CSRMA
California Sanitation Risk Management Authority

Workers' Compensation Program Manual

June 2022

Prepared by:

Alliant

Alliant Insurance Services, Inc.
560 Mission Street, 6th Floor
San Francisco, CA 94105
United States
1415-403-1400

TABLE OF CONTENTS

SECTION 1

INTRODUCTION

The Program Administrators have prepared this manual to serve as a reference for members of the Workers' Compensation Program. We recommend that it be maintained by the person at your agency who is responsible for insurance matters.

CSRMA has created a manual for each of its programs and one additional manual, which contains the Authority's general documents. Together, these manuals are a valuable resource to your agency's insurance program. Any questions about the Authority or its programs should be directed to the Program Administrators at:

CSRMA Program Administrators
c/o Alliant Insurance Services, Inc.
560 Mission Street, 6th Floor
San Francisco, CA 94105
Telephone: (415) 403-1400
Facsimile: (415) 402-0773

PROGRAM DESCRIPTION

The Workers' Compensation Program was developed by CSRMA to provide state-mandated benefits to employees of Member Agencies in a cost effective, efficient manner. Special emphasis has been placed on providing responsive claims handling and safety services.

PROGRAM STRUCTURE

Coverage

The program consists of a $250,000 SIR (Self-Insured Retention) pooled layer with Statutory per occurrence excess Workers' Compensation coverage above the SIR, and $1,500,000 Employers Liability excess of the SIR.

Deposit Premium

Each Member Agency pays a deposit premium each year based on Workers' Compensation manual premium rates for each classification of worker.

Actuarial Report

An actuarial report shall be obtained annually to determine estimated outstanding losses for each open program year and funding rates for future program years based on the experience of the Workers' Compensation Program.

Claims Administration

Claims administration is provided through a third-party administrator. More information concerning this aspect of the program can be found in Section 2 of this manual.

Claims Audit

A biennial claim audit shall be conducted on the Third-Party Administrator in order to ensure that CSRMA members benefit from above average claims handling services, and to allow the JPA to gauge the effectiveness of their work. A report of the audit will be presented to the Workers' Compensation Program Committee and Executive Board for review.

Safety Services

The CSRMA Risk Control Advisor provides safety services. Additional information on safety services can be found in Section 6 of this manual.

Workers' Compensation Program Committee

The Workers' Compensation Program Committee advises the Executive Board and the Board of Directors of all operational aspects of the program. The Committee is responsible for making recommendations on underwriting, coverage issues, claims administration, and loss control.

The Committee is composed of six members appointed by the president, one of which is an Executive Board member who serves as Committee Chair. The members and the responsibilities of the Committee can be found in Section 4 of this manual.

SECTION 2

CLAIMS ADMINISTRATION

General Claims Handling Procedures

Workers' Compensation claims are administered by:

Sedgwick Claims Management Services
10690 White Rock Road .
Rancho Cordova, CA 95670
Attn: Alyssa Dunn

E-Mail: alyssa.dunn@sedgwick.com

Telephone: 916-960-0921

If you need assistance in reporting a claim, please contact Alyssa Dunn.

ADDITIONAL CODING REQUIREMENT

You are asked to place one of the following codes on line 22 of the Form 5020, "Employers Report of Occupational Injury or Illness" (See attached sample form in the "Appendix" section):

Classification	Code
Collection line maintenance	CM
Collection line construction	CC
Treatment plant operation	TO
Treatment plant maintenance	TM
Laboratory operations	LO
Administration (100% office work)	AD
Miscellaneous out-of-office work (supervisors/engineers)	MI
Solid Waste	SW
Water Operations	WO

Please place the code on line 22 following the name of the department in which the employee is regularly employed or under which the injury occurred if the employee's time is split.

Also included in this section you will find a copy of the service contract and the standards that the Claims Administrator is to follow.

Claims Administration Standards

Processing

1. All files will be created, reserved and assigned the proper code number and entered into the computer within 5 working days following the receipt of the First Report of Injury.

2. A diary system will be established so that each case is reviewed at least every thirty (30) days.

3. Payments will be made promptly as required by State code. No penalties shall be paid by the member agencies unless it can be shown that late filing of the report is reason for the penalty.

4. Uncontroverted bills - shall be paid within ten (10) working days of receipt of same.

5. All payments, reserve revisions and file closings will be promptly entered into the computer system.

6. The reserve will take into consideration all potential payments including "allocated expenses."

File Documentation

1. The basis for all initial reserves, reserve revisions and payments will be clearly explained in the file.

2. Specific direction on the investigation and handling of all indemnity cases will be established within three (3) working days of receipt of the First Report and clearly evidenced in the file. The extent of the direction will be clearly based upon the seriousness or complexity of the case.

3. An initial file summary will be completed on all indemnity cases involving disability payments within fifteen (l5) days of receipt of the First Report.

4. Updated case analysis summaries will be completed and placed in any indemnity file at least every thirty (30) days after completion of the initial summary and will include any and all information that relates to the direction and value of the case, as well as further work to be done and a target day for completion.

5. All phone conversations, discussions and meetings held on the case will be clearly documented in each file.

6. The diary schedule will be clearly evidenced on the file jacket.

Investigation

1. Within three (3) working days of receipt of the First Report, contact will be made with the member agency in order to determine if compensability is to be acknowledged or questioned when not self-evident on member agency's report.

2. On all questionable indemnity cases, informative statements will be obtained from anyone who may have knowledge of the injury, including the claimant, witnesses and supervisor within ten (10) calendar days of receipt of the First Report, unless the file reflects a reasonable explanation for a day in obtaining same.

3. The medical facility will be contacted prior to making the initial indemnity payment to establish the extent of injury, length of disability, and causal relationship of the injury to the job or alleged work-related incident.

4. A medical report will be requested within twenty (20) working days of the first day of lost-time and as often as needed thereafter to justify continuing indemnity payments.

5. Personal contact on non-litigated indemnity cases will be maintained with the injured employee on a periodic, ongoing basis (initial, within three (3) days of receipt of First Report and follow-up within every thirty (30) days thereafter until return to work) to control their medical progress and timely return to work.

6. Where the length of disability is questioned, and upon prior approval by the member agency, a field activity check/surveillance will be conducted on the injured employee in order to determine if there is any work capability. All investigations will be coordinated with appropriate member agency personnel on a case-by-case basis.

7. Where medical evaluation is questioned, an independent medical examination will be scheduled with a qualified physician, providing to the physician any relevant medical and job information that will assist the physician in making an objective evaluation. Copies of medical evaluations will be provided to the member agency.

8. Any medical bills received will be reviewed prior to payment with regard to causal relationship to the accident/work-related injury.

9. Where needed, rehabilitation and/or retraining will be recommended and the progress will be closely monitored and controlled. The first evaluation as to the appropriateness of rehab will take place according to Workers' Compensation State requirements.

10. Subrogation will be promptly recognized and investigated.

11. All reserves will be evaluated for accuracy, based on information at hand, every time the case is handled and/or reviewed.

12. All "medical only" cases will be reviewed for closing at least every ninety (90) days.

13. Settlement evaluation will be made promptly, based on information included in the file, as well as other criteria by which a value may be based.

14. Where warranted, settlement will be pursued in a timely and aggressive manner, and all negotiations will be handled or managed internally by the claims person assigned to the case or a qualified attorney under direction of the Claim Administrator.

15. Settlement authority will be granted in accordance with the policy established by CSRMA.

Medical Control

1. Recommend the composition of medical facilities and panels, in conjunction with the member agencies.

2. Maintain close liaison with doctors and assure maximum efficiency in the management of claims and compliance with State laws regarding provision of job descriptions to determine return to work possibilities.

3. Review every Doctor's First Report and initiate the proper procedure in each claim.

4. Audit all medical bills at the level determined by the JPA. Use of PCC, Med-Data, or other software is strongly recommended.

5. Provide each member agency with copies of medical evaluations as requested by the member.

Litigation Management

1. Good judgment will be used in deciding on the need for legal counsel.

2. Within three (3) working days of referral of the case to defense counsel, a letter will be directed to the attorney, with a copy to the agency outlining the case status, work to be done, by whom and in what time frame.

3. Defense counsel will not do anything that could be accomplished just as effectively, efficiently, and economically by the Claim Administrator.

4. Within thirty (30) days after receipt of the case, defense counsel's written opinion as to compensability, value and settlement/defense strategy will be obtained. A copy will be provided to the member agency.

5. Itemized legal bills will be solicited and reviewed for payment at least quarterly, or more frequently, if appropriate.

Reporting Requirements

1. Monthly loss runs shall be provided to the CSRMA Program Director, the member agency and the excess insurance carrier.

2. As to any claim:

- reserved at $15,000 and above and/or
- involving serious injury (death, heart attack, back problems involving surgery, serious burns, brain damage, or any other extreme permanent injury), and/or
- in litigation

   a. An initial written captioned report will be completed, and submitted to the member agency within thirty (30) days after the defined reporting condition is met.

   b. Supplemental written status reports will be completed and submitted to the agency at least every ninety (90) days following the initial report and should include any pertinent information that could reasonably affect the ultimate value of the claim

3. Within ten (10) days from a reserve increase of $15,000 or more, a written notification of the fact of the increase and the basis for it will be sent to the member agency.

4. Obtain quarterly, or more frequently if appropriate, itemized billings from outside adjusters/investigators and legal counsel for payment consideration.

5. Report as appropriate to the CSRMA Program Director, the excess insurance carrier and the member agency necessary information on the current status of claims as required by the excess carrier.

6. Reconciliation of bills paid on a frequency determined by CSRMA.

Communications

1. Open communications will exist and be maintained with CSRMA member agencies on an ongoing basis. Phone calls will be returned promptly.

2. The Claim Administrator will provide CSRMA with notices dealing with changes or proposed changes in Workers' Compensation Administrative procedures and laws.

Review Procedures

1. CSRMA, its Program Director and its member agencies shall have the right to audit any and all of its claim files during normal business hours and/or to employ an outside auditor for that purpose, providing such auditor is not employed by a competitor of the Claim Administrator.

Self-Insured Annual Report

Prepare on behalf of each member agency, the Public Self-Insurer's Annual Report in accordance with current state requirements.

THE ABOVE STANDARDS AND GUIDELINES ARE INTENDED TO PROVIDE A GENERAL IDEA AS TO THE LEVEL OF SERVICE THAT IS DESIRED. COMMUNICATION IS EXTREMELY IMPORTANT AS IS THE ABILITY TO PROVIDE QUALITY SERVICE.

AS RESPECTS TO THE ABOVE STANDARDS AND GUIDELINES, THE STATE WORKERS' COMPENSATION LAWS SHALL ALWAYS GOVERN THE ADMINISTRATION OF CLAIMS.

SECTION 3

CLAIMS MANAGEMENT PROCESS

Claims Management Process

CSRMA provides its members with a Workers' Compensation Management Program. This program is designed to help member agencies comply with various State and Federal laws that mandate certain employer responsibilities. This program goes beyond compliance to provide the necessary information, tools and resources to assist you in effectively managing your workers' compensation process. This program focuses on that which is ***mutually*** beneficial to the employer and employees – expediting recovery and facilitating a successful return to work.

What is included in the Program?

This program is broken down into eight components for ease of use. These are:

1. Instruction Manual
2. New Hire Packet
3. Exposure Packet
4. Declination of Medical Treatment (DMT) Packet
5. Initial Injury Packet
6. Supervisor Checklist
7. Workers' Compensation Coordinator (WCC) Checklists
8. Reference Guide

A copy of all of these materials will be provided to you along with training from the CSRMA Return to Work Consultant. Please refer to the contact information below to make arrangements. As a member agency of CSRMA, all of these materials are also available to you through the CSRMA website in the Online Risk Control Resource Center at www.csrma.org.

CSRMA Return to Work Consultant:

Role:
Heather Truro will work on behalf of the CSRMA Members. Members may seek her assistance with particularly complex claims issues and return to work issues. Heather will **not** replace any of the functions now conducted by Sedgwick Claims Management Services, but rather, she will work as an **additional resource** to assist CSRMA members and Sedgwick, to help optimize outcomes. Heather's expertise can be utilized to assist the members in finding or ruling out transitional duties to improve return-to-work efforts and reduce indemnity expenses borne by the CSRMA Workers' Compensation pool.

Services Available:

1. ***Consultant:*** Provide consulting services to the Employer (CSRMA member) to resolve complex workers' compensation issues.

2. ***Return to Work Resource:*** Assist with bringing claims that are on extended Temporary Disability to resolution and aid in returning employees to work.

3. ***Hotline Resource***: Heather is available via phone and email to assist with the CSRMA Workers' Compensation Claims Management Program.

4. ***Job Description Builder Resource:*** Provide assistance with the use of the Job Description Builder Program and/or help in initially getting started.

5. ***Training Resource/Workshops:*** Provide additional training either in group or one on one sessions, as needed, to include: Hands on use or trouble shooting of the Workers' Compensation Claims Management Program, topics of interest such as WC Reform and recommended strategies.

6. ***Kick Start Training:*** Provide initial training to CSRMA Members who may be interested, but hesitant, to initiate the CSRMA Workers Compensation Claims Management Program without additional assistance. This training will provide a "walk through" of the program including how it works and how to get started using it. This training may be provided by David Patzer or Heather Truro depending upon availability.

How to request services:

Requesting services is as easy as calling or emailing Heather at:

Heather Truro
HT Consulting
925-922-0305
htruro@gmail.com

SECTION 4

PROGRAM COMMITTEE

Program Committee

The Workers' Compensation Program Committee is a standing committee of the Authority. The Committee consists of six members, at least one of whom is a member of the Executive Board selected by the President and serves as the Committee Chair. All members of the Committee must be: (1) affiliated with member agencies that are participants in the Authority's Workers' Compensation Program; (2) knowledgeable about the operation of the program; and (3) selected by the President. Committee members other than the Committee Chair serve two, two-year terms with the terms of two members beginning in even-numbered calendar years and the other two members' terms beginning in odd-numbered calendar years. The term of the Chair is indefinite and serves at the discretion of the President.

Purpose

The purpose of the Workers' Compensation Program Committee is to advise the Executive Board and the Board of Directors of all operational aspects of the Workers' Compensation Program and to execute and implement the directions of the Executive Board with regard to matters within the committee's powers, duties and responsibilities which are as follows:

Responsibilities

Underwriting

- Solicit information necessary to evaluate membership applications. Determine adequacy of information provided by prospective members.
- Advise and report to the Executive Board on matters relating to prospective new members to the program.

Coverage Issues

- Review coverage issues as they arise and make a determination relative to the coverage issue.

Claims Administration

- Advise and report to the Executive Board and the Board of Directors as to the status of the program.
- Solicit proposals, select and recommend to the Executive Board qualified candidates to serve as the program's Workers' Compensation administrator.

- Administer the contract for claims services and review invoices.
- Provide supervision and direction to the Authority's claims administrator.
- Review procedures for claim processing and recommend changes if appropriate.
- Review claims frequency and severity reported by participants.
- Oversee the preparation of a quarterly claims report to all participants.
- Identify needs of participants and recommend training.
- Review disputed claims and settle claims within authority granted by the Executive Board.

Safety

- Develop programs, policies and resources that will enable participants to reduce Workers' Compensation losses.
- Provide for inspections of participants facilities to assist in reducing losses and improving safety.
- Administer contract for safety services and recommend approval of payments.
- Provide supervision and direction to the Authority's safety program consultant.
- Prepare and coordinate an annual safety program.
- Coordinate safety program with Pooled Liability Program Committee.

Budget

- Recommend program budget.

Program Committee Members

The most recent and complete CSRMA Organizational Chart can be found in the "About Us" section of the CSRMA website at the below link:

http://csrma.org/docs/CSRMA-Organizational-Chart.pdf

SECTION 5

COPY OF POLICY DOCUMENT

Copy of Policy Document

If you would like to obtain a copy of the policy document, please contact Myron Leavell.

(415) 403-1404
mleavell@alliant.com

SECTION 6

SAFETY PROGRAM

Safety Program

A major part of keeping accidents to a minimum is a good safety program. To this end, CSRMA provides full-time risk control services. In conjunction with, and under the direction of the CSRMA Workers' Compensation Program Committee, the Risk Control Advisor helps member agencies identify and reduce loss exposures and assists them in developing develop sound safety programs and practices.

CSRMA's Risk Control Advisor is:

Mr. David Patzer
DKF Solutions Group
170 Dogwood Lane
Vallejo, CA 94591
Telephone: (707) 373-9709
Facsimile: (707) 647-7200
Email: dpatzer@dkfsolutions.com

TWO KEY SERVICES AVAILABLE

In addition to a number of other safety programs that CSRMA provides, the following two are of particular merit:

Risk Control Site Visits

Helping member agencies identify and reduce loss exposures is the backbone of a successful risk control program. The CSRMA Risk Control Advisor performs routine site reviews in an effort to help members develop, or enhance, their safety programs and working practices. The Risk Control Advisor also serves as a resource in helping member agencies stay in compliance with the occupational health and safety regulations.

Telephone Hot Line

One of the services provided at no charge to member agencies is access to risk control/safety information and guidance. The telephone hot line service provides member agencies with one central resource to help answer their occupational safety & health questions. If you have questions concerning occupational safety and health and wish to get advice, call the Risk Control Advisor at (707) 373-9709.

The CSRMA Risk Control Advisor also provides many other services to CSRMA member agencies including, but not limited to the following:

- Assists in the planning and development of policies, regulations, and operational procedures pertaining to member agencies' safety/risk control programs.

- Conducts a variety of research activities.
- Conducts site/facility inspections and program reviews to evaluate conditions affecting safety/risk control programs.
- Assists in analysis of member agency claim, loss and accident history in order to recommend appropriate programs.
- Plans, develops and recommends programs designed to promote safe working conditions, safe driving, and liability reduction.
- Assists in the development and coordination of and/or conducts annual in-service safety workshops.
- Conducts limited on-site safety training specific to the wastewater industry in conjunction with the site/facility inspection.
- Provides staff assistance to various CSRMA Committees.
- Provides technical advice in safety/risk control matters to member agencies as part of the CSRMA Risk Control Hotline Service.

SECTION 7

WORKERS' COMPENSATION PARTICIPATION AGREEMENT

Workers' Compensation Participation Agreement

This entity, _____ , signatory to the California Sanitation Risk Management Authority ("CSRMA") Joint Powers Agreement, have agreed by action of our Board of Directors on _____ , 20___, to participate in the CSRMA Workers' Compensation Program. As evidenced by the authorized signatures on page 4 of this document, the above mentioned entity shall become a participant in the Workers' Compensation Program and referred to as a "Program Participant."

It is understood that this Participation Agreement pertains only to the Workers' Compensation Program, and that a separate Participation Agreement is required for each CSRMA insurance program.

By completing the following steps for CSRMA and Workers' Compensation Program membership, Workers' Compensation Insurance coverage shall begin on _____ , which is the date that is acceptable to either the CSRMA Board of Directors and/or the Workers' Compensation Program underwriter, and if applicable:

1) Receiving an underwriting/loss evaluation for qualification purposes and deposit (annual premium) calculation.

2) Receiving a facility physical inspection, if required.

3) Meeting CSRMA underwriting guidelines and obtaining approval of the CSRMA Underwriting Committee.

4) Being recommended by the Executive Committee for acceptance by the Board of Directors and receiving such acceptance.

5) Executing the CSRMA "Joint Powers Agreement," the "Notice of Intent' and "Resolution to Join".

6) Completing the "Application For a Public Entity Certificate of Consent to Self-Insure" and receiving approval to self-insure from the California Department of Industrial Relations.

7) Executing this Workers' Compensation Program Participation Agreement, whereby the Estimated Annual Deposit is accepted and remittance for such is due by Coverage Inception.

MINIMUM PARTICIPATION PERIOD FOR WORKERS' COMPENSATION INSURANCE PROGRAM:

It is understood that the CSRMA Workers' Compensation Program **requires an initial three-year commitment** in order to participate in the program. Withdrawal from the Workers' Compensation Program cannot occur until not less than three years of participation has occurred; that is, from the coverage inception date until the end of the third consecutive program year, and only then if a four-month prior notice was provided.

After the initial three-year participation commitment has been met, withdrawal can occur at the end of the program year provided a four-month prior Notice of Intent to Withdraw was provided to the Authority, as noted above.

Program Participants remain subject to the "Termination" provisions of Section 22 in the CSRMA Joint Powers Agreement, despite the three-year participation commitment.

RESPONSIBILITIES OF PROGRAM PARTICIPANTS:

Program Participants shall maintain an open and ongoing flow of data and information to the Authority staff, committees and/or Board of Directors, as required, in addition to the following:

- Provide the Workers' Compensation Program with such statistical and loss experience data and other information as is necessary to carry out the purposes as outlined in the CSRMA Agreement, Bylaws or as set forth during official meetings of the Executive Committee and/or Board of Directors;

- Pay the Workers' Compensation Program when due and all Retrospective Adjustments and assessments for each Program Year. Withdrawal does not relieve the entity from liability for such retrospective adjustments and assessments;

- Cooperate fully with the Workers' Compensation Program staff and/or representatives in determining the cause of losses in the settlement of claims; and

- Comply with all provisions, policies and procedures of the CSRMA Workers' Compensation Program as set forth in Section 23 of the CSRMA Joint Powers Agreement.

RESPONSIBILITY FOR WORKERS' COMPENSATION INSURANCE PROGRAM EXPENSES:

Workers' Compensation Program members are responsible for their pro-rata share of all program expenses to include: incurred losses, margin for contingency, claims adjusting and legal fees, loss control services, general administration, excess premium costs and costs for any other services as identified by the Executive Committee per authority vested by the CSRMA Agreement and/or Bylaws.

A Program Participant's pro-rata share of the program expenses shall be based upon the Workers' Compensation Program's budgetary needs and any other expenses deemed necessary by the Board of Directors, as well as the Program Participant's premium volume. The cost allocation formula may be subject to change by the Board of Directors.

The withdrawal or termination of any Program Participant from the Workers' Compensation Program shall not terminate the responsibility to continue to contribute to its share of financial obligations incurred by reason of its previous participation (refer to CSRMA Agreement, Section 23).

RETROSPECTIVE PREMIUM ADJUSTMENT:

In accordance with the above section (and Section 19(b) 3 of the CSRMA Agreement), a financial reconciliation or audit of each program year will occur in order to determine if enough funds were collected as Deposits (annual premiums) for each program year.

In general, any deficiency or surplus in each Program Participant's Deposit amounts shall be adjusted by a Retrospective Adjustment. The Retrospective Adjustment process examines each individual participant's claims and expenses for the program year in review to determine if Deposits were adequate. If these Deposits are not adequate to meet costs of incurred claims and expenses, an "adjustment" to make up the difference, subject to minimum and maximum amounts, can take place (refer to CSRMA Agreement, Section 19(b) 3).

Specifically, Retrospective Adjustments for the Workers' Compensation Program shall be calculated within six months after the conclusion of each program year and annually thereafter until all applicable claims are finalized. In addition, the Board of Directors may have special assessments calculated at any time if, in its opinion, it becomes advisable. The results of the calculations shall be communicated to the Program Participants within one month following each calculation. The adjustments resulting from special assessments authorized by the Board shall be due as specified by the Board.

The Retrospective Adjustment of each program year shall be calculated for each Program Participant by adding the sums of (A) and (B) below, less the Deposits on hand:

(A) An amount equal to the individual Program Participant's incurred losses and share of expenses, provided, however, that such amount shall not be greater than 125% of the Deposit nor less than 75% of the Deposit.

(B) Each Program Participant's proportionate share (based upon the amounts determined pursuant to (A) above) of the difference between the sum of the individual amounts calculated pursuant to (A) above, and the total of all incurred losses, reserves, expenses and interest income.

Retrospective Adjustment formulas are subject to change by the Board of Directors.

* * * * * * *

The above Participation Agreement conveys an accurate and complete representation of all obligations of Workers' Compensation Program Participants, as generally stated in the CSRMA Agreement and Bylaws.

Any amendments to the Workers' Compensation Program Participation Agreement shall require a two-thirds vote of the entire Workers' Compensation Program membership and shall generally conform to CSRMA Agreement, Section 26.

In recognition of the above, this Participation Agreement is hereby executed on _____, 20_____, and shall remain in effect until said entity noted below provides written withdrawal notification or is terminated from such Workers' Compensation Program.

_____
Signed

_____
Title

_____
Entity

ATTEST:

_____
Name Title

_____
Date

SECTION 8

POLICIES & PROCEDURES

CSRMA
POLICY AND PROCEDURE
#1-WC

SUBJECT: **Workers' Compensation Claims Settlement Authority**

EFFECTIVE: **August 15, 1990**

REVISED: **January 18, 2017**

Policy:

Member agencies in the Workers' Compensation Program shall participate in the final claim settlement (i.e. Stipulations with Finds and Award or a Compromise & Release with Findings and Award) process to the extent provided for by this policy and procedure. Though Workers' Compensation benefits are mandated and established by State law, the amount and actual settlement of a claim is the responsibility of the Claims Administrator and/or an attorney selected to negotiate such settlement. It shall be CSRMA policy that member agencies shall have input and be a part of the claim settlement process. Various levels of settlement authority have been established as Authority policy. These levels are as follows:

Claims Settlement Authority:

$0 to $10,000 – Claims Administrator (TPA)

The TPA shall be granted settlement authority up to $10,000 on any claim. However, the TPA shall advise the Member Agency of any settlement within this authority level prior to settlement offer.

$10,001 to $50,000 – Member Agency

The Member Agency shall grant authority to the TPA for claim settlements between $10,001 and $50,000.

In the event a Member Agency and the TPA disagree on a settlement amount within this range, the Workers' Compensation Committee shall review the matter and grant authority as appropriate.

$50,001 to $250,000 – Workers' Compensation Committee

The Workers' Compensation Committee shall grant settlement authority to the TPA for claim settlements between $50,001 and $250,000.

In the event the Workers' Compensation Committee and the TPA disagree on a settlement amount within this range, the Executive Board shall review this matter and grant authority as appropriate.

$250,001 to Pool Layer Limit – Executive Board

The Executive Board shall grant settlement authority to the TPA for claim settlements between $250,001 and Pool layer limit.

The Member Agency and the TPA shall have reviewed the proposed settlement amount and shall have agreed that the settlement amount falls within the range of authority of the Executive Board.

All of the foregoing notwithstanding, if time is of the essence in a specific matter, CSRMA's President and the Workers' Compensation Committee Chairperson, on the advice of Authority's Legal Counsel, shall have the authority to determine terms of settlement.

CSRMA
POLICY AND PROCEDURE
#2-WC

SUBJECT: **Selection of Counsel for Defense of Workers' Compensation Claims**

EFFECTIVE: **August 9, 1991**

Policy Statement:

1. CSRMA shall have the sole responsibility to select legal counsel to represent members of the Workers' Compensation Program as to any matters concerning the settlement of claims of a member agency.

2. Any member agency may select and pay, at its own expense, separate counsel to advise it in the conduct of any pending workers' compensation claim matter. Such counsel shall not, without the consent of CSRMA, be permitted to associate as attorney of record in any matter concerning a workers' compensation claim.

3. A member agency may request a change in legal counsel from that selected by the claims administrator. The claims administrator shall then recommend another qualified counsel, if considered appropriate. If a member agency requests a specific counsel by name, the reasons for recommending that specific person shall be provided. In either situation, should such a substitution be considered unacceptable by the claims administrator or the member agency, the matter shall be referred to the Chairman of the Workers' Compensation Program Committee who shall have final authority in appointing legal counsel.

4. In all cases wherein a substitution of counsel is granted, the substitution shall (a) always be in the best interest of CSRMA, and (b) not create a conflict of interest under Civil Code Section 2860. The counsel selected to represent the member agency shall meet reasonable criteria established by CSRMA, including:

   a. California State Bar Workers' Compensation certification.

   b. Demonstrated competency in the defense of workers' compensation claims.

   c. Fees shall be in line with what others receive who specialize in workers' compensation cases.

CSRMA
POLICY AND PROCEDURE
#3-WC

SUBJECT: Workers' Compensation Program Award - Workers' Compensation Excellence Award Program

EFFECTIVE: August 6, 2004

REVISED: January 15, 2011
January 22, 2015
August 20, 2015

Policy:

Soft tissue injuries due to strain and overexertion are CSRMA's most frequent workers' compensation claims. CSRMA wishes to recognize those members of the Workers' Compensation Program who meet criteria developed by the Workers' Compensation Committee and adopted by the Executive Board each year that are designed to target these types of claims.

The first year this policy and procedure is implemented the type of injury to be targeted are low back injuries due to strain and overexertion. Members meeting the following criteria will be recognized:

1. Have no low back lost time claims due to strain or overexertion for the program year being evaluated.
2. Provide evidence that the CSRMA Return to Work Program, or equivalent, has been implemented in order to help injured employees heal more quickly and reduce the indemnity portion of the workers' compensation claim.
3. Perform ergonomic and biomechanical evaluations on at least 10 non-office related tasks that involve lifting, bending, twisting pushing or pulling.
4. Provide evidence of 10 ergonomic solutions that have been implemented targeting known risk factors for musculoskeletal injuries.
5. Provide annual training on the ergonomic and biomechanical principles relevant to the work activities and risk factors present at their agency, by department.
6. Provide evidence that an employee health promotion program with specific activities designed to target employee health risk factors has been implemented.
7. Provide evidence that all job descriptions have identified the specific item or task that the upper lifting requirement is based on.
8. Provide evidence that the NIOSH Lifting Equation has been applied to the item or task the lifting requirement in each job description is based on and that the identified lifting

requirement does not have a Lifting Index greater than 2.5, as calculated using the NIOSH Lifting Equation.

Procedures:

To qualify for the award members must submit an application explaining how each of the award criteria has been met, along with proof of completion. The Workers' Compensation Committee will review each application and make recommendations to the Executive Board for those members meeting the award criteria.

Applications are due April 30 of each year for the prior Workers' Compensation program year ended June 30. Applications will be evaluated and qualifying agencies announced at the following August Board of Directors meeting.

Members meeting the award criteria will share equally in a cash prize of $50,000, or an amount otherwise agreed to by the Executive Board upon a recommendation of the Workers Compensation Committee. The cash prize will be paid directly to the employees of each qualifying member in an amount not to exceed $499 per employee.

Additionally, each qualifying member will receive the following:

1. Wall Plaque
2. Lobby Banner

Each year the Workers' Compensation Committee shall review the prior years' losses and the number of members meeting the prior year's award criteria and recommend to the Executive Board that the award criteria remain the same or be updated to target a different type of injury. In the event of the latter, the Workers' Compensation Committee will provide the Executive Board with award criteria designed to reduce the frequency of the type of injury to be targeted.

CSRMA
POLICY AND PROCEDURE
#4-WC

SUBJECT: **Workers' Compensation Program Dividend from Retained Funds**

EFFECTIVE: **January 19, 2001**
Revised January 28, 2021

Policy:

Participants in the Workers' Compensation Program will receive dividends from funds that are no longer required by the Authority, and in a manner which supports the following goals:

- Protect the overall program from catastrophic loss
- Reduce reliance on non cost-effective insurance
- Stabilize future years' loss rates for payment of expected claims and expenses

An actuarial study will be relied upon to develop the funding necessary on prior program years; to assure that adequate funds are held for incurred liabilities. Funding in excess of the Program's liabilities is categorized as either designated or undesignated retained funds. Retained Funds not returned automatically through the Retrospective Rating Plan (RRP) are eligible to be paid to members participating in that program year in the form of a dividend declared by the Board of Directors.

Dividends can be declared only if, on an aggregate basis, the program is funded at the established confidence level, as described in the procedure below, and the retained funds amount is in excess of seven (7) times) the pooled layer per occurrence limit currently in force prior to the dividend calculation, subject to a minimum retained fund balance in the program after the dividend is calculated in the amount of $5,000,000 (catastrophic reserve).

Eligibility:

Dividends cannot be declared sooner than five (5) years after expiration of a Program Year.

Dividends will be paid from eligible Program Years with no more than 25% of any Program Year's retained funds being released as part of any declared dividend. All retained funds remaining will be returned to Program Year participants when that year is declared "closed" by the Board of Directors.

Procedure:

The Program Administrators will prepare a recommendation to be reviewed by the Executive Board prior to a regularly scheduled Board of Directors meeting. The purpose of the dividend will be stated, and the advantages and disadvantages of releasing the recommended amount will be addressed.

Members' share of declared dividends are *calculated as a percentage of the total dividends declared using the Retrospective Rating Plan results as a basis for the calculation*. The formula that calculates the percentage shore of a program year dividend is:

$$DS = \left(\frac{\text{Individual MD-RA}}{\text{Total of all members (MD-RA)}} \right) \text{ X } \text{AA}$$

Where:

DS = Dividend Share
MD = Member Deposits
RA = Retrospective Adjustments
AA = Amount Available for Distribution

For example:

Amount available for distribution equals 25% of each Program Years' undesignated retained funds multiplied by each member's "percentage share" which is calculated as follows:

Member's deposit plus deposit adjustments minus member's updated Retrospective Rating Plan adjustment divided by the total of all members' deposits plus deposit adjustments minus the total of updated Retrospective Rating Plan adjustments.

Confidence Level:

70% discounted

CSRMA
POLICY & PROCEDURE
#5A-WC

SUBJECT: **Retrospective Rating Plan**

EFFECTIVE: **January 19, 2001**
Revised January 20, 2006

Purpose:

This policy and procedure is written to describe the process by which the Workers' Compensation Program's retrospective rating calculations for Program Years prior to and including 2002-03 are performed. Terms and phrases with special meaning are defined in the "Definitions" section of this policy and procedure.

Policy:

In order to provide an incentive for members to control losses and to maintain a prudently funded pool, the Board of Directors adopted a "Retrospective Rating Plan" ("the retro") at the inception of the Program for calculating final member deposit amounts into the pool for each Program Year. While the plan has operated according to the wishes of the Board, the Board desires this policy and procedure to be written to more clearly describe the detailed operation of the plan. This document therefore supercedes the original document adopted by the Board.

In principle, retrospective rating works to adjust a member's initial deposit subsequent to the expiration of a rating period (Program Year) on the basis of actual losses during that period. Such a rating program allows a member to more directly determine risk transfer costs through control of its own loss experience. This concept of individual cost determination on the basis of a member's actual incurred losses is significant in that:

- A member that controls losses is rewarded for doing so;
- A member who has historically not controlled losses, is provided with incentive to do so; and
- Each member has the opportunity to earn a reasonable final deposit based upon its own actual loss experience. Retrospective rating provides more immediate recognition of favorable (or unfavorable) loss experience.

To accomplish these objectives, the basic plan design was formulated to include a retrospective rating feature.

The retrospective rating adjustment process evaluates each member's claims and expenses for each Program year to determine:

1. If the total of member pool deposit amounts (initial and subsequent adjustments) plus investment income, is adequate to cover losses and expenses; and

2. The degree to which individual member pool deposit amounts contributed to the financial success of a given Program Year.

Upon determination of these two issues, members are subject to a "retrospective rating adjustment" (an "adjustment") to their initial deposit, either positive or negative, subject to the formula utilized. The adjustment for each applicable Program Year appears on the annual member Workers' Compensation Program invoice. The first adjustment (credit or debit) is applied to the invoice for the following Program Year. Subsequent adjustments are applied to the invoices of subsequent Program Years.

Retrospective rating adjustments for the Workers' Compensation Program are calculated using data valued six months after the conclusion of each Program Year, and annually thereafter until the Program Year is declared "closed" by the Board of Directors. In addition, the Board of Directors may declare special assessments, above and beyond retro adjustments, calculated at any time if in the Board's opinion, it becomes advisable to do so. The results of each retro calculation are communicated to the membership after review by the Executive Board. Any special assessment authorized by the Board shall be due as specified by the Board.

Procedure:

Six months after the expiration of each Program Year, and annually thereafter, (currently December 31st of each year), unless otherwise directed by CSRMA, the Program Administrators are to start collection of the data needed to perform the retro calculation for that year. Data required includes:

1. Complete Workers' Compensation Program Loss Runs valued as of December 31st showing paid and reserve amounts by member for the "pooled layer" (i.e. claim amounts between $0 and the excess attachment point).

2. Initial Program Pool Deposit amounts for each Program Year, and prior adjustment amounts on years already subject to adjustment.

3. Incurred But Not Reported (IBNR) amounts for each Program Year as of December 31st.

4. Investment Income allocated to each Program Year as of December 31st.

Using the above data, the Program Administrators are to calculate the retrospective rating adjustment utilizing IBNR values representative of a "70% confidence level" for each Program Year. The results are to be presented to the Workers' Compensation Program Committee and the Executive Board no later than the last regularly scheduled meeting prior to July 1st of each calendar year. The Committee is to review the results and make a recommendation to the Executive Board concerning the appropriateness of implementing the results of the calculation.

With respect to initial Program Year Deposits, the Executive Board is granted authority to utilize an actuarial degree of confidence other than that noted above when it is appropriate to do so based upon evaluation of the following criteria:

1. Insurance market conditions that impact the viability of the Program.
2. Legislative issues expected to impact the workers' compensation environment.
3. Either favorable or unfavorable program funding issues that need to be addressed.
4. Risk exposures that impact the viability of the Program.

Upon acceptance of the results by the Executive Board, with or without modification, the Program Administrators are to credit or debit annual member invoices accordingly.

Calculation

According to the formula described below, the retrospective adjustment amount for each Program Year shall be calculated for each member:

Column #1 - Reported Losses:

This column includes actual reported losses for the Program Year in question. Losses are screened to include only values between $1,000 and $100,000 to eliminate excessive impact of very small and very large claims.

Column #2 - Percentage of Reported Losses:

This column is the percentage that each member's reported losses in Column #1 represent to the total of Column #1.

Column #3 - Manual Premium:

This is the premium developed by the standard rates and class codes used by the Workers' Compensation Insurance Rating Bureau (WCIRB), and then adjusted uniformly to the membership to achieve underlying rates that will deliver the target amount of deposits that the Authority wishes to collect for that Program Year.

Column #4 - Percentage of Manual Premium:

This column is each agency's percentage of manual premium to the total group manual premium.

Column #5 - Relative Loss Rate:

This is the quotient of Columns #2 and #4.

Column #6 - Credibility Factor:

The credibility factor is the degree to which the current year performance of a member is statistically reliable to predict loss patterns. The higher the credibility factor, the more reliable current year results are as an indicator of ultimate losses. The formula takes the members' manual premium as the numerator in a fraction that uses the lowest members' premium multiplied by three and added to the members' manual premium as the denominator. This factor is used to weigh the "Pool Experience E-Mod" with current year data, rather than relying solely on the WCIRB E-Mod which is more reflective of prior loss activity.

Column #7a – Experience E-Mod:

This column is the current year's *Retro Plan* "experience modification factor." It is developed from the relation of current year losses and the credibility of those results. The retro plan experience modification is calculated differently than the WCIRB Ex Mod described below, and is used only within this Retro Plan.

Column #7b - WCIRB Experience Modification (Ex Mod):

This is the agency's Ex Mod factor for the year being evaluated, using the formula employed by the WCIRB.

Column #7c - Pool Experience Modification:

This column is a relationship between the current year experience mod and the historical experience mod. Historical performance is given a double weight, compared to current year results.

Column #8 - Special Exposure Factor:

This is a contingency column, which may be necessary if a particular agency merits a debit or credit factor for some underwriting reason.

Column #9 - Total Exposure:

This column modifies the manual premium by multiplying it by the Pool Experience E-Mod and the Special Exposure Factor. It is used to develop a member's expected exposure to the rest of the group.

Column #10 - Percent of Total Exposure:

This column is the percentage of members' exposure to that of the total pool.

Column #11 - Incurred Program Year Losses:

This column includes the actual losses reported to the pool, including paid losses, reserves and claims expenses. It includes all losses up to the attachment of excess insurance.

Column # 12 - Allocated Losses:

This column applies the total losses to each member, based on its percentage of the total exposure.

Column #13a – Allocated IBNR:

This column allocates the Incurred But Not Reported (IBNR) claims and loss development of the Program Year.

Column #13b - Administrative Cost Allocation:

The retro allows for the insertion of an Administrative Cost Allocation.

Column # 14a - Deposit:

This column is the initial, audited deposit paid to the Authority by the member.

Column #14b - Deposit Less Administrative Costs:

This is the sum of the Deposit less the Administrative Cost Allocation.

Column # 15a – Average Invested Funds:

This is an estimate of each member's funds available for investment.

Column #15b – Allocated Investment Earnings:

This is each member's "share" of the investment income available for the Program Year.

Column #16 - Net Pool Costs:

The pool costs amount to losses, IBNR and administrative cost, less interest.

Column #17 - Maximum Deposit:

This column is the maximum amount assessable against an individual member for poor experience. It is equal to the product of the member's initial deposit (deposit less administrative expenses) and 1.25.

Column #18 - Minimum Deposit:

This is the minimum amount the Authority will retain for a member through the retro. It is the product of the member's initial deposit (deposit less administrative expenses) and .75.

Column #19 - Formula Deposit:

The Formula Deposit determines the amount the member will pay. It is equal to Net Pool Costs as shown in Column #16, unless these are more than the maximum, or less than the minimum.

Column #20 - Allocation of Overage:

If the total of Formula Deposit is insufficient to cover the losses of the pool, the "overage" (the difference between funds available and funds needed) is allocated proportionately by this formula.

Retro Deposit Adjustment:

This is the "formula deposit" plus the "allocation of overage" less the "original deposit."

Final Pool to Date:

This is the "original deposit" less the "Retro Deposit Adjustment."

DEFINITIONS:

1. Calculation Date

The retrospective rating calculation dates are established at six months following the conclusion of each Program Year (Currently June 30th) and annually thereafter for each Program Year.

2. Allocated Losses

"Allocated Losses" includes each member's actual losses ("paid and reserved") as depicted in the JPA's official loss runs **and** that members' proportionate share of IBNR for that Program Year. Loss amounts below the members' deductible (if applicable), or above the Program's excess attachment point are not counted in the calculation.

3. Pool Deposits (Deposits)

"Deposit", or "pool deposit," term refers to the amount charged either individually or collectively to the pool members to cover the expected losses and expenses of a given Program Year.

4. Claim Reserves

"Claim Reserves" is an estimate of the funds needed to be set aside for **known** events (reported) that have given rise to a claim against a member. Each claim made by an employee against a member employer is "reserved" by the Program's claims adjusting firm in accordance with the intrinsic dollar value of that claim. The aggregate value of all claims reserved make up the Authority's total "claims reserves".

5. Loss Adjustment Expenses

"Loss Adjustment Expenses" refers to expenses incurred in the course of investigating and settling claims. Allocated loss adjustment expenses (ALAE) include costs, or expected costs, associated directly with specific claims paid or in the process of settlement, such as legal and adjusters' fees. Unallocated loss adjustment expenses (ULAE) include other costs, or expected other costs, that cannot be associated with specific claims but are related to claims paid or in the process of settlement, such as salaries and other internal costs of the pool's claims administrator.

6. Incurred But Not Reported (IBNR)

Claims for covered events that have occurred but have not yet been reported to the member or pool as of the date of the financial statement preparation or evaluation. IBNR claims include (a) known loss events that are expected to later be presented as claims, (b) unknown loss events that are expected to become claims, and (c) expected future development on claims already reported.

7. Ultimate Net Loss

"Ultimate Net Loss" is the sum of claims paid to date, claim reserves and IBNR; all within the program's pooled layer. Because it is composed of two estimates, Ultimate Net Loss is also an estimate. The term is used to capture the total value of all claims that will ultimately be made against members for which the Authority is responsible. The Authority attempts to fund its programs such that member deposits for each period (Program Year) will equal the estimated ultimate net loss for that year plus program expenses and other general and administrative costs.

8. Confidence Level

"Confidence Level" is a statistical term used to express the degree to which an actuarial projection (usually "Ultimate Net Loss" or "IBNR") will be an accurate prediction of what the dollars losses will eventually be for a Program Year. The higher a confidence level, the greater surety one has that losses will not exceed the dollar value determined to attain that confidence level.

9. Contingency Margin

"Contingency margin" refers to program equity in excess of that which is needed to maintain an "expected" confidence level.

CSRMA
POLICY & PROCEDURE
#5B-WC

SUBJECT: **Retrospective Rating Plan**

EFFECTIVE: **January 19, 2001**
Revised January 20, 2006

Purpose:

This policy and procedure is written to describe the process by which the Workers' Compensation Program's retrospective rating calculations for Program Years 2003-04 and beyond are performed. Terms and phrases with special meaning are defined in the "Definitions" section of this policy and procedure.

Policy:

In order to provide an incentive for members to control losses and to maintain a prudently funded pool, the Board of Directors adopted a "Retrospective Rating Plan" ("the retro") at the inception of the Program for calculating final member deposit amounts into the pool for each Program Year. While the plan has operated according to the wishes of the Board, the Board desires this policy and procedure to be written to more clearly describe the detailed operation of the plan. This document therefore supercedes the original document adopted by the Board.

In principle, retrospective rating works to adjust a member's initial deposit subsequent to the expiration of a rating period (Program Year) on the basis of actual losses during that period. Such a rating program allows a member to more directly determine risk transfer costs through control of its own loss experience. This concept of individual cost determination on the basis of a member's actual incurred losses is significant in that:

- A member that controls losses is rewarded for doing so.
- A member who has historically not controlled losses, is provided with incentive to do so.
- Each member has the opportunity to earn a reasonable final deposit based upon its own actual loss experience. Retrospective rating provides more immediate recognition of favorable (or unfavorable) loss experience.

To accomplish these objectives, the basic plan design was formulated to include a retrospective rating feature.

The retrospective rating adjustment process evaluates each member's claims and expenses for each Program Year to determine:

1. If the total of member pool deposit amounts (initial and subsequent adjustments) plus investment income, is adequate to cover losses and expenses.

2. The degree to which individual member pool deposit amounts either contributed to the financial success of a given Program Year.

Upon determination of these two issues, members are subject to a "retrospective rating adjustment" (an "adjustment") to their initial deposit, either positive or negative, subject to the formula utilized. The adjustment for each applicable Program Year appears on the annual member Workers' Compensation Program invoice. The first adjustment (credit or debit) is applied to the invoice for the following Program Year. Subsequent adjustments are applied to the invoices of subsequent Program Years.

Retrospective rating adjustments for the Workers' Compensation Program are calculated using data valued six months after the conclusion of each Program Year, and annually thereafter until the Program Year is declared "closed" by the Board of Directors. In addition, the Board of Directors may declare special assessments, above and beyond retro adjustments, calculated at any time if in the Board's opinion, it becomes advisable to do so. The results of each retro calculation are communicated to the membership after review by the Executive Board. Any special assessment authorized by the Board shall be due as specified by the Board.

Procedure:

Six months after the expiration of each Program Year, and annually thereafter, (currently December 31st of each year), unless otherwise directed by CSRMA, the Program Administrators are to start collection of the data needed to perform the retro calculation for that year. Data required includes:

1. Complete Workers' Compensation Program Loss Runs valued as of December 31st showing paid and reserve amounts by member for the "pooled layer" (i.e. claim amounts between $0 and the excess attachment point);

2. Initial Program Pool Deposit amounts for each Program Year, and prior adjustment amounts on years already subject to adjustment;

3. Incurred But Not Reported (IBNR) amounts for each Program Year as of December 31st; and

4. Investment Income allocated to each Program Year as of December 31st.

Using the above data, the Program Administrators are to calculate the retrospective rating adjustment utilizing IBNR values representative of a "70% confidence level" for each Program Year. The results are to be presented to the Workers' Compensation Program Committee and the Executive Board no later than the last regularly scheduled meeting prior to July 1st of each calendar year. The Committee is to review the results and make a recommendation to the Executive Board concerning the appropriateness of implementing the results of the calculation.

With respect to initial Program Year Deposits, the Executive Board is granted authority to utilize an actuarial degree of confidence other than that noted above when it is appropriate to do so based upon evaluation of the following criteria:

1. Insurance market conditions that impact the viability of the Program.
2. Legislative issues expected to impact the workers' compensation environment.
3. Either favorable or unfavorable program funding issues that need to be addressed.
4. Risk exposures that impact the viability of the Program.

Upon acceptance of the results by the Executive Board, with or without modification, the Program Administrators are to credit or debit annual member invoices accordingly.

Calculation

According to the formula described below, the retrospective adjustment amount for each Program Year shall be calculated for each member:

Column #1 - Reported Losses:

This column includes actual reported losses for the Program Year in question. Losses are screened to include values between $0 and the excess insurance attachment point.

Column #2 - Percentage of Reported Losses:

This column is the percentage that each member's reported losses in Column #1 represent to the total of Column #1.

Column #3 - Manual Premium:

This is the premium developed by the standard rates and class codes used by the Workers' Compensation Insurance Rating Bureau (WCIRB), and then adjusted uniformly to the membership to achieve underlying rates that will deliver the target amount of deposits that Authority wishes to collect for that Program Year.

Column #4 - Percentage of Manual Premium:

This column is each agency's percentage of manual premium to the total group manual premium.

Column #5 - Relative Loss Rate:

This is the quotient of Columns #2 and #4.

Column #6 - Credibility Factor:

The credibility factor is the degree to which the current year performance of a member is statistically reliable to predict loss patterns. The higher the credibility factor, the more reliable current year results are as an indicator of ultimate losses. The formula takes the members' manual premium as the numerator in a fraction that uses the lowest members' premium multiplied by three and added to the members' manual premium as the denominator. This factor is used to weigh the "Pool Experience E-Mod" with current year data, rather than relying solely on the WCIRB E-Mod which is more reflective of prior loss activity.

Column #7a – Experience E-Mod:

This column is the current year's *Retro Plan* "experience modification factor." It is developed from the relation of current year losses and the credibility of those results. The retro plan experience modification is calculated differently than the WCIRB Ex Mod described below, and is used only within this Retro Plan.

Column #7b - WCIRB Experience Modification (Ex Mod):

This is the agency's Ex Mod factor for the year being evaluated, using the formula employed by the WCIRB.

Column #7c - Pool Experience Modification:

This column is a relationship between the current year experience mod and the historical experience mod. Historical performance is given a double weight, compared to current year results.

Column #8 - Special Exposure Factor:

This is a contingency column, which may be necessary if a particular agency merits a debit or credit factor for some underwriting reason.

Column #9 - Total Exposure:

This column modifies the manual premium by multiplying it by the Pool Experience E-Mod and the Special Exposure Factor. It is used to develop a member's expected exposure to the rest of the group.

Column #10 - Percent of Total Exposure:

This column is the percentage of members' exposure to that of the total pool.

Column #11 - Reported Program Year Losses:

This column includes actual reported losses for the Program Year in question. Losses are screened to include values between $0 and the excess insurance attachment point.

Column #12 - Allocated Losses:

This column applies the total losses to each member, based on its percentage of the total exposure.

Column #13a – Allocated IBNR:

This column allocates the Incurred But Not Reported (IBNR) claims and loss development of the Program Year.

Column #13b - Administrative Cost Allocation:

The retro allows for the insertion of an Administrative Cost Allocation.

Column #14a - Deposit:

This column is the initial, audited deposit paid to the Authority by the member.

Column #14b - Deposit Less Administrative Costs:

This is the sum of the Deposit less the Administrative Cost Allocation.

Column #15 – Paid Losses:

This column includes actual paid losses up to the attachment point of excess insurance.

Column #16 – Prior Adjustments:

This column includes prior retrospective rating adjustments for a given Program Year. Prior adjustments are contemplated in the distribution of investment funds.

Column # 17a – Average Invested Funds:

This is an estimate of each member's funds available for investment.

Column #17b – Allocated Investment Earnings:

This is each member's "share" of the investment income available for the Program Year.

Column #17c – Prior Investment Earnings:

This column includes the sum of prior investment earnings for a given Program Year.

Column #17d – Total Investment Earnings:

This column is the sum of "Allocated Investment Earnings" and "Prior Investment Earnings."

Column #18 - Net Pool Costs:

The pool costs amount to losses and IBNR less interest.

Column #19 - Maximum Deposit:

This column is the maximum amount assessable against an individual member for poor experience. It is equal to the product of the member's initial deposit (less administrative costs) and 1.25.

Column #20 - Minimum Deposit:

This is the minimum amount the Authority will retain for a member through the retro. It is the product of the member's initial deposit (less administrative costs) and .75.

Column #21 - Formula Deposit:

The Formula Deposit determines the amount the member will pay. It is equal to Net Pool Costs as shown in Column #18, unless these are more than the maximum, or less than the minimum.

Column #22 - Allocation of Overage:

If the total of Formula Deposit is insufficient to cover the losses of the pool, the "overage" (the difference between funds available and funds needed) is allocated proportionately by this formula.

Column #23 – Deposit Less Administrative Costs:

This column is equal to column #14b.

Column #24 – Updated Retro Adjustment:

This is the "formula deposit" plus the "allocation of overage" less the "original deposit less administrative costs."

Column #25 – Prior Adjustments:

This column is equal to Column #16.

Column #26 – Current Retro Adjustment:

This column is the sum of the "updated retro adjustment" and "prior adjustments."

Column #27 – Adjusted Deposit Less Administrative Costs:

This column is the sum of "deposit less administrative costs" and the "updated retro adjustment."

Column #28 – Allocated Administrative Costs:

This column is equal to Column #13b.

Column #29 - Final Pool to Date:

This is the "adjusted deposit less administrative costs" plus the "allocated administrative costs."

DEFINITIONS:

1. Calculation Date

The retrospective rating calculation dates are established at six months following the conclusion of each Program Year (Currently June 30th) and annually thereafter for each Program Year.

2. Allocated Losses

"Allocated Losses" includes each member's actual losses ("paid and reserved") as depicted in the JPA's official loss runs **and** that members' proportionate share of IBNR for that Program Year. Loss amounts below the members' deductible (if applicable), or above the Program's excess attachment point are not counted in the calculation.

3. Pool Deposits (Deposits)

"Deposit", or "pool deposit," term refers to the amount charged either individually or collectively to the pool members to cover the expected losses and expenses of a given Program Year.

4. Claim Reserves

"Claim Reserves" is an estimate of the funds needed to be set aside for **known** events (reported) that have given rise to a claim against a member. Each claim made by an employee against a member employer is "reserved" by the Program's claims adjusting firm in accordance with the intrinsic dollar value of that claim. The aggregate value of all claims reserved make up the Authority's total "claims reserves".

5. Loss Adjustment Expenses

"Loss Adjustment Expenses" refers to expenses incurred in the course of investigating and settling claims. Allocated loss adjustment expenses (ALAE) include costs, or expected costs, associated directly with specific claims paid or in the process of settlement, such as legal and adjusters' fees. Unallocated loss adjustment expenses (ULAE) include other costs, or expected other costs, that cannot be associated with specific claims but are related to claims paid or in the process of settlement, such as salaries and other internal costs of the pool's claims administrator.

6. Incurred But Not Reported (IBNR)

Claims for covered events that have occurred but have not yet been reported to the member or pool as of the date of the financial statement preparation or evaluation. IBNR claims include (a) known loss events that are expected to later be presented as claims, (b) unknown loss events that are expected to become claims, and (c) expected future development on claims already reported.

7. Ultimate Net Loss

"Ultimate Net Loss" is the sum of claims paid to date, claim reserves and IBNR; all within the program's pooled layer. Because it is composed of two estimates, Ultimate Net Loss is also an estimate. The term is used to capture the total value of all claims that will ultimately be made against members for which the Authority is responsible. The Authority attempts to fund its programs such that member deposits for each period (Program Year) will equal the estimated ultimate net loss for that year plus program expenses and other general and administrative costs.

8. Confidence Level

"Confidence Level" is a statistical term used to express the degree to which an actuarial projection (usually "Ultimate Net Loss" or "IBNR") will be an accurate prediction of what the dollar losses will eventually be for a Program Year. The higher a confidence level, the greater surety one has that losses will not exceed the dollar value determined to attain that confidence level.

9. Contingency Margin

"Contingency margin" refers to program equity in excess of that which is needed to maintain an "expected" confidence level.

CSRMA
POLICY AND PROCEDURE
#6-WC

SUBJECT: **Target Equity**

EFFECTIVE: **January 19, 2001**

Purpose:

It is the goal of CSRMA to prudently fund its risk sharing and group purchase Programs. It is the purpose of this policy and procedure to outline the basic financial factors and assumptions utilized in the Workers' Compensation Program to assure prudent funding. Terms with special meaning related to this policy and procedure are defined in the "Definitions" section of this policy and procedure.

Policy:

It is the policy of the CSRMA Workers' Compensation Program to:

1. Calculate each of its total initial Program Year deposit amounts at an actuarially determined confidence level equal to 70%.

2. Calculate retrospective rating adjustments and dividends according to the factors and assumptions assigned in the Policy and Procedures relating to these items.

3. To utilize the "expected" levels (approximately 50%) of actuarially determined confidence when reporting liabilities to which this terms relates in the JPA's financial statements.

4. To create and maintain a "catastrophic reserve" (designated reserve) account within the equity section of the JPA financial statements that provides a dollar amount of designated equity equal to the difference between stating Program liabilities at a 70% confidence level compared with recording such liabilities at the "expected" level.

With respect to initial Program Year Deposits, the Executive Board is granted the Authority to utilize an actuarial degree of confidence other than that noted above when it is appropriate to do so based upon evaluation of the following criteria:

1. Insurance market conditions that impact the viability of the Program.

2. Legislative issues expected to impact the workers' compensation environment.

3. Either favorable or unfavorable Program funding issues that need to be addressed.

4. Risk exposures that impact the viability of the Program.

Procedure:

With respect to the four policy items listed above, the procedure for implementing these is as follows:

1. Initial Deposits calculated at a 70% Confidence Level

   At a minimum, when recommending funding levels (deposit amounts) for each new Program Year, the Program Administrator will provide the Workers' Compensation Committee and the Executive Board with documentation for review detailing Program funding levels utilizing an actuarially determined 70% confidence level.

   The Program Administrators may also provide documentation at other confidence levels as directed by the Board or Committee.

2. Retrospective Rating Adjustments and Dividend Calculation

   When making Program Dividend Calculations and Retrospective Rating Adjustments, the Program Administrators will utilize the factors and assumptions detained in the Policy and Procedures relating to these items for such purposes.

3. Financial Statements

   When reporting Program liabilities in the JPA financial statements, the CSRMA accounting personnel and the CSRMA financial auditors will report liabilities at an actuarially determined 50% confidence level.

4. Catastrophic Reserve

   When reporting Program equity in the JPA financial statements, the CSRMA accounting personnel shall segregate equity between an equity amount entitled "Designated Catastrophic Reserve" and an equity amount entitled "Undesignated Retained Earnings." The "Catastrophic Reserve" amount shall be equal to the difference between stating Program liabilities at a 70% confidence level compared with stating such liabilities at the "expected" level.

SECTION 8

APPENDIX

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.

Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Please do not use this column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

EXTENT OF INJURY

Completed By (type or print)	Signature & Title	Date (mm/dd/yy)

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.