MAY 2008

WEST VIRGINIA INFORMATIONAL LETTER

NO. 160

TO: **All Insurance Companies Doing Business in the State of West Virginia, Insurance Trade Associations, Insurance Media Publications and Other Interested Persons**

RE: **WEST VIRGINIA WORKERS' COMPENSATION LEGISLATIVE CHANGES -- HOUSE BILL 4636**

This informational letter discusses the changes to the workers' compensation laws made by Enrolled Committee Substitute for House Bill 4636, which was enacted during the 2008 regular legislative session. The bill is effective from its passage date of March 8, 2008, although some changes are subject to different internal effective dates. In addition, amendments to workers' compensation rules are under consideration that would affect many of the same topics covered by the new legislation, so interested parties should consult the Offices of the Insurance Commissioner (OIC) website for any such changes. Unless another contact person is indicated, questions may be sent to Timothy.Murphy@wvinsurance.gov.

SURCHARGES ON POLICIES

The 2005 Workers' Compensation legislation (SB 1004), which provided for the termination of the Workers' Compensation Commission and the creation of a new mutual insurance company (Employers' Mutual Insurance Company, dba BrickStreet), also provided that BrickStreet and other private carriers would, with respect to premiums received for workers' compensation coverage, be exempt from those taxes and surcharges to which other insurance companies are subject under chapter 33 of the West Virginia Code. The Legislature instead established two surcharges on policyholders. The surcharges on policyholders are collected by carriers from their policyholders and remitted to the Commissioner. HB 4636 changes how the amount of these surcharges will be calculated.[1]

REGULATORY SURCHARGE -- W. VA. CODE §23-2C-3(f)(1) -- The regulatory surcharge is designed to cover the costs of the Insurance Commissioner's regulation of private carriers and self-insured employers. SB 1004 required the Commissioner to estimate the cost of regulating each of these groups every year and then, with respect to the carriers, to establish a percentage of last year's total premium (plus deductible payments) needed to reach the estimated amount.[2] Up to now, this percentage has been applied to each BrickStreet policyholder's premium and

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[1] HB 4636 made no changes with respect to either the debt-reduction or regulatory surcharges on self-insured employers. See W. Va. Code §23-2C-15(f)(2) & (3).

[2] A similar calculation is performed each year to arrive at a percentage to be used for the surcharge on self-insured employers, although this calculation is based on payroll rather than premium. See W. Va. Code §23-2C-3(f)(2).

collected as a surcharge on every premium bill. Under HB 4636, the Commissioner will no longer calculate the regulatory surcharge percentage every year. Instead, the new legislation substitutes a set figure of 5.5%[3] with respect to policies with an effective date of July 1, 2008 or later. This surcharge is to be assessed on the premium due as well as on "the total of all premium discounts based on deductible provisions that were applied" in arriving at the premium due.

DEBT-REDUCTION SURCHARGE -- W. VA. CODE §23-2C-9(f)(2) -- The 2005 legislation also required the Commissioner to establish surcharge percentages that would yield a total of $54 million every year -- $45 million from insured employers and $9 million from self-insured employers -- to be applied to the overall workers' compensation debt; these surcharges are to continue until the Governor decrees that the debt has been retired. *See* W. Va. Code §23-2C-3(f)(3). Such percentages would vary each year as policyholders' premium and self-insureds' payroll changed. As was done with the regulatory surcharge on policyholders, HB 4636 eliminates the requirement of an annual adjustment to the surcharge percentage on premiums and substitutes a set percentage (9%) to be used with respect to all policies issued or renewed on or after July 1, 2008. As is the case with the regulatory surcharge, the percentage is to be applied to all premium due during the preceding quarter as well as on "the total of all premium discounts based on deductible provisions that were applied" in arriving at the premium due.

REMITTANCE TO OIC -- Prior to the enactment of HB 4636, the statute required a carrier to remit the regulatory surcharge within 90 days of receipt of the premium on which the surcharge was assessed; self-insured employers, however, were subject to a quarterly remittance requirement. HB 4636 now requires that the regulatory surcharge on carriers be remitted quarterly. *See* W. Va. Code §23-2C-3(f)(1)(C). OIC's new integrated tax forms now include a schedule for these surcharges.[4]

QUESTIONS -- An explanation of the new surcharge computations can be found on the OIC website at http://www.wvinsurance.gov/wc/pdf/Surcharge-Applicability-and-Sample-Algorithm.pdf. Questions should be addressed to Michael Riley at Financial.Conditions@wvinsurance.gov.

CARRIER NOTICE RESPONSIBILITIES

NOTICE TO POLICYHODLERS OF CANCELLATIONS AND NONRENEWALS -- W. VA. CODE §23-2C-15(e) -- HB 4636 changes how carriers must notify their policyholders about cancellations and nonrenewals of policies. When the market opens on July 1, 2008, new carriers may *cancel* a policy upon 30 days' advance written notice (it had been 60 days) and may decline to renew a policy upon 60 days' advance written notice (unchanged). However, if the cancellation is based on nonpayment of premium or (as added by HB 4636) the "refusal to comply with a premium audit," only 10 days' advance written notice (it had been 15 days) must be provided to the policyholder.[5]

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[3] This figure is based on the Insurance Commissioner's estimate of the future costs of regulating the carrier side of the market. HB 4636 permits the Commissioner to revisit this figure in five years and to change it if necessary.

[4] The statute is silent with respect to when the debt reduction surcharges must be remitted. *See* W. Va. Code §23-2C-3(f)(3). However, OIC's new integrated tax forms now require remittance of these surcharges on a quarterly basis as well.

[5] On or after January 1, 2009, BrickStreet may begin to decline to cover certain employers; as of March 8, 2008, however, BrickStreet may begin to cancel on 10 days' notice for nonpayment or refusal to comply with a premium audit.

NOTICE TO OIC OF COVERAGE TERMINATIONS -- W. VA. CODE §23-2C-15(f) -- The requirements regarding when a carrier must notify the Insurance Commissioner about changes in coverage of its policyholders have also been altered by HB 4636.[6] First, whenever a carrier issues or renews a policy, it must notify the Insurance Commissioner of this fact within 30 calendar days of the policy's effective date (it had been 10 days); however, in a situation in which a carrier is informed that its out-of-state insured has already commenced operations in West Virginia for which coverage is required and the policy provides that such coverage is retroactive to the date of the commencement of such operations, the carrier has 30 days *from the time it learned of such West Virginia operations* to notify the Insurance Commissioner of the coverage. Second, whenever a carrier *cancels* a policy, it must notify the Insurance Commissioner of this fact 10 days prior to the termination's effective date (it had been 3 days after cancellation).[7] Third, when it is *the employer* who is terminating coverage, the carrier must notify the Insurance Commissioner within 10 days from when it receives the request to terminate.[8]

THIRD PARTY ADMINISTRATORS (TPAS)

The TPA Act in the general Insurance Code (W. Va. Code §33-46-1 *et seq.*) does not cover workers' compensation-related activities.[9] Since 2003, however, the Workers' Compensation Code has provided that a self-insured employer could only retain a TPA to administer the employer's workers' compensation claims if that TPA had been "*qualified* to be a [TPA]…." under rules adopted by the (former) board of managers or (since 2005) the Industrial Council. W. Va. Code §23-2-9(i). The rule adopted pursuant to this statute [85 CSR 18-21] mandates compliance with the "same financial tests" required of TPAs covered by W. Va. Code §33-46-1 *et seq.*, but does not otherwise incorporate any provisions of chapter 33.[10] Carriers, on the other hand, were limited by pre-HB 4636 law (the 2005 bill) to the use of TPAs that (1) had an office in West Virginia, and (2) were "registered" under W. Va. Code §33-46-1 *et seq*. HB 4636 makes the TPA Act apply to both carriers and self-insured employers.

The first sentence of the amendment to W. Va. Code §23-2C-17(c) provides that both carriers and self-insured employers may contract with a TPA "licensed or registered by [OIC] in accordance with [W. Va. Code §33-46-1 *et seq*.]." The second sentence then provides that any TPA doing work "in connection with workers' compensation coverage offered or provided by an

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[6] A new subsection, W. Va. Code §23-2C-15(g), provides that the transfer of a policyholder between insurance companies within the same group is not considered a cancellation or refusal to renew a workers' compensation insurance policy for purposes of §23-2C-15(e) & (f). To the extent a transfer results in a renewal, however, the Commissioner must be notified accordingly. *See* W. Va. Code §23-2C-15(f)(2).

[7] Since the carrier's report of the issuance or renewal of a policy includes the expiration date for that policy, no separate proof-of-coverage reporting is required in situations in which a carrier declines to renew or a policy simply expires because the insured elects not to accept the carrier's offer to renew. Because the OIC's system notes the expiration date at the time an issuance or renewal is initially reported, the OIC can be sure that a timely new issuance or renewal of the expired policy is received or, if not, that regulatory action against the insured is taken.

[8] HB 4636 also provides that these notifications must be "on forms or in a manner prescribed by the Insurance Commissioner." *See* W. Va. Code §23-2C-15(f). The OIC website contains instructions regarding these notifications.

[9] The definition of TPA is limited to activities connected to "life, annuities and accident and sickness coverage offered or provided by an insurer …" W. Va. Code §33-46-2(a).

[10] There is no rule covering TPAs licensed under W. Va. Code §33-46-12.

insurer[11]" be fully subject to the general TPA act in the Insurance Code. The result is to place self-insured employers and carriers in the same position; both must now use only TPAs licensed pursuant to the TPA Act.

The TPA provisions of HB 4636 have been in effect since March 8, 2008. Those TPAs retained by self-insured employers as of the date of this informational letter under the "qualification" provisions of W. Va. Code §23-2-9(i) (which was *not* amended by HB 4636) will be considered to be "licensed" for purposes of the new law until June 30, 2008. In order to act as a TPA beyond that date, these TPAs must complete the license application (available on the OIC website) and obtain a license by July 1, 2008.

HB 4636 also mandates that the Insurance Commissioner propose legislative exempt rules for adoption by the Industrial Council "to regulate the use of [TPAs]" by both carriers and self-insured employers. W. Va. Code §23-2C-17(c). Accordingly, the Insurance Commissioner intends to propose a new rule to make the requirements for workers' compensation TPAs uniform as they apply to both carriers and self-insured employers.

CLAIMS LITIGATION

CORRECTED ORDERS -- W. VA. CODE §23-5-1(d) -- Under the law as it existed prior to HB 4636, a claimant who protested a decision of a self-insured employer or carrier (or a TPA) could conceivably lose his or her right to contest that order if a "corrected order" was filed subsequent to the protest and the issuing entity later moved to dismiss the protest on the grounds that (1) the protest to the initial order was moot because the order protested had been replaced by the "corrected" order, and (2) the period in which to protest the corrected order had expired. HB 4636 changes this subsection to ensure that this does not occur by expressly providing that the initial protest will continue to act as a protest to the corrected order unless and until the Office of Judges (OOJ) issues an order stating that the changes made by the corrected order are such that the reason for the protest no longer exists.

Under prior law, an amended or corrected order could be issued for virtually any reason under the rubric of "otherwise not supported by the evidence," which led to a concern that benefit decisions effectively remained open for new evidence to be developed and thus subject to being "corrected" up to two years following the decision. HB 4636 qualifies the broad "otherwise not supported by the evidence" as a basis for an amended order so that it applies *only* when the initial order denied benefits.

TWO-PARTY SYSTEM -- W. VA. CODE §23-5-1(a) -- Under the old monopolistic system, claims invariably involved three parties, each of which had a different interest in a claim. The Workers' Compensation Commission (WCC) acted as the regulator as well as the insurance carrier; as regulator, it had to ensure that the statutory goals were being met, while as the carrier it had to protect what was then a state fund used to pay benefits. The employer usually had an interest in obtaining a favorable claims experience, and the claimant of course had an interest in maximizing benefits. These usually divergent interests might sometimes change so that, for instance, an employer might wish to see one of its employees paid benefits, while the WCC might rule the claim noncompensable. This practice of allowing the employer to file a protest to a decision by the carrier (WCC and, more recently, BrickStreet) with the OOJ was permitted by W. Va. Code §23-5-1(b), which spoke of decisions by carriers and self-insured employers being

[11] As used in article 2C, "insurer" includes both self-insured employers as well as private carriers. *See* W. Va. Code §23-2C-2(g).

final unless objected to by the "employee, employer, claimant or dependent." HB 4636 struck this language, and the statute now limits protests of carrier decisions to claimants and their dependents only. *See* W. Va. Code §23-5-1(a).[12] Moreover, whenever an employer has compensation coverage on the date of the injury or last exposure, the carrier is expressly given sole authority to litigate the employer's position.[13]

BROCHURE TO CLAIMANTS -- W. VA. CODE §23-5-1(a) -- In an attempt to educate claimants about the claims process at the earliest possible point, HB 4636 mandates that the initial decision maker – the Insurance Commissioner on Old Fund claims, carriers and self-insured employers (or the TPAs for any of these three) – send the claimant a brochure outlining the claims process and the benefits available to injured workers. Although the requirement of the use of a brochure has been in effect since March 8, self-insured employers and TPAs that have failed to include the brochure may comply by including a brochure in a subsequent communication with any claimant who has received an initial claims decision dated March 8 or later.

The brochure currently being used by the Insurance Commissioner, which can be found on OIC's website at www.wvinsurance.gov/brochures/brochures.htm, may be adapted for immediate use. Brochures that are based on OIC's form are deemed approved.

SIXTY-DAY PROTEST PERIOD -- W. VA. CODE §23-5-1(b)(1) -- Decisions by carriers (including the Insurance Commissioner), self-insured employers and their TPAs have been subject to a 30-day protest period; as a jurisdictional limit, failure to timely file barred any protests to the decision. In an effort to afford claimants more time to settle their claim and thus possibly avoid litigation, this period has been extended by HB 4636 to 60 days.[14] This new time period applies to any decision by a carrier or self-insured employer dated on or after the effective date of the bill. Therefore, the Commissioner is requiring that corrected decisions be sent to all claimants who have received a protestable decision dated March 8, 2008 or later that incorrectly referenced a 30-day protest period.

CONDITIONAL PAYMENTS OF BENEFITS -- W. VA. CODE §23-5-1(b)(2)(A) -- A claimant is often faced with the decision as to whether an injury should be filed as a new claim or as a reopening of an earlier claim. Once filed, the self-insured employer or carrier may seek to demonstrate that another person is responsible for the injury, and the ensuing litigation focuses

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[12] There remain three distinct and somewhat anomalous situations in which an employer protest will continue to be permitted: (1) Decisions "setting forth the findings of the [OP] Board" pursuant to W. Va. Code §23-4-6a; (2) decisions by the Insurance Commissioner (or its TPA) as administrator of Old Fund and other funds created in article 2C; and (3) PPD awards "based on the recommendation" of the treating physician entered pursuant to W. Va. Code §23-4-7a(c)(1). In the first and third situations, the "decisions" or "orders" from which an employer appeal is still permitted are not actually "decisions" *of the carrier* but, rather, recommendations of, respectively, the OP Board or the treating physician that the statute mandates be accepted as decisions of the carrier.

[13] These amendments establishing a two-party system do not affect OOJ's procedural rules that require that the employer be named as a party in claims. *See, e.g.*, 93 CSR 1-3.2 (effective Sept. 1, 2005). The OOJ has proposed amendment of these rules. See the OOJ's website at http://www.wvinsurance.gov/ooj/rules/newruleshearings.htm for the status of the proposed change to 93 CSR 1.

[14] This amendment relates to the period of time applicable to protests of decision to the Office of Judges only. It does not apply to appeals of OOJ decisions to the Board of Review or appeals of Board of Review decisions to the Supreme Court of Appeals.

not on whether the injury should be compensated but, rather, by whom. As this disagreement is being litigated, the claimant may not be compensated until the proper party to be charged is determined. HB 4636 attempts to ameliorate such a situation by mandating that, whenever the *only* controversy relating to compensability is whether the claim should have been filed as a new claim or as a reopening of a prior claim, the party against whom the claim or petition was initially filed must make conditional payments of benefits while the litigation proceeds. In such a case, the party against whom the protested claim or petition was filed must also inform the OOJ of the identifiable person whom it believes should be properly charged, and the OOJ must in turn join that party to the litigation. The OOJ may at any time order that another party assume the payments. Upon a final determination as to chargeability, the OOJ must order that the chargeable party reimburse any other parties as necessary. The fact that conditional payments had been made under this subsection may not be used as evidence to prove a party's liability for the claim.[15]

TOLLING -- W. VA. CODE §23-5-1(b)(2)(C) -- HB 4636 expressly authorizes the OOJ to re-designate a new application for benefits as a reopening petition or vice versa, with the re-designated filing to relate back to the date of the original filing. Similarly, if the claimant files with the wrong carrier or self-insured employer, the OOJ may substitute the proper party, and the re-designated application or petition will also relate back to the date of the incorrect filing. The OOJ intends to adopt changes to its procedural rules reflecting this statutory amendment. *See* note 13.

EFFECTIVE DATES -- Both the conditional-payments and tolling provisions apply only with respect to applications for benefits, including petitions to reopen, that are filed on or after July 1, 2008.

DEFAULTING EMPLOYERS

HB 4636 provides additional remedies against companies in "employer default" for nonpayment of premiums, surcharges or benefits. The general code section on government contracts adds these defaulting employers to the list of persons who are subject to "debarment" or ineligibility to apply for or be awarded state contracts. *See* W. Va. Code §5A-3-10a. Similarly, self-insured employers whose self-insured status has been terminated (voluntarily or otherwise) but who owe assessments or surcharges to the State or who owe "any payment required to be made as benefits … to injured employees" would also be subject to debarment and to the license revocation process to which other defaulting employers are subject pursuant to W. Va. Code §23-2C-9(d)(3). *See* W. Va. Code §23-2-9a.

MISCELLANEOUS PROVISIONS

CARRIERS' OFFICES IN STATE -- HB 4636 removed language that every private carrier have an adjuster with a "business address and telephone number in this State … ." A permanent physical presence of an adjuster in West Virginia is not required under the statutes.[16]

[15] The amendment regarding conditional payments contains no express penalties or other remedies. The OOJ, however, is considering adopting changes to its procedural rules that would permit a final decision on the conditional payment of benefits resolution to be appealed to the Board of Review. *See* note 13. Compliance with any order of the OOJ is required unless an order staying the payment of benefits is granted by the ALJ or Board of Review pursuant to 85 CSR 1.

[16] In a related change in another bill enacted in 2008, HB 4318, the definition of "private carrier" in W. Va. Code §23-2-2(n) was amended to remove the requirement that every such carrier had to "maintain an office in the state."

INFORMATION ON OFFICERS -- W. VA. CODE §23-2C-15(c) -- HB 4636 deleted the requirement that every private carrier had an ongoing obligation to provide information to the Insurance Commissioner related to officers, directors and ten percent or more owners of each carrier's policyholders.

RETURN TO WORK -- W. VA. CODE §23-4-7b -- As it existed prior to HB 4636, W. Va. Code §23-4-7b contained provisions for trial return-to-work programs; these provisions, however, sunsetted in 2007. HB 4636 revives the concept by directing that the Insurance Commissioner propose legislative exempt rules re-establishing a trial return to work program. The bill also provides that the program must be optional with the employer and must allow for the suspension of TTD benefits during any trial return to work.

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