Joint Report to the Governor

From the Superintendent of Insurance and Chair, Workers' Compensation Board, Summarizing and Benchmarking Workers' Compensation Data and Examining Progress on Prior Recommendations for Improvements in Data Collection

March 2009

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Executive Summary

On March 13, 2007, the Workers Compensation Reform Act ("Reform Act") was signed into law. Highlights of the new law included raising the maximum benefits payable to injured workers; providing return to work initiatives; limiting indemnity benefits for permanently partial non-scheduled claims to a maximum number of years (duration caps), thereby reducing costs and premiums; and strengthening penalties for fraud and abuse.

The continued and effective implementation of these reforms requires, among other things, sustained, enhanced inter-agency cooperation and data sharing. Pursuant to the Governor's directive, the Superintendent of Insurance (Superintendent), in March 2008, issued the first annual data report to the Governor about the New York State's workers' compensation system: "Summarizing Workers' Compensation Data and Recommending Improvements in Data Collection and the Development of a Research Structure for Public Policy," (2008 Data Report). The 2008 Data Report brought together data from the Workers' Compensation Board (WCB), New York State Insurance Department (NYSID), Department of Labor (DOL), Compensation Insurance Rating Board[1] (CIRB), State Insurance Fund (SIF), and other workers' compensation organizations.

The 2008 Data Report was the first step in making workers' compensation system data more available to policy makers and stakeholders. It created a baseline for the New York State workers' compensation system prior to the full implementation of reform. It also identified the limitations in existing data and recommended a structure for improved and integrated data collection and policy research for the future.

This 2009 Workers' Compensation Data Report (2009 Data Report) is a joint presentation of the Superintendent and the Chair of the WCB; it builds on the framework of the 2008 Data Report and incorporates data metrics that the WCB, in prior years, published in its Annual Report. Some of these metrics are included in the body of the report and the remainder are included in Appendix Three. This Data Report also fulfills the Board's statutory obligation to present an annual report to the Governor.

This Report has been made possible by the continued cooperation and support of DOL, CIRB and SIF, Department of Civil Service, Workers' Compensation Research Institute[2]

[1] CIRB is 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.

[2] WCRI is a not-for-profit research organization providing information about public policy issues involving workers' compensation systems.

(WCRI), and the National Council on Compensation Insurance [3](NCCI) whose data are incorporated in this Report.

The 2009 Data Report has several objectives:

- ♦ Monitor the impact of the 2007 Reform Act;
- ♦ Provide a continuing overview of New York State's workers' compensation system;
- ♦ Benchmark the performance of New York State's system;
- ♦ Provide analysis of key aspects of the workers' compensation system; and
- ♦ Update the progress on implementing long-term recommendations of the 2008 Data Report.

Impact of the Reform Act

Significant progress has been made on many of the key issues the Reform Act addressed.

Increasing the maximum weekly indemnity benefit level for injured workers was an important aspect of the Reform Act. On July 1, 2007, the maximum weekly benefit increased from $400 to $500. Fifty-seven percent of claimants awarded benefits after July 1, 2007 received higher awards due to the increase in the maximum weekly benefit.

As envisioned by the Reform Act, NYSID organized the Workers' Compensation Reform Task Force (Task Force) to develop reforms related to the legislation. The Task Force, working with an Advisory Committee designated by the Governor, developed proposed regulations to streamline the resolution of controverted claims[4], known as the "Rocket Docket." Based on these recommendations, WCB has implemented significant changes in how it identifies and handles controverted claims. The results of these changes are already evident. The number of pending controverted claims was reduced by 42% from April 1, 2008 to January 1, 2009. Currently 85% of controverted claims which have been filed post reform are resolved as to the dispute in less than 90 days. In addition, there has been over a 50% decline in the number of controverted claims over the last year.

Another improvement by the WCB in accelerating the disposition of claims has occurred in the appeals process. In March 2008, the Chair of the WCB directed the reengineering of the administrative review process which handles requests for review of WCB administrative law judge decisions. The improvements in the WCB's administrative review process have been significant and demonstrable. For example, in March 2008 there were 4,743 claims with a pending request for administrative review compared to 3,620 in December 2008, a reduction of 24%. In March 2008, over 22% of the claims awaiting an administrative review were more than 6 months old. As of February 1, 2009 the percentage had dropped to 9% of claims.

[3] NCCI 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, collects statistics and provides statistical support and services.

[4] In a controverted claim, the payor (insurance carrier or self insured employer) files notice with the WCB that it controverts the claim (i.e., denies liability) and asserts specific defenses, such as the claim was filed late or the injury is not work related.

The reform effort also focused on the quality of medical care for injured workers and controlling the growth in medical costs. NYSID's Task Force together with its Advisory Committee and highly credentialed medical professionals developed proposed Medical Treatment Guidelines and related Implementation Standards for the lower back, cervical spine, shoulder and knee (four major body parts driving medical costs). NYSID issued the proposed Guidelines and Implementation Standards to the WCB for its regulatory consideration. WCB is in the process of developing the regulations for Medical Treatment Guidelines and their implementation. In addition, WCB has developed and issued an RFP for training the estimated 50,000 individuals who will be using these Guidelines. Another effort to rein in growing medical costs focused on pharmaceutical costs. The Reform Act authorized the Chair of the WCB to adopt a pharmaceutical fee schedule. A pharmaceutical fee schedule became effective July 2007. New York is now the third lowest pharmaceutical fee schedule in the nation. Based on data from SIF, there are early indications that this schedule is slowing the growth in costs for prescription medicines.

A main focus of the Reform Act was reducing premiums for employers. The first evidence of success on this goal was a reduction in approved rates for workers' compensation coverage for the year starting in October 2007 that decreased employer costs by 20.5 percent. Employers saw another five percent average decrease in approved rates beginning in October 2008.

The Reform Act also required the Superintendent to review the rate-making process for workers' compensation insurance policies and make recommendations for improvements. Effective February 1, 2008, Chapter 11 of the Laws of 2008 established a new loss cost approach[5] for rate making. One of the primary goals of moving from the administered pricing approach for rate making to the loss cost approach was to increase price competition. Results show there is a wider range of rates filed under the new approach.

Enhancing enforcement of workers' compensation coverage and reducing fraud were another major focus of the Reform Act. Under the Reform Act, the WCB was given the authority to use stop work orders when an employer has no coverage. Candidates for stop work orders are found by use of sweeps[6] focusing on key industries. Since June 2008, the WCB has issued roughly 200 stop work orders per month.

Pursuant to the Reform Act, DOL, in consultation with the statutorily designated Advisory Council, issued its Return to Work Report as part of the safety net for permanent partial disabled claimants. The DOL Report provided analysis and recommendations for facilitating return to work for those categorized as permanently partially disabled. DOL and WCB have been meeting regularly in order to implement various recommendations as part of the WCB system.

[5] The loss costs rate system is described in detail in the Progress Section II-B

[6] A sweep is the targeting of a certain geographic area, type or segment of employers, or some other classification for inspection to determine compliance with statutory and regulatory requirements without notice or warning.

Overview of the Workers' Compensation System in New York State

In New York State, employers continue to have three options for workers' compensation coverage -- private insurance carriers, the State Insurance Fund (SIF) or self-insurance. The market shares of these three components have remained fairly constant over the past year with a small increase in the private carrier share matched by a small decline in SIF's market share.

For 2007, the estimated size of the workers' compensation system based on premium adjusted to include self insured employers, was $5.7 billion. This represents a modest increase of $200 million over the estimate for 2006 in the 2008 Data Report.

Metrics for premium administrative processing improvements are available for the 2007 On the other hand, data relating to claim costs is not available for the most recent years. Due to the long time for claim development in the New York State worker's compensation system, it is essential to use claim data with a reasonable amount of development time to obtain a more accurate picture of trends. Much of the CIRB data in this report is based on policy year data for claims with 30 months development. The most recent data from CIRB with thirty month development is 2004. The 2008 Data Report used 2003 as the most recent data for claims with 30 months of development

Overall, the multi-year decline in claim volume continues. From 2003 to 2004, indemnity claims declined by 9.5% and Medical-only claims dropped 5.7%. This trend is consistent with nationwide claim trends. The two largest groups of indemnity claims declined but at different rates. From 2003 to 2004, Temporary Total Disability (TTD) claims declined at a faster rate the more expensive Permanent Partial Disability (PPD) claims, 11.6 % compared to 5.2%. There has been a trend of declining claims, with PPD claims declining at a slower rate, over the past few years. As a result of this trend, PPD claims have become a larger share of total indemnity claims.

A key trend in overall benefit costs is the growing share of medical costs. Based on CIRB data, medical costs have risen from 29.7% of total benefit costs for 2001 compared to 46.7% for 2007. Medical costs' increased share of total benefit costs is consistent with national trends. However, nationwide medical costs constituted 59% of total benefits[7] compared to 46.7% in New York State.

Roughly half of all benefit costs are generated by a small class of claims, PPD non-scheduled. For 2004, these claims only made up 6.1% of indemnity claims but they contributed approximately 50% of indemnity and medical costs for indemnity claims.

[7] NCCI's "State of the Line" report presented in Florida on May 8 2008, Dennis Mealy

Benchmarks

This 2009 Data Report updates the benchmark framework used in the 2008 Data Report. It uses most of the same measurements, adds several new ones and modifies others to reflect available data. The following areas are benchmarked:

A. **Compliance with the Workers' Compensation Law**
A new benchmark has been added, the employer compliance rate,—what percentage of the workforce, subject to workers' compensation insurance, is covered by it. As of January 1, 2009, 94.2% of active employers had workers' compensation insurance and were in compliance. Due to delays in processing and errors in data submitted, this ratio will always be less than 100%.

B. **Timeframes for Delivery of First Indemnity Benefits for Injured Workers**
New York State's performance in notifying employers of injuries is in line with the performance of the 14 states studied by WCRI. In New York State, 52.4% of payors receive notice within 3 days of the injury, compared to 50.5% for the median of the 14 states. On the other hand, New York State continues to lag behind other states in making first indemnity payments. In the 14 states that WCRI examined, 41.5% of first indemnity payments were made within 21 days, compared to 23.4% in New York State. Possible reasons for this are discussed in a separate Section of the report, "Analysis of First Indemnity Payments"

C. **Timely Access to Quality Medical Care for Injured Workers**
A new benchmark has been added that measures the number of authorized physicians in the context of the number of claims in a county. The median number of physicians for every 10 claims in a county is 1.7. These numbers range from a high of 6.9 to a low of 0.4.

Approximately 10% of indemnity claims involve disputes over authorization for medical care and about 14% of indemnity claims involve disputes over reimbursements for medical care.

D. **Timely Claim Resolution**
From 2001 to 2003 there was a significant decline in the number of days to resolve claims involving hearings, decreasing from 232 days to 195, a 15.9.3% decline. This Report also addresses a concern that claims, despite having open issues, were relegated to "No Further Action" status. The data indicates this is not occurring. Approximately 70% of claims are resolved with only one NFA[8] finding and an additional 17% to 18% are resolved with only two NFA findings.

[8]NFA is a finding that states the WCB will take no further action in the claim as there are no unresolved issues at the current time. Once a claim is marked NFA the WCB will continue to examine incoming mail and handle phone calls about the claim. Whenever subsequent issues arise in a claim, its status is reactivated and set for the appropriate issue resolution (either administrative determination, conciliation or formal hearing).

A primary focus of the Reform Act was to reduce the number of controverted claims by providing payors with the information they need so they do not file protective notices to controvert claims. Over the past year from January 2008 to January 2009 the number of controverted claims declined by roughly 50%, after WCB put the new procedures in place.

Another area where process improvements have reduced timeframes is processing appeals. Only nine percent of claims awaiting an administrative review as of Feb. 1, 2009, were more than six months old compared to more than 22 percent of claims in March 2008.

E. **System Costs and Costs per Claim**
From 2003 to 2004, average medical costs per indemnity claim increased by 9%. From 2003 to 2004, average indemnity costs per claim increased by 5.1 %.

F. **Adequacy of Benefits**
From July 1, 2007 to June 30, 2008, 57.1% of the claimants with an accident date after July 1, 2007 benefited from the increase from $400 to $500. At the new rate, New York State ranks 5th lowest in the nation.

G. **Return to Work**
The two largest groups of claimants, those receiving TTD and permanent partial disability scheduled benefits leave the work force at a rate consistent with non-injured workers. Of all workers on New York State payrolls as of January 2006 , 20% left the New York State workforce by January 2008.[9] Workers leave the workforce for many reasons not related to work place injury such as retirement, movement out of state, return to school, or family illness.

There are however two groups of claimants that have a much lower return to work rate. Eight quarters after the accident, only 25.6% of claimants who will eventually be classified as PPD non-scheduled are working. The percentage for claimants who will accept Section 32 settlements is only slightly higher at 30.1%.

H. **Improvements to Workplace Safety**
Based on data from 2000 to first two quarters of 2006, the average number of claims per 100 workers is 1.05. The two industries with the highest number of claims per 100 workers remained the same as in the 2007 Data Report, "Transportation and Warehousing", followed by "Manufacturing". But the ratio for both industries has declined. "Transportation and Warehousing" dropped from 2.6 to 2.45 and "Manufacturing" "declined from 2.03 to 1.96. There were similar declines in most other industries. This decline is consistent with the falling number of indemnity claims.

[9] Other new workers joined the workforce over this 2 year time period so there was not a drop of 20% in the labor force.

I. Fraud

Since the passage of the Reform Act, there has been increased interagency cooperation and data sharing, between Workers' Compensation Office of Inspector General (OFIG) and the other agencies, including the Joint Enforcement Task Force on Employee Misclassification. This has resulted in decreased duplication of services, and an increase of productivity in fraud prevention.

The OFIG and NYSID referred almost 300 cases for prosecution. The OFIG identified $3.6 million in fraudulent activity, and notified insurers that $4.6 million in reserves associated with fraud cases could be released.

Analysis of First Indemnity Payments

The 2008 Data Report showed New York State was slower in making the first indemnity payments to injured workers than all of the 14 states studied by WCRI. Results in the 2009 Data report continue this pattern. Only 19.7 % of New York State's first indemnity payments were made within 21 days of the injury. In comparison, the median for the 14 WCRI states was 41.5% and the fastest state, Massachusetts paid 53.4% of its claimants within 21 days.

There are two statutory factors that may contribute to this outcome in New York State. First, New York State law allows a longer time period for payors to determine whether to accept or deny a claim and when benefits are required to be paid. Second, payors are not responsible for obtaining the medical evidence that demonstrates the claim is work related. In New York State, lack of medical evidence is an acceptable reason for delaying the first indemnity payment. In many other states, the payor is responsible for obtaining this information and lack of this evidence is not an acceptable reason to delay payment.

Finally, it should be borne in mind that the way lump sum payments to employers are handled in the calculation of this metric may tend to inflate it.

Interaction with Other Public Benefit Programs

The return to work data in the 2008 Data report and the data in the DOL's "Report of the Commissioner on Return to Work in Consultation with the Return to Work Advisory Council" revealed there are several sets of injured workers who have low rates of sustained return to work. These are injured workers with PPD non-scheduled claims and workers with temporary total disability claims who accept Section 32 settlements. The low return to work rate raises the question, how many of these claimants are receiving Social Security disability benefits?

As the first step in analyzing this issue, WCB claim data, for claims assembled between 2001 and the 2nd quarter of 2006, was matched with the disability benefit data of the U.S Social Security Administration (SSA). The match revealed that a large percentage of claimants, who were classified as PPD non-scheduled or who settled their claims, received Social Security disability benefits at some point after their injury. Sixty-eight percent of PPD non-scheduled

claimants and 46.7% of TTD's with Section 32 settlements supplemented their workers' compensation benefits with disability benefits from Social Security. Between 2001 and 2008, 14% to 15% of the PPD non-scheduled and Section 32 claimants began receiving Social Security retirement benefits.

Implementing Long Term Recommendations of the 2008 Data Report

One of the major recommendations of the 2008 Data Report was to collect more detailed medical information. The need for additional detailed medical information continues. Average medical costs for workers' compensation claims are growing and medical costs are growing as a percentage of total indemnity plus medical costs. In addition, the data will allow New York State to evaluate the impact of the medical treatment guidelines, and provide data for future refinements of those guidelines.

The WCB strongly agreed with this recommendation. It evaluated which of two major data standard systems currently used by other states was the best approach and made a preliminary decision to move forward with the IAIABC standard[10]. However, there have been two major changes during the year that impact how the WCB should move forward on this issue.

First, on November 6, 2008, CIRB announced that it had received authorization from its Board of Governors to begin collecting detailed medical data using the alternative standard from NCCI[11].

Second, on January 16, 2009, the U.S. Department of Health and Human Services (DHHS) issued a new rule that changed the standards for electronic medical transactions. Based on this mandated change, the IAIABC standard must change.

Due to this development the WCB is reviewing the situation to determine the best course of action.

In order to facilitate data storage and access to the data for research purposes, the 2008 Data Report recommended the development of a data warehouse to be the centralized repository of information gathered from the existing systems and sources. The information in the data warehouse would be stored to facilitate reporting, query and research functionality. While at this time the WCB does not have sufficient funds in its budget to devote to these projects, Governor David A. Paterson's 2009-2010 Budget Proposal includes up to a $20 million increase in Board funding via a

[10] 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

[11] NCCI standard is based on the IAIABC standard, but it includes a much smaller number of data field. It will be used by all of its participating states.

surplus recapture. If approved, some of these funds will go towards creating and maintaining a data warehouse.

I. Introduction

This Report is the second annual Workers' Compensation Data Report. This section will summarize the recommendations from the first Report issued in 2008, describe how this 2009 Report was created, and how it differs from the first Report. For readers not familiar with workers' compensation terms and acronyms used throughout this Report, please consult the glossary in Appendix One.

A. 2008 Data Report

As part of the 2007 reforms of the New York State Workers' Compensation system, the Superintendent of Insurance (Superintendent) was directed to report annually on the status of available data in the system and to make recommendations on how to improve the system's data. On March 3rd of 2008, the Superintendent issued a Report to the governor "Summarizing Workers' Compensation Data and Recommending Improvements in Data Collection and Development of a Research Structure for Public Policy." This will be referred to as the "2008 Data Report."

The 2008 Data Report was the first step in a multi-year process to make workers' compensation system data more available to policy makers and stakeholders. Through the consolidation of data from several key entities within New York State, from national organizations, and with the development of benchmarks for the system, the 2008 Data Report created a baseline for the New York State workers' compensation system prior to the full implementation of reform. It also identified the limitations in existing data and recommended a structure for improved and integrated data collection and policy research for the future. Major recommendations in the 2008 Data Report included:

- Continue to improve and report annually on the benchmarks;
- Develop a cross-walk for the Compensation Insurance Rating Board (CIRB[12])and Workers Compensation Board (WCB) data;
- Develop a mechanism for collecting data to address two major data shortfalls;
  - medical information, including medical authorizations
  - and data from self-insured employers;
- Develop a data warehouse for all workers' compensation system data;
- Enhance the on-going research function in the WCB;
- Measure the impact of the 2007 Reforms;

[12] CIRB is 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.

- Review New York State's first indemnity payments.

B. 2009 Data Report

The 2009 Data Report was drafted jointly by the Workers' Compensation Reform Task Force and senior staff of the WCB, and is a joint presentation of the Superintendent and the Chair of the Workers' Compensation Board. This joint endeavor reflects a first step in implementing one of the long term recommendations of the 2008 Data Report --- the transfer of responsibility for the annual data collection report from the NYSID to the WCB. In light of the joint nature of this Report, the WCB has decided to use the 2009 Data Report as the vehicle to publish data charts that have historically been part of the WCB's own annual Report. Some of these charts are incorporated into the body of the Report and the remaining charts are included in Appendix Two.

C. Report Organization

The Report is organized as follows: Section II provides details on the progress that has been made over the past year. Section III updates the overview of the system looking at market shares, rates, and trends in claims and costs. Section IV provides an additional year of data for the benchmarks. Section V examines delays in first indemnity payments. Section VI looks at the interaction of workers' compensation with other public benefit programs. Finally Section VII reviews the status of the long term recommendations from 2008 Data report.

II. Progress

Significant progress has been made on many of the recommendations in the 2008 Data Report.

New, more competitive procedures for setting rates for worker's compensation have been implemented. Streamlined procedures for handling controverted claims have begun to show results. In addition, the WCB has effectively redesigned its appeal process and reduced backlogs. First steps have been taken to enable the cross-walk of the two primary data sets in the workers compensation system.

The release of this second annual Data Report demonstrates the on-going commitment to providing Workers' Compensation information to the public.

The following sections discuss progress being made in the following areas:

- Implementing workers' compensation reforms:
  - Implementing the Rocket Docket to accelerate controverted claim resolution;
  - Implementing Medical Treatment Guidelines to improve quality of medical treatment and control medical costs;
- Making rate setting more competitive;

- ♦ Assisting injured workers to return to work;
    - Implementing various recommendations in Department of Labor Report on Return to Work;
    - Improving data on reduced earnings benefits;
- ♦ Cross-walking the CIRB and WCB data to provide more comprehensive information on the workers' compensation system ;
- ♦ Enhancing the availability and submissions of electronic forms;
    - Providing electronic forms for medical providers;
    - Enhancing availability of other forms electronically;
- ♦ Improving the WCB appeals process;
- ♦ Improving WCB systems to enhance the capability to respond to requests for data;
- ♦ Enhancing data sharing in support of multi-agency initiatives;
- ♦ Enhancing the availability of information on state employee claims.

A. Implementing 2007 Workers' Compensation Reforms

A.1. Implementing the Rocket Docket

Under the Workers' Compensation law , a controverted claim is a claim for benefits which the payor (the insurance carrier or self-insured employer) challenges on stated grounds listed in the Law including that the accident was not work related, or there was no timely notice. A major focus of the workers' compensation reform was to reduce the number of days it takes for controverted claims to be resolved.

As envisioned by the Reform Act, NYSID organized the Workers' Compensation Reform Task Force (Task Force). The Task Force working with an Advisory Committee which includes designees by labor, business, the Legislature and executive agencies staff, developed proposed regulations known as the "Rocket Docket." The key objective of the Rocket Docket was to reduce the timeframe from dispute of a claim to establishment or denial of a claim to 90 days. The WCB took these recommendations and with some revisions implemented them.

These recommendations included the modification of the WCB's case assembly and indexing rules, which had not been updated in almost 70 years.[13] They proposed changing when a claim is indexed by WCB – a specific act by the WCB which compels the payor (the insurance carrier or self-insured employer) to decide whether to

[13] For purposes of this report the terms "assembled" or "assembly" refer to all claims that have been assigned a WCB case number. Prior to October 2008, the WCB always assembled a case at the same time that it indexed the claim. As of October 2008, the WCB implemented the new case assembly and indexing rules to create, or assemble a case and assign a WCB case number upon receipt of any document containing sufficient and specific information. A claim is indexed only after receipt of the forms required by 12 NYCRR §300.37 (b) (1), which are a C-2 or C-3, C-4, and, if the claimant indicates a prior injury, a limited medical release (C-3.3) form. This means that as of October 2008, case assembly and indexing are separate processes which follow separate rules.

controvert the claim within 25 days. In the past carriers would preemptively controvert claims rather than risk being barred from raising these issues after 25 days.

After the release of the Rocket Docket recommendations, the WCB phased in the regulations supporting the streamlined process as well as developed forms, and technological changes necessary to handle the new process. The amended case assembly and indexing regulations were adopted in October 2008. One result of this change will be reflected in Section IV- "Benchmarks" of this Report. In the 2008 Data Report, much of the WCB claim data was based on the year the claim was indexed. Data in this and future Reports will be based on the year the claim is assembled.

In November 2008, regulations for the streamlined adjudication processes for controverted claims were issued. To allow parties additional time to prepare for compliance the implementation date was deferred until January 1, 2009.

To monitor the performance of the new processes, an interim set of performance measures was implemented in early 2008, which include the following key metrics:

- Inventory Summary, tracking how many claims have been added and removed from the inventory in a set time period;
- Controverted Claim Inventory, showing where claims are in the process;
- Report measuring the interval from controversy to conclusion;
- Report measuring the interval from controversy to pre-hearing conference;
- Tracking the age of pending controverted claims.

The substantial changes in how the WCB identifies and handles controverted claims make performance comparisons with the pre-reform process difficult. It can be shown, however, that the number of pending controverted claims is down significantly. For example, as of April 1, 2008, the WCB had 6,506 pending controverted claims. As of January 1, 2009, that inventory had been reduced by 42% to 3,773. Currently, 85% of controverted claims assembled post reform are resolved as to the dispute in less than 90 days.

In addition, in the first few months of using the new indexing procedures, there has been a 50% decline in the number of notices filed by the payors to controvert claims. (See Benchmark-D-4.b.

A.2. Implementing Medical Treatment Guidelines

The Medical Treatment Guidelines were developed by NYSID through the Task Force and the Governor's designated Advisory Committee along with their medical and other professionals. These Guidelines reflect a consensus of the medical professionals designated by the Advisory Committee and the Task Force. In December 2007, the Superintendent submitted Medical Treatment Guidelines for the lower back, cervical spine, shoulder and knee (four major body parts driving medical costs) to the Chair of the WCB. The Guidelines, contain quality standards for the medical care of injured workers, and are designed to accelerate the delivery of quality medical services to injured workers and reducing disputes and costs.

In addition to the Medical Treatment Guidelines an Education Plan was also developed. The Task Force and the Advisory Committee continued to work on the Implementation Standards for the Medical Treatment Guidelines, which were completed and forwarded to the Chair of the WCB in June 2008.

Upon receiving the Implementation Standards, the WCB began the implementation process. The first step was to issue a request for proposal (RFP) for services to develop and deliver training on the Medical Treatment Guidelines. The WCB solicited input from beneficiaries who will utilize the Medical Treatment Guidelines including insurance carriers, physicians and attorneys. Based on this outreach the WCB has estimated that approximately 50,000 individuals will need training on the guidelines. The RFP has been issued and responses are due in April 2009.

The WCB will track who receives the training, including the number of WCB employees (e.g., Workers' Compensation Law Judges and Board members), medical providers, insurance carrier employees and attorneys.

The WCB is drafting Medical Treatment Guideline regulations, which will include guiding principles and implementation standards. Soon, these draft regulations will be posted and subject to public comment. As part of this effort, WCB is developing the processes and forms to be used when issues arise regarding the use, misuse or failure to use the treatment guidelines. WCB staff, medical providers, insurance carriers' employees and attorneys will be provided training on the new processes and forms.

B. *Making Rate Setting More Competitive*

B.1. Report evaluating rate making in New York State

In September of 2007 NYSID issued a report, pursuant to Section 308(g) of the Insurance Law, that: (1) examined the functions of the Compensation Insurance Rating Board (CIRB) and evaluated its performance as a data collector and Rate Service

Organization ("RSO"); (2) assessed the administered-pricing approach to workers' compensation rate-making that was in place at the time; (3) provided recommendations for changing the rate-making process; and (4) presented recommendations relating to the collection and analysis of industry-wide workers' compensation data. This CIRB Report recommended changing the then current rate-making approach from administered pricing to a more competitive and transparent process, based on aggregate industry "loss costs."

B.2. Benefits of loss costs system of rate making

A rate-making system based on loss costs would bring New York in line with thirty-six other states. Additionally, the CIRB Report anticipated that several benefits would flow from this shift. For instance, a loss costs system should provide more price competition by insurance carriers for an employer's business through the greater availability of multiple companies authorized to offer policies at reduced rates. Also, by allowing a range of loss cost multipliers that are both higher and lower than the manual rates, the loss costs system should increase competition between private insurance carriers and the SIF, which prior to that time was the only carrier allowed this kind of pricing freedom. At the same time, by maintaining and making available the loss costs by classification, the system would reduce barriers to entry to the workers' compensation market. Having private insurance carriers file their own expense data also, should eliminate the situation where more efficient carriers receive a windfall and less-efficient carriers receive an unjustified subsidy because of an industry-wide expense load factor in the administered rates. Further, a loss cost system would be much more transparent than an administered rate system and would reduce the potential for, or appearance of, collusion amongst insurers in the rate-setting process. Finally, competition for good risks would intensify under a loss cost system. This increased competition would encourage employers to undertake safety improvements to qualify for low rates.

B.3. Implementing the new rate system

Effective February 1, 2008, Chapter 11 of the Laws of 2008 implemented the recommendations of the CIRB Report and established the new loss costs approach to rate-making. The legislation provided for a two-step process for establishing rates.

First, Insurance Law § 2304 was modified by adding Section (g) which defines the term "loss costs" for workers' compensation insurance purposes as "that portion of a rate intended to represent the anticipated costs of claim payments and loss adjustment expenses associated with such claim payments, and may include one or more trend factors." The "loss costs" reflect industry-wide losses and directly related expenses (loss adjustment expenses) and are filed with the Superintendent by the licensed rate service organization. "Loss costs" are subject to the Superintendent's approval.

Second, the insurer could modify the loss costs by a loss cost multiplier (LCM). A LCM reflects the insurer's own expenses (other than those included in "loss costs") such as rent, marketing and overhead and may reflect a loss experience that differs from that

reflected in the approved industry-wide "loss costs." LCM's are subject to the Superintendent's approval.

In May 2008, NYSID released a circular letter which provided guidance to insurers with respect to the new loss costs approach for workers' compensation rates. In addition CIRB, as the designated RSO, was instructed to develop and file for approval with the Superintendent a rate filing containing loss costs and supporting actuarial and statistical data by May 15, 2008. CIRB filed in a timely manner.

The circular letter further instructed each insurer to individually determine a final rate utilizing its LCM. For 2008, insurers were required to file their LCMs prior to the October 1 implementation date.

B.4. Impact of the new rate system

A LCM of 1.0 would translate into a rate that is equal to the approved loss cost filing by CIRB. Given that all insurers have some expenses above those directly connected to workers' compensation claims (i.e., in addition to loss adjustment expenses), a LCM is likely to be greater than 1.0. However, a carrier's LCM may be below 1.0 if its individual loss experience is sufficiently low enough to offset its expense factor.

NYSID's actuaries efficiently and effectively received, processed, and approved two hundred forty- nine carrier submissions. The following figure shows the range of approved LCM's for carriers.

Figure 1: 2009 Lost Cost Multipliers by Range

LCM Range	Carriers
.95 to 1.00	2
1.01 to 1.05	7
1.06 to 1.10	11
1.11 to 1.15	17
1.16 to 1.20	29
1.21 to 1.25	17
1.26 to 1.30	33
1.31 to 1.35	61
1.36 to 1.40	34
1.41 to 1.45	27
1.46 to 1.50	9
1.51 to 1.55	1
1.56 to 1.60	1
Total	***249***

Source: New York State Insurance Department

The above chart demonstrates that carriers, based upon each of their own unique expense structures and loss experience, filed different LCMs that spanned significant ranges from 0.95 to 1.6. This outcome was one of the primary goals of moving from

administered pricing to the loss cost approach to rate making. The above chart indicates that price competition between carriers may be increasing.[14]

Additionally, prior to the switch to loss costs, carriers were not allowed to upwardly modify the administered rate. This effectively inhibited competition with SIF for higher risk business. With the change in the rate-making approach, carriers are now able to modify the industry-wide loss costs upwardly as well as downwardly. Seventy-three out of 249 carriers have filed for upward modifications; the anticipated benefit of this should be price competition among the carriers and with SIF.

While it is premature to determine the overall impact of the move to loss costs, early indicators of the transition are favorable.

C. Improving the WCB Appeals Process and Enhancing Performance Reporting

Delivering timely and equitable claim resolution is a core mission for the WCB. Both the claimant and the payor have the right to appeal a decision of a WCB Administrative Law Judge, by filing an "Application for Board Review." WCB staff, called "writers," research the claim and write a draft response (Memorandum of Decision) to the application. These drafts are then reviewed by an attorney and submitted to a panel of three Board members who either accept the finding as written or request revisions to the proposed response. The payment of benefits awarded is stayed during the administrative review process to the extent they are the subject of the appeal. For example, if the claimant is awarded benefits of $400 per week and the payor believes benefits should only be $200 per week, during the appeal the payor must pay the $200 per week and the remainder is stayed until the appeal is decided. Handling these administrative reviews with accuracy and speed is critical to meet the mandate of timely delivery of benefits to injured workers and equitable claim resolution.

In March 2008, the Chair of the WCB directed the reengineering of the administrative review process. At that time, the number of claims pending administrative review was 4,743 and the goal was to complete 85% of the requests in 12 months. This initiative resulted in restructuring the WCB's Office of Appeals into the new Administrative Review Division as well as the implementation of technological and process changes in how the WCB handles requests for administrative review. With these changes, the WCB implemented a balanced set of performance measures and integrated a new approach to performance management. The initial suite of 18 performance reports measure key aspects of the administrative review process including efficiency, quality, volume, timeliness and outcomes. The reports break down the work to address important operational objectives, team performance and individual writer performance. Key metrics include:

- Inventory summary – the tracking of incoming work, completed work and the balance of pending administrative reviews;

[14] All approved LCMs are publicly available on the NYSID's website which is expected to provide increased transparency and facilitate competition. (http://www.ins.state.ny.us/wc/2008_lcm_appr.pdf)

- Case inventory – the tracking of claims in various stages of development within the administrative review process;
- Workload per staff reviewer – measuring the distribution of work and efficiency of the teams;
- Approval rate – measuring the quality of the drafting process by tracking the rate at which WCB commissioners approve drafts;
- Average interval from time of application to time of completion – measuring the timeliness of completing requests for administrative review;
- Age of pending reviews – tracking the age of the inventory of pending requests for administrative review;
- Age of unassigned reviews – tracking the age of the inventory of pending requests for administrative review not yet assigned for drafting;
- Workload completed per each reviewer - measuring the volume of work completed by each attorney/writer in the Administrative Review Division; and
- Outcomes – tracking the results of the administrative review process which can inform internal and stakeholder process improvement.

The improvements in the WCB's administrative review process have been significant. For example, in March 2008 there were 4,743 claims with a pending request for administrative review compared to 3,620 in December 2008, a reduction of 24 %. In March 2008, over 22% of the claims awaiting an administrative review were more than 6 months old. As of February 1, 2009 the percentage had dropped to 9% of claims.

In December 2006, 20 claims were processed by each writer per month. In December 2008 over 28 claims were processed by each writer – a 40% improvement in productivity. The goal is to complete 34 requests per writer each month. As of July 2008 less than 20 percent of the draft decisions submitted to the WCB panel by the Administrative Review Division required any revisions. Currently, the measurement of revisions does not distinguish between minor typographical corrections and issues of substance. Envisioned data system modifications will enable the separation of minor errors from issues of substance.

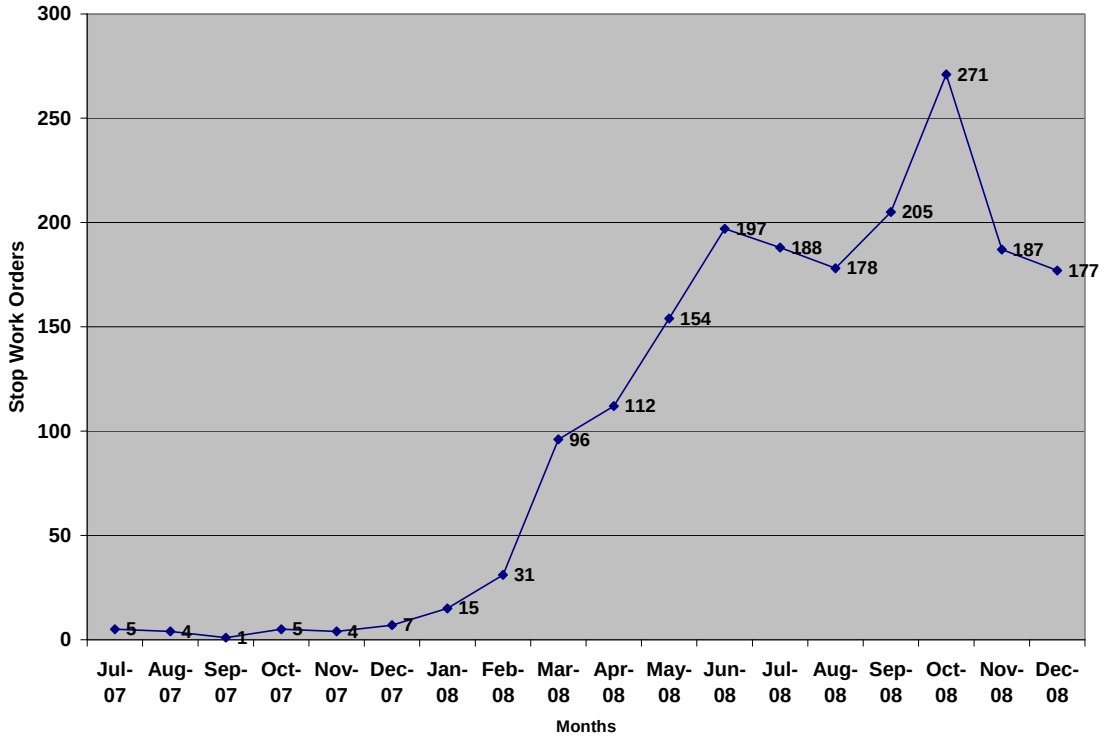
Another aspect of reengineering the administrative review process included an evaluation of how claims flow into the Administrative Review Division. Before ARD can address an application, the minutes of the pertinent hearings must be transcribed. Formerly, a claims examiner was responsible for identifying the minutes needing transcription and for requesting this work. Under the old workflow rules, the claim would not be referred to ARD until the minutes transcription was complete.

Changes in the workflow rules have claims moving to ARD immediately upon receipt of an application for administrative review. ARD is now responsible for identifying the appropriate minutes needed and for monitoring the completion of this step. By identifying the correct set of required hearing minutes needed, this change has led to the near elimination of additional transcription requests (either to obtain correct transcriptions or supplemental transcriptions). The time required to complete the transcription process has been substantially reduced with the WCB accomplishing more than a tenfold reduction in the number of claims requiring more than 30 days to complete this step.

D. Enhancing Enforcement

As part of the 2007 Reforms, the WCB was given the authority to use stop work orders when an employer is shown to have no required workers' compensation coverage. Over the past 18 months, the Board has made increasing use of this tool to enforce compliance. Candidates for stop work orders are found by use of sweeps focusing on key industries; some sweeps are WCB alone and others are coordinated investigations with several agencies including Department of Labor (DOL) and the Department of Taxation and Finance.

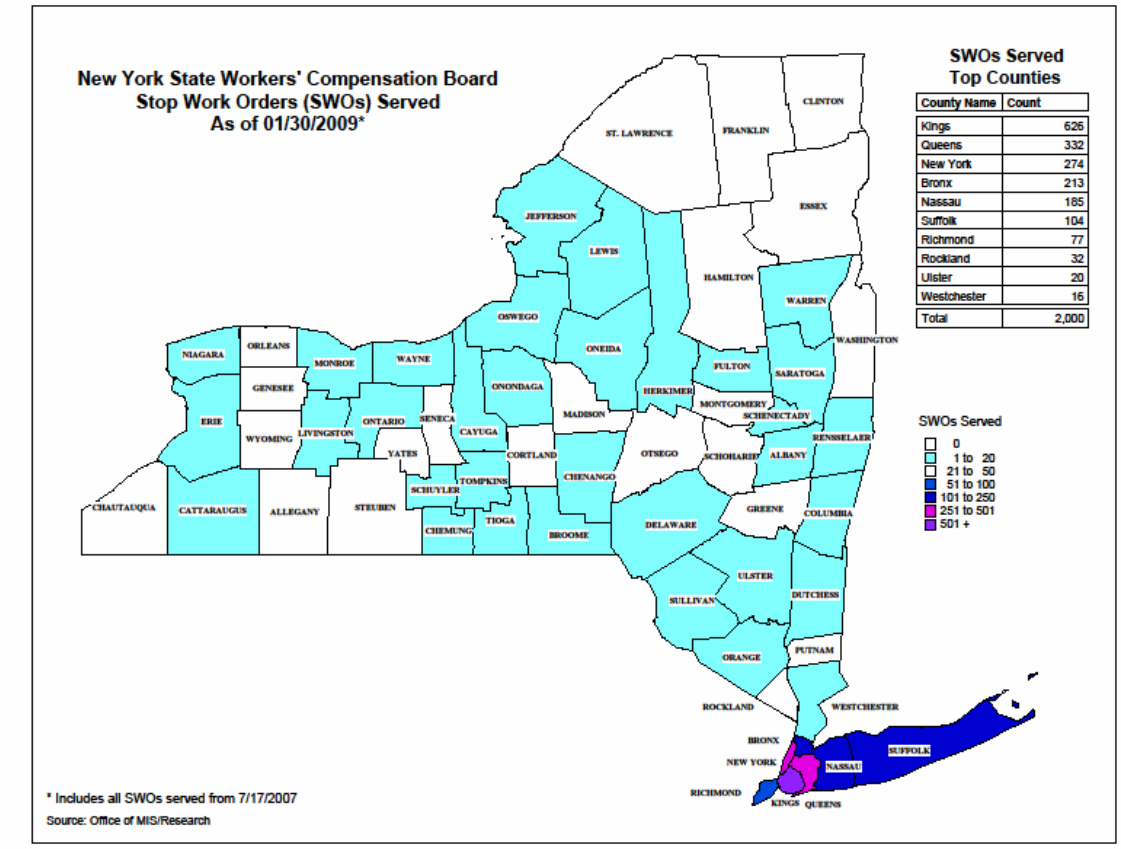
Figure 2: Monthly Stop Work Orders



Source: Workers' Compensation Board

Since June of 2008, the WCB has issued an average of roughly 200 orders a month. The following figure shows the geographic distribution of the stop work orders.

Figure 3: Stop Work Orders as of January 1, 2009



Source: Workers' Compensation Board

The WCB has made a determined effort to reach out to the public for complaints about uninsured employers. On February 7, 2008, a link to a database which allows the public to look up coverage information on any employer was placed on the WCB website. There is an electronic referral form on this web page in the event that coverage is not found. The referral goes to the WCB where an investigation is assigned and if appropriate a stop work order is issued. Businesses have used this as a way to identify competitors who have an unfair advantage because they are not in compliance. Any information received from these tips is shared with DOL as part of the broader initiative to share information to reduce fraud

E. Assisting Injured Workers to Return to Work

A primary focus of the 2007 Workers Compensation Reform effort was to assist injured workers in returning to work as soon as they are medically able. DOL was given the lead in addressing these issues. In March 2008, the Commissioner of Labor issued the "Report of the Commissioner on Return to Work" (DOL Report). The DOL Report was issued in consultation with the Return to Work Advisory Committee. The supplement to the report included a wide range of data on the return to work experience of various sets of workers. It clearly showed that certain sets of injured workers have a difficult time returning and

remaining in the workforce. For example, only 25 percent of injured workers who are classified as permanent partially disabled non-scheduled (PPD non-scheduled) [15] remain in the workforce two years after their injury. The Benchmark Section of this Report includes a number of measurements on return to work.

E.1. Implementing recommendations in DOL Return to Work Report

Many of the recommendations in the DOL Report require statutory changes or actions by other entities. However, a number of the recommendations can be implemented administratively. After carefully reviewing the report's administrative recommendations, the WCB has developed a list of initial recommendations to be implemented. One concern is that some workers may not fully understand that if they return to work they can still receive benefits if their post-injury wages are less than their pre-injury wages. This is called the "reduced earnings benefit." Another issue is that many payors have not been notifying the WCB of the need for vocation rehabilitation of claimants by filing a form known as the "R" form. Finally, there has been some confusion about what are permissible communications between employers, employees, physicians and payors in regards to return to work. This list of initiatives is designed to address these concerns:

- Improving internal return to work processes for claims examiners, workers' compensation law judges and vocational rehabilitation counselors.

- Developing model return to work programs to assist employers in establishing or enhancing such programs.

- Developing and implementing improved communications to claimants about returning to work, their eligibility for benefits if their returns to work wages are less than their pre injury wages, i.e., "reduced earnings benefits", and the advantages of staying connected to the workforce.

- Revising WCB vocational rehabilitation forms and enforcing their use.

- Developing guidance for permissible communications between employers, employees, medical providers and payors and for WCB policy and procedures to address impermissible communication.

- Educating stakeholders regarding permissible communications about RTW.

[15] PPD's are split into two categories, Scheduled and Non-Scheduled disabilities. Certain body parts are listed in the law 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. If an injured worker 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 non-scheduled claim and be classified as such when the worker has reached maximum medical improvement.

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The WCB shared the initial list of initiatives with DOL and will work with them as the recommendations are implemented.

As part of the recommendation to revise WCB's return to work processes, a process will be developed to identify triggers that claims examiners will use to send a claim to the WCB's vocational rehabilitation counselors for review. Possible triggers include: length of time the claimant is out of work, a medical report indicating the claimant can return to work with light duty, and a referral from the workers' compensation judge or claimant's legal representative. Once a trigger occurs, the claimant will be sent information about returning to work, reduced earnings and the need to stay attached to the labor market. A process will also be developed for vocational rehabilitation counselors to review claims sent by claims examiners.

The WCB vocational rehabilitation counselors will complete follow-up reports that document the claimant's program and work status. Development of these new reports will be done in tandem with changes in the claims systems to allow WCB to capture the new data.

The new communications with the injured workers will include a discussion of their obligations, including the responsibility to stay connected to the labor market, to continue to look for work that accommodates the worker's restrictions and to keep the WCB and the payors notified when they return to work. Such communications will occur through correspondence, decisions, notices and pamphlets prepared by the WCB.

When these initial recommendations are implemented, including the system changes, the WCB will be able to collect better data on the number of claimants who receive vocational services, the average length of the vocational services, how many carriers offered vocational rehabilitation services, how often each carrier offered such services and the number of claimants that return to work. This will allow WCB and DOL to continually improve their RTW programs.

E.2. Improving data on reduced earnings benefits

One particular problem with WCB data on return to work was the improper use of the data label "reduced earnings" or "RE." Reduced earnings should be used as a label only when a claimant has returned to work at a lower wage than his or her pre-injury average weekly wage (AWW), and the reduction in earnings is due, at least in part, to the work related injury. Reduced earnings are calculated as two thirds of the difference between the claimant's pre-injury AWW and the post-injury earnings. Therefore, any decision issued by the WCB where the indemnity award indicates "RE" should be based on the claimant returning to work and earning a lower wage. However, over time, the "RE" label came to be used in several situations, some of which did not involve a claimant who had returned to work. For example, the RE label was used when a claimant's benefits were changed from Temporary Total to Temporary Partial to Permanent Partial disability.

Because of the variety of uses for the "RE" label, it was impossible to determine how many claimants returned to work and had their awards based on actual reduced earnings rather than impairment ratings and earning capacity. Accurate data on the use of the reduced earnings benefits is therefore critical. Accurate data on the use of "RE" is also critical for both developing and targeting return to work programs.

The WCB has taken several steps to address this data limitation. In August, the WCB Office of General Counsel informed all staff attorneys (including judges and conciliators) they must only use the "RE" label for its original purpose, which is when the claimant has returned to work and is earning wages that are less than his or her established average weekly wage, and such reduction is causally related to his or her injury. The WCB is also changing the design in the WCB claims information system (CIS) to allow judges to more easily indicate whether or not the claimant has returned to work. The revised system should be available in the first half of 2009.

In addition, this issue has been incorporated into WCB training sessions to make sure all attorneys and other staff are aware of the change.

F. Cross walking CIRB and WCB data

One of the findings in the 2008 Data Report was that CIRB and WCB had different types of data on the workers' compensation system, each with their own strengths and weakness in both sets. While each organization collected the data it needed to fulfill its operational needs, neither was responsible for examining the entire workers' compensation system. This led to a long term recommendation to move forward with the development of a single repository of data that could provide a comprehensive view of the Workers' Compensation system.

In recognition of the long time frame needed to create a single data depository, the 2008 Data Report included a short term recommendation for the WCB and CIRB to work together to develop a method to cross walk their two data systems. Among other benefits, cross walking these two data sets would provide an accurate estimate of the full costs of non-scheduled PPD claims.

The process of cross walking these two data sets began with the WCB acquiring sample data extract from the CIRB in order to determine the feasibility of cross-walking the data without major changes to either organization's data. The WCB discovered a number of technical and procedural issues which prevented a cross walk. Using the existing data only 55 percent of the WCB data can be cross walked with the CIRB data.

Both WCB and CIRB use different numbers to track claims. WCB creates its own unique number while claim numbers in the CIRB database are those assigned by the carriers using a national standard. CIRB's data set does not include the WCB claim number. In addition, CIRB's claim data set, while including accident data and the policy number, under which the claim occurs, does not include any other unique identifying information except the CIRB

claim number. Due to privacy concerns, CIRB does not collect social security numbers or claimant names.

In the short run, to successfully cross walk WCB data with CIRB data it will be necessary to issue data calls to the insurance carrier community. These data calls will require the carriers to provide both CIRB's claim number and WCB's claim number together with a small number of additional data points to facilitate quality controlling the matching process.

G. Improved Data Sharing in Support of Multi-Agency Initiatives

Besides data exchange between the WCB and the CIRB, there are other opportunities to learn more about New York's workers' compensation system through data sharing.

Little was known about any vocational rehabilitation efforts to retrain injured workers with permanent partial disabilities. Workers' compensation reform in 2007 directed the acquisition of the data necessary to evaluate outcomes in injured workers' claims and lives. Much of the responsibility to gather data and evaluate vocational rehabilitation, return to work and the "safety net" for injured workers fell to the DOL. To assist with their efforts, in both 2007 and 2008 the WCB provided data on over 600,000 workers' compensation claims including claims involving temporary disability and worked closely with the DOL in its surveying of this data.

In addition, efforts are underway to closely study the problem of "misclassification" in workers' compensation. Misclassification of workers occurs when an employer improperly treats an individual as an independent contractor instead of as an employee in an attempt to avoid providing unemployment insurance, workers' compensation and other worker protections. These practices put law-abiding business at a competitive disadvantage because employers who misclassify employees are able to fraudulently lower costs.

Another form of misclassification occurs when employers (seeking to pay a lower premium by reporting "safer" occupation classes) describe their employees inaccurately when obtaining workers' compensation insurance. Addressing misclassification in New York in a coordinated multi-agency approach was launched in 2008. Ultimately, leveraging the available combined data in a similarly coordinated approach should provide new ways of identifying misclassification in New York.

Other outcome measures that have not readily been available to policy makers in New York relate to injured workers' dependence on local social services or federal supplemental security benefits. In November 2008, a project was initiated to acquire the data necessary to examine the interaction between workers' compensation and public benefit programs by exchanging aggregate data with the U.S. Social Security Administration and the New York State Office of Temporary and Disability Assistance ("OTDA.") The results of this data exchange are in Section VI entitled" Interaction with other Public Benefit Programs."

By combining the data available at the DOL, OTDA and others with data from the WCB, it becomes possible to both answer critical policy questions as well as introduce data mining capabilities to support proactive misclassification and other fraud detection activities.

H. Improving Customer Service, Updating Forms and Enhancing the Submission of Electronic Forms

Throughout the 2008 Data Report, areas were identified where additional data was necessary to fully implement reform measures. In addition, the 2008 Data Report also focused on the need to collect the data electronically whenever possible. This section looks at the progress the WCB has made in meeting these goals at the same time as they focus on improving customer service for the injured worker.

H.1. Customer Service and updating and enhancing the availability of electronic forms

A number of the initiatives launched by the WCB under the workers' compensation reform of 2007 involved both process improvement and enhancing available data. One such initiative included the restructuring of the WCB's customer service organization through creating the new Contact Management Office (CMO). Previously, staff who worked at the WCB's service center locations were part of the local District Office and provided part time customer service. Under the new CMO, these staff and the WCB's two "call centers" were brought under a single umbrella. Over 150 staff in the CMO are now dedicated to providing service to all first level contacts made to the WCB whether by phone, website or in person. Some of these staff also screen in-coming mail and determine whether a claim should be assembled based on the reports received.

As part of this restructuring, the WCB implemented a system to enable injured workers to complete a form "C-3 Employee Claim for Compensation" by telephone. CMO staff answers over 60,000 calls each month and can now accept C-3 filings by telephone.

Another part of the reform initiatives at the WCB included the revamping of the "core forms" filed by system participants including the "C-2 Employers Report of Work-Related Injury/Illness", "C-3 Employee Claim for Compensation" and the "C-7 Notice that Right to Compensation is Controverted". These forms were developed with extensive input from stakeholders and system participants. Forms were formally evaluated for readability. The WCB conducted focus groups to gather hands-on input about redesigned forms. Numerous revisions were made and the final draft forms were posted on the WCB's website for a public comment period. Forms were developed in English and Spanish and the WCB continues to evaluate the need to provide other language versions of the core forms.

The forms redesign initiative helped make WCB forms more user friendly and enabled the WCB to gather necessary data and prepare it for easy electronic submission.

Other forms that were already available on-line include:

- C-8/8.6 – Notice that Payment of Compensation has been Stopped or Modified;
- C-11 – Employer's Report of Injured Employee's Change in Employment Status Resulting From Injury;

- ♦ C-240 – Employer's Statement of Wage Earnings;
- ♦ C-669 – Notice to Chair of Carrier's Action on Claim for Benefits;
- ♦ RFA-1 – Claimant's Request for Further Action; and
- ♦ RFA-2 – Carrier's/Employer's Request for Further Action.

All of these forms have also been made available for batch submission through flat file submission[16].

H.2. Updating and providing electronic forms for medical providers

Section III of this report will show that total medical costs for PPD claims were growing significantly; and certain classifications of medical costs, such as prescriptions, were growing faster than others. The National Council on Compensation Insurance (NCCI)[17] has identified growing severity of injury and increased utilization as primary drivers behind increased medical costs. Collecting more 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.

As noted in the 2008 Data Report, the WCB currently has an application to receive medical billing information from providers electronically. The WCB has recently made this application available to the entire state, which will allow all physicians to submit medical data electronically.

In addition to the redesign of the forms discussed in the Section II-H.1, WCB completed a project to update its existing medical forms to capture the data needed to support the streamlined adjudication procedures, monitor the impact of the Medical Treatment Guidelines, and allow research on rising medical costs.

The WCB revised and renamed the Attending Doctor's Report (C-4) form and created additional forms. The C-4 form is now titled, Doctor's Initial Report, and requests additional information. A new form was created for subsequent visits titled, Doctor's Progress Report (C-4.2) Form, and a new form was created for reporting on maximum medical improvement or permanent impairment, Doctor's Report of MMI/Permanent Impairment (C-4.3) Form. Finally, in January 2009 the WCB released an electronic narrative version of the C-4 and C-4.2 forms, the Doctor's Narrative Report (EC-4NARR) form, which will allow providers to attach narratives to the form and will only be accepted electronically. The form part of the submission will contain the billing information.

[16] A flat file is a data processing format that contains just the data in a specified order. This allows organizations that have large quantities of forms to submit them in a condensed format.
[17] NCCI 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, collects statistics and provides statistical support and services.

To facilitate the use of the EC-4NARR, the WCB is working with clearing houses and software vendors who work with medical providers. This will allow providers to incorporate the use of this form into their systems. Providers will quickly see the benefit to the EC-4NARR as it requires less data input and allows for the use of office notes or narratives that the providers produce in the normal course of treatment.

I. Improving WCB systems

During the legislative debate over workers' compensation reform, it became apparent that the data required to make sound policy determinations needed to be reliable and readily available. This need to improve WCB data was echoed in the 2008 Data Report. In order to support the on-going demand for data, the WCB is investing in technology in ways that both meet the functional requirements and the informational requirements of policy makers and other outside entities that request information.

A key step in that process is the development of a systematic method of summarizing indemnity transactional data. This will reduce the manual effort needed for each major data request. Completion of this effort is now scheduled for the last quarter of 2009. WCB staff is also working on other improvements, including planning for an enterprise data warehouse, cleaning up key data fields, and developing new measurements for the Rocket Docket and other new processes. The pace of future improvement efforts in the WCB data is discussed in greater detail in the final section of this Report which focuses on implementing the long term recommendations of the 2008 Data Report.

J. Enhancing the Availability of Information on State Workers' Claims

Under a new law, the Department of Civil Service was required to prepare an annual report describing occupational injuries, illness and workers' compensation experience incurred by classified employees in executive branch agencies. [18]. The WCB also improved its data relating to state employees. New York State is self-insured for claims by state employees and uses SIF as a third-party administrator of those claims. SIF also provides many employers with insurance. In prior years, the insurance claims against SIF were aggregated self-insured New York State employee claims. To provide a more accurate analysis of self-insured claims, WCB implemented a data system initiative that separated and identified the New York State self-insured claims from claims insured by SIF.

III. System 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

[18] The first annual report "Fiscal Year 2007-2008 New York State Government Employees' Workers' Compensation Claims" was issued in September 2008 and is available at the agency's web site, www.cs.state.ny.us

insurance marketplace: private carriers, the SIF and self-insured employers. Next, it provides an overview of claim and benefit costs. It then looks at other major characteristics of claims and claimants.

One of the early benefits of the workers' compensation reform was a reduction in insurance rates.

For the year starting October 2007, there was a reduction in approved rates for workers' compensation coverage that decreased employer costs by 20.5%. Employers saw another 5%five average decrease in approved rates beginning in October 2008. As a result of the Reform Act, New York State's rank dropped nine places from 10th highest premium to the 19th highest.[19]. It will take several years to see the full impact of the reforms on claim costs because it takes years for claims to develop fully.[20]

Most of the trends from last year have continued. New York State continues to have a competitive marketplace for employers to obtain coverage. Claim volume continues to drop and the claims for permanent partial disabilities are declining at a slower rate than claims for temporary disability. Medical costs continue to represent a growing share of total benefit costs.

A. *Market Place*

Employers in New York State have three options for purchasing workers' compensation insurance. Employers can purchase insurance from either private insurance carriers or SIF or become authorized by the WCB to self-insure either individually or through a group trust. Many states offer only one or two of these options.

A.1. Size of the Workers' Compensation System

In 2007, the size of the New York State workers' compensation system, as measured by premium and adjusted to include self-insured employers, was approximately $5.7 billion. This estimate is based on the direct written premium of $4.2 billion for private carriers and SIF in 2007, plus an additional $1.5 billion (or 35.3%) to estimate the self-insured sector based on available market share information. There was a modest increase of $200 million from the estimate for 2006 of $5.5 billion.

A.2. Market Shares

Overall the market shares have remained fairly constant, with a minor increase in the private insurance market matched by a minor decline in SIF's share of the market place.

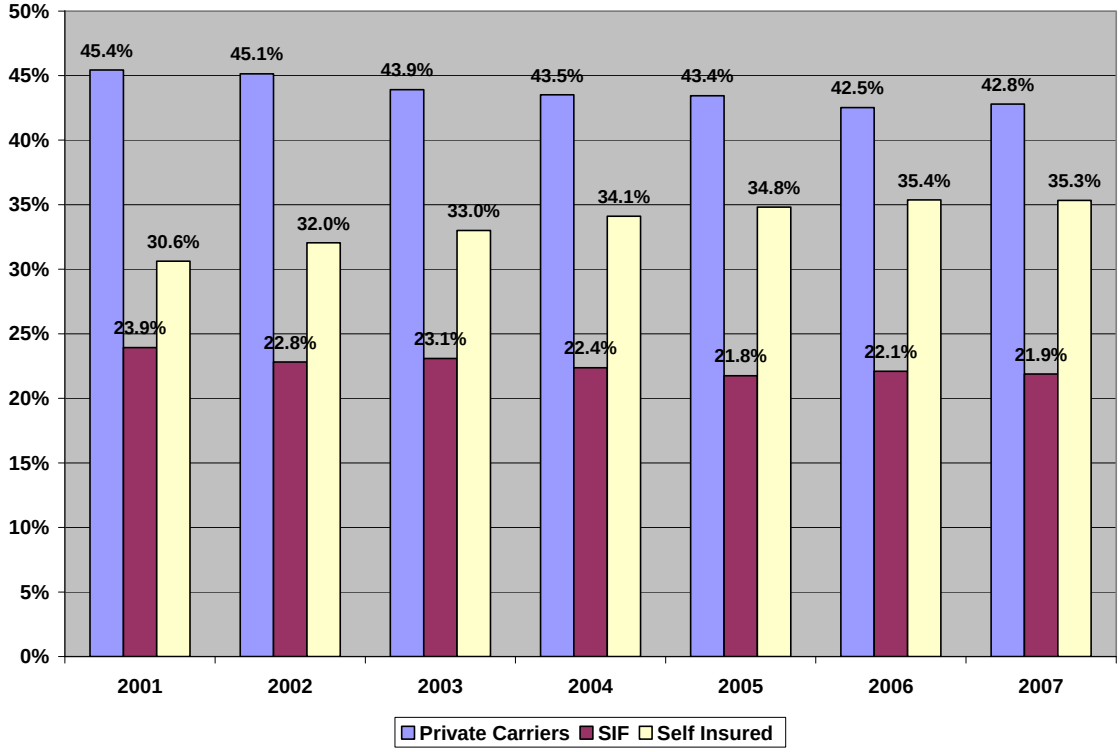
[19] 2008 Oregon Workers' Compensation Preium Rate Ranking Summary, Oregon Department of Consumer and Business Services.

[20] For the most part this Report will be using data from policy year 2004 on claim costs with 30 months development. The concept of claim development is discussed in more detail in Section III- B1

These market shares were calculated using data on paid indemnity[21] provided to the WCB for use in the calculation of industry assessments. This is the only data source available in New York State that allows a comparison of self-insured entities and insurers using a common data element.

In 2007, the self-insured sector showed its first decline in the past seven years.

Figure 4: Market Share



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

A.3. Self-Insured

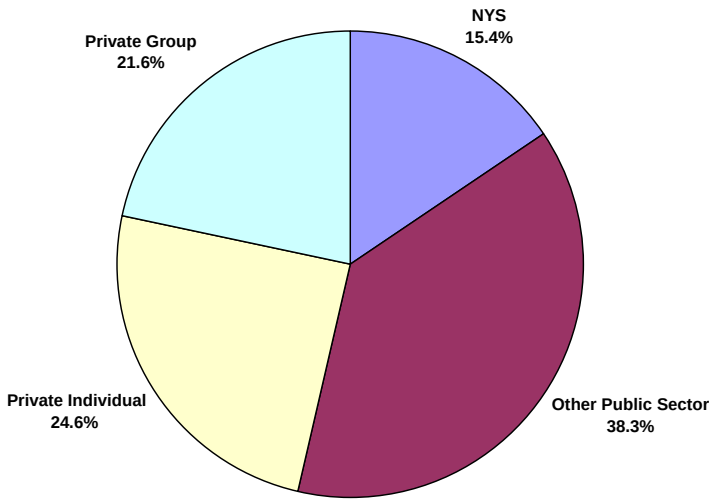
The self-insured sector is made up of a spectrum of employers, small and large, public and private. Within the self-insured sector there are several types of insurance coverage.

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. Based on paid indemnity private individual self-insured employers made up 24.6%, and group trusts made up 21.6% of the self-insured share of

[21] Paid Indemnity means the amount of indemnity benefits insurers paid in a given year . In any given year, the insurer is paying for benefits from many different accident years.

the market. New York State government constitutes another 15.4% and all other public self-insured entities compromise the remaining 38.3%.

Figure 5: Self-insured Market Shares 2007



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

The decline in the individual self-insured market was the primary factor in the modest decline in the overall self-insured market share. The individual self-insured market share dropped from 27.7% to 24.6% between 2005 and 2007. During that same time period the groups' share of the self-insured market rose from 17.9% to 21.6%.

Currently, 140 larger employers actively self-insure; this is a drop of 10 employers from 2008.[22] . There has been a major decline in the number of employers using group trusts as their method of obtaining coverage for workers' compensation. Last year there were 75 active groups; this has declined to 42 active groups. The number of employers using these groups declined from 20,942 in 2008 to 6,000 in 2009.

A.4. Private Carriers and State Insurance Fund

New York State's ranking for premium costs among states declined dramatically from 2006 when it was 10th highest to 2008 when it dropped to 19th highest.

[22] The 140 individual parent companies included 290 subsidiary companies.

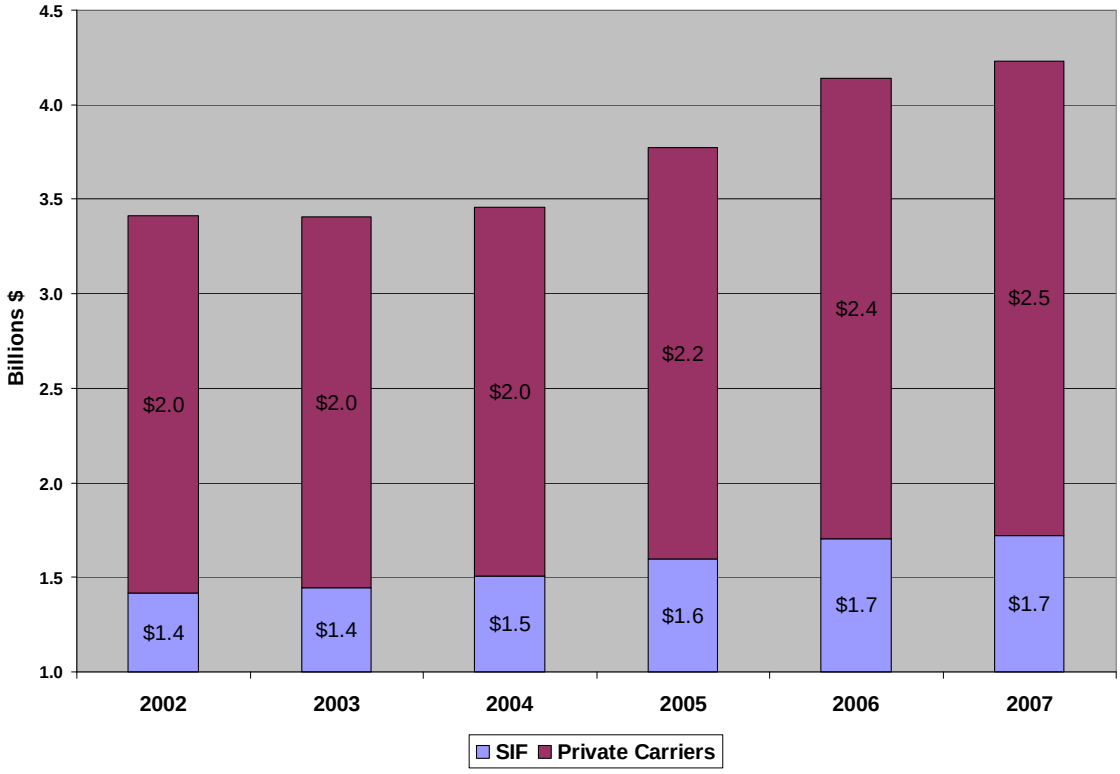
Every two years, the State of Oregon's Department of Consumer & Business Services publishes a nationally recognized study that evaluates workers' compensation insurance premium rates in all 50 states. Their Research and Analysis Section has used the same methodology (with minor enhancements) to examine rates on a biennial basis since 1986. The goal of this study is to produce a comparison of premium rates for a comparable set of occupation classifications across all states. Despite substantial issues in comparing premium rates among states, a state's rate index as a percentage of the median can be used as an indicator of a state's relative cost of providing workers' compensation coverage.[23]

The Oregon study is based on premium rates in New York that took effect in October 2007. There was a reduction in approved rates for workers' compensation coverage for the year starting in October 2007 that decreased employer costs by 20.5 percent.

In 2007, private carriers and SIF collected a total of $4.2 billion in premium, a slight increase over the prior year total of $4.1 billion. A question that often arises is why premium goes up even slightly if rates were held constant in 2006 and declined significantly in 2007. There are several reasons for this. First, new rates take effect on October 1st, therefore premium written in 2007 only reflects one quarter of the year of the 20.5% approved rate decrease. A second reason is growth in payroll. According to the DOL, the 2007 annual statewide payroll was projected to grow by 8.7% from 2006 levels, whereas premium only grew by 2.2% over the same time period. Other factors impacting the total premium are shifts of employers between self-insured and insured, changes in the large deductible business, and the overall business climate for the payors, i.e., are they offering large or small discounts.

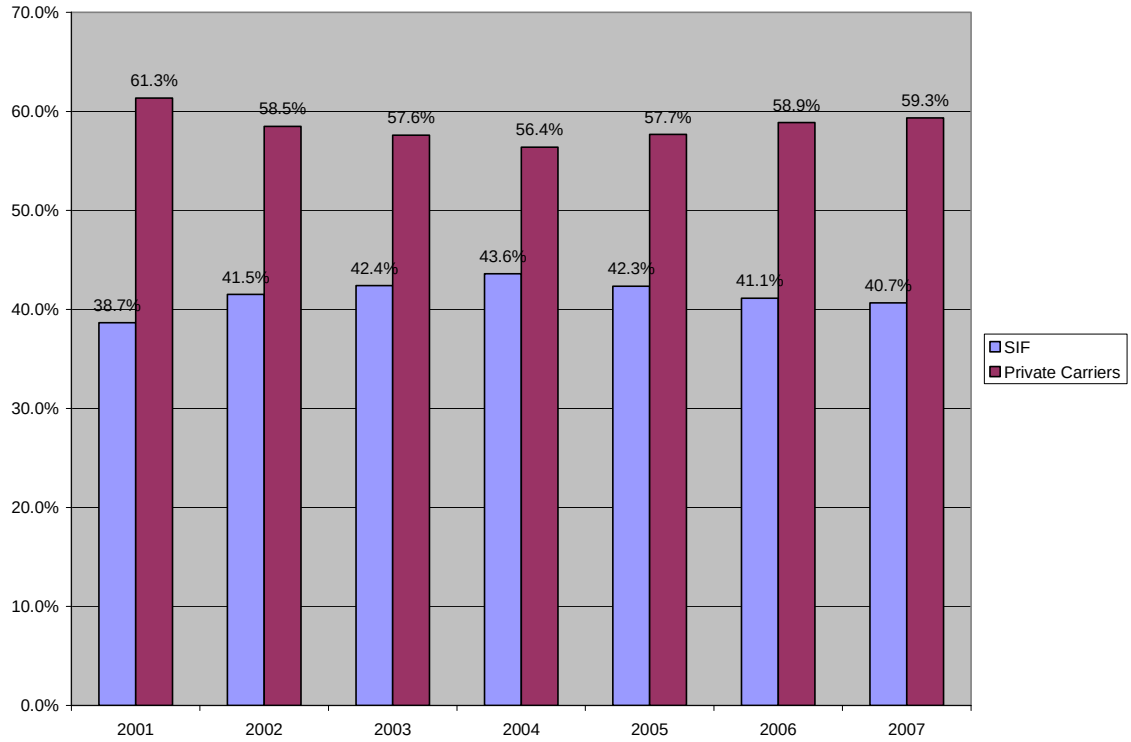
[23] Based on a discussion with Mike Manely from Oregon's Department of Consumer and Business Services.

Figure 6: Direct Written Premium of Private Carrier and SIF



Source: NYSID annual statements submitted by carriers

Figure 7: Percentage Share of Direct Written Premium (Carriers and SIF)



Source: New York State Insurance Department

In the private sector market, 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 groups rather than individual companies. From 2002 to 2007, the number of groups actively selling workers' compensation insurance in New York State declined slightly. In 2007, there were 98 private groups that wrote workers' compensation insurance compared to 106 groups in 2002. The 98 groups writing in 2007 included 237 subsidiary companies.

The vast majority of business has been concentrated in the top companies. The trend toward consolidation at the top of the market has continued. The percentage of premium written by the top 10 groups (including SIF) rose from 67% in 2001 to 87% in 2007. In 2006, 81% of the market was concentrated in the top 10 companies compared to 87% in 2007. 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

Employers with large deductible policies pay directly for all of the smaller claims they incur under the deductible amount, while their insurer pays for the more costly claims. Based on data from CIRB's aggregate data call, from 2006 to 2007, large deductible policies declined as a share of the total private carrier business according to two measures. Standard earned premium for large deductible policies declined from 38.3% to 31.8 % of total standard earned premium. And estimated total losses [24] dropped from 31.7 % to 26.8 % of total losses.

B. *Claims and Benefit Costs*

This section of the Report examines trends in claim volume and benefits, with a particular focus on any changes in trends based on the most recent year of data. The Report uses a combination of data from both CIRB and WCB. Both data sets have their strengths and weaknesses. The 2008 Data Report detailed these strengths and weaknesses; this analysis is reproduced in Appendix Two. In summary the differences are as follows:

CIRB

- ♦ Includes SIF and private carrier data, excludes self- insured data;
- ♦ Provides incurred cost data for both indemnity and medical ;
- ♦ Includes all reported Medical-only claims;
- ♦ Contains data which is reported at set points in time. First report is 18 months after the policy inception date, followed by 12 month intervals ,e.g.30, 42, 54 and 66 months up to a total of ten reports;
- ♦ Does not allow the separation of PPD scheduled and non-scheduled claims.
- ♦ Claim type is based on the carrier's projection of the type of claim it will become, which is what their reserves are based on.

WCB

- ♦ Includes all three sectors, private, SIF and self-insured;
- ♦ Contains only indemnity costs, has no medical cost data;
- ♦ Allows for the separation of PPD scheduled and non–scheduled claims;
- ♦ Only receives a sub-section of Medical-only claims
- ♦ Claim type is based on the status of the claim at the point in time when the data is taken from the claims system. It does not reflect any changes that may occur in the future.

Due to these strengths and weaknesses, different data sets will be used for analysis of different aspects of the workers' compensation system.

[24] Estimated total losses includes paid claim costs, reserves and IBNR and bulk reserves.

B.1. Claim development in New York State

This Report often relies on data from claims with 30 months development. This is known as the "2nd report" for CIRB. The first report is 18 months from the inception date of the policy year and the second report is 12 months later. This choice of using 2004 policy year data[25] with 30 month development rather than 2005 or 2006 claim data with less development, balances the need for fuller development of the claims with the need for more recent data. By using a set time-point in development, it is possible to compare costs and claim numbers across years without concern that the earlier years have had longer time to develop.

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. Permanent partial disability (PPD), permanent total disability (PTD), and Death claims are active for a very long time. Due to the long 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 for consistency to 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 maturities.

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] Using 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.

B.2. 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 2004 claims with 30 month development, CIRB reported 143,677 claims (including indemnity and Medical-only) for SIF and the private carriers.[31] When this total is

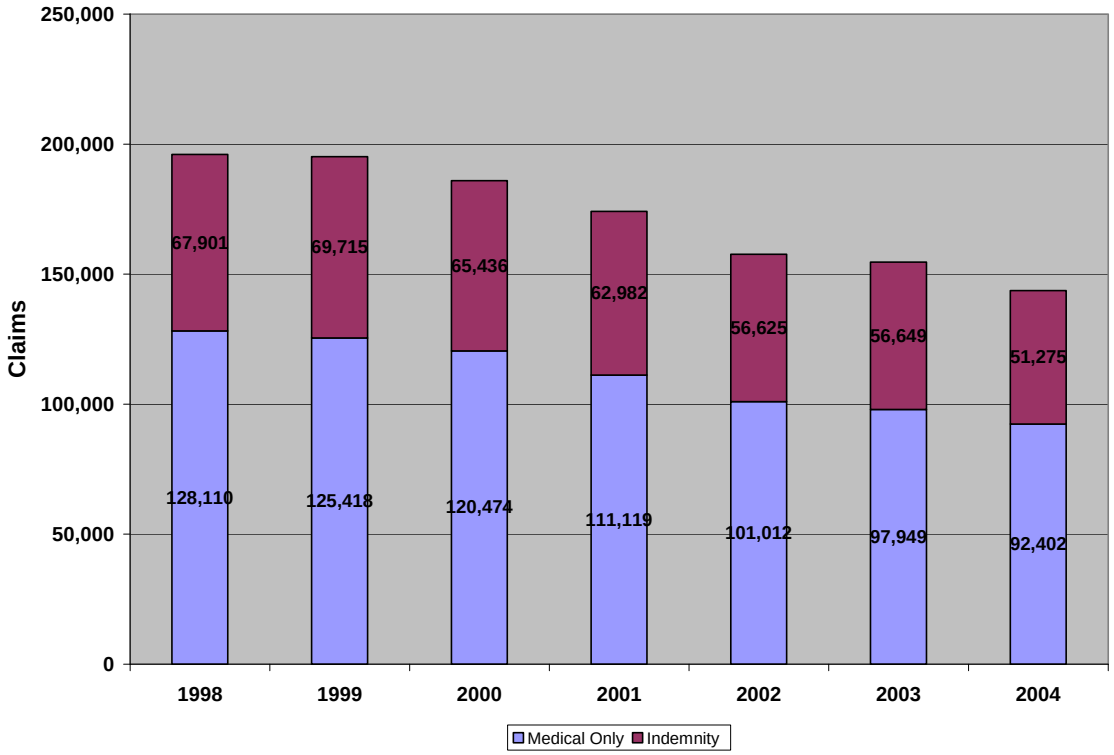
[25] The 2008 Data Report used data from 2003 policy year with 30 month development.
[26] "Baseline for Evaluating the Impact of the 2007 Reforms in New York.," Workers Compensation Research Institute, draft report issued January 14, 2008
[27] "Incurred" refers to the amounts paid plus the amounts reserved for a claim.
[28] "60 months of development" refers to indemnity costs for 5 years after the average accident date.
[29] These 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] 2nd report/30 months of development.

increased by 34.1 %[32] to include self-insured claims, the claim total increases to 192,958 claims.

This total reflects a continued downward trend in the number of workers' compensation claims. CIRB's data reflects a decline in both indemnity and medical-only claims from 1998 to 2004. Indemnity claims dropped by 24%, while medical-only claims declined 28%. From 2003 to 2004 indemnity claims declined by a larger percentage than Medical-only claims: Medical-only claims dropped 5.7% while indemnity claims dropped 9.5%.

There are several reasons for the continued decline in the number of claims. One explanation in an NCCI report is: "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 to be considered in New York State's claims decline is the changing industry mix from manufacturing to technology. However, after a review of employment by industry data from DOL, this does not appear to be a major factor. While manufacturing has declined, "transportation and warehousing" and construction, two other higher risk industry sectors, grew over the past few years.

Figure 8: Medical-only and Indemnity Claim Volume



Source: CIRB claims with 30 month development

[32] The reason the 34.1% share for the self-insured differs from the 35% share which was used to adjust the direct premium (III-A.1) is because they are from different years, 2004 and 2007 respectively.
[33] "2007 State of the Line," National Council on Compensation Insurance, May, 2007.

B.3. Trends in Medical-only claim volume

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 medical benefits. Medical-only claims constitute the majority of claims in the system. In 2004, they represented 64.3% 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 reflect the total number of medical-only claims, CIRB data must be used. WCB claim data does not include a large portion of the medical-only claims. For 2004 CIRB recorded 92,402 Medical-only claims, whereas only 28,374 claims were reported to WCB.[34]

From 2003 to 2004 the number of Medical-only claims declined by 5.7%.

B.4. Trends in indemnity claim volume

To receive indemnity benefits in New York State, a claimant must be out of work for at least seven days. Indemnity claims involve both more serious injuries and more lost time from work versus Medical-only claims. In addition, indemnity claims represent over 95% of the costs of the system. For these reasons, this Report focuses especially on indemnity claims. The Report begins with an examination of all indemnity claims and then focuses down into the major types of indemnity claims: temporary total disability (TTD), permanent partial disability (PPD), permanent total disability (PTD) and Death. Finally, it looks at the two sub sets of permanent partial disability claims: scheduled and non-scheduled.

In 2004, the majority of indemnity claims, as reported to CIRB, with 30 months development were temporary disability at 63.8%, followed by permanent partial disability at 35.8% with the remaining 0.4% made up of permanent total disability and death claims. In 2004, at 30 month development, there were 135 death claims and 75 permanent total disability claims. PTD claims include total industrial disability (TID)[35] claims.

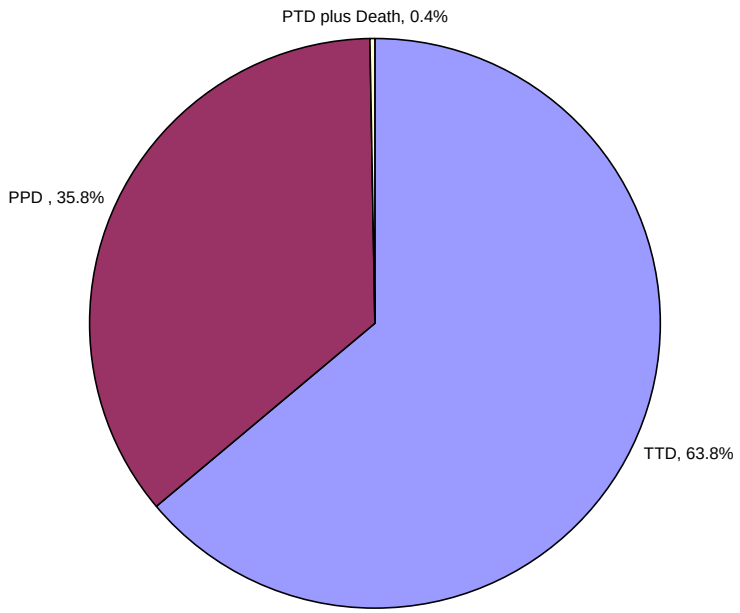
Under the Reform Act, safety net provisions allow claimants with a greater than 80% loss of wage earning capacity who have exhausted their PPD non-scheduled duration benefits to apply for reclassification as total industrial disability due to factors reflecting

[34] The reason for the difference is that the Workers' Compensation Law does not require all Medical-only claims be reported to the WCB. Section 110 of the WC Law states that a report does not have to be filed with the WCB 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.

[35] If the worker has reached maximum medical improvement and the impairment combined with other factors such as limited educational background, age, limited skills and work history renders the claimant incapable of gainful employment, an injured worker may be eligible for TID. TID is a factual issue resolved by the Workers' Compensation Board.

extreme hardship. It will be at least six years before claimants will be eligible for these benefits.

Figure 9: 2004 Indemnity Claims by Classification

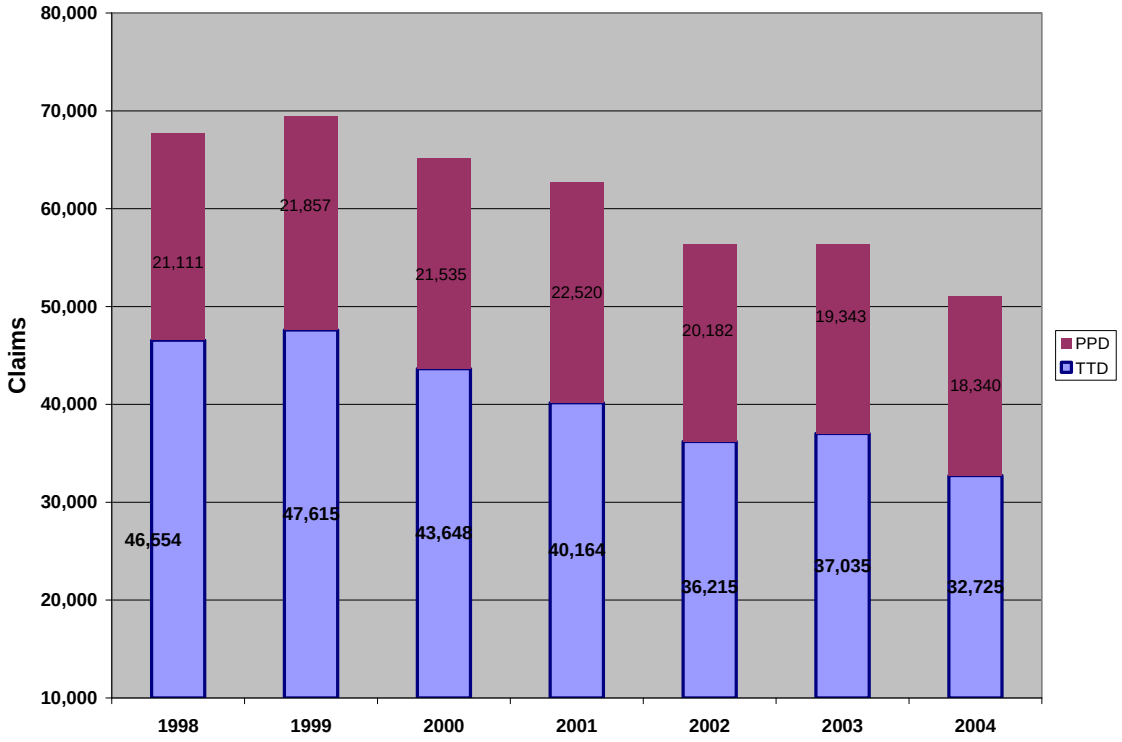


Source: CIRB claims at 30 month development

Both of the two largest types of indemnity claims, PPD and TTD have continued to decline. From 2003 to 2004, PPD claims declined 5.2% and TTD claims declined 11.6%. Over the past six years from 1998 to 2004, the rate of decline in TTD claims has been more than twice the rate of decline in PPD claims, 29.7% compared to 13.1%. The net result of these declines is PPD claims are becoming a higher percentage of indemnity claims, rising from 31.1% in 1998 to 35.8% in 2004.

In summary, all types of claims are declining, but the most severe claims, i.e., ones with permanent partial disabilities are declining more slowly than Medical-only and temporary disability claims. This trend has been fairly consistent over the past few years and is consistent with nationwide trends.

Figure 10: Claim Volume—PPD and TTD



Source: CIRB claims with 30 month development

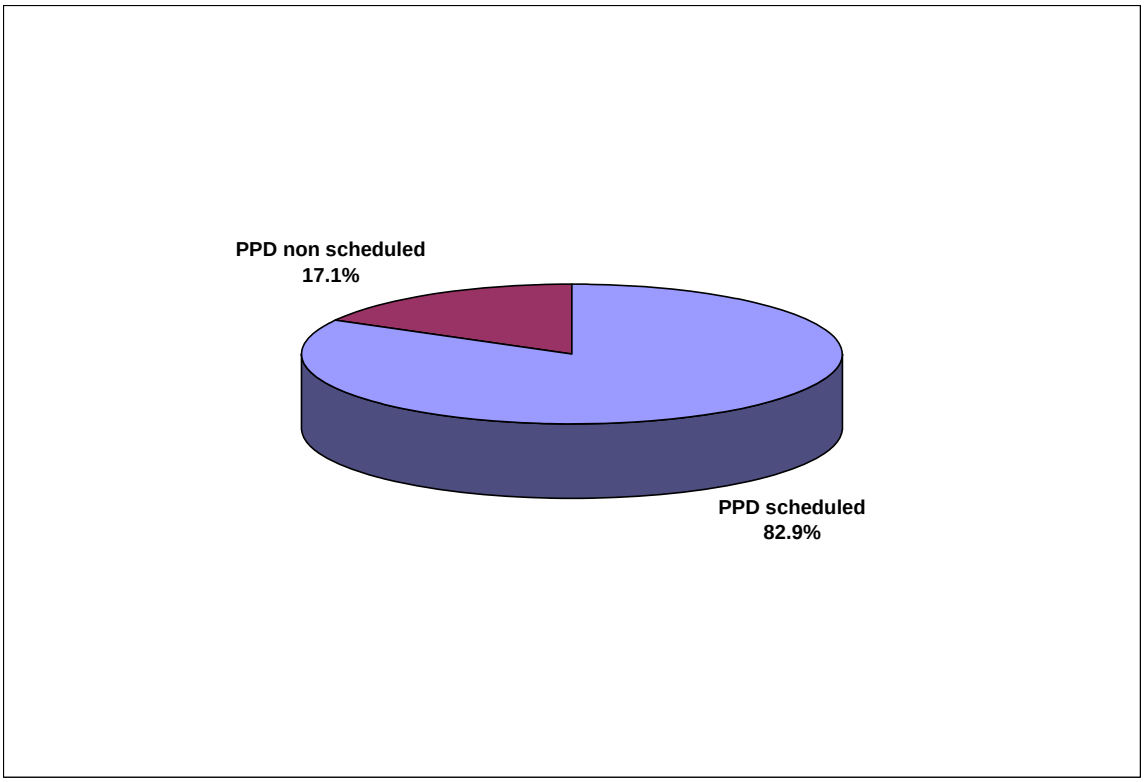
B.5. Trends in PPD claim volume

The next step is to analyze the two types of permanent partial disability claims: scheduled and non-scheduled. Scheduled claims are claims where the amount of time for wage replacement benefits is prescribed in a schedule in the Workers' Compensation Law. These include limbs, eyes and hearing. For example, a worker who loses his or her thumb will generally receive 75 weeks of wage replacement benefits regardless of the amount of time lost from work. PPD non-scheduled claims are for permanent injuries that are not scheduled; these include most injuries to the body's trunk, such as those to the back. PPD non-scheduled claims had a lifetime benefit under the law prior to the Reform Act. Pursuant to the Reform Act, the indemnity benefit is capped at a set number of weeks depending on the claimant's loss of wage earning capacity. The maximum duration is 10 years. (These benefit periods are referred to as "duration caps").

CIRB data does not capture the split between scheduled and non-scheduled claims. Thus, in order to look at PPD non-scheduled, one must use the WCB data. One important difference between CIRB and WCB data is the level of development. The 2004 data from CIRB which has been used in the earlier figures has 30 months of development. In contrast, the 2004 data from WCB will have four years of development.

For claims from 2004, the WCB claims data shows PPD non-scheduled claims make up 17.1% of all PPD claims, and 6.1% of total indemnity claims. Although PPD non-scheduled claims are a small percentage of total indemnity claims they represent a large percentage of total indemnity costs. This will be discussed in the following two sections on indemnity and medical costs.

Figure 11: 2004 PPD Scheduled and Non-Scheduled Claims



Source: Workers' Compensation Board

B.6. Trends in total benefit costs

Up to this point, the 2009 Data Report has used CIRB claim data from its unit statistical reports which are submitted for each policy at set points in time after the inception date of the policy. The other set of data CIRB collects is the aggregate financial call data. Once a year all insurers, including SIF, submit annual reports. CIRB uses the information from these reports to project an estimate of the ultimate value of losses by either accident year or policy year for use in its annual loss cost filing. This data is only for private carriers and SIF; it does not include self-insured entities. This data does not break out the separate types of claims, such as TTD or PPD, but it can be used to examine overall medical and indemnity costs. The primary advantage of the aggregate financial data is it is developed to ultimate and provides data through 2007 than using the unit statistical plan data with 30 month development.

At the request of NYSID, CIRB developed the data from the financial call to ultimate[36]. The data shows that for every year, except 2005, medical costs have been growing. It also shows that medical costs have been a growing percentage of total losses, except in 2003 and 2007. The impact of the Reform Act should result in reduced indemnity costs due to the benefit duration caps; it is expected that medical costs will represent a higher portion of overall benefit costs.

Figure 12 Aggregate Costs Projected to Ultimate

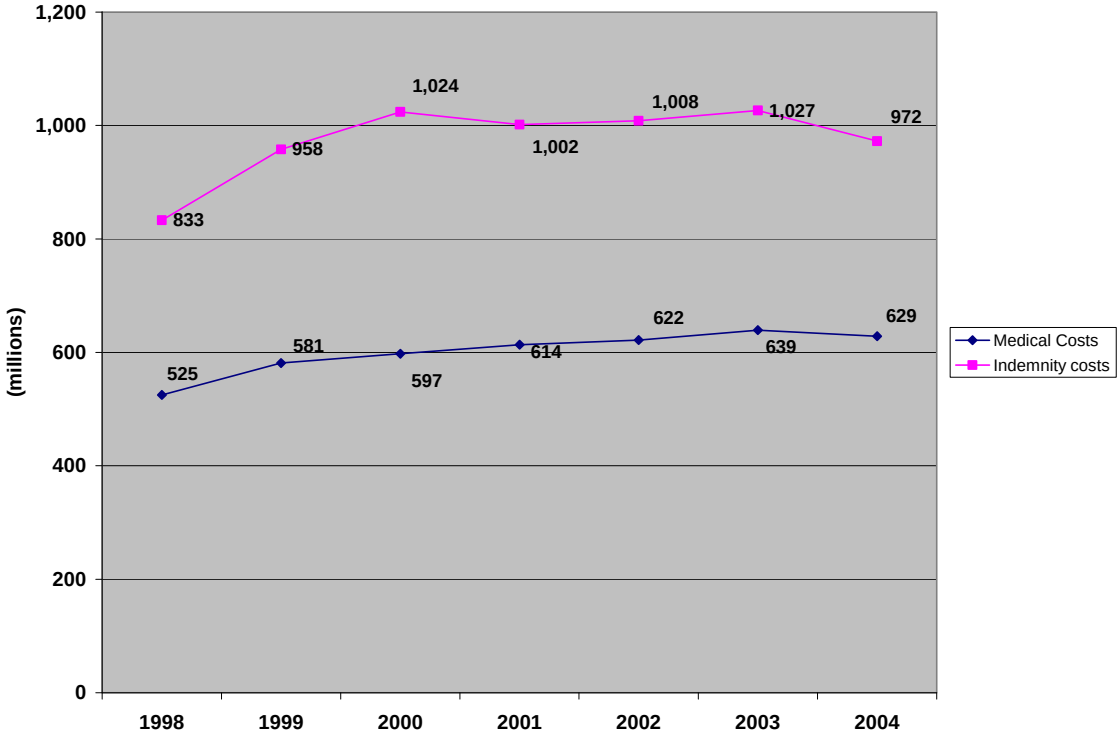
	Total Costs Projected to Ultimate		
Year	Indemnity	Medical	Medical %
2007	$ 1,799,651,386	$ 1,182,968,254	39.7%
2006	$ 1,631,546,090	$ 1,121,606,242	40.7%
2005	$ 1,689,259,663	$ 1,086,762,335	39.1%
2004	$ 1,736,166,215	$ 1,105,180,279	38.9%
2003	$ 1,811,623,254	$ 1,079,391,672	37.3%
2002	$ 1,740,957,725	$ 1,059,182,622	37.8%

Source: CIRB aggregate financial call

Based on the decline in the volume of claims one might expect the total costs of claims to be declining as well. The figure below shows that total costs declined at a much lower rate. From 2003 to 2004, indemnity costs for claims with 30 month development are showing a decline of 5.3% and medical costs are showing a lesser decline of 1.6%. Both of these declines are significantly lower than the 9.5% decline in the volume of indemnity claims discussed earlier in B-2 of this section.

[36] Developed to ultimate means the full costs for the life of the claim. Loss projections to ultimate values are based on paid losses and claim reserves and are consistent with the actuarial methodologies used in the loss cost process.

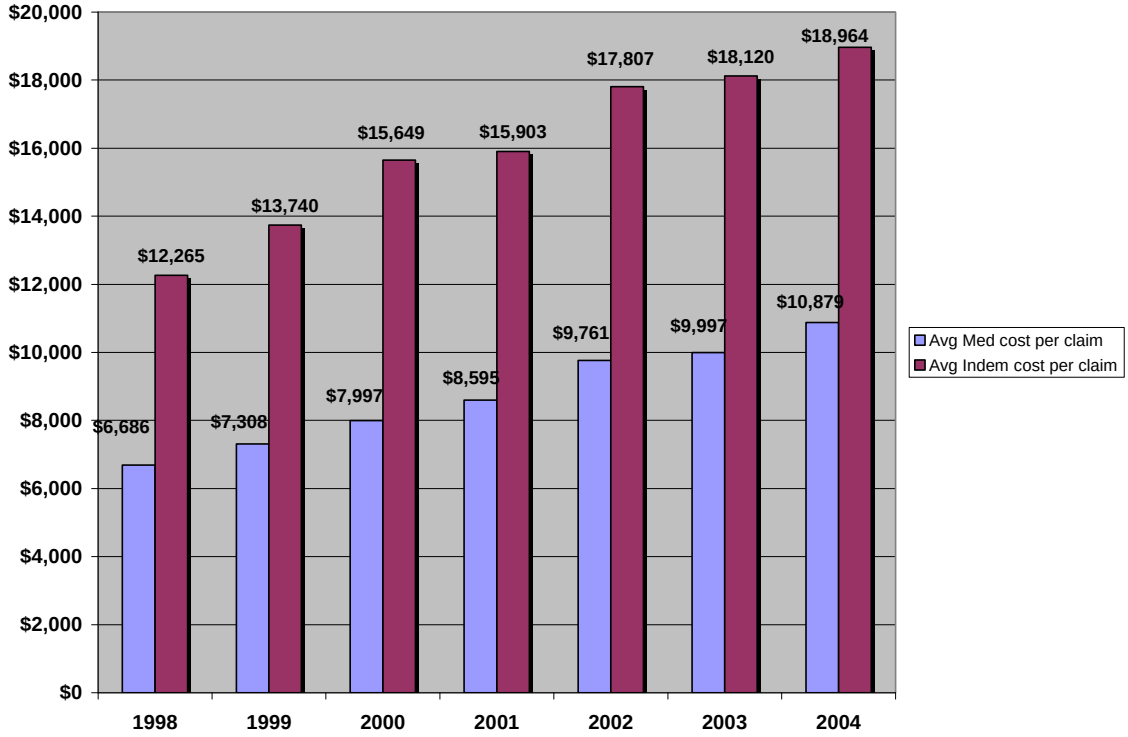
Figure 14: Total Indemnity and Medical Costs 1998 to 2004 for Claims with 30 Month Development



Source: CIRB data at 30 months development

The result of total costs declining more slowly than the volume of claims is that average indemnity and medical cost per claim has been climbing steadily. From 1998 to 2004 average indemnity cost per claim has grown by 55.3%. The single year growth from 2003 to 2004 was 5.1%. The growth in average medical costs per claim has been even greater: 54.6% from 1998 to 2004 and 4.7% for the single year from 2003 to 2004. The following segments of this Report will explore what may be behind this growth and how New York State compares to other states.

Figure 15: Average Cost Per Indemnity Claim- Indemnity and Medical

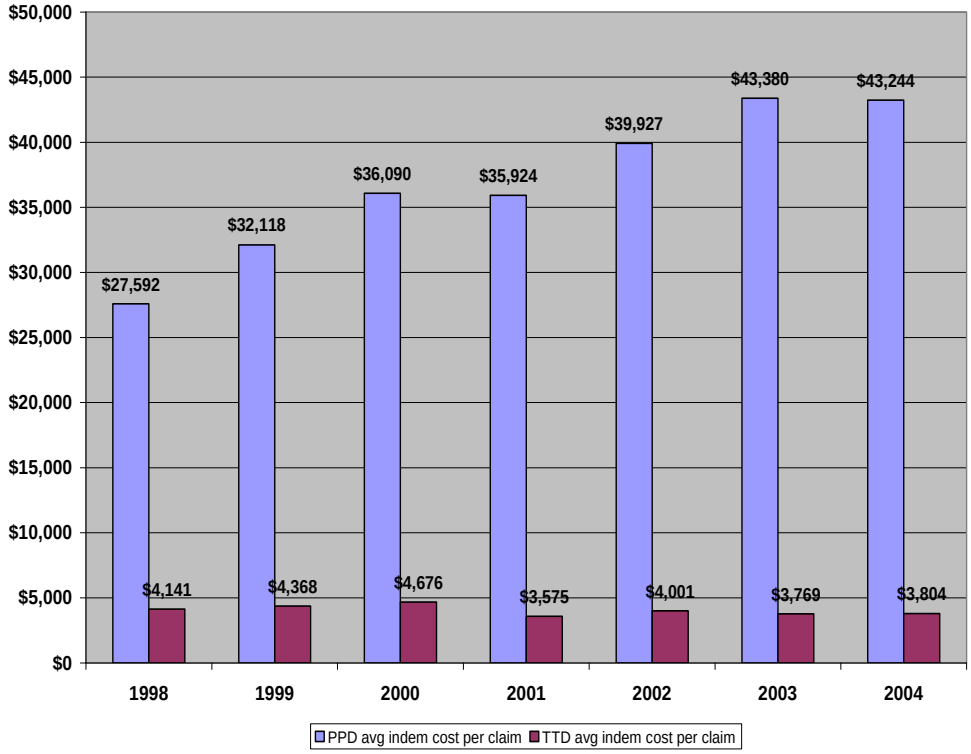


Source: CIRB data at 30 months of development

B.7. Trends in indemnity costs

Why are total indemnity costs not declining more rapidly, given claims are declining and that the maximum weekly indemnity benefit remained fixed from 1998 to 2004? Total indemnity costs are impacted by several factors in addition to the volume of claims. These include increase in average weekly wage for claimants with weekly wages that do not exceed the statutory maximum weekly benefit cap. Another factor impacting total indemnity costs is change in the case mix, i.e., a higher percentage of claims is PPD non-scheduled. Earlier this section noted that permanent partial disability claims are becoming an increasing share of indemnity claims.

Figure 16: Average Indemnity Cost per Claim—PPD and TTD



Source: CIRB data at 30 months of development

For the past few years, higher average indemnity cost per claim for PPD claims has been the driving force behind increasing average indemnity costs. However, that changed in 2004 when the average indemnity cost for PPD claims with 30 months development declined slightly from 2003 to 2004. Not only did the average indemnity cost per PPD claim decline, but the total indemnity cost for PPD claims declined slightly as a percentage of total indemnity costs from 81.7% to 81.6%.

B.8. Trends in PPD indemnity costs

As previously noted, PPD claims are comprised of two kinds of claims: scheduled and non-scheduled. WCB data must be used to explore these two subsets of claims. As also mentioned before, there are several differences between WCB and CIRB data. For the following figure the two important issues are as follows:

- ♦ WCB data includes self-insured claims so the total number of PPD claims will be higher than the CIRB data.
- ♦ The CIRB data used in this Report includes only 30 months of development. The WCB's cost data is an estimate of the lifetime costs of the claim based on the life expectancy of the claimant at the time the data was taken from the claims system.

- In the 2008 Data Report, WCB data was often displayed based on the year the claim was indexed. As a result of the changes in process under the Rocket Docket, the process of indexing can occur later in the claim process. To make the data consistent over time, it will now be displayed based on when the claim is assembled. This is consistent with when the claim was indexed prior to the new procedures. In the following figures, assembly will be used to mean both assembly and indexing for earlier years.
- WCB data reflects only what has actually been classified at the point in time the data is produced. Therefore, for cases assembled in 2004 it will only reflect the PPD non-scheduled claims that have been classified at four years of development. Since the average time to classify a PPD non-scheduled claim is roughly 4.5 years from date of injury, the following figure only reflects about 50% of the projected PPD non-scheduled claims.

The following analysis demonstrates that PPD non-scheduled claims are responsible for a very large share of costs in the workers' compensation system in New York State. However, due to the limitations in existing data the only method of estimating how large this share is requires combining data from CIRB and WCB. The WCB data provides information on the split between PPD scheduled and non-scheduled claims and costs, where the CIRB data does not. This split can then be used together with the CIRB data to estimate a percentage share of the total indemnity costs.

Figure 17: Indemnity Costs for PPD Claims Assembled in 2004

	Claims	% of PPD Claims	Avg Cost Per Claim	Total Cost	% of Total Costs
PPD SL	23,862	82.9%	$19,801	$472,479,864	37.6%
PPD NSL	4,909	17.1%	$159,677	$783,856,113	62.4%
Total	28,771	100.0%		$1,256,335,977	

excludes any claims with Data Anomalies

Source: Workers' Compensation Board data estimated to lifetime costs[37]

WCB data, for cases assembled in 2004, shows that PPD non-scheduled claims make up 62.4% of PPD indemnity costs.

This 62.4% can then be applied to the 81.6 %, which is the PPD share of total indemnity costs, resulting in a 50.9% share of total indemnity costs for PPD non-scheduled. In the earlier Section B-5 it was determined that PPD non-scheduled claims only constitute 6.1% of total indemnity claims. It is estimated that the relatively small percentage of PPD non-scheduled claims, 6.12%, generate 50.9% of total indemnity claim costs.

[37] These estimates include what has been paid to date on the claim plus an estimate of the future value of the claim based on the life expectancy of the claimant.

The percentage grows higher as PPD non-scheduled claims have more time to develop. The following figure looks at WCB claims from 2001 with 6.5 years development. It shows both that the percentage of claims and the percentage of costs have increased significantly.

Figure 18: Indemnity Costs for PPD Claims Assembled in 2001

	Claims	% of PPD Claims	Avg Cost Per Claim	Total Cost	% of Total Costs
PPD SL	28,582	78.0%	$18,099	$517,294,165	29.4%
PPD NSL	8,052	22.0%	$154,354	$1,242,859,980	70.6%
Total	36,634	100.0%		$1,760,154,145	

excludes any claims with Data Anomalies

Source: Workers' Compensation Board data estimated to lifetime costs

Using the same calculation discussed above applied to data from 2001 for claims with 6.5 years of development, PPD non-scheduled claims are only 8.7 % of indemnity claims but they generate an estimated 60.2% [38]of total indemnity claim costs.

B.9. Comparison to NCCI national averages

The 2008 Data report included data from NCCI's statistical bulletin, which uses data from CIRB, to show how New York State compared to other states on average medical and indemnity cost per claim. Based on that data the 2008 Data Report stated New York State was a high cost indemnity state and a relatively low cost medical state. With an improved understanding of the data submitted by CIRB to NCCI, which has less development than data from other states, it appears that New York State's average cost per claim in the NCCI report are not directly comparable to the other states' costs.

B.10. Medical costs

Section III-B6 that looked at total benefits showed that total medical costs for claims with 30 month development declined modestly from 2003 to 2004 by 1.7%.

Although there has been a modest decline in total medical costs from 2003 to 2004, State medical costs are an increasing share of total benefit costs, rising from 36.8% for 2000 to 39.3% for 2004 for claims with 30 month development.

[38] The 60.2% is calculated as follows: 70.6% (WCB's estimate of PPD non-scheduled percentage share of PPD costs) multiplied by 85.5% (CIRB estimate at 5th report of PPD costs as a percent of total indemnity costs).

Figure 19: Total Medical Costs for Medical-only, TTD and PPD and Annual % Change

	(Costs in Millions)						
Medical Costs	1998	1999	2000	2001	2002	2003	2004
Medical Only	$ 72	$ 72	$ 74	$ 72	$ 69	$ 73	$ 71
TTD	$ 172	$ 190	$ 184	$ 150	$ 155	$ 157	$ 144
PPD	$ 265	$ 305	$ 330	$ 363	$ 367	$ 387	$ 391
Annual Percent Change							
Medical Only		0.7%	2.9%	-2.6%	-4.6%	6.2%	-3.3%
TTD		10.7%	-3.2%	-18.3%	3.0%	1.4%	-8.2%
PPD		15.0%	8.3%	9.7%	1.3%	5.3%	1.2%

Source: CIRB data at 30 months of development

The increase in medical costs has not been uniform across all categories of claims. From 1998 to 2004, for claims with 30 months of development, costs for medical-only claims have remained relatively constant. TTD medical costs showed a significant decline from 2003 to 2004 for the first time in three years. In contrast PPD medical costs have shown growth over the same three year period.

Figure 20: Average Medical Cost per claim—Medical-only, TTD, PPD

Average Medical Cost Per Claim	1998	1999	2000	2001	2002	2003	2004
Medical-only	$ 558	$ 574	$ 615	$ 650	$ 682	$ 747	$ 766
TTD	$ 3,690	$ 3,995	$ 4,218	$ 3,745	$ 4,277	$ 4,242	$ 4,406
PPD	$ 12,562	$ 13,959	$ 15,342	$ 16,097	$ 18,194	$ 19,981	$ 21,320
Annual Percent Change							
Medical Only		2.9%	7.1%	5.6%	5.0%	9.6%	2.5%
TTD		8.2%	5.6%	-11.2%	14.2%	-0.8%	3.9%
PPD		11.1%	9.9%	4.9%	13.0%	9.8%	6.7%

Source: CIRB data at 30 months of development

Despite the decrease in total medical costs for TTD and Medical-only claims, in most years, all three types of claims showed growth in the average medical cost per claim. However, the level of growth slowed from 2003 to 2004.

B.11. Medical costs for PPD claims

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, it would be helpful to be able to look at much greater detail beginning with the trends in PPD scheduled and non-scheduled claims. Unfortunately due to the data limitations that have been discussed before, 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 cost data. WCB provides data

on the claims, but not the medical costs. The 2008 Data Report included an estimate of the PPD non-scheduled medical costs using information from SIF and the calculation was repeated for this Report.

For the current year, the estimate begins with information from SIF on its PPD non-scheduled claims. The SIF data shows that, based on medical costs incurred in calendar years 2004 to 2008, approximately 72% of PPD medical costs are generated by PPD non-scheduled claims. Applying the SIF percentage to the 2004 CIRB data at 30 month development, the estimated PPD non-scheduled medical costs are 50% of total medical costs for indemnity claims. This is an increase of 3% over last year's estimate.

B.12. Factors driving medical costs

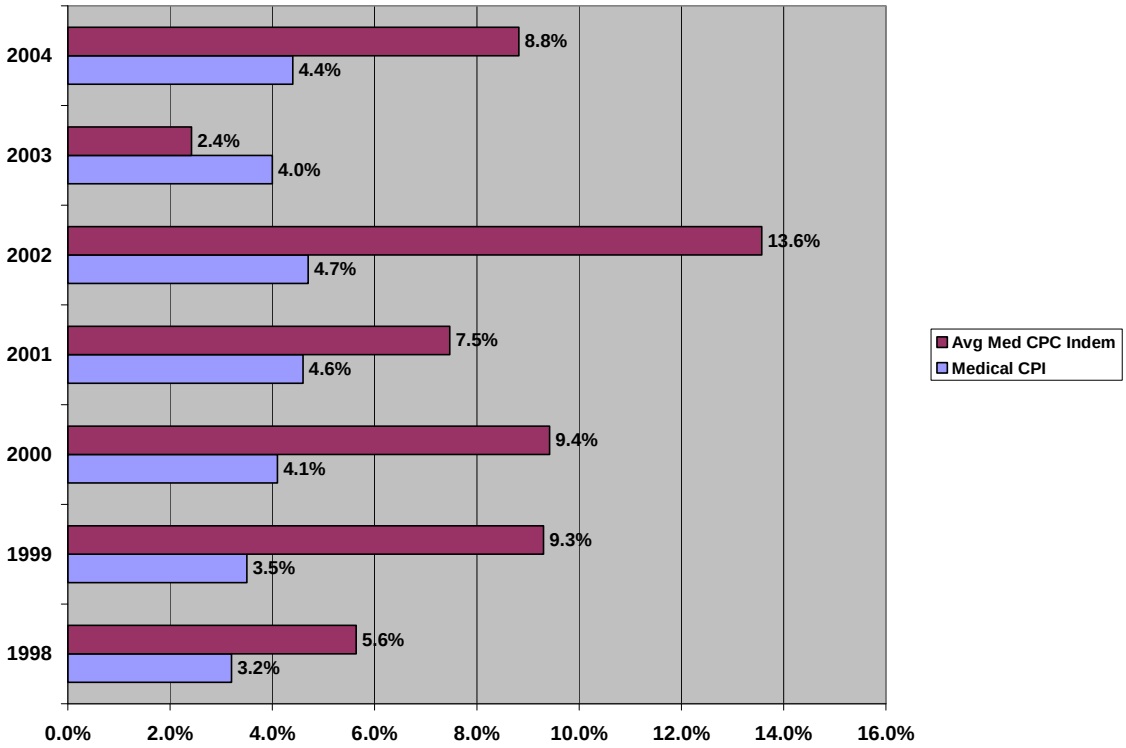
The next issue centers on what is driving the growth in medical costs for PPD claims. New York State has had a fixed medical fee schedule for many years. There are several factors that may contribute to the growing medical costs.

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. From 2003 to 2004, the fastest growing area for SIF was in pharmaceuticals.[39] To address growing medical costs stemming from pharmaceutical costs, the Reform Act authorized the Chair of the WCB to adopt a pharmaceutical fee schedule. A pharmaceutical fee schedule became effective July 2007. Based on data from SIF, there are early indications that this schedule is slowing the growth in costs for prescription medicines. The two other cost categories that drove medical costs for SIF from 2003 were: (i) out-of-state hospitals and other hospitals that are not covered by the diagnostic related groups; and (ii) hospital outpatient services.

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 ("medical CPI"), and increases have been almost twice the medical CPI in a number of years. This could be an indication of increased severity and increased utilization, given the declining number of claims.

[39] As noted in II

Figure 21: Change in National Medical CPI vs. Change in New York Average Medical Cost per Indemnity Claim (CPC)



Source: CIRB claims with 30 month development and US Department of Labor Statistics CPI Medical Care all urban consumers as of 01/08/2009.

Without detailed medical information, it is difficult to measure the utilization trends in New York State. Once CIRB begins to collect medical detail information (beginning in two years) a more in depth analysis can be done.[40]

Many other states have also been experiencing growing medical costs. A 2007 report from NCCI on medical costs for other states focused on utilization of services and severity of injury: [41]

"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."

[40] CIRB collection of detailed medical data is discussed in greater detail in Section VII-A on medical data
[41] "Measuring the Factors Driving Medical Severity: Price, Utilization, Mix," National Council on Compensation Insurance, 2007

"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."

NCCI uses costs per claim as a proxy for severity, i.e., higher medical costs per claim mean higher severity.

New York State's results for medical CPI are consistent with the NCCI's findings. The rate of growth in medical costs has substantially exceeded the medical CPI, despite a decrease in claims and a frozen medical fee schedule.

B.13. Summary of benefit costs

It will take several years to see the impacts of many of the workers' compensation reforms. Medical costs represent a growing share of total costs, increasing the need for more detailed information on medical costs. The growth in average indemnity cost per PPD claim slowed down in 2004. Although PPD non-scheduled claims only make up 6.1% of indemnity claims they contribute roughly 50% of indemnity and medical costs for claims with 30 months of development.

C. Other Characteristics of Claims

C.1. Gender

For claims assembled in 2007, 61% of accepted claims were filed by men, a higher percentage than their percentage of the labor force at 52.9 %. According to DOL, this disparity may result in part from a higher percentage of men working in more hazardous industries such as transportation, manufacturing and construction.

C.2. Body part

The following figure shows that the back remains the body part that sustains the highest number of injuries. However, this percentage share has declined over the past four years by 2.2 %. The decline has been offset by growth in the percentage share of both shoulder and leg injuries.

Figure: 22: Percent Share of Injures by Part of Body

Part of Body	Year Accepted			
	2004	2005	2006	2007
HEAD	**4.8**	**4.8**	**4.3**	**4.6**
NECK	**2.7**	**2.8**	**2.9**	**2.9**
UPPER EXTREMITIES	**21.4**	**21.4**	**21.5**	**21.4**
Finger	6.7	6.7	6.8	6.7
Wrist	7	6.8	6.7	6.5
Hand	2	2.1	2.1	2.1
Arm	3.7	3.7	3.6	3.7
Multiple Upper Ex.	1.8	2	2.3	2.3
All Other	0	0	0	0
TRUNK	**35.8**	**35.6**	**35**	**34.2**
Back	21.5	21.1	20.1	19.3
Shoulder	7.8	8.1	8.3	8.6
Abdomen	2.6	2.5	2.6	2.3
Chest	1.9	1.8	1.8	1.7
Pelvic Region	1	1	1.1	1
Multiple Trunk Locations	1	1	1.2	1.2
All Other	0	0	0.1	0
LOWER EXTREMITIES	**20.5**	**20.6**	**21.7**	**21.9**
Leg	11.9	12	12.5	12.6
Ankle	4.5	4.5	4.5	4.5
Foot	2	2.1	2.4	2.5
Toe	0.7	0.7	0.8	0.7
Multiple Lower Ex.	1.3	1.3	1.5	1.6
All Other	0	0	0	0
BODY SYSTEMS	**0.9**	**0.8**	**0.7**	**0.7**
MULTIPLE BODY AREAS	**13.2**	**13.3**	**13.4**	**13.8**
OTHER OR UNSPECIFIED	**0.8**	**0.6**	**0.4**	**0.5**
Total	**100**	**100**	**100**	**100**

Note: Percents may not add to totals due to rounding.

Source: Workers' Compensation Board

The back is the most common injury sustained for both men and women. For most body parts, the injury rate for men and women is fairly consistent, but there are a few parts where there is a significant difference. Men are more likely suffer injuries to fingers, leg and abdomen areas than women. On the other hand, women are more likely to sustain injuries to their wrists.

Figure 23: Part of Body Injured for Accepted Claims with First Indemnity Payment October 2007 to September 2008

PART OF BODY AREA Body Sub-Area	All Claims	% of all Claims	Male Workers	Female Workers	Sex Not Indicated
HEAD	**3,752**	**4.5%**	**2,669**	**1,001**	**82**
NECK	**2,359**	**2.8%**	**1,214**	**1,080**	**65**
UPPER EXTREMITIES	**17,777**	**21.2%**	**10,972**	**6,384**	**421**
Finger	5,681	**6.8%**	4,170	1,353	158
Wrist	5,345	**6.4%**	2,481	2,769	95
Hand	1,857	**2.2%**	1,346	463	48
Arm	2,977	**3.6%**	1,967	943	67
Multiple Upper Ex.	1,903	**2.3%**	1,002	848	53
All Other	14	**0.0%**	6	8	0
TRUNK	**28,444**	**33.9%**	**18,224**	**9,535**	**685**
Back	15,826	**18.9%**	9,572	5,840	414
Shoulder	7,248	**8.6%**	4,684	2,414	150
Abdomen	1,857	**2.2%**	1,663	162	32
Chest	1,535	**1.8%**	1,188	316	31
Pelvic Region	828	**1.0%**	492	307	29
Multiple Trunk Locations	1,119	**1.3%**	609	481	29
All Other	31	**0.0%**	16	15	0
LOWER EXTREMITIES	**18,532**	**22.1%**	**11,729**	**6,302**	**501**
Leg	10,648	**12.7%**	6,991	3,413	244
Ankle	3,859	**4.6%**	2,249	1,470	140
Foot	2,107	**2.5%**	1,319	725	63
Toe	697	**0.8%**	488	187	22
Multiple Lower Ex.	1,212	**1.4%**	674	506	32
All Other	9	**0.0%**	8	1	0
BODY SYSTEMS	**574**	**0.7%**	**318**	**246**	**10**
MULTIPLE BODY AREAS	**11,591**	**13.8%**	**6,084**	**5,155**	**352**
OTHER OR UNSPECIFIED	**801**	**1.0%**	**503**	**275**	**23**
Total	**83,830**	**100.0%**	**51,713**	**29,978**	**2,139**

Source: Workers' Compensation Board

C.3. Event of injury or exposure

Over time the events that result in injuries have remained fairly constant. The largest percentage of injuries result from overexertion, followed by falls on the same level.

Figure 24: Events or Exposure for Accepted Claims 2004 to 2007

Event or Exposure	Year Accepted			
	2004	2005	2006	2007
Overexertion	28.6%	29.3%	28.5%	28.2%
Fall on same level	15.3%	15.0%	15.0%	15.1%
Struck by object	9.2%	9.1%	9.3%	9.1%
Fall to lower level	7.8%	7.7%	8.4%	8.6%
Bodily reaction	7.6%	7.0%	7.0%	7.1%
Assaults and violent acts by person(s)	4.7%	5.0%	5.2%	5.7%
Repetitive motion	5.4%	5.6%	5.8%	5.6%
Highway accident	4.4%	4.5%	4.5%	4.4%
Struck against object	4.5%	4.3%	4.3%	3.9%
Caught in or compressed by equipment or objects	3.3%	3.4%	3.5%	3.7%
Other specified event	6.9%	7.2%	6.9%	7.1%
Nonclassifiable	2.4%	1.7%	1.6%	1.6%
Total	**100**	**100**	**100**	**100**

Note: Percents may not add to totals due to rounding.

Source: Workers' Compensation Board

When comparing men and women, there are significant differences in the types of events that result in injuries. For men, overexertion represents 28% of all events followed by falling on the same level at 11%, and being struck by an object and falling to a lower level which makes up 10% each.

Figure 25: Event or Exposure for Male Workers with Accepted Claims with First Indemnity Benefits from Sept. 2007 to October 2008

Event or Exposure	Claims	% of Claims
Overexertion	14,529	28.1%
Fall on same level	5,638	10.9%
Struck by object	5,421	10.5%
Fall to lower level	5,226	10.1%
Bodily reaction	3,818	7.4%
Assaults and violent acts by person(s)	2,512	4.9%
Repetitive motion	1,801	3.5%
Highway accident	2,666	5.2%
Struck against object	2,341	4.5%
Caught in or compressed by objects	2,268	4.4%
Other Specified Event	4,400	8.5%
Nonclassifiable	1,093	2.1%
TOTAL	**51,713**	

Source: Workers' Compensation Board

For women injured on the job, the top four categories are somewhat different. The two highest categories for women are the same as men. Overexertion is still the highest making up 26%, followed by falling on the same level at 24%, compared to only 11 % for men. The third most common event for women is repetitive motion; this is consistent with the wrist being a body part with a high level of injury. Finally, the fourth most common injury for women is assaults and violent acts by person(s). For women assault constitutes 8 % of all events compared to 5% of events for men.

Figure 26: Event or Exposure for Female Workers with Accepted Claims with First Indemnity Benefits from Sept. 2007 to October 2008

Event or Exposure	Claims	% of Claims
Overexertion	7,813	26.4%
Fall on same level	7,083	23.9%
Struck by object	2,032	6.9%
Fall to lower level	1,866	6.3%
Bodily reaction	1,831	6.2%
Assaults and violent acts by person(s)	2,331	7.9%
Repetitive motion	2,639	8.9%
Highway accident	995	3.4%
Struck against object	980	3.3%
Caught in or compressed by objects	583	2.0%
Other Specified Event	1,329	4.5%
Nonclassifiable	496	1.7%
TOTAL	**29,599**	

Source: Workers' Compensation Board

C.4. Age of the claimant

The following data combines claims data supplied by the WCB with data from the Unemployment Insurance database compiled by DOL. 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 0.80 claims for every 100 workers in New York State. There is a lower percentage of claimants in the younger and older age cohorts than for the general working population. In contrast, in the 35 to 44 and 45 to 55 age cohorts there are a higher percentage of claimants. For claimants in the 35-44 age range, that ratio increases to 1.01 claims per 100 workers. For the 44 to 55 the ratio is 0.90.

The 2008 Data Report examined the hypothesis propounded by some, that older workers file more claims to "supplement" their retirement.

The data in that Report appeared to disprove that hypothesis. The data in this Report continues to disprove the hypothesis. The data shows that the ratio of claims to workers for the 55-64 range group at 0.72 is actually below the average for all workers, at 0.80.

Figure 27: Average Claims per 100 workers by age of Claimant

	Indemnity Claimants			New York State Labor Force	
Age Group	Average Claims Per Year 2000 to 2006 2nd Q	Percent of Total	Claims Per 100 Workers	2007Civilian Labor Force (1,000s)	Percent of Total
Total	75,368	100.00%	0.80	9,455.5	100.0%
16-19	1,180	1.57%	0.33	361.8	3.83%
20-24	4,872	6.46%	0.55	888.7	9.40%
25-34	15,377	20.40%	0.77	2,001.2	21.16%
35-44	23,063	30.60%	1.01	2,294.8	24.27%
45-54	19,897	26.40%	0.90	2,209.1	23.36%
55-64	9,416	12.49%	0.72	1,310.8	13.86%
65+	1,562	2.07%	0.40	389.1	4.12%

Source: Workers' Compensation Board, Department of Labor—Current Population Survey

C.5. Occupational Disease claims

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

From 2001 to 2007, occupational disease claims represented an average of 5.1% of total indemnity claims.

Figure 28: Occupational Disease Claims as % of Indemnity Claims

Assembly Year	Occupational Disease Claims	Accident Claims	Total Claims	Percent OD	Percent Accident
2001	4,893	96,595	101,488	4.8%	95.2%
2002	4,837	89,601	94,438	5.1%	94.9%
2003	4,545	85,777	90,322	5.0%	95.0%
2004	4,653	79,615	84,268	5.5%	94.5%
2005	4,375	76,291	80,666	5.4%	94.6%
2006	3,918	72,205	76,123	5.1%	94.9%
2007	3,264	66,768	70,032	4.7%	95.3%
Total	**30,485**	**566,852**	**597,337**	5.1%	94.9%

Source : Workers' Compensation Board

Unlike accident claims, the majority of these claims become PPD claims rather simply TTD claims. It is interesting 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 readily to a specific body part on the statutory schedule.

For accident years 2001 to 2007, 58.5% of the occupational disease claims were PPD Scheduled. The majority of these were carpal tunnel syndrome. Carpal tunnel syndrome is considered a disease because it does not occur at a single point in time, but develops over a period of time. Since it is a disability of the wrist, and the wrist is on the statutory schedule, carpal tunnel syndrome claims are often PPD Scheduled.

Figure 29: Occupational Disease and Accident Claims 2001-2007

Case Type	Occupational Disease Claims			Accident Claims		
	Total	Percent	Avg Cost	Total	Percent	Avg Cost
Temp Total	10,807	35.5%	$12,875	397,085	70.1%	$8,098
PPD SL	17,794	58.4%	$18,185	135,881	24.0%	$19,057
PPD NSL	1,688	5.5%	$144,791	29,613	5.2%	$159,511
PTD	56	0.2%	$209,631	706	0.1%	$230,392
Death	140	0.5%	$165,650	3,567	0.6%	$173,628
Total	30,485	100%	$24,342	566,852	100%	$19,953

Source: Workers' Compensation Board

In comparison to accident claims a much higher percentage of occupational disease claims are controverted. For claims assembled from 2001 to 2007 the percentage of controverted claims for occupational disease was 48.3% compared to 10.5 % for accident claims.

Figure 30: Occupational Disease and Accident Claims 2001-2007

Assembly Year	Occupational Disease Claims			Accident Claims			Total		
	Controverted	Total	Percent	Controverted	Total	Percent	Controverted	Total	Percent
2001	2,229	4,893	45.6%	8,682	96,595	9.0%	10,911	101,488	10.8%
2002	2,324	4,837	48.0%	9,133	89,601	10.2%	11,457	94,438	12.1%
2003	2,215	4,545	48.7%	8,930	85,777	10.4%	11,145	90,322	12.3%
2004	2,297	4,653	49.4%	8,577	79,615	10.8%	10,874	84,268	12.9%
2005	2,126	4,375	48.6%	8,592	76,291	11.3%	10,718	80,666	13.3%
2006	1,905	3,918	48.6%	8,562	72,205	11.9%	10,467	76,123	13.8%
2007	1,628	3,264	49.9%	6,937	66,768	10.4%	8,565	70,032	12.2%
Total	14,724	30,485	48.3%	59,413	566,852	10.5%	74,137	597,337	12.4%

Source: Workers' Compensation Board

D. Summary of System Overview

As a result of the workers' compensation reforms, New York State's rank dropped nine places from the state with the 10th highest premium rate to the 19th highest. Medical costs are a growing percentage of total benefit costs, reinforcing the need for more detailed information on medical costs. Overall, the volume of claims continues to decline, but the decline in permanent partial disability claims is slower than temporary disability claims. PPD claims are the driving force behind growing medical costs.

IV. Benchmarks

The 2008 Data Report outlined a recommended framework for benchmarking the New York State workers' compensation system. This 2009 Data Report updates that framework, using most of the same measurements, adding several new ones and modifying others to reflect available data. The following areas are benchmarked:

A. Compliance with the Workers' Compensation Law
B. Timeframes for Delivery of First Indemnity Benefits for Injured Workers
C. Timely Access to Quality Medical Care for Injured Workers
D. Timely Claim Resolution
E. System Costs and Costs per Claim
F. Adequacy of Benefits
G. Return to Work
H. Improvements to Workplace Safety
I. Fraud

A. Compliance with the Workers' Compensation Law

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 SIF . Data from the self-insured employers is entered manually. The Bureau is one division of the WCB that currently mandates data be submitted electronically from carriers and the State Insurance Fund. The system is based on the national standard developed by the International Association of Industrial Accident Boards and Commissions ("IAIABC")[42] 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 DOL 's Unemployment Insurance Division. A match of policies to employers is then made.

In December of 2008, excluding the public sector self-insured employers, there are currently 421,673 employers with active coverage. Of this total, private carriers cover 241,979 employers, SIF covers 170,953 employers and 8,741 employers are self-insured.[43]

There are several 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 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 or if a tip is filed with the WCB. This is discussed below in the stop work order section. 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-- New Benchmark

No data was available for this measure in the 2008 Data Report. Over the past year the WCB has developed a measure called the Workers' Compensation Compliance Rate. The measure is calculated using employer information gathered by DOL and WCB. WCB subtracts those 'employers' that are active[44] but exempt from coverage, ,e.g., sole proprietors. If an employer has an active status, has no coverage in place, and the inquiry period and appeal period of the WCB's issued letters has past, the employer is considered out of compliance.

[42] 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

[43] WCB's compliance system

[44] Active employer means an employer that appears on either the WCB or DOL databases. Employers that have been reported to be "out of business" or "deceased "are excluded.

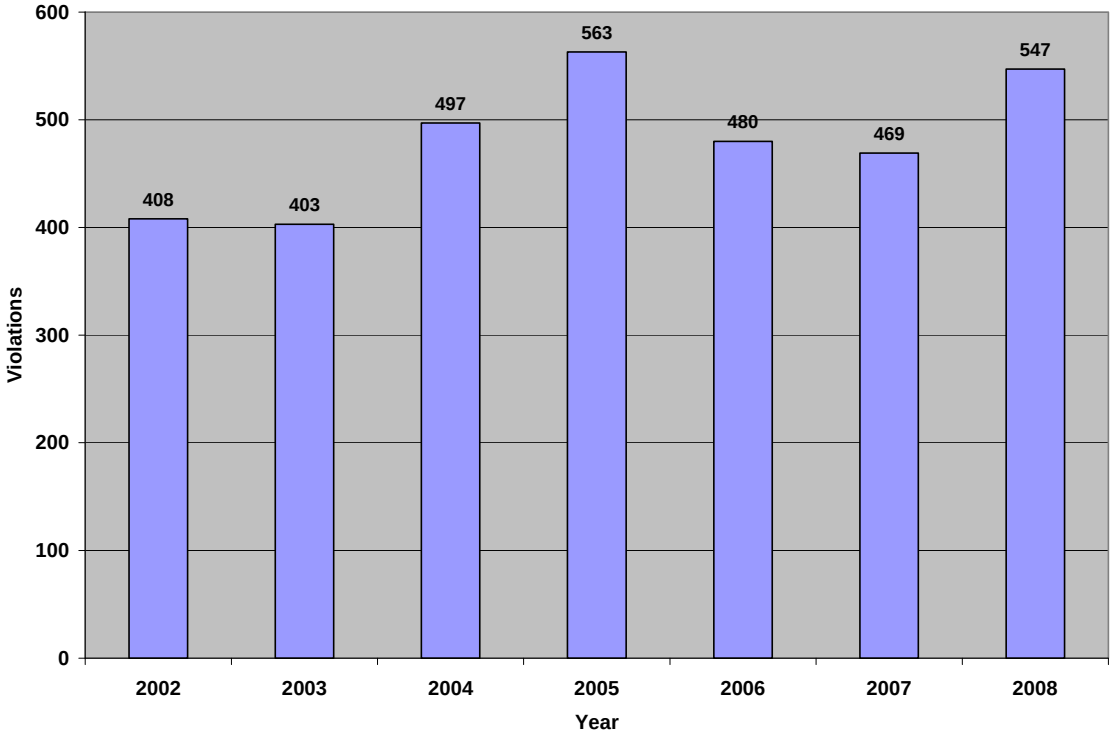
As of January 1, 2009, 94.2% of NYS active employers were in compliance. The percentage rate for small employers with 1 to 5 employees was slightly lower at 93.3% It should be noted that it would be nearly impossible for the Employer Compliance Rate to show 100% compliance from WCB data. There are a number of issues both with the timing of the WCB's receipt of coverage data and the completeness or accuracy of some coverage transactions. In addition, when employers go out of business there may be a period of time within which their business is reported as out of compliance. As a result of these data and timing issues, a currently indeterminate percentage of employers will appear non-compliant in the WCB's data while not actually failing to provide required coverage.

This measure does not include employers who are operating outside the regulatory systems and have not been on either the DOL or WCB databases. New York State is focusing on identifying these employers through other methods discussed below

A.2. Number of Coverage Violations – Revised Benchmark

The 2008 Data Report looked at the number of referrals to the No Insurance Unit of WCB ("NIU"). This unit pays for claims from uninsured employers. In 2009, WCB is changing the measure from referrals to number of violations that have been issued for lack of coverage. Referrals include instances where the WCB finds that the law has not been violated. Therefore, using actual violations is a better measurement of lack of compliance.

Figure 31: Violations for Lack of Workers' Compensation Coverage



Source: Workers' Compensation Board

From 2007 to 2008, the number of employers cited for violating the requirement for workers' compensation insurance increased by 17% or 78. This increase may in part be due to the effectiveness of discovery tools such as sweeps[45] and the WCB website that allows the public to check any employers' coverage, which have led to increased discovery of violations.

WCRI Data

In several of the following benchmarks, data from the Workers' Compensation Research Institute (WCRI) will be used. WCRI data complements the data from CIRB and WCB and provides information that is not currently available from either internal source. Last year was the first time WCRI produced data similar to the data they provide on 14 other states in their "compscope" reports. That WCRI data set for New York State included information from all of the large carriers and several of the large third party administrators. For the 2009 Data Report, the WCRI data set also includes data from SIF, so a much larger percentage of New York State's workers compensation system is represented.

[45] A sweep is the targeting of a certain geographic area, type or segment of employers, or some other classification for inspection to determine compliance with statutory and regulatory requirements without notice or warning.

There is a difference in the development times used by WCRI and CIRB. WCRI takes its first report at 12 month development after the policy year and every 12 months thereafter. CIRB, on the other hand, enters its first report at 18 months development after the policy year and every 12 months thereafter. As a result, the second report for WCRI includes 24 months of claim development and the second report for CIRB includes 30 months of claim development.

B. Timeframes for Delivery of First Indemnity 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. The 2009 Data 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 stakeholder in the process:

- ♦ Length of time from date of injury to first indemnity payment.
- ♦ Length of time from accident to employer notice to payor.
- ♦ Length of time from employee notice to employer to employer notice to payor.
- ♦ Length of time from notice to payor to first indemnity payment.

In New York, a significantly lower percentage of claimants receive their first indemnity payment within 21 days, 19.7% compared to the 41.5% WCRI median. Based on a similar finding in the 2008 Data Report an analysis was done for the 2009 Data Report. The results of that analysis are in Section V "Delays in First Indemnity Payments".

Figure 32: Time to Notice and First Indemnity Payment

	New York			WCRI 14 State Median
Performance Measure	Claims with 12 month development 2005/2006	Claims with 36 month development 2003/2006	Claims with 60 month development 2001/2006	Claims with 12 months development 2003/2006
Percent of Indemnity Claims where Payor received notification within 3 days of injury	52.4%	51.8%	48.8%	50.5%
Percent of Indemnity Claims where first indemnity payment is within 21 days of date of injury	23.4%	19.7%	17.4%	41.5%
Percent of Indemnity Claims where first indemnity payment is within 14 days of notice to payor	21.0%	17.7%	16.8%	43.5%
Percent of Indemnity Claims where Payor received notification within 3 days of notice to employer	59.7%	58.7%	53.7%	62.2%

Source: WCRI

C. Timely Access to Quality Medical Care for Injured Workers

C.1. Chiropractor and physical/occupational therapist—number of visits per indemnity claim

New York State's claimants' utilization of chiropractor and physical/occupational therapist is much higher than many other states. .

Figure 33: Visits for Chiropractor and Physical/Occupational Therapist

	New York			WCRI 14 State Median
Visits Per Indemnity Claim	Claims with 12 month development 2005/2006	Claims with 36 month development 2003/2006	Claims with 60 month development 2001/2006	Claims with 12months development 2004/2005
Chiropractor	32.5	45.4	54.3	16.6
Physical/Occupational Therapist	21.7	27.8	29.6	14.5

Source: WCRI

C.2. 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. New York State's visits per indemnity claim are consistent with the other WCRI states, but New York's claimants receive 45% more services per visit.

Figure 34: Visits for Neurological/Neuromuscular testing

	New York			WCRI 14 State Median
Neurologic/neuromuscular testing	Claims with 12 month development 2005/2006	Claims with 36 month development 2003/2006	Claims with 60 month development 2001/2006	Claims with 12months development 2004/2005
Visits per indemnity claim	1.6	2.0	2.0	1.7
Services per indemnity claim	5.8	4.8	4.9	4.0

Source: WCRI

C.3. Access to medical care

C.3.a. Percent of authorized physicians per 10 claims by county

The measure used in the 2008 Data Report as a reasonable proxy for measuring proximity of physicians to a claimant's home was the distribution of authorized physicians across the state. The metric for 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. In 2007, the median for this metric was 57%, and the range ran from a high of 79% to a low of 19%. In 2008, the median dropped slightly to 55% and the range ran from a high of 71% to a low of 18%.

This Report includes an additional measure, the percentage of authorized physicians per 10 claims. This measure looks at authorized physicians in the context of the claim volume in the county.

The median number of authorized physicians per 10 claims is 1.7. The county with the highest number of physicians per claim is Otsego at 6.9, and the county with the lowest number of authorized physicians per 10 claims is Seneca at 0.4.

Note, these numbers do not include other health care providers, do not reflect availability of doctors in neighboring counties and do not reflect the geographical distribution of specialties.

Figure 35: Physicians Licensed and Authorized by County and % of Authorized Physicians per 10 claims-- 2007

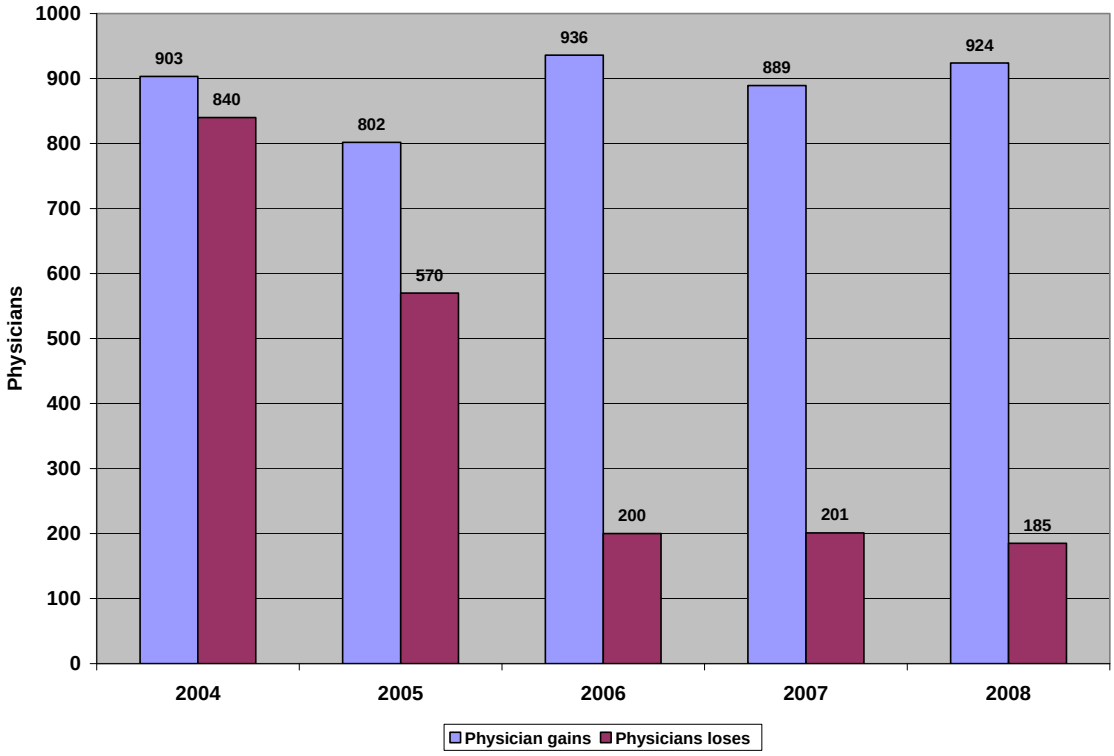
County	Licensed by New York State	Authorized by WCB	% of Licensed Physicians Authorized by WCB	2007 est Population	Claims Index in 2007 by County	# of Authorized Physicians (per 10 Claims)
Albany	1,795	908	51%	299,307	3,138	2.9
Allegany	60	36	60%	49,637	278	1.3
Bronx	2,463	623	25%	1,373,659	6,026	1.0
Broome	735	479	65%	195,973	1,598	3.0
Cattaraugus	163	81	50%	80,087	658	1.2
Cayuga	133	81	61%	80,066	682	1.2
Chautauqua	264	141	53%	133,945	1,122	1.3
Chemung	317	201	63%	88,015	983	2.0
Chenango	76	49	64%	51,207	379	1.3
Clinton	240	118	49%	82,215	675	1.7
Columbia	165	90	55%	62,363	466	1.9
Cortland	105	67	64%	48,369	387	1.7
Delaware	76	52	68%	46,286	339	1.5
Dutchess	1,001	490	49%	292,746	2,159	2.3
Erie	3,522	1,525	43%	913,338	9,199	1.7
Essex	64	35	55%	38,119	280	1.3
Franklin	131	76	58%	50,449	442	1.7
Fulton	110	69	63%	55,114	541	1.3
Genesee	99	58	59%	58,122	469	1.2
Greene	85	39	46%	49,246	377	1.0
Hamilton	4	2	50%	5,075	38	0.5
Herkimer	58	36	62%	62,558	344	1.0
Jefferson	305	150	49%	117,201	795	1.9
Kings	5,905	1,432	24%	2,528,050	9,849	1.5
Lewis	35	20	57%	26,472	150	1.3
Livingston	100	64	64%	63,196	383	1.7
Madison	145	97	67%	69,829	358	2.7
Monroe	3,458	1,550	45%	729,681	6,388	2.4
Montgomery	120	66	55%	48,695	395	1.7
Nassau	9,941	3,398	34%	1,306,533	8,313	4.1
New York	19,556	3,508	18%	1,620,867	21,105	1.7
Niagara	375	226	60%	214,845	1,821	1.2
Oneida	662	403	61%	232,304	2,286	1.8
Onondaga	2,104	1,187	56%	454,010	4,629	2.6
Ontario	327	159	49%	103,956	824	1.9
Orange	1,103	516	47%	377,169	2,640	2.0
Orleans	43	28	65%	42,371	312	0.9
Oswego	185	108	58%	121,454	621	1.7
Otsego	351	250	71%	62,397	362	6.9
Putnam	288	136	47%	99,489	406	3.3
Queens	5,908	1,639	28%	2,270,338	12,158	1.3
Rensselaer	358	181	51%	155,318	838	2.2
Richmond	1,711	572	33%	481,613	2,193	2.6
Rockland	1,428	462	32%	296,483	1,685	2.7
St.Lawrence	224	75	33%	109,809	891	0.8
Saratoga	560	309	55%	215,852	1,358	2.3
Schenectady	527	281	53%	150,818	1,113	2.5
Schoharie	26	16	62%	32,063	158	1.0
Schuyler	34	24	71%	19,027	149	1.6
Seneca	23	12	52%	34,228	290	0.4
Steuben	234	151	65%	96,874	738	2.0
Suffolk	5,279	2,569	49%	1,453,229	10,792	2.4
Sullivan	158	73	46%	76,303	652	1.1
Tioga	53	31	58%	50,453	192	1.6
Tompkins	305	168	55%	101,055	900	1.9
Ulster	460	252	55%	181,860	1,232	2.0
Warren	292	178	61%	66,143	686	2.6
Washington	54	33	61%	62,743	451	0.7
Wayne	115	76	66%	91,291	567	1.3
Westchester	7,274	2,156	30%	951,325	5,821	3.7
Wyoming	57	34	60%	41,932	336	1.0
Yates	36	25	69%	24,557	95	2.6

Source: Physician and claim data from Workers' Compensation Board and Population data from Table 1: Annual Estimates of the Population for Counties of New York: April 1, 2000 to July 1, 2007 (CO-EST2007-01-36)- US Census

C.3.b. Number of physicians gaining and losing WCB authorization

In 2008, the workers compensation system gained 924 new physicians. This is consistent with gains in the last two years. During the same time period, the system lost 185 physicians for a net gain of 739[46]. A closer review should be undertaken to consider the specialty distribution of the physicians and to determine whether the authorized physicians are still accepting workers' compensation patients.[47]

Figure 36: Physician Authorizations –Gains/Losses[48]



Source: Workers' Compensation Board

C.4. WCB's organization of data

Many of the following benchmarks use WCB data from the claims management system.[49] A unique aspect of the WCB data is "no compensation claims". These are

[46] The data is for individual physicians and does not reflect groups or associations of physicians.
[47] 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, requests removal from the list, or has his or her WCB authorization revoked for misconduct.
[48] The physicians authorizations chart starts at 2004 due to a major change in the Department of Education tracking system in 2004. Comparable numbers are not available for prior years. The Department of Education is the state agency that licenses physicians.

claims in the WCB claim system which does not include any indemnity or medical costs. Many of these claims may be Medical-only claims where the WCB is not aware of any medical payments; others are claims that were dropped by the claimant at some point in the process. The final factor with WCB claim data relates to development. WCB data is not organized into set reporting times like the CIRB data. So it is not possible to compare claims with 30 months development. Therefore, claims assembled in 2000 have 8 years of development from assembly and claims assembled in 2006 only have two years of development.

C.5. Disputes over medical care

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

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C.5.a. Volume of medical 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.

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.

Figure 37: Number of Denials of Medical Authorizations

Assembly Year	No Compensation Claims			Medical Only Claims			Indemnity Claims		
	Disputed	Assembled	Percent	Disputed	Assembled	Percent	Disputed	Assembled	Percent
2001	629	29,636	2.1%	2,169	28,554	7.6%	10,590	101,488	10.4%
2002	621	29,223	2.1%	2,097	28,837	7.3%	9,767	94,438	10.3%
2003	605	28,685	2.1%	2,028	28,457	7.1%	8,878	90,322	9.8%
2004	575	26,558	2.2%	2,106	28,374	7.4%	8,360	84,268	9.9%
2005	611	26,566	2.3%	2,052	26,811	7.7%	7,741	80,666	9.6%
2006	620	28,341	2.2%	2,036	28,627	7.1%	6,584	76,123	8.6%
2007	551	30,474	1.8%	2,031	31,429	6.5%	4,537	70,032	6.5%
Total	4,212	199,483	2.1%	14,519	201,089	7.2%	56,457	597,337	9.5%

* Excludes ADR, Cancelled, and WTC Volunteer Claims

Source: Workers' Compensation Board

The percentage of indemnity claims which include a dispute of medical treatment appears to be declining over time. But this may be more a factor of the shorter development time for the 2006 and 2007 claims, rather than an actual change in percentage. What this chart shows 9.5% of all indemnity claims involve a dispute over medical care.

[49] As noted before in Section II-A.1 , when the data is based on the year assembled, it means either the year indexed or assembled, depending on the year of the data.

C.6. Disputes of reimbursement for medical care rendered

One 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, the treatment was for a pre-existing condition, or was not medically necessary. 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 provider has indicated the proper amount to bill for the services provided, or 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 professionals.

C.6.a. Volume of disputes over reimbursement for medical care rendered

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. The table below shows the number of disputes by category of claim.

The same issue of development that was discussed in the prior measure also applies to this chart. The decline in the percentage of disputes for indemnity claims is probably more an issue of development than an actual drop off in disputes. Many disputes over medical care are linked to the length of the care, and whether on-going care is needed.

Figure 38: Disputes over reimbursements for medical care rendered

Assembly Year	No Compensation Claims			Medical Only Claims			Indemnity Claims		
	Assembled	Disputed	Percent	Assembled	Disputed	Percent	Assembled	Disputed	Percent
2001	29,636	2,185	7.4%	28,554	3,946	13.8%	101,488	16,357	16.1%
2002	29,223	2,451	8.4%	28,837	4,428	15.4%	94,438	15,556	16.5%
2003	28,685	2,320	8.1%	28,457	4,030	14.2%	90,322	14,042	15.5%
2004	26,558	2,393	9.0%	28,374	4,108	14.5%	84,268	12,651	15.0%
2005	26,566	2,393	9.0%	26,811	3,927	14.6%	80,666	11,076	13.7%
2006	28,341	2,352	8.3%	28,627	3,968	13.9%	76,123	9,211	12.1%
2007	30,474	2,129	7.0%	31,429	3,834	12.2%	70,032	6,540	9.3%
Total	199,483	16,223	8.1%	201,089	28,241	14.0%	597,337	85,433	14.3%

Source: Workers' Compensation Board

This chart shows that 14.3% of indemnity claims include a dispute of payment for medical services rendered. There may be some overlap between the 10% of claims discussed in measure C-5.a above and claims with disputes over reimbursement for medical services.

D. Timely Claim Resolution

The following sets of measures start with measures for all claims, and then examine two major subsets of claims, controverted and non-controverted.

D.1. Median time for processing claims by administrative decision, conciliation or hearing

There are three processes for resolving claims; administrative decision, conciliation, and hearing. Administrative determination is a WCB process established to address non-controverted claims involving minor injuries, uncontested issues within a claim, or certain penalties based upon the documents in the WCB file. The proposed administrative determination is sent to the parties and their legal representatives for review. Any party may object to the proposed administrative determination within 30 days of the date it is transmitted by the WCB. An administrative determination is final 30 days after it is sent to the parties by the WCB if none of the parties timely object.

Conciliation is a WCB process established to resolve, in an expeditious and informal manner (e.g, through meetings or telephone conferences), issues involving non-controverted claims in which the expected duration of benefits is fifty-two weeks or less. Failure to reach an agreement through the conciliation process results in the case being scheduled for a hearing.

Hearings are formal proceedings held before a Workers' Compensation Law Judge, after notice to all interested parties to hear and determine claims for indemnity and medical compensation for the purpose of ascertaining the rights of the parties.

From 2001 to 2006[50] the median number of days to establish claims requiring hearings has declined from 232 to 195, or 15.9%. Similar declines occurred in establishment times for conciliation claims.

[50] These tables do not include data from 2007 because it would not be comparable due to the short development period. The 2007 data would only include claims that could be established within a year, so it would show artificially lower medians.

Figure 39: Median Number of Days for Establishment – All Claims

Assembly Year	Admin. Decision		Conciliation		Hearing		Total Established	
	Claims	Median	Claims	Median	Claims	Median	Claims	Median
2001	74,163	83	18,835	174	37,044	232	130,042	115
2002	74,561	72	16,582	148	32,132	207	123,275	97
2003	74,290	73	15,735	165	28,754	198	118,779	93
2004	72,927	69	14,372	160	25,343	190	112,642	91
2005	47,225	90	27,396	156	32,856	203	107,477	137
2006	40,889	98	30,802	154	33,059	195	104,750	142
Total	384,055	77	123,722	159	189,188	204	696,965	112
Percent	55.1%		17.8%		27.1%		100.0%	

Source: Workers' Compensation Board

For simpler claims which only require an administrative decision, the time to establish a claim increased from 2004 to 2006. Part of the explanation for this increasing duration as well as the major decline in the number of administrative decisions was a change in WCB procedures. Prior to 2005, the WCB issued two types of administrative determinations: interim and final. An interim administrative determination that merely informed the parties about the information received by the WCB and that status of the claim; it was not a final decision of the claim or issue. A final administrative determination is a proposed decision which reflects the findings of the WCB. A party has 30 days to object to the final administrative determination, a party could not object to an interim administrative determination. At the end of 2004, the WCB eliminated interim administrative determinations. The elimination of the interim AD accounts for the drop in number of ADs between 2004 and 2005. Since final administrative determinations require the submission of all necessary forms and include the findings of the WCB, they take longer to issue than interim administrative determinations.

The next figure shows data for controverted claims. Roughly one-third of all claims requiring hearings are controverted claims. The median number of days for establishing those controverted claims has also declined by 16% from 219 days in 2001 to 183 in 2006.

Figure 40: Median Number of Days for Establishment of Controverted Claims

Assembly Year	Admin. Decision		Conciliation		Hearing		Total Established	
	Claims	Median	Claims	Median	Claims	Median	Claims	Median
2001	139	78	22	166	11,893	219	12,054	217
2002	137	71	25	150	11,625	204	11,787	202
2003	95	77	20	189	11,152	200	11,267	197
2004	111	72	10	205	10,513	187	10,634	185
2005	19	64	10	130	10,384	184	10,413	184
2006	7	66	12	109	10,287	183	10,306	183
Total	508	73	99	158	65,854	196	66,461	194
Percent	0.8%		0.1%		99.1%		100.0%	

Source: Workers' Compensation Board

The next figure examines the data from the perspective of non-controverted claims. The same trends of shorter time frames for claims using hearings and conciliation and increases in timeframes for administrative decisions are found with non-controverted claims.

In 2006, the median number of days for establishment by hearing in **non-controverted** claims was 198, while the median number of days for establishment by hearing of **controverted** claims was 183. This raises the question, why does it take longer to establish non-controverted claims requiring a hearing?

When a claim is controverted, the claimant is not entitled to any workers' compensation lost wage or medical benefits. Due to the hardship this imposes on the claimant, controverted claims have a high priority.

When a claim is not controverted, it has been accepted by the payor so lost wage and/or medical benefits can flow to the claimant. Disputed issues in such claims vary from the amount of lost wage benefit, authorization of medical services, resolution of disputed medical bills, determining whether impairment is permanent and the degree of impairment, and whether the payor is entitled to reimbursement from a special fund. With many of these issues, the claimant is receiving and continues to receive lost wage and medical benefits. Further, some issues, such as a payor's entitlement to reimbursement do not involve the claimant.

Different issues discussed above have a different priority with respect to order of resolution. Therefore, while the median days for resolution of issues by hearing may be higher for non-controverted claims, the additional time does not usually negatively impact the claimant or his or her receipt of benefit.

Figure 41: Median Number of Days for Establishment- Non-controverted Claims

Assembly Year	Admin. Decision		Conciliation		Hearing		Total Established	
	Claims	Median	Claims	Median	Claims	Median	Claims	Median
2001	74,024	83	18,813	174	25,151	237	117,988	108
2002	74,424	72	16,557	148	20,507	208	111,488	91
2003	74,195	73	15,715	165	17,602	197	107,512	88
2004	72,816	69	14,362	160	14,830	193	102,008	84
2005	47,206	90	27,386	156	22,472	209	97,064	133
2006	40,882	98	30,790	154	22,772	198	94,444	139
Total	383,547	77	123,623	159	123,334	208	630,504	106
Percent	60.8%		19.6%		19.6%		100.0%	

Source: Workers' Compensation Board

D.2. Average number of hearings

The following figures look at the average number of hearings from three perspectives, for all claims, for controverted claim and for non-controverted claims from 2001 to 2006. The average number of hearings dropped from 2.0 in 2001 to 1.7 in 2006.

Figure 42: Average Number of Hearing for All Claims

Assembly Year	Total Claims		
	Total Claims	Claims needing 1 or more hearing *	Average number of Hearings *
2001	130,042	37,044	2.0
2002	123,275	32,132	2.0
2003	118,779	28,754	2.1
2004	112,642	25,343	2.0
2005	107,477	32,856	1.7
2006	104,750	33,059	1.7

* based on Assembly or Reopened date to Establishment date

Source: Workers' Compensation Board

The average number of hearings for controverted claims declined from 3.1 to 2.8.

Figure 43: Average Number of Hearing for Controverted Claims

Assembly Year	Total Claims		
	Total Claims	Claims needing 1 or more hearing *	Average number of Hearings *
2001	12,054	11,893	3.1
2002	11,787	11,625	3.0
2003	11,267	11,152	3.0
2004	10,634	10,513	2.9
2005	10,413	10,384	2.8
2006	10,306	10,287	2.8

* based on Assembly or Reopened date to Establishment date

Source: Workers' Compensation Board

The average number of hearings for non-controverted claims also declined, from 1.5 to 1.2.

Figure 44: Average Number of Hearings for Non-Controverted Claims

Assembly Year	Total Claims		
	Total Claims	Claims needing 1 or more hearing *	Average number of Hearings *
2001	117,988	25,151	1.5
2002	111,488	20,507	1.5
2003	107,512	17,602	1.5
2004	102,008	14,830	1.4
2005	97,064	22,472	1.2
2006	94,444	22,772	1.2

* based on Assembly or Reopened date to Establishment date

Source: Workers' Compensation Board

D.3. Claims processing for all claims

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D.3.a. Interval from assembly to establishment –New Benchmark

For claims that were assembled between 2001 and 2007, the average time from assembly to establishment was 165 days. Seventy one percent of all claims assembled by the WCB are resolved within six months.

Figure 45: Interval from Assembly to Establishment for Claims (2001-2007)

Interval	Total		
	Total	Percent	Cumulative
0 to 3 months	227,501	38.1%	38.1%
4 to 6 months	198,967	33.3%	71.4%
7 to 9 months	89,027	14.9%	86.3%
10 to 12 months	36,425	6.1%	92.4%
13 to 15 months	18,037	3.0%	95.4%
16 to 18 months	10,185	1.7%	97.1%
19+ months	17,195	2.9%	100.0%
Total	597,337	100.0%	
Overall Average	165 Days		

excludes any claims with Data Anomalies

Source: Workers' Compensation Board

D.3.b. Number and percent of claims which remain closed for 12 months

When the WCB revised its processes eleven years ago to focus on issue resolution rather than claim resolution, it introduced the "no further action" (NFA) status. NFA is a finding that states the WCB will take no further action in the claim as there are no unresolved issues at the current time. Once a claim is marked NFA the WCB will continue to examine incoming mail and handle phone calls about the claim. Whenever subsequent issues arise in a claim, the claim is reactivated and the claim is set for the appropriate issue resolution (administrative determination, conciliation or formal hearing).

For example, if the claim is for a broken arm and it has been established, proper awards have been made and there are no outstanding issues, then the claim will be marked NFA. The WCB cannot make a determination as to any permanent loss of use until either the claimant or carrier, or both, bring forth medical evidence with the opinion of a permanent loss of use. Upon receipt of such evidence from either party, the WCB will take further action.

Since the NFA status was introduced, some stakeholders have expressed concern that claims would be marked as NFA when issues remain that can be resolved by the WCB, thereby improperly removing them from the resolution process. Claimants would then be forced to repeatedly request that the claim be restored to the resolution process to have the issues resolved.

However, the data shows that over three-quarters of the claims for years 2005 and earlier have been resolved and closed for more than 12 months. Resolved means the claim has been established and all other disputes including medical, average weekly wage and percentage disability have been resolved. For claims that are more than three years old, less than 5% have not been resolved.

Figure 46: Number of Claims Resolved and Remaining Closed (status for claims as of 3/19/08)

Assembled Year	Indexed Claims	WC Claims*	Resolved & Closed for at Least 12 Months	Resolved & Closed Within Last 12 Months	Total Resolved	Total Pending	Percentage of WC Claims* Pending
2000	171,397	160,825	151,433	5,348	156,781	4,044	2.5%
2001	172,053	159,982	149,851	6,258	156,109	3,873	2.4%
2002	164,372	152,932	140,477	7,854	148,331	4,601	3.0%
2003**	157,353	148,126	134,369	10,388	144,757	3,369	2.3%
2004	149,034	140,475	121,636	14,262	135,898	4,577	3.3%
2005	142,611	134,981	105,583	22,485	128,068	6,913	5.1%
2006	140,109	133,247	74,046	46,719	120,765	12,482	9.4%
2007	139,250	132,568	912	84,080	84,992	47,576	35.9%
Total	1,236,179	1,163,136	878,307	197,394	1,075,701	87,435	7.5%

* "WC claims" do not include Alternative Dispute Resolution (ADR), Cancelled Claims, and data anomalies (115 claims over 8 years). It is a dynamic population of claims and can change over time.

**157,811 indexed claims previously reported included World Trade Center Volunteer claims.

Source: Workers' Compensation Board (claims as of 3/19/08)

D.3.c. Percent of claims resolved with one NFA finding

For claims assembled from 2000 to 2006, 68%--74% have been resolved with only one NFA finding. An additional 17%--18% are resolved with only two NFA findings. This data indicates that the concern that claims are routinely marked as NFA even when open issues remain is not substantiated.

Figure 47: Use of No Further Action by the WCB (status for claims as of 3/19/08)

Assembled Year	Indexed Claims	WC Claims*	Resolved With One NFA** Finding	Resolved With Two NFA** Findings	Resolved With More Than Two NFA** Findings	Total Resolved	Percentage Resolved With One NFA Finding
2000	171,397	160,825	106,734	25,152	24,895	156,781	68.1%
2001	172,053	159,982	100,788	27,033	28,288	156,109	64.6%
2002	164,372	152,932	94,817	25,510	28,004	148,331	63.9%
2003***	157,353	148,126	93,229	24,782	26,746	144,757	64.4%
2004	149,034	140,475	88,269	24,397	23,232	135,898	65.0%
2005	142,611	134,981	85,934	24,159	17,975	128,068	67.1%
2006	140,109	133,247	89,619	22,134	9,012	120,765	74.2%
2007	139,250	132,568	77,133	6,971	888	84,992	90.8%
Total	1,236,179	1,163,136	736,523	180,138	159,040	1,075,701	68.5%

* WC claims do not include Alternative Dispute Resolution (ADR), Cancelled Claims, and data anomalies (115 claims over 8 years).

** NFA - "No Further Action" is the finding issued by the WCB when there are presently no remaining unresolved issues in a claim. The WCB reports the NFA event as one resolution even though multiple issues may have been resolved.

*** 157,811 indexed claims previously reported included World Trade Center Volunteer claims.

Source: Workers' Compensation Board (claims as of 3/19/08)

D.4. Rocket Docket measures

D.4.a. Percentage of claims controverted compared to total claims

The following table shows that the number of controverted claims has been declining consistent with the decline in the number of overall claims. From 2006 to 2007 the percentage of controverted claims declined from 18% to 14%.

Figure 48: Percentage of Controverted Claims

Year	Workers' Compensation Claims *	Number of Claims Controverted	% Controverted
2002	152,932	26,631	17%
2003	148,126	26,059	18%
2004	140,475	24,280	17%
2005	134,981	23,575	17%
2006	133,247	23,530	18%
2007	132,568	18,921	14%

* The number of Workers' Compensation Claims excludes ADR, Canceled, and Volunteer claims

Source: Workers' Compensation Board

The Rocket Docket is intended to reduce the number and percentage 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 to accept or to 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.

D.4.b. Number of C-7's filed

C-7 is the form a payor files when they deny the claim. One of the objectives of the Rocket Docket was to reduce the number of C-7's which payors filed protectively because the payor had not received the basic information needed to determine their position on the claim within the 25 day window. The following figure shows there was more than a 50% decline in the number of C-7's filed in the months following the implementation of the new rules for indexing a claim in connection with the Rocket Docket.

Figure 49: Number of C-7's Filed Monthly

	C-7 filed
Jan-08	2,345
Feb-08	2,143
Mar-08	2,236
Apr-08	2,308
May-08	2,108
Jun-08	2,048
Jul-08	2,177
Aug-08	2,078
Sep-08	2,013
Oct-08	1,930
Nov-08	944
Dec-08	1,007
Jan-09	850

Source: Workers' Compensation Board

D.5. 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.5.a. Average number of hearings for non-controverted claims (with and without representation)

The following figure analyzes the data from the perspective of the year the claims were assembled. This data shows that the number of hearings for non-controverted claims has been declining steadily. When the claims are split between represented and non-represented claimants, the number of hearings for non-represented claimants is significantly less. While the number of hearings for non-represented claimants has remained stable, there has been a decline in hearings for represented claimants.

Figure 50: Number of Hearings for non-controverted claims with at least one hearing

Assembly Year	Represented		Not Represented		Total	
	Claims	Hearings	Claims	Hearings	Claims	Hearings
2001	48,277	4.3	27,064	1.5	75,341	3.3
2002	45,036	4.1	24,128	1.4	69,164	3.2
2003	43,022	3.9	21,218	1.4	64,240	3.1
2004	39,398	3.8	18,371	1.4	57,769	3.0
2005	36,617	3.4	16,254	1.4	52,871	2.8
2006	34,726	3.0	15,165	1.4	49,891	2.5
2007	30,821	2.2	13,848	1.3	44,669	1.9
Total	277,897	3.6	136,048	1.4	413,945	2.9
Percent	67.1%		32.9%		100.0%	

Excludes any claims with Data Anomalies

Source: Workers' Compensation Board

D.6. Duration of PPD claims

D.6.a. Average duration for PPD scheduled claims from assembly to classification

The following figure shows data by the year the claim was classified. It is important to remember that claims from different accident years are classified in the same year. The average time from assembly to classification for PPD Scheduled claims increased slightly from 2.3 years for 2006 to 2.4 years for 2008.

Figure 51: PPD Scheduled Average and Median Years to Classify.

Classification Year	Years to Classify	
	Average	Median
2006	2.3	1.8
2007	2.3	1.8
2008	2.4	1.8
Total	2.3	1.8

Source: Worker's Compensation Board

Within three years, 80% of PPD scheduled claims are classified. About 7% of these claims take over five years to classify.

Figure 52: PPD scheduled -- Frequency Distribution of Years from Assembly to Classification

Classification Year	Years from Assembly to Classification									
	Data Issue*	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	187	2,784	11,621	5,289	2,198	1,082	621	357	755	24,894
2007	156	2,930	11,660	5,167	2,221	1,183	600	393	813	25,123
2008	121	2,617	12,201	5,334	2,279	1,094	683	407	813	25,549
Total	464	8,331	35,482	15,790	6,698	3,359	1,904	1,157	2,381	75,566
Percent	0.6%	11.0%	47.0%	20.9%	8.9%	4.4%	2.5%	1.5%	3.2%	100.0%

Source: Workers' Compensation Board

D.6.b. Average duration for PPD non-scheduled claims from assembly to establishment

Based on the year the claim is classified, the median time from assembly to classification has risen very slightly each year from 2006 to 2008 at 3.9 years. In contrast to PPD scheduled claims, it takes over 6 years for more than 80% of PPD non-scheduled claims to be classified. It is possible that the time it takes to classify claims with dates of accident or disablement on or after March 13, 2007, will decrease as the maximum number of benefit weeks do not begin until the claimant is classified.

Figure 53: PPD Non-Scheduled Average and Median

Years to Classify.

Classification Year	Years to Classify	
	Average	Median
2006	4.4	3.7
2007	4.5	3.8
2008	4.7	3.9
Total	4.5	3.8

Source: Workers' Compensation Board

Figure 54: PPD non-scheduled loss -- Frequency Distribution of Years from Assembly to Classification

Classification Year	Years from Assembly to Classification									
	Data Issue*	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	288	110	971	2,074	1,709	1,221	876	561	1,175	8,985
2007	195	96	820	1,786	1,593	1,082	810	578	1,185	8,145
2008	217	43	649	1,666	1,412	977	749	532	1,238	7,483
Total	700	249	2,440	5,526	4,714	3,280	2,435	1,671	3,598	24,613
Percent	2.8%	1.0%	9.9%	22.5%	19.2%	13.3%	9.9%	6.8%	14.6%	100.0%

* Data Issue exists with Assembly Year

Source: Workers' Compensation Board

D.7. Duration of Requests for Review

Section II-C "Progress" discussed the changes in the WCB's approach to handling requests for WCB review of decisions by administrative law judges. The following are several measures that track performance in this area.

Before the Administrative Review Division (ARD) can begin to work on a Request for Administrative Review, the minutes of all hearings pertinent to the request must be transcribed by WCB Hearing Reporters. Since reengineering ARD in 2008, the time required to complete hearing minutes transcriptions after 30 days from the transcription request, has improved significantly. As a result, the number of minutes awaiting transcription has dropped from 73 in August 2008 to only 6 in February 2009.

Figure 55: Number of Pending Hearing Minutes Transcription Requests Older than 30 Days

Date	Pending Requests Older than 30 Days
Aug 31,2008	73
Sep 28, 2008	66
Oct 26, 2008	60
Nov 30, 2008	60
Dec 28, 2008	62
Jan 25, 2009	22
Feb 15, 2009	6

Source: Workers' Compensation Board

Despite an increase in the number of requests for Administrative Review from 2007 to 2008 the pending inventory of requests at the end of the year declined by 19%.

Figure 56: Requests to the Administrative Review Division (ARD) for Administrative Review

Year	Total ARD Referrals	Pending at End of Year	Percent Inventory Change
2006	14,381	4,133	N/A
2007	13,317	4,495	9%
2008	14,516	3,620	-19%

Source: Workers' Compensation Board

The significant increase in the productivity resulting from the reengineering allowed the writers who prepare draft Memorandum of Decisions (MOD) to reduce the inventory, despite a reduction in the number of staff. The number of MODs has increased from 195 per writer in 2006 to 269 per writer, or by 38 %.

Figure 57 : Number of Memorandum of Decisions/ Referrals per Writer

Year	Total Referrals Completed	Total MODs Completed	Number of ARD Writers	MODs Per Writer	Referrals Completed per Writer
2006	14,716	11,500	59	195	249
2007	12,962	10,309	58	178	223
2008	15,503	13,191	49	269	316

Source: Workers' Compensation Board

E. System Costs and Costs Per Claim

E.1. Medical costs

Medical costs are a growing share of total costs, rising from 38.4% in 2003 to 39.3% in 2004 for claims. .

Figure 57-a: Total Medical and Indemnity Costs

($ in millions)	1998	1999	2000	2001	2002	2003	2004
Medical Costs	526	582	597	614	622	640	629
Indemnity costs	833	958	1,024	1,002	1,008	1,027	972
Total Costs	$1,358.3	$1,539.4	$1,621.4	$1,615.1	$1,629.9	$1,666.0	$1,601.0
Medical % of Total	38.7%	37.8%	36.8%	38.0%	38.1%	38.4%	39.3%
Indemnity as % of Total	61.3%	62.2%	63.2%	62.0%	61.9%	61.6%	60.7%

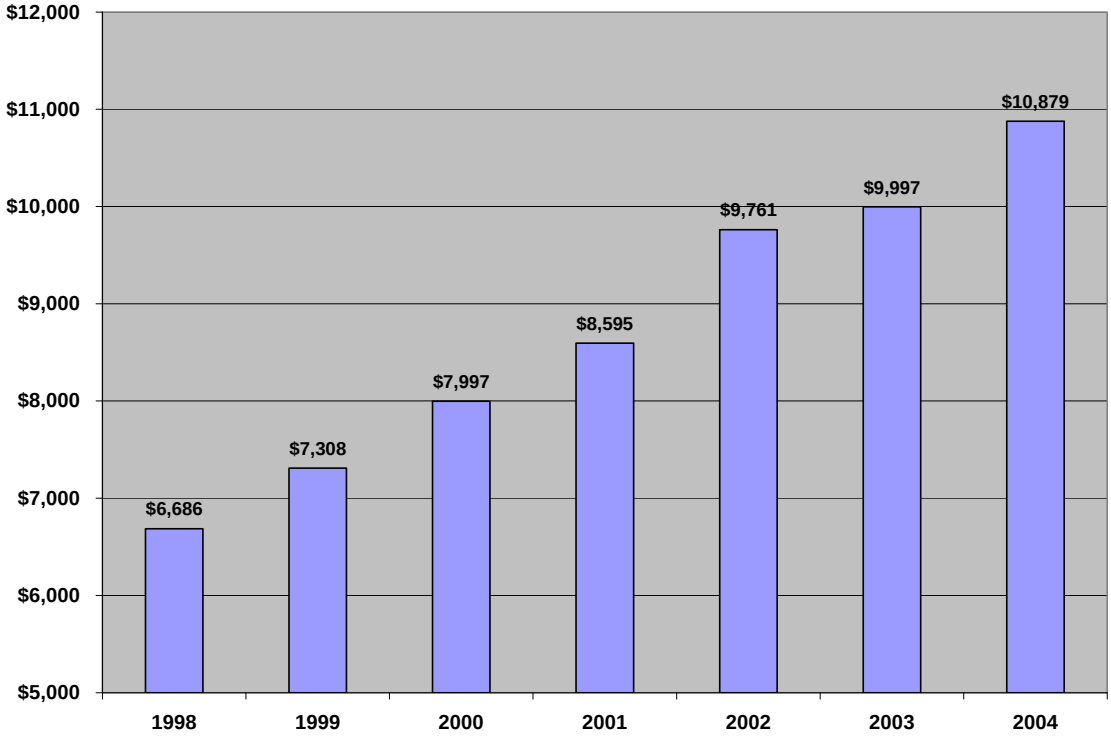
Source: CIRB claims at 30 month development

Based on national trends we expect this share to continue to rise. To control this growth the on-going reform efforts include several major initiatives including the pharmacy fee schedule and the Medical Treatment Guidelines. However the impacts of these efforts will only begin to show up in claims with accident years of 2008 and beyond.

E.1.a. Average medical cost per indemnity claim at 30 months development

This sub-section focuses on medical costs for indemnity claims. The following table shows that average medical costs per indemnity claim have been climbing steadily from 1998 to 2004. After slowing down between 2002 and 2003, the rate of growth picked up again in 2003 to 2004 to 9%.

Figure 58: Average Medical Cost Per Indemnity Claim

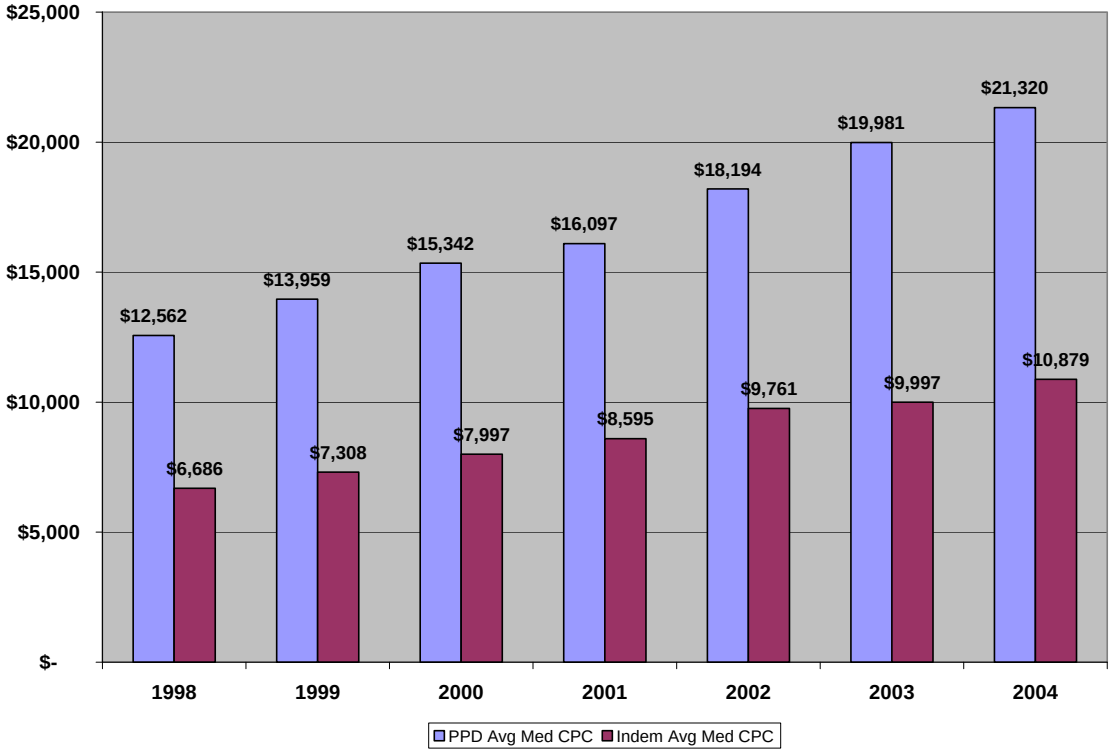


Source: CIRB data at 30 month of development

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

The majority of the growth in average medical per indemnity claim costs was due to growing average medical costs for PPD claims. While total medical costs declined in 2004, for the first time in six years, from $640 million to $629 million, total medical costs for PPD claims continued to grow from $386 million to $391 million. This has resulted in steadily rising average medical costs per PPD claim.

Figure 59: Average Medical Cost per PPD Claim and Indemnity Claim

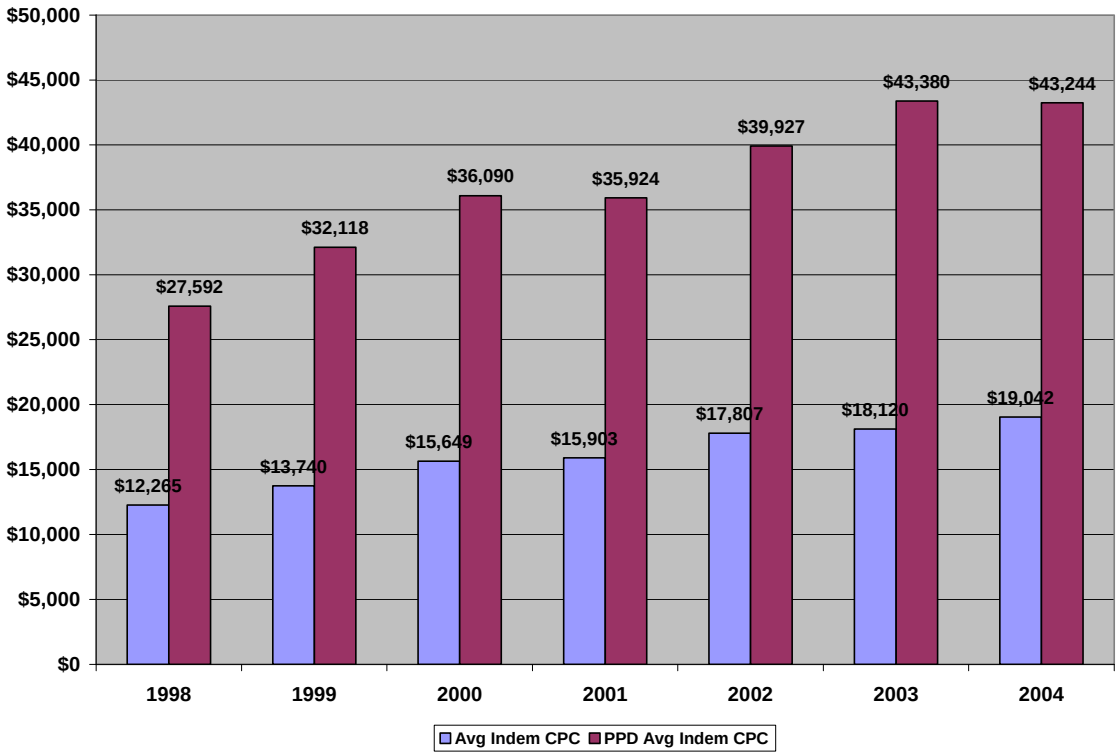


Source: CIRB data at 30 month of development (CPC= Cost per Claim)

E.2. Indemnity costs

It will be several years before the impact of the increases in the maximum weekly benefit are reflected in the CIRB data for claims with 30 month development since the first increase in the weekly benefit occurred on July 1, 2007 when the maximum weekly benefit increased from $400 to $500.

Figure 60: Average Indemnity Cost per Indemnity and PPD Claims



Source: CIRB data at 30 month of development (CPC= Cost per Claim)

E.2.a. Average indemnity cost per indemnity claim for claims with 30 month development

In 2004, indemnity cost per claim rose by 5.1 % over the prior year, continuing the trend of the past 6 years. But for the first time in many years the driving force behind the increase was not a growth in the average cost per PPD claim.

E.2.b. Average indemnity cost per PPD claim for claims with 30 months development

For the first time in the past six years the average indemnity cost per PPD claim declined slightly by 0.3% in 2004. It is unclear if this is a one year event or the beginning of a trend.

E.3. Costs of the adjudication process

E.3.a. Percent of claims with claimant representation

The percentage of indemnity claims with representation has been declining slightly from 2003 to 2006. The 2007 data is probably understated due to the short development time. In contrast, the percentage of Medical-only claims with representation increased from 26.7% in 2003 to 37.6% in 2007. The 2007 data probably overstates the percentage of represented Medical-only claims, because some of these claims will become indemnity claims with further development. Another way to look at the data is to compare it with data from the 2008 Data Report. In the 2008 Data report, Medical-only claimants for 2006, with one year of claim development, were represented by attorneys 36.2 % of the time. In the 2009 Data report, the representation percentage for Medical only claims in 2007, with the same one year claim of development, increased by 1.4% to 37.6%.

Figure 61: Claims With and Without Representation

Assembly Year	No Compensation Claims			Medical Only Claims			Indemnity Claims		
	Represented	Assembled	Percent	Represented	Assembled	Percent	Represented	Assembled	Percent
2001	8,008	29,636	27.0%	7,034	28,554	24.6%	55,750	101,488	54.9%
2002	7,937	29,223	27.2%	7,427	28,837	25.8%	53,014	94,438	56.1%
2003	7,372	28,685	25.7%	7,592	28,457	26.7%	50,996	90,322	56.5%
2004	6,706	26,558	25.3%	7,635	28,374	26.9%	47,194	84,268	56.0%
2005	6,609	26,566	24.9%	7,867	26,811	29.3%	44,376	80,666	55.0%
2006	7,222	28,341	25.5%	9,061	28,627	31.7%	41,709	76,123	54.8%
2007	7,447	30,474	24.4%	11,820	31,429	37.6%	36,024	70,032	51.4%
Total	51,301	199,483	25.7%	58,436	201,089	29.1%	329,063	597,337	55.1%

* Excludes ADR, Cancelled, and WTC Volunteer Claims

Excludes any claims with Data Anomalies

Source: Workers' Compensation Board

E.3.b. Average indemnity cost and average legal fees

One component of adjudication costs is the cost for claimant attorneys. For claims assembled in 2005, claimant attorney fees represent 5.8 % of average indemnity costs for represented claims, with an average cost of legal fees of $1,914. This percentage depends on the type of claims; the claims with larger total payouts have the smallest percentages.

Figure 62: Legal Fees for Indemnity Claims Assembled in 2005 (Legal Fees Claims only)

Case Type	Indemnity Claims	Average Indemnity*	Average Legal*	Legal Fee Percentage
Temp Total	18,203	$20,156	$1,304	6.5%
PPD Sch Loss	16,953	$20,712	$2,074	10.0%
PPD NSL	3,052	$167,529	$4,236	2.5%
PTD	68	$223,626	$4,671	2.1%
Death	220	$143,022	$7,057	4.9%
All Claims	38,496	$33,147	$1,914	5.8%

* excludes any claims with Data Anomalies

Source: Workers' Compensation Board

Another way to look at legal fees is to separate out the fees paid for settlements. In the New York State's workers compensation system, legal fees for settlements tend to be a higher percentage of total claim costs. Issues relating to settled claims are discussed in E.4. e. When the pool of claims is limited to represented claimants excluding Section 32 settlements, the average cost of legal fees drops to $1,621 or 5.1 %. The largest changes when Section 32 settlements are excluded are in TTD claims, because TTD claimants who enter into Section 32 settlements often have serious injuries that could result in a PPD non-scheduled classification if they did not settle.

Figure 63: Legal Fees for Indemnity Claims Assembled in 2005 (excluding Section 32 settlements)

Case Type	Indemnity Claims	Average Indemnity*	Average Legal*	Legal Fee Percentage
Temp Total	16,251	$16,215	$725	4.5%
PPD Sch Loss	16,930	$20,673	$2,069	10.0%
PPD NSL	2,778	$174,467	$3,672	2.1%
PTD	66	$228,262	$4,629	2.0%
Death	210	$142,821	$6,716	4.7%
All Claims	36,235	$31,551	$1,621	5.1%

* excludes any claims with Data Anomalies

Source: Workers' Compensation Board

E.3.c. Percentage of claims with Independent Medical Examinations

An IME-4 form is the form submitted by the independent medical examiner when they have completed their review. As claims get older there is a higher percentage that involves the use of an IME. Therefore, it is important to look at claims with similar development in order to get a more accurate picture of the trend in the use of IMEs. To compare claims with two years of development, the 2006 claim data from the current Report must be compared to the 2005 data from last year's Data

Report. In last year's Report 35.6% of claims with 2 years of development used an IME. The percentage of claims using an IME has increase slightly. For 2006 year claims with two years of development, 35.7% used an IME.

Figure 64: Claims involving an IME

Year Assembled	Total Claims	Claims with at least one IME-4	Percent of Claims with IME-4	Total # of IME-4s
2001	159,678	57,314	35.9%	163,531
2002	152,498	57,532	37.7%	168,485
2003	147,464	56,058	38.0%	167,559
2004	139,200	53,557	38.5%	159,057
2005	134,043	50,323	37.5%	140,848
2006	133,091	47,579	35.7%	125,037
2007	131,935	44,982	34.1%	101,540
Total	997,909	367,345	36.8%	1,026,057

Excludes any claims with Data Anomalies

Source: Workers' Compensation Board

E.3.d. Average benefit delivery expense per claim that have benefit delivery expenses

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 WCRI does not include is the cost of the claimant's attorney. New York has lower benefit delivery expenses than the WCRI 14 state median. However, New York's 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. Nonetheless, when the New York State average benefit delivery cost at 60 months is compared to the WCRI claims at 36 months, New York State is lower.

Figure 65: Average Benefit Delivery Expense Per Claims that have Benefit Delivery

	New York			WCRI 14 State Median
Performance Measure	Claims with 12 month development 2005/2006	Claims with 36 month development 2003/2006	Claims with 60 month development 2001/2006	Claims with 36 months development 2003/2006
Average benefit delivery expense per claim with benefit delivery expense	$1,095	$1,928	$2,041	$3,329.0

Source WCRI

E.3.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 for medical provider/expert testimony and depositions. The figure below shows that a much higher percentage of New York State's claims include medical-legal expenses than the other WCRI states: 36.6% at 36 months compared to 19.8%. 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.

Figure 66: Medical Legal Expenses

	New York			WCRI 14 State Median
Performance Measure	Claims with 12 month development 2005/2006	Claims with 36 month development 2003/2006	Claims with 60 month development 2001/2006	Claims with 36 months development 2003/2006
% of indemnity claims with medical-legal expenses	22.7%	36.6%	38.6%	19.8%
Average medical-legal expense per claim with medical-legal expenses	$679	$990	$1,105	$1,059

Source WCRI

E.4. Section 32 Costs

In Section 32 settlements, the parties may settle all issues by agreement. It has been argued that there will be an increase in Section 32 settlements because of the greater predictability of benefits for PPD non-scheduled claims that results from the duration caps and the new requirement for private carriers to transfer the indemnity reserve for PPD non-scheduled claims to the "Aggregate Trust Fund." (ATF) [51] Others argue that there will be less incentive for claimants to settle. WCB will be tracking 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 issues with the WCB data in this area. First, some settlements include non-cash awards[52] that cannot be easily valued. Second, there can be multiple claims associated with each other (known as associated claims), and 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.

[51] The Aggregate Trust Fund ("ATF") was created many years ago pursuant to the provisions of Section 27 of the New York Workers' Compensation Law. The purpose of the fund was to assure and oversee the regular payment of benefits on adjudicated death cases and certain statutory total permanent disability cases.

[52] 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 Aggregate Trust Fund (ATF) deposit requirements for PPD non-scheduled 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.

Figure 67: Section 32 Settlements

Settlement Year (A)	Total Settlements Without Associated Claims (B)	Waiver Agreement Settlement Benefits			
		Average Total Amount (C)	Average Fee to Attorney (D)	Average Benefit to Claimant (E)	Legal Fee % of Settlements
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%
2007	5,776	$52,586	$6,045	$46,541	11.5%
2008	5,932	$64,434	$6,548	$57,886	10.2%

(A) Year the Settlement was approved

(B) Reliable data is available on a subset of waiver agreements (65%) where the agreement settles only a single claim. The distribution of the award amount for a settlement involving multiple claims is not explicitly available as a data point.

(C) Average total settlement amount for the claims with reliable data (B).

(D) Average total attorney fee amount for the claims with reliable data (B).

(E) Average benefit to the claimant (C - D).

Source: Workers' Compensation Board

As of 2008, there was little growth in the number of Section 32 settlements. The full impact of the 2007 Reforms may not be apparent for several years when claims that could be PPD non-scheduled are close to classification.

For Section 32 claims where there does not appear to be a non-cash award, and when there are no associated claims involved, the average cost of settlements increased significantly from 2006 to 2008, by 36%. The percentage increase for the claimant's share was slightly higher, 34%.

F. Adequacy of Benefits

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.

Many jurisdictions have defined adequate benefits as a percentage of average weekly wages up to a cap or maximum benefit. The most widely used percentage 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, although it will increase again next year and in the following year be linked to 66% of the statewide average weekly wage.

F.1. Number of claimants receiving the maximum benefit.

From July 1, 2006 to June 30, 2007, when the maximum weekly benefit was $400 a week, 57.9% of indemnity claims assembled in that timeframe received the maximum benefit. In the next year, July 1, 2007 to June 30, 2008, when the benefit was raised to $500, about 14.2% of claimants received benefits between $400 and $500. Another 42.9% received the maximum benefit of $500. Consequentially, 57.1% of claimants benefited from the Reform Act raising the maximum benefit cap to $500 per week.

F.2. Rank of the maximum benefit compared to other states

On July 1, 2007 New York State's maximum benefit increased to $500, and the following July it increased to $550. A 2008 study by the U.S. Chamber of Commerce showed that as of July 2007, after the maximum was raised to $500, New York State ranked fifth lowest in the nation, tied with Georgia. Only Arizona, Kansas, Louisiana, and Mississippi were lower than New York State.

F.3. Time limits on benefits

Another aspect of benefit adequacy is benefit duration. In the recent reforms, New York State changed the duration limit on PPD non-scheduled claims from life to a maximum of 10 years based on the level of loss of wage earning capacity. Unlike the maximum benefit, where New York State ranks at the lower end of the states' rankings, New York ranks much higher regarding duration of benefits.

Thirty-seven states and the District of Columbia have a maximum number of weeks that an injured worker may receive permanent partial disability benefits. The maximum duration in New York of 525 weeks is greater than 31 of the states, while five states and the District of Columbia pay benefits for a longer period of time. Wisconsin has the longest duration of these states with 1,000 weeks of benefits. At the other end, Wyoming only provides such benefits for 44 months which is approximately 191 weeks. Six states have no durational limit on permanent partial disability benefits. With respect to the remaining states: 1) three states do not provide PPD benefits; 2) three states do not provide benefits for non-scheduled PPD; and 3) one state ends benefits at age 70. Of the states surrounding New York, New Jersey's durational limit is 600 weeks, Connecticut's is 520 weeks, Massachusetts's is 364 weeks, and Ohio's is 200 weeks.

With respect to temporary total disability benefits, in a little over half of the states (28), including New York State, benefits continue as long as the

disability continues and is temporary. Twenty-two states and the District of Columbia limit the number of weeks that temporary total benefits may be received. Six states only allow temporary total disability benefits for 104 weeks. New Mexico allows injured workers to receive such benefits for up to 700 weeks. While Pennsylvania allows benefits to continue for the duration of the disability, after 104 weeks the employer may request an impairment rating examination. If the exam results in an impairment of less than 50%, then the benefits are reclassified as partial disability compensation.

Thirty-seven states, including New York State, have no limit on permanent total disability benefits. Injured workers classified as permanently totally disabled may receive benefits for the length of the disability, which may be for life. Of the remaining thirteen states and the District of Columbia, five states end permanent total disability benefits when the injured worker reaches a specific age, which range between 65 and 75. Six states limit the duration of benefits to a maximum number of weeks, between 347 (Wyoming) and 800 (Michigan).

G. Return to Work

To put the return to work status of injured workers in context, it is important to recognize that there is a normal decline in workforce participation for all workers. DOL took the group of workers who were included on the NYS wage records in January 2006 and re-counted these workers at the end of eight quarters in January 2008. Although additional individuals had been added to the wage records, the original January 2006 group had declined by 20%.[53]. Workers leave the workforce for many reasons not related to work place injury such as retirement, to move out of state, return to school, or family illness. Based on this, a drop off in workforce participation of close to 20% is normal and is not attributed to workplace injuries. Another important issue about the DOL employment data is it only includes employment in New York State. If an injured worker has moved out of state and is working there, he or she would be shown as not having returned to work.

G.1. Return to Work: 2 years following accident

For the two largest groups of claimants, TTD and PPD-scheduled, the decline in workforce participation is fairly consistent with normal workforce declines; 73.8% of TTD had wages in the 8th quarter and 77.8% of PPD scheduled had wages in the 8th quarter.

Consistent with the findings last year, the two groups with the RTW rates that were much lower than for the average workforce were PPD non-scheduled and Section 32 claimants.

TTD claimants who choose Section 32 settlements return to work at a significantly lower rate than other claimants with temporary benefits. Based on their low rate of

[53] Data provided by DOL.

sustained RTW and the fact that the payor was willing to settle indicates these claims would have been classified as PPD non-scheduled if they had not settled. PPD scheduled and PPD non-scheduled claimants who choose Section 32 settlements also show much poorer performance in sustaining a return to work over two years than most other claimants.

The following chart shows claimants with private employers. The results are slightly higher for claimants with government employers, but they reflect the same trends for the different classification types, with Section 32 and PPD non-scheduled having the lowest RTW experience.

Figure 68: Claimants with Private Employers in Accident Quarter and % Employed Following 8 Quarters, (Accident Date 2000 to 2nd Quarter 2006)

	Temp Total		PPD SL		PPD NSL		Total	
	No Sec 32 % with wages	Sec. 32 % with Wages	No Sec 32 % with wages	Sec. 32 % with Wages	No Sec 32 % with wages	Sec. 32 % with Wages	No Sec 32 % with wages	Sec. 32 % with Wages
Total Claimants	**258,011**	**16,740**	**110,142**	**502**	**21,119**	**5,041**	**389,272**	**22,283**
Wages in Q 1	85.5%	60.3%	84.3%	79.7%	63.1%	56.5%	84.0%	59.9%
Wages in Q 2	82.3%	47.0%	82.8%	76.5%	49.8%	40.6%	80.7%	46.2%
Wages in Q 3	80.4%	41.5%	82.4%	72.3%	42.5%	34.0%	78.9%	40.5%
Wages in Q 4	78.7%	37.8%	81.9%	67.5%	37.1%	28.8%	77.3%	36.5%
Wages in Q 5	76.9%	35.0%	80.5%	62.5%	32.4%	25.6%	75.5%	33.5%
Wages in Q 6	75.8%	33.9%	79.5%	62.2%	29.6%	23.5%	74.3%	32.2%
Wages in Q 7	74.6%	32.7%	78.7%	60.2%	27.5%	21.6%	73.2%	30.8%
Wages in Q 8	73.8%	32.2%	77.8%	54.6%	25.6%	20.6%	72.3%	30.1%

Source: Department of Labor and Workers' Compensation Board

Section VI of this Report "Interaction with Other Public Benefit Programs," shows that a major percentage of claimants who choose Section 32 settlements also received Social Security Disability benefits at some time following their accident, 67.8% of PPD non-scheduled Section 32 claimants, and 46.7% of TTD Section 32 claimants.

G.2. Relationship between income and RTW experience

G.2.a. All Indemnity Claimants—Income and RTW

Another question addressed in this Report is how income level impacts a worker's return to the workplace. The hypothesis was individuals with higher average weekly wages prior to an accident may have a higher RTW rate because their job may require less physical ability and there is a higher incentive to RTW because of a higher percentage of lost wages due to the maximum benefit cap. DOL did a preliminary analysis to determine which ranges of average weekly wage would produce a smooth distribution of claimants. The range levels were chosen to

ensure an equal distribution among four subsets: less than $400, $400 to $599, $600 to $849, and $850 and above.

The data supports the original hypothesis -- workers with higher wages have higher RTW experience. Workers with wages higher than $850 per week were about 15% more likely to RTW than workers with weekly wages less than $400 per week. When comparing workers with $850 or higher to workers with wages between $400 and $600 the gaps shrinks to about 9%.

Figure 69: Percent of Indemnity Claimants with Wages in the 2 Years Following Injury in 4 Income Ranges. (Accident dates 2000-2nd Quarter 2006)

Average Weekly Wage Range	Claimants with Wages in Accident Qtr	Percent Working in Quarters Following Accident Quarter							
		1st	2nd	3rd	4th	5th	6th	7th	8th
Total Claimants									
Less than $400	108,288	76.9%	71.9%	69.4%	67.3%	65.5%	64.3%	63.2%	62.4%
$400-$599	102,052	82.0%	77.5%	75.5%	73.7%	71.8%	70.8%	69.8%	68.8%
$600-$849	106,927	85.2%	82.2%	80.6%	79.1%	77.3%	76.0%	74.9%	74.0%
$850 or more	85,959	88.5%	86.2%	84.6%	83.1%	81.1%	79.7%	78.6%	77.5%
Unknown	8,329	72.7%	65.3%	61.6%	60.1%	57.3%	57.2%	55.9%	55.1%

Source: Workers' Compensation Board and Department of Labor

G.2.b. PPD scheduled , PPD non-scheduled, and TTD –Income and RTW

Is the pattern of lower income claimants having lower RTW experiences consistent for all categories of injuries, PPD scheduled and non-scheduled, and TTD? The answer is yes. The trend remains very consistent across all classifications. In fact, the percentage gap remains relatively consistent, approximately 15% between the highest and lowest wage categories and about 9% between the highest and the second lowest wage category.

Figure 70: Percent of PPD scheduled, PPD non-scheduled, and TTD private sector Claimants with wages in the 2 years following injury in four income ranges. (Accident dates 2000-2nd Quarter 2006)

PPD Sch									
Average Weekly Wage Range	Number of Claimants with Wages	Percent Working in Quarters Following Accident Quarter							
		1st	2nd	3rd	4th	5th	6th	7th	8th
Less than $400	19,673	74.70%	72.20%	71.50%	71.10%	69.90%	68.60%	67.90%	67.00%
$400-$599	25,292	81.50%	79.90%	79.70%	79.40%	78.30%	77.50%	76.80%	75.90%
$600-$849	36,074	86.30%	85.10%	84.70%	84.10%	82.80%	81.80%	80.70%	79.90%
$850 or more	27,878	90.30%	89.50%	89.40%	88.40%	86.90%	85.90%	85.20%	84.00%
Uknown	1,727	93.20%	87.10%	83.50%	84.30%	80.50%	78.20%	76.90%	77.50%

PPS NSL									
Average Weekly Wage Range	Claimants with Wages in Accident Qtr	Percent Working in Quarters Following Accident Quarter							
		1st	2nd	3rd	4th	5th	6th	7th	8th
Less than $400	5,990	51.80%	36.90%	29.80%	25.00%	21.50%	19.30%	17.90%	17.20%
$400-$599	6,753	60.50%	44.70%	37.50%	32.20%	28.10%	25.70%	24.30%	22.10%
$600-$849	6,670	62.90%	49.50%	42.50%	37.60%	33.40%	30.40%	27.90%	26.90%
$850 or more	6,492	70.90%	59.80%	52.30%	45.60%	39.80%	36.80%	33.90%	30.90%
Unknown	255	72.90%	61.20%	57.60%	55.30%	53.30%	49.80%	46.70%	43.10%

Temp Total									
Average Weekly Wage Range	Claimants with Wages in Accident Qtr	Percent Working in Quarters Following Accident Quarter							
		1st	2nd	3rd	4th	5th	6th	7th	8th
Less than $400	82,625	79.20%	74.40%	71.80%	69.50%	67.70%	66.60%	65.40%	64.60%
$400-$599	70,007	84.30%	79.80%	77.60%	75.70%	73.70%	72.80%	71.60%	70.80%
$600-$849	64,183	86.90%	83.90%	82.30%	80.60%	78.70%	77.50%	76.50%	75.60%
$850 or more	51,589	89.80%	87.80%	86.10%	85.00%	83.20%	81.80%	80.60%	79.80%
Unknown	6,347	67.10%	59.50%	55.80%	53.70%	51.20%	51.80%	50.50%	49.50%

Source: Workers' Compensation Board and Department of Labor

G.2.c. Section 32 –Income and RTW

The final question on this issue: how are Section 32 claimants impacted? Again the answer is that the same pattern is seen for Section 32 claimants, higher wage workers having a higher, sustained level of RTW.

G.2.d. RTW and Industry

The prior measures clearly show PPD non-scheduled have the lowest rate of sustained RTW experience. This measure examines whether there is a compounding impact for certain industries. Does a worker with a PPD non-scheduled claim have a better or worse experience based on their industry? The answer is PPD non-scheduled claimants in certain industries have a lower RTW rate than other PPD non-scheduled claimants. The following figure lists PPD non-scheduled claims by industry, starting with the industry that had the lowest RTW rate in the 8th quarter following injury. Among the seven industry groups with the lowest RTW rates are five of the industries that also have a high frequency of injury. The frequency of injury is discussed in the following Section H entitled "Improvements to Workplace Safety". These five high injury industries are highlighted in yellow.

Figure 71: Percent of Indemnity Claimants with Wages in the 2 Years Following Injury by Industry (Accident dates 2000 to -2nd Quarter 2006) Sorted by 8th Quarter

PPD non-scheduled									
Case Type and Industry	Claimants with Wages in Accident Qtr	Percent Working in Quarters Following Accident Quarter							
		1st	2nd	3rd	4th	5th	6th	7th	8th
Construction	2,971	44.2%	30.9%	26.1%	23.1%	20.9%	18.8%	18.3%	17.3%
Mining	50	66.0%	48.0%	36.0%	40.0%	30.0%	34.0%	26.0%	18.0%
Real Estate and Rental and Leasing	933	57.2%	39.2%	30.9%	26.8%	23.7%	21.0%	18.9%	18.5%
Administrative and Waste Services	2,013	49.6%	32.6%	28.4%	24.4%	22.9%	20.7%	20.6%	19.3%
Agriculture, Forestry, Fishing & Hunting	111	49.5%	36.0%	33.3%	27.9%	26.1%	22.5%	21.6%	21.6%
Unclassified	73	50.7%	30.1%	27.4%	24.7%	19.2%	19.2%	24.7%	21.9%
Accommodation and Food Services	1,346	60.0%	43.5%	35.7%	31.1%	26.7%	24.8%	23.0%	22.3%
Health Care and Social Assistance	5,222	65.5%	47.8%	39.5%	33.7%	29.2%	26.4%	24.2%	22.9%
Transportation and Warehousing	2,087	65.9%	55.7%	48.4%	41.6%	33.3%	30.0%	26.9%	23.6%
Wholesale Trade	1,507	59.7%	47.8%	41.0%	34.8%	32.1%	29.0%	27.1%	24.6%
Retail Trade	3,402	59.9%	47.1%	40.7%	35.9%	31.4%	29.3%	27.4%	26.0%
Other Services	893	65.4%	50.7%	43.9%	38.0%	35.9%	32.1%	30.5%	28.7%
Finance and Insurance	605	81.2%	68.3%	55.5%	46.0%	38.3%	38.3%	32.9%	30.2%
Educational Services	415	74.2%	60.2%	50.1%	44.1%	36.9%	35.4%	33.5%	30.6%
Manufacturing	4,591	70.6%	59.8%	51.5%	45.5%	40.7%	37.4%	34.1%	31.6%
Arts, Entertainment, and Recreation	293	66.6%	49.8%	45.7%	39.6%	37.2%	35.8%	34.8%	32.8%
Professional and Technical Services	563	69.6%	53.3%	48.5%	43.0%	40.3%	36.9%	36.6%	34.8%
Government	7,467	82.4%	69.9%	62.7%	60.1%	54.7%	44.2%	40.0%	36.0%
Management of Companies and Enterprises	51	80.4%	76.5%	60.8%	54.9%	51.0%	41.2%	43.1%	41.2%
Information	481	80.7%	70.5%	62.4%	54.3%	50.3%	46.2%	44.1%	42.8%
Utilities	259	84.9%	81.5%	78.0%	71.4%	62.9%	58.7%	53.7%	48.3%

Source: Workers' Compensation Board and DOL (Industries Highlighted in Yellow have high injury rates)

G.2.e. RTW summary

The 2008 Data Report identified PPD non-scheduled and TTD claimants who accept Section 32 settlements as needing the most support to return to work successfully, and this Report confirms that. However, given the relatively long time periods it takes either to reach a Section 32 settlement or PPD non-scheduled classification, waiting for these events before providing RTW support may not be effective because the worker has been out of the workforce for too long. All of the research in this area says the longer the person is out of work the harder it is to return to the workforce.

This Report identifies several other factors that also contribute to poor RTW experience that are known at the beginning of the process; low pre-injury wages and the type of industry. If these factors can be combined with other claim characteristics, e.g., types of injuries that are most likely to end up as PPD non-scheduled, it may be possible to create a screening process for stronger RTW intervention earlier in the process.

H. Improvements to Workplace Safety

H.1. Indemnity claims per 100 workers

Based on data from 1999 to 2005, the 2008 Data Report showed the average claims per 100 workers for all industries was 1.09. This year the data set has been updated to cover the period from 2000 to the first 2 quarters of 2006. Based on this data set, the average has decreased to 1.05 for all industries. The two industries with the highest number of claims per 100 workers remained the same, "Transportation and Warehousing," followed by "Manufacturing". However, the ratio for both industries has declined. "Transportation and Warehousing" dropped from 2.6 to 2.45 and "Manufacturing" declined from 2.03 to 1.96. There were similar declines in most other industries. This decline is consistent with the falling number of indemnity claims. [54]

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[54] The employment data in the following figure is based on statewide employment; it is not adjusted to exclude workers who are not covered by the Workers' Compensation Law. It is estimated that approximately 2.5 million of New York's workers are not covered by the Workers' Compensation system. Additionally, workforce data by industry on approximately 5.5 million covered workers is unavailable.

Figure 72: Claims per 100 Workers by Industry (Claims from 2000 to 2nd Quarter of 2006)

Industry Title	Average Employment	Total Avg annual Ind. Claims	Ind. Claims per 100 workers
Transportation and Warehousing	228,801	5,604	2.45
Manufacturing	551,860	10,836	1.96
Utilities	38,520	680	1.76
Mining	5,435	94	1.73
Construction	352,062	5,880	1.67
Agriculture, Forestry, Fishing & Hunting	21,871	346	1.58
Total, All Government	1,431,603	20,899	1.46
Wholesale Trade	355,566	3,924	1.10
Administrative and Waste Services	435,169	4,786	1.10
Retail Trade	892,973	9,241	1.03
Health Care and Social Assistance	1,213,311	11,801	0.97
Real Estate and Rental and Leasing	185,171	1,760	0.95
Arts, Entertainment, and Recreation	136,974	1,102	0.80
Accommodation and Food Services	562,605	4,061	0.72
Other Services	323,433	2,177	0.67
Information	263,568	1,719	0.65
Unclassified	28,800	174	0.61
Educational Services	278,836	1,237	0.44
Professional and Technical Services	572,956	1,646	0.29
Finance and Insurance	544,076	1,346	0.25
Management of Companies and Enterprises	128,023	150	0.12
Total, All Industries	**8,551,613**	**89,464**	**1.05**
Total, All Private	**7,120,010**	**68,565**	**0.96**

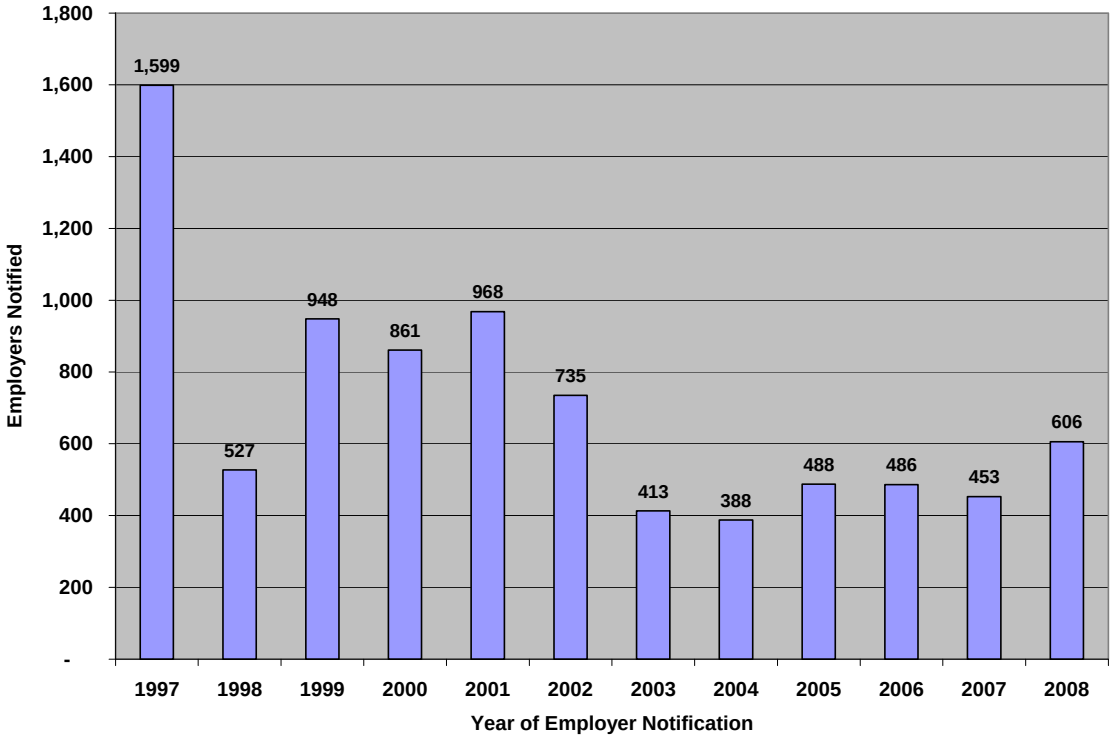
Source: Claims from Workers' Compensation Board and Employment from Department of Labor

H.2. Employers in the Mandatory Safety Program

The mandatory safety program was in statute prior to the Reform Act. CIRB notifies each employer whose annual payroll is in excess of $800,000 and has an experience modification factor of greater that 1.20 that it must undergo a mandatory safety consultation. CIRB likewise notifies DOL which employers have been sent letters. An employer who receives such a notification must have a workplace safety and loss prevention consultation and written evaluation. The employer must arrange this consultation and evaluation within thirty days of receiving the notification and within ten days thereafter notify its insurer and DOL in writing of how the evaluation will be done. Within 30 days after receiving the report from the safety and loss consultant, the employer must forward a copy to its insurer and DOL and within six months the employer must implement any recommendations made by the consultants. The insurer must conduct an inspection within 60 days after the expiration of the six months to determine whether the employer implemented the recommendations. The insurer must provide a copy of the inspection report to the employer and DOL within 45 days after the inspection. By statutue, if an employer fails to arrange for the consultation and evaluation within the prescribed time, the insurer must surcharge the employer's premium by 5% for the next policy period and there shall be an additional 5% surcharge for each year the employer does not comply. Premium credits are not granted for compliance with this program.

The following figure shows the number of notification letters that have been sent out by CIRB over the past 12 years.

Figure 73: Number of Mandatory Safety Notification Letters Sent to Employers



Source: CIRB

After three years of a declining number of new employers receiving letters, there was a major increase in the number of safety letters sent out in 2008. The number of letters rose from 453 to 606.

Employers are reviewed by CIRB on a six year cycle. This allows time for the employers to take steps to improve their safety programs and time for the results of those improvements to be reflected in the claims experience for the employer. The reason for the significant growth in the number of employers receiving notification letters for high experience ratings is unknown.

A much wider spectrum of employers may be reached with the implementation of the new voluntary safety program provided by the Reform Act. DOL and NYSID have recently completed drafting regulations for the voluntary safety program for employers. Employers can earn premium credits for compliance with this voluntary program.

I. Fraud

There are several potential areas of fraud -- employers, healthcare providers and claimants. Examples of employer fraud include (1) the falsification of documents to reflect that workers' compensation coverage is in place when it is, in fact, not in place; (2) the under-reporting of employer payrolls to avoid higher premiums; (3) the misclassification of workers (i.e. falsely labeling a high premium construction worker as a clerical worker) to fraudulently reduce the premiums owed: and (4) the use of forged documents and certificates as proof of coverage.

Healthcare provider fraud includes billing for services not rendered, double billing for the same service, upcoding to reflect a service that is more expensive than the service actually provided, unbundling to charge for an expensive service while, at the same time, charging separately for the underlying components of the more expensive service and billing for pharmaceuticals or durable medical equipment that are not provided or are medically unnecessary.

Claimant fraud refers to those cases in which a claimant is receiving benefits for loss of income while concealing from the workers' compensation system the fact that he is employed elsewhere

Two state agencies are responsible for workers' compensation fraud investigations in New York State: NYSID and WCB's Office of Fraud Inspector General (OFIG). Both conduct investigations into fraud in the system. NYSID has mandatory reporting and therefore receive data and filings from carriers with over 3,000 policies. NYSID has the broader mandate of investigating all suspicious and fraudulent activities as they relate to insurance, while the OFIG has a concurrent mandate to investigate only those activities that relate to worker's compensation fraud. Unlike NYSID, OFIG also has authority to oversee the self-insured trusts composed of public and private employers.

At this time, both NYSID and OFIG 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 OFIG 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.

Since the passage of the Reform Act, there has been increased interagency cooperation and data sharing, between OFIG and the other agencies, including the Joint Enforcement Task Force on Employee Misclassification. This has resulted in decreased duplication of services, and an increase of productivity in fraud prevention

I.1. Cases investigated, prosecuted, closed and the financial impact of fraud detection for the OFIG

There are two sets of case metrics utilized by OFIG, those cases they pursue with internal staff and those cases generated by their collaborative work with the Joint Enforcement Task Force on Employee Misclassification that are referred to as "sweep case statistics".

In 2008 the OFIG worked on the following numbers of cases:

- 1,534 cases were identified for investigation;
- 2,865 cases were closed; (these include cases opened in prior years);
- 750 cases were referred for investigations for non workers' compensation related issues;
- 137 cases were referred for prosecution;
- 2,235 are pending cases.

In 2008 the OFIG, working with the Joint Enforcement Task Force on Employee Misclassification worked on the following numbers of cases:

- 49 cases were reviewed;
- 44 cases were investigated;
- 21 cases were closed;
- 7 cases were referred;
- 23 cases are pending.

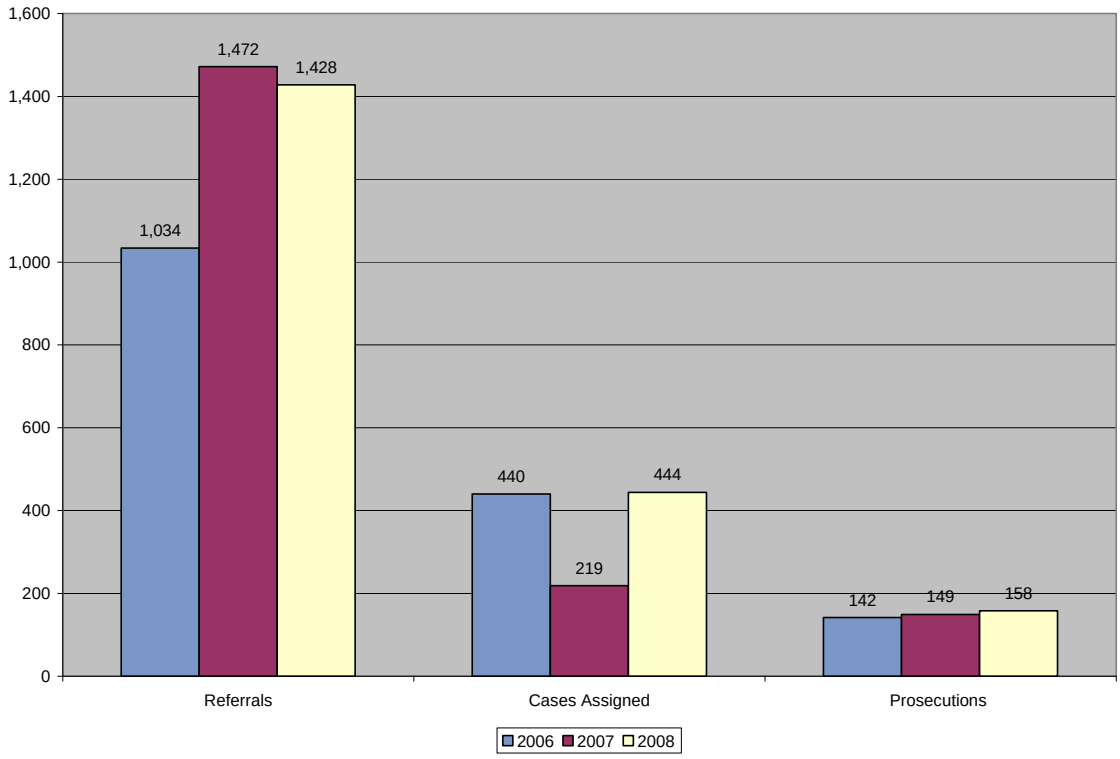
In 2008, the OFIG:

- Detected $3,591,074 in fraudulent actively;
- Prevented $4,644,123 in fraud, i.e. funds the insurance carriers had set aside to pay claimants that they no longer need to set aside because of the discovery of the fraud;
- Returned $1,212,354 to victim in restitution;
- Imposed $321,207 in fines.

I.2. **Fraud** Referrals, cases assigned and prosecutions for NYSID

In 2008, NYSID prosecuted 150 cases of fraud within the workers' compensation system.

Figure 74: NYSID Fraud referrals, Cases Assigned and Prosecutions



V. Delays in First Indemnity Payments –

The 2008 Data Report clearly showed that New York State was slower in making the first indemnity payments to injured workers than all of the 14 states WCRI studied. In 2005/2006, only 23.4% of NYS first indemnity payments were made within 21 days of the injury. In comparison, the median for the 14 WCRI states was 41.5% and the fastest state, Massachusetts paid 53.4% of its claimants within 21 days. The 2008 Report recommended " … 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." This section analyses this issue.

A. Legislative Requirements

An initial question is how the law of New York State compares with that of other states. The following chart compares key provisions of the laws in four other states as they generally apply. Massachusetts was chosen because it had the largest percentage of claimants receiving benefits within 21 days (53%). Florida and Texas were chosen because they are large states in the top five for benefit delivery within 21 days. Finally, Michigan was chosen, because like NYS, a high percentage of its workers are unionized. The importance of this factor is discussed below.

Figure 75: Legislative Requirement for NY and 4 States relating to First Indemnity Payment

	New York	Florida	Massachusetts	Michigan	Texas
First indemnity payment within 21 days[55]	29%	45%	53%	37%	48%
Legislative Requirements[56]					
Length of time out of work before indemnity payments	7 days	7 days	5 days	7 days	7 days
Employee notice to employer	In writing within 30 days	Within 30 days of injury or employee's knowledge of illness	In writing as soon as practicable	Within 90 days after injury	Within 30 days
Claim filing	Within two years of accident or illness	Within 2 after injury or death	Within 4 years after injury	Within 2 years	Within first year after injury
Employer's report of injury	Within 10 days of injury	Death within 24 hours, all others within 7 days of injury	Within 7 days of injury excluding Sundays and holidays	Immediately	Within 8 days of injury

[55] WCRI reports " Compscope Benchmarks 7th edition" and "Baseline for Evaluating the Impact of the 2007 reforms in New York " data from 2004/2005 with 12 months development.
[56] "Analysis of worker's compensation laws" 2008 US Chamber of Commerce and WCRI report: " A comparison of system features 14 states, 2007"

	New York	Florida	Massachusetts	Michigan	Texas
Payment or denial to be made within	For accepted claims, within 18 days of disability or 10 days after knowledge whichever is longer . [57]	Within 14 days of notice of disability from employer	Within 14 days of notice of disability from employer	Within 14 days of notice of disability from employer	Within 15 days of written notice of disability from employer
First payment of indemnity	Within 18 days of the insurer receiving notice from the employer (C-2) insurer begins payment (sec 25)	Due within 14 days of employer knowledge or notice of injury	Due within 14 days of insurer receipt of first report of injury	Due within 14 days of employer or insurer notice of injury	Due within 15 days of employer knowledge or within 7 days of insurer knowledge
Penalties for not making payment timely	Penalty payable to the worker of $300 may be imposed by Judge for late payment. If the payment is more than 25 days later, the penalty increases to 20% of compensation due.	Penalty of $50 per each payment that is below a 95% timeliness standard, increasing to $100 for payments below a 90% standard	$200 to worker if claim in not paid or denied within 14 days; $1,000 after 45 days, $2,500 after 60 days, $10,000 after 90 days	Additional $50 per day penalty if uncontested benefits are unpaid after 30 days, up to a maximum of $1,500	Penalty ranage up to $5,000 depending on the circumstances.
Payors may Pay without assumption of acceptance of the claim	Up to one year	For 120 days	For 180 days can be extended by judge	No limit, payment does not imply acceptance of claim	For 60 days

After examining these four states and looking at data on other states, most of the states have similar timeframes for waiting periods five to seven days. Time periods for employer notice to insurer range from immediately to 30 days but the majority of states have a seven to 10 day period.

One area where New York State differs is the time period for accepting or denying a claim and making the first indemnity payment. New York's statute has two related requirements. Section 25-(2)(a) of the Workers' Compensation Law requires that payment for accepted claims must be made within 18 days of disability or 10 days after the employer has

[57] In New York State a claim dispute must be filed by a payor within the same time periods as acceptance or within 25 days of notice of indexing of the claim by the WCB.

knowledge, whichever is greater. This is consistent with timeframes in other states. A claim denial must be filed within the same time periods **or** within 25 days of notice of indexing by the WCB according to Section 25-(2)(b) of the law. If an insurer waits for notice of indexing from the WCB, they have up to 25 days to decide to pay or deny the claim. This portion of the statute provides much more time than other states. It is unclear how much of an impact these dual provisions have on the timing for first indemnity payments, but it is probably a contributing factor.

B. Responsibility for Medical Reports

WCRI issued a flashreport in March of 2008 entitled, "Timeliness of Injury Reporting and First Indemnity Payment in New York: A Comparison with 14 States". [58] The Report identified several features of New York State's system that may contribute to longer time to first indemnity payments. One factor was the dual provisions discussed above.

The second issue raised in the WCRI report was who is responsible for ensuring the carrier has medical evidence relating to the injury. In other states, it is the insurer's responsibility to gather the medical data from the provider. In New York State, the burden shifts to the claimant. Lack of a medical report is an acceptable reason not to begin indemnity payments in New York State. Placing the burden of proof on the claimant has been a part of case law as far back as 1920. Without this evidence, the claimant may not receive any benefits. Therefore, without medical evidence that the claimant has suffered an injury or illness due to a work-related accident or exposure which results in disability, the insurance carrier is not obligated to begin payments.

In most other states, according to WCRI, the insurer must make payments within the set timeframe. It is the responsibility of the insurer to contact the providers and gather the necessary medical records. Lack of these records does not constitute an acceptable reason to delay payments.

C. Data from Lump Sum Payments Impact on the Benchmark

A factor which was not addressed in the WCRI Flashreport, but which may have an impact on New York State's statistics on first indemnity payment is the level of unionization in the state.[59] Some union contracts in New York State, such as the New York State Corrections Officers' contract, require the employer to continue paying the claimants their normal salary. In addition, Section 207-a and 207-c of the General Municipal Law requires local governments to continue to pay local police and firefighters their salary. The employer subsequently receives periodic lump sum payments from its insurer to reimburse it for the indemnity benefits which would have been paid to the claimant. According to WCRI, its

[58] The Flashreport looked at data for claims filed between October 2003 and September 2004 with development through March 2005. This WCRI data included 89% of private insurers and 35% of the private self-insured companies, but did not have any State Insurance Fund data.

[59] According to a 2008 study by Barry Hirsch and David A Macpherson using the Current Population Survey data, New York State has the highest percentage of employees covered by unions at 26% compared to Michigan with 20% and Massachusetts with 14%.

data analysis records the date of these lump sum payments as the date when the first indemnity payment is made, even through the injured worker has been continuing to receive his or her salary from the date of injury throughout the period of disability. Not all unions have this type of benefit, but it may be having an effect on New York State's statistics.

D. Conclusion – Delays in First Indemnity Payments

There is no simple and quick solution to the issue of delays in first indemnity payments. All of the factors have been either a long standing part of the New York State Workers' Compensation statute and case law or, in the case of collective bargaining agreements, outside of the system. WCB also will be improving its own data system so that the date of first indemnity payment can be tracked directly by WCB. This is not possible with existing data.

VI. Interaction with other Public Benefit Programs –

The return to work data reveals there are several sets of injured workers who have low rates of sustained return to work. These are injured workers with PPD non-scheduled claims and workers with temporary total disability claims who accept Section 32 settlements. This raises the question of what happens to these workers. How many of them receive social security disability, social security retirement or public assistance?[60]

The Department of Labor requested the U.S. Social Security Administration to match workers compensation claim data from the WCB for claims from 2000 to 2006 to see how many used federal programs. The following figure shows the total number of these claimants who received Social Security Disability (Disability Trust Fund) at any point in time after their injury. These claimants are divided between those who are continuing to receive payments (in payment status) and those who are no longer receiving payments (Terminated/Suspended)[61] The next line in the figure shows the percentage of claimants who are receiving social security retirement benefits.

A large percentage of both PPD non-scheduled and TTD with Section 32 settlements received Social Security Disability at some point following their injury. Sixty eight percent of PPD non-scheduled claimants and 46.7% of TTD's with Section 32s participated in Social Security Disability. What the data does not show is how long they participated.

[60] In addition to public benefit programs, some workers also have access to private supplementary benefit programs. New York State does not have access to information on the use of these programs.

[61] Suspension /Termination: Workers can be suspended and then terminated from SS Disability Insurance when the following occur : (1) the worker benefited from vocational training or advances in medical treatment or vocational technology and because of these can work; or (2) the worker is not following the treatment there doctor ordered (without a good reason), and the worker probably could work if you followed the treatment; or (3) the worker gave false or misleading information when SSA made an earlier decision; or (4) the worker is not cooperating with SSA does not have a good reason for not cooperating; or (5) the worker has returned to work and has average monthly earnings that exceed the program limits.

Figure 76 : Indemnity Claims 2000 to 2006 Matched to Social Security Program

	PPD Scheduled				PPD Non Scheduled				Permanent Total Disability		Temporary Total Disability -- Section 32	
	claims	% of total	Sec 32	% of total	claims	% of total	Sec 32 claims	% of total	Claims	% of total	Claims	% of total
Social Security Disability	**26,674**	**16.3%**	**312**	**34.9%**	**24,091**	**67.8%**	**3,791**	**62.8%**	**641**	**77.0%**	**9,691**	46.7%
In payment status	12,007	7.3%	164	18.4%	17,637	49.6%	1,980	32.8%	530	63.7%	4,462	21.5%
Terminated/ suspended	14,667	9.0%	148	16.6%	6,454	18.2%	1,811	30.0%	111	13.3%	5,229	25.2%
Social Security Retirement	**32,060**	**19.6%**	**87**	**9.7%**	**5,424**	**15.3%**	**672**	**11.1%**	**130**	**15.6%**	**2,989**	**14.4%**
No record	104,322	63.7%	493	55.2%	5,919	16.7%	1,532	25.4%	57	6.9%	7,930	38.2%
Bad SSN	694	0.4%	1	0.1%	109	0.3%	37	0.6%	4	0.5%	145	0.7%
Total Claims	**163,750**		**893**		**35,543**		**6,032**		**832**		**20,755**	

Source: Workers' Compensation Board claim data and Social Security administration

To examine the interaction with Public Assistance, the WCB, NYSID and DOL met with the Office of Temporary Disability Services (OTDA) and developed an approach to match the WCB claim data --- Temporary Assistance and Food Stamp data bases. The first step in the analysis was to look at participation at a set point in time, December 2008 for claims from 2003 to 2005. The results of the preliminary analysis by OTDA showed a low match rate. The match rate for public assistance for PPD scheduled and non-scheduled and Section 32 claims ranged from 0.6% to 1.9%. The rate for Food Stamps was slightly higher ranging from a low of 4% for the PPD scheduled to a high of 13% for the Section 32 claims.[62]

VII. Implementing Long Term Recommendations from the 2008 Data Report.

Section V of the 2008 Data Report identified several long term recommendations that address deficiencies in the existing data. To address the data gaps, the 2008 Report recommended that the following data be collected:

- Electronic detailed medical data from providers; and
- Financial claim level data from the private and public self-insured employers.

In addition, the 2008 Data Report recommended that the existing and additional data be stored in a new data warehouse which would facilitate access to the data for policy and research purposes.

[62] Preliminary examination of participation over time did not show any major increase in the rate of participation in temporary assistance or food stamps.

There are a range of options for continuing to improve the availability of data in the workers' compensation system in New York. The preferred side of the range is to move toward implementation of the recommendations in the 2008 Data Report. This preferred option, however, requires additional resources and legislative action. This Section of the Report will focus on the preferred option. The less preferred option is to continue to make modest improvements within existing resource levels and existing statutes.

A. Medical Data

The need for additional detailed medical information remains strong. Average medical costs for workers' compensation claims are growing and medical costs are growing as a percentage of total indemnity plus medical costs. However, due to the lack of detailed medical information, it is difficult to isolate the medical cost drivers. Collecting detailed medical information from payors will help solve this problem. In addition, it will allow New York State to evaluate the impact of the revised medical treatment guidelines, and provide data for future refinements of those guidelines.

The 2008 Report examined several options for collecting detailed medical information and recommended an electronic data interface (EDI) system to support the electronic transmission, collection and storage of medical payment data using a national standard. The two national standards for workers' compensation medical information are IAIABC or NCCI .

The WCB agrees with this recommendation and initially concluded that implementing an EDI system using the IAIABC standard was best for New York. This conclusion was based in part upon the use of the IAIABC standard in Texas and California and its ongoing implemented in Florida and Oregon. Compared to the NCCI standard, the IAIABC standard provides more information and is more flexible. Further, the NCCI standard is an adaptation of the IAIABC standard.

However, on January 16, 2009, the U.S. Department of Health and Human Services (DHHS) issued a final rule that adopts updated versions of the standards for electronic medical transactions under the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). In other words, DHHS has mandated the standards for electronically exchanging medical information change. Based on the mandated change in standards, the IAIABC standard must accordingly change. The IAIABC has begun the process.

Due to these developments the WCB is reviewing the situation to determine the best course of action, including whether the NCCI standards will require any change.

As noted in the 2008 Data Report, this medical information project is a major undertaking requiring planning, management, staffing, funding and will take several years to complete in several phases. The WCB has begun preliminary analysis of such a project. Among other things, the WCB must determine the hardware necessary to collect and store the information. It is important that the information be stored in a manner that easily allows for

research and study. The WCB must also develop a time line that provides sufficient time for payors and the WCB to prepare to send and receive the data

In the interim period, beginning in the third quarter of 2010, additional medical data will be available from CIRB. On November 6, 2008, CIRB announced that it had received authorization from its Board of Governors to begin collecting detailed medical data from the carriers. CIRB and its Board of Governors have chosen to use the NCCI standards for the collection of medical data. CIRB has notified its members -- all private carriers authorized to write workers' compensation coverage in New York, to be prepared to begin reporting the required data for medical transactions that occur in the third quarter of 2010. These transactions should then be reported by the end of the following quarter. This data will then become available for analysis and review in order to assist development of government policies.

B. Data Warehouse

In order to facilitate data storage and to ease access for research, the 2008 Data Report recommended the development of a data warehouse to be the centralized repository of information either extracted or transmitted from the existing systems and sources. The information in the data warehouse will be stored in such a manner to facilitate reporting, query and research functionality.

In order to create and maintain a data warehouse, the WCB needs sufficient financial resources. These projects require purchasing equipment, application development and hiring staff. In addition, the 2008 Data Report recommended hiring consultants with experience to assist in the planning and implementation of these projects. While at this time the WCB does not have sufficient funds in its budget to devote to these projects, Governor David A. Paterson's 2009-2010 Budget Proposal includes up to a $20 million increase in Board funding via a Surplus recapture. If provided, some of these funds will go towards creating and maintaining a data warehouse.

Until there is a fully functioning data warehouse, the WCB will continue to make as much progress as possible within existing resources.

C. Data from Self-Insured Employers

Another data deficiency noted in the 2008 Data Report is the lack of certain claim information from the private and public self-insured employers. The other two market sectors, SIF and the private carriers, supply CIRB with financial data on each claim in the unit statistical data report. This data is used to establish experience modification factors for employers, and to support the overall rate setting process. Self-insured entities use a cost plus system, and therefore do not use the experience ratings established by CIRB. Therefore they do not submit any claims information to CIRB.

Throughout the overview and benchmark sections of this Report, CIRB data has been used to support the monitoring of performance of the New York State's workers' compensation

system. Now that this is an additional use of the CIRB data, there is a need to collect the same financial claim specific data from the self-insured entities. Without this information, the WCB and others compiling system data must make estimates concerning this sector. Reliance on estimates makes it more difficult and obviously less precise for analysis, reporting and research purposes.

Section V of the 2008 Data Report ended by noting that neither the WCB nor NYSID have authority to obtain all workers' compensation data from self-insured employers which creates a data gap. Based on further research, the WCB believes it can require all entities to submit claim information to it, and to require it be submitted in electronic format. WCL §124 authorizes the Chair of the WCB to prescribe the form and format for the collection of information and data for the administration of the WCL. This Section of the law specifically provides that the Chair may require the submission of such information in an electronic form. The law, does not however, provide for any enforcement mechanism for the WCB when there is non-compliance. It would enhance the process to have specific authority to collect this data that includes enforcement mechanisms for entities that fail to comply. The WCB is drafting the necessary legislation and will be implementing new regulations and processes to collect additional claim specific data from self-insured entities.

Appendix One – Glossary

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	The minimal conditions that must be met before a claim can be established by WCB or accepted by the carrier. Specifically, it must be 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.
Assembled Claim	A claim which has had a file created and been assigned a case number by the WCB.
Compensation Insurance Rating Board	A private unincorporated association of

("CIRB")	insurance carriers responsible for the collection of workers' compensation data and the development of workers' compensation loss costs and rules regarding the proper application of 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 WCB sets a pre-hearing conference for the determination of the grounds and directs the parties to appear and present their case.
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	A claim for benefits submitted by the beneficiaries such as the spouse or minor children of a worker who dies as a result of a work-related accident.
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.
IBNR	Incurred But Not Reported are actuarial estimates of costs for claims that have not been reported yet to the payor, but based on past trends are expected to be reported for the given policy or accident year. For the most recent year, IBNR is a much higher percentage of total estimated losses than it is for claims that have several years of development.
IME	An Independent Medical Examination is an examination performed by an authorized or qualified independent medical examiner, pursuant to Sections 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	Physicians, podiatrists, chiropractors or psychologists who are authorized based on eligibility requirements or are found to be

	qualified by a WCB judge 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	Wage loss benefits paid for work-related injuries.
Indexed Claim	A claim case folder which has been assembled, the carrier has not accepted or denied and the WCB has sent a Notice of Indexing directing the carrier to accept or deny the claim.
Large Deductible	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.
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 where the WCB is not aware of any medical or indemnity benefits being recieved.
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")	PPD's are split into two categories, Scheduled and Non-scheduled disabilities.
Permanent Partial Disability Non-scheduled ("PPD NSL")	If an injured worker has reached maximum medical improvement 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. Prior to the Reform, workers with accident or disablement dates prior to March 13, 2007 that were classified as PPD NSL were entitled to benefits as long as the disability continued. For injuries due to accidents or disablement occurring, on or after March 13, 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 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.
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.
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, the Workers' Compensation Reform Act was signed into law. Highlights of the new law include raising the maximum weekly indemnity benefits payable to injured workers, and capping 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.

Rocket 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 proposed regulations to the WCB on June 1, 2007. The WCB with some modification adopted the regulations in 2008. In this Report these are referred to as the "Rocket Docket." 12NYCRR§300.38
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 fund created by Workers' Compensation Law 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.
Total Industrial Disability ("TID")	Total Industrial Disability is when the worker has reached maximum medical improvement and they have a disability that limits their ability to work. If the impairment combined with other factors such as limited educational

	background and work history renders the worker 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")	TPD claims are 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.
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 including the disability benefits provisions, the Volunteer Ambulance Workers' Benefit Law and the Volunteer Firefighters' Benefit 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 Two – Data Limitations

(Pages 21 to 23 from the 2008 Data Report)

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[63] 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. This Report l often uses 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, it is possible to 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.

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

[63] 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.

limitation is that CIRB data does not separate out PPD SL and non-scheduled claims. Instead, CIRB splits PPD into major and minor categories.64 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
Electronic Submission	All data		Proof of coverage data electronic	Mostly submitted in hard copy and then scanned with major data points

[64] 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		WCB	
	Strength	Weakness	Strength	Weakness
				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

Appendix Three Data from WCB Annual Report

Appendix Three

WCB Annual Report--2007-2008

Table of Contents

World Trade Center Cases
As of May 1, 2008

Index Date by Injured Worker Classification

(Number of cases)

Index Date	All Claims	Victims	Rescue, Recovery, Cleanup	Other and Unclassifiable
Prior to 9/11/02	6,059	5,187	716	154
9/11/02 to 9/11/03	1,007	401	542	63
9/11/03 to 9/11/04	2,226	560	1,549	114
9/11/04 to 9/11/05	288	90	185	13
9/11/05 to 9/11/06	397	91	286	19
9/11/06 to 9/11/07	853	136	697	20
9/11/07 to 5/01/08	394	53	322	17
Total	11,224	6,518	4,297	400

Including the 879 alternative dispute resolution and 131 volunteer claims yields a total of 12,234 World Trade Center cases.

World Trade Center Cases as of May 1, 2008
Nature of Injury by Injured Worker Classification

(Number of cases)

Nature of Injury	All Claims	Victims	Rescue, Recovery, Cleanup	Other and Unclassifiable
Respiratory system diseases	5,337	1,352	3,782	201
Nonclassifiable	2,446	2,285	135	25
Mental disorders or syndromes	2,385	2,192	97	96
Traumatic injuries to bones, nerves, spinal cord	263	172	69	22
Traumatic injuries to muscles, tendons, ligaments, joints, etc.	261	170	71	19
Multiple traumatic injuries and disorders	121	99	17	5
Surface wounds and bruises	94	70	18	5
Other traumatic injuries and disorders	93	61	25	7
Open wounds	48	27	16	3
Nervous system and sense organs diseases	32	10	17	4
Burns	28	21	7	0
Traumatic injuries and disorders, unspecified	25	17	6	2
Circulatory system diseases	18	6	9	2
Intracranial injuries	16	13	1	2
Malignant neoplasms and tumors (cancers, carcinomas, sarcomas)	13	2	10	1
Multiple diseases, conditions, and disorders	10	8	1	1
Digestive system diseases and disorders	8	3	4	1
Other	26	10	12	4
Total	11,224	6,518	4,297	400

Including the 879 alternative dispute resolution and 131 volunteer claims yields a total of 12,234 World Trade Center cases

.

Source: NYS Workers' Compensation Board
Office of MIS/Research

World Trade Center Cases as of May 1, 2008
Case Type by Injured Worker Classification

Case Type	All Claims		Victims		Rescue, Recovery, Cleanup		Other and Unclassifiable	
	Cases	Percent	Cases	Percent	Cases	Percent	Cases	Percent
Claims Not Accepted	5,698	51%	2,259	35%	3,133	73%	301	75%
Pending Claims	525	4.7%	57	0.9%	448	10.4%	18	4.5%
NFA'd - Denied	607	5.4%	241	3.7%	332	7.7%	32	8.0%
NFA'd - Not Pursued	4,566	40.7%	1,961	30.1%	2,353	54.8%	251	62.8%
Accepted Claims	5,526	49%	4,259	65%	1,164	27%	99	25%
Medical Only	1,322	11.8%	644	9.9%	649	15.1%	27	6.8%
Temporary Disability	1,423	12.7%	1,045	16.0%	321	7.5%	56	14.0%
PPD Schedule Loss	221	2.0%	159	2.4%	55	1.3%	6	1.5%
PPD Non-Schedule	473	4.2%	331	5.1%	132	3.1%	10	2.5%
Permanent Total Disability	31	0.3%	25	0.4%	6	0.1%	0	0.0%
Death	2,056	18.3%	2,055	31.5%	1	0.0%	0	0.0%
Total	11,224	100%	6,518	100%	4,297	100%	400	100%

Accepted claims are claims for which ANCR has been established.
Percents may not add to totals due to rounding.
Including the 879 alternative dispute resolution and 131 volunteer claims yields a total of 12,234 World Trade Center cases.

Source: NYS Workers' Compensation Board
Office of MIS/Research

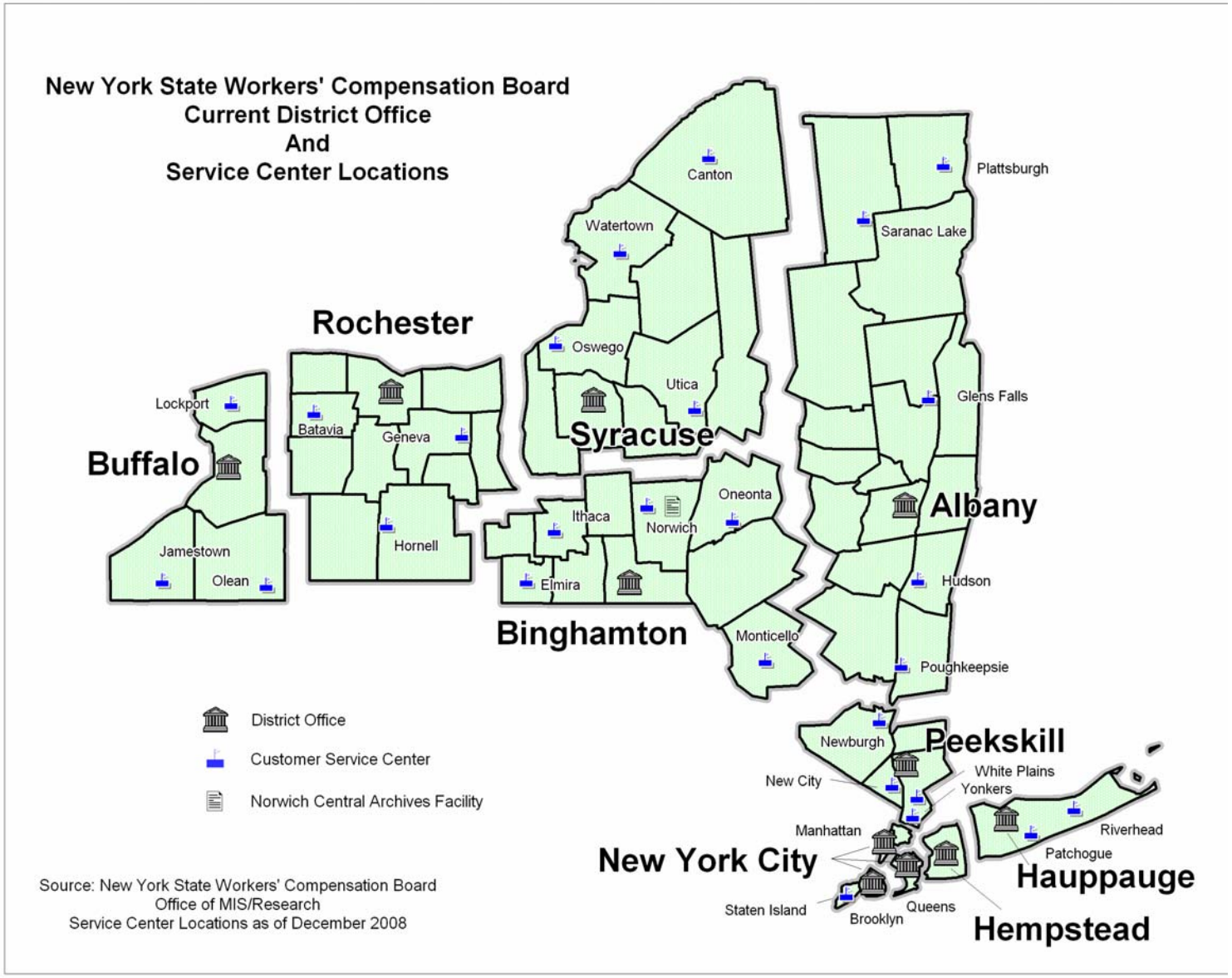
Workers' Compensation Board

Time Period

The data in the following tables are based on the time period October 1, 2007 to September 30, 2008. Using this time period enables the WCB to provide the most current available data. Calendar year reporting will continue to available with a one year lag.

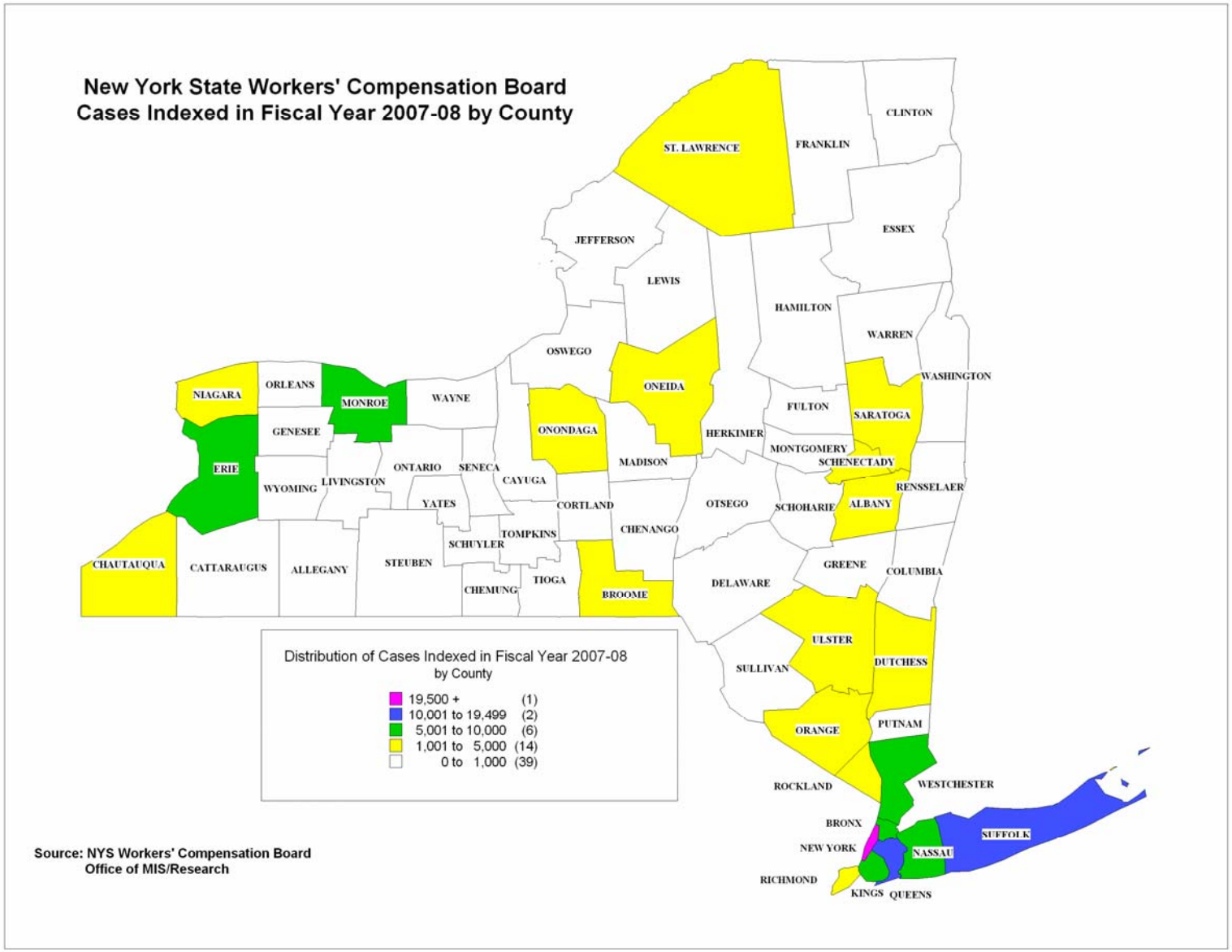
Source: NYS Workers' Compensation Board
Office of MIS/Research

District Office and Service Locations



Source: NYS Workers' Compensation Board
Office of MIS/Research

Cases Indexed By County



Source: NYS Workers' Compensation Board
Office of MIS/Research

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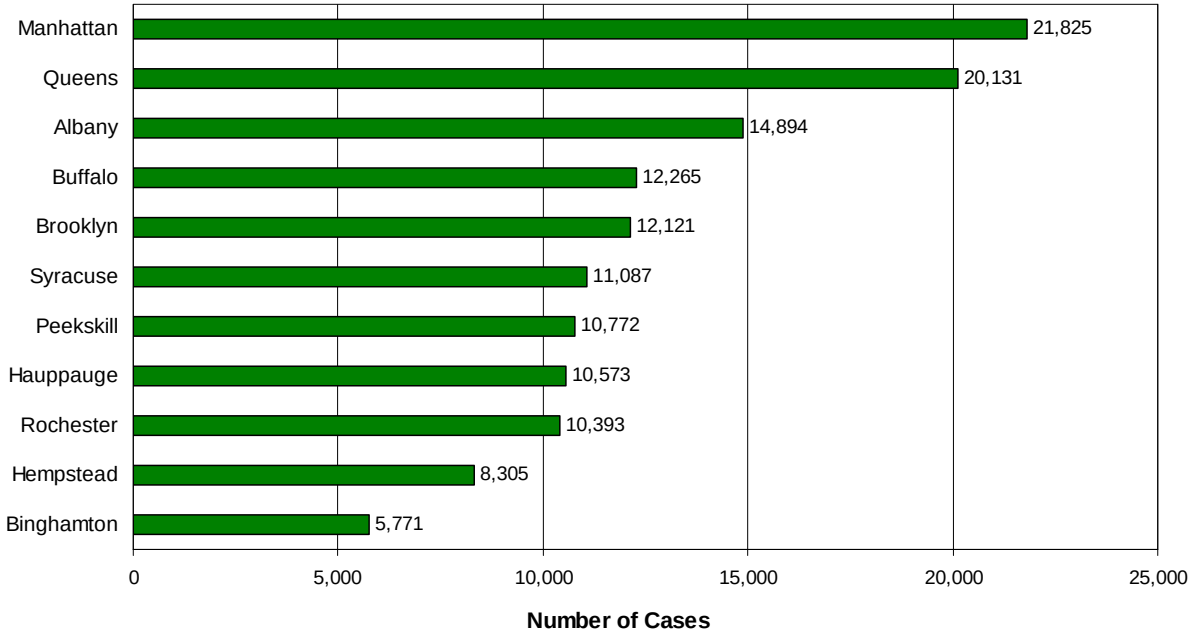
Cases Indexed in Fiscal Year 2007-08
By District Office

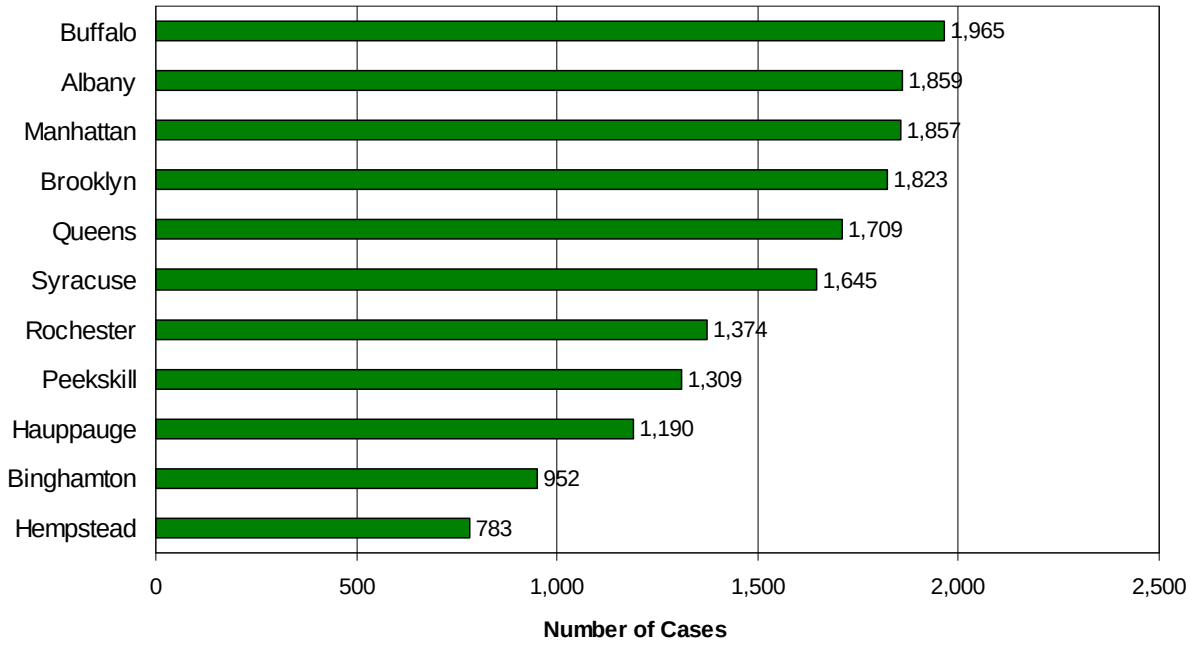


Cases Indexed and Cases Reopened in Fiscal Year 2007-08
By District Office

District Office	Cases Indexed	Cases Reopened
Manhattan	21,825	20,173
Queens	20,131	21,155
Albany	14,894	17,896
Buffalo	12,265	22,381
Brooklyn	12,121	13,030
Syracuse	11,087	19,351
Peekskill	10,772	17,086
Hauppauge	10,573	16,450
Rochester	10,393	16,289
Hempstead	8,305	15,665
Binghamton	5,771	9,125
Total	**138,137**	**188,601**

Source: NYS Workers' Compensation Board
Office of MIS/Research

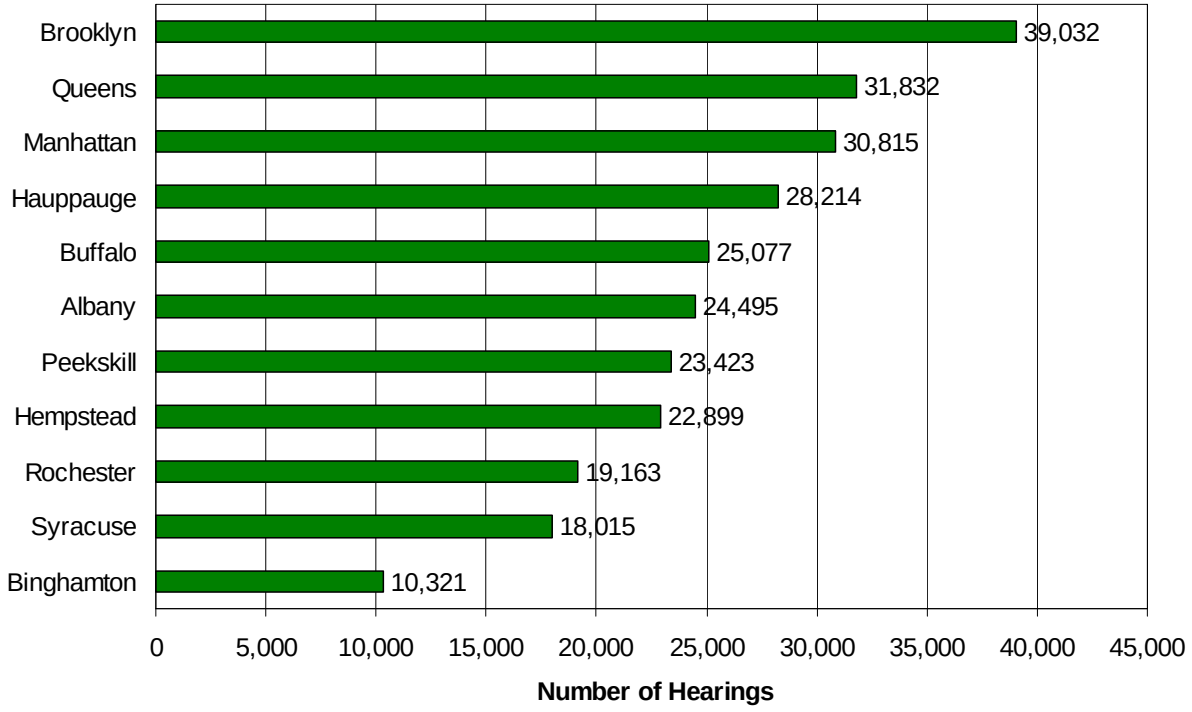
Cases Controverted in Fiscal Year 2007-08 by District Office
By District Office



District Office	Number of Cases Controverted
Buffalo	1,965
Albany	1,859
Manhattan	1,857
Brooklyn	1,823
Queens	1,709
Syracuse	1,645
Rochester	1,374
Peekskill	1,309
Hauppauge	1,190
Binghamton	952
Hempstead	783
Total	**16,466**

Source: NYS Workers' Compensation Board
Office of MIS/Research

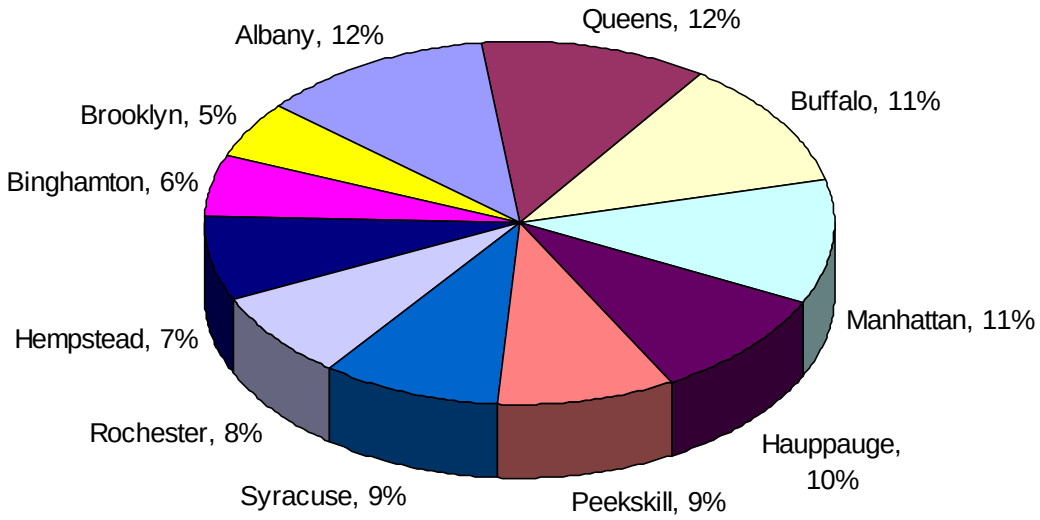
Hearings Held in Fiscal Year 2007-08
By District Office



District Office	Number of Hearings
Brooklyn	39,032
Queens	31,832
Manhattan	30,815
Hauppauge	28,214
Buffalo	25,077
Albany	24,495
Peekskill	23,423
Hempstead	22,899
Rochester	19,163
Syracuse	18,015
Binghamton	10,321
Total	**273,286**

Source: NYS Workers' Compensation Board
Office of MIS/Research

Percentage of All Claims Accepted in Fiscal Year 2007-08
By District Office



Claims Accepted in Fiscal Year 2007-08
By District Office

District Office	Claims Accepted
Albany	12,778
Queens	12,583
Buffalo	12,093
Manhattan	11,998
Hauppauge	10,610
Peekskill	9,857
Syracuse	9,670
Rochester	8,546
Hempstead	7,870
Binghamton	5,992
Brooklyn	5,427
Total	**107,424**

Source: NYS Workers' Compensation Board
Office of MIS/Research

Claims Accepted in Fiscal Year 2007-08 By Claim Type and Month

Month Accepted	Total Claims Accepted	WCL Claims (a)	VFBL Claims (b)	VAWBL Claims (c)
October-07	9,183	9,122	56	5
November-07	8,358	8,290	62	6
December-07	8,151	8,095	46	10
January-08	9,872	9,792	74	6
February-08	8,499	8,435	55	9
March-08	9,054	8,993	51	10
April-08	9,619	9,553	60	6
May-08	9,293	9,214	69	10
June-08	8,910	8,858	50	2
July-08	9,045	8,973	69	3
August-08	8,374	8,294	77	3
September-08	9,066	9,006	56	4
Total	**107,424**	**106,625**	**725**	**74**

(a) Claims under the Workers' Compensation Law
(b) Claims under the Volunteer Firefighters' Benefit Law
(c) Claims under the Volunteer Ambulance Workers' Benefit Law

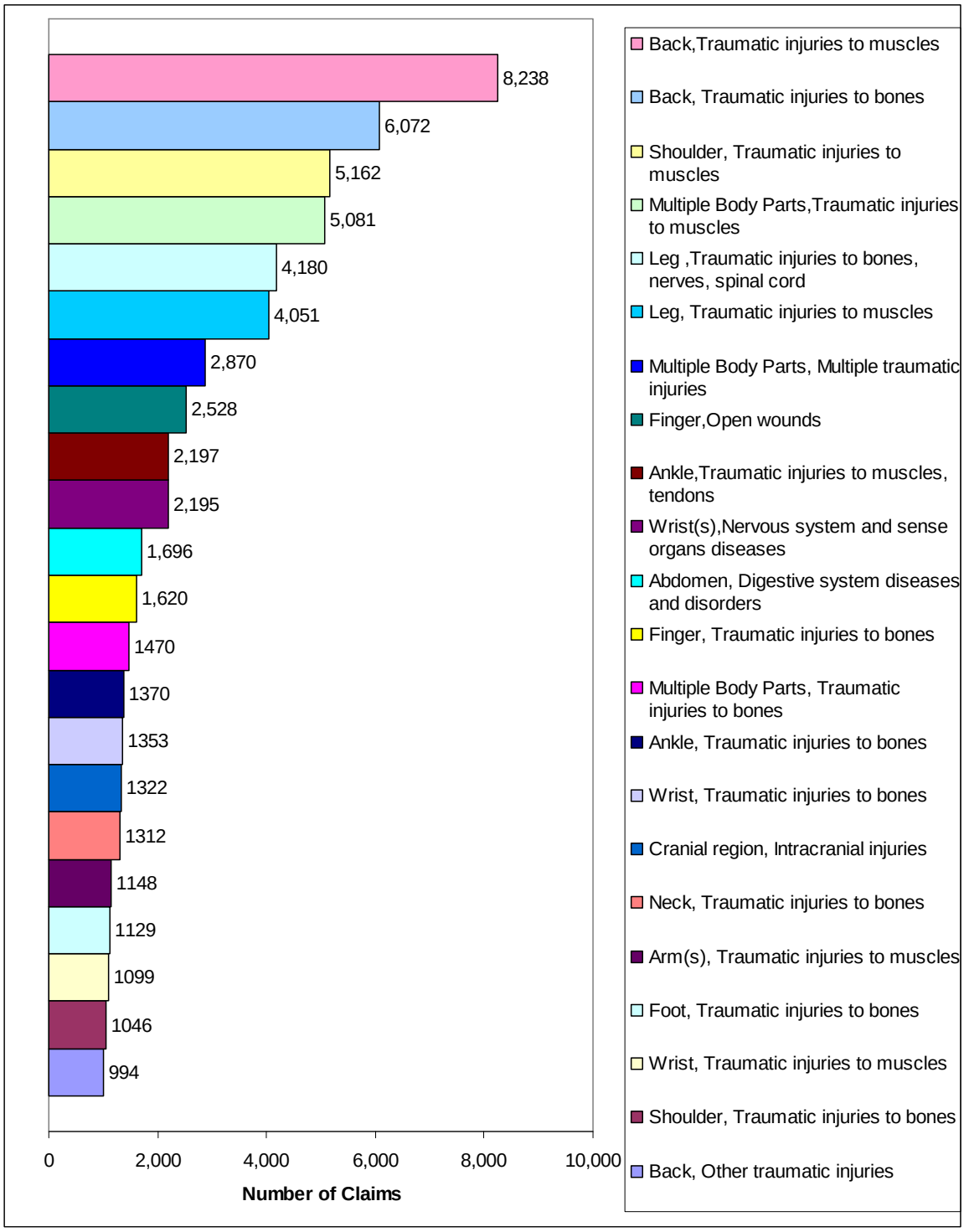
Claims Accepted in 2007-08: Claims for which there was a finding made by the Board during the fiscal year 2007-08 that (1) the claimant sustained an injury arising out of and in the course of employment; (2) timely notice thereof was given to the employer; and (3) there is a causal relationship between the work injury and a consequent disability.

(The claims accepted data for 2007-08 includes some previously established claims for which a Board finding during fiscal year 2007-08 amended or reaffirmed the claim's status; it is estimated that these affirmations account for less than 5% of the total).

Source: NYS Workers' Compensation Board
Office of MIS/Research

Source: NYS Workers' Compensation Board
Office of MIS/Research

Most Frequently Occurring Injury Types For Accepted Claims with First Indemnity Benefits Paid in Fiscal Year 2007-08



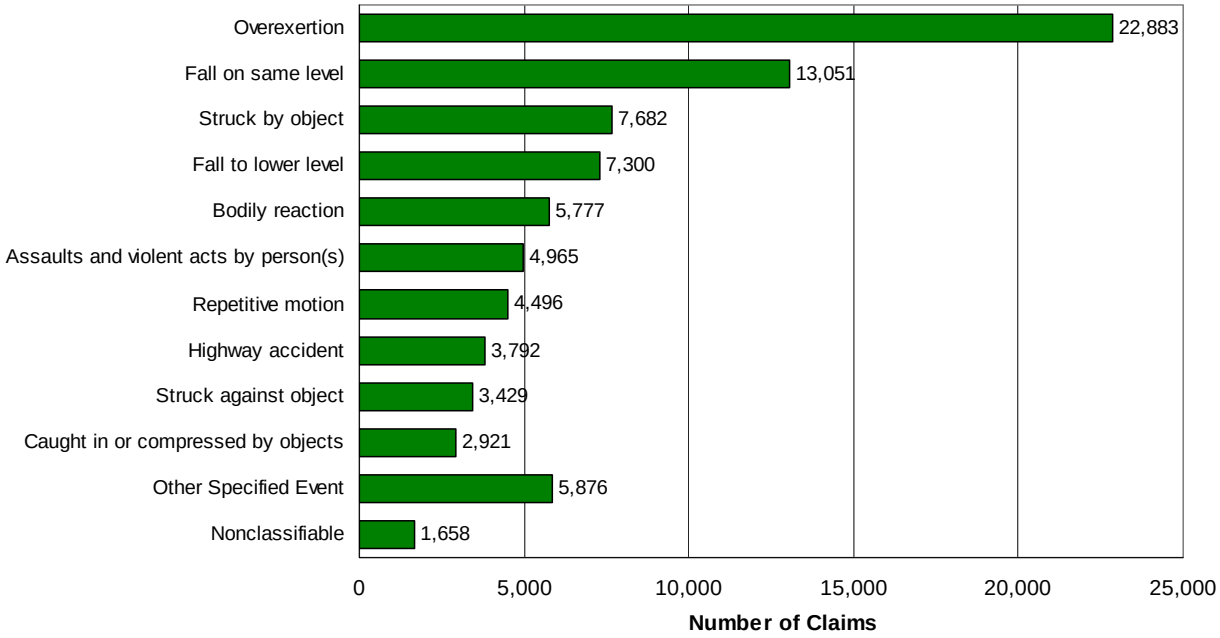
Source: NYS Workers' Compensation Board
Office of MIS/Research

Part of Body Injured Summary For Accepted Claims with First Indemnity Benefits Paid in Fiscal Year 2007-08

PART OF BODY AREA Body Sub-Area	All Claims	Male Workers	Female Workers	Sex Not Indicated
HEAD	**3,752**	**2,669**	**1,001**	**82**
NECK	**2,359**	**1,214**	**1,080**	**65**
UPPER EXTREMITIES	**17,777**	**10,972**	**6,384**	**421**
Finger	5,681	4,170	1,353	158
Wrist	5,345	2,481	2,769	95
Hand	1,857	1,346	463	48
Arm	2,977	1,967	943	67
Multiple Upper Ex.	1,903	1,002	848	53
All Other	14	6	8	0
TRUNK	**28,444**	**18,224**	**9,535**	**685**
Back	15,826	9,572	5,840	414
Shoulder	7,248	4,684	2,414	150
Abdomen	1,857	1,663	162	32
Chest	1,535	1,188	316	31
Pelvic Region	828	492	307	29
Multiple Trunk Locations	1,119	609	481	29
All Other	31	16	15	0
LOWER EXTREMITIES	**18,532**	**11,729**	**6,302**	**501**
Leg	10,648	6,991	3,413	244
Ankle	3,859	2,249	1,470	140
Foot	2,107	1,319	725	63
Toe	697	488	187	22
Multiple Lower Ex.	1,212	674	506	32
All Other	9	8	1	0
BODY SYSTEMS	**574**	**318**	**246**	**10**
MULTIPLE BODY AREAS	**11,591**	**6,084**	**5,155**	**352**
OTHER OR UNSPECIFIED	**801**	**503**	**275**	**23**
Total	**83,830**	**51,713**	**29,978**	**2,139**

Source: NYS Workers' Compensation Board
Office of MIS/Research

Event or Exposure For Accepted Claims with First Indemnity Benefits Paid in Fiscal Year 2007-08



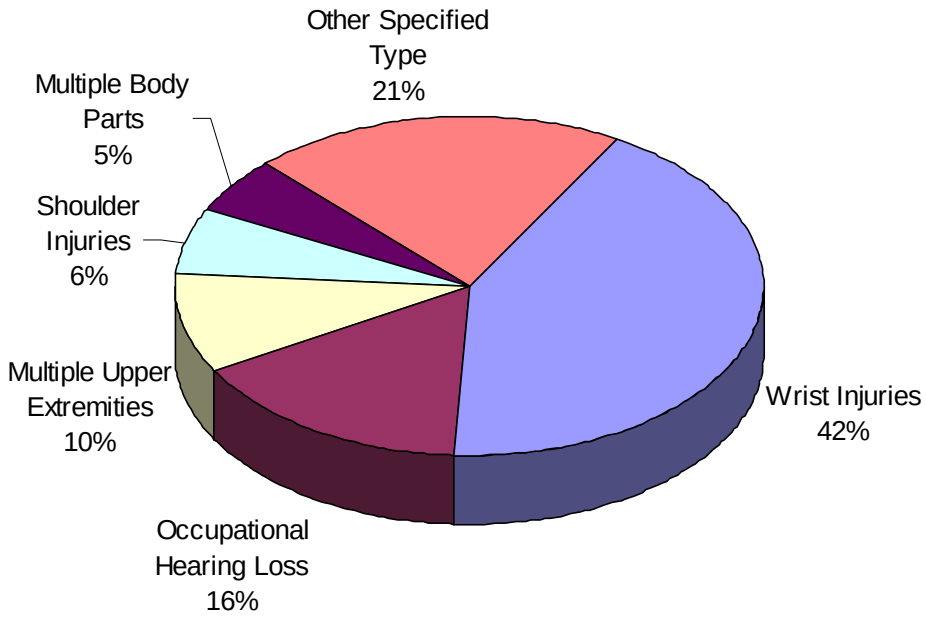
Source: NYS Workers' Compensation Board
Office of MIS/Research

Sex of Worker and Event or Exposure
For Accepted Claims with First Indemnity Benefits Paid in Fiscal Year 2007-08

Event or Exposure	All Claims	Male Workers	Female Workers	Sex Not Indicated
Overexertion	22,883	14,529	7,813	541
Fall on same level	13,051	5,638	7,083	330
Struck by object	7,682	5,421	2,032	229
Fall to lower level	7,300	5,226	1,866	208
Bodily reaction	5,777	3,818	1,831	128
Assaults and violent acts by person(s)	4,965	2,512	2,331	122
Repetitive motion	4,496	1,801	2,639	56
Highway accident	3,792	2,666	995	131
Struck against object	3,429	2,341	980	108
Caught in or compressed by objects	2,921	2,268	583	70
Other Specified Event	5,876	4,400	1,329	147
Nonclassifiable	[illegible]	1,093	496	69
TOTAL	**83,830**	**51,713**	**29,978**	**2,139**

Source: NYS Workers' Compensation Board
Office of MIS/Research

Types of Occupational Disease or Exposure Injuries
For Accepted Claims with First Indemnity Benefits Paid in Fiscal Year 2007-08

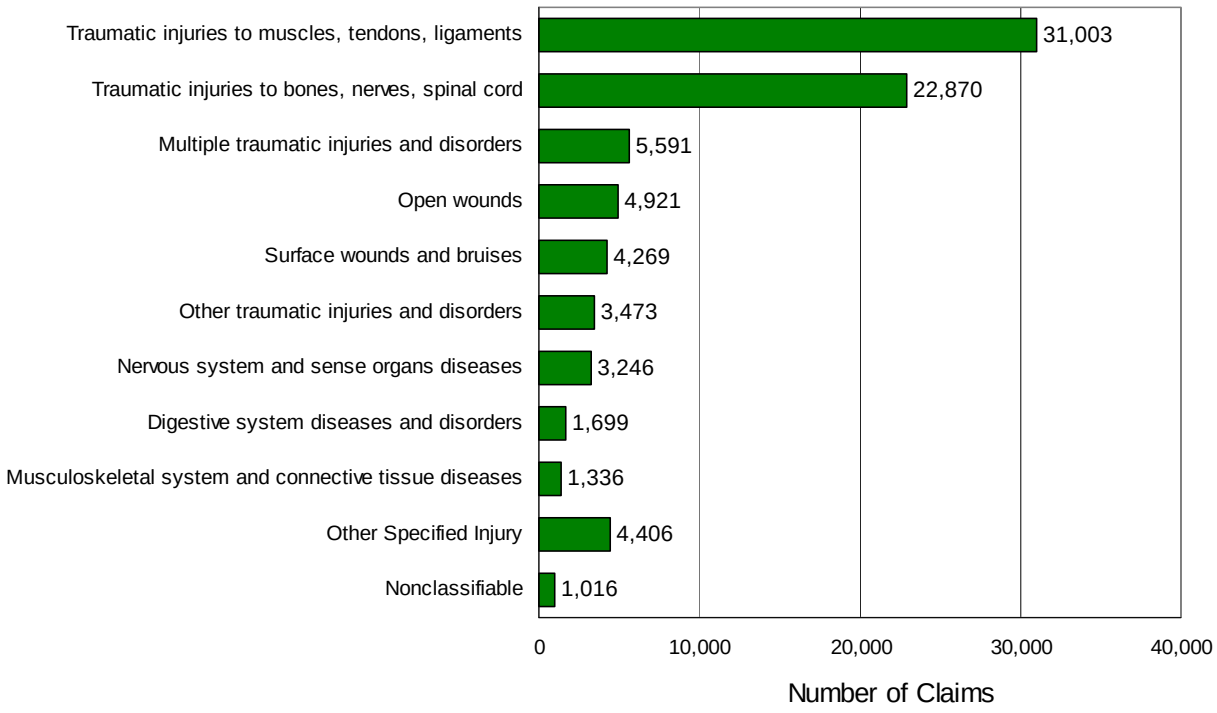


Sex of Worker and Occupational Disease or Exposure
For Accepted Claims with First Indemnity Benefits Paid in Fiscal Year 2007-08

Type of Occupational Disease or Exposure	Accepted Claims	Male Workers	Female Workers	Sex Not Indicated
Wrist Injuries	1,913	721	1,177	15
Occupational Hearing Loss	720	691	24	5
Multiple Upper Extremities	430	158	268	4
Shoulder Injuries	283	139	142	2
Multiple Body Parts	238	84	147	7
Other Specified Type	929	520	403	6
Total	**4,513**	**2,313**	**2,161**	**39**

Source: NYS Workers' Compensation Board
Office of MIS/Research

Nature of Injury
For Accepted Claims with First Indemnity Benefits Paid in Fiscal Year 2007-08



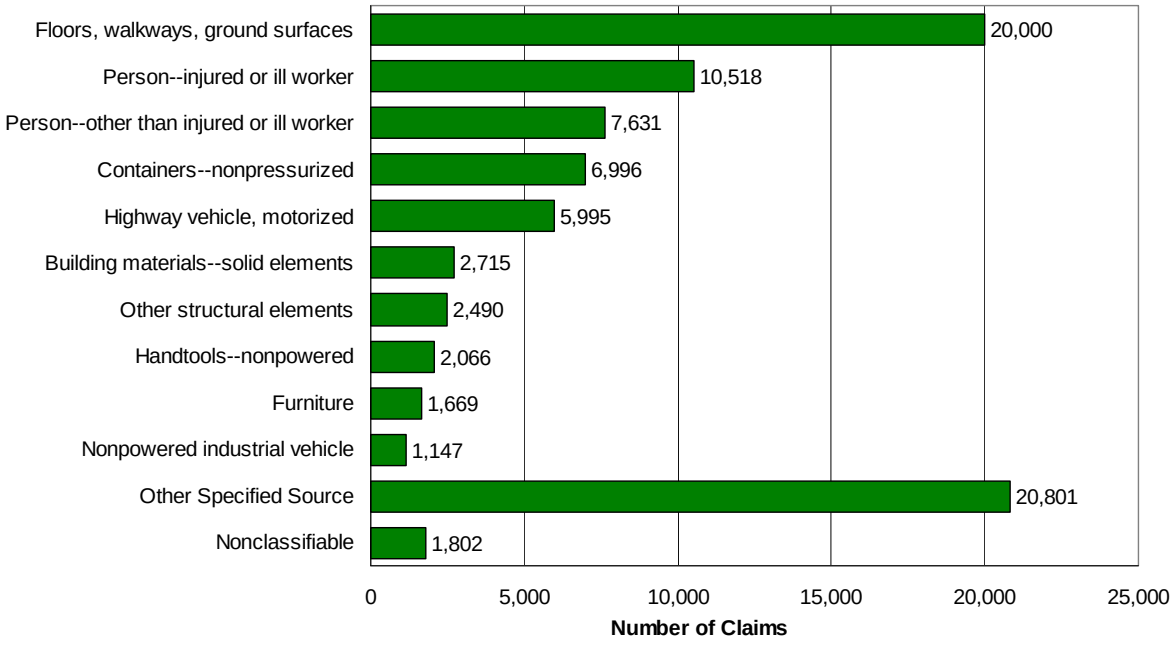
Source: NYS Workers' Compensation Board
Office of MIS/Research

Sex of Worker and Nature of Injury
For Accepted Claims with First Indemnity Benefits Paid in Fiscal Year 2007-08

Nature of Injury	All Claims	Male Workers	Female Workers	Sex Not Indicated
Traumatic injuries to muscles, tendons, ligaments	31,003	18,238	11,979	786
Traumatic injuries to bones, nerves, spinal cord	22,870	14,673	7,571	626
Multiple traumatic injuries and disorders	5,591	3,335	2,107	149
Open wounds	4,921	3,897	871	153
Surface wounds and bruises	4,269	2,274	1,873	122
Other traumatic injuries and disorders	3,473	2,075	1,328	70
Nervous system and sense organs diseases	3,246	1,757	1,457	32
Digestive system diseases and disorders	1,699	1,565	106	28
Musculoskeletal system and connective tissue diseases	1,336	571	751	14
Other Specified Injury	4,406	2,682	1,600	124
Nonclassifiable	1,016	646	335	35
Total	**83,830**	**51,713**	**29,978**	**2,139**

Source: NYS Workers' Compensation Board
Office of MIS/Research

Source Producing Injury For Accepted Claims with First Indemnity Benefits Paid in Fiscal Year 2007-08



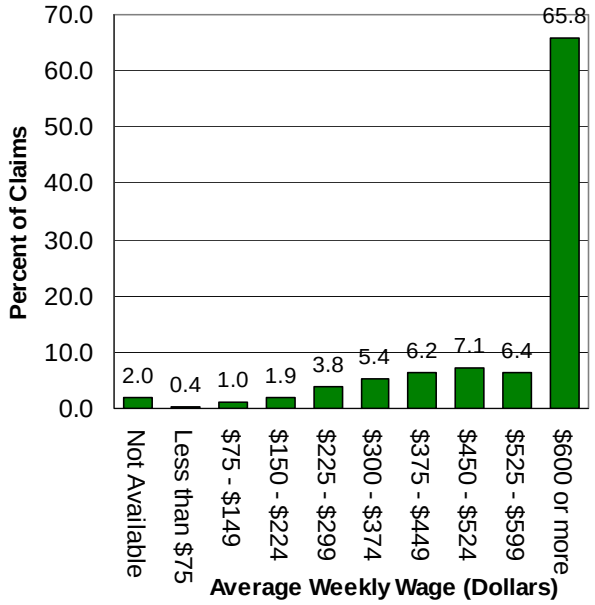
Sex of Worker and Source Producing Injury For Accepted Claims with First Indemnity Benefits Paid in Fiscal Year 2007-08

Source of Injury	All Claims	Male Workers	Female Workers	Sex Not Indicated
Floors, walkways, ground surfaces	20,000	10,732	8,757	511
Person--injured or ill worker	10,518	5,786	4,541	191
Person--other than injured or ill worker	7,631	2,478	4,970	183
Containers--nonpressurized	6,996	4,502	2,308	186
Highway vehicle, motorized	5,995	4,355	1,454	186
Building materials--solid elements	2,715	2,415	221	79
Other structural elements	2,490	1,480	935	75
Handtools--nonpowered	2,066	1,652	360	54
Furniture	1,669	848	782	39
Nonpowered industrial vehicle	1,147	750	357	40
Other Specified Source	20,801	15,512	4,768	521
Nonclassifiable	1,802	1,203	525	74
Total	**83,830**	**51,713**	**29,978**	**2,139**

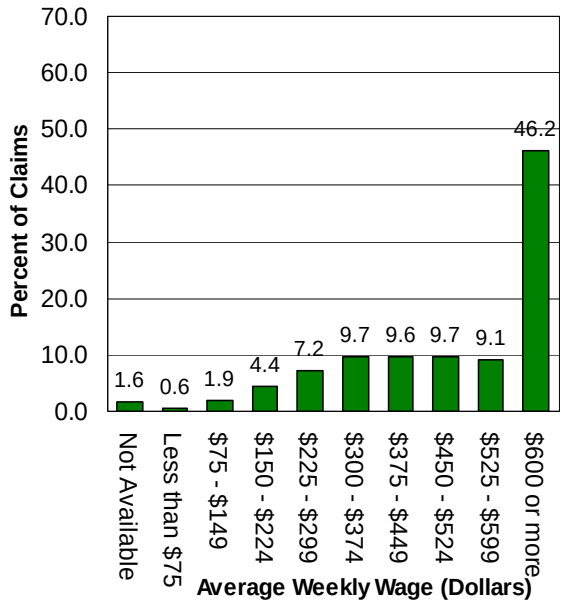
Source: NYS Workers' Compensation Board
Office of MIS/Research

Sex of Worker and Average Weekly Wage
For Accepted Claims with First Indemnity Benefits Paid in Fiscal Year 2007-08

Male Workers



Female Workers

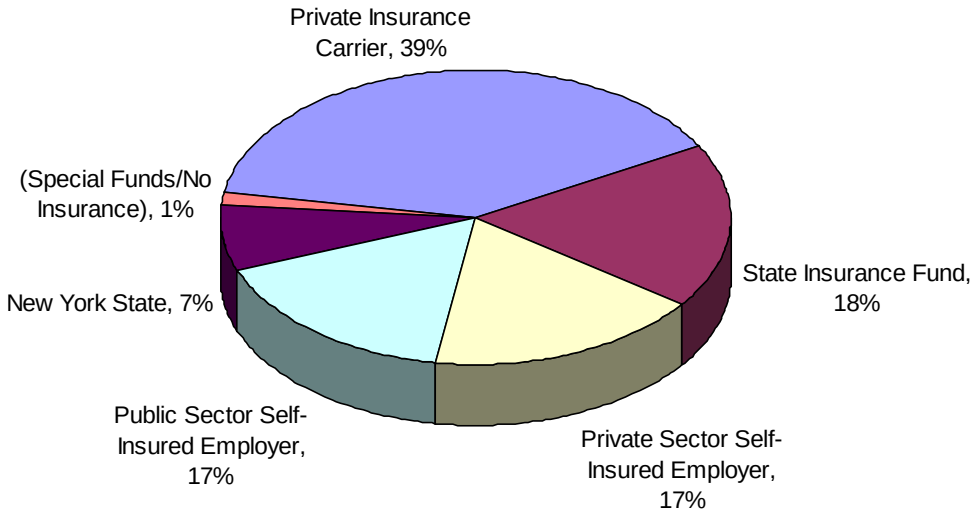


Average Weekly Wage	All Claimants	Male Workers	Female Workers	Sex Not Indicated
Not Available	1579	1056	493	30
Less than $75	392	210	176	6
$75 - $149	1127	531	577	19
$150 - $224	2333	979	1310	44
$225 - $299	4221	1971	2154	96
$300 - $374	5823	2773	2906	144
$375 - $449	6243	3229	2881	133
$450 - $524	6729	3658	2921	150
$525 - $599	6155	3284	2719	152
$600 or more	49228	34022	13841	1365
Total	**83,830**	**51,713**	**29,978**	**2,139**

Source: NYS Workers' Compensation Board
Office of MIS/Research

Source: NYS Workers' Compensation Board
Office of MIS/Research

Claim Liability
For Claims Accepted in Fiscal Year 2007-08



Type of Liability Coverage	Number of Claims
Private Insurance Carrier	41,990
State Insurance Fund	19,509
Private Sector Self-Insured Employer	18,784
Public Sector Self-Insured Employer	17,902
New York State	7,876
(Special Funds/No Insurance)	1,363
Total	**107,424**

Source: NYS Workers' Compensation Board
Office of MIS/Research

Industry Coding in the Fiscal Year 2007-08

In the fiscal year 2007-08, the Board continued to acquire data on the industrial classification of the employers for all accepted claims having indemnity benefits first paid to the injured worker in the fiscal year 2007-08. The method used to determine the industrial classification leverages new data systems in place at the Board. When employer records from claims can be matched with employer records for insurance compliance, the North American Industrial Classification System (NAICS) code can be identified or translated from an available Standard Industrial Classification (SIC) code. Once coded, multiple claims by workers from the same enterprise can be coded automatically. This provides the Board with an ability to identify the industrial classification code of the enterprise with a highly standardized process producing consistent results.

The North American Industrial Classification System (NAICS), like the Standard Industrial Classification (SIC) system before it, is based on the assignment of classification codes to establishments, which are described as generally being a single physical location where business is conducted or services provided. The concept of establishment stands in contrast to the enterprise. A single enterprise might control multiple establishments of differing industries. Enterprises that are comprised of multiple disparate establishments are common. For example, a retail furniture store chain might have a trucking division or a large warehousing operation. Coding at the enterprise level, all workers would be classified in the Retail Trade Sector (NAICS Code 44) even if they are employed in the trucking division (NAICS Code 48). While not providing the same grain of detail as coding at the establishment level, identifying the industrial classification at the enterprise level is based on the data used to determine the employer's compliance with providing workers' compensation coverage.

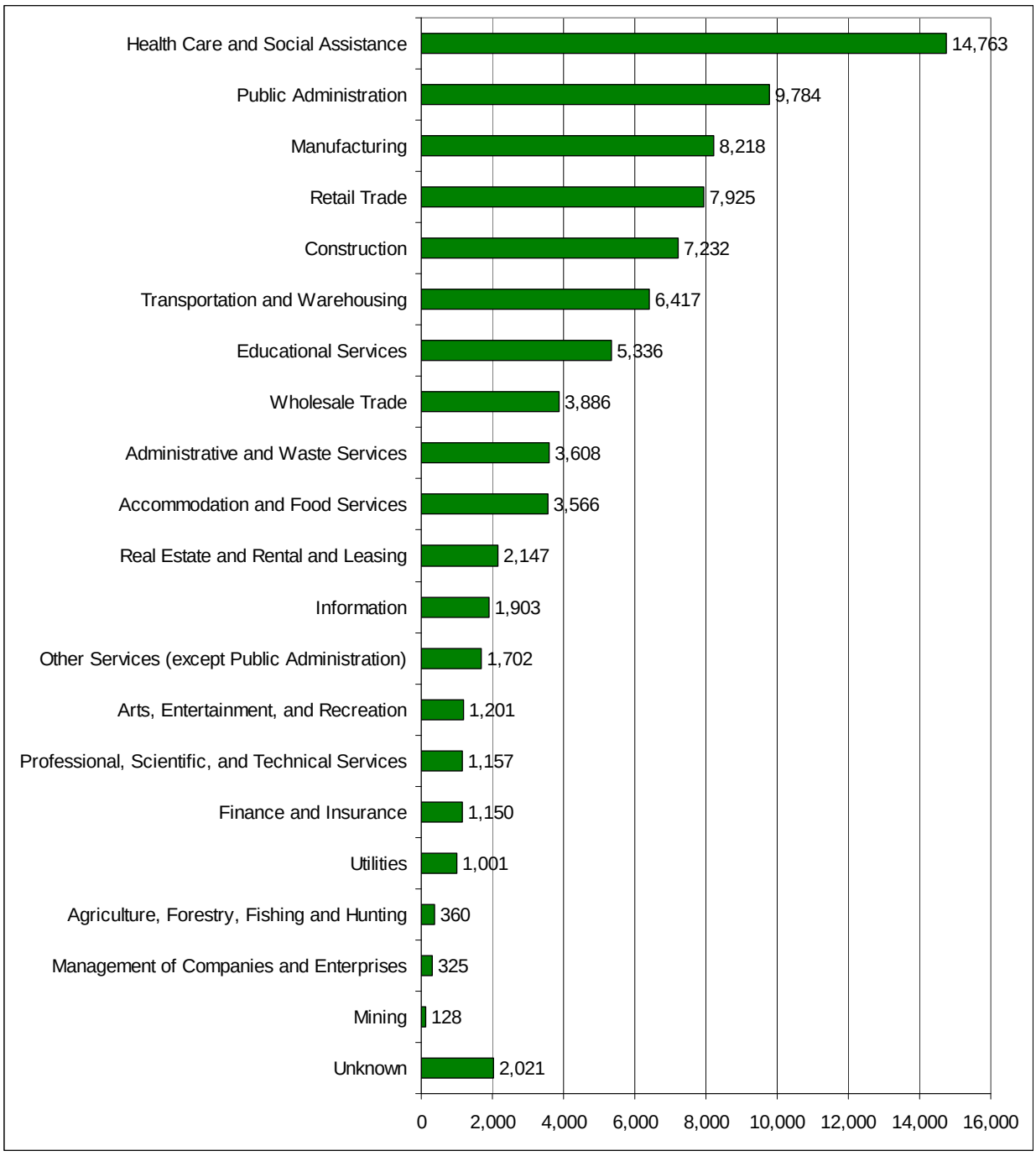
Source: NYS Workers' Compensation Board
Office of MIS/Research

Industry Sector and Percentage
For Accepted Claims with First Indemnity Benefits Paid
In Fiscal Year 2007-08

Industry Sector	Claims	Percent
Health Care and Social Assistance	14,763	17.6
Public Administration	9,784	11.7
Manufacturing	8,218	9.8
Retail Trade	7,925	9.5
Construction	7,232	8.6
Transportation and Warehousing	6,417	7.7
Educational Services	5,336	6.4
Wholesale Trade	3,886	4.6
Administrative and Waste Services	3,608	4.3
Accommodation and Food Services	3,566	4.3
Real Estate and Rental and Leasing	2,147	2.6
Information	1,903	2.3
Other Services (except Public Administration)	1,702	2.0
Arts, Entertainment, and Recreation	1,201	1.4
Professional, Scientific, and Technical Services	1,157	1.4
Finance and Insurance	1,150	1.4
Utilities	1,001	1.2
Agriculture, Forestry, Fishing and Hunting	360	0.4
Management of Companies and Enterprises	325	0.4
Mining	128	0.2
Unknown	2,021	2.4
Total	**83,830**	**100**

Source: NYS Workers' Compensation Board
Office of MIS/Research

Industry Sector
For Accepted Claims with First Indemnity Benefits Paid
In Fiscal Year 2007-08



Source: NYS Workers' Compensation Board
Office of MIS/Research