New York State WC Reform Update

How NY WC Reform Has Developed Over the Year

The New York Workers' Compensation Reform Act was signed into law on March 13, 2007. NYS government indicated that it would result in "savings that are projected to be well over 10 percent of system costs." More than a year has passed since the reform and some important procedural details of the Act still need to be ironed out. This has left both employers and carriers with questions regarding the interpretation and application of many of its provisions.

The purpose of this document is to reflect on the developments and provide you with insight based on what we are seeing at the Workers Compensation Board.

MAJOR PROVISIONS

I. Benefit Rates

What are the Benefit Rates?

- $500 for deaths, accidents or disablements on and after 7/1/07
- $550 for deaths, accidents or disablements on and after 7/1/08
- $600 for deaths, accidents or disablements on and after 7/1/09
- Two-thirds of the state average weekly wage as reported by the Commissioner of Labor to the Superintendent of Insurance on and after 7/1/10 and every July 1st thereafter.
- Minimum weekly indemnity benefit level is increased from $40 to $100 for accidents on or after 7/1/07

What are we seeing in Practice?

Increased Indemnity Payout

The first maximum weekly benefit level change from $400 to $500 has occurred for accident dates on or after 7/1/07. We have seen no evidence of this incremental change impacting return to work timeframes. We do expect to see noticeable payout increases on schedule loss awards in the coming months, as schedule loss awards for claims with accident dates of 7/1/07 or later should materialize shortly. It should be noted that schedule loss awards are typically awarded one year post- accident or post-surgery, whichever is later.

II. Permanent Partial Disability Cap

What are the Permanent Partial Disability Caps?

For accidents on or after March 13, 2007, the weekly benefits are capped based on percentage loss of wage earning capacity according to the following schedule:

% Loss of Wage Earning Capacity	Maximum Benefit Weeks	Number of Years
Greater than 95%	525	10.10
90% - 95%	500	9.62
86% - 90%	475	9.13
81% - 85%	450	8.65
76% - 80%	425	8.17

% Loss of Wage Earning Capacity	Maximum Benefit Weeks	Number of Years
71% - 75%	400	7.69
61% - 70%	375	7.21
51% - 60%	350	6.23
41% - 50%	300	5.77
31% - 40%	275	5.29
16% - 30%	250	4.81
15% or less	225	4.33

The caps do not apply to dates of accidents prior to 3/13/07 regardless of the date of classification.

We remain responsible for lifetime medical care related to injury.

What are we seeing in practice?

Impairment Guidelines are not developed yet

The WC law has always stated that permanent partial benefits are based on the loss of earning capacity. However in practice, benefit rates have been set using degrees of disability expressed in accordance with the Board's medical guidelines. These guidelines assessed disability as mild, moderate and marked with percentages of 25, 50, and 75 respectively. How these degrees of disability will translate into loss of earning capacity is still not defined.

As of today, methods used to quantify the PPD classification have essentially remained unchanged. We anxiously await the impairment guidelines to further understand how the caps will affect the overall outcome of a claim.

This section of the reform presents a challenge for the WCB and the law judges. The Medical Guidelines Task Force created at former Governor Spitzer's direction has not yet developed impairment guidelines necessary to determine % loss of wage earning capacity under the % gradations in the new statute. Accordingly law judges are not yet making findings based on the 1%-99% scale. Once the guidelines are developed and released, education will be paramount to the success of this reform initiative.

III. Aggregate Trust Fund Deposits

What is the Aggregate Trust Fund (ATF) and what must be deposited?

The ATF dates back to the 1930's and was seen as necessary to protect against potentially insolvent carriers. This provision now requires all private insurance carriers to make an immediate present day value (PDV) payment into the Aggregate Trust Fund (ATF) using a 5% rate for any classification award made on or after 7/1/07. This applies regardless of the date of accident or disablement. The deposit into the ATF is not required of self-insured employers or the State Insurance Fund. Deposits into the ATF are not required if Second Injury Relief has been established or if a third party action is pending. Once the ATF has our deposit of the Present Day Value (PDV) of the classification award, they are permitted to settle claims under a Section 32 agreement; however, the carrier is not entitled to any refund for deposits made that were more than the settlement amount.

What are we seeing in practice?

1. ***ATF deposit requirements on lifetime benefit rather than capped benefit cases***

   We believe the intent of the ATF provision was to require deposits on cases with capped benefits (dates of loss of 3/13/07or later). The wording of the provision calls for the deposit of ALL classification awards made on or after 7/1/097. The PDV on a lifetime case is significantly higher than that of a capped case so the ATF deposit requirements received to date have been relatively large.

2. ***Plaintiff attorneys are demanding indemnity-only settlements***

   We still have ongoing Medical exposure after any indemnity deposit into the ATF so they are looking to settle the piece of the file that we would otherwise have to make a deposit on.

3. ***Settlement demand figures have increased dramatically***

   Attorneys are estimating the anticipated PDV deposits and then presenting settlement demands just shy of the deposit figures. Prior settlement figures typically represented anywhere from five to eight years worth of indemnity benefits.

4. ***Delayed PPD classifications***

   Prior to any PPD classification and ATF deposit direction. We are attempting to resolve cases with a full and final settlement.

5. ***Increased Litigation Costs***

   We are appealing any ATF deposit requirement, contending that the "intent" of the provision was to require the deposit on capped benefit cases. Other appeal defenses we have raised have included: second injury pending, third party action pending, and settlement negotiations in progress.

Mandatory Section 32 Offers

Both Self-Insured employers and carriers must make a Section 32 offer within two years of the claim being indexed by the WCB or six months after the claimant is classified with a permanent disability, whichever is later. The settlement offer must state what portion of the settlement covers lost wages, medical and prescription benefits as well as attorney fees.

What are we seeing in practice?

Generally, our practice as been to offer a Section 32 settlement prior to classification; therefore we have not seen any adverse impact based on this mandate.

IV. Second Injury Fund

What is the Second Injury Fund? What is the impact of the reform on it?

If we can prove through medical records that a pre-existing condition, accident or injury has made a current injury materially and substantially greater we can obtain second injury relief and limit our liability to 260 weeks.

The reform amends Section 15.8 to close the Special Disability Fund to new claims as follows:

- No claim for second injury can be made for accidents or disabilities on or after **7/1/07**.
- After **7/1/10**, no claims for reimbursement (C-250) will be accepted regardless of the date of accident or disablement.

- All outstanding claims for second injury fund relief must be perfected by **7/1/10**.

All requests for reimbursement on claims where Second Injury has already been established must be made within one year of the carrier's payment. Cases with established Second Injury relief prior to **7/1/10** will still be subject to reimbursement after that date.

Filing Fee - **Effective 3/13/07**, all C-250s must be accompanied by a filing fee of $250.00, to be deposited in the Special Disability Fund. Upon any final ruling that a claim is eligible for second injury relief, the fund will refund $200.00 of this fee to the carrier/self-insured employer.

What are we seeing in practice?

1. Gathering our Evidence

Insurers across the industry are aggressively attempting to perfect their second injury cases. Vendor usage to help obtain prior medical records is at an all-time high.

2. Pretrials

Special Funds' pre-trial concession calendars are still open and we are actively bringing cases to pre-trial to secure concessions.

3. M&S Statements

In upstate NY, Special Funds is now routinely requiring "M & S" statements from doctors, commenting on whether or not they believe the prior conditions are making the current condition "materially & substantially" greater.

V. Medical Cost Savings

What Medical Cost Savings Benefits are imbedded in the reform provisions?

- Dental Care, Prosthetic Devices and Durable Medical Fee Schedules
- Network Direction for Diagnostic Testing and Pharmaceuticals
- Pharmaceutical Fee Schedule

What are we seeing in practice?

1. Durable Medical Equipment Fee Schedule

The durable medical equipment fee schedules have not produced significant savings to date. We continue to use dedicated vendors to dispense durable medical equipment.

2. Direction of Testing and Pharmaceuticals

The ability to direct diagnostic testing to network providers has resulted in savings. We have seen the WCB uphold our denials for diagnostic testing outside of network.

3. Pharmaceutical Fee Schedule

New York State approved a temporary pharmacy fee schedule in July of 2007 based on Medicaid payment rates. When the fee schedule emerged, nearly 2/3s of the prescriptions we commonly paid for were absent; the WCB has steadily increased the number of drugs added to the fee schedule. There was an outcry from pharmacies across the state, alleging the fees were too low. On 5/28/08, the WCB announced that the temporary fee schedule was rewritten due to calculation errors in the Medicaid system. It was reported that underpayments occurred for 651 drug lines. Effective July 7, 2008, the WCB adopted the new pharmacy fee schedule by emergency regulation. The new pharmacy fee schedule utilizes a reimbursement price

of the average wholesale price (AWP) minus 12 percent for brand name drugs plus a $4.00 dispensing fee. The reimbursement price for generic drugs is AWP minus 20 percent plus a $5.00 dispensing fee. This new fee schedule is effective for all prescriptions drugs dispensed on or after July 7, 2008. In claims that are denied, the reimbursement rate is 25 percent more than the maximum reimbursement rate for uncontroverted claims plus a dispensing fee of $7.50 for generics and $6.00 for brand name drugs. Prescriptions filled from July 11, 2007, through July 6, 2008, should be paid in accordance with the previous fee schedule. Significant savings will be realized as a result of the pharmaceutical Fee Schedule.

VI. What is the Streamlined Docket?

The streamlined docket consists of proposed regulations, not yet adopted, which are intended to streamline the adjudication of denied/controverted cases. The proposed regulations were drafted by a Task Force and submitted to the Board on June 1, 2007 for its consideration. It is believed that the Board has made some changes to the regulations and that the regulations, as revised, will be published in the State Register sometime this month which will open a 45-day public comment period. Formal adoption is not expected before September or October. The goal of the proposed regulations is to design and implement a system in which an injured worker's case will be adjudicated within 85 days of the initial dispute.

What are we seeing in practice?

1. New Forms

Form drafts have been released for the C-2 (Employer's Report of Injury); C-3 (Employee's Claim); C-4 (Attending Doctor's Report); C-7 (Notice of Controversy); and PH-16.2 (Pre-Hearing Conference Statement). We have had the opportunity to comment and to make recommendations to the WCB regarding each of these forms. The new forms will require the employer, the claimant, and the medical provider to provide far more information than is required in the forms currently in use. While the Board has not yet adopted revised forms or adopted the proposed streamed docket regulations, the Board is, nonetheless, pressing to resolve controverted cases on an expedited basis.

2. Tightened Time Frames

A pre-hearing conference will be held within 45 days from the Board's receipt of a Notice of Controversy (C-7). Although the streamlined docket regulations have not been formally established, we have been required to file a pre-hearing conference statement ten days before a pre-trial conference on each denied case. All lay testimony is now taken at an expedited hearing within 37 days of the pre-hearing conference and the IME report must be filed by the date of the lay testimony hearing. All medical testimony must be completed within 75 days of the pre-hearing conference.

3. Sanctions Imposed

The failure to produce an IME report when directed will result in a waiver of the carrier's right to an IME. If a carrier fails to file or files an incomplete PH-16.2 Form when required, it can be barred from ever raising a defense or calling a particular witness. We are seeing witnesses who fail to appear at one hearing being precluded from testifying at a later date. We have not seen any excuse for non-attendance that has been considered a viable excuse. We will be looking for employers to help us ensure that each employer witness identified appears at any and all hearings scheduled.