Revisiting the Reforms

October 2012
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Executive summary

On July 17, 2012, Governor Andrew M. Cuomo announced that the annual loss cost increase for workers’ compensation premium rates recommended by the New York Compensation Insurance Rating Board (CIRB) had been deemed unnecessary by the state Department of Financial Services (DFS). According to a press release from the Governor’s office, policyholders would see a 1.2 percent decrease in rates, the first such reduction since 2008. Further, the release went on to state that "...the last measures of the 2007 Workers’ Compensation Reform Law, which secured necessary benefit increases for injured workers and cost reductions for businesses, have now been fully implemented by the state.”

The 2007 workers’ compensation reforms were intended to balance increased benefits to injured workers with policy and administrative reforms that provide premium reductions for employers. However, concerns have been raised by the business community that this legislation has been too slowly implemented and that the measures intended to result in tangible cost savings to employers, estimated at over 10 percent at the time of the reform, have not been realized. In fact, the only post-reform years to show any cost savings to employers have been those in which the loss cost rate was established in spite of actuarial findings.

In Revisiting the Reforms, the Public Policy Institute (PPI) explores major provisions of the 2007 reforms, including: increasing the maximum weekly benefit; capping non-schedule permanent partial disability (PPD-NSL) payments; closing the Second Injury Fund; implementing medical treatment guidelines; instituting an expedited hearing process (aka Rocket Docket); and promoting return to work.

According to estimates from the New York State Workers’ Compensation Board (WCB), there were roughly 240,000 claimants receiving benefits in 2011 (the actual number of claims could vary from this figure for a number of reasons). The total cost of New York’s workers’ compensation system is estimated to be $6 billion, according to the WCB, approximately the same as it was before the 2007 reforms. (The WCB noted that these are rough estimates based on the data available in its systems and a limited time frame for analysis and quality control).
Workers’ compensation laws were enacted as a matter of public policy, with an ultimate goal of getting an injured worker to a point where he or she is able to return to work. The laws have a two-fold purpose, which is to:

- Provide that a worker injured or made sick on the job will receive medical, surgical and hospital treatments, and when required, receive either indemnity payments to replace lost wages or disability benefits if he or she cannot return to work; and
- Guarantee to employers, who are mandated by law to purchase workers’ compensation insurance, that the covered worker will be barred from suing the employer for on-the-job injuries or illness.

The cost of workers’ compensation claims continues to rise in New York State; additionally, New York imposes an 18.8 percent assessment on premiums to pay for system costs, an assessment level that is nearly five times the average imposed in other states (Jahn, Stickle, & Morris, 2012b). Oliver Wyman Actuarial Consulting Inc. predicted that the average total claim cost in New York in 2013 will be $50,000, including the cost of state-imposed assessments under Sections 15-8 and 25A of the New York Workers’ Compensation Law. In 2007, according to Oliver Wyman, the average total claim cost including these assessments was $27,533. On a national level, medical costs associated with workers’ compensation continue to increase, despite Bureau of Labor Statistics data that indicate a 10-year trend of decreasing severity of workplace injuries and declining fatalities (as cited in Deitz, 2011, p. 4).

A 2012 study by the Oregon Department of Consumer and Business Services indicates that New York has the fifth highest workers’ compensation premium rates in the nation (Dotter & Manley).

As is typically the case with insurance industry data, there is a multi-year lag between collection and publication (Lefkowitz & McKinnon, 2012a). The most recent claims data available from CIRB is from policy year 2008. However, after analyzing available data and speaking with individuals in the private insurance industry, self-insured employers, high deductible employers, medical practitioners and the WCB, PPI concludes that — although the WCB and the Executive have acknowledged the full implementation of the 2007 reforms — New York continues to see increases in claim costs and delays in the classification of PPD-NSL claims. These factors contribute to the growing costs of a system paid for exclusively by New York’s employers and act as a disadvantage to economic development.

At the five-year anniversary of the reforms, PPI — after speaking to various workers’ comp professionals — has made the following observations:

- **PPD-NSL classifications have taken far longer to achieve than before the reform.** Several disincentives against such classifications exist. Claimants and claimants’ attorneys may be reluctant to begin a countdown to durational caps on indemnity payments, and private carriers may be reluctant to classify due to the required deposit of a PPD’s present value into the Aggregate Trust Fund (ATF).
In 2011, according to data from the WCB, the 3,937 PPD-NSL cases that were classified had taken an average of six years to do so. In 2005, it took an average of 4.9 years for such cases to classify.

- **Schedule loss-of-use (SLU) ratings are costly and outdated.** The system by which SLU awards are determined utilizes medical guidelines from 1996 — parts of which are carried over from 1984 guidelines — for determining the loss of use of extremities. Additionally, with the near doubling of the maximum weekly indemnity benefit under indexing, the cost of SLU awards has dramatically increased. According to data provided by the WCB, for claims with a date of accident in 2006, the average monetary value of an SLU award was $21,231. Three years later, this figure had increased over 30 percent, with SLU awards averaging $27,695 in 2009.

- **The maximum weekly benefit (MWB), which has nearly doubled in the past five years, is driving up costs.** This major upswing in the MWB, coupled with the delay in classifying claims, has added considerably to costs in the workers’ compensation system.

- **Medical treatment guidelines, when utilized, are widely regarded as an effective tool in providing up-to-date treatment for claimants, while simultaneously controlling costs by excluding excessive, ineffective treatments.** Data on the effectiveness of the guidelines, promulgated in 2010, is still premature. However, practitioners interviewed by PPI agreed that evidence-based medical treatment guidelines are crucial in producing positive health outcomes for claimants.

- **Pharmaceutical networks remain underutilized by self-insured employers.** Significant penalties for noncompliance with the WCB’s detailed regulations and an employer’s obligation to notify all “potential” claimants of its designated pharmacies have resulted in below-average participation on the part of self-insured employers.

In order to remedy the shortcomings of the 2007 reforms, PPI recommends:

- **Modernizing the SLU rating system** by updating the applicable medical treatment guidelines, to more accurately reflect the severity of an injury with respect to its effect on a claimant’s ability to perform necessary job duties, recovery time and amount of permanent disability. Educating judges — from a medical perspective — on how to apply SLU ratings would also be beneficial in reducing workers’ comp costs. Re-examining the formula through which SLU awards are determined — perhaps by reducing the rate of compensation for SLU awards that are unrelated to any lost time — would also make the system more equitable.

- **Implementing a training program through which physical and occupational therapists can determine SLU to help assure more objective, consistent and cost-effective determinations in regard to range of motion.**

- **De-indexing the MWB** (which has increased at over six times the rate of increase in cost-of-living adjustments) to control growing program costs, allow for future necessary program reforms and reduce any unintended disincentive for claimants to return to work. At the minimum, there needs to be further examination of the MWB with respect to regional average weekly wages.

- **Limiting total temporary disability (TTD) benefits by presuming that maximum medical improvement is reached two years from the date of an accident,** to help incentivize quicker classification on the part of claimants and their attorneys. Other possible alternatives to remedy this problem include beginning the cap at the date of injury, or reducing the amount of a capped award by a portion of the TTD benefits received prior to classification of a PPD-NSL.

- **Mandating the use of panel providers for the first 90 days of treatment.** New York should consider the approach used in Pennsylvania, where employers may post a list of designated health care providers and direct workers to select from the list when seeking treatment for a work injury or illness.
• **Eliminating the ATF requirement for commercial carriers.** Requiring commercial carriers to deposit the present value of a PPD into the ATF provides a disincentive to classify claims. Amending the law to remove this mandate, and restoring the pre-2007 WCB discretion to require ATF deposits, would help — on the private carriers’ end — to lessen the time frame from the date of an accident to classification.

• **Creating a partnership between the Office of Professional Misconduct and the WCB to form an oversight board on appropriateness of care.** This new entity would review those cases in which patients were receiving care outside of the normal range of treatment (e.g., cases where patients are being given over 130 mg of Oxycontin per day would be flagged). This would weed out bad actors from the system by not only threatening WCB action, but that of licensure.

• **Blocking attempts to undo the cost-savings measures in the reforms.** There have been several attempts to undo such provisions in the workers’ comp reforms. Legislation introduced in 2012 would limit the retroactive application of medical care guidelines, which were adopted in 2010 to provide quality care to claimants while ensuring that practitioners utilized evidence-based, up-to-date treatments. Another measure would permit an injured employee to utilize pharmacies out of his or her employer’s network, as long as that pharmacy matched the state’s published prices, often higher than negotiated volume discount prices.

• **Removing the universal notification requirement for pharmaceutical networks** so that the requirements for participation in these networks more closely mirror the provisions for diagnostic network participation.

• **Streamlining data collection** so that researchers, legislators and the public at large will be able to better gauge the effectiveness of the 2007 reforms. Recent quantifiable data on claims is largely unavailable.

• **Instituting enhanced training of administrative law judges** to promote stronger adherence to laws and regulations, and medical treatment guidelines. (For example, a self-insured employer that PPI interviewed noted that in many cases, claimants and their attorneys fail to provide sufficient information on employee claim [C-3] forms. This is a problem that could be remedied through further training).

• **Achieving greater balance by shifting the culture at the WCB away from perceived presumption in the employee’s favor.**
Introduction

New York enacted its workers’ compensation statute in 1914; prior to that time, the burden of proof for an on-the-job injury was on the employee, who had to sue the employer and prove negligence in order to recover damages. The Empire State’s century-old, no fault system was spurred by the tragic Triangle Shirtwaist Factory Fire in 1911, which claimed the lives of 146 predominantly young, female immigrants, and underscored the need for greater workers’ protection.

According to New York Workers’ Compensation Law, disability or death benefits for an employee are ensured without regard to fault, with limited exceptions.

Most employers are mandated to acquire workers’ compensation insurance, which can be obtained through private insurance carriers, through the State Insurance Fund or by becoming authorized by the WCB to be self-insured. Small organizations may join safety groups, and counties, cities, villages, town, school or fire districts or other state political subdivisions are considered to be self-insured unless a policy is purchased.

The Employers’ Handbook to Workers’ Compensation in New York State indicates that premiums paid by employers for workers’ comp insurance reflect the employer’s potential liability for claims based on individual experience, wages paid to employees and industry type (WCB, p. 64). Assessments cover the operational costs of the Board and related activities of other agencies, and fund the Special Disability/Second Injury Fund, Fund for Reopened Cases, Uninsured Employers Fund and the Special Fund for Disability Benefits.

The 2007 Workers’ Compensation Reform Act

In 2007, then-governor Eliot Spitzer signed into law legislation reforming the workers’ comp system in New York. The bill, touted as a consensus between labor and business, included provisions to:

- Increase the maximum weekly benefit level, and then index it to two-thirds of the average weekly wage;
- Cap PPD-NSL awards by applying a 525-week durational limit;
- Promote return to work rates by creating a Return to Work program and incentives;
- Close the Second Injury Fund and create the Waiver Agreement Management Organization to help settle second injury cases;
- Require the promulgation of regulations instituting pharmaceutical fee schedules and authorize pharmaceutical and diagnostic networks; and
- Mandate private insurance carriers to pay the present value of benefits to the ATF.

Spitzer, in a letter to the commissioner of labor, WCB chair and acting superintendent of the state Insurance Department dated March 13, 2007, stated, “But these statutory reforms are not enough. The public expects all of us in government to use our existing resources in a better and smarter way.” He directed an undertaking of additional initiatives, which included designing a data collection system and a streamlined docket, through which claimants’ cases would be adjudicated within 90 days of the date of dispute. Spitzer also called for updated medical guidelines. He stated, “Experts in New York’s system unanimously report that existing medical guidelines for the workers’ compensation system are inadequate. They do not take into account modern diagnostic and treatment techniques, and are insufficient to rationalize outcomes in benefit determinations across the State.”
Doubling of maximum weekly benefit drives up claims costs

The 2007 reforms increased the permanent or temporary partial disability and permanent or temporary total disability benefits in set increments for several years, and then required that it increase to two-thirds of the state average weekly wage each year thereafter. At the time of the reform, the MWB was $400. Subsequent increases were as follows:

- $500 on or after July 1, 2007
- $550 on or after July 1, 2008
- $600 on or after July 1, 2009
- $739.83 on or after July 1, 2010
- $772.96 on or after July 1, 2011
- $792.07 on or after July 1, 2012

*COLAs are based on data from the Bureau of Labor Statistics. Please note the different calendar cycles for determining the MWB and COLAs.
Unlike the cost-savings portions of the 2007 reforms, the effects of which are debatable, the fact that the MWB has nearly doubled since 2006 is irrefutable.

By 2013, Oliver Wyman Actuarial Consulting Inc. expects the average cost of a lost time claim to be approximately $130,000 and the average total cost of a workers’ compensation claim to be approximately $50,000. These estimates include provisions for indemnity and medical benefits, as well as 15-8 and 25A assessments.

"The $130,000 and $50,000 forecasts are based on the same New York State insurance industry data used to determine workers’ compensation premium rates in New York, without adjustment," said Scott McKinnon, senior consultant at Oliver Wyman. "If one were to believe the optimistic assumptions that form the basis of the most recent decision by New York State regarding workers’ compensation premium rates, these values would likely be closer to approximately $95,000 and $37,500, respectively. The primary issue with these assumptions is that they are generally not supported by data that has emerged to date in New York State."

Examining the post-reform delay in classification

The anticipated major cost-savings provision of the 2007 reform was the cap on the maximum number of weeks that PPD-NSL claimants are able to receive indemnity payments, based on an injured worker’s loss of wage earning capacity.

Claimants may receive an exemption on caps if the PPD is determined to be 80 percent or greater. Prior to the finding that a claimant has reached maximum medical improvement (MMI) and has been classified, claimants may collect TTD benefits. It’s still too early to determine if the durational caps on PPD-NSL benefits will result in a large number of claimants attempting to reclassify as permanently totally disabled.

While some research cautions that the full effect of capping permanent partial disability payments will not be seen until 2018 (Telles & Tanabe, 2011) industry professionals are wary that this provision, which was intended to be the central cost-savings measure, has not been successful. This skepticism is centered on the fact that there has been a post-reform delay in the classification of PPD-NSL claims that is driven — according to some of those interviewed — by unwillingness on the part of claimants and claimants’ attorneys to begin the countdown on durational caps.
Since there was no cap on indemnity benefits pre-reform, claimants (and their attorneys) were inclined to settle at a quicker rate. Some of those in the business community who were interviewed pointed out that the limitations implemented in 2007 eliminated the incentive to settle and have the cap applied, since claimants receive indexed benefits in the interim.

In testimony given to the DFS, Ziv Kimmel, vice president and chief actuary at CIRB, stated that the timeline from the date of an injury to the date of classification had “substantially increased,” despite initial predictions that the waiting time would remain the same (2012, p. 2).

“With respect to the cost-savings elements, most of them required some action by the Board, notably in the indexing of claims, and that whole process has been very slow; it’s only now beginning to occur on a consistent basis,” stated Fred Buse, managing director at Schwartz Heslin Group. “So only in the future will we expect to see any of the benefits of the cap on permanent partial disability.”

Some of those interviewed by PPI noted that durational caps provided an incentive for the earlier and more timely settlement of potential PPD claims. “Caps do change the legal landscape,” noted Steve Scotti, assistant general counsel at Consolidated Edison, who said he has seen many cases settled via a Section 32 Agreement in lieu of litigation regarding the imposition of a PPD cap.

Brian Trick, claims manager for Wegmans, stated that there had been some success in settling potential PPD cases that would have been subject to the cap. However, he also noted that out of the company’s lost time claims post-reform, only five had been capped.

Some of those interviewed noted that delays in implementing the caps, and the lack of guidance provided to administrative law judges on how to apply them, also contributed to the slow classification rate of PPD-NSL claims.

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<th>Classification year</th>
<th># of cases classified</th>
<th>Average # of years</th>
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<td>2005</td>
<td>8,848</td>
<td>4.9</td>
</tr>
<tr>
<td>2006</td>
<td>8,791</td>
<td>5.1</td>
</tr>
<tr>
<td>2007</td>
<td>8,080</td>
<td>5.1</td>
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<tr>
<td>2008</td>
<td>7,406</td>
<td>5.3</td>
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<tr>
<td>2009</td>
<td>6,447</td>
<td>5.9</td>
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<tr>
<td>2010</td>
<td>3,684</td>
<td>6.1</td>
</tr>
<tr>
<td>2011</td>
<td>3,937</td>
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Source: WCB
Aggregate Trust Fund

The WCB points to an additional source of delay in classification. In his June 2012 testimony to the DFS on CIRB’s rate filing request, Mark Humowiecki, the WCB’s deputy executive director of policy and program development, stated:

"The Board took the step of pushing the parties to raise classification because the data showed that carriers were not actively pursuing it at the rate one would expect. Whether because of the requirement to pay into the ATF or for other reasons, carriers have pursued classification at rates far below that of the State Fund, self-insured employers, or what was contemplated in 2007."

Several of those interviewed identified this ATF requirement as an impediment to classification.

"It took a while for the Board to put disability guidelines in place ... however, there was a certain amount of validity to the Board testimony that carriers have not pursued classification because of the Aggregate Trust Fund," said Paul Jahn, executive director of the Workers’ Compensation Policy Institute.

The ATF is a state entity that — up until the reforms of 2007 — collected money from private carriers only in claims involving death and permanent total disability. In the eleventh hour of negotiations, according to Jahn, a measure was included that required commercial carriers to deposit the present value of any PPD into the trust fund. "It was an odd request, but there was a desire to have the reform package done," said Jahn. As a result the carrier has to write a check to the state for the full value of their reserves any time a claimant is classified as PPD.

Jahn noted that if the requirement that insurers put PPD reserves into the ATF was removed, it could incentivize quicker classification.

One of the major questions surrounding this ATF stipulation, according to Jahn, is whether or not it creates a volatile insurance market. "If big carriers are required to write these checks, they’ll either disappear, or private insurance will only be available for major interstate corporations that are important clients to the carriers," he noted.

Growth of 25A assessments: An unintended consequence of durational caps

Jahn noted that an unintended consequence of the 2007 reforms was that the Special Fund of Reopened Cases was going to grow. For cases in which the date of the injury or death is more than seven years old, and in which the date of the last indemnity payment is more than three years ago, medical and indemnity payments are made by the Special Funds Conservation Committee if the WCB establishes a Section 25A claim.

When the system paid benefits over the life of a permanently disabled claimant, explained Jahn, that claimant could not apply for 25A because there was an ongoing obligation to pay indemnity benefits. With the imposition of caps, claims that would not qualify for 25A in the past will become eligible for 25A in the future.

Jahn also noted that 58 percent of the Public Employer Risk Management Association Inc.’s Section 32 settlements negotiated over the last six months settled the indemnity portion of the claims but left the medical open, making such claims eligible for 25A relief in several years.

"This is a long term problem for the system that will likely not emerge for another few years, just about the time when second injury assessments will begin to decline," Jahn said. "The eventual elimination of the Second Injury Fund will probably outweigh the increase in 25A over time, but the savings are not as great as I think we anticipated back in 2007."
Data from the WCB indicates that the number of reopened claims jumped by over 15 percent between 2010 and 2011 (from 196,160 to 227,030).

Closing of the Special Disability/Second Injury Fund expected to be revenue neutral

The 2007 reforms also closed the pay-as-you-go Special Disability/Second Injury Fund which, according to Buse, was never properly funded. The fund is furnished through Section 15-8 assessments levied on workers’ comp carriers and self-insured employers by the WCB; five years after the date of the second injury, reimbursement is provided for indemnity and medical benefits. The 2007 reforms laid out a plan for shutting the fund to new claims on or after July 1 of 2007, and closing the fund down for all new reimbursement claims by July 1, 2010.

The closing of the fund has not resulted in any significant cost savings and — as discussed later in this section — may actually serve as a disincentive for employers to hire part-time employees.

The passage of the Americans with Disabilities Act in 1990 removed the need for the fund, which was created in 1916 to ensure that employers did not discriminate against veterans on account of injuries incurred during war by reducing employer liability in cases where workers’ comp injuries are exacerbated by previous injuries.
Currently, the assessment surcharge in New York added to workers’ comp costs (to pay for the Special Disability/Second Injury Fund, Fund for Reopened Cases, Uninsured Employers Fund and the Special Fund for Disability Benefits) dwarfs that in other states. According to the Workers’ Compensation Policy Institute, it is more than double that of the second most expensive state in the nation. The institute found that, in a study of 32 states that impose an assessment tax on premiums paid by employers, the average assessment levied was 3.8 percent. In contrast, New York’s was 18.8 percent (Jahn et. al, 2012).

“It is not like an insurance company, which funds all reserves for all anticipated payments,” explained Buse. “The Second Injury Fund is this huge bucket of claims for which monies are going to be paid out well into the future despite the fact that future claims have been capped.”

He added that the Second Injury Fund is, in effect, a transfer cost; no one ever expected it to result in lower overall expenses. Second Injury Fund discussions in the reform bill were not net savings, but increased efficiencies in the system. The closing of the fund eliminated the need for a second set of adjusters to examine second injury claims.

“In the foreseeable future, (we) will continue to see new cases added to the Second Injury Fund.”
-Paul Jahn

In recent testimony on CIRB’s application for an average loss cost change of +11.5 percent, Scott Lefkowitz, partner with Oliver Wyman Actuarial Consulting Inc., noted that the long term effect of closing the Special Disability Fund “is expected to be at least revenue neutral to the overall system because while employers will no longer be able to seek reimbursements from the fund, they will no longer have to pay assessments. The expectation, however, is that closing of the fund will produce a net savings, given that insurers and employers are expected to more efficiently manage claims than the fund” (2012, p. 2).

The Waiver Agreement Management Organization, established as part of the 2007 reforms to help settle special injury claims, has aided in the closure of 223 Section 32 cases.

Buse stated that, because of the closing of the fund, “Subsequent special injury claims became the responsibility of the insurance industry itself. We’ve increased, marginally, the need for premiums by insurance companies in order to cover (special injury) claims, and we’ve eliminated for the need for some increase in assessments, which were the vehicle that funded the Second Injury Fund.”

In a recent CIRB survey, a majority of private insurance carriers indicated that these claims were settled faster since the closing of the fund, since carriers did not have to obtain the approval of the Second Injury Fund on claims that involved a prior injury.

According to Jahn, “In the foreseeable future, (we) will continue to see new cases added to the Second Injury Fund.” He noted that this should start tapering off in 2014, as claims are settled and in the natural course of claimants aging.

Prior to the 2007 reforms, noted Jahn, the average claim was classified about four years after the accident date. Now, the classification time period is stretching out to five, six, or seven years. As PPI noted earlier in this report, the source of this delay in classification remains an issue of debate.
Another outcome of closing of the Second Injury Fund was the unintended effect on part-time employees. The fund no longer covers Section 14-6 cases, or those of concurrent employment. In cases when an injured employee is concurrently engaged in more than one job at the time of an injury, the employer under which the injury occurred must now pay the full compensation rate for all of the worker’s employment. The additional benefits resulting from the employee’s increased average weekly wage due to concurrent employment between the lost wages of the immediate employment and other employment used to be reimbursed by the Second Injury Fund. Now, an employer has to pick up the full bill for average weekly wage based on both jobs. This could act as a disincentive for employers to hire part-time employees.

The importance of utilizing evidence-based medical treatment guidelines

Practitioners interviewed by PPI touted the use of evidence-based medicine in guidelines as a means to both provide quality care to patients and deter excessive or ineffective treatment.

In New York State, guidelines for the back, neck, knee and shoulder took effect on Dec. 1, 2010. According to the WCB, these represent the most common workplace injuries, accounting for 40 percent of workers’ comp claims and 60 percent of the system’s medical costs. These guidelines represent doctor developed determinations of effective care. Generally speaking, treatment of comp claimants are required to be consistent with these guidelines, although variances can be requested, subject to WCB approval. The WCB has yet to release guidelines for the treatment of carpal tunnel syndrome and chronic pain, which are expected to be implemented by the end of 2012.

Dr. Warren Silverman, medical director of Access Health Systems and president of the New York Occupational and Environmental Medical Association, noted that the guidelines have the potential to reduce workers’ compensation costs, particularly in the use of rehabilitation services, physical therapy, chiropractic medicine and management of medication (predominantly narcotics).

“As far as physical therapy and chiropractic care ... if the ongoing intervention has not made a big change in functionality, it probably shouldn’t be used,” he stated. “It’s the bread and butter for a lot of chiropractors and physical therapists; when it comes to long term care or therapy, I’m not sure how much penetration they get in terms of having the care approved by the carrier. For people who’ve had physical therapy or chiropractic care, if they haven’t had any improvement, continuing to fund the modality is a waste of money. Medical treatment guidelines are designed to try to help control those nonproductive costs — if they are utilized.”
Silverman continued, “Concern with Oxycodone/Oxycontin and various other narcotics has been a big issue, including increasing awareness in the lay press and in the political arena. Workers’ compensation treatment guidelines say that for a chronic condition, two weeks is as long as you should utilize that type of medication.” Continued use beyond that point should be on the basis of a variance request accompanied with evidence of benefit in objective measurable terms which overrides the risk of use and does not exceed reasonable use.

He described a case he recently encountered where an orthopedist was administering 3100 mg per day of Oxycontin to a workers’ compensation claimant. To put this dosage in perspective, Silverman explained that, on average, patients with terminal cancer receiving palliative care received 120 mg per day. The total bill to the carrier for pain medication was between $4,000 and $5,000 each month. Under the New York State guidelines, the two-week limit on narcotics use for chronic conditions might have considerably reduced costs by reducing excessive usage.

Dr. David Deitz, vice president and national medical director of Liberty Mutual Group, emphasized that quality of care, and the use of evidence-based medicine, was a key factor in more efficient treatment for claimants and better return to work rates, but discussed the pushback that existed in utilizing evidence-based medicine.

“It’s the weirdness of workers’ comp, this notion that evidence-based medicine is a controversy and that medical best practices is a controversy ... that notion exists only in workers’ comp,” said Deitz. “If you look at the Mayo Clinic, Park Nicollet, Virginia Mason ... if you look at group health, it’s a non-issue. As long as people (here) accept the status quo, it will never get better.”

Dr. Joseph Pachman, regional medical director at Liberty Mutual Group, explained that he was “cautiously optimistic” with respect to the cost-savings element of medical treatment guidelines. He indicated that in terms of the number of shoulder arthroscopies performed, the guidelines have had no observable impact. He had observed a decline in unnecessary knee surgeries since the implementation of the guidelines.

In a recent survey by CIRB, most private carriers indicated that requests for variance from medical treatment guidelines were generally below 20 percent on new claims; the percentage varied from 50 to 80 percent for existing claims, with several smaller carriers reporting lower percentages.

Average carrier approval rating for variance requests, according to the results of the survey, was 50 percent. When asked if their experience with requests for variance was likely to be stable, or was distorted, by the fact that the guidelines were recently implemented, approximately 50 percent of those carriers surveyed by CIRB indicated that the level of requests would stabilize as providers became more familiar with the guidelines. However, half of the carriers indicated that the levels might increase as providers became more comfortable in “pushing the envelope” on treatments.
Further, many carriers indicated an increase in costs associated with more litigation, increased use of independent medical examiners, additional costs for medical professionals to review cases, an increase in the number of hearings, and investment in the claims system to incorporate guidelines and the variance process.

“We recommended that variance be a medical dispute resolution rather than going through the legal dispute resolution process,” said Deitz. “While folks who file variances can take them to medical directly, for the most part, they’ve chosen not to. They take them to a hearing process instead.”

Deitz noted that, although administrative law judges have supported carriers in many instances on request for variance disputes, the process itself was costly and time consuming. He suggested enhanced training for judges in the dispute resolution process, as well as for treating physicians who aren’t as familiar with the guidelines.

One possible solution to decreasing the amount of variance requests is implementing provider panels and directing employees to utilize only those employer-selected practitioners during the first 90 days of care. In Pennsylvania, employers may post a list of designated health care providers and direct workers to select from the list when seeking treatment for a work injury or illness. A recent survey by the Pennsylvania Department of Labor & Industry found that workers with proper access to such panel providers had returned to work quicker, and reported greater satisfaction with the care they received, than all other respondents (Pennsylvania Department of Labor and Industry, 2011).

Clarification of language in the treatment guidelines for mid and low back injuries, which now states that prescription of opioids for pain is “acceptable in appropriate cases” beyond a two-week timeframe, would also be beneficial.

Narcotic abuse in workers’ comp

Nationwide, employers and insurers will spend $1.4 billion on narcotics for workers’ comp claimants, a majority of which will pay for opioids that are not indicated for the vast majority of workers’ comp injuries (Paduda, 2012, p. 24).

Using a mix of pre- and post-reform data, the Workers Compensation Research Institute found that in New York, the average morphine equivalent amount per claim in nonsurgical cases with seven or more days of lost time was 4,040 milligrams, which was 125 percent greater than the average amount for the 17 state-median in the study (Wang, Mueller, & Hashimoto, 2011). According to the report, New York also had an average number of pills per claims that was 120 percent higher than the median.

“Excessive use of opioids/opium derivatives is a nationwide problem, even beyond workers’ comp,” said Deitz. “The particular issue in workers’ comp is that it has made it difficult for people to recover from some injuries. The impact is not just the cost of the drugs, but the increased disability that the drugs have created.”
There is a larger issue of narcotic abuse in New York State. The proposal for the Internet System for Tracking Over-Prescribing (I-STOP) came on the heels of a harrowing report from the New York State Attorney General showing that the number of prescriptions for narcotics increased from 16.6 million in 2007 to nearly 22.5 million in 2010.

Instituting greater documentation and checks in New York for prescription drugs will help to reduce workers’ comp costs by curbing abuse and over-prescribing.

The skyrocketing cost of schedule loss-of-use awards

Guidelines for SLU have not been updated since 1996. While some SLU injuries are unquestionably devastating, others, given today’s medical treatment procedures, result in little permanent loss of use or work time. In some cases, an individual could return to work the day after an injury and receive the full amount of his or her SLU award.

“We have not addressed the issue of excessive use of schedule injuries which now are three times more frequent than permanent partial,” said Buse.

Nearly all of those who were interviewed agreed that the SLU rating system is extremely costly and unsustainable in its current form. Data from the WCB indicates a steady and significant upward trend in SLU awards — for claims with a date of accident in 2006, the average monetary value of such an award was $21,231. Three years later, this figure had increased over 30 percent, with SLU awards averaging $27,695 in 2009.

Workers’ comp SLU guidelines have not kept up with advancements in medicine, despite the availability of more refined surgical procedures to get patients back to functionality.

Over the years, SLU — the original intent of which was to deal with the actual loss of limbs or use thereof — has taken on other types of injuries. Where a loss of limb would have equaled a total loss of function, many of today’s injured workers regain much of the functionality in injured extremities. As example, carpal tunnel and injuries to the hip or rotator cuff now fall under this umbrella.

Silverman, too, expressed concerns with the current SLU rating system. “You might have a person who can only raise an arm from waist to shoulder, but does the job and is quite functional. At the same time, we have people with good range of motion but they have a lot of pain, atrophy, etc. that causes them to be significantly more disabled than what range of motion suggests. It’s not fair to the claimant or to any of the parties to judge loss of use solely by measuring degrees.”

“As far as determining loss of ability, it’s crude and mediocre, and not terribly helpful,” he added.

Silverman suggested that, under the current system of determining loss of use, the commonsense solution to reduce bias on the part of the carriers and practitioners would be to train physical and occupational therapists to measure range of motion utilizing the guidelines. With training on the guidelines, and certification of these examiners, an accurate and objective result can be obtained.

“People who work with rehabilitation are probably the least expensive and the most efficient (at performing this task),” said Silverman.
Exploring the under-utilization of pharmaceutical networks

Companies that utilize pharmaceutical networks have been able to contract for prices below the pharmaceutical fee schedule. However, the implementation of emergency regulations, which have been in effect since 2007, imposed several barriers to self-insured employer participation in pharmaceutical networks, according to Scotti; namely, universal notification for all employees (whether injured or not), complex program restrictions and substantial penalties for any non-compliance.

Scotti noted that in September 2012, the WCB finally published final regulations to implement this 2007 reform measure, and that the proposed regulations do soften the complex program restrictions and eliminate the problematic compliance penalties contained in the prior emergency regulations. For example, the requirements regarding how far from the claimant’s place of residence or employment a mandated non-mail-order pharmacy may be located have been changed from 10 miles to 15 miles in rural areas, and from one mile to five miles in urban areas.

But the universal notification requirement for all potential claimants remains, and Scotti predicts that this will likely continue to prevent maximum participation by self-insured employers. He explained that notifying 100 percent of employees when 3 percent or less of all employees have an accident in any given year is overbroad and burdensome.

“Universal notification — with the remaining complexity of the regs — continues to have a chilling effect on the utilization of these networks.”

-Steve Scotti

Scotti noted that the WCB does not have the universal notification requirement in its diagnostic regulations (also part of the 2007 reform package), which only require notification to actual claimants.

Some employers have also expressed concerns that universal notification of prescriptions with no deductibles or co-payments may have the unintended consequence of leading to more frivolous claims, he added.

“Universal notification — with the remaining complexity of the regs — continues to have a chilling effect on the utilization of these networks,” said Scotti.
More work to be done with Rocket Docket regulations

The implementation of rocket docket regulations — intended to streamline the adjudication process and decrease the number of controverted claims — was partially successful, said Scotti.

The regulations require that cases be adjudicated in tight time-frames, giving employers little time to evaluate and challenge the sometimes sparse information provided on employee claim (C-3) forms. Scotti noted that enhanced claimant/medical reporting forms and pre-hearing conferences, which were intended to provide employers with some meaningful discovery in exchange for the expedited adjudication time schedules contained in Rocket Docket, have not had the desired effect.

Enhanced forms were released in March 2009. However, Scotti warns that “there is often little information provided on these forms — they may only say ‘claimant is injured.’” Scotti noted that, in many cases, claimants and their representatives do not provide sufficient information on C-3 forms and/or pre-hearing conference statements.

Also, the two-tiered evidentiary system created by Rocket Docket has different sets of rules for claimants and employers, with the bar for claimants’ representatives appearing to be far lower than it is for employers’ representatives.

For instance, “If the claimant’s representative fails to list a document or witness on the pre-hearing conference statement, the document may be introduced into the record and the witness may provide testimony, whereas if the employer’s representative fails to list a document or witness on the statement, the regulation provides that the employer has waived the right to introduce the document and waived the right to call the witness for testimony (requiring good cause affidavits to be granted to excuse the waivers). Likewise, the regulation provides for the automatic preclusion of the employer’s IME for the first non-appearance for cross-examination at a hearing but grants an automatic 30-day extension for the first non-appearance of the claimant’s physician for cross-examination,” added Scotti.

“On a positive note, the expedited timetable has required employers to expedite their evaluation of claims, thereby facilitating the prompt adjudication of contested claims,” added Scotti. He noted that judges typically exercise appropriate discretion in relation to Rocket Docket regulations, and that the regulations are typically not imposed in a rigid fashion.

The system could be improved further by requiring enhanced compliance with regard to filling out the claim reporting forms and treating pre-hearing conferences as discovery hearings, Scotti explained, the way the “enhanced forms and pre-hearing conference statements were envisioned.” He noted that objections to the Rocket Docket process would be much more prevalent, but for the appropriate discretion exercised by judges in applying the regulations.

“The Rocket Docket process was not an employer initiative because there was always the concern that expediting an adjudication system that combines low evidentiary thresholds with no discovery may lead to an adjudication process more concerned with technical requirements than the merits of the claim,” said Scotti.

“Employers want hearings to be expedited but not at the expense of the fair adjudication of claims on the merits,” he added.
Challenges in navigating Code Rule 60

Industrial Code Rule 60, also known as the Workplace Safety and Loss Incentive Program, gives credit against workers’ comp premiums to high deductible employers and insured employers with an experience rating of less than 1.3 and an annual workers’ compensation premium of at least $5,000.

According to 11 NYCRR Sections 151-3.3, 3.4 and 3.5, credit is given for implementing one or more of the following programs:

- **Safety** – 4 percent in the first full year that the insured is entitled to a credit and 2 percent in each consecutive full year thereafter.
- **Drug and Alcohol Prevention** – 2 percent in each full year for which the insured is entitled to a credit.
- **Return to Work (RTW)** – 4 percent in the first full year for which an insured is entitled to a credit and 2 percent in each consecutive full year thereafter.

Recent data indicates that post-reform, PPD-NSL claimants continue to show low return to work rates, similar to PPD-NSL claimants pre-reform. One year after an injury, most of these claimants are not employed (New York State Department of Labor, 2010).

“Return to Work has been a disappointment so far,” said Silverman, in reference to the New York State Department of Labor Code Rule 60 program. “Initially, there was a lot of enthusiasm about getting people focused and promoting the concept of a Return to Work specialist.” He continued, “There have been a small number of programs approved throughout the state, but overall, it’s been a failure. Back in the eighties, the idea of an injured worker on light duty was novel. In the nineties, there was this realization that safety was going to save money. If you look at big companies during the nineties, injury and accident rates went down. What’s happened is that there has been a drying up of money toward safety. One of the things that has hindered Return to Work is the economy; no one has money to hire someone to coordinate this.”

Although the RTW program can be done aggressively, according to Silverman, it takes a dedicated person who can oversee and organize the program. Small businesses, he noted, just do not have the funds to coordinate such efforts.

Trick noted that Wegmans hadn’t utilized RTW credits, and that he didn’t know of anyone who had.

The Public Policy Institute spoke with Margaret Barberis, corporate occupational health manager for Cascades Inc. and an experienced RN, who was in the process of navigating Code Rule 60.
Barberis explained that often, doctors will say that the patient can return to work in seven days full duty, when a restrictive duty program would be a more favorable option. “Many companies do understand that Return to Work, coupled with a great safety program, is important, but they can’t get to where they need to,” she noted.

“Many companies do understand that Return to Work, coupled with a great safety program, is important, but they can’t get to where they need to.”

-Margaret Barberis

As example, Barberis added that she has been trying to get information on how to become certified as a safety and loss management specialist for six months, contacting the New York State Department of Labor and the WCB, but that “no one I spoke to had any knowledge about Code Rule 60’s requirements for a safety and loss management specialist or how to guide the program.”

“Part of the problem is the way that Return to Work is set up; you could get the state to (certify) it, but it would cost money,” said Silverman. “The state was overwhelmed. And for employers, Return to Work wasn’t just a rubber stamp; it takes a lot of work to try to get that in place, and requires manpower, policy rewriting, putting in place medical evaluation systems, negotiating with labor unions ... it costs a fair amount of money to even apply for this.”

According to the state Department of Labor, there are currently 49 RTW consultants in New York.
Conclusion/recommendations

As previously stated in this report, quantitative data on the effectiveness of cost savings provisions in the 2007 reforms is still largely unavailable.

However, based on discussions with various workers’ comp professionals, PPI concludes that further action must be taken to control workers’ comp costs. The Public Policy Institute recommends the following:

• **Modernizing the SLU rating system.** Medical and surgical procedures have advanced greatly over the last 30 years. Schedule loss-of-use guidelines need to be updated in order to more accurately reflect the severity of an injury with respect to its effect on a claimant’s ability to perform necessary job duties, recovery time and amount of permanent disability. Educating judges — from a medical perspective — on how to apply SLU ratings would also be beneficial in reducing workers’ comp costs.

Re-examining the formula through which SLU awards are determined — perhaps by reducing the rate of compensation for SLU awards that are unrelated to any lost time — would also make the system more equitable.

• **Implementing a training program through which physical and occupational therapists can determine SLU.** This would be an objective, consistent, cost-effective way to determine range of motion.

• **De-indexing the MWB.** Workers’ compensation was never intended to provide full wage replacement benefits. De-indexing the MWB will control growing program costs, allow for future necessary program reforms, and reduce any unintended disincentive for claimants to return to work.

Since the reforms, the MWB has increased at over six times the rate of increase in cost-of-living adjustments. At the minimum, there needs to be further examination of the MWB with respect to regional average weekly wages. For example, based on the region’s average weekly wage, the North Country would have a MWB of $472.94, while New York City would have a MWB of $1,025.77. Alternatively, removing the outliers for the highest and lowest paying sectors (finance/insurance and accommodation/food services) would result in a MWB of $771.91. Looking at the MTA region compared to the rest of the state, the MWBs would be $910.09 and $517.74, respectively.

• **Limiting TTD benefits.** Placing durational caps on PPD-NSL claims creates an incentive for claimants to delay classification because they receive TTD benefits in the interim. Limiting the time during which claimants can receive such benefits by presuming that maximum medical improvement is reached two years from the date of an
accident would incentivize quicker classification on the part of claimants and their attorneys. There are other reasonable alternatives to remedy this problem, such as beginning the cap at the date of injury, or reducing the amount of a capped award by a portion of the TTD benefits received prior to classification of a PPD-NSL claim.

- **Mandating the use of panel providers for the first 90 days of treatment.** In Pennsylvania, employers may post a list of designated health care providers and direct workers to select from the list when seeking treatment for a work injury or illness. A recent survey by the Pennsylvania Department of Labor & Industry found that workers with proper access to such panel providers returned to work quicker, and reported greater satisfaction with the care they received, than all other respondents (Pennsylvania Department of Labor and Industry, 2011).

- **Eliminating the ATF requirement for commercial carriers.** Requiring commercial carriers to deposit the present value of a PPD into the ATF provides a disincentive to classify claims. Amending the law to remove this mandate, and restoring the pre-2007 WCB discretion to require ATF deposits, would help — on the private carriers’ end — to lessen the time frame from the date of an accident to classification.

- **Creating a partnership between the Office of Professional Misconduct and the WCB to form an oversight board on appropriateness of care.** This new entity would review those cases in which patients were receiving care outside of the normal range of treatment (ex. Cases where patients are being given over 130 mg of Oxycontin/day would be flagged). This would weed out bad actors from the system by not only threatening WCB action, but that of licensure.

- **Blocking attempts to undo the cost-savings measures in the reforms.** There have been several attempts to undo such provisions in the workers’ comp reforms. Legislation introduced in 2012 would limit the retroactive application of medical care guidelines, which were adopted in 2010 to provide quality care to claimants while ensuring that practitioners utilized evidence-based, up-to-date treatments.

Another measure would permit an injured employee to utilize pharmacies out of his or her employer’s network, as long as that pharmacy matched the state’s published prices, often higher than negotiated volume discount prices. The ability of insurance carriers and self-insured employers to contract with pharmaceutical networks was expected to result in 20 percent cost savings at the time of the reforms, by allowing for volume discounts for employers and claimants through in-network pharmacies. The New York Compensation Insurance Rating Board estimated that the measure would result in an increase of between 0.1 percent and 0.3 percent in system costs, and that the impact would be even greater if out-of-network pharmacies were able to charge more than the amounts in the pharmacy fee schedule.

- **Removing the universal notification requirement for pharmaceutical networks.** If requirements for participation in pharmaceutical networks more closely mirrored the provisions for diagnostic network participation, PPI believes that more self-insured employers would take advantage of pharmaceutical cost reductions.

- **Streamlining data collection.** The sooner this system comes to fruition, the sooner researchers, legislators and the public at large will be able to better gauge the effectiveness of the 2007 reforms. Recent quantifiable data on claims is largely unavailable.

On a positive note, in April 2012, the WCB released an RFP for a reengineering project to modernize the processing and monitoring of claims.
• **Instituting enhanced training of administrative law judges to promote stronger adherence to laws and regulations, and medical treatment guidelines.** As example, a self-insured employer that PPI interviewed noted that in many cases, claimants and their attorneys fail to provide sufficient information on C-3 forms. This is a problem that could be remedied through further training.

• **Achieving greater balance by shifting the culture at the WCB away from perceived presumption in the employee’s favor.** Workers’ comp was created to benefit both employers and employees by removing workers’ injuries from the tort litigation system. Over the years, there has been a culture shift that has allowed for more leniencies toward claimants in procedural matters, coupled with strict adherence for employers.

In relation to disability ratings, findings tend to be considerably higher than those found in independent medical examinations by employers’ health practitioners. Workers’ Comp Board hearings need to return to balance and provide unbiased and fair adjudications based squarely on the law and applicable regulations.
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**Glossary of acronyms**

ATF.............................Aggregate Trust Fund
CIRB.............................New York Compensation Insurance Rating Board
DFS............................New York State Department of Financial Services
MWB...........................Maximum weekly benefit
PPD-NSL......................Non schedule permanent partial disability
RTW............................Return to Work Program
SLU.............................Schedule loss-of-use
TTD.............................Total temporary disability
WCB............................New York State Workers’ Compensation Board
The Public Policy Institute is the research and educational arm of The Business Council of New York State, Inc. The organization’s purpose is to formulate and promote public policies that will restore New York’s economic competitiveness.

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