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A Guide to Self-Insurance under the West Virginia Workers' Compensation System

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A GUIDE TO SELF-INSURANCE UNDER THE WEST VIRGINIA WORKERS' COMPENSATION SYSTEM

TIMOTHY E. HUFFMAN*

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I. INTRODUCTION

In his authoritative treatise on workers' compensation law, Professor Arthur Larson described the typical workers' compensation system as "a mechanism for providing cash-wage benefits and medical care to victims of work-connected injuries, and for placing the cost of these injuries ultimately on the consumer, through the medium of insurance, whose premiums are passed on in the cost of the product."¹ Such an insurance system may be funded and administered through private insurance, either competitive or captive state fund insurance, employer's self insurance, or some combination thereof.²

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1. ARTHUR LARSON, WORKMEN'S COMPENSATION LAW § 1.00 (1993).
2. *Id.* § 1.10.

Throughout the United States, most jurisdictions require employers to carry workers' compensation insurance either through a private carrier or a state fund that will allow self insurance either individually or through a group program where the employer has pledged adequate security and demonstrated sufficient financial responsibility. West Virginia is a compulsory insurance state, allowing insurance only through the state fund or through self insurance on an individual basis. Specifically, West Virginia law requires that "all persons, firms, associations and corporations regularly employing another person or persons for the purpose of carrying on any form of industry, service or business in this state, . . . are hereby required to subscribe to and pay premiums into the workers' compensation fund"³ The only exception to that requirement is individual self-insurance. West Virginia Code Section 23-2-9 contains the provisions for self-insuring an employer's workers' compensation risk. The primary requirements for self-insurance in West Virginia are (1) that the employer must demonstrate "sufficient financial responsibility" to be able to make all benefit payments which would be due to an injured employee or dependents of any employee who died from a work-related injury; and (2) that the employer must furnish sufficient bond or security to the Commissioner to secure the payment of any benefits due.⁴

When an employer has made application for self-insurance and has completed the steps required by regulation for self-insuring, quarterly reports must still be filed, showing the total earnings of all employees for the previous quarter and paying a self-insurance premium. This premium includes a component for a portion of the expenses of the administration of the Workers' Compensation Fund, a component for a portion of the expenses for delinquent employers failing to make premium payments, a component for a portion of expenses attributable to the Disabled Workers' Relief Fund,⁵ and an amount sufficient to be

3. W. VA. CODE § 23-2-1 (Supp. 1993).

4. W. VA. CODE § 23-2-9(a)(1) (Supp. 1993).

5. W. VA. CODE §§ 23-4A-1 to -8 (1985 & Supp. 1993) creates the Disabled Workers' Relief Fund. The purpose of this Fund is to provide supplementary benefits to the claimant or dependent receiving benefits under a permanent total disability award or an award of dependent's benefits where the benefit amount is less than 33⅓% of the average weekly wage in the State of West Virginia. The purpose of these supplemental benefits is

maintained on account as an advance deposit. Consequently, the primary differences between regular subscribership and self-insurance are the amount of premium paid each quarter and the fact that a self-insured employer issues benefit checks directly to claimants after a pay order is issued by the Commissioner. The administration of claims, including litigation before the Office of Judges, the Appeal Board, and the Supreme Court, is identical. The only exception is when an employer elects to make direct payment to medical vendors without the issuance of pay orders, in order to avoid unnecessary delays caused through the claim handling process.

II. PRESENT REQUIREMENTS

The application process, the maintenance of self-insured status and the termination of that status are presently governed by Series 9 of the Legislative Rules of the Workers' Compensation Division of the Bureau of Employment Programs.⁶ Pursuant to those rules, any employer who elects to become self-insured may self-insure not only the workers' compensation risk, but may also chose to self-insure the coverage available from the catastrophe reserve of the surplus fund.⁷ An employer may also choose to insure its workers' compensation risk directly or have this risk self-insured by a parent or related business if (1) the relationship between the two companies can be "adequately documented;" and (2) the parent or related company can satisfy the overall requirements for self-insurance.⁸

to raise the benefit payment amount in life awards and dependent awards to a level of payment closer to current levels.

6. 85 W. VA. C.S.R. 9 §§ 1 to 19 (1993).

7. W. VA. CODE § 23-3-1 (Supp. 1993) creates the surplus fund which is intended to provide coverage for the catastrophe hazard, the second injury hazard, and all losses not otherwise specifically provided for in Chapter 23. Under this section, a catastrophe is defined as a single incident where three or more employees are killed or receive very serious injuries such as loss of sight of both eyes or loss of both hands or feet. When an employer carries such coverage, the payments for all benefits, medical and otherwise, are payable from the catastrophe reserve of the surplus fund and not charged to an individual employer.

8. 85 W. VA. C.S.R. 9 § 4.1 (1993).

A. *The Application Process*

When applying for self-insurance, appropriate forms must be obtained from the Commissioner's office and if coverage is sought as a part of the self-insurance coverage of a parent or related company, the business relationship must be documented.⁹ Also, as a part of the application process, the employer must disclose its management and financial structure, as well as the type of security to be offered. The employer must also furnish audited financial statements for the preceding three fiscal years. Additionally, if a parent or related business is involved, that same information must be furnished.¹⁰ When audited financial statements are not available, financial statements prepared by an outside accounting firm, covering the same three year period, may be substituted.¹¹ The employer may provide any other relevant information regarding its financial position and must enclose with the application a fee of \$2,500. This fee is used by the Commissioner to offset the cost of the review of the financial information analyzed in making a decision on self-insurance.¹²

A regular subscribing employer who wishes to self-insure its risk must make application for self-insurance by December 31 of a given year in order for the self-insurance, if granted, to be effective on July 1 of the following year. An employer who has not subscribed to the Fund in the past may apply for self-insurance at the time it registers with the Fund to do business, and is generally not subject to the same time frames that apply to regular subscribing employers.¹³ With regard to those time periods, the rules generally provide a schedule of dates aimed at having information in the Commissioner's hands for analysis in sufficient time for self-insurance to be effective on July 1 of the year after the application is filed. However, the rules also make provision for extension of the deadlines, provided good cause can be established by the employer. It is also imperative that a regular sub-

9. *Id.* § 5.1.

10. *Id.* § 5.2.

11. *Id.* § 5.2.2.

12. *Id.* § 5.4.

13. *Id.* § 5.5.

scribing employer who applies for self-insurance, continue to make its quarterly premium payments in a timely manner until self-insurance is approved.¹⁴

Once the financial information has been received by the Commissioner, a careful review of the employer's account, if previously a regular subscriber, is undertaken. A regular subscribing employer, whose account shows a liability against the Workers' Compensation Fund as a result of benefits paid in excess of premiums received, shall not be permitted to self-insure its risk. An employer whose account shows such a negative balance is required to pay to the Fund the entire amount of the excess liability before self-insurance can become effective. In certain circumstances, the amount of such excess liability may be repaid on a repayment schedule, rather than in a lump sum, provided that such repayment agreement does not compromise the Commissioner's "fiduciary responsibility" to the Fund as a whole and such repayment term does not extend beyond three years.¹⁵

B. The Pre-Certification Audit

Once an employer is granted the right to self-insure its risk, any future cost of awards or medical benefits payable after the effective date of self-insurance become the direct responsibility of the employer. Generally, at the time the application is reviewed, the Commissioner may attempt to determine an amount sufficient to cover claims that are incurred but not reported and may allow an employer to buy out that liability.¹⁶

Essential to the granting of self-insurance, the Commissioner must review and approve the "form, type, and amount of the security or bond" provided by the employer to insure the continued payment of self-insured benefits.¹⁷ Once the security has been approved, the employer's open and closed claims are transferred from regular sub-

14. *Id.* § 5.6.

15. *Id.* § 6.1.

16. *Id.* § 6.2.

17. *Id.* § 6.2.1.

scriber status to the self-insured account.¹⁸ If an employer is required by the Commissioner to pay in advance the estimated cost of any future liability, that amount may also be paid under a repayment agreement which shall not exceed three years.¹⁹

When an employer's regular subscriber account shows an excess of premiums paid over liabilities incurred, the Commissioner must consider that factor in determining the amount of security required for self-insurance. Unfortunately, for the employer, such an excess of premium payments is not an entitlement to any type of credit or refund.²⁰

At the time of application for self-insurance, an employer has two elections to make in setting its coverage. Prior to 1991, an employer had the opportunity to self-insure its second injury risk as well as its catastrophe risk. Second injury coverage is now mandatory through the surplus fund for all self-insured employers.²¹ However, as noted previously, the employer may elect to self-insure its catastrophe risk or may continue to pay into the surplus fund for that coverage. If an employer elects to self-insure the catastrophe risk, additional security will be required by the Commissioner to cover that particular hazard.²²

The employer must also determine whether to elect to make direct payments to health care providers or to have such payments processed through the Commissioner's office for the generation of pay orders. In order to qualify for direct payments, the employer must (1) designate a responsible party who will actually make the payments; (2) maintain a

18. *Id.* § 6.2.1.a.

19. *Id.* § 6.2.2.

20. *Id.* § 6.3.

21. W. VA. CODE § 23-3-1 (Supp. 1993) creates the Surplus Fund which includes both the catastrophe reserve and the second injury reserve. The purpose of the second injury reserve is to create a fund for payment of life awards where an individual claimant becomes permanently and totally disabled due to the combined effects of more than one injury or occupational disease. In a second injury situation, the employer is chargeable only for the permanent partial disability attributable to the injury which occurred in his workplace, with the remainder of the permanent total disability award being paid from the second injury reserve of the Surplus Fund.

22. 85 W. VA. C.S.R. 9 § 7.1.2 (1993).

file on each claimant, with a copy of each invoice received and a record of the action taken; (3) pay invoices within thirty days of receipt or give notification to the health care provider and the Commissioner the reason for any delay; (4) consult the Commissioner when an invoice is disputed for assistance in resolving the dispute; (5) provide invoices to the Commissioner for processing in allocated claims; (6) provide invoices for Occupational Pneumoconiosis Board evaluations to the Commissioner for processing; (7) bear the responsibility for collecting any overpayments or duplicate payments; (8) when invoices are to be paid by the Commissioner, provide them to the Commissioner's office for handling along with an explanation of the same; (9) provide the appropriate Internal Revenue Service reporting forms to the various health care providers for payments made during any given calendar year; and (10) furnish the Commissioner with an annual report of all medical payments made during the previous fiscal year.²³

C. *Failure To Meet Requirements*

When an employer fails to meet any of the above requirements, the privilege of direct payments will be revoked after notice of the revocation and an opportunity for a hearing. The employer may also, at any time, request to change its election for direct vendor payments or contribution to the catastrophe reserve, with the status being reviewed by the Commissioner and a decision on the same being rendered and effective at the beginning of the next quarterly reporting period.²⁴

In the review process itself, the Commissioner is charged with the duty of assessing the employer's financial strength to determine whether or not such an employer is capable of meeting its benefit payment obligations. The Commissioner generally performs this evaluation with the assistance of an actuary and the Fund's in-house staff.

23. *Id.* § 7.1.3.

24. *Id.* § 7.1.3.a.

D. Bonding

With regard to bonding requirements, the minimum amount of security presently required is \$1 million. The amount of that security may be greater depending upon the circumstances and the Commissioner's determination of an amount sufficient to secure the payment obligations of the employer. The Commissioner has the authority and is obligated to review the sufficiency of the security on a periodic basis and is required to mandate additional security where the circumstances merit.²⁵

At the present time, the Commissioner accepts several types of security and bonds which include "occurrence type" bonds and letters of credit. The "occurrence type" security should be sufficient to guarantee payment for benefits payable during the period for which it is effective. The security would remain encumbered at the time the award is made or during the period of time for which benefits continue to be paid.²⁶

If marketable securities are utilized for this requirement, the rules require that the same be fixed term debt instruments, that the issuer must be a governmental entity, that the instrument not have a maturity greater than ten years, and that the principle and interest be payable in United States dollars at a fixed rate.²⁷ Finally, a letter of credit may also be posted to satisfy the security requirements if issued by a bank operating in the United States and if it contains language approved by the Commissioner and an "evergreen" clause.²⁸

As previously noted, the present minimum security requirement is \$1 million. How much additional security shall be required is based upon the employer's financial situation and previous loss experience.²⁹ The Commissioner will review each employer's situation annually upon application for the privilege of continued self-insurance. As a part of

25. *Id.* § 9.1.

26. *Id.* §§ 9.3 to 9.3.1.

27. *Id.* § 9.3.2.

28. *Id.* § 9.3.3.

29. *Id.* § 9.4.

that review, the Commissioner may determine to adjust security requirements and may require additional security or reduce the present security held, but not to an amount less than the \$1 million minimum.³⁰

When the Commissioner determines that an employer's security is inadequate, an order will be entered directing the employer to increase the security within a specified period, not to exceed ninety days.³¹ Should an employer fail to obtain the additional required security, the privilege of self-insurance is terminated.³² If an employer believes that a decreased adjustment in its security is necessary, a request may be made by written petition. If all necessary information is available, a decision on the petition will be rendered within ninety days.³³

All new self-insuring companies are now required to subscribe and pay premiums into the second injury reserve of the surplus fund. Those premiums are merit rated on the basis of industrial classes grouped together to reflect common risks related to the payment of such awards. As with premium rate determination for regular subscribers, the Commissioner is required to assign base rates to each industrial class for the second injury premium. Based upon an individual employer's use of the second injury reserve, as compared to the base rate, the Commissioner may modify the assigned rate on an annual basis to reflect that use. Again, as with the premium generation mechanism for regular subscribers, a three year period is utilized by the Commissioner in determining modification factors for the second injury premium.³⁴

In order to remain self-insured, an employer must maintain its financial position and must undergo an annual review.³⁵ The employer must also continue to meet all of its self-insurance obligations throughout the course of the fiscal year. In that regard, any self-insured employer who has elected to make direct payments to medical vendors

30. *Id.* § 9.5.

31. *Id.* § 9.5.1.

32. *Id.* § 9.5.2.

33. *Id.* § 9.5.3.

34. *Id.* §§ 10.1 to 10.2.2.

35. *Id.* § 11.1.

must continue to comply with those specific provisions. A self-insured employer must also continue to meet its obligations to honor pay orders generated by the Commissioner's office. A pay order for temporary total disability benefits must be paid within ten days from receipt. Likewise, pay orders for permanent partial disability benefits are required to be honored within fifteen days from receipt, and all pay orders for medical bills are required to be paid within thirty days of receipt.³⁶

If an employer fails to comply with any self-insured requirement, the Commissioner may suspend or terminate the self-insured status, after written notice. Under certain circumstances, the Commissioner has the discretion to allow an employer to correct any failure within a ninety day period without a revocation of the self-insurance privilege.³⁷ In addition to the specific provisions contained in the Series 9 rules, additional rules exist governing the performance of self-insured employers. In *UMWA v. Lewis*,³⁸ the West Virginia Supreme Court of Appeals held that West Virginia Code Section 23-2-9 places upon the Commissioner the responsibility for terminating self-insurance when a claimant has shown that a self-insured employer is not meeting its statutory obligations.³⁹ The Court also held that the Commissioner must establish a procedure for claimants to raise the issue of non-compliance. When non-compliance is found, penalties to that employer may include suspension of self insurance, termination of self insurance, or substantial fines payable to the claimant.⁴⁰

As a result of the decision in *UMWA v. Lewis*, Series 5 of the Workers' Compensation Fund Rules was promulgated and became effective on May 23, 1985.⁴¹ Those rules establish a procedure for the filing of complaints by individual claimants, where a self-insured employer refuses or fails to meet its self-insured obligations for benefit payments or payment of medical expenses. These rules also provide

36. *Id.* § 11.2.

37. *Id.* § 11.3.

38. 309 S.E.2d 58 (W. Va. 1983).

39. *Id.*

40. *Id.*

41. 85 W. VA. C.S.R. 5 §§ 1 to 4 (1985).

for the investigation of complaints, decisions based upon such investigations, and a hearing and appeal process.⁴² The Series 5 rules also prescribe the possibility of a financial penalty to be assessed against a non-complying employer, payable to the claimant in an amount not to exceed \$5,000, as well as a revocation of self-insurance.⁴³

E. Termination of Self-Insurance Status

In addition to the *involuntary* termination of self-insurance status, an employer may *voluntarily* terminate its self-insured account and return to the Fund as a regular subscriber. As with the initial application to become self-insured, when voluntary termination is sought, the employer must pay a \$2,500 fee for an actuarial review to determine the estimated future cost of outstanding liability. The Commissioner will not permit an employer to terminate its self-insured status and become a subscriber until provisions are made for the maintenance of adequate security or the payment of the estimated outstanding liability.⁴⁴ In certain circumstances, the cost of the future liability may be paid under a repayment agreement not to exceed three years, provided that such an agreement does not compromise the Commissioner's fiduciary responsibility to the Fund. Any interest on such a repayment agreement would also be calculated.⁴⁵

When a self-insured employer decides to terminate its business entity, notification must be given to the Commissioner, and again, a \$2,500 fee must be paid in order to cover an actuarial review for calculating the estimated future liability. The employer must also decide whether or not to continue making benefit payments while maintaining adequate security, or pay the full amount of the future liability either in a lump sum or by repayment agreement.⁴⁶

42. *Id.* §§ 2.1 to 3.3.

43. *Id.* §§ 4.1 to 4.3.

44. 85 W. VA. C.S.R. 9 §§ 13.1 to 13.1.2 (1993).

45. W. VA. CODE § 23-2-13 (Supp. 1993).

46. 85 W. VA. C.S.R. 9 §§ 13.2 to 13.2.1 (1993).

F. Sale, Transfer, Or Reorganization of Business

These same basic provisions apply when a self-insured employer ceases doing business as a result of the sale or transfer of its business to another company. When the contract of sale anticipates an assumption of liability by the successor company, a copy of the contract must be filed with the Commissioner before the closing date of the transaction. After a review of the contract, the Commissioner will determine whether or not to give effect to the terms of the contract and will issue a written decision to that effect.⁴⁷ If the Commissioner decides to give effect to the agreement, the successor company must either buy out the estimated future liability or post sufficient security to cover the outstanding obligation.⁴⁸ The penalty for not filing a copy of the contract of sale and obtaining permission in advance is the continued liability of the seller for all accruing obligations.⁴⁹

The Series 9 rules also contain provisions applicable to a situation where an employer's business has been reorganized or modified in some manner with the acquisition of additional assets, operations, or other business. When any such modification has taken place, the employer has an obligation to notify the Commissioner of the change and may be required to file an application for self-insurance for any new business that has been acquired.⁵⁰ The Commissioner's staff will then undertake a review of the security requirements and make any necessary adjustments.

G. Buy-Outs

At any time, the Commissioner may require, or an employer may propose, a "buy out" of the outstanding self-insured liability for the present value of all unpaid benefits. The Commissioner may require this on an individual claim basis if the same is in keeping with his

47. *Id.* § 13.4.

48. *Id.* § 13.4.1.

49. *Id.* § 13.4.2.

50. *Id.* §§ 12.1 to 12.2.

fiduciary responsibility to the Fund. Additionally, as with the other "buy out" provisions, a repayment agreement may be utilized that does not exceed three years and that carries interest pursuant to West Virginia Code Section 23-2-13.⁵¹ Finally, any employer who in the past may have been self-insured and is presently a regular subscriber, may also enter into a "buy out" agreement for extinguishing any outstanding self-insured obligations.⁵²

The Series 9 rules also contain extensive provisions for administrative hearings and protests by employers to decisions made on their self-insured status. In short, the employer has the right to protest any written decision by the Commissioner by filing a written protest within thirty days from receipt of the objectionable order or decision.⁵³ The appeal of any final decision is to the Circuit Court of Kanawha County pursuant to West Virginia Code Section 23-2-17, or through the hearing and appeal process set forth in West Virginia Code Section 23-5-1, the normal route of litigation in workers' compensation claims.⁵⁴

III. PRACTICAL CONSIDERATIONS

The first question to be answered by an employer contemplating self insurance is whether or not the business is financially sufficient to guarantee the workers' compensation risk and has the ability to meet the security requirement. Individual self-insurance generally operates best when an employer is of such a size that the risk can be spread among a great number of employees. Assuming that the initial question has been answered in the affirmative, the employer must next consider the premium/loss payout condition of its account. If the Fund has paid more in losses than has been collected in premium, the employer will be required to pay the difference before self-insurance is granted. The employer who benefits most from self-insurance is the one who has

51. *Id.* § 14.

52. *Id.* § 15.1.

53. *Id.* § 17.

54. *Id.* § 17.6.

paid in more premium dollars than the Fund has paid out in benefit payments.

An employer should also look closely at the nature of its business enterprise. Specifically, consideration must be given to the long term prospects of continuing in business in West Virginia. Additionally, the employer must determine whether or not sufficient administrative personnel are available to handle the daily oversight necessary to administer a self-insurance program. There is simply no substitute for competent people to monitor ongoing claims when benefit payments are being made directly.

Another important consideration is the travel distance involved for employees traveling either to and from work or as a part of the work itself. A major cost of any workers' compensation claim is the medical expense and associated payments for temporary total disability benefits. It is difficult to have any control over such expenses when dealing with physicians or medical facilities in a different state or geographical area.

Finally, it is helpful to examine the labor/management relationship of the business and the likelihood that an injured employee will be motivated to return to work. The ability to successfully encourage employees to return to work quickly has a direct impact on temporary total disability benefit payments and will determine how well benefit costs are controlled.

In summary, self-insurance, in the right business situation, can be a very valuable part of controlling workers' compensation claim costs. Consequently, not only is a careful analysis of the statutory and regulatory requirements necessary, but sufficient thought should be given to the practical effects of such a decision.