

WORKERS' COMPENSATION INDUSTRIAL COUNCIL
NOVEMBER 29, 2007

Minutes of the meeting of the Workers' Compensation Industrial Council held on Thursday, November 29, 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:

Bill Dean, Chairman
Delegate Nancy Guthrie
Kent Hartsog
Dan Marshall
Walter Pellish
Delegate Carrie Webster

1. Call to Order

Chairman Bill Dean called the meeting to order at 3:00 p.m.

2. Approval of Minutes

Chairman Dean: The first item on the agenda is the approval of minutes of the October 18, 2007, meeting.

Dan Marshall made the motion to approve the minutes from the October 18, 2007, meeting. The motion was seconded by Walter Pellish and passed unanimously.

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

Judge Timothy Leach: Mr. Chairman, members of the Council, Deputy Commissioner and members of the audience, I think this is my last report for this year. I can't keep the calendar straight. This report. . .first of all it goes out with a notice saying that we will be at a meeting this month because I didn't look at my calendar correctly. And then when I found out there was a meeting I decided to attach a narrative [page 5]. Page five actually is about page 25. So I stapled it to the wrong part of the report. But I've stumbled on this report.

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We received 1,041 protests for October. On page two, the Protests by Month for the last four calendar years – that is just about their average for this calendar year; slightly down from last calendar year. Last calendar year the average was up a little bit because of that bump we had in March where we had almost 2,000 protests in March of 2006. For the rest of the year it looks like it's kind of leveled off.

Our inventory is down to 6,677 cases at the end of October. That has been as high as 25,000. Obviously we're a lot more efficient when we do not have that type of case inventory. It reflects in numbers the reduced positions, lower budget, more timely responses.

If you look at Chart (D), that's the Acknowledgment of Timeliness – 2.69% are protested in more than 30 days, which would be the untimely figure. So 97% are within what we consider timely and that figure for the year-to-date is going to look better than any of the previous six calendar years that I've reported.

Skipping ahead to Report (F), for October only 0.2% of our decisions were untimely, and for the year-to-date only 0.4% are untimely; 66.8% for the month; and 63.7% of our decisions for the year have been issued in less than 30 days from the end of our evidence development to the issuing of a decision. We are actually in a position where we have to sometimes ask judges to hold off issuing a decision. Our process allows the following of closing argument ten days after the timeframe for evidence ends, and some of our judges are getting to their decisions within ten days of assignment. So, we're asking people – if they're going to do it that quickly – how about just sitting on it for a few days to see if any last minute arguments come in. So we actually have to put the brake on some of those decisions.

Our timeliness for the year of 99.6% – if that holds – will clearly be the best out of the seven years that I've reported to you. Then our overall Time Standard Compliance, which is from coming in the door to going out the door, is at 91.7% year-to-date. It slumped just a little bit, 87.8% for October. Even that month was better than last year, and the year-to-date is almost 6% better than last year.

There were two matters that had occurred to me to bring to your attention that we're facing as problems right now – our case management system. The first involves the "Treatment Denial Grievance Process." This issue has an unhappy history to which I personally contributed and have apologized many times. Rule 21 – passed by your predecessor – provided for approval of PPO's or health management plans. One of the plan's requirements in order to be approved was that for disputes over treatment

medications and medical treatment denials the plan had to offer or had to provide an informal grievance procedure to resolve the disputes. The question that has come up about the language of that rule was: Is that a mandatory step that you have to go through before your statutory right to appeal to the Office of Judges, or is that an optional step that you can go through in addition to appealing to the Office of Judges, or concurrently with appealing to the Office of Judges? The statute does not directly provide for such a grievance process, only the regulation does.

So initially I think the first plan that was approved. . .my read of it was that the rule – was that it was mandatory and you had to go through the process before you could get an appealable order to the Office of Judges. Then upon reconsideration when a couple or more plans got approved I think the Insurance Commissioner's legal staff took the position that that was an option as opposed to mandatory. Then the elephant in the room – BrickStreet – developed a plan that covered all 39,000 employers. And their read was that it was an optional plan, except you couldn't pursue both at the same time. It was one or the other, or it was one followed by the other. Grievance first, if you chose to, and then appeal or you could skip the grievance step and go straight to the appeal. But you couldn't have both going at the same time. Then we had a self-insured provided plan which provided for a mandatory requirement. You had to go through the grievance process before you could appeal.

So the plans are all over the board from our point of view and this creates two problems for us. Number one; we don't know which employer belongs to which plan. Number two; we don't know what the actual wording of the plan is. What we have is a summary – some very diligent and hard work done by the Insurance Commissioner's staff for us that lists the names of all the plans. And I believe if I look closely at that spreadsheet, which is dozens of pages long, I can figure out which company belongs to which plan. But then the Insurance Commissioner relied upon the company to say, "Is your plan mandatory or optional?" We think the actual language of the plan would control in a legal dispute as opposed to what the company says the plan means, and we've never seen any of the plans.

How does that impact the appeal system? Well, we'll get a protest which does not appear to be a "protestable" order because the order will say, "If you disagree you have to grieve." So, we'll have a lawyer or a claimant trying to protest that without going through the grievance. And our question becomes, "Should we acknowledge this protest?" Or should we send it back and say, "No, you've got to go through your grievance first." We don't know because we don't know which companies belong to which plans and we don't know what the language of these plans are.

So I just throw this out there for the Council's information because it is starting to become more frequent where we're having attempts to protest when the plan appears not to allow the protest – that it's untimely; or where we will get a motion to dismiss a protest. And I gave a few examples of the confusion that's confronting us. We had a TPA down in Arkansas that was applying the terms of a plan – one of their clients belonged to the plan – to a client for this TPA who did not belong to the plan. They're thinking this is our plan, everybody is covered by it, and they were refusing to issue a protestable order because grievance hadn't been followed. But the second client of theirs did not have a plan approved. So once we could trace down that information we resolved that.

The second problem is we are setting up for these new TPA's to take over the Old Fund. One of their graphs, or flow charts that we saw, provided for mandatory grievance before treatment protest. We're doing some checking and we think the answer to that is there is no PPO; there is no managed care plan for the Old Fund. That's an illegal interference with your right to appeal to the Office of Judges. We're still trying chase down that answer, but that's the answer for the time being.

It is causing confusion and I don't lay the blame at anybody's feet. The parties are confused. As I said, I had contributed to some of that confusion a year or two ago when that rule first came out. The Insurance Commissioner's TPA's are used to dealing with some other process. So, it's just out there and it's an issue for the public and we are working on it.

That kind of segways into the final point, which is that effective December 1st Cambridge is replaced by three new TPA's for the Old Fund and for the Uninsured Fund and for all the special funds that the Insurance Commissioner has responsibility for. And that's going to cause us to change all of our databases. Our IT people promised – as much as you can count on that – that it's all set up and ready to go Saturday when we throw the switch. I think we are running some testing this evening. We will generate on Monday notices and orders to the correct TPA instead of to Cambridge. Now, of course, if we send them to Cambridge or if we send them to BrickStreet and it's the wrong place, we believe that they are going to help us out by calling it to our attention and forward on the mail to the right place.

More problematic for us is the parties on the outside – the lawyers, the claimants and the employers' counsel who send anything to us have to also send it to the TPA, and will they know the right people to send it to and the right address. I know a mass mailing was done a week or two ago by the Insurance Commissioner's staff telling every claimant and every lawyer for a claimant, and I assume every employer and their

lawyer, who the new TPA would be and what the contact address was. But knowing from past experiences from our very limited mass mailings at the Office of Judges – which might go to 200 or 300 people – if you get ten percent of them to pay attention that's a good result. So you're going to have a high percentage of people who are going to get that notice and not even recognize what it means and they will still be trying to deal with Cambridge and Cambridge won't be there. And they will be sending documents to me and sending a copy to Cambridge and we won't be able to accept it because that's not the TPA. So there is going to be some stumbling around there at the changeover. Not because of the fault of anyone, just sort of human nature. But we believe that we are prepared to take our part and run with it on Saturday. That's all I wanted to report to you in terms of issues before the Office of Judges. I'll be happy, as always, to entertain any questions.

Chairman Dean: Does anyone have any questions for Judge Leach?

Walter Pellish: With the first issue you mentioned – if you know it's out there and there is all this confusion, is there any way to head the thing off and come up with recommendations as to how things should be handled?

Judge Leach: Well, it would have been helpful if there was just one plan. Then we would know it applies to everybody and we don't have to come up with different things. But that's not the way it works. Some plans have different language. Each plan could be approved by the Insurance Commissioner. I think the correct legal interpretation is if we approve the plan, we're bound by whatever the language of the plan is. So, that means that you could have two options according to each plan. Now that is compounded and multiplied by the fact that we don't know which employers belong to which plans. The self-insureds belong to their own plans. What we have to do. . .I really don't think there is a good answer, Mr. Pellish. But what we have to do is program our system by employer; identify which plan applies to that employer. If a protest comes in, and it should not be a protestable order, then we'll reject it because we'll get a red flag that says, "This employer has a mandatory grievance." It's going to take us a while to compile all those different employers. I mean, there are forty some thousand of them. We've got to figure out which plan controls each employer. Then you have another. . .if it's an old claim, it's not part of that. The Old Fund does not have a plan. Even though it's the same employer, it's a different case identity. We have a multiplying factor of 41,000 or so employers by two different plans – whether it's an Old Fund or not. So that's four times 41,000. I don't know. The only answer I can see is by programming per employer and then also by date of injury, which is what determines. . .

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Mr. Pellish: What you're saying is there is no way to prevent getting whip-stalled on this then?

Judge Leach: I think we are going to be dealing with a lot of motions over those issues.

Mr. Pellish: That's unfortunate. It seems to me that there ought to be some way to try and get a handle on it. But I understand what you are saying.

Judge Leach: Well, I think as we build our database and get it corrected it will be easier to deal with those motions and requests. But if you've got a TPA that's incorrectly stating that you've got to grieve and they don't even have a plan approved, that just compounds the problem. So it's a matter of education – of educating that TPA – your plan has to be approved by the Industrial Council before you can do that.

Chairman Dean: Mr. Pellish, do you have any other questions? Ms. Webster, do you have a question?

Delegate Carrie Webster: I do. Judge, my first question is. . .first you were just saying. . .I came in late. . .The three new TPA's, who are they?

Judge Leach: Sedgwick I think has got the bulk of the cases.

Delegate Webster: Right.

Judge Leach: Wells Fargo and American Mining have OD/OP's split up in a way which. . .I can't tell you how it's split up.

Delegate Webster: Okay. That's fine.

Judge Leach: Our IT people are supposed to be given the identifiers by the Insurance Commissioner's folks so that we can program it in and get the changes all done this week.

Delegate Webster: And when you say Wells Fargo, Sedgwick. . .something. . .what?

Judge Leach: The third one is American Mining Insurance.

Delegate Webster: Okay. And these are TPA's for the Old Fund. Right?

Judge Leach: And also for all the special funds – the Security Risk Fund, the Uninsured Fund – everything that the statute gave to the Insurance Commissioner.

Delegate Webster: Okay. With respect to the follow-up on some of your questions about. . . obviously the Old Fund as we shifted from public to private comp creates its own set of problems. But removing that from the equation, if you have. . . you were saying like 40,000 plans, and that I guess is based on the number of employers that provide insurance or have insurance. Is that right?

Judge Leach: It's just a number I've heard published. I don't really have the. . .

Delegate Webster: Well, with respect. . . you were saying different plans and maybe you didn't mean that literally. What do other states do? I mean talking about how you have to master a computer system to, you know, deal with all of these, wouldn't there be some. . .

Judge Leach: There are not 40,000 plans. There is only about six or eight plans right now, and the biggest one is BrickStreet. It covers their 39,000 or so different client/employers for their new cases. The self-insured employers – 125 or so of those belong – some of them just have one individual company; some four, five, six companies can buy into different plans. So there are six or eight different plans out there.

Delegate Webster: Is this common with other states? Is this just working out the glitches as we move forward or are we going to have to have you all equipped to like have a system but deals with. . .

Judge Leach: I cannot. . . I can't possibly comment. I don't have any idea about other states.

Delegate Webster: Okay.

Judge Leach: I think where the problem is going to be is people getting in and out of plans – employers changing carriers or joining a managed care plan. We need to know then because. . . If we have anchored our review of the process on the name of the employer and the employer switches to a different plan, which is optional rather than mandatory, somebody has got to let us know so that we will not continue to resolve those disputes with the old and incorrect plan information.

Delegate Webster: And this may be a question for the Insurance Commission. But to follow that, if at whatever time an employer can renew their contract. . .for example, say they are with BrickStreet and then at a later time renew or go to somebody else, is there a time period within that change that there is notice given to you all in order to allow the transition from one insurance company to the other?

Judge Leach: I really don't remember the details of Rule 21. That's where it is going to be covered if it's in there.

Delegate Webster: Do you know, Mary Jane?

Mary Jane Pickens (General Counsel OIC): I don't have the rule in front of me and I don't know. But I wouldn't think that it would be in there.

Delegate Webster: Let's say on July 1 the person's new insurance takes effect and between the companies it's probably not an issue you know because that would be common. But on July 1. . .if say. . .you know "Insurance B" takes over the insurance for the person, is there any communication? Does it trigger something with you all or the ALJ?

Ms. Pickens: With us it does. We know. We have a system to track employers that are covered, and if they have coverage who their insurer is. So we know. And if we know that that carrier or that self-insured employer has had a managed health care plan approved by us. . .I mean to me it just sounds like getting all the right information and there may be some technology issues or some programming, but it doesn't sound that difficult to me. We should have the information that the Office of Judges needs. It is just a matter of making it available.

Delegate Webster: It's just a matter of making it happen. And I didn't know if that's a concern. I mean that obviously would be something the Insurance Commission probably can address through whatever exists to do that. But you're right. I mean if somebody comes in July 1st and has a new insurance company and you are unaware that it has changed, that would be something I think that we need to make sure happens.

And my final question is – you were talking about these mandatory grievance provisions in plans and expressing I suppose a premature opinion but believing you can't do that, and I guess my question is: Is that because they didn't have an existing plan or because that would be contrary to State law?

Judge Leach: Well there are two reasons why you couldn't do it. One is if they don't have a plan. It can only happen if you have a plan, or at least that's our belief at this point in time. But the statute does not allow for mandatory grievance processes. It says you issue a decision; it goes to the Office of Judges if you disagree with it. Well regulation puts a step in between. But the regulation only applies to the managed plans which have been approved through the regulatory process. So if you don't go through the regulatory process then you don't get that option as an employer. But the second thing is some of the plans make that grievance process mandatory and some of the plans – the actual terms of the plans – make it an option. If you elect to, you can grieve as opposed to going straight to the Office of Judges. We just don't know which plans have which language in it. So we have two compounded problems. If somebody writes in and says, "I'm protesting and I'm an employee of XYZ Corporation." We don't know if XYZ Corporation has a plan at all. If they have a plan, we don't know which plan they belong to. And third, if we do know which plan they belong to – unless we actually see the wording of the plan – we don't know if it's mandatory or optional.

Delegate Webster: And whose call is it to decide if they could even insert that? I mean is that a regulatory or a State law statutory?

Judge Leach: That's a regulation.

Delegate Webster: That's not in our regs that they can create a mandatory. . .

Judge Leach: Yes. It is in Rule 21.

Delegate Webster: It is?

Judge Leach: In fact it requires – I think you missed this part – It requires that there be a plan that provides for grievance. What is not clear from the regulation is – does the regulation require that it be a mandatory grievance or does the regulation just say you have to make it available which would make it an optional grievance and the worker could then go either way if it was optional. If it's mandatory you've got to go through this grievance before you even get an appeal to the Office of Judges. But that's going to be controlled by what the language of the plan itself says.

Delegate Webster: But that would have to be consistent with the rule, right? Which you say. . .or at least you represent it. . .leaves some uncertainty whether it's optional or mandatory, right?

Ms. Pickens: In my opinion, when you read it I think it contemplates a mandatory grievance process. It doesn't clearly say that. But the way it reads it talks about polling the protest period during the period that the grievance is happening. I think it strongly suggests it's mandatory, but it doesn't actually say that it must be mandatory before exercising your rights to protest an order.

Delegate Webster: And how would that grievance process work as opposed to how we've been doing it?

Judge Leach: The grievance has to be over in 30 days according to the regulation.

Delegate Webster: Say you file a claim. . .

Judge Leach: No, it's not a claim.

Delegate Webster: Okay.

Judge Leach: It's a medical treatment only. It only applies to medical treatment.

Delegate Webster: Okay.

Judge Leach: So your doctor writes in and says I need six weeks of physical therapy. The insurance carrier says, "Not approved. It is not reasonable. It is not related to the claim." Now under the statute you can appeal to the Office of Judges. Under the regulation they have to provide this grievance process. And then the question becomes: Is the grievance process an option that you have to try to resolve it informally within 30 days or is it a mandatory prerequisite before you can appeal?

Delegate Webster: What did you say the statute says?

Judge Leach: There is no mention of the statute about a grievance process.

Delegate Webster: No not the grievance, but you said. . .right before you said that about a grievance you said the statute says what?

Judge Leach: The statute says if they deny any claim request the worker can protest it to the Office of Judges.

Delegate Webster: Wouldn't the statute be. . .I mean the law is pretty clear. I mean the statute would prevail over a regulation.

Judge Leach: That's generally the right interpretation, yes.

Delegate Webster: So it's your understanding that we have a statute and a rule that could be viewed as being inconsistent.

Judge Leach: It could be argued that they are inconsistent. I think in some cases that argument has already being made. But we haven't addressed that formally at the Office of Judges. I'm sure that the Insurance Commissioner's staff that wrote the rule would have an argument to the contrary. I don't think it's black and white.

Delegate Webster: Okay. Thanks.

Chairman Dean: Any other questions from the Industrial Council? Yes, Ms. Guthrie. . .

Delegate Nancy Guthrie: Would there be any benefit at all or would it make your life easier, even the Insurance Commissioner's life easier, if there was some uniform language in the statute that. . .or uniform language in the plan so that the plans would be portable from employer to employer?

Judge Leach: Sure. It would make my life easier. But I don't know if that's the right legal answer or not. Obviously if everybody is covered by the same plan, we don't have to figure out do you fit in this niche or do you fit in that niche? So that makes our life easier. I agree with what Mary Jane said. In my first reading I thought it was a mandatory plan. Since then I've heard some arguments to the contrary and I've kind of backed down from that. I don't think it's black and white on that answer either. You know lawyers can always disagree over how to read something. But the terms of the plan itself are going to control it. And I think the regulation allows both processes – mandatory or regulatory. So it depends on how the writers of the plan wrote the language. They both could comply with the regulation – a mandatory or an optional grievance process. The idea is it's not to penalize people. And I don't want to preach or get on a soapbox too much. The idea is it takes us at the Office of Judges 90 days or so, maybe 120 days, to resolve a treatment issue. This is supposed to be done in 30. Now obviously if there is never a reversal, if the mandatory grievance is a rubber stamped denial again, then you just delayed 30 days or longer of getting to where you got a chance to win. If, however, there is a reasonable reversal chance – I don't know what the numbers would balance out. . .if it's 20%. If one in five cases you could win in 30 days then you don't have to take those to the Office of Judges and be tied up for four months or longer trying to get your treatment. It is obviously intended for good. But

some people would argue it is intended only to add further delay before you get to the Office of Judges. And I think the answer to whether which side is right about that depends on the reversal rate.

Chairman Dean: Any other questions from the Industrial Council? Thank you, sir.

Judge Leach: That was interesting. Thank you.

**4. Title 85, Series 2 – Request Permission to Final File – Mary Jane Pickens
“Workers’ Compensation Claims Index”**

Mary Jane Pickens (General Counsel OIC): Good afternoon, Mary Jane Pickens, General Counsel for the Insurance Commissioner. This is the opportunity to present Rule 2 in a final version to the Industrial Council. Rule 2, just to refresh everyone’s memory, is the Claims Index rule and the Legislature in Code §23-2C-5 required – as one of the specific duties of the Industrial Council – that the Council establish a method of indexing claims of injured workers that will make information concerning the injured workers of one insurer available to other insurers. This is a system whereby an insurance company, when it is adjusting a claim, could at least get contact information. And that’s really how we’ve interpreted this – as a pointer to places where you can go to get information about other claims filed by that same injured worker. So this is a rule that should implement that process. I’ll just go through the comments and our responses to the comments. I think that’s the way Ryan usually does it.

The rule has been out for the 30-day public comment period, a written comment period and we’ve had a public hearing on it. We like to do it both ways because there are some people I think that are more comfortable sending in written comments or by e-mail or even by telephone as opposed to showing up in a forum of a public meeting and talking. So we think that that meets the needs of the public and the stakeholders to have both the written comment period as well as the public hearing.

One of the comments that we received related to timely reporting of information. We received a comment suggesting that the rule be amended to specify a timeframe for private carriers and self-insured employers to report claims information, and that is already in the rule. It is now in Section 6.1 of the rule, which requires information to be reported to EDI within five business days of the receipt of relevant information. So that is both the self-insured employers and private carriers. In response to that comment, it’s already in there.

Another comment that we received had to do with a "fine." We kind of struggled with this. It was complicated by the fact that there is already a fine for failure to timely report certain information within Rule 18, which is a self-insured rule. We didn't want and couldn't do I don't think anything inconsistent with Rule 18. So what we've done is pick up the Rule 18 language, made it applicable to all reporters. In Section 6.2 of the rule there is a fine not to exceed \$500.00 per occurrence of untimely reporting. And it's a discretionary type of fine and it's got top limit of \$500.00 per occurrence. So the fine is in there.

We received another comment relating to specific information that's included within the index, such as area of body or body part, treating physician and types of benefits granted. The data that is in the index currently consists of the claim number; the claimant's full name; the accident date/date of injury or last exposure; the claimant's social security number; all of the contact information for the private carrier; self-insured employer or TPA that may have other claims information; and we've added "body part." That is currently part of the index. There is certainly no reason not to put that in the rule. The rule does say "any other fields of information as the Commissioner deems necessary." We think that it is appropriate to have a little bit of discretion. If we felt that this list of data should be expanded or changed in some fashion, we would simply come back to the Industrial Council, talk about it at that time, and make those system changes from a technology perspective to capture more data. The information in the claims index is actually drawn from another system called EDI, which stands for Electronic Data Interchange. That is a system that gathers certain information about claims. Rather than create a redundant type of reporting requirement on self-insured employers and carriers since we basically already have enough information to fill the claims index, we just internally – kind of as an administrative IT function – that the Insurance Commissioner's office pull data that is reported through EDI and we create the index and put it out there. So what is in the claims index is necessarily dependent upon what's reported through EDI. But the way the rule is now it gives us some discretion to make changes that are appropriate after we come back and talk about it with the Industrial Council. But again "body part" is added.

Another comment that we received had to do with "access." And the rule does say in Section 5.3 that an attorney practicing in the area of workers' comp. . .well that was the comment – an attorney practicing being allowed to have access. The rule in 5.3 already includes attorneys representing claimants and the claimants themselves. Prior to this. . .I'll go ahead and mention this now. Prior to this meeting I spoke with a health care provider who is here. The public comment period has officially closed. But he made a point that I think is worthy of consideration and if the Industrial Council agreed I think that one of you all could make a motion to add this language to [Section] 5.3. The

suggestion was that 5.3 read, "A claimant, an attorney representing a claimant," and then insert, "or a duly authorized health care provider." I don't think that's a problem to put that in there. Obviously it would have to be a "duly authorized health care provider."

Dan Marshall: Would that be authorized by the claimant?

Ms. Pickens: Authorized by the claimant. If you want to just hold that in your thoughts right now and I can finish my responses and then we can have some discussion on that.

Another comment that we received was a suggestion that we specifically require insurance carriers to make their claims files open and share them with other carriers. We suggest that that suggestion not be accepted. Insurance carriers are competitors. I mean I can see business reasons why they would not necessarily want to – without a subpoena perhaps – be required by a regulator to open their claims files. I think the index again is intended to be a pointer for a place where you can go and ask for that information, and you may have to subpoena, but we give you the list of contact information. You know who has the claims files and where to go to get it. But we felt that it would be going too far certainly in this rule to require that carriers are required to share their files with one another. We would suggest that that comment not be acted upon.

We also received comments relating to release of information. It was suggested that the rule state that by signing an application for benefits the claimants agreed to permit carriers to release the information to other carriers. And again we would suggest that that recommendation not be accepted. I guess we have some concerns again about placing that type of provision in the rule. I think on a case by case basis if a claimant wants to authorize release of a claims file, he or she certainly can do that. But we had a little bit of concern about putting it on a claim application when you file your claim that you automatically release a carrier to release information to other carriers. So we would suggest that that not be placed in the rule.

That is the end of the comments. Again, this is a short rule. I think it's a real straightforward rule. One of the things that we have done that I think is worthy of pointing out and explaining – the rule has been changed in Section 6 to "Duty to Timely Report to EDI." We would suggest that we strike Section 7. Section 7 related to updating certain information. Again, in order to not create a redundant and somewhat burdensome reporting requirement since carriers and self-insured employers are reporting through EDI anyway, EDI itself has guidelines and requirements for updating information as appropriate. And we want to make sure – because EDI is a national

standard file layout – that we not do anything in a rule that. . . I don't think we can do anything in a rule that would change the nature of EDI itself. But if reporting is done through EDI and that's complied with, then information will be updated as necessary. And again as the index pulls the information from that system it will necessarily be updated. I hope that wasn't too complicated. It gets a little technical. That's the presentation on the comments and the responses. If anyone has questions. . .

Walter Pellish: Mary Jane, What would cause someone to not report on a timely basis?

Ms. Pickens: I suppose it could be a number of things, probably just internal procedural issues. With the self-insured employers I don't think that has been an issue. They have been reporting through EDI since 2004 and I get the impression they are pretty good with it and used to. And we would expect carriers who have been operating in other states, you know, when they come in here this is something they are very familiar with and we wouldn't expect there to be a problem.

Mr. Pellish: Why do we need the "fine" issue? I'm missing something.

Ms. Pickens: Well you want to make sure that they do. Yes we believe that they will and it shouldn't be a problem, but it is important information. It's important that the regulator receive the information on a timely basis, and now that we have the requirement to keep the claims index up to date it's important that that be kept up to date. It's in there simply to ensure that that happens, plus I think it is already in Rule 18 anyway with regard to the self-insured employers. You know we can't have the self-insured employers subject to a penalty that private carriers would not be subject to.

Mr. Pellish: Well is that not the proper place to address the fines then. . . 18 rather than. . . ? I'm just having a problem with understanding. The claims index I thought was something that everybody thought was a real good thing and it was going to help in the resolution of claims; and help to an extent to go back and measure against fraud or repetitive kind of situations. I just have a feeling that this is going a little off-track. I just need to understand it.

Ms. Pickens: Well I personally have learned a lot more about this and about other systems that are out there to detect fraud. I think that your large self-insured employers and private carriers in other states are used to reporting through EDI. They are used to also reporting claims information to ISO which is used for detecting fraud. So there are other systems out there to do what you are talking about. Based on our research it's unusual for a state to have a claims index like what we're talking about which would

assist a carrier in adjusting a claim. I mean, as we know, carriers are out there adjusting claims in every state today and have been for a long, long time I think without this type of a tool, but it's a statutory requirement. Again, the penalty thing we kind of struggled with. It was a public comment that we received. When we went back to consider that public comment it is already in Rule 18. There is not a corresponding penalty for carriers. It is kind of repetitive of 18 but at least they mirror one another. It's not a different penalty.

Mr. Pellish: The amounts are the same?

Ms. Pickens: Yes. It's not a double penalty. We put it in there to make it consistent with Rule 18 plus apply it to carriers.

Kent Hartsog: How can I tell it's not a double penalty?

Bill Kenny (Deputy Commissioner OIC): Does 18 apply to carriers?

Ms. Pickens: No.

Mr. Kenny: Rule 18 only applies to self-insureds?

Ms. Pickens: Correct.

Mr. Hartsog: But there is also a penalty I think in Rule 1 that maybe applies to carriers.

Ms. Pickens: I don't think it does. Ryan [Sims] would know. But I know we would have looked at that.

Mr. Hartsog: If I look at Rule 18 and then this rule, how do I know that that is not redundant for a self-insured?

Ms. Pickens: Because it would make no sense for it not to be. It's a . . .

Mr. Hartsog: Because you are really requesting. . .you're really doing the same thing twice.

Ms. Pickens: Well that's absolutely not the intent. The intent was simply to make it consistent with [Rule] 18 for self-insureds. If there is a violation, there is only going to be one violation and that's a failure to report timely to EDI. I really don't think it is

susceptible to an interpretation that you apply it twice. I mean this should mirror 18. I mean if there is a way to clarify that I'm certainly not opposed to that. But we did kind of struggle with how to write this.

Chairman Dean: Are you okay with that answer?

Mr. Hartsog: Well, I was actually just kind of looking at it and looking at it with regard to is it possible then to insert. . .I take you totally at your word in that regard. This may well survive us all I would think. Is there a place to insert the words to say that this won't be duplicated with the fines delineated. . .in Rule 18?

Ms. Pickens: I think we could. I mean you could put a proviso at the end provided that this penalty may not be duplicative of penalties provided for. . .I hate to refer to a specific rule in a rule.

Mr. Hartsog: Are there any rules out there that address carriers. . .for not reporting, which I guess right now it's BrickStreet?

Ms. Pickens: That would be in Rule 1. I don't think this particular. . .I'm sure this particular provision is not in Rule 1.

Mr. Hartsog: So the fine [or fines] in Rule 1 are different than what this fine would be?

Ms. Pickens: Yes. This is a different act; a different type of thing.

Mr. Hartsog: Okay. I understand.

Chairman Dean: Any other questions?

Mr. Hartsog: Well I was just going to ask if she had some wording there that she thought would work.

Ms. Pickens: I think you could put a proviso that says, "Provided that this penalty may not be duplicative of penalties provided for in other applicable rules relating to this type of report."

Mr. Hartsog: Say "with regard to". . .what is it late reporting, EDI information. . .or something like that.

Ms. Pickens: Yes. But, again, I can't conceive of an interpretation that would allow it to be done twice. I just cannot conceive it.

Mr. Hartsog: I would like to move that we add that additional language to the rule that Mary Jane came up with.

Chairman Dean: And that will be Section 7.3?

Ms. Pickens: Section 6.2.

Delegate Nancy Guthrie: Could you repeat it again?

Ms. Pickens: What I've got is, "Provided that the penalty may not be duplicate penalties. . ."

Mr. Kenny: Mary Jane, when it says "per occurrence" would that not limit it to not being duplicative?

Ms. Pickens: Well not necessarily. I think that "per occurrence" would actually allow you to. . .you may report. . .I mean that is "per employer" or "per claim" type of thing. "Provided that this penalty may not duplicate penalties provided for in other applicable rules relating to late reporting to EDI."

Chairman Dean: After all the questions, then we'll come back and make a motion to change the language. Ms. Webster, do you have a question?

Delegate Webster: On the fine issue, I'm assuming Mary Jane and the Insurance Commission for a while has been able to assess fines. And my issue is not so much on the amount or anything but just. . .We had counsel at the Legislature look at a few of the provisions and one was. . .Is the Insurance Commission statutorily authorized to assess fines? Because I know my counsel in Judiciary was saying that you've got to be permitted by statute. And per the Constitution, generally have to be placed in a school fund unless we otherwise provide. I was just told that maybe to raise. . .are you all authorized by statute to do that?

Ms. Pickens: A lot of the fines are in rule. I didn't come prepared to talk about specific statutory provisions relating to fines and I apologize.

Delegate Webster: No, I don't think you need to be. You are right. I have seen other provisions, but it was just sort of a statutory/constitutional issue. I wasn't

necessarily even expecting you to. They just brought it to my attention a couple of hours ago. The main interest that I have is from the claims index. The objective primarily is what?

Ms. Pickens: The objective according to the statute is to establish a method of indexing claims of injured workers that will make information concerning the injured workers of one insurer available to other insurers. So it's sort of, again, an information sharing type of system which at least gives you a place to go, ask for the information about the other claimant.

Delegate Webster: I would presume that it is also designed to help the Insurance Commission and other interested parties know how information is coming in and out, right?

Ms. Pickens: Well, that's the thing. That's what made it kind of redundant we thought with EDI because if they report. . .and I know this is confusing because it is kind of technical. Self-insureds have already been doing that in pursuant to Rule 18 requirements. The information that comes in through EDI, you know, we're getting anyway. The index is a separate thing, but it's built using the data that we pull from the other system.

Delegate Webster: I heard somebody say one objective. . .or at least I guess the consequence of it would be if there is fraud or repetitiveness. So is that one of the things that would allow employers to look at if multiple claims go from one company to another? I mean was that a stated objective in the reg or the statute?

Ms. Pickens: Not that I'm aware of. And again there are other systems out there that would probably fill that purpose but has nothing to do with the Insurance Commissioner's office.

Delegate Webster: Would it fall under fraud and abuse? I guess my question is how are we since we passed measures to try to monitor abuse and fraud by all parties – employers, claimants, etc.? I just wondered if this was a mechanism that was designed to do that or was something that could be used to do that.

Mr. Pellish: The answer to that, Mary Jane, is that is something that could happen. I don't think that's the intent of the claims index.

Ms. Pickens: I think you're right.

Mr. Pellish: But it is a source of possible information. There is nothing magic about this.

Ms. Pickens: I agree with Mr. Pellish. It could be used. Again, there are other systems. We require insurers, agents, those people. . .I mean that's a requirement to report suspected fraud. So we're gathering information about fraud all the time. I suppose you could see patterns of same body part with different insurers, but I don't think that's the motivating factor.

Delegate Webster: Now with body part added to this, is there any reason that we wouldn't have disposition. . .like new outcome. If this information is going to be available to insurers and employers and we're having them provide the number, the accident date, name, social security number, body part, wouldn't it be helpful to also know what the outcome was?

Ms. Pickens: Well, that was part of some of the comments that we got. Because the claims index is built upon information reporting through EDI, I don't believe that EDI would have the type of information you are talking about in terms of percentages of permanent partial disability award and that type of thing. That's not what EDI was established to do. And again that's a national product. That was built specifically to meet the needs of regulators all over the country so it's a common denominator type thing. It wouldn't be useful for any tracking of unique West Virginia law type issues. So I don't think that it is going to have that type of information. And as long as the index is built upon that system, I don't think it's possible to put some of that in there.

Delegate Webster: Okay. That would probably respond to my next one. We've got different interests but all at the same time important interests. I mean with this transition from public to private the next question is why would we not be able to also add the claim history? As a State legislator and public policymaking body, I think knowing the number of claims that are filed – and this may be a different issue than an employer and insurance company may want – but you know as the regulator being the Insurance Commission and us enabling you all to regulate is. . .when I say claims history I'm not talking about underwriting information. I'm talking about information about the stuff that we've provided under the Old Fund system. It's just basic claim history. You know, what was filed and other information. . .it's not set up to do that. What mechanism has the Insurance Commission, as a State regulator, do we have to do that?

Ms. Pickens: Well I think what you are getting into in my opinion goes way beyond what the claims index was intended to do and we would not recommend that you do that. I don't think that's in keeping with the statutory authority.

Mr. Pellish: Absolutely.

Delegate Webster: And that's why I said you may have already addressed that. But while we're talking about that, what is there in statute or through the regs that enables the Insurance Commission and the State Legislature, and anybody else, to know the number of claims that are filed with an employer, i.e., insurance company, the number denied; the kind of information that is helpful in determining what kind of regulation is needed on the claimant side because you know there is a lot of focus on the employer and insurance company.

Ms. Pickens: Well we're talking about private insurance industry. They're used to some reporting like EDI and they're used to that layout. They've got systems developed to do that on a regular basis. If you are talking about reporting that would allow us to track – again unique West Virginia issues – there is nothing that would require that to be just reported on a regular basis. I mean its private industry now and we're not going to have access to that.

Delegate Webster: Obviously with workers' comp. . .like automobile and homeowners, we've got a no fault system; a waiver of your common law rights. And the contract that you negotiate in a homeowner or automobile situation is different. And I know when the State moved from public to private I don't think we intended to not be able to have that information in order to find out what's working and if things aren't or if things need to be changed. As you all pointed out in the old statute, that information was there about the Old Fund. And while insurance companies may not. . .you know you say be subject to that in other forms of insurance. I just don't know how we are going to be able to gauge how claims are being processed; the number; how many. If Insurance Company X has 100 claims for a certain type of injury, how many of those are denied? How many of those are approved? I mean do we have any data collection ability?

Ms. Pickens: Well you have a regulator. And it's the Insurance Commissioner's job to track complaint activity, to do market analysis and determine how carriers are acting in the marketplace and to examine. We've got very broad examination authority to go in and look at claims files and look at information and determine whether laws and rules are being complied with. And that's the regulator's role and it's the regulators' role in every state in the country. This is what we do. That's why we exist basically.

Delegate Webster: I understand. I'm just saying that. . .or pointing out that unless you have a complaint, you know. . .and somebody might have. . .you know obviously the Legislature. . .we've been interested in that Interim Committee in knowing. . . because one of the complaints with the Old Fund in particular has been. . .there has been a pattern of denial, denial, denial. And statutorily there is supposed to be information there for us to look at and for you all as the regulator to look at that. And I don't even know if that information is even being collected even though it's statutorily required. So I'm just saying with the New Fund as we call it – Old Fund versus what we're doing now – how are you all able to look for any pattern of practice if there is no data or information upon which to do that analysis? You all are very busy. . .I mean like any industry. Unless somebody complains, how would you all be able to do that other than through that?

Ms. Pickens: Well EDI serves that function to a great degree. And if it would be a benefit to have somebody from our IT group to come talk about EDI, that's something I'm sure we could talk about putting on a future agenda so there is a better understanding of that. But that whole system was intended to track certain data. But again – and I'm apologizing – I'm not prepared to go through all of that because it's rather complex and it's technical. I don't know for example if it requires reporting of denials of claims. But again I think you have to trust the regulator. We get lots of complaints. It's not like no one is complaining. We hear when people are not happy with their claims handling and we do track that just the way we do with other lines of insurance.

Mr. Pellish: Mary Jane, I'm getting a feeling we're getting way off track here and going into some areas that. . .

Delegate Webster: Sir, I had the floor and all I was doing was asking some questions.

Mr. Pellish: Whoa, whoa, whoa. I was recognized. . .

Delegate Webster: No, I had the floor.

Chairman Dean: Go ahead Ms. Webster. You had the floor.

Delegate Webster: Thank you, Mr. Chairman. The information that is permitted to be exchanged between an employer and an insurer, which includes social security numbers and other information that would otherwise be viewed as private. When that

occurs, what mechanism is there to make sure – and I think somebody said it has to be used for just that intended purpose. We all read or heard about. . . situation where they were selling, detailing information that they weren't authorized to do. Is there anything to make sure that the information that is provided or exchanged between an employer and insurer isn't shared beyond the scope upon which it's being contemplated?

Ms. Pickens: Well insurers are subject to privacy rules which are in Title 114 Legislative rules. Workers' comp insurers are going to be subject to that privacy rule just the way the auto or homeowners insurer would. So that's covered on that regulatory front. In terms of the index itself, in order to be given access to the index an application has to be filed and approved here. Once you have access you have a password. You don't just go in and get a list of every claimant and all their social security numbers. It has to be a specific search for a specific claimant with a specific social security number.

Delegate Webster: So you all think that the adequate protections are there to make sure the social security numbers and any other information would not be sold or circulated. It is prohibited from other parts of the statute or regs, right?

Ms. Pickens: Yes.

Delegate Webster: Thank you.

Chairman Dean: Any other questions? Mr. Pellish, do you. . .

Mr. Pellish: Now that I have been duly recognized, we get way off where we should have been with this. I would ask Mary Jane to please read again the purpose of the procedure and go from there, and that's what we're trying to do here.

Chairman Dean: Are there any other questions? Go ahead, Mary Jane, please.

Ms. Pickens: Well the announced purpose by the Legislature is to establish a method of indexing claims of injured workers that will make information available concerning the injured workers of one insurer available to the other insurer. I think I read that wrong.

Mr. Pellish: It seems to me that that's adequately covered here.

Ms. Pickens: We would agree. And with the changes that we've suggested I do think that it is a better rule. The body part I think is appropriate to add. Again, I don't

want to overlook the comment that was made by Mick Bates earlier about the duly authorized health care provider being authorized to get information regarding other claims. And then we've got the proviso about the penalty. There would need to be motions for both of those changes.

Chairman Dean: We'll do that. Are there any other questions or comments? We have two things here – two language changes to add.

Mr. Hartsog: Mr. Chairman, let me ask one quick question. I just want to clarify one thing with regard to any changes in what gets reported. The Insurance Commissioner will come back to this group with suggested changes and then at that point a timeline will be established for insureds. . .self-insureds or TPA's or whomever to get their systems working to be able to report.

Ms. Pickens: That's the beauty of how this is set up. First of all the answer is yes. I think any time we are going to make a change to it we would come back and talk to the Industrial Council. But because it's based on EDI which is a standard format, if we change it you've already got your systems to report through EDI. It would just be a matter of establishing our index to pull different information so it wouldn't even be noticeable to the carrier or the reporting self-insureds.

Mr. Hartsog: Thank you.

Chairman Dean: Any other comments? We have two places where we need to add language. One was to Section 5.3 with suggested changes. Is the Industrial Council in favor in making those changes to the language?

Mr. Hartsog: Could you read the changes on the language again?

Ms. Pickens: Yes. This would be a change to 5.3 to make it read, "A claimant, an attorney representing a claimant," and insert, "or a duly authorized health care provider shall be permitted to request a list of the claimant's prior claims available from the claims index."

Mr. Hartsog: On that last part where you say, "duly authorized," could you insert the word "duly authorized by the claimant?" Or is that redundant?

Ms. Pickens: We could say, "or a health care provider duly authorized by the claimant."

Mr. Hartsog: Yes. Yes ma'am. I would just like to make it clear that that authorization comes from the claimant.

Ms. Pickens: Okay.

Chairman Dean: Is there a motion to approve the language change?

Mr. Hartsog: So moved.

Mr. Pellish: Second.

Chairman Dean: A motion has been made and seconded to approve the language change. Any questions on the motion? All in favor signify by saying "aye." All opposed? The aye's have it.

[Language change approved in Section 5.3, Title 85, Series 2, "Workers' Compensation Claims Index."]

Chairman Dean: We also have a language change to Section 6.2. Would you like to read the other change?

Ms. Pickens: We would add a proviso to the end of the only sentence in 6.2 regarding untimely reporting and the penalty: "Provided that this penalty may not duplicate penalties provided for in other applicable rules relating to late reporting to EDI."

Chairman Dean: Is there a motion to approve this language change?

Mr. Hartsog: So moved.

Mr. Pellish: Second.

Chairman Dean: A motion has been made and seconded to approve the language change to Section 6.2. Are there any questions on the motion? All in favor signify by saying "aye." All opposed? The aye's have it.

[Language change approved in Section 6.2, Title 85, Series 2, "Workers' Compensation Claims Index.]

Chairman Dean: Is there now a motion to adopt and final file Title 85, Series 2, "Workers' Compensation Claims Index" with the added language?

Mr. Pellish: So moved.

Mr. Marshall: Second.

Chairman Dean: Motion made and seconded to approve. Any questions on the motion? All in favor, "aye." All opposed? The aye's have it.

[Motion passed to adopt and final file Title 85, Series 2, "Workers' Compensation Claims Index" rule with the added language changes.]

Ms. Pickens: Thanks you.

5. General Public Comment

Chairman Dean: We'll move onto general public comment. Does anybody in the general public have comments today?

6. New Business

Chairman Dean: We'll move onto new business. Does anybody from the Industrial Council have new business to discuss today?

Mr. Pellish: I would like to proper suggest, Mr. Chairman, or request. When this group was convened a couple of years ago after the Legislature made some very good news to try and get some reforms, there was a lot of commentary about the actuarial ramifications of what was happening. We saw all these numbers before the Legislature took action that said we're all doomed and we're going to collapse and then two months after the legislation was passed there were new actuarial numbers that said everything is peachy keen. I'd like to know where we are. So I am requesting that whoever should do that would make a presentation at the next meeting. Or if that is too short a period of time, whenever it makes sense so that we as a Council can get a feel as to where we are.

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Chairman Dean: I was just looking at the calendar and I don't think we meet again until January so I don't think it should be a problem. Mary Jane, I'm not sure. Bill, did you do that the last time? It's been so long I forgot who made the presentation.

Mr. Hartsog: Is this in reference just to the Old Fund?

Mr. Pellish: No. I just want to get a feel for where we are with workers' comp at this point – total numbers. We got money coming in. We got money going out. We got all kinds of things happening.

Mr. Kenny: We produce that all the time. We are developing a report to go to the Legislature on a monthly basis. I think we can include the Industrial Council on that. It is beyond even what you are looking for. We will include you.

Mr. Pellish: That's great. Let's put it on the agenda.

Chairman Dean: Ms. Guthrie. . .

Delegate Guthrie: Excellent idea. In addition to that, one of the things and one of the points that Chairman Webster was trying to get at, which I think you are trying to get at as well, Mr. Pellish – if we could get some sort of a notion of what kind of claims are being filed. And is there an inordinate amount of claims being filed for certain body types by certain employees or employers. I'd like to have that information because I think that was the whole intended purpose to find out whether or not any particular employee or employer is gaming the system. And I think that's the reason for us to be here. If we could include that kind of a report as well, I'd like to get an analysis of exactly where we are in terms of claims being filed, claims being processed and the claims being paid out.

Mr. Pellish: I have a suspicion that most of that information. . . Judge, where are you?

Judge Leach: Right here, sir.

Chairman Dean: Can you answer that question?

Delegate Guthrie: Can you do that by body part?

Mr. Pellish: You are constantly reporting on that sort of thing.

Judge Leach: Right. But I can only tell you the outcomes that are appealed.

Mr. Pellish: Right.

Judge Leach: I have no idea of what the percentage is of the non-appealed ones. It would just be speculation to extrapolate my numbers into what the entire. . .

Mr. Pellish: I'm not suggesting that you do. I'm just saying that from protesting that sort of thing you constantly report on that and there are reams of information available. Anybody who wants to sit and look at all the claims filed and that sort of thing, I don't think there is any problem in generating that but. . .

Delegate Guthrie: Mr. Pellish, I'm not. . .

Mr. Pellish: I'm looking for a. . .

Delegate Guthrie: Mr. Pellish, I'm looking for just some general trends.

Mr. Pellish: And that's what I'm looking for is. . .

Delegate Guthrie: And that's all I'm asking for, sir.

Chairman Dean: Is this doable, Bill or Mary Jane? I think it would be.

Mr. Kenny: I think whatever we collect from EDI certainly can be summarized and I'm happy to do that.

Chairman Dean: I think it's a reasonable request.

Mr. Kenny: Getting into each individual private company's file. . .

Delegate Guthrie: That's not what I'm asking for Mr. Kenny.

Mr. Kenny: That's problematic but. . .EDI would certainly. . .

Chairman Dean: Could you try to get us some information, summarize it and bring it back and we'll look at it and see if this is what we want? Maybe you can't come up with what we want, but could we. . .

Ms. Pickens: It has been my plan to explore reporting activity through EDI to better educate myself about it, and I'm not sure if we can have that available by the next meeting but it is something. . .

Mr. Pellish: If you need more time. . .

Delegate Webster: When is the next meeting?

Chairman Dean: It will be January 24, 2008, I believe. If you can't come up with the information maybe you can give us an update, you know, certainly just that you will have it.

Dan Marshall: If I can just offer a comment. EDI and the information that they generate is not something we've seen before and I think it's likely – at least a good starting place. Let's start getting that data and getting that data reported here and let's see if that doesn't give us the kind of handle on things and kind of a macro-view of things that I think the Legislature is looking for, for their purposes and we're looking for to our purposes. If that turns out to be inadequate, then we can look at other means of obtaining that data. But let's see what we get out of this EDI system.

Mr. Kenny: The State of West Virginia is really no different than the other states that have privatized. All of those states face these same issues, same questions. What we're trying to avoid is reinventing the . . .for our market and saying to insurance companies, "If you want to play in this little tiny market, you've got to go through all of this great expenditure. . ." I think perhaps maybe the thing for us to do is get everybody here accustomed to what states typically do and we can do that by. . .with other states and see how it's done. I just can't imagine that we have any unique problem that they haven't already addressed. This can't be a unique problem.

Mr. Pellish: Bill, that's your call and you know what you're dealing with. You guys are the experts. It's just a matter of a little feedback.

Chairman Dean: While we're on new business, Mary Jane, do you have something under new business?

Ms. Pickens: Yes. I have a couple of things. I just wanted to report that about three weeks ago I did write a letter to every member of the Legislature to see if they would like to be added to the "stakeholders list." That's the list that we e-mail – it's already over a couple hundred people – all of the agendas for the Industrial Council meetings and the rules and that type of information. So far I've received back requests

to be added from ten delegates and two senators and we expect obviously more to come in. But I just wanted to report on where we are today. We are creating a separate e-mail list just for the legislators. So we're going to implement that with the next meeting.

Chairman Dean: Mr. Hartsog, do you have something to say?

Mr. Hartsog: Yes. Just one question. With regard to the Old Fund, is there a recent actuarial report?

Mr. Kenny: Yes, but not yet fully audited for release. But, yes, there was one done for the period of time ending June 30th.

Mr. Hartsog: When could we expect to see that?

Mr. Kenny: Usually it's around January.

Mr. Hartsog: So we could expect to see it at the January meeting.

Mr. Kenny: Hopefully. I obviously can't release it until all the financials are released. Normally around January all the auditors' work is done. But I can give you basic information.

Mr. Hartsog: I'd like to understand what is going on with the Old Fund. And my second question is: Is the Old Fund being audited with regard to audited financial statements?

Mr. Kenny: Yes.

Mr. Hartsog: Are those being prepared?

Mr. Kenny: Yes.

Mr. Hartsog: Will those be issued at the same time?

Mr. Kenny: They will be incorporated into the state's financials. We have done that and sent them to the consolidated statement and they are now doing. . .

Mr. Hartsog: Will there be a separate report issued just for the Old Fund or just with regard of what's incorporated in the state's financial statements?

Mr. Kenny: There is a separate report and it will be released as soon as everybody has had a chance to look at it. I don't want to release it until it has been declared accurate.

Mr. Hartsog: So hopefully we'll see it at the January 24th meeting.

Mr. Kenny: Yes. I would anticipate that.

Chairman Dean: Very good. Anything else under new business?

7. Next Meeting

Chairman Dean: The next meeting will be January 24, 2008.

Ms. Pickens: May I comment on that? We had only scheduled meetings up through this one. With the Session starting in January we suggested the next meeting for January 24th, and I think the members should have a proposed calendar that schedules the meetings up through July of next year.

Mr. Marshall: Except February, Mary Jane.

Ms. Pickens: Except February which is my point about the Session. We were suggesting that because things get so hectic at that time of year that we would schedule a meeting on January 24th which is kind of later in the month of January and then pick up again on the 20th of March, which is after the Session is over and take February off. And again that is simply because of the hectic nature of that time of the year for us. The dates we worked out so that it would still work with the rulemaking process. For example, if we were to bring a new rule before the Industrial Council on January 24th it would still work time wise to have the public hearing in March. That would still be in compliance with the required time periods. So that's our suggestion. You may want to – I can't remember how we did this before – whether you voted on adopting. . .or we just all agreed to that's when you would have it. But I did want to point out the February issue.

Mr. Marshall: Why don't we just affirm this next meeting date and go from there? That's what we've been doing I think.

Mr. Pellish: And then we could get preliminary approval for the entire schedule in January.

Chairman Dean: The next meeting will be on January 24, 2008, at 3:00 p.m. here [Offices of the Insurance Commissioner]. Is there a motion to approve that?

Mr. Marshall made the motion to approve the January 24, 2008, meeting. The motion was seconded by Mr. Pellish and passed unanimously.

8. Executive Session

Chairman Dean: I will entertain a motion to go into Executive Session.

Mr. Marshall made the motion to go into Executive Session. The motion was seconded by Mr. Pellish and passed unanimously.

[These matters involve discussion as specific confidential information regarding a self-insured employer that would be exempted from disclosure under the West Virginia Freedom of Information Act pursuant to West Virginia Code §23-1-4(b). Therefore it is appropriate that the discussion take place in Executive Session under the provisions of West Virginia Code §6-9A-4. If there is any action taken regarding these specific matters for an employer this will be done upon reconvening of the public session.]

The Executive Session began at 4:37 p.m. and returned to regular session at 4:47 p.m. There was no formal action taken in the Executive Session and it was for informational purposes only.

Chairman Dean: We have a Resolution whereas the Bon Ton Department Stores, Inc., has applied for self-insurance status. Is there a motion to approve the Resolution?

Mr. Pellish: So moved.

Mr. Marshall: Second.

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Chairman Dean: A motion has been made and seconded to approve the Resolution. Any question on the Resolution? All in favor "aye." All opposed? The aye's have it.

Mr. Marshall made a motion to adjourn the meeting. The motion was seconded by Mr. Hartsog and passed unanimously.

There being no further business the meeting adjourned at 4:49 p.m.