Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Commerce & Labor Committee

SSB 5789

Brief Description: Expanding the role of self-insurers in the workers' compensation system.

Sponsors: Senate Committee on Labor, Commerce, Research & Development (originally sponsored by Senators Prentice and Parlette).

Brief Summary of Substitute Bill

- Expands the authority of self-insured employers to cover the powers and duties necessary to adjudicate most aspects of the industrial injury claims of their injured workers.

Hearing Date: 3/23/05

Staff: Chris Cordes (786-7103).

Background:

Industrial insurance is a no-fault state workers' compensation program that provides medical and partial wage replacement benefits to covered workers who are injured on the job or who develop an occupational disease. Employers must insure with the state fund operated by the Department of Labor and Industries (Department) or, if qualified, may self-insure.

To self-insure, the employer must meet the following criteria:
- be in business for 3 years;
- have net worth of at least $5 million;
- meet a specified surety requirement;
- have an approved, effective safety/accident prevention program; and
- have sufficient financial ability to make certain the prompt payment of all compensation to its injured workers.

Group self-insurance is also permitted for school districts and educational service districts, and hospitals (one group for public hospitals, one group for other hospitals).

Self-insurers must provide their injured workers with the same benefits that are provided to injured workers in state fund claims, including medical and partial wage replacement benefits, permanent partial and total disability benefits, and death benefits. Self-insurers manage many aspects of their injured worker claims including:
- paying time loss benefits directly to their injured workers and reporting these payments to the department;

- scheduling medical appointments required by the employer, referring injured workers to vocational rehabilitation counselors, and closing certain undisputed claims; and
- determining and paying permanent partial disability benefits if the claimant has returned to work with the employer. In other claims, the Department determines permanent disability benefits and closes the claim.

For other aspects of self-insured claims, the Department must make determinations and issue orders, such as orders allowing or denying a claim. The Department also pays pension benefits to self-insured injured workers, and the self-insurer pays the pension reserve for these costs. The Director of the Department (Director) has authority to intervene on his or her own initiative in disputes and enter orders to promptly determine the matter and protect the rights of all parties.

Self-insurers pay certain assessments to the Department to cover the Department's administrative costs of regulating self-insurance and for an insolvency trust fund that covers the costs of self-insured employers who become unable to meet their workers' compensation obligations.

Self-insurers are subject to decertification or corrective action for failing to meet financial requirements or for various prohibited actions against employees. If a self-insurer unreasonably delays or refuses to pay benefits when due, the Director may order the self-insurer to pay an additional penalty of $500 or 25 percent of the amount due, which is paid to the worker with the benefits that were due.

Summary of Bill:

Self-insurers are vested with the powers and duties necessary to adjudicate most aspects of the industrial insurance claims of their injured workers without prior approval of the Department of Labor and Industries (Department). With specified exceptions, these powers and duties are the same as those vested in the Department with respect to state fund claims.

Claim Applications

On receiving a notice of accident, the self-insurer must immediately forward a notice of rights to the worker or beneficiary. The self-insurer is no longer required to send a copy of the application to the Department. Self-insurers must, however, submit to the Department monthly reports on claims filed or closed during the previous month.

In self-insured cases, statutory notices from physicians regarding a claimant's occupational disease are filed with the self-insurer instead of the Department. An application for reopening a self-insured claim because of aggravation of the injury or for an increase of compensation due to change of circumstances is made to the self-insurer instead of the Department.

The self-insurer is required to allow or deny a claim within 60 days of claim filing, unless the time period is extended to 90 days for good cause. The claim is deemed allowed if not denied within that time period.

As part of their administrative assessment, self-insurers must pay their proportionate cost of an ombudsperson contracted by the Department. The ombudsperson must advocate on behalf of the injured worker and may inspect injured workers' claim files when rendering assistance to the worker.

Medical and Vocational Rehabilitation Benefits

Like the Department, a self-insurer may recommend particular health care services and providers if specialized treatment is indicated or if cost-effective rates are obtained by the self-insurer. A self-insurer may select the physician that will perform a medical examination required by the self-insurer.

A self-insurer may, in its sole discretion:

- determine whether to continue medical benefits as permitted by statute, and issue an order providing or denying continued treatment;
- decide whether vocational rehabilitation is both necessary and likely to enable the injured worker to become employable at gainful employment, whether vocational rehabilitation benefits are to be authorized for a second 52-week period, and whether job modifications are to be authorized to enable the worker to participate in training or to perform the essential functions of the job; and
- determine whether residence or vehicle modifications are reasonable and necessary for workers who have sustained catastrophic injuries.

In each of these cases, the self-insurer must issue a written determination, which includes notice to the worker that the determination becomes final unless a written protest is filed with the Department within 15 days. This determination may not be appealed to the Board of Industrial Insurance Appeals, but if the worker protests the determination to the Department, the Department may issue an appealable determination on the matter.

A self-insurer is authorized to issue orders, with an explanation, denying claimants copies of their claim files when the self-insurer determines that it is not in the claimant's best interests.

A self-insurer is authorized to suspend, without Department approval, action on a worker's claim for not cooperating with medical treatment or vocational rehabilitation.

Compensation Benefits

A self-insurer is authorized to make permanent disability determinations on all claims, not just the claims in which the worker has returned to employment with the self-insurer. A self-insurer, rather than the Department, must approve any conversion of a monthly permanent partial disability award to a lump sum award depending on the merits of the application. The self-insurer is authorized to make a finding of eligibility for permanent total disability (pensions), but pension payments to the claimant continue to be made by the Department with the self-insurer responsible for paying the pension reserve fund according to statutory requirements.

A self-insurer, like the Department, may assess an overpayment of benefits because of adjudicator error when the payment order is not yet final. However, only the Department is permitted to determine when benefits have been induced by willful misrepresentation. A self-insurer may also waive overpayments.

A self-insurer, like the Department, may issue an order confirming the distribution of third party recoveries, file a warrant in court for the unpaid lien, and issue notices to withhold and deliver property for payments due to the self-insurer. A self-insurer may determine the compensation paid and estimated to be paid in the future for purposes of determining whether a compromise or settlement of a third party claim is void because it is less than the amount to which the claimant is entitled.

Audits

The claims processing practices of self-insurers are subject to audit under rules adopted by the Department. For an audit, the self-insurer must furnish, on forms approved by the Department, all information it has within 20 days of the Department's written request.

These audits must be conducted as necessary to determine compliance with the Industrial Insurance Act (Act), but will not disturb final orders issued in good faith. The Department's authority to require, within two years of claim closure, a self-insurer to correct benefits paid because of clerical error, mistake of identity, or innocent misrepresentation is limited. This authority exists until December 31, 2011, and may be invoked only after an audit determines the error.

Penalties

The penalty for unreasonable delay or refusal to pay benefits applies only before an order closing the claim becomes final by operation of law. Each day of failure to comply is a separate violation. These penalties may not be waived or reduced. Instead of being required to issue an order determining whether there was unreasonable delay or refusal to pay benefits within 30 days, the Department may require the self-insurer to submit a response within 20 days and issue the determinative order within 60 days of receiving the response. The Department's failure to issue a timely order requires issuance of an order denying the penalty. The Department may also summarily deny a request that is deemed frivolous on its face.

A self-insurer is subject to new civil penalties of up to $2,500 if an audit determines that the self-insurer:

- failed to pay benefits on a timely basis;
- paid benefits in an incorrect amount;
- failed to issue allowance or rejection orders on a timely basis; or
- failed to issue a closing order within 60 days after the attending physician finds the injured worker to be fixed and stable and the permanent disability level has been established

If these violations are intentionally and repeatedly committed, the Department may impose penalties of up to $25,000. However, claims processing errors and clerical errors not involving these violations are not subject to penalties. The Department must adopt a schedule of penalties that will take into account the severity and number of violations.

A self-insurer is subject to the following new penalties that are paid to the claimant:

(1) Level one violations are subject to a $500 penalty for:

- failing to comply with certain records requirements;
- inducing employees to fail to report injuries; or
- unauthorized obtaining or disclosing of claim file information.

(2) Level two violations are subject to a $1,000 penalty for:

- unreasonably or negligently failing to comply with certain records requirements;
- unreasonably or negligently inducing employees to fail to report injuries;
- willfully making it unreasonably necessary for a claimant to resort to proceedings; or
- unreasonably or negligently obtaining or making unauthorized disclosure of claim file information.

(3) Level three violations are subject to a $5,000 penalty for:

- willfully inducing employees to fail to report injuries when the failure results in the claim being denied under the statute of limitations;
- willfully inducing claimants to treat workplace injuries as off-the-job injuries; or
- willfully persuading claimants to accept less than the compensation due under this title.

The Department may not waive or reduce these new penalties or a penalty imposed on a self-insurer for violating a Department rule.

Additional grounds for withdrawal of a self-insurer's certification are established. It is grounds for withdrawal of certification if the self-insurer is penalized for:

- a level three violation;
- two or more level two violations within one year;
- three or more level three violations within one year; or
- violations that resulted in penalties of more than $25,000 within one year.

It unlawful for a self-insured employer to discharge or discriminate against an employee for making a complaint that could result in a penalty assessment against the employer. It is a violation for a self-insurer to obtain or disclose information unrelated to its injured worker's claim, or to obtain or disclose such information in violation of Department rules.

In an action to collect penalties, the court must award reasonable attorneys' fees and reasonable litigation costs to the prevailing plaintiff.

Disputes and Appeals

The Director's authority to intervene in all cases in which a dispute arises between a worker and an employer before the worker's condition becomes fixed is limited to state fund cases. The Director no longer has authority to intervene on his or her own initiative, or on receiving information from a claimant, in a dispute regarding payment of compensation or vocational rehabilitation benefits. Instead, in an allowed claim, the worker may request the Department to direct the self-insurer to issue an order regarding benefits. The Department may make inquiries as required and request information from the self-insurer which must be submitted with 10 working days. The Department may, in writing, direct the self-insurer to issue an order within 90 days or provide good cause for not doing so. If the self-insurer does not comply, the Department may, within 30 days, issue an order determining whether the worker was entitled to benefits and directing the self-insurer accordingly.

The Director must issue a subpoena on behalf of a self-insurer to compel attendance or production of documents in connection with a self-insured claim if the self-insurer demonstrates a reasonable basis for the subpoena.

Except for the special orders that are subject to protest only, if a worker or beneficiary requests reconsideration of or appeals a self-insurer order, the Department may review the order, or may direct further submission of evidence, as provided in the Act, and issue a subsequent appealable order. The self-insurer must submit the claim file to the Department.

The self-insurer must serve its orders on the parties in the same manner as the Department serves its orders. Except for the special orders that are subject to protest only, self-insurers' orders must be protested or appealed within 60 days under the same procedures that apply to Department

orders. If a self-insurer's order is protested to the Department, the Department must request the self-insurer's file and issue an order affirming, modifying, reversing, or remanding the order within 60 days, unless the period is extended for good cause for an additional 90 days. If not acted on timely, the self-insurer's order is deemed affirmed, subject to appeal. The Department must notify all parties of the date on which the self-insurer's order will be deemed affirmed if the Department fails to take timely action. If appealed, the Department may not direct the submission of further evidence.

Application

These provisions apply to pending claims and claims for which reopening applications are made or pending on or after January 1, 2007.

Rules Authority: The bill does not contain provisions addressing the rule-making powers of an agency.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect on January 1, 2007, except for sections 3, 19, 21, 23, 32, 36, 43, and 47, reinstating prior law related to health services providers after a scheduled expiration, which take effect June 30, 2007, and section 51, repealing authority providing for correction of benefits paid by self-insurers, which takes effect December 31, 2011.