HOUSE BILL REPORT
HB 2431

As Reported by House Committee On:
Labor & Workforce Development

Title: An act relating to claim files and compensation under the industrial insurance laws.

Brief Description: Addressing claim files and compensation under the industrial insurance laws.

Sponsors: Representatives Reykdal, Appleton, Ladenburg, Green, Ormsby, Moeller and Kenney.

Brief History:
Committee Activity:
Labor & Workforce Development: 1/17/12, 1/30/12 [DPS].

Brief Summary of Substitute Bill

- Requires self-insured employers, when issuing payments to workers, to provide notice of the type of benefit and other information, and provides a penalty for failure to comply.
- Requires surveillance or other investigation information to be provided immediately to a worker under certain conditions.
- Requires employer communications with workers' treating medical providers to be provided to workers.
- Requires the Department of Labor and Industries to make a permanent disability determination within 60 days of a worker's request.
- Requires overpayment orders to include information about the overpayment.
- Requires payment of attorney's fees and costs when the Board of Industrial Insurance Appeals reverses a denial of the reopening of a claim settled with a structured settlement agreement.
- Defines "claim file" to include electronic information, phone logs, and other information.

HOUSE COMMITTEE ON LABOR & WORKFORCE DEVELOPMENT

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.

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 8 members: Representatives Sells, Chair; Reykdal, Vice Chair; Green, Kenney, Miloscia, Moeller, Ormsby and Roberts.

Minority Report: Do not pass. Signed by 5 members: Representatives Condotta, Ranking Minority Member; Shea, Assistant Ranking Minority Member; Fagan, Taylor and Warnick.

Staff: Joan Elgee (786-7106).

Background:

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. Depending on the injury, workers injured in the course of employment receive medical benefits, temporary time-loss benefits including loss of earning power benefits, and vocational rehabilitation benefits, as well as benefits for permanent disabilities.

Self-insurers manage some aspects of injured worker claims, including closing certain types of claims. Self-insurers must maintain records of all payments of compensation and provide to the Director of the Department all information the self-insurer has relating to a disputed claim.

If a worker's representative (e.g., attorney) or the worker requests, the Department or self-insurer must provide a copy of the claim file to the worker. The Department or self-insurer may deny the request of a worker if release is not in the worker's best interests.

Certain payments by the Department or self-insurer may result in an overpayment order. For example, if benefits are paid because of a clerical order, the worker must repay the benefits and recoupment may be made from future benefits.

A worker or attorney may ask the Department or Board of Industrial Insurance Appeals (Board) to fix the attorney's fee under specified circumstances. For claim resolution structured settlement agreements, attorney's fees are limited to 15 percent of the total amount to be paid to the worker.

Summary of Substitute Bill:

Self-Insurer Payments and Records. When issuing a payment to a worker, a self-insurer must simultaneously provide written notice of the type of benefit or other purpose of the payment. For temporary time-loss payments, the notice must also state the time period the payment covers, the daily rate of payment, and the Department claim number. For payments of temporary partial time-loss (loss of earning power benefits), the notice must indicate the full manner in which the payment was calculated. Notice must also be given of any change in the rate of benefits or the value of the worker's earning power and the reason for the change. A self-insurer's failure to comply with the notice requirements subjects the self-insurer to a

penalty not to exceed $500. Within 30 days of a request by a worker, the Director of the Department must issue an order determining whether a violation occurred.

The self-insurer's duty to maintain records is modified to include payments to medical providers and other persons. A self-insurer must also keep a record of all requests for payments.

In the event of a disputed claim, or an audit or request by the Department, the self-insurer must provide the requested element of worker's claim file to the Department within 15 days.

Investigations. When the Department, employer, or employer's representative conducts, or a third-party administrator or claims management entity initiates surveillance or other investigation, investigation materials and reports become part of the claim file. Investigation materials and reports must be immediately provided to the worker: (1) if information obtained is used for any claims management decision; (2) 10 days before review of the information by a medical or vocational professional; or (3) if the investigation is closed.

Medical Information. If an employer, third-party administrator, or claims management entity communicates with a worker's current or former treating medical provider:

- Copies of written communications to a provider must be sent simultaneously to the claimant.
- Copies of reports or other writings received from the provider must be sent to the claimant within five days of receipt.
- Thirty days or more after a claim has been filed, the employer must give the claimant at least 14 days notice before a scheduled conversation or meeting, and a memorandum of the conversation or meeting must be sent to the claimant within five days, regardless of the source, any claim of privilege, or attorney work product. If the employer is legitimately offering stay-at-work employment, the 14 days notice requirement does not apply and notice must be provided to the worker contemporaneously with the scheduling of the meeting or conversation.

Permanent Disability Determination if an Injured Worker Requests the Department to Issue an Order. After an injured worker's condition becomes fixed, the Department must issue an order within 60 days of receipt of the worker's request for the Department to issue a permanent disability determination. If a self-insurer requests a disability determination, the self-insurer must submit the claim file with the request. If an injured worker makes the request, the self-insured employer must submit the claim file to the Department within 15 working days of receiving notice of the request.

Overpayments. An order assessing an overpayment must itemize each overpayment, including the manner in which the overpayment will be calculated. If the information is not identified in the order, any subsequent overpayment is deemed waived. The provision does not apply to social security overpayments.

Attorney's Fees and Costs. If the Board reverses or modifies a decision of the Department denying the reopening of a claim previously resolved with a structured settlement agreement and the relief sought by the claimant is fully or partially awarded, the Board must fix a reasonable attorney's fee, and order reimbursement for all reasonable costs of litigation,

including fees of medical and other witnesses. The amounts set are paid by the self-insurer, or the Department, as appropriate.

Definitions. A "claim file" is defined as all documents and information regarding the claim or claimant under the control of the Department, self-insurer or representative, third-party administrator, or claims management entity and includes but is not limited to electronic information, medical treatment records, phone logs, and other specified information. A "third-party administrator" is an entity that contracts to administer claims for self-insured employers. A "claims management entity" is an individual designated by a self-insured employer to administer claims, including self-administered organizations and third-party administrators.

The provisions apply to all claims open after January 1, 2013.

Substitute Bill Compared to Original Bill:

The substitute bill:

- deletes a requirement that surveillance or other investigation information be provided to a worker when no investigatory activity has taken place for 30 days;
- provides that the claim file information a self-insured employer must provide to the Department under certain circumstances is the requested elements of the claim file;
- provides that the requirement for employers to provide advance notice to workers of meetings and conversations with medical providers does not apply until 30 days or more after the claim is filed; provides that the 14-day notice requirement of meetings and conversations does not apply when the employer is legitimately offering stay-at-work employment, in which case notice must be provided contemporaneous with the scheduling; and clarifies references to meetings and conversations;
- changes the requirement that information on overpayments be provided to workers to apply to overpayment orders, rather than orders that may result in overpayment, and deletes reference to recoupment;
- deletes the requirement to pay attorney's fees and costs for medical matters not part of a structured settlement agreement (retains the requirement to pay attorney's fees and costs for reversals of denials of a reopening following a structured settlement agreement); and clarifies that for State Fund cases, fees and costs must be paid out of appropriate funds (rather than "the administrative fund"); and
- deletes medical billing records from the definition of "claim file" and clarifies the definition.

Appropriation: None.

Fiscal Note: Requested on January 13, 2012.

Effective Date of Substitute Bill: 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 is about transparency, basic fairness, and the integrity of the injured worker safety net. Being able to see how benefits are calculated will help workers understand benefits and identify mistakes. Workers are being spied upon in their homes by third party administrators. Workers deserve respect. What is in the claim file needs to be clarified.

Last year's bill allowed continued medical benefits with a structured settlement agreement. However, it is unclear how a worker is to get medical benefits. If the Department or employer disputes the reopening, how will workers pay for needed experts before the Board? There are no benefits from which an attorney could be paid so effectively further medical benefits will be denied.

(Opposed.) This bill is complex and may cause delays. The bill will cause administrative difficulties by focusing on deadlines rather than claims management. Defining "claim file" may be helpful but the definition is too broad. The bill makes self-insured employers submit the entire claim file if there is a dispute but the Department may not want all of the claim file. The 14-day notice requirement before conversations with medical providers conflicts with the Stay at Work program and with occupational best practices.

This bill will make discovery of fraud more difficult. Knowledge of an investigation defeats the purpose. Public disclosure laws exempt investigatory information. The Department may want to keep an investigation open longer than 30 days.

The bill changes the balance in litigation between the self-insured employer and the worker. It makes discovery by the worker's attorney unnecessary. Some items are work-product.

Persons Testifying: (In support) Representative Reykdal, prime sponsor; Nicole Grant, Certified Electrical Workers of Washington; Rebecca Johnson, Washington State Labor Council; Cody Arledge, United Food and Commercial Workers Local 21; Kathy Comfort, Washington Association of Justice; Craig Soucy, Washington State Council of Fire Fighters; and Sean O'Sullivan, Western Pulp and Paper Workers.

(Opposed) Kathleen Collins, Washington Self Insurers Association; Alan Gruse; and Vickie Kennedy, Department of Labor and Industries.

Persons Signed In To Testify But Not Testifying: None.