

DIVISION 050 – Employer/Insurer Coverage Responsibility
Rulemaking advisory committee meeting
Oct. 1, 2015

Committee members attending:

Jennifer Flood, Ombudsman for Injured Workers
Jaye Fraser, SAIF Corporation
DeAnne Hoyt, SAIF Corporation
John Powell, representing Liberty Insurance, State Farm, AIG
Krista Stevens, Portland General Electric
Maria Thomas, AIG

Agency staff members attending:

Adam Breitenstein
Fred Bruyns
Sally Coen
Cara Filsinger
Mary Schwabe

Fred welcomed the committee members, requested input on fiscal impacts of potential rule changes discussed, and asked members to present any new issues before the committee considered the prepared agenda.

Meeting minutes have been entered below in italicized text. The following is not a transcript, and some comments have been paraphrased for brevity.

ISSUE #1 – OAR 436-050-0060 - “Transition from Guaranty Contract Filings to Policy-Based Proof of Coverages”

Issue: Given Oregon’s transition six years ago from required guaranty contract filing by insurers to policy-based, electronic proof of coverage reporting, should this rule now be deleted from the Division 050 rules?

Background: In July 2009, the Workers’ Compensation Division (WCD) transitioned from its historical reliance on guaranty contracts filed by insurers to electronic proof of coverage (POC) reporting based on policies in force for Oregon employers, as the basis for establishing required workers’ compensation coverage. As part of that transition, the rule provided that any “active” guaranty contract still on file with the director on or after July 1, 2010 would no longer serve as proof of coverage for any employer. 050-0060 was intended to provide direction to insurers before, during, and shortly after the 2009 transition about how the new POC filings would replace prior guaranty contracts. OAR 436-162, “Electronic Data Interchange; Proof of Coverage,” now provides the requirements for insurer POC transactions. Those rules also direct

insurers to contact the director regarding coverage predating the July 2009 transition for which they aren't able to make EDI filings. It no longer appears that there is a reason to retain this rule.

Notes:

04:27, Jaye Fraser: SAIF doesn't see any reason for the rule any more.

ISSUE #2 – OAR 436-050-0110(1) – “Notice of Insurer’s Place of Business in State; Coverage Records Insurer Must Keep in Oregon”

Issue: Should this rule be amended to clarify that an insurer may not have more than eight claims “processors” at any one time? Or, alternately, to define what qualifies as a “location?”

Background: This rule requires insurers to maintain at least one Oregon location where its claims are processed and records are maintained. It also states that an insurer may not have more than eight locations at any one time, mirroring a 1975 statute’s use of the word “location.” Specifically, ORS 731.475 originally established a limit of one processing location per insurer. The 1989 Legislature, however, increased the allowed number to eight claims processing locations for insurers. At that time, Oregon was one of only three states with a single-processor limit and the intent in allowing multiple locations was to facilitate increased competition (potentially improving system-wide claims processing performance and reducing insurance costs) and acknowledge the business realities of processing claims for national clients.

The eight-location limit imposed by the legislature addressed the division’s testimony that workers need to easily find out who is processing their claims and WCD’s concerns about auditing and regulating an unlimited number of locations, while still allowing insurers some flexibility in using different servicing companies. WCD provided testimony that the eight locations could be made up of that many different service companies with one location each, that many locations for just one service company, or a combination of both. [In all such cases, though, if an insurer is self-administering some of its claims, that counts as one of the allowed processing locations.]

WCD is increasingly addressing situations with insurers exceeding their allowed number of processing locations. Some even use different (unrelated) processors located in the same building and attempt to count those as one “location.” These practices aren’t consistent with the intent of the 1989 law. The rule could be improved by clarifying what constitutes a location, as it relates to the number of allowed processors.

Alternatives:

- Amend the rule to define “location,” as it relates to the allowed number of locations.
- Amend the rule to replace “location” with “different service company responsible for processing...” language (or something along those lines).
- Clarify that if an insurer self-administers (processes) any of its claims that site is included in its allowed number of processing locations.
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Notes:

07:41, Jaye Fraser: *I guess I'm not clear on the issue. Is it a location issue? How much of a problem is it?*

07:52, Jennifer Flood: *I would point toward WCD Audit because of the auditing function. From the injured worker's perspective, we track down where the claim is at. We look at it on an individual claim basis. ... Workers certainly need to know where their claim is, which is not always very easy.*

08:23, Sally Coen: *We have had instances with national insurance carriers who have been exceeding their eight locations. A few years ago we had issues of them using more than eight service companies. ... Now we have a situation in Portland where smaller service companies are contained in the same building ... This is a newer argument that has been raised that these companies all have the same address, so it's really only one location. ... We've said that's not the intent of the law, but the law and the rule simply say "location." ...*

09:39, Jaye Fraser: *This is probably not an issue for SAIF.*

09:51, John Powell: *We'll look at it and get back to you.*

09:53, Jaye Fraser: *I would certainly support anything that makes it easier for you to find information to do your work. The statute is there for a reason.*

10:06, Jennifer Flood: *Is part of it ensuring that the body that is processing the claims, that we have tracking that they are certified and following the laws and the rules?*

10:25, Sally Coen: *Absolutely.*

10:30, Jennifer Flood: *Something that might help with some conversations with the national companies – what we have run into in our office is where they may have a national contract with a service company that they don't have contracted here in Oregon, or they might be at their limit.*

10:47, Sally Coen: *Or that service company may not actually have a location in Oregon.*

10:56, Jennifer Flood: *I don't know if there are loopholes or it is just things that are happening, where the service company that is charged with processing the claim, really doesn't have as much control over it, because this unspoken group is actually processing, because they are the ones that do it on a national level. ... just making it clear what the intent of the law is, how the system expects that they be processed. ...*

11:46, Jaye Fraser: *So maybe we need a definition of what it means to adjust a claim.*

11:51, Sally Coen: *We do have in the division 050 rules in the definitions ... "process claims."*

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12:08, *Jaye Fraser: So maybe linking them.*

12:23, *Sally Coen: We've had more instances recently where the service company who has contracted, frequently with large national accounts, that arrangement is with the employer directly instead of with the carrier. So, the service company may not have a location in Oregon. We have circumstances where those service companies have opened mini-offices in another service company's office. ... we really have two companies operating in the same space, maybe by the same adjuster working for two different companies. We are having difficulty defining whether that is one or two locations.*

13:18, *Jaye Fraser: From SAIF's perspective, when we get claims where a worker goes to another employer who we actually insure, and then we try to get records, and can't get the records – we care about it from that perspective. The other issue is companies that come to us that have been with another carrier, and maybe they have been a different class code and processing is different ... claims have been managed differently, maybe out of state, with people not up to speed on Oregon processes and laws – that creates a bit of friction we would as soon not have to deal with. So again, we would support whatever makes it easier for you guys. *

ISSUE #3 – OAR 436-050-0110(1), (4), and (5) - “Notice of Insurer’s Place of Business in State; Coverage Records Insurer Must Keep in Oregon”

Issue: Should these rules be amended to require the insurer to provide email contact information to the director?

Background: These rules currently require insurers to provide “location, mailing address, telephone number, and any other contact information” of the Oregon location where claims are processed and records maintained, and similar information for each service company it uses. This information is also required when there are changes in the business location or contact information. A significant amount of contact between WCD and insurers and their service companies occurs by email. Communication between the division and insurers would be facilitated by requiring all insurers to provide the director email contact information along with address and phone information. 050-0110 currently requires insurers to provide contact information for “a designated person or position” who can assure payment of penalties and resolve collections issues, respond to policy and proof of coverage filing inquiries, and respond to claims processing inquiries. Since specific staff may come and go, it would be helpful for WCD to have “central” email contact information that is tied to a position or team. However, the division is interested in hearing from stakeholders about feasible alternatives.

Notes:

16:04, *John Powell: This would be in addition to the person designated or in place of a person – the email?*

16:10, *Sally Coen: In addition.*

16:16, *Jaye Fraser: I thought that was already required.*

16:24, Sally Coen: We routinely ask for it but it is not in the rules.

16:27, Fred Bruyns: About five years ago we had an advisory committee meeting and we had this on the agenda. At the time they said fine, do it, no problem. But, make sure you don't require us to enter it into a database before you have the database built. And, we've now built the database.

16:41, Jaye Fraser: I do remember the conversation. I think that makes sense. I know SAIF has kind of a corporate in-box that somebody looks at every day. That makes sense to me. I would urge you not to have just a person's email, because people leave.

17:06, Fred Bruyns: When we spoke with self-insurers, we got kind of the opposite approach. They said, no, tie it to an individual, and if they leave it will bounce back to you and you'll know, or recertify it once per year. We sort of thought of it as being a corporate in-box, but there are arguments being made both ways.

17:34, Krista Stevens: We do have a workers' comp email box that is checked daily that anyone in our group can get into, so that would be fine on our end.

18:00, Fred Bruyns: So, it sounds like there are no particular concerns about providing email to the department. ...

ISSUE #4 – OAR 436-050-0110(3) - “Notice of Insurer’s Place of Business in State; Coverage Records Insurer Must Keep in Oregon”

Issue: Given the problems identified by the division when reviewing insurers’ service agreements with their service companies, this rule needs to plainly state that prior to using a service company, an insurer must receive approval from the division.

Background: The current rule states that “prior to using the service company in Oregon” the insurer must file a copy of the service agreement with the director “for approval.” This language is unclear that the agreement must be approved by the division prior to the insurer using the service company to process claims. The rule provides several requirements for those agreements, including that the agreements may only be between the insurer and the service company, must provide the service company power of attorney, and may “contain only those provisions for workers’ compensation activities that are allowed in Oregon.” In recent years, however, the division has increasingly addressed service agreements involving third parties, entities not authorized to do business in Oregon, lacking power of attorney, referencing other states throughout the document, and containing provisions addressing claims processing activities that are prohibited in Oregon. It is important that the division approve the service agreement prior to a service company processing claims, to ensure the requirements of 050-0110(3) are met.

Notes:

19:47, Jennifer Flood: *There have been times where it has been identified that claims were being processed out of state and they need to come into Oregon. That approval process of getting it to a service company approved by the state of Oregon – that needs to be a quick process ... making sure nothing prevents or delays payments on those claims ... that approval by WCD doesn't impede timely payment of the claim.*

20:57, Jaye Fraser: *The real issue is that insurers need to use service companies that have been approved.*

21:05, Sally Coen: *It is not just the company itself, but it's the agreement. Again, sometimes these agreements are employer specific. ... a common thing we routinely reject has to do with managed care activities that are outside of our Oregon MCO process.*

21:30, John Powell: *I don't know – I'm sure what insurers would come back with would be the timeliness issue and perhaps a deemer clause given the amount of time you need, given the staff you have – but 60 days or 30 days or whatever the division could live with in terms of expediting that part of the process.*

ISSUE #5 – OAR 436-050-0110(5) - “Notice of Insurer’s Place of Business in State; Coverage Records Insurer Must Keep in Oregon”

Issue: Should this rule require insurers to notify the estate of a deceased worker or the beneficiaries of changes in its claims processing locations, service companies, or self-administration?

Background: When an insurer changes claims processing locations, service companies, or self-administration status, this rule requires that it notify workers with open or active claims, their attorneys, and attending physicians of the new contact information, at least 10 days before the change. Among the changes made for fatality claims based on the Management-Labor Advisory Committee’s 2009 review of death benefits, insurers, self-insured employers, and their service companies were required to send the worker’s copy of the claim acceptance/denial letter and Notice of Closure to the worker’s estate. This year’s SB 371 also addressed the right of beneficiaries to request reconsideration of a claim closure. Because representatives for a deceased worker’s estate and beneficiaries may have processing or benefit questions and certain appeal rights, it seems reasonable that the estate (perhaps only until the claim closure is final) and any beneficiaries still receiving benefits be included in the parties that must receive prior notice of changes in a self-insured’ [should say “an insurer’s] processing location or entity.

Notes:

23:43, Jaye Fraser: *It seems like the requirements for notice for beneficiaries all said “may.” ... I get the estate needing to have the notice. That’s mandatory.*

24:11, Jennifer Flood: *From my perspective, if it’s a fatal claim, it happened four years ago and benefits are being given, are being mailed monthly to beneficiaries, it’s important for them to know if those checks are going to be generated through another venue, another company. ...*

24:59, *Jaye Fraser: If they are receiving benefits, yes.*

25:10, *Adam Breitenstein: Looking at rule 0110(5), it says the insurer must provide at least 10 days prior notice.*

25:17, *Jaye Fraser: But to the beneficiaries who are receiving benefits.*

25:23, *Jennifer Flood: Not the unknowns ... to me it's important to those families to know.*

25:36, *Fred Bruyns: I think we decided not to be too specific in the rules about requiring notice to every beneficiary, because that could be a very long list, potentially, and if they are receiving benefits, they should be known*

25:46, *Jaye Fraser: Yes, they should know where the benefits are coming from.*

ISSUE #6 – OAR 436-050-0110(5) - “Notice of Insurer’s Place of Business in State; Coverage Records Insurer Must Keep in Oregon”

Issue: This rule should be amended to clarify:

- a) the information the director must receive when an insurer changes its claims processing location(s), service companies, or self-administration;
- b) that the insurer must provide any additional information requested by the director; and
- c) failure to provide the director advance notice of claims transfers or the required information may result in civil penalties.

Background: When an insurer changes claims processing locations, service companies, or self-administration status, it must notify the director at least 10 days before the change occurs. The current rule requires that notice to include contact information for the sending and receiving claims processors, verification of whether closed claims will be transferred, and a list of transferred claims that includes the insurer, employer, and claimant names, date of injury, and sending processor’s claim numbers. However, when all of an insurer’s claims are moved from one processing location to another, the department is able to make the related updates in its data systems without needing all of that claim-specific information. In these instances, the rule creates an unnecessary reporting burden for insurers. It is only when a portion of an insurer’s claims are moving to another location that claim-specific information is necessary to ensure WCD has accurate information about the various parties responsible for specific claims.

Also, depending on the circumstances of the pending transfer, the director may need additional information. For example, sometimes WCD learns that an insurer’s statement that “all” claims are being moved actually means “all open claims” and it may be necessary to request information about where closed or denied claims will be maintained, how the insurer is delineating “open” from “closed,” etc. It would be helpful for the division and stakeholders to

discuss the information that should be required in notices of claim transfers, and the types of follow-up information that might be requested by the director.

When insurers don't provide the required advance notice of changes in claims processing locations or self-administration status, it can cause problems for workers, medical providers, and the division, potentially delaying benefits, treatment, and dispute resolution. While ORS 656.745 provides the director general authority for assessing civil penalties, WCD suggests that this rule also state that failure to provide the required advance notice and information may result in the assessment of civil penalties.

Notes:

29:01, Jaye Fraser: It is not a SAIF issue. Again, to the extent that you have rules that allow you to do your job, we would support that. It seems reasonable that notice would be given.

29:36, Fred Bruyns: With this and the other issues on our agenda, if you think of anything after the meeting, we would certainly welcome your advice. It would be helpful if you can provide it in the fairly near term. ... in the next couple of weeks, certainly in the month of October, if you have additional input on these issues or related issues.

New issue:

30:14, Jaye Fraser: I alluded to this at the beginning of the meeting. We do periodically have difficulty getting claim information ... old information. I know that there is a rule out there that talks about – that insurers keep records until the claim doesn't have any more chance of coming out, which would be like never. There is always a chance you will see a claim develop. The worker is going to need medical care or whatever. ... to the extent the department would ever consider sanctioning insurers who destroy their documents, that would make me happy. I hear from our lawyers that so and so said that after seven years they get rid of their records. ... or even putting a longer period of time, such as twenty years ... so we have a little easier time getting records.

31:33, Fred Bruyns: You mean setting a minimum, regardless of what it says now? In addition to for as long as benefits may be payable, set some kind of minimum in addition to that?

31:40, Jennifer Flood: Doesn't the rule have one of those?

31:45, Sally Coen: It doesn't have a period. It says until all potential for benefits has been exhausted. On a denied claim there is a time frame, I think.

31:58, Jennifer Flood: If the records can't be found or have been destroyed, the insurer does have the burden of recreating the file, but that is extremely, extremely difficult.

32:14, Jaye Fraser: It is and it just doesn't happen.

32:16, Jennifer Flood: And then they try to put the burden on the worker, to say, well you don't have anything. But the Ombudsman office and I believe in WCD as well, pushes back on the

insurer, saying you have an obligation to try and figure this stuff out. Even though it might be futile, the worker still has that right to have the services looked at at that time.

32:41, Fred Bruyns: Occasionally we are contacted as well as a last resort. They say, can you give us what claim information you have. If enough time has gone by, we've already destroyed the claim information, and we let the industry know a couple times that we were going to do that.

32:54, Jaye Fraser: I know you have. That concept of – when all right to benefits has been exhausted – we all know that is a very long time.

33:12, Cara Filsinger: You can always bring those cases to our attention so we can look into the matter.

33:18, Jaye Fraser: I haven't raised the issue with the department for a very long time. The last time I raised the issue I was pretty much told that nothing would happen, that you guys could not do anything. Faces around the table have changed.

33:54, Jennifer Flood: On the cases where workers are involved – that's not very many. We pull in WCD and the insurer, and sometimes it is the service company that has the claim – may be responsible now, but there have been three other service companies, and the files have been moved. I'm hoping that with some tightening or clarification regarding the expectations of where claims are moving, that that will help with that issue.

35:13: Meeting closed.