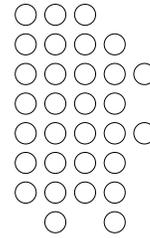


# OFFICE OF SELF-INSURANCE PLANS

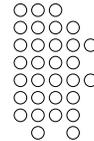
## OVERVIEW OF SELF-INSURANCE AND THE AUDIT PROCESS

**Presenters:**

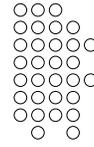
**James A. Ware**  
**Marilee Robinson**  
**Lyn Asio**



## WHAT IS Self-Insurance Plans?

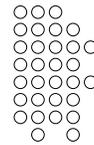


## Overview of Self-Insurance

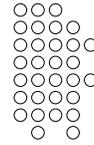


- Self Insurance Plans (SIP), a program within the director's office of the Department of Industrial Relations (DIR), authorizes qualified employers to provide their own coverage for workers' compensation liabilities. The director of Industrial Relations is responsible for certification of public and private self insured employers, third-party administrative agencies that oversee self insurance programs, and individual claims adjusters. Self insurers are required to post a security deposit -- adjusted annually to cover liabilities incurred -- and to submit to SIP audits.

## Overview of Self-Insurance

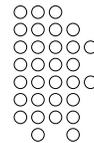


- SIP determines the deposit requirement for all employers to cover expected future claim costs in the event the entity defaults in its California workers compensation obligations.
- The required security deposit ranges from 135% to 200% of estimated future claim liabilities (less any applicable excess insurance coverage of specific open claims). The claim liabilities are based upon the formula contained in each self-insured's most recent Annual Report (year ending Dec 31). An SIP claim audit of a self-insured may result in adjustments to its stated Annual Report claim liabilities. These adjustments may impact the self-insured's required deposit as well as its annual assessments.



## Overview of Self-Insurance

- Based on the information provided and an organization's financial health and status, self-insured employers will fall into one of two major categories:
  - (1) Participating in the Alternative Security Program (ASP) which covers the deposit by payment of an annual fee of 1 to 3% of the deposit requirement; or
  - (2) Excluded, which requires the posting of a cash, securities, letter of credit or surety bond or any combination of these four types of collateral to cover the deposit requirement.



## Overview of Self-Insurance

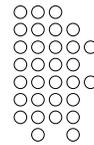
- Eligibility for the ASP is based on credit worthiness. An employer with an A or B public credit rating will be eligible unless within the first 3 years of self insurance or specifically requested to be excluded by the Self Insurer's Security Fund (SISF). SISF may also request an employer with a high credit rating be included in the first 3 years. If there is no public rating SISF will review the employer's financial information and give a credit equivalency of a 1 through 16 corresponding with the range of A and B credit ratings.
- All self insured employers belong to the SISF, only some belong to the ASP.

## Overview of Self-Insurance



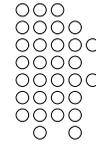
California has one of the largest workers' compensation self insurance programs in the nation. As of January 1, 2011, a total of 7466 California employers were actively self insured and 1734 past self insured employers were still paying claims from their periods of self insurance. These totals include both private and public employers.

## The Audit Process



## **The Audit Process**

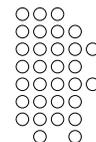
### **Why We Audit**



- To determine if the security deposit posted by the self-insurer is adequate to cover liabilities incurred.
- To ensure compliance with the estimating, reporting and recordkeeping requirements in the regulations.
- To ensure compliance with the workers' compensation laws of California.

## **The Audit Process**

### **Consequences**



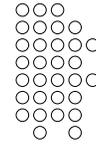
Our primary focus when auditing is to determine if the estimates of future liability are adequate so in the event of an employer default there will be enough funds to pay benefits to injured workers.

When a default occurs the Self-Insurers' Security Fund assumes the workers' compensation obligations of an insolvent self-insurer.

#### **Labor Code 3744(c)**

The fund shall have the right to bring an action against any person to recover compensation paid and liability assumed by the fund, including, but not limited to, any excess insurance carrier of the self-insured employer, and any person whose negligence or breach of any obligation contributed to any underestimation of the self-insured employer's total accrued liability as reported to the director.

## The Audit Process Consequences

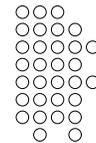


When there appears to be a pattern of improper action with regard to payment of benefits to injured workers' or other violations of the workers' compensation laws of California, we may make a referral to the Division of Workers' Compensation Audit Unit or other State agencies to facilitate further investigation and action.

### Revocation:

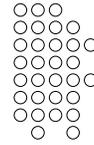
Labor Code Section 3702 outlines good cause for revocation of a certificate of consent to self-insure.

## The Audit Process You Received Notice of an Audit – Now What?



## **The Audit Process**

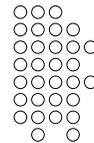
### **You Received Notice of an Audit – Now What?**



- There are three types of audits: routine, revocation and special.
  - Routine audits are conducted every three years.
  - Revocation audits are conducted when the self-insurer is leaving the program and special audits are ordered when problems found during a routine audit are so severe that additional claims require review.
  - A special audit may also be ordered due to negative information obtained from other sources. The expenses incurred as a result of routine and special audits are paid by the self-insurer.

## **The Audit Process**

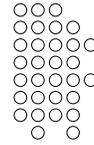
### **You Received Notice of an Audit – Now What?**



- The auditor will notify you of the anticipated start date and provide you with a list of claims that will be reviewed.
- Pursuant to CCR §15400.2(d) All claim files and claim logs, together with records of all compensation benefit payments, shall be readily available for inspection by the Manager or his representatives.
- CCR §15400.1 outlines the required contents of the claim log. The claim log must be kept up to date at all times.

## The Audit Process

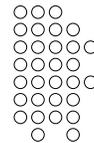
### You Received Notice of an Audit – Now What?



- CCR §15400 and CCR §10101.1 outline the required contents of the claim file.
  - The claim file may be paper, electronic or a combination of both.
  - File is complete and current for each claim
  - Documents include but not limited to:
    - DWC Form 1 or, if the DWC Form 1 was not returned by the employee, documentation that the employer provided a claim form to the employee or documentation that the administrator has provided the claim form to the employee.
    - DLSR Form 5020
    - Every notice, correspondence either initiated or received by the claims administrator, or report sent to the Division of Workers' Compensation.
    - Doctor's First Report of Occupational Injury or Illness
    - Every medical report pertaining to the claim, or documentation of reasonable attempts to obtain them.
    - All orders or awards of the WCAB or Rehabilitation Unit pertaining to the claim
    - Record of payment compensation.
    - Bills and liens, explanations of benefits, requests for consideration of payment, denials of bill.

## The Audit Process

### You Received Notice of an Audit – Now What?



The self-insurer's annual report is also reviewed for accuracy.

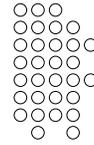
#### The Annual Report, CCR §15251

List of ALL separate, but affiliated or subsidiary companies covered by the certificate.

#### Location of Claims Records Information

- Name and address of any location other than the current administrator where claims records are stored

**The Audit Process**  
**You Received Notice of an Audit – Now What?**

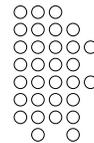


The Annual Report, CCR §15251

Specific excess workers' compensation insurance policy

- List claims covered by excess insurance
- Name of Specific Excess Carrier, Policy Number and period
- Employer's Retention and Upper Policy Limit
- Was claim reported to carrier?
- Was claim acknowledged or accepted by the carrier or was liability denied either partially or fully by the carrier?
- Total payment by excess carrier to date of the claim
- Total paid on the claim

**The Audit Process**  
**You Received Notice of an Audit – Now What?**



The Annual Report, CCR §15251

List of Indemnity Claims

- By year reported
- Alphabetically within the year
- Name of claimant
- Date of injury
- Description of injury
- Amount of benefits paid, indemnity
- Amount of benefits paid, medical
- Estimated future liability, indemnity
- Estimated future liability, medical

## The Audit Process

### You Received Notice of an Audit – Now What?



#### Maintenance of Records, CCR §15400.2

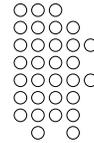
Keep and maintain claim files for a period of five years from the date of injury or from the date of the last provision of benefits, whichever is later.

Future medical claims:

- Shall not be destroyed
- May be converted to inactive or closed status but only if there is no reasonable expectation that future benefits will be claimed or provided.

## The Audit Process

### You Received Notice of an Audit – Now What?



#### Maintenance of Records, CCR §15400.2

Storage of inactive and closed claim files:

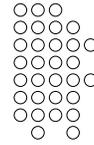
Microfilm- must be readily reproducible into legible paper form if requested for an audit

Electronic- must be readily reproducible into legible paper form if requested for an audit

Paper

## The Audit Process

### You Received Notice of an Audit – Now What?



Storage of all claim files and claim logs

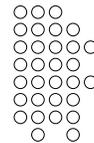
In California only

Storage in a location outside of California requires written approval from the Manager.



## The Audit Process

### Estimating Future Liability



#### CCR §15300

Subsection (b):

- Set a realistic estimate of future liability
- EFL should reflect what is reasonably expected to be due over the life of a claim
- EFL is based on information and documents in the file as of December 31<sup>st</sup> of the reporting year

Subsection (b)(1): Indemnity Reserves

- TD
- PD
- Death benefits, including burial
- Vocational Rehabilitation, including vendor costs
- Supplemental Job Displacement Benefit Voucher

## The Audit Process Estimating Future Liability



### Subsection (b)(1): Medical Reserves

- All medical treatment
- Before 2011, medical cost containment if costs are allocated to a particular claim
- Starting 2011, medical cost containment programs will not be included
- Future cost of medical evaluations

### Subsection (b)(1): Additional estimates

- Labor Code §132a filing (discrimination against workers who are injured in the job) Employee's compensation is increased by half, but no more than \$10,000 plus reinstatement and reimbursement for lost wages and work benefits caused by the acts of the employer.

## The Audit Process Estimating Future Liability



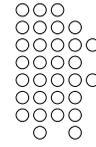
### Subsection (b)(1): Additional estimates

- Labor Code §4553 filing (serious and willful misconduct) Compensation is increased by half and costs and expenses not to exceed \$250.
- Labor Code §5814 filing (unreasonable delay or refusal of payment of compensation) Amount of payment unreasonably delayed or refused is increased up to 25% or up to \$10,000, whichever is less.

### Subsection (b)(2): Permanent Disability

- Where there are conflicting permanent disability ratings, the estimate shall be based on the higher rating unless there is sufficient evidence in the claim file to support a lower estimate.
- Include life pension, if permanent disability rating warrants life pension benefits.
- Reserve for life pension using the life expectancy tables.

## The Audit Process Estimating Future Liability



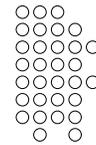
Subsection (b)(3): Reserving for medical when the employee has not reached a P&S/MMI status

- Where the employee's injury has not yet reached maximum medical improvement or permanent and stationary status, estimate based on projected costs for the total anticipated period of treatment throughout the life of the claim.
- For certain injuries, it is known that future medical treatment will be needed for the employee's life expectancy.

Subsection (b)(4): Reserving for medical when the employee is P&S/MMI

- Reserves shall be based on average annual costs over the past three years since the injury reached MMI/P&S status, or a lesser period if three years have not passed since the injury reached MMI/P&S status, projected over the life expectancy of the injured worker
- Reserve for any additional costs such as medical procedures or surgeries that can reasonably be expected over the life of the claim

## The Audit Process Estimating Future Liability



Subsection (b)(5): Reserving for medical when the employee is P&S/MMI

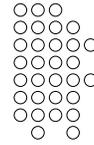
- Include any costs that can reasonably be expected to occur that are not included within the averages to reserves based on average past costs.
- Reserves may be reduced to account for any treatment not reasonably expected to occur in the future based on medical documentation in possession of the administrator.

Subsection (b)(6): Reserving for medical when the employee is P&S/MMI –  
To reduce or not to reduce

- Do not reduce based on undocumented anticipated reductions in frequency of treatment.
- Do not reduce based to reflect the substitution of treatments with a lower cost than utilized by the injured worker that may be available but that the injured worker is not utilizing.

## The Audit Process

### Estimating Future Liability



Subsection (b)(6): Reserving for medical when the employee is P&S/MMI –  
To reduce or not to reduce

- Reserves may be reduced based on reductions in the approved medical fee schedule and based on utilization review, except when the reductions are reasonably disputed.
- Reserves may be reduced based on the expectation of a third party recovery **only** in instances where an Order allowing credit has been issued pursuant to Labor Code Section 3861.

Subsection (b)(7): Life expectancy tables

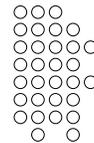
- Estimates of lifetime medical care and life pension benefits shall be determined based on the injured workers' life expectancy according to the most recent U.S. Life Expectancy Tables as reported by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

The most recent life expectancy tables can be found at:

<http://www.dir.ca.gov/sip/pubandforms.htm>

## The Audit Process

### Estimating Future Liability



Subsection (b)(8): Apportionment

- Permanent disability reserves shall not be reduced based on apportionment unless the claim file includes documentation supporting apportionment

Subsection (b)(9): To reduce or **not** to reduce

- Estimates shall not be reduced to reflect present value of future benefits

Subsection (d): To reduce or **NOT** to reduce

- Do not reduce based on projected third party recoveries or projected reimbursements from aggregate excess insurance
- Do not reduce reported paid costs based on third party recoveries or aggregate excess insurance reimbursements.

## **The Audit Process**

### **Estimating Future Liability**



Subsection (g): How often should you adjust reserves?

- Immediately upon receipt of medical reports.
- Immediately upon receipt of orders of the Appeals Board.
- Immediately upon receipt of other relevant information that affects the valuation of the claim.
- No less than annually.

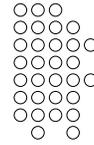
## **The Audit Process**



- Depending on the findings of the audit, other documents may be requested by the auditor during the audit.
- You may discuss the audit findings with the auditor at any time during the audit.
- When the audit is complete a post-audit conference will be held with the employer and the administrator to discuss the findings of the audit.
- If you have an EFL shortfall, an amended annual must be submitted if you are claiming additional credit for specific excess insurance not reported on your annual report.
- After receipt of the audit report the employer may informally or formally request an appeal of the audit findings.

**Website:**

**<http://www.dir.ca.gov/SIP/>**



**For:**

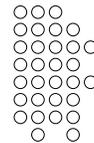
List of certified administrators, self-insured employers and third-party administrators

Rulemaking

Forms

Additional information regarding self-insurance

**Labor Code and Regulation Sections  
Pertaining to Self-Insurance**



- Labor Code Sections 3700 through 3747
- 8CCR§ 15200 through 15481

**OFFICE OF SELF-INSURANCE PLANS**  
**OVERVIEW OF SELF-INSURANCE**  
**AND THE AUDIT PROCESS**

**3744.** (a) The fund shall have the right and obligation to obtain reimbursement from an insolvent self-insurer up to the amount of the self-insurer's workers' compensation obligations paid and assumed by the fund, including reasonable administrative and legal costs. This right includes, but is not limited to, a right to claim for wages and other necessities of life advanced to claimants as subrogee of the claimants in any action to collect against the self-insured as debtor.

(b) The fund shall have the right and obligation to obtain from the security deposit of an insolvent self-insurer the amount of the self-insurer's compensation obligations, including reasonable administrative and legal costs, paid or assumed by the fund. Reimbursement of administrative costs, including legal costs, shall be subject to approval by a majority vote of the fund's trustees. The fund shall be a party in interest in any action to obtain the security deposit for the payment of compensation obligations of an insolvent self-insurer.

(c) The fund shall have the right to bring an action against any person to recover compensation paid and liability assumed by the fund, including, but not limited to, any excess insurance carrier of the self-insured employer, and any person whose negligence or breach of any obligation contributed to any underestimation of the self-insured employer's total accrued liability as reported to the director.

(d) The fund may be a party in interest in any action brought by any other person seeking damages resulting from the failure of an insolvent self-insurer to pay workers' compensation required pursuant to this division.

**3702.** (a) A certificate of consent to self-insure may be revoked by the director at any time for good cause after a hearing. Good cause includes, among other things, the impairment of the solvency of the employer to the extent that there is a marked reduction of the employer's financial strength, failure to maintain a security deposit as required by Section 3701, failure to pay assessments of the Self-Insurers' Security Fund, frequent or flagrant violations of state safety and health orders, the failure or inability of the employer to fulfill his or her obligations, or any of the following practices by the employer or his or her agent in charge of the administration of obligations under this division:

(1) Habitually and as a matter of practice and custom inducing claimants for compensation to accept less than the compensation due or making it necessary for them to resort to proceedings against the employer to secure compensation due.

(2) Where liability for temporary disability indemnity is not in dispute, intentionally failing to pay temporary disability indemnity without good cause in order to influence the amount of permanent disability benefits due.

(3) Intentionally refusing to comply with known and legally indisputable compensation obligations.

(4) Discharging or administering his or her compensation obligations in a dishonest manner.

(5) Discharging or administering his or her compensation obligations in such a manner as to cause injury to the public or those dealing with the employer.

(b) Where revocation is in part based upon the director's finding of a marked reduction of the employer's financial strength or the failure or inability of the employer to fulfill his or her obligations, or a practice of discharging obligations in a dishonest manner, it is a condition precedent to the employer's challenge or appeal of the revocation that the employer have in effect insurance against liability to pay compensation.

(c) The director may hold a hearing to determine whether good cause exists to revoke an employer's certificate of consent to self-insure if the employer is cited for a willful, or repeat serious violation of the standard adopted pursuant to Section 6401.7 and the citation has become final.

**3702.6.** (a) The director shall establish an audit program addressing the adequacy of estimates of future liability of claims for all private self-insured employers, and shall ensure that all private self-insured employers are audited within a three-year cycle by the Office of Self Insurance Plans.

(b) Each public self-insurer shall advise its governing board within 90 days after submission of the self-insurer's annual report of the total liabilities reported and whether current funding of those workers' compensation liabilities is in compliance with the requirements of Government Accounting Standards Board Publication No. 10.

(c) The director shall, upon a showing of good cause, order a special audit of any public self-insured employer to determine the adequacy of estimates of future liability of claims.

(d) For purposes of this section, "good cause" means that there exists circumstances sufficient to raise concerns regarding the adequacy of estimates of future liability of claims to justify a special audit.

### ***§15403. Audits.***

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(a) Pursuant to Labor Code Sections 129 and 3702.6, the Manager may order an audit of any self insurer or individual claim file at such reasonable times as is deemed necessary. Such audits shall include, but not be limited to, an audit of the files and records required by Section 15400 of these regulations. Such files and records shall be made readily available by the self insured employer or its administrative agency.

(b) In the event of an audit, the Manager may require that claims administered at the home of a telecommuting adjuster be presented for audit at a California office location of the administrator, or at a California location of the self insured employer.

Note: Authority cited: Sections 54, 55 and 3702.10, Labor Code. Reference: Sections 59, 129, 3700, 3702 and 3702.6, Labor Code.

### **HISTORY**

1. Amendment filed 6-1-72; effective thirtieth day thereafter (Register 72, No. 23).

2. Amendment filed 2-19-92; operative 3-20-92 (Register 92, No. 13).

3. Amendment designating first paragraph as subsection (a) and new subsection (b) filed 2-9-2006; operative 3-11-2006 (Register 2006, No. 6).

**§15400. Claim File.**

---

(a) Every self-insurer or its administrative agency shall keep a claim file of each indemnity and medical-only work-injury occurring on or after January 1, 1990, in accordance with Title 8, Section 10101 and Section 10101.1.

(b) For work injuries occurring prior to January 1, 1990, every self insurer shall keep a claim file including those claims which were denied. Said claim file shall contain, but not be limited to, a copy of:

- (1) Employers Report of Occupational Injury or Illness, Form No. 5020;
- (2) Every report made to the Administrative Director of the Division of Industrial Accidents; including but not limited to the letter of denial to the employee;
- (3) Doctor's First Report of Occupational Injury or Illness, Form No. 5021;
- (4) Every subsequent relevant medical report;
- (5) All applicable orders of the Workers' Compensation Appeals Board and reports relating thereto;
- (6) A record of payment of compensation benefits as compensation is defined in Section 3207 of the Labor Code, together with a record of the periods covered by disability payments, including a copy of DIA Form 500, Notice of Termination of Benefits;

(c) For injuries reported on or after January 1, 2006, each self administering self insurer and claims administrative agency shall maintain a claim file for each indemnity and medical-only claim, including denied claims, and shall ensure that each file is complete and current for each claim. Contents of claim files may be in hard copy, in electronic form, or some combination of hard copy and electronic form. Files maintained in hard copy shall be in chronological order with the most recently dated documents on top, or subdivided into sections such as medical reports, benefit notices, correspondence, claim notes, and vocational rehabilitation. In addition to the contents specified in Title 8, California Code of Regulations, Section 10101.1, each indemnity file shall contain itemized written documentation showing the basis for the calculation of estimated future liability and for each change in estimated future liability for the claim. Files or portions of files maintained in electronic form shall be easily retrievable.

Note: Authority cited: Sections 54, 55, 59 and 3702.10, Labor Code. Reference: Sections 59, 129, 3700, 3700(b), 3701, 3702, 3702.1, 3702.5, 3702.6, 3703, 3704 and 3705, Labor Code.

**HISTORY**

1. Amendment filed 12-3-69; effective thirtieth day thereafter (Register 69, No. 49).
2. Amendment filed 11-19-75; effective thirtieth day thereafter (Register 75, No. 47).
3. New subsection (g) filed 11-21-78; effective thirtieth day thereafter (Register 78, No. 47).
4. Amendment filed 2-19-92; operative 3-20-92 (Register 92, No. 13).
5. Change without regulatory effect amending subsection (a) filed 11-3-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 46).

6. Repealer and new subsection (c) filed 2-9-2006; operative 3-11-2006 (Register 2006, No. 6).

***§10101.1. Claim File--Contents.***

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This section applies to maintenance of claim files for injuries occurring on or after January 1, 1994.

Every claims administrator shall maintain a claim file of each work-injury claim including claims which were denied. For injuries reported on or after June 19, 2009 each claims administrator shall maintain a claim file for each indemnity and medical-only claim, including denied claims, and shall ensure that each file is complete and current for each claim. Contents of claim files may be in hard copy, in electronic form, or some combination of hard copy and electronic form. Files maintained in hard copy shall be in chronological order with the most recently dated documents on top, or subdivided into sections such as medical reports, benefit notices, correspondence, claim notes, and vocational rehabilitation. Files or portions of files maintained in electronic form shall be easily retrievable. All open claim files shall be maintained at the adjusting location responsible for administering the claim. The file shall contain but not be limited to:

- (a) Either (1) a copy of the Employee's Claim for Workers' Compensation Benefits, DWC Form 1, showing the employer's date of knowledge of injury, the date the employer provided the form to the employee and the date the employer received the completed form from the employee; or (2) if the employee did not return the claim form, documentation of the date the employer provided a claim form to the employee. If the administrator cannot obtain the form or determine that the form was provided to the employee by the employer, the file shall contain documentation that the administrator has provided the claim form to the employee as required by Title 8, California Code of Regulations section 10119.
- (b) A copy of the Employer's Report of Occupational Injury or Illness, DLSR Form 5020, or documentation of reasonable attempts to obtain it;
- (c) A copy of every notice, correspondence either initiated or received by the claims administrator, or report sent to the Division of Workers' Compensation.
- (d) A copy of every Doctor's First Report of Occupational Injury or Illness, DLSR Form 5021, or documentation of reasonable attempts to obtain them.
- (e) The original or a copy of every medical report pertaining to the claim, or documentation of reasonable attempts to obtain them.
- (f) All orders or awards of the Workers' Compensation Appeals Board or the Rehabilitation Unit pertaining to the claim.
- (g) A record of payment of compensation.
- (h) A copy of the application(s) for adjudication of claim filed with the Workers' Compensation Appeals Board, if any.
- (i) Copies of the following notices sent to the employee:
  - (1) Benefit notices, including vocational rehabilitation notices and supplemental job displacement benefit

notices, required by California Code of Regulations, title 8, section 9810, or by California Code of Regulations, title 8, section 10122 through section 10133.60;

(2) Notices and forms related to the Qualified Medical Evaluation or Agreed Medical Evaluator process required by Labor Code sections 4060 et seq.;

(j) Documentation sufficient to determine the injured worker's average weekly earnings in accordance with Labor Code sections 4453 through 4459. Unless the claims administrator accepts liability to pay the maximum temporary disability rate, including any increased maximum due under Labor Code section 4661.5, the information shall include:

(1) Documentation whether the employee received the following earnings, and if so, the amount or fair market value of each: tips, commissions, bonuses, overtime, and the market value of board, lodging, fuel, or other advantages as part of the worker's remuneration, which can be estimated in money, said documentation to include the period of time, not exceeding one year, as may conveniently be taken to determine an average weekly rate of pay;

(2) Documentation of concurrent earnings from employment other than that in which the injury occurred, or that there were no concurrent earnings, or of reasonable attempts to determine this information;

(3) If earnings at the time of injury were irregular, documentation of earnings from all sources of employment for one year prior to the injury, or of reasonable attempts to determine this information.

(4) If the foregoing information results in less than maximum earnings, documentation of the worker's earning capacity, including documentation of any increase in earnings likely to have occurred but for the injury (such as periodic salary increases or increased earnings upon completion of training status), or of reasonable attempts to determine this information.

(k) Notes, correspondence, and documentation, including correspondence to or from any individual or entity, related to the provision, delay, or denial of benefits.

(l) Notes, correspondence, and documentation, including correspondence to or from any individual or entity, related to any utilization review process conducted under Labor Code section 4610.

(m) Notes, correspondence, and documentation, including correspondence to or from any individual or entity, related to a return to regular, modified, or alternative work as defined by Labor Code section 4658.1

(n) Notes, correspondence, and documentation, including correspondence to or from any individual or entity, evidencing the legal, factual, or medical basis for non-payment or delay in payment of compensation benefits or expenses.

(o) Notes, correspondence, and documentation, including correspondence to or from any individual or entity, describing telephone conversations relating to the claim which are of significance to claims handling, including the dates of calls, substance of calls, and identification of parties to the calls.

Note: Authority cited: Sections 59, 129.5, 133, 138.4, 4603.5 and 5307.3, Labor Code. Reference: Sections 124, 129, 129.5, 138.3, 138.4, 139.48, 139.5, 4060, 4061, 4062, 4453, 4454, 4600, 4603.2, 4616, 4621, 4622, 4636, 4637, 4641, 4643, 4644, 4650, 4658.5, 4658.6, 4701-4703.5, 5401, 6409 and 6409.1, Labor Code.

## HISTORY

1. New section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).
2. Amendment of section and Note filed 4-20-2009; operative 5-20-2009 (Register 2009, No. 17).

### ***§15400.1. Claim Log.***

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(a) After January 1, 1993, every self-insurer or its administrative agency shall maintain:

(1) a manually prepared log of all work injury claims for each self-insurer at each adjusting location in accordance with Title 8, Section 10103 and 10103.1; or

(2) a computerized log of claims for each self-insurer at each adjusting location in accordance with Title 8, Section 10103 and 10103.1.

(b) The claim log shall be maintained at each of the self-insurer's or its administrative agency's claims adjusting locations. The claim log at each location shall be kept current and shall include all claims reported to the adjusting location.

(c) A claim log shall be found to be materially deficient if it fails to contain the elements of Title 8, Section 10103 and 10103.1; or fails to include all reported claims; or is not provided to the Manager or any subsequent administrator in readable form.

Note: Authority cited: Sections 54, 55 and 3702.10, Labor Code. Reference: Sections 59, 129, 3700, 3702.1 and 3702.10, Labor Code.

## HISTORY

1. New sections 15400.1, 15400.2, and 15400.3 filed 12-3-69; effective thirtieth day thereafter (Register 69, No. 49).
2. Amendment filed 2-19-92; operative 3-20-92 (Register 92, No. 13).
3. Change without regulatory effect amending subsections (a)(1)-(2) and (c) filed 10-18-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 42).

4. Change without regulatory effect amending subsections (a)(1)-(2) and (c) filed 1-9-98 pursuant to section 100, title 1, California Code of Regulations (Register 98, No. 2).

***§15400.2. Maintenance of Records.***

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(a) All claim files shall be kept and maintained for a period of five years from the date of injury or from the date on which the last provision of compensation benefits occurred as defined in Labor Code Section 3207, whichever is later. Claim files with awards for future benefits shall not be destroyed, but two years after the date of the last provision of workers' compensation benefits as defined in Labor Code Section 3207, they may be converted to an inactive or closed status by the administrator, but only if there is no reasonable expectation that future benefits will be claimed or provided.

(b) Inactive and closed claim files may be microfilmed for storage, however, the original paper files shall be maintained for at least two years after the claim has been closed or become inactive. Such microfilmed files must be readily reproducible into legible paper form if requested by the Manager for audit.

(c) All claim files and the claim logs shall be kept and maintained in California unless the Manager has given written approval to a self insurer or former self insurer to administer its workers' compensation self-insurance plan from a location outside of California.

(d) All claim files and claim logs, together with records of all compensation benefit payments, shall be readily available for inspection by the Manager or his representative.

Note: Authority cited: Sections 54, 55 and 3702.10, Labor Code. Reference: Sections 59, 129, 3700, 3702.1 and 3702.10, Labor Code.

**HISTORY**

1. Amendment filed 2-19-92; operative 3-20-92 (Register 92, No. 13).
2. Amendment of subsection (a) filed 2-9-2006; operative 3-11-2006 (Register 2006, No. 6).

***§15251. Self Insurer's Annual Report.***

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(a) Each self insurer shall file a Self Insurer's Annual Report every year as required by subsections (b) through (g) of this section and shall continue to file a Self Insurer's Annual Report annually after revocation of the Certificate of Consent to Self Insure until a final Self Insurer's Annual Report has been filed showing all claims have been closed and there are no remaining claims with the expectation of future liabilities. Each year no later than 60 days before the deadline for filing the Self Insurer's Annual Report pursuant to subsection (b) or subsection (c) of this section, whichever applies, the Manager shall post the Annual Report form, along with instructions for completing the form and showing the years to be reported, on the website of the Office of Self Insurance Plans at <http://sip.dir.ca.gov/>. Each self-insurer shall file a Self-Insurer's Annual Report on forms supplied by the Manager as follows:

- (1) Form A4-40a (Rev. 6/2001) for individual private and private group self insurers;

(2) Form A4-40b (Rev. 4/92) for all public self insurers, including those that are members of a Joint Powers Authority;

(b) For private self insurers, individual or with a group, the report shall be filed on or before March 1 of each year and shall include the following information:

(1) General Information.

(A) Certificate to Self Insure number, status of certificate, and period of report.

(B) Name and address of master certificate holder, state of incorporation, federal tax identification number, and first four digits of North American Industry Classification System (NAICS).

(C) List of all subsidiaries or affiliate companies that are covered by the master certificate to self insure, their state of incorporation, and their subsidiary/affiliate certificate number.

(D) Notification of any reincorporation, merger, change in name or identity or any additions to the self insurance program by the master certificate holder or any subsidiary/affiliate company during the reporting period.

(E) Name and address of person to whom all correspondence related to self insurance should be addressed.

(F) Employment and wages paid in that calendar year as reported to Employment Development Department on the employer's Form DE-6 Quarterly Report.

Exception: A Certificate to Self Insure that is revoked for three full years is not required to submit this employment and wage information.

(2) Claims Liability and Administrator Information.

A Liabilities by Reporting Location report shall be submitted by each claims administrator administering claims for the said self insurer and shall include:

(A) All claims reported on or before December 31 of each of the five prior calendar years (January 1 through December 31), showing indemnity and medical payments grouped as incurred liability, paid to date and future liability.

(B) All open claims reported prior to the five years shall also be reported as in subsection (b)(2)(A), but in a single line entry;

(C) For the reporting year of the annual report the total of indemnity and medical future liability, the total estimated future liability of claims, the total benefits paid, number of medical only cases reported, number of indemnity cases reported; number of fatality cases, number of claims for which the employer or administrator was notified of representation by an attorney or legal representative in the reporting year, and number of new applications for adjudication received for any claims that year.

(D) Total number of open indemnity cases in all years.

(E) Name, address and Certificate to Administer number of the self insurer's claims administrator.

(F) Notification of any change in administrator during the period covered by the report and, if applicable, the name and address of the prior administrator.

(G) A certification by the qualified claims administrator that the report is true, correct and complete with respect to the workers' compensation liabilities incurred and paid, signed and dated with the name and address of the said administrator completing the Liabilities by Reporting Location page.

(3) Location of Claims Records Information. The name and address of any location other than the current administrator where self insurance claims records are stored.

(4) Insurance Information. Name and policy number of any standard workers' compensation insurance policy, specific excess workers' compensation insurance policy, or aggregate worker's compensation insurance policy held by the self insurer along with policy issue date and retention levels of liability of the policies.

(5) Open Indemnity Claims Information. A list of all open indemnity claims by reporting location by year, and alphabetically within each year. The list shall:

(A) Show the name of each claimant, date of injury, description of injury, amount of benefits paid-to-date in indemnity and medical payments and estimated future liability of claim for indemnity and medical benefits.

Note: Computer Loss Runs showing the information requested and organized as set forth in this subsection will be acceptable in lieu of the List of Open Indemnity Claims, a section of Form A4-40a (Rev. 6/2001) or Form A4-40b (Rev. 4/92) provided by the Manager.

(B) Show any open claim reported to the carrier of a specific excess insurance policy, and for which the carrier has not denied in writing the claim liability in whole or part above the retention level of the policy. The list shall include the name of the claimant, claim number, date of injury, description of injury, carrier name and policy number, policy coverage period, retention level of policy and paid to date in indemnity or medical benefits, and the estimated future liability of the claim minus the total unpaid employer retention, which equals the total unpaid carrier liability. The list shall also indicate whether the claim has been reported to a carrier, if the claim has been accepted by the carrier, if the carrier has denied any part of the liability of the claim.

(6) Specific Excess Coverage Calculation. A calculation which includes a total of all unpaid carrier liability times the applicable deposit rate for the self insurer. This number will be included in the deposit calculation as provided for in Section 15251(b)(7).

(7) Deposit Calculation Information. A Deposit Calculation which includes the estimated future liability from the Liabilities Report multiplied by the deposit rate factor to determine a minimum deposit required for known liabilities; plus a deposit in advance for the current new year based on the average estimated future liability of claims for the past five years to secure average unpaid liability in the current year's new claims; less any credit for claims exceeding the retention level of any specific excess insurance policy for which the carrier has accepted liability in writing to arrive at the deposit required calculation. The specific excess credit shall be not exceed \$500,000 per occurrence unless the excess carrier or its parent company has as of December 31 of the last year covered by the Self Insurer's Annual Report an acceptable credit rating as set forth below:

(A) Standard and Poors Insurer Financial Strength Rating of A or better rating, or

(B) A.M. Best Company, Financial Strength Rating of B+ or better rating.

The total of the current security deposit is then subtracted from the minimum deposit required to determine if a deposit increase is due or a deposit decrease is indicated.

(8) Company Officer Certification Information. The name, title, address, phone number and original signature of the company officer authorized by Board Resolution to certify that the report is true, correct and complete and acknowledging the company's responsibility to post and maintain the required security deposit that is due as a result of this report.

(c) For all public self insurers, whether or not a member of a joint powers authority, the report shall be filed by October 1 of each year to cover liabilities during the July 1-June 30 fiscal year and shall include:

(1) General Information.

(A) Name and address of master certificate holder (individual agency or joint powers authority as applicable), federal tax identification number, and type of public agency.

(B) Agency name and certificate numbers of all of the joint powers authority's members.

(C) A certification by the individual public agency or joint powers authority official that the report is true, correct and complete.

(D) Notification of any reincorporation, merger, change in name or identity or any additions to the self insurance program by the master certificate holder or any subsidiary/affiliate company during the reporting period, and identification of any employees not included in the self insurance program.

(E) Name and address of person to whom all correspondence related to self insurance should be addressed.

(F) Employment and wages paid in that fiscal year as reported to Employment Development Department on the employer's Form DE-6 Quarterly Report.

Exception: A public employer whose Certificate of Consent to Self Insure has been revoked is not required to submit employment and wage information.

(2) Liability Report and Administrator Information.

(2) Liability Report and Administrator Information.

A Liabilities Report which shall include:

(A) All claims reported shall be on a fiscal year basis (starting July 1 and ending June 30 of the reporting years), with all claims reported on or before June 30 of each of the five prior fiscal years, showing indemnity and medical payments grouped as incurred liability, paid to date and future liability.

(B) All open claims reported prior to the five years shall also be reported as required in (b)(2)(A), but in a single line entry.

(C) Each Joint Powers Authorities (JPA) shall report the consolidated liabilities of all members of the JPA on one Liabilities Report.

(D) A Liabilities by Reporting Location Report shall be completed in full for each claims adjusting location in addition to the consolidated report totaling liabilities from all locations.

(E) For any Joint Powers Authority, one list of all open indemnity claims may be consolidated into a single listing for the entire JPA, as long as the individual JPA member is identified for each claim.

(3) Claims Information for each year shall meet the requirements of subsection (b), except that no deposit calculation page shall be submitted as required for private self insurers pursuant to subsection (b)(7).

(d) The Manager may, for good cause, require any self insurer to submit a Self Insurer's Annual Report covering a six-month interim period, in addition to the annual report specified in subsection (b) and (c) of this section.

(1) For private self insurers, such interim reports, when required, shall cover the period starting January 1 and ending June 30 of each year and shall be due on September 1 of each year.

(2) Public self insurer's interim reports shall cover July 1 through December 31 and shall be due on March 1 of each year.

(e) The Manager shall assess the civil penalty set forth in Labor Code Section 3702.9(a) against any self insurer for failure to file a complete and timely Self Insurer's Annual Report. Continued failure to file an Annual Report sixty days after assessment of civil penalties pursuant to Section 3702.9(a) shall be good cause for revocation of a certificate to self insure.

(f) For good cause shown by the self insurer or its administrative agency, the Manager may grant additional time to a self insurer to file the report without penalty.

(g) Unless otherwise approved by the Manager, the consolidated liabilities report (page 2 of the annual

report) and reporting location reports (page 3 of the annual report) shall be signed by a competent person, as demonstrated pursuant to Section 15452(b) of these regulations, in the employment of the self insurer or administrative agency for the self-insurance plan.

(h) The employer's certification on the Self Insurer's report shall be signed by:

(1) an officer or employee of the self insurer authorized by the Board of Director's Resolution to sign documents for self insurance matters; or

(2) an authorized public self insurer officer or employee; or

(3) an authorized officer or employee of the joint powers authority to which the public agency is a member; or

(4) an authorized officer or employee of the Self Insurer's Security Fund where the Director has turned over responsibility for an insolvent private self insurer's claim liability to the Fund pursuant to Labor Code Section 3701.5(c).

Note: Authority cited: Sections 54, 55 and 3702.10, Labor Code. Reference: Sections 59, 129, 3700, 3701.5, 3702.2, 3702.3, 3702.9 and 3702.10, Labor Code; and Sections 1063.1 and 1063.3, Insurance Code.

#### HISTORY

1. Amendment filed 6-1-72; effective thirtieth day thereafter (Register 72, No. 23).
2. Amendment of section heading and text filed 10-16-92; operative 11-16-92 (Register 92, No. 42).
3. Amendment of subsections (a) and (b)(5)(B) and new subsection (b)(5)(B)1 filed 8-10-93; operative 8-10-93 (Register 93, No. 33).
4. Amendment of subsections (a)-(b), (b)(1)(F) Exception and (b)(5)(B) filed 6-30-94; operative 6-30-94 (Register 94, No. 26).
5. Change without regulatory effect amending subsections (b)(1)(F) and (c)(1)(F) filed 10-18-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 42).
6. Amendment filed 5-7-2001; operative 6-6-2001 (Register 2001, No. 19).
7. Change without regulatory effect amending subsection (a)(1) and form A4-40a (incorporated by reference) filed 8-1-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 31).

8. Change without regulatory effect amending subsection (b)(2)(A)(7.) filed 4-7-2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 15).

9. Amendment of section and Note filed 3-2-2009; operative 3-2-2009 pursuant to Government Code section 11343.4 (Register 2009, No. 10)

***§15300. Estimating and Reporting Work Injury Claims.***

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(a) A list of open indemnity claims shall be submitted with each self insurer's annual report as required by Section 15251(b)(5)(A)-(B) and (c)(7).

(b) The administrator shall set a realistic estimate of future liability for each indemnity claim listed on the self insurer's annual report based on computations which reflect the probable total future cost of compensation and medical benefits due or that can reasonably expected to be due over the life of the claim. Each estimate listed on the self insurer's annual report shall be based on information in possession of the administrator at the ending date of the period of time covered by the annual report. Estimated future liabilities listed on the annual report must represent the probable total future cost of compensation for the injury or disease based on information documented as in possession of the administrator at the ending date of the period of time covered by the annual report. In setting estimates of future liability, the administrator shall adhere to the following principles:

(1) Each estimate of future liability shall separately reflect an indemnity component and a medical component. The indemnity component shall include the estimated future cost of all temporary disability, permanent disability, death benefits including burial costs, and vocational rehabilitation including vendor costs. The medical component shall include the estimated future cost of all medical treatment, including costs of medical cost containment programs if those costs are allocated to the particular claim, and the estimated future cost of medical evaluations. Estimates of future liability shall include any increases in compensation in either component reasonably expected to be payable pursuant to Labor Code Sections 132a, 4553, and/or 5814.

(2) In estimating future permanent disability costs, where there are conflicting permanent disability ratings, the estimate shall be based on the higher rating unless there is sufficient evidence in the claim file to support a lower estimate.

(3) In estimating future medical costs where the injured worker's injury has not reached maximum medical improvement or permanent and stationary status, the estimate shall be based on projected costs for the total anticipated period of treatment throughout the life of the claim.

(4) In estimating future medical costs where the injured worker's injury has reached maximum medical improvement or permanent and stationary status, the estimate shall be based on average annual costs over the past three years since the injury reached maximum medical improvement or permanent and stationary status, or a lesser period if three years have not passed since the injury reached maximum medical improvement or permanent and stationary status, projected over the life expectancy of the injured worker. Estimates shall include any additional costs such as medical procedures or surgeries that can reasonably be expected over the life of the claim.

(5) Estimates based on average past costs shall be increased to include any costs that can reasonably be expected to occur that are not included within the averages. Estimates based on average past costs may be reduced to account for any treatment not reasonably expected to occur in the future based on medical documentation in possession of the administrator.

(6) Estimates of future medical costs based on average past costs shall not be reduced based on undocumented anticipated reductions in frequency of treatment or to reflect the substitution of treatments with a lower cost than utilized by the injured worker that may be available but that the injured worker is not utilizing. Estimates based on average past costs may be reduced based on reductions in the approved medical fee schedule and based on utilization review, except that reductions in estimates based on utilization review may not be reduced if the reductions are reasonably disputed. Estimates of future liability may be reduced based on the expectation of a third party recovery only in instances where an Order allowing credit has been issued pursuant to Labor Code Section 3861.

(7) Estimates of lifetime medical care and life pension benefits shall be determined based on the injured worker's life expectancy according to the most recent U.S. Life Expectancy Tables as reported by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Note: the most recent life expectancy tables can be found at <http://www.cdc.gov/nchs/datawh/nchsdefs/lifeexpectancy.htm>.

(8) Estimates of permanent disability shall not be reduced based on apportionment unless the claim file includes documentation supporting apportionment.

(9) Estimates shall not be reduced to reflect present value of future benefits.

(c) All medical-only claims reported on the self insurer's annual report shall be estimated on the basis of computations which will develop the total future cost of medical benefits due or that can reasonably expected to be due based on information documented as in possession of the administrator at the ending date of the period of time covered by the annual report.

(d) Estimates of future liability shall not be decreased based on projected third party recoveries or projected reimbursements from aggregate excess insurance, nor shall reported paid costs be decreased based on third party recoveries or aggregate excess insurance reimbursements.

(e) The incurred liability estimate on known claims may be capped at the retention level of any specific excess workers' compensation insurance policy to the extent that each claim has not been denied in writing by the carrier. The self insurer's claims administrator shall list each claim covered by a specific excess insurance policy on Part VI-B of the Self Insurer's Annual Report. An adjustment to the total deposit required to be posted shall be made for claims covered by specific excess insurance policy on the annual report to the extent that they meet the requirements in Section 15251(b)(5)(B) of these regulations.

(f) Estimates of incurred liability, payments-made-to-date and estimated future liability of all compensation benefits shall be made immediately available at the time of audit if not already documented in the claim file, or when requested by the Manager.

(g) The administrator shall adjust the estimate immediately upon receipt of medical reports, orders of the Appeals Board, or other relevant information that affects the valuation of the claim. Each estimate shall be reviewed no less than annually. Estimates set by a prior administrator shall be reviewed by the current administrator before filing the Self Insurer's Annual Report.

Note: Authority cited: Sections 54, 55 and 3702.10, Labor Code. Reference: Sections 54, 55, 59, 129, 132a, 3700, 3702.3, 3702.6, 3702.10, 3703, 3740-3745, 3861, 4553 and 5814, Labor Code.

## HISTORY

1. Amendment filed 12-3-69; effective thirtieth day thereafter (Register 69, No. 49).

2. Amendment of article heading, section heading, section and new Note filed 8-10-93; operative 9-9-93 (Register 93, No. 33).

3. Repealer and new subsection (b), new subsections (b)(1)-(4), amendment of subsection (c), repealer and new subsection (d), new subsection (g) and amendment of Note filed 2-9-2006; operative 3-11-2006 (Register 2006, No. 6).