

# **WORKERS' COMPENSATION INDUSTRIAL COUNCIL**

**MARCH 22, 2007**

Minutes of the meeting of the Workers' Compensation Industrial Council held on Thursday, March 22, 2007, at 3:00 p.m., Offices of the West Virginia Insurance Commissioner, 1124 Smith Street, Room 400, Charleston, West Virginia.

## Industrial Council Members Present:

Charles Bayless, Chairman  
Bill Dean  
Dan Marshall

### **1. Call to Order**

Chairman Charles Bayless called the meeting to order at 3:00 p.m.

Chairman Bayless: We are trying to get Mr. Pellish on the phone. He left a number but we can't seem to reach him.

[We were unable to reach Mr. Pellish on his cell phone, but we did leave a message for him to call in. Mr. Pellish called the Offices of the Insurance Commissioner to inform us that his cell phone service was not clear in that particular area and that he would be unable to participate in the meeting.]

### **2. Approval of Minutes**

The first item is the approval of the minutes of the February 15<sup>th</sup> meeting. Are there any comments or corrections?

Bill Dean made the motion to approve the minutes from the February 15, 2007, meeting. The motion was seconded by Dan Marshall and passed unanimously.

### **3. Office of Judges Report – Alan Drescher, Deputy Chief Administrative Law Judge**

Judge Alan Drescher: Thank you, Mr. Chairman. The report this month is very similar to the previous month, at least in terms of the numbers. Last month we acknowledged 952 protests to Orders of claims administrators and this is shown on the chart on page two. This is reflective of a leveling off of the numbers. The last three months we've been right around 1,000 protests a month. While that's significantly less than we were receiving two years ago it

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appears that perhaps we've hit the spot where they are starting to level off. It might be just a bit too early to say that for sure, but it appears that we've got a trend going.

Under the Pending Caseload Report we now have 7,475 open claims in our system, down from 7,941 at the beginning of last month. So we are continuing to issue more decisions and resolve more issues than we are getting in. That's also been a steadily declining number and I'm sure it is reflected by the fact that we are getting fewer protests. But as you can see 12 months ago we had 13,000 protests in the system. So we're almost down half from where we were a year ago.

I guess another ramification of having fewer protests is the fact that we are able to acknowledge the ones we receive in a very timely manner. As indicated by the chart on page three, we're at a very high percentage within 30 days. These things are all somewhat related to each other.

I did want to point out our Final Decision Timeliness as shown on page four. Again, that number is going up and it is directly related to the fact that we had fewer protests in the system. But we did over 63% within 30 days of the Order to submit. So that's a very high number historically. We actually did over 99.5% within 90 days. Those numbers continue to go up and stay high.

If anybody has any questions about any of those statistical matters, I'll be happy to address those. If not I'll move on to some other things that have come up in the last month.

The first thing I want to address was an issue that came up at the last meeting of the Workers' Compensation Committee of the State Bar, which is a group of practitioners in the workers' compensation area, both claimant and employer representatives. An issue came up with regard to administratively closed claims dealing with medical benefit issues. And basically there has been some confusion about that issue because the Code allows for the closing of claims with regard to permanent partial and temporary total disability issues, but does not require reopening for medical treatment. The Commission, shortly before it was terminated and I think BrickStreet has continued that practice, began administratively closing claims that were just opened for medical treatment, which was fine. But the problem was when parties wanted to get additional medical treatment they were treating them as if they were reopening – either permanent partial or temporary total – which there was really no basis to do that and they were denying them. So, that all came out in the meeting. We are trying to develop a process to address that now. I think actually BrickStreet probably agrees with us in how that ought to be handled. It's just a matter of trying to get the Titanic to turn a few degrees to the left. I don't think it's going to be a long-range or a continuing problem, but it is a matter we're going to address and we are addressing.

The other thing I wanted to mention was the fact that during a recent Legislative Session that just concluded there was a change to a couple of parts – well actually more than a couple – but a couple that specifically deal with the Office of Judges. One, the Legislature changed the

definition of the record to be considered by the Office of Judges when they were deciding claims. Previously it was any documents introduced to our office during the litigation of the claim, any evidence presented at a hearing, which of course would also be done in litigation.

And the third thing was documents in the claim file which relate to the subject matter of the litigation. Now that actually came about originally because the Office of Judges and the Workers' Compensation Commission shared a computer system and therefore we shared access to the same record. So documents that were introduced before the Workers' Compensation Commission could in fact be viewed by our office and anything that they had we had access to so we could look at. That's no longer the case. I am sure you're tired of hearing it. Our computer systems are separate now. We don't see documents they have necessarily unless they give them to us. In addition – the self-insured employers – we haven't had access to their documents since December of 2004. It was a problem for us to try to meet this requirement in the Code and to know what those documents were. We had a system to try to deal with that when we asked the insurer to provide those documents. But there was always a question about whether or not we were getting everything we were supposed to be getting; whether or not we were asking for the right thing and questions of that nature. Now that last requirement has been deleted from the Code, so the record now is whatever the parties give us. In fact that's a lot cleaner in terms of the litigation system. So, the burden is on the parties to give us the evidence they want us to consider and they cannot rely on some report they may have provided to the insurer two or three years ago before the matter was even in litigation. They can submit that report to us and we will be happy to consider it. But they can't just say, "Well, I gave that to the insurance company three years ago. You should have known about it." We're not going to know about it. This just makes that clear. We're going to have to revise our Procedural Rule to address that as well and we're in the process of starting that.

Finally, and probably most pertinent, is the provision dealing with "stays of awards" made by the Office of Judges. The former Workers' Compensation Commission had a rule that allowed for awards to be "stayed" while pending appeal before the Board of Review. . . could be imposed by BrickStreet or by the self-insured employer. The Legislature dealt with that in Senate Bill 595. They added some language which essentially says that there is no stay unless it is requested and approved by either the Administrative Law Judge that made the decision or the Board of Review. So, again, that is going to require some changes in the rules to address that. The statute is effective for passage, which was March 10<sup>th</sup>. So there is a question about how we're going to address those that come up today or tomorrow because we don't have a rule in place yet. We have met with both the Insurance Commission staff and the Board of Review. And our thinking right now is we're going to issue sort of a policy memorandum, if you will, that will outline what our thoughts on how the process should be and essentially telling the parties how we are going to address "requests for stays" until an actual formal rule is promulgated. We hope to have that out shortly. That's all I have today.

Chairman Bayless: Any questions from anybody? Thank you. The next item on the agenda is Title 85, Series 6. The Public Hearing was last month. There were quite a few

comments. I'll ask Mr. Sims to come up to go through this and then we'll ask for additional comments.

#### **4. Rule 6, Workers' Compensation Debt Reduction Fund Assessments – Ryan Sims**

Ryan Sims: Good afternoon, Chairman Bayless and members of the Industrial Council. As Chairman Bayless noted this is the final version of Rule 6 that we are bringing before you today. Series 6 entitled, under the amended version, "Workers' Compensation Debt Reduction Fund Assessments and Regulatory Surcharges." The rule was presented initially to you at the January Industrial Council meeting and you granted permission at that time to initially file it with the Secretary of State. We did so on January 16, 2007, at which time it was out for public comment for 30 days. The public comment period concluded at the February 15<sup>th</sup> Industrial Council meeting. There were some comments given at the hearing and we also received some written comments which should have been forwarded to you during that time. This is the final stage where we are asking you to approve and give us permission to file this rule in its final version with the Secretary of State. When we originally made changes to this rule – other than technical and stylistic cleanup which we always attempt to do – we had three substantive changes we wanted to make. One was to add the regulatory surcharge. The rule originally just included the debt reduction surcharge. The second was to provide clarification that you cannot stack one surcharge on top of the other, that the surcharges are basically imposed upon only the basic premium. You can't apply one surcharge and then apply the other surcharge after applying that one. And thirdly, we wanted to clarify that the Insurance Commissioner has discretion to differentiate in certain types of premiums what constitutes workers' compensation and what constitutes general insurance. General insurance has surcharges under Chapter 33 instead of Chapter 23.

We did receive, as I said, several comments. We prepared a response to written comments that should be in your packet which I think address both the comments we did make changes upon and the comments we chose not to make any changes in the rule upon. Again, that document is for the purpose of giving our explanation. I'll just go through the actual final draft of the rule. The highlighted portions of that rule are the portions we changed between the draft version that was initially filed and this final version. About 80 percent of these changes are stylistic and technical so I'm not going to go through those, but I will go through what we would deem the substantive changes that we made between the last version and this final version.

The first would be on page five of the rule under Section 4. Essentially that was just some rewording to . . . it may be considered technical. But at any rate it was some rewording to clarify that the obligation – this is in Section 4.4 at the bottom of page five – the obligation of the private carrier is only to collect the surcharges from the premium they actually are able to receive from insureds. That is to say, if the insured lapses and doesn't pay their premium the insurance companies aren't responsible for paying the surcharge. They are only responsible for paying it on premium they receive. Actually I missed a couple. In the middle part of page five, in 4.1 after (a) and (b) at that last paragraph, the first one is there were some requests that

instead of just requiring that we provide sufficient notice before we change the percentage amounts that we actually provide a time certain notice. This requires that we provide carriers at least 30 days notice prior to changing any of the percentage amounts so that they have time to get those changes reflected in their system. We also received comment. . .in that same paragraph at the bottom there is a sentence added there that clarifies when we do change the percentage amounts of the surcharges they will only apply to issuances of policies or renewal of policies that take place after we change. If a private carrier is issued a policy before we made the percentage change, for the whole term of that policy the previous percentage amount will apply and it's for policies they issue or renew after we make the percentage change. They need to implement them in those but not the ones that are already in effect.

At the top of page six, subsection 4.5, that sentence was just added to clarify that these surcharges for purposes of a carrier being able to cancel for failure to pay premium are considered part of the premium despite the fact that they actually go to the Insurance Commissioner and the carrier doesn't keep them. There was a scenario brought to our attention where someone could pay their premium but not pay their surcharge and say, "Well, we paid our premium so you can't cancel us." This is just clarifying that a carrier can and should cancel the insured if they try to attempt to pay their premium but not the surcharges. That's ground for cancellation.

In the middle of page six under Section 5, the bottom paragraph after subsections (a) and (b), it notes again that – for self-insureds as well – if we change the percentage amount we need to provide at least 30 days notice to the self-insureds before implementing the change, before making the change effective.

Those were all the substantive changes we made to the rule. And again we always attempt to incorporate all the comments as best we can. We believe we've done so and believe we have a final product that is now ready for the Industrial Council to consider for final filing with the Secretary of State.

Chairman Bayless: Thank you. Any of the Council members have any questions? Does any member of the public have any comments that they would like to make? I would then request a motion that we approve.

Mr. Dean: Motion to approve.

Mr. Marshall: Second.

Chairman Bayless: It has been moved and seconded to approve the Workers' Compensation Debt Reduction Fund Assessments and Regulatory Surcharges," Title 85, Series 6. All in favor, "aye." Opposed, "nay." Thank you. Good job. [The "ayes" have it. Motion passes unanimously.]

## **5. Update from 2007 Legislative Session – Mary Jane Pickens**

Mary Jane Pickens: Thank you. A lot of the people in this room probably followed Senate Bill 595 closely during the Session and may already know all of this. So I apologize for telling people things that they already know. This was an Insurance Commission Bill [Senate Bill 595]. It was intended to address some things that were somewhat technical in nature and we considered basically cleanup, but we felt that they were very important for getting the market ready to open in 2008. I'll go down through it with each section that was amended. Again, some of them were purely technical cleanup.

The first section in the Bill that was amended is §23-1-1, which is where the Workers' Compensation Commission is created. It's an old section. Basically just some additional legislative findings were added which clarifies a legislative intent to move towards privatization. That was something that one of the committee's counsel felt was a wise thing to do. That was added to the Bill.

There are some sections in §23-1-1f that have to do with the ability of the Insurance Commissioner to hire a certain number of exempt positions in the agency and to be exempted from purchasing rules with regard to certain types of professional contracts. These were things that the old Workers' Compensation Commission had. When the transition occurred the Insurance Commissioner didn't have that same leeway with those types of things. There are some rather technical and highly important and somewhat urgent matters that we need to take care of here during the transition. It's very helpful if we have little bit of leeway in terms of hiring people and in terms of getting contracts. For example, with TPA's to administer the Old Fund and to handle certain types of claims and that type of thing very quickly without having to go through a lengthy purchasing process. So that's what those sections were intended to address.

In §23-2-9, the self-insurance section, there was a lot of cleanup. There were a few substantive things that happened. But again I don't think it changed it dramatically. It reworded the basic requirements to obtain self-insured status. It also clarified that at the time of an annual review the Insurance Commission can require a bond or excess insurance policy from a self-insured employer. Language was deleted that was really outdated and no longer relevant. There was a lot of language in there that referred to the old premium tax that self-insured employers paid. All that language was deleted because it has been replaced by the surcharges and some of the things that Ryan talked about.

The references to catastrophic risk and reinsurance of catastrophic risk – those references were deleted from that Code section, and then there was just other technical cleanup. It looks like there are a lot changes to that section but most of it really was in the nature of cleanup.

When you get into Article 2C of Chapter 23, in §23-2C-3, which is the section that creates the employers' mutual as a successor organization of the West Virginia Workers' Compensation Commission, the only substantive changes to that section relate to the time within which private

carriers and self-insured employers have to remit this regulatory surcharge to the Insurance Commission. It was a really tight turnaround in the original legislation and we felt that it was kind of an administrative burden to both the carriers, the self-insureds and I think to our office to some extent. The law for private carriers had been to remit the surcharge within ten days of receipt from the policyholder. It is now 90 days. For self-insureds it was to be remitted monthly. It is now quarterly.

In §23-2C-8, this is the Uninsured Employers' Fund section. This is the Fund that we spend so much time being concerned about and wanting to protect. There were a lot of amendments. If you were to see the strick-through language and the deletions, it would look like it was a major amendment. But really we just reworded it. It was kind of awkwardly worded. It flows a lot better now. It's just easier to read and understand how that process will work with uninsured fund claims and our rights to collect the costs of those claims back against the employer; those types of things. So nothing really changed except that it's a whole lot easier to understand, we hope.

In §23-2C-15, this is a section that addresses changing of coverage when the market opens. There were references to employers notifying the Insurance Commissioner when they changed carriers, and those were deleted. When Senate Bill 1004 was drafted no one was really sure how all this was going to work. And some of this is technical cleanup resulting from that.

The private carrier notification requirements are amended to require private carriers to provide information on officers, directors and ten percent or more owners of each policyholder to us – to the Insurance Commission – within 60 days of the issuance of a policy or within 60 days to any changes of that information. It also requires private carriers to notify the Insurance Commissioner or a designee of the Insurance Commissioner of the issuance or renewal of policies. So if you issue a new policy or you renew an existing policy, the Insurance Commissioner or her designee must know about that within ten calendar days of the effective date of that coverage so we can track employers and to make sure that they are covered or not. There are three business days for us to be informed of cancellations or terminations. We can keep pretty close track on employers and whether they are getting new coverage, whether their old coverage is terminated and that type of thing. But the burden – it's not on the employer to call us up and tell us. It's on the insurance carrier to report that information to us.

In §23-2C-18, which was an existing Code section, it addressed ratemaking. We were concerned that the language that was in the Bill before didn't really reflect what insurance carriers are used to encountering when they come into a state to do business. We had some concerns about that. So the ratemaking provisions were substantially changed. The Code now requires that provisions in both Chapter 23 and 33 apply and that they are intended to be read to be harmonious. Chapter 23 applies in the case of any conflicts, so we wanted to clarify that. It requires an insurer to file its rates by filing a multiplier to be applied to prospective loss costs filed by the NCCI and allows carrier specific rating plans to be filed. We spent a lot of time,

especially in House Judiciary with their counsel and with BrickStreet, talking about that language and I think we ended with something that everybody believes works and it's going to put our law on par with other states in the ratemaking arena.

We added a new Code section in this Bill and it's §23-2C-18a, and that deals with the designation of a rating organization. This is NCCI that we talk about a lot. It defines some terms. It allows us to designate a rating organization to compile and report statistical information; file manual rates and those types of things. Insurers are required in this new Code section to record and report their workers' compensation experience to the rating organization and to adhere to the uniform classification and experience rating plans that are developed by the rating organization. And we've got rule making authority if we need to in that Code section also.

Section 23-2C-19 was changed to take out some language that we really felt put a regulatory burden on insurance carriers. And this was another concern that we had going to open market. We determined that some of these provisions just aren't what you encounter in other states and it could have had perhaps a chilling effect on companies wanting to come in and do business here. So we took out references to things that we just really didn't think reflected private insurance. We also deleted a "due diligence" requirement that required private carriers to make sure that there were no monies owed to the State of West Virginia before they could issue a policy to an employer. It also had a penalty in there for an insurance company that did that. If an insurance company had sold a policy to an employer that owed the State of West Virginia, it could be penalized up to \$10,000.00. Our goal really should be to get companies insured. Even though we understand the Legislature's intent in Senate Bill 1004 to make sure that companies pay their fines and to pay their Old Fund debt and to pay their obligations to the State, sometimes in the real world it's difficult to get that to happen. And in the meantime you've got a company that could be out there operating uninsured. It's not good for their employees and it's not good for the Uninsured Employer Fund. The due diligence requirement is really another example of a regulator's burden being placed on a private carrier and we felt that it was our job to regulate employers. So that was deleted. The \$10,000.00 fine against the carriers was deleted.

One thing to keep in mind though is if an employer owes money to the State they will technically be in employer default and they will be on the Commissioner's default list, and they will be subject to all of the administrative results of being on that default list in terms of us collecting that money. Also they would be subject to another agency that may license that entity if it's a contractor, logging company, what have you. The Department of Labor would start processes to revoke a contractor's license. But in the meantime they would at least hopefully be insured and they just wouldn't be operating uninsured. That was important to us.

The remaining section of Senate Bill 595 is §23-5-9 which Alan Drescher talked about with regard to the make-up of the record in a claim and with regard to the stays pending appeal to the Board of Review. We've spent a lot of time this week, and I know his office spent some time at the end of last week, working on this temporary process that we'll need to get in place I

think very quickly to give guidance to the litigants in these claims about how stays will be handled pending the rules. Chairman Bayless had asked about amendments to rules as a result of Senate Bill 595, and I think clearly you're talking about Rule 1 on the stay provision. And it may be that we need to address it in Rule 18 which is the self-insured rule on administering claims. Down the road I want to look at Rule 11 which is the collections rule, as a result of some changes in here, and possibly Rule 32 which is the rule that directs other agencies to take actions against uninsured employers to revoke other types of licenses, certificates and permits. I haven't looked at it yet so it may not need any changes, but that's another rule that comes to mind. That is my report on Senate Bill 595.

Chairman Bayless: Any questions? Does any member of the public have questions or comments on the report? Thank you.

**6. General Public Comment**

Chairman Bayless: Does anybody have any comments?

**7. New Business**

Chairman Bayless: Any new business to come before the Council?

**8. Next Meeting**

Chairman Bayless: The next meeting is Thursday, April 26, 2007, here at 3:00 p.m. Do I have motion to adjourn?

Mr. Dean made the motion to adjourn. The motion was seconded by Mr. Marshall and passed unanimously.

There being no further business the meeting adjourned at 3:40 p.m.