

The Success of New York's 2007 Workers' Compensation Reform

Andrew M. Cuomo, Governor

Robert E. Beloten, Chair

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Message from Chairman Robert E. Beloten

The Workers' Compensation Board employs almost 1,400 dedicated individuals charged with administering two mandatory insurance systems: workers' compensation and disability benefits. The WCB's core mission is to protect the rights of employees and employers by ensuring the proper delivery of benefits to those who are injured or ill, and by promoting compliance with the law.

2007 brought the largest reform to the workers' compensation system in its almost 100 year history. Government, working together with the business community and organized labor, was able to overcome the obstacles that had hindered meaningful workers' compensation reform for so long. Five years later, the 2007 reform legislation has increased benefit rates, increased employer compliance, sped up dispute resolution, improved medical care with medical treatment guidelines, and controlled system costs through a combination of capped permanent partial disability benefits (PPD), new health care fee schedules, pharmacy benefit and diagnostic testing networks.

Unfortunately, while some of these changes took effect immediately, others struggled to be implemented using the same consensus process that produced the landmark legislation. As 2011 approached, several meaningful reforms had not yet been completed.

Undeterred, in 2011 and early 2012 the Board worked with our stakeholders and completed those important elements of the reform that had been hindered by complexity and disagreement. Specifically, the Board:

- Implemented Medical Treatment Guidelines to greatly improve the quality of medical care for the most common work related injuries;
- Released *Guidelines for Determining Permanent Impairment and Loss of Wage Earning Capacity*, along with important process changes so employers will realize the savings associated with permanent partial disability benefit caps while ensuring those benefit caps are applied to injured workers in a fair way; and
- Adopted Diagnostic Testing Network regulations to help curb the high cost of diagnostic testing in workers' compensation.

The changes the reform brought about will have long lasting positive impact on the workers' compensation system in New York. Now, injured workers receive a fair lost wage benefit along with improved medical care and employers see reductions in waste, fraud, and abuse that the system ignored for too long.

However, there is still work to do and room for improvement. Over the next several years, the Board will embark on an aggressive agenda to leverage best practices in the workers' compensation and health care industries along with improved technology and process to create a system in New York that works better for our stakeholders, delivers needed medical and indemnity benefits faster to our injured workers, captures important data for policy making, and improves system oversight to continue to weed out waste, fraud, and abuse. I look forward to working with both the business community and organized labor to accomplish those goals.

Introduction

Nearly a century ago, New York adopted a no-fault workers' compensation law. Hailed as The Great Compromise between business and labor, workers' compensation replaced a slow, costly and uncertain tort litigation system with a simplified no-fault social insurance system. Workers gained a level of security that they would receive defined medical and lost wage benefits in the event of a workplace injury, regardless of fault. Employers assumed the cost of these benefits in exchange for legal immunity from lawsuit.

Like all institutions, workers' compensation has grown and changed over time, sometimes in ways contrary to the original goals of workers' compensation. In 2007, New York, with the support and involvement of business and labor, enacted a comprehensive set of reforms designed to improve the workers' compensation system and to restore the benefits of the Great Compromise to both business and labor.

The goals of the 2007 Reform were myriad and included:

- Increasing the minimum and maximum indemnity benefit to more adequately compensate injured workers while they are unable to work
- Reducing the cost of workers' compensation on employers
- Speeding the determination of eligibility for benefits
- Rooting out fraud and improving employer compliance
- Helping injured workers return to work

Since 2007, the Workers' Compensation Board, in partnership with the Department of Insurance (now Financial Services), Department of Labor, its labor and business partners, and other stakeholders, labored to implement all of the components of the 2007 reform. While some changes were self-effectuating, others required the development of guidelines, regulations, processes, forms, and other administrative changes.

Over the last year, the final three pieces of the 2007 Reform were fully implemented.

- Medical Treatment Guidelines have been fully implemented throughout the system.
- The Board broke a stalemate between the stakeholders and released new permanent partial disability guidelines and processes. These will promote the fair and timely evaluation of permanent partial disability claims and application of the new duration caps.
- Diagnostic testing network regulations have been adopted to generate medical savings to employers while preserving high quality diagnostic testing and substantial choice for injured workers and their physicians.

Five years later, the Reform has been fully implemented and the results have been impressive.

- The maximum indemnity rate has nearly doubled.
- Medical cost controls have been put in place to reduce spending on prescription drugs, diagnostic testing, and unnecessary medical care.

- Evidence-based treatment guidelines are promoting prompt delivery of the most effective medical treatment with reduced administrative hassle, while discouraging ineffective and harmful treatment.
- Modern guidelines for determining permanent impairment and loss of wage earning capacity in permanent partial disability claims have been established.
- The rate of controversy has been cut by 59% (from 17% in 2006 down to 7% in 2011). The time to resolve controverted claims has been reduced by more than 50%. Controverted claims are resolved within 75 days on average.
- Improved employer compliance has resulted in more than 47% fewer uninsured claims than four years ago.
- More than 7,700 stop work orders have issued to non-compliant employers, with more than three-quarters becoming compliant, often within 48 hours.
- In 97% of instances, carriers submit their proof of coverage on time, compared with just 67% in early 2008.
- A new livery fund, combined with strong enforcement measures, has produced very high rates of compliance in an industry with a history of non-compliance.
- The Board has improved its data sharing, coordinated with CIRB to facilitate integration of claim data for analysis, and begun to build a data warehouse.

Having completed implementation of the 2007 Reform, the Board is now looking ahead to produce further improvement in New York's workers' compensation system. The Board has taken the first step of identifying its mission, core values, and vision. This led to the creation of a Modernization Program that serves to coordinate several projects whose joint purpose is to bring about substantial improvements in the administration of workers' compensation in New York.

The Modernization Program includes the adoption of the national electronic data interchange (EDI) standard for claim filing, a post-implementation evaluation of the Board's new medical reporting forms, a system-wide business process reengineering project, and the creation of new technology to support the reengineered system and its processes. These efforts will require the full participation of the Board's many stakeholders and should lead to substantial improvement in many areas.

I. Reform Has Doubled the Maximum Weekly Benefits for Injured Workers

Workers' compensation provides indemnity (cash) benefits to compensate injured workers who are unable to work after an injury. The weekly benefit is two-thirds the person's average wage, up to a maximum weekly benefit. For nearly 15 years, the maximum benefit remained stagnant. As of January 1, 2007, New York's statutory benefit maximum for total disability (\$400) ranked 49th out of 51 jurisdictions — the 50 states and the District of Columbia. Only Arizona, with a statutory benefit maximum of \$374.01, and Mississippi, with a statutory benefit maximum of \$387.68, ranked lower.¹

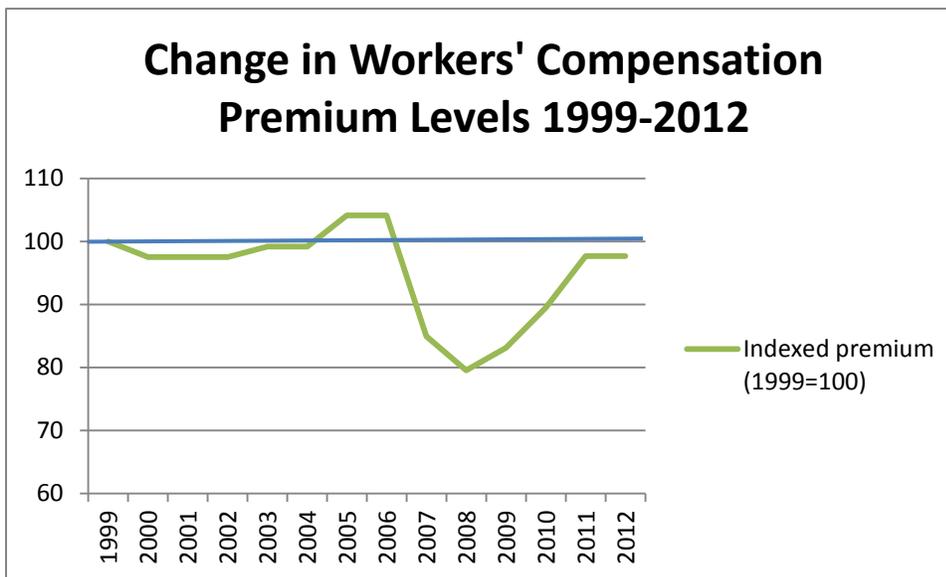
The 2007 Reform dramatically improved the adequacy of indemnity benefits for injured workers. It provided for incremental increases through 2009 and then indexed the maximum rate annually at two-thirds of the statewide average weekly wage in New York.

In five years, the maximum rate nearly doubled from \$400 to \$792. In 2011, New York ranked 32nd out of 51 jurisdictions. Reform also increased the minimum rate from \$40 to \$100.

II. New York Businesses Saved Billions in Workers' Compensation Premiums

The 2007 Reform immediately produced dramatic savings for New York employers. In July 2007, the Department of Insurance reduced workers' compensation insurance rates by 18.4%. Rates declined another 6.4% in 2008. Together those reductions saved New York businesses an estimated \$1 billion per year in workers' compensation premiums.

Despite recent increases, workers' compensation premium costs remain below 1999 levels and well below pre-reform levels.² This is particularly significant because costs declined despite nearly doubling the maximum benefit rate.



Note: In July 2010, the maximum benefit rate was indexed to the state's average weekly wage.

III. Reform Has Helped Control Rising Medical Costs and Improve Quality of Care

Nationally, medical care is driving workers' compensation costs and now accounts for more than 50% of costs. In New York, however, medical costs continue to produce less than half of claim costs.³ While medical inflation remains an issue nationally, and in workers' compensation in particular, the reform included several measures that help contain medical costs. In addition, adoption of evidenced-based medical treatment guidelines promotes speedier and higher quality care while eliminating ineffective and harmful treatment.

Pharmaceutical Fee Schedule

The reform law authorized a pharmaceutical fee schedule. The current fee schedule is based on the average wholesale price (AWP), with generic drugs reimbursed at AWP – 20% plus \$5 dispensing fee and name-brand drugs paid at AWP – 12% plus \$4 dispensing fee.⁴ The law also authorizes employers and carriers to use pharmacy networks and/or pharmacy benefit managers, which further control prescription drug costs. Prior to the reform, claimants could go to any pharmacy and reimbursement was at usual and customary rates.

The data shows that the fee schedule has already produced substantial savings on prescription drugs. WCRI estimates that the fee schedule has reduced the price per pill by 10-20%, depending on the specific drug and dosage. The early data on overall pharmaceutical costs shows a 15% decrease in prescription costs for new claims at 12 months.⁵

Nevertheless, New York has higher than average prescription drug usage, particularly narcotics.⁶ The Medical Treatment Guidelines (discussed below) take aim at the high use of narcotics, and it is expected that future chronic pain guidelines will target narcotic usage in its recommendations.

Diagnostic Testing Networks

The Reform permitted carriers to require claimants to have diagnostic testing (e.g. MRIs, x-rays, CT scans) done within a network. While the legislation went into effect immediately, several aspects of the legislation required clarification. In February 2012, the Board adopted regulations that clarify what is required to be a “legal and properly organized” diagnostic network, minimum quality requirements for the network providers, how carriers must notify claimants and physicians about the existence of a network, and how far a claimant may be required to travel.

It is expected that more carriers will take advantage of mandatory diagnostic testing networks with the passage of the regulations. This should result in substantial savings. The current New York fee schedule for MRIs and other major diagnostic tests ranks high compared with the rest of New York's fee schedule and with other states.⁷ As a result, networks are able to obtain significant discounts over the fee schedule.

Medical Treatment Guidelines

As part of the 2007 Reform, a task force and advisory committee at the Insurance Department developed evidence-based medical treatment guidelines (MTG). The advisory committee, which included highly credentialed physicians and other professionals representing organized labor, the business community, and government, developed guidelines for treatment of common injuries involving the neck, back, shoulder and knee.

In 2010, the Workers' Compensation Board formally adopted the four MTGs as the standard of care for injured workers in New York. The implementation of the MTGs was designed to speed the delivery of necessary care, improve the overall quality of care, ensure consistency of treatment with evidence-based standards of treatment, and to reduce overuse of harmful or ineffective treatment.

The MTGs pre-authorized all but 13 procedures, as long as they are performed consistent with the guidelines. This removes the delay associated with seeking prior approval from insurance companies in the majority of cases and should help speed return to work. The guidelines also

provide greater certainty for providers and carriers about what medical treatment is appropriate and will therefore be paid. Reducing billing disputes and uncertainty about payment is important to retain high quality medical providers.

The MTGs improve care by promoting the use of the most effective treatment and preventing use of ineffective or harmful treatment. The MTGs set objective standards for the appropriate use of procedures such as spinal fusions, neuro-stimulators, and others whose overuse has been well-documented. Further, the guidelines limit the use and duration of physical therapy, chiropractic treatment, and steroid injections, which had previously been subject to substantial abuse. Extensions of therapy and other treatment beyond the recommended course of treatment require a variance.

The Board recognizes that a patient's unique circumstances may warrant treatment that falls outside the guidelines. The regulations allow providers to seek a variance from the MTGs to provide care that is different from or goes beyond the MTG recommendations. Providers must provide objective medical evidence in support of the variance, including documentation of improvement for continuation of treatment.

Prior to implementation, the Board provided comprehensive educational programs on the MTGs for medical providers, administrative staff, claims professionals, and attorneys as well as internal Board staff. Medical professionals earned continuing education credits. Stakeholders report that the education programs were helpful and provided an easier transition given the large change in administration of medical services.

In the first year, the Board received a high volume of variance requests. More than 80% of these variance requests involve requests for continuation of physical therapy and chiropractic treatment, often in cases that are several years old. More than half of the requests came from 250 providers, many of whom submitted multiple variance requests per case and submitted variance requests for the majority of their workers' compensation patients. Nevertheless, more than half of variance requests have been approved by the employer or carrier or by the Board. Most variance requests that are rejected by the Board at a hearing or by review of the Medical Director's Office fail to provide any documentation of functional improvement to warrant continued treatment.

The Board continues to work with carriers and medical providers to improve the medical treatment guidelines process. In an increasing number of disputes, the parties are agreeing to have their variance requests decided by the Board's Medical Director's Office, rather than by hearing. This produces a much quicker resolution by those with expert medical training.

The Board expects to develop additional MTGs for other common workplace injuries and diseases. The Insurance Department task force developed a carpal tunnel syndrome MTG in the fall of 2011, which the Board expects to adopt in 2012. Chairman Beloten appointed a Medical Advisory Committee in October 2011 to begin developing chronic pain guidelines. These chronic pain guidelines will supplement current recommendations on chronic pain and provide a national model for treating chronic pain in workers' compensation. The MAC includes eleven highly qualified physicians from a range of specialties who were appointed by the AFL-CIO, the Business Council of NYS, and the Board. The MAC will also be responsible for updating the existing MTGs and developing additional guidelines.

IV. New Permanent Partial Disability Guidelines Ensure Fair and Timely Application of Benefit Caps

The 2007 Reform imposed new limitations on the duration of non-schedule permanent partial disability (PPD-NSL) claims. The shift from lifetime benefits for those injured before March 13, 2007, to time-limited PPD benefits is expected to produce significant savings. Claimants injured post-reform are eligible for five to ten years of PPD-NSL benefits depending on the severity of claimant's loss of wage earning capacity. Generally, PPD-NSL claims take at least a year or two before the injured worker has achieved maximum medical improvement and is ready for classification.

To carry out the new duration limits, the Insurance Department task force was charged with developing new guidelines for determining loss of wage earning capacity. The task force, which included representatives from the AFL-CIO and the Business Council of NYS, spent more than two years developing new medical impairment and functional loss guidelines and negotiating guidelines for determining loss of wage earning capacity. The task force members could not reach consensus and the ultimate issue was referred to the Board for determination.

While the Board had been imposing duration limits using existing medical guidelines and non-medical factors since the reform, it assumed responsibility for developing formal guidelines. In 2011, the Board announced the 2012 NYS Guidelines for Determining Permanent Impairment and Loss of Wage Earning Capacity (2012 Guidelines), which incorporate the task force's medical impairment and function guidelines and provide guidance on how to determine loss of wage earning capacity using medical and non-medical factors (education, skills, age, literacy, etc.). The guidelines went into effect January 1, 2012 along with a new procedure for guiding claims through the classification process. In anticipation of implementation, the Board provided stakeholder education on the 2012 Guidelines and the new forms and processes.

The new processes and guidelines are expected to simplify and speed up the classification of PPD-NSL claims. They will ensure employers will realize significant cost savings through the fair application of benefit caps for PPD-NSL claimants.

V. The Board Has Reduced Disputed Claims and Sped Up Claim Resolution

Rocket Docket

When an employer or insurance carrier disputes (or *controverts*) a claim, the Workers' Compensation Board must determine, through administrative hearing, whether the injured worker is entitled to receive benefits. Prior to the 2007 Reform, insurance carriers and employers controverted more than 15% of claims. It took the Board more than 200 days, on average, to resolve each disputed claim. During this delay, injured workers would not receive benefits. In the worst cases, injured workers waited a year or more to have their claim resolved by the WCB.

The Reform established new requirements to speed the resolution of controverted claims. Pre-hearing conferences must occur within 45 days and resolution within 90 days. A new streamlined adjudication process, adopted by regulation, requires all parties to provide greater information at the

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outset of the claim to avoid unnecessary disputes and schedules discovery quickly to enable resolution within three months. The Board has prioritized the resolution of controverted claims in the hearing process and has taken significant steps to change the culture that tolerated extended delays in the hearing process.

The improvement has been impressive. The rate of controverted claims has fallen dramatically, from 17.2% in 2006 to 7.2% in 2011. Meanwhile, on average, controverted claims are resolved in 75 days. More than three quarters are resolved within the 90 day timeframe.

Change in Rate of Controversy, 2006 through 2011

Year of Assembly	Total Assembled ¹	Total Controverted	Rate of Controversy
2006	136,736	23,530	17.2%
2007	135,620	18,921	14.0%
2008	124,481	12,909	10.4%
2009	115,811	7,469	6.4%
2010	119,208	8,660	7.3%
2011 ²	99,588	7,217	7.2%

¹ Excludes Alternative Dispute Resolution (ADR) claims.

² Data through October 21, 2011.

Percent of Streamlined Controverted Claims Concluded Within 90 Days, 2009 through 2011

Concluded in Year	Concluded within 90 Days or Less	Concluded in more than 90 Days	Total Concluded	Percent Concluded within 90 Days
2009 ¹	6,332	1,777	8,109	78.1%
2010	7,628	2,243	9,871	77.3%
2011	7,264	2,141	9,405	77.2%

¹ Data for 2009 is from April through December.

Improved Conciliation

In 2010, the Board completed a project to improve the use of conciliation at the Board. Conciliation, which includes the use of proposed decisions that can be objected to by either party, has been a part of the workers' compensation law for more than 20 years. Together with administrative determinations, these "informal resolutions" are alternatives to formal hearings that produce agreed-upon decisions with less cost and inconvenience.

Conciliation is most effective for certain types of issues where there is no actual factual dispute or where the differences between the parties are minimal. The conciliation project standardized how and which claims are referred to conciliation and improved the forms by which claimants and carriers requested action from the Board. The project also developed a new streamlined process for the resolution of schedule loss of use awards that takes the scheduling of medical examinations and medical testimony off-calendar, thereby reducing unnecessary hearings. These efforts enable the Board to informally resolve appropriate claims by proposing an outcome to all parties and to reserve limited hearing time for matters, such as controverted claims, that require formal hearings.

The project has resulted in the successful use of conciliation throughout the state. In 2011, the Board reduced the number of formal hearing resolutions by 5% (from 188,708 to 179,236) and increased the level of conciliation resolutions by 64% (from 34,537 to 56,666). More than 85% of proposed decisions were accepted by both parties. The reduced hearing volume ensures timely access to a hearing when necessary and is critical to successfully managing a large workers' compensation docket in these tight fiscal circumstances.

Claims Resolved by Process, 2006 through 2011

Year	Hearing ¹	Waiver Agreements	Conciliation	Examining ²	Total
2006	176,796	9,482	44,525	75,732	306,535
2007	175,450	9,595	47,743	73,451	306,239
2008	173,797	10,066	54,476	79,910	318,248
2009	185,770	10,418	39,910	69,452	305,550
2010	188,708	10,576	34,537	69,708	303,529
2011	179,236	12,256	56,666	71,334	319,492

¹ Includes waiver agreement settlements

² Includes administrative determinations, closures, and cancellations

VI. Reform Has Improved Compliance, Reduced Fraud and Waste, and Promoted an Equal Playing Field Among Employers

Employers who violate the law by failing to maintain proper workers' compensation insurance cheat their workers, drive up insurance costs, and compete unfairly against legitimate businesses that follow the rules. In addition, companies that misclassify employees as independent contractors, underreport payroll, or use lower cost occupational classifications unfairly shift costs onto law-abiding employers. For years, the Board was relatively powerless against these problems. Though the Board could issue fines against uninsured employers, those fines often went uncollected and the scofflaw employer continued to operate with impunity. No penalties existed for underreporting payroll and misclassifying workers.

The Board has dramatically improved employer compliance through a combination of administrative and technological improvements, coordinated enforcement and new and strengthened enforcement mechanisms.

Improved Technology

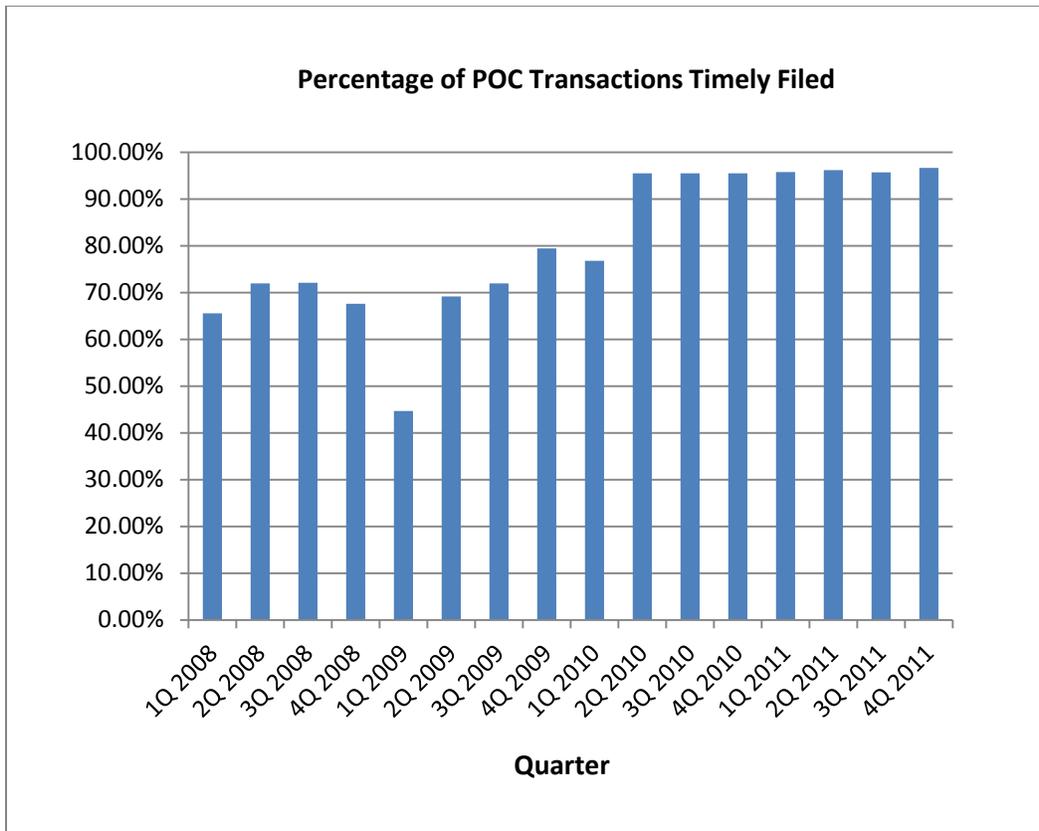
Technology has played an important role in identifying non-compliant employers and processing compliance penalties. The Board's Insurance Compliance database system, IC-2, receives electronic proof of coverage (POC) filings from carriers on every policy written or cancelled. The IC-2 also receives a feed from the Department of Labor on all New York employers, which it compares to the POC filings to identify employers that do not maintain active coverage. IC-2 includes an automated, seamless process by which non-compliant employers are identified, contacted, penalized, referred for collection, and subjected to judgment. Through technology that enables automation of much of the filing and enforcement process, the Board can efficiently and effectively monitor compliance and process compliance actions.

In addition, the Board has created an Employer Proof-of-Coverage tool on its website. Now anyone can look up a New York or out-of-state employer's Workers' Compensation or Disability Benefits Policy on the IC-2 system, and then contact the Board's Compliance Office if they see an employer lacks the required coverage. For example, a business can look up a competitor's record to determine if that business carries coverage. This tool has also proven invaluable to government agencies that verify that their contractors maintain workers' compensation policies. It's also useful to insurance carriers during premium audit to determine if subcontractors were properly covered for the policy period. The tool is well used: in 2010 there were 291,000 hits, increasing 23% to 359,000 hits in 2011.

Timely Proof-of-Coverage Filing

The effectiveness of IC-2 to identify non-compliant employers depends on receiving timely and accurate proof of coverage filings from carriers. In 2008, the Board gained new powers to promote timely proof of coverage filing. The Board has used these powers strategically, along with greater communication and cooperation with carriers, to dramatically improve the timeliness of POC filings. In early 2008, fewer than two-thirds of POC filings were on-time; by the end of 2011, nearly 97% of filings were timely. Improved timeliness results in better data about employer compliance and is necessary for accurate and timely enforcement.

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Stronger Penalties for Noncompliance

Since 2007, the Board has gained several new enforcement tools:

- The Board can issue a stop work order if an employer does not maintain the appropriate level of workers' compensation coverage or has unpaid compliance penalties.
- The penalty for failure to maintain coverage increased from \$250 to \$2,000 for every 10 days of non-coverage.
- The penalties for failure to maintain coverage also apply to any employer that intentionally misrepresents its payroll or employee classification in order to reduce its insurance premium.
- Failure to maintain coverage by an employer with six or more employees is now a felony.
- An employer that fails to maintain coverage is subject to debarment and may not bid on public works contracts for a period of one or five years.

The Board has issued over 7,700 stop work orders. More than three-quarters of those employers have come into compliance, generally within a day or two.

In 2010, New York passed the Construction Industry Fair Play Act, which clarified the definition of independent contractor in the construction industry and introduced additional penalties for misclassification of employees.

In addition, the Board has enhanced its enforcement through participation in several multi-agency efforts. The Joint Enforcement Task Force on Employee Misclassification, which includes

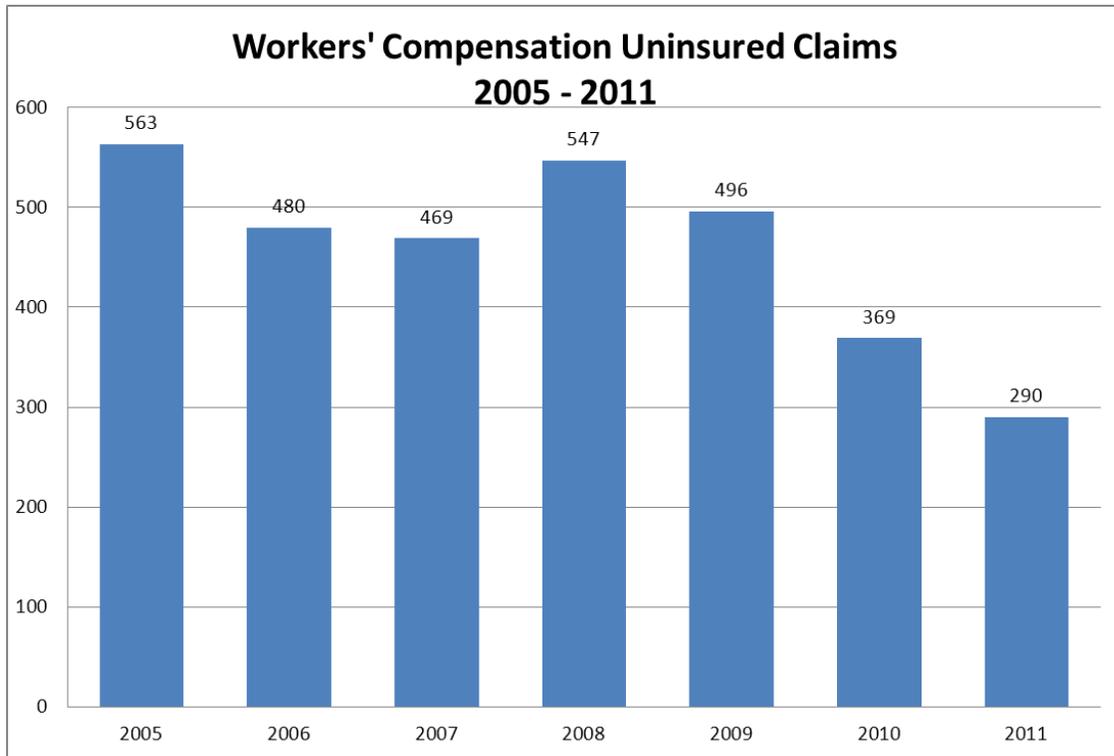
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Department of Labor, Department of Tax and Finance, NYS Attorney General and NYC Comptroller, has conducted regular sweeps of construction sites and other industries at greater risk of non-compliance. It has also cross-trained investigators at various agencies and facilitated data exchanges and case referrals to make member agencies more effective. Board investigators have also participated in New York City's Multi Agency Response to Community Hotspots (M.A.R.C.H.). The task force, which includes representatives of New York City's Police Department, Fire Department, Department of Health, Department of Environmental Protection, Department of Buildings and the New York State Liquor Authority, conducts late night raids against bars and clubs that have been subject of numerous community complaints. The Board also works with insurance carriers, the Compensation Insurance Rating Board, and the Department of Financial Services to identify, investigate, and prosecute employer fraud.

Compliance Efforts Have Significantly Reduced Uninsured Claims

This multi-faceted approach to employer compliance has produced tangible improvements.

While the exact number of employers who fail to have appropriate insurance is unknowable, the Board tracks the frequency of claims with an uninsured employer. Between 2008 and 2011, the number of uninsured claims has fallen 47%.



VII. The Board Has Taken Steps to Improve Data Integration and Develop a Data Warehouse

As part of the reform, the Insurance Department prepared two comprehensive reports on relevant data regarding workers' compensation claims, costs, and other indicators of system performance and recommending improvements in data collection and development of a research structure for public policy. The Department compiled the data from various sources, including the Board, Compensation Insurance Rating Board (CIRB), Department of Labor, Department of Insurance, the State Insurance Fund and others. The Department acknowledged the Board for its role in providing the critical data that led to agreement over significant components of the Reform.

The report included several recommendations:

- The CIRB should collect the WCB claim number of past and future claims so that claim data from the Board and CIRB can be integrated for analytical purposes
- The Board should be the central repository of workers' compensation data
- The Board should develop a data warehouse in which various system data is stored and can be easily analyzed using business intelligence software.

The Board is following all three recommendations.

In 2010, the Board and Insurance Department collaborated to issue a data call that includes the WCB claim number and CIRB claim number to allow integration of claim level data between the two organizations. In July 2011, carriers began reporting the WCB claim number as a mandatory requirement of their claim report to CIRB. Since 2011, the Board has been working with CIRB to validate the data call results and to determine how to share data in the future.

The Board has also expanded its data sharing with other sources, including Department of Labor and State Insurance Fund, and expects to continue these efforts.

Finally, the Board is in the process of developing a comprehensive data warehouse. Planning has been completed and the Board anticipates completing the first portion of its data warehouse, including an easy to use business intelligence application, in 2012.

VIII. Next Steps: Continuing System Improvements

Having completed implementation of the 2007 reforms, the Board began a process of study and strategic planning to determine how to further improve the workers' compensation system. As a result of these efforts, the Board has rearticulated its mission, core values, and vision for the future. The vision includes seven goals for an improved workers' compensation system:

- Ensure Benefits Delivery
- Improve Access to Quality Medical Care
- Support Return to Work Programs
- Promote Workplace Safety

- Foster a Cost Effective Market
- Re-enforce Dignified Customer Service
- Increase Adaptability and Responsiveness

The Board has initiated a Modernization Program to coordinate several key strategic initiatives that will significantly advance the Board's vision. The program currently includes:

Implementation of Claims EDI (eClaims)

The Board will transition from a paper to an electronic employer report of injury system by adopting the IAIABC (International Association of Industrial Accident Boards and Commissions) Claims Electronic Data Interchange (EDI) Standard Release 3.0. The anticipated benefits include:

- Improving the timely delivery of benefits to injured workers
- Providing a single, consistent data format
- Reducing waste, abuse, and delay in the system
- Reducing paper handling costs to system participants outside the Board, i.e., handling, completing, and shipping
- Reducing high costs to the Board for handling, processing, and scanning paper documents as well as certain data entry costs
- Reducing duplicative claim form filings
- Increasing the quality and timeliness of information received by the Board
- Improving data collection for system oversight and policy making

Claim System Business Process Reengineering and New Technology Solution

The Board will undertake a comprehensive reengineering study with the help of a reengineering consultant. The Board and its consultant will work closely with system stakeholders to identify the core business needs of the Board and its stakeholders (injured workers, carriers, medical providers, claimants, attorneys, employers, etc.). Based on stakeholder input and national best practices, the study will design business processes that utilize the latest technology to:

- Improve service to the injured worker
- Speed the delivery of medical services and indemnity benefits
- Reduce costs for the Board and system stakeholders through greater automation, reduced reliance on manual and paper processes, and streamlined processes
- Prevent unnecessary disputes and speed the resolution of legitimate disputes
- Improve turnaround times of administrative processes
- Provide data to enable informed policy making and system performance measurement
- Measure and improve stakeholder performance.

The reengineering study will recommend a set of reengineered processes and a technical solution to implement the envisioned environment. The Board anticipates making a major technology investment in order to achieve the benefits of the reengineering.

Post-Implementation Study of C-4 Medical Report

The Board has begun a post-implementation study of the C-4 medical reports that were implemented in 2008. The post-implementation study includes feedback from internal and external stakeholders and quantitative analysis of the utilization of the new forms, including specific data elements.

The Board anticipates using the results of the study to inform other modernization efforts, including the reengineering study. Medical reporting requirements will likely be an important component of the reengineering project. The study will produce findings about the Board's process of designing and implementing new forms as well as the effectiveness of the particular forms, the data elements, and the current process for reporting and billing.

Conclusion

After nearly 100 years, workers' compensation continues to provide important benefits to both injured workers and employers. The 2007 Reform set in motion a comprehensive package of system changes that benefit both workers and employers. With the implementation of medical treatment guidelines, new permanent partial disability guidelines, and diagnostic testing network regulations, the Board has completed implementation of the Reform. Overall, the Board has succeeded in raising the benefit level, improving medical quality, speeding claim resolution, and utilizing data while reducing costs, combatting fraud, and improving employer compliance.

Yet, through the implementation of these reforms, other areas for improvement have come to light. New technology and reengineered business process offer enormous potential to improve service to injured workers and employers while reducing costs. The Board is committed to working with its stakeholders to design and implement a modernized system that better serves New York's injured workers and employers.

Endnotes

¹ U.S. Chamber of Commerce. "2007 Analysis of Workers' Compensation Laws". Chart VI.

² In 2008, the Insurance Department began approving loss costs instead of manual premium rates. This change is accounted for in the graph showing changes in workers' compensation premium levels.

³ Ishita Sengupta et al., *Workers' Compensation: Benefits, Coverage, and Costs: 2009*, Table 9, pp. 25-26. Washington, DC: National Academy of Social Insurance, August 2011.

⁴ New York first adopted the state's Medicaid pharmacy fee schedule for workers' compensation in July 2007. In July 2008, the Board adopted the current fee schedule. 12 N.Y.C.R.R. Part 440.

⁵ Carol A. Telles and Ramona P. Tanabe, Early Impact of the 2007 Reforms in New York, WC-11-38, Table A11, p. 82, Cambridge, MA: Workers' Compensation Research Institute, December 2011 [2011 WCRI Report].

⁶ 2011 WCRI Report, 23.

⁷ Nicole M. Coomer and Te-Chun Liu, Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2009, Table TA.4d, p.48, WC-10-32, Cambridge, MA: Workers' Compensation Research Institute, June 2010.