HOUSE BILL REPORT
ESHB 1487

As Passed House:
March 5, 2011

Title: An act relating to claims management by retrospective rating plan employers and groups.

Brief Description: Concerning claims management by retrospective rating plan employers and groups.

Sponsors: House Committee on Labor & Workforce Development (originally sponsored by Representatives Springer and Condotta).

Brief History:
Committee Activity:
Labor & Workforce Development: 2/8/11, 2/16/11 [DPS].
Floor Activity:
Passed House: 3/5/11, 70-27.

Brief Summary of Engrossed Substitute Bill

- Gives retrospective rating employers and groups who administer their plans with an approved claims administrator authority to schedule medical examinations and vocational assessments and close certain claims.

HOUSE COMMITTEE ON LABOR & WORKFORCE DEVELOPMENT

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 10 members: Representatives Sells, Chair; Condotta, Ranking Minority Member; Shea, Assistant Ranking Minority Member; Fagan, Green, Miloscia, Moeller, Roberts, Taylor and Warnick.

Minority Report: Do not pass. Signed by 3 members: Representatives Reykdal, Vice Chair; Kenney and Ormsby.

Staff: Joan Elgee (786-7106).

Background:

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Under the state's industrial insurance laws, employers must either insure through the State Fund administered by the Department of Labor and Industries (Department) or, if qualified, may self-insure. For State Fund employers, participation in a retrospective rating (retro) plan is available for employers or group of employers that meet specified requirements. Participation in retro allows an employer or a group of employers to assume a portion of industrial insurance risk and receive premium refunds or be assessed additional premiums based on claim losses. Retro is designed to reward employers that are able to keep claim costs below a preselected level as a result of improvements in workplace safety and injured worker outcomes.

Injured workers must submit to an independent medical examination (IME) when requested by the Department or self-insured employer. An IME may be used to establish a diagnosis, outline a treatment program, evaluate a worker's restrictions, and for other matters relating to a worker's claim. The Department maintains a list of examiners qualified to conduct examinations. A worker who unreasonably refuses to submit to or obstructs an IME may have his or her benefits suspended.

Vocational rehabilitation services are available to an injured worker when these services are necessary and likely to enable the injured worker to become employable at gainful employment. After an assessment and determination of eligibility for services, a vocational rehabilitation plan is developed.

Self-insured employers process and manage claims of their injured workers. A self-insurer may schedule IMEs and assessments for vocational rehabilitation. A self-insurer may also issue an order closing certain types of claims.

Direct practice is a type of primary health care in which providers enter agreements with patients to provide primary care services for a monthly fee. State law regulates direct practice.

Summary of Engrossed Substitute Bill:

Claims Management Authority.
Retro employers and groups who administer their plans with an approved claims administrator may assist the Department in the processing of claims when approved by the Department. The Department retains the final authority for claims decisions. Retro employers and groups may:

Schedule Medical Examinations and Consultations.
Retro employers and groups may schedule an IME when the claim file includes medical reports indicating that an examination may be necessary to establish a diagnosis, outline a treatment program, evaluate what conditions are related to the industrial injury or disease, determine whether an injury or disease has aggravated a preexisting condition, establish an impairment rating, evaluate whether the injury or disease has worsened, or evaluate the worker's mental or physical restrictions as well as the worker's ability to work. Examiners and consultants must be on the Department's approved list. No more than two IMEs on a claim may be scheduled within any 24-month period. Results must be sent to the Department.

The Department must enforce penalties on a worker for refusals to submit to or obstruction of an IME.

Schedule Vocational Assessments.
Providers must be on the Department's qualified provider list. Providers may be selected based on Department quality or performance indicators and based on industry experience. Assessments must be sent to the Department.

Close Certain Claims.
Claims closure authority is limited to claims that:
- involve only medical treatment and/or the payment of time-loss for 30 days or less;
- do not involve permanent disability; and
- concern a worker who has returned to work with the employer or employer of the group at the worker's previous job or a job with at least 95 percent of the worker's wages as determined for industrial insurance purposes at the time of injury.

The retro employer or group must send the worker a notice developed by the Department describing the worker's rights.

If a dispute arises from the retro group or employer's exercise of authority, the worker, employer, or group may request the Department to intervene. When exercising any claims processing authority, the employer or group must inform a worker in writing that the worker may request the Department to intervene at any time.

The Department must require the retro employer or group to notify the Department before exercising any authority. The Department is given rule-making authority. Rules must minimize the Department's need to respond, and ensure that any delay in response by the Department does not impede the timely administration of the claim. Charges incurred by the retro employer or group for IMEs or vocational rehabilitation assessments are charged against the claim.

To qualify as an "approved claims administrator," a person must meet Department qualifications to manage claims. Claims managers employed by an approved claims administrator must pass a certification test approved or provided by the Department. The Department may audit or review the group or employer's claims management process. If the Director of the Department determines that a claims manager is not following proper industrial insurance claims procedures, the Director must take corrective action against the retro employer or group. Corrective actions may include:
- a probationary period of time for the claims manager;
- additional mandatory training; and
- monitoring of the activity of the retro employer or group to determine progress towards compliance.

The retro employer or group may appeal the corrective action to the Board of Industrial Insurance Appeals. If compliance is attained, no further action may be taken. If compliance is not attained, the Director may take additional corrective action, including the removal of the authority to assist with claims processing. The withdrawal of approval does not otherwise affect the administrator's status or the retro employer or group's status in the retro program.

The claims management provision expires July 1, 2016. The Joint Legislative Audit and Review Committee must conduct a study of the impact of the claims management authority on the workers' compensation system, including the impact on retro performance and refunds, the Department's processes, and worker outcomes and satisfaction, and submit the study to the appropriate committees of the Legislature by July 1, 2015.

Direct Practice.
Payment by an employer for direct primary care services does not disqualify an employer from participating in retro, a group sponsor from promoting a retro plan, or a plan administrator from administering a retro plan. The Department may adopt rules requiring a direct practice to provide information so the Department may establish refunds and assessments. Any billing rule requiring a provider to bill for services does not apply to a direct practice.

Medical Provider Communications.
When a retro employer or group or its representative communicates with a medical provider, the employer must provide the worker and send to the claim file a copy of any written communication received and a memorandum of any oral communication. These must be provided within 72 hours of receiving the information. The information must be provided regardless of the source and any claim of privilege or work product.

Records.
A retro employer or group must maintain complete records of claims. Under conditions and procedures established by the Director of the Department, the records may be maintained by service companies or at an out-of-state location. The retro employer or group must make the records available to the Department, worker or beneficiary, or their representative, within five business days of a request and at a requested location within the state. The retro employer or group bears the expense.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) This bill provides a way for uncomplicated claims to be adjudicated quickly to help meet the goal of getting workers back on the job as fast as possible. There are lots of sideboards; for example, the claims cannot involve permanent disability. This bill will help thousands of small employers cut their workers' compensation costs while maintaining benefits. Department claims manager caseloads are two to three times the national average. Giving some authority to retro groups and employers will reduce the burden on Department staff and allow them to focus on the long-term claims which are the cause of dissatisfaction and costs. There is a 64-day delay from the time an IME is deemed necessary to the time it is scheduled. Employers have better access to worker schedules and the burden on the

Department will be reduced by qualified persons setting appointments. The pool of money for retro has been reduced by nearly half; this bill will help make retro work better and reduce the 284 average days workers spend on disability.

Some tweaks are needed. The return to work wage should be at 95 percent of the customary wage because workers could be released to a different employer.

(With concerns) The purpose of retro is to reward employers for improved safety and improve worker outcomes. This bill is about claims management, which is the responsibility of the Department. The authority is similar to what self-insured employers do but self-insured employers remain responsible for the claim while a retro employer and group's concern is with three years. Some of the claims will be contentious and after three years, the Department will have to administer the claim.

(Opposed) This bill is a dangerous step towards privatization. It would be like the fox guarding the henhouse because claims managers represent the employer. There is no duty of good faith or monetary penalties for abuse. It would cause unnecessary delay, with two claim managers, and make things more complicated for workers.

Persons Testifying: (In support) Representative Springer, prime sponsor; Jan Gee, Washington Food Industry Association; Lauren Gubbe, Association of General Contractors; Trish Leimbach, Vigilant; John Meier, Employer Resources; Tammie Hetrick, Washington Retail Association; and Kris Tefft, Washington Association of Business.

(With concerns) Vickie Kennedy, Department of Labor and Industries.

(Opposed) David Lauman, Washington State Association for Justice.

Persons Signed In To Testify But Not Testifying: None.