wage loss. In many cases, the result is a very

[57] This does not take into account the loss of employment benefits (such as health insurance, accrued time, pension benefits, etc.) or other benefits (such as credit earned for Social Security benefits) the worker forfeits while out of work.

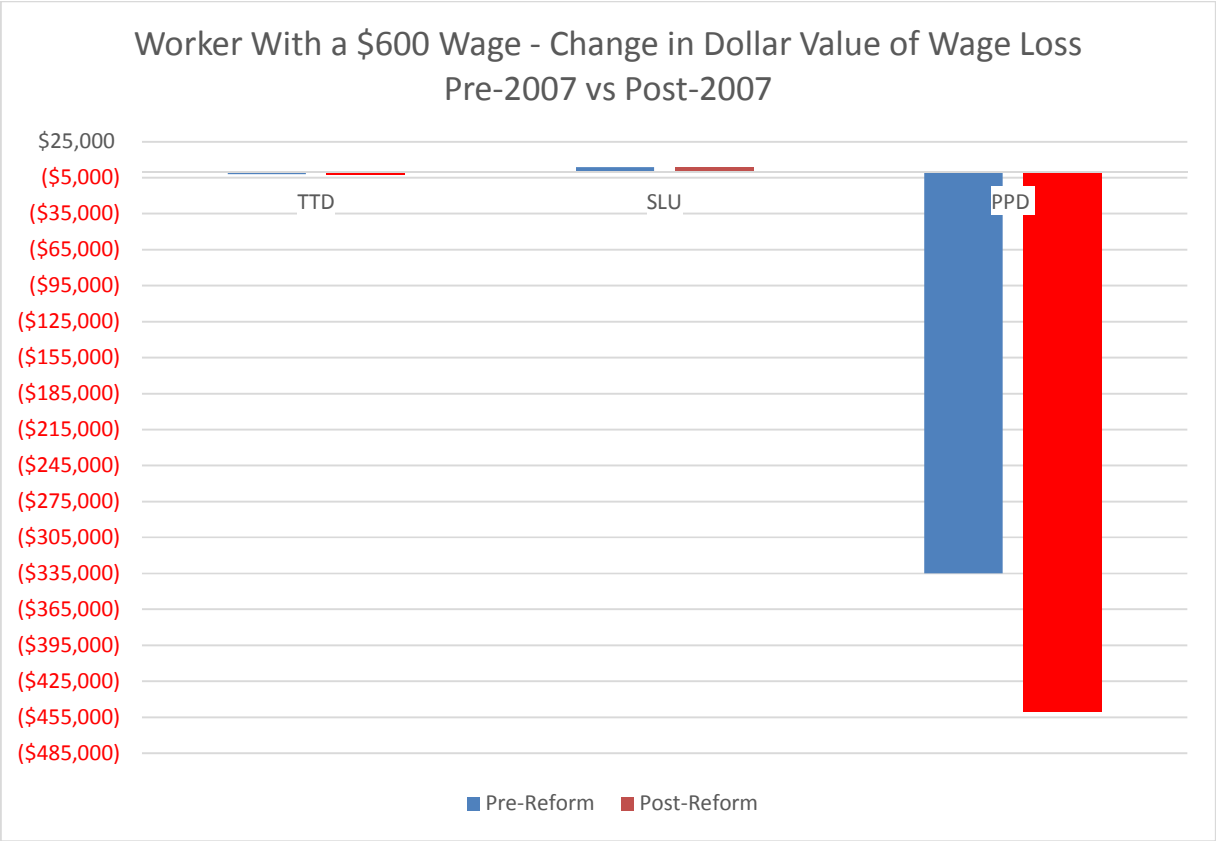
significant increase in uncompensated wage loss, even in cases that only involve temporary disability from work.

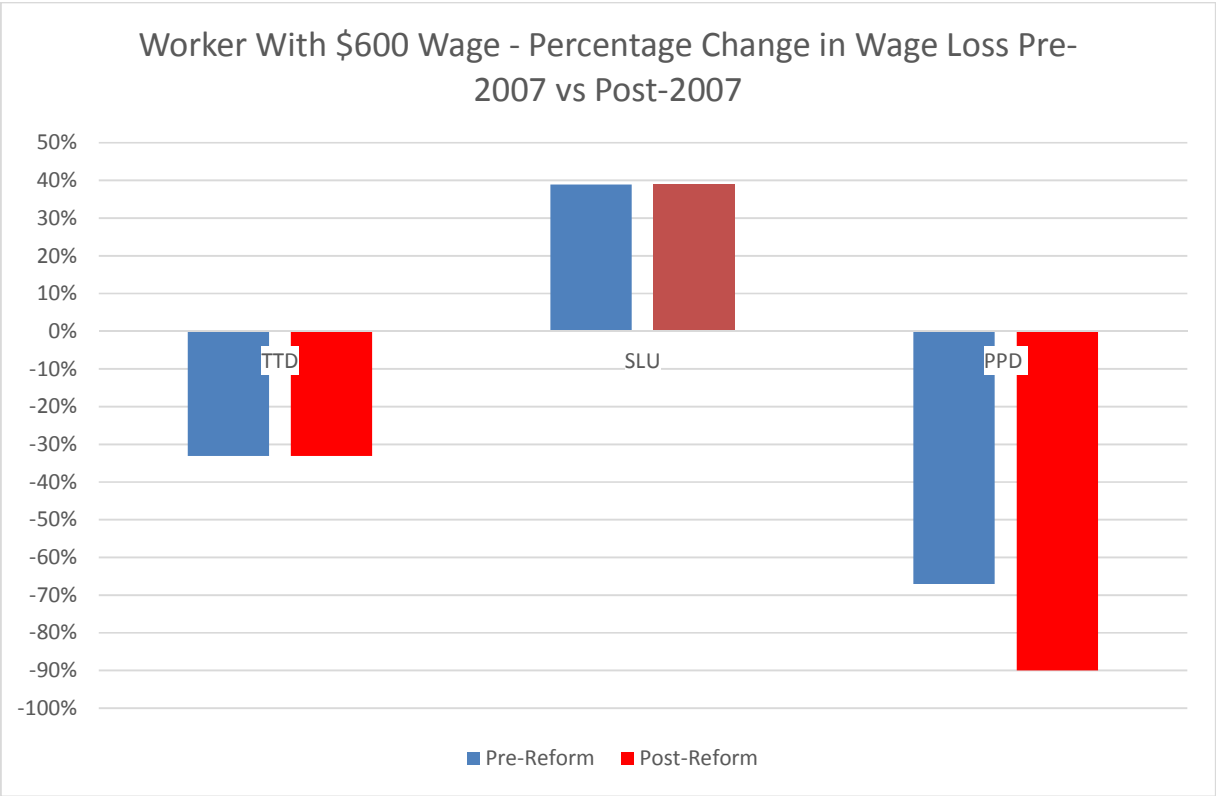
Scenario 8: Schedule Loss of Use Benefits. Similarly, in Scenario 2, we saw that if Juana loses ten weeks from work and is later found to have a "schedule loss of use" of 10% of her hand, her real award is $3,760 after her lost wages are taken into account. Again, the result is the same for her regardless of the 2007 legislation.

Scenario 9: Permanent Partial Disability Benefits. In Scenario 3, we saw that the 2007 reforms slashed Juana's compensation for permanent disability by 70%, from $165,000 to $50,000. What was not shown in Scenario 3, however, was Juana's uncompensated wage loss for her permanent partial disability. If Juana had not been injured, then her future earnings would have been more than $500,000 over the rest of her working career.[58] Before the PPD caps imposed by the 2007 reforms, Juana's uncompensated wage loss was $335,000, or 67%. With the application of those caps, it rose to $450,000 – meaning that 90% of Juana's lost wages are uncompensated by the workers' compensation system.

Summary: Both before and after the 2007 reforms, Juana suffered an uncompensated wage loss of 33% for injuries resulting in temporary disability, while receiving a small benefit for injuries involving a schedule loss of use. However, Juana suffered from enormous uncompensated wage loss if she had a permanent partial disability before the 2007 reform, and as a result of that reform her compensation benefits now replace barely 10% or her lost earnings. These outcomes are shown on the charts below.

[58] This figure represents the present value of her average weekly wage over her estimated work life, without taking into account inflation or cost of living increases. It is therefore the most conservative possible figure from which to calculate her uncompensated wage loss.


Worker With a $600 Wage - Change in Dollar Value of Wage Loss Pre-2007 vs Post-2007
$25,000
($5,000)
($35,000)
($65,000)
($95,000)
($125,000)
($155,000)
($185,000)
($215,000)
($245,000)
($275,000)
($305,000)
($335,000)
($365,000)
($395,000)
($425,000)
($455,000)
($485,000)
TTD
SLU
PPD
Pre-Reform
Post-Reform


Worker With $600 Wage - Percentage Change in Wage Loss Pre-2007 vs Post-2007
50%
40%
30%
20%
10%
0%
-10%
-20%
-30%
-40%
-50%
-60%
-70%
-80%
-90%
-100%
TTD
SLU
PPD
Pre-Reform
Post-Reform

Scenario 10: Temporary Disability Benefits. In Scenario 1, we saw that if Fred missed ten weeks from work before the 2007 reforms, he was paid $400 per week in workers' compensation benefits and lost $800 per week, meaning that $8,000, or 67%, of his wage loss was uncompensated. By contrast, following the 2007 reforms, he can be paid $800 per week in compensation and loses $400 per week. As a result, the 2007 reforms reduced his uncompensated wage loss from 67% to 33% - but the system still leaves him with a significant uncompensated wage loss of $4,000.

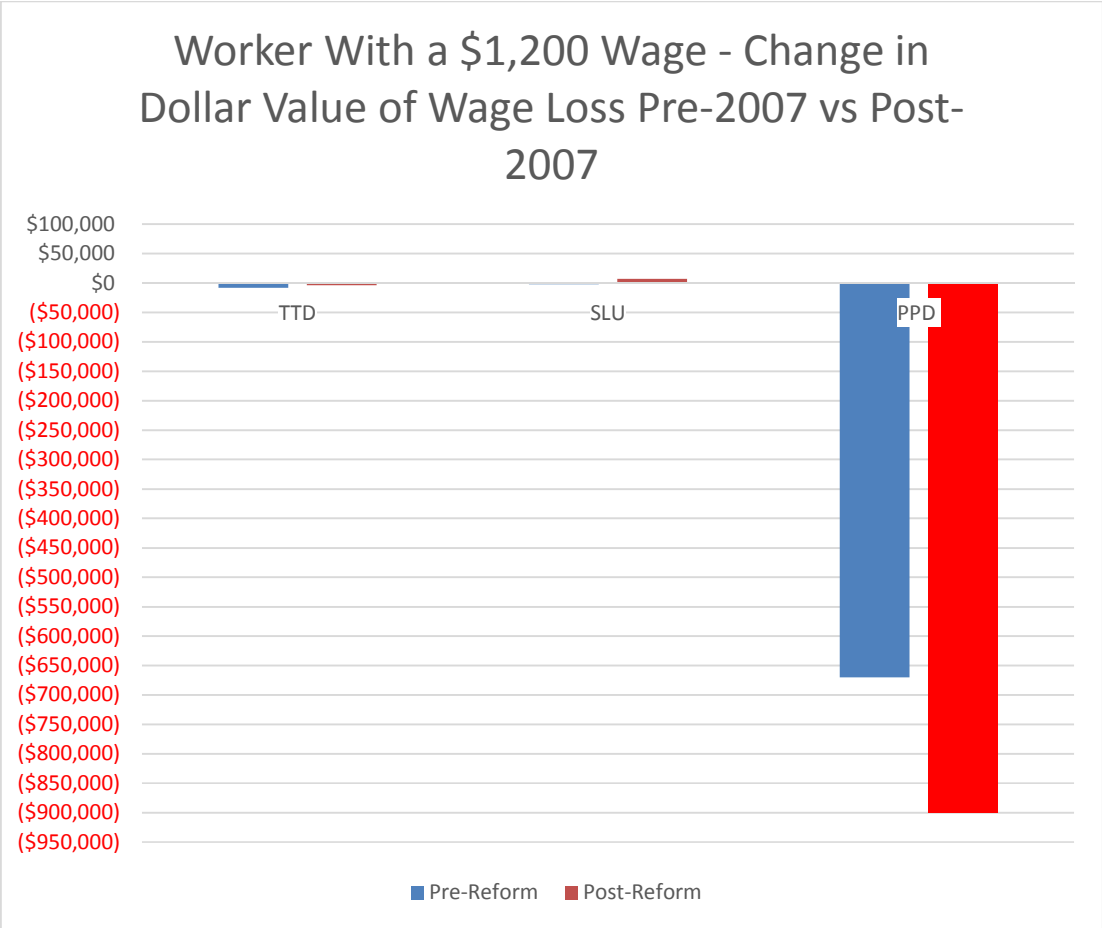
Scenario 11: Schedule Loss of Use Benefits. In Scenario 2, we saw that if Fred missed ten weeks from work and was later found to have a "schedule loss of use" of 10% of his hand, his total workers' compensation benefit was $9,760, while his lost wages were $12,000. As a result, he suffered a 19% wage loss of $2,240 even after receiving a schedule loss award. By contrast, after the 2007 reform Fred finally receives something for his injury, with a gain of $7,520 – the same benefit as Juana on a percentage basis.

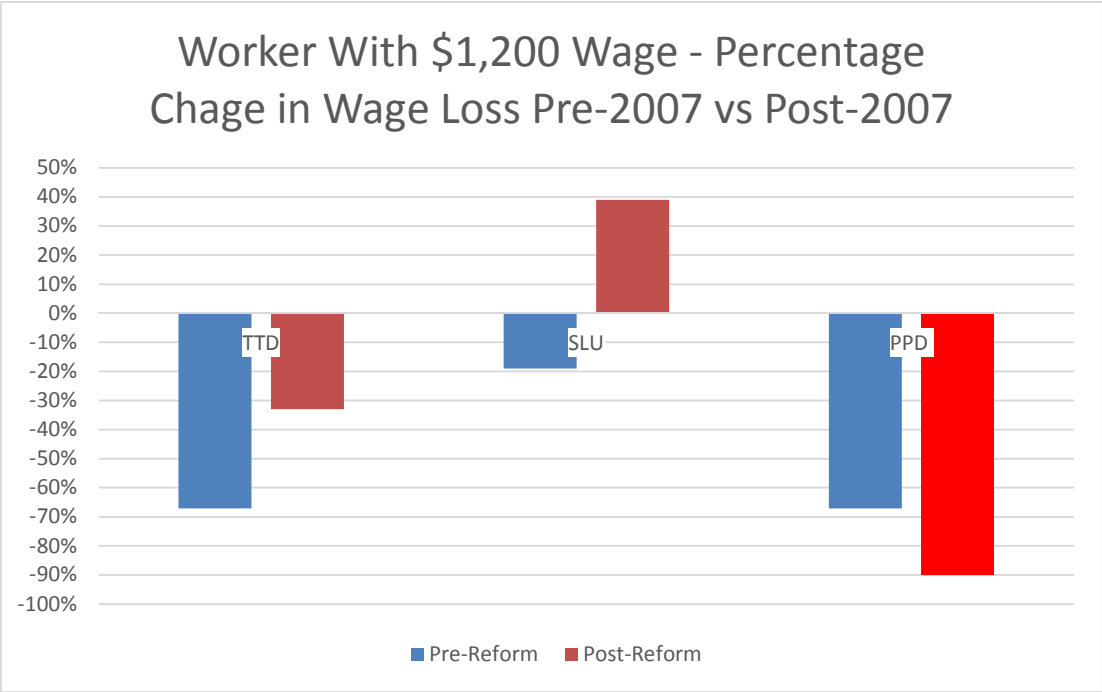
Scenario 12: Permanent Partial Disability Benefits. In Scenario 3, we saw that the 2007 reforms slashed Fred's compensation for permanent disability by 70%, from $330,000 to $100,000. Like Juana, however, Fred also suffers from enormous uncompensated wage loss, made far more severe by the 2007 reforms. If Fred had not been injured, then his future earnings would have been more than $1,000,000 over the rest of his working career.[59] As a result, before the PPD caps imposed by the 2007 reforms, Fred's uncompensated wage loss was $670,000, or 67%. With the application of those caps, it rose to $900,000 –

[59] The same conservative approach is taken in estimating Fred's future earning potential as in Scenario 9; a more accurate figure would be far greater.

meaning that 90% of Fred's lost wages are uncompensated by the workers' compensation system.

Summary: Before the 2007 reforms, Fred suffered an uncompensated wage loss of 67% for injuries resulting in temporary disability. After the reforms, Fred still has an uncompensated wage loss of 33%. The 2007 reforms also eliminated Fred's 19% uncompensated wage loss in cases involving schedule loss of use, resulting in his receipt of the same benefit from schedule loss awards as Juana (on a percentage basis). However, like Juana, Fred suffered from enormous uncompensated wage loss if he had a permanent partial disability before the 2007 reform, and as a result of that reform his compensation benefits now replace barely 10% or his lost earnings. These outcomes are shown on the charts below.


Worker With a $1,200 Wage - Change in Dollar Value of Wage Loss Pre-2007 vs Post-2007
$100,000
$50,000
$0
($50,000)
($100,000)
($150,000)
($200,000)
($250,000)
($300,000)
($350,000)
($400,000)
($450,000)
($500,000)
($550,000)
($600,000)
($650,000)
($700,000)
($750,000)
($800,000)
($850,000)
($900,000)
($950,000)
TTD
SLU
PPD
Pre-Reform
Post-Reform


Worker With $1,200 Wage - Percentage Chage in Wage Loss Pre-2007 vs Post-2007
50%
40%
30%
20%
10%
0%
-10%
-20%
-30%
-40%
-50%
-60%
-70%
-80%
-90%
-100%
TTD
SLU
PPD
Pre-Reform
Post-Reform

Impact of the 2007 Reforms on Compensation Benefits.

The examples above illustrate four important facts about the impact of the 2007 reforms on uncompensated wage loss.

First, the 2007 reforms did not affect uncompensated wage loss for low-wage workers with temporary disabilities, nor did it increase their benefits from schedule loss awards.

Second, while the 2007 reforms did reduce uncompensated wage loss for high wage workers in cases of temporary disability, these workers still suffer from significant uncompensated wage loss as the result of on-the-job injury.

Third, the 2007 reforms eliminated uncompensated wage loss for high wage workers in some schedule loss cases, providing them with the same benefit (in percentage terms) as low-wage workers.

Fourth, before the 2007 reforms workers suffered uncompensated wage loss of 67% or more in cases of permanent partial disability. As a result of the 2007 reforms, this figure rose to 90%, meaning that the workers' compensation system now replaces less than 10% of the wages lost by a permanently disabled worker.

IV. THE IMPACT OF THE BUSINESS COUNCIL AGENDA AND THE EXECUTIVE BUDGET

The Business Council's legislative agenda and portions of the 2016 Executive Budget must be considered in the context of (1) the impact of the 2007 reforms on reducing benefits; and (2) the degree to which the workers' compensation system already fails to replace the lost wages of injured workers.

The Executive Budget proposes to eliminate the requirement that insurers deposit the present value of their future liability into the Aggregate Trust Fund in cases involving permanent partial disability, permanent total disability or death benefits. As a result of this action, permanently disabled workers, widows and dependents would no longer receive the "present value" of their benefits discussed in Scenarios 3, 6, 9 and 12. Instead, they would receive an even lower amount, in some instances perhaps half as much. Instead of receiving 10% of their lost wages, injured workers would be reduced to 5%. Nineteen of every twenty dollars of lost wages would be uncompensated, rendering the workers' compensation system virtually meaningless as a source of income for the permanently disabled and beneficiaries of death benefits.

The Budget also proposes to replace the current method by which a worker's "average weekly wage" is calculated with one which would reduce that figure for most workers, and especially for those who are paid on a daily or hourly basis. This would have a particularly adverse impact on low wage and immigrant workers. As shown in every scenario, a worker's compensation benefits depend in large part on their pre-accident wage. A reduction in average weekly wage would translate into a reduction in compensation benefits – and further exacerbate the issue of uncompensated wage loss.

Meanwhile the Business Council has advanced a proposal to cap temporary disability benefits, in addition to the existing caps on permanent disability benefits. This would, of course, further reduce benefits for injured workers and create still more uncompensated wage loss. Given the existing rate of 90% uncompensated wage loss and the fact that the Budget proposal would increase that figure to perhaps 95%, it appears that the Business Council's position is that the workers' compensation system should provide

workers with no more than 1% of the wages they lose as the result of on-the-job injury and illness that permanently rob them of the ability to earn a living.

The Business Council has simultaneously advanced a proposal to reduce schedule loss awards. As shown in Scenarios 2 and 8, the 2007 reforms did not increase the value of these awards for low-wage workers, while slashing their wage replacement benefits in cases of permanent disability. The Business Council's proposed change would further impoverish this group of workers, and create still more cases in which the workers' compensation system fails to replace their lost wages. Meanwhile, as shown in Scenarios 5 and 11, one of the very few benefits for workers from the 2007 reforms was a modest improvement in schedule loss benefits for high-wage workers. The Business Council proposal would retain and expand the enormous savings to insurers from the PPD caps, and add still further savings from schedule loss awards. All of this would come at great cost to injured and disabled workers.

V. CONCLUSION

Before the 2007 reforms, the workers' compensation system did not adequately compensate injured workers for lost wages due to temporary disability, permanent disability, or (in many instances) schedule loss of use. For low-wage workers, the 2007 reforms did not improve benefits for temporary disability or schedule loss, and drastically reduced their compensation for permanent disability. In almost every instance, these workers suffer from significant uncompensated wage loss, which was made worse by the 2007 reforms and would further deteriorate if the Executive Budget or Business Council proposals were adopted.

The situation is little better for high wage workers. While the 2007 reforms improved their compensation for temporary disability and schedule loss, they suffered the same blow as low wage workers in cases of permanent disability. In many ways, the Executive Budget and Business Council proposals would roll back the few areas in which the 2007 reforms improved benefits for these workers.

The pressing need in the workers' compensation system is not for benefit reduction, but rather for benefit improvements to reduce the uncompensated wage loss of injured workers and keep them from impoverishment and reliance on taxpayer-funded benefits, as opposed to employer-funded benefits. The costs of workplace injury should not be borne by injured workers or the public, but instead by employers, who in return are shielded from all other liability.

Dated: Farmingdale, New York
February 1, 2016

EXHIBIT C

THE TRUTH ABOUT THE BUSINESS COUNCIL'S PLAN TO ONCE AGAIN SLASH COMPENSATION FOR PERMANENT INJURY:

A CONTINUED ASSAULT ON LOW WAGE WORKERS

By: Robert E. Grey

In its 2015 Legislative and Regulatory Agenda, the Business Council called for a reduction in "schedule loss awards," which are paid to workers who suffer permanent damage to limbs, vision or hearing on the job.[60] If this were to be carried out, it would slash benefits for workers, many of whom would actually receive less money for the same injury than they would have received twenty-five years ago. After adjusting for inflation, they would be even further behind.

Contrary to the Business Council's claims, schedule loss awards are not a "windfall" to workers with permanent injuries. Workers' compensation benefits failed to keep pace with inflation for two decades, with balance being restored only recently. A reduction in schedule loss awards would amount to a twenty-year rollback in benefits, with the most severe impact being felt by low wage workers, many of them immigrants.

Workers' compensation benefits largely depend on how much a worker earns, known as the "average weekly wage" (or "AWW"). An injured worker's maximum weekly payment is two-thirds of his or her average weekly wage, subject to the maximum rate in effect on the date of the accident.

From 1992 through 2007, the maximum weekly benefit rate was $400 per week. This rate was potentially available to any worker who earned at least $600 per week, while

[60] "Fix New York: The 2015 Legislative and Regulatory Agenda," Business Council of New York State, available at: http://www.bcnys.org/inside/gac/2015/Fix-New-York-2015-Legislative-and-Regulatory-Agenda.pdf

those who earned less received benefits commensurate with their wages.[61] For example, a worker who earned $450 per week was paid $300 per week for total disability (two-thirds of his or her average weekly wage), while a worker who earned $800 per week was paid $400 per week (the maximum weekly benefit rate).

In 2007, the Legislature increased the weekly maximum benefit rate in stages for future years, while simultaneously imposing new time limitations (or "caps") on permanent partial disability benefits. As a result, the maximum weekly benefit rate has increased over the past eight years as shown on the chart below.

Date of Injury	**Maximum Rate**
7/1/1992	$400
7/1/2007	$500
7/1/2008	$550
7/1/2009	$600
7/1/2010	$739.83
7/1/2011	$772.96
7/1/2012	$792.07
7/1/2013	$803.21
7/1/2014	$808.65

It is important to remember that for the reasons discussed above, these increases in the maximum weekly benefit did not affect all workers equally. According to the Workers' Compensation Board's Annual Report for 2013, "[t]here is a wide distribution of AWW in accepted claims in 2012. Approximately one-third of claims had an AWW of less than $600. One quarter of claims had an AWW between $600 - $899. Nearly 40% of claims had

[61] The amount of benefits an injured worker actually receives also depends on other factors, such as his or her "degree of disability." In practice, this often results in workers receiving less than the maximum rate for the period of temporary disability.

an AWW of $900 or more."[62] The Board's data about the wage distribution of injured workers is reproduced below.

Average Weekly Wage	Number of Claimants	Percentage of Claimants
Not Available	1,604	2.2%
$149 or less	1,020	1.4%
$150 - $299	4,831	6.7%
$300 - $449	8,685	12.0%
$450 - $599	9,191	12.7%
$600 - $749	9,769	13.5%
$750 - $899	8,046	11.1%
$900 - $1,204.81	12,447	17.2%
$1,204.82 or more	16,834	23.2%

Although the 2007 legislation increased the maximum weekly benefit rate available to workers earning more than $600 per week, there was no increase for those earning $600 per week or less – about one-third of those in the system. Moreover, low wage workers were subject to the new time limitations on permanent partial disability benefits, which could previously be paid for life. Overall, these workers received no benefit from the increase in the maximum weekly benefit rate, while losing thousands of dollars individually (and millions of dollars collectively) in benefits for injuries that permanently prevent them from returning to work.[63]

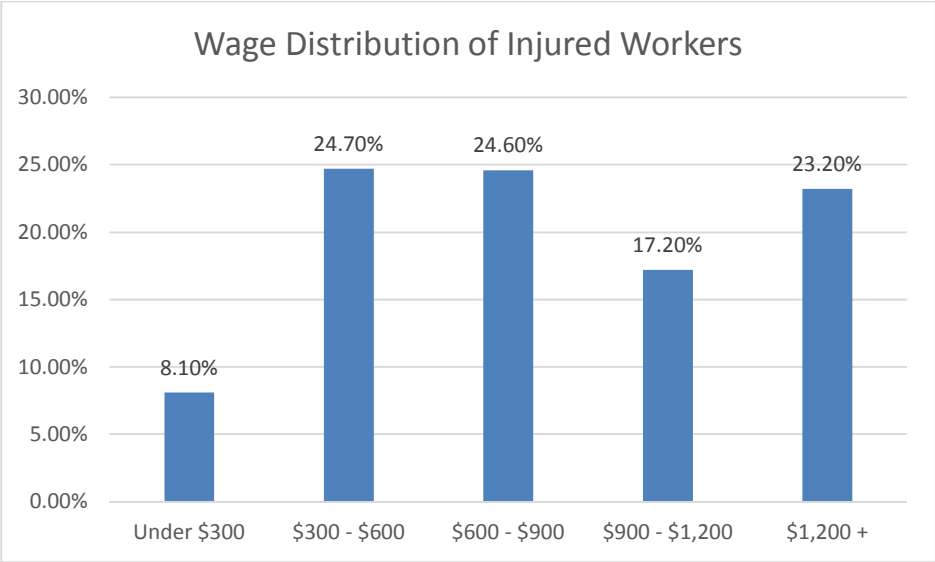
[62] New York State Workers' Compensation Board 2013 Annual Report, available at: http://www.wcb.ny.gov/content/main/TheBoard/2013AnnualReport.pdf

[63] The "safety net reports" produced by the New York State Department of Labor in 2008, 2009 and 2010 (the last year the report was produced) show that low wage workers have a higher rate of permanent partial disability than those with higher earnings. It should also be noted that although high-wage workers with short-term disabilities benefit from the increased maximum weekly benefit rates, those gains are more than offset by the loss of permanent disability benefits for workers in these wage distribution categories as well.

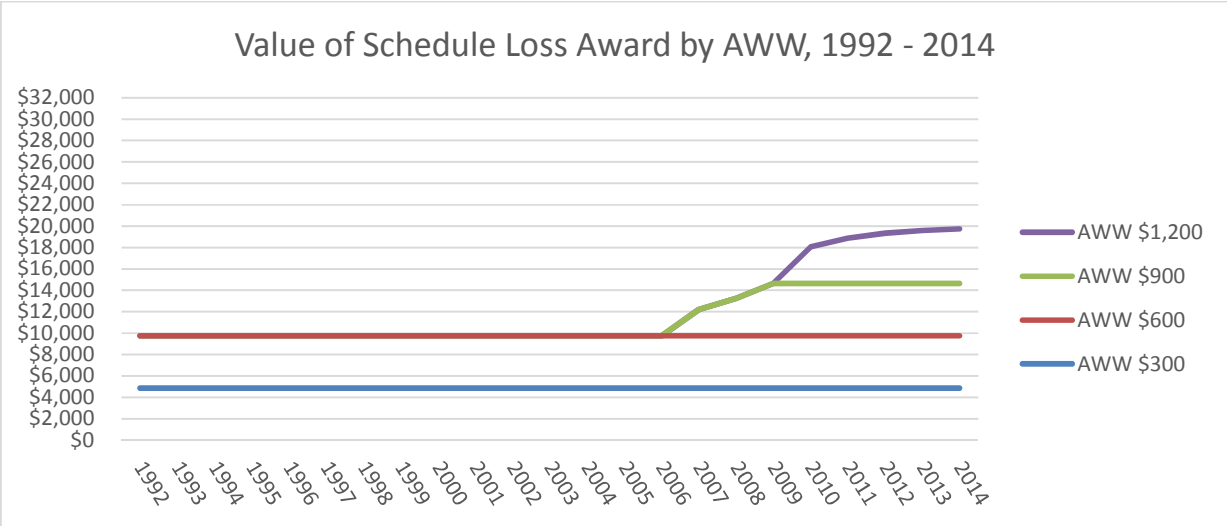
The increase in the maximum weekly benefit rate primarily affected two types of workers' compensation benefits: temporary total disability benefits and schedule loss of use awards for workers who earn more than $600 per week. The Business Council now advocates for the reduction of schedule loss of use awards not only for workers whose benefits increased as a result of the 2007 legislation, but for **all** injured workers. If enacted, this policy would re-victimize the same low wage workers whose benefits were slashed in 2007.

The Workers' Compensation Law provides benefits for the permanent loss or loss of use of an arm, leg, hand, foot, finger, toe, vision, or hearing. These awards are paid in weeks of benefits, which depend on which body part was injured and the extent of the loss. For example, a ten percent loss of use of a hand entitles the worker to payment of twenty four and two-fifths weeks of benefits. The benefit weeks are paid at the injured worker's maximum weekly benefit rate, which in turn depends on his or her average weekly wage and date of accident. Thus, a worker who earned $600 per week would be entitled to $9,760 for a ten percent "schedule loss" of a hand (24.4 weeks x $400 per week = $9,760). However, any wages or compensation the worker was paid for time out of work would be deducted from this award.

Because the amount of a schedule loss award depends on the rate of compensation, which in turn is based on the injured workers' wage, these awards have not increased for low wage workers since 1992. As shown on the chart below, nearly one-third of all injured workers fall into this category. Another twenty-five percent earn between $600 and $900 per week, which means that they have received no benefit from increases in the maximum weekly rate since 2009, when it rose to $600 per week.



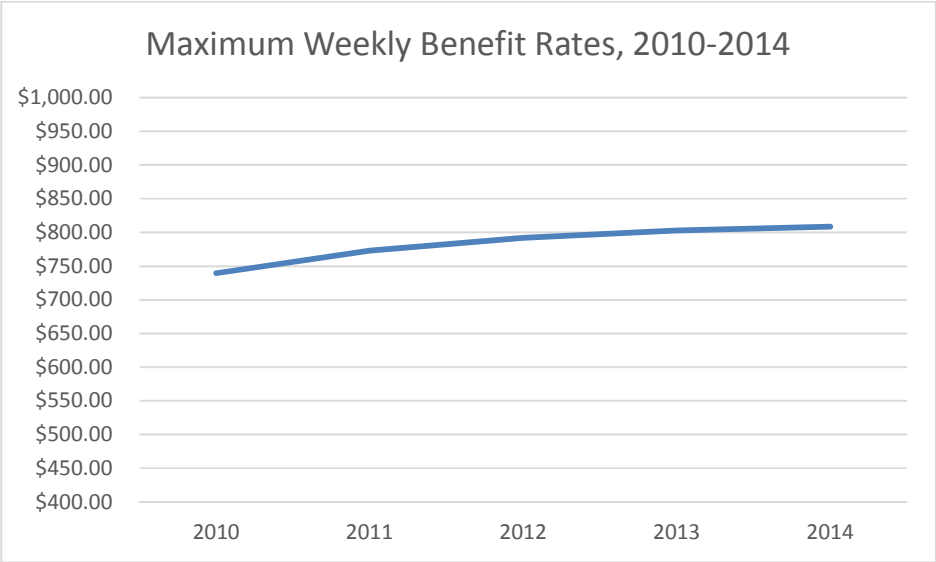
The graph below shows the change in value of a schedule loss award for a ten percent loss of use of the hand for workers earning $300 per week, $600 per week, $900 per week and $1,200 per week over a twenty-three year period from 1992 to 2014.



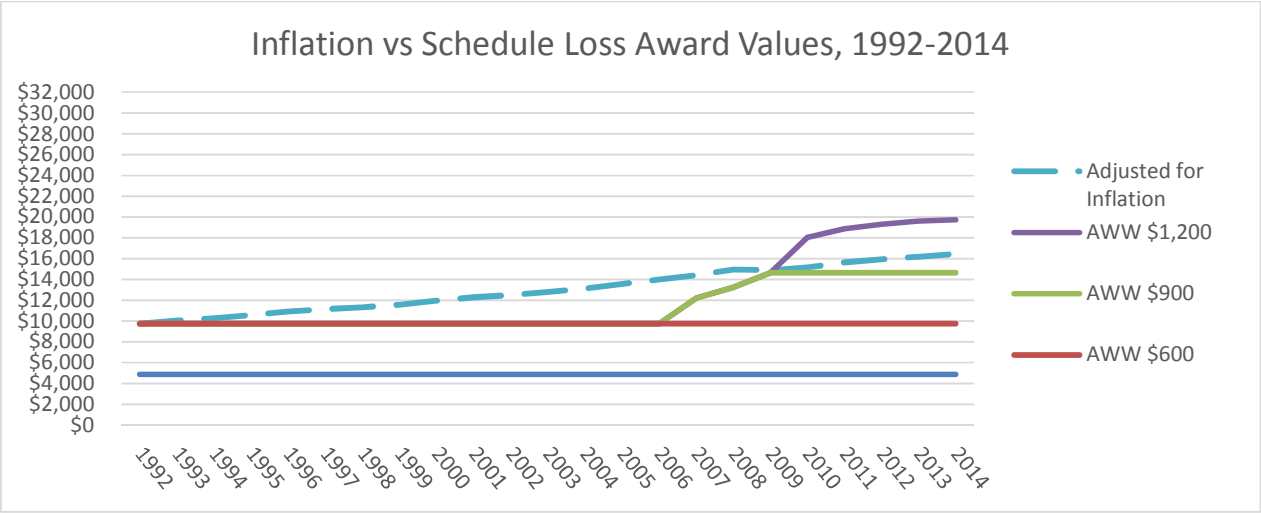
As the graph shows, there has been no increase in the value of schedule loss awards for workers who earned $600 per week or less since 1992, nearly a quarter-century. Workers who earn between $600 and $900 per week saw a modest increase in the value of their awards between 2007 and 2009, after which they have remained flat for the past five

years. Workers at the upper end of the bracket between $900 and $1,200 per week continued to receive incremental increases between 2009 and 2014, but awards for these workers will not rise further in future years. Only those who earn more than $1,200 per week – less than a quarter of injured workers – will receive any future increase in schedule loss awards, and those increases will be minimal and incremental.

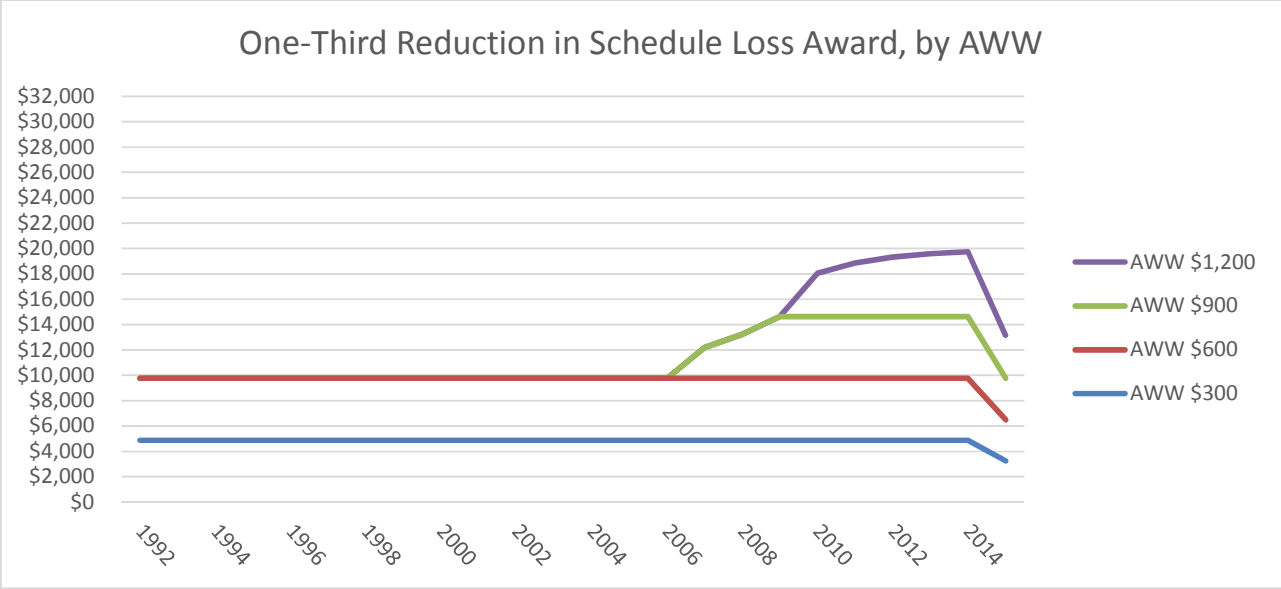
The graph below shows the incremental rate of increase in the maximum benefit rate (and associated schedule loss awards) from 2010 to 2014. As noted above, these incremental changes impact only workers who earn in excess of $900 per week.



The historic inadequacy of workers' compensation awards for schedule loss is easily demonstrated by including the impact of inflation. As shown in the previous graph, the value of schedule loss awards for workers who earn less than $600 per week has remained flat for the past twenty-three years. Awards for those earning between $600 and $900 per week remained flat for fifteen years, rose for three years and have since remained flat for the past five. The graph below shows awards failed to keep pace with inflation for all workers in every year from 1992 to 2009, and has continued to lag inflation for three-quarters of injured workers through 2014.



Against this background, the Business Council and others advocate for the outright reduction of schedule loss awards. The graph below shows the impact of a one-third reduction in schedule loss awards.

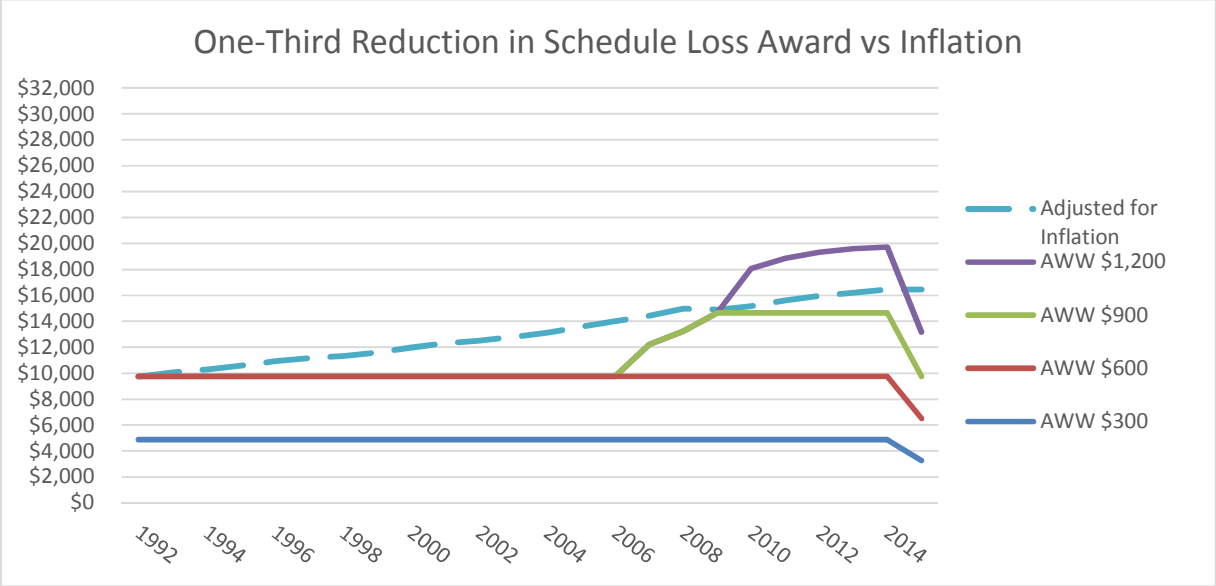


It is apparent that a one-third reduction in schedule loss awards would cut benefits for low wage workers to a level below what they received for the same injury in 1992 in "nominal dollars."[64] Workers who earn between $600 and $900 per week would return to

[64] "Nominal dollars" are dollars unadjusted for inflation. In the example shown on the chart, a worker who received $9,760 for his or her injury in 1992 would receive $6,506 for the same injury in 2015, a reduction

their 1992 benefit levels (in nominal dollars), while benefits for high wage workers would be only minimally higher than they were in 2007.

The graph below includes data for inflation, showing that a decrease in schedule loss awards would only further exacerbate the inadequacy of workers' compensation benefits compared to rising costs.



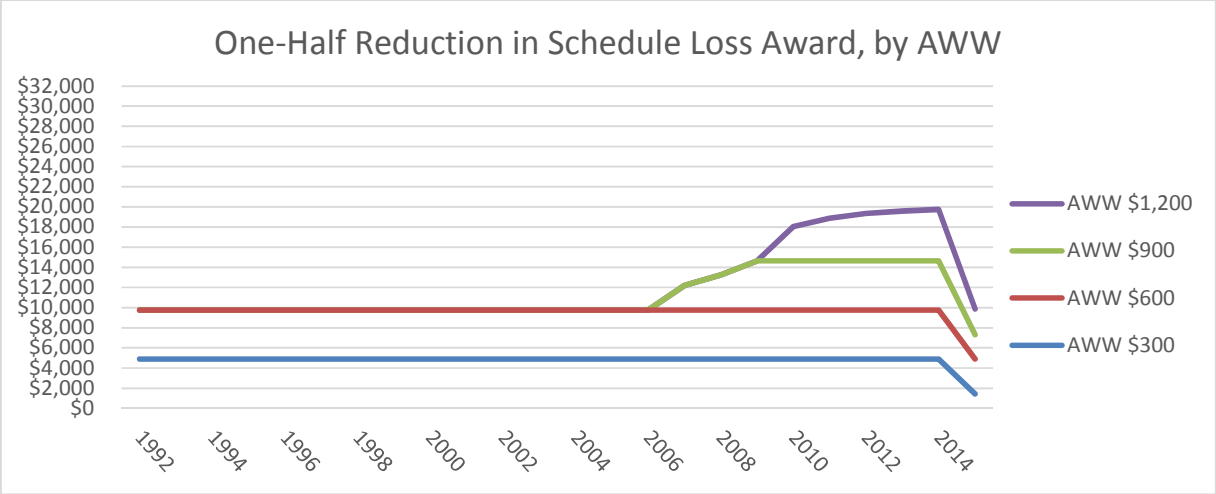
It is apparent that a downward adjustment in schedule loss awards would leave workers in all wage categories with fewer "real dollars" in compensation than they received for same injury in 1992.[65] For many, benefits in 2015 would be worth less than half of what they received in 1992.

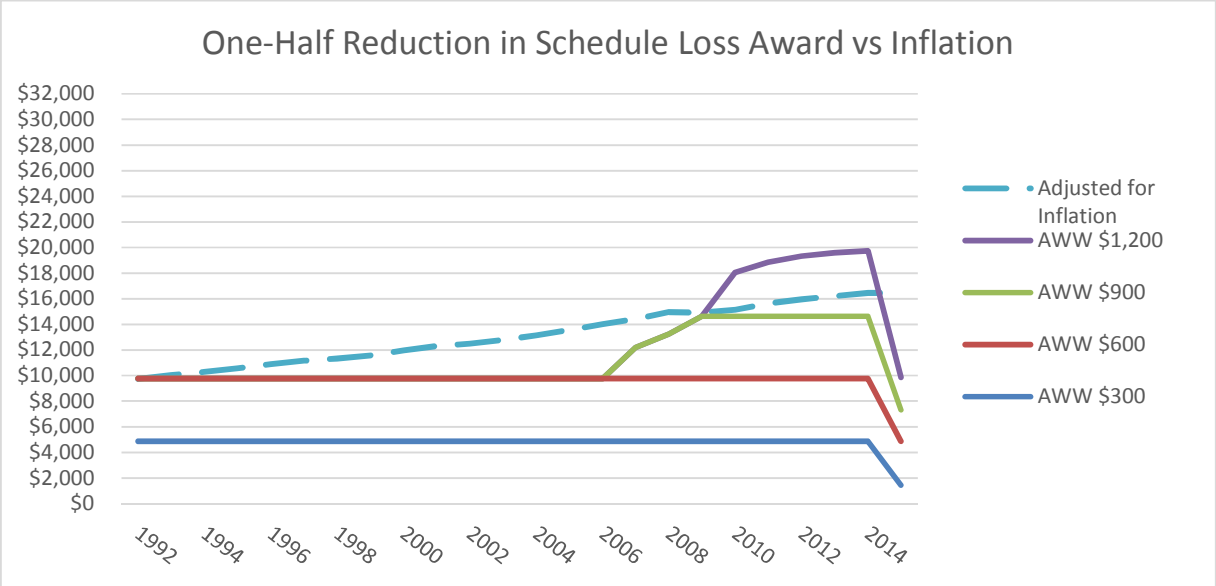
The graphs below show the impact of a fifty percent reduction in schedule loss awards, both in nominal dollars and against inflation. A reduction of this magnitude would slash benefits for all workers who earn less than $1,200 per week (seventy-seven percent of

of $3,254 nominal dollars. By contrast, "real dollars" include the impact of inflation. By this measure, $9,760 in 1992 was worth $16,468 in 2015. This means that the loss in "real dollars" is $9,962. Put another way, a one-third reduction in an award in nominal dollars in 2015 means that the award is worth less than half of what it was worth in 1992 in real dollars.

[65] See note 5, above

injured workers) to a lower figure in nominal dollars than they received in 1992. The loss would be especially severe for low-wage workers. In real dollars, awards in 2015 would be worth about twenty-five percent of their value in 1992.





Although the harshest impact of a reduction in schedule loss awards would fall on low wage workers, it must also be noted that existing schedule loss awards also often fail to adequately compensate high wage workers for their wage loss. According to the Board's data, twenty-three percent of injured workers earn more than $1,200 per week, while the

maximum workers' compensation benefit is $808.65 weekly.[66] As a result, a worker who earns $1,600 per week does not receive two-thirds of his or her wage loss for an on-the-job injury, but instead only receives about half.

An example may help illustrate the issue. A construction worker earning $1,600 who breaks his hand on the job and is out of work for fifteen weeks loses $24,000 in wages ($1,600 per week multiplied by 15 weeks). If he is later found to have a ten percent schedule loss of use of his hand, the award is worth $19,731.06 (twenty four and two fifths weeks multiplied by $808.65 per week). For this high-wage worker, the schedule loss award fails to adequately compensate him for over $4,000 of his actual wage loss.

Conclusion

The data shows that schedule loss awards have not increased for low wage workers since 1992. Those who earn $600 per week or less – about one-third of all injured workers – receive the same benefits for an injury today as they did twenty-three years ago. When inflation is taken into account, their awards today are worth forty percent less than their value in 1992.

With the exception of a three year period from 2007-2009, schedule loss awards have also been stagnant for workers who earn between $600 per week and $900 per week – another twenty-five percent of the injured worker population. For these workers, too, the value of their awards continues to lag inflation by about twelve percent.

Overall, schedule loss awards fail to adequately compensate three-quarters of injured workers as compared to inflation. On the opposite end of the spectrum, the awards fail to adequately compensate high wage earners for their actual wage loss.

[66] For injuries occurring between July 1, 2014 and June 30, 2015.

The Business Council's proposal to reduce schedule loss awards would serve only to further exacerbate the existing inequities of the workers' compensation system. A reduction in schedule loss awards would have a severe impact on low wage workers. These workers would receive less compensation in 2015 than they did in 1992 for the same injuries, and would fall even farther behind inflation. At the same time, uncompensated wage loss for high-wage workers would increase.

At a time when the insurance industry is reaping record profits from workers' compensation insurance, and employer costs are near their lowest point in a quarter-century, there is simply no justification for this assault on benefits for injured workers.

Dated: Farmingdale, New York
April 18, 2015

NYS Workers' Compensation Fund
2015 Results

Financial Highlights 2011 - 2015

NET INCOME

In thousands	2011	2012	2013 Adjusted	2014	2015	2015 less 2014	% Change
Written Premium	$ 1,495,865	$ 1,943,838	$ 2,283,287	$ 2,374,259	$ 2,437,325	$ 63,066	3%
Earned Premium	1,470,934	1,878,020	2,265,141	2,353,550	2,486,751	133,201	6%
Underwriting income (loss) gain	(539,738)	(258,583)	(113,536)	84,977	319,022	234,045	275%
Net investment income	597,494	720,057	766,401	549,350	615,559	66,209	12%
Other expenses	(52,369)	(149,943)	(348,663)	(496,271)	(415,492)	80,779	-16%
Net income	$ 5,387	$ 311,531	$ 304,202	$ 138,056	$ 519,089	$ 381,033	276%

SURPLUS, RESERVES AND ASSETS

In thousands	2011	2012	2013 Adjusted	2014	2015	2015 less 2014	% Change
Total surplus	$ 2,796,001	$ 3,127,996	$ 3,590,711	$ 3,714,515	$ 3,977,205	$ 262,690	7%
Total loss and LAE reserves	9,240,702	9,588,821	10,418,611	9,370,072	9,896,102	526,030	6%
Total admitted assets	$ 14,267,620	$ 14,957,256	$ 16,220,111	$ 15,620,945	$ 16,579,544	$ 958,599	6%

TESTIMONY
OF THE
NEW YORK WORKERS' COMPENSATION ALLIANCE
AND THE
NEW YORK COMMITTEE FOR OCCUPATIONAL SAFETY AND HEALTH
TO THE
NEW YORK DEPARTMENT OF FINANCIAL SERVICES
REGARDING
THE 2013 WORKERS' COMPENSATION RATE FILING REQUEST
OF THE
COMPENSATION INSURANCE RATING BOARD

By: Robert E. Grey
Chair, Workers' Compensation Alliance
Treasurer, New York Committee for
Occupational Safety and Health

I. INTRODUCTION.

The New York Compensation Insurance Rating Board (CIRB) has submitted a Loss Cost Filing for October 1, 2013 seeking an increase of 16.9%.[1] In support of its filing, CIRB cites increased medical costs, slow implementation of the time limitations on permanent partial disability claims, closure of the Reopened Case Fund, and increases in the maximum and minimum rate.[2] Contrary to CIRB's lost cost filing, Governor Cuomo previously estimated that the portions of the 2013 budget related to the workers' compensation system would achieve savings of $800 million.[3]

The Workers' Compensation Alliance ("WCA") is a political action committee that advocates for the interests of injured workers in New York's workers' compensation

[1] NYCIRB Loss Cost Filing, October 1, 2013; see also R.C. 2235, 5/29/13.
[2] R.C. 2335
[3] http://www.governor.ny.gov/press/03292013-2013-14-budget

system.[4] The New York Committee for Occupational Safety and Health (NYCOSH) is a non-profit coalition of labor unions and individuals dedicated to ensuring that every worker has a safe and healthful job.[5] Its membership includes more than 175 local unions and over 300 individual workers, physicians, lawyers and other health and safety activists. The WCA and NYCOSH submit this testimony in opposition to the rate filing request of the Compensation Insurance Rating Board ("CIRB").

Our testimony broadly addresses four areas: (1) CIRB's lack of transparency and accountability as a rate service organization; (2) the inconsistency of the rate filing with legislative and regulatory developments; (3) the inconsistency of the rate filing with state and national trends; (4) the profit motive underlying the rate filing.

II. THE SYSTEM LACKS TRANSPARENCY AND ACCOUNTABILITY.

Despite the addition of several public members to the CIRB Board in 2007, its data continues to be drawn from the unaudited self-report of information by private insurers. Moreover, due to a variety of factors – not least of which is the failure of certain public members to fulfill their responsibility to appoint representatives to all of the relevant committees – CIRB continues to be controlled by private insurers. As a result, the inclusion of public members on the CIRB Board has failed to achieve the goal of creating transparency and accountability regarding the data that forms the basis of CIRB rate filings.

The absence of transparency and accountability by CIRB is exacerbated by the historic lack of reliability of its projections, due in part to significant inconsistencies

[4] http://www..nyworkerscompensationalliance.org
[5] http://ww.nycosh.org

between CIRB's data collection and the nature of New York's workers' compensation system. This is especially unfortunate given the fact that CIRB analyses and rate filings play a role in the development of public policy. Good public policy cannot be derived from poor or unreliable data.

The failure to create effective public participation in CIRB is detrimental to the interests of employers, injured workers, and the State of New York. The existing "rate service organization" model fails to appreciate that private insurers have an inherent interest in maintaining employer costs at a high level, because carrier profits are derived as a percentage of those costs.

These concerns are further detailed below.

A. Lack of transparency, credibility, and corroboration.

By statute, CIRB is New York's statutory rate service organization. However, its structure, data sources, and lack of accountability preclude it from functioning as a credible rate-filing entity. Prior to the 2007 statutory amendments, CIRB was composed solely of representatives of the private insurance industry. It receives self-reports from private insurance carriers regarding their claim experience, and translates those reports into "data" in support of rate applications. Said rate applications, of course, benefit the very entities that compose CIRB itself. There are a number of fundamental issues raised regarding the transparency, accuracy, and credibility of this process.

The 2007 amendments added several public members to CIRB in an effort to encourage transparency and accountability. Regrettably, the addition of the public members has failed to alter the dynamic of the CIRB Board, which results in retention of

control by the private insurers. This situation is exacerbated by the failure of certain public members to designate participants in all stages of CIRB's processes.

There continues to be no evidence that CIRB effectively audits or verifies the accuracy of the information it receives from insurers. As a result, the reliability of CIRB data has been previously criticized by the Department of Financial Services (and its former component, the Insurance Department). For example, in 2006 the Insurance Department disapproved CIRB's filing for a rate increase based on skepticism about the accuracy of insurer claims.[6] The Insurance Department observed at that time that insurers 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." In 2011 CIRB's rate filing was significantly reduced based on its inability to explain the divergence between the alleged experience of private insurers and the experience of the State Insurance Fund, and in 2012 its rate filing was again disallowed in the entirety by the Department of Financial Services.[7]

B. CIRB data cannot be verified by or compared to data from other sources.

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.[8] The self-insured sector of the market (the other one-third) does not report data to CIRB or to any other

---

[6] 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.

[7] Opinion and Decision of the Department of Financial Services, July 16, 2012, available at http://www.dfs.ny.gov/insurance/hearing/wc_06252012/wc_06252012_Opinion_Decision.pdf

[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, at pp. 21-22, available at http://www.ins.state.ny.us/wc/wc_index.htm.

source. The lack of reporting by self-insurers represents a loss of invaluable data that could be used as to verify the accuracy and credibility of CIRB rate filings.

Similarly, the Insurance Department previously found it to be difficult, if not impossible, to compare CIRB's data to that collected by the Workers' Compensation Board ("the WCB") because the systems used by these entities are fundamentally incompatible.[9] As a result, the accuracy of the information collected and reported by one cannot be cross-checked by reference to that of the other.

For example, in its 2008 Report to the Governor, the Insurance Department found that CIRB had reported 154,598 claims for 2003. The Department therefore added one-third to that figure in order to account for the self-insured sector, arriving at the conclusion that there were 206,079 claims in 2003.[10] The WCB, however, had indexed only 149,808 claims in 2003.[11] In short, CIRB (accounting for two-thirds of the market) had more claims reported to it than the WCB (covering the entire market) indexed.

Clearly there is a significant variation between the data collection and reporting mechanisms of CIRB and the WCB. This variation, like the absence of data from the self-insured sector of the market, deprives the Department of critical information that could be used to verify CIRB's data.

In addition, the manner in which CIRB collects data is not compatible with relevant workers' compensation practice. The most relevant example is 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 CIRB calculated the cost of permanent

---

[9] Report to the Governor at pp. 21-23.
[10] Id. at p. 24.
[11] Summary Annual Report of the Workers' Compensation Board, 2003.

partial disability awards was not generally available. In 2008, the Insurance Department found that CIRB does not 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."[12] The Insurance Department further observed that 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.[13] Assuming that CIRB has continued to use the same methodology, a worker earning $900 per week who was injured after July 1 2009 would be entitled to an award of $22,000 or more with a schedule loss award for 11.5% of an arm, or 12.5% of a leg. It is therefore apparent that counting all "major PPD" claims as permanent partial disabilities results in a vast overestimation of the cost of permanent partial disabilities.

The lack of reliability, transparency, and accountability in CIRB data, which is compounded by the inability to easily compare and corroborate it with information from other data sources, calls into question the extent to which it should be utilized by the Department in setting workers' compensation loss costs. We continue to believe that authorization for CIRB to function as a rate service organization should be permitted to sunset and that the Department of Financial Services should assume those functions.

III. THE RATE FILING IS INCONSISTENT WITH LEGISLATIVE AND REGULATORY DEVELOPMENTS.

There are four areas of legislative and regulatory development that significantly impact CIRB's rate filing: permanent partial disability claims ("PPDs"),

[12] Report to the Governor at p. 22.
[13] Id. at p. 22, footnote 24.