WORKERS’ COMPENSATION IN NEW YORK STATE: STATE OF THE SYSTEM 2014

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INTRODUCTION

This paper will review the current legislative, regulatory and administrative status of the New York State workers’ compensation system. The system has undergone significant changes in the past two decades. There were major changes as a result of the reform legislation enacted in 2007. In addition, some trends that pre-dated the 2007 legislation have subsequently accelerated.

This paper will consider developments in the workers’ compensation system over the past six years in three primary areas: (1) benefits for injured workers; (2) costs for employers; and (3) administration by the state (primarily by the Workers’ Compensation Board). It will address areas of improvement, stagnation, and deterioration in the system’s core mission of delivering compensation and medical benefits to injured workers.

This is the third 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 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

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2 Id. at page 4.
statutory changes. 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.

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I. EXECUTIVE SUMMARY

A. **Background.**

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

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. Meanwhile, a series of administrative initiatives has prevented workers from accessing their benefits as the Board’s mission shifted from protecting injured workers to “protecting the rights of workers and employers.”

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4 Summary Annual Reports 2000 through 2005, New York State Workers’ Compensation Board.
5 New York State Workers’ Compensation Law, Sections 2, 3, 11.
7 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 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 or ill, and by promoting compliance with the law;” [http://www.Wcb.ny.gov/content/main/TheBoard/mission.jsp](http://www.Wcb.ny.gov/content/main/TheBoard/mission.jsp)
Against this background, the 2007 legislation made a number of significant changes to the Workers’ Compensation Law.\textsuperscript{10} Task Forces were created to study and report on additional legislation and potential regulatory and administrative reforms of the workers’ compensation system.\textsuperscript{11} These Task Forces included committees addressing the Streamlined Docket,\textsuperscript{12} Medical Treatment Guidelines,\textsuperscript{13} Return To Work,\textsuperscript{14} and Medical Impairment and Loss of Wage Earning Capacity,\textsuperscript{15} as well as a data study by the Insurance Department (now the Department of Financial Services).\textsuperscript{16} By the end of March, 2008, the Streamlined Docket, Return to Work and data task forces had issued reports regarding their respective study areas.\textsuperscript{17} Those reports were considered in the 2008 White Paper and will

\begin{itemize}
\item \textsuperscript{10} 2007 New York Workers’ Compensation Reform Act, 3/13/07.
\item \textsuperscript{11} Id.
\item \textsuperscript{12} Recommended Workers’ Compensation Streamlined Docket Regulations, NYS Insurance Dept., available at \url{http://www.ins.state.ny.us/wc/wc_index.htm}.
\item \textsuperscript{13} 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 \url{http://www.ins.state.ny.us/wc/wc_index.htm}.
\item \textsuperscript{14} Report of the Commissioner on Return to Work, NYS Dept. of Labor, available at \url{http://www.labor.state.ny.us/agencyinfo/ReturntoWorkReportMarch12_2008.shtm}.
\item \textsuperscript{15} Disability Duration Guidelines, September, 2010; \url{http://www.dfs.ny.gov/insurance/wc/wc-guidelines.pdf}.
\item \textsuperscript{16} Report to the Governor from the Superintendent of Insurance Summarizing Workers’ Compensation Data and Recommending Improvements in Data Collection and Development of a Research Structure for Public Policy, NYS Insurance Department, available at \url{http://www.ins.state.ny.us/wc/wc_index.htm}.
\item \textsuperscript{17} Report to the Governor from the Superintendent of Insurance Summarizing Workers’ Compensation Data and Recommending Improvements in Data Collection and Development of a Research Structure for Public Policy, NYS Insurance Department, available at \url{http://www.ins.state.ny.us/wc/wc_index.htm}; Report of the Commissioner on Return to Work, NYS Dept. of Labor, available at \url{http://www.labor.state.ny.us/agencyinfo/ReturntoWorkReportMarch12_2008.shtm}; Recommended Workers’ Compensation Streamlined Docket Regulations, NYS Insurance Dept, available at \url{http://www.ins.state.ny.us/wc/wc_index.htm}; Individual Self-Insurance Alternative Funding Models, NYS Workers’ Compensation Board, available at \url{http://www.Wcb.state.ny.us/content/main/PressRe/2007/NewFundingModelForSIClaims.jsp}; Knee Injury Medical Treatment Guidelines, NYS Insurance Department, available at \url{http://www.ins.state.ny.us/wc/wc_index.htm}; Low Back Injury Medical Treatment Guidelines, NYS Insurance Department, available at \url{http://www.ins.state.ny.us/wc/wc_index.htm}; Shoulder Injury Medical Treatment Guidelines, NYS Insurance Department, available at \url{http://www.ins.state.ny.us/wc/wc_index.htm}; Cervical Spine Injury Medical Treatment Guidelines, NYS Insurance Department, available at \url{http://www.ins.state.ny.us/wc/wc_index.htm}; General Principles: Medical Treatment Guidelines, NYS Insurance Department, available at \url{http://www.ins.state.ny.us/wc/wc_index.htm}; Medical Treatment Guidelines Education Plan, NYS Insurance Department, available at \url{http://www.ins.state.ny.us/wc/wc_index.htm}.
\end{itemize}
not be extensively reviewed again here. The Medical Treatment Guidelines and Medical Impairment Guidelines were issued in 2010 and 2011, respectively, and will be discussed in Section III of this paper.

The Board has issued numerous “Subject Numbers” announcing new “streamlined calendaring;” new case assembly, indexing, and adjudication processes; a “streamlined adjudication process;” medical treatment guidelines; medical impairment guidelines; an effort to “promote permanency classifications;” a “business process re-engineering” project; and a host of new forms and new administrative procedures, among other initiatives. For purposes of adjudication and administration, the Board treats its Subject Numbers as though they are equal to a statute, regulation, or appellate court decision.

Taken together, the 2007 legislation, the Task Force reports, and the Board’s initiatives have had a significant impact on benefits for injured workers, costs for employers, and the administration of the workers’ compensation system. These issues are discussed below.

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18 Subject Number (SN) 046-247, 7/25/08; http://www.Wcb.ny.gov/content/main/SubjectNos/sn046_247.jsp
19 SN 046-254, 10/3/08; http://www.Wcb.ny.gov/content/main/SubjectNos/sn046_254.jsp
20 SN 057-282, 12/1/09; http://www.Wcb.ny.gov/content/main/SubjectNos/sn046_282.jsp
21 SN 046-456, 1/22/09; http://www.Wcb.ny.gov/content/main/SubjectNos/sn046_456.jsp
23 SN 046-548, 5/28/13; http://www.Wcb.ny.gov/content/main/SubjectNos/sn046_548.jsp
24 SN 046-623, 9/20/13; http://www.Wcb.ny.gov/content/main/SubjectNos/sn046_623.jsp
25 See generally, http://www.Wcb.ny.gov/content/main/SubjectNos/subjectNos.jsp
26 This approach has been criticized by the Appellate Division, Third Department. See Hazan v. WTC Volunteer Fund, 987 N.Y.S.2d 484, 2014 N.Y. App. Div. LEXIS 4031 (3rd Dept. 2014): “to the extent that the Board has consistently relied upon the subject orders in denying benefits to volunteers who were not affiliated with an authorized rescue entity or volunteer association, we need note only that while Workers’ Compensation Law § 141 vests the Board’s chair with certain powers to administer the provisions of the Workers’ Compensation Law, it does not vest him or her with the authority to supplement or amend duly enacted legislation. Accordingly, whatever the net effect of such orders may be, they ‘cannot overrule the statute itself.’"
B. **Benefits.**

Workers’ compensation benefits include payment for wage loss (indemnity) and medical treatment. Wage loss payments are made for both temporary and permanent disability. Depending on the nature of the injury, some medical treatment is governed by the Board’s Medical Treatment Guidelines and some is not. The system does not include any formal legal rules or regulations about an employer’s obligation to provide a return to work program, or about an injured worker’s right to return to work at full or modified duty.

The workers’ compensation system can be improved in each of these areas. These include the maximum benefit rate (page 21); the minimum rate (page 27); permanent disability and loss of wage earning capacity (pages 28 and 29); the safety nets (page 31); and schedule loss of use (page 33).

We make the following recommendations about benefit issues:

1. The current maximum weekly benefit rate is below the national and regional averages. **New York should maintain or further increase the maximum weekly benefit rate.**

2. New York’s minimum benefit rate is not indexed, which ensures that it will become inadequate in the intermediate or long term absent continued legislative oversight and statutory correction. This can be obviated by fixing the minimum rate at 25% of the maximum rate. **New York should index the minimum weekly rate to the maximum weekly benefit rate.**

3. The permanent partial disability time limitations (the PPD caps) are an unjust and artificial limitation on compensation for the lost wage earning capacity of permanently disabled workers. However, assuming that the caps will not be rescinded, we recommend the adoption of a uniform approach to the determination of loss of wage earning capacity. Such an approach would assign a standard weight or range of weights to various factors, providing more specific guidance about the impact of functional and vocational losses on wage earning capacity, improving clarity and predictability within the
system, and reducing litigation. New York should adopt a uniform system to determine loss of wage earning capacity in connection with the PPD caps.

4. The 2007 legislation includes a “safety net provision” for permanently disabled workers who have lost more than eighty percent of their wage earning capacity. The threshold for safety net consideration should be reduced from loss of wage earning capacity in excess of eighty percent to loss of wage earning capacity in excess of fifty percent. Workers who have been determined to lose more than half of their pre-accident wage earning capacity and have been unable to return to work should be eligible for safety net evaluation. New York should reduce the threshold for safety net eligibility.

5. Eligibility for the safety net requires a showing of “extreme hardship.” This should be defined by reference to the injured worker’s financial circumstances or the totality of the circumstances that may render him or her unemployable. New York should define “extreme hardship.”

6. The law provides “schedule loss” awards for certain injuries. The current schedule loss evaluation system should be preserved, but schedule loss awards should be paid in addition to compensation for temporary disability (as under the Longshore & Harbor Workers’ Compensation Act), rather than having such compensation deducted from the schedule loss award. Schedule loss awards should be in addition to awards for temporary disability.

Issues related to medical treatment include the Medical Treatment Guidelines (page 36); treatment not covered by the Medical Treatment Guidelines (page 43); and the Board’s proposed revisions to the Medical Fee Schedule (page 45).

We make the following recommendations about medical treatment issues:

1. The existing statutory procedure makes more treatment available to injured workers with less administrative process and at a lower expense than that directed by the Medical Treatment Guidelines. The Medical Treatment Guidelines should be eliminated.

2. The medical fee schedule and the Board’s administrative procedures create a set of disincentives for specialists and high-quality physicians to participate in the system. Reimbursement rates for specialists should be increased and

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the bureaucratic burden reduced. **The medical fee schedule should be improved, and the bureaucratic burden on health care providers must be reduced.**

Issues related to return to work include the failure to implement the recommendations of the Return to Work Task Force (page 50); and the need for a legal standard covering the circumstances in which an injured worker must show “labor market attachment (page 51).

We make the following recommendations about return to work issues:

1. In 2008, the Commissioner of Labor issued a report with recommendations on improving the rate of return to work among injured workers. These recommendations should be implemented. **The recommendations of the Return to Work Task Force should be implemented.**

2. The statute should be amended to define the circumstances in which an injured worker must demonstrate that he or she is “attached to the labor market” as a condition of receiving benefits. **“Voluntary withdrawal from the labor market” should be defined.**

**C. Costs.**

Although business and insurance interests have claimed that workers’ compensation is a “high cost,” data and system trends paint a very different picture. Our analysis shows that New York is not a high cost state (page 54); workers’ compensation costs have not increased over the past twenty years (page 56); assessments to employers have been significantly reduced (page 61); and that problems persist with the transparency of insurer data (page 63).

We make the following recommendation about cost issues:

1. **The use of the New York Compensation Insurance Rating Board (CIRB) as a rate service organization impedes the collection of credible data and precludes transparency regarding insurer income, expenses, claim costs and**
profit. **CIRB’s authorization to function as the statutory rate service organization should be permitted to sunset.**

**D. Administration.**

The Workers’ Compensation Board’s administration and adjudication has a major impact on the system. The Board controls the degree to which the system is available to injured workers, which we refer to as “access to benefits.” Issues related to access to benefits are discussed at page 67. The Board also controls whether the system chooses to protect injured workers or employers through its decision making process, known as adjudication. Issues related to adjudication are discussed at page 81.

We make the following recommendations about the Board’s administrative process:

1. The Board’s forms are too complex, and there are too many of them. This hampers access to benefits and obstructs the system’s mission of delivering substantial justice with a minimum of technicality. **The Board should simplify its forms for use by injured workers.**

2. The Board’s convoluted “assembly and indexing” procedure sows uncertainty and delays claims. A return to the former indexing approach would improve clarity and transparency in the system and expedite the delivery of benefits to injured workers. **The Board should index all claims upon receipt of information indicating a work-related injury.**

3. Participants in the system are in substantial agreement that holding an initial hearing is more efficient than the use of non-hearing determinations. More importantly, an initial hearing ensures that unrepresented workers are given adequate information about their claim, their rights, and system benefits, and that they have a meaningful opportunity to be heard by the Board. **The Board should hold an initial hearing in every case.**

4. The Board should discontinue the host of bureaucratic initiatives that operate to deny injured workers a hearing before a Workers’ Compensation Law (WCL) Judge upon request. **The Board should hold hearings upon the request of a party as required by law.**

5. Board employees should be encouraged to interact with injured workers and to render decisions with these principles foremost in their minds. **Instruction about the history and purpose of the law should be**
distributed to the Board’s employees, including examiners, customer service personnel, WCL Judges, appeal writers, and commissioners.

6. The Board’s appellate process should be sufficient to correct any errors of fact or law. This is the purpose of a meaningful appeals process, which does not need to be supplemented by “guidance” that results in the prejudgment of claims. The Board should avoid “legislation by subject number,” and permit its WCL Judges to decide cases on their merits and on the WCL Judge’s reasoned interpretation of the law.

7. The Board’s commissioners must become more active in the decision of cases, and their perspective must be informed by participating in oral argument at the Board’s hearing locations, where they can interact in person with injured workers. Decisions must be issued far more expeditiously, and the outcome of cases must be based consistently on the principles of the law, and not the perspective of the individual commissioners. Disincentives should be utilized to discourage appeals that are filed simply because there is “nothing to lose,” to delay the case, or on the theory that an employer-friendly Board Panel may result in a windfall victory to the carrier. The Board’s appeals process must be reformed.
II. BACKGROUND

A. The 2007 Legislation.

The 2007 legislation made major changes to New York’s workers’ compensation system. It was intended to improve benefits and to expedite the process for injured workers while cutting costs for employers. The legislation increased the maximum weekly benefit rate, limited payments for permanent disability, created new rules for medical treatment, diagnostic tests and prescription medication, and made many other significant technical changes the law that have affected workers, employers, insurers, health care providers and attorneys. A detailed discussion of the legislation may be found the 2008 White Paper. A summary appears below.

In the area of benefits, the legislation attempted to address the gross inadequacy of the statutory maximum benefit rate by increasing it incrementally from $400 per week (the rate in effect from July 1, 1992 to June 30, 2007) to $600 per week (as of July 1, 2009), and then indexing the maximum rate to the New York State average weekly wage as determined by the Commissioner of Labor effective July 1, 2010. The increase in the statutory maximum benefit was tied to the imposition of time limits on permanent partial disability benefits, which were previously paid for the full length of the disability. It was estimated that the net effect of the rate raise and the permanent disability time limitations was a savings to employers (and a reduction in benefits to workers) of approximately $700 million per year.

29 Workers’ Compensation Law Section 15.
30 Summary 2007 Rate Revision Pre-Filing. New York Compensation Insurance Rating Board, June 26, 2007; NYS Governor’s Office Press Release: Workers’ Compensation Rates to Drop by Record 20.5%.
In consideration of the new time limits on permanent partial disability benefits, the Legislature attempted to ensure fair claim settlement practices by insurers by requiring that the present value of those awards be deposited into the Aggregate Trust Fund (“ATF”) if the insurance carrier did not arrive at a settlement with the injured worker. This requirement has been upheld by New York Court of Appeals.

In the area of medical treatment, the legislation increased the pre-authorization threshold for specialized treatment or diagnostic testing from $500 to $1,000, while giving employers and carriers control over the facilities to be used by injured workers. The legislation also directed the Board to promulgate a list of “pre-authorized procedures,” as well as fee schedules for prescription medication and durable medical goods. The direction to produce a list of “pre-authorized procedures” resulted in the Board’s Medical Treatment Guidelines, which pre-authorize certain medical treatment and pre-denymall other treatment, subject to the Board’s “variance” process.

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

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31 Workers’ Compensation Law Section 27
33 2007 New York Workers’ Compensation Reform Act Sections 25-30, 72, 3/13/07
34 Knee Injury Medical Treatment Guidelines, NYS Insurance Department; Low Back Injury Medical Treatment Guidelines, NYS Insurance Department; Shoulder Injury Medical Treatment Guidelines, NYS Insurance Department; Cervical Spine Injury Medical Treatment Guidelines, NYS Insurance Department; General Principles: Medical Treatment Guidelines, NYS Insurance Department; Medical Treatment Guidelines Education Plan, NYS Insurance Department. All are available at http://www.ins.state.ny.us/wc/wc_index.htm
35 2007 New York Workers’ Compensation Reform Act Sections 1, 7-24, 3/13/07.
The primary purpose of the statutory amendments regarding employer fraud was to recapture insurance premium that previously escaped through the underreporting of payroll and the misclassification of employees. A recent report by the District Attorney of New York County indicates that these issues remain endemic to the system.\textsuperscript{36} The District Attorney’s report indicates that the 2007 legislation has not been entirely effective in achieving the goal of a level competitive playing field for legitimate employers, or in improving worksite safety.

The legislation also made a large number of secondary changes to the Workers’ Compensation Law, including the closure of the Second Injury Fund (the Special Funds WCL Section 15(8) Fund).\textsuperscript{37} This was followed in 2013 by the closure of the Reopened Case Fund (the Special Funds WCL Section 25-a Fund).\textsuperscript{38}

\textbf{B. The Task Forces.}

In connection with the legislation, a number of Task Forces were created to study and report on additional legislation, as well as potential regulatory and administrative reforms of the workers’ compensation system.\textsuperscript{39} The Task Forces included committees

\textsuperscript{37} 2007 New York Workers’ Compensation Reform Act Sections 1, 75-79, 3/13/07.
\textsuperscript{39} Id.
addressing the Streamlined Docket,\textsuperscript{40} Medical Treatment Guidelines,\textsuperscript{41} Return To Work,\textsuperscript{42} and Medical Impairment and Loss of Wage Earning Capacity,\textsuperscript{43} as well as a data study by the Insurance Department (now the Department of Financial Services).\textsuperscript{44} By the end of March, 2008, the Streamlined Docket, Return to Work and data task forces had issued reports regarding their respective study areas.\textsuperscript{45} Those reports were considered in the 2008 White Paper and will only be reviewed briefly here. The Medical Treatment Guidelines and Impairment Guidelines were issued in 2010 and 2011, respectively, and will be discussed in detail in Section III of this paper.

\textsuperscript{40} Recommended Workers’ Compensation Streamlined Docket Regulations, NYS Insurance Dept., available at \url{http://www.ins.state.ny.us/wc/wc_index.htm}

\textsuperscript{41} 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 \url{http://www.ins.state.ny.us/wc/wc_index.htm}

\textsuperscript{42} Report of the Commissioner on Return to Work, NYS Dept. of Labor, available at \url{http://www.labor.state.ny.us/agencyinfo/ReturntoWorkReportMarch12_2008.shtm}

\textsuperscript{43} Disability Duration Guidelines, September, 2010; \url{http://www.dfs.ny.gov/insurance/wc/wc-guidelines.pdf}

1. **The Streamlined Docket Task Force.**

   The issue of “controverted claims,” in which the employer or carrier contest the worker’s basic entitlement to benefits on grounds such as “no jurisdiction,” “untimely notice to the employer,” or “no accident arising out of and in the course of employment,” was identified as an area of particular concern following the 2007 legislative process. This led to the creation of the Streamlined Docket Task Force (known generally as “the Rocket Docket”), which was charged with identifying a means of reducing controversies and expediting the resolution of controverted claims.

   The Streamlined Docket Task Force recommended that the Board adopt an expedited schedule to litigate controverted accident claims where the worker has an attorney, which are approximately 30% of all controverted claims.46

   Because the expedited schedule would begin to run from the date the Board “indexes” a claim, the Task Force recommended that the Board avoid “indexing” a claim until all of the necessary documents were filed. The concept was that if insurance carriers had more information, they would contest fewer claims.

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

   The Board adopted the recommendations of the Streamlined Docket Task Force. Unfortunately, the forms it created as a result have significantly increased the complexity of the workers’ compensation system. The formality of the new forms and procedures now

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46 *Recommended Workers’ Compensation Streamlined Docket Regulations*, NYS Insurance Dept., available at [http://www.ins.state.ny.us/wc/wc_index.htm](http://www.ins.state.ny.us/wc/wc_index.htm).
more closely resemble a civil litigation system, replacing what was historically an informal system intended to permit workers to easily pursue their claims.47

2. The Return to Work Task Force.

The Return to Work Task Force issued a report making recommendations on subjects in which agreement could be reached and identifying areas in which agreement could not be reached, as well as the reasons for disagreement.48 The Task Force recognized that an essential element of the 2007 legislation was the use of vocational factors in benefit determinations, and that this was tied to the availability and efficacy of vocational rehabilitation evaluations and programs. As a result, the Task Force recommended (1) development of return-to-work educational programs for employers; (2) requirement of formal return-to-work policy by employers of more than 25 workers; (3) re-design of Board forms regarding vocational information; (4) education of physicians in occupational health issues; (5) Board-paid vocational rehabilitation evaluation of all claimants who reach maximum medical improvement and have not returned to work; (6) development of incentive programs for hiring disabled workers; (7) payment of attorneys in “medical only” cases; (8) Board review of cases to ensure proper awards for reduced earnings; and (9) data collection on return to work rates.

The Task Force was unable to reach agreement on whether many of these programs should be mandatory, the extent of the programs, how to implement the statutory “safety net” and funding issues. The primary reason for the lack of agreement appears to have been

47 See, e.g., Workers’ Compensation Law Section 118 (“Technical rules of evidence or procedure not required.”)
the unwillingness of employers and carriers to incur up-front costs in exchange for longterm savings. As a result, none of the recommendations of the Return To Work Task Force have ever been implemented.


The 2007 legislation directed the Chair of the Board to promulgate a list of “pre-authorized procedures.” A Task Force was formed by the Insurance Department to study the issue. Less than 9 months later, the Task Force recommended Medical Treatment Guidelines (“the Guidelines”) to the Board.  

Ultimately, on June 30, 2010, the Board proposed regulations with a set of medical treatment guidelines. The Board issued a statement proclaiming that “[t]his week, the Board fulfilled a promise of the 2007 Workers' Compensation reforms by publishing proposed regulations that will make evidence based medical treatment guidelines mandatory in our system.” The Board also stated that “additional guidelines will be developed that will address chronic conditions.” The Board implemented its Guidelines on December 1, 2010. To date, however, it has not issued guidelines for chronic pain.

The Guidelines are exclusive, which means that any medical treatment not included is deemed denied. If a treating physician wants to provide “medical care that varies from the Medical Treatment Guidelines” he or she must “request a variance.”

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49 Workers’ Compensation Law Section 13-a(5)
52 Adoption and Implementation of the Medical Treatment Guidelines, http://www.wcb.ny.gov/content/main/wclaws/RecentlyAdopted/Adopted_MTG_Public_Comment.jsp.
53 12 NYCRR § 324.2 (a).
54 12 NYCRR § 324.3 (a) (1).
The Guidelines provide that “the burden of proof to establish that a variance is appropriate for the claimant and medically necessary shall rest on the Treating Medical Provider requesting the variance.”\textsuperscript{55} A variance request must include:

\begin{itemize}
  \item a medical opinion by the Treating Medical Provider, including the basis for the opinion …, and a statement that the claimant agrees to the proposed medical care, and an explanation of why alternatives under the Medical Treatment Guidelines are not appropriate or sufficient; and for appropriate claims, a description of any signs or symptoms which have failed to improve with previous treatments provided in accordance with the Medical Treatment Guidelines; or if the variance involves frequency, or duration of a particular treatment, a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment.\textsuperscript{56}
\end{itemize}

Under the Guidelines, the employer or insurer is not required to submit a conflicting medical opinion in order to deny a request for treatment. “The insurance carrier or Special Fund may deny a request for a variance on the basis that the Treating Medical Provider did not meet the burden of proof that a variance is appropriate for the claimant and medically necessary … without review by the insurance carrier or Special Funds’ medical professional, a review of the records, or an independent medical examination.”\textsuperscript{57} The burden of proof remains with the injured worker and the treating physician throughout the process. “The claimant and the Treating Medical Provider who requested the variance shall have the burden of proof that such variance is appropriate for the claimant and medically necessary.”\textsuperscript{58}

\textsuperscript{55} 12 NYCRR § 324.3 (a) (2).
\textsuperscript{56} 12 NYCRR § 324.3 (a) (3)
\textsuperscript{57} 12 NYCRR § 324.3 (b) (2) (i) (c)
\textsuperscript{58} 12 NYCRR § 324.3 (d) (4)
The Guidelines, as promulgated by the Board, have resulted in a flood of variance applications since their inception.\(^5^9\)

4. **Medical Impairment Guidelines Task Force.**

As a result of the new time limitations imposed on permanent partial disability (“PPD”) benefits by the 2007 legislation, a Task Force and Advisory Committee were created in the New York State Insurance Department to study the method by which PPD benefits were awarded and to recommend improvements.\(^6^0\)

On September 15, 2010, the Insurance Department transmitted its recommendations to the Board in a 108-page document entitled Disability Duration Guidelines.\(^6^1\) The Insurance Department proposed a three-part structure to determine loss of wage earning capacity. First, the worker’s medical impairment(s) related to the accident would be identified, described, categorized, and assigned a severity ranking. Second, the functional limitations (ability to perform physical activities) associated with the medical impairment would be assessed. Third, the extent to which the functional limitations affected the worker’s ability to engage in gainful employment would be determined. To the extent that the post-injury wage earning capacity was less than the pre-injury wage earning capacity, the difference was the “loss of wage earning capacity” upon which an award of compensation would be based and the associated cap figure applied.\(^6^2\)

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\(^{62}\) Id. at 4-7.
The Insurance Department gave the Board specific recommendations regarding medical impairment and functional loss, but offered only limited guidance as to how to decide the ultimate issue of loss of wage earning capacity, explaining that its Task Force “was not able to achieve consensus” on that issue.63

In December, 2012, the Board issued its 2012 New York State Guidelines for Determining Permanent Impairment and Loss of Wage Earning Capacity (“the 2012 Guidelines”).64 In issuing the 2012 Guidelines the Board agreed to “adopt the recommended three part analysis for determining loss of wage earning capacity,” particularly in the areas of medical impairment and functional loss.65 In the area of wage earning capacity, the Board stated that

the 2012 Guidelines . . . set forth relevant medical factors (impairment and functional ability/loss) and vocational factors (education, skills, English language proficiency, age, etc.) that the Board should consider in evaluating the impact of a permanent impairment on a claimant’s wage earning capacity. They provide general guidance regarding the impact of medical and vocational factors on an injured worker’s earning capacity.66

The Board did not, however, provide any method or structure to assign weight to medical and vocational factors. As a result, participants in the workers’ compensation system have found the 2012 Guidelines ambiguous and difficult to apply, creating uncertainty in the system and leading to substantial litigation.

63 *Id.* at 5.
66 *Id.*
III. BENEFITS

The workers’ compensation system provides two fundamental benefits to injured workers: wage loss (indemnity) and medical treatment. The area of wage loss benefits can be further subdivided into temporary and permanent disability; medical treatment can currently be subdivided into treatment covered by the Board’s Medical Treatment Guidelines and that which is not.

A. Temporary Disability.

1. Maximum benefit rate.

As a result of the 2007 legislation, the weekly maximum benefit rate rose from $400 (for accidents prior to July 1, 2007) to $808.65 (for accidents on or after July 1, 2014). Over two-thirds of the increase occurred between July 1, 2007 and July 1, 2010 as part of the transition from a fixed maximum rate to one indexed to the state average weekly wage.

From 1992 until 2007, the maximum rate remained unchanged at $400 per week. Between 2007 and 2009, it was increased in stages from $400 per week to $600 per week. In 2010, the maximum rate was set at two-thirds of the state average weekly wage as determined by the Commissioner of Labor. This “indexing” approach resulted in a maximum rate of $739.83 per week as of July 1, 2010, which has increased incrementally since that time to the current maximum of $808.65.

While it is true that the statutory maximum benefit rate doubled in a seven year period, over 91% of the increase occurred between July 1, 2007 and July 1, 2011 (the second year of the indexed maximum rate). Since 2011, the rate of increase has been incremental and diminishing (2.5% in 2012, 1.4% in 2013, and 0.7% in 2014). The first

67 Workers Compensation Law § 15(6)
chart below shows the weekly maximum benefit rate from 2006 through 2014; the second chart below shows the increases in percentage terms from 2010 (when indexing began) through 2014.

Moreover, although the increase in the maximum weekly benefit rate may appear dramatic (at least from 2007 – 2010), the rate is still inadequate when placed in a national and regional context. The chart below demonstrates that despite the increase stemming
from the 2007 legislation, New York’s maximum weekly benefit rate is currently the 30th lowest in the country out of 50 states and the District of Columbia.68

As shown above, at $803.21 New York’s maximum weekly benefit rate is lower than both the national average of $882.59 and the median of $843 (New Jersey). From a regional standpoint, as shown on the chart below, New York’s maximum weekly benefit rate is still the lowest among states in the Northeast.69

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68 Data available at https://secure.ssa.gov/poms.nsf/lnx/0452150045
69 Id.
It is important to note that the maximum benefit rate for an injured worker is two-thirds of his or her average weekly wage.\textsuperscript{70} As a result, workers who earn $600 per week or less did not benefit from the increases in the maximum rate. In 2010, the Department of Labor reported that more than two-thirds of permanently partially disabled workers had an average weekly wage below $800 per week, meaning that the most they can receive is $533.33 per week in compensation benefits, regardless of the statutory maximum rate.\textsuperscript{71} Fewer than 20\% of permanently partially disabled workers had an average weekly wages in excess of $1,000.\textsuperscript{72}

The chart below is drawn from the 2009 and 2010 Annual Safety Net Reports of the Commissioner of Labor and demonstrates the wage distribution of permanently partially disabled claimants.\textsuperscript{73} Over two-thirds of injured workers have average weekly wages below $800, which limits their maximum workers' compensation benefit to $533.33 per week or less. Therefore, increases in the maximum benefit rate beyond $533.33 per week are relevant to less than one-third of injured workers. Fewer than 20\% of injured workers have average weekly wages in excess of $1,000, which means that few benefit for a maximum rate in excess of $666.67 per week.

\begin{itemize}
\item[\textsuperscript{70}] Id.
\item[\textsuperscript{71}] 2010 Annual Safety Net Report of the Commissioner of Labor.
\item[\textsuperscript{72}] An average weekly wage of $1,000 would entitle an injured worker to $666.67 per week for temporary total disability. The most recent published Department of Labor report does not provide the distribution of wages in excess of $1,000, which would permit a more accurate analysis of the limited impact of increases in the maximum benefit rate.
\item[\textsuperscript{73}] It does not appear that the Department of Labor has produced this statutorily mandated report since 2011.
\end{itemize}
### Average Weekly Wage for PPD NSL Claimants

<table>
<thead>
<tr>
<th>Average Weekly Wage</th>
<th>2009 No. of Claimants</th>
<th>2009 % of Total</th>
<th>2010 No. of Claimants</th>
<th>2010 % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $200</td>
<td>5</td>
<td>4.4%</td>
<td>12</td>
<td>2.1%</td>
</tr>
<tr>
<td>$200 - $299</td>
<td>11</td>
<td>9.6%</td>
<td>32</td>
<td>5.5%</td>
</tr>
<tr>
<td>$300 - $399</td>
<td>11</td>
<td>9.6%</td>
<td>55</td>
<td>9.5%</td>
</tr>
<tr>
<td>$400 - $499</td>
<td>17</td>
<td>14.9%</td>
<td>77</td>
<td>13.3%</td>
</tr>
<tr>
<td>$500 - $599</td>
<td>9</td>
<td>7.9%</td>
<td>70</td>
<td>12.1%</td>
</tr>
<tr>
<td>$600 - $699</td>
<td>21</td>
<td>18.4%</td>
<td>99</td>
<td>17.2%</td>
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<tr>
<td>$700 - $799</td>
<td>11</td>
<td>9.6%</td>
<td>58</td>
<td>10.1%</td>
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<tr>
<td>$800 - $899</td>
<td>7</td>
<td>6.1%</td>
<td>38</td>
<td>6.6%</td>
</tr>
<tr>
<td>$900 - $999</td>
<td>4</td>
<td>3.5%</td>
<td>26</td>
<td>4.5%</td>
</tr>
<tr>
<td>$1,000+</td>
<td>18</td>
<td>15.8%</td>
<td>107</td>
<td>18.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>114</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>577</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Even the minority of injured workers who earn enough to receive the maximum benefit rarely do so for any appreciable length of time. The law provides reduced benefits for partial disability. In cases of temporary disability, insurer use of so-called "independent medical examinations" generally results in benefit reduction within 8 – 12 weeks after the date of accident. In cases of permanent disability, few workers are found to be permanently totally disabled. Thus, there is a significant discrepancy between the existence of an increased maximum rate and its actual utilization in the system.

Thus, although the 2007 legislation initially resulted in a significant increase in the maximum benefit rate, it remains low by national and regional standards. Increases over the past three years have been minimal and at a rapidly diminishing pace. Moreover, only a small percentage of injured workers have been affected by increases in the maximum rate in
the past six years, as increases after that date had no impact on over two-thirds of those suffering on-the-job injury or illness.\textsuperscript{74}

There is no basis to disturb the current maximum weekly benefit rate or the mechanism in place indexing it to the state average weekly wage, which is still inadequate by comparison to national and regional standards.

2. Minimum benefit rate.

The 2007 legislation also increased the minimum benefit rate from $40 per week to $100 per week, effective July 1, 2007.\textsuperscript{75} An additional increase to $150 per week became effective on May 1, 2013.\textsuperscript{76} These increases in the minimum rate offer a significant benefit to low-wage workers, who account for the majority of injuries and claims in the workers’ compensation system. However, the minimum benefit rate was not indexed as part of the 2007 legislation, and as a result it declined from 20\% of the maximum rate in 2007 to 12.6\% of the maximum rate in 2012. The legislative adjustment in 2013 restored the minimum rate to 18.9\% of the maximum rate (still lower than the 2007 ratio), from which it has again begun to decline. The trend in the minimum rate as a percentage of the maximum rate is shown on the chart below.

\textsuperscript{74} The maximum rate increased to $550 per week as of July 1, 2008; as outlined above, more than two-thirds of injured workers do not earn more than $800 per week, making their effective maximum rate $533.33 per week.\textsuperscript{75} Workers’ Compensation Law § 15(6)\textsuperscript{76} Id.
The minimum rate is currently fairly stable as a percentage of the maximum rate because there has been no significant change in the maximum rate over the past three years. As wages rise over time and the maximum rate rises due to indexing, however, the failure to index the minimum rate will result in attrition of its value. This will ultimately require further legislative correction in order to ensure that the workers’ compensation system remains a relevant protection for the low-wage workers it was intended to protect and compensate.

We therefore recommend that the minimum rate be indexed at 25% of the maximum benefit rate, so that the two increase in tandem in future years without the need for additional legislative intervention.
B. Permanent Disability.

1. Loss of wage earning capacity.

The 2007 legislation imposed time limitations (“caps”) on permanent partial disability (“PPD”) benefits.\(^\text{77}\) However, it was clear at the time of the legislation that the impact of the PPD caps would not result in benefit termination for many years into the future. By way of example, if a worker was injured on March 13, 2007 (the effective date of the PPD caps), was found to be permanently partially disabled precisely two years later\(^\text{78}\), and was awarded the shortest cap period provided in the statute (225 weeks), that worker would still be entitled to workers’ compensation benefits until July of 2013. Again, this example represents the shortest conceivable time frame in which a permanently partially disabled worker could have his or her benefits terminated as a result of the 2007 amendments. In most cases, the time frame to benefit suspension as a result of the PPD caps was anticipated to be – and has been – much longer.

According to the Workers’ Compensation Research Institute (WCRI), “the limitation on the weeks of PPD benefits is expected to result in large savings for the New York system, [but] it will likely be several years before significant changes will be reflected in the data.”\(^\text{79}\)

As a result of the new PPD caps, an attempt was made to focus attention on loss of wage earning capacity, instead of medical disability, as the basis for an award of compensation benefits. After an Insurance Department Task Force failed to reach

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\(^\text{77}\) Workers’ Compensation Law §15(3)(w)

\(^\text{78}\) Two years was historically the shortest time frame to classification under the 1996 Workers’ Compensation Board Medical Guidelines, which remained in effect until 2012.

\(^\text{79}\) Monitoring the Impact of the 2007 Reforms in New York, WCRI (Telles, Tanabe), October, 2012, at p. 11
consensus on the issue, the Board issued guidelines in 2012 (“the 2012 Guidelines”). These guidelines are not formal regulations and are supposedly only the Board’s “advisory” interpretation of the law, but in practice they are applied Board as though they were a formal statute or regulation.

Section 15 of the Workers’ Compensation Law uses the word “disability” in the sense that a worker is “disabled” if the injury affects his or her ability to earn a living. Section 15(5) specifically states that in cases of “temporary partial disability,” “the compensation shall be two-thirds of the difference between the injured employee’s average weekly wages before the accident and his wage earning capacity after the accident in the same or other employment.” Thus, the term “disability” in workers’ compensation practice refers to loss of wage earning capacity, not medical impairment.

The worker’s average weekly wage establishes his or her pre-injury earning capacity. If the injury results in a medical impairment (a disease or condition) that limits the worker’s ability to function, the Board must determine what effect the loss of function has had on the worker’s earning capacity. Compensation must then be awarded based on the difference between the pre-accident earning capacity (the average weekly wage) and the post-accident earning capacity.

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81 Section 37 of the Workers’ Compensation Law, relating to occupational disease, defines “disability” as “the state of being disabled from earning full wages at the work at which the employee was last employed.”


83 See, e.g., Marhoffer v. Marhoffer, 116 N.E. 379, 380 (1917) (“The word ‘disability’ in the law as we read it, therefore, means ‘impairment of earning capacity’ and not ‘loss of a member.’”) (citation omitted).

84 This is emphasized by the provisions of section 14 of the Workers’ Compensation Law that authorize the Board to adjust the average weekly wage using statutory formulas, to use the earnings of a “similar worker” if the injured worker was only with the employer for a short time, or to increase the average weekly wage of workers under the age of twenty-five in cases of permanent disability.
It is therefore inappropriate to use medical impairment as the sole basis for awards of compensation in a system that defines disability based on loss of wage earning capacity. For example, a construction worker and an accountant who suffer identical back injuries may have identical medical impairments that result in identical functional losses. When the nature of their respective occupations and educational levels are taken into consideration, however, it becomes clear that the construction worker has a greater “disability” than the accountant because the injury results in a far greater reduction of the construction worker’s earning capacity.

Before the PPD caps, however, awards for permanent disability were based almost exclusively on medical impairment. While this resulted in some unfairness in the amount of the weekly award, it did not affect the time period in which the worker could receive benefits. With the creation of the PPD caps, however, the disability determination affects both the amount and the duration of benefits. Therefore, to prevent the inequities that were already present in the system from expanding, the Board was directed to award benefits based on wage earning capacity, and not merely medical impairment.

Determining loss of wage earning capacity is more complex than determining medical impairment. Medical impairment can be determined based solely on evidence about diagnosis and clinical findings, without regard to any of the injured worker’s particular non-medical factors. To determine loss of wage earning capacity, however, consideration of the nature of the worker’s past employment, as well as his or her functional limitations, age, education, skills, language proficiency ability, literacy, and other factors is required. The 2012 Guidelines were developed with these concepts in mind, but do not address all of the factors in a comprehensive manner. Moreover, while the 2012 Guidelines identify the relevant factors, they do not offer guidance regarding their respective weight.
As a result, participants in the workers’ compensation system have found the 2012 Guidelines ambiguous and difficult to apply, creating uncertainty in the system and leading to substantial litigation.

We oppose the PPD caps as an unjust and artificial limitation on compensation for the lost wage earning capacity of permanently disabled workers. The imposition of time limits on the length of time for which benefits can be paid does not limit the duration of the disability itself. By their very nature, the caps ensure that many of the most disabled workers will be undercompensated as a matter of law. Thus, the artificial legal construct creates a manifest injustice for permanently disabled workers.

Assuming, however, that the PPD caps are irremediable, we recommend the adoption of a uniform approach to the determination of loss of wage earning capacity. Such an approach would assign a standard weight or range of weights to various factors, providing more specific guidance about the impact of functional and vocational losses on wage earning capacity, improving clarity and predictability within the system, and reducing litigation.  

2. **Safety net eligibility.**

The 2007 legislation also created a “safety net” provision permitting the Board to relieve workers who have lost more than 80% of their wage earning capacity from the PPD caps. Due to the effective date of the statute, the passage of time to the date of classification as permanently partially disabled, and the duration of the caps, no cases have

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86 *Workers’ Compensation Law* § 35
yet become eligible for safety net consideration. The Commissioner of Labor is required by law to issue an annual report regarding the return to work rates of permanently partially disabled workers and utilization of the safety net.\textsuperscript{87} However, this report has not been published on the Department of Labor website since 2008, and does not appear to have been issued in any form since 2010.\textsuperscript{88} Absent this report, it is difficult to assess the impact of the PPD caps on injured workers.

The safety net statute provides that “[i]n cases where the loss of wage-earning capacity is greater than eighty percent, a claimant may request, within the year prior to the scheduled exhaustion of [PPD benefits], that the board reclassify the claimant to permanent total disability or total industrial disability due to factors reflecting extreme hardship.”\textsuperscript{89}

In the absence of data from the Workers’ Compensation Board or the Department of Labor, it is impossible to determine how many permanently partially disabled workers have been found to have a loss of wage earning capacity in excess of eighty percent. Historically, however, data has demonstrated a low level of correlation between the Board’s conclusion regarding “degree of disability” and return to work rates.\textsuperscript{90} It is highly probable that the 81% threshold excludes from safety net consideration many workers who are unable to return to work, but whose loss of wage earning capacity was inadequately assessed by the Board.

\textsuperscript{87} Id.
\textsuperscript{89} Workers’ Compensation Law § 35(3)
\textsuperscript{90} 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 44, 90-104., available at \url{http://www.ins.state.ny.us/wc/wc_index.htm}. 
The safety net statute directs the Board to “reclassify” eligible workers based on “factors reflecting extreme hardship,” without further clarification. It would appear that this evaluation is intended to be based on the worker’s financial circumstance, rather than his or her medical/functional/vocational status (which would have been determined by the Board at the time of the original classification). To date, however, the Board has issued no decisions and has promulgated no regulations defining “extreme hardship.” In the absence of such guidance, it is difficult for system participants to assess the impact of the safety net provision on benefits for workers or costs for employers and carriers.

We therefore recommend that the threshold for safety net consideration be reduced from loss of wage earning capacity in excess of eighty percent to loss of wage earning capacity in excess of fifty percent. Workers who have been determined to lose more than half of their pre-accident wage earning capacity and have been unable to return to work should be eligible for safety net evaluation.

We further recommend that “extreme hardship” be defined as meeting any of the following tests: (1) the injured worker’s income from Social Security disability benefits and disability pension (if applicable) would be less than 50% of his or her average weekly wage upon termination of PPD benefits; OR (2) the injured worker will be unable to meet expenses for himself or herself and any dependents upon termination of PPD benefits; OR (3) additional medical, functional or vocational factors arising subsequent to the classification of permanent partial disability have further eroded the injured worker’s wage earning capacity; OR (4) the injured worker’s income would be below the federal poverty guidelines upon termination of PPD benefits.91

91 The federal poverty guidelines are published annually in the federal register and are available at https://www.federalregister.gov/articles/2013/01/24/2013-01422/annual-update-of-the-hhs-poverty-guidelines
3. **Schedule loss awards.**

The Workers’ Compensation Law also provides benefits for “schedule loss of use.” The awards are made primarily for permanent loss or loss of use of limbs, vision or hearing. The amount of the award in any given case depends on the extent of the loss of function, the worker’s average weekly wage, and the date of the accident. The loss of function is medically determined based on criteria set forth in the 2012 Guidelines. Any wages or compensation paid for time out of work are deducted from the award to the injured worker.

Because schedule loss awards are based in part on wages and the maximum compensation benefit rate, the 2007 legislation initially resulted in an increase in schedule loss awards for injured workers earning more than $600 per week. As discussed above, however, fewer than 15% of injured workers have benefited from increases in the maximum rate since 2010, and increases in the maximum benefit rate have been negligible since 2011. As a result, there has been little increase in the cost of schedule loss awards since 2010.

Moreover, to the extent that schedule loss awards have increased, this was projected as part of the 2007 legislation as a necessary result of increases in the maximum rate. This projection was, however, expected to be offset by the impact of the PPD caps. It is anticipated that increases in schedule loss awards will be fully absorbed by that impact in future years, as part of the “large savings” forecast by WCRI from the PPD caps.

It is also important to note that schedule loss awards often result in inadequate compensation for injured workers. Because employers and carriers are permitted to deduct wages and compensation benefits paid from the award, workers sometimes receive little or

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92 Workers’ Compensation Law § 15(3)
93 Id.
no money for “schedule loss” despite the permanency of the injury.\textsuperscript{94} For example, a highway laborer with a broken hand may be disabled from work for three months. If the worker is ultimately found to have a 5% “schedule loss” of the hand, the salary or compensation paid for time out of work would exceed the value of the award, and the worker would be paid nothing for the injury.

In other cases, the worker is unable to return to work at all, but his or her award is limited to the schedule loss, which fails to adequately replace the loss of wages. For example, a 26 year old worker with an amputated dominant arm would receive a maximum of $250,000 if he or she earned more than $1,200 per week and was entitled to the current maximum benefit rate. If that worker is unable to return to employment, the lost wages over his or her lifetime would exceed $2 million. It is apparent that the schedule loss award is inadequate measure of wage loss in many cases.

Schedule loss awards also provide tangible system savings by limiting the extent of medical treatment, issues in dispute, and litigation. Schedule loss awards tend to limit prolonged medical treatment, curtail lost time and provide a well-defined issue that is often resolved by agreement of the parties. Litigation, when required, is targeted to a specific question that can be easily determined by the Workers’ Compensation Law Judge.

We therefore recommend that the current schedule loss evaluation system be preserved, but that schedule loss awards be paid in addition to compensation for temporary disability, rather than having such compensation deducted from the schedule loss award.

\textsuperscript{94} By contrast, under the Longshore & Harbor Workers Compensation Act, schedule loss awards are paid in addition to compensation benefits for lost wages.
C. Medical Treatment.

1. Medical Treatment Guidelines.

On December 1, 2010, the New York State Workers’ Compensation Board implemented Medical Treatment Guidelines (“MTG”) that were recommended by the Insurance Department.95 The MTG apply to treatment for the neck, back, knee, shoulder and carpal tunnel syndrome. Physicians are required to provide treatment “consistent with the Medical Treatment Guidelines,” although they may seek a “variance” from the Board.96 In order to obtain a variance, however, the MTG provide that the “burden of proof to establish that a variance is appropriate for the claimant and medically necessary shall rest on the Treating Medical Provider requesting the variance.”97 The variance procedure is discussed further below.

On January 13, 2012, the New York Committee for Occupational Safety and Health (NYCOSH) submitted a Freedom of Information Law (FOIL) request to the Board seeking information about the MTG. On February 13, 2012 the Board responded, providing data through February 4, 2012.98 The Board’s reply indicated that in the first ten months the MTG were effective, it received 202,643 variance requests, an average of approximately 20,000 variance requests each month.99

The Board further indicated that it held 19,479 hearings on variance requests in the first ten months, and that another 1,347 hearings had been scheduled but not yet held. An

95 New York Medical Treatment Guidelines, http://www.Wcb.ny.gov/content/main/hcpp/MedicalTreatmentGuidelines/MTGOverview.jsp
96 12 NYCRR § 324.2 (a).
97 12 NYCRR § 324.3 (a) (2).
98 Workers’ Compensation Board letter to Joel Shufro, NYCOSH Executive Director, dated February 13, 2012
99 Id. More current data is presently unavailable.
average of almost 2,000 hearings per month were held to address variance issues. These statistics are discussed in greater detail below.

Variances are required for treatment that departs from the MTG in any way. This includes varying from the MTG to (1) provide the MTG-prescribed treatment earlier or later than the juncture recommended by the MTG, (2) provide treatment different than that prescribed by the MTG, or (3) provide more or less treatment than that prescribed by the MTG. As a matter of process, the provider must send a form to the insurer, which may grant or deny the request. The overwhelming majority of requests are denied, in which event the injured worker must request either a hearing or a decision by the Board’s Medical Director’s Office (MDO).

Under the MTG, the insurer does not have to issue written authorization for treatment that is covered, including expensive diagnostic testing and surgery. Whether a type of treatment or procedure is indicated at a particular point in time is, however, subject to interpretation by providers and insurers. This creates uncertainty on the part of many health care providers about whether the insurer will agree with their interpretation and pay for the medical treatment.

The Board established an “optional prior approval” process by which a provider can ask an insurer if it agrees with his or her reading of the MTG before proceeding with treatment. Regrettably, virtually all insurers have opted out of this process, and many providers therefore use variance requests rather than assume the risk that the insurer will decline payment.

Insurer denial of a variance request generally results in either a hearing or determination by the Board’s MDO. The Board has provided the statistics above regarding the number of variances filed and hearings held as a result of the MTG. There are
significant costs associated with this process, which are discussed below. In addition, it is important to note that the Board has limited capacity to schedule hearings to address issues raised by injured workers and employers, and therefore every hearing caused by the MTG carries a hidden cost by preventing the Board from addressing other issues.

a. **Variance statistics as of February 4, 2012.**

- In the first year of the MTG, the Board received 202,643 variance requests. In that year and subsequently, the Board received an average of approximately 20,000 variance requests each month.

- The Board rejected almost 28% of variance requests without awaiting a response from the insurer. While all 202,643 variance requests were received and reviewed by both the insurer and the Board for initial processing, the Board’s preliminary rejection left about 150,000 variance requests for further processing, including the scheduling of a hearing.

- The Board held 19,479 hearings on variance requests in the first year of the MTG. Another 1,347 hearings were scheduled but not yet held within the first year. Over the last 9 months of the first year of the MTG there were an average of 1,987 variance hearings per month.

- 1,301 variance hearings (about 6.5%) required testimony from at least one physician.

- 8,622 variance hearings (44%) resulted in denial of the variance request. Assuming that every “non-denial” was an approval, 10,857 variances were granted at hearings.

- **Summary:** Out of a total of 202,543 variance requests, over 50,000 were rejected by the Board without awaiting a response from the insurer. Another 8,522 were denied at hearings. Only 10,857 (about 5%) were granted at hearings. The status of the remaining 130,621 variance requests is unknown, but it is likely that a high percentage were denied or awaiting a hearing.

b. **Optional Prior Approval Statistics as of February 4, 2012.**

- The Board received 28,901 applications for optional prior approval of treatment in the first year of the MTG.

- The Board rejected more than half of the applications without awaiting a response from the insurer.
- The Board granted 2,151 applications for optional prior approval.

- **Summary:** The Board denied more than half of the applications without awaiting an objection from the insurer, and approved less than 7.5% of all optional prior approval applications. This means that 92.5% of the applications for optional prior approval were denied either by the Board or the insurer.

c. **Cost estimates.**

In 2012, WCRI indicated that it was unable to determine whether the MTG had resulted in any medical cost savings, other than a significant increase in reopened claims to address the need for medical treatment terminated by the MTG. However, it is clear that the MTG carry significant costs for both the Board and for employers and carriers. The Board and the carrier must review each variance application as it is received. Through 2012, Board reported that it rejected approximately 50,000 variance requests and another 15,000 optional prior approval requests on initial review without awaiting a response from the insurer. The Board’s preliminary rejection did not entirely eliminate the costs associated with the process. The insurer must still receive and process the various correspondence from the provider and the Board.

If a nominal figure of $15 per application is used, the rejected paperwork still carries an annual cost of about $1 million to insurers ($15 x 65,000 denied variances/prior approvals). The Board incurs a similar cost in rejecting these requests.

Insurers must also review, process, and respond to the remaining 150,000 variances that the Board did not reject outright by either approving or denying the request. The least expensive choices for the insurer are (1) adjuster review of the file; (2) review by a non-physician (such as a nurse case manager); and (3) review by a non-examining physician (such as a “peer review” company). If one of these methods is used, then we conservatively

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100 Monitoring the Impact of the 2007 Reforms in New York, WCRI (Telles/Tanabe), October, 2012 at p 27
estimate a cost of between $100 and $200 per variance request. Using an average of $150, this would be an annual cost to insurers in excess of $22 million ($150 x 150,000 variance requests).

If the insurer denies the variance application, then the injured worker may request a hearing or request a decision from the Board’s Medical Director’s Office (MDO). If MDO decision is requested, then the cost to the insurer is limited to reviewing the MDO decision. However, the Board incurs significant costs as it must employ staff to review and decide variance requests.

The Board has not provided information regarding how many of the 150,000 variance applications it has not rejected outright are granted, how many are referred to the MDO, and how many require hearings. For purposes of this paper, we will assume an equal distribution of 50,000 in each category.\textsuperscript{101}

If the Board’s MDO decides 50,000 variance requests per year, and assuming further that the MDO’s costs are comparable to the insurer’s cost for reviewing variances, this would be an annual cost to the Board of $7.5 million ($150 x 50,000 variances).

There are substantial additional costs for the Board and the insurer regarding the 50,000 variance requests that are handled through the hearing process. If no medical testimony is taken, then the insurer will still incur defense costs related to the hearing. The Board’s data indicates that it held almost 20,000 variance hearings in the past year. Based on our assumption that 50,000 variances require a hearing, this means that the MTG have created a backlog of 30,000 hearings – two and a half times the Board’s capacity to handle annually.

\textsuperscript{101} This assumption almost certainly overestimates the number of variances that are granted and that are decided by the MDO, and therefore results in a extremely conservative cost figure.
With regard to the hearings that have been held, we estimate that the average cost to the insurer for defense at a variance hearing is $250, again using a conservative estimate. This would be an annual expense of $5 million (20,000 hearings x $250 per hearing). Using the same calculation another $7.5 million must be included for the backlog of 30,000 hearings that have not yet be held. The Board also incurs substantial costs related to variance hearings, and its capacity to schedule hearings on non-variance issues is substantially reduced.

There are yet additional costs associated with the 1,301 hearings in which medical testimony was required. If the treating physician is a chiropractor, then the statutory fee to the physician for his or her appearance is $300; if the treating physician is a medical doctor, then the statutory fee is $400. The insurer will also typically incur at least $750 in defense costs for its attorney and a stenographer. As a result, these hearings each have an average cost of at least $1,200 to the insurer, or about $1.5 million annually (1300 hearings x $1,200 per hearing).

**Summary of Costs.** The minimum annual cost of the variance process is shown below:

<table>
<thead>
<tr>
<th>Action</th>
<th>Insurer Cost</th>
<th>WCB Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rejected Variance</td>
<td>$1 million</td>
<td>$1 million</td>
</tr>
<tr>
<td>Denied Variance</td>
<td>$22 million</td>
<td>n/a</td>
</tr>
<tr>
<td>MDO decision</td>
<td>n/a</td>
<td>$7.5 million</td>
</tr>
<tr>
<td>Hearing (held)</td>
<td>$5 million</td>
<td>$5 million</td>
</tr>
<tr>
<td>Hearing (backlog)</td>
<td>$7.5 million</td>
<td>$7.5 million</td>
</tr>
<tr>
<td>Trial hearing</td>
<td>$1.5 million</td>
<td>$1.5 million</td>
</tr>
<tr>
<td>Total Cost</td>
<td>$37 million</td>
<td>$22.5 million</td>
</tr>
</tbody>
</table>
As shown above, the MTG cost employers and insurers at least $37 million annually. It is likely that the actual cost is far higher.

In addition to the direct cost to employers and insurers, the Board’s costs are almost $23 million annually. Again, it is likely that the actual costs are far higher.

The Board’s costs are passed on to employers and insurers through assessments. The ultimate cost of the MTG to employers and insurers is therefore at least $60 million annually.

The cost of the MTG can be placed in context when compared to the cost of the medical treatment that is being denied, generating the flood of variance requests. Many variance requests involve a limited number of physical therapy or chiropractic sessions in order to provide pain relief and/or improve function. Under the workers’ compensation/No-Fault fee schedule, the cost of each such visit is approximately $33. Variance requests typically seek approval for one visit per week for four to eight weeks, an average cost of $200 per variance in medical treatment ($33 x 6 visits).

It is probable that the 50,000 variance requests rejected by the Board were subsequently resubmitted and are reflected in the existing statistics, so that the actual number of treatment requests is 150,000, not 200,000. We have also assumed that another 50,000 variances were granted voluntarily by the insurer. This would leave a net figure of about 100,000 disputed variances.

If the MTG and the variance process were discontinued, and if every one of those treatment requests were to be approved in its entirety, this would result in a cost of $20 million (100,000 treatment requests x $200 per request).

102 http://www.wcb.state.ny.us/content/main/hcpp/MedFeeSchedules/medfee.jsp
It is clear that the cost of the litigation process associated with the MTG far outweighs the cost of the medical treatment it prohibits. By our analysis, the cost of the litigation process is at least three times the cost of the medical treatment requested.

Indirect costs associated with the MTG, while more difficult to quantify, are also significant. The processing of over 200,000 variance requests and the scheduling of 20,000 hearings annually places an undue burden on the Board’s limited resources and has had a major impact on the Board’s ability to timely and properly adjudicate other issues, such as controverted claims, wage loss, and permanency.

d. **Non-MTG treatment.**

The validity of the MTG is presently on appeal to the New York State Court of Appeals. If the MTG are invalidated, then treatment would be covered by the Workers’ Compensation Law, instead of the Board’s regulations and “guidelines.”

The legal provision covering the “treatment and care of injured employees,” is Workers’ Compensation Law § 13(a). The law provides that “[t]he employer shall promptly provide for an injured employee such medical, dental, surgical, optometric or other attendance or treatment, nurse and hospital service, medicine, optometric services, crutches, eye-glasses, false teeth, artificial eyes, orthotics, prosthetic devices, functional assistance and adaptive devices and apparatus for such period as the nature of the injury or the process of recovery may require.”

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104 WCL § 13 (a)
The law’s language is broad because the Legislature’s purpose in enacting the law was to protect injured workers and their dependents from consequential harm following an injury on the job.\textsuperscript{105}

Authorization for medical treatment beyond doctor’s appointments is covered by Workers’ Compensation Law § 13-a(5). Both before and after the MTG, this statute laid out the circumstances, time frame, manner and method in which an employer may pre-denial medical care. Under Section 13-a(5), only medical services in excess of $1,000 can be pre-denied, and then only if the employer or carrier obtains a contrary medical opinion within 30 days of receiving the request.\textsuperscript{106}

These Section 13 rules in favor of access to medical treatment are buttressed by Workers’ Compensation Law § 21(5), which provides that “[i]n any proceeding for the enforcement of a claim for compensation under this chapter, it shall be presumed in the absence of substantial evidence to the contrary … [t]hat the contents of medical and surgical reports introduced in evidence by claimants for compensation shall constitute prima facie evidence of fact as to the matter contained therein.”\textsuperscript{107} Under the law, the Board must accept as true what treating doctors report to it about their injured patients until employers

\textsuperscript{105} See, e.g., Waters v William J. Taylor Co., 218 NY 248, 252; 112 N.E. 727 (1916): “That act is framed on broad principles for the protection of the workman … It rests on the economic and humanitarian principles that compensation should be given at the expense of the business to the employee …, and this not only for his own benefit but for the benefit of the state which otherwise might be charged with his support.”

\textsuperscript{106} WCL § 13-a(5) provides that “[n]o claim for [special services] costing more than one thousand dollars shall be valid and enforceable, as against such employer, unless such special services shall have been authorized by the employer or by the board, or unless such authorization has been unreasonably withheld, or withheld for a period of more than thirty calendar days from receipt of a request for authorization, or unless such special services are required in an emergency, provided, however, that the basis for a denial of such authorization by the employer must be based on a conflicting second opinion rendered by a physician authorized by the board.”

\textsuperscript{107} WCL § 21 (5)
or carriers offer substantial evidence to the contrary. The presumption controls until the evidence is specifically controverted.  

Taken as a whole, the law establishes a presumption that the injured worker is to receive the medical care and treatment that has been prescribed by the treating physician. The burden of proof is on the employer to demonstrate a lack of causal relationship or medical necessity if it objects to the doctor’s bill or request.

e. **Recommendation.**

The existing statutory procedure makes more treatment available to injured workers with less administrative process and at a lower expense than that associated with the Medical Treatment Guidelines. We recommend that the MTG be eliminated.

2. **Medical Fee Schedule.**

On July 28, 2014, the Board released a “discussion document” proposing significant changes in the workers’ compensation medical fee schedule, which has not been significantly updated in two decades.  

The Board’s document proposes a transition of the fee schedule to the “resource-based relative value scale” (“RBRVS”) used by Medicare.

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108 In re Magna, 258 NY 82, 84; 179 N.E. 266 (1932) “Not infrequently the carrier does not wish to contest the extent or nature of the injuries. In such circumstances, the claimant is permitted to make out his case in the first instance by a verified report. If, however, the carrier disputes the injury and produces substantial evidence that the report is wrong, the case ceases to be one for presumptions.”


110 Subject Number 046-710, 7/28/14, available at [http://www.wcb.ny.gov/content/main/SubjectNos/sn046_710.jsp](http://www.wcb.ny.gov/content/main/SubjectNos/sn046_710.jsp); also [http://www.wcb.ny.gov/content/main/hcpp/MedFeeSchedules/MedicalFeeScheduleDiscussionDocument.pdf](http://www.wcb.ny.gov/content/main/hcpp/MedFeeSchedules/MedicalFeeScheduleDiscussionDocument.pdf)
According to the Board, under the existing fee schedule “some providers and services are vastly overcompensated while others are undercompensated.” Orthopedic surgeons, diagnostic test centers, and other specialists are viewed as “overcompensated,” while general practitioners and primary care doctors are viewed as “undercompensated.”

As a result, the Board proposes to reimburse health care providers at Medicare rates plus a New York “conversion factor” of about 30% across the Board. One impact of the proposed transition to RBRVS would be to cut reimbursement rates in half for many specialists and diagnostic test facilities, while doubling reimbursement rates for primary care physicians. A second consequence of the transition would be the transfer of some services from specialists to general practitioners.

The Board’s proposal raises serious questions about access to quality care for injured workers. Rather than creating incentives for specialists and high quality health care providers to enter the system, it is likely to drastically reduce the number and quality of specialists available to treat injured workers. It is unlikely that the gap will be filled with a surge of primary care physicians and general practitioners. As a group, these physicians have little familiarity with or experience in the workers’ compensation system (or with litigation systems in general) and are unlikely to make the investment of time and resources that are required to participate.

Even if some primary care physicians choose to enter the system as a result of financial incentives offered by the proposed RBRVS fee schedule, their participation may have an adverse impact on injured workers. While these physicians may be able to provide treatment or perform procedures at a lower cost than specialists, there is little assurance that delivery of health care at lower cost would improve the quality of care for injured workers.

\[111 \text{Id.}\]
In addition, the workers’ compensation system requires physicians to be familiar with principles of occupational medicine, the biomechanics of trauma, and disability evaluation. Physician participation in the system requires more than simply rendering treatment; the health care provider must also be familiar with complex medical-legal principles in order to file the necessary reports and provide testimony when required. While these issues are a characteristic feature of practice for orthopedists, neurologists, and other specialists, they are atypical for most primary care physicians and general practitioners. As a result, it is likely that the quality of medical evidence available to injured workers would suffer if specialist participation is discouraged in favor of general practitioners.

The proposed RBRVS fee schedule also fails to fully consider the bureaucratic burden on health care providers in the workers’ compensation system. Physicians are now required to be fully familiar with hundreds of pages of Medical Treatment Guidelines (covering five separate body parts and chronic pain), over 100 pages of Medical Impairment Guidelines, the principles of functional loss evaluation, the variance procedure, the procedure to obtain authorization where a variance is not required and the treatment is not covered by the Medical Treatment Guidelines, principles of causal relationship, reporting, billing, testifying and more.

Providers are currently confronted with no fewer than 37 different Board forms which are required for various purposes. These forms are summarized on the chart below.\footnote{See, \url{http://www.wcb.ny.gov/content/main/forms/Forms_HEALTH_PROVIDER.jsp}}
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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
<td>C-4 (1/11) - Paper Version</td>
</tr>
<tr>
<td>2</td>
<td>C-4 - On-line submission</td>
</tr>
<tr>
<td>3</td>
<td>C-4.2 (1/11) - Paper Version</td>
</tr>
<tr>
<td>4</td>
<td>C-4.2 - On-line submission</td>
</tr>
<tr>
<td>5</td>
<td>EC-4NARR (12/10) - On-line submission</td>
</tr>
<tr>
<td>6</td>
<td>C-4.3 (1/12) - Paper version</td>
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<tr>
<td>7</td>
<td>C-4.3 - On-line submission</td>
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<tr>
<td>8</td>
<td>C-4 AMR (1/11) - Paper version</td>
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<td>9</td>
<td>EC-4 AMR On-line submission</td>
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<tr>
<td>10</td>
<td>C-4 AUTH (2-13)</td>
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<tr>
<td>11</td>
<td>C-4.1 (9/08)</td>
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<td>12</td>
<td>C-5 (1/11)</td>
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<td>C-27 (1/11)</td>
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<td>14</td>
<td>C-64 (1/11)</td>
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<tr>
<td>15</td>
<td>C-72.1 (1/12)</td>
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<tr>
<td>16</td>
<td>DT-1 (3/12)</td>
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<tr>
<td>17</td>
<td>FCE-4 (1/11)</td>
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<td>18</td>
<td>HP-1 (8/13)</td>
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<td>19</td>
<td>HP-4 (4/05)</td>
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<tr>
<td>20</td>
<td>HP-J1 (7-08)</td>
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<tr>
<td>21</td>
<td>ME-3 (1/11)</td>
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<tr>
<td>22</td>
<td>ME-4 (1/11)</td>
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<td>ME-5 (1/11)</td>
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<tr>
<td>24</td>
<td>ME-7 (4/05)</td>
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<td>25</td>
<td>IS-1 (2-13)</td>
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<tr>
<td>26</td>
<td>IS-1R (2-13)</td>
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<tr>
<td>27</td>
<td>IS-4 (2-13)</td>
</tr>
<tr>
<td>28</td>
<td>MD-1 (1/11)</td>
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<tr>
<td>29</td>
<td>MG-1 (2-13)</td>
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<tr>
<td>30</td>
<td>MG-1.1 (2-13)</td>
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<tr>
<td>31</td>
<td>MG-2 (2-13)</td>
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<tr>
<td>32</td>
<td>MG-2.1 (2-13)</td>
</tr>
<tr>
<td>33</td>
<td>MR/IME-1 (4/05)</td>
</tr>
<tr>
<td>34</td>
<td>MR-4 (1/11)</td>
</tr>
<tr>
<td>35</td>
<td>OT/PT-4 (1/11) - Paper version</td>
</tr>
<tr>
<td>36</td>
<td>OT/PT-4 - On-line submission</td>
</tr>
<tr>
<td>37</td>
<td>PS-4 (1/11)</td>
</tr>
</tbody>
</table>

The inadequate medical fee schedule, multiplicity of forms, limitations of the Medical Treatment Guidelines, complexity of the Medical Impairment Guidelines, and the many other burdensome obligations of the workers’ compensation process have increasingly deterred providers from participating in the system, as reflected on the chart below.
These factors and others have had an adverse impact on the ability of injured workers to obtain medical treatment. In response to a survey conducted by the Workers’ Compensation Board in connection with its recent Business Process Re-Engineering Project (“BPR”), nearly half of injured workers reported that they had not received medical care quickly or easily in their case.\footnote{http://www.wcb.ny.gov/BPR/InjuredWorkerSurveyResults.pdf}

The proposed revision of the medical fee schedule would only serve to exacerbate the existing set of disincentives for specialists and high-quality physicians to participate in the system. Instead we recommend that reimbursement rates for specialists be increased,
and the bureaucratic burden reduced in order to attract more quality physicians to provide health care to injured workers.

**D. Return To Work.**

The report and recommendations of the Return to Work Task Force were discussed above in Section II.B.\(^{114}\) The Task Force’s goal was to create policies that would encourage employers to provide return to work programs, enable partially disabled workers to return to gainful employment, and to educate system participants about the proper role of return to work programs in the workers’ compensation system.\(^{115}\)

Regrettably, none of the Task Force’s recommendations have ever been implemented. As a result, in response to the Board’s BPR survey nearly two-thirds of injured workers reported that they had received no information regarding return to work, and a similar percentage reported that they believed their injury resulted from inadequate safety procedures by their employer.\(^{116}\)

The Workers’ Compensation Law provides compensation benefits for injured workers who return to employment earning less than their pre-accident wage.\(^{117}\) In these circumstances, the compensation is two-thirds of the difference between the worker’s pre-accident wage and his or her post-accident earnings.\(^{118}\) In many instances, the benefits payable for “reduced earnings” are greater than the compensation awarded by the Board for disability if the injured worker does not return to work.

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115 Id.
116 http://www.wcb.ny.gov/BPR/InjuredWorkerSurveyResults.pdf
117 Workers’ Compensation Law §§ 15(5); 15(5-a).
118 Id.
For example, a worker who has an average weekly wage of $1,200 and is found to be “mildly disabled” would be entitled to compensation of $200 per week as long as he or she remains out of work. If, however, the worker obtains a lighter job paying $600 per week, then his or her compensation would be two-thirds of the lost wages, or $400 per week ($1,200 average weekly wage - $600 earnings = $600 lost earnings x 2/3 = $400). Thus, the law offers injured workers a significant incentive to return to work. In the foregoing example, the worker would receive only $200 per week while unemployed, but $600 per week in wages plus $400 per week in compensation upon a return to work, more closely restoring him to his pre-accident financial status.

Regrettably, the Workers’ Compensation Board has elected in many instances to impose a forfeiture of benefits if a worker does not maintain “attachment to the labor market.” Although compensation is payable only for the portion of wage earning capacity that has been lost as a result of the accident, the Board’s position is that the claimant’s failure to exercise his or her remaining wage earning capacity (if any) should result in loss of benefits for the disability. Put another way, if the injured worker does not attempt to do what he or she is able to do, the Board will deny compensation for what it has found the worker is not able to do.

This punitive approach is especially unfortunate in view of the failure to implement any of the recommendations of the Return to Work Task Force, the Department of Labor’s failure to report on the return to work status of permanently partially disabled workers, and the built-in statutory incentive for injured workers to seek employment. Moreover, the Workers’ Compensation Law presently contains no provisions regarding “voluntary withdrawal from the labor market” or “labor market attachment.” As a result, these issues

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119 Id.
have generated substantial litigation before the Board. Over one hundred appeals involving these issues have been decided by the Appellate Division, Third Department in the past decade.

On May 1, 2012, a sharply divided Court of Appeals issued a 4-3 decision in which it gave the Board wide latitude to decide these issues, without providing any additional standards or guidance. This decision has perpetuated and expanded litigation in the workers’ compensation system. There is no existing statutory, regulatory, or judicial authority that establishes how long a partially disabled worker must remain attached to the labor market, what constitutes such attachment, the consequences of lack of attachment, the relationship of labor market attachment to the Board’s existing guidelines for loss of wage earning capacity, whether the failure to find employment entitles the injured worker to total disability benefits, the impact of the time limitation on permanent partial disability benefits in Workers’ Compensation Law Section 15(3)(w), the standard for reopening closed cases, the distinction between cases of permanent and temporary disability, and other issues. Instead, these issues are determined in an inconsistent, piecemeal fashion by the Board on a case-by-case basis.

We recommend that the statute be amended to include a standard that clarifies these questions, thus reducing litigation in the workers’ compensation system. Such a standard would provide that the Board may deny compensation for partial disability if the worker’s separation from employment was unrelated to the compensable injury, or if the employer offers proof that the loss of wages is wholly unrelated to such injury. This would preserve and codify the requirement of a causal connection between the injury and the loss of

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earnings, as well as the right of the employer or insurer to contest the claim. However, where the Board finds that the injured worker left employment due to the injury and also that the worker has an ongoing partial disability, the statute would expedite payment of the reduced partial disability award without unnecessary litigation.

We also recommend that the recommendations of the Return to Work Task Force be reviewed, adopted, implemented and enforced.

IV. COSTS

Over the past two decades, business and insurance interests have repeatedly claimed that workers’ compensation is a “high cost” to employers, that it saps New York’s economic competitiveness, and that the system must be “reformed” to reduce costs.

None of these claims are true. To the contrary, workers’ compensation costs in New York have declined dramatically in the past twenty years, and workers’ compensation is a small and declining portion of employer costs. Trends in the law, accelerated by statutory changes in 2007 and a host of administrative and regulatory initiatives, have reduced worker access to benefits and have reduced claim costs across the board. Overall, the cost of workers’ compensation in New York is lower than other costs in the state, and is comparable to similarly situated states.

Invariably, the target of these cost reduction efforts is benefits for injured workers, whose claims are portrayed as driving increased costs. However, the driving factor in the debate about workers’ compensation is not claim costs, but insurer profits. The simple fact is that insurers benefit from greater system costs. As more money flows through the system,
insurer profits increase. To deflect attention from this fact, insurers blame the claims of injured workers when attempting to increase their charges to employers.

A. New York is Not a High Cost State for Workers’ Compensation.

The 2012 Oregon Workers’ Compensation Premium Rate Ranking\(^\text{121}\) placed New York fifth in the country for workers’ compensation costs. This must, however, be placed into an appropriate context.

The Oregon report is issued every two years, and while the 2012 report included the impact of premium increases that were approved by the New York State Insurance Department in 2010 and 2011, it did not include the impact of the Department of Financial Services (“DFS”) denial of a premium increase in 2012. After approving a 9.5% increase in 2013, DFS again denied a premium increase in 2014. The Oregon report also did not include the impact of the 2012 reduction in assessments, which were reduced still further in 2013 and 2014 with the closure of New York’s Reopened Case Fund.\(^\text{122}\)

In 2012, New York’s rank was consistent with states that are similarly situated from an economic and geographic standpoint. Within the top 11 states, Connecticut (#2), California (#3), and Illinois (#4) ranked higher than New York; New Jersey (#2), New Hampshire (#9), Maine (#10), and Pennsylvania (#11) were just behind. The Oregon rankings generally reflect regional differences, with a majority of Northeast states positioned in the top quarter (including Connecticut (#2), New Jersey (#7), New Hampshire (#9), Maine (#10), Pennsylvania (#12) and Vermont (#14)).


Workers’ compensation premium rates in New York must also be considered in context with the general costs of living and working in the state. While the 2012 Oregon report ranked New York fifth in the nation in workers’ compensation costs, CNBC’s America’s Top States for Business 2012 ranks New York fourth in both Cost of Living and for Cost of Doing Business.\(^\text{123}\) Taking the two together, it appears that New York is a cost-efficient state for workers’ compensation.

Of the top ten states in the 2012 Oregon study, New York was the only one in which workers’ compensation costs rank lower than the combined costs of living and doing business. With a fourth place ranking for cost of living and doing business and a fifth place ranking for workers’ compensation costs, New York had a deviation of -1, with workers’ compensation being less expensive than other costs in the state. By comparison, Illinois ranked fourth in workers’ compensation costs but 29th in the cost of living and doing business (a deviation of +25); Oklahoma ranked sixth in worker’s compensation costs but 48th in the combined costs of living and doing business (a deviation of +42).\(^\text{124}\)

Additional context for the Oregon report was provided by the New York Compensation Insurance Rating Board, which issued a critique of the methodology and the conclusions of the report.\(^\text{125}\) The Rating Board commented that a more nuanced analysis based on payroll instead of losses “could possibly yield significantly different results.”\(^\text{126}\)


\(^{126}\) Id.
In short, New York is one of the few states in which workers’ compensation is less expensive than other costs in the state, making it a cost-efficient state for workers’ compensation when those costs are placed into the appropriate context.


From 1995 through 2008, there were only two years in which workers’ compensation premium rates rose – 2003 (1.7%) and 2005 (5%). By contrast, there were seven years in which premiums declined (including a 14.9% drop in 1996 and an 18.4% drop in 2007), and five more in which they remained flat.127 This long-term trend was somewhat offset by the insurance industry’s applications for rate increases from 2009 – 2011, which were wholly or partially approved by the New York State Insurance Department. These recent rate increases did not, however, correlate with actual costs in the workers’ compensation system, but were driven purely by issues of insurer profitability.

From 1994 through 2014 there were reductions in New York workers’ compensation premiums totaling 61.3%. Over that same period there were premium increases totaling 38.9%. The net result is that there has been a 22.4% decrease in workers’ compensation premium rates since 1994.

The table and graph below, which are drawn from New York Compensation Insurance Rating Board (‘CIRB”) R.C. Bulletins, outline the history of these premium changes.

The impact of the various rate changes can also be analyzed by reference to actual employer dollar costs. The table and graph below demonstrate the actual dollar costs for an employer that was paying $100 for workers’ compensation coverage in 1994, aggregating the impact of the various increases and decreases over the years.
It is clear that in real terms, employer expenses for workers’ compensation have declined over the past two decades. This is further verified by the National Council on Compensation Insurance ("NCCI") State of the Line Report from May 10, 2012.\footnote{NCCI State of the Line, Dennis Mealy, May 10, 2012. Available at www.ncci.com/Documents/AIS-2012-SOL-Presentation.pdf}
According to the NCCI chief actuary, workers’ compensation costs, as a share of all employer costs, declined from 1.6% in 2001 to 1.5% in 2011. The NCCI graph is reproduced on the following page.

More recently, NCCI has observed an improving workers compensation market — including better policy underwriting, increasing comp premiums and a national decline in claim frequency. As a result, NCCI has recommended premium reductions in over three-quarters of the states in which it functions as a rate service organization.\textsuperscript{129}

\textsuperscript{129}http://www.businessinsurance.com/article/20140914/NEWS08/309149977?tags=|73|304|92&CSAuthResp=1%3A173549157660724%3A109186%3A64%3A24%3Aapproved%3AB8115FBC561FEE93DAD65C1428AF5B2B&=#

\textsuperscript{130}Id.
2011

- Wages and Salaries: 20.4%
- Health Insurance: 19.9%
- Workers Compensation: 1.5%
- All Other: 7%
- Total Compensation: 70.5%

2001

- Wages and Salaries: 19.9%
- Health Insurance: 19.9%
- Workers Compensation: 1.6%
- All Other: 7.6%
- Total Compensation: 72.9%

Private Industry

Total Compensation

Employee Costs as Percentage of
C. **Assessments Have Declined and Will Decline Further.**

In addition to premium, employers also pay assessments in order to fund two Special Funds and the operations of the Board. The Second Injury Fund, which was closed as part of the 2007 legislation, reimbursed employers and carriers for all payments they make after 260 weeks if they can demonstrate that the injured worker had a prior permanent impairment and that his or her current condition is materially and substantially worse than it would have been if not for the prior condition. This Fund socialized the cost of claims among employers and carriers, instead of requiring each individual employer or carrier to bear the entire burden of its own claim costs.

The Reopened Case Fund, which was closed as part of the 2013 state budget, assumed liability for claims that are more than seven years old and in which no payments have been made in the past three years. Like the Second Injury Fund, this fund socialized the cost of “stale” claims, instead of requiring employers and insurers to remain individually liable in perpetuity.

In essence, the Special Funds operated as a reinsurance system in which employers and carriers pay assessments and also receive reimbursement. Almost 98% of the payments employers and insurers make towards Special Funds assessments (79% of the total assessment figure) are returned to those same employers and insurers in the form of payments from the Special Funds. Only a fraction of assessments relate to the administration of the Workers’ Compensation Board and other programs.

Historically, the cost of assessments was a direct function of the extent to which employers and insurers chose to socialize their costs and seek reimbursement from the

Special Funds, which depended in part on the applicable legal rules. The table and graph below show the trend in assessments over the past decade.\textsuperscript{132}

<table>
<thead>
<tr>
<th>Year</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/03</td>
<td>14.30%</td>
</tr>
<tr>
<td>10/1/04</td>
<td>15.10%</td>
</tr>
<tr>
<td>10/1/05</td>
<td>17.50%</td>
</tr>
<tr>
<td>10/1/06</td>
<td>18.60%</td>
</tr>
<tr>
<td>10/1/07</td>
<td>15.00%</td>
</tr>
<tr>
<td>10/1/08</td>
<td>13.40%</td>
</tr>
<tr>
<td>10/1/09</td>
<td>14.20%</td>
</tr>
<tr>
<td>10/1/10</td>
<td>18.10%</td>
</tr>
<tr>
<td>10/1/11</td>
<td>20.20%</td>
</tr>
<tr>
<td>10/1/12</td>
<td>18.80%</td>
</tr>
<tr>
<td>10/1/13</td>
<td>13.80%</td>
</tr>
</tbody>
</table>

It is apparent that assessments have fluctuated within a relatively narrow range over the past decade, with periodic increases and decreases, and are now at a 10-year low. In addition, as discussed below, assessments will naturally decrease over the long term due to the closure of the Special Funds.

Connecticut and Kansas closed their Second Injury Funds in 1995 and 1996, respectively.\textsuperscript{133} In Connecticut assessments declined from 15% in 1995 to 4% in 2006; over the same period Kansas assessments declined from 15.7% to zero in 2003, before rebounding to 1% in 2006.\textsuperscript{134}

It is clear that the elimination of the Special Funds will result in a dramatic long-term cost savings for employers. Due to the unfunded liability for existing Second Injury

\textsuperscript{132} NYCIRB Bulletins R.C. 2005, R.C 2044, R.C. 2065, R.C. 2093, R.C. 2118, R.C. 2139, R.C. 2169, R.C. 2206, R.C. 2279; R.C 2307; R.C. 2353; R.C. \url{http://www.nycirblib.org/rcb/}.


\textsuperscript{134} Id.
Fund claims, there will necessarily be a short-term cost associated with its closing. This was reflected in a slight increase in assessments from 2010-2011, which was reversed in 2012, followed by a steep decline in 2013.

D. The System Lacks Transparency and Accountability Regarding Insurer Data and Profits.

1. Lack of transparency, credibility, and corroboration.

In New York, the statutory rate service organization is the New York Compensation Insurance Rating Board. The structure, data sources, and inability to verify CIRB’s data 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, some public members have failed to designate participants in all stages of CIRB’s processes, and have largely perpetuated insurer control of the entity.

There is little 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 criticized by the Department of Financial Services (“DFS”) and its predecessor, 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.\textsuperscript{135} 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 and again in 2014 its rate filings were disallowed in the entirety by the Department of Financial Services.\textsuperscript{136}

2. 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.\textsuperscript{137} The self-insured sector of the market (the other one-third) does not report data to CIRB or to any other 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.\textsuperscript{138}

\textsuperscript{135} 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 \url{http://www.ins.state.ny.us/wc/wc_index.htm}.


\textsuperscript{137} 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 \url{http://www.ins.state.ny.us/wc/wc_index.htm}.

\textsuperscript{138} Report to the Governor at pp. 21-23.
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.\textsuperscript{139} The WCB, however, had indexed only 149,808 claims in 2003.\textsuperscript{140} In short, CIRB (accounting for two-thirds of the market) had more claims reported to it than the WCB (covering the entire market) indexed.

There is clearly 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 DFS 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 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.”\textsuperscript{141} The Insurance Department further observed that

\textsuperscript{139} Id. at p. 24.
\textsuperscript{141} Report to the Governor at p. 22.
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. 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. More importantly, the CIRB’s role impedes transparency regarding the transparency of insurer distribution of premium dollars.

We recommend that the 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.

V. ADMINISTRATION.

Substantial changes in the Board’s administration and adjudication have had a major impact on the workers’ compensation system. Taken as a whole, the Board’s administrative processes have contributed to the development of a system that is markedly less accessible to injured workers, and one in which compensation for their injuries is uncertain and long-delayed. This is, of course, wholly inconsistent with the spirit and intent of the law. Each of these issues – access to benefits and adjudication – is considered separately below.

142 Id. at p. 22, footnote 24.
A. **Access to Benefits.**

Four Board initiatives, taken together, have restricted access to benefits for injured workers, especially in the low-income and immigrant populations who are most likely to require access to the system.

1. **The “Rocket Docket” and basic claim forms.**

In June, 2007, the Insurance Department recommended “streamlined docket regulations” to the Board. These regulations (known as “the Rocket Docket”) were intended to expedite the processing of controverted claims, which at the time approached 20% of the cases in the system.

The Insurance Department’s suggested means of “expediting” the resolution of controverted claims was to defer the commencement of formal action by the Board in any given case until a variety of forms were filed by the injured worker, the employer, and the treating physician. While the Board was to “assemble” a file upon receipt of information about an on-the-job injury, it would not “index” the case (and begin the adjudication process) until a full set of initial claim documents was received. This mechanism reduced the apparent time for resolution of controverted claims by starting the clock running at a later point in time than when the injury actually occurred. The assembly and indexing process is discussed in greater detail below.

A basic principle of the Rocket Docket was the concept that claims were controverted because insurers did not possess enough information at the outset to make a reasonable claim determination. Under this hypothesis, delaying the commencement of the adjudication process until more information was provided would reduce the number of
controversies. As a result, the three basic claim forms – the C-2 Employer’s Report of Injury, the C-3 Employee’s Claim for Compensation, and the C-4 Medical Report – were substantially modified to address this concern. Each of these documents was formerly an uncomplicated one-page form, but all were made substantially longer and more complex as a result of the Rocket Docket process. The C-2 form grew to three pages,\textsuperscript{143} the C-3 form was doubled in size and in some instances was required to be accompanied by a medical release form prescribed by the Board,\textsuperscript{144} and the C-4 form was quadrupled in length to four pages.\textsuperscript{145}

The workers’ compensation system was intended to provide easy access to benefits for injured workers, avoiding technicality and legal formality wherever possible.\textsuperscript{146} Indeed, the law expressly states that “[t]echnical rules of evidence or procedure [are] not required. The chairman or board in making an investigation or inquiry or conducting a hearing shall not be bound by common law or statutory rules of evidence or by technical or formal rules of procedure … but may make such investigation or inquiry or conduct such hearing in such manner as to ascertain the substantial rights of the parties.”\textsuperscript{147}

The forms and procedures created by the Rocket Docket now more closely resemble a civil litigation system, replacing what was historically an informal system intended to

\textsuperscript{143} Form C-2, \url{http://www.wcb.ny.gov/content/main/forms/Forms_EMPLOYER.jsp}. This form has recently been superseded by the requirement that employers submit a “FROI” or “SROI,” which are if anything more complex than the C-2 form and which must be submitted electronically.

\textsuperscript{144} Forms C-3, C-3.3; \url{http://www.Wcb.ny.gov/content/main/forms/Forms_CLAIMANT.jsp}

\textsuperscript{145} Form C-4.0, \url{http://www.wcb.ny.gov/content/main/forms/Forms_HEALTH_PROVIDER.jsp}. The C-4.0 later became only part of “the C-4 family of forms” as the bureaucratic burden on health care providers was significantly expanded. See Section III.C.2., supra.

\textsuperscript{146} See, e.g., Balcerak v County of Nassau, 94 NY2d 253, 259 – 260; 723 N.E.2d 555, 701 N.Y.S.2d 700 (1999); “The Workers' Compensation Law … is the State's most general and comprehensive social program, enacted to provide all injured employees with … medical expenses … when the Legislature wishes to create presumptions in the social legislation field, it does so unmistakably. There are precise ‘presumptions’ set forth in the Workers’ Compensation Law, which favor employees by granting easy initial access to benefits.”

\textsuperscript{147} Workers’ Compensation Law § 118
permit workers to easily pursue their claims. If a case is controverted, the Board now requires attorneys for the parties to file “pre-hearing conference statements” amounting to discovery and pre-trial legal briefs. Failure to timely submit such a statement results in the preclusion of evidence.\textsuperscript{148} It is difficult to reconcile these forms and regulations with the language of the statute.

In practice, increased complexity and formality have created a disincentive among some workers to file claims. This is reflected in the frequency of claims filed, which has fallen nearly 60% in the past twelve years. The Board’s data on claims indexed is shown on the chart below.

Complex forms and procedures create a special set of disadvantages for low-wage and immigrant workers, particularly those with limited English proficiency or low literacy skills. These populations face a variety of challenges in accessing benefits in the workers’ compensation system, and the advent of expanded forms serves to exacerbate the situation.

\textsuperscript{148} See, 12 NYCRR 300.38
\textsuperscript{149} Source: New York State Workers’ Compensation Board Summary Annual Reports, available at \url{http://www.wcb.ny.gov/content/main/TheBoard/publications.jsp}
Nearly two-thirds of injured workers who responded to the Board’s BPR survey reported that their information about the system came from their attorney.\footnote{http://www.wcb.ny.gov/BPR/InjuredWorkerSurveyResults.pdf} Many immigrant workers are reluctant to consult an attorney or to institute what they view as a legal proceeding, even if documentation is not an issue.\footnote{See, e.g., Employment Law Principles Applicable to Claims By Low-Wage Immigrant Workers, Beardall, May, 2010 available at http://equaljusticecenter.org/wp-content/uploads/Low-Wage-Immigrant-Employment-Law.pdf} As a result, the increasing complexity and formality of the Board’s forms has an adverse impact on claims filed by these workers, which is reflected in the data above.

It should also be observed, however, that the Board’s statistics reflect a decline in controverted claims since the onset of the “Rocket Docket.” The Board’s reported statistics are shown on the chart below.

![% of Cases Controverted](chart.png)

It is difficult to determine, however, whether the drop in controverted claims is due to the success of the Rocket Docket, the inability of injured workers to complete the Board’s\footnote{Source: New York State Workers’ Compensation Board Summary Annual Reports, available at http://www.wcb.ny.gov/content/main/TheBoard/publications.jsp. The Board issued Joint Data Reports with the Insurance Department in lieu of Summary Annual Reports for 2007 and 2008. The Joint Data Reports do not include all of the data that appears in the Summary Annual Reports.}
forms or to obtain medical evidence to pursue their claims, or other factors. However, only 21% of those who responded to the Board’s BPR survey felt that disputes in their claim were quickly resolved.\(^{153}\) This would tend to indicate that the Rocket Docket has had limited success.

We recommend that the Board simplify its forms for use by injured workers. This would improve access to benefits and return the system to its mission of delivering substantial justice with a minimum of technicality.

2. “Assembly” and “Indexing.”

Prior to 1996, the Board would “index” a claim and assign a case number (a “WCB number”) upon the receipt of any information indicative of a work-related injury. Under the statute, the employer or carrier’s time to accept or contest the claim begins to run from the date the claim is indexed by the Board.\(^ {154}\) An injured worker who received a WCB number therefore understood that his or her claim had been received by the Board and also that the Board would take steps to ensure that benefits were delivered or the claim adjudicated.

Regrettably, the clarity of this process has been defeated by the Board’s byzantine “assembly and indexing” regulations. Under the new regulations, the Board will not index a claim until it receives a C-2 from the employer or a C-3 from the injured worker and a C-4.0 from the treating physician and a C-3.3 limited medical release from the injured worker if there was any relevant prior injury.\(^ {155}\) Only the prescribed forms are accepted to index the case (although the C-2 has recently been superseded by the requirement that employers

\(^{153}\) [http://www.wcb.ny.gov/BPR/InjuredWorkerSurveyResults.pdf](http://www.wcb.ny.gov/BPR/InjuredWorkerSurveyResults.pdf)

\(^{154}\) See, e.g., Workers’ Compensation Law § 25(2)(b)

\(^{155}\) 12 NYCRR §§ 300.37.
submit a “FROI” or “SROI,” which are if anything more complex than the C-2 form and which must be submitted electronically.)

Where the Board receives only one of the prescribed forms, it now issues a “Notice of Case Assembly.” This document assigns a WCB number, but does not signify that the Board will take any steps to adjudicate the claim or to ensure benefit delivery. Under the Board’s regulations, the adjudicatory process does not begin until the claim is indexed. Thus, unlike the former system, the worker who receives a WCB number has no assurance that his or her claim is moving forward. Moreover, workers may well be misled by the receipt of a case number into believing that their claim will be processed by the Board, while in fact the Board will not take action until additional information is received.

Further complicating the situation is that the Board disregards its own regulations and will not index the case even if the proper forms are filed, as long as the employer or carrier voluntarily accepts the claim. By internal, non-regulatory process, the Board has determined that accepted claims need not be indexed.

The result of this process is that there are claims that are “assembled” but never move forward due to the absence of one or more the required forms, there are claims that are “assembled” and accepted by the employer or carrier and are thus not indexed (but will move forward), and there are claims that meet the Board’s criteria and are indexed.

This convoluted state of affairs creates substantial uncertainty for injured workers about the status of their claim in the workers’ compensation system, and operates to deny access to benefits for the many workers who are unable to contend with the complexity of the system. We therefore recommend that the Board return to the former process of indexing claims upon receipt of information indicating a work-related injury. This approach
will improve clarity and transparency in the system and expedite the delivery of benefits to injured workers.

3. **Non-Hearing Decisions.**

Prior to 1996, the Board held a hearing in each case that was indexed. A WCL Judge would explain the process to the injured worker, suggest that he or she consult with an attorney if indicated, and verify the accuracy of the information on the forms submitted before rendering a decision. The hearing mechanism ensured that language barriers or technical terms did not impede the workers’ ability to understand his or her rights and to access available system benefits.

The Board now attempts to “resolve” the constricted number of cases that are indexed by issuing non-hearing determinations, known as “administrative” or “proposed” decisions. “Administrative” decisions are issued by the Board’s claim examiners pursuant to the Board’s authority to resolve “first-aid only” claims administratively. In practice, many administrative decisions involve cases in which the injured worker would be entitled to an award for lost time or schedule loss, and the Board’s use of these decisions is therefore improper. “Proposed” decisions are issued by the Board pursuant to a provision of the statute authorizing a “conciliation” hearing in cases involving less than 52 weeks of disability. The statute requires a procedure associated with conciliation, including a meeting with a conciliator, an explanation of the injured workers’ rights, and an option for the injured worker to withdraw from the conciliation process and to request a hearing before

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156 12 NYCRR 313.1
157 Workers’ Compensation Law §25(2-b)
a WCL Judge. The Board’s issuance of “proposed” decisions without the associated process vitiates the injured workers’ rights under the statute.

Both administrative and proposed decisions are prepared by the Board’s non-judicial personnel, are issued in English only, and include legal determinations and language that cannot be properly interpreted by most injured workers.158 The charts below show the Board’s increased reliance upon each type of these decisions, and its overall use of non-hearing processes to decide claims. This use has increased over 30% in the past four years.

![Administrative Decisions Chart]

158 The Board asserts that proposed decisions are reviewed by its WCL Judges prior to being issued. Assuming that such review occurs, it does not provide the WCL Judge with the opportunity to interact with the injured worker, flesh out the details of the claim, and to provide information to the injured worker in terms he or she can understand.
The Board’s use of administrative and proposed decisions exceeds its authority under the statute. As noted above, administrative decisions are routinely issued in claims that involve more than minor injuries, and proposed decisions are issued without any effort

159 Source: New York State Workers’ Compensation Board Summary Annual Reports, available at http://www.wcb.ny.gov/content/main/TheBoard/publications.jsp. The Board issued Joint Data Reports with the Insurance Department in lieu of Summary Annual Reports for 2007 and 2008. The Joint Data Reports do not include all of the data that appears in the Summary Annual Reports.
to comply with the statutory requirements that conciliation be requested by the carrier, that the injured worker be present at a meeting, and that the injured worker be permitted to opt out of the conciliation process in favor of a hearing before a WCL Judge.

More importantly, non-hearing determinations are not an effective means of communication between the Board and the injured worker. These decisions are issued primarily in reliance on forms filed by the employer, carrier, and physicians, and without benefit of interaction between the Board and the injured worker. As a result, many decisions are factually incorrect. While insurers and attorneys routinely object and request correction, unrepresented workers who are unsophisticated in the system are deprived of a meaningful opportunity to ensure that the decision in their case is accurate. As a result, they routinely suffer a loss of rights and benefits. This occurs not only due to the inadequacy of the findings and awards in many non-hearing determinations, but also because the decisions do not adequately inform the worker about their rights or about additional benefits they may be entitled to under the law.

There is no reasonable substitute for an initial hearing in every case. Participants in the system are in substantial agreement that holding an initial hearing is more efficient than the use of non-hearing determinations. More importantly, however, an initial hearing ensures that unrepresented workers are given adequate information about their claim, their rights, and system benefits, and that they have a meaningful opportunity to be heard by the Board. We therefore recommend that an initial hearing be held in every case, in lieu of the use of non-hearing determinations.

4. **Hearings**.
Workers’ Compensation Law Section 20 provides that “[t]he chair or board shall make or cause to be made such investigation as it deems necessary, and upon application of either party, shall order a hearing … Upon a hearing pursuant to this section either party may present evidence and be represented by counsel.” Regrettably, the Board has increasingly denied injured workers their statutory right to be given a hearing upon request.

The chart below shows the declining trend in hearings held.

The figures shown represent nearly a 30% reduction in hearings held over the past decade. This reduction is due to a variety of factors, including the decline in claims indexed, the use of non-hearing determinations, and bureaucratic processes that delay and deny hearings.

The chart below demonstrates the correlation between the Board’s use of non-hearing determinations and the decline in hearings held.

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¹⁶⁰ Source: New York State Workers’ Compensation Board Summary Annual Reports, available at [http://www.wcb.ny.gov/content/main/TheBoard/publications.jsp](http://www.wcb.ny.gov/content/main/TheBoard/publications.jsp). The Board issued Joint Data Reports with the Insurance Department in lieu of Summary Annual Reports for 2007 and 2008. The Joint Data Reports do not include all of the data that appears in the Summary Annual Reports.
The trend from 2010 through 2013 is especially noteworthy. In that time span non-hearing determinations rose almost 50,000 from 102,245 to 152,523 while hearings declined almost 30,000 from 291,737 to 262,878. Thus, it is increasingly apparent that the Board uses non-hearing determinations as a substitute for the statutory hearing process.

Other bureaucratic initiatives also impede the ability of injured workers to utilize the hearing process to access benefits under the law. In order to obtain a hearing, the injured worker or his attorney must submit a Request For Further Action form to the Board (form RFA-1) identifying the reason for the hearing request and attaching evidence in support of the request. These requests are evaluated by the Board’s administrative personnel, who routinely issue a variety of responses that do not include the scheduling of a hearing. The Board has effectively used this process to evade its statutory obligation to hold a hearing upon request as required by law. As set forth above, the statute mandates that the Board “shall order a hearing” upon application of either party.

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161 Source: New York State Workers’ Compensation Board Summary Annual Reports, available at http://www.wcb.ny.gov/content/main/TheBoard/publications.jsp

162 Typical responses include advice that the Board will attempt to address the issue raised without holding a hearing (often followed by the issuance of a Proposed Decision); that the evidence submitted is inadequate (in many cases because it has been separated from the request and discarded by the Board’s scanning vendor); that no hearing can be held because the Board is waiting for the carrier to file forms; and the like.

163 Workers’ Compensation Law § 20
When a hearing is scheduled, the Board will rarely continue the matter to another date to ensure that the injured worker’s issues have been resolved. Instead, cases are routinely marked “no further action,” or “NFA.” This designation permits the Board to claim that the case has been “resolved,” while placing the burden on the injured worker to apply for another hearing to pursue his or her benefits. The charts below depict the Board’s claim about the number of cases that it “resolves” at hearings as compared to the total number of hearings it holds.

Based on these statistics, it would appear that the Board “resolves” a large number of the cases that are scheduled for hearings. Translated into percentages on the chart below, the use of the “no further action” designation permits the Board to claim that it now “resolves” nearly two-thirds of the cases that come on for hearing, up from about 50% a decade ago.

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164 Source: New York State Workers’ Compensation Board Summary Annual Reports, available at [http://www.wcb.ny.gov/content/main/TheBoard/publications.jsp](http://www.wcb.ny.gov/content/main/TheBoard/publications.jsp) The Board issued Joint Data Reports with the Insurance Department in lieu of Summary Annual Reports for 2007 and 2008. The Joint Data Reports do not include all of the data that appears in the Summary Annual Reports.
In fact, however, far fewer than two-thirds (and likely fewer than half) of claims are truly “resolved” at a hearing. Although one or more specific issues may be resolved at a hearing, in most instances there are other parts of the claim that will require adjudication. Rather than continuing the case to ensure that the entirety of the claim is resolved, however, the Board takes the case off of its calendar and requires the injured worker (or the carrier) to request further action in order to obtain another hearing.

The chart below demonstrates the number of cases the Board actually reopens upon receipt of requests for further action. It should be observed that the chart underrepresents the actual number of applications to reopen because the Board does not act on many of the requests it receives.
It is apparent that the more cases the Board “resolves,” the more it is required to “reopen.” In fact, the Board now reopens significantly more cases than it indexes, as reflected on the chart below.

While the use of non-hearing determinations and the “no further action” designation permits the Board to claim that it “resolves” a high percentage of claims, it is evident that

\[\text{Claims Indexed vs. Claims Reopened}\]

\[\text{Claims Reopened}\]

\[\text{Year}\]

\[\text{Claims Indexed}\]

\[\text{Claims Reopened}\]

\[\text{Id.}\]

\[\text{Id.}\]
this is not the case. Instead, these procedures reduce access to benefits by injured workers, who are frequently required to take affirmative action to apply to reopen their cases to receive benefits. We recommend that the Board discontinue the artificial closure of cases through the use of “no further action” and continue cases until they are finally resolved.

B. Adjudication.

Workers who do obtain access to the system often find that the Board appears motivated to limit and deny them benefits. While there are many concrete examples of this behavior, some of which are outlined below, it is also evident in a myriad of less-identifiable ways which create a perception that the system is not “worker-friendly.”

1. World Trade Center Volunteers.

One example of the Board’s adjudicatory tendency to limit benefits was its decision to narrowly define coverage for World Trade Center Volunteers. Although the statute was enacted “to remove statutory obstacles” impeding the claims of those who engaged in rescue, recovery and cleanup efforts at the World Trade Center site, in 2006 the Board issued a Subject Number restricting coverage for volunteers to those who were serving “under the direction of an authorized rescue entity or volunteer agency.” This amounted to an administrative decision to exclude hundreds (if not thousands) of volunteers from coverage, including many who served heroically in the “bucket brigades” in the days immediately following the September 11 attacks.

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Eight years later in 2014, the Appellate Division, Third Department found that the Board had used its Subject Number to “routinely [apply] this definition of volunteer to deny awards to claimants who were not associated with an authorized rescue entity or volunteer agency.”\textsuperscript{170} In reversing the Board’s decision ruling against an individual volunteer, the court reminded the Board that its Subject Numbers “cannot overrule the statute itself,” particularly where “neither the statutory language nor the legislative history supports the Board’s requirement.”\textsuperscript{171}

While the injured worker in the case before the Court won the right to compensation, it is unknown how many other workers were deprived of benefits by the Board’s interpretation, or how many were dissuaded from seeking benefits due to the Board’s published message that they would not be covered.

2. **Acceleration of the PPD Caps.**

The Board’s use of a published Subject Number to pre-judge legal issues against injured workers is not limited to the issue of World Trade Center Volunteers. In 2013, the Board published a Subject Number expressly stating that it intended to expedite permanency classifications of injured workers in order to ensure that their benefits would be terminated by the PPD caps as expeditiously as possible.\textsuperscript{172}

Prior to the 2007 legislation which imposed the PPD caps, it was in the interest of injured workers to seek permanency classifications in order to secure their ongoing benefits. Such applications were routinely opposed by insurers. The Board took no position for or against classification, and merely decided the claims in its role as an adjudicatory agency.

\textsuperscript{170} \textit{Id.}  
\textsuperscript{171} \textit{Id.}  
\textsuperscript{172} SN 046-548, 5/28/13; \url{http://www.Wcb.ny.gov/content/main/SubjectNos/sn046_548.jsp}
As a result of the PPD caps, employers and carriers gained an interest in obtaining classification of injured workers. When they did not do so by 2013, the Board abandoned the neutrality it had shown when classification was a worker-friendly issue. Instead, the Board issued a Subject Number declaring that the “caps were the 2007 Reform's central cost-savings measure and were expected to produce annual savings of approximately $1 billion” and lamenting the fact that “carriers have not achieved the level of PPD-NSL classifications that were expected.”\textsuperscript{173}

The Board therefore abandoned its role as an impartial adjudicator in order to advance initiatives to accelerate the termination of benefits to injured workers and benefit the insurance industry. The pre-ordained outcome of the decisions directed by the Subject Number was exemplified the statement that that outstanding issues involving other sites of injury or surgery are “not a bar to” a finding of maximum medical improvement or classification.\textsuperscript{174} It is difficult to comprehend how it would be appropriate to find that an injured worker who requires surgery is at “maximum medical improvement.” It is equally difficult to understand how a determination as to the causally related loss of wage earning capacity could be reached without knowing which sites of injury are included in the case. It is clear, however, that the Board chose to abandon neutrality and common sense in favor of terminating benefits for permanently partially disabled workers. This is, of course, contrary the Board’s obligation under the statute and nearly a century of case law to protect injured workers.\textsuperscript{175}

\textsuperscript{173} Id.
\textsuperscript{174} Id.
\textsuperscript{175} See, e.g., Waters v. William J. Taylor Co., 218 N.Y. 248, 252; 112 N.E. 727, 728 (1916). (the Workers’ Compensation Law “rests on the economic and humanitarian principles that compensation should be given at the expense of the business to the employee or his representatives for earning capacity destroyed by an accident in the course of or connected with his work, and this not only for his own benefit but for the benefit of the state which otherwise might be charged with his support.”}
The Board’s drive to achieve classification and benefit termination included a number of sanctions to be imposed on attorneys and parties who “hindered” its drive to terminate payments for injured workers. These sanctions made it clear that the Board had acquired its own interest in the outcome of cases, which is plainly an improper role for a supposedly neutral adjudicator.

The Board further ruled (by Subject Number) that the failure of the injured worker’s treating physician “to use the appropriate form and guidelines or produce the report in the directed timeframe may result in waiver of the ability to present medical evidence on the issue and/or the imposition of penalties.” This fails to recognize the fact that unlike “independent medical examiners” who are retained, directed, controlled, and paid by insurers, treating physicians are not within the control of the injured worker or the injured workers’ attorney. While an injured worker or an attorney may make a request to a treating physician, it would obviously be improper to demand that the treating physician provide a particular medical opinion. The injustice of the Board’s approach is further exacerbated by its policy precluding injured workers from seeking a second medical opinion if the treating physician does not submit the necessary report.176

The Board’s decision to accelerate classification of permanently disabled workers in order to impose the PPD caps and terminate their benefits can only be interpreted as a policy decision to favor the interests of insurers over injured workers.

3. Late Payment Penalties.

The Board has continued to issue Subject Numbers designed to control the adjudicatory process and limit benefits payable to injured workers. More recently, the

176 See,. 12 NYCRR 300.2
Board issued a Subject Number in which it advised that it would not apply all of the late payment penalties available under the law, but rather would limit its adjudication to one penalty.177

The Workers’ Compensation Law contains two independent penalties, one for late payment of an award and a second for failure to comply with a “conciliation” decision.178 The purpose of the late payment penalty is to discourage employers from issuing late award payments to claimants, while the purpose of the conciliation penalty is to encourage compliance with the conciliation process.179 Although the Legislature could have made these penalties mutually exclusive, it did not do so.

Despite the language of the statute, however, the Board issued a Subject Number stating that it would “subsume” one penalty into the other where late payment occurred, and impose only the higher of the two.180 As in the case of its Subject Number regarding World Trade Center volunteers, the Board chose to issue a system-wide directive limiting the benefits available to injured workers. It is noteworthy that in issuing Subject Numbers the Board avoids the regulatory process and prevents WCL Judges and its Office of Appeals from rendering independent decisions in the cases before them. Such subject numbers are invariably aimed at limiting, rather than improving, benefits for injured workers.

178 Workers’ Compensation Law §§ 25(2-b), 25(3)(f). The Board’s “proposed decisions” are treated as the outcome of the conciliation process, although as outlined above the Board does not comply with the statutory requirements of that process.
179 Keser v. New York State Elmira Psychiatric Center et al., Workers’ Compensation Board, 243 A.D.2d 783; 305 A.D.2d 893 (1997); see also, Voorhees v. Wal-Mart et al., Workers’ Compensation Board, 305 A.D.2d 893, 894; 758 N.Y.S.2d 857, 2003 N.Y. App. Div. LEXIS 5794 (“[t]he penalty provisions…advance a ‘public policy in favor of prompt payment of Workers’ Compensation benefits to injured employees’ since ‘the uniform assessment of penalties in all cases of late payment will ultimately benefit employees by deterring carriers from delaying award payments…” )
4. Labor Market Attachment.

Perhaps the clearest example of the Board’s decision to adjudicate claims in favor of employers was its decision to litigate against an injured worker in the courts.\textsuperscript{181} In December, 2010 the Appellate Division, Third Department reversed a decision of the Board that denied benefits to an injured worker.\textsuperscript{182} Instead of adjudicating the claim as directed by the court, however, the Board appealed the reversal of its decision to the Court of Appeals.

The Board’s action was roughly equivalent to a trial judge deciding a case in favor of one of the parties, and upon being reversed by an appellate court, appealing on behalf of that party to the Court of Appeals. It is difficult to imagine a more egregious example of an adjudicator more thoroughly biased in favor of one side. In this case, as in the case of its various Subject Numbers, the Board chose to support the position of the employer and insurance carrier against the injured worker.

The basic issue in the case was whether a worker who can no longer perform his or her job due to a work-related injury must prove entitlement to benefits not only through medical evidence of disability, but also by conducting a work search. This principle – itself created by the Board - is known as “voluntary withdrawal from the labor market.” The defense does not exist in the statute, which simply provides that “the compensation shall be sixty-six and two-thirds per centum of the difference between his average weekly wages and his wage earning capacity thereafter in the same employment or otherwise, payable during the continuance of such partial disability.”\textsuperscript{183}

The history of “voluntary withdrawal” correlates directly with the Board’s increasing shift away from protecting New York State’s injured workers. In a period of

\textsuperscript{183} Workers’ Compensation Law § 15(3)(w).
thirty years from 1970 through 1999 the Appellate Division issued a total of forty decisions on the issue, slightly more than one per year. In the past decade, it has issued 124 decisions – slightly more than one per month. The dramatic rise in the frequency of this issue is a direct result of the Board’s increasing willingness to tolerate – and ultimately actively support - the insurance industry’s attacks on the statutory wage replacement benefits of injured workers.

The Board’s decision to file an appeal against an injured worker was nearly unprecedented. Since 1922, the Board has participated in 1,251 matters before the Court of Appeals. It was an appellant in only 214 of those matters (about 17%), and in 212 of those 214 cases it argued in support of the claimant. In short, the Board appeared at the Court of Appeals in opposition to an injured worker only twice in 90 years before doing so in 2013.

Nevertheless, the Board opted to pursue an appeal to the Court of Appeals on behalf of the employer and insurer arguing that a permanently partially disabled worker should not be entitled to receive benefits for her loss of wage earning capacity unless she satisfied a set of ambiguous Board-created conditions that do not exist in the law. In a 4-3 decision, a sharply divided Court of Appeals held that the Board could require labor market attachment as a condition for partially disabled workers to receive benefits, regardless of whether their injury was the cause of their loss of earnings and notwithstanding the fact that such workers are not compensated for their remaining ability to work, but only for their loss of earning power.

The decision pursued by the Board perpetuates and expands litigation in the workers’ compensation system, favoring insurers at the expense of injured workers. There is no existing statutory, regulatory, or judicial authority that establishes how long a partially disabled worker must remain attached to the labor market, what constitutes such attachment, the consequences of lack of attachment, the relationship of labor market attachment to the Board’s guidelines for loss of wage earning capacity, whether the failure to find employment entitles the injured worker to total disability benefits, the impact of the time limitation on permanent partial disability benefits in Workers’ Compensation Law Section 15(3)(w), the standard for reopening closed cases, the distinction between cases of permanent and temporary disability, and other issues. In short, the decision permits the Board to arbitrarily deprive permanently disabled workers of benefits for lost wages.

5. **Appeals.**

When an injured worker is successful in obtaining an award of benefits from a WCL Judge, the employer or carrier almost invariably files an appeal. While appeals are signed by commissioners appointed by the Governor, they are almost invariably composed by writers employed in the Board’s Administrative Review Division. In the past decade, the Board has eliminated oral argument on appeals. As a result, the Board’s commissioners decide cases without exposure to the arguments of counsel, appearance at a hearing point, or ever seeing an injured worker. Their perspective is almost entirely shaped by the material given to them by legal writers who are supervised and directed by the Board’s General Counsel.

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187 Four of the current commissioners, including the Board’s vice-chair, were appointed by Governor George Pataki, whose term ended eight years ago in 2006. Two of those commissioners are serving despite their terms having expired. Two more commissioners associated with employer interests were recently appointed by Governor Andrew Cuomo.
If an employer or carrier appeals a WCL Judge’s decision, it is permitted to withhold payment for lost wages and medical treatment while the appeal is pending. If the decision is upheld, then the only additional cost to the carrier is a nominal charge for interest. There is therefore no financial disincentive for an insurer to appeal any decision favorable to an injured worker.

The Board’s Administrative Review Division exemplifies the maxim that “justice delayed is justice denied.” It is commonplace for an injured worker to wait a year or more for the decision on an appeal. In many instances the worker receives little or no benefits for the duration of the appeal. This permits unscrupulous insurers to use the Board’s process as a vehicle to “starve out” the claimant (compelling the worker to return to work before he or she is able, or to settle the case cheaply because of financial distress). It also effectively precludes an injured worker from taking an appeal from an adverse interim decision, because the litigation process takes less time than an appeal.

When decisions are issued, participants have little sense that justice is being done. Many practitioners have observed an extraordinarily high correlation between the members of the panels who decide appeals and whether the outcome is in favor of the employer or the injured worker. The sense that the Board’s adjudicatory process is unfavorable to injured workers is particularly pervasive in its decisions on appeal. The concept that the outcome of a case is based more on the ideological views of the decision maker than on the merits of the case is corrosive to any system of justice.

6. **Centennial Conference.**
The Workers’ Compensation Law recently reached its 100th anniversary, which the Board commemorated by holding a conference in Albany, New York.\textsuperscript{188} The conference attendees were a reflection of the parties who feel engaged and supported by the Board, and those who do not.

The Workers’ Compensation Law was created as a compromise between business and labor, and was intended for the benefit of injured workers.\textsuperscript{189} Indeed, the New York State AFL/CIO and the Business Council of New York State were deeply engaged in the 2007 legislative reforms, and served as members of all of the many Task Forces that were created as result.\textsuperscript{190}

Several hundred participants in the workers’ compensation system attended the Board’s Centennial Conference. Only one attendee was a representative of organized labor, and that individual had been invited to serve as a panelist. The conference was not attended by a single injured worker, although slightly more than a dozen attorneys for injured workers were present. The balance of the attendees – well over 95% of those present - were representatives of employers, insurance carriers, third-party administrators, and defense law firms.

\textsuperscript{188} Subject Number 046-668, available at \url{http://www.wcb.ny.gov/content/main/SubjectNos/sn046_668.jsp}; see also Subject Number 046-707, available at \url{http://www.wcb.ny.gov/content/main/SubjectNos/sn046_707.jsp}


\textsuperscript{190} The various Task Force reports are discussed in Section II.B., \textit{infra}. 
While it is likely that the location and cost of the conference played a role in the lack of attendance by injured workers and labor unions, the role of their perception of the Board’s adjudicative bias should not be underestimated.

7. Conclusion.

The adjudication issues discussed above play a significant role in the experience of injured workers in the system, and in their perception of the Board’s actions. In response to the Board’s BPR survey nearly half of injured workers said that they had not received medical care quickly or easily. Nearly two-thirds reported that they had difficulty accessing benefits for wage loss. About 40% felt that they did not “receive good service from the Workers’ Compensation Board,” and more than half were dissatisfied with how their claim was handled by the system.

We recommend that the Board take concrete, affirmative and visible steps to revise its adjudication of claims. Actions should be taken and decisions rendered with the foremost objective being the protection and compensation of injured workers, instead of protection and cost reduction for employers and carriers. The courts have spoken eloquently about the basic principles of the law on many occasions.

“The Workmen's Compensation Law is a new step in the field of social legislation. We should interpret it in accordance with the spirit which called it into existence. Our reverence for the traditional rules of our common-law system should not lead us to restrict it by subjecting it to the operation of these rules. This court is under no obligation to see to it

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191 Administration of the conference was outsourced to a Florida non-profit organization, which charged participants a $300 fee to attend.
192 http://www.wcb.ny.gov/BPR/InjuredWorkerSurveyResults.pdf
193 Id.
194 Id.
that laws enacted to remedy abuses arising from new industrial and social conditions shall
be made to square with ancient conceptions of the principles of the common law. Indeed, if
the common law had not had woven into it by judicial construction the doctrines of
assumption of risk and fellow-servant, and the doctrine of contributory negligence, it is
doubtful whether the legislation now under consideration would have been rendered
necessary.”

“And certainly it would be a narrow and disappointing view if in judging the
conduct of a workman under the remedial provisions of the Workmen’s Compensation Act
we should hold that the legislature intended to deprive him of the benefits of that act
because in going to the rescue of another workman under such circumstances as arose here
he has stepped somewhat beyond the limits which would fix the scope of his employment
under ordinary circumstances. That act is framed on broad principles for the protection of
the workman. Relief under it, generally speaking, is not based on the negligence of the
employer or limited to the absence of negligence on the part of the employee. It rests on the
economic and humanitarian principles that compensation should be given at the expense of
the business to the employee or his representatives for earning capacity destroyed by an
accident in the course of or connected with his work, and this not only for his own benefit
but for the benefit of the state which otherwise might be charged with his support. This
purpose ought not to be defeated by placing too narrow a limit upon the nature of the acts
which will be regarded as pertaining to his employment.”

“The compensation law from the beginning has received, and quite properly so, a
liberal interpretation in accordance with its remedial character as a broad social enactment.

The presumption in section 21 has been prescribed by our Legislature by reason of the difficulty in establishing the cause of death in cases, among others, where the person injured dies as a result of an unwitnessed occurrence, so that, as a social problem, his dependents may not suffer because there were no witnesses present. Much more so is that the case in workmen's compensation cases since the act was passed as a new step forward in the field of social legislation and originally provided, as it still does (§ 118, formerly § 68), that the board was not to be bound either by common-law or statutory rules of evidence but was to act on the hearing in such manner as to ascertain the substantial rights of the parties.”\textsuperscript{197}

“Contrary to the carrier’s argument as to where its greater duty lay, the fundamental principle of the compensation law is to protect the worker, not the employer, ... and the law should be construed liberally in favor of the employee.”\textsuperscript{198}

“The broad scheme of compensation for work-related injuries or death contained in the Workers’ Compensation Law has as its purpose the provision of a swift and sure source of benefits to injured employees or the dependents of deceased employees. The compensation law was intended to obviate, among other things, the delay and expense to the claimant caused by the protracted litigation involved in pursuing a negligence claim. That such relief is a legitimate legislative objective hardly need be stated. ... [T]he statute clearly promotes the over-all objective of ensuring adequate economic relief to the employee or his family.”\textsuperscript{199}

“We have previously emphasized that the Workers' Compensation Law is remedial in nature and must be ‘construed liberally to accomplish the economic and humanitarian

\textsuperscript{197} McCormack v. National City Bank, 303 N.Y. 5, 14, 16-17; 99 N.E.2d 887, 891, 893 (1951)
objects of the act.’ It is significant that although we have consistently interpreted the statute in this way, and the Legislature has amended and revised it repeatedly, the list of activities which will disqualify an employee from compensation for work-related injuries has remained unchanged for over 70 years.”

“Given the remedial nature of the Workers' Compensation Law, the courts have historically construed this requirement liberally to effectuate the statute's economic and humanitarian purposes.”

“The Workers' Compensation Law … is the State's most general and comprehensive social program, enacted to provide all injured employees with some scheduled compensation and medical expenses, regardless of fault for ordinary and unqualified employment duties. … [W]hen the Legislature wishes to create presumptions in the social legislation field, it does so unmistakably. There are precise "presumptions" set forth in the Workers' Compensation Law, which favor employees by granting easy initial access to benefits.”

“It is a ‘fundamental principle’ that the Workers' Compensation Law should be construed liberally ‘to accomplish … [its] economic and humanitarian object[ives],’ and there exists a litany of judicial determinations exemplifying both the broad and liberal interpretation of these salubrious objectives.”

“As we stated in Matter of Smith v. Tompkins County Courthouse, it is a ‘fundamental principle that the Workers' Compensation Law is to be liberally construed to accomplish the economic and humanitarian objects of the act.’”

200 Richardson v. Fiedler Roofing, 67 N.Y.2d 246, 252; 493 N.E.2d 228, 231; 502 N.Y.S.2d 125, 128 (1986)
“It is a ‘fundamental principle that the Workers' Compensation Law is to be liberally construed to accomplish the economic and humanitarian objects of the act.’ Consistent with this liberal construction, procedural technicalities are generally relaxed for claimants. ‘The underlying reasons supporting the relaxation of strict and technical procedural requirements apply with equal force to appeals at the administrative levels.’”

There are many steps that the Board can take to reaffirm its commitment to these basic principles. Instruction about the history and purpose of the law can and should be distributed to the Board’s employees, including examiners, customer service personnel, WCL Judges, appeal writers, and commissioners. Board employees should be encouraged to interact with injured workers and to render decisions with these principles foremost in their minds.

The Board should avoid “legislation by subject number,” and permit its WCL Judges to decide cases on their merits and on the WCL Judge’s reasoned interpretation of the law. The Board’s appellate process should be sufficient to correct any errors of fact or law. This is the purpose of a meaningful appeals process, which does not need to be supplemented by “guidance” which results in the prejudgment of claims.

The Board’s appeals process must be reformed. The Board’s commissioners must become more active in the decision of cases, and their perspective must be informed by participating in oral argument at the Board’s hearing locations, where they can interact in person with injured workers. Decisions must be issued far more expeditiously, and the outcome of cases must be based consistently on the principles of the law, and not the perspective of the individual commissioners. Disincentives should be utilized to discourage

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appeals that are filed simply because there is “nothing to lose,” to delay the case, or on the theory that an employer-friendly Board Panel may result in a windfall victory to the carrier.

These steps and others can have a significant impact on the Board’s adjudication of claims, and help restore the system’s ability to uphold the fundamental values for which it was created.

VI. Recommendations

We make the following recommendations in each area considered by this paper:

A. Benefits.

1. **Maintain or further increase the maximum weekly benefit rate.** The current maximum weekly benefit rate is below the national and regional averages.

2. **Index the minimum weekly rate to the maximum weekly benefit rate.** The failure to index the minimum benefit rate ensures that it will become inadequate in the intermediate or long term absent continued legislative oversight and statutory correction. This can be obviated by fixing the minimum rate at 25% of the maximum rate.

3. **Adopt a uniform system to determine loss of wage earning capacity in connection with the PPD caps.** We oppose the PPD caps as an unjust and artificial limitation on compensation for the lost wage earning capacity of permanently disabled workers. However, assuming that the caps will not be rescinded, we recommend the adoption of a uniform approach to the determination of loss of wage earning capacity. Such an approach would assign a standard weight or range of weights to various factors, providing more specific guidance about the impact of functional and vocational losses on wage earning capacity, improving clarity and predictability within the system, and reducing litigation.  

4. **Reduce the threshold for safety net eligibility.** The threshold for safety net consideration should be reduced from loss of wage earning

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capacity in excess of eighty percent to loss of wage earning capacity in excess of fifty percent. Workers who have been determined to lose more than half of their pre-accident wage earning capacity and have been unable to return to work should be eligible for safety net evaluation.

5. **Define “extreme hardship.”** “Extreme hardship” should be defined by reference to the injured worker’s financial circumstances or the totality of the circumstances that may render him or her unemployable.

6. **Schedule loss awards should be in addition to awards for temporary disability.** The current schedule loss evaluation system should be preserved, but schedule loss awards should be paid in addition to compensation for temporary disability (as under the Longshore & Harbor Workers’ Compensation Act), rather than having such compensation deducted from the schedule loss award.

7. **The Medical Treatment Guidelines should be eliminated.** The existing statutory procedure makes more treatment available to injured workers with less administrative process and at a lower expense than that directed by the Medical Treatment Guidelines.

8. **The medical fee schedule should be improved, and the bureaucratic burden on health care providers must be reduced.** The medical fee schedule and the Board’s administrative procedures create a set of disincentives for specialists and high-quality physicians to participate in the system. Reimbursement rates for specialists should be increased and the bureaucratic burden reduced.

9. **The recommendations of the Return to Work Task Force should be implemented.** In 2008, the Commissioner of Labor issued a report with recommendations on Improving the rate of return to work among injured workers. These recommendations should be implemented.

10. **“Voluntary withdrawal from the labor market” should be defined.** The statute should be amended to define the circumstances in which an injured worker must demonstrate that he or she is “attached to the labor market” as a condition of receiving benefits.

**B. Costs.**

1. **CIRB’s authorization to function as the statutory rate service organization should be permitted to sunset.** The use of CIRB as a
rate service organization impedes the collection of credible data and precludes transparency regarding insurer income, expenses, claim costs and profit.

C. Administration.

1. **The Board should simplify its forms for use by injured workers.**
   This would improve access to benefits and return the system to its mission of delivering substantial justice with a minimum of technicality.

2. **The Board should index all claims upon receipt of information indicating a work-related injury.**
   This approach will improve clarity and transparency in the system and expedite the delivery of benefits to injured workers.

3. **The Board should hold an initial hearing in every case.**
   Participants in the system are in substantial agreement that holding an initial hearing is more efficient than the use of non-hearing determinations. More importantly, an initial hearing ensures that unrepresented workers are given adequate information about their claim, their rights, and system benefits, and that they have a meaningful opportunity to be heard by the Board.

4. **The Board should hold hearings upon the request of a party as required by law.**
   The Board should discontinue the host of bureaucratic initiatives that operate to deny injured workers a hearing before a WCL Judge upon request.

5. **Instruction about the history and purpose of the law should be distributed to the Board’s employees, including examiners, customer service personnel, WCL Judges, appeal writers, and commissioners.**
   Board employees should be encouraged to interact with injured workers and to render decisions with these principles foremost in their minds.

6. **The Board should avoid “legislation by subject number,” and permit its WCL Judges to decide cases on their merits and on the WCL Judge’s reasoned interpretation of the law.**
   The Board’s appellate process should be sufficient to correct any errors of fact or law. This is the purpose of a meaningful appeals process, which does not need to be supplemented by “guidance” that results in the prejudgment of claims.

7. **The Board’s appeals process must be reformed.**
   The Board’s commissioners must become more active in the decision of cases, and their perspective must be informed by participating in oral argument
at the Board’s hearing locations, where they can interact in person with injured workers. Decisions must be issued far more expeditiously, and the outcome of cases must be based consistently on the principles of the law, and not the perspective of the individual commissioners. Disincentives should be utilized to discourage appeals that are filed simply because there is “nothing to lose,” to delay the case, or on the theory that an employer-friendly Board Panel may result in a windfall victory to the carrier.
VII. CONCLUSION.

We hope that the facts, data and opinions outlined in this White Paper are helpful in offering context for the current state of the workers’ compensation system, and that they provide a basis for the development of some of the significant improvements that are needed.

Dated: October 7, 2014
Farmingdale, New York

By: _________________________
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