WORKERS' COMPENSATION INDUSTRIAL COUNCIL

SEPTEMBER 28, 2006

Minutes of the meeting of the Workers' Compensation Industrial Council held on Thursday, September 28, 2006, at 3:00 p.m., Charleston Civic Center, Rooms 207-209, 200 Civic Center Drive, Charleston, West Virginia.

Industrial Council Members Present:
Bill Dean, Vice-Chairman (Acting Chairman)
Walter C. Pelish
Dan Marshall
Richard Slater

1. Call to Order

CHAIRMAN DEAN: We'll call the meeting to order. And anybody wishing to speak today, if you would, please come to the microphone. We have a new recorder today and she'll need all the help she can get, so identify yourself when you come to the mic, if you would, please.

We do have a quorum. Let the minutes show that Mr. Marshall is here and Mr. Pellish.

2. Approval of Minutes

CHAIRMAN DEAN: Do we need approval of the minutes of the previous meeting?

MR. MARSHALL: So moved

MR. PELLISH: Seconded.

CHAIRMAN DEAN: Any question on that motion?

(NO RESPONSE)

CHAIRMAN DEAN: All in favor, aye.

MR. MARSHALL: Aye.

MR. PELLISH: Aye.

CHAIRMAN DEAN: None opposed, the aye's have it.

3. Office of Judges Report – Timothy G. Leach, Chief Administrative Law Judge

CHAIRMAN DEAN: We'll move on to the Office of Judge's report.

JUDGE LEACH: Mr. Dean, members of the Council, you have received my report a couple weeks ago. I just wanted to highlight to your attention, call your attention to a couple of matters.

First of all, a brief explanation for the corrected first page. We had started running a new report the first of this year. Actually, we were requested to run the report probably in March and that's when we started dividing our claims into old fund, new fund and self-insured and we had a programming, a report preparation misunderstanding. And what we were doing was tracking all of the cases that had never appeared before us at any time in the history of the claim as a new fund claim. That's not the legal definition, but that was the programmer's understanding of the program definition. But if a claim was ten years old or had never been in our claim system at any time in its claim history and came in after January 1, it was being picked up in this report as a new fund claim.

So consequently, we were rather grossly exaggerated under new fund cases. Our percent of protest for year-to-date dropped from 38.6% to 16.2% after we found our error and corrected it. The self-insureds were reported correctly, but both the new fund and old fund cases were incorrect. We discovered that after mailing out the report earlier this month and sent you a corrected first page and those numbers will be accurate in the future.

Pending caseload because of the decline in numbers of protest is now down to 10,000. When we started this report in August of 2005, that number was about 18,000. So it's a significant decline there.

The timeliness for parts of the report are satisfactory to me, except for the one on page four that's highlighted in red, subpart (f). Our August final decision timeliness was 4.3% for the month. As you can see from the chart or graph underneath that, our year-to-date is within 2% or so of the last three years. It's not a significant drop or decline, but I don't like to see a figure that high on the month, so I didn't highlight it in red to call your attention to the negative part of the report. But immediately above it, you can see highlighted in yellow that we're now doing over 50% of our decisions that we did for August and we're almost at 50% year-to-date, within 30 days of the assignment to the judge.

So we feel like we don't have full control over the case while the attorneys are litigating the case. They can ask for continuances, they can ask for extensions, they can ask for postponements, and to a large extent or to a large degree, we grant those continuances and extensions. But then once the parties have agreed that we're through developing the case and now want the decision, that is definitely on our watch, and that's why we track these numbers, how many decisions were within 30 days, which is the positive part of the report and how many takes us more than 90 days to decide, which is the negative part of the report. So I'm pleased with positive results there. I'm not pleased with the 4.3% negative result.

Finally, the last item, standard compliance. This is an overall time standard. Our mark is supposed to be 80%, according to our rule. As you can see, it was 85.9 for August and is over 85% for year to date. And those represent the highest figures that we have recorded since in at least five years since we put in our computer tracking system of cases.

The other matter to report of a non-statistical matter is to remind the public present today and members, that you are all invited to attend these workshops. I also included a separate agenda for the workshops. They're going to be three hours long. Three of the four start at 9:00 and are over by noon and the one in Morgantown because of the length of travel involved for people starts at 1:00 and is over at 4:00.

We have traditionally done our Morgantown meeting at 9:00, which meant that many people had to spend the night in Morgantown, including our own staff, to get there by nine, so we felt we would do better doing it a little bit later in the afternoon. So we have Thursday October 12th in Morgantown. Tuesday October 17th in South Charleston. Tuesday October 24th in Beckley and Tuesday October 31st in Charleston. Those are free. They're designed for both lawyers and for attorneys' staff and for the TPAs to explain our processes and some of our interpretations of some legal issues.

Mr. Chairman, that will conclude my oral report. I'm ready to accept any questions.

MR. PELLISH: A comment for you. As I mentioned to you when you came in, I would like you to take a look at the possibility of the eastern panhandle.

JUDGE LEACH: I appreciate that comment and I acknowledge that we tend to neglect the eastern panhandle. When we plan these tours, we tend to lump the eastern panhandle into a more central part of the state.

So what I told you I would do is perhaps have a public meeting of some type up there. We tried this before where we just scheduled staff to go up and advertise they were going to be there and just take questions from employers and claimants and just generally hold an information session without a fixed agenda or training session.

So I'll look into it and see if we can do that. I certainly enjoy my trips to the eastern panhandle when I've been there.

CHAIRMAN DEAN: Do you have any questions?

MR. SLATER: No.

CHAIRMAN DEAN: Let the minutes show that Mr. Slater is present.

4. Presentation of Rule 9 Final Draft – Ryan Sims

CHAIRMAN DEAN: Mr. Sims, would you like to come up and do the Commission Finalized Title 85, Series 9?

MR. SIMS: I'm here to present to you the final draft version of Title 85, Series 9, which deals with the administration of the uninsured employers' fund, which was created by the Legislature in Senate Bill 104 to be a fund for claimants whose employers were noncompliant or not carrying workers' compensation coverage.

We presented this rule initially to you in our pre-stage process, first, on 6/20/06 for the initial filing, and then several days after you gave us permission to initially file and we did file with the Secretary of State on 6/19. Subsequent to that, there was 30 days for public comment, which concluded with a public hearing before you during the 7/20/06 meeting. And then we did not present it for final filing in August because of some ongoing issues and time constraints due to comments we received, making sure that we had dealt with all the comments we received. And we believe we have done that now.

I'll just take you, briefly, through the changes we have made based on the comments we've received. One of the first things, really, is 3.5. Under the definitions, we just created a definition for the term "workers' compensation coverage". That was just done to clarify that when we refer to the term "workers' compensation coverage" in the rule, it's referring to West Virginia Workers' Compensation because we didn't want it to be misconstrued that it was talking about any other state's coverage.

Moving on to Section 4, we tweaked some of the provisions regarding applying for benefits to the fund. Essentially, initially, the way the rule read is the only determination we made before we sent it on to the TPA was whether the employer stated in the application they had insurance coverage or not, and if they didn't, we were going to send it on to the TPA.

And in 4.3, Section 4.3 and subdivisions (a) and (b), we tweaked it because we believed that if an employer wasn't required to have insurance such if they were an extraterritorial employer that was permitted to cover the employee in another state, we also can initially deny it. So we added that determination. We believe that goes part and partial with whether the employer was carrying coverage. If they didn't have to carry it, then it's irrelevant whether they have West Virginia coverage or not. So we just included that in our initial determination.

But the long and short of it is we make those two initial determinations. If we determined the employer was supposed to be carrying coverage and didn't have West Virginia coverage, then it goes on to our TPA and the claim begins to be administered for the claimant. If we have determined that the employer didn't have to have coverage or did have coverage, contrary to the allegations of the claimant, then that goes through a hearing examiner or hearing process through the Insurance Commission and is appealable to the Circuit Court.

All other claims issues, if it's sent on to the TPA, would go through the Office Of Judges process. We think that's consistent with our reading of 23.2(c)(8) and the relevant provision that we make the special determinations. And if it's met, then it is sent on to the TPA.

Moving on to 4.5, that section discusses -- we just tweaked the appeal provisions and basically clarify that if we receive a -- regarding the initial threshold determination I just discussed, if we receive a protest within 30 days, we provide it through an expedited process and we'll schedule a hearing before a hearing examiner on relevant issues to that determination. If either the employer or the employee challenges our finding in 4.3, we'll provide a hearing within 15 days.

Now, to be clear, as long as we find that the employer should have had coverage and didn't, we send it on to the TPA immediately and it begins to be administered. However, the employer would still have the right to challenge our findings in that regard; that is to say, if an employer disagreed with the Insurance Commission and said, no, I had coverage in another state or no, I wasn't required to have coverage for this employee in another state, they can challenge that, but the claim would begin to be administered right away as long as that threshold determination administration is met.

So the uninsured claimant will immediately begin receiving benefits, and if later an employer shows that they weren't required to have coverage or had coverage, then there will be a corrective letter issued by the Commissioner or a corrective order.

We didn't make any changes from the last version in Section 5 regarding the irrevocable assignment of subrogation rights; however, as you know, we recently -- there were some comments on that initially, but we felt it read okay as it was.

But there was recently some additional comments received by several claimants' attorneys who expressed a concern over this provision. And the concerns, I think, primarily, can be summarized as twofold. The first one is that we permit subrogation against other potential insurance policies out there such as if there's a comp policy in another state or if there's a disability policy that provides coverage for the injury that the UI is paying benefits on.

There was a concern over us making it so broad because workers' compensation subrogation for private carriers and self-insured employers is limited only to third-party lawsuits. It doesn't specifically -- Title 2.8 doesn't extend to other insurance policies and isn't as broad as we make it here.

We believe that 2.8, the provision which created the uninsured fund, that the Legislature was creating a broader subrogation provision that basically permits the uninsured claimant to go after any collateral source fund that's available to a claimant. What needs to be made very clear, though, is it's only up to the amount of benefits paid to the claimant, so that is to say, the Insurance Commissioner has a subrogation lien or subrogation rights against any collateral funding the UIF, uninsured fund claimant has, but only up to the amount of medical indemnity funds paid. So after we get the fund reimbursed for what we have paid out to the claimant, then the rest goes to the claimant. That already is stated in 5.2.

The second concern that was expressed -- there was a concern by the claimants' bar that a claimant because when they made an application to the fund and started receiving benefits, they have to make -- and it's according to the code -- irrevocable assignment of subrogation rights to the fund. Again, as I mentioned, it's only to the extent of benefits actually paid to the fund.

But there's a concern that we somehow preempted a claimant's right to get their own plaintiff's attorney and pursue the claim on their own. There was some concern that maybe we were writing this language to have them assign their rights in a manner in which only we could prosecute the lawsuit.

That was not our intent at all in Section 5, and we think Subsection 5.2 took care of that; however, to thoroughly address the concerns that were recently espoused in regard to Section 5, we have two additional provisions proposed some -- a slight tweaking, a couple additional provisions -- well, really, two additional provisos in Section 5.1, which we think make it very clear.

First of all -- and it should've been handed out to you. It actually would be in our response to Mr. Skaggs' request to reopen public comment. It's not in the version you have, but you all should have our response to this request to reopen. Are you all not finding that? It will be on page seven of that response.

MR. SLATER: Page seven of?

CHAIRMAN DEAN: Page seven of their response.

MR. SLATER: There's only five pages that I have.

MR. SIMS: Well, maybe you have a copy that was single-spaced. There actually was a double-spaced response. We did general comment responses that were sent out several days ago, and then most recently after we sent those general comment responses out, there was a motion -- it should've been sent to you all as well -- from Mr. Skaggs requesting to reopen.

MR. MARSHALL: We have the motion, but your response is five pages in length. And this is double-spaced.

MR. SIMS: Oh, you have the double-spaced version? Either way. In the single-spaced version, it's on page four.

MR. MARSHALL: Page four and it's highlighted in yellow?

MR. SIMS: Correct.

CHAIRMAN DEAN: And essentially, there was some concern over that language in that it assigns all of his or her rights, that that might create some confusion that they were assigning the whole claim to the Insurance Commission, and then the Insurance Commission would be able to keep all of the proceeds.

That's why we took out that language, "all of". It just says "Assigns his or her rights to recover money," and then at the end of that provision in 5.1, even though we think 5.2 also makes this clear, just to be abundantly clear, we included two provisos. The first one provides that the irrevocable assignment is only to the extent of actual monetary benefits received by the claimant from the uninsured claim fund. Are we all on the same –

MR. MARSHALL: Ryan, this draft of the Series 9 that we have with the yellow lines is highlighted, am I to understand it does or does not contain --

MR. SIMS: Does not have this provision.

MR. MARSHALL: Okay.

MR. SIMS: And what we're doing to respond to these most recent claims we've received or most recent responses we've received in the last few days is we are suggesting the additional provisos and crossing out the language "all of" that's in our response to Mr. Skaggs' request that that be added to the draft.

MR. MARSHALL: And I don't have any problem with what you're saying substantively, but it seems like we ought to have a corrected final version in front of us before we act.

MR. PELLISH: I agree with you completely. I agree with you.

MR. SIMS: Okay. I mean that's certainly up to you all. I mean traditionally this was done in front of the Board of Managers. With regularity, there was just verbally suggested additions that they could accept, but if you all are uncomfortable doing that, of course, that's completely in your authority.

MR. PELLISH: I'm not comfortable pursuing it that way.

MR. MARSHALL: I'm not either, simply because I don't understand it sufficiently to act on it.

MR. SIMS: Again, the idea was that this highlighted yellow provision would just be added to 5.1.

MR. MARSHALL: I don't have anything that's highlighted other than the rule itself.

CHAIRMAN DEAN: I think we're just not -- we don't have everything that you have.

MR. PELLISH: I think you're looking at the wrong thing. It's on page four.

MR. SIMS: Yeah. What I have is a document entitled "Insurance Commissioner's response to the request of John H. Skaggs to reopen for comment before hearing the final version of the West Virginia Code of Regulations 85-9-1. It's that document and it's single-spaced. And in addition, we are recommending an addition to be added to the current draft you have is on page four of that document. Now, it sounds to me like maybe not everyone received that.

MR. PELLISH: I think maybe where the confusion arises is there is about three separate responses in this packet.

CHAIRMAN DEAN: Nothing is highlighted on ours. The one I have isn't.

MR. MARSHALL: Let me ask you this, are there any serious adverse consequences if we defer this action on a particular item until this little bit of confusion gets clarified, if we did it the next time?

MR. SIMS: Well, again, it's certainly up to you all. I mean we wanted to get this rule through today because we have staff that are currently operating this rule. Of course, I mean before we go forward, I need to make sure you have this provision we're talking about. It's just what is in yellow.

MR. SLATER: Ryan, would you please read the provision for the record so we will have it?

MR. SIMS: Absolutely. The current provision, as stated in the rule says -- it's 5.1 -- "Pursuant to West Virginia Code 23-2(c)-8(b)1(c) as a condition to receiving benefits to the fund, a claimant under the fund irrevocably assigns all of his or her rights to recover money from a collateral source from occurrence or exposure, which resulted in claimant's injury." I'll stop there.

The first change would be to strike the words "all of" so under the new change it would read "Pursuant to West Virginia Code 23-2(c)-8(b)1(c) as a condition to receiving benefits from the fund, a claimant under the fund irrevocably assigns his or her rights." And it wouldn't say "all of" -- that would be the first change in the amendment as contained in the final version.

And the second would be two provisos. Now, do you all have the version highlighted in yellow now? I just need to make sure we're reading from the same document.

CHAIRMAN DEAN: Yeah.

MR. SIMS: The second would be the two provisos that are highlighted in yellow after -- and I'll just start again, "Pursuant to West Virginia Code 23-2(c) -8(b)1(c) as a condition of receiving benefits from the fund, a claimant under the fund irrevocably assigns his or her rights to recover money from a collateral source for the occurrence or exposure which resulted in the claimant's injury including but not limited to" and again, we struck "all of", and then it would say, (a) -- and this is how the current version reads -- "Any benefits from other existing insurance policies such as a later discovered workers' compensation policy providing coverage or a disability insurance policy; and (b) any funds resulting from a settlement or jury verdict stemming from a cause of action under statutory or common law against a third party who has liability for the occurrence or exposure which resulted in the claimant's occupational injury or disease."

And this is the addition. It would say -- and again, these provisos we think this is reiterated in 5.2, but we wanted to be abundantly clear on these and that's why we're adding them -- "provided that the irrevocable assignment of rights and recovery is only to the extent of the actual monetary benefits received by the claimant from the fund."

And again, that's to clarify. We can only recover up to the amount we paid them. "Provided further that nothing in this subsection shall be construed to prevent a claimant from pursuing a claim on his or her own against a collateral source for the occurrence or exposure."

That, again, is to address the concern that the claimants -- that somehow we were taking away the claimant's right to get their own attorney and pursue their own cause of action, such as if there was a car wreck that was work-related, but there was also a car wreck, we think this leaves no doubt that they can still get their own attorneys and that they can only subrogate up to that amount.

So we're suggesting those following two amendments in addition to the draft version we gave you.

MR. PELLISH: I guess from my point of view, I'm uncomfortable dealing with this on this basis where you're bouncing from the recommended changes, and then we've got to look at a draft.

I would prefer to operate when we come in here to have the discipline of having any final language in one document that we're supposed to look at. I agree completely with what you're recommending, but I just don't like to do business in this way, and I think that's what you were alluding to earlier.

MR. MARSHALL: Right. However, having seen the substance of the language here, I certainly don't have any problem with it and if it would move the administrative process along, I'm okay with doing it today with the proviso that we adopt Mr. Pellish's suggestion that in the future, we have a clean and final draft in front of us.

MS. PICKENS: And if I might, and I certainly appreciate those comments, you are absolutely right. I think it was handled this way because we did get some very last minute comments from a member of the public.

CHAIRMAN DEAN: Were they made timely, Mary Jane?

MS. PICKENS: No, they were not, but yet any time someone brings something to us, if they call or write or whatever, we're going to listen to their comments because I think that's how you get the best public comments.

But it was approached this way because Ryan had already received the official public comments and had already prepared a response to those comments. Then we got the last-minute comment and he addressed this specifically to take care of that comment.

So what we envisioned, if it met with the approval of this Council, is that you would approve -- again, if after a thorough discussion if you were fine with this approach, that you would approve final filing with the amendment that has been suggested by the Insurance Commission.

That's just by way of explanation. That's why it was approached this way. And I understand and apologize for any confusion in the packets. Our usual person, we found out at the last minute, Margaret would not be here, and we had someone else substitute, so it may not have been as easy a packet as you would normally get.

CHAIRMAN DEAN: Any questions for Ryan, Mr. Pellish? Mr. Marshall?

MR. MARSHALL: No.

MR. SLATER: I move we approve the provisions to 5.1 as read and stated.

CHAIRMAN DEAN: I do have one question for you, Ryan. And you mentioned there if an employee got injured and he went to -- he wasn't covered or they didn't feel like they covered him to fall back on another insurance type of thing, he went to workers' comp and you feel that that employer was covered, how long is it before he can get attention or get his claim paid for?

MR. SIMS: You're saying if the claim was denied by us in the threshold term, we either found that there was coverage or that the employer didn't have to have coverage?

CHAIRMAN DEAN: Uh-huh.

MR. SIMS: Well, I guess that would be addressed separately. If we found there was coverage, we would certainly tell the claimant who we believe the coverage is with and tell them that we think it would be appropriate to file a claim with that insurer, in which case, it would be handled just like filing a claim with BrickStreet or any workers' comp insurer.

If we found that the employer did not have to have West Virginia coverage because you're dealing with the extraterritorial situation where they're an out-of-state employee just coming in here temporarily or something like that, in that scenario, that's why we provided that expedited process in such a form where basically we would inform them in a letter and so long as they protested to that within 30 days, that finding, we would give them a hearing within 15 days.

We think that's very expedited. It's difficult to get a hearing set up in 15 days, but we would do that so they could get that issue resolved, and then either, obviously, if the hearing examiner found that we were incorrect and that the employer should have had coverage, then it would be sent immediately to the TPA. If not, either way, it would be resolved shortly after the 15 days.

CHAIRMAN DEAN: But he wouldn't have care for 15 days until this was decided or would he go ahead and continue to get his check?

MR. SIMS: If we don't make the threshold determination -- if the employer wasn't required to carry coverage, then he should be making it with another state or, wherever that employer's coverage is. If they're required to carry West Virginia coverage, then we would obviously send it on to the TPA.

Like I said, the employer then on the other side could come in and protest that. The only way they wouldn't get care right away is if we found that their claim didn't belong initially with our threshold, that it just does not belong; in other words, they have no West Virginia Workers' Compensation coverage or there's an insurance policy covering them.

CHAIRMAN DEAN: And that was my concern between BrickStreet and if he was covered by another state and that other agency or BrickStreet got to battling back and forth, who would cover him if that guy was sitting out there with no care.

MR. SIMS: Are you asking me more of a general question now, if the insurer --

CHAIRMAN DEAN: Yeah. If the two insurers, each one saying the other one should cover him and still the employee's not getting care, how long could he go without care?

MR. SIMS: Well, if it was sent to an insurer, supposing we found this doesn't belong on the uninsured fund and say there was some confusion over the insurers, say from July 1, 2008, they initially -- I'll give you an example. They file the claim with BrickStreet. BrickStreet doesn't have coverage for this employer, but maybe they were confused because they thought it was always on BrickStreet, but now the market's opened up, their employer has it with Nationwide. We would inform that claimant, your coverage is with Nationwide. Go file the claim with Nationwide. Our findings is that your coverage is with them. Then they can file a claim with Nationwide just like filing one with BrickStreet. In other words, Nationwide would have to -- their TPA would have to make the finding within the time required in the statute, which I think initial rulings, I think, are made within 30 days, and then if they denied the coverage, then they would be able to go to the Office Of Judges and challenge that, in fact on a rather expedited basis and an expedited process for a resolution.

CHAIRMAN DEAN: So there could be a time he's not getting care because you know how business is at times.

MR. SIMS: Well, there's always that risk, but there's a statutory requirement that workers' comp care would rule on an application for benefits within so many days and I think that's designed to get any issues resolved in an expeditious process.

CHAIRMAN DEAN: I just wanted to make sure I understood that.

MR. SIMS: I guess I'll suggest that maybe I go through the rest of the rule before you all vote.

CHAIRMAN DEAN: Very good.

MR. SIMS: We went through 5, and again, in the initial draft, there's no changes to 5, but we are recommending that you adopt it with the changes highlighted in yellow in our response to Mr. Skaggs' request to address the recent concerns.

Moving on, there were no changes in Section 6. Well, there was a small cosmetic change in Section 6, just changing "will be held" to "are liable". It's a cosmetic change.

And moving on. The last substantive changes were in Section 8 and that was other than these issues that came about regarding the subrogation provision. I would say the most major concern expressed was regarding the self-insured, the liability to self-insured employers for assessment in the case that the uninsured fund needs funding.

As you know, we believe that Section 8 is consistent with the way that we read the statute, which is that it's discretional on the part of the Insurance Commissioner whether to impose assessments on both self-insured and insured employers or just insured employers.

Now, obviously, as you know, there was some disagreement over that. The self-insured community believes this shouldn't, that they shouldn't be subject to assessment, while the insured community, at least some folks from the insured community, expressed a contrary opinion that the self-insured community should have to be subject to them equal to what the insured employers are subject to based on payroll or something similar.

We didn't make any changes because we feel our construction of the relevant statute 2(c)(a) is consistent with the intent of the Legislature, that is, to make it discretionary on the part of the Insurance Commissioner whether to levy assessments between both communities or just the insured community.

We did make a couple changes for clarification purposes. Well, first, in subdivision 8(a), which is on the last page of the rule, there was language that read "expenditures for claims". That was actually an error. The assessments in regard to insured employers are based on premiums to be received. So in other words, the premiums to be received by the carrier, those are estimated and the assessment is passed on to the employers in that fashion. And again, the language expenditure claim actually was the language for self-insured employer assessments, not insured employers assessments. So we corrected that error.

And then in 8.2, there was some concern that the 30-day notice requirement when we're going to impose assessments was too short a time period, that they needed a little bit more time for accounting purposes and to be able to take in the effect that the assessments would have. So we moved it up to 60 days. So now, instead of 30 days' notice, we have to provide 60 days' notice before we begin to impose assessments to insured employers or self-insured employers.

And also requires that -- the previous version required the assessments to be posted on our website. We were informed by the insurance community that they prefer that we send each licensed workers' comp insurer that's writing here a written notice of what the assessments are. We thought that was very reasonable. So we now require in the rules, a written notice of the assessments. Those were the changes in 8.2.

With that, we're presenting to you this rule, but I think there might be some members of the public that want to make comments before you all vote.

MR. PELLISH: I have a question on that last --

MR. SIMS: Yeah.

MR. PELLISH: What do you mean by "other means deemed appropriate by the Commission"?

MR. SIMS: Well, I guess we struck the provision dealing with posting on the website. That would be one. So, basically, the way the rule reads now is we have to provide a written notice to every carrier. That's required, and then another means would be posting on the website. I suppose there could be other means.

MR. MARSHALL: Something like --

MR. SIMS: An information letter. I don't know. Any other means we think is appropriate to let them know what the assessments are.

We think it was well taken that they should all be sent in writing, initially, to every licensed insurance carrier that's writing comp, so they know in writing, this is the assessment.

CHAIRMAN DEAN: Any other questions for Ryan?

(NO RESPONSE)

CHAIRMAN DEAN: Thank you. Mr. Skaggs, you would like to speak on Rule 9?

MR. SKAGGS: Yes. If I may make some brief comments. I'm John Skaggs, 500 Randolph Street, Charleston, West Virginia. I appreciate the fact the Commissioner's staff did respond to an extent to the comments I made. I really do appreciate the responsiveness to that, but I do not think that cures the difficulties with the regulation.

And without going into the very important issues of why should they be able to give some claimant's disability policy to protect his car payment or his home payment, which are very important issues, I think we should focus on 5.2 because they still haven't fixed the underlying problem, which is that as it says, "Pursuant to the irrevocable assignment of subrogation rights." Irrevocable, once they're assigned, that's it as far as the claim is concerned.

"The commissioner shall" -- it's mandatory -- "have the discretion to pursue subrogation directly, including bringing a civil action in the name of the claimant against the liable source."

So what they're proposing here is that this Insurance Commissioner is going to undertake to represent either directly through her legal staff or through some lawyers that she would hire, individual claimants who have been injured. And so you have, first of all, an apparent conflict of interest because her interest, of course, is to protect the fund, recover indemnity, recover medical, but that is the end of it. The claimant's interest is to get himself what he can in terms of the money necessary to live if he can't work, for rehabilitation or what have you.

And the investigation of these matters to determine who is the liable party, particularly, in more complicated situations is a very difficult and expensive undertaking. And I don't want to get into war stories, but we have a case now for an individual who was working on a dragline in a strip mine and the manlift that he used to get up to the top where the operator sits collapsed and fell off of this piece of the equipment.

Without knowing anything more, you've got the manufacturer of the dragline, you've got his employer, you've got third parties who maintained it. In this situation, you've got third parties who fabbed the manlift, and then you've got the people who make parts of the manlift, so you're lawyer's already up to six potential responsible parties.

Is the Commissioner really going to dedicate the time and resources and expertise that are required in these type situations to explore those cases? The other problem is that, as it stands on its face, now they're saying, well, the claimant is free to file a case, but then so is the Commissioner. So you've got the potential of two different cases being filed, conflicting jurisdictions, conflicting judges, conflicting outcomes.

So it simply isn't a sensible thing for the regulation that is now before you to authorize multiple lawsuits when one should be sufficient. In addition, there is absolutely nothing in the regulation about the Commissioner's duties to these claimants. If they're going to undertake the benefit of representing these people, then you get the good, the bad and the ugly. You get the responsibility of representing them also.

And there's absolutely nothing in here about timeliness, how long does the Commissioner have to make a decision whether to file a lawsuit, whether the claimant is told about this process, what is claimant's role in approving any kind of settlement, nothing to address any statements of the claimant about the conflict of interest, nothing about the civil statute of limitations. You've got six months to file a traumatic injury claim, three years to file an occupational disease claim, two years to file a civil suit. What if the Commissioner sits on it for three years in the comp case and the two-year runs? What if the Commissioner misses a good defendant or a theory or doesn't properly work up the case?

There's a magnitude of issues, I think, that may not have been addressed in this regulation, and I think if you set aside claimant versus employer and all the rest of this baggage that we all carry around and if you think about it from the standpoint of the Commissioner, does she even really want to do what this regulation proposes? Are they really going to implement what it proposes?

And in follow up on one of the questions about the insurers, it's not just a question of whether the insurers are responsible. In an occupational disease case, I initiated a claim against one employer who was uninsured. Well, what if after two years of comp litigation, it turns out that there is an employer who is held chargeable after you go through the appeal process and the Supreme Court process and you go back to an insured employer, which is quite likely to happen. It happens in OP cases all the time. It happens in asbestos cases. Well, then, what do you do if the Commissioner settled the case or recovered subrogation and it turns out there was really at the end of the day an insured employer who is responsible for it that somehow got missed? Well,

who's going to pay all that money back to the Commissioner? How is all that mess going to be sorted out?

So I would urge the board to withhold approval of this rule. It has tremendous ramifications. It's a classic example of one of those things that sounds easy; well, we should just subrogate this and get our things back, and if you're unfamiliar with the legal process and you're unfamiliar with the complexity of modern problems of a product-liability case, it doesn't seem like such a bad idea. Believe me, there is an awful lot of unresolved issues here that are going to adversely affect claimants and potentially employers in the fund. I'll be happy to answer any questions.

CHAIRMAN DEAN: Any questions from the Council?

MR. MARSHALL: Comment. I think Mr. Skaggs made some exceptionally valid points that need our attention. My view is that the principle of subrogation, obviously, will stand here. The fund needs to have the subrogation rights, but this thing, I believe, does need some work. I don't know what the solution is, but it's something in my mind toward subrogation of an amount of an award as opposed to the right to pursue actions against parties.

And by that, I mean if there is recovery from another entity to the extent benefits were paid out of this fund, the fund should recover, but we need to leave the right to pursue causes of action, I think, importantly, to the individual claimants. This thing, it needs some more work. Your points are well taken in my view.

CHAIRMAN DEAN: Mary Jane, would you or Ryan either one like to comment on this?

MS. PICKENS: We're doing a tag-team thing here. Ultimately, it is this Council's decision how the rule needs to read. We want to make sure that everyone has the information that they need to make these decisions and that everybody is as educated as they need to be.

We again, want to stress that we do need this rule because we have these claims coming in right now, so we need a rule to administer -- to use those instructions to administer these claims.

Also, just to respond a little bit to Mr. Skaggs. Certainly, it's not the Insurance Commissioner's decision to get in the habit of constantly representing claimants. I mean what I am told is that, first of all, in other jurisdictions, it's not uncommon for the regular workers' compensation, with regard to insurers and self-insured employers to be able to file lawsuits on behalf of claimants if they just don't do it.

We would not want to get in a position of doing that and probably what we would do and what I'm informed of, what usually happens in other jurisdictions, you are appointed plaintiff's counsel so that they are represented by an independent attorney looking out for their interests. So I think some issues have been raised. We don't think those are going to be problems that actually occur.

We, again, feel the need to get the rule filed. And in our interest in doing that, I think the biggest sticking point from what I'm hearing is that the Commissioner would have the ability to file a lawsuit on behalf of the claimant. If that's something that you want to hear more about, we'll certainly do more research and get back to you in whatever fashion you want us to do that.

MR. MARSHALL: Well, just a suggestion I would add is the staff could work with Mr. Skaggs. I think we all understand where we want to be at the end of the day here. We want the fund to be protected and we want the individual claimants to be able to pursue claims independently and with their own counsel.

And what we have here are, I think, are some drafting issues that can be resolved. I'm uncomfortable with what we have in front of us, and appreciating what you said that we need to get a rule that you all can implement being -- having been made aware of some problems that cause me some concern, I'm personally not ready to approve this rule in the form that is before us today.

MS. PICKENS: And we'll certainly try to do that. I don't know if there is a compromise or it's just a decision on your all's part, but we'll certainly try to work with whoever we need to work with to try to resolve it.

MR. MARSHALL: I certainly think the issues can be resolved. I hate to go ahead and pass the rule and then go changing it in 60 days. Meanwhile, there's a rule that at least this member feels is defective as it sits here and I kind of think we ought to try to fix it first.

CHAIRMAN DEAN: Mr. Pellish, do you have something?

MR. PELLISH: I've got to come at this from a different direction and it's probably my bad guy hat.

I have a problem with hearing Mr. Skaggs present his point of view, and I think he does offer some significant points of view, but if those arguments were so cogent, why weren't those things filed on a timely basis for consideration?

It seems to me that staff did take the time -- even upon receiving the comments late, they did try and comprehend them and address them with the response back to Mr. Skaggs and, also, in making some changes.

I don't think this is a never ending process where we can just receive things after the proper timeline has been exceeded. And I guess I'm also a little bit bothered by what I think I'm hearing that plaintiffs' attorneys may need sufficient time to go out and find more people to go after in terms of a fishing expedition. That bothers me.

Some and substance, I've got to go back a little bit on what I said earlier. I've seen enough evidence here today from my point of view to, on a one-time basis, except a proposed change -- to accept a proposed submission with the one change, but never to do it again in the future unless there was really something strange. I think we need to adhere to the disciplinary measures that are out there so that we can act in good faith and on a timely basis.

CHAIRMAN DEAN: Do you have anything, Mr. Slater?

MR. SLATER: Just to say that I think that 85 Series 9 and 5.1 I think has been spoken to clearly. I think it satisfies all the requirements that we need in the rule and the Commissioner has made a very good-faith effort to respond outside of normal cause and days and I think that was done in a sufficient fashion.

So I think as stated and with the revision that we just went through, I think it should be approved as such.

CHAIRMAN DEAN: Is that a motion?

MR. SLATER: That would be a motion.

MR. MARSHALL: I would second it.

CHAIRMAN DEAN: A motion to approve and a second. Any questions on the motion? All in favor, aye?

MR. SLATER: Aye.

MR. MARSHALL: Aye.

CHAIRMAN DEAN: All opposed?

MR. PELLISH: No.

CHAIRMAN DEAN: Ayes have it.

5. Permission to Withdraw Current Series 8 Rule – Ryan Sims

CHAIRMAN DEAN: The Commission to withdraw current version of Title 85, series 8, Ryan, would you like to speak on that?

MR. SIMS: Sure. Just briefly, I believe it was the June or July meeting, we brought before you a version of Title 85, Series 8 or a revised version of it, an amended version. It already existed previously, which is entitled "Workers' Compensation Coverage Issues Policies and Related Topics."

As you probably know, that rule relates to a wide variety of topics, including coverage issues for workers' comp, independent contractor issues, how the workers' comp policy should read, issues dealing with how the carrier deals with their insured employer, that type of thing.

Again, when we initially brought that rule before you, we curiously did not receive any public comments on it, at least written comments. And we never had a public hearing. We withdrew it before it was time for the public hearing the following month. I think we presented it, initially, in July and withdrew it sometime in August.

We've also internally gone over some of the issues in there and some things have been brought to our attention that this rule just basically needs more work before it's right and we don't want to rush a rule through when it's not right.

So we are going to request that we withdraw the initial version that we filed with you, I believe, in July and our hopes are to revise it and to withdraw it for now and bring a brand-new version to you after we've had time to reach out to the various communities and solicit some comments to some of these very important issues and hopefully work with them in addressing some of these extraterritorial coverage and independent contractors.

We think that the rule needs to be amended, but again, we want to get all these very, very crucial issues right. So again, we're going to ask you to withdraw the current version filed with the Secretary of State with hopes that we can bring you a new version, maybe, in the November meeting or at least the December meeting.

MR. SLATER: Ryan, absent the Series 8 being approved here today, how does that affect the daily operations?

MR. SIMS: We think right now, although, we think there are some areas in the rule that need addressed, we don't think there's any current vital problems being caused by the way the Rule 8 reads right now. I mean we only have one carrier right now and BrickStreet is very cooperative with us and we're able to meet with them if there are any issues. And we have the self-insured community.

But we think there needs to be a new version of Rule 8 prior to the market opening up in July of 2008. So again, our concern is getting it right. We don't think there's any crucial issue that immediately needs to be addressed, although we do want to get a new version out there before the market opens up, hopefully before.

MR. PELLISH: I have a question, not specifically related to this rule, but more about your general approach to any of these rules.

When you and staff take up a given rule, do you start with a blank piece of paper, and then say what do we need to put down to do what the Legislature does or are we starting with the rule as it exists, and then going from there? If we're doing the latter, I think maybe we're missing the opportunity to consider all possibilities and do things right from the get-go.

MR. SIMS: Well, that's an excellent question and the answer is it depends on what type of rule you're dealing with. If it already exists, as you know, we've received all of the Title 85 rules as they were written on 1/1/06, with those rules, we hope to address them all. We think probably all of them at least need some type of technical cleanup language in them to reflect the new privatized workers' compensation system.

All that comp could do was reflect that the transition was coming in the rule, but we think there needs to be technical cleanup that reflects what happened on 1/1/06 with the now privatized system.

In addition to that, we review each rule to see if there needs to be some substantive changes. If it's an existing rule, usually, it occurs with a meeting in our legal division, plus any other units that deal with workers' comp that are directly affected by issues involved in the rule. There's one, two, maybe more meetings. And we all go through the rule and say, well, we think this needs changed and we think that needs changed. And then the attorneys work with other people, actuaries or other accountants that might be involved in the relative area of Workers' Compensation that the rule addresses.

After that and we all come to an agreement that these things need changed in the rule, then we create an initial version, as you know, and we present it to you with strikethroughs and underlining, and then there's 30 days of public comment.

Now, however, I think you were also getting at with the blank piece of paper, well, Rule 9, for example, the uninsured fund rule was started from scratch. There was no uninsured fund prior to 1/1/06. So with that, again, I got together with the relevant members of staff that are currently operating an uninsured fund or handling the uninsured fund and I asked them, what do you all want in the rule with the uninsured fund, what do you think needs addressed, what do you think needs to be put in here?

And again, the same type of thing, we had internal meetings, discussing it, and then we feel after we create a draft version rule, then that's the public's opportunity, the stakeholders, and if there was any member of the public, they can find out at any time when it was filed and how many days they have for public comment. They have 30 days for public comment. And when we send it out to stakeholders, my e-mail address is given and they also have the opportunity for a public hearing before you.

I think they have sent correspondence to you all before on a particular rule. So we feel very confident in the process. I'm not sure exactly what you were trying to say we might do differently.

MR. PELLISH: I'm not suggesting you do anything differently. I'm just suggesting that you have an opportunity here to look at things from scratch, recognizing, of course, that you've got to pay attention to the law, but I think if we start with a piece of paper that has all this writing on it and focus on just what's on there, you might miss something.

I guess I'm suggesting you've got to look at it both ways. If you had your druthers, what would you do? And maybe you come up with something stupid and something doable, but at least you've looked at it.

MR. SIMS: I think I follow what you're saying. You're saying is it possible that instead of doing a strike-through and underline version, write a brand-new rule, even though it's an existing rule, but just do an all-out replacement of the rule.

MR. PELLISH: I'm not suggesting that you've got to reinvent the wheel, but I am suggesting that before you get funneled in on a piece of paper that you say what do we need to think about, what should it look like.

MR. SIMS: That is well taken and we'll certainly consider that in the future rulemaking process.

CHAIRMAN DEAN: Mr. Marshall, do you have any questions?

MR. MARSHALL: No, thank you.

CHAIRMAN DEAN: Is there a motion?

MR. PELLISH: So moved.

MR. MARSHALL: Second.

CHAIRMAN DEAN: Being moved and seconded to approve, any questions?

(NO RESPONSE)

CHAIRMAN DEAN: All in favor, aye?

MR. PELLISH: Aye.

MR. MARSHALL: Aye.

MR. SLATER: Aye.

CHAIRMAN DEAN: None opposed, the ayes have it.

6. Presentation of Rule 19 – Tim Murphy

CHAIRMAN DEAN: We'll move on to Title 85, Series 19 self-insured risk pool. Mr. Murphy.

MR. MURPHY: The bubbles in the right-hand column, those note the changes between this copy and the one that was sent out to you last week. They're mostly minor. On page seven, the shaded part in the bottom, the $1 million. That should go back in. That's a mistake.

Most of the changes in this rule are clean up. The substantive changes start on Page 7, Section 9.1. The change continues the current assessment method from the guarantee pool from -- it keeps it at 2% the prior year's indemnity payments. It continues indefinitely and it cancels out the current rule to increase the 5% of projected claims liabilities. If this rule were to not be changed, the amount of guaranteed pool assessment would be greatly increased. This goes back to what it has been to the last year-and-a-half, I think it is.

The second change is on page eight with respect to new self-insureds. It clarifies that when they begin their assessment coming in as a self-insured for three years at 5% of the previous year's premium. That continues for three years regardless of whether they go back to the self-insured status. Also, a change if the pool is fully funded, then they're not going to get the benefits I just mentioned.

The concept that the assessments will be suspended if the fund is fully funded stays except that the amount of fully funded is now provided as 10 million rather than 30 million. If the fund gets to 10 million, payments will be suspended until it goes below. If the Commissioner decides that a new methodology or a new amount is necessary, she has to come to you before she can do so.

CHAIRMAN DEAN: Anything else? Any questions, Mr. Pellish?

MR. PELLISH: Yeah. I think we're back to where we were before, are you saying that on page seven, the yellow language should be back in and not deleted?

MR. MURPHY: Oh, the $1 million number?

MR. PELLISH: Yeah.

MR. MURPHY: That's giving you an example and for some reason that number came out, that line came out.

MR. SLATER: This is not for final approval, is it?

MR. PELLISH: I'm just trying to understand. Also, I'd like to hear some comments about the $10 million versus $30 million.

MR. MURPHY: I would defer to our financial expert for that.

MS. KISS: We were taking a look at the required funding level and the funding analysis. We've done some research with it, done some authoritative accounting with it. Basically, what it really comes down to is what do you actually need this fund to do? And the reality of it is you need to have a guaranteed fund to immediately take over the payment if you have a defaulting self-insured.

The role of that guaranteed fund of the state and the administrator of the fund is to step in and immediately take over the payment so that the employees of that self-insured employer do not get the benefits. That's the primary role. We have to be able to honor the claims payments on a cash basis and we have to be able to pay a TPA to administer those claims because the self-insured would not be doing it, so we would need to be able to have available cash for that.

This statute and, of course, I'm sure we'll have a public comment period and I know we'll have a lot of hopefully good debate and I know I can count on the self-insureds and their representatives to debate this at great length.

But really, we have the ability to assess self-insurers for any money that is needed to fund that and maintain a solvent guaranteed fund. So I think the question becomes how much resource do we want to take out of the economy, so to speak, how much do you want to tie up cash to sit in a fund, how much do you really need to fund it and have it sitting there so that you have available cash?

And I think the answer and we've looked at that and we've been doing analysis is the $10 million -- you don't know. The truth of it is you don't know exactly how much cash you'll even need. I guess I can also point out, this Council has stood behind the recommendations of staff.

Certainly, Commissioner Cline has stood firmly behind the recommendations that self-insured employers who are in a weak financial position will post this security as required. And if so, you have an asset that we're holding out there should we need to draw down on that asset and convert that to cash. Generally, that conversion isn't going to take -- sometimes it's a matter of days, but it could take more than a quarter.

So, really, I think the question comes down to how much cash do you need to have set aside in this pool to earn investment income? So I think that's kind of what we'll be looking for in the public comment period. Did that help?

CHAIRMAN DEAN: Any other questions?

MR. MARSHALL: Is there an action required on this today?

MR. MURPHY: I believe so.

CHAIRMAN DEAN: Do we have a motion to put it out for public comment?

MR. MARSHALL: So moved.

MR. SLATER: Seconded.

CHAIRMAN DEAN: Being moved and seconded for being put out for public comment, any questions? All in favor, aye?

MR. MARSHALL: Aye.

MR. PELLISH: Aye.

MR. SLATER: Aye.

CHAIRMAN DEAN: None opposed, the ayes have it.

7. Presentation of Rule 20 – Mary Jane Pickens

CHAIRMAN DEAN: We're going to Amendment on Title 85, Series 20, right?

MS. PICKENS: This is -- Rule 20 is a very lengthy and complex rule. You have the entire rule in front of you and I hope that you got a little red tag on it that takes you directly to the page with the one substantive change that we're talking about today. We're not prepared to -- this is a complex rule and is a very important rule.

We have recently been talking about an issue among ourselves that relates to subsection 12, that relates to subsection 12.4, which is where you have your red tag. We're not prepared at this point to address anything else in this rule because it just requires a lot of caution and a lot more work to do so.

The issue in 12.4 relates to the type of mental health provider that can do an initial evaluation in a claim. And it's my understanding that, originally, or at some point before the last amendment of this rule by the former workers' comp commission, it referred rather broadly to qualified mental health professionals or terms to that effect.

Now it says psychiatrist. The Commissioner is of the opinion that it should refer to psychiatrists and psychologists because psychologists are qualified to do this. It's within the scope of the authority of the services that they can legally perform. It's within their license. They used to do it. They do it in other states around West Virginia. She was a little concerned about issues of patient care and things of that nature. I think it's a very straightforward proposal. We did not feel that it needed to be made as broad as the language before.

We didn't want to open it up to the possibility of counselors and social workers and things of that nature. We really felt, obviously, you do need to be licensed and qualified to do this type of medical service, but we could find no compelling reason why it should be limited to a psychiatrist. At that's the proposal.

We would also -- there's some technical cleanup that would be required and I just didn't have time to get that done to present that part to you. And by technical cleanup, I mean taking out references to the Board of Managers and putting in references to the Industrial Council and taking out references to the former workers' compensation and things that are purely technical cleanup.

And if the Council is inclined to filing this for public comment, we would want the motion to include allowing me further time for technical clean up.

MR. SLATER: Mary Jane, is this the initial filing of the entire series 20 or just 12.4?

MS. PICKENS: The entire series, unfortunately. That's why the technical cleanup is needed.

MR. PELLISH: I want to make sure I understand. You're saying, your point of view, the only substantive change that you comprehend right now is this reference?

MS. PICKENS: Yes.

MR. MARSHALL: And everything else is --

MS. PICKENS: Nothing else will be changed except for changing references, just technical clean up.

MR. MARSHALL: Ongoing, we can anticipate sometime in the future some subsequent provisions?

MS. PICKENS: Perhaps. Again, this isn't a rule that we have spent -- that I certainly have spent a whole lot of time with. This particular issue, the Commissioner -- we have been looking at that particular issue and felt that that could be done soon, but yeah, we may come back at a later point and talk about that, about other revisions to the rule.

MR. PELLISH: My gut tells me that there's something in here that is going to generate some discussion. I don't know what, but I have to tell you as a quick aside, usually when I get things in, I just go directly to print, so I can print off at home and look through it, and I saw this thing hitting 75, 80, 85, 90 and I said well --

CHAIRMAN DEAN: Any other questions?

MR. SLATER: If it's going to be filed even with blatant errors ie, 1.1 talks about the Workers' Compensation Board of Managers -- obviously, the Board of Managers is not alive anymore, will that be changed?

MS. PICKENS: That will be changed. Yes. That's within the technical cleanup that I was referring to. We would need to get that done.

CHAIRMAN DEAN: Any other questions? Do we have a movement to approve those changes?

MR. PELLISH: I move.

MR. MARSHALL: So moved including the technical corrections.

MR. SLATER: Seconded.

CHAIRMAN DEAN: The motion has been moved and seconded to approve. All in favor, aye?

MR. MARSHALL: Aye.

MR. PELLISH: Aye.

MR. SLATER: Aye.

CHAIRMAN DEAN: The ayes have it.

8. Report on Type of Information on Uninsured Employers that can be Disclosed to the Public – Mary Jane Pickens

CHAIRMAN DEAN: We will move on to Number 8.

MS. PICKENS: This will be brief. If you all will recall at the August meeting Mr. White had some questions and some public comments about the identity of employers. And we certainly appreciate his comments and he was in contact with us outside of these meetings as well where he asks questions about various employers, and it is certainly helpful to work with folks like him to identify employers that we need to get on the path to having insurance.

There was a question about what type of information he could release about insureds to the public and you all had asked me to report back on that. Of course, we have The Freedom of Information Act in West Virginia. One of the exceptions to The Freedom of Information Act is if the Legislature has specifically said this isn't subject to The Freedom of Information Act.

So then there's actually one in Chapter 23, in Section 23-1-4, and I'll just briefly read it in subsection (b). It says, "Except as expressly provided in the subsection, information obtained regarding employers and claimants pursuant to Chapter 23 is not subject to the provisions of FOIA."

We want to make sure that we don't release something that shouldn't be released. We have to work within the realms of the statute and not run afoul of it; however, it does specifically say there's no transition language in this. I mean it doesn't refer to the Insurance Commissioner, but I think, clearly, the Legislature meant for us to inherit this. We can -- it says specifically that base premium tax rates can be released. Also, whether or not a specific employer has obtained coverage under Chapter 23, whether or not a specific employer is in good standing or is delinquent or at fault in the time period thereof.

And the fourth thing that can be released is if a specific employer is delinquent or in default, what the payments to the Commission are.

So we feel that, clearly, the name of an employer, we feel that the address of the employer could be released because you might get a Smith's Grocery Store and there could be five or six of those in the state, so to identify them, the address would need to be released. The amount owed to the state of West Virginia, the default status and periods of default can be released.

And we've been working with Mr. White and providing information and I think we're going in the right direction and should try working with each other to try to get the right information that the public needs, but not run afoul of the statute.

CHAIRMAN DEAN: Is there a chance we could all get a copy of that somehow?

MS. PICKENS: Certainly, and I apologize that I didn't prepare a handout or anything, but I'm happy to do that.

CHAIRMAN DEAN: Could you e-mail it to us or whatever?

MS. PICKENS: Sure.

9. General Public Comment

CHAIRMAN DEAN: We'll move onto general public comments. Is there anybody from the public that would like to speak?

(NO RESPONSE)

CHAIRMAN DEAN: Nobody has anything to say today.

10. New Business

CHAIRMAN DEAN: With that, we'll move on to new business. Anybody have anything under new business today?

MR. MARSHALL: Mr. Chairman, I'd like to suggest that at some meeting in the not too distant future, and we'll leave it to staff to determine when it's convenient to do that, that we do revisit Series 9 to take into account the comments we heard today and see if we can come up with, perhaps, some amendments to the rule we adopted today that would address those circumstances.

CHAIRMAN DEAN: Okay. Mr. Pellish, do you have anything?

MR. PELLISH: No.

CHAIRMAN DEAN: Mr. Slater, do you have anything?

MR. SLATER: Just a couple of things. I circulated out to the members of the commission recently a Power Point presentation that was delivered at the Joint Commission on Finance and Judiciary on September 11th. Did you receive that?

MR. PELLISH: Yes, thank you.

MR. MARSHALL: Yes.

MR. SLATER: I thought it was a very enlightening presentation to the public in that with the recent workers' compensation reform and also with the advent of the NCCI rates and what information was presented, it showed, virtually, about 70 percent of the employers from the state, their premiums had decreased. And NCCI rates, we were able to take those classifications from 90 or so up to about 70, which I think has been a great help to employers.

I still note, however, that there are still, I think, over 5,000 employers in the state that did receive workers' compensation premium increases and those 5,000 were over 20 percent increase. That does create a significant burden on a lot of companies within the state.

I know that the Insurance Commission and BrickStreet are going to be working with those companies to try to get them through that process, but I still feel compelled to let folks know that there's a lot of work we have to do, so it's important that we stay on top of that.

I was talking to members of BrickStreet last night and I guess there's going to be 38,000 or so audits and examinations underway for all these employers in West Virginia so proper classifications can continue to be verified and changed.

A recent situation that just came up, which I think shows there's a gap between where we are now and where we need to be, there was a situation brought to my attention as it relates to a classification for mechanics. You may have one company where the mechanic is physically on-site all day, performing car repairs, let's just say, from eight to five, but then you may have another mechanic in the company who may be doing truck repairs for a day on heavy industrial trucks for equipment, and then getting in those heavy trucks and equipment and driving 50 miles for delivery of something a little bit later.

Clearly, to me, there's a differential in that risk between the individual performing maintenance and repair on vehicles and getting into vehicles and driving for some period of time. But under the current classifications, that mechanic from eight to five has the same rate and the mechanic that doesn't leave the grounds has the same rate as the mechanic over here that's performing a much, much different job description.

So I'm hopeful as BrickStreet undergoes the audits and examinations of these companies, that will be brought to light and that, I guess, the liability of the classification and the nonreliability of some of them will be challenged further as we go forward. That's the end of my comments.

CHAIRMAN DEAN: Anybody else have anything else?

11. Next Meeeting

CHAIRMAN DEAN: The next meeting is Thursday, November the 2nd at 3 p.m. here at the Civic Center. I'll move for adjournment so we can go into executive session.

MR. SLATER: So moved.

MR. MARSHALL: Seconded.

CHAIRMAN DEAN: Thank you all for coming and we'll be in executive session.

[Executive Session held]

CHAIRMAN DEAN: We're back in regular session. Regarding the resolution for 84 Lumber to be granted self-insured status. Is there a motion to move?

MR. SLATER: So moved.

MR. MARSHALL: Seconded.

CHAIRMAN DEAN: It's moved and seconded. Any questions? All in favor, aye?

MR. MARSHALL: Aye.

MR. PELLISH: Aye.

MR. SLATER: Aye.

CHAIRMAN DEAN: None opposed, the ayes have it.

CHAIRMAN DEAN: The next one will be Appalachian Mine Services asking for the Industrial Council to grant self-insured status to them. Is there a motion?

MR. PELLISH: So moved.

MR. MARSHALL: Second.

CHAIRMAN DEAN: It's been made and seconded, any questions? All in favor aye?

MR. PELLISH: Aye.

MR. MARSHALL: Aye.

MR. SLATER: Aye.

CHAIRMAN DEAN: None opposed, the ayes have it.

CHAIRMAN DEAN: The third one is TA Operating Corporation to be granted self-insured status. Is there a motion?

MR. PELLISH: So moved.

MR. SLATER: Seconded.

CHAIRMAN DEAN: It's been made and seconded. Any questions? All in favor aye?

MR. MARSHALL: Aye.

MR. PELLISH: Aye.

MR. SLATER: Aye.

CHAIRMAN DEAN: The ayes have it. Everybody is approved. If there is no other business, I would call for a motion to adjourn.

MR. SLATER: So moved.

MR. MARSHALL: Second.

CHAIRMAN DEAN: Motion made and seconded. Any questions? All in favor aye.

MR. PELLISH: Aye.

MR. MARSHALL: Aye.

MR. SLATER: Aye.

CHAIRMAN DEAN: The ayes have it.

There being no further business the meeting was adjourned.