Report to the Governor

From the Superintendent of Insurance Summarizing Workers' Compensation Data and Recommending Improvements in Data Collection and Development of a Research Structure for Public Policy

March 2008

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Executive Summary

On March 13, 2007, Governor Spitzer signed the Workers' Compensation Reform Act ("Reform Act") into law. Highlights of the new law include raising the maximum benefits payable to injured workers; initiation of return to work programs to help workers return to gainful employment; strengthening penalties for fraud and abuse; and providing a maximum number of years that a permanently partially disabled, non-scheduled[1] ("PPD NSL") claimant can collect workers' compensation indemnity benefits.

Pursuant to the Reform Act, the Governor directed the Superintendent of Insurance ("Superintendent") to issue a Report by March 1, 2008, and annually thereafter, summarizing the available data and making recommendations to improve and refine the data collection systems going forward. In a March 13, 2007 letter the Governor stated that "[t]here cannot be accountability without data" and "[t]he State cannot make policy determinations if it lacks basic information." Further:

> The Superintendent of Insurance is directed to take the steps necessary to gather all data on a regular and ongoing basis necessary to make appropriate policy judgments and determine whether to approve rates. This effort must include data regarding: wage loss, the type of injury, and age of beneficiaries; medical costs, including testing and imaging fees; frictional costs (including costs of lawyers, IMEs[2] and law judges); indemnity benefits paid and medical care provided; the time for adjudication of claims, including the time from filing to classification as permanently partially disabled; the time for payment of claims and the provision of care; information necessary for the Superintendent to make evaluations regarding premium amounts; flags that can serve as fraud indicators; the size of the workers' compensation market; and any other data deemed by the Superintendent – in consultation with interested parties – necessary or advisable.

In accordance with the Governor's March 13th letter, this Report provides a detailed data description of the current workers' compensation system, sets out a framework for benchmarking the system, identifies major data limitations and the currently available data for the benchmarks and recommends a structure for improved and integrated data collection and for policy research using such data.

[1] Permanent Partial Disability Non-Scheduled claims involve a permanent partial injury that is not covered by the statutorily scheduled body part losses.

[2] Providers who meet eligibility requirements to conduct independent medical examinations of persons suffering injuries or illnesses which are the subject of claims under the Workers' Compensation Law.

In preparing this Report, the New York State Insurance Department ("NYSID") consulted with numerous parties involved in the workers' compensation system, including representatives from organized labor, private insurance carriers, the State Insurance Fund ("SIF")[3], the Workers' Compensation Board ("WCB") and representatives of other state's workers' compensation systems. The data, on which the conclusions below are based, predate the Reform Act, and do not reflect any changes that may have been brought about by the Reform Act. [4]

Key findings in this Report include the following:

Overall

- New York State has a competitive market for workers' compensation coverage;
- Overall claims are decreasing;
- The combination of decreasing numbers of claims and slightly increasing total cost trends result in costs per claim growing significantly.
- Indemnity and medical costs per claim --- the two components of claim cost-- are both rising.
- The combination of decreasing numbers of claims and slightly increasing total cost trends result in rising average per claim costs for both indemnity and medical costs.

Indemnity, Medical and Frictional Costs

- In most other states, medical costs are a higher percentage of total costs than indemnity costs. According to National Council on Compensation Insurance[5] ("NCCI"), in 2003 medical payments made up 55% of total benefit costs nationally and indemnity payments represented 45% of total benefit costs. In contrast, in New York State indemnity costs are higher at 62% and medical costs are lower at 38%.
- New York State's average medical cost per indemnity claim is growing moderately faster than indemnity. From 1997 to 2003, medical costs per indemnity claim increased by 58% compared to a 52% growth in indemnity cost per claim.
- The driving forces behind rising costs are PPD NSL claims. Based on 2003 policy year data projected by CIRB to 5.5 years, PPD NSL claims are estimated to represent 83 % of PPD costs and 74 % of total indemnity costs. [6]
- Back and neck injuries represent almost 40% of total medical payments.

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[3] SIF is a New York State agency whose activities include a) providing workers' compensation insurance coverage to private and public employers; b) providing disability benefits and employer liability insurance coverage; and c) acting as the third party administrator for New York State government employees. SIF must offer workers' compensation insurance to any employer requesting it, making the SIF an "insurer of last resort" for employers otherwise unable to obtain coverage

[4] The terms used in this summary are defined in Appendix B

[5] The National Council on Compensation Insurance is an association of workers' compensation insurers which serves as the workers' compensation rating organization in about two-thirds of the states. The group establishes standards for use in rate making, develops policy forms, collects statistics, and provides statistical support and services.

[6] CIRB refers to the Compensation Rating Board that is a private unincorporated association of insurance carriers responsible for collection of workers' compensation data and development of workers' compensation rates and rules regarding the proper application of these rates to workers' compensation policies. CIRB also administers various individual risk rating plans such as the Experience Rating Plan and the Retrospective Rating Plan.

- One indicator of high frictional costs in New York State is the relatively high percentage of claims using independent medical examinations ("IME"). In New York State, for 2004 claims with three years of development, 37% of claims used an IME. For 13 other states studied by WCRI, only 17 % used IMEs. Since 2004 the percentage in New York has declined to 32%.

Section 32 settlements

- Workers who enter into a Section 32 settlement, demonstrate as poor results as PPD NSL claimants for return to work and remaining at work. In the first quarter after their injury, 52 % of these workers have returned to the workforce. This percentage continues to decline to 24% remaining in the workforce by 8 quarters after injury.
- Workers who agree to a Section 32 settlement have significantly lower pre-injury wages ($19,627) than the pre-injury wages of all workers compensation claimants ($34,344).
- Section 32 claimants use a higher percentage of their benefits to pay legal fees (12%) than any other category of claim.

Claims Administration

- The average length of time from injury to first indemnity payment is significantly longer than in many other states. In New York State, a first indemnity payment has been made within 21 days on 29% of claims. In 14 other states studied by the Workers Compensation Research Institute ("WCRI"),[7] the median percentage of claims where a first indemnity payment is issued within 21 days is 41%.
- The percentage of claims that are controverted has grown modestly over the 6 years preceding 2006, from 15% in 2000 to 17% in 2005. The timeframe to resolve these claims has been declining, 348 days in 2000 to 240 days in 2004 but it is still long. The proposed improvements in processing controverted claims were designed to reduce these timeframes significantly to an average of 90 days for claims covered by the Streamlined Docket. .
- The number of appeals resolved in four months or less has risen from 37% in 2000 to 54% in 2007. However, the average time to resolve an appeal in 2007 was 5.6 months.

Return to Work

- The percentage of PPD NSL claimants that return to work and remain at work is low. While, 68% of these injured workers have returned to work by the first quarter after the injury, this percentage drops steadily until the 13th quarter after the injury, where it levels off at approximately 20%.

Data Limitations

- The two primary data sources for claims adjudication (WCB) and claims cost (CIRB) can not be cross-walked. As a result, the costs of PPD NSL can not be easily tracked and they are the driving factor behind medical and indemnity claim costs. Therefore, these costs have to be estimated in part.
- Although medical costs are projected to be the faster growing portion of the workers' compensation system, New York State does not collect the detailed medical information on cost or utilization of procedures, diagnosis, types of health care

[7] The Workers Compensation Research Institute is an not-for-profit research organization providing information about public policy issues involving workers' compensation systems

providers and other information essential to understanding the factors behind growth. This data is also essential for the evaluation of quality of medical care.

- Basic financial information at the claims level is not collected from the one-third of the workers' compensation system covered by self-insured public and private employers.

A. Overview of Marketplace

Employers in New York State have the benefit of a marketplace that provides three options for workers' compensation insurance: self-insurance, coverage by private carriers or coverage by SIF. In 2005, 35% of the market is self-insured, 43% was covered by private carriers and SIF covered the remaining 22%. The self-insured sector constitutes a significant and growing share of workers' compensation coverage in New York State. Both SIF and the private carriers have lost market share over the past five years. During that time period, the relative share of premium of SIF and the private carriers has varied within a 5% range.

In 2006, the size of the New York State workers' compensation system was approximately $5.5 billion. This estimate is based on the direct written premium of $4.1 billion for SIF and the private carriers in 2006, plus an additional $1.4 billion, representing an additional 33% to estimate the self-insured sector based on available market share information

B. An Analysis of Claims and Benefits Costs to the Workers' Compensation System

1. Medical Costs

In New York State, medical costs are a relatively modest share, constituting 38% of total system costs. Overall, these costs are moderate in comparison to other states. A primary reason for its lower medical costs is the medical fee schedule. In a WCRI study,[8] New York State's fee schedule ranked as the 11th lowest medical fee schedule of all the states. For physical services (therapeutic physical medicine, chiropractic and osteopathic manipulations), New York State ranked as the second lowest of the states.

However, medical costs are the fastest growing component within the New York State system. This Report focuses on the growing costs for PPD NSL injury claims that are ultimately driving the increasing medical costs. However, to understand fully all the drivers within the medical system, as well as to ensure that claimants are receiving quality medical care it is essential to improve the collection of detailed medical information at the claim level and medical service level.

2. Indemnity Costs

New York State ranks third highest in the nation in terms of indemnity cost per case. The average indemnity cost per claim of $32,040 is almost twice the national average of $18,996. A primary cause of these high costs is the lifetime indemnity benefits for PPD NSL claims. The Reform Act capped the duration of PPD NSL benefit payments to eligible injured

[8] "Benchmarks for Designing Workers' Compensation Medical Fee Schedules", Workers Compensation Research Institute, 2006

workers. In 2003, this small group of claimants represented 74 % of total indemnity costs.[9] The duration cap should reduce costs to the system over time. However, current data limitations render it impossible to accurately track the full costs of the workers' compensation system.

C. Slow Claim Resolution

New York State's workers' compensation system is slow to resolve claims. The Governor's March 13, 2007 letter directed the New York State Insurance Department ("NYSID") to examine the resolution of disputed cases at the WCB and to design methods for resolving them within ninety days of a dispute. The Superintendent sent his recommended changes to the process and draft regulations to implement these changes on June 1, 2007. In this Report, these proposed changes will be referred to as the "Streamlined Docket." This Report addresses data limitations and makes recommendations for collecting additional data on the time for processing both controverted and non-controverted claims.

The proposed Streamlined Docket focused on controverted claims.[10] A claim is controverted when the payor challenges one of the following three items:

- Whether the accident was work-related;
- Whether the claimant notified his or her employer within the statutory time limit; and
- Whether there is a causal relationship between the accident and the resulting injury or disability.

During deliberations over the controverted issues, the claimant does not receive any indemnity payments. Delays in indemnity benefits cause economic hardship. The claimant may also have trouble receiving appropriate medical care. In order to receive medical treatment, the doctor may require the claimant to sign a release stating if the treatment is not covered by workers' compensation, the worker will pay for the treatment. Many claimants are not willing to risk being held liable for the cost of treatment so treatments are delayed. Delays in medical benefits can affect the worker's long term medical prognosis and the ability to return to work.

According to available data, the average number of days necessary to determine the liability for a controverted claim in 2005 was 240 days. The goal of the proposed Streamlined Docket is to reduce this time to 90 days to cases covered by the Streamlined Docket. The average number of hearings on claims that require at least one hearing is 5.6 hearings. The average time to classify a PPD NSL is 4.5 years.

Due to data limitations, it is difficult to fully evaluate the different factors that contribute to these delays. This Report shows there are equally significant delays in providing timely benefits to claimants with non-controverted claims. Non-controverted claims often require at least one hearing to resolve disputes over medical care or average weekly wage, and have an average of 3.6 hearings.

[9] Based on CIRB data for 2003 projected for 5.5 years development.
[10] Unrepresented claimants and complex claims including many occupational disease claims are excluded from certain requirements of the Streamlined Docket.

D. Evaluating and Establishing Benchmarks for the Workers' Compensation System

This Report outlines a recommended framework for evaluating New York State's workers' compensation system. To monitor the quality of New York State's worker's compensation system, it is important to benchmark at least the following nine areas:

A. Workers' Compensation Insurance coverage rates
B. Timeframes for delivery of indemnity benefits to injured workers
C. Timely access to quality medical care for injured workers
D. Adequacy of benefits
E. Workplace safety
F. Return to Work
G. System costs
H. Timely and equitable claim resolution
I. Performance of major players in the system

For some benchmark areas, such as controlling system costs, it is relatively easy to choose a number of measurements that can be used to track system performance. On the other hand, it is much more difficult to develop quantitative measurements that accurately measure other benchmark areas such as "access to quality health care." In these cases, qualitative measures are proposed.

E. Recommendations for Industry Wide Data Collection

This Report addresses the following two questions. First, how can New York State improve the scope and quality of data on the workers' compensation system? Second, how can New York State ensure that that the enhanced data is used to effectively monitor and improve the workers' compensation system? In response, this Report delineates short and long-term recommendations to address the significant data limitations identified throughout the Report and to create a central data collection warehouse. The data warehouse can then serve as the foundation for research necessary to address public policy issues.

1. Short-Term Recommendations

These recommendations can be implemented in tandem with the long-term data improvement project. Short-term recommendations include adding new fields to existing data collections, linking existing data sources, and implementing new procedures to ensure consistent use of data fields across the WCB claims system.

2. Long-Term Recommendations:

To address the significant gaps in data, it is recommended that the following major areas of data be collected and retained to support system monitoring and research regarding the workers' compensation system:

- Detailed medical payment data;

- Detailed medical billing data; and
- Financial claim level data from the private and public self-insured employers

Another long term recommendation is that both the private and public self-insured entities be required to submit detailed claim data on a regular basis to the WCB.

3. Ongoing Research

To ensure the success of the reforms, this Report recommends that there be a centralized data collection organization that would provide the foundation for an on-going research function about the workers' compensation system. It is recommended that the organization would take the form of an independent data warehouse and research division at WCB that reports directly to the WCB Chair. This structure is designed to encourage the division's independence and enhance its authority.

WCB and NYSID have limited authority to obtain data from two major segments of the market: (a) self-insureds and self-insured trusts; and (b) SIF. WCB oversees self-insureds and self-insured trusts in certain respects beyond claims administration. However, its authority to make data calls on those entities is limited. To support effective benchmarking and other system and public policy research projects, the WCB should be granted new statutory authority to collect from self-insureds and self-insured trusts, including their members, workers' compensation data. WCB and NYSID, the agency that generally regulates insurance carriers, should each have new statutory authority to collect from SIF workers' compensation data. In addition, new legislation should give WCB, through its research division, the authority to request from other state agencies data relevant to workers compensation.

To assist the data warehouse and research division, it is further recommended that a research advisory committee be established with representatives from the Legislature, WCB, Department of Labor ("DOL"), NYSID, labor, business, academia, and the insurance industry. The chairperson of the committee would be designated by the Governor. The committee would advise the research division on areas where further research is needed. Together, the research division and the advisory committee would explore the potential of building a partnership with a university in New York State, preferably a public one, to undertake specific research projects on workers' compensation.

I. Introduction

This Report is organized as follows: Section II provides an overview of the current status of the workers' compensation system based on data that is currently available. It also points out some of the major limitations in the available data. Section III establishes a framework for monitoring the performance of the workers' compensation system. For some measures the data is currently available. For others, new or modified systems need to be developed to collect the missing data. The next two sections provide recommendations regarding how the missing data can be collected and analyzed. The final section provides a plan to ensure that enhanced data collection is used to further policy research to improve the workers' compensation system.

The framework and measures in this Report are based on reviews of the methods used by national organizations and other states to evaluate the workers' compensation systems as well as discussions with major stakeholders in the system. This Report provides a starting point for New York State to evaluate the system. These framework and measures will continue to evolve over time as more information is available and different policy issues arise.

II. The New York State Workers' Compensation System: An Overview

This section of the Report provides an overview of the New York State workers' compensation system. It reviews the three segments of the workers' compensation insurance marketplace: private carriers, the State Insurance Fund ("SIF") and the self-insured employers. Next, it provides an overview of the claim and benefit costs. It then looks at the age of claimants, claims by industry, and occupational disease claims. Throughout this section, major limitations in existing data are identified and discussed.

A. *Market place*

This segment answers the following questions. What does the workers' compensation marketplace look like? Is it competitive? How does it compare with other states markets? These questions are critical to set a baseline for characterizing the marketplace before the Workers' Compensation Reform Act ("Reform Act") and to determine what types of data are needed to fully evaluate the workers' compensation system.

Employers in New York State have the benefit of a marketplace that provides three options for workers' compensation insurance. Employers can purchase insurance from either private insurance carriers or SIF, or become authorized by the Workers' Compensation Board ("WCB") to self-insure either individually or through a group trust.[11] Many states offer only one or two of these options. Some states do not have a state fund, while others

[11] A group of employers may assume the liability for the payment of workers' compensation benefits through a trust administered by a group administer.

only have a state fund and self-insurance. Many states do not have a competitive state fund, but rather limit the state's involvement to providing a residual market[12] for employers. In contrast, New York State has a marketplace that has three competitive sectors.

In addition, the changes in rate setting were recently signed into law, and should enhance the level of price competition among private carriers by providing more flexibility in rate setting.[13]

A.1. *Market shares*

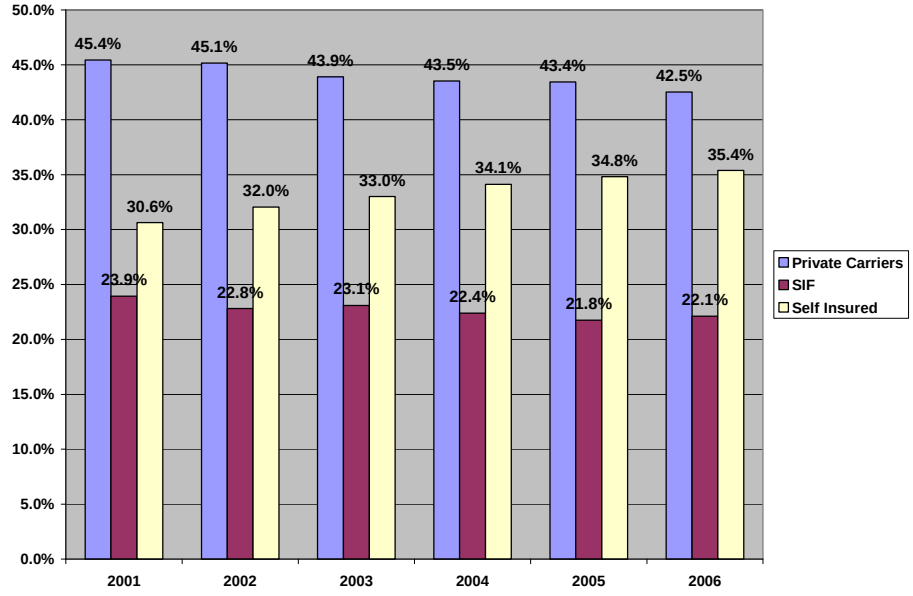
In 2006, 35% of the market was self-insured, 43% was covered by private carriers and SIF covered the remaining 22%.[14] These market shares were calculated using data on indemnity costs provided to the WCB for use in the calculation of industry assessments. Several other states have also used this approach in estimating market shares. The assessment data is the one source that has consistent information across all three market sectors. To ensure the reasonableness of this method, market shares in terms of the percent of claims generated by each sector were also examined. The claims percentages are comparable to the indemnity shares calculated by the WCB. For example, for 2006 the indemnity share shows that 43% of the market was covered by private carriers, while the percent of claims for private carriers was 40%. Figure 1 below, based on the indemnity data shows a modest growth from 2001 to 2006 in market share of the self-insured. This is offset by modest declines in the market shares of SIF and the private carriers. According to the National Council on Compensation Insurance ("NCCI"), self-insurance is a cyclical business. When the insurance market is tight and private carriers are not offering significant discounts employers become more interested in self-insurance. The last few years have been characterized by a tightening market. According to NCCI, the market showed signs of softening in late 2007, so there could be a reduction in the market share of self-insurance over the next few years.

[12] The residual market is comprised of higher risk employers that cannot obtain coverage in the voluntary market.

[13] See Chapter 11 of the Laws of 2008, NYSID's report to the Governor issued in September 2007 provides the recommendations upon which the legislation was based.

[14] In addition to providing insurance, the SIF also acts as a third party administrator for the State of New York, which changed from privately insured to self-insured in 1981. Thus, New York State is included in the market share for the self-insureds but is excluded from the SIF market share. New York State represents 5 % of total market share.

Figure 1: Payors' Indemnity Market Share



Source: New York Workers' Compensation Board claim data

A.2. *Size of the Workers' Compensation System*

In 2006, the size of the New York State workers' compensation system was approximately $5.5 billion. This estimate is based on the direct written premium of $4.1 billion for SIF and the private carriers in 2006, plus an additional $1.4 billion (or 33%) to estimate the self-insured sector based on the available market share information.[15]

In 2006, the $4.1 billion in workers' compensation direct written premium represented 12.3% of total property/casualty insurance premium in New York State. Workers' Compensation premium is comparable in size to homeowners insurance ($3.6 billion and 10.7%).[16]

According to the National Academy of Social Insurance, ("NASI")[17] in 2004,, approximately 8.1 million workers and $405.9 billion in wages were covered by the system. New York State's benefits represented 5.8% of total workers' compensation benefits paid nationally.

A.3. *Self-Insured*

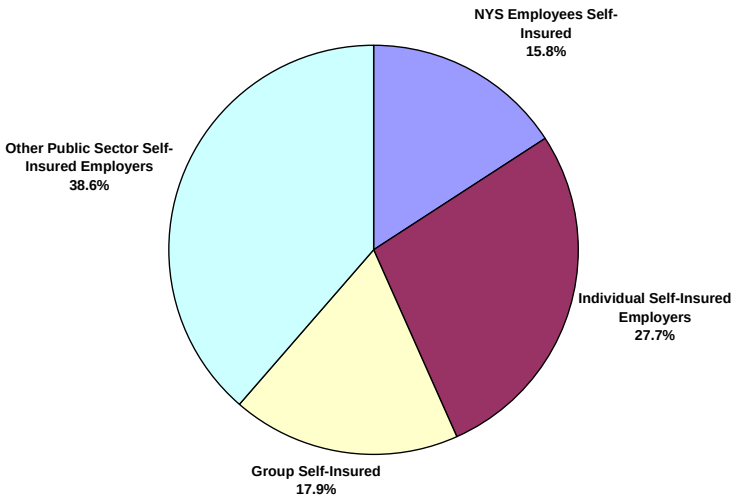
The data above illustrates that the self-insured sector has a growing share of workers' compensation coverage in New York State. Its market share in New York State is larger than in many other states. Given its growing prominence, it is essential that the workers' compensation data system include comprehensive data on this market sector. One of the

[15] Data provided by NYSID based on annual statements of carriers.
[16] *Id.*
[17] NASI is a non-profit organization comprised of experts on social insurance. Its mission is to promote understanding and informed policymaking on social insurance and related programs through research, public education and training.

major weaknesses in the current data collection is the lack of a central repository of claim level financial detail or medical detail from the self-insurance sector. Both SIF and private carriers provide detailed claim level financial information to Compensation Insurance Rating Board ("CIRB"). Self-insureds do not provide data to CIRB. As a result, the analysis of trends in benefit costs and claims in subsequent sections of this Report only include limited information available from the WCB on the self-insured sector. Proposals to address this deficit are delineated in the recommendations section of this Report. It should be noted that New York State is not alone in its lack of self-insurance data as many other states also do not have full data on self-insurance.

The self-insured sector is made up of a diverse spectrum of employers, small and large, public and private. Within the self-insured sector there are several types of insurance coverage. For the private sector, the employers are either an individual company with full responsibility for the risk, or part of a group trust that shares the risk with other similar employers. Only very large private employers can meet the requirement to self-insure as an individual company. Currently, 150 larger employers actively self-insure.[18] Self-insurance by individual companies made up 27.7% of the self-insured market sector.

Figure 2: The 2005 New York State Self-Insured Market



Source: New York Workers' Compensation Board data

Group trusts constituted 17.9% of the self-insured market sector in 2005. Currently there are 75 groups serving 20,942 active employers.[19] The WCB report on the individual self-insured market, released in December 2007, contained an appendix dealing with the growing cost of

[18] The 150 active companies contain 285 subsidiary companies. An active company is one that is covering is workers' compensation risk as a self-insured entity.
[19] There are another 15,553 inactive employers who no longer insure through the group but have claims from prior years that are still being handled by the group.

defaults in the group trusts.[20] It is estimated that there would be "tens of millions" of dollars in additional costs beginning in 2008 due to defaults in the group trusts. Any changes in the market to address these growing defaults will have an impact on the size of the self-insured market.

In 2005, the remaining 54.4 % of the self-insured sector was made up of the public sector including New York State, New York City and many other local municipalities, school districts and other local government entities. Unlike individual and group trusts, public entities do not have to be authorized to self-insure. For public entities, the option to self-insure is a right not a privilege. Public entities do not have to maintain security deposits with the WCB. Thus, there is even less information available on these entities than private sector self-insureds. Public sector entities (excluding New York State government) represent 38.6% of the self-insured sector. These entities include 722 individual public sector entities and 1,949 public employers in county plans.[21] New York State government constitutes the remaining 15.8 % of the self-insured market sector. The one exception to the lack of data for the public sector self-insureds is New York State government which can provide full data on its claims.

A.4. *Private Carriers and SIF*

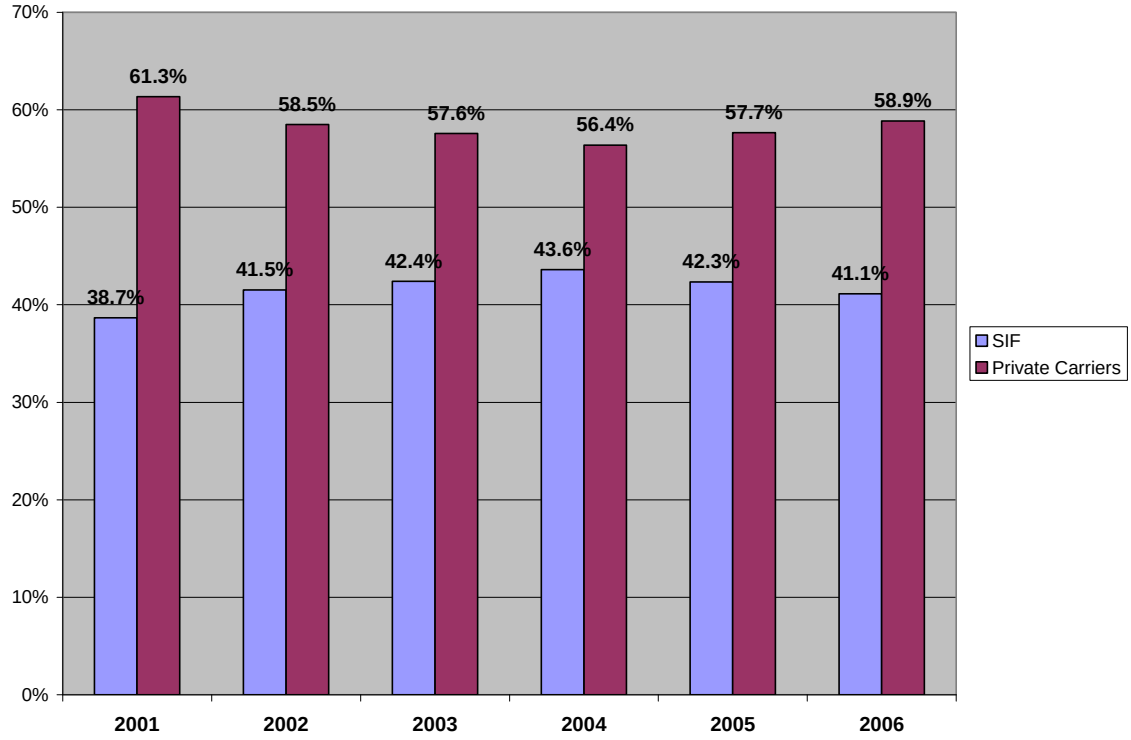
The remaining two-thirds of the New York State workers' compensation marketplace are covered by SIF and private carriers. Their market share has been declining slightly in contrast to the growth in self-insurance.

SIF and the private carriers provide a major portion of the overall workers' compensation coverage, 57.5% in 2006. Over the past five years, the relative share of premium of SIF and the private carriers has varied within a 5% range. In that time, SIF's premium share ranged from a low of 38.7% to a high of 43.6 %. In the last two years, SIF's share of the insured market dropped by 2.5%. The changes within a 5% range indicate that there is no trend toward either private carriers or SIF.

[20] WCB report "Individual Self-Insurance Alternative Funding Models," December 2007

[21] Pursuant to Workers' Compensation Law, article 5 (§60 et seq.), a county may, by local law, establish a plan of workers' compensation self-insurance. Section 62 of that law provides that each plan shall have at least two municipal corporations as participants. The county shall be one of the participants in a plan.

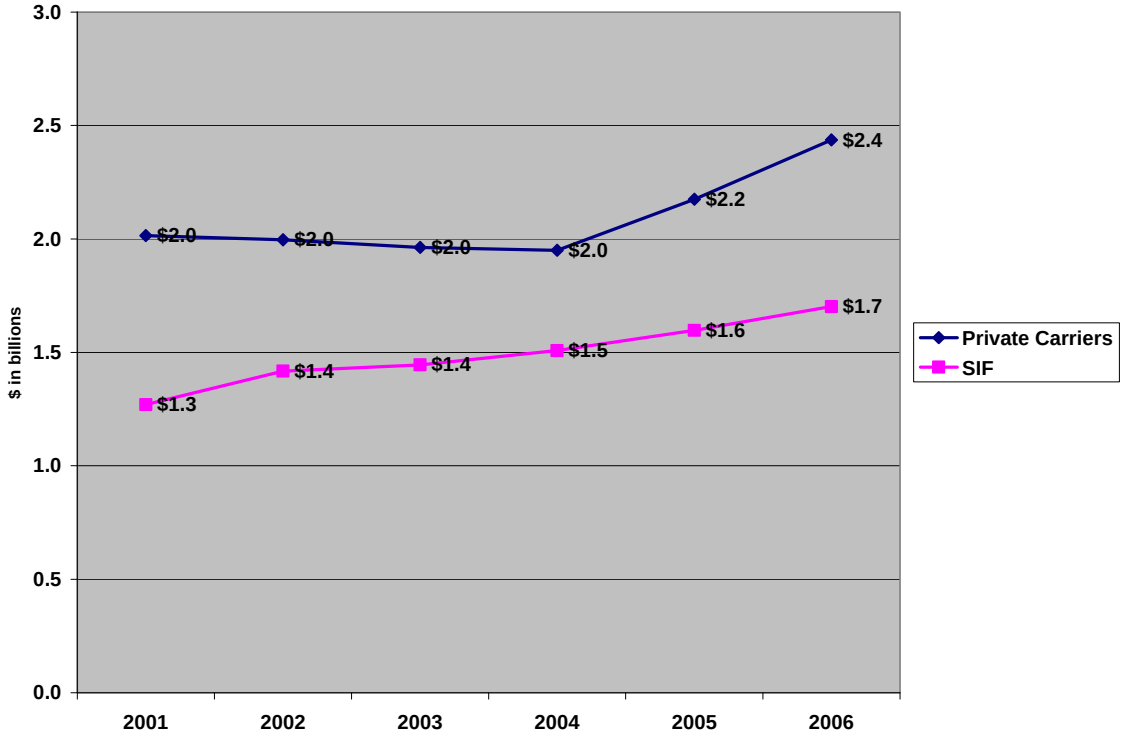
Figure 3: Percent of Total Premium Written By SIF and Private Carriers



Source: NYSID data

In 2006, SIF and the private carriers collected a total of $4.1 billion in direct written premium. As illustrated by Figure 4, premiums were relatively flat from 2001 to 2004. However, premium dollars did rise in 2005 and 2006. Both SIF and the private carriers showed premium growth over the last two years. The growth in the private carriers' premium dollars (20%) was substantially higher than that of SIF (13%). There is no single explanation for the different rates of growth. Workers' compensation, like other lines of insurance, is a cyclical business. In 2005 and 2006, the market was tighter, meaning insurers are less motivated to offer discounts. In addition, there was a 7.2% overall increase in rates.

Figure 4 – Direct Written Premiums: Private Carriers and SIF



Source: NYSID data

In the private sector market, the insurance carriers can be considered either as individual companies or as groups. Groups refer to the parent company which can have many subsidiary companies. Each of these subsidiaries may underwrite different aspects of the marketplace, but they share a single infrastructure for claims processing, administration, and investment. From the perspective of competition and claims processing, this Report focuses on the groups rather than the individual companies. From 2003 to 2006, the number of groups actively selling workers' compensation insurance in New York State remained relatively constant. In 2006, there were 92 private groups that wrote workers' compensation insurance compared to 93 groups in 2003. The 92 groups writing in 2006 included 239 subsidiary companies.

However, there has been a trend toward increased consolidation at the top of the market. The percentage of premium written by the top 10 groups rose from 67% in 2001 to 81% in 2006. Increased consolidation in the top groups is consistent with the trends in other major property lines in New York State, including auto and homeowners.

A.5. *Large Deductible*

Another trend among the private carriers is a shift towards large deductible policies. They are a form of limited self-insurance. Employers with large deductible policies pay directly for all of the smaller claims they incur under the deductible, while their insurer pays for the

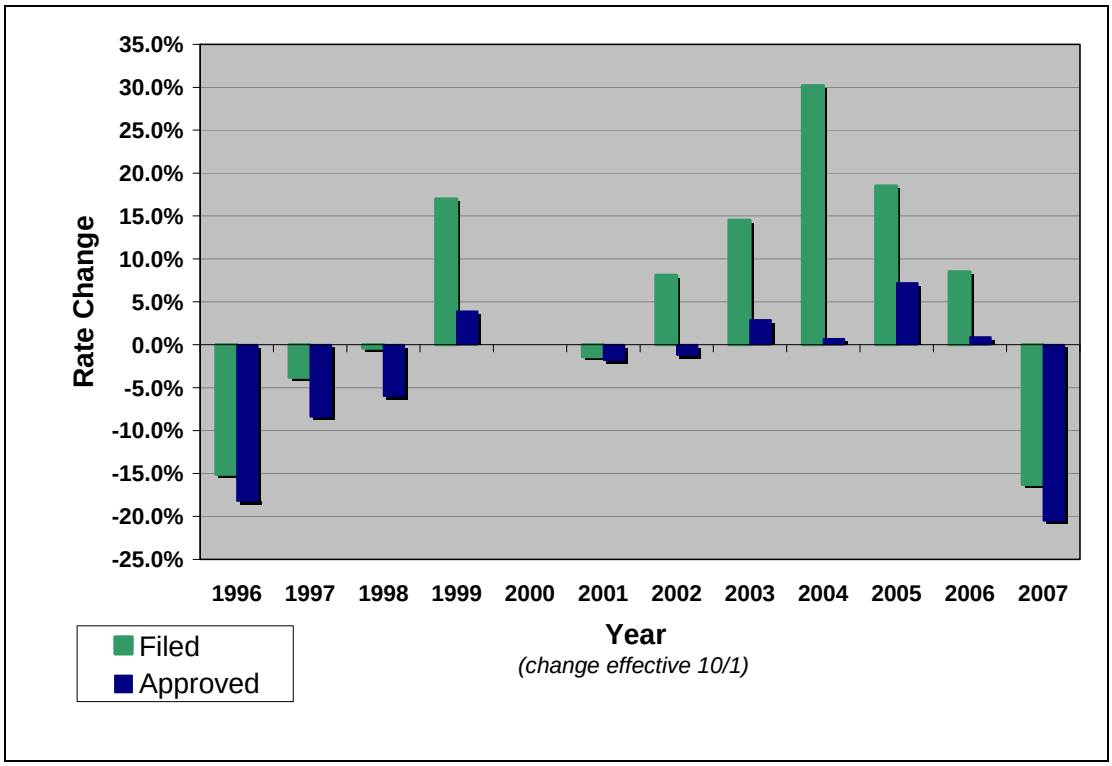
more costly claims. Over the past few years, the percentage of the private insured market choosing large deductible policies has grown from a low of 25% of the market to a high of 39% in 2003. The increase in large deductibles in New York State follows a national trend.[22]

B. *Rates*

Historically, New York State has employed an "administered-pricing" approach to private insurance carrier rate regulation for workers' compensation insurance. Under this approach, CIRB collects a significant amount of data from SIF and private insurance carriers. It then aggregates and actuarially analyzes the data to forecast the overall workers' compensation costs for New York State for the following year. These forecasted costs are comprised of: (1) the expected costs arising from the indemnity and medical benefits to be provided to injured workers; (2) an added industry average expense factor to cover the general costs of doing business; and (3) other factors such as medical and indemnity cost trends. CIRB then files for an overall rate change which must be approved by New York State Insurance Department ("NYSID"). CIRB then calculates the rates that are paid by each of the over 600 employer classifications, based on their risk levels and historical losses. The rates that most employers are charged are based on these "manual rates." The following figure illustrates the filed and approved manual rate history for the last eleven years.

[22] Data provided by NASI.

Figure 5: Filed and Approved Rate History



Source: NYSID data

Based on the recommendations in the 2007 CIRB Report, and the recent legislation, New York State has moved to a loss cost system for workers' compensation rates this year. In a loss cost system, CIRB will continue to collect and aggregate industry data, but rather than file a manual rate with NYSID for approval, it will only submit the loss costs, which is that portion of the rate that does not include general expenses such as overhead, taxes, or profit. Rates, subject to NYSID approval, will then be determined using carrier-specific "Loss Cost Multipliers" that are filed by each carrier and reflect each carrier's individual underwriting skill and expense structure. This lost cost approach is currently used by a majority of states. It is anticipated that this rate-setting process will increase price competition among insurers.

Due to concerns regarding CIRB's responsiveness to policymakers, the CIRB Report proposed a number of changes to CIRB's governance structure. After receiving input from a number of stakeholders, new restrictions were placed on workers' compensation rate service organizations ("RSO") in the recently passed legislation. As a New York State's workers' compensation RSO, CIRB must abide by these changes. The changes include: 1) adding four public members to CIRB's Governing Board and Underwriting Committee, including representatives from the AFL-CIO, the New York Business Council, WCB, and NYSID; 2) ensuring that the private insurance carriers no longer comprised a majority of the Governing Board; and 3) adding a Medical and Claims Committee to study the administration of claims under Workers' Compensation Law. The legislation also mandated

that CIRB retain all data used to calculate rates, classification relativities, and experience modifications, and made explicit NYSID's right to request data from RSOs.

C. *Claims and Benefit Costs*

This section of the Report examines claim and benefit costs and related trend data. The objective is to determine where the overall costs in the system are trending and what is driving those costs. The first step is to analyze the types of claims, their frequency and their severity. What are the different categories of claims in New York State? What are the trends in the categories? This section also details the limitations in the data regarding claims. It then reviews the trends in costs, and the forces driving those trends. An understanding of what the drivers in the system are will show where to focus additional research to improve the overall functioning of the system. Next, this section examines the ages and industries of workers' compensation claimants and how they compare to the wider population.

C.1. *Categories of Benefits*

Insured workers can receive both medical and indemnity benefits. Medical benefits cover medical costs resulting from a workplace injury or disease. A worker is entitled to medical benefits for any injury directly related to his or her employment. Indemnity payments are wage replacement benefits, which are paid in New York State when a worker has lost more than 7 days of work.

There are several categories of benefits in New York State's workers' compensation system. They are:

Medical Only - Claims for injured workers who have no time loss or time loss of less than seven days and who require medical treatment. These claims tend to be for relatively minor injuries.

Indemnity - The following claim categories all involve payment of wage loss benefits.

- **Temporary Total Disability ("TTD")** – Claims for workers who have lost more than seven days due to a work-related injury or illness. Injured workers received TTD benefits during the period in which they are too injured to perform any of their work duties.

- **Temporary Partial Disability ("TPD")** – Claims for workers who can perform some work but still have limitations and are healing. Workers can transition from TTD to TPD benefits; if a worker returns to work with limitations and cannot earn their pre-injury salary, they are entitled to reduced earning benefits. A reduced earning benefit is two-thirds of the difference between a claimant's pre-injury average weekly wage and the lower average weekly wage earned post-injury due to a condition related to a compensable work-connected injury. Alternatively, claimants, who have not returned to work, will have their benefits calculated based on the degree of their physical impairment and lost wage earnings capacity. At the current time, neither the CIRB data nor the WCB data can identify which claimants are receiving reduced earnings-based TPD benefits, and which are receiving

reduced benefits due to a change in the level of impairment , nor can they identify the magnitude of lost earnings capacity. Recommendations to address these limitations will be discussed in the recommendations sections of the Report. For purposes of this Report, all TPD claim data is included as part of TTD.

- **Permanent Partial Disability ("PPD")** – Claim for workers who have reached maximum medical improvement (the healing process is complete) but their injury or illness has caused the permanent loss of use or function of some part of the body which impairs their ability to work. PPD's are split into two categories, Scheduled and Non-Scheduled disabilities:

    - **PPD Scheduled Loss ("PPD SL")** – Claims for workers whose injuries have resulted in the complete or partial loss of use or function of an arm, leg, foot or other extremity of the body, or the loss of visual or hearing ability. These body parts are listed on a statutory schedule with an amount of weeks of benefits assigned to each body part. For example, a worker with total loss of the use of a thumb receives 75 weeks of indemnity benefits, while a worker with loss of use of one arm receives 312 weeks of total disability payment; and

    - **PPD Non-Scheduled Loss ("PPD NSL")** – Claims for workers who have reached MMI and have a permanent bodily impairment that is not amenable to a schedule, such as a lower back injury, he or she will have a PPD NSL claim. Where the injured worker has not returned to work, the amount of the indemnity benefit depends on the degree of their physical impairment and lost wage earning capacity. Prior to the Reform, workers claims classified as PPD NSL were entitled to life-time benefits. For injuries occurring, on or after March 1, 2007, the Reform Act capped these benefits at a specified number of weeks depending on the degree of lost wage earning capacity. The maximum length of benefits is ten years.

- **Permanent Total Disability ("PTD")** – Claims for workers who have reached maximum medical improvement and cannot perform any work. The worker receives lifetime wage replacement benefits.
.
- **Total Industrial Disability ("TID")** – Claims for workers who have reached maximum medical improvement and have a partial disability that limits their ability to work. If the impairment combined with other factors such as limited educational background and work history render the claimant incapable of gainful employment, the worker may be eligible for TTD. TID is a factual issue resolved by the WCB.

- **Death** – Claims for workers who have died and lifetime benefits are paid to surviving spouse and dependents.

Over its lifetime, a claim can move from one category to another. For example, a worker who injures his or her foot may initially be back to work within a few days, resulting initially in a medical-only claim. Over time the injury may not heal and may require further treatment and additional time off, resulting in the claim being reclassified to a TTD. Under another scenario, a worker injures his or her back and has a TTD claim. After treatment, the worker continues to have restrictions on his ability to work and the claim is classified as a PPD NSL. Throughout this Report statistics on WCB claims are based on the claim's category at a given point in time. The status of a claim can change over time. For example, if a data query is done in September, a claim may be in a different category than for a data query in February.

C.2. *Current Limitations on Claim Data*

In New York State, claim level data is collected by two entities, WCB and CIRB, for two very different purposes. Throughout this Report, both sources of data are examined for claims level information for types of claims, cost and frequency, because both sources have their own limitations. CIRB's data collection focuses on information necessary to participate in the rate setting process as the rate service organization and to provide experience rating for each classification[23] and the employers in each classification. On the other hand, WCB data focuses on the information required to process and adjudicate claims. Neither entity has the authority or responsibility for collecting system-wide data for research and policy analysis purposes. While the gaps in current data need to be corrected for the future, there is still a large base of information that can be used from the current systems. A table at the end of this section summarizes the strengths and weakness of both data sources.

CIRB: There are several advantages to using the CIRB data for analysis of claim development. The first advantage is that all data is submitted to CIRB electronically. The second advantage is that CIRB data facilitates trend analysis, because the data is collected at set points in time of the claim's development. Age of claims is a critical issue for workers compensation research because some claims have a long tail, meaning they are paid over a long period of time. PPD, PTD and Death claims can last a very long time, depending on the life of the claimant or his or her survivors, and whether the claim was made prior to the duration caps. In addition, due to the lengthy delays in the New York State system, it takes more time than in other states to obtain a reliable estimate of total claim costs. In this Report, we will often use claims with 30 months development. This is known as the "2nd report" for CIRB. The first report is at 18 months from the end of the policy year and the second report is 12 months later. This choice of using 2003 policy year balances the need for fuller development of the claims with the need for more recent data. By using a set time-point in development, we can compare costs and claim numbers across years without concern that the earlier years have had longer time to develop.

The third advantage of using the CIRB data is that it has both indemnity and medical cost data at the claim level from SIF and private carriers. These entities represented 67 % of the market place in 2003. Finally, CIRB data includes information on all medical-only claims filed with this sector of the market place, whether or not the claim was formally filed with WCB.

[23] Classifications are types of employment such as office employees, sewer construction, law office, and bakery. Workers' Compensation premiums are based on the classification the majority of an employer's workers.

On the downside, CIRB data does not include any information from the self-insured portion of the marketplace, which is the remaining 33% of the market. Another equally important limitation is that CIRB data does not separate out PPD SL and NSL claims. Instead, CIRB splits PPD into major and minor categories.[24] Separating PPD data as scheduled and non-scheduled is critical information for tracking the impact of the Reform Act, as it limited the number of years a claimant can receive non-scheduled PPD benefits. Finally, neither CIRB nor WCB collect detailed medical information in a form it can be easily analyzed.

WCB: WCB data covers all sectors of the system because the private carriers, SIF, and the self-insureds are all required to submit the same forms in connection with claims filed with WCB by injured workers. Most of the forms are submitted to WCB in hard copy and not electronically. They are then scanned and important data fields are keyed into the database. The one major exception to this rule is that the vast majority of proof of coverage information is submitted electronically from all of the payors. A major advantage of WCB data is that it tracks PPD claims by scheduled and non-scheduled, which CIRB does not. The WCB dataset also has a wealth of information on the claims adjudication process. There are, however, some major limitations to this data. Some data fields, such as reduced earnings, are not used consistently across the state, and other fields are not always entered if they are not essential for the processing of a claim. Another limitation is entering data into an electronic database did not start until 2000, following the implementation of the electronic case folder system. There is limited data on claims closed prior to 2000. Claims that had an accident year prior to 2000 but were closed after 2000 may have partial data.

Figure 6: Summary of Strengths and Weaknesses of Major Data Categories

	CIRB		WCB	
	Strength	Weakness	Strength	Weakness
Sectors covered	SIF and Private Carrier data	No Self-insured data	Covers all three sectors, private carrier, self-insured and SIF	
Cost	Cost data for both indemnity and medical		Indemnity cost	No medical costs
PPD Scheduled non-Scheduled mix		Does not split between scheduled and non-scheduled	Does split between scheduled and non-scheduled	
Medical-only cases	All from SIF and private carriers			Only 22 % of cases reported to the board

[24] CIRB's electronic data collection system is a shared system developed jointly with several other States' independent rating organizations. The system does not collect PPD scheduled and non-scheduled because all States have different definitions of scheduled and non-scheduled. In the CIRB data a major PPD claim has benefits costs of $22,000 or more, a minor PPD claim is under $22,000.

	CIRB Strength	Weakness	WCB Strength	Weakness
Electronic Submission	All data		Proof of coverage data electronic	Mostly submitted in hard copy and then scanned with major data points keyed into the system
Detailed medical information		No data		Does not have detailed medical information in a format that allows manipulation or analysis.
Adjudication Information		No data	Has information on adjudication process at claim level	Some data fields are not used consistently in all regions and other are not all filled in.
Timeframe	Has data from 1994			Began collecting data in electronic database in 2000

C.3. *Claim Development in New York State*

As noted in the prior section, much of this Report uses CIRB data from 2003 instead of more recent data, i.e. 2005 and 2006. This choice of using 2003 policy year balances the need for development of the claims with the need for more recent data.

The age of claims is a critical issue for workers' compensation research because some claims have a long tail, meaning benefits can be paid out over many years. PPD, PTD and Death claims are active for a very long time, depending on the life of the claimant or his or her survivors[25] and whether the duration caps apply. According to SIF its oldest active PPD claim has an accident date of November 22, 1937. Due to the lengthy claim development time in the New York State system, it takes more time than in other states to get a reliable estimate of total claim costs. While it is important to consistently use New York State claims with 30 months of development for this analysis, the nature of New York State's system makes it difficult to compare to other states, even when using consistent development times.

[25] *See* supra footnote 23.

According to the Workers' Compensation Research Institute ("WRCI"): "[a]ssessing the performance of the New York State system using less mature data is more likely to produce misleading results than in most other states."[26] Pursuant to its analysis of data from the NCCI, WCRI reported that incurred[27] indemnity costs in New York State at 60 months of development[28] represented only 74% of ultimate indemnity payments[29]. In other words, even 5 years after the accident year, 26% of the ultimate costs of claims have not been reserved for, compared to 7% in other states. The WCRI study included 14 states,[30] and identified a median value for the 14 states.

The slow development of indemnity claims in New York State, caused by the lengthy delays in New York State's system, supports the notion that the most mature data available should be used. There is a difference in the development times used by WCRI and CIRB. WCRI enters its first report at 12 months and every 12 months thereafter. CIRB, on the other hand, enters its first report at 18 months development and every 12 months thereafter. As a result, the fifth report for WCRI is at 60 months and the fifth report for CIRB is at 66 months. If the analysis in this Report were limited to claims with 66 months of development, the most recent CIRB information available would go back to 2000,[31] and all data from 2000 forward would be excluded. Therefore, a focus on claims with 30 months of development was chosen to strike a balance between mature claims and current claims.

C.4. *Volume and trend in claims*

The total number of claims is estimated by taking the CIRB data and increasing it to account for the self-insured sector. As noted above, CIRB data does not include any claims from the self-insured sector. Given the limitations with both CIRB and WCB claims data, it is necessary to estimate the total number of claims in New York State. For 2003, CIRB reported 154,598 claims for SIF and the private carriers.[32] When this is increased by 33% to include self-insured claims, the total increases to 206,079 claims.

Another issue is whether or not these 200,000 plus claims represent a growing or shrinking total. There has been a steady downward trend in the number of workers' compensation claims filed in New York State. New York State's downward trend is consistent with the national patterns of declining claims. The downward trend for New York State is reflected in several different measures. CIRB's data reflects a decline in both indemnity and medical-only claims from 1994 to 2003. Indemnity claims dropped by 38%, while medical-only claims declined 42%. WCB data indicates that the number of cases indexed annually dropped 19% from 2000 to 2006, from 168,557 to 136,736.

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[26] "Baseline for Evaluating the Impact of the 2007 Reforms in New York.," Workers Compensation Research Institute, draft report issued January 14, 2008

[27] "Incurred" refers to the amounts paid plus the amounts reserved for a claim.

[28] "60 months of development" refers to indemnity costs for 5 years after the accident date.

[29] Theses numbers will likely change as a result of the duration caps instituted by the Reform Act.

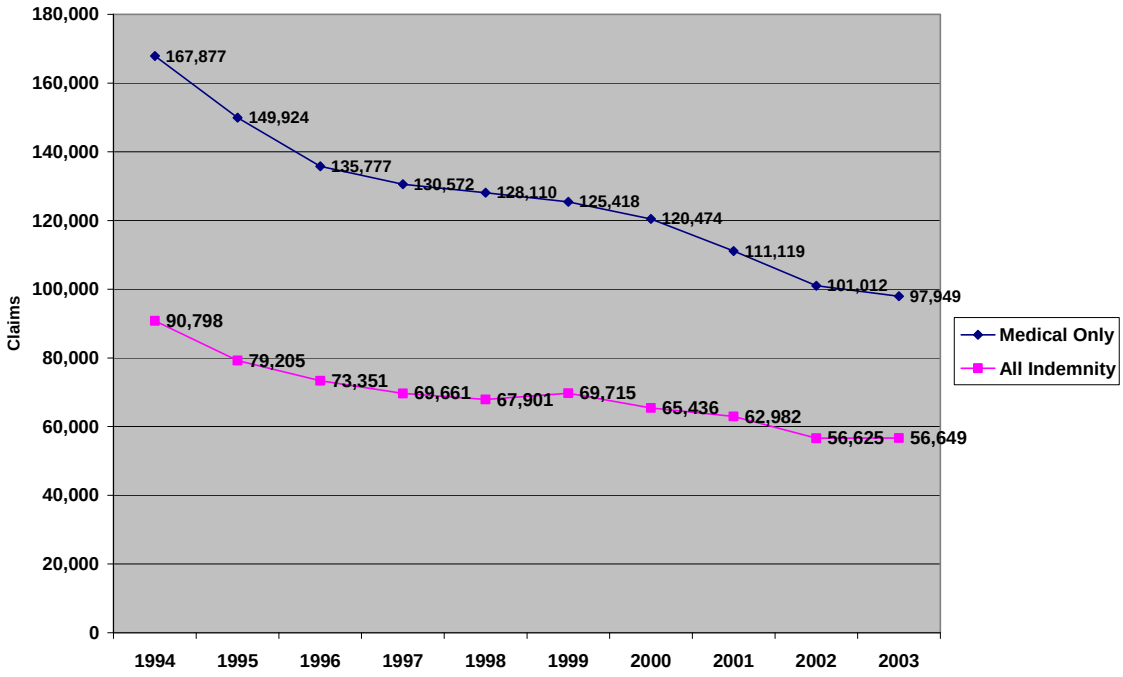
[30] Arkansas, California, Florida, Illinois, Indiana, Louisiana, Maryland, Massachusetts, Michigan, North Carolina, Pennsylvania, Tennessee, Texas and Wisconsin.

[31] CIRB currently collects its unit report data for 78 months, and each year it is expanding its data collection by one year. This is to address the long tail in the New York business.

[32] 2nd report/30 months of development.

A recent NCCI report states: "Our research indicates that the decline in claim frequency is a long-term phenomenon related to improved technology and competitive market forces and their application in the economy to create ever safer workplaces over time."[33] Another possible factor in New York State's claims decline is the changing industry mix from manufacturing to technology. After a review of employment by industry data from DOL, this does not appear to be a major factor. While manufacturing has declined, several of the higher risk industry sectors and the lower risk industry sectors have remained fairly constant over the past few years.

Figure 7: Number of Medical-Only and Indemnity Claims



Source: CIRB data at 30 months of development

C.5. Medical-Only Claims

Medical-only benefits are paid for claimants who did not lose any time from work or lost fewer than 7 days of work. In these instances the claimant only receives reimbursement for their medical costs. Medical-only claims constitute the majority of claims in the system. In 2003, they represented 63.4% of claims but only a small fraction of the costs of the system, 4.4%. There has been a steady downward trend in the number of medical-only claims.

In order to accurately estimate the total number of medical-only claims, CIRB data must be used. This is because the WCB claims data does not include a large portion of the medical-only claims. CIRB recorded 97,949 medical-only claims whereas the WCB recorded 27,817

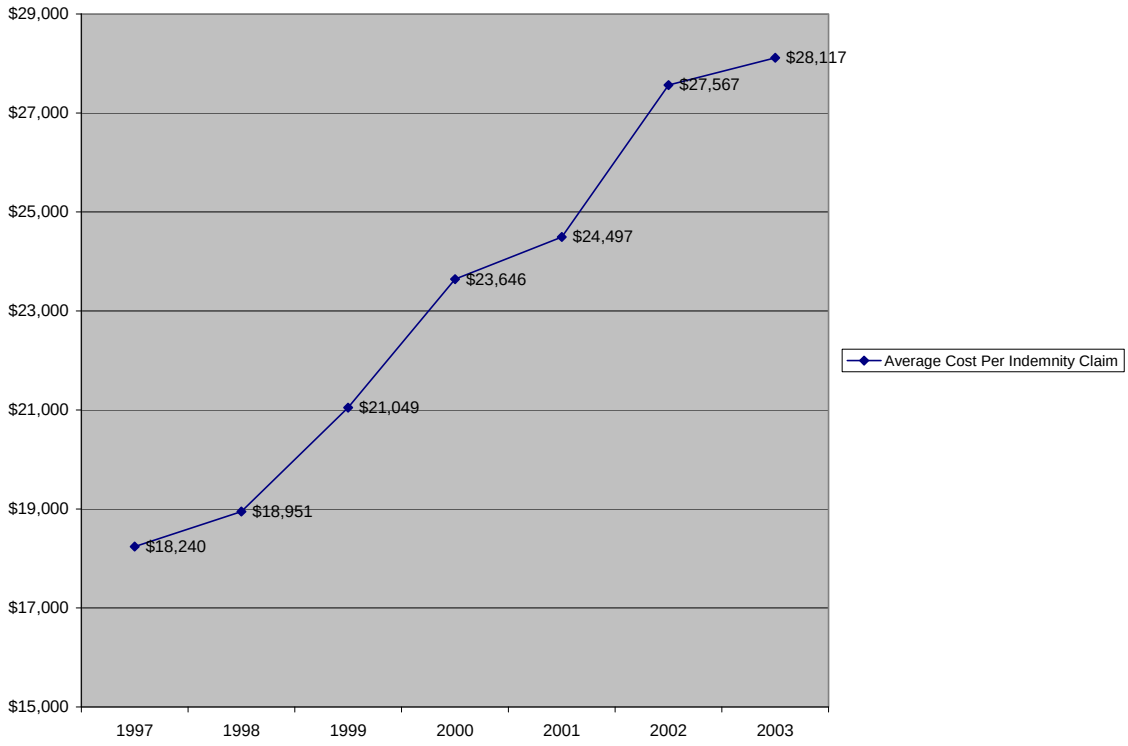
[33] "2007 State of the Line," National Council on Compensation Insurance, May, 2007.

claims. The reason for the discrepancy is that the Workers' Compensation Law does not require all medical-only claims be reported to the WCB.[34]

D. *Indemnity Claims*

Indemnity benefits are paid when the claimant losses more than seven days of work. The following section focuses on the different categories of indemnity claims and the patterns within those categories. In 2003, indemnity claims only made up 36.6% of total claims but constituted 95.6% of the benefit costs, based on claims with 30 months of development. According to CIRB data at 30 months of development, there were 56,649 indemnity claims reported for policy year 2003. The average cost per indemnity claim has risen from $18,240 in 1997 to $28,117 in 2003.

Figure 8: Average Cost Per Indemnity Claim



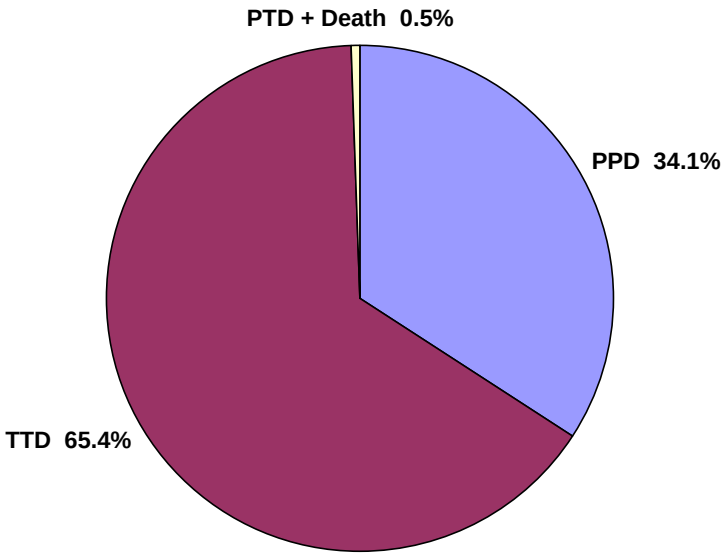
Source: CIRB data at 30 months of development

TTD and PPD make up the vast majority of those claims. Slightly more than two-thirds of these cases are TTD, but over the next few years some of them will develop into PPD scheduled and non-scheduled as they mature. It is important to note that all the data in this

[34] Section 110 of the WC Law states that a report does not have to be filed with the Board if the worker does not lose an additional day of work other than the day when the injury occurred, or if the medical treatment requires 2 or fewer visits.

Report is as of a set point in time. This ensures that a single claim is not counted more than once.

Figure 9: 2003 Indemnity Claims By Type

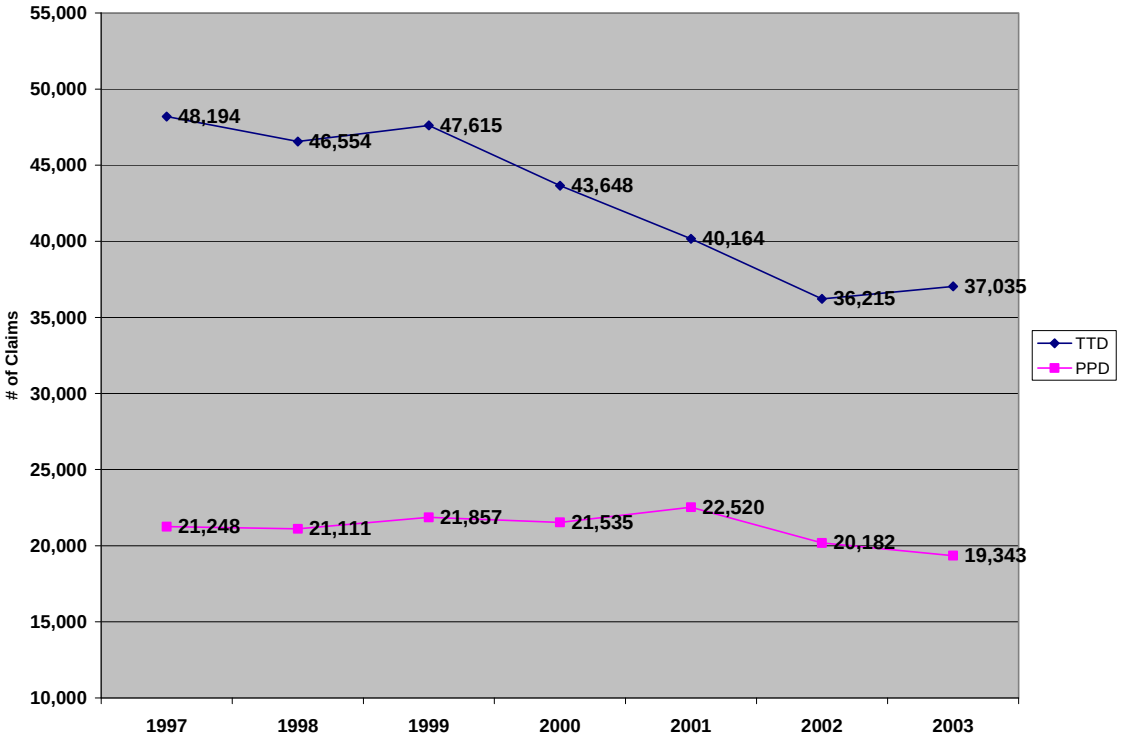


Source: CIRB data at 30 months of development

As Figure 9 indicates, there are relatively few PTD and Death claims. In 2003, there were only 95 PTD claims and 176 Death claims. Under the Reform Act, some growth can be expected in the number of total industrial disability cases due to and the safety net provision that allows claimants who have exhausted their PPD NSL duration benefits to apply for total industrial disability if they meet certain hardship criteria.

The next step in the analysis is to look at the trends in PPD and TTD over time.

Figure 10: Number of TTD and PPD Indemnity Claims



Source: CIRB data at 30 months of development

Figure 10 shows that TTD claims have been decreasing more rapidly than PPD claims. In other words, over time PPD claims have become a larger percentage of total claims. A growing percentage of PPD claims lead to higher costs per claim for all claims, due to the much higher costs of PPD claims.

The next step is to analyze the two types of PPD claims, scheduled and non-scheduled. Scheduled claims are claims where the amount of time for the wage replacement benefits is prescribed in a schedule in the Workers' Compensation Law. For example, a worker who loses his or her thumb will receive 75 weeks of wage replacement benefits regardless of the amount of time lost from work. PPD NSL claims are for permanent injuries that are not scheduled, such as those to the back. These are claims that had a lifetime benefit under the pre-existing law. Pursuant to the Reform Act, the indemnity benefit is capped at a set number of weeks depending on the claimant's lost wage earning capacity. The maximum duration is 10 years.

Unfortunately, CIRB data does not capture the split between scheduled and non-scheduled claims. Thus, in order to look at PPD NSL, one must use the WCB data. This is illustrative of one of the major problems in the current system: there is no easy way to merge the two data systems. Both systems currently use different identifying numbers.[35] Moreover, CIRB

[35] Several years ago, CIRB decided to eliminate social security numbers from its system due to privacy concerns. WCB uses social security as its claim identifier.

and WCB show somewhat different totals for the types of injury cases in a given accident year.

Figure 11: 2003 WCB and CIRB Indemnity Claim Comparison

	CIRB 2003	CIRB plus 33% (Adjustment for Self-insureds)	WCB 2003
PPD SL			22,321
PPD NSL			3,756
Total PPD	19,343	25,784	26,077
TTD	37,035	49,368	59,735
PTD	95	127	67
Death	176	235	203
All Cases	56,649	75,513	86,082

Source: New York Workers' Compensation Board and CIRB data

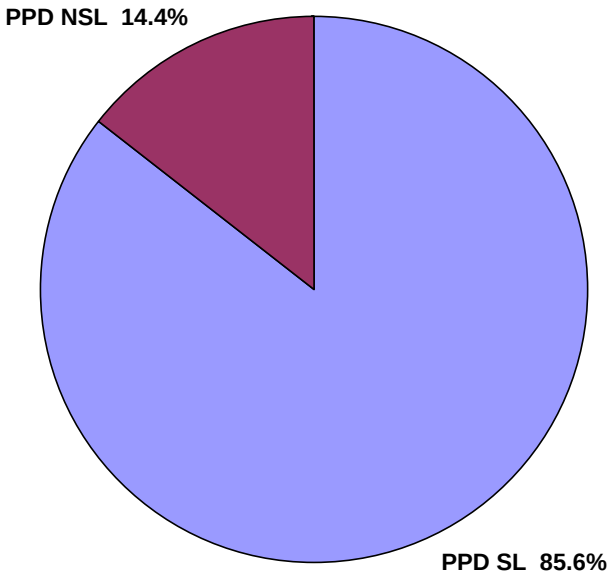
The discrepancies noted in the figure above can be explained in part:

- The CIRB data does not include self-insured claims; WCB data does include self insured claims.
- CIRB classifies the data as it is projected by the payor, i.e., when an insurer projects that a TTD case will become a PPD case, it reserves the case as a PPD and forwards the case data to CIRB as a PPD.
- WCB uses the actual classification at any point in time and does not predict an injured worker's ultimate claim status.
- CIRB data shows the status of the 2003 claims as of 30 months of development, while the WCB data shows the status of the 2003 claims as of 3.5 years of development.
- The CIRB data is on a policy year basis, while WCB is on an accident year basis.[36]

In 2003, according to the WCB data, there were a total of 59,735 TTD claims. In contrast, the CIRB data, adjusted for self-insured claims, shows 49,368 claims. In order to fully resolve the differences between these two data sets, there must be a way to merge the claims between the two data sources and review the differences. Currently, this is not possible. One of the Report recommendations is to adjust the two systems to enable such a merge.

[36] Policy year refers to the year a policy was issued. Accident year refers to the year the accident occurred

Figure 12: 2003 PPD NSL and PPD SL Claims



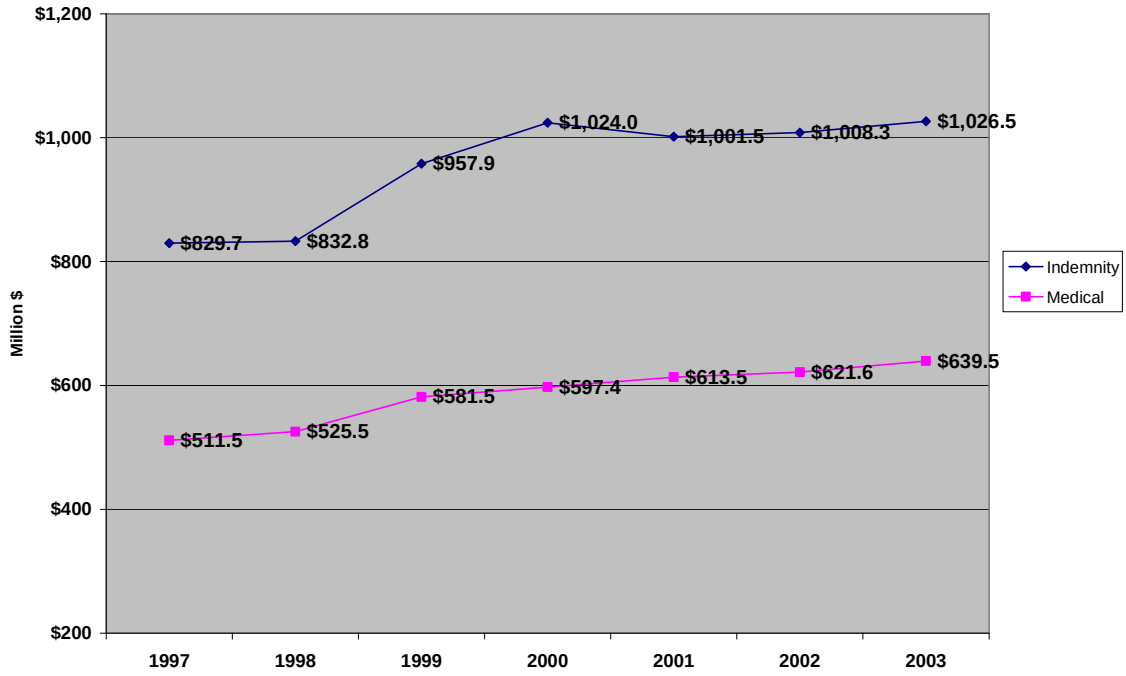
Source: New York Workers' Compensation Board claim data

Using the WCB data, the percent of PPD claims that are non-scheduled can be determined. In the WCB data for claims with an accident in 2003, PPD NSL claims equaled 14.4 % of total PPD claims and 4.4 % of all indemnity claims. These claims had at least 3 years of development as of the beginning of 2007 when the data query was made. This percentage is applied to the CIRB data for 2003 to estimate the number of PPD NSL claims. Since PPD claims have a long development period it is helpful to look at claims with a longer development period to see if the percentage changes. The percentages appear to increase as claims age. For WCB claims with an accident year of 2000 (three years more development) PPD NSL claims represent a higher percentage share than they do for 2003 accident year claims; 20.4 % of all PPD claims and 7.2 % of all indemnity claims .

D.1. *Trends in Benefit Costs*

A major goal of the Reform Act was to address costs in the workers' compensation system. At first glance, total indemnity costs in the chart below look like they have been leveling off from 2000 to 2003 after growing significantly in prior years, while medical costs have been growing modestly throughout the period.

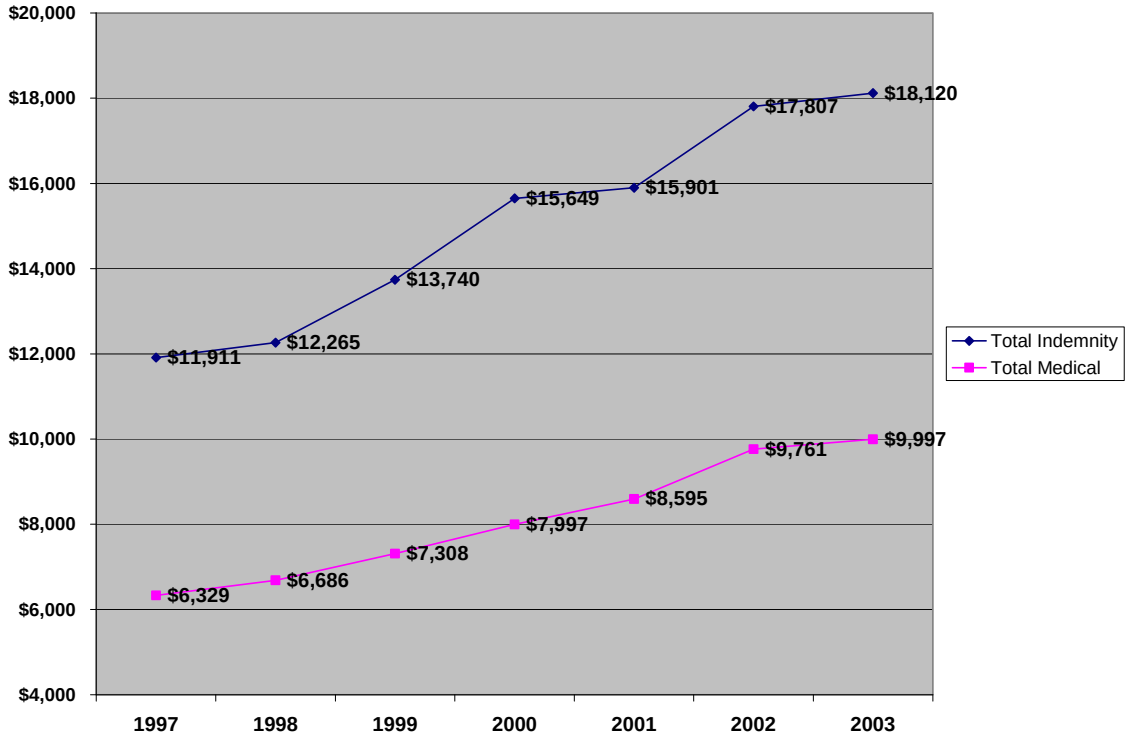
Figure 13: Total Indemnity and Medical Costs



Source: CIRB data at 30 months of development

Over the same time period, however, claims have been decreasing steadily. The combination of decreasing numbers of claims and slightly increasing total cost trends result in rising average per claim costs for both indemnity and medical costs.

Figure 14: Average Medical and Indemnity Cost Per Indemnity Claim



Source: CIRB data at 30 months of development

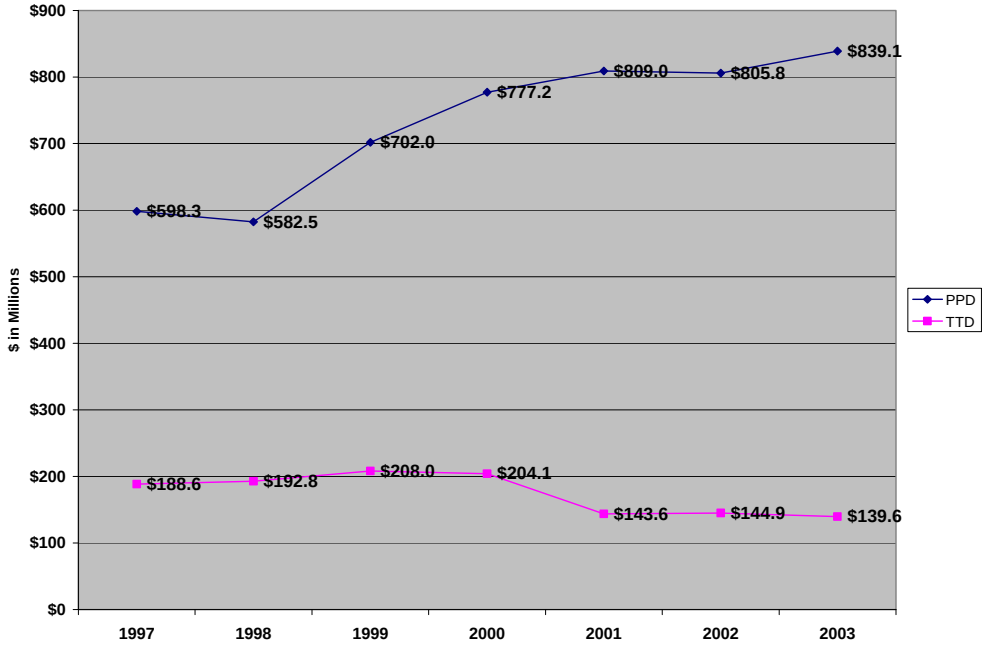
D.2. *Indemnity Costs*

New York State ranks third in the nation in terms of indemnity cost per case.[37] According to NCCI, the average indemnity cost per claim of $32,040[38] is almost twice the national average of $18,996. A primary cause of these high costs was the lifetime indemnity benefits for PPD NSL claims. Most other states already have some type of duration cap on their benefits. The caps in the Reform Act should reduce costs over time. Despite these high costs, New York State's maximum weekly indemnity payment of $400 was the third lowest in the nation[39].

With the number of claims decreasing and an unchanged maximum benefit of $400 per week, one would expect indemnity costs to decrease. However, indemnity costs rose from 1997 to 2000, then began to level off. The two major categories of indemnity claims, PPD and TTD, have been trending differently. TTD total costs have decreased, while PPD total costs have increased significantly.

[37] 2007 Annual Statistical Report from NCCI based on 2003 data.
[38] The reason the NCCI 2003 average cost per indemnity claim of $32,040 is so much higher than the CIRB data in Figure 13 ($18,120) is because CIRB is only looking at 30 month development, while NCCI is looking at costs over the entire estimated life of the claim.
[39] "Analysis of Workers' Compensation Laws 2007," United States Chamber of Commerce, 2007

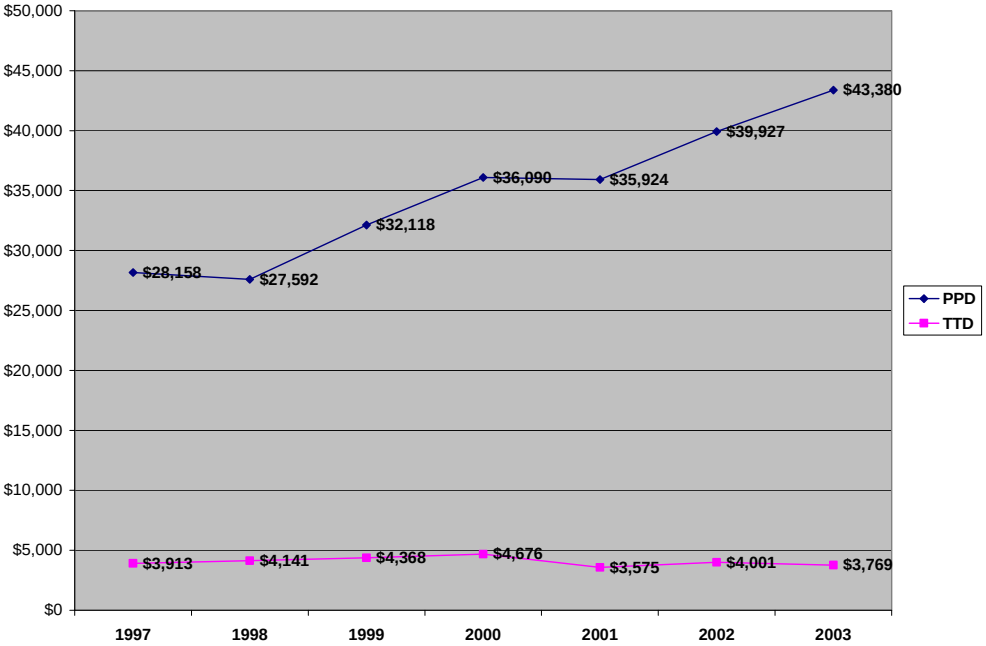
Figure 15: Total Indemnity Costs for PPD and TTD Claims



Source: CIRB data at 30 months of development

As a result of these trends, the average indemnity cost per claim at 30 months of development for a PPD claim was more than 10 times the cost of a TTD claim.

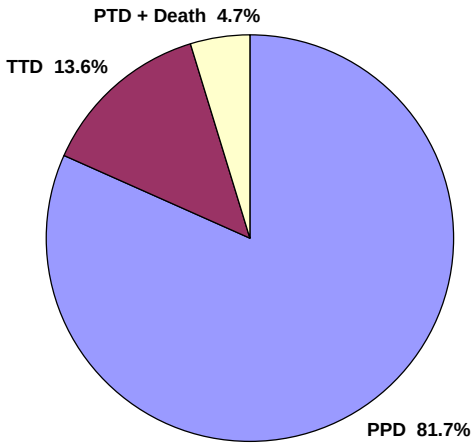
Figure 16: Average Indemnity Cost Per PPD and TTD Claim



Source: CIRB data at 30 months of development

For 2003, PPD indemnity costs represented 81.7% of total indemnity costs.

Figure 17: 2003 Total Indemnity Costs By Type of Claim

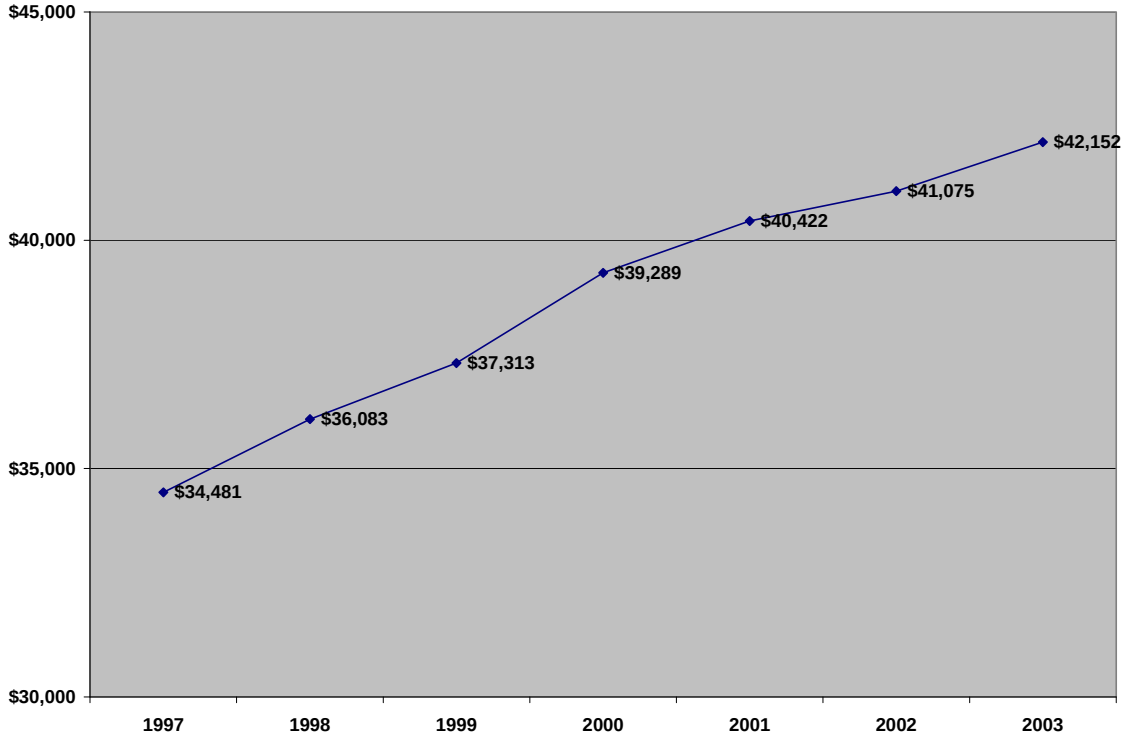


Source: CIRB data at 30 months of development

As these claims develop over time, the cost difference will continue to widen because PPD claims will continue to develop. As noted earlier, the WCRI Report stated that after 5 years, 25% of the indemnity costs had not yet been included in the claims reserves of the insurance carriers. It is also important to note that while the average PPD indemnity costs per claim have been growing, the average indemnity costs per TTD have remained relatively flat from 1997 to 2003. Therefore, PPD claims are the primary driving factor behind the growth in overall indemnity cost per claim.

A second factor that may make a limited contribution to these growing indemnity costs per claim is growth in wages. From 1997 to 2003 the New York State average weekly wage grew by 22%.[40]

Figure 18: New York State Average Annual Wage (excluding Finance and Insurance sectors)



Source: New York State Department of Labor

Due to the cap on maximum weekly indemnity benefits at $400, it is likely that a significant percentage of claimants did not receive a higher weekly benefit due to increased wages. From 2004 to 2006, 54% of indemnity claimants received the maximum benefit of $400 per week. Since July 2007, when the Reform Act raised the maximum benefit to $500 per week, the percent of claims (where the accident occurred on or after July 1, 2007) receiving the maximum benefit has dropped to 40%.[41] The final factor that may be impacting the growth in indemnity costs per claim is the severity of the PPD claims.

In sum, PPD claims are the driving force behind indemnity cost growth. The question is whether scheduled and non-scheduled claims are contributing equally to this growth. As in the earlier discussion on numbers of claims, WCB data must be used to examine the split between PPD SL and PPD NSL. For accident year 2003, the WCB data shows the average indemnity costs of a PPD NSL claim is 8.5 times the costs of a PPD SL claim.

[40] Data provided by DOL.
[41] Data provided by WCB.

Figure 19: 2003 Indemnity Costs For PPD Claims

	Claims	% of PPD Claims	Avg Cost Per Claim	Total Cost	% of Total Costs
PPD SL	22,321	85.6%	$18,609	$415,368,960	41.2%
PPD NSL	3,756	14.4%	$157,749	$592,506,470	58.8%
Total	26,077	100.0%		$1,007,875,430	

Source: The New York Workers' Compensation Board

PPD NSL claims represent only 14.4 % of total PPD claims and 4.4% of indemnity claims for accident year 2003. Their indemnity costs generate almost 60% of the total PPD indemnity costs and 48% of total indemnity costs. Since PPD NSL claims take a long time to develop NYSID asked CIRB to develop the 2003 policy year second report data to its estimated costs as of the fifth report, which is 66 months of development. That analysis showed that the percent of costs grew to 83 % of PPD costs and 74 % of total indemnity costs.

The following figure uses WCB data. Unlike CIRB data, the WCB data can not be adjusted for development. Therefore, the 2000 data includes 6+ years of development, while the 2003 data only includes 3+ years. The other factor impacting this data is PPD SL claims develop more quickly than PPD NSL. Nonetheless, although the rate of growth of the costs per PPD SL claims is higher than that of PPD NSL claims, the actual dollar growth of those costs is much lower.

Figure 20: Average Cost Per PPD Claim

	Accident Year				Growth 00 to 03	% Growth 00 to 03
	2000	2001	2002	2003		
PPD SL	$17,040	$17,950	$18,329	$18,609	$1,569	9.2%
PPD NSL	$149,521	$154,775	$157,398	$157,749	$8,228	5.5%

Source: The New York Workers' Compensation Board

In summary, the reason indemnity costs are not decreasing as the number of claims decline is due in large part to the slower decline in the number of PPD NSL claims combined with the increase in their costs. Based on 2003 policy year data developed by CIRB to 5.5 years, PPD NSL claims are estimated to represent 83 % of PPD costs and 74 % of total indemnity costs.

D.3.*Low Maximum Weekly Benefit State*

New York State's status as a low indemnity benefit state was addressed in the Reform Act. It seems contradictory to state that New York State's indemnity costs per claim are very high, and that it is also a low indemnity benefit state. However, the prior sections have shown that the driving factor behind the high indemnity costs per claim is the lifetime benefits for the PPD NSL claims and not due to high weekly benefits.

In terms of the number of indemnity claims, TTD represents almost 65% of the claims for 2003. The distribution of weekly benefits for 2004-2006 was $334.90, which was below the $400 maximum benefit. Nearly 100,000 TTD claimants were impacted by the pre-reform maximum weekly benefit cap. WCB is unable to electronically calculate the average weekly benefit being paid for all active cases because some of them were initiated prior to 2000 when the claims information system was first implemented and are not in the WCB database.

Figure 21: Distributions of Weekly Benefits for 2004 to 2006

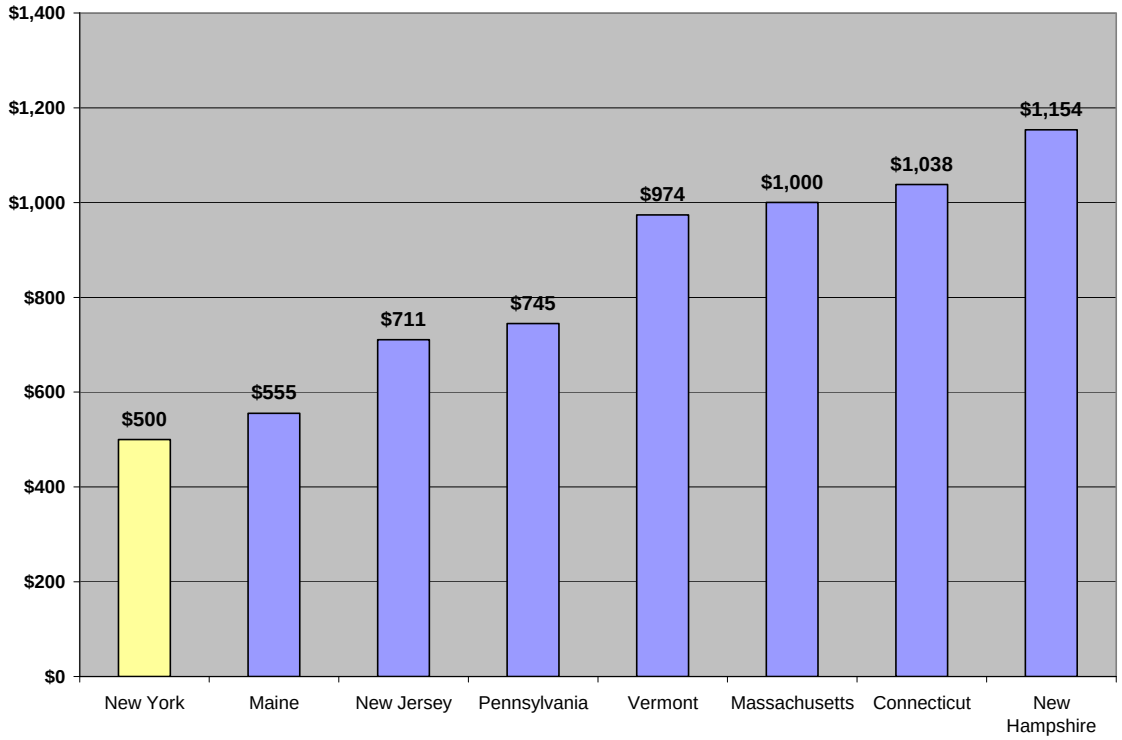
Award Type	Distibution of Benefit Rates					Total Claims	Average Rate
	$1 to $99	$100 to $199	$200 to $299	$300 to $399	$400		
Temp Total	3,576	18,533	31,432	31,137	99,590	184,268	$334.90
% Of Temp Total Claims	1.9%	10.1%	17.1%	16.9%	54.0%	100.0%	

Source: The New York Workers' Compensation Board

According to a 2007 study by the U.S. Chamber of Commerce, New York State had the third lowest benefits in the nation, exceeding only Mississippi $387 and Arizona $397.[42] The following chart compares New York State's maximum weekly benefit to near Northeastern states.

[42] "Analysis of Workers' Compensation Laws," United States Chamber of Commerce, 2007.

Figure 22: Maximum Weekly Benefit By State



Source: United States U.S. Chamber of Commerce, Analysis of Workers' Compensation Laws, 2007

As of July 2007, when New York State's maximum benefit was increased to $500, its rank moved to 6th lowest in the nation. In July 2010, when the cap is linked to two-thirds of New York State's average weekly wage, New York State's benefits will be more in line with the rest of the nation.

D.4. Medical Costs

In most other states, medical costs are a higher percent of total costs than indemnity costs. According to NCCI, in 2003 medical payments made up 55% of total benefit costs nationally and indemnity payments represented 45% of total benefit costs.[43] In contrast, in New York State indemnity costs are higher at 62% and medical costs are lower at 38%. The reason for this reversal is the relatively high indemnity costs discussed above combined with relatively modest medical costs. Using NCCI data, New York State appears to be a moderate medical cost state in comparison to other states. However, using the NCCI data has the same caveat as the WCRI data - - it does not account for the longer claim development time in New York State. Using data from claims developed for 18 months, in 2003-2004, New York State had the 18th highest medical costs per case out of 46 states. However, New York State had the 5th lowest medical costs per permanent partial disability

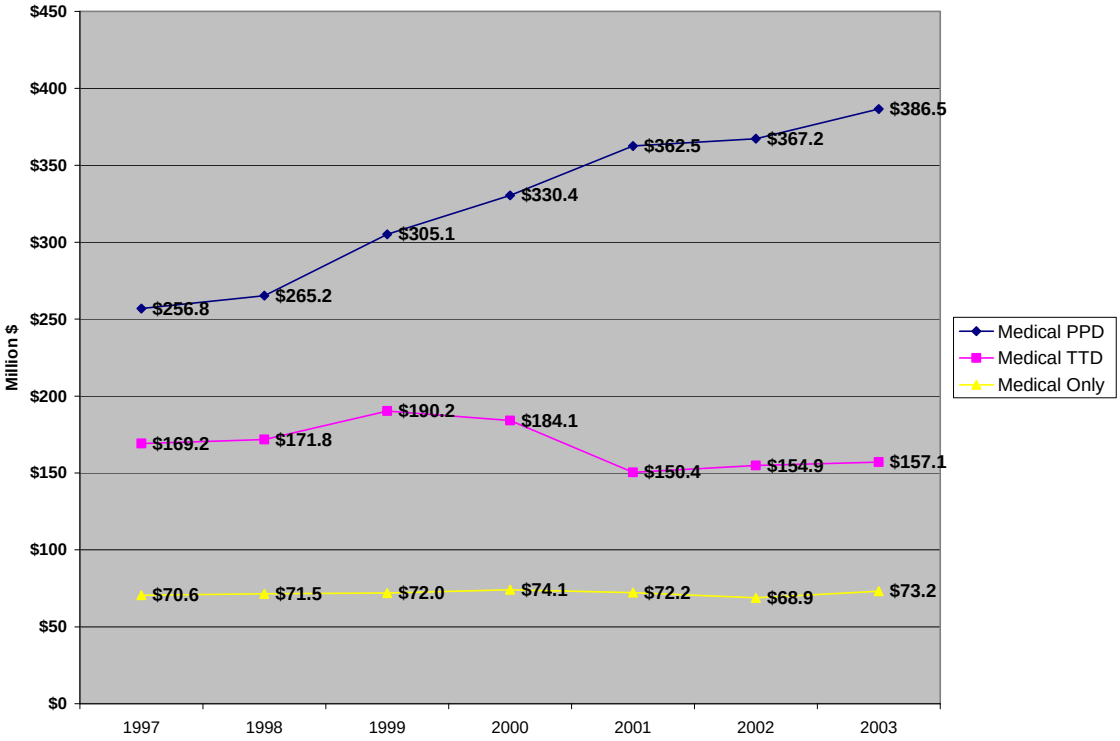
[43] Data provided by NCCI.

case, and the 9th lowest medical costs per total temporary disability case.[44] New York State remains a relatively low medical cost state using data from 1999 which has been developed for 66 months. A primary reason for the lower medical costs in comparison to other states is the medical fee schedule. In a WCRI study, New York State's fee schedule ranked as the 11th lowest medical fee schedule of all the states.[45] For physical services (therapeutic physical medicine, chiropractic and osteopathic manipulations), New York State ranked as the second lowest of the states.

Although New York State's medical costs are modest, they are growing faster than indemnity costs. From 1997 to 2003, medical costs grew from $511.5 million to $639.5 million, an increase of 25%. From 1994 to 2003, the share of total benefits comprised by medical costs grew from 34% to 38% of total benefits. However, from 2001 to 2003, the medical share of total benefits has remained constant at 38% of benefits. The increase in medical costs has not been consistent across all categories of claims. From 1997 to 2003, costs for medical-only claims have remained relatively constant. TTD medical costs have followed the same flat trend, while PPD medical costs have shown substantial growth. The growth pattern of medical costs associated with PPD claims is similar to the growth pattern of the indemnity portion of these claims.

[44] "*Annual Statistical Report 2007 Edition*," National Council on Compensation Insurance, 2007. New York's moderate ranking for overall medical costs per case compared to its lower ranking for PPD and TTD cases may be due to New York's apparently having more higher-cost cases relative to other states.
[45] "Benchmarks for Designing Workers' Compensation Medical Fee Schedules," WCRI, 2006.

Figure 23: Total Medical Costs By Type Of Claim



Source: CIRB data at 30 months of development

This analysis shows that growing PPD medical costs are a key driver in the overall growth of medical costs. In order to better understand the PPD medical costs, NYSID needs to look at scheduled and non-scheduled costs. The same data limitation problems that were discussed in the Indemnity Cost Section apply here. (CIRB data does not split costs between scheduled and non-scheduled PPD claims). However, with respect to medical costs, the data limitations are more severe because the WCB data does not include any information on medical costs. NYSID can identify what percent of the PPD claims are non-scheduled, but cannot identify what percent of the medical costs are generated by the PPD-NSL claims. In order to develop an estimate of this percent, NYSID requested information from SIF on its PPD NSL claims. The SIF data shows that, based on medical costs incurred in calendar years 2004 to 2007, approximately 69% to 71% of PPD medical costs are generated by PPD NSL claims. Applying the SIF percentage to the 2003 policy year CIRB data at 30 month development, it can be estimated that PPD NSL costs are roughly 47% of total medical costs for indemnity claims. When the SIF percentages are applied to 2003 CIRB data developed to 5.5 years the percentage increases to 53.4%.

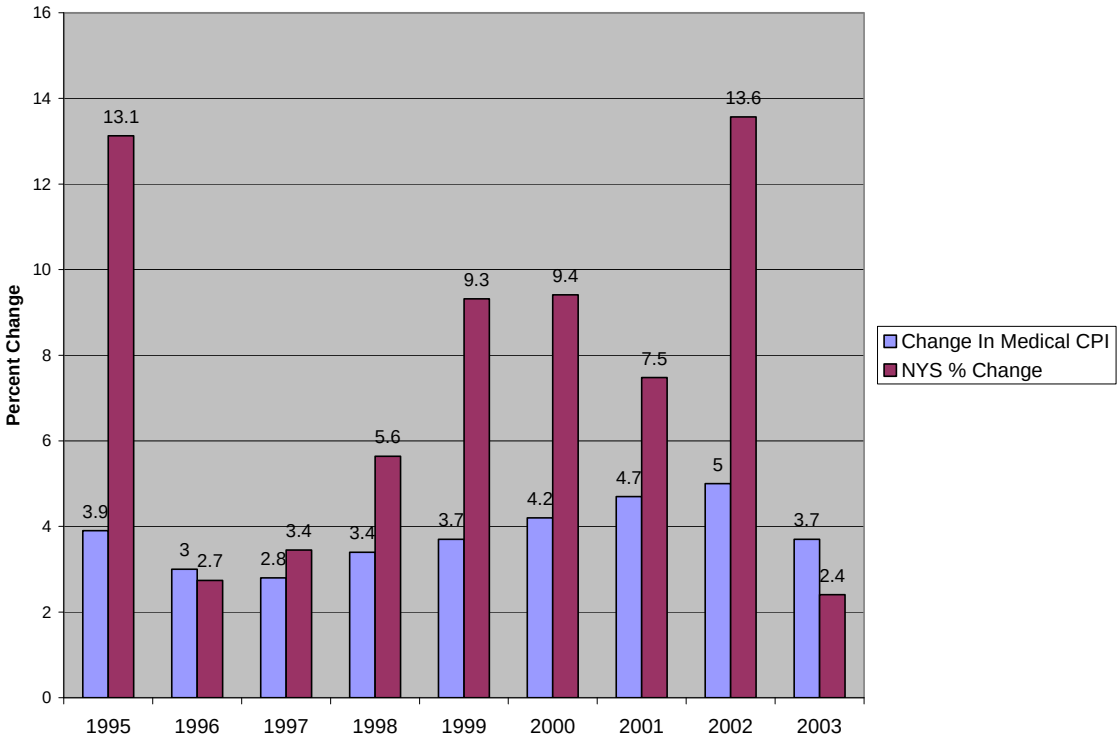
In summary, NYSID estimates that for 2003, PPD NSL claims projected for 5.5 year development will represent about 53% of medical costs and 74 % of indemnity costs for indemnity claims.

The next issue centers on what is driving the growth in medical costs for PPD claims. New York State has had a fixed medical fee schedule for many years and, as shown above, that fee schedule is lower than in many other states. There are two possible explanations for the growth in costs.

First, there are several major areas that have not been covered by fee schedules in the past. To explore this issue, NYSID asked SIF for data. For SIF, the two fastest growing classes of medical expenditures from 2002 to 2006 were Medical Inpatient costs (for out of state hospitals and hospitals that do not use diagnostic related groups and prescriptions. Neither of these areas was covered by the fee schedule. Overall, from 2002 to 2006, SIF medical costs grew by 22%, whereas its prescription costs grew by 64%. Prescription costs represented 8.8% of total medical costs in 2006. Under the Reform Act, a pharmacy fee scheduled was imposed for the first time in order to control the growth in prescription costs.

Other factors that may be driving the growth in medical costs are an increase in utilization and medical severity. With the exception of 2003, medical costs increases for indemnity claims have been substantially above the medical consumer price index ("CPI"), and in a number of years, increases have been almost twice the medical CPI. This could be an indication of increased severity and increased utilization, given the declining number of claim.

Figure 24: Change In Medical CPI vs. Change In Medical Costs Per Indemnity Claim



Source: CIRB data at 30 months of development and U.S. Bureau of Labor Statistics

However, without detailed medical information, it is difficult to measure the utilization trends in New York State. However, there is data from WCRI that reveals NYS has higher utilization of chiropractic services and neurological/neuromuscular testing. [46]

Many other states have been experiencing growing medical costs. According to a recent report from NCCI on medical costs for other states focused on utilization of services and severity of injury:

> "It is clear that in recent years, workers' compensation medical claims severities have been increasing at a faster rate than would be expected based on medical inflation alone. Over the 1996/1997 to 2001/2002 period, the medical care component of the Consumer Price Index increased by 21% compared with an increase of 73% for paid medical severity on lost-time claims closed within 24 months of date of injury."
>
> "The key driver, accounting for approximately a 35% increase in medical severities over the years studied, is the markedly higher number of treatments within each diagnosis and a different mix of treatments across service categories."[47]

[46] There is a discussion of these two items in Section IV 3.1.b and 3.1.c

[47] "Measuring the Factors Driving Medical Severity: Price, Utilization, Mix," National Council on Compensation Insurance, 2007.

In addition, NYSID asked WCRI to examine which medical conditions drive most of the costs. In response, WCRI issued a Flash Report[48] on New York State's medical cost drivers. Following the New York State report, other states requested a similar analysis. The following figure displays the results the WCRI analysis. The two conditions driving the highest percentage of medical costs in New York State are back and neck injuries, which comprise 38.4 % of total medical payments.[49] While these two conditions are also the top two conditions for the 14 other large states that WCRI examined, they represent a smaller portion of total medical costs in those states, 32.8% of total medical payments.

Thus, the WCRI's analysis is consistent with this Report's earlier conclusion that PPD NSL claims are a major driver in medical costs.

Figure 25: Percentage of Costs and Claims Attributable to Injuries, By Body Part

	New York			Avg of 14 WCRI States	
	% Of Medical Payments	% Of Claims	Average Cost Per Claim	% Of Medical Payments	% Of Claims
Back					
Disc conditions and/or radicular findings	17.9%	4.5%	$9,847	13.9%	2.3%
Nonspecific low back pain (e.g. strain)	10.1%	13.9%	$1,864	11.1%	14.3%
Total Back	28.0%	18.4%		25.0%	16.6%
Neck					
Disc and/or radicular findings	6.4%	1.5%	$11,181	3.6%	0.6%
Nonspecific cervical pain (e.g strain)	4.0%	3.2%	$3,232	4.2%	3.0%
Total Neck	10.4%	4.7%		7.8%	3.6%
Knee					
Derangement	5.6%	2.0%	$7,201	4.0%	1.1%
Spain and strain	2.0%	2.2%	$2,356	2.2%	2.4%
Total Knee	7.6%	4.2%		6.2%	3.5%
Shoulder or Arm					
Spain and strain	6.0%	5.4%	$2,853	6.9%	5.8%
Inflammation (due to overuse)	5.5%	2.6%	$5,451	5.0%	2.1%
Fracture	1.5%	0.9%	$4,537	1.8%	0.7%
Total Shoulder or Arm	13.0%	8.9%		13.7%	8.6%
Hand or Wrist					
Lacerations and contusions	2.4%	11.7%	$646	3.1%	13.1%
Carpal tunnel	2.8%	1.8%	$4,149	3.3%	1.3%
Fracture	1.4%	1.8%	$2,039	1.4%	1.5%
Total Hand or Wrist	6.6%	15.3%		7.8%	15.9%
Leg, Foot and Hip					
Sprain and strain	2.5%	5.0%	$1,262	2.5%	4.8%
Fracture	2.8%	1.6%	$4,686	2.5%	1.2%
Total Leg, Foot and Hip	5.3%	6.6%		5.0%	6.0%
Total of conditions listed above	70.9%	58.1%		65.5%	54.2%

Source: Workers Compensation Research Institute Flash Reports, July and August 2007

[48] A flash report is issued by the WCRI in response to a specific policy question by one or more states, or other members of WCRI.

[49] An analysis of the CIRB data shows similar results.

D.5.*Age of Claimants.*

The following data combines claims data supplied by the WCB with data from the Unemployment Insurance database and was compiled by Department of Labor ("DOL") to support the work of the Return to Work Advisory Committee.

One factor that impacts the overall cost to the workers' compensation system, as well as the efforts to return workers to jobs, is the age of claimants. On average, there are 0.88 claims for every 100 workers in New York State. The bulk of the claimants are in the 35-54 age group. In the younger age group, 16-24 year olds, and in the older age group, over 55, there are fewer claims per 100 workers. There has been an on-going belief that older workers file more claims to "supplement" their retirement. The data appears to disprove that theory.

Figure 26: Age of Claimants

	Indemnity Claimants*			New York State Labor Force**	
Age Group	Average Claims Per Year	Percent of Total	Claims Per 100 Workers	Total Workers	Percent of Total
Total	83,140	100.00%	0.88	9,463,600	100.00%
16-19	1,202	1.40%	0.33	367,000	3.90%
20-24	4,868	5.90%	0.59	822,900	8.70%
25-34	15,659	18.80%	0.78	2,013,500	21.30%
35-44	23,038	27.70%	0.96	2,387,700	25.20%
45-54	19,330	23.30%	0.89	2,165,800	22.90%
55-64	9,192	11.10%	0.70	1,311,500	13.90%
65+	1,550	1.90%	0.39	395,500	4.20%

* Includes claimants classified as permanent partial disability (scheduled), permanent partial disability (non-scheduled), and temporary total disability.

** Source: Current Population Survey.

Source: New York Workers' Compensation Board and New York State Department of Labor

(The figure above and the figure below in subsection D.6 use different data sources to compute the number of total workers in New York State. Therefore, the two tables reflect different totals for the number of workers as well as different totals for total number of claims per worker.[50])

D.6. *Claims by Industry*

Figure 27 examines claimants by industry. As one would expect, certain industries are more dangerous and therefore have a higher number of claims per 100 workers. For the total civilian workforce, there are 1.09 claims per 100 workers in New York State. Government has both the highest number of employees and a relatively high incidence rate, at 1.5 claims per 100 workers. The two industries with the highest number of claims per 100 workers are Transportation and Warehousing, and Manufacturing, followed closely by Construction, Utilities, and Mining. One of the goals in the following section is to analyze how safety can be improved for workers. The analysis by industry points to the industries where the most improvements are needed to enhance the safety of workers.

[50] Figure 26 relies on the Civilian Labor Force data included in the Current Population Survey developed by the U.S. Department of Labor. It defines the labor force as employed individuals and individuals actively seeking employment and is based on place of residence. The data contains characteristics by individual, such as age. Figure 27 "Claims By Industry" uses data from the quarterly census conducted by the U.S. Bureau of Labor Statistics which contains data supplied by employers for Unemployment Insurance. It is based on place of employment. An individual may have more than one job and is counted in each job. This source contains data by industry code.

Figure 27: Indemnity Claims By Industry
Indemnity claimants with accident dates between 4th quarter 1999 and 1st quarter 2005

Industry	All Indemnity Claimants for 5.25 years			2006 New York State Annual Average Employment		Claims Per 100 Workers
	Number	% of Total Claimants	Avg Claims Per Year	Number	% of Total Employment	
Total	481,890	100.00%	91,789	8,424,621	100.00%	1.09
Government	111,901	23.20%	21,314	1,418,248	16.80%	1.50
Health Care & Social Assist.	62,706	13.00%	11,944	1,184,479	14.10%	1.01
Manufacturing	60,055	12.50%	11,439	564,857	6.70%	2.03
Retail Trade	50,025	10.40%	9,529	877,790	10.40%	1.09
Construction	31,568	6.60%	6,013	335,391	4.00%	1.79
Transport.& Warehousing	30,868	6.40%	5,880	225,844	2.70%	2.60
Admin.& Waste Services	25,554	5.30%	4,867	425,410	5.00%	1.14
Accommodation & Food Services	21,747	4.50%	4,142	542,494	6.40%	0.76
Wholesale Trade	21,066	4.40%	4,013	351,759	4.20%	1.14
Other Services	11,724	2.40%	2,233	316,208	3.80%	0.71
Real Estate, Rental & Leasing	9,430	2.00%	1,796	183,572	2.20%	0.98
Prof. & Tech. Services	9,319	1.90%	1,775	549,842	6.50%	0.32
Information	8,854	1.80%	1,686	266,661	3.20%	0.63
Finance & Ins.	7,956	1.70%	1,515	538,065	6.40%	0.28
Educational Services	6,540	1.40%	1,246	273,638	3.20%	0.46
Arts, Entertainment, & Rec.	5,771	1.20%	1,099	132,763	1.60%	0.83
Utilities	3,658	0.80%	697	38,810	0.50%	1.80
Agric., Forest., Fish. & Hunt.	1,860	0.40%	354	21,617	0.30%	1.64
Mgt of Companies & Enterprises	795	0.20%	151	126,541	1.50%	0.12
Mining	488	0.10%	93	5,252	0.10%	1.77
Public Admin. (Indian Tribal Councils)	5	< 0.1%	1	not available	-	

Sources: Workers' Compensation Board (includes claimants classified as PPD SL, PPD NSL and TTD). Quarterly Census of Employment and Wages developed through a cooperative program between New York State and the U.S. Bureau of Labor Statistics.

D.7. *Occupational Disease Claims*

Another important subset of indemnity claims is occupational disease claims. Occupational disease claims refer to claims in which an injured worker has a disease produced as a natural incident of a particular employment, such as asbestosis from asbestos removal. There must be a recognizable link between the disease and some distinctive feature of the workers job. For example, asbestosis is related to working with asbestos removal. A worker must file a claim within two years of when he reasonably should have known that the disease was due to the nature of the employment. Occupational disease claims are more heavily contested.

From 2000 to 2006, occupational disease claims represented an average of 4.6% of total claims. Unlike accident claims, the majority of these claims are PPD claims rather than TTD claims. It may be surprising that the overwhelming majority of the PPD occupational disease claims are PPD Scheduled, rather than Non Scheduled since a disease claim does not appear to lend itself to a specific body part on the statutory schedule. For accident years 2000 to 2006, 46% of the occupational disease claims that were PPD SL were carpel tunnel syndrome. Carpel tunnel syndrome is considered a diseases, because it does not occur at a single point in time, rather, it develops over a period of time. Since it is a disability of the wrist, and the wrist is on the statutory schedule, carpel tunnel syndrome claims are often PPD SL.

Figure 28: Occupational Disease Claims 2000-2006

Injury Case Type	Occupational Disease Claims			Accident Claims		
	Total	Percent	Avg Cost	Total	Percent	Avg Cost
Temp Total	10,322	40.6%	$10,945	408,454	73.6%	$7,054
PPD SL	13,711	53.9%	$17,136	118,508	21.3%	$17,813
PPD NSL	1,275	5.0%	$132,784	24,309	4.4%	$155,126
PTD	35	0.1%	$177,141	476	0.1%	$233,647
Death	81	0.3%	$162,397	3,372	0.6%	$167,119
Total	25,424	100%	$21,105	555,119	100%	$17,002

Source: New York Workers' Compensation Board data

Almost half, 46.7%, of these claims were controverted from 2000-2006, compared to 7.7% of accident claims. This higher level of controverted claims also leads to longer times to establish the claims. On average, occupational disease claims took 246 days to establish compared to 156 days for accident claims. As one would expect, with the higher percentage of controverted claims there is also a higher proportion of claimants being represented by attorneys: 76.4 % for occupational disease and 53.6% for accident claims.

III. Evaluating and Establishing Benchmarks for the Workers' Compensation System

The prior section of this Report established that the New York State workers' compensation system costs employers over $5 billion per year and that the system's indemnity costs are among the highest in the nation. Prior to the recent raise in the maximum indemnity benefit cap, its indemnity benefits per claim were the third lowest in the nation. On top of being a high cost, low benefit state, New York State's system is slow.

The Reform Act was designed to address all of these problems - reduce costs, increase benefits and speed up the process. To ensure that the reforms are achieving their goals and to continue to monitor the system for on-going improvements, it is essential to have a methodology to measure the impacts of the reforms and the overall performance of the system.

It is important to recognize that with all of the changes occurring simultaneously in the workers' compensation system it is very difficult to attribute changes to a single reform. What we can do is measure if there are any changes in the target areas of the specific reforms. Another key issue to keep in mind when looking at the proposed measures is that it will take several years before we have a full picture of the impact of reforms on the system, due to the long development tail of PPD NSL claims. Metrics for cost per claim need at least 18 months of development to compare to baseline metrics in this Report. Therefore for claims beginning in 2008, the 18 month development will not be completed until 2010. However, other metrics impacted by the Reform Act will be visible earlier, such as changes in processing time, utilization, return to work and percent of claims impacted by the change in the maximum weekly benefit.

This section of the Report outlines a recommended framework for benchmarking the New York State workers' compensation system. Over time, as more data becomes available and different areas require focus, these goals and methods of measurement should be revised.

Areas to Benchmark the System

To monitor the quality of New York State's worker's compensation system, it is important to benchmark the following nine areas:

A. Coverage of the workers' compensation system;
B. Timeframes for delivery of benefits to injured workers;
C. Timely access to quality medical care for injured workers;
D. Timely claim resolution;
E. Improve workplace safety;
F. System costs and costs per claim;
G. Adequacy of benefits and return to work;
H. Performance of major players in claims administration system; and
I. Fraud.

This section will discuss each benchmark area and evaluate the type of data currently available to measure the system's performance relative to the benchmark. For some benchmark areas, such as controlling system costs, it is relatively easy to choose a number of measurements that can be used to track system performance. On the other hand, it is much

more difficult to develop quantitative measurements that accurately measure other benchmark areas such as "access to quality health care." Recommendations are included to collect the additional data needed for more effective measurements.

In developing the proposed measurements, NYSID reviewed internal New York State data as well as available national comparative data. Sources for the New York State data are as follows:

- CIRB
- WCB
- DOL

This section also uses data from the WCRI, much of which comes from a recent report, "Baseline For Evaluating the Impact of the 2007 Reforms in New York." For this Report, WCRI used its own data from private carriers and large self-insured third party administrators that operate in New York State. This data does not include any information from SIF or from any public sector self-insureds.

When the data is available, this section also shows current performance relative to each of the benchmarks. Appendix B of this Report summarizes the benchmarks and proposed measurements in a table.

A. *Coverage of the Workers' Compensation System*

All employees who work for employers covered by the workers' compensation law should have workers' compensation coverage. The WCB Bureau of Compliance ("Bureau") is responsible for ensuring that employers have workers' compensation coverage. To carry out its function, the Bureau uses a data system that receives proof of coverage data electronically from insurance carriers and the self-insured. The Bureau is one division of the WCB that currently receives data electronically from carriers and the self-insureds. The system is based on the national standard developed by the International Association of Industrial Accident Boards and Commissions[51] ("IAIABC") for "proof of coverage." This data is fed into the Board's insurance compliance system. The insurance compliance system also receives an electronic feed of all employers who register with the Department of Labor's Unemployment Insurance Division. A match of policies to employers is then made.

In 2008, excluding the public sector self-insured employers, there are currently 402,538 employers with active coverage. Of this total, private carriers cover 215,524 employers, SIF covers 168,482 employers and 18,532 employers are self-insured

There are two ways for the Bureau to identify employers who do not have coverage. First, it matches proof of coverage with the DOL's list of employers in the Unemployment Insurance database. It also receives updates when new employers file with the DOL. If an

[51] The IAIABC is a group comprised of state agencies, insurance carriers and vendors who are involved in workers' compensation. IAIABC EDI standards cover the transmission of claims, proof of coverage and medical bill payment information through electronic reporting. The standards are developed and maintained through a consensus process that brings together representatives from jurisdictions, claim administrators, vendors and others interested in participating.

employer in the Unemployment Insurance database does not have a proof of coverage filed with the WCB, the Board follows up with the employer to ensure that it purchases coverage or is legally exempt from coverage requirements.

In addition, employers who are operating illegally may be uncovered in compliance investigations or if an employee files a claim and there is no record of insurance for the employer. It should be noted that the WCB and the DOL also share data from their auditors' visits to worksites.

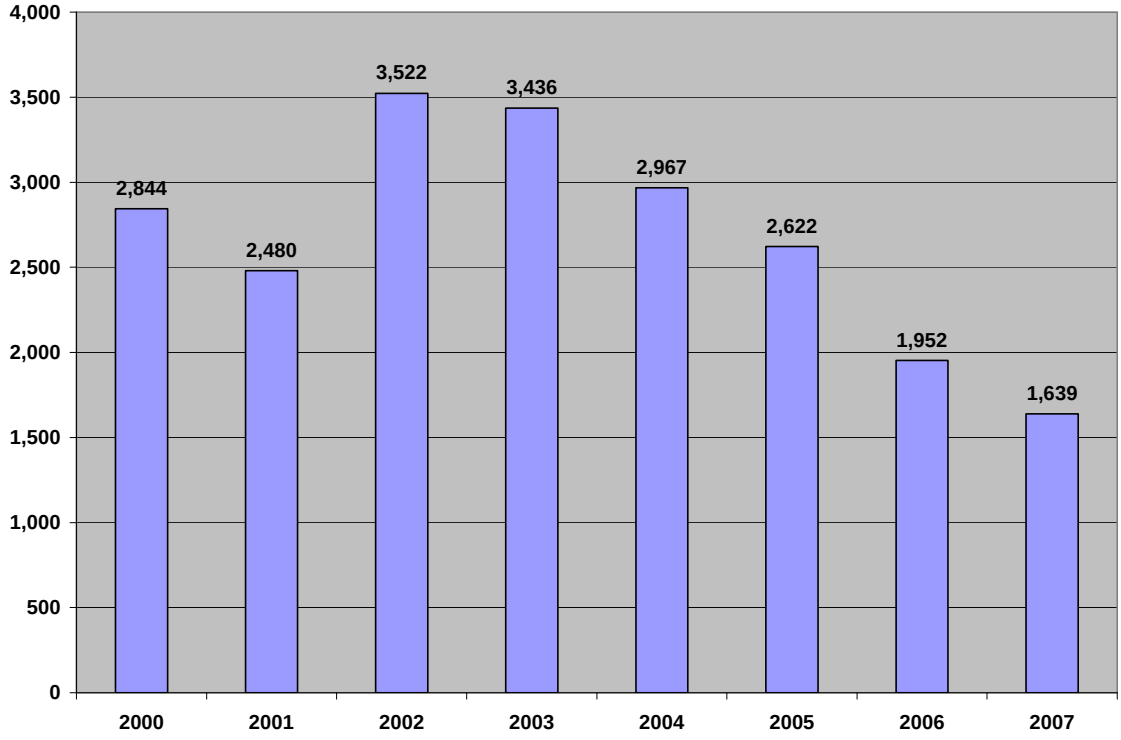
A.1. *Percentage of workforce that has Workers' Compensation coverage - trend over years*

Currently this data is not available.

A.2. *Number of Referrals to the No Insurance Unit of the WCB*

One indicator of the size of the uninsured market is the number of claims the WCB receives from employees that work for uninsured employers. These claims are referred to the No Insurance Unit of WCB ("NIU"). This unit pays for claims from uninsured employers. These claim referrals have been decreasing for several reasons. First, system wide claims are declining. However, NIU claim referrals declined more quickly than the decline in overall claims. NIU claim referrals declined by 31% from 2000 to 2006. Over the same period of time, the number of claims indexed by the WCB dropped by 19%. It has been argued that employers operating without insurance have become more effective at preventing employees from filing claims. However, there is no way to confirm or disprove this factor with the existing data.

Figure 29: Referrals To the No Insurance Unit (NIU)



Source: New York Workers' Compensation Board

B. Timeframes for Delivery of Benefits to Injured Workers

One of the basic functions of a workers' compensation system is to provide wage replacement benefits to workers who are injured on the job. Those benefits should begin as quickly as possible. This Report uses the same basic measures used by WCRI to assess the delivery of indemnity benefits. The first measure looks at the total time from injury to the first indemnity payment. The other measures identify the amount of this total time attributable to each relevant player in the process:

1. Length of time from date of injury to first indemnity payment.
2. Length of time from accident to employer notice to payor.
3. Length of time from employee notice to employer to employer notice to payor.
4. Length of time from notice to payor to first indemnity payment.

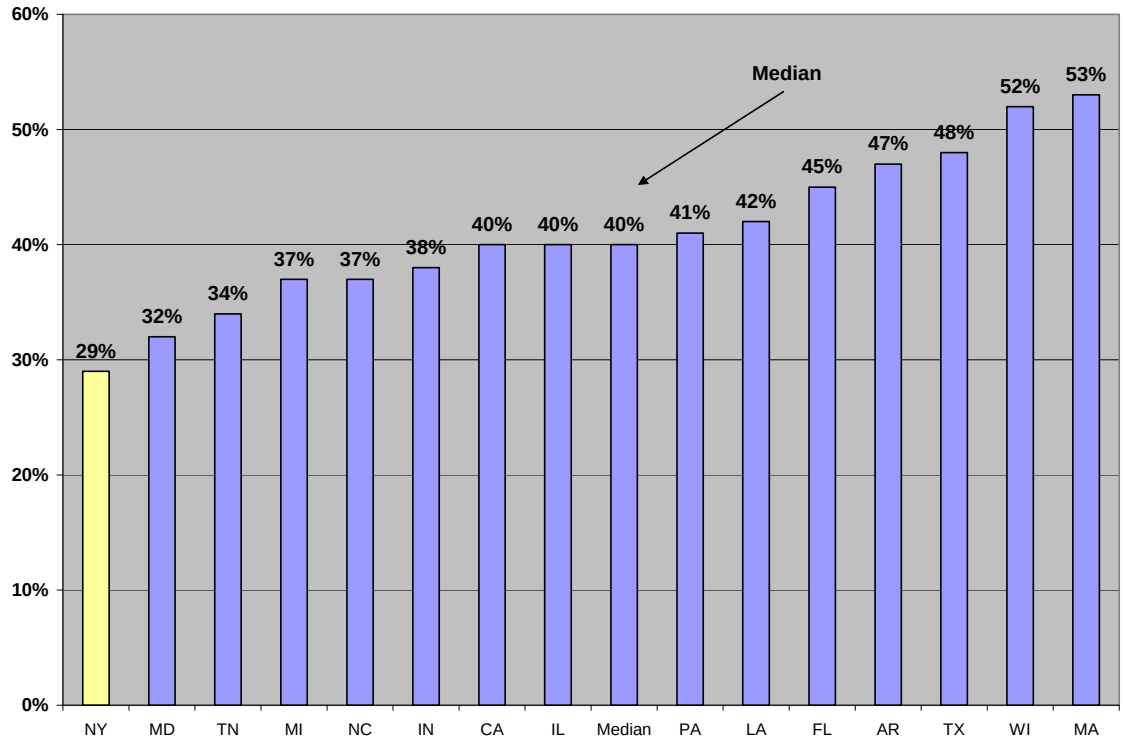
On these four measures, New York State ranks as the slowest on B.1 and performs below the median on all four measures. Currently, the WCB does not have the data to track these metrics. The WCB data includes date of injury, and it has just begun to track the date of the first indemnity payment. However, it does not currently track the date of the employer's notice to payor or the date of the employee's notice to the employer. As discussed in further detail in the short-term solution section of this Report, NYSID recommends adding this additional data to the WCB database.

Since the WCRI analysis does include this data it can be used as a benchmark to establish a baseline, recognizing that the WCRI data does not include all market segments.

B.1. *Percentage of Claims: Time from Injury to First Indemnity Payment is less than 21 days*

This measure includes the time the employee takes to notify the employer of the injury, the time the employer takes to notify the payor, and the time the payor takes to make the first indemnity payment. WCRI examines the percent of claims in which indemnity payments have been made within 21 days. For the 14 WCRI states,[52] the median percentage of claims in which the first payment is made within 21 days is 40%. The chart below shows New York State is the slowest of all these states, with only 29% of its indemnity claimants receiving their first payment within 21 days.

Figure 30: Percentage of Claims With Date of Injury To First Indemnity Payment Less Than or Equal To 21 Days



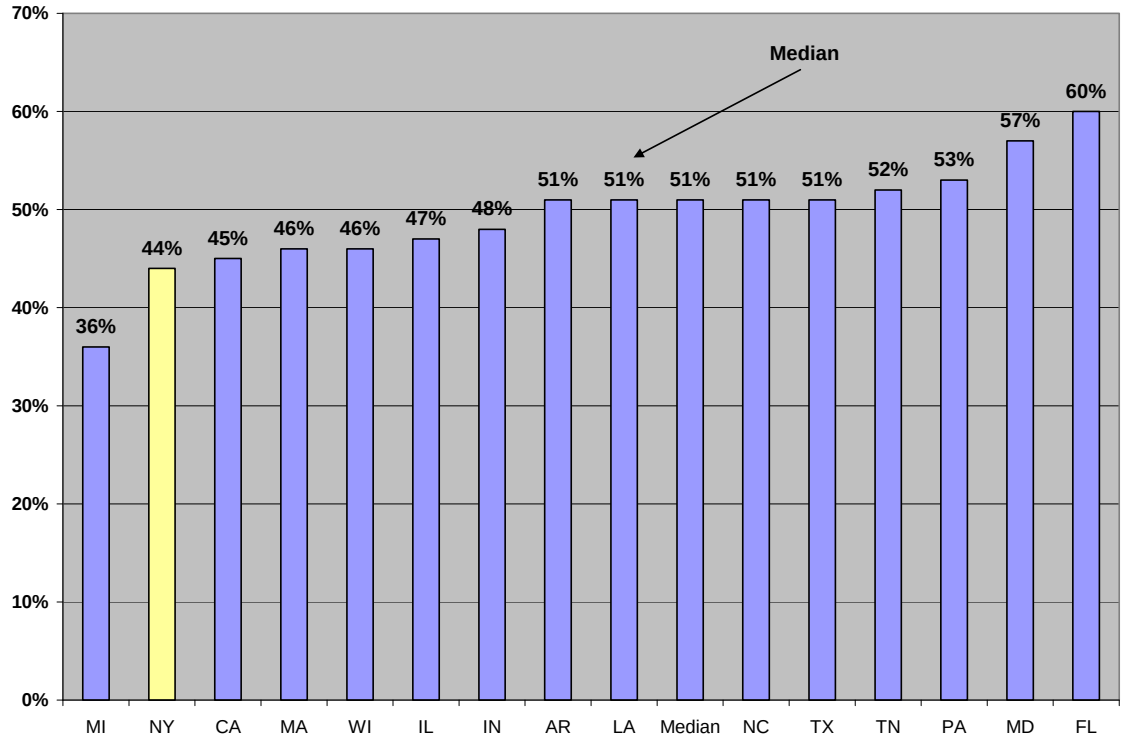
Source: Workers Compensation Research Institute data 2004/2005 with 12 months of development

[52] *See* supra Footnote 29.

B.2. *Percentage of claims: time between injury and notice to payor is 3 days or less.*

This measure includes both the employee and the employer performance in giving notice to the payor, which is generally the employer's insurance carrier. The median percentage of claims in which notice was given to the payor within 3 days of injury for the 14 states is 51%. New York State is the second slowest state, with 44% of its claims meeting this goal.

Figure 31: Percentage of Claims With Date of Injury To Payor Notice Less Than or Equal To 3 Days

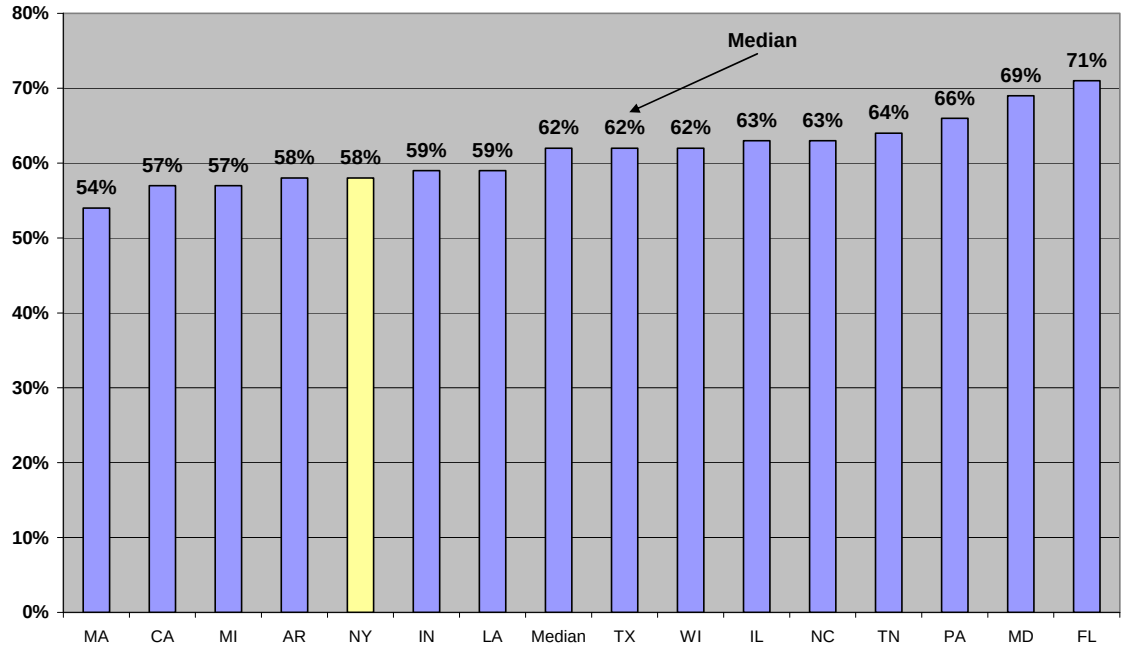


Source: Workers Compensation Research Institute data 2004/2005 with 12 months of development

B.3. *Percentage of claims: time employee's notice to the employer to employer's notice to the payor is 3 days or less.*

This measure focuses solely on the employer's performance. That is, the time it takes from when the employer is first notified by the worker that an accident has occurred to the time it takes for the employer to notify the payor that an accident has occurred. This is New York State's best performance measure. Although it is still below the median, it is 5th lowest and only 4% points off the median. This indicates that the delays are more attributable to the claimant than the employer.

Figure 32: Percentage of Claims With Date of Employer Notice To Payor Notice Less Than or Equal To 3 Days

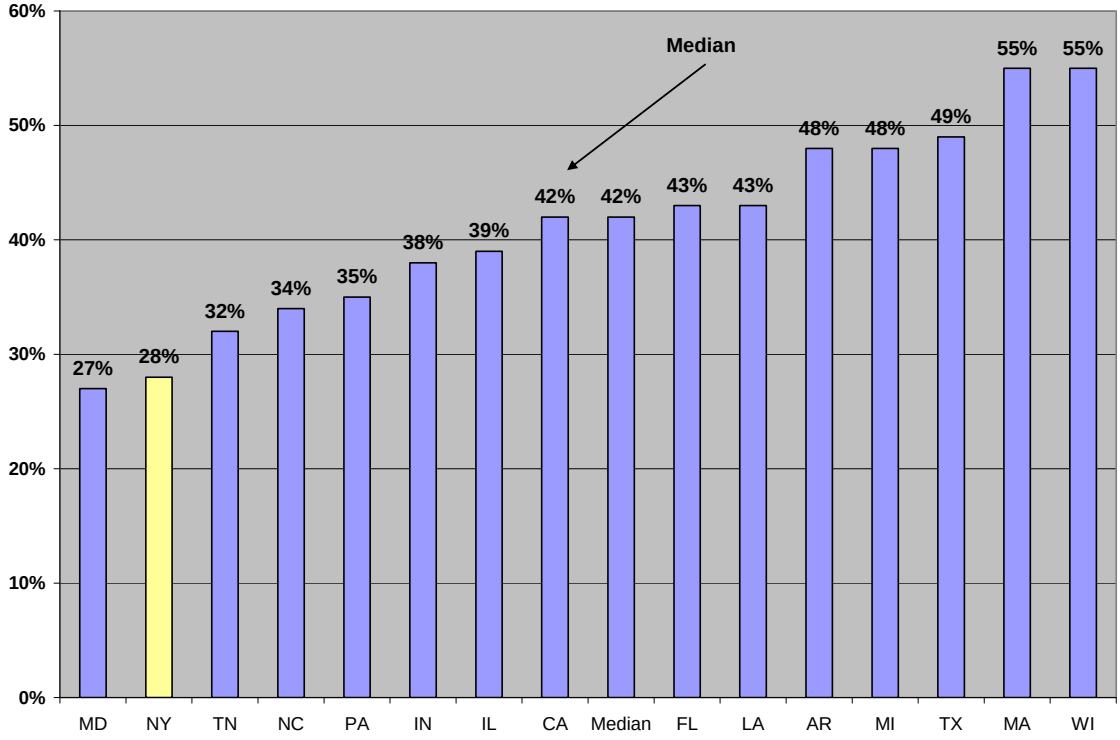


Source: Workers Compensation Research Institute data 2004/2005 with 12 months of development

B.4. *Percentage of claims processed in 14 days or less from date of notice to payor to first indemnity payment.*

This measure focuses on payor performance from the date the payor receives notice to when the first indemnity payment is made. This measure shows the poorest performance for New York State, with only 28% of claimants receiving benefits within 14 days of the payor's notice. Not only is New York State's performance ranked second to last, it is 14 percentage points below the median.

Figure 33: Percentage of Claims With Date of Payor Notice To First Indemnity Payment Less Than or Equal To 14 Days



Source: Workers Compensation Research Institute data 2004/2005 with 12 months of development

The poor performance of New York State in this area of time for first indemnity payment is not solely attributable to the payors, claimants and employers are not acting timely. It is unclear whether this is impacted by the particular requirements of New York State's workers' compensation system. Given New York State's poor performance in this area, NYSID recommends a more in-depth analysis to determine how New York State differs from other states and what short and long term changes should be implemented to improve performance.

C. *Timely Access to Quality Medical Care for Injured Workers*

Access to quality and timely medical care is a basic function of the workers' compensation system. One aspect of the reform process that was designed to address this issue has been the development of medical treatment guidelines. The proposed medical treatment guidelines were developed by NYSID, working with representatives of labor, business and other state agencies. The participants selected highly credentialed physicians and other professionals to serve as resources in the creation of the proposed guidelines, which reflect the consensus of the expert professionals. The guidelines are evidence-based, reflect the sound clinical judgment of the physicians and provide a consistent quality standard for the medical care of injured workers. The guidelines focus on the treatment of injuries of the

lower back, cervical spine, knee and shoulder. WCRI recently reported that these injuries account for nearly 60% of total medical costs in New York State's system.[53]

This Report proposes objective measurements to evaluate the impact of medical treatment guidelines that the WCB may adopt. It is important to note that, due to the wide range of changes resulting from the Reform Act, it may be difficult to isolate the impact of the guidelines alone. However, the proposed measurements should provide indicators of the changes that result from the treatment parameters for the body parts covered by the newly proposed medical guidelines. The proposed measurements also take a broader look at system performance in providing timely access to quality medical care.

Data Limitations:
There are major limitations on available medical data. The current system does not have the detailed medical information (including utilization of services, types of procedures, associated parts of the body treated, costing services, etc.) to allow for the necessary analysis and monitoring of the workers' compensation system. In addition, the current workers' compensation system does not track key data points relating to the adjudication of medical issues, such as the date of initial medical treatment, or timeframes for medical treatment from the date of the medical authorization request until the time of approval or denial of a treatment request. The following list of measurements will include some proposed measures for which data is not currently available. Proposals to address these data deficits will be discussed in the recommendation sections.

The proposed measurements, each of which is discussed below, are:

- Impact of medical treatment guidelines to be adopted by WCB
- Average time for initial access to medical care
- Timeframes for resolving disputes over medical care
- Quality of medical care
- Access to medical care
- Disputes over medical bills

C.1. *Impact of Medical Treatment Guidelines*

The measures in this subsection C.1 are related to measuring medical treatment guidelines. While guidelines are intended to enhance quality medical care, it is important to examine the impact of the guidelines on cost. Given all the changes in the system, it is impossible to show a cause and affect relationship between the implementation of medical guidelines and increased or decreased costs for the major body parts. Nonetheless, it is important to know what is happening to the costs for the four major body parts. The following charts are based on data from CIRB from 2000 and 2003. For these injuries, treatment and recovery to maximum medical improvement may take a long time, so it is helpful to look at older data.

[53] " What are the Most Important Medical conditions in New York's Workers' Compensation " WCRI Flashreport July 2007

C.1.a. *Average cost per claim for injuries by body part*

Figure 34: Number and Average Cost Per Claim By Body Part

Body Part	2000			2003		
	# Claims	Medical $	Avg $ Per Claim	# Claims	Medical $	Avg $ Per Claim
Back	23,106	$141,867,223	$6,140	14,992	$77,533,627	$5,172
Neck	7,742	$70,203,771	$9,068	8,619	$64,709,638	$7,508
Knee	10,515	$58,782,038	$5,590	9,874	$42,107,584	$4,264
Shoulder	4,670	$28,597,236	$6,124	4,940	$27,143,584	$5,495

Source: CIRB data, 2003 at 30 months of development, 2000 at 66 months of development

The second step in evaluating the impact of the medical guidelines is to examine the utilization of services. Using the WCRI data, NYSID looked at system-wide numbers of visits for certain types of providers. Note, for medical data WCRI uses only 13 states rather than the 14 states used for non-medical data. The data for New York State includes claims at 12, 24 and 60 months of development. For the other states studied, WCRI publishes only 12 month development data. For purposes of the following measures, the Report compares New York State to the median of 13 other states. The current data does not allow examination of the use of services by body part. Once detailed medical payment information is added to the data, these measurements can be refined to examine specific body parts.

C.1.b. *Chiropractor and Physical/Occupational Therapist - number of visits per indemnity claim*

New York State's utilization of Chiropractor and PT/OT services is substantially greater than the WCRI 13 state median. Although the guidelines do not set limits on the number of visits to chiropractors, they do establish limits on services. Since we do not have data on services we are using visits as a proxy.

Figure 35: Visits Per Indemnity Claim – Chiropractor and Physical/Occupational Therapist

	New York State			WCRI 13 State Median
Visits Per Indemnity Claim	Claims with 12 Months Development 2004/2005	Claims with 36 Months Development 2002/2005	Claims with 60 Months Development 2000/2005	Claims with 12 Months Development 2003/2004
Chiropractor	32.9	50.1	54.6	18.3
Physical/Occupational Therapist	20.4	28.3	28	15.2

Source: Workers Compensation Research Institute

C.1.c. *Neurological/Neuromuscular Testing - number of visits per indemnity claim:*

WCRI defines Neurological/ Neuromuscular testing to include: motor and sensory nerve conduction studies, Range of Motion tests, and application of neurostimulators. The nerve conduction studies are described and indications for their use identified in the guidelines (Low Back, C-spine and Shoulder). These studies are indicated when there is a concern about nerve damage/injury.

Figure 36: Visits Per Indemnity Claim – Neurological/Neuromuscular Testing

	New York State			WCRI 13 State Median
Visits Per Indemnity Claim	Claims With 12 Months Development 2004/2005	Claims With 36 Months Development 2002/2005	Claims With 60 Months Development 2000/2005	Claims With 12 Months Development 2003/2004
Neurological/Neuromuscular Testing	2.4	2.8	3.4	1.5

Source: Workers Compensation Research Institute

C.1.d. *The number and percent of Medical Forms filed by Health Care Providers that identify application of the medical guidelines for the covered body part.*

The WCB should track this information based on the number of C-4 forms submitted by health care providers.

Education about Medical Treatment Guidelines

An important aspect of new medical treatment guidelines is proper guideline education for all stakeholders who use the guidelines. To ensure that this education is adequate and ongoing, the following data should be collected and tracked.

C.1.e. *The number and percent of Adjudicators who receive training in the medical guidelines.*

The WCB should track this information based on training and education programs provided to the system adjudicators such as WCB judges and medical bill dispute arbitrators**.**

C.1.f. *The number and percent of Health Care Providers who receive training in the medical guidelines.*

The WCB should track this information based on training and education programs provided to the health care providers who treat injured workers.

C.1.g. *The number of Medical Reviewers at the insurers who receive training in the medical guidelines.*

The NYSID and/or the WCB should track this information based on an annual certification program for the medical reviewers at the insurers.

C.2. *Access to Medical Care*

C.2.a. *Access to physicians within a reasonable distance from claimant's home.*

A reasonable proxy for measuring proximity of physicians to a claimant's home is to look at the distribution of authorized physicians across the state. A measure of this is the number of physicians who are authorized to provide workers' compensation service in a county as a percentage of all of the physicians practicing in that county. There are some counties that do not have an adequate number of physicians licensed to practice. As a proxy, this measure uses the number of physicians within a county that serve workers' compensation clients as a percent of the total number of physicians licensed to provide care in the county. Note these numbers do not include other health care providers. .

Figure 37: Physicians Licensed and Authorized By County – 2007

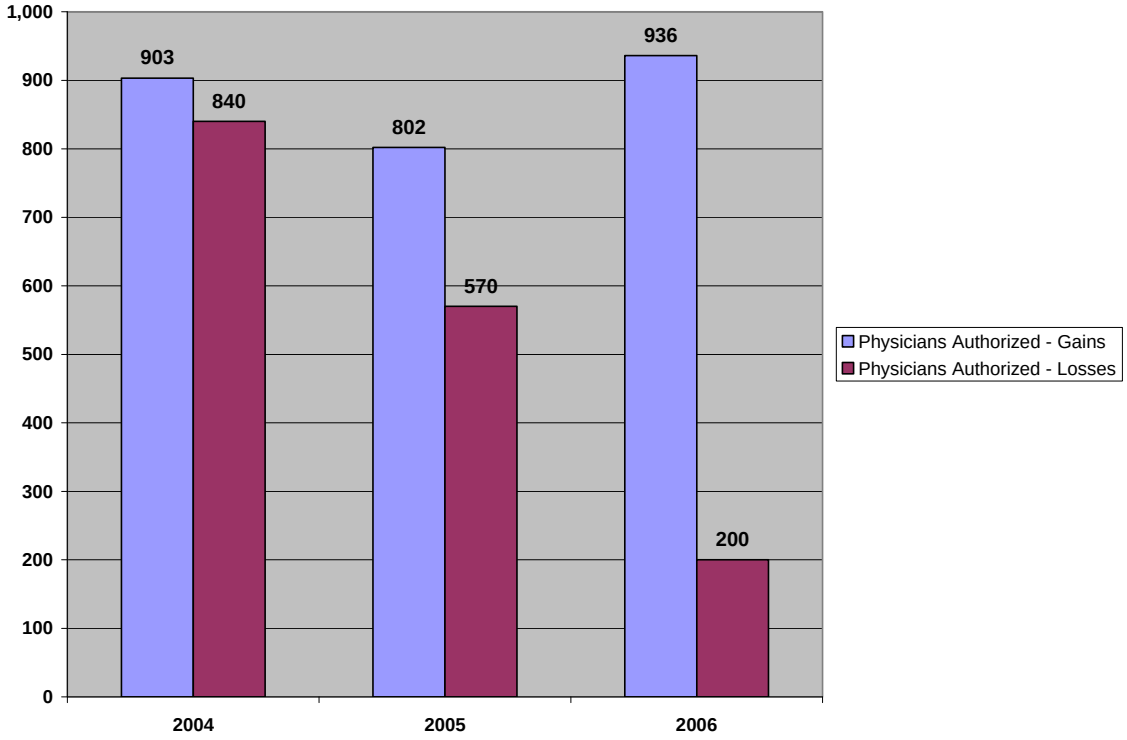
County	Licensed	Authorized	% Authorized	2006 Population
Yates	34	27	79%	24,732
Otsego	340	254	75%	62,583
Madison	132	92	70%	70,197
Schuyler	33	23	70%	19,415
Delaware	74	51	69%	46,977
Chenango	75	51	68%	51,787
Broome	703	470	67%	196,269
Cortland	89	59	66%	48,483
Chemung	305	201	66%	88,641
Wayne	108	71	66%	92,889
Herkimer	60	39	65%	63,332
Steuben	231	150	65%	98,236
Washington	54	35	65%	63,368
Cayuga	122	78	64%	81,243
Warren	280	179	64%	66,087
Oneida	643	408	63%	233,954
Orleans	43	27	63%	43,213
Livingston	91	57	63%	64,173
Niagara	365	228	62%	216,130
Oswego	177	110	62%	123,077
Genesee	100	61	61%	58,830
Tioga	51	31	61%	51,285
Lewis	33	20	61%	26,685
Schoharie	25	15	60%	32,196
Fulton	106	63	59%	55,435
Wyoming	56	33	59%	42,613
Allegany	58	34	59%	50,267
Onondaga	2062	1190	58%	456,777
Schenectady	533	307	58%	150,440
Ulster	469	269	57%	182,742
Saratoga	549	314	57%	215,473
Montgomery	115	65	57%	49,112
Tompkins	288	160	56%	100,407
Franklin	124	68	55%	50,968
Chautauqua	267	143	54%	135,357
Cattaraugus	155	82	53%	81,534
Columbia	158	83	53%	62,955
Essex	65	34	52%	38,649
Ontario	316	165	52%	104,353
Albany	1739	900	52%	297,556
Rensselaer	358	185	52%	155,292
Sullivan	151	77	51%	76,588
Seneca	22	11	50%	34,724
Jefferson	291	145	50%	114,264
Suffolk	5084	2528	50%	1,469,715
Clinton	239	118	49%	82,166
Orange	1056	507	48%	376,392
Dutchess	955	456	48%	295,146
Putnam	286	136	48%	100,603
Greene	84	39	46%	49,822
Monroe	3336	1517	45%	730,807
Erie	3382	1527	45%	921,390
Hamilton	5	2	40%	5,162
St. Lawrence	218	82	38%	111,284
Nassau	9595	3385	35%	1,325,662
Richmond	1674	580	35%	477,377
Rockland	1418	474	33%	294,965
Westchester	7135	2202	31%	949,355
Queens	5704	1653	29%	2,255,175
Bronx	2345	620	26%	1,361,473
Kings	5592	1424	25%	2,508,820
New York	18768	3537	19%	1,611,581

Source: New York Workers' Compensation Board

C.2.b. *Number of individual physicians gaining and losing WCB authorization by year.*

Over the past three years, there has been an addition of 2,641 individual physicians to the system.[54] A closer review should be undertaken to determine whether the authorized physicians are still accepting workers' compensation patients and to consider the specialty distribution of the physicians. Once a physician is authorized by the WCB, he or she remains on the WCB list until he or she no longer maintains a current New York State medical license or requests removal from the list. Additional research should be done in this area to define the best method of measuring access to physicians.

Figure 38: Physician Authorizations – Gains/Losses By Year[55]



Source: New York Workers' Compensation Board

C.2.c. *Claimant satisfaction with access to care*

Currently there is no data available on this measure. One way to obtain data on claimant satisfaction with access to care is to conduct a survey of a sample of claimants.

[54] The "Physician Authorizations" chart starts at 2004, because in the prior year there was a major change in the Department of Education tracking system, so comparable numbers are not available prior to 2004. The Department of Education is the state agency that licenses physicians.

[55] The data is for individual physicians and does not reflect groups or associations of physicians.

C.3. *Determine appropriate measure for quality of care*

One approach to measuring quality of care is a random sample of claimants' perspective on quality of care via a survey. Another approach is to contract with an organization that has developed a process to evaluate the quality of care based on scientifically developed quality indicators. We recommend that the WCB review possible measures of quality of care including both surveys and quantitative measures.

C.4. *Timeframes for resolving disputes over medical care*

The following measure focus on the timeframes for receiving medical care and resolving disputes over medical care.

C.4.a. *Median number of days to resolve denials of medical care disputes*

Payors must file a C-8.1A form when they deny a pre-authorization request or deny that further medical care is needed. Using the current system, WCB cannot produce an electronic report on the timeframes for resolution of this issue. Both WCB and SIF took samples of medical authorizations and did manual evaluations and, where possible, electronic evaluations to measure the timeliness of this process. The median timeframes ranged from 90 to 135 days. After waiting for 4 months or longer for a resolution, the cases were largely decided in favor of the claimant's doctor and the medical procedure was approved. In the samples taken, the percentage of doctors' decisions or requests being upheld ranged from 72% to 78%.

Although there is currently incomplete data on the length of time to resolve denial of care disputes, there is data to show the number of medical requests filed. The percentage of claims with disputes over denial of care has remained relatively constant at 2% for no-compensation claims[56], 7% to 8% for medical-only claims, and 9% to 10% for indemnity claims. Use of medical guidelines could result in a lower number of disputes over certain types of medical care. In addition, the higher dollar threshold when pre-authorization of care is required, another change required by the Reform Act, should also result in a lower number of these disputes.

[56] No-compensation claims includes a variety of claims including: accidents reported to WCB by the employer where the employee does not pursue the claim, claims where the claimant does not appear for a hearing, and claims that are denied by the WCB

Figure 39: Number and Percentage of Disputed Medical Pre-Authorizations

Indexed Year	No Compensation Cases			Medical Only Cases			Indemnity Cases		
	Disputed	Indexed	Percent	Disputed	Indexed	Percent	Disputed	Indexed	Percent
2000	755	34,678	2.2%	2,376	27,546	8.6%	11,169	104,765	10.7%
2001	633	36,886	1.7%	2,193	28,716	7.6%	10,547	101,607	10.4%
2002	624	36,259	1.7%	2,152	29,114	7.4%	9,668	94,527	10.2%
2003	614	34,067	1.8%	2,087	28,861	7.2%	8,727	90,470	9.6%
2004	599	31,398	1.9%	2,238	29,229	7.7%	8,038	84,497	9.5%
2005	652	31,258	2.1%	2,180	28,299	7.7%	7,050	79,608	8.9%
2006	718	34,068	2.1%	2,227	31,557	7.1%	5,066	71,032	7.1%
Total	4,595	238,614	1.9%	15,453	203,322	7.6%	60,265	626,506	9.6%

Source: New York Workers' Compensation Board

C.4.b. *Median number of days from when a WCB Form MD-1 is filed to issuance of an Order of the Chair authorizing the requested medical care.*

Workers' Compensation Law §13-a (5) requires medical providers to obtain authorization from the insurance carrier, self insured employer or State Insurance Fund in order to be paid for specialist consultations, surgical operations, physical therapy, occupational therapy, or diagnostic tests costing more than $1,000. The form filed to obtain pre-authorization is the MD-1 form. This data is currently not available.

C.4.c. *Number of days from when a request for payment is made for medical care authorized by Order of the Chair to payment for such care*

This data is currently not available.

C.5. *Disputes over Billing for Services Rendered*

Another factor that influences physicians' willingness to participate in the workers' compensation system is timeliness of payment for their medical services. There are two basic types of disagreements over medical bills, legal and value. Legal disputes include: treatment was not pre-approved, medical reports were not filed on a timely basis or the treatment was for a pre-existing condition. In these disputes, the payor files a C-8.1B form and the dispute goes to a hearing. The second type of dispute pertains to value. That is, payors do not agree that the service already preformed was medically necessary, e.g. it was too frequent or the injury did not require the level of care received. In order to reach a resolution on value disputes, the claim is sent to an arbitration panel which consists of medical peers.

C.5.a. *Average number of days from submission of bill to payment for services.*

Currently the WCB does not track this information. A requirement to begin tracking this information is included in the recommendations section.

C.5.b. *Time to resolve disputes over liability for medical bills*

A payor files a form C8.1B when it receives a medical bill it does not believe it is legally obligated to pay. The WCB tracks the numbers of these disputes but not the timeframes for resolving the disputes or which party won the dispute. Requirements to track this data are included in the recommendation section. The table below shows the number of disputes by category of claim. Due to the lack of development in more recent claims, i.e., 2005/2006, we focused on the 2000 to 2004 data. In this range, the percent of claims with medical disputes has remained fairly constant.

Figure 40: Number and Percentage of Disputes Over Medical Billing Liability

Indexed Year	No Compensation Cases			Medical Only Cases			Indemnity Cases		
	Disputed	Indexed	Percent	Disputed	Indexed	Percent	Disputed	Indexed	Percent
2000	1,913	34,678	5.5%	3,631	27,546	13.2%	15,701	104,765	15.0%
2001	2,188	36,886	5.9%	3,952	28,716	13.8%	16,135	101,607	15.9%
2002	2,450	36,259	6.8%	4,490	29,114	15.4%	15,267	94,527	16.2%
2003	2,344	34,067	6.9%	4,099	28,861	14.2%	13,721	90,470	15.2%
2004	2,420	31,398	7.7%	4,276	29,229	14.6%	12,220	84,497	14.5%
2005	2,458	31,258	7.9%	4,138	28,299	14.6%	10,009	79,608	12.6%
2006	2,523	34,068	7.4%	4,205	31,557	13.3%	7,188	71,032	10.1%
Total	16,296	238,614	6.8%	28,791	203,322	14.2%	90,241	626,506	14.4%

Source: New York Workers' Compensation Board

C.5.c. *Time to resolve medical value disputes in arbitration*

The second type of dispute over medical bills is a dispute over the value of the service. In this case, the dispute goes to a panel of medical experts for arbitration. The following table shows the number of arbitrations, the amount of the award, the length of time to hearing and the length of time from hearing to award. As of 2006, the length of time from request to the hearing was over 300 days or over 10 months.

Figure 41: Average Award and Average Time To Resolve Medical Claim Value Disputes

Year	# Of Cases	Avg Dispute $	Avg Award $	Avg Days From Request To Hearing	Avg Days From Hearing To Award
2004	884	$1,521	$415	290	10
2005	734	$1,723	$515	267	12
2006	947	$1,494	$538	310	9
Total	2,565	$1,569	$489	291	10

Source: New York Workers' Compensation Board

C.5.d. *How soon do payors pay an award*

This data is currently not available, but it is included in the recommendations for new data to collect.

D. *Timely claim resolution*

The Governor's March 13, 2007 letter directed the NYSID to examine the resolution of disputed cases at the WCB and to design methods for resolving them within ninety days of a dispute. The Superintendent of Insurance ("Superintendent") sent his recommended changes to the process and draft regulations to implement these changes on June 1, 2007. Those proposed regulations are referred to as the "Streamlined Docket." The first seven measurements in this segment are designed to measure areas addressed by the proposed Streamlined Docket. This section will also focus on other measures of claim processing that are not directly addressed by the Streamlined Docket.

D.1. *Proposed Streamlined Docket*

The proposed Streamlined Docket focused on controverted claims with some exceptions. Unrepresented claimants and complex claims including many occupational disease claims are excluded from certain requirements of the Streamlined Docket. A claim is controverted when the payor challenges one of the following items:

- Whether the accident was work-related;
- Whether the claimant notified his or her employer within the statutory time limit;
- Whether there is a causal relationship between the accident and the resulting injury or disability;
- Whether the employer is insured by the payor.

During deliberations over the controverted issues, the claimant does not receive any indemnity payments. Delays in indemnity benefits cause economic hardship. In order to receive medical treatment, the doctor may require the claimant to sign a release stating if the treatment is not covered by workers' compensation, the worker will pay for the treatment. Many claimants may not be willing to risk being held liable for the cost of treatment so treatments are delayed. Delays in medical benefits can affect the worker's long term medical prognosis and the ability to return to work.

All tables in this section are based on data from the WCB from its claims information system.

The Streamlined Docket proposes fundamental changes to the indexing process. Under the recommended process, claims will not be indexed until forms from the employer or employee and the doctor are received. Furthermore, the Streamlined Docket proposes to start the clock running when a notice of controversy (WCB Form C-7) is filed by the payor, which occurs after indexing. The figures in this section use the indexing date as a starting point. While it may not be an exact measure for the new system, this is a reasonable method to evaluate timeframes for the current system.

Resolution of a controverted claim means the claim has been either accepted as a workers' compensation claim or denied or the claimant has stopped pursuing the claim.

It should be noted that even after a controversy has been resolved, there may still be outstanding issues such as the type of medical care, or amount of average weekly wage. In each of the following measures D.1.a through D.1.j, there are two sets of charts. The first chart looks at all controverted claims. The second chart excludes claims that did not have prima facie medical evidence ("PFME"), [57] claims where the worker was not represented by an attorney (non-represented claims), and occupational disease claims. The exclusions drop the number of controverted claims by a total of 41%. These alternatives are an attempt to provide baseline measures for the types of claims that will be impacted by changes in the adjudication processes.

D.1.a. *Percentage of claims controverted compared to total claims.*

The following table shows that while the total number of controverted claims has been declining consistent with the decline in the number of overall claims, there has been a modest increase in the percentage of claims controverted. Over the past few years, the percentage of controverted claims rose from 15.0% in 2000 to 16.9% in 2006. The Streamlined Docket is intended to reduce the number and percent of controverted claims. A principal tool for achieving this is to provide payors at an early stage in the process with more information to decide whether or not to accept or controvert a claim. This should reduce the need for protective defenses by the payor, such as when the payor controverts a claim when it does not have adequate information to make an informed decision regarding its merits.

The following figure includes no-compensation claims. This category includes a variety of claims including: accidents reported to WCB by the employer where the employee does not pursue the claim, claims where the claimant does not appear for a hearing, and claims that are denied by the WCB. It is important to include these claims when examining WCB processing because they represented 22% of indexed claims. In addition, in 2004, 41.5% of no-compensation claims were controverted.

[57] PFME is a medical report by an attending medical provider that gives a history of the accident or occupational disease and a statement that the claimant's injury is causally related to the accident or occupational disease and a diagnosis.

Figure 42: Percentage of Controverted Claims

Indexed Year	No Compensation Cases			Medical Only Cases			Indemnity Cases			Total Cases		
	Contro-verted	Indexed	% Contro-verted	Contro-verted	Indexed	% Contro-verted	Contro-verted	Indexed	% Contro-verted	Contro-verted	Indexed	% Contro-verted
2000	13,439	34,678	38.8%	2,041	27,546	7.4%	9,536	104,765	9.1%	25,016	166,989	15.0%
2001	14,226	36,886	38.6%	2,111	28,716	7.4%	9,996	101,607	9.8%	26,333	167,209	15.7%
2002	14,107	36,259	38.9%	2,117	29,114	7.3%	9,743	94,527	10.3%	25,967	159,900	16.2%
2003	14,113	34,067	41.4%	2,225	28,861	7.7%	9,121	90,470	10.1%	25,459	153,398	16.6%
2004	13,040	31,398	41.5%	2,216	29,229	7.6%	8,490	84,497	10.0%	23,746	145,124	16.4%
2005	12,825	31,258	41.0%	2,444	28,299	8.6%	7,808	79,608	9.8%	23,077	139,165	16.6%
2006	13,522	34,068	39.7%	2,840	31,557	9.0%	6,693	71,032	9.4%	23,055	136,657	16.9%
Total	95,272	238,614	39.9%	15,994	203,322	7.9%	61,387	626,506	9.8%	172,653	1,068,442	16.2%

Source: New York Workers' Compensation Board

Excluding claims with no PFME, occupational disease claims and non-represented claims cuts the percentage of controverted claims by more than half in 2004, from 16.4% to 6.6%. The reason to focus on 2004 rather than later years is that the more severe claims in 2005 and 2005 have not had adequate time to mature.

Figure 43: Percentage of Controverted Claims Excluding Occupational Disease, Non-represented Claims and Claims With No PFME

Indexed Year	No Compensation Cases			Medical Only Cases			Indemnity Cases			Total Cases		
	Contro-verted	Indexed	% Contro-verted	Contro-verted	Indexed	% Contro-verted	Contro-verted	Indexed	% Contro-verted	Contro-verted	Indexed	% Contro-verted
2000	2,665	34,678	7.7%	799	27,546	2.9%	6,537	104,765	6.2%	10,001	166,989	6.0%
2001	3,004	36,886	8.1%	913	28,716	3.2%	6,919	101,607	6.8%	10,836	167,209	6.5%
2002	2,971	36,259	8.2%	941	29,114	3.2%	6,669	94,527	7.1%	10,581	159,900	6.6%
2003	2,915	34,067	8.6%	1,003	28,861	3.5%	6,230	90,470	6.9%	10,148	153,398	6.6%
2004	2,859	31,398	9.1%	1,038	29,229	3.6%	5,682	84,497	6.7%	9,579	145,124	6.6%
2005	2,916	31,258	9.3%	1,208	28,299	4.3%	5,283	79,608	6.6%	9,407	139,165	6.8%
2006	3,533	34,068	10.4%	1,470	31,557	4.7%	4,617	71,032	6.5%	9,620	136,657	7.0%
Total	20,863	238,614	8.7%	7,372	203,322	3.6%	41,937	626,506	6.7%	70,172	1,068,442	6.6%

Source: New York Workers' Compensation Board

D.1.b. *For controverted claims, average number of days for the WCB to determine Prima Facie Medical Evidence.*

PFME determination is important to a claim, because it must be made before the claim can progress. The WCB does not record this metric. The proposed Streamlined Docket sets a goal of 6 days from date of dispute to PFME determination. The time for PFME determination is a new data element that NYSID recommends the WCB collect.

D.1.c. *For controverted claims, average number of days from dispute to the Early Settlement Mediation and from date of dispute to pre-conference statements.*

The Streamlined Docket proposes a new process which is early settlement mediation with a goal of 20 days from date of dispute. Pre-hearing conference statements are required to be filed by represented claimants. NYSID recommends that WCB collect the timeframes in which each of these events occurs and the outcomes of the mediation.

D.1.d. *The percentage of controverted claims resolved at pre-hearing conferences and the average days from date of dispute to pre-hearing conference for cases resolved at the pre-hearing conference.*

The Reform Act requires that a pre-hearing conference take place within forty-five days of the payor's or employer's receipt of a notice of controversy and medical report referencing an injury.[58] The following table examines controverted claims. It shows that the percentage of cases resolved at a pre-hearing conference has risen slightly over the past 7 years from 50.8% to 54.3.5%. Another improvement is that the average number of days from indexing to resolution at the pre-hearing conference has declined from 79 days in 2000 to 59 days in 2006. Since the pre-hearing conference usually occurs within the first year, it is reasonable to examine the trend through 2006 for this measure.

Implementation of a proposed Streamlined Docket should produce a significant decline in both the percent of claims going to a pre-hearing conference, and the percent of claims resolved at the pre-hearing conference. As noted in the prior measure, there will be two processes that will occur before the pre-hearing conference, the early settlement mediation and the pre-hearing conference statements. These processes, through settlement of the controversy should eliminate some claims that used to go to the pre-hearing conference. Further, about 43% of the claims marked "resolved" at the pre-hearing conference are resolved because the claimant does not show up or reschedule. These types of claims may be "resolved" prior to the pre-

[58] Workers' Compensation Law § 25(2-a)(a).

hearing conference at the early settlement mediation - either by the claimant's non-appearance or as discussed above, through settlement. .

Figure 44: Number and Percentage of Controverted Claims Resolved at the Pre-Hearing Conference

Indexed Year	Total Controverted	Resolved at Pre-Hearing Conference		
		Total Claims	Percent Resolved	Avg Days From Indexing
2000	25,016	12,719	50.8%	79
2001	26,333	13,466	51.1%	74
2002	25,968	13,636	52.5%	68
2003	25,459	13,542	53.2%	66
2004	23,746	12,605	53.1%	63
2005	23,078	12,420	53.8%	60
2006	23,055	12,509	54.3%	59
Totals	172,655	90,897	52.6%	67

Source: New York Workers' Compensation Board

Excluding claims with no PFME, occupational disease and non-represented claims reduces the percentage resolved at the pre-hearing conference in 2006 from 54.3% to 28%. On the other hand, the average number of days to resolve a dispute increases for 2006 from 59 days to 74 days.

Figure 45: Number and Percentage of Controverted Claims Resolved at the Pre-Hearing Conference Excluding Occupational Disease, Non-represented Claims and Claims with No PFME

Indexed Year	Total Controverted	Total Controverted w/Qualifying Medical	Resolved at Pre-Hearing Conference		
			Total Claims	Percent Resolved	Avg Days From Indexing
2000	11,202	10,001	2,317	23.2%	100
2001	11,966	10,836	2,654	24.5%	89
2002	11,704	10,581	2,636	24.9%	84
2003	11,285	10,148	2,432	24.0%	79
2004	10,585	9,579	2,365	24.7%	77
2005	10,439	9,407	2,436	25.9%	76
2006	10,608	9,620	2,693	28.0%	74
Totals	**77,789**	**70,172**	**17,533**	25.0%	**83**

Source: New York Workers' Compensation Board

D.1.e. *The percent of controverted claims resolved at first hearing, and the average number of days from date of dispute to first hearing for these claims.*

In 2006, for claims resolved at the first hearing for claimants with and without legal representation, the average length of time from the pre-hearing conference to the first hearing was 142 days or almost five months. Under the proposed Streamlined Docket, if the case is not resolved at the pre-hearing conference, the first hearing must be held the same day as the pre-hearing conference. The goal is to have the first hearing within 45 days of indexing for represented claimants.

Figure 46: Number and Percentage of Controverted Claims Resolved at the First Hearing

Indexed Year	Total Controverted	Resolved at First Hearing		
		Total Claims	Percent Resolved	Avg Days From Indexing
2000	25,016	5,273	21.1%	198
2001	26,333	5,377	20.4%	182
2002	25,968	5,450	21.0%	164
2003	25,459	5,312	20.9%	160
2004	23,746	5,097	21.5%	153
2005	23,078	4,906	21.3%	145
2006	23,055	5,096	22.1%	142
Totals	172,655	36,511	21.1%	164

Source: New York Workers' Compensation Board

Excluding claims with no PFME, occupational disease and non-represented claims appears to have little impact on the average number of days from indexing to resolution. It is unclear what this means - either that occupation disease claims are not taking more time or that having an attorney does not have a major impact on the time it takes to resolve a claim. Further analysis is needed.

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Figure 47: Number and Percentage of Controverted Claims Resolved at the First Hearing Excluding Occupational Disease, Non-represented Claims and Claims With No PFME

Indexed Year	Total Controverted	Total Controverted w/Qualifying Medical	Resolved at First Hearing		
			Total Claims	Percent Resolved	Avg Days From Indexing
2000	11,202	10,001	2,826	28.3%	189
2001	11,966	10,836	3,081	28.4%	179
2002	11,704	10,581	3,171	30.0%	160
2003	11,285	10,148	3,127	30.8%	157
2004	10,585	9,579	3,076	32.1%	152
2005	10,439	9,407	3,058	32.5%	145
2006	10,608	9,620	3,158	32.8%	144
Totals	**77,789**	**70,172**	**21,497**	30.6%	**160**

Source: New York Workers' Compensation Board

D.1.f. *For controverted cases, the number and percentage of claims resolved at the second hearing, and the average number of days from date of dispute to date of resolution for claims resolved at the second hearing*

Under the proposed Streamlined Docket, the goal is to have the second hearing (if necessary) within 85 days from dispute for claimants with legal representation. In 2004, claims took an average of 253 days from indexing to resolution. On this measure we focus on 2004 because some claims that require a second hearing can take longer than a year to reach the second hearing.

Figure 48: Number and Percentage of Controverted Claims Resolved at the Second Hearing

Indexed Year	Total Controverted	Resolved At Second Hearing		
		Total Claims	Percent Resolved	Avg Days From Indexing
2000	25,016	2,678	10.7%	316
2001	26,333	2,966	11.3%	301
2002	25,968	2,820	10.9%	276
2003	25,459	2,905	11.4%	264
2004	23,746	2,749	11.6%	253
2005	23,078	2,820	12.2%	252
2006	23,055	2,804	12.2%	228
Totals	**172,655**	**19,742**	**11.4%**	**270**

Source: New York Workers' Compensation Board

Once again, excluding claims with no PFME, occupational disease and non-represented claims appears to have no impact on the average length of time to resolve claims.

Figure 49: Number and Percentage of Controverted Claims Resolved at the Second Hearing Excluding Occupational Disease, Non-represented Claims and Claims With No PFME

Indexed Year	Total Controverted	Total Controverted w/Qualifying Medical	Resolved at Second Hearing		
			Total Claims	Percent Resolved	Avg Days From Indexing
2000	11,202	10,001	1,759	17.6%	306
2001	11,966	10,836	2,023	18.7%	293
2002	11,704	10,581	1,907	18.0%	274
2003	11,285	10,148	1,959	19.3%	261
2004	10,585	9,579	1,807	18.9%	250
2005	10,439	9,407	1,897	20.2%	251
2006	10,608	9,620	1,917	19.9%	231
Totals	**77,789**	**70,172**	**13,269**	18.9%	**266**

Source: New York Workers' Compensation Board

D.1.g. *For controverted cases, the number and percentage of claims resolved after the second hearing, and the average number of days from the date of dispute to date of resolution for claims resolved after the second hearing*

For claims that take more than 2 hearings to resolve, the average number of days to resolution has also dropped, but for 2004, it still took 512 days, or almost 1 and a half years on average, to resolve these claims from indexing. The reason we focused on 2004 is, more recent years, i.e., 2005 to 2006, do not include some of the PPD NSL and other claims that take more the 3 years to classify, and therefore, understate the number of days to resolution.

Figure 50: Number and Percentage of Controverted Claims Resolved After the Second Hearing

Indexed Year	Total Controverted	Resolved After Second Hearing		
		Total Claims	Percent Resolved	Avg Days From Indexing
2000	25,016	4,276	17.1%	653
2001	26,333	4,382	16.6%	605
2002	25,968	3,990	15.4%	579
2003	25,459	3,633	14.3%	556
2004	23,746	3,231	13.6%	512
2005	23,078	2,796	12.1%	448
2006	23,055	2,311	10.0%	351
Totals	172,655	24,619	14.3%	548

Source: New York Workers' Compensation Board

Once again, excluding claims with no PFME, occupational disease and non-represented claims has little impact on the average time to resolve claims.

Figure 51: Number and Percentage of Controverted Claims Resolved After the Second Hearing Excluding Occupational Disease, Non-represented Claims and Claims With No PFME

Indexed Year	Total Controverted	Total Controverted w/Qualifying Medical	Resolved after Second Hearing		
			Total Claims	Percent Resolved	Avg Days From Indexing
2000	11,202	10,001	3,058	30.6%	654
2001	11,966	10,836	3,021	27.9%	630
2002	11,704	10,581	2,827	26.7%	594
2003	11,285	10,148	2,593	25.6%	563
2004	10,585	9,579	2,294	23.9%	522
2005	10,439	9,407	1,920	20.4%	459
2006	10,608	9,620	1,591	16.5%	359
Totals	**77,789**	**70,172**	**17,304**	24.7%	**560**

Source: New York Workers' Compensation Board

D.1.h. *Average number of days to resolve a controverted case from indexing to establishment.*

The following chart shows in 2004, 10,706 had to wait an average of 240 days for their controverted claims to be established as a workers' compensation claim. The proposed Streamlined Docket sets a goal to reduce this time to 90 days or less.

Establishment of a case occurs when the WCB has determined Accident, Notice and Causal Relationship. This means the Board has established that: (1) an accident or disease occurred, (2) notice was received on a timely basis, and (3) the cause of the accident or disease is directly related to the claimant's employment. The following chart shows that as of 2004 it took an average of 264 days to establish a claim. The reason we focus on 2004 is the data from 2005 and 2006 is not developed enough to be compared to the earlier years. The percentage of claims won by the claimant has dropped slightly from 46.3% in 200 to 45.1% in 2004. This percentage is somewhat ambiguous, because it does not mean that the payor won in all of the other claims. Many of those claims were never actively pursued by claimants. This is a major limitation in the WCB data: it does not distinguish between the claims that were dropped and the claims where the WCB decided in favor of one of the parties. This limitation is addressed in the recommendation section.

Figure 52: Average Number of Days To Resolve Controverted Claims From Indexing To Establishment

		Established					Not Established			Pending	
Index Year	Total Contro-verted Claims	Estab. Total	Estab. Pct	Avg Days to Estab.	Estab. <= 120 Days	Estab. <= 120 Days Pct	Total	Pct	Avg Days to Close	Total	Pct
2000	25,016	11,577	46.3%	348	2,866	11.5%	13,350	53.4%	201	89	0.4%
2001	26,333	12,107	46.0%	328	3,092	11.7%	14,135	53.7%	187	91	0.3%
2002	25,968	11,861	45.7%	300	3,270	12.6%	13,953	53.7%	173	154	0.6%
2003	25,459	11,346	44.6%	290	3,121	12.3%	13,955	54.8%	165	158	0.6%
2004	23,746	10,706	45.1%	264	3,131	13.2%	12,866	54.2%	147	174	0.7%
2005	23,078	10,253	44.4%	240	3,105	13.5%	12,440	53.9%	133	385	1.7%
2006	23,055	9,533	41.3%	205	2,917	12.7%	12,433	53.9%	112	1,089	4.7%
Totals	**172,655**	**77,383**	**44.8%**	**285**	**21,502**	**12.5%**	**93,132**	**53.9%**	**161**	**2,140**	**1.2%**

Source: New York Workers' Compensation Board

When claims with no PFME, occupational disease and non-represented claims are excluded the percentage of controverted claims established in 2004 grows from 45.1% to 70.1% and the length of time to establish a claim increases from 264 days to 278 days.

Figure 53: Average Number of Days To Resolve Controverted Claims and From Indexing To Establishment Excluding Occupational Disease, Non-represented Claims and Claims With No PFME

		Established					Not Established			Pending	
Index Year	Total Contro-verted Claims	Estab. Total	Estab. Pct	Avg Days to Estab.	Estab. <= 120 Days	Estab. <= 120 Days Pct	Total	Pct	Avg Days to Close	Total	Pct
2000	10,001	7,334	73.3%	365	1,486	14.9%	2,640	26.4%	473	27	0.3%
2001	10,836	7,832	72.3%	341	1,727	15.9%	2,973	27.4%	420	31	0.3%
2002	10,581	7,610	71.9%	312	1,828	17.3%	2,936	27.7%	397	35	0.3%
2003	10,148	7,233	71.3%	305	1,672	16.5%	2,799	27.6%	383	116	1.1%
2004	9,579	6,719	70.1%	278	1,668	17.4%	2,720	28.4%	333	140	1.5%
2005	9,407	6,491	69.0%	252	1,679	17.8%	2,620	27.9%	292	296	3.1%
2006	9,620	6,087	63.3%	214	1,604	16.7%	2,700	28.1%	221	833	8.7%
Totals	**70,172**	**49,306**	**70.3%**	**299**	**11,664**	**16.6%**	**19,388**	**27.6%**	**361**	**1,478**	**2.1%**

Source: New York Workers' Compensation Board

D.1.i. *Average number of adjournments for claims that have adjournments*

.Another area the Streamlined Docket focus on is reducing the number of adjournments. WCB data currently does not track this information. It is recommended that this data be collected.

D.1.j. *For claims that have adjournments the average number of days between hearings.*

D.2. *Non-Streamlined Docket Measures of Claim Resolution*

All of the prior measures focused on controverted claims, the subset of claims directly impacted by the proposed Streamlined Docket. The following measures look at the broader spectrum of claims including both controverted and no-controverted claims.

D.2.a. *Average number of hearings for indemnity claims that require hearings.*

For this measure, we look at claims by the year they were resolved. Resolved means the claim has been established and all other disputes including medical, average weekly wage, and percent disability have been resolved. Seventy percent of the indemnity claims resolved in the last two years had at least one hearing before they were resolved. For the subset of claims that had at least one hearing, the average number of hearings was 5.6.

Figure 54: Average Number of Hearings For Indemnity Claims

Resolution Year	Indemnity Claims Resolved	Indemnity Claims Resolved By Hearing	Percent Resolved by Hearing	Number of Hearings
2006	124,029	82,246	66.3%	5.6
2007	168,810	124,272	73.6%	5.7
Total	292,839	206,518	70.5%	5.6

Source: New York Workers' Compensation Board

D.2.b. *Median number of days for resolution of each process type.*

This table looks at only claims that were established

Figure 55: Median Days To Claim Resolution By Process Type

Indexed Year	Admin. Decision		Conciliation		Hearing		Total Established	
	Claims	Median Days	Claims	Median Days	Claims	Median Days	Claims	Median Days
2000	31,032	108	25,815	159	64,120	169	120,967	148
2001	33,247	88	26,030	112	59,293	129	118,570	108
2002	32,296	76	25,601	91	54,186	106	112,083	90
2003	33,495	77	24,513	90	50,218	103	108,226	88
2004	34,448	72	23,273	90	45,494	99	103,215	84
2005	34,601	96	22,117	146	41,012	163	97,730	133
2006	34,573	97	23,457	152	34,963	169	92,993	137
Total	233,692	88	170,806	120	349,286	133	753,784	112

Source: New York Workers' Compensation Board

D.3.*Non-Controverted Claims*

The next few measures look at the claims where the payor accepts that the claim is covered by workers' compensation. Although the payor accepts, there can be disputes over medical treatment, average weekly wage, or other items.

D.3.a. *Average number of hearings for when the claimant was represented by an attorney compared to claimants without legal representation.*

The following table shows that overall the number of hearings for non-controverted claims has been declining steadily. However, when the claims are split between represented and non-represented claimants, a different picture emerges. While the number of hearings for non-represented claimants has remained stable, there has been a decline in hearings for represented claimant. In addition, the number of claimants who are represented has also declined.

Figure 56: Number of Claims and Hearings For Non-Controverted Claims

Indexed Year	Represented		Not Represented		Total		%
	Claims	Hearings	Claims	Hearings	Claims	Hearings	Represented
2000	46,664	4.7	17,456	1.7	64,120	3.9	27%
2001	44,054	4.6	15,239	1.7	59,293	3.8	26%
2002	41,573	4.4	12,613	1.7	54,186	3.8	23%
2003	39,621	4.2	10,597	1.7	50,218	3.7	21%
2004	36,412	3.9	9,084	1.7	45,496	3.5	20%
2005	32,877	3.4	8,136	1.6	41,013	3.1	20%
2006	27,586	2.7	7,377	1.6	34,963	2.5	21%
Total	268,787	4.1	80,502	1.7	349,289	3.6	23%
Percent	77.0%		23.0%		100%		

Source: New York Workers' Compensation Board

D.3.b. *Average duration of TTD claims from indexing to establishment.*

On average, a TTD claim takes six months to establish, and 94.5% of the claims are established within the first 12 months.

Figure 57: Average Duration of TTD Claims From Indexing to Establishment

Established Year	Years from Indexing to Establishment (ANCR / ODNCR)								
	0 to 1	1 to 2	2 to 3	3 to 4	4 to 5	5 to 6	6 to 7	Over 7	Total
2006	56,411	2,527	275	122	67	30	21	157	59,610
2007	55,422	3,069	302	115	37	32	24	97	59,098
Total	111,833	5,596	577	237	104	62	45	254	118,708
Percent	94.2%	4.7%	0.5%	0.2%	0.1%	0.1%	0.0%	0.2%	100.0%

Source: New York Workers' Compensation Board

D.3.c. *Average length of time from indexing to classification for PPD SL and PPD NSL claims*

The following two tables show data by the year a claim is classified. Claims from many different accident years can be classified is the same year. On average a PPD SL takes 2.3 years to establish, the median time is 1.8 years. The average time to classify a PPD-NSL is 4.5 years, and the median is 3.8 years

Figure 58: Average Duration For PPD SL Claims From Indexing to Classification

Classification Year	Years from Indexing to Classification								
	0 to 1	1 to 2	2 to 3	3 to 4	4 to 5	5 to 6	6 to 7	Over 7	Total
2006	3,216	11,568	5,131	2,132	1,056	620	344	628	24,695
2007	3,369	11,699	4,988	2,187	1,171	606	397	702	25,119
Total	6,585	23,267	10,119	4,319	2,227	1,226	741	1,330	49,814
Percent	13.2%	46.7%	20.3%	8.7%	4.5%	2.5%	1.5%	2.7%	100.0%

Source: New York Workers' Compensation Board

Figure 59: Average Duration For PPD NSL Claims From Indexing to Classification

Classification Year	Years from Indexing to Classification								
	0 to 1	1 to 2	2 to 3	3 to 4	4 to 5	5 to 6	6 to 7	Over 7	Total
2006	131	986	2,091	1,733	1,235	892	584	1,333	8,985
2007	106	827	1,792	1,601	1,095	823	593	1,308	8,145
Total	237	1,813	3,883	3,334	2,330	1,715	1,177	2,641	17,130
Percent	1.4%	10.6%	22.7%	19.5%	13.6%	10.0%	6.9%	15.4%	100.0%

Source: New York Workers' Compensation Board

D.4.*Appeals*

D.4.a. *Pending Inventory of Appeals at Year End the end of the Year and Age of Pending Appeals*

A recent internal study by the Office of Appeals within the WCB showed that the average time from filing an appeal from a judge's decision to issuance of an appellate Memorandum of Decision by the WCB was 5.6 months. This study looked at appeals filed between May 2007 and December 2007. This is an improvement over the results of an earlier study that revealed it took an average of 6.2 months to decide appeals filed between January 2005 to May 2007. The following figure shows that the number of new appeals filed in recent years, from 2004 to 2007, have been declining modestly and the percentage of pending appeals that are four months or less has been increasing. In 2004, 49.7% of pending appeals were pending 4 months or less. In 2007 that percentage increased to 53.6%.

Figure 60: Number and Age of Pending Appeals

	New Appeals Filed	Pending Appeals At Year End	Age of Pending Appeals	
			4 Months or Less	8 Months or Less
2000	12,886	5,799	37.3%	69.2%
2001	12,969	3,787	47.6%	67.3%
2002	14,643	5,346	45.8%	80.8%
2003	13,092	4,638	48.9%	77.3%
2004	13,565	4,568	49.7%	86.8%
2005	13,722	4,373	52.7%	76.6%
2006	13,258	4,138	59.3%	86.2%
2007	12,977	4,497	53.6%	93.3%

Source: New York Workers' Compensation Board

In summary, the current timeframes for resolving claims are long. Resolutions range from 88 days for claims that are not controverted and can be resolved through an administrative decision, to over four years for the most complex claims, the PPD NSL. The percentage of total claims which are controverted has been growing slowly from 15% in 2000 to 16.9% in 2006. Currently, about 50% of controverted claims are resolved at the pre-hearing conference, but many of these resolutions would occur earlier in the process under the proposed Streamlined Docket. As of 2004, it took an average of 264 days to establish a controverted claim. There are 5.6 hearing on average for controverted claims that go to a hearing, and 3.6 for non-controverted claims. Finally, there are limitations in the data, such

the lack of a method to separate the denied claims from the claims that have not been pursued by the claimant.

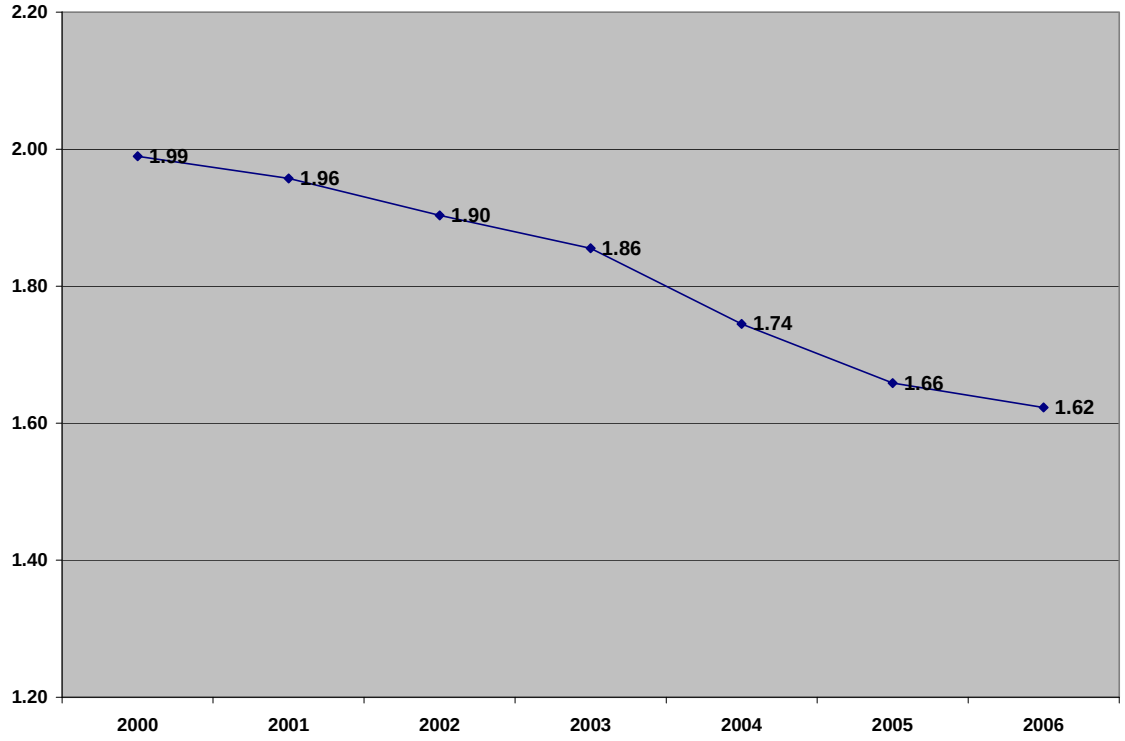
E. *Improve workplace safety.*

An effective workers' compensation system does not focus solely on workplace injuries. It also focuses on ways to reduce the number and severity of workplace injuries. A safer workplace has benefits for all stakeholders in the system: workers, employers as well as the State.

E.1. *Number of claims indexed by the WCB per 100 workers*

The first step is to look at claims in the context of total employment in the state. Workers' compensation claims have been declining, while statewide employment has remained fairly steady over the most recent six years (2000-2006) for which data are available. The job count stood at 8.5 million in 2000, dipped to 8.2 million in 2003, and climbed to 8.4 million in 2006. However, over the same time period, there has been a steady decline in the number of indexed claims per 100 workers (see Figure 61).

Figure 61: Number of Indexed Claims Per 100 Workers in New York State



Source: New York Workers' Compensation Board and the United States Bureau of Labor Statistics

E.2. *Indemnity Claims per 100 workers by industry*

Numbers of injuries per 100 workers vary depending on the type of job. Currently, the best data available to use is the number of claims by type of industry Using 5.25 years of indemnity claims shows that the two industries with the highest number of claims per 100 workers are Transportation/Warehousing and Manufacturing, followed closely by Construction, Utilities and Mining. This analysis should be run annually to track changes in the incidence by industry. The results can be used to focus safety programs.

Figure 62: Number of Indemnity Claims Per 100 Workers in New York State By Industry - Indemnity claimants with accident dates between 4th quarter 1999 and 1st quarter 2005

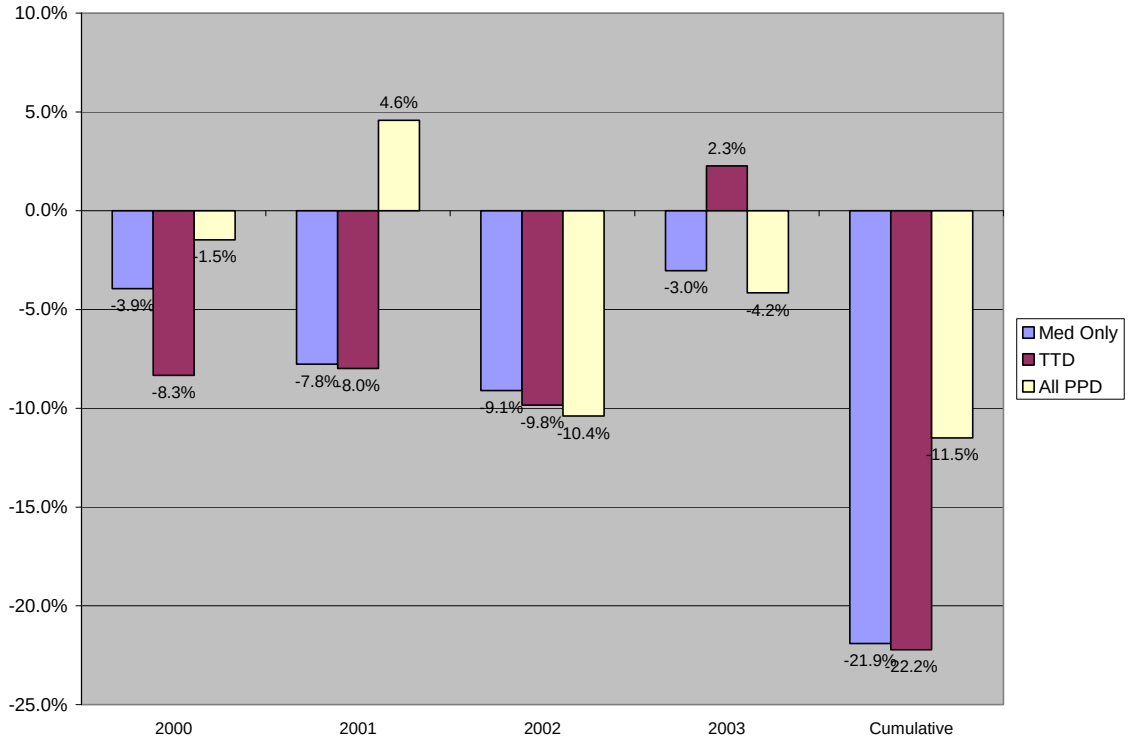
Industry	All Indemnity Claimants for 5.25 years			Claims Per 100 Workers	2006 New York State Annual Average Employment	
	Number	% of Total Claimants	Avg Claims Per Year		Number	% of Total Employment
Total	481,890	100.00%	91,789	1.09	8,424,621	100.00%
Government	111,901	23.20%	21,314	1.50	1,418,248	16.80%
Health Care & Social Assist.	62,706	13.00%	11,944	1.01	1,184,479	14.10%
Manufacturing	60,055	12.50%	11,439	2.03	564,857	6.70%
Retail Trade	50,025	10.40%	9,529	1.09	877,790	10.40%
Construction	31,568	6.60%	6,013	1.79	335,391	4.00%
Transport.& Warehousing	30,868	6.40%	5,880	2.60	225,844	2.70%
Admin.& Waste Services	25,554	5.30%	4,867	1.14	425,410	5.00%
Accommodation & Food Services	21,747	4.50%	4,142	0.76	542,494	6.40%
Wholesale Trade	21,066	4.40%	4,013	1.14	351,759	4.20%
Other Services	11,724	2.40%	2,233	0.71	316,208	3.80%
Real Estate, Rental & Leasing	9,430	2.00%	1,796	0.98	183,572	2.20%
Prof. & Tech. Services	9,319	1.90%	1,775	0.32	549,842	6.50%
Information	8,854	1.80%	1,686	0.63	266,661	3.20%
Finance & Ins.	7,956	1.70%	1,515	0.28	538,065	6.40%
Educational Services	6,540	1.40%	1,246	0.46	273,638	3.20%
Arts, Entertainment, & Rec.	5,771	1.20%	1,099	0.83	132,763	1.60%
Utilities	3,658	0.80%	697	1.80	38,810	0.50%
Agric., Forest., Fish. & Hunt.	1,860	0.40%	354	1.64	21,617	0.30%
Mgt of Companies & Enterprises	795	0.20%	151	0.12	126,541	1.50%
Mining	488	0.10%	93	1.77	5,252	0.10%
Public Admin. (Indian Tribal Councils)	5	< 0.1%	1		not available	-

Sources: Workers' Compensation Board (includes claimants classified as PPD SL, PPD NSL and TTD). Quarterly Census of Employment and Wages developed through a cooperative program between New York State and the U.S. Bureau of Labor Statistics.

E.3. *Total number of claims by classification - trend over years.*

A proxy measure for looking at changes in the severity of claims is to compare the trends in different types of claims. Medical-only claims are the least severe, followed by TTD, and PPD. The PTD and Death claims are excluded from this analysis because of their relatively small numbers. The following chart tracks the year to year percentage changes in each of these claim types. PPD claims, the more severe claims, demonstrate a slower rate of decline, while medical-only and TTD claims, the less severe claims, have double the rate of decline. This could be an indication of an increase in the severity of injuries.

Figure 63: Annual Percentage Change in Number of Claims By Type



Source: CIRB data at 30 months of development

E.4. *Number of Employers in the Safety and Drug and Alcohol Prevention Initiatives.*

The Reform Act requires DOL to develop premium credit programs[59] for workplace safety and drug and alcohol prevention. The third component is return to work which is included in the return to work benchmarks in this Report. Once these programs are in place, NYSID recommends that the number of employers in these programs, as well as the effectiveness of the programs, should be tracked.

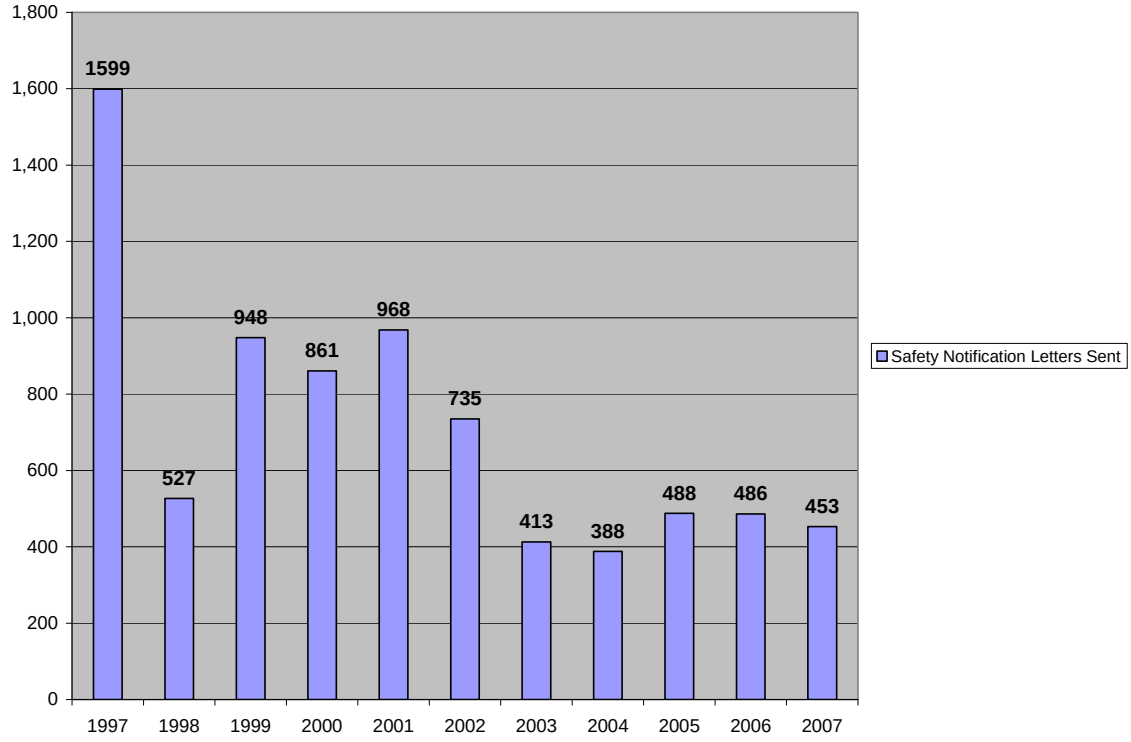
[59] For self-insureds the premium credit takes the form of a different economic incentive. See Workers' Compensation Law § 134.

E.5. *Track Employers in the Mandatory Safety program.*

The mandatory safety program was in place prior to the Reform Act for employers with annual payrolls in excess of $800,000 and with an experience rating greater than 1.2. CIRB is required to notify employers and DOL when an employer has an experience rating of 1.2 or greater. The following figure shows the number of notification letters that have been sent over the past 12 years. Although it appears that there has been a substantial decline in the number of employers being notified, there currently is no follow up with these employers. In other words, once the employers are notified, they stay in the program, but they do not receive a new letter each year. Therefore, some or all of the employers notified in 1997 may or may not still have high experience ratings. There is no formal mechanism for removing employers from the program or following up if they continue to have a high experience rating. Two reasons contribute to the lack of follow-up: the statute does not require CIRB annually to update regarding changes in the experience rating and no resources have been allocated to the DOL to administer this program. The second issue for this program is the continued use of 1.2 experience rating as the cut-off. While experience modifications are designed to have an average of 1.0, the average experience modification in New York is actually between 0.80 and 0.90. As a result of this skewed average, the mandatory safety program may not be applied as widely as intended, with fewer employers being subject to mandatory participation.

NYSID recommends tracking employers in this program and continuing to follow up each year they remain above a 1.2 experience rating. This measure should show the number of employers in three categories: new, continuing and improved experience ratings below 1.2 of the mandatory program and their respective experience ratings.

Figure 64: Number of Safety Notification Letters Sent To Employers



Source: CIRB data

E.6. *Explore collaboration with OSHA on safety inspections*

At the federal level, the Occupational Safety and Health Administration ("OSHA"), part of the U.S. Department of Labor, has responsibility for promoting employee health and safety in the workplace and enforcing standards. In some states, OSHA has a close working relationship with the state that includes sharing state data, workers' compensation data to help OSHA and state OSHA enforcement programs. This data sharing does not occur in New York State. New York State (including WCB, DOL, the Department of Environmental Conservation and the Department of Transportation) should explore working collaboratively with OSHA and sharing workers' compensation data and other safety data. One effective example of this type of cooperation that New York State should review is the state of Washington's "Safety and Health Assessment and Research for Prevention" program.

F. *System Costs and Costs Per Claim*

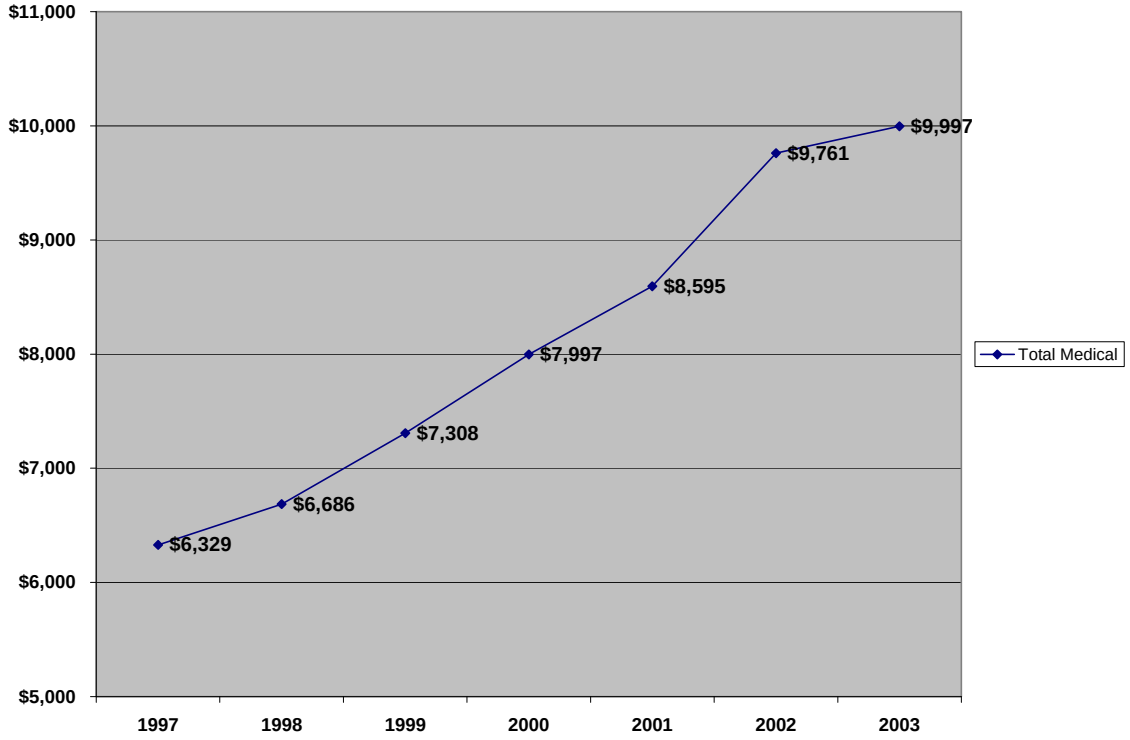
To evaluate system performance in terms of costs it is important to examine cost per claim rather than total system costs. Declines in total system costs may be due more to declines in the number of claims than improved system performance. Due to the lengthy delays in case development, it will take several years to see impacts on costs per claim resulting from the Reform Act. On the other hand, the number of claimants benefiting from the higher maximum weekly benefit will be visible immediately.

F.1. *Medical Costs*

F.1.a. *Average medical cost per indemnity claim at 30 months of development*

This sub-section focuses on medical costs for indemnity claims. Due to the large number of medical-only claims and their relatively small costs, including them in a cost per claim analysis can skew the overall results. The following table shows that medical costs per indemnity claim have been climbing steadily from 1997 to 2003, even though the rate of increase has slowed from 2002 to 2003.

Figure 65: Average Medical Cost Per Indemnity Claim

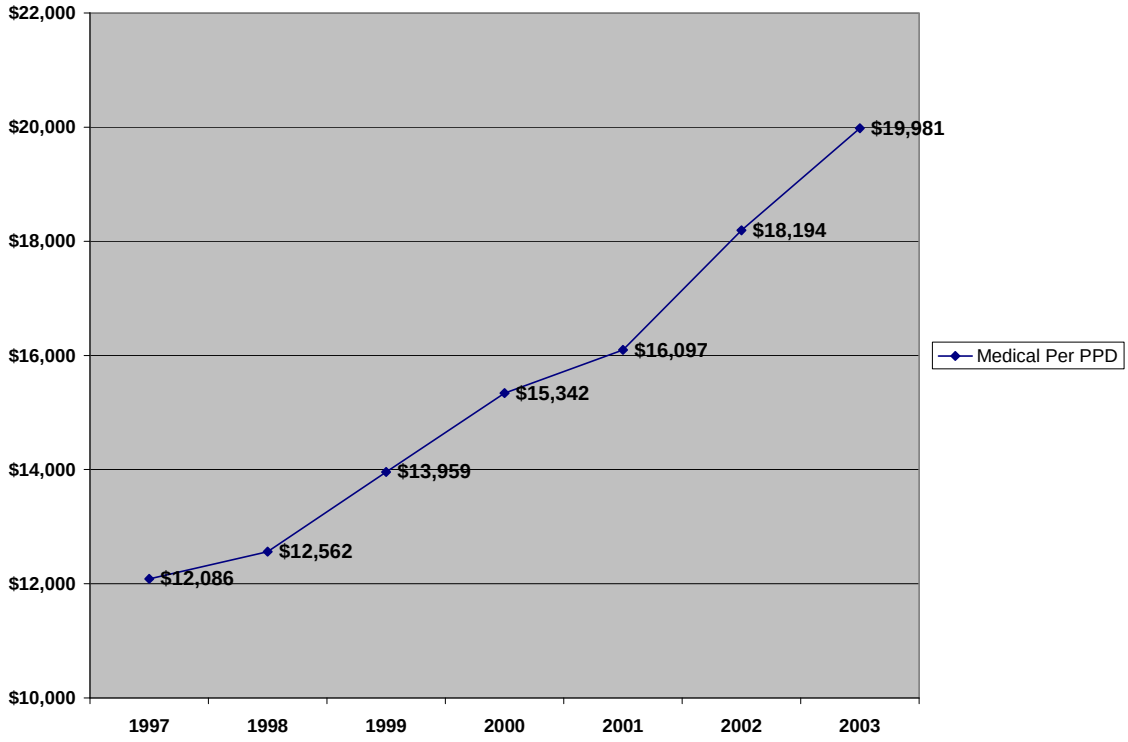


Source: CIRB data at 30 months of development

F.1.b. *Average medical costs per PPD claim at 30 months of development*

The overview section showed that PPD claims were driving medical costs. The following chart shows the steady growth in the average medical cost per costs of PPD claim from 1997 to 2003.

Figure 66: Average Medical Cost Per PPD Claim



Source: CIRB data at 30 months of development

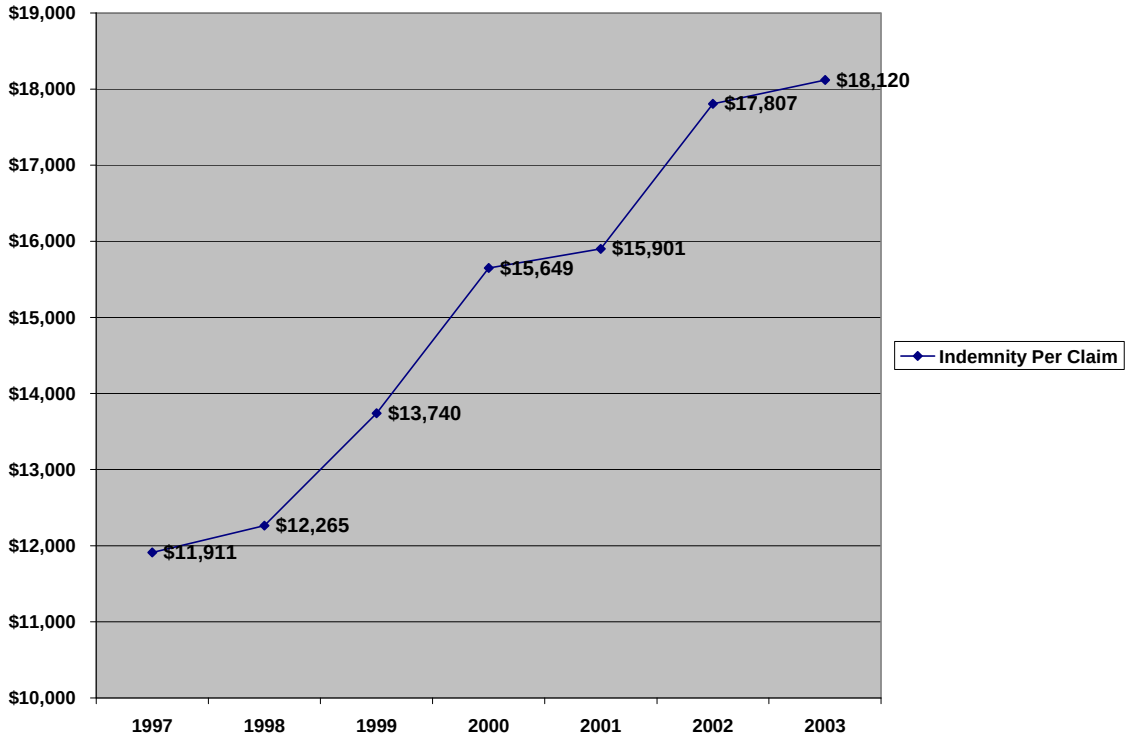
F.2. *Indemnity Costs*

The next set of measures looks at indemnity costs.

F.2.a. *Average indemnity cost per indemnity claim – 30 month development*

The Reform Act included two major changes that will have opposite impacts on indemnity costs. First, the maximum weekly benefit per claim of $400 increases each year until 2010 when the maximum is indexed to New York State's average weekly wage. The impact of the change will grow over time, as new claims enter the system and will effect over 50% of new claimants. In 2007, over 50% of claimants were capped by the $400 maximum weekly benefit. The second change is from lifetime indemnity benefits for PPD NSL claimants to duration caps, depending on the lost wage earning capacity. It will take several years for the full impact of this change to emerge in the cost data due to the lengthy delays in classification of PPD NSL.

Figure 67: Average Indemnity Cost Per Indemnity Claim

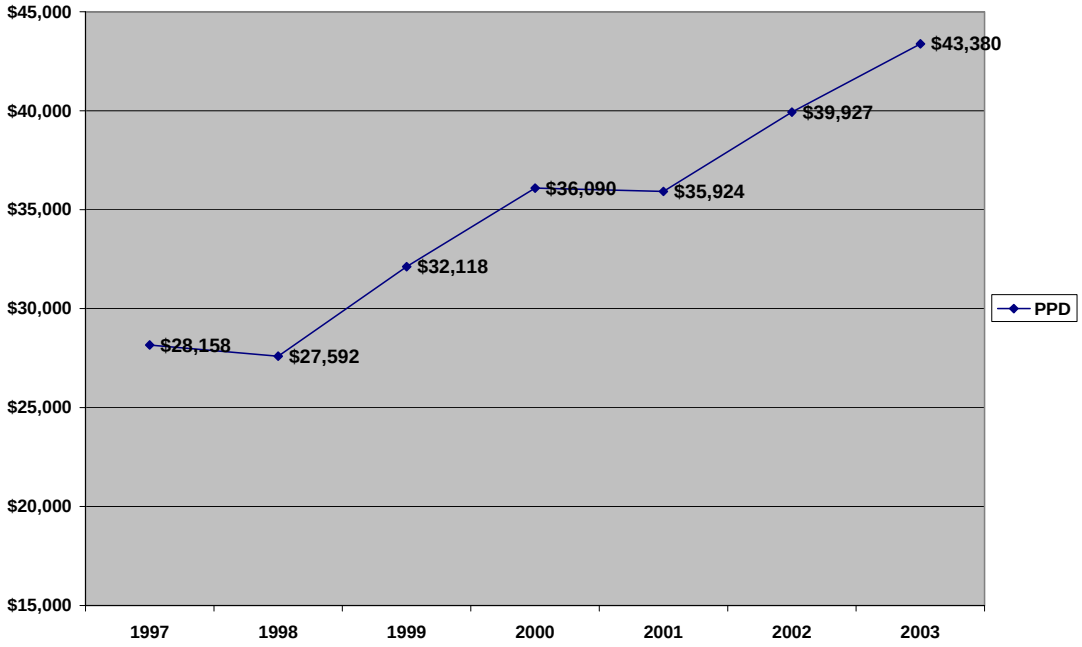


Source: CIRB data at 30 months of development

F.2.b. *Average Indemnity Cost per PPD claim at 30 months of development*

Average indemnity costs per PPD claim have been rising fairly steadily since 1998.

Figure 68: Average Indemnity Cost Per Claim



Source: CIRB data at 30 months of development

F.3. *Section 32 Costs*

In Section 32 settlements, the parties may settle all issues by agreement, in accordance with Section 32 of the Workers' Compensation Law. It has been argued that that there will be an increase in Section 32 settlements because of the greater predictability of benefits for PPD NSL and the new requirements for private carriers to transfer the indemnity reserve for PPD NSL claims to the "Aggregate Trust Fund."[60] Others argue that there will be less incentive for claimants to settle. NYSID should track the impact the Reform Act has on Section 32 settlements.

The figure below uses WCB data on Section 32 settlements based on the year the claims were resolved. There are two problems with the WCB data in this area. First, some settlements include non-cash awards that can not be easily valued.[61] Second, there can be multiple claims associated with each other, (known as associated claims). WCB does not have the means to electronically determine if the settlement amount applies to all of the claims, some of the claims or just one of the claims. .

[60] The Aggregate Trust Fund ("ATF") was created pursuant to the provisions of Section 27 of the New York Workers' Compensation Law. The purpose of the fund is to assure and oversee the regular payment of benefits on adjudicated death cases and certain permanent disability cases. The ATF derives its funds from insurance carriers and self-insured employers who are required to deposit into the ATF the present value equivalent of the indemnity portion of all such adjudicated cases. The ATF is administered by SIF.

[61] Non-cash awards include requirements for the payor to fund the purchase of specific equipment or changes in the work environment as an accommodation for an employee's return to work.

Recording of Section 32 data in the future will be complicated by the broader ATF deposit requirements for PPD NSL claims. Under the Reform Act, the ATF will have the authority to negotiate a Section 32 settlement and keep any remaining funds from the original deposit. These requirements add a new actor-SIF and the ATF – that plays a part in Section 32 agreements, and that will have data relevant to the issues raised in this section.

F.3.a. *Number of settlements, average settlement cost, and legal fees.*

The following table shows the average settlement amount for claims where there does not appear to be a non-cash award, and when there are no associated claims involved. The table shows that the average cost of settlements has been increasing slowly. Another factor that must be included in the analysis of settlements is the amount that the claimant receives net of legal fees. The table below shows average legal fees and the net payment to the claimant after an average of 12% of the settlement is used to pay legal fees.

Figure 69: Number of Section 32 Settlements, Average Settlement Costs and Legal Fees

Settlement Year	Total Settlements Without Associated Cases	Section 32 Settlements			
		Average Total Amount	Average Fee to Attorney	Average Benefit to Claimant	Legal Fee % of Settlement
2002	6,757	$42,938	$4,979	$37,958	11.6%
2003	6,715	$44,745	$5,240	$39,504	11.7%
2004	6,658	$46,479	$5,474	$41,004	11.8%
2005	6,253	$50,143	$5,825	$44,318	11.6%
2006	6,110	$47,506	$5,595	$41,911	11.8%

Source: New York Workers' Compensation Board

Section 32 settlements are also discussed in the benchmark section that focuses on return to work outcomes. (G.4) That section shows that Section 32 claimants have low rates of returning to work and remaining at work similar to PPD NSL claimants. In addition, it shows that the average pre-injury annual earnings of Section 32 claimants were significantly lower than the pre-injury earnings of all other categories of claimants. In the following section there is a discussion of average legal fees for the different categories of indemnity claims. The average legal fee for a PPD NSL for accident years 2000 to 2006 was $3,594, $2000 less than the average legal fee for a Section 32 settlement. At the same time, the value of the average PPD NSL claim including a reserve for lifetime benefits was $173,077 compared to the average

settlement in 2006 of $47,500. This appears to be an area where further research is needed.

F.4. *Costs of the Adjudication Process*

Costs that result from the adjudication of a claim are an area where the data is limited. There is the impression that given the relatively high number of hearings (an average of 5.6 hearings for controverted claims that require at least one hearing, and an average of 3.6 hearings for non-controverted claims that require at least one hearing) the New York State system must have high adjudication costs. There is insufficient data to support or dispute this hypothesis. However, one indication is the data in the WCRI report discussed below.

F.4.a. *Percent of claims with claimant attorneys*

From 2000 to 2006, the percentage of workers with indemnity claims who were represented by an attorney has remained between 53% and 56%. During the same time period, the percent of medical-only claimants who were represented has increased from 25% to 36%. As with other measures, the 2006 data is not developed sufficiently to be comparable to the other years. This data raises two questions:

- Why are the claimants with the simplest claims increasingly using attorneys?
- Will the increased early disclosure required under the proposed Streamlined Docket reduce the percentage of claims which are represented?

Figure 70: Number and Percentage of Claims With Claimant Representation

Indexed Year	No Compensation Cases			Medical Only Cases			Indemnity Cases		
	Represented	Indexed	Percent	Represented	Indexed	Percent	Represented	Indexed	Percent
2000	7,906	34,678	22.8%	6,989	27,546	25.4%	57,128	104,765	54.5%
2001	8,153	36,886	22.1%	7,145	28,716	24.9%	55,746	101,607	54.9%
2002	8,123	36,259	22.4%	7,649	29,114	26.3%	52,977	94,527	56.0%
2003	7,617	34,067	22.4%	7,906	28,861	27.4%	50,985	90,470	56.4%
2004	7,101	31,398	22.6%	8,279	29,229	28.3%	47,016	84,497	55.6%
2005	7,197	31,258	23.0%	8,997	28,299	31.8%	42,783	79,608	53.7%
2006	8,875	34,068	26.1%	11,438	31,557	36.2%	36,560	71,032	51.5%
Total	54,972	238,614	23.0%	58,403	203,322	28.7%	343,195	626,506	54.8%

Source: New York Workers' Compensation Board

F.4.b. *Average claimant attorney fees as percent of average indemnity cost for represented claims.*

One part of adjudication costs is the costs for claimant attorneys. The first table below shows that, on average, claimant attorney fees represent 5.5% of average indemnity costs for represented claims, with an average cost of legal fees of $1,781.

Figure 71: Average Claimant Attorney Fees and Percentage of Average Indemnity Cost -- Claims With Legal Fees For Accident Years 2000-2006

Case Type	Total Claims	Average Indemnity	Average Legal	Legal Fee Percentage
Temp Total	130,778	$17,741	$1,212	6.8%
PPD SL	101,932	$19,096	$1,814	9.5%
PPD NSL	23,936	$160,674	$4,459	2.8%
PTD	484	$236,950	$5,896	2.5%
Death	1,176	$154,628	$6,008	3.9%
All Cases	258,306	$32,553	$1,781	5.5%

Source: New York Workers Compensation Board

When the pool of claims is limited to represented claimants excluding Section 32 settlements, the average cost of legal fees drops to $1,385 or 4.7%. About 20% of Section 32 settlements are for PPD NSL claims where the claimant decides to enter into a settlement after the claim as been classified. These settlements can occur several years after the classification. In this situation, the legal fees received by the attorney would include not only a fee at classification, but also an additional fee at settlement.

Figure 72: Average Claimant Attorney Fees and Percentage of Average Indemnity Cost – Claims Having a Legal Fee For Accident Years 2000-2006, excluding Section 32 Settlements

Case Type	Total Claims	Average Indemnity	Average Legal	Legal Fee Percentage
Temp Total	114,495	$13,024	$601	4.6%
PPD SL	101,567	$18,952	$1,798	9.5%
PPD NSL	19,229	$173,077	$3,549	2.1%
PTD	449	$235,321	$4,955	2.1%
Death	1,116	$154,956	$5,640	3.6%
All Cases	236,856	$29,649	$1,385	4.7%

Source: New York Workers Compensation Board

F.4.c. *Percentage of claims with Independent Medical Examinations*

There was a substantial growth in the percentage of claims with Independent Medical Examinations ("IME") in 2001, but since that time the percentage has remained constant. However, the total number of examinations has been decreasing since 2004 at a rate greater than the rate of decline in the number of claims. An IME-4 form is the form submitted by the independent medical examiner when they have completed their review.

Figure 73: Percentage of Claims Where Independent Medical Examiner Used

Indexed Year	Total Claims	Claims with at least one IME-4	Percent of Claims with IME-4	Total # of IME-4s
2000	166,989	38,534	23.1%	96,168
2001	167,210	57,384	34.3%	161,629
2002	159,901	57,696	36.1%	165,982
2003	153,398	56,334	36.7%	163,426
2004	145,126	53,763	37.0%	152,133
2005	139,167	49,527	35.6%	126,771
2006	136,657	44,067	32.2%	97,165
Total	1,068,448	357,305	33.4%	963,274

Source: New York Workers' Compensation Board

F.4.d. *Average benefit delivery expense per claim that have benefit delivery expenses.*[62]

WCRI defines benefit delivery expenses as the cost of delivering medical and indemnity benefits to injured workers, allocated to the individual claim. These expenses include litigation-related expenses such as defense attorney fees, medical-legal expenses and ancillary legal expenses, as well as costs associated with the medical management of the claim and any administrative assessments. One cost they do not include is the cost of the claimant's attorney. As the figure below shows, the benefit delivery cost of $1,822 represents about 10% of the average total cost per indemnity claim at 36 months development in the WCRI report. It is important to note that benefit delivery costs will continue to grow for much longer on New York State claims than for the other states in the WCRI study. This is because some claims in New York State take much longer to resolve when compared to other states. However, when the New York State average benefit cost at 60 months is compared to the WCRI claims at 36 months, New York State is still much lower.

[62] The data in this subsection and from subsections F.4.f. and F.4.g. are from WCRI's recent report on New York State. In reviewing the data, one caveat is that the New York State cost data is not comparable to the other states data because of the long development time in New York State.

Figure 74: Average Benefit Delivery Expense Per Claims That Have Benefit Delivery Expenses

	New York			WCRI 14 State Median
Performance Measure	Claims with 12 month development 2004/2005	Claims with 36 month development 2002/2005	Claims with 60 month development 2000/2005	Claims with 36 months development 2002/2005
Average benefit delivery expense per claim with benefit delivery expense	$1,127	$1,822	$1,803	$2,813.0

Source: Workers Compensation Research Institute

F.4.e. *Percent of indemnity claims with medical-legal expenses and the average medical legal expense.*

WCRI defines medical-legal expenses as payments for medical examinations and reports initiated for either party or an adjudicator, and medical provider/expert testimony and depositions. The figure below shows that a much higher percent of New York State's claims include medical-legal expenses than the other WCRI states: 37% compared to 17%. This is one indication that New York State is more litigious than other states. New York State's costs per claim are in line with other states but the utilization of medical-legal consultants is much higher, thus generating higher adjudication costs.

Figure 75: The Average Medical Legal Expense and the Percentage of Indemnity Claims With Medical-legal Expenses

	New York			WCRI 14 State Median
Performance Measure	Claims with 12 month development 2004/2005	Claims with 36 month development 2002/2005	Claims with 60 month development 2000/2005	Claims with 36 months development 2002/2005
% of indemnity claims with medical-legal expenses	25.5%	37.2%	37.3%	17.0%
Average medical-legal expense per claim with medical-legal expenses	$641	$963	$984	$1,043

Source: Workers Compensation Research Institute

F.4.f. *Percent of claims with defense attorney expenses greater than $500 and the average defense attorney expense for claims with defense attorney expenses greater than $500.*

WCRI defines defense attorney payments as the expense to an insurer or employer of having an attorney defend a workers' compensation claim. It includes payments for in-house and/or outside defense counsel. The figure

shows that New York State is below the WCRI state median in only having 12.2% of its claims at 36 months with these expenses. Even when one looks at 60 months of development, the percentage only grows to 13.6%, still well below the 20% median for the WCRI states.

Figure 76: The Average Defense Attorney Expenses For Claims With Defense Attorney Expenses Greater Than $500

	New York			WCRI 14 State Median
Performance Measure	Claims with 12 month development 2004/2005	Claims with 36 month development 2002/2005	Claims with 60 month development 2000/2005	Claims with 36 months development 2002/2005
% of claims with defense attorney payments greater than $500	2.5%	12.2%	13.6%	20.0%
Average defense attorney payment per claim with defense attorney payments greater than $500	$1,031	$1,352	$1,401	$3,496

Source: Workers Compensation Research Institute

G. *Adequacy of Benefits and Return to Work*

A fundamental purpose of the workers' compensation system is to provide workers with wage replacement benefits to support them during the healing period and to assist them in returning to work as early as practicable.

This benchmark area is divided into three subsections. The first focuses on the maximum indemnity benefit level, the second examines lost wage earning capacity, and the final examines the percentage of workers returning to work and their earnings thereafter.

Many jurisdictions have defined adequate benefits as a percentage of average weekly wages up to a cap or maximum benefit. The most widely used percent is the one used in New York State, 66%. While New York State's percentage is the same as many states, its present dollar cap is substantially lower than most states. As mentioned earlier in the System Overview section, a 2007 study by the U.S. Chamber of Commerce showed that as of July 2007, when the maximum was raised to $500, New York State ranked sixth lowest in the nation.

The Reform Act addressed this benchmark area in two ways: 1) by raising the maximum benefit and; 2) requesting DOL to examine issues relating to return to work. One of the DOL's first steps was to work with WCB to explore possibilities of combining DOL unemployment insurance data on employee earnings with WCB claims data. The common metric to cross-walk the two data sets was social security numbers. However, WCB requests but does not require social security numbers. The unemployment insurance program, on the other hand, is prohibited under federal rules and regulations to serve anyone who does not

have a federally acceptable identification number. It was thus unclear how many WCB claims had valid social security numbers. DOL, using data supplied by WCB, ran a cross-walk of the quarterly wage data against the claimant data and found that there was a very high rate of match. Slightly more than 92% of claimants in the WCB file had a wage record match. The data in the following tables are the match of the two datasets and is based on analysis conducted by the DOL.

G.1. *Maximum Benefit*

G.1.a. *Number of claimants receiving the maximum benefit*

From 2004 to 2006, 54% of claimants received the maximum benefit of $400. For accidents that occurred post-reform, 40% of the claimants received the maximum benefit of $500.

G.1.b. *Rank of the maximum benefit compared to other states*

In 2007, the new $500 maximum weekly benefit for New York State was 6th lowest in the nation. Pursuant to the Reform Act, the New York State maximum benefit will continue to climb until it is linked to two-thirds of New York State's average weekly wage for accidents that occur on or after July 1, 2010.

G.2. *Return to Work and Remain at Work*

G.2.a. *Percent of Claimants With Wages Throughout the Eight Quarters Following the Accident.*

The figure below examines how many claimants returned to work and remained at work over the two year period following their accidents. It is based on claims with accident dates between the 1st quarter of 2000 and the 1st quarter of 2005. An important caveat to consider when evaluating these results is the percentage of people who stop earning wages in New York State for reasons other than a workers' compensation injury. To establish this baseline, DOL examined workers earning wages in the first quarter of 2002. Eight quarters later, 19% of these workers were no longer earning wages in New York State. The reasons they may have stopped earning wages include leaving the state, retiring, losing a job, and becoming ill.

For claimants with a temporary disability, 61% were working two years after the injury. Eight quarters after the injury, 78% of PPD SL claimants were earning wages. The largest decline in employment was for PPD NSL claimants. Only 25% were still earning wages eight quarters after the injury. For all categories of claims, the longer claimants were out of work the less likely they were to return to work.

Figure 77: Percentage of Claimants With Wages By Quarter After Accident – Claimants With Accidents From 1st Quarter 2000 to 1st Quarter 2005

Case Type	Qtr After Accident	Number of Claimants	% Of Claimants With Wages In Qtr
Temp Total	0	445,771	
	1	389,288	87.3%
	2	373,087	83.7%
	3	359,340	80.6%
	4	343,129	77.0%
	5	324,498	72.8%
	6	305,727	68.6%
	7	289,274	64.9%
	8	273,647	61.4%
PPD Sch	0	139,978	
	1	122,832	87.8%
	2	121,574	86.9%
	3	121,585	86.9%
	4	120,977	86.4%
	5	119,079	85.1%
	6	116,473	83.2%
	7	113,877	81.4%
	8	110,155	78.7%
PPD NSL	0	26,548	
	1	17,089	64.4%
	2	13,334	50.2%
	3	11,518	43.4%
	4	10,172	38.3%
	5	8,988	33.9%
	6	7,814	29.4%
	7	7,217	27.2%
	8	6,682	25.2%

Source: New York Workers' Compensation Board and New York State Department of Labor

G.2.b. *PPD NSL Claimants With Wages By Quarter After Accident*

Earlier in the measurement section, there was a discussion with respect to the long timeframe for classifying PPD NSL claims. It has been hypothesized by some that PPD NSL claimants waited until their claims were classified, which entitled them to lifetime indemnity benefits, before returning to work. The median time for classification of a PPD NSL claim is 3.8 years, or 15 quarters. To examine the hypothesis, NYSID looked at PPD NSL claims over the longest time period possible. We started with claims from 2000 and 2001 the oldest years for which WCB has complete data. In order to have comparable data for all of the years we limited the time period to 22 quarters. This is the most quarters of data available for the final quarter of 2001. The following table examines PPD NSL claims over 22 quarters, or 5 and half years. As of five years, almost 70% of PPD NSL claims are classified. Therefore, most of the claims in this data pool should be classified.

The data does not appear to support the hypothesis. There does not appear to be any specific time when PPD NSL claimants begin to re-enter the labor market. The percent of these claimants with New York State wage records continues to drop each quarter, then stabilizes around 20% in the thirteenth quarter.

Figure 78: Number of PPD NSL Claimants With Wages By Quarter Following Accident – Claimants With Accident Dates From 1/1/2000 to 12/31/2001

	PPD NSL Claimants With Wages	
Qtrs Following Accident	Number	% Of Total
0	13,137	100.00%
1	8,890	67.70%
2	7,130	54.30%
3	6,161	46.90%
4	5,491	41.80%
5	4,948	37.70%
6	4,237	32.30%
7	3,955	30.10%
8	3,646	27.80%
9	3,431	26.10%
10	3,224	24.50%
11	3,121	23.80%
12	2,986	22.70%
13	2,870	21.80%
14	2,770	21.10%
15	2,754	21.00%
16	2,717	20.70%
17	2,712	20.60%
18	2,635	20.10%
19	2,647	20.10%
20	2,627	20.00%
21	2,615	19.90%
22	2,605	19.80%

Source: New York Workers' Compensation Board and New York State Department of Labor

G.3. *Change in Earnings*

G.3.a. *Average Wages Pre- and Post-Injury where the claimant returned to work with any New York State Employer or where the claimant returned to work with the same New York State Employer*

The following two figures are based on claimants with accident dates between the 4th quarter of 1999 and the 1st quarter of 2005. They look at wages for four quarters prior to the injury and four quarters following the injury. The data shows that all types of claims experienced a drop off in wages when the injured

worker returns to work. The most significant decline was for the PPD NSL. The wage loss is consistent for returning to work at the same employer or a different employer. The following two figures reflect only claimants that return to work.

Figure 79: Average Claimant Wages Pre- and Post-Injury When Returning To Work With Any New York State Employer – Claimants With Accident Dates From 4th Quarter 1999 to 1st Quarter 2005

Average Wages With Any NYS Employer				
			Change In Earnings From Pre To Post	
Case Type	Pre-Accident Avg Wage	Post-Accident Avg Wage	Dollars	% Change
All Claimants	$34,344	$30,035	-$4,309	-12.5%
Temp Total	$32,642	$29,215	-$3,428	-10.5%
PPD Sch	$38,758	$34,300	-$4,458	-11.5%
PPD NSL	$34,939	$16,588	-$18,350	-52.5%

Source: New York Workers' Compensation Board and New York State Department of Labor

Figure 80: Average Claimant Wages Pre- and Post-Injury When Returning To Work With The Same New York State Employer - Claimants With Accident Dates From 4th Quarter 1999 to 1st Quarter 20005

Average Wages With Same NYS Employer				
			Change In Earnings From Pre To Post	
Case Type	Pre-Accident Avg Wage	Post-Accident Avg Wage	Dollars	% Change
All Claimants	$30,187	$26,393	-$3,794	-12.6%
Temp Total	$28,962	$25,820	-$3,143	-10.9%
PPD Sch	$33,193	$29,532	-$3,662	-11.0%
PPD NSL	$31,114	$15,145	-$15,969	-51.3%

Source: New York Workers' Compensation Board and New York State Department of Labor

G.3.b. *Comparison of injured workers' wages post-injury to non-injured workers in similar jobs.*

The analysis in the previous measurement is a good first step in understanding the lost wage earning capacity of workers' compensation claimants. However, a longer time frame and more in-depth analysis have been utilized in other states, including California. California conducted an econometric study that measured wage loss by comparing the pre- and post-injury wage records for injured workers to wage records for similar workers that were not injured. The study then determined whether higher wage loss was correlated with higher disability ratings, as would be expected if the rating system effectively compensated workers depending on their level of disability and lost wage earning capacity. The study also examined whether workers with injuries to different body parts that had similar wage loss were given similar disability ratings. This type of study allows policy-makers to understand whether ratings are equitable, both in terms of compensating injured workers based on their level of disability, and in terms of compensating injured workers fairly, regardless of body part injured.

NYSID recommends that a research study of lost wage earning capacity be considered by New York State. In addition, it is recommended that an additional study be done to compare PPD NSL wage losses in New York State to other states.

G.4. *Section 32 Settlements*

The prior measurements show that PPD NSL claimants experience the greatest wage loss compared to other types of claimants. They also have the lowest return to work percentage, and drop out of the workforce at an increasing percentage over time.

There are two common beliefs about Section 32 claims. First, in the majority of the cases if these claims were not settled they would have become PPD NSL. The second is that claimants wait until they settle, and then return to work. In this section we examine both of these hypotheses.

In each of the following tables, the data shows Section 32 claims split by their classification at the time of the Section 32 settlements. The majority of the claims are classified as TTD.

G.4.a. *Section 32 Wages After Accident Date*

This measure looks at the decline in wages post-injury for Section 32 claimants. The average pre- and post-injury annual wages are based on individuals who showed wages in the four quarters before and the four quarters after the injury. If the first hypothesis were correct -- Section 32 claims would have become PPD NSL claims if they had not settled -- we would expect the lost earning to be similar to the lost earning for PPD NSL claimants.

G.3.a shows that PPD NSL claimants' wages decline 52% in the four quarters post injury. The following chart shows, on average, that Section 32 claimants' wages only decline 22%. At first glance this would indicate that Section 32 claimants may not be equivalent to PPD NSL. However, there is a major caveat that needs to be included in the analysis. The average pre-injury earnings for Section 32 claimants was significantly lower, at $19,627, than the average for PPD NSL, PPD SL or TTD, which ranged from $33,000 to 39,000. In short this data does not provide a definitive answer.

It does, however, raise a new question as to why lower wage claimants are more likely to agree to section 32 settlements? This issue needs further study.

Figure 81: Section 32 Claimant Average Annual Wages and Average Settlement – Claimants With Accident Dates From 2000-2006

	Temp Total	PPD Sch	PPD NSL	Total
Total Section 32 Claimants	12,645	177	3,401	16,223
Total Settlement $	$530,441,506	$4,913,022	$213,932,950	$749,287,478
Average Settlement $	$41,948.72	$27,757.19	$62,902.95	$46,186.74
Avg. Pre-injury Annual Wage	$19,628.60	$22,197.11	$19,488.49	$19,627.14
Avg. Post-injury Annual Wage	$15,945.28	$17,380.32	$11,790.93	$15,308.90
% Change Pre to Post Injury Annual Wage	18.8%	21.7%	39.5%	22.0%

Source: New York Workers' Compensation Board and New York State Department of Labor

G.4.b. *Section 32 - Claimants earnings following injury and following settlements.*

The following figure shows the number and percentage of Section 32 claimants who settled their claims and continued earning wages in New York State for eight quarters following their injury, and then the eight quarters following their settlement. If many Section 32 claims are similar in injury to PPD NSL claims, the hypothesis is that they should experience the same poor return to work performance as PPD NSL claimants. The following data supports this.

The data is based on the number of non-government Section 32 claimants with accident dates from 2000 to 2006. Data for non-government claimants is being used because wage records for these claimants had previously been pulled from the statewide wage record files. Therefore, an analysis could be done much more quickly.

The data shows that only 52% of Section 32 claimants return to work the first quarter after injury and the percentage continues to decline over the next eight quarters to a low of 24% in the eighth quarter. This is actually slightly worse than the data for PPD NSL claimants in Figure 77, which shows 64.4% of PPD

NSL claimants return to work in the first quarter following injury dropping to 25.2 % in eight quarters.

Figure 82: Number and Percentage of Section 32 Claimants With New York State Wages By Quarter Following Accident – Claimants With Accident Dates From 2000-2006

Section 32 Settlements - Post-Accident								
	Temp Total	% of Temp Total	PPD SL	% of PPD SL	PPD NSL	% of PPD NSL	Total	% of Total
Claimants With Wages In Qtr 1	6,563	51.9%	113	63.8%	1,729	50.8%	8,405	51.8%
Claimants With Wages In Qtr 2	4,898	38.7%	118	66.7%	1,220	35.9%	6,236	38.4%
Claimants With Wages In Qtr 3	4,251	33.6%	113	63.8%	994	29.2%	5,358	33.0%
Claimants With Wages In Qtr 4	3,828	30.3%	107	60.5%	795	23.4%	4,730	29.2%
Claimants With Wages In Qtr 5	3,576	28.3%	100	56.5%	738	21.7%	4,414	27.2%
Claimants With Wages In Qtr 6	3,422	27.1%	96	54.2%	670	19.7%	4,188	25.8%
Claimants With Wages In Qtr 7	3,332	26.4%	97	54.8%	614	18.1%	4,043	24.9%
Claimants With Wages In Qtr 8	3,253	25.7%	93	52.5%	605	17.8%	3,951	24.4%

Source: New York Workers' Compensation Board and New York State Department of Labor

To examine the second hypothesis -- Section 32 claimants are waiting until receiving a settlement before returning to work -- the next figure shows return to work in the eight quarters following the settlement. The data disproves the hypothesis; these claimants are not returning to work after the settlement. It shows in the first quarter following settlement, only 23% of these claimants were working. Over the next eight quarters this drops to 17%.

Figure 83: Number and Percentage of Section 32 Claimants With New York State Wages By Quarter Following Settlement – Claimants With Accident Dates From 2000-2006

Section 32 Settlements - Post-Settlement								
	Temp Total	% of Temp Total	PPD SL	% of PPD SL	PPD NSL	% of PPD NSL	Total	% of Total
Claimants With Wages In Qtr 1	3,191	25.2%	53	29.9%	521	15.3%	3,766	23.2%
Claimants With Wages In Qtr 2	3,309	26.2%	52	29.4%	580	17.1%	3,942	24.3%
Claimants With Wages In Qtr 3	3,283	26.0%	47	26.6%	590	17.3%	3,921	24.2%
Claimants With Wages In Qtr 4	3,150	24.9%	35	19.8%	553	16.3%	3,738	23.0%
Claimants With Wages In Qtr 5	2,983	23.6%	36	20.3%	495	14.6%	3,514	21.7%
Claimants With Wages In Qtr 6	2,782	22.0%	31	17.5%	467	13.7%	3,280	20.2%
Claimants With Wages In Qtr 7	2,544	20.1%	29	16.4%	410	12.1%	2,983	18.4%
Claimants With Wages In Qtr 8	2,317	18.3%	27	15.3%	361	10.6%	2,705	16.7%

Source: New York Workers' Compensation Board and New York State Department of Labor

In summary, this data shows that Section 32 claimants have similarly low rates of returning to work and remaining at work as PPD NSL claimants. In addition, it raises the question of whether the lower average pre-injury earnings for Section 32 claimants compared to all other claimants is a factor leading to settlement. It is recommended that further study be done on the Section 32 claimant population, and that this group of claimants be tracked after settlement, similar to PPD NSL claimants after classification. The study should look at their work experience, as well as other benefits they receive, such as federal Social Security Disability benefits.

G.5. *Percent of Employers Receiving the Return to Work Credit.*

The Reform Act requires DOL to establish a program that provides a credit to employers who have voluntary Return to Work programs. NYSID recommends that the number of these employers and their experience should be tracked.

G.6. *Vocational Rehabilitation*

The following three measures examine the use of vocational rehabilitation services and the impact on return to work. This data is not currently available, but its collection is proposed in the recommendations section.

G.6.a. *Number of injured workers receiving vocational rehabilitation services.*

G.6.b. *Average length of vocational rehabilitation services.*

G.6.c. *Percentage of workers receiving vocational rehab returning to work and remaining at work for 4 quarters.*

H. *Performance of Major Players in the Claim Administration System*

This section of the Report outlines recommended benchmarks for measuring the major players in the New York State workers' compensation system. These measures are intended to lend transparency to the system as a whole, to enable performance to be evaluated and to provide a basis for improving performance. It is a suggested framework and starting point to establish measurements so that progress and performance throughout the system can be measured and analyzed.

Measurements are proposed for:

- Payors
- Judges
- Treating Health Care Providers
- Claimant Attorneys
- Employers

H.1.*Payors*

Very little data is currently collected or available in the current system at the payor level of detail. Delays in the acceptance of claims results in delays of benefits for injured workers, as to both indemnity payments and medical care. The following measures look at the impact of the processing of claims at the payor level, and its impact on the overall speed of the system. This data is not currently available, but its collection is recommended and proposed in the recommendations section.

H.1.a. ***Average number of days from date of injury to 1st indemnity payment.***

H.1.b. ***Percentage of indemnity claims with time from date of injury to 1st indemnity payment <= 21 days.***

H.1.c. ***Average number of days from submission of bill to payment for services.***

H.1.d. ***Number and Percentage of claims which are controverted and then not established.***

H.1.e. ***Average number of days from date of controversion to resolution of controversy.***

H.1.f. ***Number and Percentage of medical bills that are disputed.***

H.1.g. ***Number and Percentage of disputed medical bills resolved in favor of payor.***

H.1.h. ***Number and percent of request for pre-authorization approval for medical care that are disputed, and the percent of the disputes that are resolved in favor of the payor.***

H.2. *Judges*

The Reform Act identified the number of hearings and the number of adjournments as contributing factors to the extended time for the resolution of many claims. The WCB does collect data at the judge level. It is recommended that the data be collected to support the following measures at the judge level.

H.2.a. ***Number of claims that are adjudicated.***

H.2.b. ***Number and percentage of judge's decisions that are appealed.***

H.2.c. ***Number and percentage of appealed decisions approved by the WCB.***

H.2.d. ***Number and percentage of claims that have adjournments.***

H.2.e. ***Average number of adjournments per claims that have adjournments.***

H.2.f. ***For claims that have adjournments, average number of days between hearings.***

H.2.g. ***For claims involving parts of the body that are covered by medical guidelines, the numbers and percentage of cases in which the judge applied the medical guidelines in deciding the medical dispute.***

H.3. *Health care providers*

Little data is currently collected at the health care provider level. For increased transparency, it is proposed that the following data be collected at this level.

H.3.a. ***Number of workers' compensation claimants that are provided service.***

H.3.b. ***Number and percentage of submitted bills that are disputed.***

H.3.c. ***Number and percentage of disputed bills resolved in favor of the health care providers.***

H.3.d. ***For claims involving parts of the body that are covered by medical treatment guidelines, the numbers and percentage of health care providers that used the medical treatment guidelines when completing the WCB form C-4.***

H.3.e. ***Number and percent of requests for pre-authorization approval for medical care that are disputed, and the percentage of the disputes that are resolved in favor of the payor.***

H.4. *Claimant Attorneys*

The following measures look at the number of claims handled, settlement data and legal fees assessed at the claimant attorney level. This data is not currently available, but its collection is recommended and proposed in the recommendations section.

H.4.a. ***Number of workers' compensation claimants that are represented.***

H.4.b. ***Number of claims and percentage of claims that are resolved with a Section 32 settlement.***

H.4.c. ***Average settlement award for Section 32 settlements.***

H.4.d. ***Average legal fees per claim.***

H.4.e. ***Average number of hearings per claim.***

H.4.f. ***Average number of adjournment requests and length of adjournments.***

H.5. *Employers*

The following measures look at the impact of the internal processing of claims at the employer level, and its impact on the overall speed of the system. This data is not currently available, but its collection is recommended and proposed in the recommendations section.

H.5.a. ***Number of claims and percentage that are indemnity claims.***

H.5.b. ***Percentage of claims processed within 3 or less days from date of injury to payor notice by employer.***

H.5.c. ***Percentage of claims processed in 3 or less days from date of employee notice to date of notice to payor by employer.***

H.5.d. ***Percentage of claims where the length of time from date of injury to first indemnity payment is less than 21 days.***

I. *Fraud*

This section of the Report proposes several measures to quantify the efforts in detecting and prosecuting workers' compensation fraud in the state.

There are currently two state agencies responsible for workers' compensation fraud investigations in New York State: NYSID and WCB. Both conduct investigations into fraud in the system. Both agencies have mandatory reporting and therefore receive data and filings from carriers and other entities. NYSID has the broader mandate of investigating all suspicious and fraudulent activities as they relate to insurance, while the WCB has a concurrent mandate to investigate only those activities that relate to worker's compensation fraud. At this time, both NYSID and WCB maintain databases which can only be accessed by their own respective staffs. NYSID database consists of the mandatory reporting of suspicious and fraudulent activities by carriers and whistleblowers; the WCB database

identifies an employer's worker's compensation coverage by carrier, with attendant history. In addition to state agency investigations, many payors, particularly carriers, have Special Investigation Units (SIU) to conduct their own fraud investigation operations.

There are several potential areas of fraud -- employers, provider and claimants.

Examples of employer fraud are falsifying documents to reflect that coverage is in place, underestimating payroll and misclassifying workers (i.e. the number of clerical workers or construction workers) in an attempt to pay lower premiums, and the presentation of forged certificates of worker's compensation as a false verification of coverage. Examples of possible medical professional provider fraud include billing for services not rendered, double billing, upcoding the billing category of the medical treatment provided, and the billing of pharmaceuticals or medical treatment procedures not provided.. An example of possible claimant fraud is collecting benefits while actively employed. There is no reliable way to estimate the extent of workers' compensation fraud in New York State, but given the size of the market the potential impact of fraud could be significant.

There currently is no single agency with overall responsibility for the collection of data regarding workers' compensation fraud. It is recommended that data be collected and summarized in a central reporting system.

I.1. ***Number of Workers' Compensation Fraud Referrals***

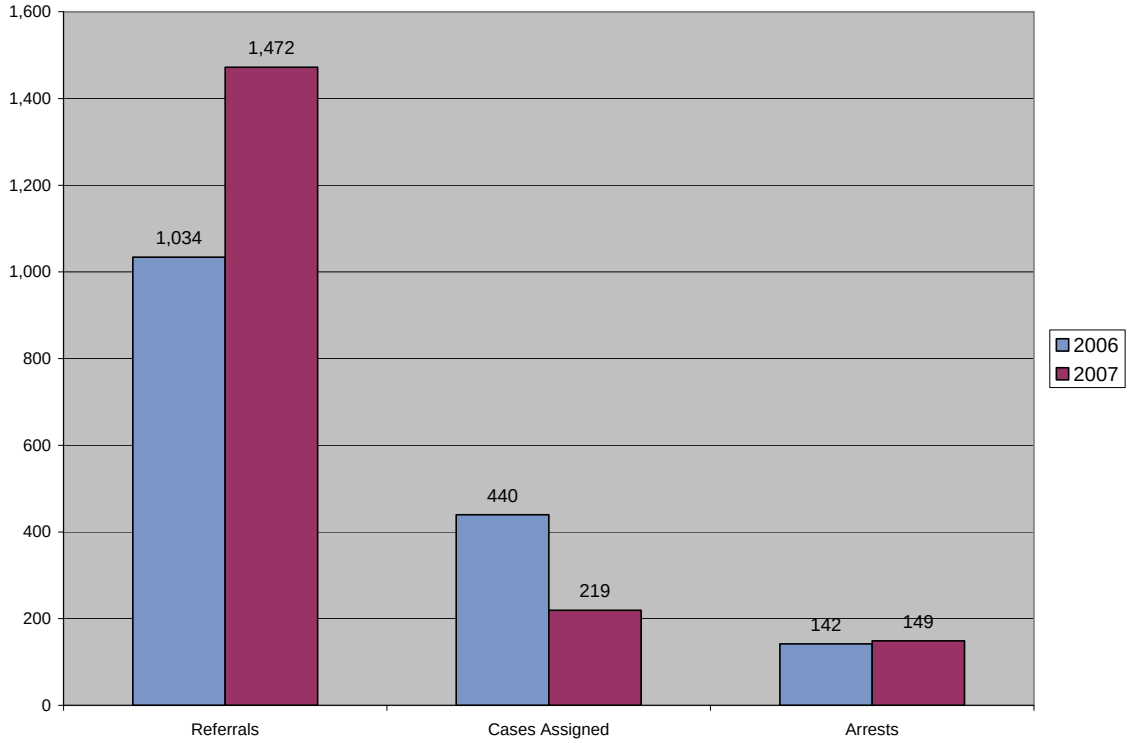
I.2. ***Number of Workers' Compensation Fraud Investigations***

I.3. ***Number of Workers' Compensation Fraud Prosecutions***

I.4. ***Amount of Restitution and Penalties Collected***

Data form NYSID's Fraud Bureau is contained in the figure below. Currently, NYSID does not collect data on restitutions, but there are plans to collect this data in the future.

Figure 84: 2006-2007 Fraud Referrals, Cases Assigned and Arrests Made



Source: NYSID Fraud Bureau

Tracking worker's compensation fraud investigation and prosecution data is a means of measuring fraud deterrence success. It is also recommended additional data be collected as a means of identifying potentially suspicious or fraudulent activities. Collection of the latter type of data will enable the agencies and other investigation operations to thwart fraudulent activity more effectively.

IV. Recommendations for Short and Mid-Term Improvements in Data Collection.

A. *Overview*

The next section focuses on major long term initiatives to enhance the availability of comprehensive information on the workers' compensation system for policy makers, agency executives and managers as well as other stakeholders and researchers. While these longer term initiatives are being developed and implemented, there are several shorter and mid-term actions that could address some of the current data limitations. Many of these actions, if undertaken and completed, would work in conjunction with the longer term recommendations to develop an improved data collection and reporting function throughout the workers' compensation system. These short and mid-term initiatives will provide more information on the system's effectiveness and on where improvements are needed.

B. *Workers' Compensation Board Recommendations*

Currently, the WCB collects and stores large quantities of data on an individual claim basis. Attention has been paid to cleansing data that is used in the on-going operations of the WCB. There is, however, a large quantity of data that is currently received which is not essential to day to day operations and therefore is not cleansed[63] and may or may not be entered into the electronic database. In addition, there are several new data elements that would be useful for policy analysis and research that could be collected by the WCB. The collection of additional data by the WCB would assist in future reporting, analysis and benchmarking activities. It is recommended that the WCB either clean up existing data that is collected or begin to collect and electronically store the following data on an individual claim basis.

Short Term:

- Identify whether the partial indemnity benefits are based on a claimant worker returning to work and receiving a reduced earning benefit or on a partial temporary award based a disability rating. There is apparently a problem with consistency across the state on this data element. In order to evaluate the adequacy of benefits, and to support return to work efforts, it is essential to have this data.
- Collect the impairment rating and lost wage earning capacity of an injured worker. In conjunction with the Reform Act, these ratings need to be clearly identified and tracked to evaluate the impact of the Reform Act.
- Collect the date of classification of PPD NSL.
- Record the insurer's claim number should be stored on a per claim basis. This will facilitate cross-matching data with CIRB and the insurers.
- Use a flag showing when an IME has been used and the cost of the IME. This will assist in capturing adjudication costs of the system as well as allowing analysis of the usage of IME's and their impact on the system.
- Consistently capture and collect claimant attorney fee data. This will assist in evaluating adjudication costs of the system.
- Collect C-8.1 Part A data (medical authorization objection), C-8.1 Part B data (billing objections) and the outcomes of these disputes. In order to evaluate the performance of the system in providing timely access to quality medical care this data is essential.
    - Date of the request for authorization of medical treatment or when the bill is submitted.
    - The date of approval or denial by the insurer.
    - If approval is denied, the reason the request was denied by the insurer.
    - If approval is denied, the hearing date and outcome of the decision of the judge or arbitrators.
    - The reason for the judge's decision.
- Consistently collect the reasons for hearings including multiple reason codes if applicable. This data is essential to evaluate the impact of the proposed Streamlined

[63] Data cleansing is the act of detecting, correcting or removing inaccurate data from a file or database.

Docket reforms, to analyze system performance and to identify areas for future performance enhancements.

- Record the date that maximum medical improvement is determined should be collected and retained. Key decisions for the claimant cannot be made until maximum medical improvement has been reached. Capturing this date on a consistent basis will allow research relating to the effectiveness of medical care as well as supporting return to work programs.
- Require forms on vocational rehabilitation. WCB already collects information on vocational rehabilitation from the "Carrier's Report on Rehabilitation" form, which relates to vocational rehabilitation. Currently these forms are not often used, but it is anticipated that the filing requirements will be more vigorously enforced. Data should be collected on when evaluations are conducted, the recommendations of the evaluations and the outcomes from the recommendations.
- Evaluate pilot programs enacted as part of the Reform Act.

Mid-Term:

- Develop a system to cross match data between the existing WCB claims processing system and the WCB Bureau of Compliance system. This will allow WCB to match claims adjudication information with the medical and indemnity cost per claim, thus allowing a split between PPD NSL and PPD SL costs.
- Provide employers with the same access to WCB data that the carriers currently have via a secure web-site.
- Provide all stakeholders with access to information on coverage information. This information is available in existing WCB systems. There is a project in progress within the WCB Bureau of Compliance to develop a web-based application system with access to coverage information. Once completed and implemented, the system's functionality should be communicated to and made available to all stakeholders, especially the carriers and SIF.

C. *CIRB Recommendations*

Similar to the Workers' Compensation Board, CIRB currently collects and stores large quantities of data on an individual claim basis. This data is used primarily by CIRB in the experience rating and rate setting processes. The collection of additional data by CIRB would assist in future reporting, analysis and benchmarking activities. It is recommended that the WCB claim number be collected and stored for all claim level data received by CIRB. This would facilitate the ability to "cross walk" data between CIRB and WCB, which would be very beneficial for analysis purposes.

D. *To Support Proposed Benchmarks*

To support the proposed benchmarks described previously in Section III, it will be required that additional data be collected. It is recommended that this data be collected by the WCB unless otherwise noted. This additional data includes:

Coverage of the Workers' Compensation System

- Number of active employers by sector of coverage (i.e. private carriers, self-insured or SIF).
- Percentage of workforce that has workers' compensation coverage.

Timeframes for Delivery of Benefits to Injured Workers

- Date of the employee's notice to the employer.
- Date on employer notice to payor.
- Date of first indemnity payment.

Section 32 Settlements

- The value of non-cash awards.[64]
- The total settlement amount if there are multiple claims associated with the agreement.
- The comparative value of settlements entered into by carriers, and those entered into by the ATF.

Streamlined Docket

- Date of submission of PFME.
- Date of early settlement mediation.
- Date pre-conference statements are filed.
- Claim indicator for claims not established because not actively pursued by claimant.
- Claim indicator for claims not established because claim was denied by WCB.

Medical Treatment Guideline Training

- Number and percentage of Adjudicators who receive training in the medical guidelines.
- Number of Health Care Providers who receive training in the medical guidelines.
- Number of Medical Reviewers at the insurers who receive training in the medical guidelines.
- Number and percentage of Health Care providers who indicate on their forms a use of the Medical Treatment Guidelines.

Payors

- Per claim: date of injury, date of 1st indemnity payment, date of submission of bill, date of payment for services.
- For controverted claims: Number of claims that are controverted, date of controversion, number of controverted claims that are resolved in favor of payor, date of resolution of controversy.

[64] Non-cash awards include requirements for the payor to fund the purchase of specific equipment or to make changes in the work environment.

- For medical claims: Number of medical claims that are disputed, date of dispute, the number of disputed medical claims resolved in favor of payor.

Judges

- Number of claims that are adjudicated.
- Number and percentage of judge's decisions that are appealed.
- Number and percentage of appealed decisions found in favor of the judge.
- Number and percentage of claims that have adjournments.
- For claims that have adjournments, date of adjournment and date of next hearing.
- Number of appeals taken per case.

Health Care Providers

- Number of workers' compensation claimants that are patients.
- Number and percentage of submitted bills that are disputed.
- Number and percentage of disputed bills resolved in favor of the physician.
- Number and percentage of pre-authorization requests that are approved and denied.
- Number and outcomes of disputed denials.
- The time between resolution of a bill dispute and payment of the bill.

Claimant Attorneys

- Number of workers' compensation claimants that are clients.
- Number of claims and percentage of claims that are resolved with a Section 32 settlement.
- Average settlement award for Section 32 settlements.
- Legal fees per claim.
- Hearing dates.
- Hearings per claim.
- Adjournments per claim and average length of adjournment.

Employers

- Number of claims and percentage that are indemnity claims.
- Per claim: date of injury, date of employer notice, date of payor notice, date of first indemnity payment.

Improve Workplace Safety

To measure improvements in workplace safety, it is recommended that the DOL collect the following data:

- Number of employers receiving the premium credit and other incentives for safety and drug and alcohol prevention programs, and number of their employees.
- Number of new employers in the mandatory safety program.
- Number of employers continuing in the mandatory safety program.
- Number of employers graduating from the mandatory safety program.

- Evaluation of the effectiveness of the workplace safety programs

Vocational Rehabilitation and Return To Work
To measure improvements in providing vocational rehabilitation service and return to work programs, it is recommended that the Department of Labor collect the following data:

- Number of employers receiving the premium credit under the Reform Act program, and number of their employees.
- Number of injured workers receiving vocational rehabilitation services.
- Length of vocational rehabilitation services.
- Percentage of workers receiving vocational rehab returning to work and remaining at work for 4 quarters.
- Number and percentage of judges, health care providers and others who are trained in return to work principles.

E. *General Recommendations*

- A tracking system should be developed to follow PPD NSL claimants from the time of classification until several years after their benefits expire, or they return to work. .

- To assist in future analysis and benchmarking, a common insurer identifying code should be used by both the WCB and CIRB systems. There are currently different carrier codes used in these systems which make it more complicated to compare data from the two systems for analysis and reporting purposes.

- Data to measure quality of care and access to medical care should be collected, using both surveys of claimants to measure claimant satisfaction with access to care.

    - Average benefit delivery expense per claim for claims with benefit delivery expenses should be determined. These expenses are the cost of delivering medical and indemnity benefits to injured workers, allocated to the individual claim. These expenses include litigation-related expenses such as defense attorney fees, medical-legal expenses and ancillary legal expenses, as well as costs associated with the medical management of the claim and any administrative assessments. The one cost they do not include is the cost of the claimant's attorney.

    - Percentage of indemnity claims with medical-legal expenses and the average medical legal expense should be calculated. These expenses are payments for examinations and reports initiated by either party or an adjudicator, and medical provider/expert testimony and depositions.

V. Recommendations for Long Term Improvements in Data Collection

This section of the Report will address the following two questions. First, how can New York State improve the scope and quality of data on the workers' compensation system?

And second, how can New York State effectively use the data to monitor and improve the workers' compensation system, including undertaking research to answer public policy questions. Major complaints in other states that have implemented enhanced data collection systems are that payors have to provide much of the new data, which can be time consuming and costly, and that other stakeholders do not see the data enhancements resulting in improvement in the system. New York State should ensure that the data is used to support research to improve system performance.

A. *Enhancing Data Collection To Address Major Data Limitations*

Prior sections of this Report discussed limitations in existing data and short and mid term recommendations to enhance workers' compensation data. This section will focus on three major deficiencies that require implementation of new systems. To address these gaps in data, it is recommended that the following data be collected and retained to support system monitoring and research regarding the workers' compensation system:

- Detailed medical data;
- Electronic medical billing data from providers (Pilot)
- Financial claim level data from the private and public self-insured employers

A.1. *Collection of Workers' Comp Detailed Medical Data*

Section II showed that total medical costs for PPD claims were growing significantly; certain classifications of medical costs, such as prescriptions, were growing faster than others; and NCCI has identified growing severity of injury and increased utilization as primary drivers behind increased medical costs. However, New York State cannot isolate the cost drivers in its system due to a lack of detailed medical information. Collecting detailed medical payment information will allow New York State to research what is driving costs in our state. It will also provide the information needed to evaluate the impact of medical treatment guidelines.

Various options for collecting this data have been explored. As part of that process, several other states were consulted. The main criteria used to determine which states would be reviewed included the comparability in terms of the size of the state's workers' compensation system and the status of its current workers' compensation electronic data collection activities. The four states chosen for review were: California, Pennsylvania, Oregon and Florida. In addition, several national organizations were also consulted, as well as several insurance carriers. Based on these discussions, four possible options were identified:

- Collect non-standardized data feeds from the insurers;
- Collect sample data using data calls and surveys;
- Develop a unique New York State Electronic Data Interchange[65] ("EDI") format; and

[65] Electronic Data Interchange is a general term used to describe the electronic exchange of data between two entities. In workers' compensation, these transactions can include claims, proof of coverage and medical bill payments.

- Collect data via EDI from the insurers using a standard format, such as the IAIABC standard or the NCCI format already in use in other jurisdictions (i.e. California and Texas)

Each of these options is discussed below.

Collect Non-standardized Data: WCRI, a national organization, collects data electronically from each carrier. This "non-standardized" data means that the data is provided by each carrier in each carrier's own unique format. WCRI then converts the data into a common format using a unique mapping program developed for each carrier. This approach requires the collecting entity to work with each of its partners to understand their data and how it needs to be converted to fit the standard format. This approach is unrealistic for New York State given the large number of private carrier groups, over 90, in addition to over 2,500 public and private self-insured entities.

Collect Sample Data: Given the size and complexity of New York State's system, the use of surveys requesting sample information is a reasonable approach if the only use of the data will be for research purposes. If, however, some of the data will be used for operational purposes, a sample approach would not be adequate. Although this is not the recommended approach, New York State may need to do sampling during the transition to a new system.

Develop a Unique New York State Format: Developing a standard format specifically for New York State would allow New York State to tailor the data format to meet all of its specific requirements. The downside of this approach is that it would be more costly for New York State to develop a standard format, and it would also be more costly for carriers to develop a special application to compile the data for New York State.

Use a National Standard: New York State is not alone in the need for medical payment information. There is a growing interest among states in capturing this type of data. In September 2006, California began the first phase of a multi-year plan to collect medical bill payment data electronically. California will utilize the IAIABC[66] standard format for collecting its medical data. Oregon currently has a project in progress to convert its current proprietary medical data collection system from a manual to an electronic system utilizing EDI and the IAIABC standard. Florida is also currently upgrading its medical data collection process. It will also be deploying the IAIABC standard. The IAIABC standard is also currently in use in Texas.

The IAIABC standard transaction set for medical billing detail is based on the American National Standards Institute[67] standard 837 transaction for medical billing. The American National Standards Institute standard is required for Health Insurance Portability and Accountability Act[68] participants. Workers' compensation is exempt from Health Insurance

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[67] A private, non-profit organization that oversees the development of voluntary consensus standards for products, services, processes, systems and personnel in the United States. Its membership is comprised of government agencies, organizations, corporations, academic and international bodies, and individuals.

[68] Enacted by the U.S. Congress in 1996. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II requires the establishment of national standards for electronic health care transactions. It also addresses the security and privacy of health data.

Portability and Accountability Act requirements. The IAIABC standard is a subset of the American National Standards Institute transaction and had been designed specifically to meet workers' compensation requirements. This standard was developed and is maintained through a consensus process that brings together representatives from various jurisdictions, claim administrators, vendors and others interested in participating.

NCCI has also developed a standard for collecting medical data. It will be used by all of its participating states. The NCCI standard is an adaptation of the IAIABC standard.

Recommendation
The recommended option for collecting this data is to implement an EDI system to support the electronic transmission, collection and storage of this medical payment data, utilizing a national standard, either the IAIABC or NCCI standard. This recommendation is based on discussions with other jurisdictions, carriers and other industry experts, and an analysis of the requirements of this data in New York State.

A.2. *Electronic Medical Billing Data from Providers (Pilot)*

The prior section focused on collecting detailed medical information from the insurers. This section focuses on electronic data from the health care providers. A gap in available electronic data is detailed medical billing data. The WCB currently receives paper copies of medical bills as attachments to the C-4 form submitted by health care providers. The medical bills are sent off-site for scanning and are then stored as part of the electronic case folder system. The data is then available on-line to WCB claims examiners for reviewing cases and as a data source in disputed cases. Since the medical bills are scanned, the data contained on the bills is not available in a format that can be used for data reporting or research. It is only available for on-line viewing. Some of the data on the medical bills is included on the WCB C-4 form and is keyed into the database. This limited set of data can be retrieved and reported on.

Recommendation
It is recommended that the WCB initiate a review and evaluation of the current business process used in the collection and scanning of these medical bills. A reengineered process could potentially automate the collection of this data, make the data more accessible and reduce the WCB's dependency on the outsourced scanning function.

The WCB has already developed an application to electronically receive this data. It is not widely utilized – only a small percentage of medical billing data is collected in this manner. It is recommended that a voluntary pilot program be implemented with a sample set of doctors or third-party administrators to submit this data directly to WCB utilizing this system.

Legislation should also give the WCB authority to require participants in the workers' compensation system to submit data electronically. This would greatly ease the data collection process, as well as add to the efficiency of processing and adjudication of claims. The Workers' Compensation Board has submitted a departmental bill which would allow it to impose such requirements.

Based on the results and outcome of the pilot program, WCB can rate the pilot program's success and determine whether a roll-out to additional providers is warranted

A.3. *Collection of Detailed Claim Data From Self-Insured Employers*

Another major gap in available data is claim information from the private and public self-insured employers. This gap necessitates estimates for this sector of the market when compiling system data such as total system costs. This need to estimate makes it more difficult, and potentially less accurate, for analysis, reporting and research purposes. The ability to collect this information from the self-insured employers would eliminate this gap in data.

It will be necessary to collect this data at the claim level. The types of data to be collected include claim number, accident date, paid medical costs, incurred medical costs, paid indemnity costs and incurred indemnity costs.

This is a large group of employers from which to collect data. Currently, 150 large employers actively self-insure. There are also 75 group trusts serving 20,942 active employers. Public sector entities (excluding New York State government) include 722 individual public sector entities and 1,949 public employers in county plans.

Recommendation

It is recommended that both the private and public self-insured entities be required to submit detailed claim data on a quarterly basis.

B. *Project Implementations*

Based on the previous recommendations, there are several projects needed to support long term improvements in New York State's workers' compensation data collection capabilities. The two major projects necessary are the implementation of an EDI system to collect medical payment data and the development of central data warehouse to store the data from the disparate data sources system-wide (i.e. WCB, CIRB, DOL) in addition to the new medical data that will be collected.

EDI Implementation Project - Medical Payment Data

An EDI project of this magnitude for New York State is a major undertaking. It will require proper planning, management, staffing and funding. The project will take several years to complete. The following is an overview of a proposed EDI project.

The EDI project will consist of several phases:

- Analysis and Planning
- Systems Development and Programming
- EDI Rollout Program

Analysis and Planning

In the Analysis and Planning phase a project team will need to be identified. The team will analyze the existing business issues and processes, identify the new requirements and document their findings. The result of this phase of the project will be a project plan.

In carrying out this project, it may be helpful to retain a consultant with specific experience with the unique issues associated with collecting and editing medical data. Oregon's workers' compensation agency recommended that a consulting resource be selected based on their expertise with medical data. Oregon did not utilize an experienced medical consultant at the start of their analysis and planning phase. After experiencing problems the resource was added, but the lack of medical experience within the original project team resulted in data collection issues, editing issues, project team frustration and delays in the eventual implementation phase.

During this phase, the availability of experienced in-house EDI expertise will have a major impact on costs. An EDI coordinator must be identified and a dedicated project team assigned. This staffing can be done with internal staff, if available, or outside consulting resources, which would add to project costs.

It should be noted that WCB has experience implementing an EDI project utilizing the IAIABC standard for proof of coverage. This required coordination of trading partners, technical development and negotiating partner agreements. These experienced resources should be assigned to the project if at all possible.

Systems Development and Programming
The next phase of the project will be the technical development or Systems Development and Programming phase. This will include the selection of standards (such as the IAIABC format), installation of EDI software, programming and the development of any application interfaces that would be required. It will also include the review, testing and installation of EDI communications alternatives.

During this phase there are several factors that will impact the effort required and thus the cost. How the data will be used – as transactional data, to update an existing system or database, or to populate a new database or system – directly impacts the complexity of the development effort. A second factor is the status of the existing telecommunications system and infrastructure and the decision of what protocols will be supported for the EDI system. Examples may be an internet-based File Transfer Protocol site or a Value Added Network. A third factor is the availability of internal analysts and programmers to be assigned to the project. The alternative use of outside consultants and contractors is an option but would add to project costs.

EDI Rollout Program
The next phase of the project will be the EDI Rollout Program. This will involve extensive trading partner relations (trading partners are two entities that have entered into an agreement to exchange data electronically).

The first step of this program will be an EDI pilot program. Based on the experience of other states, it is recommended that the pilot program include 20-30 trading partners. The group should include the large private carriers that are already filing medical data

electronically in California and/or Texas. The pilot program should take from 6-12 months to complete. After the successful completion of the pilot program, the general rollout to additional trading partners will be planned, scheduled and completed.

Based on reviews with other states, it is recommended that the next phase of the rollout be SIF. This will provide a large additional amount of data electronically since SIF represents over 20% of the market. Further, because SIF administers the ATF, it will play a significant role in all PPD NSL claims after the Reform Act. This phase should take up to six months to complete.

The final phase of the rollout will be the remaining trading partners. Again, it is recommended that there be a cutoff as to what entities should be required to submit electronically, based on criteria to be determined, such as the number of annual indemnity claims.

To facilitate a phased implementation of the collection of this data from the self-insured entities, it is recommended that New York State begin with the larger self-insureds and phase in the smaller self-insured entities over time. There may need to be special accommodations for the smaller self-insured particularly smaller municipalities that do not use a third party administrator. Some states use a cut-off level below which entities are not required to submit this data. Annual indemnity claims is a logical measure to use, with the cut-off level to be determined after additional analysis.

A major factor in determining the cost of the project for both the payors and the state is the level of data quality that is desired. Two factors are: what data will be required and how strictly the data will be edited. The more data required and the complexity of the edits will directly impact the initial testing time required per trading partner as well as ongoing costs for data cleansing

C. *Data Collection Warehouse*[69]

C.1. *Development of the Data Warehouse*

Considering the prior recommendations for adding major categories of data to the system and the many new metrics that will be recorded and tracked, as well as the different entities that have the data, it is recommended that a central data collection warehouse be established.

The data warehouse will be a central repository of data. It will contain all of the pertinent workers' compensation data required to support the reporting, analysis and research requirements of the state and stakeholders.

[69] A data warehouse is the main repository of an organization's historical data. It contains the data required to support an organization's analytical requirements, decision support systems and data mining. It is specially organized for rapid search and data retrieval.

The existing workers' compensation system in New York State is complex. To retrieve data from the varied sources and data streams, and to logically store this data for reporting and research purposes, the new data warehouse will also need to be complex. These varied data sources include data currently collected internally by sources such as WCB, CIRB, SIF, private insurance carriers and self-insured entities.

It is not recommended that the new data warehouse replace any of the existing systems already in place. Rather, it is suggested that the new data warehouse be a centralized data repository of information either extracted or transmitted from the existing systems and sources. In addition to the existing data sources, the new data warehouse should also be augmented with additional data. The new data will be collected from new sources and will fill existing information gaps in the current system, such as the self-insured entities. It should also contain the new medical data to be collected in the EDI project described above.

The new data warehouse will not be a transactional system. It is not intended as a source of data to support the normal day-to-day processing requirements of the existing systems. The transaction systems in place (i.e. at the WCB, SIF and the private carriers) will continue to function as they do currently. Periodically, at time intervals to be determined, the data from these transaction systems will be either extracted or transmitted to the new data repository. The data will then be stored in a manner to facilitate reporting, query and research functionality, which will likely be a structure unlike the original data systems.

It is also strongly recommended that the development of the new data warehouse be done collaboratively with the EDI project for detailed medical data previously described. This would facilitate the design of the data warehouse, incorporating the eventual collection of the new medical data. Use of an outside consultant should be considered, similar to the consultant described in regard to the EDI project. Any such consultant should have specific experience in designing data structures that contain detailed medical data, and the retrieval and utilization of that data.

A key feature of the new data warehouse will be security. The privacy issues associated with collecting data from disparate sources are substantial. It is imperative that the data warehouse be designed and implemented with these issues in mind. The privacy of an individual's information must be incorporated into the design and implementation. It is envisioned that this data will eventually be made available for research purposes to system stakeholders, outside research groups and New York State agencies. For this to be possible, security and privacy issues will be a key determinant.

It is also important that the design of the data warehouse include the linking of claim data and medical detail data. This will provide the basis for enhanced reporting and research functionality. The ability to match an individual medical bill to a specific claim will also provide additional analysis capabilities that are currently not available in the New York State system. This link is currently not available in any of the states with which the NYSID held discussions, although all have identified it as a major functional improvement requirement in their own systems. This link would put New York State in a unique position and provide it with enhanced capabilities for research purposes.

C.2. *Legislation for the Deficiencies in Data Collection Authority*

There are major segments of the insurance market from which neither WCB nor NYSID currently have authority to obtain all workers' compensation data. These segments are the self-insureds and SIF, which represented 57.5% of the market in 2006. Moreover, as noted, SIF administers the ATF, which makes it a particularly important repository of data. The data gaps created by this lack of authority are obvious obstacles to benchmarking the system, conducting research and answering public policy questions. To remedy these data deficiencies, it is recommended that legislation be enacted authorizing: (a) WCB, the agency that for limited purposes regulates self-insureds, to have the right to obtain all workers' compensation data from public and private self-insureds, including self-insured trusts and their members; and (b) WCB and NYSID (the agency regulating insurance carriers) each to have the right to obtain all workers' compensation data from SIF. This authority should include the right to require that any submitted data be in electronic form insofar as the submitting party maintains it in that form.

VI. Ongoing Research

The data collection warehouse will be the foundation for research, both on an ongoing basis and for special projects. To ensure New York State continues to build on the progress of the Reform Act, it is essential that there be a research capability in the workers' compensation system.

A. *New WCB Division for Combined Function of Data Warehouse and Research*

The organization, management and staffing of the development and support for the new combined data warehouse and research capability will be a key factor in its level of success. The two state agencies where this combined function of data/research could be located are NYSID or WCB.

Workers' compensation insurance is only a small portion of the NYSID's overall responsibility and it does not currently have any role in overseeing the self-insurance market. On the other hand, workers' compensation WCB's central function. In addition, WCB is the state agency responsible for overseeing the self-insureds from a solvency perspective, as well as administering claims filed by their employees.

Accordingly, it is recommended that an independent WCB division be created that reports directly to the Chair of the WCB. This division should be given the authority to oversee the development and operation of the data warehouse and to undertake and direct research projects to address public policy issues. The reporting structure will enhance the authority and independence of the new division. To maximize the usefulness of the data, the division may permit interested parties to have access to its data to conduct their own research projects, subject to protecting matters of privacy and competitive or proprietary data. The data warehouse/research division should be required to issue an annual report on the performance of the workers' compensation system

B. *Advisory Committee to the New WCB Division*

Labor and business have been involved in the various task forces focused on implementation of the Reform Act. To ensure that this productive dialogue continues, transparency is fostered, and advice from public and private interests is considered, it is recommended that a research advisory committee be established. The advisory committee members would be comprised of representatives of the Legislature, NYSID, DOL, WCB, and representatives of labor, business, academia and insurers appointed by the Governor. The chairperson of the committee would be designated by the Governor. The committee would advise the data/research division on areas it considers research desirable. The division, with advice from the advisory committee, should explore the potential of building a partnership with a university in New York State, preferably a public one that has the capacity to undertake special research projects on workers' compensation issues, the results of which could be made publicly available.

Appendix A - Glossary of Terms

* The definitions for these terms were taken in whole or in part from the Workers' Compensation Board web-site.

Accident Date *	Refers to either (a) the date the accident is deemed to have occurred or (b) the date of onset assigned to an occupational disease. The accident date is officially established by a WCB judge.
Aggregate Trust Fund *	The Aggregate Trust Fund was created pursuant to the provisions of Section 27 of the New York Workers' Compensation Law. The purpose of the fund is to assure and oversee the regular payment of benefits on adjudicated death cases and certain permanent disability cases. The fund derives its income from insurance carriers and self-insured employers who are required to deposit into the fund the present value equivalent of all such adjudicated cases.
Accident, Notice and Causal Relationship *	Establishment of a case occurs when the WCB has determined Accident, Notice and Causal Relationship. This means the board has established that: (1) an accident or disease occurred, (2) notice was received on a timely basis, and (3) the cause of the accident or disease is directly related to the claimant's employment.
American National Standards Institute	A private, non-profit organization that oversees the development of voluntary consensus standards for products, services, processes, systems and personnel in the United States. Its membership is comprised of government agencies, organizations, corporations, academic and international bodies, and individuals.
Compensation Insurance Rating Board ("CIRB")	A private unincorporated association of insurance carriers responsible for the collection of workers' compensation data and

	the development of workers' compensation rates and rules regarding the proper application of these rates to workers' compensation policies. CIRB also administers various individual risk rating plans such as the Experience Rating Plan and the Retrospective Rating Plan.
Claim *	A request, on a prescribed WCB form C-3, for workers' compensation for work-connected injury, occupational disease, disablement, or death (Form C-62). A claimant must file a claim within a two-year period from the occurrence of the accidental injury, knowledge of occupational disablement, or death. Failure to file a claim may bar an award for compensation unless the employer has made advance benefit payment or fails to raise the issue, in which event the claim filing requirement is deemed waived.
Classification Code *	A system of insurance risk classification based on industrial or occupational categories, supported by the National Council on Compensation Insurance and in use in about 40 states where private insurance is available. The system, which includes several thousand 4-digit numeric codes (with more than 700 classifications in use in New York), is extensively used to identify an employer's rate making class(es) and establish basic pricing for workers' compensation insurance.
Controverted Claim *	A claim challenged by the insurer on stated grounds. The Workers' Compensation Board sets a pre-hearing for the determination of the grounds and directs the parties to appear and present their case.
Controverted Claim w/o PFME	Controverted claims excluding claims that did not have prima facie medical evidence This adjustment is made to create data which will be more comparable to the controverted claims after new docket measures are adopted.

County Plan	Pursuant to Workers' Compensation Law, article 5 (§60 et seq.), a county may, by local law, establish a plan of workers' compensation self-insurance. Section 62 of that law provides that each plan shall have at least two municipal corporations as participants. The county shall be one of the participants in a plan.
Data Warehouse	The main repository of an organization's historical data. It contains the data required to support an organization's analytical requirements, decision support systems and data mining. It is specially organized for rapid search and data retrieval.
Death Claim	Lifetime benefits paid to surviving spouse and dependents when a work injury or illness results in death.
Electronic Data Interchange	A general term used to describe the electronic exchange of data between two entities. In workers' compensation applications these transactions can include claims, proof of coverage and medical bill payments.
Group Trust	A group of employers who perform related activities in an industry who agree to be jointly and severally liable for the payment of workers' compensation benefits to the employees of the employer members by contributing to a trust, the assets of which must exceed the liabilities, out of which benefits are paid. The group deposits with the Chair of WCB a minimal deposit of securities or a surety bond in an amount set by the Chair of WCB.
Health Insurance Portability and Accountability Act ("HIPAA")	The Health Insurance Portability and Accountability Act was enacted by the U.S. Congress in 1996. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II requires the establishment of national standards for electronic health care transactions. It also addresses the security and privacy of health data. Workers'

	compensation insurance is not covered by HIPPA.
International Association of Industrial Accident Boards and Commissions. ("IAIABC")	A group comprised of jurisdictions, insurance carriers and vendors who are involved in workers' compensation. IAIABC Electronic Data Interchange standards cover the transmission of claims, proof of coverage and medical bill payment information through electronic reporting. The standards are developed and maintained through a consensus process that brings together representatives from jurisdictions, claim administrators, vendors and others interested in participating.
IME	An Independent Medical Examinations is an examination performed by an authorized or qualified independent medical examiner, pursuant to Section 13-a, 13-k, 13-l, 13-m or 137 of the Workers' Compensation Law, for purposes of evaluating or providing an opinion with respect to schedule loss, degree of disability, validation of treatment plan or diagnosis, causal relationship, diagnosis or treatment of disability, maximum medical improvement, ability to return to work, permanency, appropriateness of treatment, necessity of treatment, proper treatment, extent of disability, second opinion or any other purpose recognized or requested by the WCB.
IME Examiners	Providers who meet eligibility requirements to conduct independent medical examinations of persons suffering injuries or illnesses which are the subject of claims under the Workers' Compensation Law.
Incurred	Amounts paid plus the amounts reserved for a claim.
Indemnity	Claims involving the payment of wage loss benefits.
Indexed Claim *	A claim case folder which has been assembled and assigned a case number by the Workers' Compensation Board's Claims Unit.

Large Deductible	These types of policies are a effectively a form of limited self-insurance. An insurance policy with an optional deductible authorized by Insurance Law § 3443 greater than those allowed by Workers' Compensation Law §50(3-e). These types of policies are subject to approval by the Superintendent and the insurer is required to pay indemnity and medical benefits to the claimant or provider and then seek reimbursement from the policyholder up to the deductible amount.
Maximum Medical Improvement *	An assessed condition of a claimant based on medical judgment that (a) the claimant has recovered from the work injury to the greatest extent that is expected and (b) no further change in his/her condition is expected. A finding of maximum medical improvement is a normal precondition for determining the permanent disability level of a claimant.
Medical-Only	Claims for injured workers who have no time loss or time loss of less than seven days and who require medical treatment. These claims tend to be for relatively minor injuries.
National Academy of Social Insurance	A non-profit organization comprised of experts on social insurance. Its mission is to promote understanding and informed policymaking on social insurance and related programs through research, public education and training.
National Council on Compensation Insurance	An association of workers' compensation insurers which serves as the workers' compensation rating organization in about two-thirds of the states. The group establishes standards for use in rate making, develops policy forms, collects statistics, and provides statistical support and services.
No-Compensation Case	A case which has not received any medical or indemnity benefits.
Occupational Disease	A subset of indemnity claims. In workers' compensation, an occupation disease claim refers to claims in which an injured worker

	has a disease produced as a natural incident of a particular employment, such as asbestosis from asbestos removal.
Occupational Safety and Health Administration	Part of the U.S. Department of Labor and is responsible for promoting employee health and safety in the workplace.
Payors	Insurance companies, self-insureds, the State Insurance Fund and the Uninsured Employers Fund and the Reopened Case Fund.
Permanent Partial Disability ("PPD")	When an injured worker is classified as PPD, it means they have reached maximum medical improvement (the healing process is complete) but their injury or illness caused the permanent loss of use or function of some part of the body which impairs their ability to work without limitations. PPD's are split into two categories, Scheduled and Non-Scheduled disabilities.
Permanent Partial Disability Non-Scheduled Loss ("PPD NSL")	If an injured worker has reached MMI and has a permanent bodily impairment that is not amenable to a schedule, such as a lower back injury, he or she will have a PPD NSL claim. Where the injured worker has not returned to work the amount of the indemnity benefit depends on the degree of their physical impairment and lost wage earning capacity.. Prior to the Reform, workers claims classified as PPD NSL were entitled to life-time benefits. For injuries occurring, on or after March 1, 2007, the Reform Act capped these benefits at a specified number of weeks depending on the degree of lost wage earning capacity. The maximum length of benefits is ten years.
Permanent Partial Disability Scheduled Loss	The complete or partial loss of use or function of an arm, leg, foot or other extremity of the body, or the loss of visual or hearing ability. These body parts are listed on a schedule with an amount of weeks of benefits assigned to each body part. For example, a worker with total loss of the use of a thumb receives 75 weeks of indemnity

	benefits, while a worker with loss of use of one arm receives 312 weeks of total disability payment.
Permanent Total Disability	The worker has reached maximum medical improvement and cannot perform any work. The worker receives lifetime wage replacement benefits.
Pre-hearing Conference	The purpose of the pre-hearing conference is to provide a mechanism for the identification of issues and relevant evidence and to permit the parties in interest an opportunity to assess their case and to resolve outstanding issues prior to trial. In all cases in which a notice of controversy (form C-7) is filed, the case shall be scheduled for a pre-hearing conference to be held as soon as practicable, but in no event more than 45 calendar days after receipt by the WCB of the notice of controversy and a medical report referencing an injury.
Prima Facie Medical Evidence	A medical report by an attending medical provider that gives a history of the accident or occupational disease, a statement that the claimant's injury is causally related to the accident or occupational disease, and a diagnosis.
Reduced Earnings	Two-thirds of the difference between a claimant's pre-injury average weekly wage and the lower average weekly wage earned post-injury due to a condition related to a compensable work-connected injury.
Reform Act	On March 13, 2007, Governor Spitzer signed into law the Workers' Compensation Reform Act. Highlights of the new law include raising the maximum indemnity benefits payable to injured workers, capping of the maximum number of years for which a Permanently Partially Disabled Non –Scheduled worker can collect workers' compensation benefits.
Residual Market	Employers that can not obtain coverage in the voluntary market.

Self-Insurance	In lieu of purchasing insurance from an insurance carrier, an employer or group of employers may assume the liability for the payment of workers' compensation benefits to employees. Such employers or groups must deposit securities or a surety bond with the Chair of the WCB in an amount required by the Chair of the WCB.
Section 32 Settlement *	The parties to a claim for compensation may settle upon and determine any and all issues by agreement, in accordance with Section 32 of the Workers' Compensation Law.
State Insurance Fund	A New York State agency whose activities include a) providing workers' compensation insurance coverage to private and public employers; b) providing disability benefits and employer liability insurance coverage; and c) acting as the third party administrator for New York State government employees The State Insurance Fund must offer workers' compensation insurance to any employer requesting it, making the Fund an "insurer of last resort" for employers otherwise unable to obtain coverage.
Streamlined Docket	The Governor's March 2007 letter directed New York State Insurance Department to examine the resolution of disputed cases at the Workers' Compensation Board and to recommend methods for resolving them within ninety days of a dispute. The Superintendent of Insurance sent his recommended changes to the process and draft regulations to implement these changes on June 1, 2007. These proposed regulations are referred to as the "Streamlined Docket" in this Report.
Total Industrial Disability ("TID") *	The worker has reached maximum medical improvement and they have a partial disability that limits their ability to work. If the impairment combined with other factors such as limited educational background and work history render the claimant incapable of gainful employment, the worker may be eligible for TTD. TID is a factual issue

	resolved by the Workers' Compensation Board.
Temporary Partial Disability ("TPD")	Claims for workers who can perform some work but still have limitations and are healing. Workers can transition from TTD to TPD benefits; if a worker returns to work with limitations and cannot earn their pre-injury salary, they are entitled to reduce earning benefits. A reduced earning benefit is two-thirds of the difference between a claimant's pre-injury average weekly wage and the lower average weekly wage earned post-injury due to a condition related to a compensable work-connected injury Alternatively a claimant, who has not returned to work, will have their benefits calculated based on the degree of their physical impairment and lost wage earnings capacity. At the current time, neither the CIRB data nor the WCB data can identify which claimants are receiving reduced earnings-based TPD benefits, and which are receiving reduced benefits due to a change in the level of disability, nor can they identify the magnitude of lost earnings.
Temporary Total Disability ("TTD")	Claims for injured workers who have lost more than seven days due to a work-related injury or illness. Injured workers received TTD benefits during the period in which they are too injured to perform any work duties.
Workers' Compensation Board *	The agency charged with administering the Workers' Compensation Law, the Volunteer Ambulance Workers' Benefit Law and the Volunteer Firefighters' Benefit Law and the Disability Benefits Law. The thirteen member Board is responsible for determining appeals of workers' compensation law judge decisions in panels of three and all together deciding appeals of panel decisions. . Members are appointed to seven-year terms by the Governor, by and with the advice and consent of the Senate. The Governor designates the Chair and Vice-Chair.
Workers Compensation Research Institute	A not-for-profit research organization providing information about public policy

issues involving workers' compensation systems.

Appendix B – Chart of Benchmarks

Measurements	Baseline Data
A. Coverage of the Workers' Compensation System.	
A.1. Percentage of workforce that has Workers' Compensation coverage – trend over years.	Data is not currently available.
A.2. Number of Referrals to the No Workers' Compensation Unit.	2006: 1,952 2007: 1,639
B. Timeframes for Delivery of Benefits to Injured Workers.	
B.1. Percentage of claims where the length of time from date of injury to first indemnity payment is less than 21 days.	2004/2005: 29%
B.2. Percentage of claims where the length of time between injury and notice to payor is 3 days or less.	2004/2005: 44%
B.3. Percentage of claims where the length of time from the date of the employee's notice to the employer to the employer's notice to the payor is 3 days or less.	2004/2005: 58%
B.4. Percentage of claims processed in 14 days or less from date of notice to payor to first indemnity payment.	2004/2005: 28%
C. Timely Access to Quality Medical Care for Injured Workers.	
C.1. Impact of Medical Treatment Guidelines.	
C.1.a. Average cost per claim for injuries by body part.	2003 Back: $5,172 Neck: $7,508 Knee: $4,264 Shoulder: $5,495
C.1.b. Chiropractor and Physical/Occupational Therapist - number of visits per indemnity claim.	2000/2005 (60 months development) Chiropractor: 54.6 Physical/Occupational Therapist: 28.0
C.1.c. Neurological/Neuromuscular testing – number of visits per indemnity claim.	2000/2005 (60 months development): 3.4

Measurements	Baseline Data
C.1.d. The number and percent of Medical Forms filed by Health Care Providers that identify application of the medical guidelines for the covered body part.	Data is not currently available.
C.1.e. The number and percent of Adjudicators who receive training in the medical guidelines.	Data is not currently available.
C.1.f. The number and percent of Health Care Providers who receive training in the medical guidelines.	Data is not currently available.
C.1.g. The number of Medical Reviewers at the insurers who receive training in the medical guidelines.	Data is not currently available.
C.2. Access to Medical Care.	
C.2.a. Access to doctors within a reasonable distance from claimant's home.	2007 Percent Authorized by County High Low Yates: 79% New York 19%
C.2.b. Number of physicians gaining and loosing WCB authorization by year.	Year Gained Lost 2005 802 570 2006 936 200
C.2.c. Claimant satisfaction with access to care.	Data is not currently available.
C.3. Determine appropriate measure for quality of care.	Data is not currently available.
C.4. Timeframes for resolving disputes over medical care.	
C.4.a. Median number of days to resolve denials of medical care disputes.	90 to 135 days
C.4.b. Median number of days from when a Form MD-1 is filed to resolution of the dispute, and the percentage of disputes found in favor of the payor..	Data is not currently available.
C.5. Disputes over Billing for Services Rendered.	
C.5.a. Average number of days from submission of bill to payment for services.	Data is not currently available.
C.5.b. Time to resolve disputes over the liability for medical bills.	Data is not currently available.
C.5.c. Time to resolve medical value disputes in arbitration.	2006: 300 days
C.5.d. How soon do payors pay an award.	Data is not currently available.
D. Timely and Equitable claim resolution.	
D.1. Proposed Streamlined Docket.	
D.1.a. Percentage of claims controverted compared to total claims.	2005: 16.6% 2006: 16.9%

Measurements	Baseline Data
D.1.b. For controverted claims, average number of days for the WCB to determine Prima Facie Medical Evidence (PFME).	Data is currently unavailable.
D.1.c. For controverted claims, average number of days from dispute to the Early Settlement Mediation and from date of dispute to pre-conference statements.	Data is not currently available.
D.1.d. The percentage of controverted claims resolved at pre-hearing conferences and the average days from date of dispute to pre-hearing conference for cases resolved at the pre-hearing conference.	Percentage resolved at pre-hearing conference in 2006: 42.5% Average number of days from indexing to resolution in 2006: 63
D.1.e. The percent of controverted claims resolved at first hearing, and the average number of days from date of dispute to first hearing for these claims.	Percentage of controverted claims resolved at the first hearing in 2006: 27.2% Average number of days from pre-hearing conference to first hearing in 2006: 142
D.1.f. For controverted cases, the number and percentage of claims resolved at the second hearing, and the average number of days from date of dispute to date of resolution for claims resolved at the second hearing.	Number of claims in 2006: 2,743 Percentage of claims in 2006:15.5% Average number of days:227
D.1.g. For controverted cases, the number and percentage of claims resolved after the second hearing, and the average number of days from the date of dispute to date of resolution for claims resolved after the second hearing.	Number of claims in 2004: 3,187 Percentage of claims in 2004: 17.7% Average number of days in 2004: 513
D.1.h. Average number of days to resolve a controverted case from indexing to establishment.	2005: 222
D.1.i Average number of adjournments for claims that have adjournments	Data is not currently available
D.1.j For claims that have adjournments , average number of days between hearings	Data is not currently available
D.2. Non Streamlined Docket Measures of Claim Resolution.	
D.2.a. Average number of hearings for indemnity claims that require hearings.	2006: 5.6 2007: 5.7

Measurements	Baseline Data
D.2.b. Median number of days for resolution for each process type.	Median number of days for administrative decision in 2006: 97 Median number of days for conciliation in 2006: 152 Median number of days for hearing in 2006: 169
D.3. Non-Controverted.	
D.3.a. Average number of hearings for when the claimant was represented by an attorney compared to claimants without legal representation.	Represented in 2006: 2.7 Not represented in 2006: 1.6
D.3.b. Average duration of TTD claims from indexing to establishment.	Six months.
D.3.c. Average length of time from indexing to classification for PPD SL and PPD NSL.	PPD SL: 2.3 years PPD NSL: 4.5 years
D 4. Appeals.	
D.4.a. Pending inventory of appeals at year end and age of pending appeals.	
E. Improve workplace safety.	
E.1. Number of claims indexed by the WCB per 100 workers.	2005: 1.66 2006: 1.62
E.2. Indemnity Claims per 100 workers by industry.	1999-2005 All Industries: 1.09 Government: 1.50 Manufacturing: 2.03 Transportation/ Warehousing: 2.60 Construction: 1.79 Utilities: 1.80
E.3. Total number of claims by classification - trend over years.	% Change 2000-2003 Medical Only: -21.9% TTD: -22.0% All PPD: -11.5%
E.4. Number of employers participating in the safety and Drug and Alcohol prevention initiatives.	Data is not currently available.
E.5. Track Employers in the Mandatory Safety program.	Data is not currently available.
E.6. Explore potential of collaborating with OSHA on safety inspections.	Data is not currently available.
F. System Costs.	
F.1. Medical Costs.	
F.1.a. Average medical cost per indemnity claim at 30 months of development.	2003: $9,997
F.1.b. Average medical costs per PPD claim at 30 months of development.	2003: $19,981

Measurements	Baseline Data
F.2. Indemnity Costs.	
F.2.a. Average indemnity cost per indemnity claim – 30 month development.	2003: $18,120
F.2.b. Average cost per PPD indemnity claim at 30 months of development.	2003: $ 43,380
F.3. Section 32 costs.	
F.3.a. Number of settlements and average settlement costs.	Number in 2006: 9,372 Average cost in 2006: $47,506
F.4. Frictional Costs.	
F.4.a. Percent of claims with claimant attorneys.	2006 No Compensation: 26.1% Medical Only: 36.2% Indemnity: 51.5%
F.4.b. Average claimant attorney fees as percent of average indemnity cost for represented claims.	2000 – 2006 All claims: 4.6% Claims with legal fees: 5.5%
F.4.c. Percentage of claims using independent Medical Experts.	2006: 32.2%
F.4.d. Average Benefit delivery expense per claim that have benefit delivery expenses.	2002 – 2005: $1,822
F.4.e. Percent of indemnity claims with medical-legal expenses and the average medical legal expense.	2002 – 2005 Percentage of claims: 37.2% Average expense: $963
F.4.f. Percent of claims with defense attorney expenses greater than $500 and the average defense attorney expense for claims with defense attorney expenses greater than $500.	2002 – 2005 Percentage of claims: 12.2% Average expense: $1,352
G. Adequacy of Benefits and Return to Work.	
G.1. Maximum Benefit.	
G.1.a. Number of claimants receiving the maximum benefit for the year.	2006: 55%
G.1.b. Rank of the maximum benefit compared to other states.	2007: 6th lowest
G.2. RTW and Remain at Work.	
G.2.a. Percent of claimants with wages throughout the eight quarters following the accident.	2002 – 2005 TT: 61.4% PPD SL: 78.7% PPD NSL: 25.2%
G.2.b. PPD NSL claimants with wages by quarter after accident.	Accident date 1/1/200 – 12/31/2001: 67.7%
G.3. Change in Earnings.	

Measurements	Baseline Data
G.3.a. Average Wages Pre- and Post-Injury where the claimant returned to work with any New York State Employer or where the claimant returned to work with the same New York State Employer.	All claimants with accident dates between 4th quarter 1999 and 1st quarter 2005. Pre Post Any NYS employer: $ 34,344 $30,035 Same NYS employer: $30,187 $26,393
G.3.b. Comparison of injured workers' wages post-injury to non-injured workers in similar jobs.	Data is not currently available.
G.4. Section 32 Settlements.	
G.4.a. Section 32 Wages After Accident Date.	2000 – 2006: $15,308.90
G.4.b. Section 32 - Claimants earnings following injury and following settlements.	2000 – 2006 1st quarter post-injury: $8,405 1st quarter post-settlement: $3,766
G.5. Percent of employers receiving the RTW credit.	Data is not currently available.
G.6. Vocational Rehabilitation.	
G.6.a. Number of injured workers receiving vocational rehabilitation services.	Data is not currently available.
G.6.b. Average length of vocational rehabilitation services.	Data is not currently available.
G.6.c. Percentage of workers receiving vocational rehab returning to work and remaining at work for 4 quarters.	Data is not currently available.
H. Performance of Major Players in the Claim Administration System.	
H.1. Payors.	
H.1.a. Average number of days from date of injury to 1st indemnity payment.	Data is not currently available.
H.1.b. Percentage of indemnity claims with time from date of injury to 1st indemnity payment <= 21 days.	Data is not currently available.
H.1.c. Average number of days from submission of bill to payment for services.	Data is not currently available.
H.1.d. Number and Percentage of claims which are controverted and then not established.	Data is not currently available.
H.1.e. Average number of days from date of controversion to resolution of controversy.	Data is not currently available.
H.1.f. Number and Percentage of medical bills that are disputed.	Data is not currently available.

Measurements	Baseline Data
H.1.g. Number and Percentage of disputed medical bills resolved in favor of payor.	Data is not currently available.
H.1.h. Number and percent of request for pre-authorization approval for medical care that are disputed, and the percent of the disputes that are resolved in favor of the payor.	Data is not currently available.
H.2. Judges.	
H.2.a. Number of claims that are adjudicated.	Data is not currently available.
H.2.b. Number and percentage of judge's decisions that are appealed.	Data is not currently available.
H.2.c. Number and percentage of appealed decisions approved by the WCB.	Data is not currently available.
H.2.d. Number and percentage of claims that have adjournments.	Data is not currently available.
H.2.e. Average number of adjournments per claims that have adjournments.	Data is not currently available.
H.2.f. For claims that have adjournments, average number of days between hearings.	Data is not currently available.
H.2.g. For claims involving parts of the body that are covered by the medical guidelines, the numbers and percentage that the judge applied the medical guidelines in deciding the medical dispute.	Data is not currently available.
H.3. Health care providers.	
H.3.a. Number of workers' compensation claimants that are provided service.	Data is not currently available.
H.3.b. Number and percentage of submitted bills that are disputed.	Data is not currently available.
H.3.c. Number and percentage of disputed bills resolved in favor of the health care provider.	Data is not currently available.
H.3.d. For claims involving parts of the body that are covered by the medical guidelines, the numbers and percentage that the health care provider used the medical guidelines when completing the WCB form C-4.	Data is not currently available.
H.3.e. Number and percent of requests for pre-authorization approval for medical care that are disputed, and the percentage of the disputes that are resolved in favor of the payor.	Data is not currently available.
H.4. Claimant Attorneys.	
H.4.a. Number of workers' compensation claimants that are represented.	Data is not currently available.

Measurements	Baseline Data
H.4.b. Number of claims and percentage of claims that are resolved with a Section 32 settlement.	Data is not currently available.
H.4.c. Average settlement award for Section 32 settlements.	Data is not currently available.
H.4.d. Average legal fees per claim.	Data is not currently available.
H.4.e. Average number of hearings per claim.	Data is not currently available.
H.4.f. Average number of adjournments and length of adjournments.	Data is not currently available.
H.5. Employers.	
H.5.a. Number of claims and percentage that are indemnity claims.	Data is not currently available.
H.5.b. Percentage of claims processed within 3 or less days from date of injury to payor notice by employer.	Data is not currently available.
H.5.c. Percentage of claims processed in 3 or less days from date of employee notice to date of notice to payor by employer.	Data is not currently available.
H.5.d. Percentage of claims where the length of time from date of injury to first indemnity payment is less than 21 days.	Data is not currently available.
I. Fraud.	
I.1. Number of workers' compensation fraud complaints.	NYSID 2006: 1,034 2007: 1,472
I.2. Number of workers' compensation fraud investigations.	NYSID 2006: 440 2007: 219
I.3. Number of workers' compensation fraud prosecutions.	NYSID 2006: 142 2007: 149
I.4. Total dollar amount of restitution and penalties collected.	Data is not currently available.