FINAL BILL REPORT
E2SHB 3139

C 280 L 08
Synopsis as Enacted

Brief Description: Providing for stays of industrial insurance orders on appeal.

Sponsors: By House Committee on Appropriations (originally sponsored by Representatives Conway, Wood, Green, Moeller, Simpson and Ormsby).

House Committee on Commerce & Labor
House Committee on Appropriations
Senate Committee on Labor, Commerce, Research & Development

Background:

Under the Industrial Insurance Act (Act), employers must insure with the state fund managed by the Department of Labor and Industries (Department) or may self-insure if the employer meets certain criteria. The Act permits employers and workers on state fund and self-insured claims to contest orders regarding benefits. Aggrieved parties may appeal directly to the Board of Industrial Insurance Appeals (Board) or may first request reconsideration by the Department. When an appeal is filed, the Department transmits the record to the Board. If the Board does not deny the appeal or allow the relief requested based on the record, the appeal is granted and the appeal proceeds.

The Act allows the Department to adopt policies regarding payment of benefits pending appeal. The Department's written policy, which applies to employers insured with the state fund, states that time-loss benefits are not paid while an employer's appeal is pending unless the issue does not involve the payment of time-loss benefits or the allowance or reopening of the claim, or unless the employer's appeal is unfounded. The Department's policy states that it is intended to avoid unnecessary recoupment costs when an employer prevails. If benefits are not paid and the worker prevails, the worker is entitled to interest on the award.

The Act provides procedures for recovery of benefits overpaid because of clerical error, innocent misrepresentation, an erroneous adjudication as determined by a final decision of the Board or a court, and for other reasons. If benefits are overpaid, the recipient must repay the benefits, and recoupment may be made from future payments due to the recipient on any claim with the state fund or self-insurer, as applicable. Recipients of benefits include workers and health service providers. Under some circumstances, the Director of the Department may waive all or part of the overpayments. If an order assessing an overpayment becomes final, the Department or self-insurer may obtain a warrant in superior court.

Summary:

Payment of Benefits Pending Appeal.

An order awarding industrial insurance benefits becomes effective and benefits due when the order is issued. Benefits are generally paid pending appeal unless the Board orders a stay or the worker requests that benefits cease. When the Board issues an order granting an appeal, it must notify the worker of the potential for an overpayment and the requirements for interest on unpaid benefits. The worker may request that benefits cease pending appeal by submitting written notice to the employer, the Board, and the Department.

In certain types of appeals, payment of some benefits is stayed without further action by the Board. If the Department orders an increase in a permanent partial disability award upon reconsideration, the worker receives the amount reflected in the earlier order. If a party appeals an order establishing a worker's wages or the compensation rate for purposes of temporary or permanent total disability or loss of earning power benefits, the worker receives payment based on the wage or rate not in dispute. In these cases, payment of an increased award, or at a higher wage or rate, is stayed without further action by the Board pending a final decision on the merits.

Motions to Stay Orders Awarding Benefits.
Procedures are established for motions to stay. A motion for a stay must be filed within 15 days of an order granting an appeal. The Board must conduct an expedited review of the claim file as it existed on the date of the Department order. Within 25 days of the filing of the motion or the order granting appeal, whichever is later, the Board must issue a decision on the stay motion. The Board must grant a motion to stay if the person seeking the stay demonstrates that it is more likely than not to prevail on the facts as they existed at the time of the order. The Board must not consider the likelihood of recoupment of benefits as a basis to grant or deny a stay.

Recoupment From Other Claims.
Recoupment of overpayments resulting from an erroneous adjudication may be made from any claim, whether state fund or self-insured. The Department must collect information concerning self-insured claim overpayments and recoup the overpayments from any state fund or self-insurer claims. The Department may also provide overpayment information to a self-insurer from whom payments may be collected on behalf of the Department or another self-insurer. If overpayments are collected in these cases, the self-insurer must pay the Department, and the Department must credit the amounts to the appropriate state funds or forward the amounts to the other self-insurer.

Overpayment Fund Reimbursement.
A self-insured employer overpayment reimbursement fund is created to reimburse the reserve fund (for certain amounts paid by the Department on self-insured claims pending appeal) and self-insured employers for benefits overpaid and not recovered. The Director of the Department (Director) must determine an amount to be retained from self-insured employee earnings for deposit into the fund. The moneys collected must be no more than necessary to make the payments on a current basis. A self-insurer must be reimbursed from the fund for any overpayments the Director waives and for any amounts not fully reimbursed within 24 months of the first attempt at recovery through collection from other claims and through court action.

Overpayments to Health Service Providers.
Health service providers who provided treatment or services to a worker are not considered recipients of benefits from whom the Department or a self-insurer may recover overpayments as a result of an erroneous adjudication. The Department or self-insurer must first attempt recovery of overpayments from any entity that provided health insurance to the extent that entity would have provided health insurance benefits but for workers' compensation coverage.

Study.
The Department is directed to study appeals of workers' compensation cases and collect information on the impacts of the legislation on state fund and self-insured workers and employers. The study must consider the types of benefits that may be paid pending an appeal and must include the frequency and outcomes of appeals, the duration of appeals and any procedural or process changes made by the Board to implement the legislation and expedite the process, the number of and amount of overpayments resulting from decisions of the Board or court, and the processes used and efforts made to recoup overpayments and the results of those efforts.

A report on preliminary results of the study is due to the Workers' Compensation Advisory Committee (Committee) by July 1, 2009. By December 1, 2009, and December 1, 2010, with the final report due by December 1, 2011, the Department must report to the Committee and the appropriate committees of the Legislature on the results of the study. The Committee must provide its recommendations for addressing overpayments, including the need for and ability to fund a permanent method to reimburse self-insured employer and state fund overpayment costs.

The legislation applies to orders issued after the effective date of the act.

Votes on Final Passage:

House	62	32	
Senate	49	0	(Senate amended)
House			(House refused to concur)

Conference Committee

Senate	35	14	
House	62	35	

Effective: June 12, 2008
January 1, 2009 (Section 2)