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Workers' Compensation in NYS:
Did 2007 Reforms Make a Difference?

October, 2012

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Rochester Business Alliance

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SUMMARY

In 2007, state leaders achieved what was hailed as a grand compromise for reforming New York's workers' compensation system. Benefits for injured workers would be raised, while new medical treatment guidelines, administrative streamlining and limitations on certain types of benefits would reduce costs for employers.

But 5 years later, the reforms appear to be only partially implemented. Benefit increases have been phased in, resulting in nearly doubling the maximum weekly benefit to almost $800. Yet medical treatment guidelines and benefit limitations haven't fully taken effect, and so costs continue to rise. The state Workers' Compensation Board, which carefully monitored the reforms in the first two years with help from the state Insurance Department, has stopped producing detailed reports about the progress of the changes.

This year, workers' compensation insurance carriers sought state permission to increase base premium rates, arguing that the benefit increases and sluggish pace of reforms have driven up costs. State regulators denied the request. They asserted that costs will go down as reforms continue to take hold and said premium increases would only hurt business and the state's economy. And yet, a just-released national study of average premiums ranked New York 5th highest in the nation, up from 19th just four years ago.

At the same time, New York imposes a tax on workers' comp premiums that is by far the highest in the nation at 19% in 2012, more than double the next highest state. Moreover, a looming crisis in the group self-insurance market threatens to increase costs even further for all employers.

This report compiles information from existing studies, analyzes available data from national and state sources, and reflects the perspectives of employers and other participants in the system. Our findings:

- Promised cost savings have yet to be realized, largely because limits on payments to "permanently partially disabled" (PPD) workers are not uniformly taking effect. It may be years or decades before significant cost reductions are achieved.

- Workers who qualify for a "scheduled loss" payment for an injury resulting in permanent impairment to extremities, eyesight or hearing or facial disfigurement are receiving about twice as much as they used to, even if they never miss a day of work. These payments are based on 1990s medicine, and don't reflect the updated medical guidelines adopted for other PPD cases.
- New York's highest-in-the-nation taxes on workers' comp premiums show no sign of coming down anytime soon.
- According to insurance carriers, medical treatment guidelines are having limited impact on costs. The Compensation Insurance Rating Board, which receives data from all carriers, estimates the guidelines have cut overall medical costs just 5%.
- Administrative streamlining seems to be at least partially successful, but the evidence is mixed as to whether claims are being processed more efficiently.
- The Workers' Compensation Board is not adequately monitoring and reporting on the progress of the reforms or basic metrics about the overall system in New York, though its leaders are working to remedy this.

The business community is only one stakeholder group dissatisfied with the implementation and impact of the 2007 reforms—advocacy groups for workers have weighed in on issues such as the costs and benefits of the medical treatment guidelines. The findings of our study and other reports make clear that New York State needs to revisit the issue of workers' compensation, level with the public about what has and has not worked well from the 2007 reforms, and take additional actions to reform the workers' compensation bureaucracy and reduce costs. Specifically, the state should:

- **Require the Workers' Compensation Board to track and publicly report on progress**. The state should regularly report on such areas as claims processing and other measures of agency performance; classification of workers by disability level; number and disposition of requests for variances from Medical Treatment Guidelines; assessment levels; the status of the Second Injury Fund and its outstanding claims; and overall costs, including for self-insured employers.
- **Appoint a Workers' Comp Czar**. Accelerate New York's reform effort by engaging an expert with reform experience from other states to critically assess New York's system, similar to Gov. Cuomo's hiring of Jason Helgerson from Wisconsin as "Medicaid czar."
- **Reform the approach to indexing benefits**. Eliminate the indexing of benefits to statewide average weekly wage, or adopt a regional approach. Higher downstate salaries unfairly drive up benefits for Upstate workers and costs for employers.

- **Implement updated medical standards in calculating scheduled loss awards**. This would bring scheduled loss payments in line with current medical practice by acknowledging how advances in medicine have improved healing and reduced permanent impairments. Reflecting the fact that many workers lose no or little time from work, the Board should return to a practice of using half the benefit rate in the calculation of benefits.
- **Reduce New York's highest in the nation assessments**. Through accelerating settlements of Second Injury Fund cases or reducing state administrative expenses, the state must find a way to bring premium taxes more in line with the national level.
- **Make the caps on permanent partial disability cases work**. The state can take several immediate steps to improve in this area. They include adopting a presumption that maximum medical improvement has been reached within 6 months to 2 years, and providing more training and guidance to practitioners and administrative law judges on how to implement the new system for classifying workers.
- **Reject legislative rollbacks**. Some legislators have proposed changing the compromise on which the reforms were based. Proposals such as exempting pre-2007 claimants from the Medical Treatment Guidelines or creating loopholes in the pharmaceutical fee schedule should be defeated.

Acknowledgements

CGR would like to thank the Rochester Business Alliance and its Workers' Compensation Committee for their invaluable help providing perspectives to inform this report. In particular, we thank the RBA's Vice President for Public Policy and Advocacy Chris Wiest for shepherding this project.

Staff Team

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Introduction and Background

New York's workers' compensation system was created in the aftermath of the 1911 fire at the Triangle Shirtwaist Factory near Washington Square

in New York City. Of 500 employed at the factory, 146 died.* The workers compensation system was established to speed settlements for workers injured or killed on the job and to reduce the cost of litigation. Owners of the Triangle factory faced 23 civil suits in the aftermath of the fire. A settlement, under which the owners paid $75 per life lost—about $1,800 in current dollars—took three years.

Purpose of Workers' Compensation System

New York's workers' compensation system was one of the first in the country. Like all such systems, it reflects a compromise between employers and workers. Workers gave up the right to sue over workplace injuries, and employers agreed to purchase insurance to cover the costs of medical care and provide cash benefits to injured workers. It functions as a no-fault system; neither employee carelessness nor employer negligence affect how a case is handled. The only exception is an injury caused by a worker's drug or alcohol use or attempt to injure himself or someone else.

The workers' compensation system combines characteristics of a disability insurance policy—with pre-determined payouts for "death and dismemberment" and disability—and a health insurance policy that pays the cost of medical care when an injury occurs.

* The illustration pictures a mural commissioned by the International Ladies Garment Workers Union (ILGW). *History of the Needlecraft Industry* (1938), by Ernest Feeney, High School of Fashion and Industry.

Replaces Personal Injury Lawsuits

A substantial share of legal advertising—billboards, radio and television—comes from law firms specializing in personal injury law. Firms in this specialty practice often take cases on a contingent fee basis, giving access to the legal system to injured parties without the funds to pay for an attorney's services. Critics argue that contingent fees create an incentive for personal injury specialists to pursue cases with weak or ambiguous evidence and to employ emotional arguments to secure very large settlements. Neither side of the debate would disagree that the pursuit of personal injury cases is very expensive both for plaintiffs—who pay a third or more of the settlement in attorney's fees—and defendants.

In the workplace, personal injury lawsuits are replaced by the workers' compensation system. Instead of the costly collection of evidence claiming negligence on the part of the employer or culpability on behalf of the worker, fault is not at issue. With limited exceptions, if injury occurs, compensation is paid. Nor is there debate over the size of the settlement in many cases. From loss of a finger to loss of life, many payments are pre-determined—for example, under New York law the complete loss of the use of a first finger pays 46 weeks of benefits, calculated at two-thirds the worker's weekly pay; complete loss of an arm pays 312 weeks of benefits. When an injury leads to death, cash benefits to a spouse or children are based on the worker's average annual pay for the year prior to the injury. If the worker has neither spouse nor children, the estate is paid a lump sum of $50,000 plus $5,000 (Upstate) or $6,000 (NYC Metro area) for funeral expenses.

The state has also set up procedures to determine payment when the injured worker has been temporarily or permanently disabled as well as an appeals process—though these procedures are more complicated, open to interpretation and subject to debate between claimant and employer/carrier attorneys.

Replaces Health Insurance When Workplace Injury Occurs

Regardless of the worker's health care coverage, the workers' compensation system pays medical costs when an injury occurs. Like all health insurance, however, there are inevitable disagreements about necessary treatment and the cost of care. The Workers' Compensation Board and statute govern these decisions. Unlike with private health insurance, though, costs are determined by a provider reimbursement schedule set by the state, similar to government programs like Medicare or Medicaid.

Debate Over New York's System

For years, New York's workers' compensation system has been fiercely criticized by all stakeholders, with employers angry about high costs, workers distressed by slow and sometimes meager payments, and all sides frustrated at times by a large and seemingly unresponsive bureaucracy. At the head of the system is the Workers' Compensation Board, with 13 members appointed by the Governor and approved by the state Senate and 1,500 employees – in total a $200 million agency.

In 2007, state leaders achieved what was hailed as a grand compromise for reforming New York's workers' compensation system. Benefits for injured workers would be raised, while new medical treatment guidelines, administrative streamlining and limitations on certain types of benefits would reduce costs for employers. New York has historically been both a high-cost and low-benefit state – the 2007 reforms promised to fix this.

Before the 2007 reforms, the last attempt to improve workers' compensation was a 1996 legislative package championed by former Gov. George Pataki that restricted worker lawsuits against employers, stepped up efforts to reduce fraud, and expanded the use of managed care for treating hurt workers. Yet the drumbeat for reform began to beat again in the early 2000s as employers faced years of double-digit increases in insurance premiums.

In 2007, then-Gov. Eliot Spitzer and lawmakers approved a package of reforms that they said would slash $1 billion in costs from the system. Key provisions of the law included:

- Increasing the $400 weekly maximum benefit to $550 in 2008 and $600 in 2009, then setting it at two-thirds the statewide average weekly wage in 2010. The benefit was then indexed each year to changes in the statewide average; the current weekly maximum is just over $792.
- Ending lifetime benefits for workers with permanent partial disabilities (PPD). Studies had shown these cases represented less than 15% of total cases, but over 70% of overall costs. Injured workers would instead receive benefits for a finite number of weeks depending on the degree of their disability, with a maximum of 525 weeks, or a little more than 10 years.
- Creation of evidence-based medical treatment guidelines to reduce unnecessary treatments, improve the effectiveness of care and speed returns to work.
- Closing of the state's "Second Injury Fund" created to encourage employers to hire disabled workers – which reimbursed employers after 5 years of payments for any claim made worse by an injured worker's

prior permanent disability. Its elimination was supposed to reduce New York's workers' comp assessments.

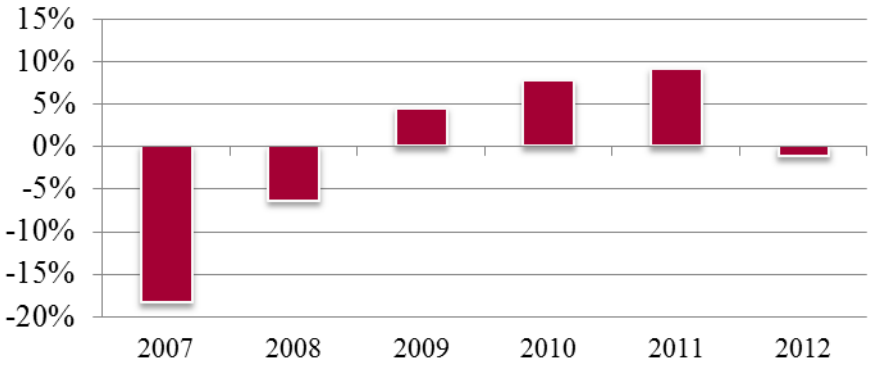
- Rocket Docket: Streamlining claims processing by the Workers' Comp Board, specifically by reducing the timeframe from dispute of a claim to establishment or denial to 90 days.

The body of this report discusses the status and impact of each of these reforms, using available data and qualitative information.

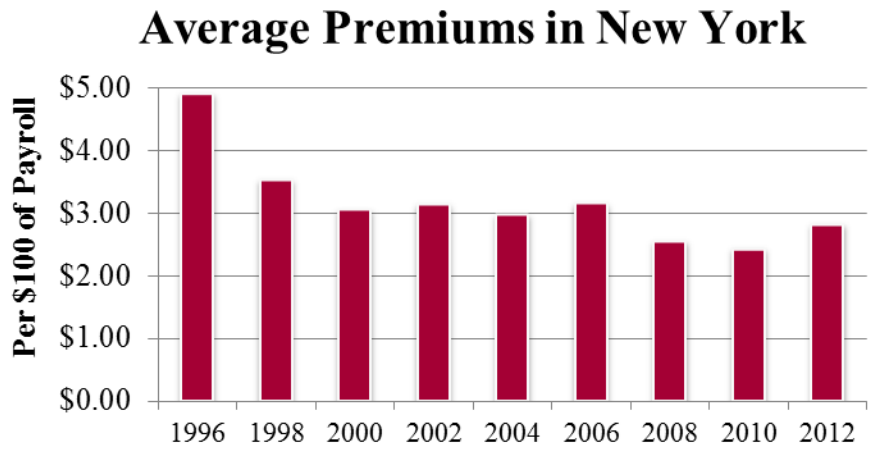
Costs and Benefits

The chief concern in the employer community is that while benefit levels have increased as envisioned under the legislation, cost savings have not materialized.

Premium Costs to Employers



Source: NY Compensation Insurance Rating Board
*Insurers add administrative expenses & profit to generate actual rates.



Source: Oregon Workers' Compensation Premium Rate Ranking

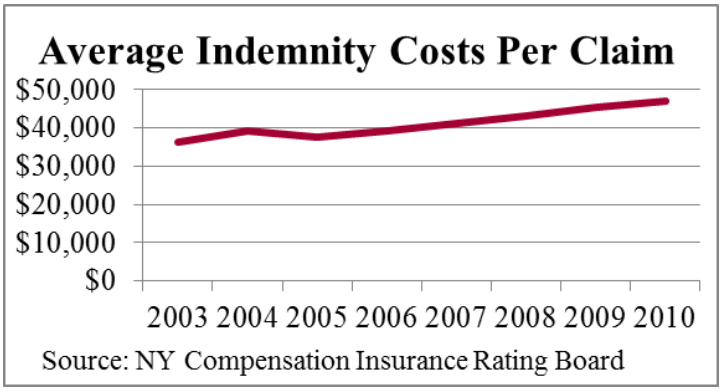
After the reforms passed in 2007, the state approved a reduction in base premium* costs to workers' comp insurance policyholders of 18.4%. The decrease allowed state leaders to claim victory, but observers note that the state can in effect order a reduction in rates through the regulatory power of the state Insurance Department, now part of the state Department of Financial Services. Each year, state regulators appointed by the governor approve or reject the request to increase base premiums made by New York's Compensation Insurance Rating Board (CIRB), the nonprofit industry group legally charged to collect data and recommend workers' comp rates.

In the years following 2007, base premiums declined for one additional year, and then began to climb until 2012, when

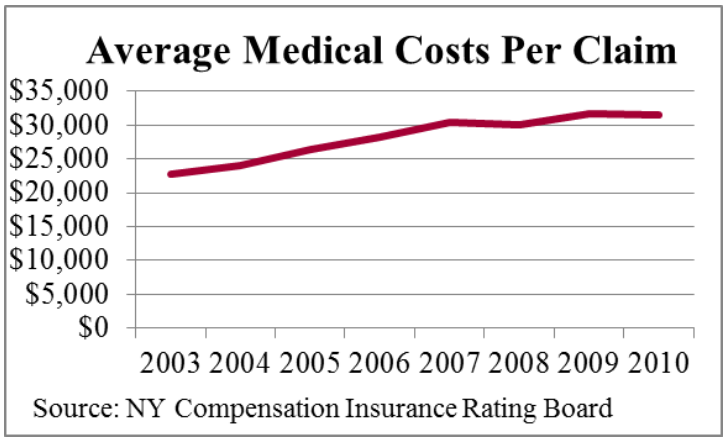
* What we are calling the "base premium" is the loss cost change submitted by the Compensation Insurance Rating Board and approved or denied by state regulators. To get to actual premium rates, insurance carriers add administrative expenses and profits. Also, the base premium reflects the average across occupational classes, which cover a wide range.

CIRB's request for an 11.5% increase was rejected by the Department of Financial Services. Furthermore, base premiums don't mirror the costs to employers – employers are charged the base premium, plus administrative expenses and insurer profits. Therefore, even in a year when base premiums decline, employer rates can increase. This year, for example, the average base premium is to decline 1%, yet some carriers report their total premiums will rise 5-13%.

As a result of the recent increases, New York has reached a 16-year high in a national comparison of average premium costs. A just-released study places New York at #5 in 2012, up from #19 in 2008.[*] In 2012, the average premium rate across occupational classes was $2.82 per $100 payroll in New York, about 150% of the national median. The last time New York ranked similarly high was 1996, when it was #4.



Self-insured employers report no relief in costs, as the changes in premiums in the early years did not benefit them. In fact, many report that the security deposits they are required to keep to cover claims have skyrocketed in recent years. In the Rochester region, one large employer reports a 72% hike in the last five years, and a big nonprofit employer has seen a 30% increase.



Claim Costs

Employer costs reflect the costs of claims. These have been rising as benefit increases have taken hold. Even after adjusting for inflation, average indemnity costs per claim have risen 20% since 2006 from $39,380 to $47,130 in 2010 dollars.[†] Among private carrier claims, the increase was a bit steeper at 24%. Average medical costs per claim are up 11% in the same

[*] Oregon Workers' Compensation Premium Rate Ranking, Oregon Department of Consumer & Business Services. The only public national study of premium rates, this report bases its indexed rates on premiums for a mix of occupational classes reflecting payroll in Oregon. Its authors believe this does not significantly skew the results, and they have successfully tested their hypothesis.

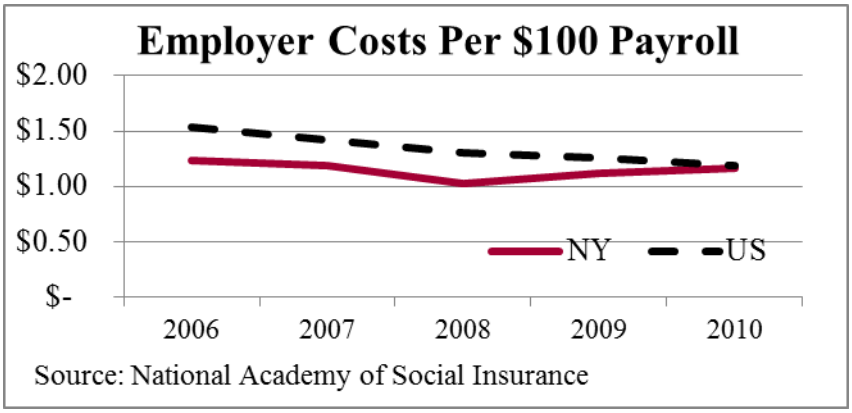
[†] Analysis conducted for CGR by the NYS Compensation Insurance Rating Board of private carrier and State Insurance Fund claims.

time period, rising from $28,250 to $31,440 (also in 2010 dollars).

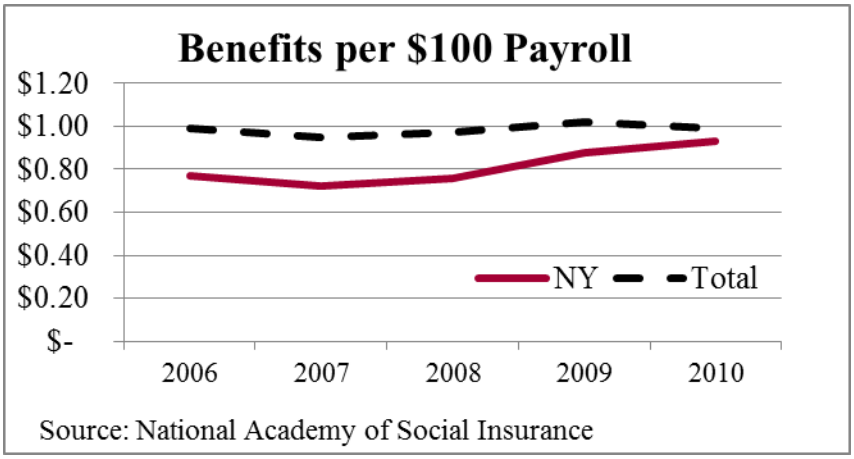
Costs and Benefits – the National Perspective

A national study of workers' compensation finds that New York's overall costs, including costs for self-insured employers, declined in 2007 and 2008 but then began a steady trajectory upward. Relative to national costs per $100 of payroll, New York's costs have been lower, but caught up in 2010. Differences among states are due to many different factors, including benefit levels, mix of occupational classes, regulations about what injuries are considered work-related, and other variables.

Even with the recent, large increases, New York was about in the middle of the states in benefit levels in 2010. New York ranked 29th in temporary total disability benefits and 26th in both permanent total disability and dependency benefits. When it comes to permanent partial disability benefits, New York was significantly higher, 15th among the states.*



Source: National Academy of Social Insurance



Source: National Academy of Social Insurance

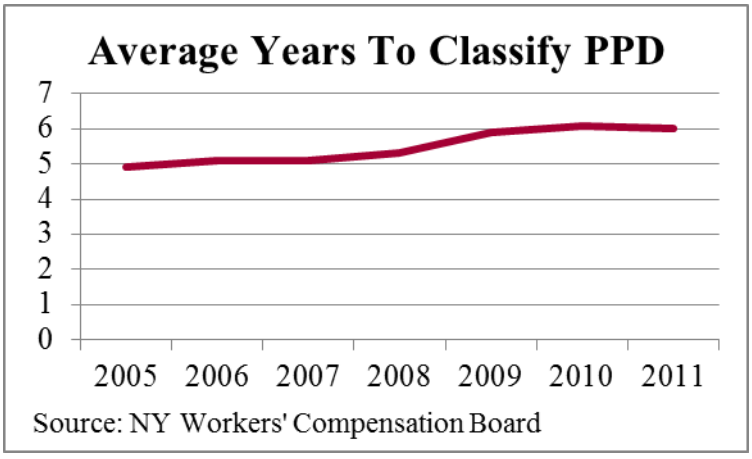
In 2010, average premiums as reported by the national premium study were 13th in the nation, a finding that seems at odds with the national results for overall employer costs. While the two studies seem to have divergent results, understanding the details of the methodologies helps us reconcile them. In the National Academy of Social Insurance report estimates of employer costs, the authors use a national average to estimate the costs of assessments. We know that NY's assessments are in fact dramatically higher than all other states. If we account for that fact and estimate that total employer costs may be as much as 20% higher than the NY figure reported in the

* Workers' Compensation: Benefits, Coverage, and Costs, 2010, National Academy of Social Insurance.

study, that puts NY about 20% higher than the national level, close to the 115% above national median finding of the premium study.

PERMANENT PARTIAL DISABILITIES

The key change in 2007 from a cost-savings perspective was the adoption of time limits on benefits to workers with permanent partial disabilities. For employers, this was the change that made them willing to support a package that included higher benefits. Before 2007, workers with permanent partial disabilities were classified as mild, moderate or markedly disabled and awarded benefits for as long as their disability persisted and reduced their ability to work and earn a living. The 2007 reforms called for a more fine-grained determination of a worker's level of disability and the impact on his/her wage-earning capacity, which would drive the number of weeks the worker would be eligible for benefits. Lifetime benefits would no longer be available to workers with partial disabilities; instead cases would be "capped" with the number of weeks of benefits tied to the level of disability and loss of wage-earning capacity of the worker.



But the new system has taken years to develop and implement, and many observers say implementation is far from complete. Two groups of employer, worker and state representatives wrestled with the issues of how to evaluate levels of disability and determine loss of wage-earning capacity, and the state's advisory committee didn't even recommend guidelines until 2010. Those guidelines took effect Jan. 1, 2012. They call for injured workers to be classified into 1 of 12 gradations of disability (from 0-15% disabled to 95-99% disabled) and then awarded a corresponding number of weeks of benefits (from 225 to 525 weeks).

But to what degree are the new guidelines being used by participants in the system – treating physicians, independent medical examiners hired by carriers and employers, claimant and carrier attorneys, and administrative law judges who must eventually rule on these issues – and resulting in caps? Many in the employer community believe the guidelines are not being uniformly applied. In fact, some question whether the guidelines are being used much at all, reporting that system participants instead default to the old set of rules and that cases are not being capped.

According to the Workers' Compensation Board, as of late September, 3,505 post-reform cases had been classified and benefits capped. Further,

the Board reports that it has made significant efforts to educate both doctors and administrative law judges in using the guidelines and implementing the new system. In fact, Executive Director Jeffrey Fenster said the agency has told its judges that if medical providers (treating physicians or independent medical examiners) use the old system for rating disability levels, they should consider that evidence unpersuasive. Also, in February the Board sent letters to insurance carriers about 3,500 cases that it thought might be ready to be classified and capped, but carriers took action in only about 13% of the cases.

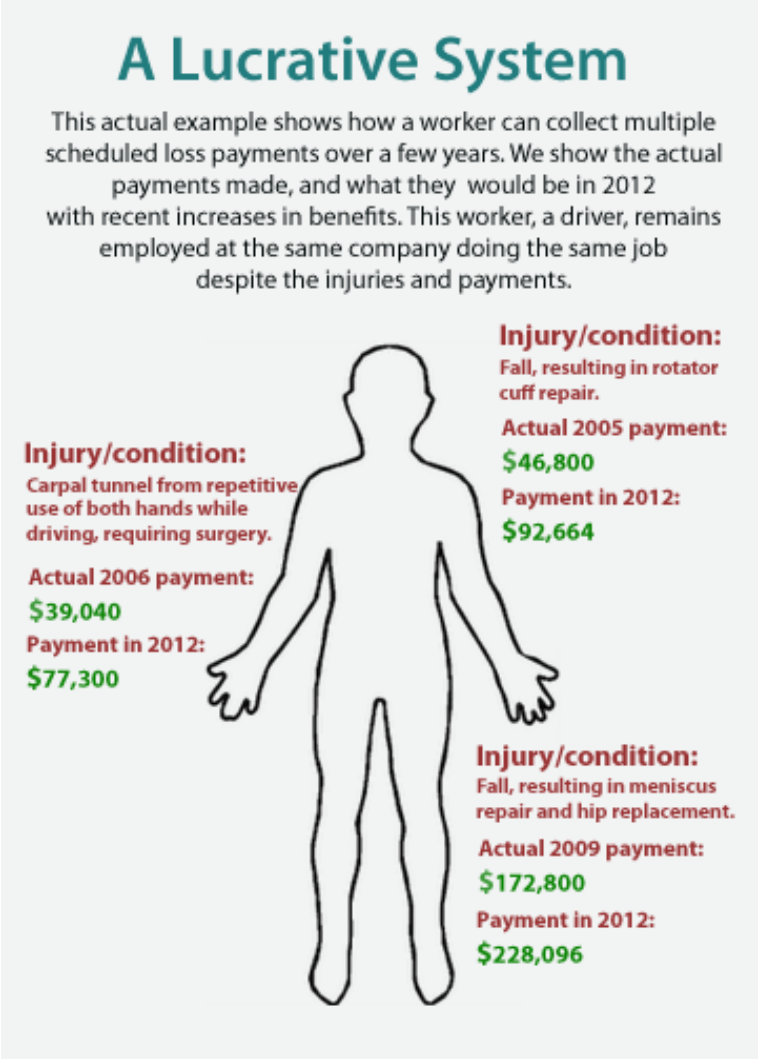
In addition, settlements are up, rising 17% since 2006 to about 11,000 in 2011 – which the Board attributes at least partially to the reforms and caps in PPD cases.

However, cases are also apparently taking longer to resolve. Already one of the slower states in classifying permanent partial cases, New York has become even slower, from about an average of about 5 years from accident to classification in 2006 to 6 years in 2011. This means any significant cost savings is still years away.

Scheduled Losses – an Unanticipated Cost Increase

While these reforms may be working their way into the system, one set of permanently partially disabled workers saw a dramatic increase in benefits – those with "scheduled losses." Workers who suffer permanent impairment to extremities, eyesight or hearing, or facial disfigurement qualify for a "scheduled loss" payment that is based on the overall maximum benefit level. A one-page chart published by the Workers' Compensation Board lists the relevant body parts, percentage loss of use and resultant number of weeks of benefits. For example, an injury resulting in a 25% loss of the use of one's arm qualifies a worker for 78 weeks of benefits, while a complete loss drives 312 weeks of benefits.

But workers with scheduled losses are being evaluated according to impairment guidelines last considered in 1996. Critics say the levels of impairment and payments are being driven by decades-old medicine that doesn't reflect dramatic advances in surgery and other treatments since then. And while updated medical guidelines weren't adopted, higher benefit rates were, so a 25% loss to an arm can cost nearly double what it cost in 2007, more than $61,000. Furthermore, these benefits are made regardless of whether an employee loses any time from work.



A good example is a hip replacement, surgery from which many people make a full recovery. Under NY's scheduled loss guidelines, a hip replacement is considered to result in permanent, 60% loss in the use of a leg, an impairment that calls for nearly 173 weeks of benefits in the schedule. In 2006, that would have resulted in a maximum payment of just over $69,000, but with the benefit increases, that amount has increased to nearly $137,000. Scheduled losses have become so lucrative that some in the employer community report there are employees who "work their way" through all the eligible body parts, gaining hundreds of thousands of dollars in benefits.

MEDICAL TREATMENT GUIDELINES

In 2007, employers were also heartened by the promise of new treatment guidelines that would spell out how injuries should be assessed and treated using the latest medical knowledge. On the cost side, employers hoped to reduce unnecessary tests and treatments, and more effective treatment also promised to help workers heal and return to their jobs more quickly.

Here too, implementation was drawn out, with employer, worker and state representatives on a task force struggling to reach agreements. It wasn't until Dec. 1, 2010 that the first guidelines took effect, covering the neck, shoulder, lower back and knee. The Workers' Compensation Board has issued draft guidelines for treatment of carpal tunnel syndrome and is seeking public comments, and guidelines for treatment of chronic pain are in the works.

As with many of the 2007 reforms, there is little data documenting the impact of the guidelines. Generally, medical costs have continued to rise (one factor was an increase in provider reimbursements adopted as part of the 2007 reforms), but the trend has flattened out in the last few years.* The Compensation Insurance Rating Board estimates that the impact of the medical treatment guidelines as a separate factor has been an annual 10% reduction in costs for the covered body parts, or 5% overall, based on surveys and qualitative information gathered from carriers.

Another unknown is the extent to which providers are adhering to the guidelines, and what the impact is. One indication may be requests to provide treatment not authorized by the guidelines. Insurers and the Board receive about 4,000 variance requests a week; about a quarter are approved by carriers, 40% denied by carriers or the Board, and 30% unanswered by carriers, according to the Workers' Compensation Board. Denied variances can be appealed to the Board; about a third of denials are, and most of those (80%) are rejected by the Board.

The Board is working with stakeholders on ways to reduce variances, which most stakeholders believe are increasing overall costs. The solutions the Board is examining include pre-authorizing additional chiropractic, physical therapy and occupational therapy visits up to 10 per year (total in all 3 categories), as the vast majority of variance requests pertain to these types of treatments. Executive Director Fenster said he believes this will not dramatically increase medical costs since much of the requested treatment is already occurring.

Fenster said the Board will study the impact of the Medical Treatment Guidelines and assess not only whether they are reducing costs but also if they are speeding employees' return to work. Further, he said anecdotally he believes that those in the system who are aggressively using the guidelines to challenge unauthorized treatments are seeing greater cost savings than 5-10%.

The guidelines have stirred up resentment in the injured worker community, particularly because they apply retroactively, to workers injured before 2007, some of whom may have been receiving now-disfavored treatments for years. As a result, worker advocates have pushed for bills in the state Legislature arguing that the guidelines should not apply to workers injured before 2007, which employers oppose on the grounds that the guidelines reflect current standards of care.

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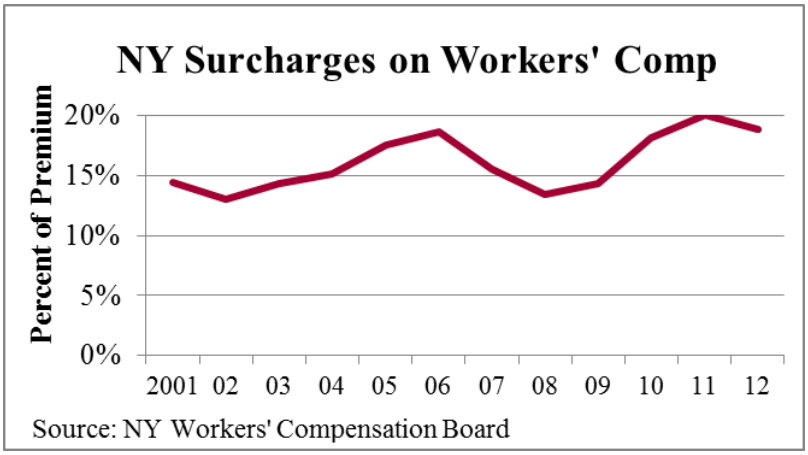
* See chart of average medical costs per claim on Page 5.

ASSESSMENTS

At the same time that premiums have for the most part been rising, so too have New York State's surcharges on those premiums, reaching a decade-high of 20.2% of premiums in 2011. In 2012, the assessment fell to just under 19%, still far more than twice as much as the next highest state.* The average assessment among the 32 states with such a surcharge was just 3.8% in 2012.

Although the 2007 reforms also took aim at this issue, they've clearly failed to hit their mark. The reform closed the Second Injury Fund, which consumes half the revenue from the state surcharge, to new cases. The Fund, created after World War II as an inducement to employers to hire disabled war veterans, reimburses employers after 5 years of payments for claims made worse by an injured worker's prior permanent disability.



As envisioned by the reforms, the Second Injury Fund and its need for revenue would decline as the state reached settlements with claimants. However, only about 8,000 of 58,000 cases have been settled, according to the Workers' Compensation Board. Another idea was to sell some of the Fund's liabilities to a private insurer, who theoretically could make a profit through more aggressive management of cases. But that didn't pan out – no insurers were willing to buy at a price that would make sense for the state.

The two other largest expenses funded from the surcharge are a Reopened Case Fund and the administrative cost of the Workers' Comp Board itself. Without significant changes, neither of these is expected to decline in the near term; in fact, the reforms to permanently partially disabled cases may result in an increase in reopened cases, which pays costs on claims that have been closed for more than 7 years but are reopened. The Board's executive director said the state is considering ways of reducing the assessments, but he could not provide specifics.

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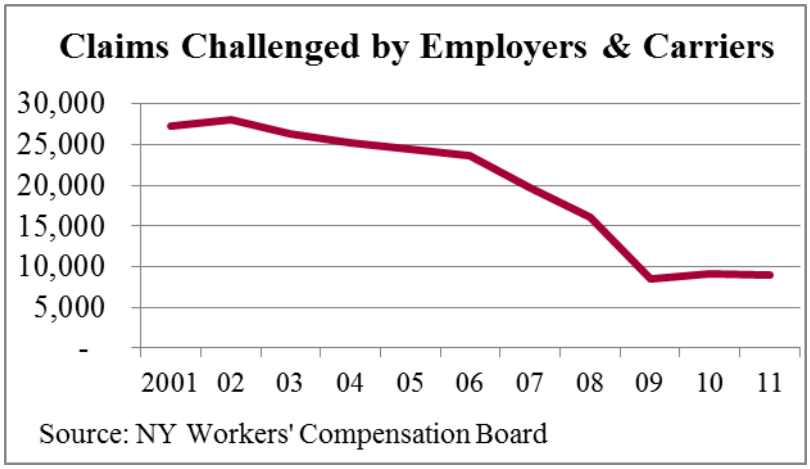
* Workers' Compensation Assessments 2012: New York Remains the Highest in the Nation, Sept. 4, 2012, Workers' Compensation Policy Institute.

In addition, a looming crisis in the group self-insurance market may affect future assessments. Several group trusts have become insolvent due to an inability to cover claims, and estimates are that the total in unfunded liabilities may reach $700 million to $1 billion. Some argue the state played a role by failing to adequately supervise the group trusts, and how the state will manage this problem is unknown.

ADMINISTRATIVE STREAMLINING

Another key provision of the 2007 reforms was an attempt to streamline the bureaucracy, particularly around claims that are disputed by employers. Before 2007, employers and carriers often routinely challenged claims rather than risk being barred from raising issues if they waited more than 25 days from the time a claim was filed. The streamlining effort, known as "Rocket Docket," changed the Workers' Compensation Board's rules for assembling and indexing cases, and required employers and carriers to compile more information and evidence in order to challenge a claim. As a result, challenged, or controverted claims, have declined more than 60% since 2006. Another measure, the number of claims still pending at the end of the year, has also moved in the right direction, falling 19% since 2006. But that number still stood at just under 100,000 claims in 2011.



It's not clear whether claims that are challenged are moving through the Workers' Comp Board more quickly than they used to, or whether in general the Board's processes have improved. One goal of the Rocket Docket was to resolve challenged claims within 90 days. While 58% of challenged claims met that benchmark in 2011, the average number of days to resolve challenged claims increased from 67 in 2009 to 75 in 2011, according to the Board's annual reports.*

The Board's executive director acknowledges that despite some successes the entire system needs an overhaul and has issued a request for proposals for a consultant to design a business process re-engineering effort. The goal will be to reduce the Board's involvement in routine claims and better focus the agency's effort on monitoring the system at a macro level.

* See http://www.wcb.ny.gov/content/main/TheBoard/publications.jsp

Potential vendors will be interviewed this fall, and Fenster expects the design to be completed in 18 months, with construction of the system to follow, a model which has provided successful in other states.

An unintended consequence of the streamlining effort: the new forms put in place to speed procedures are lengthier and more cumbersome for medical providers. As a result, some providers have given up taking workers' comp cases, surrendering their state-provided authorizations. No numbers were available from the Workers' Comp Board, but there were enough disaffected providers in the Rochester area that the Board declared a temporary provider shortage and is allowing area providers to use the old forms.

Tracking Progress

In both 2008 and 2009, the Board in conjunction with the state Insurance Department issued lengthy, data-packed reports tracking the impact of the 2007 reforms. Specific benchmarks measured progress on administrative streamlining, cost, medical treatment guidelines, access to medical care, adequacy of benefits, return to work and fraud. But these "Joint Reports" are no longer being produced, and our request to the Board for such data under the Freedom of Information Law was denied. The Board said it did not have the data and couldn't obtain it without devoting dozens and in some cases hundreds of programming hours to the task.

Board Executive Director Fenster said the Joint Reports had required the equivalent of $300,000 in person hours to produce and that a key player in that effort retired. The Board could no longer afford such an expensive study. However, the Board is working to build a Data Warehouse that will speed data extraction and analysis. A small research team recently given a new leader will be doing more analysis and providing relevant reports in the near future.

RECOMMENDATIONS

The job begun in 2007 is far from over; while benefits have increased as promised under the reforms, cost savings pledged to employers have failed to materialize. New York State needs to revisit the issue of workers' compensation and take additional actions to reform the workers' compensation bureaucracy and reduce costs. Specifically, the state should:

- **Require the Workers' Compensation Board to track and publicly report on progress**. The state should regularly report on such areas as claims processing and other measures of agency performance; classification of workers by disability level; number and disposition of requests for variances from Medical Treatment Guidelines; assessment

levels; the status of the Second Injury Fund and its outstanding claims; and overall costs, including for self-insured employers.

- **Appoint a Workers' Comp Czar**. Accelerate New York's reform effort by engaging an expert with reform experience from other states to critically assess New York's system, similar to Gov. Cuomo's hiring of Jason Helgerson from Wisconsin as "Medicaid czar."
- **Reform the approach to indexing benefits**. Eliminate the indexing of benefits to statewide average weekly wage, or adopt a regional approach. Higher downstate salaries unfairly drive up benefits for Upstate workers and costs for employers.
- **Implement updated medical standards in calculating scheduled loss awards**. This would bring scheduled loss payments in line with current medical practice by acknowledging how advances in medicine have improved healing and reduced permanent impairments. Reflecting the fact that many workers lose no or little time from work, the Board should return to a practice of using half the benefit rate in the calculation of benefits.
- **Reduce New York's highest in the nation assessments**. Through accelerating settlements of Second Injury Funds cases or reducing state administrative expenses, the state must find a way to bring premium taxes more in line with the national level.
- **Make the caps on permanent partial disability cases work**. There are several steps the state can take immediately to make this happen:
  - Adopt a presumption that maximum medical improvement has been reached within 6 months to 2 years, unless there is evidence to the contrary;
  - Provide more training and guidance to practitioners and administrative law judges about how to convert from the old system to the new system for classifying workers;
  - Study the disability ratings of medical providers to identify outliers – providers who routinely and significantly depart from their colleagues.
- **Reject legislative rollbacks**. Some legislators have proposed changing the compromise on which the reforms were based. Proposals such as exempting pre-2007 claimants from the Medical Treatment Guidelines or creating loopholes in the pharmaceutical fee schedule should be defeated.