BULLETIN

April 17, 2013

R.C. 2332

To: The Members of the Board

RE: Workers Compensation Board Subject Number 046-520
2013-14 NYS Budget Includes Significant Changes to the Workers’ Compensation Law

The New York State Workers’ Compensation Board has just released Subject Number 046-520 which indicates several significant changes to the workers compensation system as a result of the passage of the 2013-14 New York State Budget.

A Copy of Subject Number 046-520 is attached for your information and reference.

Please note that the NYCIRB’s estimated effect of the closure of the Reopened Case Fund and the increase in the minimum weekly benefit are included as part of a report on the original proposed budget bill. The report can be found in the Actuarial section of the Rating Board’s website under Legislative Analyses. Any other questions regarding this subject number should be directed to the Workers’ Compensation Board.

Please distribute this information to the appropriate personnel within your organization.

Very truly yours,

Monte Almer

President

MA: jg
Encl.
2013-14 NYS Budget Includes Significant Changes to the Workers' Compensation Law

Date: April 15, 2013

The recently adopted 2013-14 NYS Budget contains the Business Relief Act, which implements a myriad of major changes to the Workers' Compensation Law (Part GG, page 130, 2013-14 Executive Budget Legislation). This subject number summarizes many of the new statutory changes. Future subject numbers will provide additional and more detailed information on certain aspects of the new laws.

Workers' Compensation Assessments

**New:** The Workers' Compensation Board (Board) will charge employers one unified annual assessment that is passed through directly to the Board.

**Background:** The Board currently administers many separate assessments for various expenses including the Special Disability Fund, the Fund for Reopened Cases, and the Board's administrative expenses. The assessments are paid by the employer, directly to the Board if self-insured or to the insurance carrier if the employer has an insurance policy. The amount that the Board bills the insurance carrier may vary from what the insurer collects from policyholders. The basis for determining an employer's assessment liability varies depending on what type of workers' compensation coverage it selects. The assessment for employers with private insurance is based on premium, whereas the assessment for self-insured employers and those with State Insurance Fund policies is based on indemnity payments.

The new law dramatically simplifies the assessment calculation and billing process. It creates one unified assessment based on premium or premium equivalent for all employers. Carriers must now pass the assessment amount as it is collected to the Board. The Board will announce additional details about the assessment methodology as it is developed and will announce the assessment charges by October 1, 2013. The new assessment methodology will take effect January 1, 2014.

**Fund for Reopened Cases (25-a Fund)**

**New:** The Fund for Reopened Cases (25-a Fund) is closing to new cases.

**Background:** A significant and growing component of the employer assessment is for the 25-a Fund. Claims are eligible for transfer to the 25-a Fund after seven years from the date of accident and three years since the last payment of compensation to the claimant. Upon transfer to the 25-a Fund, the carrier or self-insured employer is no longer responsible for payment or management of the claim.

The 25-a Fund, which does not exist in most workers' compensation systems, generates significant litigation over the transfer of claims without any benefit to the injured worker. The closure of the 25-a Fund will reduce the annual employer assessment by approximately $300 million, producing real savings for businesses, with no impact on injured workers.

No application for the transfer of liability to the 25-a Fund will be accepted on or after January 1, 2014. The Board will make 25-a decisions after January 1, 2014, in connection with timely submitted applications, though applications must meet the eligibility requirements at the time of submission.

**Increased Minimum Benefit**

**New:** The minimum weekly benefit is increasing to $150.

**Background:** The 2007 reform increased the minimum benefit to $100; however, unlike the maximum benefit rate, it did not index to annual changes in statewide average wage. To ensure adequate compensation for low wage workers, the minimum weekly compensation benefit will increase from $100 to $150, effective May 1, 2013. The increase is subject to the existing
rule that one's compensation benefit plus current earnings (or earning capacity) may not exceed one's average weekly wage prior to the accident.

**Group Self-Insurance Trust Bonding Authority**

**New:** Bonds were authorized to mitigate group self-insurance liabilities.

**Background:** A series of defaults by group self-insurance trusts (GSITs) left thousands of claims with a shortfall of nearly one billion dollars to be paid and administered by the Board. The Board is pursuing collection from members of the GSITs who are jointly and severally liable for the claims. However, the Board has had to assess the entire self-insurance industry to make up any shortfall in funding to continue to pay claim benefits.

The Board has successfully purchased assumption of workers' compensation liability policies (ALP) to cap and transfer the unfunded GSIT liabilities. This has facilitated voluntary collections from the GSIT members, which reduces the outstanding liability.

The Act authorizes the Dormitory Authority to issue up to $900 million in bonds as part of the self-insured bond financing agreement to cover the costs of the defaulted group self-insurance trusts (GSITs). The bonds will enable the Board to purchase additional ALPs to settle outstanding liability and maximize recoveries from former GSIT members.

**Health Care Practice Committees**

**New:** Changes to the composition of health care practice committees.

**Background:** The Workers' Compensation Law provides for separate chiropractor and psychology practice committees to help oversee the authorization, discipline, and arbitration of billing disputes involving these professionals. Historically, these committees required one member to be a physician, but the Board has never been able to fill the physician position. As a result, the practice committees have operated with only two members, each of the same profession (chiropractor or psychologist).

The Act modifies the composition of the committees to eliminate the requirement of a physician member and replaces it with a third member of the profession governed by the committee. The Chair will entertain recommendations for new members of the practice committees and will announce his selections as they are made.

**Desk Arbitration of Medical Bill Disputes**

**New:** One arbitrator may now hear health care bill disputes under $1,000.

**Background:** Previously, panels of three arbitrators (either physicians or the health care practice committee members) performed any arbitration of health care bills. In some cases, the dispute involves less than $100, and the cost of the arbitration approaches the amount in dispute. Most of these disputes are simple and can be resolved by a single arbitrator.

Under the Act, health care bill disputes involving $1,000 or less are to be resolved by a single arbitrator. Providers who seek arbitration in disputes of greater than $1,000 may elect a single arbitrator instead of panel arbitration. Single arbitrators will conduct desk arbitration based on the parties' paper submissions.

The single arbitrator process will take effect when the Chair issues regulations implementing the change. The Board will also revise Form HP-1, which is used to seek medical arbitration, and adjust the filing fees for arbitrations with a single arbitrator to reflect the reduced costs of a single arbitrator.

**Discretionary Full Board Reviews**

**New:** Discretionary Full Board review must now be requested within 30 days of the panel decision.

**Background:** Parties may seek administrative review of the ruling of a workers' compensation law judge by a panel of three Board members. If the panel decision is split (2-1), parties have 30 days to ask for the entire Board to review the case. This is known as a mandatory Full Board review.

If the panel decision is unanimous, parties may ask the Full Board to review the case. The Board may decline; this is known as discretionary Full Board review. While today there is no time limit on parties to ask for discretionary review, the new law imposes the same 30 day time limit on requests for discretionary Full Board review. This change takes effect 90 days from the signing of the budget bill.
Data Sharing

**New:** The Board will have access to data from the New York Compensation Insurance Rating Board (CIRB) for purposes of administering the assessment and managing the workers' compensation system.

**Background:** The Department of Financial Services (DFS) designates the CIRB as its rate service organization (RSO) for workers' compensation. As the RSO, the CIRB collects data from insurance carriers regarding their workers' compensation policies and claims made on such policies, and makes recommendations to the DFS regarding changes in loss costs for determining insurance premium.

The data collected by the CIRB are essential to the effective administration of the new assessment process. CIRB data are also essential for policymakers and administrators to understand and improve the effectiveness of the workers' compensation system. The Act authorizes the Board and the DFS to request data from CIRB for these purposes.

Special Funds

**New:** The Chair shall appoint an attorney to represent and defend special funds in connection with WCL §§ 15(8) & 25-a cases.

**Background:** Annual disbursements from the Special Disability Fund and 25-a Fund are in excess of $900 million. Presently, WCL §§ 15(8) and 25-a contain inconsistent provisions concerning who represents and defends the special funds. Both sections contain references to a committee, board, or organization representative of the interest of employers or insurance carriers but neither section provides clear direction for the oversight of the funds. The budget amendments make clear that the Chair shall appoint an attorney to represent and defend the funds and that the Board shall provide direct oversight of the funds' operations.

Definition of Surviving Spouse

**New:** The Volunteer Firefighters' Benefit Law (VFBL) and the Volunteer Ambulance Workers' Benefit Law (VAWBL) are amended to delete references to husband and wife in the definition of a surviving spouse.

**Background:** Both the VFBL and the VAWBL contain outdated references to the "wife of a deceased male volunteer …" and the "husband of a deceased female volunteer …". Both sections have been amended to simply say a surviving spouse means the legal spouse of a deceased volunteer.

Robert E. Beloten
Chair