

DIVISION 050 – Employer/Insurer Coverage Responsibility
Rulemaking advisory committee meeting
Sept. 24, 2015

Committee members attending:

Suzanne Barthelmess, Port of Portland
Bob Brandkamp, AVISTA
Sue Cline-Quinones, City of Portland
Joe Crelier, Portland Public Schools
Shelley Dalmau, Brown & Brown
Kathy de Domingo, Progressive Rehabilitation Associates
Pete Devine, Safety National Casualty Corporation
Michael Doherty, S | D | A | O
Bob Erickson, Less Schwab Tire Centers
Sherry Fitzpatrick, Northwest Permanente
Karl Granlund, Beaverton School District
Ken Harms, Deschutes County
Chris Hill, S | D | A | O
Bruce Hoffman, SAIF Corporation
Willard Jackson, Daimler Trucks North America LLC
Brendan McCarthy, Portland General Electric
Michael Mischkot, City County Insurance Services
Rich Reynolds, Interstate Distributor Co.
Krista Stevens, Portland General Electric
Gary St. John, BBSI

Agency staff members attending:

Adam Breitenstein
Fred Bruyns
Sally Coen
David Dahl
Cara Filsinger
Tasha Fisher
Jody Howatt
Mary Schwabe

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

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

ISSUE #1 – OAR 436-050-0150, 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?

Notes:

11:25, Bob Brandkamp: Regarding regulated utilities, one of the challenges WCD faces is trying to apply a common set of ratios, such as the liquidity-type ratios. Utilities derive a lot of our returns from our asset base. We are very capitol intensive. We don't carry a lot of cash on hand. We either use it to pay dividends to our shareholders, or the majority of it goes back to capitol expenditures. We are rated by both Standard & Poor's and Moody's. Their write-up shows Avista has very strong liquidity ... The easiest thing for WCD to do is to rely on the investment rating. The rating services are doing a broad review. 40% of it is financial. They are not looking at the quick ratios for liquidity, but rather cash flow from operations, and can we service our capitol needs, dividends, and etc. They also recognize our line of credit. We don't have liquidity issues in terms of being able to pay workers' compensation claims, because we are so large and have access to the capitol markets. ... When you score us under your ratios it makes us look like a very weak company and that we need to carry higher reserves, when in fact just the opposite is true. ...

16:44, Mike Mischkot: I agree. The ratios are sort of designed for self-insured groups. The premium to surplus ratio is an excellent measure for the self-insured group, because the premium, our income, is derived from the workers' compensation rate multiplied by payroll exposure. It is the very thing that quantifies and defines the risk that the surplus is protecting against. That is not the case in any of the individual, self-insured municipalities, counties, or private businesses that do that – most definitely a different approach for the type of self-insured you are looking at. As Bob said, a lot of that work is done by Moody bond ratings, for instance for cities ... I think a strategy for WCD to take advantage of the work already done for you would be good.

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.

Notes:

19:10, Fred Bruyns: *This one-word change would provide more discretion for the agency not to go immediately to revocation. Would you have any concerns about that?*

Committee: No discussion.

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.

Notes:

20:34, Bob Brandkamp: *I think this ties back to issue #1 and whatever you determine. As it stands now, I think there are issues with it, but if you amend it for other concerns and tie it back, I think that is fine.*

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.

Notes:

23:21, Rich Reynolds: As it relates to certification prior to the inception date, 30 days can be constraining, I think, for some self-insureds because of time needed to finalize the agreement. There could be notice to the division of who will be used, and if they are approved to do business in Oregon, then have a certain time frame after inception ... it is common with a lot of self-insureds that the TPA agreement might not be signed off on completely until 15 to 30 days after the inception date. ...

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?

Notes:

26:12, Rich Reynolds: 30 days. I think it is quite common if you are going through policy changes that terms are being finalized a lot closer to the actual effective date of the policy. Between the 30 and 60 day window is where you finalize pricing, etc. So I think 30 days would be much more feasible.

26:37, Mike Mischkot: Even 30 days can be constraining if you go to market annually for your reinsurance. Assuming reinsurers provide 60 day renewals, that might be true, but we never know that we are going with our current provider. The same is true for a lot of self-insured groups and individual self-insureds. I recommend that self-insureds provide what they know within either of those windows, but also provide what's on the table that might change. It can make a big difference, up to \$100,000.

27:43, Chris Hill: The approval – accepting a quote or even getting a quote – is sometimes contingent upon board of director's approval. They meet monthly. ... We could come and get approval when we are asking for a quote, between 45 and 30 days ... as close to that 30-day mark as possible would be helpful.

28:36, Shelly Dalmau: I concur with these gentlemen, that, especially with the market changes and retentions, it is difficult to get some insurers to hold to the retention levels they offered in the past. It is problematic to get all of those decisions made, especially in the public sector, 30 days in advance. 14 days. 7 days.

29:11, Ken Harms: Sometimes the 30 days would be really tight. Generally we know what we are shooting for ... but the actual executed agreement can be tough to get.

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.

Notes:

30:40, Mike Mischkot: Is the question whether it should be applied to individuals as well as groups or is the question if financial viability is considered as part of the excess insurance and reinsurance strategy?

30:58, Adam Breitenstein: The latter.

31:00, Sally Coen: *I was going to say the former.*

31:03, Mike Mischkot: *They are both rolled in here. The last line of the background, where it says “The rule should include the same factor for individual self-insured employers.” – if it said the rule should include the same “consideration” – it is probably not going to be the same factor.*

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.

Notes:

33:03, Fred Bruyns: *We don’t know how often this occurs, but it has occurred.*

33:12, Rich Reynolds: *One issue could be, does that excess insurer have a subsidiary that is authorized to do business in Oregon. ... I think it should remain with the original company that was processing. It creates continuity. They could work out the funding behind the scenes if there is a bankruptcy situation.*

33:45, Ken Harms: *I would agree with that. I wouldn’t be comfortable handing over any claims to a subsidiary to my excess carrier.*

33:59, Chris Hill: *My first thought was did that company even know it was a provision of their policy.*

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.

Notes:

36:00, Ken Harms: I see this as impacting WCD more than self-insureds, because you will have to set up protocols. I like the “may” language, because it gives you some wiggle room. ...

36:47, Rich Reynolds: I agree that changing the word to “may” give the director more discretion as to what action to take and to encourage compliance prior to revocation.

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 it’s 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.

Notes:

38:38, Rich Reynolds: *I think having separate rules is a good idea. You are talking about a whole different type of financials for an individual versus a group.*

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.

Notes:

Committee: No discussion.

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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Notes:

46:46, Chris Hill: I know from Special Districts' perspective, just getting the information to aggregate is arduous, if we can at all. We have every confidence that the net worth of our group exceeds by far \$3 million. I think just having a statement that certifies that fact would be beneficial.

47:17, Mike Mischkot: Same comment for CIS. It is cumbersome to get all of the numbers. We can certify the net worth exists.

47:26, Chris Hill: It is also a matter that the statute for public entities or group of public entities, the net worth of a public entity has nothing to do with financial viability. They have to have a balanced budget. They can't go bankrupt.

47:47, Brendan McCarthy: I think that is probably the same for PGE. While it is possible for a public utility to go bankrupt, it is extremely rare. We would seek public protection from the Public Utilities Commission ... for recovering costs. I'm not sure what our net worth would look like or why it would be important ... or a connection to financial viability.

48:34, Ken Harms: It seems like the requirement is so low that it would be a lot of effort - \$3 million is not hard to hit.

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.

Notes:

51:24, Chris Hill: *We are already providing the information.*

51:27, Rich Reynolds: *It makes perfect sense to me.*

51:33, Fred Bruyns: *Would there be any concerns about doing that?*

51:37, Chris Hill: *It would be nice to go back to just aggregating it, just because of the volume, but it is not that big of a deal.*

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.

Notes:

53:00, Rich Reynolds: *I support that. It makes sense to keep current with NCCI.*

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.

Notes:

54:45, Joe Crelier: *Is there more background?*

54:58, Fred Bruyns: *You mean increased frequency of reporting and why? Maybe one of my coworkers can address that. What would be a circumstance where we would require more frequent reporting?*

55:16, Mary Schwabe: *The self-insurance program conducts an annual financial review. When they get the reports depends on the timing of the entity’s fiscal year. It may be that the review has been conducted, and six months later, something bad happens, the company is suddenly insolvent, or there is bad financial news. The way the rule is currently worded, we get that information annually. It was amended for the groups to allow us to get it more frequently. ... Similar circumstances might occur with an individual self-insured employer. The department would want the ability to request that information as needed.*

56:09, Rich Reynolds: *So the intent of a rule change would be to address concerns.*

56:17, Mary Schwabe: *For those types of things. The rule lists some examples. ... There is no interest in having everyone report constantly.*

56:50, Joe Crelier: *... It is kind of open ended though. The director could request very frequent financials. There are no controls on it.*

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).

Notes:

59:20, Sue Cline-Quinones: A significant amount of time and money is put into these annual reports. The actuarial we get done every year is a significant cost factor. So is the CAFR [Comprehensive Annual Financial Report]. I understand how you want to line this up with the self-insured employer groups, but I can see this being a hardship for public entities. Where it says it would be warranted in certain situations. What types of situations would you envision requesting that for public entities?

01:00:08, Fred Bruyns: As for the last issue, an indication of financial trouble on the part of the entity.

01:00:25, Mike Mischkot: It would be helpful to hear concerns from the individual self-insureds that it may be a more cumbersome cost issue for them to provide additional information, that WCD defines the need. To me, to fulfill its mission, I agree that there needs to be some further action available to WCD to see that workers are getting their claims paid. The trigger for this could be related to the ability of the entity to pay their claims being somehow threatened, which would further narrow the situations that would call for this, such as a bond failure. ...

01:01:32, Rich Reynolds: I think having language in there regarding what the reason would be could be more clearly defined. From a private employer's perspective, we don't have statements going out – we are not publically traded. So information isn't published as frequently as for some publically traded employers.

01:01:56, Brendan McCarthy: The concern is different for a publically traded company such as PGE. We are governed by a strict set of reporting requirements to issue SEC-required reports. I

would be concerned that the department might ask for information that might not be publically available. If it was out of timing with other reports it might unduly affect our stock price. ...

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.

Notes:

01:06:17, Joe Crelier: Yes, there should be some clarity to what occurs when the director conducts claim reserve audits. Using the terminology of claim reserve audit – cleaning that up makes sense. If it is a sample size issue that affects the confidence level, I don’t think it needs to be in the rule, but it comes back to who is doing the audit, a CPA, or someone who is following a

sample size standard. If there is a civil penalty for being 10% off, all of the self-insureds have an interest in that methodology.

01:07:33, Rich Reynolds: Sample size and confidence – I think that is a great point. Some thought should be given to a percentage basis for sample size to create a higher level of confidence. I agree with clarifying the language to refer to claim reserve audits.

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.

Notes:

01:09:55, Bob Brandkamp: Again this goes back to my comments on issue #1 on differentiating ratios and types that you use – how those categories are defined. I had a question in reference to a weak rating, the director may substantially increase the deposit. I think it would be helpful if there was a number or a range around that, instead of it being so open ended. That could be a hardship on some smaller self-insureds.

01:10:49, Rich Reynolds: I agree there needs to be some type of parameter.

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.

Notes:

01:16:40, Mike Mischkot: Any calculation of current claims liability should include IBNR. My first reaction when I saw the notice was where does the 20% come from? I think it would help everyone if this was explained. One industry might be vastly different from another. For instance, industries that have a lot of folks in high risk positions would have a very different IBNR from an industry with mostly in-office/clerical/sales.

01:17:39, Rich Reynolds: That was going to be my question. Who is going to get hit hardest by something like this. It looks like there is the possibility of differences for individuals versus groups. Or, is the intent that everyone is assessed in that range?

01:18:08, Sally Coen: The latter.

01:18:10, Adam Breitenstein: Anyone with a security deposit.

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.
-

Notes:

01:22:05, Mike Mischkot: It makes sense. The common claims fund is redundant to the fund requirement for an exempt group. If one was placed on top of the other to meet the actual liability, it might make sense, but as applied, the fund takes care of both items. The common claim fund was an account used to pay claims, so the money will still be there. ...

01:23:15, Joe Crelier: We would support this. We have an additional interest, being that we are eligible to have a loss reserve account. We currently maintain an actuarially based loss reserve account on our own, plus the standby letter of credit.

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.

Notes:

01:26:00, speaker unknown: What would the division be looking for? ...If you are looking for some kind of audited statement, it might be challenging.

01:26:50, Adam Breitenstein: I don't think we are necessarily looking for something audited. We are still considering what we would look at – something that gives us reasonable assurance that the increase has been made. We weren't necessarily stuck on something audited, because of the possible burden that would cause.

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]

Notes:

01:29:45, Rich Reynolds: No concerns. It seems like an appropriate change.

01:29:52, Brendan McCarthy: When I read sub (4), it addresses reorganization of business, requiring new operations, merging with another business, filing bankruptcy, emerging from bankruptcy – it seems somewhat different in kind than just potentially a change in financial viability based on factors. I’m envisioning a utility going into a rate case and having its authorized rate of return changed from 9.75 to 9.5. Would that trigger a report to the Workers’ Compensation Division? ...

01:31:29, Bob Brandkamp: I concur with Brendan’s comments. It seems a little vague in terms of what would trigger reporting.

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.

Notes:

01:34:55, Fred Bruyns: Requested input on the first question - 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?

01:35:20, Rich Reynolds: That certainly sounds acceptable.

01:35:33, Fred Bruyns: And then a time frame for providing evidence of subsequent coverage. Is that appropriate? If you have advice on the time frame that would be welcome – or any concerns about a time frame.

01:35:55, Rich Reynolds: For subsequent time frame, I think if you are going in stating you have to give 60 days notice, I think you should have that as part of your plan, and have the same 60 day requirement regarding the subsequent coverage to have in place. I think that would be sufficient.

01:36:19, Fred Bruyns: Someone on the phone said a week.

01:36:23, speaker unknown: Yes, a week from when it is canceled.

01:36:34, Sally Coen: From when the self-insurance certification has terminated?

01:36:40, Fred Bruyns: A week before the termination of the self-insurance?

01:36:41, speaker unknown: Yes, a week prior to it being actually canceled.

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).
-

Notes:

01:40:30, Rich Reynolds: I think we are placing location with different service company responsible for processing – that type of language, makes sense. It must be a logistical nightmare to have several different ones, not only from the self-insureds perspective, but from the department's as well. ...

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.

Notes:

01:42:18, Rich Reynolds: I agree it should be provided. It is the electronic age.

01:42:27, Chris Hill: You probably already have that information.

01:42:29, Fred Bruyns: We have wrestled with questions of whether it should be a corporate or headquarters in-box versus an individual adjuster, that kind of thing.

01:43:00, Chris Hill: My experience with general in boxes is that it would be more problematic for you because nobody checks it.

01:43:08, Rich Reynolds: Exactly – who’s going to monitor that? I think you are better off having it tied to an individual, just recertifying once a year that is the appropriate contact.

01:43:30, Fred Bruyns: I guess it would bounce back if that individual’s email address was no longer good.

01:43:39, Rich Reynolds: Or it is being forwarded to somebody else.

01:43:42, Fred Bruyns: Which might be invisible to us but it probably wouldn’t matter.

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.
-

Notes:

01:46:49, Karl Granlund: I think if it works for the department and DOJ – the last part of it where you had some language that says if it is not allowed under Oregon's workers' compensation law, it will not be applied, would be beneficial. Out-of-state companies would probably like to use a single contract. Or generally so, because now they are going to add this in.

01:47:22, Rich Reynolds: For example, I have a program that covers the whole lower 48 states, so I don't want a separate agreement just for Oregon. It is too much from an administration standpoint, so I think just adding some language would be sufficient.

01:47:48, Fred Bruyns: And, no concerns about requiring legal name? Okay.

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.

Notes:

01:48:43, Rich Reynolds: Once again, timing can be an issue, because of it being a contract. Is it possible to have it within 30 days of inception if they are on the approved list of venders?

01:49:07, Joe Crelier: Yes, if it is already an approved vender or a recognized service provider ...

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.

Notes:

01:50:54, Mary Schwabe: I’d like to add one clarifying point. In working on a similar document for insurer changes, when we reference the estate, we don’t mean ten years after the fact. The intent would be that the estate would only be notified until closure on the claim is final.

01:51:34, Brendan McCarthy: *Would that include closure of probate?*

01:51:45, Mary Schwabe: *The focus would be on the claims process. The estate may continue separately for other reasons. The existing rules already require the acceptance and denial notices and notices of closure go to the estate. Our intent is not to drag out reporting or the notification requirement. ... Under Senate Bill 371 (2015) there are rights to pursue a request for reconsideration, so we want to make sure those parties know that claims are being transferred.*

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.
-

Notes:

01:54:54, Fred Bruyns: *With the first bullet we are saying we are getting a little more information than we currently need or want, so there would be less information to provide to us if everything is to be moved. Then, we don't have to have the specific information on the claims.*

01:55:12, speakers unknown: *Makes sense.*

01:55:18, Fred Bruyns: *Any concerns about clarifying that the director may request additional information about the claims transfer or specific claims, as needed?*

01:55:27, Rich Reynolds: *That seems to be appropriate language to add.*

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.

Notes:

01:57:38, Mike Mischkot: *It should absolutely be included in the totals. Those recoveries are basically negative claim payments. As the background states, this affects a lot of things calculated based on the true value of the claim.*

01:57:58, Rich Reynolds: *Agreed.*

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.

Notes:

01:59:46, Mike Mischkot: *It should be clarified.*

01:59:51, Chris Hill: *It needs to reflect the statute.*

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.

Notes:

02:01:55, Fred Bruyns: Any concerns about extending this provision to new groups?

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?

Notes:

02:05:15, Fred Bruyns: First, what are your thoughts on the premium to surplus ratio in terms of its sufficiency or appropriateness in measuring financial viability?

02:05:27, Mike Mischkot: It is helpful. It shouldn't be used by itself for a comprehensive decision, but it is helpful as I mentioned earlier – a direct connection to the liability of the group and the risk it is able to handle through its surplus. It is the net position or net worth of the group itself and not the members combined – that would make the ratio pretty useless because the number would be so huge. ... Other measures that are useful - this gets to the same issue discussed by the individual groups and private-sector groups that we get pretty diverse pretty quickly. Even these top level metrics don't quite apply to self-insured individuals and even private groups.

02:06:39, Mike Doherty: Your question references the premium to surplus ratio. Is this the time to talk about other ratios? SDAO has differing thoughts on the other two ratios simply because of the definition of current assets. By GAAP [generally accepted accounting principles], you only include certain things in current assets, which excludes probably 80 percent of our assets. Most of our assets are in equities and in long-term bonds. Those are excluded from that ratio. We have plenty of funds in our portfolios and in cash. There are no issues with timely payment of claims. ... Because of the definition of current assets, we fail miserably on the other two ratios. I don't think that is necessarily warranted with the types of assets we have. Stocks and long-term bonds can be sold tomorrow. ... While it is not cash, it is certainly readily available to use if we need it.

02:07:57, Chris Hill: This goes back to issue #1. When you so closely define the ratios and what every word in those ratio calculations means, you are almost regulating yourself into a corner, and not able to take in the broader picture of the organization, given the variation even between CIS and us. How we account for things is different, so our ratios are going to be different. We could in principle be in the same financial position.

02:08:37, Fred Bruyns: I know we probably already discussed this with issue #1, but because it is mentioned here again, I wonder if there are additional thoughts on appropriate long-term measures, in addition to the premium to surplus.

02:09:03, Fred Bruyns: Or any additional distinctions that should be made between public and private groups.

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.

Notes:

02:10:50, Committee: No concerns.

“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.

Notes:

02:12:19, Fred Bruyns: Closed meeting.