IDAHO INDUSTRIAL COMMISSION
NEGOTIATED RULEMAKING – PROMPT CLAIMS SERVICING
DOCKET # 17-0208-1701; 17-0210-1701; 17-0211-1701

MEETING MINUTES
(Second Session)
Thursday, June 29, 2017
9:00 Am
700 S. Clearwater Ln., Boise, Idaho
1st Floor Conference Room

The Industrial Commission conducted Negotiated Rulemaking (Second Session), pursuant to IC §§ 67-5220(1) and (2) and as authorized by IC §§ 72-508 and 72-806 regarding Docket #s 17-0208-1701; 17-0210-1701; and 17-0211-1701 on Thursday, June 29, 2017.

Public Attendees: State Insurance Fund: Stephanie Butler, In-house Counsel State Insurance Fund, Lisa Kerns, and Paulette Boyle; Attorney Michael McPeek, Gardner Law; Mike Haxby, Intermountain Claims; Lene O'Dell, Gallagher Bassett; Scott McDougall; Angela Richards, Attorney Lobbyist; Jeanne James, St. Luke's RMC; Shellie Martin; Travelers Insurance; Attorney Bob Nauman, Litster Frost; NCCI Representatives Cynthia Wood and Susan Schulte (via conference call); Attorney Joseph Jarzabek (via conference call)

Industrial Commission: Chairman Tom Limbaugh, Commissioners Tom Baskin and R. D. Maynard; Director Mindy Montgomery; Benefits Administration Manager Patti Vaughn; Gayle Roark; Richelle Flores; and Public Information Specialist Nick Stout

(*See* handout of Attendance Roster.)

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Welcome & Introductions: Benefits Administration Manager Patti Vaughn opened the meeting at 9:04 am (MT) and led with introductions of participants. She 'recapped' the discussions of the first meeting session of June 20th including the Options A & B text language that was presented for consideration. She also thanked the members of the Subcommittee for attending today's meeting. She reported that the Subcommittee of the Commission's Advisory Committee had met on March 16, 2016, April 11, 2016, May 23, 2016, and October 12, 2016.

Purpose of Meeting: The Commission is seeking further public input to amend the rules governing prompt servicing of workers' compensation claims.

Ms. Vaughn summarized further the Options A and B; the Option A language was prepared as a result of suggestions made by the Subcommittee. The Subcommittee recommended approval to the Advisory Committee which includes two members of the state legislature. Ms. Vaughn read into the record the Advisory Committee members who saw these draft amendments. The Option A drafts were submitted as a temporary rules package to the Governor's office and were subsequently rejected. Between that time and to date, a couple of

Supreme Court opinions have created uncertainty of how permanent partial impairment benefits are paid. The Option B drafts include additional language addressing PPI benefits.

Materials: In addition to the handouts previously provided to participants at the June 20th meeting labeled as Option A and Option B of the changes to IDAPAs 17.02.04, 17.02.08, 17.02.10 and 17.02.11, the following additional materials were handed out to participants for their further consideration: (1) a copy of the WCRI Table 12 report on Initial Payments, Waiting Periods, Retroactive Payments, and Time Frames for TTD as of January 1, 2016; and (2) Attorney Mike McPeek's email comments of Wednesday, June 28th. Attendees participating via conference phone were also provided the additional materials in an email at the start of the meeting session.

Ms. Vaughn reported the language in IDAPA Docket 17-0210-1701 for insurance carriers is mirrored in the language in 17-0211-1701 for self-insured employers. Again, all these rules were vetted by both the Subcommittee and the Commission's Advisory Committee.

Discussion: Mr. McPeek reported that he participated in the Subcommittee meetings; and also apologized to the Commission and attendees that he had not thoroughly focused on the language in the drafts following the October 12th Subcommittee meeting on the triggering date for what starts the time to run for a decision to be made within the 28 days. He is uncertain if the date starts from when the claims administrator receives the notice, or the date when employer has knowledge of the accident or injury; the draft language is ambiguous. He believed consensus had been reached that the 28 days began to run from the date when the claims administrator receives knowledge and suggested the rule change for the 28 day trigger start after the third-party administrator receives written or electronic notice that will capture reporting to EDI when it is implemented.

Mr. Haxby concurred with Mr. McPeek's summation of the 28 day trigger to run from the date the claims administrator receives knowledge. He reported he attended the November 9, 2016 Advisory Committee meeting; a lot of discussion was held during that meeting to also include a new definition for 'claims administrator' for when EDI is implemented. He would like 'claims administrator' defined in both sections of rules for insurance carriers and self-insured employers. Ms. James (St. Luke's) concurred with the comments of Messrs. McPeek and Haxby. She also participated in the Subcommittee and recalled the discussion was also on the timely reporting of employers and she wanted that issue as a separate issue to be enforcement by the Commission under the regulations. Ms. Boyle (State Ins. Fund) also served on the Subcommittee and concurred with the comments the two issues were separated.

Mr. McDougall inquired whether the Commission had data on average the number of additional days, two or more, would be added to the days when the injured worker receives notice. Ms. Vaughn reported the Commission has not tracked that information. Ms. Martin opined that report would be misleading anyway, even if it was available; it would not accurately assess the time period to "start the clock running" as it would also depend when the injured worker first seeks medical treatment. She further commented that 28 days regardless of when the start date of acceptance or denial of the claim few situations have no option for 'pending' a

decision to complete an investigation and forces the adjuster to deny a claim. For some claims a decision cannot be made so adjuster is forced to deny the claim pending additional information and investigation. Ms. Martin reported that some states provide for the voluntary payment on a claim pending further investigation; other states allow a 60-day period to make a decision - the injured worker gets the benefit of the investigative time.

Ms. James (St. Luke's) thanked everyone for their comments during the Subcommittee meeting. St. Luke's and some other sureties pay voluntarily even before or after 28 days. The rules provide 28 days. We considered at the time of those Subcommittee meetings that not all the information is available at 28 days. The Subcommittee did have that conversation. Mr. Haxby concurred the Subcommittee had vetted for hours and reached a compromise. Mr. McPeek agreed it was felt it would be the 'cleanest' way to do it. The Commission's audit staff looks at how quickly claims are processed. A conditional denial is often the main focus. The concern on an audit finding will be the date/time the claims administrator receives knowledge, an otherwise impossible standard. Can we measure whether the adjuster took reasonable time? Ms. Martin agreed that if we're looking to satisfy an audit, Mr. McPeek's summation is on point.

Commissioner Baskin posed this question to Mr. McDougall: Does the change Mr. McPeek is suggesting make a material difference, if we use 28 days from the date the claims administrator receives notice, as compared to 28 days when the surety receives notice or knowledge of an accident or injury? Mr. McDougall opined it would increase the time frame for an action on the claim because of the way the claim is being reported. The mechanics of reporting will depend on the claim; it will be at a case-by-case basis.

The Commission has no control over third party administrators (TPA). Commissioner Baskin quoted the notice language from IC § 72-307. The 28 day trigger date would only be pertinent in terms of audits – no financial sanctions exist against TPAs for unreasonable delay made on the claim.

Mr. McPeek remarked there needs to be a distinction between audit guidelines and a standard for satisfying the statutory requirements. He further said the audit findings are a due process concept; the claims administrator should not be held to an audit finding for the unreasonable performance of employer or surety. Mr. McDougall concurred with Mr. McPeek on his summation of the audit findings and that the Commission can't have 'free-floating' guidelines; they should be based on statute and rule.

Commissioner Baskin expressed his opinion, "We don't "whack" TPAs; we penalize the surety over whom we have jurisdiction." Mr. Jaynes and Ms. Vaughn also interjected that audits are done of sureties not sureties' third-party administrators.

Mr. Haxby opined the issue of non-compliance is over a small piece of claims; the industry best practices standards calls for adjusters to get on board within 24 hours. In some rare occasions, Intermountain Claims would not know when the surety may have received the claim from the employer, sometimes claims will sit on a desk 10 days before it is sent on to the TPA. The issue of a § 72-307 (Knowledge of Employer to Affect Surety) 'occurs in only a small sliver

of claims.' In a high percentage of claims, the carrier has notice and gets the file to the TPA. Ms. O'Dell agreed with Mr. Haxby's summation that the usual delay in reporting is on the employer side; and suggested the audit guidelines would assist in going after employers and sureties who delay in reporting.

Commissioner Baskin requested an explanation of Intermountain Claims process for receiving the claim from employers.

Mr. Haxby summarized Intermountain Claims' process for receiving FROIs through its custom-generating reporting service. The FROI received is not in the traditional format, but does have the FROI information contained in the electronic submission. The claims are received in electronic format *via* email or directly to the clients' computer system, except for a few smaller groups in Idaho. Intermountain Claims represents the better share of smaller employers – less than 1% of claims.

Ms. Martin (Travelers Ins.) reported that Gallagher Basset is the TPA for Travelers. Ms. Martin sees the issue as apples and oranges. Issue A is the claims handler who handles a claim and administers benefits due the injured worker. Issue B is the audit finding – a judgment on how prompt the claim was serviced. The goal is to get benefits to the injured worker 14 days from the date of disability, regardless of the audit concern of making the decision within the 28 days to determine compensability. Why not audit on whether the employer got it reported timely? Travelers Insurance sends letters to recalcitrant employers who do not meet the 10 day reporting requirement per statute. The onus is on the surety to educate the employer on the filing requirement. In her opinion, the majority of claims are handled timely and that is reflected in the case law.

Commission Chairman Limbaugh reported that IC 72-402 controls when benefits need to be paid regardless of the employer's actions. He referenced the WCRI report of January 21, 2016, a joint publication with the IAIABC, indicating jurisdictional benefits payments schedules.

Mr. Jaynes sees the issue is based on audits, as opposed to statutory requirements, and allows the Commission the ability to "pull their ticket" on the surety for non-compliance.

Mr. Haxby shared his opinion that the Subcommittee worked hard on these rules and a lot of good work was a result of that vetting of where we are today on the language; 98.5% of claims are processed promptly. He shared the process Intermountain Claims utilizes for receiving the claim simultaneously, for instance, from Simplot Co. that has an intra-net portal through their claims department and is then accessed by adjusters at Intermountain Claims. The employer is held to the 10-day standard.

Mr. McPeek interjected with his additional suggested language for the insurance carrier and self-insured rules on the provision to make a decision to accept or deny a claim, under IC § 72-402 that, he opined, would effectively solve the issue by shortening the 28 day time period and would force claims administrators and sureties to make voluntary payments sooner:

(*see* 17.0210.051.09.a and 17.0211.051.09.a)

a. Making an initial decision to accept or deny a claim for an injury or occupational disease within 28 days after the ~~surety~~Claims Administrator received written or electronic knowledge of the same~~.~~; provided, however, that nothing herein shall affect the provisions of IC § 72-402 regarding the time frame for initiation of payment of income benefits following the onset of disability. The worker shall be given notice of that initial decision in accordance with Idaho Code § 72-806.

Mr. Haxby opined that more likely than not a claim is compensable and those payments would be made.

Mr. Nauman was asked his opinion on the 14 day or 28 day time periods; he had no comment to add of substance.

Ms. Martin (Travelers Ins.) requested clarification on the Commission's position for a notice of a change of status on medical-only claims.

Lengthy discussion was held about the carrier's process for handling medical only claims and whether or not notices on a change of status (COS) are sent out to the injured worker. Commissioner Baskin inquired whether Travelers sends a letter to the injured worker that the claim has been closed and final bill paid. Ms. Martin reported Travelers' practice is to not send a letter to the injured worker because medical-only claims remain open for possible future medical care; it is not possible to send a COS on every medical-only claim. Ms. Martin (Travelers Ins.) opined that Idaho should not consider implementing Oregon's system of using codes on their forms; the lay person is not aware of the codes that Oregon now requires in its forms submissions. She would not want to be limited to using a 'per code' method and being held to a code standard as a measurement on an audit finding; if there is a time loss, Travelers is speaking with the injured worker.

Mr. Haxby and Ms. James (St. Luke's) requested a status of the Commission's audit guidelines more for out of state insurers to be aware of the Commission's expectations. Ms. James also inflected that closing of the claim does not necessarily mean you send another claim status notification; and is that something that can be addressed in the audit guidelines.

Mr. Haxby requested Ms. Vaughn elaborate on the effects of the Supreme Court decisions and how that changed the industry's consideration for the treatment of impairment ratings and benefits payments on impairment.

Ms. Vaughn summarized the differences in rules language for Options A and B was the elimination of PPI and replaced with permanent disability; Mr. Jaynes further explained that Option B takes into account the *Corgatelli* case and other cases. Commissioner Baskin reflected that the case of *Corgatelli* appears to differentiate between impairment and disability in a way that the Commission has not historically treated these benefits. The reason for changing the draft language is to recognize that impairment is not payable as such, but is only payable as a component of disability. Therefore, payment of impairment is couched in terms of its

contribution to disability. The Commission 'cloaked' the language in terms of impairment is a component of disability.

Ms. O'Dell asked for clarification that the language in Option B of 17.02.04 is based on permanent impairment ratings. Mr. McPeek inflected that the additional language in the draft as presented makes the rule consistent with the statutory provisions.

Mr. McDougall inquired whether a discussion could be held on the waiver, see 051.09.c. The first payment shall constitute an application for waiver. This language seems to give a blanket waiver against insurance carriers, the mechanism for the Commission for a revocation of the waiver. He shared his concern that the Freedom of Information Act may impact information being received into the Commission. Because the Commission is required to evaluate every payment in accordance with Idaho law, could it be subject to a public records request?

Messrs. McPeek and Jaynes did not concur with Mr. McDougall's concern since the public can't know claimant's information; and would be burdensome upon the claimant.

(Mr. Jaynes was excused from the remainder of the meeting to attend to other business of the Commission.)

Explanation of Next Process of Negotiated Rulemaking: Ms. Vaughn explained the next process in the negotiated rulemaking process is for the Commission to meet and consider carefully the comments. The information will be shared with the Commission's Advisory Committee at its August 9, 2017 meeting for further vetting and for recommendations to the Commission. Participants were instructed to mail any additional comments to Commission Secretary Beth Kilian for the Commission's consideration. Further written comments will be received through July 10th. The results from the first meeting session and this meeting of the minutes or written testimony will be posted to the Commission's website. The deadline for agency proposed rules submittals is September 1st for the legislature's consideration in the next session.

No further meetings were requested or scheduled. Ms. Vaughn closed the meeting by thanking everyone for their time and efforts into the process.

There being no further discussion, the meeting adjourned at 10:58 am.

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