

Agenda

Rulemaking Advisory Committee

Workers' Compensation Division Rules
OAR chapter 436, division 050
Employer/Insurer Coverage Responsibility

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	9/24/15 9:00 a.m. to Noon, Room 260 (self-insurance) 10/1/15 10:30 to Noon, Room 260 (insurers' claim processing and record-keeping) 10/5/15 9:00 a.m. to 11:30, Room 260 (self-insurance) 10/13/15 9:00 a.m. to Noon, Room F (self-insurance) All meetings are in the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon Dial-in information (all meetings): 213-787-0529 Access code: 9221262#
Facilitator:	Fred Bruyns, Workers' Compensation Division
Steps:	Welcome and introductions; meeting objectives Request for new issues – discussion of new issues Discussion of issues on agenda Summing up – next steps – thank you!

Attachments:

- [Issues document \(self-insurance only\)](#)
- [OAR 436-050](#)
- [Bulletin 209](#) (and related forms)

**DIVISION 050 – RULES ADDRESSING SELF-INSURANCE
ISSUES DOCUMENT
September 16, 2015**

ISSUE #1 – OAR 436-050-0150, new (4) and (5) – “Qualifications of a Self-Insured Employer”

Issue: What information should applicants for individual self-insurance certification and certified self-insured employers provide to the director to demonstrate “acceptable financial viability? Should the information and ratios or measures required for individual self-insured employers be the same as, or differ from, those currently required for self-insured groups? And, should different information or measures be required for individual self-insured employers that are government entities or public utilities than are used for private sector self-insured entities?

Background: A primary objective for this rulemaking is to complete implementation of 2014’s SB 1558 that required all self-insured employers, in addition to providing a security deposit, to demonstrate “acceptable financial viability based on information required by the director by rule.” Rules effective September 2014 added related requirements for self-insured groups. This rule is one of several that need to be amended to similarly implement SB 1558 for individual self-insured entities. 050-0150(3) can be rewritten in an (a) and (b) format, similar to 050-0260(11)(a) and (b)(C) applying to groups, to address both the deposit and the new financial ratios or measures. Then, a new (4) and (5) addressing the specific financial ratios or measures for individual self-insured entities, similar in format to the 050-0260(12) and (13) rules for self-insured groups, can be added.

OAR 436-050-0260, effective September 15, 2014, required self-insured groups to demonstrate acceptable current and liquidity ratios (two short-term measures commonly used to evaluate financial viability relating to working capital and access to assets) and a longer-term industry metric, the premium to surplus ratio. Both WCD and the DCBS Insurance Division consider working capital and liquidity important factors since they reflect an entity’s ability to access its net worth to pay claim liabilities. While there isn’t a statutory or rule requirement that WCD use certain ratios, the division’s long-standing certification and annual financial reviews for both applicants and certified entities have relied on nine common ratios (four of them having an associated point scoring system). Those nine ratios are:

- Current ratio (working capital), a scored ratio;
- Quick ratio (quick assets; excludes inventory and prepaid expenses);
- Liquidity ratio, a scored ratio;
- Equity ratio (total liability divided by shareholder’s equity);
- Asset ratio (net worth; total assets divided by total liability);
- Long-term debt to equity ratio, a scored ratio;
- Return on investment ratio;
- Net income to shareholder’s equity ratio, a scored ratio; and
- Net income to sales ratio.

WCD also reviews the revenue and sales for the entity, as warranted.

One question for discussion is whether some or all of the measures required for self-insured groups should be used for individual self-insured employers? If there should be differences, what are the reasons and alternatives? For example, groups must demonstrate a satisfactory premium to surplus ratio, but if the same ratio for an individual self-insured entity is weak, it might indicate the entity is trying to increase its net worth. While that ratio may make sense for groups, measures for individual self-insureds should perhaps focus on income. More generally, it may be appropriate to use a broader set of factors to determine financial viability for both individual and self-insured groups than those initially implemented for groups.

Another issue for the committee(s) to discuss is whether different measures or methods for evaluating financial viability should be used for individually self-insured governmental entities and public utilities, given their fundamentally different revenue, budgeting, and financial reporting mechanisms and requirements? If so, what types of measures should be used?

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #2 – OAR 436-050-0150(4) – “Qualifications of a Self-Insured Employer”

Issue: Should this rule be amended to state that failure of a certified self-insured employer to maintain the qualifications required in this rule section “may” result in revocation of the employer’s certification?

Background: The current rule, by using “will,” requires the director to revoke a self-insured employer’s certification for violations of this rule’s basic self-insurance qualifications. Changing the language to “may” will provide the director the discretion to determine when revocation is warranted or when other remedial actions or plans may be appropriate in a particular situation.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #3 – OAR 436-050-0160(1)(c) – “Applying for Certification as a Self-Insured Employer”

Issue: Based on the financial criteria established in 050-0150 (Issue #1), this rule will need to be amended to require that financial statements or reports submitted by self-insurance applicants demonstrate working capital in an amount that “establishes financial strength, liquidity, and viability” based on those measures.

Background: In addressing applications for private group self-insurance, 050-0270(1)(e)(B) requires applicants to provide statements or reports establishing financial viability consistent with the group self-insurance financial qualifications in 050-0260. Similarly, with 050-0150 being amended to specifically address the financial viability qualifications for individual self-insured entities, this rule should clarify that financial statements or reports submitted with individual self-insurance applications must demonstrate financial strength consistent with those qualifications.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #4 – OAR 436-050-0160(1)(f) and (2) – “Applying for Certification as a Self-Insured Employer”

Issue: Should these rules be amended to require an employer applying for self-insurance certification and intending to use a service company to process its claims to provide a signed service agreement that meets the requirements of 050-0210(3) with the other required information and materials in its application? [see Issue #25 for suggested amendments to 050-0210(3)]

Background: OAR 436-050-0160(1)(f) currently states that if the applicant for self-insurance certification will be using a service company, that it must provide the signed service agreement within 30 days after the date of certification. This provision originally acknowledged that such employers would not have previously, as a carrier-insured employer, directly contracted with a service company and would need time to get such an arrangement in place. However, this timeframe is inconsistent with the 050-0110(3) requirement for the director’s prior review and approval of insurers’ service company agreements before the latter entities may begin processing claims. In recent years, WCD has identified increasing problems with service company agreements submitted by both insurers and self-insured employers. Problems include the use of service companies not authorized to do business in Oregon, delegation to out-of-state third parties for portions of claims processing, agreements between parties other than the insurer/self-

insured employer and service company, absence of a power of attorney provision, agreement provisions for processing activities prohibited in Oregon, etc.

Because it is important that such issues are corrected before processing by a service company may begin, WCD recommends that self-insurance applicants be required to provide the service agreement prior to the desired certification date, for the director's review and approval. As part of an applicant's planning and pricing for the self-insurance option, it is reasonable to expect that the applicant will be able to submit the service agreement for review before it takes effect. Assuming this rule change is made, 050-0160(2) would also be amended to reflect that the director's notice to the applicant that it qualifies as a self-insured employer would include approval of the service agreement.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #5 – OAR 436-050-0170(4) – “Excess Insurance Requirements”

Issue: Should this rule be amended to specify a required timeframe for a self-insured employer or group to submit requests to WCD to change the self-insured retention level and policy limits on its excess policy?

Background: The current rule states that changes in self-insured retention level and policy limits require the director's prior approval, but doesn't indicate a time period sufficient for WCD to consider the request and respond. In some cases, WCD finds out about a change after it has been made and must sometimes direct the self-insured to re-adjust the retention level or security deposit amount. Because the director considers self-insured retention levels and policy limits in the context of the entity's security deposit amount, claim liabilities, risk and exposure, and financial status and viability, it's important that the division review and approve any proposed changes beforehand. It would be helpful if the rule specified when the self-insured employer/group must submit the change request. Assuming excess insurers are providing 60-day policy renewal notices to self-insured employers, is requiring self-insureds to submit any proposed changes to WCD for approval 45 days prior to the excess policy's effective date sufficient time for self-insureds to evaluate their option? Or is 30 days prior to the policy effective date more feasible?

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #6 – OAR 436-050-0170(4)(b) or new (c) – “Excess Insurance Requirements”

Issue: Should this rule specify, for individual self-insured employers, that “financial viability as determined under OAR 436-050-0150” is one of the criteria considered by the director when reviewing requests to change excess policies’ self-insured retention level or policy limits?

Background: This rule was amended in September 2014 to include similar language for self-insured groups (regarding financial viability determined under 050-0260) as part of the changes to implement SB 1558’s provisions. The rule should include the same factor for individual self-insured employers.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #7 – OAR 436-050-0170(7) – “Excess Insurance Requirements”

Issue: Should this rule be amended to state that a self-insured employer must not transfer claims for processing to any service company subsidiary of its excess insurer?

Background: When a claim reaches the excess policy’s self-insured retention level, the self-insured employer or group still retains full responsibility for claims processing and the payment of compensation. The self-insured will be reimbursed for subsequent amounts it pays on that claim by the excess insurer. The prohibition on transferring claims to the excess insurer for processing is intended to avoid processing decisions that may inappropriately focus on limiting subsequent costs in ways that may not meet all ORS Chapter 656 requirements, delay benefits, or increase litigation; this is particularly of concern to WCD when the excess claims of a bankrupt self-insured employer are involved. In a recent case, an active self-insured’s claim reaching the excess retention level was, at the excess insurer’s direction, transferred to the latter’s service company subsidiary for processing; all other claims remained with the self-insured employer. Doing so seems to conflict with the director’s intent in these situations. Because the parties may be making such transfers based on separate agreements or policy provisions, it may be that the rule needs to prohibit either self-initiated or carrier-directed transfers of excess claims to the

excess carrier's processing subsidiary. It would be helpful to hear the committee's perspectives regarding the processing of excess claims.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #8 – OAR 436-050-0170(9) - “Excess Insurance Requirements”

Issue: Should this rule be amended to state that if a self-insured employer fails to comply with the excess insurance requirements, its “certification as a self-insured **may** be revoked?” If so, should the rule address the possible assessment of civil penalties for violations, as an alternative? Should the last sentence be reworded to more generally reference coming into compliance with all requirements in this section as the means for ending a pending revocation action?

Background: The current rule states that if a self-insured employer doesn't comply with the excess insurance requirements the director will revoke its self-insurance certification. As with Issue #2, changing the language to “may” will provide the director the discretion to determine when revocation is warranted or when other actions, including assessing civil penalties, may be appropriate in a particular situation. If this change is made, then a sentence about the possible assessment of civil penalties by the director should also be added to the rule.

This rule is intended to address the consequences for not complying with all of the excess insurance requirements in this section. However, the last sentence narrowly addresses only the situation of not providing the required insurance. This section also addresses using only excess insurers authorized to do business in Oregon, particular coverage provisions and minimum retention levels, obtaining prior director approval for changes in retention levels and policy limits, not transferring excess claims to the excess insurer for processing, etc. WCD recommends rewriting the sentence to more generally address the timely resolution of violations relative to any pending revocation action.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #9 – OAR 436-050-0175, new (3) – “Annual Reporting Requirements”

Issue: Should a rule be added to state that the financial statements and reports filed annually by an individual self-insured employer must demonstrate its acceptable financial viability based on the criteria added under OAR 436-050-0150 (see Issue #1), including, but not limited to satisfactory financial ratios or measures?

Background: The current rule 050-0175(3) was added in the September 2014 rulemaking implementing SB 1558 provisions for self-insured groups, to address what the financial statements and reports submitted annually by groups under (1) of the same rule must sufficiently demonstrate. With this rulemaking implementing financial viability measures for individual self-insureds, a similar rule is needed to address their reports. Since the financial criteria for individual and group self-insureds will be in different rules (050-0150 and 050-0260, respectively), and this rule currently addresses net worth which doesn't apply to individual self-insureds, the agency committee suggested it may be clearer to have separate 050-0175 rules address individual and group self-insured reports instead of rewording the current (3) to address both.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #10 – OAR 436-050-0175(4)(a) – “Annual Reporting Requirements”

Issue: Should this rule be amended to clarify that “the amount of the group’s combined net worth” means the aggregate total of its members’ net worth? Or should this clarification be made in OAR 436-050-0260(3)?

Background: In the September 2014 rulemaking for self-insured groups, 050-0260(3) was amended to address the new minimum, combined net worth requirement for groups, and for private employer groups, the minimum net worth requirement for each member. This rule, 050-0175(4)(a), requires groups to annually file with the director a statement certifying the amount of the group’s combined net worth. Based on some of the initial statements filed by groups and questions to self-insurance program staff, it appears there is confusion about whether the combined net worth reported and certified should be that of the self-insured group entity itself, or the total of the members’ individual net worth, combined. It is the latter amount. Both the prior version of ORS 656.430(7) and amendments made by SB 1558 established that employer members “as a group” must have “combined net worth” meeting specified requirements; this does not refer to the group business entity itself. While this reporting rule could be amended to

clarify that distinction, the agency committee suggests that it would be better to make the clarification in 050-0260(3), which establishes the combined net worth requirement for groups. That latter rule is already referenced in 050-0175(4)(a), linking the two rules.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #11 – OAR 436-050-0175(4)(a) and (5)(a) – “Annual Reporting Requirements”

Issue: Should these two related rules be amended to more clearly communicate the director’s intent for how self-insured groups are to demonstrate annually that they continue to meet the net worth requirements, and to address the related concerns raised by groups?

Background: SB 1558, effective April 1, 2014, replaced the longstanding minimum combined net worth of at least \$1 million by requiring employers in a self-insured group to meet combined net worth requirements adopted by the director by rule. The new law reflected legislative intent that as an important aspect of financial viability, the net worth threshold for group self-insurance certification needed to be more robust and the director needed the ability to more closely monitor the ongoing financial health of the groups. OAR 436-050-0260(3), adopted September 15, 2014, provided both the specific net worth requirements and that “the employers as a group” must “demonstrate and maintain” the required amounts [at least \$3 million combined net worth for each group, and for private groups, at least \$150,000 net worth for each member]. That rule further requires private groups to obtain annual financial data from all members, as the basis for demonstrating that both the groups’ combined net worth and members’ individual net worth meet the respective requirements. These two rules, 050-0175(4)(a), and 050-0175(5)(a) for private groups, were also adopted to address how groups demonstrate to the director that they continue to meet the net worth requirements for self-insurance certification.

In their initial application, however, these rules have raised some questions. For example, does a statement certifying that a group’s combined net worth meets or exceeds the required \$3 million (and \$150,000 for private group members, under the second rule) satisfy the 050-0175(4)(a) requirement? Or does the current wording “certifying the amount of” require that the annual statement specify a group’s actual total net worth? When promulgating the rule, the division intended that groups annually certify the “fact” that they currently meet the net worth requirement(s) but that the division could verify that statement by requesting additional, supporting information and the group(s) would have to provide it. However, because the rule refers to certifying “the amount of” the group’s net worth, it appears that the annual certification must actually provide the specific net worth amount. While this interpretation is consistent with the 050-0260(3)(a) requirement that groups “demonstrate” that they meet the minimum

qualification for initial and continued certification, and “maintain” an amount of at least \$3 million, the agency committee suggests that these two rules be amended to reflect the division’s original intent. The rules would clarify that 1) each group must annually certify the fact that members’ aggregate (combined) net worth meets or exceeds the \$3 million requirement, 2) for private groups, that each member’s individual net worth is at least \$150,000, and 3) that the director may request additional information about the specific amounts as needed to verify continued compliance with self-insurance requirements including, but not limited to, certification, financial status, and group membership.

When the director seeks to verify a group’s specific aggregate net worth, or the individual net worth of private groups’ members, and requests that information, some groups have expressed concerns about the sensitive nature of the groups’ or members’ net worth information and the possibility that it may be subject to disclosure under a public records request. Under Public Records laws, specifically ORS 192.501(2) and 192.502(4), even if information qualifies as a trade secret or a confidential submission, the division must disclose it if the public interest regarding that particular disclosure outweighs the interest in maintaining confidentiality. Considering the particular circumstances of any public records request (the reasons for the request, the interest served, and the factual circumstances surrounding the request) is part of the agency’s determination of whether information must be disclosed. For these reasons, the division cannot provide a prospective opinion or certification that certain documents will be maintained as confidential. Inherent in the director’s authority to ensure that regulated parties continue to meet chapter 656 requirements is the ability to request and obtain information that demonstrates those requirements are being met. However, WCD can discuss options with each group for how they can satisfy the net worth information reporting requirement while also addressing the group’s concerns about its sensitive information. In the case of private groups, for example, it may be that a list showing each member’s net worth with the members designated (“coded”) by number rather than name, and an aggregate total, may be possible.

Alternatives:

- Clarify that the self-insured group is certifying the fact that it meets or exceeds the required combined (aggregate) net worth requirement of \$3 million, and for private groups, that each member’s net worth is at least \$150,000.
- Amend the rule to state that the director may request additional supporting information demonstrating the specific amount of the group’s net worth, and for private groups, the specific amount of some or all members’ individual net worth.
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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #12 – OAR 436-050-0175(6)(a)(A)(iv) and (v) – “Annual Reporting Requirements”

Issue: Should these rules be amended to require that a separate list of all claims with incurred losses of \$15,500 or less be provided for each experience rating period to the director when claim loss data described in this rule is reported each year?

Background: Every year, self-insured employers must report claim loss data described in Bulletin 209 to the director by March 1st. For claims occurring during the experience rating period, they are required to report every individual claim with total incurred losses greater than \$15,500 for each specified period, using the Report of Losses format. In doing so, they must list claims in alphabetical order by the worker’s name and include the date of injury, claim number, total paid, outstanding reserves, and total incurred losses. For smaller claims (those with incurred losses of less than \$15,500), self-insured employers need only report the aggregate total paid for all claims under \$15,500 and the number of such claims, for each period.

However, Bulletin 209 requests that self-insureds also provide a separate list of the “under-\$15,500” claims for each experience rating period including worker names, dates of injury, and claim numbers. Almost all self-insured employers do provide these lists to WCD, indicating that it is little trouble to do so (likely because they must use this same information to produce the aggregate dollar totals and claim counts they report to the division). This information is extremely helpful to WCD staff reviewing the Reports of Losses and conducting claims reserve audits, to ensure that all claims and related costs are included for each period and to facilitate any needed adjustments to aggregate “under \$15,500” totals or “over-\$15,500” claims listed individually on the Report of Losses. To ensure the receipt of this information from all self-insured employers, the division recommends making this a requirement for the annual Reports of Losses rather than continuing to request the lists in the bulletin. If this change is made, the two rules could be rewritten as one rule, similar to (6)(a)(A)(vi) which addresses reporting for the “over-\$15,500” claims.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #13 – OAR 436-050-0175(6)(a)(A)(iv), (v), and (vi) – “Annual Reporting Requirements”

Issue: Should the specific dollar amounts referenced in these rules be deleted and a reference added, instead, to the National Council on Compensation Insurance (NCCI) dollar threshold?

Background: For many years, the NCCI threshold for distinguishing smaller and larger losses for data reporting purposes remained the same. In the last few years, however, NCCI increased the threshold incrementally to reach the current \$15,500 level. This amount will likely change in the future, so the agency committee suggests replacing the dollar amount in the rule with a general reference to the NCCI reporting threshold. Then, the annual Bulletin 209 which provides instructions to self-insureds for preparing Reports of Losses submitted to the director could provide the current dollar amount in effect.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #14 – OAR 436-050-0175(7) – “Annual Reporting Requirements”

Issue: Should this rule allowing the director to obtain financial statements, reports, or information from self-insured groups more frequently than required in 050-0175(1) – (5) for reasons related to financial status or viability be amended to pertain to all self-insured employers?

Background: SB 1558, effective April 1, 2014, applied to both individual and group self-insured employers in certain respects, including the requirement to demonstrate “acceptable financial viability based on information required by the director by rule.” This rule currently provides examples of situations when the director might require a self-insured group to submit more frequent financial information. Some of those reasons, such as changes in financial status or viability, net worth, and incurred claims costs, would also be reasons for the director to request more frequent financial reporting from an individual self-insured employer in certain situations. It seems this rule should be amended to apply, then, to both individual and group self-insured employers.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #15 – OAR 436-050-0175(7) – “Annual Reporting Requirements”

Issue: Should this rule allowing the director to obtain financial statements, reports, or information from self-insured groups [and individual self-insured employers, depending on the outcome of Issue #14] more frequently than required in 050-0175(1) – (5) be amended to allow the director to require the provision of more financial information in those situations?

Background: Part of the legislative intent in passing SB 1558 in 2014 was to strengthen the director’s ability to more closely monitor the financial condition of self-insured entities so as to facilitate timely and appropriate regulatory actions and decisions regarding continued certification and sufficient securitization of claim liabilities in case of default or insolvency. The current provisions in 050-0175(1) – (5) only address the required annual submission of audited financial statements or annual reports by all self-insureds, and net worth certifying statements by self-insured groups. In the circumstances given as examples in 050-0175(7) as potentially warranting greater scrutiny by the director, it is possible the director may need more information than that provided in a self-insured entity’s financial statements or annual report. This rule currently addresses only the director’s ability to obtain financial information more frequently when warranted. Consistent with SB 1558’s provision that self-insured entities demonstrate financial viability based on information the director requires by rule, it seems reasonable to also provide the director the ability to ask for more, or different types of, financial information when warranted for a particular self-insured. Examples might include Dun & Bradstreet reports, or an actuarial valuation (though the division recognizes a significant cost factor with this option that would warrant its use in only certain situations).

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #16 – OAR 436-050-0175(10) – “Annual Reporting Requirements”

Issue: Should this rule be amended to clarify what occurs when the director conducts claims reserve audits of a self-insured employer or group?

Background: Many years ago, self-insureds’ claims reserves were audited annually and all open claims were reviewed. In subsequent years, audits were scheduled every other year and relied only on small samples. In reviewing this methodology in 2012, WCD found that in many cases, those samples were too small given an entity’s claim volume and weighted disproportionately towards the smaller claims; this hampered the division’s ability to ensure claims were “valued appropriately” as the rule states. At the same time, WCD sometimes finds that open claims “drop off” Reports of Losses submitted from one year to the next, while other reported amounts don’t

include future medical reserves when warranted (or perhaps only for one year's time), rather than reflecting "life of the claim" potential. Similarly, auditors sometimes find that there aren't reserves on "under \$15,500" claims even though some can reasonably be expected to have additional costs. For all of these reasons, WCD resumed reviewing all open claims over \$15,500 and a sample of "under \$15,500" claims in audits that occur every two to three years. Longer periods may apply to smaller self-insureds with few claims, and low, stable claims liability and deposits.

Since the purpose of the director's Claims Reserve audits is to ensure self-insured employers' claim liabilities "are appropriately valued" as the basis for determining annual deposit amounts to securitize those liabilities, when audits are conducted by WCD, the director's determined values are used to calculate the security deposit, experience rating factor, and retrospective rating adjustments. It isn't sufficient to only recalculate the experience rating factor, and only when the director's and reported claim values differ by 10% or more. The experience rating factor is applied to the self-insured's simulated premium to obtain the estimated premium assessments due. That latter amount is a small component in the deposit calculation that also includes the greater of the self-insured's annual or future claims liability and the claims processing administrative cost. The director's audited values also need to be used for the claims liability-based components in the deposit calculation. Then, if the self-insured's reported values differ by 10 percent or more from the director's determined values, civil penalties may be assessed. The rule can be more clearly worded to clarify what occurs when the director conducts audits of claims reserves. Also, because "test audits" are commonly understood in the industry to refer to payroll and classification audits, that phrase should be replaced with "claims reserve audits" to more clearly reference the director's audits of self-insured claim liabilities.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #17 – OAR 436-050-0180, new (4) – “Determination of Amount of Self-Insured Employer’s Deposit”

Issue: Should a new rule address the percentage factors that will modify the annual deposit amount calculated for individual self-insured employers with financial ratios or measures equaling a "moderate" rating based on criteria in the new OAR 436-050-0150(4) and (5), as proposed in Issue #1?

Background: Currently, 050-0180(4) addresses the percentage factors applied to the deposit amount calculated for self-insured groups with financial ratios equaling a "moderate" rating under 050-0260(13)(b). These factors increase the security deposit for groups with combined

financial ratios falling in the middle and lower portions of the “moderate” range, in consideration of the potentially greater financial risk posed by their financial status. This mechanism is intended to contrast with the more serious consequences for groups with financial ratios falling in the “weak” rating; in those cases, the director may substantially increase the deposit, mandate a financial correction plan, or provide notice of intent to revoke self-insurance certification. Assuming that financial ratios or measures are added to 050-0150 by which individual self-insured employers will demonstrate financial viability, this rule should similarly address how individual self-insureds’ annual deposit amounts will be adjusted for moderate financial ratings.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #18 – OAR 436-050-0180(8) – “Determination of Amount of Self-Insured Employer’s Deposit...”

Issue: Should this rule be amended to clarify how the “Incurred but not reported” (IBNR) amount is calculated, and that the IBNR will be applied to all self-insured employers with a security deposit?

Background: OAR 436-050-0180(1)(b) and (c) state that a self-insured employer’s annual security deposit includes an IBNR. 050-0180(8) states the IBNR is calculated by applying a loss development factor against “the employer’s annual paid losses.” However, DCBS actuaries advised WCD that the IBNR should actually be determined by applying the loss development factor against the self-insured employer’s incurred losses. Clarifying how the IBNR is determined is important in years when the director decides to apply an IBNR factor of greater than 0 percent to self-insured employer’s claim liabilities as part of deposit calculations, particularly since the division’s deposit calculation methodology only considers claims through the end of the prior fiscal year. Claims occurring after that date are not otherwise contemplated in the security deposit, which may be problematic if a self-insured employer defaults during the following 12 – 17 months before the next deposit calculation incorporates those liabilities. To the extent that the existing deposit doesn’t cover all claim liabilities (including those incurred but not yet reported), additional amounts are paid from the Self-Insured Employer Adjustment Reserve (SIEAR) and Self-Insured Employer Group Adjustment Reserve (SIEGAR). These reserves are funded by all self-insured employers and employer groups through premium assessments.

By industry notice dated September 17, 2015, the division notified self-insured employers and groups of its decision to begin applying an IBNR of greater than the 0 percent used previously, in annual security deposit calculations beginning in 2017. When OAR 436-050-0180 was revised in 2004, the division decided at that time to apply an initial IBNR of 0 percent and that factor has

not changed since that time. Since 2004, however, and especially during the 2007-2009 economic recession, a number of self-insured employers and employer groups faced solvency and financial viability challenges. In all cases of insolvency since 2009, the employers' or groups' security deposits have not been, or are not expected to be, sufficient to cover the remaining claim obligations. This has resulted in increased reliance on the SIEAR and SIEGAR to cover the remaining costs.

To better ensure that self-insured employers' and employer groups' security deposits are sufficient to cover their respective claim liabilities and other amounts due the director under ORS chapter 656 in the event of default or insolvency, the division will increase the IBNR factor from its current level of 0 percent starting in 2017. DCBS actuaries are advising a factor of 20 percent to safely include all costs of injuries that will be filed as claims at a later date. To provide self-insured employers and employer groups sufficient time to plan and finance the resulting increases in their security deposits, the division will likely raise the IBNR over a period of three years, reaching 20 percent of incurred claims in the third year. The factor will remain 20 percent thereafter, with periodic reviews of its sufficiency. WCD understands this is a significant shift in the security deposit calculation process that will require additional financial contribution from self-insured employers and employer groups. However, the division believes this change is necessary to ensure the long-term health of the self-insurance coverage option in Oregon while placing the financial burden of insolvent self-insured employers and employer groups on the responsible entities. Given this change, this rule should be amended to clarify the annual application of the IBNR in all self-insured employers' and groups' deposit calculations. The IBNR used each year could then be communicated in an annual bulletin.

Alternatives:

- Clarify that IBNR is applied to a self-insured employer's or groups' incurred losses.
- Clarify that the IBNR will be applied in the annual calculation of all self-insured employers' and groups' security deposits.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #19 – OAR 436-050-0185(3)(b) – “Qualifications for Deposit Exemption for Self-Insured Cities, Counties, and Qualified Self-Insured Employer Groups...”

And

OAR 436-050-0300(1) – “Self-Insured Employer Group, Common Claims Fund”

Issue: Should these rules be amended to provide that a qualified self-insured employer group approved by the director to use a loss reserve account in lieu of the security deposit required under ORS 656.407(2) is not required to maintain a common claims fund under OAR 436-050-0300?

Background: ORS 656.407(3) and OAR 436-050-0185 allow a self-insured city, county, or qualified self-insured employer group (those that are a municipal or public corporation under ORS 297.405) to apply for an exemption to the requirements for a security deposit under 656.407(2). The current 050-0185(1) rule establishes that one qualification for the exemption is that the entity must have “a workers’ compensation loss reserve account that is actuarially sound and...adequately funded as determined by the annual audit” submitted to the Secretary of State to pay all compensation to injured workers and amounts due the director. Separately, under 050-0300, all self-insured groups must establish and maintain a common claims fund (CCF) to ensure the “availability of funds to make certain the prompt payment of all compensation” and other payments due. Given the division’s requirements that self-insured employers and groups report losses occurring through the end of the prior fiscal year when submitting annual Reports of Losses every March 1st (meaning that more current claims are not included in each year’s calculated security deposit amount) and the potential with groups to add members (exposure) during the most recent year, the intent of the CCF is to provide additional assurance that in combination with a group’s security deposit, there will be sufficient funds to cover all claim liabilities in the event that a group defaults.

However, the nature of the actuarial “procedures, methods, and criteria” or actuarial study used as the basis for demonstrating each year that an exempt group’s loss reserve account is actuarially sound and adequately funded contemplates more recent losses and development, as well as claims incurred but not reported. Thus, the division suggests that it may not be necessary for a qualified self-insured group approved to use a loss reserve account in lieu of a security deposit to also maintain a CCF. In effect, where an actuarial valuation with an IBNR is used as the basis for the loss reserve account, that valuation would include the potential claim development contemplated by the CCF. Put another way, the required CCF balance would be an offset to the IBNR.

If this change is made, then 050-0185(3)(b) would be amended to provide that the director’s notice approving the exemption will include authorization for releasing the bank account held by a group as its CCF under 050-0300. That latter rule would also be revised to state, under 050-0300(1), “Except for qualified self-insured employer groups approved by the director as exempt from security deposit requirements under OAR 436-050-0185,” to indicate that these particular groups are exempt from the CCF requirement. [See Issue #33 for a related suggestion potentially affecting self-insured groups with security deposits.]

Alternatives:

- Delete the requirements in 050-0185 and 050-0300 for public groups approved to use a loss reserve account in lieu of a security deposit to also maintain a CCF.
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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #20 – OAR 436-050-0185; new (5) – “Qualifications for Deposit Exemption for Self-Insured Cities, Counties, and Qualified Self-Insured Employer Groups...”

Issue: For self-insured entities exempt from the security deposit requirements, should a rule be added to this section to specify the timeframe in which the self-insured must comply with the director’s order to increase the amount in its loss reserve account? Also, how should the self-insured demonstrate to the director that the increase has been made to the account?

Background: This rule addresses self-insured cities, counties, or groups that are a municipal or public corporation that apply to the director to be exempt from the security deposit requirements. Applicants must meet specific requirements including establishing a workers’ compensation loss reserve account that is actuarially sound and adequately funded. If the director approves the exemption, the self-insured must continue to maintain the loss reserve account at an actuarially sound and adequately funded level. At times, based on financial, actuarial, and claims information, WCD may direct an exempt self-insured to increase the amount of its loss reserve account. OAR 436-050-0180(6) provides a self-insured employer 30 days to comply with a director’s “order” to increase the amount of its security deposit to ensure the director has timely access to the appropriate level of securitization for each self-insured employer or group. Similarly, this rule should specifically address the timeframe for increasing a loss reserve account balance.

Separately, given the differences in governmental entities’ budgeting and finance mechanisms and the timing of related reporting (Comprehensive Annual Financial Reports, or CAFRs) and fiscal year budgets, it would be helpful to discuss how exempt self-insureds should demonstrate that a director-required increase to a loss reserve account has been made.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #21 – OAR 436-050-0190(4) - “Using Self-Insured Employers’ Security Deposit/Self-Insured Employer Adjustment Reserve...”

Issue: Should this rule be amended to include a requirement that individual self-insured employers notify the director of any change to their businesses or operations that affect financial viability?

Background: In September 2014 rulemaking, 050-0190(6) was added to require groups to notify the director within 30 days of any change in their business or operations that affect workers’ compensation claims liability, or financial viability as determined under 050-0260. This

change reflected SB 1558's intent that the director more closely monitor the financial status of self-insured employers. The new rule essentially mirrored language in (4) that now addresses individual self-insured employers, except that this older rule only requires notice to the director about changes affecting workers' compensation liability. With this rulemaking implementing similar oversight by the director of individual self-insureds' financial status, it seems reasonable that 050-0190(4) be amended to include "in any manner that affects its workers' compensation claims liability, **or financial viability as determined under OAR 436-050-0150...**" [see Issue #1]

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #22 – OAR 436-050-0200(2) and (3) – “Self-Insured Certification Cancellation; Revocation”

Issue: Should these rules clarify that if a self-insured employer does not provide all required items, correctly completed and in the required timeframes, regarding its request to cancel its certification that the actual date of self-insurance termination may be later than the date it requested? Should 050-0200(3) provide a specific time frame for providing the director evidence of subsequent coverage?

Background: 050-0200(2) requires self-insureds wanting to cancel certification to provide certain reports, statements, and monies at least 60 days prior to the requested date of cancellation. Under 050-0200(3), they must also provide evidence of subsequent coverage for any subject workers the employer will continue to have after its self-insurance certification ends, prior to the desired date of cancellation. However, some self-insured employers make these requests with shorter notice (30 days, or just a few weeks, before the desired date, for example), and are still correcting or providing required items and information up until the last minute before their desired cancellation date. At times, related matters must still be resolved or corrected in the days or weeks after the official cancellation date. The purpose of the current timeframes is to provide the director and self-insured employer sufficient time to accurately resolve all issues related to the certification termination. Failure to properly address all related matters by the termination date can unnecessarily create legal issues for the division and self-insured, complicate coverage and claims performance, and hamper the division's ability to timely resolve issues for other self-insured employers. While the director makes every effort to effect the termination on the self-insured's desired date in these cases, WCD suggests that these rules state that if all required items are not timely and correctly provided in the stated time frames, the self-insured's actual termination date may be later than the date requested.

The committee(s) should also discuss whether 050-0200(3) should state a specific timeframe for providing the director a proof of coverage filing, evidence of a working leasing arrangement, or assigned risk binder to satisfy subsequent coverage requirements. The current rule says only that this filing or information must be provided “prior to the desired date of cancellation.” WCD understands that these arrangements aren’t always in place until shortly before the cancellation date, but it is problematic to be receiving required coverage information on the last day, or in the last hours, of the self-insured period. Should this rule specify that the subsequent coverage information be filed or provided by three days, or one week, prior to the desired termination date, or the actual termination date may be later than the date requested? Providing a specific timeframe will provide both the division and self-insured employer time to resolve any remaining problems by the desired date.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #23 – OAR 436-050-0210(1) – “Notice of Self-Insurer’s Place of Business in State; Records Self-Insured Must Keep in Oregon”

Issue: Should this rule be amended to clarify that a self-insured employer may not use more than three claims “processors” at any one time? Or, alternately, to define what qualifies as a “location?”

Background: This rule currently requires self-insured employers to maintain at least one Oregon location where their claims are processed and records are maintained. It also states that a self-insured employer may not have more than three such locations at any one time, mirroring a 1975 statute’s use of the word “location.” Specifically, ORS 731.475 established a limit of one processing location per insurer, and the original limit subsequently applied to self-insured employers under ORS 656.455(3). The 1989 Legislature, however, increased the allowed number of claims processing locations for insurers and self-insured employers to eight and three, respectively. 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 number-of-location limits imposed by the legislature addressed the Department’s testimony about workers needing 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 and self-insured employers some flexibility in using different servicing companies. The difference in the number of processing locations allowed insurers and self-insured employers recognized the

difference between the former having to handle claims for a large number of employers with a variety of existing processing arrangements (some tied to multi-state operations) and the latter involving single employers responsible only for their own employees' claims. WCD also testified that the eight locations allowed insurers or three locations allowed self-insured employers 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 or self-insured employer is self-administering some of its claims, that counts as one of the allowed processing locations.]

WCD is increasingly addressing situations with insurers or self-insured employers exceeding their allowed number of processing locations. Some have even used different (unrelated) processors located in the same building and counted those as one "location." These practices aren't consistent with the intent of the 1985 law. The rule should clarify what constitutes a location as it relates to the number of allowed processors, and that self-administration of any portion of the claims counts as one of the allowed locations.

Alternatives:

- Amend the rule to define "location," as it relates to the allowed number of locations, and clarify that self-administration of claims counts as one of the allowed locations.
- Amend the rule to replace "location" with "different service company responsible for processing..." language (or something along those lines).
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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #24 – OAR 436-050-0210(1), (3), and (4) - "Notice of Self-Insurer's Place of Business in State; Records Self-Insured Must Keep in Oregon"

Issue: Should these rules be amended to require the self-insured employer to provide email contact information to the director?

Background: These rules currently require self-insured employers to provide "location, mailing address, telephone, and any other contact information" of at least one Oregon location where claims are processed and records maintained, and similar information for each service company it uses. This information is required upon initial self-insurance certification and when there are changes in the business location or contact information. A significant amount of contact between WCD and regulated parties and their service companies occurs by email. Communication between the parties would be facilitated by specifically requiring all self-insured employers to provide email contact information along with address and phone information.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #25 – OAR 436-050-0210(3) - “Notice of Self-Insurer’s Place of Business in State; Records Self-Insured Must Keep in Oregon”

Issues: Should this rule requiring a self-insured employer to provide the director a copy of its agreement with each service company it uses for claims processing be amended to specify the required elements of the service agreements, similar to those in OAR 436-050-0110(3) that apply to insurer service agreements?

Background: The current rule addressing self-insured employers’ agreements with service companies is very general, although the division’s interests in what such agreements must demonstrate or contain, or may not do, are similar for both carrier-covered and self-insured employers. Current 050-0110(3) requirements that could be added to this rule for self-insureds’ agreements would be that the agreements:

- Be between the [self-insured employer] and a service company incorporated in or authorized to do business in Oregon, and must not be between any other third parties;
- Identify the [self-insured employer] by company name;
- Identify the service company by name;
- Grant the service company a power of attorney to act for the [self-insured employer] in claim proceedings under ORS chapter 656; and
- Contain only those provisions for workers’ compensation activities that are allowed in Oregon.

When assisting the division with problematic service agreements, the Department of Justice (DOJ) has recommended that the self-insurance rule be more specific about the required and prohibited provisions for service company agreements, as is done with insurer agreements. In particular, the specific inclusion of the power of attorney grant and only Oregon-allowed claims processing activities are important. Service agreements for processing in Oregon shouldn’t be copies of contracts clearly intended for use in other states, as reflected in the opening paragraph identifying the parties and repeated references to another jurisdiction. Some self-insured employers (or their service companies) operating in multiple states have indicated a preference for using standard language or the same agreement in all jurisdictions. Where such agreements include provisions for activities not allowed in Oregon, the DOJ has advised the division that it should disapprove the agreement. In some cases, depending on the particular agreement, the division may approve the agreement if language is added stating that any provisions or services not allowed under Oregon workers’ compensation law will not be applied when processing Oregon claims.

Separately, regarding the identification of the self-insured employer's or group's name in the agreement, the division would like the reference to be the legal name of the self-insured entity.

Alternatives:

- Amend this rule to include the specific required elements of a self-insured employer's or group's service agreement.
- Clarify that the service agreement must specify the self-insured entity's legal name.
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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #26 – OAR 436-050-0210(3) - “Notice of Self-Insurer’s Place of Business in State; Records Self-Insured Must Keep in Oregon”

Issue: Should this rule specify that self-insured employers must submit the service agreement and obtain the director's approval of the agreement before it may begin to use the named service company to process claims in Oregon?

Background: The current rule language is somewhat general about the timing of the director's required approval. It would be helpful to clarify, as with insurers in 050-0110(3), that the self-insured employer “must, prior to using the service company in Oregon, file the agreement” with the director. The rule should also be clear that the director must approve the agreement before a self-insured employer begins using a given service company to process its Oregon claims.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #27 - OAR 436-050-0210(5)(a) - “Notice of Self-Insurer’s Place of Business in State; Records Self-Insured Must Keep in Oregon”

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

Background: When a self-insured employer 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 and any beneficiaries still receiving benefits be included in the parties that must receive prior notice of changes in a self-insured’ processing location or entity.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #28 – OAR 436-050-0210(5)(b) - “Notice of Self-Insurer’s Place of Business in State; Records Self-Insured Must Keep in Oregon”

Issue: Should this rule be amended to require that notice to the director of a pending claims transfer to another processing location include the list of claim numbers, claimant names, and injury dates only when a portion of claims are being transferred? More generally, should the rule indicate that the director may request additional information as needed?

Background: Currently, a self-insured employer’s notice to the director that it is moving claims to another location requires this information be provided for all claims. However, when all of a self-insured employer’s (or insurer’s) claims are moved from one processing location to another, the department is able to make that change in internal data systems without needing the claim-specific information. It is only when a portion of an entity’s claims are moving to another location that this claim-specific information is necessary to ensure WCD has accurate information about the respective parties responsible for specific claims.

If 050-0210(5)(b)(C) is changed to clarify what information is needed in the two situations (moving all, or a portion of, claims), (5)(b)(B) will remain. This is an important qualifier because sometimes WCD learns that a self-insured employer’s or insurer’s statement that “all” claims are being moved actually meant “all open claims.” Satisfying both (5)(b)(B) and (C) requires clear communication to WCD about what is occurring with open, closed, and denied claim records. In discussing possible changes to the information required in (5)(b)(C), then, the committee may want to discuss whether (5)(b)(B) needs clarification.

Finally, because there are sometimes situations where the director needs additional information regarding partial or full transfers of claims to another location, the rule should be amended to indicate the self-insured employer will need to provide that information, too.

Alternatives:

- Clarify that the required information (claims numbers, claimant names, and injury dates) must only be provided when a portion of a self-insured's claims will be moved to a new processing location.
- Clarify that the director may request additional information about the claims transfer or specific claims, as needed.
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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #29 – OAR 436-050-0220(3)(b) and (d) – Records Self-Insured Employer Must Keep in Oregon; Period to be Retained, Removal and Disposition”

Issue: Should these rules be amended to require self-insured employers and their service companies to identify reimbursements and recoveries received on each claim, with net cumulative totals, in the same records showing compensation payments?

Background: These rules require self-insured employers to maintain written records showing all payments made on each claim, including documentation of the date payments were mailed. Claims must have a summary sheet showing disability, medical, and vocational assistance payments with separate cumulative totals. On certain claims, self-insured employers receive Worker Benefit Fund (WBF) reimbursements under the Retroactive, Reopened Claims, or other programs, or may otherwise obtain subrogation recoveries. Some self-insured employers may also choose to pay some or all of the allowed medical cost “deductible” on specific nondisabling claims. Practices among self-insured employers and service companies for identifying and tracking reimbursements and recoveries vary, and related information isn't always clearly designated in the summary sheets showing cumulative compensation totals. This can result in inaccurate claims costs being reported on the annual Reports of Losses submitted to the director and make it difficult for WCD auditors to accurately capture paid costs during claims reserve audits. In both cases, the amounts are likely to be higher than an accurate net, cumulative total. Where this happens on a high-cost claim or on several claims, such differences may affect the aggregate liabilities considered in the annual security deposit calculation and the experience rating modification. It would be helpful if the rule required that reimbursements and recoveries be clearly identified and calculated in the cumulative totals on each claim's payment summary sheet.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #30 – OAR 436-050-0260(3)(a) – “Qualifications of a Self-Insured Employer Group”

Issue: Should this rule be amended to clarify that a group’s “combined net worth of at least \$3 million” means the aggregate total of its members’ net worth?

Background: This rule addresses the qualifications for five or more employers to be certified as a self-insured group. In the September 2014 rulemaking for self-insured groups, 050-0260(3) was amended to address the new minimum, combined net worth requirement for groups, and for private employer groups, the minimum net worth requirement for each member. Based on some of the initial annual statements filed by groups under 050-0175(4)(a) and questions to self-insurance program staff, it appears there is confusion about whether the combined net worth requirement refers to the net worth of the self-insured group entity itself, or to the total of the members’ individual net worth, combined. It is the latter amount. Both the prior version of ORS 656.430(7) and amendments made by SB 1558 established that employer members “as a group” must have “combined net worth” meeting specified requirements; this does not refer to the group business entity itself. It would be helpful for this rule to clarify that distinction.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #31 – OAR 436-050-0260(9) - “Qualifications of a Self-Insured Employer Group;” and possibly, OAR 436-050-0270(1)(m) – “Applying for Certification as a Self-Insured Employer Group; Private Employers,” and OAR 436-050-0280(1)(m) – “Applying for Certification as a Self-Insured Group; Governmental Subdivisions”

Issue: Should these rules be amended to allow an applicant for group self-insurance certification to include the required Common Claims Fund balance in its initial security deposit amount?

Background: OAR 436-050-0300 requires self-insured groups to establish and maintain a Common Claims Fund (CCF) to ensure, in addition to the security deposit that considers claim liabilities through the end of the prior fiscal year, the availability of funds to pay compensation due and other amounts due the director. The required balance in the CCF is calculated each year under 050-0300(3) for private groups and 050-0300(6) for public groups. Groups must provide the director by March 1st of each year either documentation of the CCF balance or notice that the required amount is to be included in the group's security deposit amount. Because 050-0300 addresses group's annual provision of CCF information to the director, it implies that the option of "rolling" the required CCF amount into the group's total security deposit is only available to existing certified groups. WCD doesn't see any reason why new self-insured employer groups shouldn't have the same option upon initial certification. 050-0260(9) can be amended to allow new groups to either create a CCF or "specify that the amount calculated under 050-0300(3) or (6) is to be included in the determination of the self-insured employer group's security deposit under OAR 436-050-0180." If this change is made, 050-0270(1)(m) and 050-0280(1)(m) should also be amended to reflect similar language.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #32 – OAR 436-050-0260(12)(c) - "Qualifications of a Self-Insured Employer Group"

Issue: Should the division reconsider this rule's requirement for self-insured groups to demonstrate and maintain acceptable financial strength in the premium to surplus ratio? Or, should the rule, instead, clarify the net worth amount to be used when calculating the ratio? If this ratio is not used, what longer-term financial ratio(s) should be used for groups to establish their financial viability?

Background: One of the key provisions of 2014's SB 1558 required all self-insured employers to demonstrate "acceptable financial viability based on information required by the director by rule." New rules effective September 2014 focused first on implementing financial measures (ratios) for self-insured groups, with this subsequent rulemaking intended to measures for all self-insured employers. In the current 050-0260, groups are required to demonstrate satisfactory financial health in three ratios: the shorter-term current and liquidity ratios, and this longer-term measure, premium to surplus ratio. The rule states that this ratio is to be calculated by dividing a group's earned contributions (member assessments) by its adjusted net worth. The resulting ratio is then translated into a point score, that when combined with the point scores for the other two ratios, is used to determine if a group's annual security deposit amount is to be increased by a

percentage factor under 050-0180(4); that rule increases the deposits of groups with ratios indicating a “moderate” rating.

Since implementing this rule, some self-insured groups have commented that WCD’s use of groups’ combined net worth to calculate this ratio reduces its effectiveness as a measure of financial viability. Specifically, combined net worth (the aggregate of a group’s members’ own net worth) is usually so large that it almost always results in the premium to surplus ratio equaling the maximum number of points (six). As long as earned contributions are less than combined net worth, the resulting ratio will earn the maximum points. Discussion in the agency committee, however, identified that the net worth amount that should be used in the calculation of this ratio is the net worth of the group itself. This differs from the aggregate net worth that the group certifies annually under 050-0175; in that case, the group is certifying the combined amount of all members’ net worth. Given this distinction, it appears the premium to surplus ratio remains a good measure for self-insured groups and that the rule need only be clarified to reflect that distinction. It would still be helpful for the stakeholder committee to discuss the usefulness of this and other potential measures of longer-term financial viability for groups.

Another issue for the committee to discuss is whether different measures or methods for evaluating financial viability should be used for public self-insured groups, given their fundamentally different revenue, budgeting, and financial reporting mechanisms and requirements? If so, what types of measures should be used?

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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ISSUE #33 – OAR 436-050-0300 – “Self-Insured Employer Group, Common Claims Fund”

Issue: Should this rule be amended to state that in any year where the director applies an incurred but not reported (IBNR) factor of greater than 0 percent in the security deposit calculations determined under 050-0180, that self-insured groups with security deposits will not be required to maintain a common claims fund during that year?

Background: Under 050-0300, self-insured groups must establish and maintain a common claims fund (CCF) to ensure the “availability of funds to make certain the prompt payment of all compensation” and other payments due. Given the division’s requirements that groups report losses occurring through the end of the prior fiscal year when submitting annual Reports of Losses every March 1st (meaning that more current claims are not included in each year’s calculated security deposit amount) and the potential with groups to add members (exposure) during the most recent year, the intent of the CCF is to provide additional assurance that in

combination with a group's security deposit, there will be sufficient funds to cover all claim liabilities in the event that a group defaults.

However, IBNRs contemplate more recent losses and development, as well as claims incurred but not reported. Thus, the division suggests that it may not be necessary for self-insured groups with security deposits including a director-imposed IBNR under 050-0180 of greater than 0 percent, to also maintain a CCF during that year. In those years, their security deposits would include the potential claim development contemplated by the CCF.

Alternatives:

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Fiscal Impacts, including cost of compliance for small business:

Recommendations:

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“HOUSEKEEPING CHANGE”

050-0165(2) – Based on provisions of SB 1558, effective April 1, 2014, the first sentence of this rule should be amended to clarify that provision of a security deposit is a (one) condition for establishing proof of financial ability.

**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 050**

EMPLOYER/INSURER COVERAGE RESPONSIBILITY

TABLE OF CONTENTS

RULE	PAGE
436-050-0001 Authority for Rules	1
436-050-0002 Purpose	2
436-050-0003 Applicability of Rules	2
436-050-0005 Definitions	2
436-050-0006 Administration of Rules.....	3
436-050-0008 Administrative Review and Contested Cases	3
436-050-0015 Suspension and Revocation of Authorization to Issue Workers' Compensation Insurance Policies	3
436-050-0025 Service of the Notice of Civil Penalty Orders	4
436-050-0040 Responsibility for Providing Coverage When a Contract Is Awarded.....	4
436-050-0045 Non-Subject Workers	4
436-050-0050 Corporate Officers, Partnerships; Limited Liability Company Members; Subjectivity	5
436-050-0055 Extraterritorial Coverage	5
436-050-0060 Transition from Guaranty Contract Filings to Policy-Based Proof of Coverages	5
436-050-0110 Notice of Insurer's Place of Business in State; Coverage Records Insurer Must Keep in Oregon	6
436-050-0120 Records Insurers Must Keep in Oregon; Removal and Disposition.....	7
436-050-0150 Qualifications of a Self-Insured Employer	7
436-050-0160 Applying for Certification as a Self-Insured Employer	7
436-050-0165 Security Deposit Requirements.....	8
436-050-0170 Excess Insurance Requirements.....	10
436-050-0175 Annual Reporting Requirements.....	11
436-050-0180 Determination of Amount of Self-Insured Employer's Deposit; Effective Date of Order to Increase Deposit	13
436-050-0185 Deposit Exemption for Self-Insured Cities and Counties, Qualifications, Application Procedures, Conditions and Requirements, Revocation and Requalification.....	13
436-050-0190 Using Self-Insured Employers Security Deposit/Self-Insured Employers Adjustment Reserve/Self-Insured Employer Group Adjustment Reserve.....	15
436-050-0195 Requirements for Self-Insured Entity Changes	15
436-050-0200 Self-Insured Certification Cancellation; Revocation	16

436-050-0205 Notice of Self-Insurer's Personal Elections..	16
436-050-0210 Notice of Self-Insurer's Place of Business in State; Records Self-Insured Must Keep in Oregon.....	16
436-050-0220 Records Self-Insured Employer Must Keep in Oregon; Period to be Retained, Removal and Disposition.....	17
436-050-0230 Out-of-State Recordkeeping and Claims Processing by Self-Insured Employer; Conditions and Procedure for Permit; Revocation.....	18
436-050-0260 Qualifications of a Self-Insured Employer Group.....	18
436-050-0270 Applying for Certification as a Self-Insured Employer Group: Private Employers	20
436-050-0280 Applying for Certification as a Self-Insured Employer Group: Governmental Subdivisions	21
436-050-0290 Commencement/Termination of Employers with a Self-Insured Employer Group; Effect on Net Worth; Extension of Coverage; Change in Entity; Change of Address; Recordkeeping.....	22
436-050-0300 Self-Insured Employer Group, Common Claims Fund	23
436-050-0340 Group Self-Insurance Revocation	24
436-050-0400 Responsibility for Providing Coverage under a Lease Arrangement.....	24
436-050-0410 Notice to Director of Lease Arrangement; Termination	24
436-050-0420 Temporary Worker Distinguished from Leased Worker	25
436-050-0440 Qualifications, Applications, and Renewals for License as a Worker Leasing Company..	25
436-050-0450 Recordkeeping and Reporting Requirements.....	27
436-050-0455 Reporting Requirements of a Self-Insured Worker Leasing Company.....	27
436-050-0460 Suspension or Revocation of License.....	27
436-050-0470 Monitoring/Auditing	28
436-050-0480 Assessment of Civil Penalties	28

436-050-0001 Authority for Rules

These rules are adopted under the director's authority contained in ORS 656.407, 656.430, 656.455, 656.726, 656.850, 656.855, and 731.475.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.017, 656.018, 656.021, 656.023, 656.027, 656.029,
656.031, 656.037, 656.039, 656.126, 656.128, 656.140, 656.403, 656.407, 656.419,
656.423, 656.427, 656.430, 656.434, 656.440, 656.443, 656.447, 656.455, 656.614,
656.745, 656.750, 656.850, 656.855, and 731.475
Hist: Amended 6/22/01 as WCD Admin. Order 01-054, eff. 7/1/01
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0002 Purpose

The purpose of these rules is to carry out the workers' compensation law related to employers' and insurers' responsibilities to cover subject workers for compensable injuries and illnesses.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.017
Hist: Amended 6/22/01 as WCD Admin. Order 01-054, eff. 7/1/01
Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0003 Applicability of Rules

(1) These rules are effective Jan. 1, 2015, to carry out the provisions of:

- (a) ORS 656.017 – Employer required to pay compensation and perform other duties.
- (b) ORS 656.029 – Independent contractor status.
- (c) ORS 656.126 – Coverage while temporarily in or out of state.
- (d) ORS 656.407 – Qualifications of insured employers.
- (e) ORS 656.419 – Workers' compensation insurance policies.
- (f) ORS 656.423 – Cancellation of coverage by employer.
- (g) ORS 656.427 – Cancellation of workers' compensation insurance policy or surety bond liability by insurer.
- (h) ORS 656.430 – Certification of self-insured employer.
- (i) ORS 656.434 – Certification effective until canceled or revoked; revocation of certificate.
- (j) ORS 656.443 – Procedure upon default by employer.
- (k) ORS 656.447 – Sanctions against insurer for failure to comply with orders, rules, or obligations under workers' compensation insurance policies.
- (l) ORS 656.455 – Records location and inspection.
- (m) ORS 656.745 – Civil penalties.
- (n) ORS 656.850 and 656.855 – Worker leasing companies.
- (o) ORS 731.475 – Insurer's in-state location.

(2) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.017, 656.029, 656.126, 656.407, 656.419, 656.423, 656.427, 656.430, 656.434, 656.443, 656.447, 656.455, 656.745, 656.850, 656.855, and 731.475
Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14
Amended 11/26/14 as WCD Admin. Order 14-062, eff. 1/1/15

436-050-0005 Definitions

For the purpose of these rules unless the context requires otherwise:

- (1) "Audited financial statement" means a financial statement audited by an outside accounting firm.
- (2) "Board" means the Workers' Compensation Board of the Department of Consumer and Business Services.
- (3) "Cancel" or "cancellation" of coverage means ending a policy at a date before its expiration date.
- (4) "Client" means a person to whom workers are provided under contract and for a fee on a temporary or leased basis.

(5) "Complete records" means written records required to be kept in Oregon as described in OAR 436-050-0110 and 0120 and OAR 436-050-0210 and 0220.

(6) "Controlling person" means a person having substantial ownership or who is an officer or director of a corporation; a member or manager of a limited liability company; a partner of a partnership; or an individual who has, directly or indirectly, the power to direct or cause the direction of the management, policies, or operation of a person offering worker leasing services.

(7) "Days" means calendar days unless otherwise specified.

(8) "Default" means failure of an employer, insurer, or self-insured employer to pay the moneys due the director under ORS 656.506, 656.612, and 656.614 at such intervals as the director directs.

(9) "Department" means the Department of Consumer and Business Services.

(10) "Director" means the director of the Department of Consumer and Business Services or the director's delegate for the matter, unless the context requires otherwise.

(11) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(12) "Fiscal Year" means the twelve-month period beginning July 1 and ending June 30.

(13) "Governmental subdivision" means cities, counties, special districts defined in ORS 198.010, intergovernmental agencies created under ORS 225.050, school districts as defined in ORS 255.005, public housing authorities created under ORS chapter 456, or regional council of governments created under ORS chapter 190.

(14) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(15) "Insurer" means the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon.

(16) "Leased worker" means any worker provided by a worker leasing company on other than a "temporary basis" as described in OAR 436-050-0420.

(17) "Nonrenewal" means the insurer's decision not to renew a policy at its expiration date.

(18) "Person" means an individual, partnership, corporation, joint venture, limited liability company, association, government agency, sole proprietorship, or other business entity allowed to do business in the state of Oregon.

(19) "Premium" means the monetary consideration for an insurance policy.

(20) "Premium assessments" means moneys due the director under ORS 656.612 and 656.614.

(21) "Process claims" is the determination of compensability and management of compensation by an Oregon certified claims examiner. Determining compensability and managing compensation must be done from within this state under ORS 731.475 and this definition. Insurers and self-insured

employers may receive claims reports at locations out-of-state as long as claims are forwarded to an Oregon location for processing. The act of making payment may be done from out-of-state as directed from the Oregon place of business.

(22) "Proof of coverage" for purposes of OAR 436-050 has the same meaning as defined in OAR 436-162-0005.

(23) "Renewal" or "renew" means the issuance of a policy succeeding a policy previously issued and delivered by the same insurer or the issuance of a certificate or notice extending the terms of an existing policy for a specified period beyond its expiration date.

(24) "Reinstatement" means the continuation or reestablishing of workers' compensation insurance coverage, as noted by the effective date of the reinstatement, under a workers' compensation insurance policy that was previously canceled.

(25) "Self-insured employer" means an employer who has been certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407.

(26) "Self-insured employer group" means five (5) or more employers certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407 and OAR 436-050-0260 through 436-050-0340.

(27) "State" means the State of Oregon.

(28) "Substantial ownership" means a percentage of ownership equal to or greater than the average percentage of ownership of all the owners, or ten percent, whichever is less.

(29) "Worker leasing company" means a "person," as described in section (18) of this rule, who provides workers, by contract and for a fee, as established in ORS 656.850.

(30) "Written" means that which is expressed in writing, and includes electronic records.

Stat. Auth: ORS 656.704 and 656.726(4)

Stats. Implemented: ORS 656.704 and 656.726(4)

Hist: Amended 9/17/08 as WCD Admin. Order 08-061, eff. 7/1/09

Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0006 Administration of Rules

Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and these rules are considered orders of the director.

Stat. Auth: ORS 656.704 and 656.726(4)

Stats. Implemented: ORS 656.704 and 656.726(4)

Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04

Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0008 Administrative Review and Contested Cases

(1) Any party as defined by ORS 656.005, including an assigned claims agent under ORS 656.054, aggrieved by an action taken under these rules in which a worker's right to compensation or the amount thereof is directly in issue may request a hearing by the Hearings Division of the Workers' Compensation Board under ORS chapter 656 and the board's Rules of Practice and Procedure for Contested Cases under the

workers' compensation law except where otherwise provided in ORS chapter 656.

(2) Any party as described in section (1) aggrieved by a proposed order or proposed assessment of civil penalty of the director or division issued under ORS 656.254, 656.735, 656.745, or 656.750 may request a hearing by sending a written request to the Workers' Compensation Division's administrator within 60 days after the order was mailed.

(3) A hearing will not be granted if the request:

(a) Fails to state the specific grounds for which the party contests the proposed order or assessment; or

(b) Is mailed or delivered to the administrator more than 60 days after the order was mailed.

(4) Under ORS 656.704(2) and 731.240(1), any party that disagrees with an action or order of the director or division under these rules, other than as described in section (2), may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

(5) Any party described in section (1) aggrieved by an action taken under these rules by another person except as described in sections (1) through (3) above may request administrative review by submitting a written request to the administrator. The request must specify the grounds upon which the action is contested and be received by the administrator within 90 days of the contested action unless the administrator determines there was good cause for delay or that substantial injustice may otherwise result.

Stat. Auth: ORS 656.704, 656.726(4), and 656.745

Stats. Implemented: ORS 656.254, 656.735, 656.740, 656.745, and 656.750

Hist: Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08

Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0015 Suspension and Revocation of Authorization to Issue Workers' Compensation Insurance Policies

(1) Under ORS 656.447, the director may suspend or revoke the insurer's authority to renew or issue workers' compensation insurance policies upon a determination that the insurer has failed to comply with its obligations under the policy or that it has failed to comply with the law, rules, or orders of the director.

(2) For the purpose of this rule:

(a) "Suspend" or "suspension" means a stopping by the director of the insurer's authority to issue new workers' compensation insurance policies for a specified period of time.

(b) "Revoke" or "revocation" means a permanent revocation by the director of an insurer's authority to renew or issue workers' compensation insurance policies.

(c) "Show-cause hearing" means an informal meeting with the director or designee in which the insurer will be provided an opportunity to be heard and present evidence regarding any proposed orders by the director to suspend or revoke an insurer's authority to issue workers' compensation insurance policies.

(3) Suspension or revocation under this rule will not be made until the insurer has been given notice and the opportunity to be heard through a show-cause hearing before the director and show cause why it should be permitted to continue to issue workers' compensation insurance policies.

(4) A show-cause hearing may be held at any time the director finds that an insurer has failed to comply with its obligations under a workers' compensation insurance policy or has failed to comply with law, rules, or orders of the director.

(5) Following a show-cause hearing, the director may rescind the proposed order if the insurer establishes to the director's satisfaction its ability and commitment to comply with ORS Chapter 656 and these rules.

(6) A suspension may be in effect for a period of up to 18 months. A suspended insurer may continue to serve existing accounts and renew any existing policy, unless the policy nonrenews or is canceled during the period of suspension.

(7) After 12 months of the suspension has elapsed, the division may audit the performance of the insurer. If the insurer is in compliance, the administrator may request the director to lift the suspension before the 18 months has elapsed. If the insurer is not in compliance, the administrator may request the director revoke the insurer's authority to issue workers' compensation insurance policies.

(8) When an insurer's authority to issue workers' compensation insurance policies has been revoked, the insurer may serve an existing account only until the policy is canceled or until the next renewal date, whichever first occurs.

(9) After a revocation of an insurer's authority to issue workers' compensation insurance policies has been in effect for five years or longer, it may petition the director to restore its authority by submitting a plan demonstrating its ability and commitment to comply with the workers' compensation law, these rules, and orders of the director.

(10) Appeal of proposed and final orders of suspension and revocation issued under this rule may be made as provided in OAR 436-050-0008.

(11) Any order of suspension or revocation issued under ORS 656.447 and this rule is a preliminary order subject to revision by the director.

Stat. Auth: ORS 656.704 and 656.726(4)

Stats. Implemented: ORS 656.447

Hist: Amended 9/17/08 as WCD Admin. Order 08-061, eff. 7/1/09
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0025 Service of the Notice of Civil Penalty Orders

When the director issues a civil penalty order, it will be served by certified mail, return receipt requested, or in any other manner provided by Oregon Rules of Civil Procedure (7)(D). Proof of service may include a hard copy signed receipt or electronic verification.

Stat. Auth: ORS 656.704 and 656.726(4)

Stats. Implemented: ORS 656.704, 656.726, and 656.740

Hist: Adopted 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0040 Responsibility for Providing Coverage When a Contract Is Awarded

(1) In the operation of ORS 656.029 a subject employer who fails to comply with ORS 656.017 is a "noncomplying employer" as defined by ORS 656.005.

(2) For the purposes of this rule:

(a) "Assistance of others" means one or more individuals directly and immediately aiding in a common undertaking.

(b) "Normal and customary part or process of the person's trade or business" refers to the day-to-day activities or operations which are necessary to successfully carry out the business or trade.

(3) Under ORS 656.037, a person contracting to pay remuneration for professional real estate activity as defined in ORS chapter 696 to a qualified real estate broker or qualified principal real estate broker, as defined in ORS 316.209, is not an employer of the qualified broker.

Stat. Auth: ORS 656.704 and 656.726(4)

Stats. Implemented: ORS 656.029 and 656.037

Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0045 Non-Subject Workers

(1) As used in ORS 656.027(1):

(a) "Private employment contract" means direct employment of the worker by the owner of the private home.

(b) As used in this rule, "owner of the private home" means any person who occupies and either owns, leases, or rents the private home, or any person related by blood, marriage, or an Oregon registered domestic partnership to that person, or any person who by direction of that person or by order of a court has become responsible for managing the household affairs of that person.

(2) As used in ORS 656.027(19):

(a) "A person performing foster parent duties" means any person certified by the Oregon Department of Human Services under ORS chapter 418 as a foster parent, or any person employed by that person in the operation of a foster home as defined in ORS chapter 418 and any rules promulgated thereunder.

(b) "A person performing adult foster care duties" means any person licensed by the Oregon Department of Human Services or Oregon Health Authority to operate an adult foster home, or any person employed by the operator to perform services of assistance to the residents of the adult foster home.

(3) As used in this rule, "adult foster home" means any family home or facility, licensed under ORS 443.705 to 443.825, in which room, board, and 24-hour care services are provided, for compensation, to five or fewer adults who are not related to the operator by blood or marriage.

Stat. Auth: ORS 656.704 and 656.726(4)

Stats. Implemented: ORS 656.027

Hist: Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0050 Corporate Officers, Partnerships; Limited Liability Company Members; Subjectivity

(1) Under ORS 656.027, a corporation, limited liability company, or partnership must elect in writing to its insurer to provide workers' compensation coverage for otherwise nonsubject workers. The election must be made at the inception of a coverage policy and remain in effect until a revised written designation is given to the insurer. A self-insured employer must file the election with the director. If an entity does not file its initial election, or is not in compliance under ORS 656.017 and 656.407, then those exempt individuals will be determined in the following order:

- (a) For a corporation:
 - (A) President;
 - (B) Secretary, if any;
 - (C) Vice President, if any;
 - (D) Secretary/Treasurer, if any;
 - (E) Treasurer, if any;
 - (F) All other officers, if any.
- (b) For a limited liability company or partners of a partnership:
 - (A) The member or partner with the largest ownership interest;
 - (B) The next largest ownership interest.
- (c) If there is more than one person or the ownership interest is the same in any of the offices listed in subsections (a) and (b) of this rule, the sequence of those persons will be determined by whose birthday falls earlier in a year.

(2) Noncomplying corporations, noncomplying limited liability companies, or noncomplying partnerships, regardless of the number of employees, are limited to two exempt officers, members, or partners to be determined in accordance with section (1) of this rule.

(3) For purposes of clarifying terms used in ORS 656.027:

- (a) "Commercial harvest of timber" means all commercial activities relating to harvest of timber from a parcel of property including, but not limited to, road building, marking of trees to be cut, timber falling, slash removal, and transportation of timber to the location where it will be processed into lumber or other products.
- (b) "Director" means a person elected or appointed to a corporation's board of directors in accordance with its articles of incorporation or bylaws.
- (c) "Eligible officer" means a corporate officer who is also a director of the corporation and who has a substantial ownership interest in the corporation.
- (d) "Eligible partner" or "eligible member" means a partner or member who has substantial ownership in the business entity.

(e) "Noncomplying" means an employing legal entity of subject workers which is in violation of ORS 656.017(1).

Stat. Auth: ORS 656.704 and ORS 656.726(3)
Stats. Implemented: ORS 656.027

Hist: Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0055 Extraterritorial Coverage

(1) Criteria to be used in determining whether a worker is temporarily in or out of state under ORS 656.126 may include, but are not limited to:

- (a) The extent to which the worker's work within the state is of a temporary duration;
- (b) The intent of the employer in regard to the worker's employment status;
- (c) The understanding of the worker in regard to the employment status with the employer;
- (d) The permanent location of the employer and its permanent facilities;
- (e) The circumstances and directives surrounding the worker's work assignment;
- (f) The state laws and regulations to which the employer is otherwise subject;
- (g) The residence of the worker;
- (h) The extent to which the employer's work in the state is of a temporary duration, established by a beginning date and expected ending date of the employer's work; and
- (i) Other information relevant to the determination.

(2) Within 30 days after coverage of an Oregon employer is effective, the insurer providing the coverage must notify the employer in writing of the provisions of ORS 656.126 and this rule.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.126

Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0060 Transition from Guaranty Contract Filings to Policy-Based Proof of Coverages

(1) Proof of coverage reporting requirements are prescribed by OAR 436-162.

(2) An active guaranty contract on file with the director on or after July 1, 2009 meets the Oregon proof of coverage requirement until it is replaced by a proof of coverage filing for renewal or new coverage effective on or after July 1, 2009, or until canceled under ORS 656.423 or 656.427. Active guaranty contracts on file with the director will not serve as proof of coverage on or after July 1, 2010.

(3) Filings for policies with a coverage effective date before July 1, 2009 create, endorse, cancel, or reinstate a guaranty contract. Filings for policies with a coverage effective date on or after July 1, 2009 establish, endorse, cancel, or reinstate proof of coverage filings.

(4) A guaranty contract in effect on or after July 1, 2009 is canceled the earliest of:

- (a) The employer obtaining other Oregon workers' compensation coverage and causing the insurer to make a coverage filing with the director;

(b) The employer providing the insurer 30 days written notice of cancellation; or

(c) The insurer mailing notice of cancellation to the employer at least 45 days prior to the cancellation effective date, 90 days notice if the cancellation is based on an insurer's decision not to offer insurance to employers with a specific premium category, or 10 days notice if the cancellation is based on nonpayment of premium.

Stat. Auth: ORS 656.704 and 656.726(4)

Stats. Implemented: ORS 656.419, 656.427

Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04
Amended 9/17/08 as WCD Admin. Order 08-061, eff. 7/1/09

436-050-0110 Notice of Insurer's Place of Business in State; Coverage Records Insurer Must Keep in Oregon

(1) Every insurer that is authorized to issue workers' compensation coverage to subject employers as required by ORS chapter 656 must give the director notice of the location, mailing address, telephone number, and any other contact information in this state where the insurer processes claims and keeps written records of claims and proof of coverage as required by ORS 731.475. The insurer may not have more than eight locations at any one time where claims are processed or records are maintained. While the insurer may have more than one location in this state, the information provided to the director must reasonably lead an inquirer to a person who can respond to inquiries as to workers' compensation insurance policy, claim filing, and claims processing location information and to access an in-state Oregon certified claims examiner who can respond within a reasonable time to specific claims processing inquiries. A response time of 48 hours or less, not including weekends or legal holidays, would satisfy a reasonable expectation.

(2) Notice under section (1) of this rule must be filed with the director within 30 days after the insurer becomes authorized and starts writing workers' compensation insurance policies for Oregon subject employers, and must also include contact information for:

(a) A designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director; and

(b) A designated person or position within the company who can respond to workers' compensation policy and proof of coverage filing inquiries.

(3) If an insurer elects to use a service company to satisfy the purposes of ORS 731.475 with respect to all or any portion of its business, the insurer must, prior to using the service company in Oregon, file with the director a copy of the agreement between the insurer and each company for approval, and must give the director notice of the location and mailing address of each service company. The service agreement must:

(a) Be between the underwriting insurer and a service company that is incorporated in or authorized to do business in Oregon, and must not be between any other third parties;

(b) Identify the insurer by company name, or if multiple insurers related by ownership, by the name of the group if it includes all affiliates;

(c) Identify the service company by name;

(d) Grant the service company a power of attorney to act for the insurer in workers' compensation claims proceedings under ORS chapter 656; and,

(e) Contain only those provisions for workers' compensation activities that are allowed in Oregon.

(4) If the insurer's or its service company's place of business or contact information will change, the insurer must notify the director of the new location, mailing address, telephone number, and any other contact information at least 30 days before the effective date of the change.

(5) When an insurer changes claims processing locations, service companies, or self-administration, the insurer must provide at least 10 days prior notice to workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, and mailing address of the new claim processor. The insurer must also provide at least 10 days prior notice to the director of which claims will be transferred. The notice to the director must include:

(a) Contact information for both the sending processor and receiving processor of the claims to include a contact person, telephone number, mailing address, and physical address where the claims are to be processed;

(b) Verification of whether the claims to be transferred include closed claims; and

(c) A listing of the claims being transferred that identifies the underwriting insurer, employer, claimant name, date of injury, and sending processor's claim number.

(6) For the purpose of this rule, those activities conducted at designated in-state location(s) and by the authorized representative(s) of the insurer must include, but need not be limited to:

(a) Processing and keeping complete records of claims for compensation;

(b) Responding to specific claims processing inquiries;

(c) Keeping records of payments of compensation;

(d) Keeping records, including records of claims processed by prior service companies, in a written form, not necessarily original form, and making those records available upon request; and

(e) Accommodating periodic in-state audits by the director.

(7) Records every insurer is required to keep in this state include all the written records of the insurer that show its insured employers have complied with ORS 656.017, including the records described by OAR 436-050-0120.

Stat. Auth: ORS 731.475, 656.704, and 656.726(4)

Stats. Implemented: ORS 731.475

Hist: Amended 9/17/08 as WCD Admin. Order 08-061, eff. 7/1/09
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0120 Records Insurers Must Keep in Oregon; Removal and Disposition

(1) The records of claims for compensation that each insurer is required to keep in this state include:

(a) Written records used and relied upon in processing claims;

(b) A written record of all payments made as a result of any claim including documentation of the date the payment was mailed. Documentation may be the actual mailing date, or an explanation of the time period between the date of issuance and mailing; and

(c) A written record as to whether supplemental temporary disability benefits, as required under ORS 656.210(5) for workers employed in more than one job, were approved or denied.

(2) Records of a denied claim may be removed from this state after all the appellate procedures have been exhausted and the denial has been affirmed by operation of law.

(3) Records of any claim for a compensable injury may be removed from this state after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur.

(4) When a denied claim is found to be compensable, the records of the claim are subject to section (3) of this rule.

(5) The insurer may destroy claims records when the insurer can verify that all potential for benefits to the worker or the worker's beneficiaries is gone.

(6) The records relating to proof of coverage that insurers are required to keep in the state include:

(a) A written record of each workers' compensation insurance policy and related endorsements, reinstatements, or cancellations issued as required under the workers' compensation law;

(b) Written records of premiums due and premiums collected by the insurer from its insured employers as a result of coverage issued under the workers' compensation law; and

(c) Written records that segregate and show specifically for each employer the amounts due from the employer and all such money collected and paid by the insurer for premiums for insurance coverage, premium assessments, and any other moneys due the director or required to be remitted to the director.

(7) If all remittances have been made, proof of coverage records may be disposed of after the next Insurance Division examination under ORS 731.300 or the end of three full calendar years following the calendar year in which the workers' compensation insurance policy cancels or is not renewed, whichever occurs later.

Stat. Auth: ORS 731.475, 656.704, and 656.726(4)

Stats. Implemented: ORS 731.475

Hist: Amended 9/17/08 as WCD Admin. Order 08-061, eff. 7/1/09

Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0150 Qualifications of a Self-Insured Employer

(1) To qualify as a self-insured employer, the employer must:

(a) Establish proof that the employer has an adequate staff qualified to process claims;

(b) Establish proof of the financial ability to make certain the prompt payment of all compensation and other payments due under ORS chapter 656;

(c) Obtain excess insurance coverage in the amounts approved by the director; and

(d) Be registered and authorized to do business in this state under ORS chapters 58, 60, 62, 63, 65, 67, 70, and 648, as applicable.

(2) An employer establishes proof of an adequate staff qualified to process claims by:

(a) Employing and retaining at each claims processing location, at least one person that is qualified in accordance with OAR 436-055-0070 and is actually involved in the claims processing function; or

(b) Contracting the services of one or more service companies that employ at each claims processing location in this state, at least one person qualified in accordance with OAR 436-055-0070 and that is actually involved in the self-insured employer's claims processing.

(3) An employer establishes proof of financial ability by providing a security deposit that the director determines is acceptable in accordance with OAR 436-050-0165, and in an amount as determined in accordance with OAR 436-050-0180.

(4) Failure of a certified self-insured employer to maintain the qualifications required in this rule will result in revocation of the employer's self-insured certification. The employer will be given 30 days written notice of the intent to revoke the self-insured certification, to be effective 30 days from the date of receipt of the revocation notice. If the employer complies with the qualification requirements within the 30-day period, the revocation will be canceled and the certification will remain in effect.

Stat. Auth: ORS 656.407, 656.704, and 656.726(4)

Stats. Implemented: ORS 656.407

Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04

Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0160 Applying for Certification as a Self-Insured Employer

(1) An employer applying for certification as a self-insured employer must submit:

(a) A completed "Application for Self-Insurance" (Form 440-1868);

(b) Proof of the employer's claims processing ability by employing and retaining at each claims processing location, at least one person that is actually involved in the claims processing function and is qualified in accordance with OAR 436-055-0070; or by contracting with a service company that will have at least one person qualified in accordance with OAR

436-055-0070, that will be processing the employer's claims in this state, under ORS 656.455(1);

(c) The employer's audited financial statements or audited annual reports for the last three fiscal or calendar years. If the audited financial statements of a parent company are provided in lieu of statements for the employer, the director will not authorize the individual employer to be self-insured under its own program, unless a parental company guarantee can be obtained. Otherwise, it will be necessary for the parent company to be the self-insured employer or to separately insure the employer. In the context of this section, a parent company is a legal entity that owns a majority interest in the employer, or owns a majority interest in another entity or succession of entities that own a majority interest in the employer;

(d) The employer's most recent experience rating modification worksheet and supporting documentation. Applicants with prior Oregon experience who do not submit this data will be assigned a 1.50 experience rating modification pending receipt of the data. All those without prior Oregon experience will be assigned a 1.00 experience rating modification;

(e) The type, retention, and limitation levels of excess workers' compensation insurance the employer is planning to obtain as required by OAR 436-050-0170;

(f) If applicable, within 30 days after the date of certification, a service agreement between the employer and service company that has been signed by both parties. The agreement must also contain the location, mailing address, telephone number, and any other contact information of the service company;

(g) Evidence from a surety bond company admitted to do surety business in this state that they will issue a surety bond for the employer, as Principal, and the Oregon Department of Consumer and Business Services, Workers' Compensation Division, as Obligee; or evidence from a qualified bank that they will issue an irrevocable standby letter of credit for the employer with the Oregon Department of Consumer and Business Services as the beneficiary;

(h) Evidence of an occupational safety and health loss control program in accordance with OAR 437-001 as required by ORS 656.430(10); and

(i) Evidence of authorization to do business in this state under ORS chapters 58, 60, 62, 63, 65, 67, 70, and 648, as applicable.

(2) Within 30 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the employer that the request for certification as a self-insured employer is denied and the reason therefore; or, that the employer is qualified as a self-insured employer. If the employer qualifies as a self-insured employer, the notice will include:

(a) The type and the amount of the security deposit required;

(b) Approval of the type, retention, and limitation levels of the excess insurance; or

(c) The type, retention, and limitation levels of excess insurance required.

(3) If approved, the certification of self-insurance will be issued upon receipt of the security deposit and the appropriate excess insurance binder.

(4) Unless a later date is specified by the applicant, the effective date of certification will be the first day of the month following the date the requirements of section (3) of this rule are met.

(5) Notwithstanding subsection (1)(c) of this rule, an employer making application may submit certified financial statements in lieu of audited financial statements or annual reports. However, the director may require the employer to submit audited financial statements if the certified financial statements submitted are insufficient to evaluate the employer's financial status.

Stat. Auth: ORS 656.430, 656.704, and 656.726(4)

Stats. Implemented: ORS 656.430

Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04

Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0165 Security Deposit Requirements

(1) For the purposes of this rule:

(a) "Employer" includes employer groups;

(b) "Self-insured employer" includes self-insured employer groups; and

(c) "ISLOC" means irrevocable standby letter of credit.

(2) A self-insured employer is required to provide a security deposit that is acceptable to the director, to establish proof of its financial ability, and to be qualified and certified as a self-insured employer or to be certified as a self-insured employer group. In accordance with ORS 656.407, a surety bond or an irrevocable standby letter of credit (ISLOC) may be accepted for the required security deposit if it complies with the following conditions and requirements:

(a) An ISLOC may be approved by the director as all or part of the security deposit. The director may approve the ISLOC if the issuing bank and the ISLOC meet the requirements of this rule:

(A) The ISLOC must be issued by or confirmed by an Oregon state chartered bank or a federally chartered bank from which funds will be immediately payable on demand. The bank issuing the ISLOC must, at the time of issuance, have a credit rating as set forth below:

(i) An "Aaa", "Aa", or "A" long term certificate of deposit (CD) rating in the current monthly edition of "Moody's Statistical Handbook" prepared by Moody's Investors Service Inc., New York; or

(ii) An "AAA", "AA" or "A" long term certificate of deposit (CD) rating in the current quarterly edition or monthly supplement of "Financial Institutions Ratings" prepared by Standard & Poors Corporation, New York.

(B) Federally chartered instrumentalities of the United States operating under authority of the Farm Credit Act of 1971 as amended, are acceptable without rating.

(C) An ISLOC issued by a bank that does not meet the credit rating set forth in paragraph (A) at the time of issuance will only be accepted with a confirming ISLOC issued by an Oregon state chartered bank or federally chartered bank meeting the credit criteria of paragraph (A). The confirming ISLOC must state that the confirming bank is primarily obligated to pay on demand the full amount of the ISLOC regardless of reimbursement from the bank whose ISLOC is being confirmed.

(D) The issuing bank must use the Irrevocable Standby Letter of Credit, Form 440-3640, issued by the director.

(E) The ISLOC will be automatically extended without amendment for an additional one (1) year from the expiry date, or any subsequent expiry date, unless, at least 60 days before the expiry date, the director is notified in writing by registered mail or overnight delivery, that the bank has elected not to extend the ISLOC for another period.

(F) If the issuing bank or any confirming bank is closed at the time of expiry of the ISLOC for any reason that would prevent delivery of a demand notice during its normal hours of operation, the ISLOC will be automatically extended for a period of 30 days commencing on the next day of operation.

(G) The ISLOC can be called immediately if:

(i) The self-insured employer has defaulted in payment of its workers' compensation liabilities or obligations, or in payments due to the director under ORS chapter 656;

(ii) The self-insured employer has filed for bankruptcy;

(iii) The self-insured employer has failed to renew or provide acceptable substitute security by fifteen (15) days prior to the expiry date of the ISLOC; or

(iv) The beneficiary has determined the existing security is deemed inadequate, that additional or replacement security must be provided by the self-insured employer, and that neither has been provided, notwithstanding written notice to the self-insured employer.

(H) The credit must be available by presentation of the beneficiary's draft drawn at sight on the issuing bank, payable within three business days, when accompanied by one of the statements contained in 436-050-0165(2)(a)(G) signed by the director of the Department of Consumer and Business Services, or the administrator of the Workers' Compensation Division, or their designated authorized representative.

(I) The ISLOC is not subject to any qualifications or conditions by the issuing bank or confirming bank and is each bank's individual obligation, which is in no way contingent upon reimbursement.

(J) An ISLOC must include a statement that the funds provided by the ISLOC are not construed to be an asset of the self-insured employer and a statement that if legal proceedings are initiated by any party with respect to the payment of any

ISLOC, it is agreed that such proceedings must be subject to the jurisdiction of Oregon courts and Oregon law.

(K) Payment of any amount under an ISLOC must be made only by wire transfer in the name of the "Department of Consumer and Business Services In Trust For [the legal name of the certified self-insured employer]" to a department account, with the State Treasurer, at a designated bank.

(L) An ISLOC is subject to the International Standby Practices 1998 (ISP98), ICC Publication No. 590, which is hereby incorporated by reference, and a reference to this publication must be included in the text of the ISLOC. ICC Publication 590 may be obtained from the International Chamber of Commerce website:

<http://iccwbo.org/policy/banking/>.

(M) All bank charges for the ISLOC are for the account of the applicant.

(N) Any amendment to the ISLOC must be approved and accepted by the director before the amendment is effective.

(O) If a bank's rating subsequent to the issuance of the ISLOC falls below the acceptable rating level as set forth in paragraph (A), the self-insured employer must, within 60 days of the publication of the lower credit rating:

(i) Replace the ISLOC with a new ISLOC issued by an Oregon state chartered bank or with a federally chartered bank with an acceptable credit rating;

(ii) Confirm the ISLOC by an Oregon state chartered bank or a federally chartered bank that has an acceptable credit rating; or

(iii) Replace the ISLOC with a policy of insurance or a surety bond of equal amount that is approved by the director, as substitute security for the ISLOC, if the policy of insurance or surety bond covers all workers' compensation liabilities and obligations that would have been covered by the ISLOC.

(P) Each self-insured employer that submits an acceptable ISLOC as its security deposit, must furnish a memorandum of understanding with the ISLOC, on the department's Form 440-3529, that affirms the self-insured employer's acceptance of all of the following requirements:

(i) An ISLOC is furnished to the director instead of a surety bond or other forms of security that may be determined to be acceptable for certification as a self-insured employer or for continuing as a certified self-insured employer;

(ii) The self-insured employer understands the ISLOC will be automatically extended without amendment for an additional one (1) year from the expiry date, or any subsequent expiry date, unless, at least 60 days before the expiry date, the director is notified in writing by the bank that the ISLOC will not be renewed;

(iii) The ISLOC may be replaced with an ISLOC or surety bond of equal amount or a policy of insurance that is accepted by the director as substitute security for the ISLOC, if the new ISLOC or surety bond or policy of insurance covers all workers' compensation liabilities and obligations that would have been covered by the ISLOC to be replaced;

(iv) The self-insured employer affirms that the ISLOC, in the amount required, is being offered with the understanding that the ISLOC can be called immediately, at the director's discretion, if the director receives notice that the ISLOC will not be renewed; if the self-insured employer fails to pay its workers' compensation liabilities, obligations, or payments due to the director under ORS chapter 656; or the self-insured employer files bankruptcy; or the self-insured employer fails to renew or provide acceptable substitute security by fifteen (15) days prior to the expiry date of the ISLOC; or the director has determined the existing security is deemed inadequate, that additional or replacement security must be provided by the self-insured employer and that neither has been provided, notwithstanding written notice to the self-insured employer; and

(v) If legal proceedings are initiated by any party with respect to payment of any ISLOC, then it is agreed that the proceedings will be subject to the jurisdiction of Oregon courts and application of Oregon law.

(b) A surety bond may be accepted by the director as a security deposit or substitute security deposit for an ISLOC, government securities, monies, or time deposits. A surety bond may be accepted as all or part of the security deposit. The director, in each particular case, will determine if the surety bond submitted is acceptable, if the issuing surety is acceptable, and if its language and format are acceptable.

(A) The surety bond must be issued by a surety company authorized to transact surety business in Oregon;

(B) Surety Bond Form 440-824 must be used for all surety bonds;

(C) Surety bonds submitted for the self-insured employer's security deposit must be continuous in form;

(D) Surety bonds may be terminated by the surety company by giving the director and the Principal written notice stating that on a date not less than thirty days after the date the notice is received by the director, such termination will be effective. Such termination in no way limits the liability of the Surety for subsequent defaults of the Principal's liability or obligations incurred under ORS chapter 656 prior to the effective date of such termination;

(E) Surety Bond Rider Form 440-1810 must be used for all department required increases or authorized decreases in the penal sum of the surety bond. The surety bond rider is not effective until it is accepted by the department;

(F) Surety bonds and all riders to the surety bonds must be executed by the surety company's attorney in fact and the attorney in fact's appointment and power of attorney must accompany all surety bonds and riders submitted. The power of attorney must authorize the attorney in fact to execute the surety bond in the amount of the penal sum of the bond;

(G) The liability of a surety company under its surety bond may only be discharged in the event that:

(i) The Principal files acceptable substitute security as the security deposit that is accepted by the director as substitute

security for the surety bond to be released, covering all past, present, existing, and potential liability of the Principal under ORS chapter 656 and covering all the Surety's liability under the surety bond to be released, in an amount required by the director; and

(ii) The surety bond is released as documented in writing from the director or the administrator of the Workers' Compensation Division, or their designated authorized representative.

(iii) A policy of insurance or an ISLOC of equal amount that is acceptable by the director may be accepted as substitute security for the surety bond if the policy of insurance or ISLOC covers all workers' compensation liabilities and obligations that would have been covered by the surety bond.

(H) The surety company or its parent must have and maintain an acceptable credit rating in accordance with the following:

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

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

(I) A surety bond must be replaced by the self-insured employer with an acceptable type of security deposit within 30 days after notice from the department that the Surety has been placed in conservatorship, is seized, or declares insolvency, or the current credit rating is below the ratings required in subsection (H).

(c) Government securities, certificates of deposit, or time deposit accounts that were accepted by the director as a self-insured employer's or a self-insured employer group's required security deposit prior to January 1, 2004, may remain as the security deposit until the maturity date of those investments. At that time, the government securities, certificates of deposit, or time deposit accounts pledged to the department as security deposits must be replaced by a surety bond or ISLOC acceptable to the director. A self-insured employer that has government securities, certificates of deposit, or time deposit accounts as all or part of its security deposit must complete a "Security Agreement and Notice to Intermediary," Form 440-4023, granting the department a security interest in and control over those financial assets.

(d) Government securities, certificates of deposit, or time deposit accounts will not be accepted as security deposits for certified self-insured employers who must increase their security deposit or for employers whose self-insurance certification was granted after January 1, 2004.

Stat. Auth: ORS 656.430, 656.704, and 656.726(4)

Stats. Implemented: ORS 656.430

Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14

436-050-0170 Excess Insurance Requirements

(1) A self-insured employer must have excess workers' compensation insurance coverage appropriate for the employer's potential liability under ORS 656.001 to 656.990 with an insurer authorized to do business in this state. Except

for endorsements requiring pre-approval by the director in sections (4) and (5), the policy providing such coverage and any endorsements thereto must be filed with the director not later than 30 days after the date the coverage is effective. A self-insured public utility with assets in excess of \$500 million as reflected by the employer's audited financial statement submitted in accordance with OAR 436-050-0160 or 436-050-0175, may obtain the required excess workers' compensation insurance coverage from an eligible surplus lines insurer.

(2) The excess insurance:

(a) Must include a provision for reimbursement to the director of all expenses paid by the director on behalf of the employer under ORS 656.614 and 656.443 in the same manner as if the director were the insured employer, subject to the policy limitations or amounts and limits of liability to the insured employer; and

(b) Coverage must be continuous and remain in effect from the date of certification until the certification is revoked or canceled; and

(c) Coverage must be specific on a per occurrence basis; and

(d) Coverage may include aggregate excess insurance; and

(e) Coverage may include a deductible endorsement acceptable to the director under sections (4) and (5) of this rule.

(3) The self-insured retention level for a self-insured employer group's excess insurance policy must not be less than \$300,000.

(4) Changes in the self-insured retention level and policy limits of the excess insurance require prior approval of the director. The director may require a reduction in the self-insured retention level or an increase in the policy limits. Those items considered in determining and approving the retention and limitation levels of the excess insurance will be the employer's:

(a) Financial status;

(b) For self-insured employer groups, financial viability as determined under OAR 436-050-0260;

(c) Risk and exposure;

(d) Claim history; and

(e) The amount of the required security deposit.

(5) Endorsements addressing a per-accident deductible in excess of a self-insured employer group's retention level require prior approval of the director. In determining whether to approve a deductible endorsement, the director will consider the group's retention level, policy limits, and the items in section (4) of this rule. The director will not approve per-accident deductible endorsements in excess of the retention level that contain language allowing the excess insurer, at its discretion, to limit its obligations under section (2)(a) of this rule.

(6) A self-insured employer will be allowed a period, not to exceed 30 days, within which to comply with an order of the director to the employer to reduce the self-insured retention

level or increase the policy limitation or amounts and limits of liability of the excess insurance.

(7) Excess insurance obtained under this section does not relieve any self-insured employer from full responsibility for claims processing and the payment of compensation required under ORS chapter 656 and these rules. Regardless of the types and amounts of excess coverage a self-insured employer must not transfer claims to the excess insurer(s) for processing.

(8) When an excess insurance policy is canceled by the excess insurer or the employer, a copy of such notice must be filed with the director 30 days before the effective date of cancellation.

(9) If a self-insured employer does not comply with the requirements of this section, the employer's certification as a self-insured will be revoked. The employer will be given written notice of such revocation which will be effective 30 days from receipt of the notice. If the required excess insurance is obtained within the 30 days, the revocation will be canceled and certification will remain in effect.

Stat. Auth: ORS 656.430, 656.704, and 656.726(4)

Stats. Implemented: ORS 656.430

Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14

436-050-0175 Annual Reporting Requirements

(1) To determine the financial status of a self-insured employer and to evaluate the employer's continuity of operation, a self-insured employer must file annually with the director an audited financial statement or annual report with audited financial statement, including SEC Form 10K if issued, for the just completed fiscal year. A self-insured employer that is not a municipality must make the filing within 120 days of the fiscal year end and a self-insured employer that is a municipality must make the filing within 180 days of the fiscal year end. All financial statements and annual financial reports filed, as required by this section, will be retained by the director for a period of at least three years. In lieu of an audited financial statement or annual report, a self-insured employer may file a financial statement certified by the employer that the financial statement is true and accurate and presents the employer's financial condition and results of operations as of the date of the statement.

(2) Notwithstanding section (1) of this rule, the director may require an employer to submit an audited financial statement if the certified financial statement submitted is insufficient to evaluate the employer's financial status.

(3) The financial statements and reports filed by a self-insured employer group must demonstrate the group's acceptable financial viability based on criteria under OAR 436-050-0260 including, but not limited to, satisfactory financial ratios and net worth.

(4) By March 1 of each year, self-insured employer groups must file with the director:

(a) A statement certifying the amount of the group's combined net worth under OAR 436-050-0260(3)(a), as of the date of the statement; and

(b) A copy of the fidelity bond furnished to the group by the administrator or a copy of the comprehensive crime policy obtained by the group, in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities. If the fidelity bond or policy covers more than one year, is still in effect, and a copy was provided to the director in the prior year, the group's annual filing may state that fact in lieu of providing an additional copy.

(5) By March 1 of each year, self-insured employer groups consisting of private employer members must file with the director:

(a) A statement certifying that each employer member of the group meets the individual net worth requirement under OAR 436-050-0260(3)(b), as of the employer member's most recent fiscal year end; and

(b) A list of the group's current board members and their professional affiliations.

(6) The self-insured employer must report claim loss data described in Bulletin 209 by March 1 of each year for the purposes of experience rating modification, retrospective rating calculations, and determining deposits.

(a) The report must be certified to be true and accurate by an authorized representative of the self-insured employer, and must include:

(A) A report of losses for each year in the experience rating period. The report must cover all claims incurred during the reporting period and must be valued as of January 1 of the current year. Reports must include:

- (i) Contract medical expenses;
- (ii) Total maximum medical reimbursement amount;
- (iii) Number of claims for which the maximum medical reimbursement amount is claimed;
- (iv) For claims with incurred losses of \$15,500 or less, total paid, outstanding reserves, and total incurred losses;
- (v) Number of claims with incurred losses of \$15,500 or less; and
- (vi) For each claim with incurred losses exceeding \$15,500, worker's name, date of injury, claim number, total paid, outstanding reserves, and total incurred losses. Claims must be listed in alphabetical order.

(B) A report of losses covering the self-insured period prior to the experience rating period. The report must list all open claims and must be valued as of January 1 of the current year. The report must include:

- (i) The worker's name, listed in alphabetical order;
- (ii) Date of injury;
- (iii) Claim number;
- (iv) Total paid;
- (v) Outstanding reserves; and
- (vi) Total incurred losses.

(C) Identification of claims involving catastrophes, Workers with Disabilities Program, permanent total disability or fatal

benefits, third party recoveries, and claims where the total incurred has or is expected to exceed the self-insured retention of the self-insured employer's excess insurance policy.

(D) The total annual paid losses for the previous four fiscal years valued as of January 1 of the current year.

(b) Bulletin 209 provides guidelines for self-insured employers and their authorized representatives to use in submitting the required data.

(c) Each self-insured city, county, or qualified self-insured employer group that is exempted from the security deposit requirements under ORS 656.407(3) and OAR 436-050-0185 must, in addition to the above, provide the director by March 1 of each year, the procedures, methods, and criteria used in the process of determining the amount of their actuarially sound workers' compensation loss fund, including procedures for determining the amount for injuries incurred but not reported. The director may require a qualified self-insured employer group exempted from the security deposit requirements to provide an actuarial study that demonstrates its loss reserve account is actuarially sound and adequately funded under OAR 436-050-0185(2)(d).

(7) Notwithstanding sections (1) through (5) of this rule, the director may require a self-insured employer group to submit financial statements, reports, or information more frequently for reasons including, but not limited to, changes in the group's financial status or viability, private employer members' individual net worth, group membership, private employer groups' board membership, or incurred claims costs.

(8) Notwithstanding section (6) of this rule, the director may require a self-insured employer to submit claim loss data more frequently if the nature of the self-insured employer's business has changed since the last annual loss report for reasons including, but not limited to, mergers or acquisitions, changes in employment level, nature of employment, or incurred claims costs.

(9) If a self-insured employer fails to comply with the requirements of sections (1) through (8) of this rule, the director may impose any or all of the following sanctions:

- (a) Require the self-insured employer to increase its deposit and premium assessments by 25%;
- (b) Conduct an audit to obtain the necessary loss information at the self-insured employer's expense;
- (c) Assess civil penalties of up to \$250 per day that the information is not provided beyond the deadline; or
- (d) Revoke the employer's certification for self-insurance.

(10) To ensure each self-insured employer's claims are valued appropriately for use in deposit, experience rating, and retrospective rating calculations, the director will perform routine test audits. If a self-insured employer's total claims values are found to be 10 percent or more below the director's determined values, the current experience rating will be recalculated using the director's determined values and will be used in the security deposit and retrospective rating calculations. In addition, penalties may be assessed.

Stat. Auth: ORS 656.407, 656.430, 656.704, and 656.726(4)

Stats. Implemented: ORS 656.407 and 656.430

Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14

Amended 11/26/14 as WCD Admin. Order 14-062, eff. 1/1/15

436-050-0180 Determination of Amount of Self-Insured Employer's Deposit; Effective Date of Order to Increase Deposit

(1) The deposit a self-insured employer is required by ORS 656.407 to maintain with the director must be an amount not less than the greater of:

(a) \$100,000; or

(b) Future claim liability, including losses incurred but not reported (IBNR), a claims processing administrative cost, and the anticipated assessments payable to the director for the employer's next fiscal year; or

(c) The annual incurred losses for the self-insured's last fiscal year, including IBNR, a claims processing administrative cost, and anticipated assessments payable to the director for the employer's next fiscal year.

(2) Notwithstanding section (1) of this rule, if the employer is applying for self-insurance, the amount of the deposit must not be less than the greater of:

(a) The anticipated assessments payable to the director for the employer's next fiscal year, plus an amount equal to 65 percent of the annual premium the employer would pay if carrier-insured using the applicable occupational base rate premium, as such rate is applied to the anticipated payroll of the employer's Oregon operations for the employer's next fiscal year; or

(b) \$300,000 plus \$30,000 additional for each \$100,000 the employer's net worth is below \$2 million; or

(c) The amount of the approved self-insured retention level for the employer's excess workers' compensation insurance.

(3) In determining the amount of deposit the director will take into consideration:

(a) The financial ability of the employer to pay compensation and other payments due;

(b) The employer's probable continuity of operation;

(c) A self-insured employer group's financial viability, as determined by the director under OAR 436-050-0260;

(d) Retention and limitation levels of the employer's excess insurance in relation to the employer's financial status;

(e) Changes in the employer's business including, but not limited to, mergers or acquisitions, changes in employment level, nature of employment, incurred claims costs, or material growth in self-insured exposure; and

(f) The balance of the Self-Insured Employer Adjustment Reserve or the Self-Insured Employer Group Adjustment Reserve.

(4) The amount of the deposit determined in sections (1) through (3) of this rule for a self-insured employer group with financial ratios equaling a "moderate" rating under OAR 436-050-0260(13)(b) will be increased by the following percentage factors:

(a) 12 total combined points = no change in calculated deposit;

(b) 11 total combined points = no change in calculated deposit;

(c) 10 total combined points = 5%;

(d) 9 total combined points = 10%;

(e) 8 total combined points = 15%; or

(f) 7 total combined points = 20%.

(5) Assessments payable to the director referred to in this section include moneys and assessments due under ORS 656.506, 656.612, and 656.614.

(6) A self-insured employer will be allowed a period, not to exceed 30 days, within which to comply with an order of the director to the employer to increase the amount of its deposit.

(7) "Claims processing administrative cost" will be determined by developing a percentage rate to be applied against the employer's unpaid losses. The rate will be based on the information contained in Schedule P, Part ID of the Annual Statement for the previous calendar year as reported to the Insurance Commissioner by SAIF Corporation and the 20 private insurers who had the highest earned premium reported for the preceding calendar year. The rate will be computed annually to be effective for the subsequent fiscal year. The rate will be 105 percent of the median of ratios determined as follows for each of these insurers:

(a) "Loss expenses unpaid" for losses incurred in the latest eight years, divided by

(b) "Losses unpaid" for losses incurred in the latest eight years.

(8) "Incurred but not reported" (IBNR) will be calculated by applying a loss development factor against the employer's annual paid losses. The loss development factor will be calculated annually by the director. An IBNR may be included in the security deposit calculation when the director identifies factors including, but not limited to, a decrease in the self-insured employer's credit rating, a negative net worth, negative cash flow, high debt-to-equity ratio, or material growth in self-insured exposure.

Stat. Auth: ORS 656.407, 656.704, and 656.726(4)

Stats. Implemented: ORS 656.407

Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14

436-050-0185 Qualifications for Deposit Exemption for Self-Insured Cities, Counties, and Qualified Self-Insured Employer Groups, Application Procedures, Conditions and Requirements, Revocation and Requalification

(1) A self-insured city, county, or self-insured employer group that is a municipal or public corporation under ORS 297.405, may apply to be exempt from the security deposit requirements of ORS 656.407(2). Under ORS 656.407(3), the requirements to qualify for exemption are as follows:

(a) The city, county, or qualified self-insured employer group must be in compliance with ORS 656.407(2) and OAR 436-050-0180 as an independently self-insured employer or

self-insured employer group for the three consecutive years immediately prior to applying for the exemption; and

(b) The city, county, or qualified self-insured employer group must have in effect a workers' compensation loss reserve account that is actuarially sound and that is adequately funded as determined by the annual audit under ORS 297.405 to 297.740 to pay all compensation to injured workers and amounts due the director under ORS chapter 656. The workers' compensation loss reserve account must also be dedicated to and expended only for payment of compensation and amounts due the director by the city or county under ORS chapter 656.

(2) A written application requesting exemption from ORS 656.407(2) must be submitted to the director no later than 45 days prior to the date the exemption is desired to become effective. The application must include the following supporting documentation for review and approval:

(a) A copy of the city's, county's, or qualified self-insured employer group's most recent annual audit as filed with the Secretary of State under ORS 297.405 to 297.740 that identifies the actuarially sound funded amount in the dedicated workers' compensation loss reserve if not previously filed as required by OAR 436-050-0175(1);

(b) A copy of the city's, county's, or qualified self-insured employer group's current fiscal year's approved budget documents for internal service funds that state the budgeted amount for the funded workers' compensation loss reserve account;

(c) A resolution or ordinance passed by the city's, county's, or qualified self-insured employer group's governing body that establishes an actuarially sound and adequately funded workers' compensation loss reserve account that dedicates the workers' compensation loss reserve account to and limits expenditures to only the payment of compensation and amounts due the director under ORS chapter 656. The resolution must also include the director's first lien and priority rights to the full amount of the workers' compensation loss reserve account required to pay the present discounted value of all present and future claims under ORS chapter 656; and

(d) A statement giving the amount of the current reserves for present and future liabilities, the amount funded in the workers' compensation loss reserve account, and the procedures, methods, and criteria used in the process of determining the amount funded in their actuarially sound workers' compensation loss fund, including procedures for determining the amount for injuries incurred but not reported.

(A) The statement must include the city's, county's, or qualified self-insured employer group's certification that the loss reserve account is actuarially sound and adequately funded if an actuarial study is not available.

(B) The director may require a qualified self-insured employer group to demonstrate its loss reserve account is actuarially sound and adequately funded based on an actuarial study requested under OAR 436-050-0175(6)(c). The actuarial

study must include an IBNR estimate and a copy of the study must be provided to the director.

(3) Within 45 days of receipt of all information required by section (2) of this rule, the director will review the application and supporting documentation and notify the city, county, or qualified self-insured employer group that the request for exemption under ORS 656.407(3) is approved or denied.

(a) If denied, the notice will provide the reasons for the denial, any requirements for reconsideration, and the right to administrative review as provided by OAR 436-050-0008.

(b) If approved, the notice will include:

(A) The confirmation of the effective date of exemption;

(B) Authorization for cancellation of any surety bond or ISLOC held as security under ORS 656.407(2) and OAR 436-050-0180; and

(C) Procedures for release of any government securities or time deposits held as security under ORS 656.407(2) and OAR 436-050-0180.

(4) Probable cause to believe the workers' compensation loss reserve account is not actuarially sound includes but is not limited to:

(a) The annual audited financial statement under ORS 297.405 to 297.740 not containing a statement by the auditor that the workers' compensation loss reserve account is adequately funded, or containing a disclaimer regarding the auditor's qualifications or ability to determine adequacy of the loss reserve account; or

(b) For qualified self-insured employer groups required by the director to conduct an actuarial study under OAR 436-050-0175(6)(c) and section (2)(d)(B) of this rule, the actuarial study not containing a statement by the actuary that the loss reserve account is actuarially sound, or containing a disclaimer regarding the actuary's qualifications or ability to determine the adequacy of the reserves for current or future liabilities.

(5) A city, county, or qualified self-insured employer group that has been exempted from ORS 656.407(2) and desires to terminate its self-insurance certification or elects to discontinue maintaining an actuarially sound and adequately funded workers' compensation loss reserve must:

(a) Submit a written request to the director at least 60 days prior to the desired effective date the self-insured certification is requested to be terminated or 60 days prior to the effective date that the qualifying workers' compensation loss reserve account is to be discontinued;

(b) If the self-insured certification is to be terminated, the request for termination must comply with OAR 436-050-0200. Prior to the effective date of termination the city, county, or qualified self-insured employer group must provide a security deposit, as required by the director, in an amount determined under OAR 436-050-0180 and ORS 656.443; and

(c) If the city, county, or qualified self-insured employer group desires to remain self-insured, the city, county, or qualified self-insured employer group must requalify for self-

insurance certification by depositing, prior to the date the qualifying workers' compensation loss reserve account is to be discontinued, a security deposit as required by the director under ORS 656.407(2) and OAR 436-050-0180. Under ORS 656.407(3)(e) failure to deposit the required security deposit with the director prior to the date of discontinuance of the qualifying workers' compensation loss reserve account will cause the city's, county's, or qualified self-insured employer group's self-insurance certification to be automatically revoked as of that date.

Stat. Auth: ORS 656.407, 656.704, and 656.726(4)

Stats. Implemented: ORS 656.407

Hist: Amended 11/12/13 as WCD Admin. Order 13-061, eff. 1/1/14

Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14

436-050-0190 Using Self-Insured Employers Security Deposit/Self-Insured Employers Adjustment Reserve/Self-Insured Employer Group Adjustment Reserve/Director-Ordered Assessments of Private Employer Members of Self-Insured Employer Groups

(1) In the event a self-insured employer defaults or is unable to make all payments due under ORS chapter 656, the director will, on behalf of the employer, assure continued payments in accordance with ORS 656.407, 656.443, and 656.614 and in such a manner as to ensure minimum delay in the processing of injured workers' claims.

(2) If a self-insured employer defaults and is being serviced by one or more service companies, the director will, on behalf of the employer, designate those service companies to continue processing claims in accordance with the contracts in effect. At least 90 days prior to the time the contract expires, the service company can submit a proposal to continue processing the claims. The director will consider such proposal along with other options which may include referral of the claims for processing to an assigned claims agent selected under ORS 656.054.

(3) If a self-insured employer defaults and is self-administering, the director will, on behalf of the employer, negotiate to have the employer's claims processed or may refer the claims for processing to an assigned claims agent as secured under ORS 656.054.

(4) In the event a self-insured employer reorganizes its business, assumes additional liability, acquires new operations, buys an additional business, merges with another business, files bankruptcy, emerges from bankruptcy, or otherwise changes its operation in any manner that affects its workers' compensation claims liability, the self-insured employer must notify the director of the modification of business within 30 days of the event.

(5) In the event a self-insured employer group defaults or is unable to make all payments due under ORS chapter 656, is decertified by the director under ORS 656.434, or cancels its self-insurance certification, the director will, on behalf of the employer, assure continued payments in accordance with ORS 656.407, 656.443, and 656.614 and in such a manner as to ensure minimum delay in the processing of injured workers' claims.

(6) In the event a self-insured employer group reorganizes its business, assumes additional liability, acquires new operations, buys an additional business, merges with another business, files bankruptcy, emerges from bankruptcy, or otherwise changes its operation in any manner that affects its workers' compensation claims liability, or financial viability as determined under OAR 436-050-0260, the self-insured employer group must notify the director of the modification of business within 30 days of the event. Failure to comply with this rule may result in revocation of the self-insured employer group's certification.

(7) If a self-insured employer group defaults, cancels its self-insurance certification, or is decertified by the director under ORS 656.434, the director may designate the service company responsible for continuing to process the group's claims. The director's designation may include referral of the claims for processing to an assigned claims agent selected under ORS 656.054.

(8) If a self-insured employer group consisting of private employer members defaults, cancels its self-insurance certification, or is decertified by the director under ORS 656.434, the director may order private employer members of the group to pay an assessment for the group's continuing claim liabilities, under ORS 656.430(7)(a)(D)(i). Failure of the group's members to pay director-ordered assessments under this rule will subject members to civil penalties under ORS 656.745.

Stat. Auth: ORS 656.407, 656.434, 656.704, and 656.726(4)

Stats. Implemented: ORS 656.407, 656.443, and 656.614

Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14

436-050-0195 Requirements for Self-Insured Entity Changes

(1) If there is any change in the legal entity, changes in addresses, telephone numbers, and points of contact, or ownership changes, a self-insured employer must notify the director in writing within 30 days after the change occurs.

(2) A self-insured employer must submit requests to add or delete entities under its self-insured certification by submitting a completed "Endorsement to Self-Insured Group Application" (Form 440-1869) signed by an officer of the company. Each entity to be approved for inclusion in a self-insured employer's certification must enter into an agreement, signed by an officer of the entity being included in the self-insured employer's certification, making the entity jointly and severally liable for the payment of any compensation and moneys due to the director by the certified self-insured employer or any other entity included in the self-insured employer's certification.

(3) The director will determine, based on the information provided, the effect of the change on the deposit required and whether the entities can be combined for experience rating purposes.

(4) Failure to provide notification as required by this section may result in assessment of penalties or revocation of self-insurance certification, or both.

Stat. Auth: ORS 656.407, ORS 656.430, ORS 656.704 and ORS 656.726(3)

OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
EMPLOYER/INSURER COVERAGE RESPONSIBILITY

Administrative
Order No.
14-062

Stats. Implemented: ORS 656.407 and ORS 656.430
Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

**436-050-0200 Self-Insured Certification Cancellation;
Revocation**

(1) A certification to a self-insurer issued by the director remains in effect until:

(a) Revoked as provided by OAR 436-050-0150 through 436-050-0230, ORS 656.434, and ORS 656.440; or

(b) Canceled by the employer with the approval of the director.

(2) If a self-insured employer wishes to cancel certification as a self-insured or cancel self-insurance for any legal entity included under the self-insurance certification, the employer must make written request to the director. Such a request must be submitted at least 60 days prior to the desired date of cancellation and include:

(a) What arrangements have been made to process present and future claims for which the employer is responsible;

(b) A statement of all present and future claims liabilities for all liabilities incurred during the period of self-insurance; and

(c) Any reports and moneys due the director under ORS 656.506, 656.612, and 656.614.

(3) If the employer will continue to have subject workers after the cancellation date, the employer must provide the director, prior to the desired date of cancellation, one of the following:

(a) An insurer filed proof of coverage for a workers' compensation insurance policy under ORS 656.017 and 656.419;

(b) Evidence of a worker leasing arrangement as allowed under ORS 656.850; or

(c) An assigned risk binder that demonstrates compliance with ORS 656.052.

(4) If the self-insured employer fails to provide the director evidence of subsequent coverage under section (3) prior to the desired date of cancellation, the self-insurance certification, including reports and moneys due the director under ORS 656.506, 656.612, and 656.614, will remain in effect.

(5) If a workers' compensation insurance policy is in effect and an active self insurance certification is on file with the director for the same employer for the same time period, the self-insured employer has the responsibility of processing claims occurring during the time period as provided under the self insurance certification.

(6) The certification of a self-insured employer may be revoked if:

(a) The employer fails to comply with ORS 656.407 or 656.430 and applicable rules;

(b) The employer defaults, under ORS 656.443; or

(c) The employer commits any violation for which a civil penalty could be assessed under ORS 656.745.

(7) Except as provided in OAR 436-050-0170 (9), notice of certificate revocation will be issued in accordance with the provisions of ORS 656.440.

Stat. Auth: ORS 656.704 and 656.726(4)

Stats. Implemented: ORS 656.434 and 656.440

Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14

436-050-0205 Notice of Self-Insurer's Personal Elections

When a person makes an election under ORS 656.039, 656.128, or 656.140, the self-insured must notify the director in writing of the election and of any cancellation of the election within 30 days of the effective date.

Stat. Auth: ORS 656.704 and 656.726(4)

Stats. Implemented: ORS 656.039, 656.128 and 656.140

Hist: Amended 6/22/01 as WCD Admin. Order 01-054, eff. 7/1/01
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

**436-050-0210 Notice of Self-Insurer's Place of Business
in State; Records Self-Insured Must Keep in Oregon**

(1) Every employer certified as a self-insured employer must give the director notice of the location, mailing address, telephone number, and any other contact information of at least one location in this state where claims will be processed and claim records kept as well as other records as required by this rule and OAR 436-050-0220. The employer must give notice of the location, mailing address, telephone number, and any other contact information upon application for certification. The employer may not have at any one time more than three locations where claims are processed or records are maintained.

(2) Notice under section (1) of this rule must include contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director.

(3) With the approval of the director, a self-insured employer may use one or more service companies as authorized by ORS 656.455 instead of establishing its own place of business in this state. To obtain approval or to change or add service locations, the employer must file with the director a copy of the agreement entered into between the employer and each company, and must give the director notice of the location, mailing address, telephone number, and any other contact information of each service company.

(4) If a self-insured employer's or its service company's place of business or contact information will change, the self-insured employer must notify the director of the new location, mailing address, telephone number, and any other contact information 30 days before the effective date of the change.

(5) When a self-insured employer changes claims processing locations, service companies, or self-administration, the employer must provide at least 10 days prior notice to:

(a) Workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, and mailing address of the new claim processor;

(b) The director of which claims will be transferred. The notice must include:

(A) Contact information for both the sending processor and receiving processor of the claims to include a contact person, telephone number, mailing address, and physical address where the claims are to be processed;

(B) Verification of whether the claims to be transferred include closed claims; and

(C) A listing of the claims being transferred that identifies the sending processor's claim number, claimant name, and date of injury.

(6) For the purpose of this rule, those activities conducted at designated in-state location(s) and by the authorized representative(s) of the self-insured employer must include, but need not be limited to:

(a) Processing and keeping complete records of claims for compensation;

(b) Responding to specific claims processing inquiries;

(c) Keeping records of payments for compensation;

(d) Keeping records, including records of claims processed by prior service companies, in a written form, not necessarily original form, and making those records available upon request; and,

(e) Accommodating periodic in-state audits by the director.

(7) Written records every self-insured employer is required to keep in this state include, but are not limited to, the records described by OAR 436-050-0220.

(8) Notwithstanding section (1) of this rule, the director may approve up to two additional claims processing locations, if the self-insured employer can show:

(a) That meeting the requirements of section (1) of this rule will impose a financial or operational hardship on the employer;

(b) That such additional locations will result in improved claims processing performance of the employer; and

(c) That the auditing functions of the director can be met without unnecessary expense to the director.

(9) If, upon review of a self-insured employer's claims processing performance, the performance has not remained at the levels as described in OAR 436-060, approval for additional locations provided in section (6) will be withdrawn.

(10) Notwithstanding section (1) of this rule, a self-insured employer may, with the prior approval of the director, make compensation payments from a single location other than the designated claims processing location. Approval of such a location may be revoked if at any time:

(a) Timeliness of compensation payment falls below the minimum standards as established in OAR 436-060;

(b) Written record of compensation payments is not available; or

(c) There is not sufficient written documentation to support the issuance of a check for compensation.

(11) Notwithstanding section (1) of this rule, a self-insured employer may, with prior approval of the director, have one additional location, in or out of state, for maintaining payroll records pertaining to premium assessments and assessment/contributions.

Stat. Auth: ORS 656.455, 656.704 and 656.726(4)

Stats. Implemented: ORS 656.455

Hist: Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08

Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0220 Records Self-Insured Employer Must Keep in Oregon; Period to be Retained, Removal and Disposition

(1) The written records self-insured employers are required to keep in this state to ensure compliance with ORS 656.506, 656.612, 656.614, and 656.622 include:

(a) A record of payroll by National Council on Compensation Insurance classification; and

(b) Complete records of all assessments, employer and employee contributions, and all such money due the director.

(2) The self-insured employer must maintain at a place of business in this state; those written records relating to its safety and health program as required by ORS 656.430(10) and OAR 437-001.

(3) The records of claims for compensation that each self-insured employer is required to keep in this state include, but are not limited to:

(a) Written records used and relied upon in processing claims;

(b) A written record of all payments made as a result of any claim including documentation of the date the payment was mailed. Documentation may be the actual mailing date or an explanation of the time period between the date of issuance and mailing;

(c) A written record as to whether supplemental temporary disability benefits, as required under ORS 656.210(5) for workers employed in more than one job, were approved or denied; and

(d) A summary sheet for each claim showing all payments made, separated into disability, medical, and vocational assistance payments with cumulative totals. The record of disability payments should be limited to statutory benefits and not include any additional employer obligations. Expenses must not be included in any of the three columns required on the summary sheet. "Expenses" are defined in National Council on Compensation Insurance, Workers' Compensation Statistical Plan, Part IV.

(4) Records of a denied claim may be removed from this state after all the appellate procedures have been exhausted and the denial is final by operation of law.

(5) Records of any claim for a compensable injury may be removed from this state after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur.

(6) Notwithstanding sections (4) and (5) of this rule, if administrative or judicial review is requested, the claim records may not be removed from this state or disposed of until after either the review is concluded and the time for an appeal from such review has expired or at least one year after final payment of compensation has been made, whichever is the last to occur.

(7) During administrative or judicial review, if a denied claim is found to be compensable the records of the claim are subject to section (5) of this rule.

(8) The self-insured employer may destroy claim records when the self-insured employer can verify that all potential for benefits to the injured worker or the worker's beneficiaries is gone.

(9) Records retained as required by section (1) of this rule may be removed from the state or destroyed at the end of three full calendar years after the calendar year in which the money was remitted.

Stat. Auth: ORS 656.455, 656.704 and 656.726(4)

Stats. Implemented: ORS 656.455

Hist: Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0230 Out-of-State Recordkeeping and Claims Processing by Self-Insured Employer; Conditions and Procedure for Permit; Revocation

(1) Notwithstanding OAR 436-050-0220, if a self-insured employer wishes to keep the claims records and process claims at a location outside this state, the employer may apply to the director for permission to do so. The application shall contain the reasons for the request and the location, mailing address, telephone number, and any other contact information where the records will be kept and the claims processed. The application must provide the director contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director. Upon receipt, the director will review the application and notify the employer that the request has been denied and the reason therefor; or, that the employer will be allowed to process claims from outside this state.

(2) The director may grant permission to the self-insured employer unless the employer has committed acts or engaged in a course of conduct that would be grounds for revocation of permission or that are contrary to any of the provisions of section (3) of this rule.

(3) A self-insured employer that keeps claims records and processes claims at a location outside this state must:

- (a) Process claims in an accurate and timely manner;
- (b) Make reports to the director promptly as required by ORS chapter 656 and the director's administrative rules;
- (c) Pay to the director promptly all assessments and other money as it becomes due;
- (d) Increase or decrease its security deposit promptly when directed to do so by the director under ORS 656.407(2); and

(e) Comply with the rules and orders of the director in processing and paying claims for compensation.

(4) After notice given as required by ORS 656.455(2), permission granted under this section will be revoked by the director if the employer has committed acts or engaged in a course of conduct that are in violation of any provisions of section (3) of this rule.

(5) A self-insured employer must provide written records which have been removed from this state to the director as requested within a reasonable time not to exceed 14 days or as otherwise negotiated.

Stat. Auth: ORS 656.455, 656.704 and 656.726(4)

Stats. Implemented: ORS 656.455

Hist: Amended 12/5/05 as WCD Admin. Order 05-075, eff. 1/1/06
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0260 Qualifications of a Self-Insured Employer Group

Five or more employers may qualify as a self-insured employer group if the employers as a group:

(1) Incorporate or are a cooperative under ORS chapter 60, 62, or 65. If the group is a governmental subdivision, it must have formed a governmental entity as provided under ORS 190.003 to 190.110;

(2) Designate:

- (a) A board of trustees; and
- (b) An administrator, subject to section (10) of this rule;
- (3) Demonstrate and maintain:

(a) A combined net worth of at least \$3 million; and

(b) For private employer groups, individual member net worth of at least \$150,000. Private employer groups must obtain annual financial data from all members regarding their individual fiscal year end net worth;

(4) Have excess insurance coverage of the type and amounts approved by the director, including a self-insured retention of at least \$300,000;

(5) Demonstrate that accident prevention is likely to improve through self-insurance;

(6) Engage an adequate staff under OAR 436-055-0070 qualified to process claims;

(7) Develop a method approved by the director to notify the director of:

(a) The commencement or termination of membership by employers in the group, and the effect on the remaining combined net worth of the employers in the group; and

(b) Whether an employer who terminates membership in the group continues to be a subject employer; and if the employer remains a subject employer what arrangements have been made to continue coverage;

(8) Establish a safety and health loss prevention program as required by OAR 437-001;

(9) Create a common claims fund approved by the director;

(10) Designate an entity for the group responsible for centralized claims processing, payroll records, safety

requirements, recording and submitting assessments and contributions and making such other reports as the director may require. For groups consisting of private employer members, the designated entity may not be a member of the group or the group's board, or a trustee for the group. With the approval of the director, a self-insured employer group may use service companies as authorized by ORS 656.455 instead of establishing its own place of business in this state. To obtain approval or to change or add service locations, the employer group must file with the director a copy of the agreement entered into between the employer group and each company, and must give the director notice of the location, mailing address, telephone number, and any other contact information of each service company;

(11) Establish proof of financial ability by:

(a) Providing a security deposit that the director determines is acceptable under OAR 436-050-0165 and in an amount determined under OAR 436-050-0180; and

(b) Demonstrating financial viability based on factors including, but not limited to:

(A) The group meeting the combined net worth requirements in section (3)(a) of this rule;

(B) For private employers that are members of a self-insured group, meeting the individual net worth requirements in section (3)(b) of this rule; and

(C) Demonstrating acceptable financial strength based on the total combined points for the group's financial ratios, in section (12) of this rule.

(12) Self-insured employer groups must demonstrate and maintain acceptable financial strength in the following three financial ratios. "Acceptable financial strength" means the group has total combined points for the three ratios equaling "strong" or "moderate" ratings, under section (13) of this rule.

(a) The current ratio equals current assets divided by current liabilities.

(A) For purposes of calculating this ratio:

(i) Current assets identified in the financial statements and reports provided annually to the director under OAR 436-050-0175(1) through (3) must reasonably be expected to be converted into cash, or could become the equivalent of cash, within one year in the normal course of business. Examples of such assets include readily available cash, investments, marketable securities, and bonds where maturity occurs within one year and their value upon conversion to cash is not reduced by penalties or fees, accounts receivable, inventory, and prepaid expenses. Current assets must not include fixed assets, accumulated depreciation, intangible assets, or investments, marketable securities, or bonds with maturity dates of one year or longer.

(ii) The face value of a self-insured group's irrevocable standby letter of credit (ISLOC) used to satisfy the director's requirement for a security deposit must not be included in the self-insured group's reported assets, since funds provided by an ISLOC are not construed to be an asset of the group under

OAR 436-050-0165(2)(a)(J) and the required language in the ISLOC, Form 440-3640.

(iii) Current liabilities identified in the financial statements and reports provided annually to the director under OAR 436-050-0175(1) through (3) are obligations expected to be due within the next year. Examples of such liabilities include accounts payable, notes payable, accrued taxes, and wages and salaries owed to workers. Current liabilities must not include debts or claims on assets that will be due a year or more in the future or longer-term liabilities intended to provide more permanent funds for the business, including bank loans and long-term bonds.

(B) A maximum of six points are possible for this ratio, with a 2:1 ratio the desired standard. Points for the current ratio are determined as follows:

Ratio	Points
At least 2:1	= 6 points
At least 1.75:1	= 5 points
At least 1.6:1	= 4 points
At least 1.4:1	= 3 points
At least 1.25:1	= 2 points
At least 1.1:1	= 1 point
At least 1:1	= 0 points

(b) The liquidity ratio equals cash divided by current liabilities.

(A) For purposes of calculating this ratio:

(i) Cash identified in the financial statements and reports provided annually to the director under OAR 436-050-0175(1) through (3) must include all readily available funds such as bills, coin, or checking account balances. Cash funds exclude those held in special deposit or escrow accounts where some degree of legal constraint against their use exists.

(ii) Current liabilities identified in the financial statements and reports provided annually to the director under OAR 436-050-0175(1) through (3) are obligations expected to be due within the next year. Examples of such liabilities include accounts payable, notes payable, accrued taxes, and wages and salaries owed to workers. Current liabilities must not include debts or claims on assets that will be due a year or more in the future or longer-term liabilities intended to provide more permanent funds for the business, including bank loans and long-term bonds.

(B) A maximum of six points are possible for this ratio, with 40% the desired standard. Points for the liquidity ratio are determined as follows:

Ratio	Points
At least 50%	= 6 points
At least 40%	= 5 points
At least 30%	= 4 points
At least 25%	= 3 points
At least 20%	= 2 points

At least 10% = 1 point

At least 5% = 0 points

(c) The premium to surplus ratio equals earned contributions divided by the group's adjusted net worth.

(A) For purposes of calculating this ratio:

(i) Earned contributions identified in the financial statements and reports provided annually to the director under OAR 436-050-0175(1) through (3) are the net revenues from group members' contributions. Financial statements and reports may otherwise refer to this component as net premium, member contributions, or operating revenue. At the director's discretion, excess insurance premiums may be deducted from earned contributions when there is a reasonable likelihood of performance by the excess insurance carrier.

(ii) Adjusted net worth is the net worth identified in the certified statement provided annually to the director under OAR 436-050-0175(4)(a) less disallowed assets, which are prepaid expenses, inventory, and accounts receivable over 90 days old. Financial statements and reports may otherwise refer to net worth as net position, net assets, surplus, owner's equity, or shareholders' equity. The adjusted net worth is the total assets minus the sum of the total liabilities and the disallowed assets.

(B) A maximum of six points are possible for this ratio, with up to 1.00 the desired standard. Points for the premium to surplus ratio are determined as follows:

Ratio	Points
0.00 – 0.99	= 6 points
1.00 – 1.49	= 5 points
1.50 – 1.99	= 4 points
2.00 – 2.24	= 3 points
2.25 – 2.49	= 2 points
2.50 – 2.74	= 1 point
2.75 and over	= 0 points

(13) The sum of the three ratios equals a maximum of 18 points. That sum determines the rating for a self-insured employer group's financial strength and the potential consequences, as follows:

(a) 13 to 18 points: strong. Based on meeting all requirements of this rule, the director will approve initial or continued self-insured group certification. The group's security deposit amount will be determined based on OAR 436-050-0180 (1) through (3).

(b) 7 to 12 points: moderate. Based on meeting all requirements of this rule, the director will approve initial or continued self-insured group certification. The director will increase the security deposit amount calculated in OAR 436-050-0180 (1) through (3) by the percentage factor indicated for the sum of the group's ratio points, under section (4) of that rule.

(c) 0 to 6 points: weak. The director will not approve the application for initial self-insured employer group certification. For an existing certified self-insured employer group, the director may:

(A) Provide the group notice of the director's intent to revoke its self-insurance certification under OAR 436-050-0340(1); or

(B) Increase the security deposit calculated in OAR 436-050-0180 by an amount based on factors including, but not limited to:

(i) The considerations identified in OAR 436-050-0180(3); or

(ii) The determination that a financial correction plan submitted by the group demonstrates the ability to improve its financial viability sufficient to achieve the moderate financial rating in subsection (b) of this rule in a reasonable time period and without hampering the group's ability to pay compensation and other amounts due under ORS chapter 656.

(14) Comply with the requirements of OAR 436-050-0165, 436-050-0170, 436-050-0175, 436-050-0180, 436-050-195, 436-050-0200, 436-050-0205, 436-050-0210 and 436-050-0220. Failure to comply with these requirements will result in the actions prescribed in those rules.

(15) Every self-insured employer group must maintain at least one place of business in this state where the employer processes claims, keeps written records of claims and other records as required by OAR 436-050-0210 to 436-050-0220.

(16) Failure of a private employer that is a member of a self-insured employer group to maintain individual net worth of at least \$150,000 will result in cancellation of that member's participation in the group, under OAR 436-050-0290.

(17) Failure of a certified self-insured employer group to maintain the qualifications required in this rule will result in revocation of the self-insured employer group's certification. The group will be given 30 days written notice of the intent to revoke the self-insured certification, to be effective 30 days from the date of receipt of the revocation notice. If the self-insured employer group complies with the qualification requirements within the 30-day period, the revocation will be canceled and the certification will remain in effect.

Stat. Auth: ORS 656.407, 656.430, 656.704 and 656.726(4)

Stats. Implemented: ORS 656.407 and 656.430

Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14

436-050-0270 Applying for Certification as a Self-Insured Employer Group: Private Employers

(1) Employers applying for certification as a self-insured employer group must submit:

(a) A complete "Application to Become a Self-Insured Employer Group: Private Employers" (Form 440-1867);

(b) Proof in the form of a certificate from the Secretary of State's Corporation Division showing the employer group as a corporation or cooperative;

(c) A copy of the bylaws or corporate minutes which include:

(A) Designation of specific individuals as trustees for the corporation or cooperative;

(B) Naming an administrator to administer the financial affairs of the group who may not be a member of the group or the group's board, or a trustee for the group; and

(C) The criteria utilized by the trustees and administrator when approving applications for new membership and requests for withdrawal by members of the group;

(D) A copy of the fidelity bond furnished to the group by the administrator or a copy of the comprehensive crime policy obtained by the group, in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities;

(e) A current financial statement of each member making application which shows individual net worth of at least \$150,000 and taken collectively shows the following:

(A) A combined net worth of all members making application for coverage of at least \$3 million; and

(B) Working capital in an amount establishing financial strength, liquidity, and viability of the business, based on OAR 436-050-0260;

(f) An individual report by employer showing the employer's payroll by class and description and loss information for the last four calendar years;

(g) A completed "Group Self-Insured Indemnity Agreement" (Form 440-1866), or another form authorized by the director, that jointly and severally binds each member for the payment of any compensation and moneys due to the director by the group or any member of the group. Government subdivisions do not need to submit this agreement;

(h) Evidence of a safety and health loss prevention program designed to demonstrate that accident prevention will improve due to self-insurance;

(i) Proof of an adequate staff qualified to process claims by:

(A) Employing and retaining at each claims processing location, at least one person that is actually involved in the claims processing function and is qualified in accordance with OAR 436-055-0070; or

(B) Contracting the services of one or more service companies that employ, at each claims processing location, at least one person that is qualified in accordance with OAR 436-055-0070 and is actually involved in the self-insured employer's claims processing. If one or more service companies are used, a service agreement between the employer group and each service company, that meets the requirements of OAR 436-050-0260(10), must be submitted for approval of the director;

(j) The type, retention and limitation levels of excess insurance the employers as a group are planning to obtain in accordance with OAR 436-050-0170;

(k) A procedure for notifying the director of:

(A) The commencement or termination of employers within the group and the effect on the remaining combined net worth of the group; and

(B) Arrangements made by an employer leaving the group to continue insurance coverage.

(L) A program whereby each employer within the group contributes to a common claims fund in accordance with OAR 436-050-0300; and

(m) The type of security deposit the employer group wishes to provide, with appropriate justification.

(2) Notwithstanding subsection (1)(e) of this rule, the director may require an audited financial statement before considering an application by a group for self-insurance.

(3) Within 60 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the employer group that the request for certification as a self-insured employer group is denied and the reason therefore; or, that the group is qualified as a self-insured employer group. The notice must include:

(a) The amount of security deposit required;

(b) Approval of the type, retention and limitation levels of the excess insurance as determined under OAR 436-050-0170; and

(c) The type, retention and limitation levels of excess insurance required.

(4) The certification of self-insurance will be issued upon receipt of the security deposit and the appropriate excess insurance binder.

(5) Unless a later date is specified by the applicant, the effective date of certification will be the first day of the month following the date the requirements of section (4) of this rule are met.

Stat. Auth: ORS 656.407, 656.430, 656.704 and 656.726(4)

Stats. Implemented: ORS 656.407 and 656.430

Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14

436-050-0280 Applying for Certification as a Self-Insured Employer Group: Governmental Subdivisions

(1) Governmental subdivisions applying for certification as a self-insured employer group must submit:

(a) An application for the group applying for self-insurance in a form and format prescribed by the director;

(b) Proof that the governmental subdivisions have formed an intergovernmental entity as provided under ORS 190.003 to 190.110;

(c) An intergovernmental agreement which includes:

(A) Designation of specific individuals as trustees for the group and naming an administrator to administer the financial affairs of the group; and

(B) The criteria to be used by the trustees and administrator when approving applications for new membership and requests for withdrawal by members of the group;

(d) A copy of the fidelity bond furnished to the group by the administrator or a copy of the comprehensive crime policy obtained by the group, in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities;

(e) A current financial statement of each member making application which taken collectively shows the combined net worth of all members making application for coverage must not be less than \$3 million;

(f) An individual report by employer showing the governmental subdivision's payroll by class and description and loss information for the last four calendar years;

(g) A resolution by the governing body of each governmental subdivision binding it to be liable for the payment of any compensation and other amounts due to the director under ORS Chapter 656 incurred by that governmental subdivision during the period of group self-insurance;

(h) Evidence of a safety and health loss prevention program designed to demonstrate that accident prevention will improve due to self-insurance;

(i) Proof of an adequate staff qualified to process claims by:

(A) Employing and retaining at each claims processing location, at least one person that is actually involved in the claims processing function and is qualified in accordance with OAR 436-055-0070; or

(B) Contracting the services of one or more service companies that employ, at each claims processing location, at least one person that is actually involved in the self-insured group's claims processing, that is certified in accordance with OAR 436-055-0070. If service companies are used, a service agreement between the group and each service company, that meets the requirements of OAR 436-050-0260(10), must be submitted;

(j) The type, retention and limitation levels of excess insurance the employers as a group are planning to obtain in accordance with OAR 436-050-0170;

(k) A procedure for notifying the director of:

(A) The commencement or termination of governmental subdivisions within the group and the effect on the remaining combined net worth of the group; and

(B) Arrangements made by a governmental subdivision leaving the group to continue insurance coverage;

(L) A program whereby each employer within the group contributes to a common claims fund in accordance with OAR 436-050-0300; and

(m) The type and amount of security deposit the group wishes to provide, with appropriate justification. In no case will the amount be less than \$300,000.

(2) Notwithstanding subsection (1)(e) of this rule, the director may require an audited or certified financial statement before considering an application by a group for self-insurance.

(3) Within 60 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the group that the request for certification as a self-insured employer group is denied and the reason therefore; or, that the group is qualified as a self-insured employer group. The notice must include:

(a) The amount of the security deposit required; and

(b) Approval of the type, retention and limitation levels of the excess insurance as determined under OAR 436-050-0170; and the type, retention and limitation levels of excess insurance required.

(4) The certification of self-insurance will be issued upon receipt of the security deposit, the appropriate excess insurance binder and if applicable, a service agreement between the employer and service company that has been signed by both parties.

(5) Unless a subsequent date is specified by the applicant, the effective date of certification will be the date the certification is issued.

Stat. Auth: ORS 656.407, 656.430, 656.704 and 656.726(4)

Stats. Implemented: ORS 656.407 and 656.430

Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14

436-050-0290 Commencement/Termination/Cancellation of Employers with a Self-Insured Employer Group; Effect on Net Worth; Extension of Coverage; Change in Entity; Change of Address; Recordkeeping

(1) Prospective new members of a self-insured employer group must submit an application to the board of trustees, or its administrator. The administrator of a group consisting of private employer members may not be a member of the group. The trustees, or administrator, may approve the application for membership under the bylaws of the self-insured group. Once approved, the administrator or board of trustees must submit to the director, within 30 days of the effective date of membership, a completed "Endorsement to Self-Insured Group Application" (440-1869) or a form approved by the director, which must be accompanied by:

(a) A current financial statement of the employer applying;

(b) Evidence of at least \$150,000 individual net worth if the prospective new member is a private employer;

(c) An agreement signed by the administrator of the self-insured group and the employer, making the employer jointly and severally liable for the payment of any compensation and moneys due to the director by the group or any member of the group; or, if a governmental subdivision self-insured group, a resolution by the governing body of each governmental subdivision binding it to be liable for the payment of any compensation and other amounts due to the director under ORS Chapter 656 incurred by that governmental subdivision during the period of group self-insurance;

(d) A statement showing the effect on the new combined net worth of the group; and

(e) The employer's payroll by class and description and loss information for the last four fiscal or calendar years.

(2) Incomplete submissions or incorrectly completed endorsements to add new members received by the director will not be considered filed. Failure to file a correct and complete endorsement with the required supporting documentation within 30 days of the effective date of membership may result in the assessment of civil penalties.

(3) Individual members may elect to terminate their participation in a self-insured group or be subject to cancellation by the group under the bylaws of the group. Groups consisting of private employer members must also cancel the membership of any private employer member that fails to maintain the minimum individual net worth required, under OAR 436-050-0260 (16). Such cancellation must occur within 30 days of the group's receipt of the employer member's most recent fiscal year end financial data demonstrating insufficient net worth. The self-insured group must submit the following information to the director no later than 10 days before the effective date of the member's termination or cancellation:

(a) A statement, without disclaimers or qualifying language as to the accuracy of the information provided:

(A) Showing the effect of the member's termination or cancellation on the remaining combined net worth of the group; and

(B) Certifying that the group continues to meet the combined net worth requirements in OAR 436-050-0260;

(b) Evidence that the employer requesting termination or being cancelled has made alternate arrangements for coverage if the employer continues to employ;

(c) Evidence that the employer requesting termination or being cancelled has been provided a written reminder about its potential future liability as described in section (1)(c) of this rule; and

(d) The expected date of cancellation or termination.

(4) In the event the director determines the cancellation or termination of a group member adversely affects the net worth of the group to the extent that the group no longer qualifies for self-insurance certification, the director may revoke the self-insured employer group's certification under OAR 436-050-0340(3).

(5) An employer within a group must, if there is a change in the employing legal entity, again apply for membership within the group, in accordance with this rule. A change in legal entity includes, but is not limited to:

(a) When a partner joins or leaves the partnership;

(b) When the employer is a sole proprietorship, partnership, or corporation, and changes to a sole proprietorship, partnership, or corporation; or

(c) When an employer sells an existing business to another person(s), except in the case of a corporation.

(6) An employer within a group must, within 10 days after there is a change of address or assumed business name, notify the board of trustees or administrator of the change. The

administrator or board of trustees must, within 10 days, submit to the director an endorsement as notice of the change. A change of address includes, but is not limited to:

(a) Establishment of a new or additional location; or

(b) Termination of an existing location.

(7) The endorsement required by section (6) of this rule must state specifically which location is being deleted or which is being added. It must also identify the type of address, whether it is mailing, operating, or the principal place of business.

(8) The employer group is responsible for maintaining coverage records relating to each member, to include:

(a) The employer's application for membership in the group, with original signatures;

(b) The employer's liability agreement under OAR 436-050-0270(1)(g), or resolution under OAR 436-050-0280(1)(g), with original signatures;

(c) Cancellation or termination notices;

(d) Reinstatement applications and notices; and

(e) Records on the whereabouts of employers that have been canceled or have terminated their participation in the group.

Stat. Auth: ORS 656.704 and 656.726(4)

Stats. Implemented: ORS 656.434 and 656.440

Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14

436-050-0300 Self-Insured Employer Group, Common Claims Fund

(1) A self-insured employer group must establish, under the direction and control of the board of trustees and administrator, a common claims fund for the sole purpose of ensuring the availability of funds to make certain the prompt payment of all compensation and all other payments that may become due from such self-insured employer group under the workers' compensation law.

(2) The common claims fund must be maintained in an account held by an Oregon state chartered or a federally chartered bank. Government subdivisions certified as a self-insured employer group may also maintain the common claims fund in a "Local Government Investment Pool" account held by the Office of the State Treasurer.

(3) Except as provided in section (6) of this rule, the balance of the common claims fund must be maintained in an amount at least equal to 30 percent of the average of the group's paid losses for the previous four years. The full sum of the required common claims fund balance must be maintained at all times.

(4) The director may require the self-insured group to increase the amount maintained in the common claims fund.

(5) By March 1 of each year, a self-insured employer group must provide the director with adequate documentation to validate the balance in the common claims fund or notice that the amount calculated in section (3) or (6) of this rule must be included in the determination of the self-insured employer group's security deposit under OAR 436-050-0180. The director may require a self-insured employer group to provide

documentation of the common claims fund balance more frequently.

(6) For governmental subdivisions certified as a self-insured employer group, the balance of the common claims fund must be maintained in an amount at least equal to 60 percent of the average of the group's yearly paid losses for the previous four years.

Stat. Auth: ORS 656.704 and 656.726(4)

Stats. Implemented: ORS 656.430

Hist: Amended 7/3/13 as WCD Admin. Order 13-056, eff. 7/22/13
Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14

436-050-0340 Group Self-Insurance Revocation

Notwithstanding ORS 656.440, the certification of a self-insured employer group may be revoked by the director after giving 30 days notice if:

(1) The employer group does not comply with ORS 656.430(7) or (8) or OAR 436-050-0260, 0270, 0280, 0290, or 0300;

(2) There are fewer than five employers within a group;

(3) The net worth of the group falls below that required by OAR 436-050-0260(3);

(4) The employer group defaults in payment of compensation or other payments due the director;

(5) The employer group commits any violation for which a civil penalty could be assessed under ORS 656.745; or

(6) The employer group or any member of the group submits any false or misleading information.

Stat. Auth: ORS 656.704 and 656.726(4);

Stats. Implemented: ORS 656.434 and 656.440

Hist: Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14

436-050-0400 Responsibility for Providing Coverage under a Lease Arrangement

(1) Every worker leasing company providing workers to a client must satisfy the requirements of ORS 656.017, 656.407, or 656.419.

(2) Every worker leasing company providing leased workers to a client must also provide workers' compensation insurance coverage for any subject workers of the client, unless the client has an active workers' compensation insurance policy proof of coverage on file with the director or is certified under ORS 656.430 as a self-insured employer. In the latter circumstance, the client's insurer or the self-insured employer will be deemed to provide insurance coverage for all leased workers and subject workers of the client.

(3) If an insured client allows its workers' compensation insurance policy to cancel or does not obtain a renewal of the policy, or if a self-insured client allows its certification to terminate, and the client continues to employ subject workers or has leased workers, the client will be considered a noncomplying employer unless the worker leasing company has made the filing with the director under OAR 436-050-0410(1).

(4) A client can obtain leased workers from only one worker leasing company at a time unless the client has an active

workers' compensation insurance policy proof of coverage on file with the director or is certified under ORS 656.430 as a self-insured employer.

(5) A worker leasing company must not provide workers' compensation coverage for another worker leasing company doing business in Oregon whether or not any of the worker leasing companies involved is licensed for worker leasing in Oregon.

(6) A client employer may not obtain workers by contract and for a fee on a non-temporary basis from an unlicensed worker leasing company.

Stat. Auth: ORS 656.704, 656.726(4), 656.850 and 656.855; **Stats. Implemented:** ORS 656.850 and 656.855

Hist: Amended 9/17/08 as WCD Admin. Order 08-061, eff. 7/1/09
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0410 Notice to Director of Lease Arrangement; Termination

(1) Within 14 days after the effective date of the lease arrangement or contract, a worker leasing company must file written notice with the director and its insurer, using Form 440-2465, that it is providing leased workers to a client and workers' compensation coverage. The notice must be correct and complete, and must include:

(a) The client's:

(A) Legal name;

(B) FEIN or other tax reporting number;

(C) Type of ownership;

(D) Primary nature of business;

(E) Mailing address; and

(F) Street address in Oregon;

(b) The worker leasing company's:

(A) Legal name;

(B) Mailing address;

(C) FEIN or other tax reporting number;

(D) WCD worker leasing license number, if any;

(E) Workers' compensation insurer's name (or "self-insured");

(F) Effective date of leasing contract;

(G) Contact name and phone number; and

(H) A signature of a representative of the worker leasing company.

(2) A worker leasing company may terminate its obligation to provide workers' compensation coverage by giving to its insurer, its client, and the director written notice of the termination. A notice of termination must state the effective date and hour of termination, but the termination will be effective not less than 30 days after the notice is received by the director. Notice to the client under this section must be given by mail, addressed to the client at its last-known address.

Stat. Auth: ORS 656.704, 656.726(4), 656.850 and 656.855

Stats. Implemented: ORS 656.850 and 656.855

Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0420 Temporary Worker Distinguished from Leased Worker

(1) A person who provides a worker to work for a client will be considered to be providing the worker on a "temporary basis" only if there is contemporaneous written documentation that indicates the duration of the work to be performed and that the worker is provided for a client's special situation under ORS 656.850(1)(b). Contemporaneous documentation means documents that are created at the time the temporary service provider and the client employer make the arrangements for placement of the worker. Upon the director's request, the documentation must be provided to the director by either the temporary service provider or the client. Contemporaneous documentation in support of workers being provided on a temporary basis includes one or more of the following conditions:

- (a) To cover employee absences or employee leaves, including but not limited to such things as maternity leave, vacation, jury duty, or illness from which the permanent worker will return to work;
- (b) To fill a professional skill shortage, including but not limited to, professionals such as engineers, architects, electricians, plumbers, pharmacists, nurses, or other professions, whether licensed or not, to supplement or satisfy a shortage of that skill for a known duration. Supporting documentation may include license information and whether the worker is supplementing or satisfying a client employer's need for the skill;
- (c) To staff a seasonal or sporadic increase in workload, indicated by a temporary increase in demand upon an employer's normal workload that requires additional assistance to meet the demand. When the increased demand ends, the additional positions are eliminated. Documentation must include what constitutes the demand establishing why this special situation is beyond the norm;
- (d) To staff a special assignment or project outside of the routine activities of the business where the worker will be terminated or assigned to another temporary project upon completion. For example, a construction contractor may need assistance on a construction site to help clear branches and other debris after a windstorm so the regular construction crew can continue its work. Documentation must describe the project and why it is unusual;
- (e) To hire a student worker that will be provided and paid by a school district or community college through a work experience program. Documentation must include the name of the school and the work experience program; or
- (f) To cover special situations where the worker has a reasonable expectation of transitioning to permanent employment with the client employer and the client employer uses a pre-established probationary period in its overall employment selection program. Documentation must include copies of the client employer's written program or other evidence supporting the pre-established probationary period and overall employment selection program.

(2) If a person provides workers, by contract and for a fee, to work for a client and any such workers are not provided on a "temporary basis," that person will be considered a worker leasing company.

(3) If a person provides both leased workers and workers on a temporary basis, that person must maintain written records that show specifically which workers are provided on a temporary basis. If the written records do not specify which workers are provided on a temporary basis, all workers are deemed to be leased workers.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855

Stats. Implemented: ORS 656.850 and 656.855

Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0440 Qualifications, Applications, and Renewals for License as a Worker Leasing Company

(1) Each person applying for initial license or renewal as a worker leasing company must:

- (a) Be either an Oregon corporation or other legal entity registered with the Oregon Secretary of State, Corporations Division to conduct business in this state;
 - (b) Maintain workers' compensation coverage under ORS 656.017; and
 - (c) Upon application approval and prior to licensure, pay the required licensing fee of \$2,050.
- (2) Each person applying for initial license or renewal as a worker leasing company must submit an Application for Oregon Worker Leasing License Form 440-2466. The form and accompanying documentation must include:
- (a) Legal name;
 - (b) Mailing address;
 - (c) In-state and out-of-state phone numbers;
 - (d) FEIN or other tax reporting number;
 - (e) Type of business;
 - (f) Physical address for Oregon principal place of business;
 - (g) Assumed business names;
 - (h) Name of workers' compensation insurer (or "self-insured") and policy number;
 - (i) Name(s) and contact information of the representative(s) at the Oregon location(s);
 - (j) List of controlling persons, and in the case of privately held entities all owners, including their names, titles, residence addresses, telephone numbers, email addresses, and dates of birth;
 - (k) For a person applying for an initial license, a list of all states where the person operates as a leasing company or professional employer organization (PEO), copies of licenses, registrations, recognitions, or certifications from states that require those actions, and a verifiable statement that the remaining states of operation, if any, do not require licensure, registration, recognition, or certification to provide worker leasing or PEO services;

**OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
EMPLOYER/INSURER COVERAGE RESPONSIBILITY**

**Administrative
Order No.
14-062**

(l) Verification of compliance with tax laws from Oregon Employment Department, Oregon Department of Revenue, and the Internal Revenue Service, using Attachments A, B, and C of Form 440-2466, the worker leasing license application;

(m) A record of any present or prior experience of providing workers by contract and for a fee in any state, by the person or any controlling person, and an explanation of that experience;

(n) A record of any bankruptcies, liens, or any actions involving or demonstrating dishonesty or misrepresentation, including but not limited to: fraud, theft, burglary, embezzlement, deception, perjury, forgery, counterfeiting, bribery, extortion, money laundering, or securities, investments, or insurance violations on the part of the person or any controlling person. Records of such actions must include:

- (A) Charges, guilty pleas, or pleas of no contest;
- (B) Criminal convictions;
- (C) Lawsuits;
- (D) Judgments; or
- (E) Discharges or permitted resignations based on allegations of these actions.

(o) Full details regarding any bankruptcy, liens, or action under subsection (n) of this section, including:

- (A) The nature and dates of the action(s);
- (B) Outcomes, sentences, and conditions imposed;
- (C) Name and location of the court or jurisdiction in which any proceedings were held or are pending, and the dates of the proceedings; and

(D) The designation and license number for any actions against a license;

(p) Full details of any administrative actions against the person by a regulatory agency of any state regarding matters listed in subsection(2)(n) or worker leasing activities;

(q) A plan of operation that demonstrates how the worker leasing company will meet the requirements of ORS chapter 654, The Oregon Safe Employment Act;

(r) A plan of operation that demonstrates how the worker leasing company will collect and report the information necessary to establish each client's separate experience rating to the insurer providing workers' compensation coverage for each client, or to the National Council on Compensation Insurance for a self-insured worker leasing company and

(s) A notarized signature of an authorized representative of the applicant.

(3) The director may request additional information to further clarify the information and documentation submitted with the application. Under ORS 656.850(2), no person may perform services as a worker leasing company in Oregon without first being licensed to do so.

(4) The director will review complete applications, and may conduct a background investigation of the person applying for a license, an owner, or any controlling person. Information

learned through a background investigation, or other information submitted during the application process, may be the basis for the director to refuse to issue or renew a license, or to disqualify the person from making further application.

(5) If the application is approved, the director will issue a license. Each license issued under these rules will automatically expire two years after the date of issuance unless renewed by the licensee. To renew a license, the worker leasing company must submit a renewal application to the director at least 90 days before the expiration of the current worker leasing license. Any supplemental material, whether requested by the director or submitted by the worker leasing company to establish a complete application, must be received by the director at least 45 days before expiration of the current license.

(6) The director may refuse to issue or renew a license or may disqualify a person, controlling person, or worker leasing company from applying for a license in the future for misrepresentation, failure to meet any of the requirements of ORS 656.850, 656.855, or these rules, or for reasons including, but not limited to:

(a) Denial of a previous application for, or prior suspension or revocation of, a worker leasing license by the director;

(b) Denial, suspension, or revocation of a license, registration, or certification, or other discipline by any governmental agency or entity;

(c) Having exercised authority, control, or decision-making responsibility concerning any worker leasing company at the time that company had its authorization to provide worker leasing services denied, suspended, revoked, or restricted;

(d) Having been the subject of an order, adverse to the person, controlling person, or worker leasing company, by any governmental agency or entity in connection with any worker leasing activity;

(e) Having been found by any governmental agency or entity to have made a false or misleading statement, material misrepresentation, or material omission, or to have failed to disclose material facts;

(f) Violations of worker leasing statutes or regulations;

(g) Failure to establish minimum experience, training, or education that demonstrates competency in providing worker leasing services;

(h) Having been the subject of a complaint, investigation, or proceeding related to an action in subsection (2)(n) of this rule;

(i) Having been charged with, convicted of, or pleaded guilty or no contest to any felony or misdemeanor specified in subsection (2)(n) of this rule; or

(j) Having failed to provide documents the director has requested.

(7) "Disqualification," as used in this rule, means a person or a prospective worker leasing company may reapply no sooner than two years from the disqualification date.

(8) A disqualification may apply to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company's assets to another person, owner, or controlling person.

(9) A person may appeal the director's refusal to approve and issue or renew a license, or a disqualification, under this rule as provided in OAR 436-050-0008 and OAR 436-001.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855

Stats. Implemented: ORS 656.850 and 656.855

Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07

Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0450 Recordkeeping and Reporting Requirements

(1) Every licensed worker leasing company must give notice to the director of one Oregon location where Oregon leasing records are kept and made available for review by the director. The notice must include the physical address, mailing address, telephone number, and any other contact information in this state.

(2) Every licensed worker leasing company must have at least one representative of the worker leasing company at the Oregon location authorized to respond to inquiries and make records available by the date specified in the director's request or demand for information regarding leasing arrangements and client contracts.

(3) The following records must be kept and made available for review at the Oregon location:

(a) Copies of signed worker leasing notices for the most recent three years;

(b) Copies of signed notices of termination of leasing arrangements for the most recent three years;

(c) Copies of signed contracts between the worker leasing company and clients for the most recent three years; and

(d) Payroll records for the most recent seven years for all workers that identify leased workers subject to coverage by the worker leasing company; leased workers not subject to coverage by the worker leasing company; and, written records for all regular and temporary employees of the worker leasing company.

(4) The worker leasing company must notify the director within 30 days of the effective date of a change in any items listed in OAR 436-050-0440(2).

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855

Stats. Implemented: ORS 656.850 and 656.855

Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07

Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0455 Reporting Requirements of a Self-Insured Worker Leasing Company

(1) A self-insured worker leasing company must maintain and report to the National Council on Compensation Insurance separate statistical data for each client whose coverage is provided by the self-insured employer. Reporting must be according to the uniform statistical plan prescribed by the director according to ORS 737.225(4).

(2) Records relating to the client statistical data for self-insured worker leasing companies must be made available for review by the National Council on Compensation Insurance upon request.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855

Stats. Implemented: ORS 656.850 and 656.855

Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07

Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0460 Suspension or Revocation of License

(1) Reasons for suspension or revocation of a worker leasing license include, but are not limited to:

(a) Insolvency, whether the worker leasing company's liabilities exceed their assets or the worker leasing company cannot meet its financial obligations;

(b) Judgments against or convictions, within the last ten years, of any worker leasing company or controlling person for the reasons identified in OAR 436-050-0440(2)(n);

(c) Administrative actions involving worker leasing activities resulting from failure to comply with the requirements of any state;

(d) Nonpayment of taxes, fees, assessments, or any other monies due the State of Oregon;

(e) If the worker leasing company or controlling person has failed to comply with any provisions of ORS chapters 654, 656, 659, 659A, 731 or 737; or any provisions of these rules; or

(f) If the worker leasing company or controlling person is permanently or temporarily enjoined by a court from engaging in or continuing any conduct or practice involving any aspect of the worker leasing business.

(2) For the purposes of this rule:

(a) "Suspension" means a stopping by the director of the worker leasing company's or controlling person's authority to provide leased workers to clients for a specified period of time. A suspension may be in effect for a period of up to two years. When the suspension expires, the worker leasing company or controlling person may petition the director to resume its worker leasing company activities.

(b) "Revocation" means a permanent stopping by the director of the worker leasing company's or controlling person's authority to provide leased workers to clients. After a revocation has been in effect for five years or longer, the worker leasing company or controlling person may reapply for license.

(c) "Show-cause hearing" means an informal meeting with the director in which the worker leasing company will be provided an opportunity to be heard and present evidence regarding any proposed actions by the director to suspend or revoke a worker leasing company's authority to provide leased workers to clients.

(3) The director may revoke a license upon discovery of a misrepresentation in the information submitted in the worker leasing application.

(4) Suspension or revocation under this rule will not be made until the worker leasing company has been given notice and the opportunity to be heard through a show-cause hearing before the director and "show cause" why it should be permitted to continue to be licensed as a worker leasing company.

(5) A show-cause hearing may be held at any time the director finds that a worker leasing company has failed to comply with its obligations under a leasing contract or that it failed to comply with the rules or orders of the director.

(6) Appeal of proposed and final orders of suspension or revocation issued under this rule may be made as provided in OAR 436-050-0008 and OAR 436-001.

(7) Notwithstanding section (4) of this rule, the director may immediately suspend or refuse to renew a license by issuing an "emergency suspension order" if the worker leasing company fails to maintain workers' compensation coverage; or if the director finds there is a serious danger to public health or safety.

(8) A suspension or revocation may apply to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company's assets to another person.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855

Stats. Implemented: ORS 656.850 and 656.855

Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0470 Monitoring/Auditing

(1) The division will monitor and conduct periodic audits of employers as necessary to ensure compliance with the worker leasing company licensing and performance requirements.

(2) All pertinent records of the worker leasing company required by these rules must be disclosed upon request of the director.

(3) Under ORS 656.726 and 656.758, the director may inspect the books, records and payrolls of employers pertinent to the administration of these rules. Employers must provide the director with all pertinent books, records and payrolls upon request.

(4) For the purposes of this rule, both the worker leasing company and its clients will be considered employers.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855

Stats. Implemented: ORS 656.850 and 656.855

Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0480 Assessment of Civil Penalties

(1) Failure to provide timely notice to the director for proof of coverage and cancellation of workers' compensation insurance policies under ORS 656.419 or OAR 436-162, or failure to provide timely worker leasing notice to the director under ORS 656.850(5) and OAR 436-050-0410, may result in civil penalties under ORS 656.745.

(2) The director may assess a civil penalty under ORS 656.745 against an employer who fails to respond to requests for information or fails to meet the requirements of 436-050-

0470. Assessment of a penalty does not relieve the employer of the obligation to provide a response.

(3) An employer failing to meet the requirements set forth in OAR 436-050-0410, 436-050-0450, and 436-050-0455, may be assessed a civil penalty under ORS 656.745.

(4) An employer who is found to be operating a worker leasing company without having obtained a license or after having failed to renew a license, or who continues to operate in Oregon as a worker leasing company after a prior Oregon license expired, may be assessed a civil penalty for each violation under ORS 656.745.

(5) For the purposes of ORS 656.850(2), a violation is defined as any month or part of a month for each client in which an employer provides leased workers to a client without having first obtained a worker leasing license.

(6) An employer obtaining workers by contract and for a fee from an unlicensed worker leasing company on a non-temporary basis may be subject to penalties under ORS 656.745. Upon a subsequent or continuing violation where written notice of such violation has been served, penalties under ORS 656.745 will be assessed against the employer.

(7) Any person or controlling person may also be subject to penalties under ORS 656.990.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855;

Stats. Implemented: ORS 656.850 and 656.855

Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07
Amended 9/17/08 as WCD Admin. Order 08-061, eff. 7/1/09
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

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Oregon

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BULLETIN NO. 209 (REV.) Nov. 26, 2014

TO: Self-insured employers and self-insured employer groups

SUBJECT: Report of losses instructions and guidelines

EFFECTIVE: Jan. 1, 2015

This bulletin explains reporting requirements under OAR 436-050-0175(6), which requires all self-insured employers to submit claims loss data to the department for calculation of annual experience rating modifications, security deposits, and retrospective rating plan adjustments.

Revisions to this bulletin and the attached forms include:

- **Increasing the self-insured employers' reporting threshold for individual claims from \$13,500 to \$15,500.**
- **Updating the Life Expectancy Table from 2009 to 2010 values, per Social Security Administration.**
- **Structural changes for improved clarity.**

This bulletin replaces Bulletin 209 issued Nov. 1, 2013.

I. DEFINITIONS

- A. "Closed claim" means a claim for which the employer expects no future indemnity or medical payment or litigation.
- B. "Contract medical" means the costs of employer-furnished first aid and medical facilities, including personnel or retainer fees for nurses and physicians that are not allocated to individual claims. Report the same contract medical amount for the succeeding experience rating years.
- C. "Maximum medical reimbursement amount." Refer to Bulletin 345. **This provision may not be applied retroactively. See OAR 436-060-0055(7).**
- D. "Net losses" means the amount the self-insured employer incurs after receiving any recovery allowed by law or reimbursements from Workers' Benefit Fund (WBF) programs.
- E. "Open claim" means a claim for which the employer expects future indemnity or medical payments or there is current litigation.

- F. "Outstanding reserves" means estimated future payments for the life of the worker and any eligible beneficiaries.
- G. "Recoveries" means monies recovered through subrogation.
- H. "Reimbursements" means monies received from WBF programs.
- I. "Total incurred losses" means paid losses minus medical reimbursement amount on non-disabling claims plus outstanding reserves. Round to the nearest dollar.
- J. "Total paid" means indemnity paid plus medical paid.

II. HOW TO REPORT LOSSES

Use the attached "Report of Losses" forms, or comparable computer-generated reports to report loss information. Provide loss figures for total paid, outstanding reserves, and total incurred losses. Loss figures should reflect net losses only (except for experience rating period Self Insured Retention (SIR) claims; refer to section III E (3)). For specific information on reportable losses, see Part IV of the National Council on Compensation Insurance Workers' Compensation Statistical Plan. You can order copies through NCCI Products and Services by calling 800-622-4123.

Each year, the Workers' Compensation Division (WCD) will notify the self-insured employer of the reporting periods. **The self-insured employer is responsible for submission of accurate reports, whether submitted by the self-insured employer or its service company.** Service companies should communicate with the self-insured employer to reconcile claims, financial, and excess information prior to submission.

Submit reports to the Performance Section, Self-Insurance Specialist Team, by **March 1**. Under OAR 436-050-0175(9), if a self-insured employer does not comply with reporting requirements, the director may impose penalties or other sanctions, including revocation of the self-insurance certification. **No extensions will be granted.**

Under OAR 436-050-0175(8), the director may require a self-insured employer to submit claims loss data more frequently than once per year if the nature of the self-insured employer's business has changed since the submission of the last Report of Losses. Examples of changes in business include, but are not limited to, mergers or acquisitions, changes in employment level, changes in the nature of employment, and incurred claims costs.

Directions for the Report of Losses:

- A. List all claims in **alphabetical** order.
- B. Round totals to the nearest dollar.
- C. All claims must be valued as of Jan. 1.
- D. Do not report preferred worker claims that qualify for claims cost reimbursement or any supplemental disability payments.
- E. Report loss information for all entities covered under the self-insurance plan.

F. Report only Oregon losses.

G. Include only claims occurring while self-insured.

Refer to **Figure 1. Report of Losses Reporting Guidelines** below for examples of what to include and exclude from your Report of Losses.

Claims should be reserved for the ultimate probable cost for the life of the claim.

Figure 1. Report of Losses Reporting Guidelines

	Include in Losses	Exclude from Losses
	<ul style="list-style-type: none"> • Statutory benefits: Any benefits payable to or on behalf of the worker under the law in effect at the time of the injury 	<ul style="list-style-type: none"> • Amounts recovered through subrogation (after excluding recovery expenses)
Indemnity costs:	<ul style="list-style-type: none"> • Time loss compensation • Awards • Remarriage allowance • Stipulation amounts and fees, settlement amounts and fees (Claims Disposition Agreement and Disputed Claims Settlement) • Penalties, if the reason for the penalty was within the self-insured employer's control 	<ul style="list-style-type: none"> • Amounts reimbursed or reimbursable from the WBF. Reductions may only be taken on claims determined, by department order, to be eligible for relief • Supplemental Disability Benefit amounts paid to eligible workers with more than one employer at the time of injury • Social security offset (SSO) amounts applicable to permanent total disability claims
Medical costs:	<ul style="list-style-type: none"> • Scheduled exams for closure/rating, e.g., Independent Medical Exams, Worker Requested Medical Exams, arbiter exams • Physical therapy, work hardening • Prosthetic appliance purchase/replacement • Prescriptions • Surgeries • Transportation • Burial • All other medical care as provided under ORS 656.245 	<ul style="list-style-type: none"> • Medical costs to determine compensability of the injury or condition • Nurse case management fees • Bill audit fees • IME for compensability or management
Legal costs:	<ul style="list-style-type: none"> • Fees paid to worker attorneys 	<ul style="list-style-type: none"> • Defense attorney costs • Legal costs to determine compensability of the injury or condition • Settlement costs for termination/release agreements
Vocational assistance costs:	<ul style="list-style-type: none"> • Include if the date of injury was on or after Jan. 1, 1986. Also include if the injury was prior to Jan. 1, 1986 and reimbursement was not approved by WCD 	<ul style="list-style-type: none"> • Preferred worker claims qualifying for claims cost reimbursement

III. EXPERIENCE RATING PERIOD

The normal experience rating period consists of losses from the last three completed fiscal years (July 1 through June 30). **Include all claims, open, closed, accepted, deferred, denied, disabling, or non-disabling**, with dates of injury during the experience rating period. Report the claims for each fiscal year on a separate Self-Insured Employer Report of Losses Experience Rating Period, Form 2809.

The following letters correspond to those shown on the Self-Insured Employer Report of Losses Experience Rating Period, Form 2809.

- A. Report contract medical costs not allocated to individual claims, such as employer-provided nurses, physicians, medical clinics, and physician retainer fees. Report the same amount for all three experience years. Report \$0 if there are no costs.
- B. Report the aggregate total paid for all claims under \$15,500. When totaling these claims, use each claim's net paid costs. Report medical reimbursement amount paid for accepted non-disabling claims under ORS 656.262(5). (See Bulletin 345). Report \$0 if none was taken. Report outstanding reserves and total incurred losses.

Note: The division requests a separate list of claims with losses of less than \$15,500 for each of the experience rating periods provided. List claims in alphabetical order by worker's complete name. Include date of injury and claim number.

- C. Report the total number of claims where the medical reimbursement amount has been taken. Report zero claims if none was taken.
- D. Report the number of claims with incurred losses of \$15,500 or less. Include the claims reported in "C."
- E. Report each claim with total incurred losses greater than \$15,500. List claims in **alphabetical** order by worker's complete name. Report date of injury and claim number. Report total paid. (This should be the net amount paid after accounting for any recovery or reimbursed amounts. See section II, Figure 1.). Report medical reimbursement amount (for previously reported accepted non-disabling claims refer to Bulletin 345). Report outstanding reserves, and total incurred losses. Indicate CAT (catastrophe), SIR (self-insured retention level), PTD (permanent total disability), F (fatal), and third party, if applicable. Provide totals for number of claims, total paid, medical reimbursement amount, outstanding reserves, and total incurred.

Note: If, under ORS 656.262(4)(b) and OAR 436-060-0025(2), the self-insured employer continues to pay the same wage at the same pay interval that the worker received at the time of injury, in lieu of issuing separate time-loss payments, the employer must include indemnity costs in the paid and outstanding reserve amount. Report the indemnity costs in the same amounts as would otherwise be due if Temporary Total Disability or Temporary Permanent Disability were paid.

The following claims require further information:

1. Catastrophes: If any one accident results in two or more claims where the combined incurred losses exceed \$20,000, identify each claim as CAT 1. Identify claims resulting from a second catastrophe as CAT 2, etc.
2. Permanent total disability and fatality: Identify as PTD or F.

Submit a Claim Reserve Worksheet, Form 2808:

- with the first report of loss (experience rating period or non-experience rating period) submitted after the PTD or fatality status has been assigned;
- when PTD benefits change to fatal benefits, i.e., when a PTD worker dies and the beneficiary becomes entitled to fatal benefits; or
- upon request by the division.

In claims where a beneficiary of fatal benefits remarries, please note this on the report of losses submitted after the remarriage occurs. Report statutory amounts paid and reserved.

3. Claims where the self-insured retention (SIR) level is applicable: Report all paid costs and all outstanding reserves.

Example: A claim with an SIR level of \$100,000, paid costs \$75,000 and outstanding reserve \$350,000. Report total paid \$75,000, outstanding reserve \$350,000, and total incurred \$425,000. Identify as SIR and the amount of the SIR level. The division will make the necessary adjustment for deposit purposes. In order to receive credit for the excess, complete the Claims Reserved in Excess of Self-insured Retention, Form 2937.

4. Claims with third party recovery (subrogation): Report net amount incurred. Identify as third party.

IV. NON-EXPERIENCE RATING PERIOD

- A. **Report only claims with dates of injury prior to the experience rating period that were open with outstanding reserves as of Jan. 1 of the current year.** These must be valued as of Jan. 1 of the current year. Report all applicable claims, whether disabling or non-disabling, on a Self-Insured Employer Report of Losses Non-Experience Rating Period, Form 2810. List claims in alphabetical order by last name first, then first name. Indicate PTD, F, CAT, Workers with Disabilities Program (WDP), second injury, third party, or SIR where applicable. Provide a total of: number of claims listed, total paid, outstanding reserves, and total incurred losses.
- B. Workers with Disabilities Program (Handicapped Workers Program): Identify as WDP and indicate percentage of relief. Report the net amount incurred based on percentage relief. When a claim has 100 percent relief, report only the \$1,000 deductible as paid, \$0 as outstanding reserve, and \$1,000 as total incurred.

- C. Claims where the self-insured retention level (SIR)* is applicable. Report all paid costs and outstanding reserves:
 - 1. **Where the paid costs have exceeded the SIR level.** For example, a claim with an SIR level of \$100,000, paid costs \$175,000 and outstanding reserve \$250,000. Report total paid \$175,000, outstanding reserve \$250,000, and total incurred \$425,000. Identify as SIR and the amount of the SIR level. The division will make the necessary adjustment for deposit purposes.
 - 2. **Where the paid costs have not exceeded the SIR level, but are expected to.** For example, a claim with an SIR level of \$100,000, paid costs \$75,000 and outstanding reserve \$350,000. Report total paid \$75,000, outstanding reserve \$350,000, and total incurred \$425,000. Identify as SIR and the amount of the SIR level. The division will make the necessary adjustment for deposit purposes.

***Note:** *In order to receive credit for the excess, you must complete the Claims Reserved in Excess of Self-Insured Retention, Form 2937. Failure to identify applicable claims by correct excess carrier and SIR will result in reserving without regard to excess, which may affect the security deposit calculation. Some excess carriers issue policies for self-insured municipalities with different SIR levels for particular NCCI classification codes (for police and firefighters, for example). Where a different SIR applies to a claim identified on Form 2937 for this reason, ensure that the accurate SIR is reported.*

V. CERTIFICATION

Include the following statement with each self-insured employer’s report of losses, signed by an authorized representative of the self-insured employer:

I certify this is a true and accurate statement of all claims occurring during the experience rating period, and includes all open claims occurring prior to the experience rating period with outstanding reserves as of Jan. 1, (year) for:
(SELF-INSURED EMPLOYER NAME)

_____	_____
(Signature)	(Date)
_____	_____
(Title)	(Name and phone number of contact person)

The division will return reports of losses that do not include the certification.

VI. FACTORS TO CONSIDER WHEN ESTIMATING OUTSTANDING RESERVES

- A. Pre-existing medical conditions that may extend disability or length of treatment.
- B. Age of worker.
- C. Level of education/training.

- D. Prior claims history.
- E. If a hearing request has been received or there is a likelihood of litigation (worker is represented by an attorney, has had an attorney in prior claims, etc.), reserves should reflect the potential for additional claims costs. Refer to file notes, attorney correspondence, investigative reports, etc.
- F. If a claim file indicates the worker will be granted PTD, or PTD has been granted, reserves should include:
 - 1. Statutory benefits to the worker for his or her remaining life expectancy, based on the attached period life table. If the worker has received a Social Security offset (SSO), reduce future PTD benefits by the amount of future SSOs, starting at the worker's full retirement age.
 - 2. Maximum potential benefits to the spouse, based on the attached period life table. This will include widow(er) benefits if the spouse's life expectancy is greater than the worker's. For example, if a worker's remaining life expectancy is 30 years and the spouse's remaining life expectancy is 40 years, reserves for the spouse should include PTD spousal benefits for 30 years and widow(er) benefits for 10 years.
 - 3. Maximum potential benefits to other beneficiaries. For example, for dates-of-injury on or after July 1, 1983, if a child/dependent is currently in school, benefits should be reserved to age 23.
 - 4. Burial allowance should be included in accordance with the law in effect at date of injury.
 - 5. Upon death of worker, reserve for future benefits as a fatal claim.
- G. Fatal claim reserves should include:
 - 1. Benefits to a widow(er) for his or her remaining life expectancy, based on the attached period life table. Do not estimate for remarriage.
 - 2. Maximum potential benefits to other beneficiaries. For example, for dates of injury on or after July 1, 1973, if a child/dependent is currently in school, benefits should be reserved to age 23.
 - 3. For dates of injury on or after Sept. 20, 1985 through June 6, 1995, statutory widow(er) benefits will increase approximately \$300/month after the last child's eligibility for benefits has expired. In those cases, it will be necessary to allocate future widow(er) benefits between the two applicable rates. For example, if the youngest child is eligible for benefits an additional 18 months and the widow's remaining life expectancy is 43 years, reserves for the widow should include benefits for 1.5 years as a widow with children and 41.5 years as a widow without children.

Note: ***Benefits for an invalid child will remain in effect for the life of that child.***

Refer to Claim Reserve Worksheet, Form 2808, which may be used for establishing outstanding reserves for those self-insured employers that may not have an existing claims reserving procedure or reserve worksheet. However, all self-insured employers are to use the Claim Reserve Worksheet, Form 2808, for reporting PTD and fatal claims, as indicated on page 5 of this bulletin.

If you have questions about this bulletin or related forms, contact the Performance Section at the address above or call 503-947-7722.

/s/ John L. Shilts

John L. Shilts, Administrator
Workers' Compensation Division

Distribution: WCD-LY, electronic mailing lists

Attachments: Form 2808, "Claim Reserve Worksheet" (Rev. 1/09)
Form 2809, "Self-Insured Employer Report of Losses Experience Rating Period" (Rev. 1/15)
Form 2810, "Self-Insured Employer Report of Losses Non-Experience Rating Period"
(Rev. 1/13)
Form 2937, "Claims Reserved in Excess of Self-Insured Retention" (Rev. 11/13)

PERIOD LIFE TABLE, 2010

Exact Age	Male	Female	Exact Age	Male	Female	Exact Age	Male	Female
0	76.1	80.94	50	29.45	33.07	100	2.1	2.45
1	75.62	80.39	51	28.6	32.18	101	1.99	2.31
2	74.65	79.43	52	27.76	31.29	102	1.88	2.17
3	73.67	78.44	53	26.93	30.4	103	1.78	2.03
4	72.69	77.46	54	26.1	29.52	104	1.68	1.91
5	71.7	76.47	55	25.29	28.65	105	1.59	1.79
6	70.71	75.47	56	24.48	27.77	106	1.5	1.67
7	69.72	74.48	57	23.69	26.91	107	1.41	1.56
8	68.73	73.49	58	22.9	26.04	108	1.32	1.45
9	67.74	72.5	59	22.12	25.19	109	1.24	1.35
10	66.74	71.5	60	21.34	24.34	110	1.17	1.26
11	65.75	70.51	61	20.57	23.49	111	1.09	1.17
12	64.76	69.52	62	19.81	22.65	112	1.02	1.08
13	63.76	68.52	63	19.05	21.83	113	0.95	1
14	62.78	67.53	64	18.3	21.01	114	0.89	0.92
15	61.8	66.54	65	17.57	20.2	115	0.83	0.84
16	60.82	65.56	66	16.84	19.4	116	0.77	0.77
17	59.86	64.57	67	16.13	18.62	117	0.71	0.71
18	58.9	63.59	68	15.43	17.84	118	0.66	0.66
19	57.95	62.61	69	14.75	17.08	119	0.6	0.6
20	57	61.63	70	14.07	16.33			
21	56.06	60.66	71	13.4	15.59			
22	55.13	59.68	72	12.75	14.87			
23	54.2	58.71	73	12.12	14.16			
24	53.27	57.74	74	11.49	13.46			
25	52.34	56.77	75	10.89	12.77			
26	51.41	55.79	76	10.3	12.11			
27	50.48	54.82	77	9.72	11.46			
28	49.55	53.85	78	9.17	10.83			
29	48.62	52.88	79	8.63	10.21			
30	47.68	51.92	80	8.1	9.61			
31	46.75	50.95	81	7.6	9.03			
32	45.82	49.98	82	7.11	8.47			
33	44.88	49.02	83	6.65	7.93			
34	43.95	48.06	84	6.21	7.41			
35	43.02	47.1	85	5.78	6.91			
36	42.08	46.14	86	5.38	6.44			
37	41.15	45.18	87	5	5.99			
38	40.22	44.23	88	4.64	5.56			
39	39.3	43.27	89	4.3	5.17			
40	38.37	42.32	90	3.99	4.8			
41	37.45	41.38	91	3.7	4.45			
42	36.53	40.43	92	3.44	4.13			
43	35.62	39.5	93	3.2	3.84			
44	34.72	38.56	94	2.98	3.58			
45	33.82	37.63	95	2.79	3.34			
46	32.93	36.71	96	2.62	3.13			
47	32.05	35.79	97	2.47	2.94			
48	31.17	34.88	98	2.34	2.76			
49	30.31	33.97	99	2.22	2.6			



Claim Reserve Worksheet

Self-insured employer: _____

Worker's name: _____ Sex: M/F _____

Date of injury: _____ Date of birth: _____ Claim number: _____

Average weekly wage at D/I: _____

Valuation date: Jan. 1, _____

SI employer notes:

Total paid

Outstanding reserves

Indemnity

TTD/TPD paid: _____

Future TTD/TPD _____ (# weeks) X _____ (TTD rate): _____ **\$0.00**

PPD awarded — paid _____ (percent scheduled/unscheduled): _____

PPD awarded — unpaid _____

Estimated future PPD _____ (percent scheduled/unscheduled): _____

Medical

Medical paid: _____

Future medical: (show burial allowance on reverse side only): _____

If applicable, life expectancy _____ (yrs.) X \$ _____ : **\$0.00**

Vocational assistance

Vocational assistance paid: _____

Future vocational assistance:
TTD while in ATP (weeks) X _____ (TTD rate): \$ _____ **\$0.00**

Other vocational assistance costs _____

Other

Litigation — potential liability: _____

PTD/fatal benefits (see reverse side for calculation of outstanding reserves) _____ **\$0.00**

Totals

SIR \$ _____ **Subtotals: \$0.00 \$0.00**

HWR _____ % **\$0.00 \$0.00**

Total paid, outstanding reserves \$0.00 \$0.00

Total incurred losses: Total paid + outstanding reserves = \$0.00

2808

PTD/Fatal Reserving Worksheet

(complete both sides)

PTD Benefits — Complete PTD and Dependents sections

PTD effective date: _____

Future anticipated PTD benefits

D.O.B.		Remaining years	Months		Monthly statutory rate	Outstanding reserves
_____	Workers	_____	X	12	X	\$0.00
_____	Spouse	_____	X	12	X	\$0.00
_____	Widow(er)	_____	X	12	X	\$0.00

Social Security offset effective date: _____

# Months to worker's full retirement age		Monthly offset amount up to max. of stat. rate		=	
_____	X	_____	=	_____	\$0.00

Burial allowance (in accordance with law in effect at date of injury) _____

Fatal benefits — Complete Fatal and Dependents sections

Fatal benefits effective date: _____

Future anticipated fatal benefits

D.O.B.		Remaining years	Months		Monthly statutory rate	Outstanding reserves
_____	Widow(er)	_____	X	12	X	\$0.00
_____	Widow(er) without child (DOI eff. 9/20/85)	_____	X	12	X	\$0.00

Dependents — PTD or fatal

D.O.B.		Remaining months	Monthly statutory rate		Outstanding reserves
_____	Child #1	_____	X	_____	\$0.00
_____	Child #2	_____	X	_____	\$0.00
_____	Child #3	_____	X	_____	\$0.00
_____	Child #4	_____	X	_____	\$0.00

Total (carry forward to front of worksheet, "Other" section)

\$0.00

