WEST VIRGINIA
SECRETARY OF STATE
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ADMINISTRATIVE LAW DIVISION

Form #5

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OFFICE WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF AGENCY ADOPTION OF A PROCEDURAL OR INTERPRETIVE RULE
OR A LEGISLATIVE RULE EXEMPT FROM LEGISLATIVE REVIEW

AGENCY: Insurance Commissioner (Workers' Compensation Rules) TITLE NUMBER: 85

CITE AUTHORITY WV Code §§23-2C-5(c)(2); 23-2C-22; 33-2-10(b) & 33-2-20(a)

RULE TYPE: PROCEDURAL _____ INTERPRETIVE _____

EXEMPT LEGISLATIVE RULE X

CITE STATUTE (s) GRANTING EXEMPTION FROM LEGISLATIVE REVIEW

WV Code §§23-2C-5(c)(2) and 33-2-10(b)

AMENDMENT TO AN EXISTING RULE: YES X NO _____

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 9

TITLE OF RULE BEING AMENDED: Workers' Compensation Uninsured Employers' Fund

IF NO, SERIES NUMBER OF NEW RULE BEING ADOPTED: _____

TITLE OF RULE BEING ADOPTED: _____

THE ABOVE RULE IS HEREBY ADOPTED AND FILED WITH THE SECRETARY OF STATE. THE EFFECTIVE DATE OF THIS RULE IS December 17, 2006

John C. Musgrave
Acting Cabinet Secretary
West Virginia Department of Revenue

TITLE 85
EXEMPT LEGISLATIVE RULE
WORKERS' COMPENSATION RULES OF THE
WEST VIRGINIA INSURANCE COMMISSIONER

SERIES 9
WORKERS' COMPENSATION UNINSURED EMPLOYERS' FUND

Section

TITLE 85
EXEMPT LEGISLATIVE RULE
WORKERS' COMPENSATION RULES OF THE WEST VIRGINIA INSURANCE COMMISSIONER

SERIES 9
WORKERS' COMPENSATION UNINSURED EMPLOYERS' FUND

§85-9-1. General.

1.1. Scope. -- These rules shall govern the administration of the Workers' Compensation Uninsured Employers' Fund pursuant to W. Va. Code §§23-2C-2(o); 23-2C-7(a); and 23-2C-8.

1.2. Authority. -- W. Va. Code §§23-2C-5(c)(2); 23-2C-22; 33-2-10(b); and 33-2-20(a). Pursuant to W. Va. Code §§23-2C-5(c)(2) and 33-2-10(b), rules adopted by the Industrial Council and the Insurance Commissioner as related to workers' compensation under chapter twenty-three of the West Virginia Code are not subject to legislative approval as would otherwise be required under W. Va. Code, §29A-3-1 et seq. Public notice requirements of that chapter and article, however, must be followed.

1.3. Filing Date. -- November 17, 2006.

1.4. Effective Date. -- December 17, 2006.

§85-9-2. Purpose.

The purpose of this rule is to establish a procedure and process to govern the administration of the Workers' Compensation Uninsured Employers' Fund pursuant to W. Va. Code §§23-2C-2(o); 23-2C-7(a); and 23-2C-8.

§85-9-3. Definitions.

As used in this exempt legislative rule, the following terms have the stated meanings unless the context of a specific use clearly indicates another meaning is intended.

3.1. "Commissioner" means the Insurance Commissioner of West Virginia as provided in W. Va. Code §23-2-1, or any designated third-party administrator of the Insurance Commissioner.

3.2. "Industrial Council" means the Industrial Council created pursuant to W. Va. Code §23-2C-5.

3.3. "Private carrier" means any insurer authorized by the Commissioner to provide workers' compensation insurance pursuant to chapters twenty-three and thirty-three of the West Virginia Code.

3.4. "Fund" is the Workers' Compensation Uninsured Employers' Fund, as defined and established in W. Va. Code §§23-2C-2(o); 23-2C-7(a); and 23-2C-8.

3.5 "Workers' compensation coverage," as the term is used in this rule, means mandatory workers' compensation coverage pursuant to W. Va. Code §23-2C-1, et seq.

§85-9-4. Application for Benefits from the Fund.

4.1. If an individual believes that he or she may be entitled to benefits under the Fund, then he or she shall complete an application for benefits from the Fund on a form created by the Commissioner. The Commissioner reserves the right to change the Fund application from time to time as deemed necessary. Completion of the application for benefits is an absolute prerequisite for any entitlement to benefits from the Fund.

4.2. Upon receipt of an application for benefits, the Commissioner shall send a letter to the employer named in the application which notifies the employer that one of its employees has made a claim against the Fund.

4.3. Within five (5) business days of receiving an application for benefits, the Commissioner shall determine whether: (1) the employer named in the application was required to carry workers' compensation coverage on the date of the injury or last exposure; and (2) if the employer named in the application was required to carry workers' compensation coverage on the date of the injury or last exposure, whether the employer named in the application was carrying workers' compensation coverage on the date of injury or date of last exposure. If the Commissioner needs additional time to make this determination, the Commissioner shall be granted up to an additional thirty (30) calendar days to make the determination. The Commissioner shall also send a letter to the claimant, copied to the employer, informing them that the determination cannot be made within five (5) business days, the reason(s) why it cannot be made and that the decision will be made within the next thirty (30) calendar days.

a. If the Commissioner determines that: (1) the employer named in the application was carrying workers' compensation coverage on the date of injury or date of last exposure; or (2) the employer named in the application was not required to carry workers' compensation coverage on the date of injury of last exposure, then the Commissioner shall send the claimant a letter, copied to the employer, informing the claimant of this determination, and that coverage for the claim through the Fund is therefore denied. Additionally, in the case that the Commissioner determines that the employer named in the application was carrying workers' compensation coverage on the date of injury or date of last exposure, the letter described in this subdivision shall also be copied to the insurance carrier.

b. If the Commissioner determines that: (1) the employer named in the application was required to carry workers' compensation coverage on the date of injury or date of last exposure; and (2) the employer named in the application was not carrying workers' compensation coverage on the date of injury or date of last exposure, then the Commissioner shall send the claimant a letter, copied to the employer, informing the claimant of this determination, and that the claim will be accepted into the Fund: *Provided*, That the letter

accepting the claim is not a compensability ruling, but rather is only an initial determination that the claim is chargeable to the Fund, if in fact the claimant is ultimately found by the claims adjuster to be otherwise entitled to benefits under the law. The Commissioner shall then administer the claim or forward the claim to its designated third-party administrator for further administration of the claim consistent with the provisions of chapter twenty-three of the West Virginia Code and the rules promulgated thereunder.

4.4. If, after rendering a determination as described in subdivisions a and b, subsection 4.3 of this section, the Commissioner receives evidence to indicate that the determination was erroneous, the Commissioner reserves the right to enter a corrective determination remedying the previous erroneous determination.

4.5.a. Any decision rendered by the Commissioner under subdivision a or b of subsection 4.3 or subsection 4.4 of this section may be contested by an aggrieved party by filing a protest and request for hearing within thirty (30) calendar days of receiving the determination and in a manner otherwise consistent with the protest instructions contained in the decision. The Insurance Commissioner will then schedule a hearing on the matter before a hearing examiner to take place within fifteen (15) days of the receipt of the protest: *Provided*, That the only issues that may be argued by any party contesting any such determination are: (1) whether the employer named in the application was required to carry workers' compensation coverage on the date of injury or date of last exposure; and (2) whether the employer named in the application was in fact carrying workers' compensation coverage on the date of injury or date of last exposure. Hearings under this subdivision shall otherwise proceed pursuant to the provisions of W. Va. Code St. R. § 85-7-4 through 85-7-13. All appeals from the final order or decision of the commissioner following the hearing shall be taken pursuant to W. Va. Code, § 29A-5-4.

§85-9-5. Irrevocable Assignment of Subrogation Rights.

5.1. Pursuant to W. Va. Code §23-2C-8(b)(1)(C), as a condition of receiving benefits from the Fund, a claimant under the Fund irrevocably assigns his or her rights to recover money from a collateral source for the occurrence or exposure which resulted in the claimants' injury, including, but not limited to: (a) any benefits from other existing insurance policies, such as a later discovered workers' compensation policy providing coverage, or a disability insurance policy; and (b) any funds resulting from a settlement or jury verdict stemming from a cause of action under statutory or common law against a third-party who has liability for the occurrence or exposure which resulted in the claimant's occupational injury or disease: Provided, That this irrevocable assignment of rights of recovery is only to the extent of the actual monetary benefits received by the claimant from the fund: Provided further, That nothing in this subsection shall be construed to prevent a claimant from pursuing a claim on his or her own against a collateral source for the occurrence or exposure. The subrogation language contained in the application for benefits from the Fund, which is signed by the claimant, is deemed to constitute the irrevocable assignment from the claimant to the Commissioner of a right to be subrogated to the rights of the claimant as contemplated by this subsection and W. Va. Code §23-2C-8(b)(1)(C).

5.2. Pursuant to the irrevocable assignment of subrogation rights as contemplated in subsection 5.1 of this section and W. Va. Code §23-2C-8(b)(1)(C), the Commissioner shall have

discretion to pursue subrogation directly from any collateral source with liability, by contacting the collateral source and demanding the funds for which the source is liable, and bringing a civil action in the name of the claimant against the liable source if necessary; or seeking subrogation from the claimant of any funds the claimant has successfully recovered from any collateral source; or any combination thereof: *Provided*, That the Commissioner shall only be permitted to seek collateral source funding as described in this section up to the amount of benefits paid from the Fund, including all medical and indemnity benefits.

§85-9-6. Employer Liability.

6.1. Pursuant to W. Va. Code §23-2C-8, an employer of claimant(s) who receive benefits from the Fund are liable to the Fund for all expenditures from the Fund on behalf of their injured employee(s), including, but not limited to:

a. All benefits, including all medical and indemnity payments, made from the Fund;

b. All claims administration costs related to the administration of claim(s) against the Fund;

c. All attorney fees related to defense of claim(s) made against the Fund; and

d. Interest on the above expenditures, as calculated under W. Va. Code §23-2C-8(b)(8).

6.2. An employer shall remain on the Commission Default List or Private Carrier Default List, whichever is applicable, as defined in 85CSR11, until it pays all of its liability to the Fund, enters into a full and final settlement with the Commissioner for its liability to the Fund or enters into a repayment agreement with the Commissioner for its liability to the Fund. As such, the employer will be subject to all of the sanctions associated with being on the Default List, including, but not limited to:

a. Not being permitted to obtain or renew mandatory workers' compensation coverage;

b. Having a posting placed on the employer's front door informing its employees that the employer is uninsured and therefore may be sued by its employees for work related injuries;

c. A penalty of up to $10,000, pursuant to W. Va. Code §23-2C-8(b)(10); and

d. Being subject to an action in the Circuit Court of Kanawha County to enjoin the employer from continuing business operations.

6.3. If an employer incurs liability to the Fund after being removed from the Commission Default List or Private Carrier Default List, whichever is applicable, and the

employer fails to remit payment for such liability to the Fund on a timely basis, as described in subsection 7.1 of this rule, the employer will be placed on the Default List until the liability is fully paid or otherwise resolved pursuant to section 7 of this rule.

§85-9-7. Methods for Determining and Collecting Employer Liabilities Owed to the Fund.

The Commissioner shall have discretion, on a case-by-case basis, based on what is considered to be in the best interests of the Fund, to utilize one or more of the following methods to determine and collect amounts owed to the Fund:

7.1. As benefit payments are made from the Fund, issue pay orders to liable employers ordering them to reimburse the fund, within a specific and reasonable amount of time, as selected by the Commissioner, for the amounts described in subsection 6.1 of this rule;

7.2. Enter into repayment agreements with employers to reimburse the Fund for the amounts described in subsection 6.1 of this rule, and then enter pay orders to employers as described in subsection 7.1 of this section;

7.3. Using generally accepted accounting and actuarial principles, reduce the estimated amount of a claim or claim(s) against the Fund, including all the amounts described in subsection 6.1 of this rule, to a present value reserve for the claim, and then deem the responsible employer to be liable for this amount. The Commissioner may then pursue this amount as a judgment against the employer, including filing a civil action in Circuit Court against the employer, seeking a judgment lien against the employer, and all other accepted methods of collection as set forth in article two, chapter twenty-three of the West Virginia Code and 85CSR11.

7.4. The Commissioner shall have discretion, if it is found to be in the best interests of the Fund, to enter into a full and final settlement with an employer for its liability to the Fund. Further, if it is found to be in the best interests of the Fund, the Commissioner shall have discretion to waive amounts owed to the Fund as part of a repayment agreement or a full and final settlement with the employer.

§85-9-8. Methods for Determining Assessments for the Fund.

8.1. If at any time the Commissioner determines, based on generally accepted accounting and actuarial principles, despite the collection of, or projected collection of, amounts owed to the Fund, that: (1) the Fund has incurred a deficit balance; or (2) it appears imminent that it will incur a deficit balance, then, in order to maintain the solvency of the Fund, the Commissioner may, pursuant to W. Va. Code §23-2C-8(a)(3), impose assessments against either private carriers, self-insured employers, or both, in the following manner:

a. Monthly or quarterly assessments against workers' compensation private carriers that reflect the relative hazard of the employments covered by the private carriers, results in an equitable distribution of costs among the private carriers and is based upon expected annual premiums to be received: Provided, this assessment may be collected by each private

carrier from its policy holders in the form of a policy surcharge, and private carriers will have no liability for the amounts of this assessment which are not paid by employers defaulting on their premium payments;

b. Monthly or quarterly assessments against self-insured employers that result in an equitable distribution of costs among the self-insured employers and is based upon expected annual expenditures for claims.

8.2. Prior to imposing the assessments described in this section, the Commissioner shall provide at least sixty (60) days notice to the entities being assessed. Notice shall be provided in writing to all entities being assessed and through other means deemed appropriate by the Commissioner.

§85-9-9. Severability.

If any provision of these rules or the application thereof to any person, party, or circumstances is held unconstitutional or invalid, such unconstitutionality or invalidity shall not affect the other provisions or application of these rules, and to this end the provisions of these rules are declared to be severable.

PUBLIC HEARING

JULY 20, 2006

WEST VIRGINIA INSURANCE COMMISSION
WORKERS' COMPENSATION INDUSTRIAL COUNCIL

WORKERS' COMPENSATION UNINSURED EMPLOYERS' FUND
TITLE 85, SERIES 9

Transcript of the Public Hearing held on Thursday, July 20, 2006, at 3:00 p.m., Charleston Civic Center, Room 104, 100 Civic Center Drive, Charleston, West Virginia, related to the proposed Workers' Compensation Uninsured Employers' Fund (85CSR9) for the Workers' Compensation Industrial Council.

Industrial Council Members Present:

Charles Bayless, Chairman
Bill Dean, Vice-Chairman
Jane L. Cline, Commissioner
Dan Marshall (via telephone)
Senator Brooks McCabe
Walter Pellish
Rick Slater

Chairman Bayless: Series 9 is the initial reading of the Workers' Compensation Uninsured Employers' Fund. We have received a couple comments on this already from Spilman and BrickStreet. This talks about setting up the Fund. There were comments on the subrogation rights. Basically it has boiled down to whom is the first paid – the private insurance or workers' compensation? There are other comments on the method of the assessment for the Fund. At this point if anybody would like to make any public comments. . .I talked to Mr. Sims and he said the staff will just wait until after public comment. If anybody would like to say anything publicly about Rule 9, I think the first is Mr. Bowen.

Henry Bowen: Chairman Bayless, members of the Industrial Council and Commissioner Cline, thank you very much. I'm Henry Bowen, Executive Secretary of the West Virginia Self-Insurers' Association. I have not filed written comment. I decided to simply make some oral comments today to express our Association's concern about this rule – the decision that the Insurance Commissioner has made to come forward with this rule now and the fact that self-insurers are listed in the rule as potential employers to be assessed for payment of this.

I wanted to make sure the Industrial Council was very clear that our Legislature in 2003 created two alternative methods in ratifying a decision that had been made by the prior Workers' Compensation Commission and its predecessor, the Board of Managers, to require that self-

insured default be solely the responsibility of other active self-insurers. In fact, prior to that time Chapter 23, Article 2, Section 9 that authorizes employers to become self-insured and had a premium tax requirement that self-insurers contribute to other losses. Historically other losses were simply the losses that the former agency incurred due to default or employers not subscribing for mandatory coverage as they were required. It was a policy determination that was ratified by the Workers' Compensation Board of Managers. The bright line should be drawn between the liabilities of those employers who are authorized under §23-2-9, the self-insurer, and direct pay their obligations under the West Virginia law.

There are two funds now that were ratified and incorporated within Senate Bill 1004 when it was enacted by the Legislature in January of 2005. Those two funds were already a part of the rule that was adopted by the Board of Managers one year prior to that legislative action. For all liabilities that arise for dates of injuries after July 1, 2004, there is a Guaranty Fund to which the Insurance Commission turns for payment of any self-insured claim default or any obligations that are incurred for which the self-insured defaults. That is a prospective cash pool and it was negotiated and part of the rulemaking process to take the place of the typical commercial surety that became so very difficult for many types of self-insurers to obtain in the commercial market. Most namely bonds that were commonly used to secure self-insured liabilities became increasingly expensive and in certain classifications of employers simply were not available. Letters of credit require substantial deposit of monies to secure those letters of credit. I don't think it's an exaggeration to say that the self-insurer puts up a $1 million dollar letter of credit it has to tie up $1 million dollars of cash it would otherwise use for some appropriate purpose.

Whatever reasons the drafters of this legislation – and let's cut to the bottom line – wasn't drafted initially by the Legislature. It was drafted initially by the executive branch and then given to the Legislature. . .decided in this important fund – this is the fund that takes West Virginia out of the workers' comp business. In the past, if there was a default, the State had the obligation to pay claims for employees whose coverage was mandatory and his employers failed to secure that coverage. The State remained on the hook for self-insured default, if there were a default such as Weirton Steel's default that led substantial unsecured liabilities to be addressed. Had the Legislature, as an example, not addressed the Weirton default in the manner in which it did – let's put those unsecured liabilities in the Old Fund – those liabilities would be self-insure only liabilities. Under our present law, under our present rules, if the Office of the Insurance Commissioner comes before you and tells you that any self-insurer has defaulted on its obligations, these funds that I just now mentioned are the mechanism to pay claims for those obligations. It is absolutely unconscionable. It is, in my judgment, legally deficient and I believe unconstitutional for the Legislature to ratify a scheme in which self-insurers may be charged anything to pay for the liability that results from default by insured employers when no such authority is given in the law for this agency to turn against the insured community for any contribution if there is a self-insured default. There is simply no justification for the self-insured community to be put in this. We weren't given any notice about it. It was

simply done. It was passed quickly. We had no opportunity to address it. In our discussions with the Insurance Commission to a person, we have received very sympathetic, understanding. . .gee, this really isn't fair. Well, it isn't fair. It's not right. What the Association would like you to do is simply strike the self-insurers from this. You may be told by the Insurance Commissioner that's not an option. You have a statute. The statute puts us in it. It's up to us to get it changed at the Legislature. Only the good Lord knows when the Legislature will decide to reopen the workers' compensation act.

Now if Governor Manchin is serious about West Virginia being open for business, and you recall that of those 115 corporate employers and municipalities that they are included among some of the largest corporations and largest wage pay that's in there, you are sending a clear resounding message that underscores the unfairness of this. I don't know why the drafters of this legislation thought it would be legally proper to charge self-insurers to contribute when the insured community had no such corresponding contribution to be legally asked of them in self-insured default. But the self-insured community can ill afford to wait until the Legislature addresses this again prospectively. So we would urge that we be stricken from this rule as a recognition that it is the right thing to do. We are mindful that that may not be possible. But we wanted to make this public statement to express our outrage as an Association of being taxed to pay for default obligations of insured employers when there is not corresponding legal obligation whatsoever on any insured employer to contribute one dime. And let me give one further illustration of this. You have five municipalities that are authorized to self-insured. Under this rule the cities of Charleston, Parkersburg, Wheeling, Huntington and Fairmont will be asked to contribute for insured employer default, but no other municipality will be contributing in that fashion. Even though, under the self-insured rules, the municipality can't be treated any differently than a corporation. It makes no sense. It is in the law. We ask that we receive the kind of fair and equitable treatment that we believe you have the discretion to do. There will be undoubtedly future litigation involving this when the first assessments are issued if, God forbid, any are issued – undoubtedly they will be. If, however, you feel you cannot pass this rule without including the self-insured community in it, and if you do that because you feel that the statute compels that action, we would ask you to consider drawing a bright line in the sand on how this assessment should be administered. There are currently 115 I believe – Ms. Shepherd and others can correct me – self-insured employers, including those municipalities.

There is absolutely under no rationalization that I can think of any basis for discriminating among that class of employers by charging assessments – additional taxes to pay for other people's defaults based on any methodology that will result in 30% or 40% of the self-insurers paying 80% or 90% of the assessment. That's the way most assessments are handled. There is no reason whatsoever not to allocate this assessment on a pro-rata basis across the board. Small self-insurers, retailers, restaurants won't like that. They complain vigorously about that. But is it any fairer to make CAMC, Wal-Mart pay disproportionately higher assessments simply because they are larger? Unless you reach the conclusion that there is always justification based on ability to pay, I submit to you there is no justification to

follow the scheme that the statute has in it. It is very unclear. It says that it is to be based on expected annual expenditures for claims. What claims? Who knows what it's talking about.

In summary, we wanted to make sure that you understood that we think it is patently unfair to be included in this rule. We recognize the limitation that might prevent you from excluding us from the rule. If you keep us in, we simply ask that we get a fair and equitable allocation based on the number of self-insurers because there is no rationalization that justifies another methodology. And this is just being a member of the class that we're stuck – we're stuck until the legislative decision is reversed. Thank you very much.

Chairman Bayless: Let me ask a question. Do you have any knowledge that this was specifically taken up in the Legislature? I mean did they debate this question and rule against you?

Mr. Bowen: Mr. Bayless, it is my understanding that it was never discussed. I wasn't there on the day the Bill actually was voted on. As you may recall, it was voted on during the five day period that culminated January 29, 2005, passage. If it was discussed, I wasn't unfortunately invited to the discussion in the hall and I was never the recipient of any report that was discussed on the floor. I rather imagine the Bill was villainous and I rather imagine it just didn't catch anybody's eye. So many other significant changes were made. And as I said, our Association learned about it after the first published copy of the Bill was made available.

Chairman Bayless: You said why should large pay more? I'm asking a question. Wouldn't you agree with me that large employers. . .expected annual expenditures for claims be a function of your size and your historical claims rate? Wouldn't that be the two main indicators?

Mr. Bowen: Well, historically we have always looked at a methodology that ties your actual risk. For example, the administrative assessment that used to be called the premium tax, which is now an assessment, is nonetheless taxed on the basis of payroll. One can certainly understand the explanation of the large employer with a large payroll may have larger numbers of claims. Certainly if you used the methodology of claims, one can tie the number of claims to an administrative charge to defray the cost of the administration by the Commission of the statute. But on this it is strictly an add-on assessment. It's the cost of doing business in West Virginia now. The State is out of the payment business. If these claims arise and are not funded, he may direct that they be assessed. And we're simply saying there is nothing that ties the assessment to the size of the employer. It's really the class of the employer. If self-insurers, for goodness sakes, are going to be made to contribute, even though no insured employer will ever pay a penny for a self-insured default, then we simply ask that it be done on an equitable allocation among all members of the class. We are trying to make clear that people understand this isn't a tax. It isn't an assessment. It's an add-on simply to pay for those who don't keep their insured coverage or never take out the coverage as required by law.

Chairman Bayless: Senator McCabe is now joining us.

[Senator Brooks McCabe joined the meeting.]

Chairman Bayless: Let me ask since Senator McCabe walked in. Senator, the question before the floor – you may have some knowledge of this – this is Series 9 covering the Uninsured Fund and it is setting up the Uninsured Fund. Mr. Bowen represents the self-insurers and has brought up a point that the language in Section 8.1, "it appears imminent that it will incur a deficit balance. . ." If the Fund is going to have a deficit, then the Commissioner can "impose assessments against either private carriers, self-insured employers, or both. . ." And Mr. Bowen says the legislative scheme was that the self-insureds sort of took care of theirs. If there is a default over there, the insured carriers do not have to help the self-insured. It's sort of a self-contained unit over here and over here, and he said therefore it is unconscionable to ask the self-insured people to come in and bail out the insured fund. Do you have any recollection of how that was taken up in the Senate? We can give you a few minutes to think about that.

Senator Brooks McCabe: I should have come in a little later.

Chairman Bayless: Your timing was not good.

Senator McCabe: Let me respond in just a minute.

Chairman Bayless: Okay. Let me ask you a public policy question then. The self-insured employers – presumably taking self-insureds because it was cheaper. . .it was cheaper not to. . .they would have bought the other. So they are getting cheaper rates to start with. The odds of a default within the self-insured fund are probably much lower than a default by other employers. I mean if you look at the grilling that the self-insured people have to go through and the standards they have to meet to become self-insured, I think that the odds of a default are minuscule. So they are getting lower rates or they would be over here by definition and they have a lower default risk. Why should they be able to escape the obligation of the whole business community to pick up uninsured workers?

Mr. Bowen: Mr. Bayless, first I disagree with the characterization of "lower rates." It certainly is normally the case that one elects the self-insured because one believes it's cheaper for the self-insurer to do that and particularly with self-administration being mandated into law. It is generally felt to be a cost savings, but you are direct paying those obligations. You are not transferring the risk of those obligations to any carrier or any third party. And prior to the change in the law in 2003, self-insuring in West Virginia was simply the obligation to direct pay a benefit that all the claims were administered and all the decisions were made by the prior agency. Being in a. . .system then it was no great deal to have that direct obligation. Actually it became extremely costly and reserves are an issue. Legacy costs were always a huge issue

for large corporate self-insurers particularly in certain industries, the legacy costs of those claims. Yes, I certainly understand your suggestion. I can't speak to the issue of probability and default. Only the government allows the decision to allow someone to become and remain self-insured. All of that is treated in the name under proprietary reviews of financial conditions, and unless they are a public corporation no one really knows about the financial condition, so I can't really speak. Generally I'd agree with you. Everyone knew for a long, long time that Weirton Steel was a calamity waiting to happen. We spent some ten years dealing with the agency about how to address that. The law has addressed that. That type of unsecured liability should never again occur. Everybody should be fully secured as of June 30. Whether or not that's done, Ms. Shepherd and others would have to comment on that.

Generally speaking from 1913 to 2003 the law did not require self-insurers only to pay for self-insured default. I remember having this debate with Senator McCabe at a Board of Managers' meeting. . .I think he made a comment, "the Legislature intended to ratify this notion that self-insurers had to be responsible for self-insurers." If that's the case, from this day forward the State of West Virginia is never going to be on the hook for a dollar of self-insured default. So the last self-insured standing pays all liability. Then why can you justify asking the self-insurers to contribute to the funding of claims for employers who fail either to secure mandatory coverage or default in coverage?

Chairman Bayless: That's a good question. . .Senator McCabe.

Senator McCabe: I would concur that the intent, at least on the Senate side, which is really all that I can comment on with any real knowledge. We were trying to set up separate systems and there was in fact some debate about the self-insurers and the risk that put them under. From my recollection I would have to agree that the intent was to put the two Funds in parallel and each responsible for their respective piece of it. I'm not sure. . .I just had part of the Legislation pointed out to me. I'm not sure that we were completely consistent in the drafting of the legislation in that regard. My suspicion is that it is an item that needs to be looked at and corrected. I would have to say that it was the intent that the self-insureds were taking on not insignificant risks on their own behalf depending on who would be in that self-insured pool. Mr. Bowen was correct that. . .last man standing pays. The intent was that it was clearly on that side and they needed to deal with it. So, I would have to concur that my understanding was similar to what has been explained here. But I think it is contrary to what ended up in the legislation, so we clearly have a disconnect.

Chairman Bayless: Does anybody else have any comments?

Walter Pellish: I'd like to suggest, Mr. Bowen, it would be helpful to me. . .is we think this through and at some point take action and to have the comments in writing so that we can focus on them, particularly the historical point that you had mentioned about prior to the new legislation.

Chairman Bayless: Do you think we have any legal authority to override the legislation?

Mr. Bowen: I don't think you have legal authority to override legislation. I think you have great discretion in your rulemaking capability. Certainly if you excluded us someone could complain, which is okay with us. We would like to have the issue ultimately either in front of the Legislature and fixed or in front of the Court on the theories that the Legislature has power to do many things. But in giving such an assessment I think it really does touch on the West Virginia Constitution and this is not the proper forum for that. I don't want my comments to be construed that I'm ever asking you all to do something you feel is a violation of the law. I'm not asking for that. I just wanted to point out how strongly we feel that this is unfair. If you didn't include us in there, it's problematic as to whether or not someone would bring an action to compel you to include us. I really don't know. . .

Chairman Bayless: Thank you, Mr. Bowen. Mr. Cox from Spilman, representing Travelers and St. Paul's.

Randy Cox: Mr. Chairman, members of the Commission, I'm Randy Cox. I am an attorney with Spilman Thomas and Battle and I'm here today, very briefly, to comment on Series 9, and in particular Section 8 of Series 9 which Mr. Bowen briefly touched upon.

Our concerns are about the method of calculating or determining the assessment. We also have trouble with. . .based upon expected annual expenditures, we would prefer that if you based on premium dollars written, it's simpler, it's consistent with what you've got in the Code. For example, both the Life and Health and the Property and Casualty Guaranty Association makes their assessments based on the percentage of premiums you have in this issue. And from an accounting standpoint – I'm told that I am going to defer to Mr. Slater – under FASB it makes more sense for an insurance company to calculate it this way as opposed to what you've suggested. We would also suggest that it be 60 days notice instead of 30 days because we just don't think 30 days is adequate notice. Other than that we're comfortable with the rule. I give it on behalf of St. Paul's. They are very interested in what's going on. They intend to participate in the market in 2008 or 2009 when it opens up and have been watching very closely, as have a number of other carriers. I would be happy to answer any questions.

Chairman Bayless: Thank you. That was everybody that signed up that wanted to make comments. We have received written comments from BrickStreet.

Steve White: I'm Steve White with Affiliated Construction Trades Foundation. This is in regard to Section 7.4 where it talks about the Commissioner having the discretion to waive amounts owed. My point is I would hope that we would clarify here that this public knowledge. The public has the right to know when money is being waived. It is my recollection, and I could be wrong, but in the past we only were able to waive interest and penalties and not premium. I

would like some clarification if this is going beyond what had been allowed in the past and whether that was the intention to now be able to waive premium as well as interest and penalties. But my number one suggestion and comment would be that this should be clearly public knowledge that we know when this forgiveness is taking place. And I have to remark – I'm not going to take a position on the self-insured situation, but if you do find a way to go beyond the law, I've got a number of issues that I think are unfair in the Bill too and I'd love to bring them to you. Thank you.

Chairman Bayless: Thank you, Mr. White. Does anybody else have any comments on Rule 9? Mr. Siims, does the staff have any comments?

Ryan Sims: I don't think that it is any surprise that the comments raised by Mr. Bowen were. . .worse has been raised on the other side by several commenters. The way we have the rule reading right now it's discretional as to whether we assess the self-insureds anything or not. We believe when you read the statute as a whole the Legislature was to make it discretional. That is if the Fund got into a little more trouble than just assessments against insured employers could handle, then we could do some assessments against self-insured employers. You can describe that as a compromise. But we think the legislation. . .the word of the statute lets us do that. It happens to be a compromise, but I think that's the way we read the legislation. You are going to have the self-insureds saying that it is absolute unfair. You are going to have carriers saying, hey, it is in the Code. And the carrier's position, from several comments we got, was that if you are going to assess the insured employers, you should also assess the self-insured employers. They think it has to be in hand, not an either/or. So the way we did it is that we can assess either/or and we feel that's the way the legislation currently reads. Many people will disagree. One side will want it totally one way and one side will want it totally the other. I'm not going to disagree with much of what Mr. Bowen said. I think when you look at it it's questionable whether it's appropriate to assess self-insureds at all. There is another way to look at it from policy perspective. I'm just throwing this out there. I don't want to get attacked by any self-insureds. There is a public policy concern. It's basically a privilege to be self-insured in West Virginia. It can be looked on as that is their tax for the privilege of being self-insured. Again, I'm just throwing that out there. I don't know exactly what the thoughts of the Legislature were when they promulgated this particular statute, but I just wanted to throw that out there – some more perspective. I think most people would agree that it is a privilege in West Virginia to be self-insured. Some might argue that as part of that they could be subject to assessments even though their employees will never benefit from the Fund.

In regard to both Mr. Bowen's and Mr. Cox's comments about expenditures being the measuring stick for how we assess, again, that's the wording of the legislation. We can try to expound upon what "expenditures" mean, but the legislation says "expenditures" both in regard to assessing the self-insureds and the insured community. So I really don't know what we'd do beyond giving more definition to what expenditures mean. We could say expenditures really means payroll for self-insureds. We could say it means premium for insureds, but it says

"expenditures" in the Code. So we're kind of stuck with what the Legislature gave us in that regard.

In regard to Mr. White's comment on 7.4, again, in there I say if we do "waive" and he said that wasn't the way it was done with the premium. Well, you are really not involved in premium first of all in the Uninsured Fund. The Uninsured Fund involves recouping from the uninsured employers, the bad acting employers – the amounts that are paid to their employees. If they end up being uninsured, their employee files a claim, they are on a hook for every cent we pay out – all administrative costs and all attorney fees in defending the claim. So you're not really talking about premiums any more. This is really a totally different kind of settlement. It would be the money they owe based on the claim that was filed by their uninsured employee. The intent when putting that in the rule was in some instances. . .for example, if it's a self-insured employer that's quickly going under anyway or maybe they are already in bankruptcy, it might be beneficial to waive some of the money they owe to get something. And that was the intent of that. Now as far as whether it would be subject to public information, I would think as a general proposition what we expend from these funds would be subject to FOIA. Now I can't speak specifically on the Uninsured Fund, but as a general proposition what agencies expend from funds is subject to FOIA. I'll be glad to take any questions.

Mr. Pellish: Ryan, I have a couple of questions. The first of which has to do with the subject that several people have mentioned. Whatever we do in 8.1.a. is based upon expected annual expenditures for claims. I would like to know how that's going to be determined. Are you saying it because somebody generated "x" number of claims last year that we can expect that they are going to be the same for this year? The other concern I have there is that it states, "reflect the relative hazard of the employments. . ." I expect that means "employers." That's probably a typo. But that suggests to me that because someone is in a hazardous industry that the assessment for those folks is going to be greater than a non-hazard. But that doesn't take into consideration safety records. You can be in a horribly hazardous industry and if year after year after year you've got a good safety program and there's no claims being generated, it doesn't seem logical to me to assess based on that. On the other hand, if you have an industry that theoretically has zero claims that should happen and people aren't paying attention to what's going on safety wise, they could be generating a lot of claims. Somehow or other we've got to get a handle on measuring that.

Mr. Sims: In regard to your second issue regarding the word "hazards," can you tell me where you found that in the rule because I'm trying to look for it?

Mr. Pellish: Yes, it's in 8.1.a. It says, "Monthly or quarterly assessments against workers' compensation private carriers that reflect the relative hazard of the. . ." I suspect it means "employees" rather than "employments."

Mr. Sims: All I can tell you, again, like I just said, that term "expenditures" is just a troubling term in general. I mean it probably would have been more favorable for the Legislature to use something such as "payroll or premium" or something more definitive. I think the intent of the Legislature was for carriers and their insurers to pay assessments based on the risk that is being taken on, and there needs to be some methodology for determining they were all risk. I think that can be done through the NCCI classification system.

Mr. Pellish: I am just suggesting that you take a further look at this. You've got it there and also in (b), "based upon expected annual expenditures for claims." There has got to be a better method.

Mr. Sims: It's a well taken point. That language is taken directly from the legislation. I think what you're saying is expand upon what that means. That may not be the easiest thing to do, but we can certainly try.

Mr. Pellish: The other concern I have – and maybe you have addressed it – I still don't believe that there are enough teeth in the employer liability's section for this. We talked the last time about "rogue" employers versus people who just happen to get in on the default list by accident. Someone had raised a concern about West Virginia being "open for business" and the teeth in this thing might hinder that. My reaction after thinking about it is exactly the opposite. If I'm contemplating coming into this State, I would prefer to see that people are going to take action against companies that don't care and don't pay. It would indicate to me that they are serious about the safety of the workforce.

Mr. Sims: I think the last time we had a little bit of discussion about the employer enforcement issues and one point I made is if you all review Rule 11, that's where most of our employer enforcement issues are addressed – Sections 19 through 23 of Rule 11. It discusses the various default lists. Additionally the Commissioner will be making a presentation later on in regard to what our duties are. But I'm not sure that this is the proper rule, if we are even going to beef up or get more teeth to employer enforcement. I think Rule 11 has a lot of teeth if you review it.

Mr. Pellish: I think I asked you to send that out.

Mr. Sims: We did. We sent it out last week. If you review it, in my opinion, again take a look at Sections 19 through 23 of that rule. I think it has pretty good teeth in there. When the Commissioner goes over what our remedies are against employers on the default list – number one, they are pretty severe; and number two, there is some ability within those remedies to decide to use some of them against some employers, but not others. That is to say, for example, when we fine them. . .uninsured fund liability or something like that or they owe some money. If it's a bad acting employer that just decided to be a scofflaw and not comply with the law, we can decide to aggressively sue them first or perhaps. . .again, that's why we have the

ability to waive amounts in situations like this. Actually had one claim hit the Uninsured Fund, got back to being insured and maybe we would settle with them and waive for some type of percentage. I think within the remedies we have there is ability to differentiate. It is going to be a difficult task within a rule to differentiate between bad acting employers and good acting employers. The employer either pays their premium or they don't. That isn't to say when we find out that one employer has repeatedly scoffed at the law, repeatedly fallen in the uninsured status, clearly doesn't care, is in good financial status but just doesn't want to carry comp insurance, that we won't handle them more harshly within our remedies then we would an employer that falls in once because they ran behind on their bills but they appear to be a business that can get back on their feet.

Mr. Pellish: I look forward to the Commissioner's comments. Thank you.

Mr. Sims: Are there any other questions?

Chairman Bayless: Thank you. Are there any more questions from the public on Rule 9? I think the staff has their work cut out for them.

Industrial C ıncil Meeting
PUBLIC HEARING
Title 85, Series 9, Workers' Compensation Uninsured Employers' Fund
Charleston Civic Center, Room 104
July 20, 2006

Name	Address	Telephone Number	Group Affiliation	Do you desire to address the Council?	Agenda item to which you desire to speak
Henry Bowen			WV SIA		
Tandy Cox			St Paul/Travelers	Yes	
Becky Adkins			Accroun	No	

INSURANCE COMMISSIONER RESPONSES TO STAKEHOLDER AND PUBLIC COMMENTS RECEIVED ON W. VA. CODE ST. R. § 85-9-1 ET SEQ.

Introduction

Below is the written response of the Insurance Commissioner of West Virginia to the stakeholder and public comments received in regard to the new Title 85 Rule, W. Va. Code St. R. § 85-9-1 et seq. ("Workers' Compensation Uninsured Employers' Fund"), which was filed with the West Virginia Secretary of State for public comment on 6/19/06. This response is itemized by topic, and addresses all of the comments received by the public at the 7/20/06 Industrial Council meeting as well as other selected substantive written comments received by stakeholders.

Uninsured Fund Assessments on the Self-Insured Employer Community

Several individuals and entities expressed concern about section 8 of the Rule. The primary issue of concern was the permissibility of assessments against the self-insured employer community. Section 8 of the Rule permits the Insurance Commissioner to make assessments against the self-insured community to fund the Uninsured Employer's Fund ("UIF"), but does not make these assessments mandatory.

The self-insured employer community expressed concern over the potential that they could be subject to assessments to the UIF. Specifically, while the self-insured community recognized that the relevant statute – W. Va. Code § 23-2C-8(a)(3) – specifically permits these assessments against self-insured employers, they believe it is fundamentally unfair for the self-insured community to be subject to such assessments when no employee of a self-insured employer could ever receive benefits.[1] Further, the self-insured community believes that the provision subjecting them to UIF assessments is contrary to the changes made in 2003 to the workers' compensation code which make it clear that the self-insured community is generally liable for all the obligations of all self-insured employers (in other words, the state will no longer be responsible for claims of a bankrupt self-insured employer; rather, the funds mentioned in footnote 1, funded by self-insured employers, will pay these obligations). Finally, the self-insured community argues that subjecting it to UIF assessments could be unconstitutional, although this was not expounded upon by the self-insured community.

Conversely, several entities representing the workers' compensation insurance industry had a different concern with section 8 of the Rule. They expressed concern that the assessments against the self-insured community were discretional on the part of the Insurance Commissioner. They took the position that 23-2C-8 clearly requires that both insured employers and self-insured employers be subject to assessments for funding the UIF.

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[1] W. Va. Code § 23-2C-8(c) specifically prevents an employee of a self-insured employer from receiving UIF benefits. If a self-insured employer is not able to meet its workers' compensation obligations, these obligations would either be paid by the self-insured employer security risk pool or the self-insured employer guaranty risk pool, as defined under W. Va. Code § 23-2C-2 et seq.

The Insurance Commissioner has given the relevant provision of 23-2C-8 careful review, and believes that the current version of 85-9-8 appropriately reflects the intent of the legislature. Specifically, 23-2C-8(a)(3) reads as follows:

§23-2C-8. West Virginia Uninsured Employer Fund.

> (a) The West Virginia Uninsured Employer Fund shall be governed by the following:
>
> * * * *
>
> ***(3) The Insurance Commissioner shall assess each private carrier and all self-insured employers an amount to be deposited in the fund.*** The assessment may be collected by each private carrier from its policy holders in the form of a policy surcharge. To establish the amount of the assessment, the Insurance Commissioner shall determine the amount of money necessary to maintain an appropriate balance in the fund for each fiscal year and ***shall allocate a portion of that amount to be payable by private carriers, a portion to be payable by self- insured employers*** and a portion to be paid by any other appropriate group. After allocating the amounts payable, the Insurance Commissioner shall apply an assessment rate to:
> (A) Private carriers that reflects the relative hazard of the employments covered by the private carriers, results in an equitable distribution of costs among the private carriers and is based upon expected annual premiums to be received;
> (B) Self-insured employers that results in an equitable distribution of costs among the self-insured employers and is based upon expected annual expenditures for claims; and
> (C) Any other categories of payees that results in an equitable distribution of costs among them and is based upon expected annual expenditures for claims or premium to be received.

[Emphasis added].

The relevant parts of this section are emphasized above. While the first emphasized part seems to indicate that the UIF assessments should be against both insured employers (through their private carriers) and self-insured employers, the subsequent emphasized part indicates that it is within the Commissioner's discretion to determine how much of the needed money to assess to the insured employers and how much to the self-insured employers. Therefore, as a matter of plain statutory construction, the Commissioner believes that there is discretion whether to assess the self-insured community any amounts at all. Consequently, the Insurance Commissioner believes that the current version of section 8 of Rule 9 most appropriately reflects the intent of the legislature regarding UIF assessments.

Methodology of Uninsured Fund Assessments

The other concern expressed about section 8 of Rule 9 was regarding the methodology of the assessments, both against insured and self-insured employers. Specifically, an entity representing workers' compensation insurance carriers stated that they believed the methodology as stated in section 8 based on ". . . [m]onthly or quarterly assessments against workers' compensation private carriers that reflect the relative hazard of the employments covered by the private carriers, results in an equitable distribution of costs among the private carriers and is based upon expected annual expenditures for claims" was ambiguous and needed more clarity so that there could be some predictability as to what type of assessment would need to be passed through to their insured employers. Moreover, the self-insured community expressed the same concern for this "expenditures for claims" methodology.

In regard to the insured employers, to the extent that the relevant methodology language contained the "expenditures for claims" language in subdivision 9.8.a., this was an error. Consistent with W. Va. Code § 23-2C-8(a)(3)(A), the methodology should have read ". . . [m]onthly or quarterly assessments against workers' compensation private carriers that reflect the relative hazard of the employments covered by the private carriers, results in an equitable distribution of costs among the private carriers and is based upon expected ***annual premiums to be received.***" [emphasis added]. Rule 9 has been modified to reflect this correction. Other than this correction, if and when a situation arises whereby it becomes necessary to impose assessments, the Insurance Commissioner will do its best to use a methodology reflecting what is stated in the Code and reflected in subdivision 9.8.a. of the Rule.

In regard to the self-insured employers, the language in subdivision 9.8.b. correctly reflects the language of the W. Va. Code as stated in W. Va. Code § 23-2C-8(a)(3)(B). As with insured employers, if and when a situation arises whereby it becomes necessary to impose assessments, the Insurance Commissioner will do its best to use a methodology reflecting what is stated in the Code and reflected in subdivision 9.8.b. of the Rule.

Broad Subrogation Against All Collateral Sources

An entity representing workers' compensation insurance carriers had a concern regarding section 5 of Rule 9, which addresses the irrevocable assignment of subrogation rights by a UIF claimant to the UIF. The specific concern was that section 5 of the Rule compels the claimant to assign broad subrogation rights to the UIF in regard to any collateral source from which the claimant might be able to receive benefits for the work related occurrence or exposure, including a later discovered workers' compensation insurance policy or a disability policy. The concern is that other insurance policies providing benefits to a claimant should not be subject to an "offset" from the UIF, because this essentially penalizes the claimant for having procured the benefit of the other insurance.

In response to this comment, the Insurance Commissioner believes that the UIF was created by the legislature as a fund of last resort to provide workers' compensation benefits to employees who are injured while working for employers who are not in compliance with the law by way of not carrying mandatory workers' compensation insurance at the time of the injury. Therefore, the Commissioner believes it is consistent with the intent of the legislature under W. Va. 23-2C-8(b)(1)(C) that the UIF be granted broad subrogation rights against all collateral source funding available to UIF claimants for an injury or exposure covered by the UIF.

Notification to the Workers' Compensation Insurance Carrier

A workers' compensation insurance carrier suggested that if the Insurance Commissioner makes a determination under subdivision 4.3.a. of Rule 9 that the employer named in the UIF application had workers' compensation insurance on the date of injury or last exposure, that the letter denying the UIF claim also be copied to the insurer. This comment is well taken and subdivision 4.3.a. of Rule 9 was amended to require such notice to the carrier.

Time Limitation for Making a Corrective Determination

A workers' compensation insurance carrier suggested that there be a time limitation on the Insurance Commissioner's ability to issue a corrective determination under subsection 4.4 of the Rule. While the Insurance Commissioner understands the concern that if there is no limitation on the Commissioner's ability to make corrective UIF determinations under section 4 of the Rule there could be a lack of repose of potential undiscovered carriers, the Commissioner believes that this issue should be sufficiently addressed by the statutory time limitations on filing workers' compensation claims which are currently contained in Chapter 23. In other words, the Commissioner would only be able to make a corrective determination that workers' compensation insurance was in fact available to the UIF claimant if the date of injury or last exposure was still within the time limitations of Chapter 23 for filing a claim with a carrier. If the time limitation has run, the Commissioner would not make such a corrective determination.

Time and Form of Notice Given to Private Carriers for Assessments

A workers' compensation insurance carrier expressed concern over both the amount of time and the form of notice given to private carriers in regard to assessments for the UIF under section 8 of the Rule. Specifically, there was concern expressed over the thirty (30) day notice and the lack of a specific requirement of written notice to the carrier regarding the UIF assessments. These comments were well taken and subsection 8.2. of the Rule was amended to provide at least sixty (60) days written notice to the entities being assessed.

Additional Issues Regarding Subrogation

A claimant attorney raised several issues regarding the subrogation provisions contained within section 5 of the Rule. First, there was concern expressed that this section would prevent a UIF claimant from obtaining their own counsel to represent them in a third-party tort claim related to the work related injury. The Insurance Commissioner is of the opinion that section 5 does not prevent a UIF claimant from obtaining their own counsel to represent them in a tort claim against a third party. Rather, it provides the Commissioner alternative methods of seeking subrogation from any proceeds received by the UIF claimant resulting for such a lawsuit. If the claimant obtains their own counsel to represent them, the Commissioner will file a subrogation lien on the lawsuit and subrogate against any amounts recovered in it. However, if the UIF claimant chooses not to pursue a viable cause of action against a third-party, the Commissioner can pursue the action, based on the assignment of subrogation rights made by the UIF claimant.

Second, there was concern expressed over the ability of an attorney retained by a UIF claimant to obtain an offset in the subrogation amount for the UIF in the event that proceeds are recovered in a third-party cause of action. While the Commissioner understands that a plaintiff attorney often must expend substantial resources in pursuing a personal injury claim, the Commissioner believes that the duty to maintain the solvency of the UIF prevents the Commissioner from creating such an offset in regard to UIF subrogation against third-party lawsuits. Specifically, as discussed above, the UIF was created by the legislature as a fund of last resort to provide workers' compensation benefits to employees who are injured while working for employers who are not in compliance with the law by way of not carrying mandatory workers' compensation insurance at the time of the injury. Moreover, there is no provision within W. Va. Code § 23-2C-8 permitting the Commissioner to allow an offset for attorney fees against UIF subrogation against third-party lawsuits. Consequently, the Commissioner cannot add a provision in section 4 permitting for an attorney fee offset.

Finally, concern was expressed that if the Commissioner pursues subrogation directly against a third-party (in the event that a UIF claimant chooses not to pursue the claim on his own), then the claimant may not receive the full and fair amount to which the claimant might be entitled based upon the merits of the cause of action against the third-party. Again, while the Commissioner understands this concern, the Commissioner's primary concern is the solvency of the UIF. Consequently, if a UIF claimant chooses not to pursue a viable cause of action against a third-party, the Commissioner's primary concern in pursuing subrogation will be to seek reimbursement for amounts paid to the claimant from the UIF.

Joy Zirkle

From: Linda M. Blackshire [lblackshire@spilmanlaw.com]
Sent: Wednesday, June 14, 2006 10:14 AM
To: Ryan Sims
Cc: tcosby@aiadc.org
Subject: Rule 9

This message is from Randy Cox:

Ryan – Here are preliminary comments from AIA re proposed Rule 9.

(1) Irrevocable Assignment of Subrogation Rights (Sec. 85-9-5)

This section grants overly broad subrogation rights against "collateral sources," as defined. I can understand clarifying that the Fund would have a subrogation lien against 3rd party tort recoveries, as well as other employer-funded insurance policies providing the same coverage for workplace injury. However, the language also would encompass any personally funded coverage, such as a personal disability or accident policy. We have always taken the position that that goes too far, that an employee should not be effectively penalized for securing his/her own coverage at their own expense, by having those proceeds subject to a lien. I could even quibble with employer-funded disability. We also have taken the position that workers' compensation should be the primary payer for a workplace injury, that other employer-funded disability should not offset workers' compensation's obligation but should rather be offset by that obligation. Therefore, this section should be amended by clarifying its non-application to personally secured insurance, funded with the employee's own funds, and by deleting reference to disability insurance entirely. Employers frequently negotiate these generous benefits with their unions and then try avoiding their workers' compensation obligations later on by offsetting those benefits rather than having to do battle with the unions to negotiate offsets of the disability benefits.

(2) Methods for Determining Assessments for the Fund (Sec. 85-9-8)

This is curious. The Commissioner should not have the discretion of imposing these assessments against insurers or self-insurers. We believe the entire employer community should be subject to any assessments.

Second, language should be clear that the assessments are to be imposed on "all self-insured and insured employers," not carriers, to be consistent with accounting practices.

Third, the assessment should be levied in proportion to losses paid by self-insured employers and insured employers, so insured employers are not subsidizing losses disproportionately with the self-insured community. This is the same approach we recommend with respect to assessments for a second injury fund. For insurers, the amount of loss to be collected from their policyholders via the surcharge is to be translated into a premium factor, then a uniform surcharge factor.

Fourth, the surcharge language itself is good, but the basis for the surcharge, confusing. There should be a uniform surcharge factor, applicable to all policies. This language refers to assessments against carriers "that reflect the relative hazard of the

employments covered by the private carriers." What does that mean and how on earth is that to be calculated? This is unnecessarily complex.

The key policy objective is to prevent cost-shifting from self-insured employers to insured employers (via their insurers), and to impose a simply calculated, uniform surcharge factor.

Further, while we understand that the term "relative hazard" is in the statute, we do not know what it means and believe it needs clarification.

Finally, we would prefer that any assessments be made on an annual rather than quarterly or monthly basis.

Randy Cox/lb

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Joy Zirkle

From: Suter Randy [Randy.Suter@brickstreet.com]
Sent: Tuesday, June 27, 2006 4:38 PM
To: Ryan Sims
Cc: Obrokta TJ
Subject: BrickStreet Comments 85CSR9 Uninsured Employers' Fund
Attachments: Comments 6-27-06.doc

Ryan:

Attached you will find BrickStreet's initial comments on the Uninsured Fund rule. We may make further comments prior to the cut-off date.

Thanks for the opportunity to provide comment.

Randy

Randall B. Suter, Attorney
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BrickStreet Insurance Comments: Rule Proposal 85CSR9,
"Workers' Compensation Uninsured Employers' Fund"

4..3.a. It would seem reasonable to **notify the insurance carrier** in addition to the employer and claimant when the determination is made that the employer is insured. Leaving the employer (possibly defunct) to notify the carrier leaves too much to chance and may have the effect of preventing legitimate protests to the ruling.

4.4. This provision is bothersome because the Insurance Commissioner, **at any time upon receipt of additional evidence, can make a corrective determination**. There is **no time limitation** for the exercise of this provision. It would seem reasonable that once the decision becomes final, i.e. the employer has failed to assert that it has coverage and does not contest the ruling or it does contest the ruling and has either stopped or exhausted its appeal remedies, then in the absence of fraud on the part of the carrier, the matter will not be overturned. This makes sense because the provisions, as proposed, allow the Insurance Commissioner to make a determination **at any future date** that the OIC determines that the employer had coverage with a carrier. In the meantime, the carrier has not been able to manage the claim, has not been able to develop evidence in the claim and has had no recourse or due process in the expenditures that have occurred within the claim. It seems fundamentally unfair to tell a carrier that they are covering the claim long after the claim has worked through the process.

§6. Suggested minor changes regarding employer liability.

6.1. from "will be held liable" to "are liable"

6.1.d. Provision of Code incorrectly cited as 23-2C-8(b)(4)(8). Should strike the (4).

§8. Determining Assessments to the Fund

8.1. This provision provides for assessments when the Uninsured Employer's Fund incurs a "deficit balance." This is not defined.

W. Va. Code §23-2C-8(a) says the assessments will be apportioned between private carriers, self-insured **and** other appropriate groups. On the other hand, the proposed rule says **either** private carriers, self-insured employers, **or** both. The statute contemplates assessments to all and provides that the self-insured portion shall result in an equitable distribution of costs among the self-insured employers based on expected annual expenditures for claims.

8.1.a. Allows for the pass through of the assessments to policy holders. This is all right and contemplated by the statute -- **but**

8.2. Provides that the OIC shall give 30 days notice to the entities being assessed. This time period may not be adequate to allow BrickStreet the opportunity to pass the assessment through to its policyholders. It seems reasonable that instead of monthly and quarterly assessments to the carriers that the amounts be passed through and remitted **when paid by the policyholders**.

One additional troublesome provision in this section states: that the 30 day notice described above -- "Notice shall be provided by posting the intended assessment dates and amounts on the Commissioner's web site, and also through other means considered appropriate by the Commissioner." This does not seem adequate. At a minimum, written notification to each carrier should be required..