Workers' Compensation

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The Evolution of Workers' Compensation

The concept that workers should be protected from and compensated for injury or illness occurring in the workplace came about with the rise of the trade union movement at the beginning of the 20th century. Workers' compensation insurance is a direct result of public awareness and outrage at the poor and often dangerous working conditions people were forced to labor under in order to make a living, and the financially devastating effects of a work-related injury or illness on the worker and the worker's dependents.

Workers' compensation insurance is the oldest social insurance program in the United States; in fact, it is older than both social security and unemployment compensation.

California adopted workers' compensation laws in the 1910s along with most other states. Workers' compensation is based on a no-fault system, which means that an injured employee does not need to prove that the injury or illness was someone else's fault in order to receive workers' compensation benefits for an on-the-job injury or illness.

Since almost every working Californian is protected by the workers' compensation system, it is important that employers and employees alike have an understanding of workers' compensation insurance and how it works.

What Benefits Are Available in a Workers' Compensation Policy?

Depending on the circumstances of the injury or illness, injured workers are entitled to specific benefits as structured by workers' compensation insurance. There are five basic types of workers' compensation benefits that include medical care, temporary disability benefits, permanent disability benefits, supplemental job displacement benefits, and death benefits. Injured workers may be entitled to one or more of these benefits.

Medical Care

Injured workers are entitled to receive all medical treatment reasonably required to cure or relieve the effects of a work-related injury or illness. Medical care can include physician services, hospitalization, physical restoration, physical therapy, chiropractic treatment, dental care, prescriptions, x-rays, laboratory services, or any other care considered necessary and reasonable by the treating physician, subject to applicable treatment guidelines. Other than certain treatment requests made by treating physicians in an employer's Medical Provider Network (MPN), all requests for medical treatment are sent by the treating physician to the workers' compensation insurer for utilization review (UR). Treatment requests will be either allowed, modified, or denied. An injured worker may challenge a decision to modify or deny treatment by requesting an independent medical review (IMR). For more information on UR and IMR, contact the Division of Workers' Compensation's (DWC) Medical Unit, which is a division of the Department of Industrial Relations (DIR), using the information shown in the "Resources" section.

Generally, the employer is responsible for arranging medical treatment for the first 30 days from the date the injury or illness is reported. However, an employee may obtain treatment from his/her personal physician if the physician is predesignated prior to the work-related injury or illness, which means the employee must notify his/her employer that he/she opts to obtain treatment from his/her personal physician in the event of a workers' compensation injury or illness. In most cases, if the employee did not predesignate and the employer or its workers' compensation insurer opted to provide treatment through a Health Care Organization (HCO) or an MPN, the injured employee will first be treated in the HCO or MPN. An injured employee's ability to switch treating physicians will depend on whether he/she is being treated in an HCO, MPN, or by his/her predesignated physician. For further information, employees may contact the Information and Assistance Officer at their local DWC office using the information shown in the "Resources" section.

First Aid Treatment

First aid treatment is included as medical care that all employers must provide for their injured employees. In conjunction with the DWC, the California Department of Insurance (CDI) wants to remind all employers, physicians, insurance companies and self-insurers of the need to comply with Section 6409(a) of the California Labor Code.

Section 6409(a) requires a physician who treats an injured employee to file a "Doctor's First Report of Occupational Injury or illness" (DFR) with the claims administrator for every work illness or injury, including first aid cases where there is no lost time from work. Although the Labor Code contains "first aid" exceptions for the Employer's Report (Form 5020) and the Employee Claim Form (DWC-1), there is no such exception for the DFR. The insurance company (or the employer if the employer is self-insured) must forward DFRs to the DIR.

The CDI and DIR believe there are improper arrangements in place between some medical providers and employers that allow the employer to dictate how injuries are to be classified by the physicians. In some cases, and at the request of the employers, the physicians send the DFR only to the employers and not to the insurance companies. This arrangement occurs even though the injuries clearly are beyond first aid. This agreement is often marketed to employers as a way to keep premiums from rising or to lower them. Such marketing practices are improper and may contribute to possible criminal violations related to premium fraud and the fraudulent denial of workers' compensation benefits to injured workers.

Temporary Disability

When a worker is unable to return to work within three days of his/her injury or illness, the worker is entitled to temporary disability benefits to help partially replace wages lost as a result of the injury or illness. A physician must verify that an injured employee cannot work because of the on-the-job injury or illness before temporary disability benefits are payable. Payments are not made for the first three days an employee is off the job unless he/she is hospitalized overnight or cannot work for more than 14 days.

The benefits are designed to replace two-thirds of lost wages, up to the current maximum prescribed by law. Benefits are generally payable every two weeks until the employee is able to return to work or until the employee's condition becomes permanent and stationary. There are statutory limits on the period during which temporary disability benefits are paid. These limits depend on the date of the injury and the type of injury.

Permanent Disability

If a work-related injury or illness results in permanent impairment to an employee, the employee may become eligible for permanent disability benefits. The amount (percentage) the employee receives is based on a formula that considers the extent of the physical injury or disfigurement, the age of the employee when injured, the employee's occupation, and the date of injury. Other factors that are considered when calculating permanent disability include: apportionment (how much the disability is caused by work, compared to how much it is caused by other factors) and an adjustment factor that takes into account an injured worker's loss of future earning capacity.

Current workers' compensation law sets the benefit amount and the minimum and maximum amounts payable, and the benefits are paid every two weeks until the maximum amount is reached or a lump sum settlement is made.

The percentage of permanent disability is determined by using the formula found in the Schedule for Rating Permanent Disabilities after an assessment of the injured worker's permanent impairment and limitations. There are three schedules and each one is applicable to specific dates of injury. These Schedules for Rating Permanent Disabilities can be accessed through the DIR's website at http://www.dir.ca.gov/dwc/dwcrep.htm. Please see the "Resources" section of this brochure for complete DIR contact information.

The assessment of the injured worker's permanent impairment and limitations is made by a physician who is either the treating physician, a Qualified Medical Evaluator (QME), or an Agreed Medical Evaluator (AME) if the employee is represented by an attorney.

QMEs are appointed and regulated by the DWC's Medical Unit. (Please see the "Resources" section of this brochure for DWC Medical Unit contact information.) If there is a disagreement regarding the treating physician's opinion, and the worker is not represented by an attorney, the worker can choose a QME from a three-member panel provided by the DWC's Medical Unit to perform a separate evaluation.

When a worker is represented by an attorney, the attorney and workers' compensation insurer must attempt to agree on an AME to perform the evaluation if there is a disagreement regarding the treating physician's opinion. If the parties are unable to agree on an AME and the date of injury is 2005 or later, a three-member QME panel will be appointed by the DWC's Medical Unit. The parties try to agree on a physician from this three-member panel. If there is no agreement, each party is allowed to strike off one physician's name from the panel in order to narrow the selection down to one final physician who will perform the evaluation. If there is no agreement on an AME and the date of injury is before 2005, each party may select its own QME. If the evaluations are different, the amount of permanent disability will be determined through negotiation or litigation, if necessary.

Supplemental Job Displacement Benefit (for injuries after 01/01/04 and before 01/01/13)

The Supplemental Job Displacement Benefit (SJDB) is a nontransferable voucher for education-related retraining and/or skill enhancement that is payable to a state-approved or accredited school if the date of injury is on or after 01/01/04 and before 01/01/13. The voucher can be used to pay for tuition, fees, books, or other expenses required by the school for retraining or skill enhancement. Up to 10 percent of the voucher may be used to pay for a vocational or return-to-work counselor. In order for the injured worker to qualify for this benefit, the injured employee must have sustained permanent disability, the injured employee must not have been able to return to work within 60 days after temporary disability ended, and the employer must have failed to timely offer modified or alternative work. There is a maximum voucher amount set by law and the amount varies based upon the extent of permanent disability.

Supplemental Job Displacement Benefit (for injuries on or after 01/01/13)

This benefit is a nontransferable voucher for education-related retraining and/or skill enhancement if the date of injury is on or after 01/01/13. The voucher can be used to pay for tuition, fees, books, tools, or other expenses at California public schools or any other provider listed on the state's eligible training provider list. It can also be used to pay for licensing or professional certification fees, related exam fees, and examination preparation course fees, as well as to purchase computer equipment of up to $1,000 and to reimburse up to $500 in miscellaneous expenses. Employees who have injuries that result in permanent disability and who are not timely offered regular, modified, or alternative work by his/her employer must be offered this benefit. The voucher is redeemable for up to $6,000, regardless of the extent of permanent disability. In most cases, the voucher cannot be redeemed as part of a settlement.

Return-to-Work Supplement Program (for injuries on or after 01/01/13)

The Return-to-Work Supplement Program (RTWSP) benefit, administered by the DIR, is a one-time supplemental payment to employees who experience a loss of earnings that is disproportionate to their permanent disability ratings. Employees who have a date of injury on or after 01/01/13 and who have received an SJDB voucher for that injury can apply for this benefit. To apply, the employee must complete an online application, located at https://www.dir.ca.gov/RTWSP/RTWSPApplication.html which must be received by the DIR within one year of the date the SJDB voucher was sent to the employee. If found eligible, current law allows the employee to receive a one-time $5,000 payment.

Death Benefits

When a worker is fatally injured on the job, reasonable burial expenses are paid up to the current maximum set by law. Additionally, qualified surviving dependents may receive support payments for a period of time. These benefit payments are usually paid at the same weekly rate as the maximum temporary disability benefit. The total death benefit amount of support payments depends on the number of dependents and whether they are partially or totally dependent.

How Is Coverage Structured in a Workers' Compensation Policy?

Workers' compensation coverage is offered under Part One of a workers' compensation insurance policy. In Part One, the insurance company agrees to promptly pay all benefits and compensation due to an injured worker. These payments are imposed on the employer by workers' compensation law or laws of the state or states listed on the Declarations/Information page of the policy. Workers' compensation insurance is considered the exclusive remedy for injured employees.

What this means is that an employer assumes absolute liability for all work-related injuries, and workers' compensation benefits are the sole remedy for injured workers against their employers. Generally, an injured employee covered under workers' compensation laws cannot sue his/her employer for damages in civil court.

Despite the fact that workers' compensation is considered to be the exclusive remedy for employees with work-related disabilities, employers' liability insurance can provide important coverage in addition to workers' compensation insurance. Employers' liability insurance is offered under Part Two of a workers' compensation and employers' liability insurance policy. Employers' liability Part Two protects the employer against instances in which an employee's injury or disease is not subject to the workers' compensation laws. Employers may contact a licensed commercial broker-agent to discuss employers' liability coverage as a part of the workers' compensation policy.

Who Is Required to Purchase Workers' Compensation Insurance?

All California employers must provide workers' compensation benefits to their employees under California Labor Code Section 3700. If a business employs one or more employees, it must satisfy the requirement of the law. In some instances, the law requires specified contractors to carry workers' compensation insurance even if they have no employees.

Sometimes a business owner (sole-proprietor) may desire to purchase workers' compensation insurance to cover himself/herself only. The inclusion of a sole-proprietor must be clearly stated in the workers' compensation policy or must be added as a coverage endorsement to the policy. Since workers' compensation insurance is a type of liability insurance where the employer assumes complete liability for all work-related injuries, a workers' compensation policy for a sole-proprietor may not be the best choice.

Purchasing health, life, and/or disability income insurance can be viable alternatives to workers' compensation for a sole-proprietor. Contact a licensed commercial broker-agent or a casualty broker-agent for further information and consultation.

Executive officers and directors of quasi-public or private corporations must be included in workers' compensation coverage while rendering actual service for the corporation for pay, unless the officers or directors elect to be excluded from coverage. An officer or director who individually owns at least 10 percent of the corporation's issued and outstanding stock (or at least 1 percent of outstanding stock if a specified family member owns at least 10 percent of outstanding stock) and is covered by a health insurance policy or health care service plan may elect to be excluded from workers' compensation coverage by executing a written waiver. Similarly, a general partner of a partnership or a managing member of a limited liability company receiving wages irrespective of profits may elect to be excluded from workers' compensation benefits by executing a written waiver.

Employers may want to discuss the option to include or exclude these individuals with a licensed commercial broker-agent.

California Labor Code Section 3351 defines who is an employee and, therefore, who must be covered under a workers' compensation policy, subject to any applicable exclusion. California Labor Code Section 3352 automatically excludes certain workers from the definition of "employee", and provides how other specific workers may waive coverage. This Section does not prohibit an employer from choosing to provide workers' compensation insurance coverage for these workers if the employer desires to do so. Whether a business is a sole-proprietorship, partnership, Limited Liability Company or a corporation, it is beneficial to develop a working relationship with a reliable, competent broker-agent who can explain coverage eligibility issues and present options based on the organizational model of a business.

How Is Workers' Compensation Insurance Purchased?

Employers must purchase workers' compensation insurance from either a licensed insurance company or through the State Compensation Insurance Fund (State Fund). Employers may also have the option to self-insure for workers' compensation.

A commercial broker-agent can assist a business with purchasing workers' compensation insurance from a licensed insurance company and can provide information regarding State Fund and self-insurance. Also, information regarding insurance companies that are licensed to sell workers' compensation insurance, and an online rate comparison of the top 50 workers' compensation insurers, can be accessed on the California Department of Insurance (CDI) website at www.insurance.ca.gov.

State Fund is a state-operated entity that exists in order to transact workers' compensation on a non-profit basis. State Fund competes with private workers' compensation insurance companies for business and also operates as the insurer of last resort if private companies are not willing to offer workers' compensation insurance.

Businesses that are interested in learning more about State Fund can contact State Fund directly by using the information provided in the "Resources" section of this brochure or a licensed commercial broker-agent.

To become self-insured, a business must obtain a certificate from the DIR's Office of Self-Insurance Plans (OSIP). Private employers must post security, or enter into alternative security deposit program agreements with the Self-Insurers' Security Fund, as a condition of receiving a certificate of consent to self-insure.

While historically, only very large companies could self-insure because of legal requirements, in recent years, group self-insurance, in which several small employers in the same

homogenous industry pool their workers' compensation liabilities, has increased in popularity as an alternative to traditional coverage.

For complete information on workers' compensation self-insurance, contact the OSIP with the information shown in the "Resources" section.

What Happens If an Employer Fails to Purchase Workers' Compensation Insurance?

Employers that fail to purchase workers' compensation insurance are in violation of the California Labor Code. The Division of Labor Standards Enforcement (DLSE) has the authority to issue a stop order against any employer that is discovered to be unlawfully uninsured for workers' compensation. A stop order closes down business operations until workers' compensation insurance is secured. Besides issuing a stop order, the DLSE can assess fines based on whether an employer has been discovered to be unlawfully uninsured through normal investigation or through the filing of an injured worker's claim with the Uninsured Employers Benefits Trust Fund.

Failing to have workers' compensation coverage is a criminal offense. Section 3700.5 of the California Labor Code makes it a misdemeanor punishable by either imprisonment in the county jail for up to one year, a fine of up to double the amount of workers' compensation premium that would have been necessary to secure coverage during the illegally uninsured period (in an amount not less than $10,000), or both. Additionally, the state issues penalties of up to $100,000 against illegally uninsured employers. If an employee gets hurt or sick because of work and the employer is not insured, the employer is responsible for paying all bills related to the injury or illness. Employers may want to contact the Information and Assistance Officer at their local DWC office for further information. Workers' compensation benefits are the exclusive remedy for injuries suffered on the job only when the employer is properly insured.

If an employer is illegally uninsured and an employee gets sick or hurt because of work, the employee can file a civil action against the employer in addition to filing a workers' compensation claim.

Employers that fail to pay required benefits may also be liable to reimburse the Uninsured Employers Benefits Trust Fund. Employers can be prosecuted for insurance fraud for the willful failure to secure workers' compensation insurance as required by law. The CDI works closely with other agencies to investigate potential instances of fraud and also works with local district attorneys' offices to prosecute those caught violating the law.

What Is the Uninsured Employers Benefits Trust Fund and the Subsequent Injuries Benefits Trust Fund?

When a work-related injury or illness occurs to an employee, and the employer is unlawfully uninsured for workers' compensation, the employee can file a claim with the Uninsured Employers Benefits Trust Fund (UEBTF).

The UEBTF steps in and handles workers' compensation claims when the employer has no insurance or has failed to pay or post a bond in order to pay the compensation owed to the injured worker. The UEBTF will attempt to recover the amounts paid on behalf of an uninsured employer. Please see the "Resources" section of this brochure for contact information regarding the UEBTF.

An employee who has a previous permanent disability or impairment and suffers a subsequent workplace injury or illness may be eligible to receive additional compensation from the Subsequent Injuries Benefits Trust Fund (SIBTF). The combined permanent disability must be at least 70 percent to qualify and additional eligibility requirements must be met. It is important to note that employers are not liable under workers' compensation law for the combined disability of an injured worker if part of the injury is due to non-industrial factors. An employer is only liable for that portion of compensation that is owed to the worker from the later work-related (not previous) injury. For further information on the SIBTF, see the contact information located in the "Resources" section of this brochure.

How Is Workers' Compensation Premium Calculated?

Classification

Workers' compensation premium calculations are based on how employers are classified according to their operations and the rate assigned to each corresponding employer classification. Classifications that group distinct and identifiable occupations, industries, or business are developed and assigned codes by the Workers' Compensation Insurance Rating Bureau of California (WCIRB) and are approved by the Insurance Commissioner. Workers' compensation insurers generally use these classifications when writing workers' compensation policies. Insurance companies are allowed to develop and submit their own classification system to the CDI for

approval, but this is uncommon due to the strict standards required to file a separate workers' compensation classification system. The WCIRB provides a policyholder ombudsman, who is available to answer questions from employers on classification, experience modification, and rating issues. Please see the "Resources" section at the end of this brochure for contact information regarding the WCIRB and the policyholder ombudsman.

Open Rating

Workers' compensation insurers assign a specific rate to each industry classification code. These rates must be filed with the CDI. Currently, California workers' compensation insurers operate under an "open" rating system. This means that individual companies set rates based on their ability to adequately cover losses and expenses in each industry classification. Open rating requires that all workers' compensation insurers file their rates and all applicable supplementary rate information with the CDI before they may be used. Rate review is based on many factors. One of the most important factors for rate review is rate adequacy.

Rates must be adequate to maintain the solvency of an insurance company. Adequate rates also act to secure the proper surplus monies insurance companies are required to have in order to meet potential and continuing claim obligations. The Insurance Commissioner will not allow rates if they are inadequate to cover an insurer's losses and expenses, are unfairly discriminatory, or if they tend to create a monopoly in the marketplace. The Commissioner does not have the authority under law to disapprove rates that may be considered excessive only.

Premium Modification

The classification code with its corresponding rate is the first part of premium calculation. The rate itself is expressed in dollars and cents. The payroll for each classification is estimated and then multiplied (per each $100 of payroll) by the applicable rate. The sum of the equation is referred to as the "base" premium. The base premium continues to be modified (increased or decreased) using rating plans (usually schedule or judgment rating) and by experience modification. (Please see the "Glossary" section for definitions of schedule and judgment rating.)

Experience Modification

An employer's experience modification is calculated from payroll and loss information that insurance companies are required to submit to the WCIRB on an annual basis. The WCIRB uses a mathematical formula approved by the CDI to calculate an experience modification for each qualifying employer. The formula takes into account the employer's payroll and losses (paid losses and loss reserves) for an experience period. The experience modification compares the loss (or claims) history of the employer to all other employers in the same industry that are similar in size. Generally, an experience modification of less than 100% reflects better-than-average experience, and an experience modification of more than 100% reflects worse-than-average experience. When the experience modification is applied to the base premium, along with any other modifications (schedule or judgment), the estimated premium is established.

Prospective Rating

The basic workers' compensation rating formula illustrated above is called prospective rating. While workers' compensation premiums can be calculated using different rating plans (such as dividend plans or retrospective rating), prospective rating is the most common workers' compensation premium calculation rating method. Businesses interested in learning more about workers' compensation rating methods should contact a licensed broker-agent for further information.

Premium Audit

The final premium of a workers' compensation policy cannot be calculated until the policy term is over and the employer's payroll records have been audited. The final audit of payroll records determines if the initial payroll estimate was either high or low. If the payroll has gone up from the estimate, then the employer will owe additional premium. If the payroll has gone down from the estimate, then the insurance company will owe the employer a return premium. Since many employers experience fluctuating payrolls, some workers' compensation insurers offer a monthly payroll reporting option. If monthly reporting is not available, the employer can work closely with its broker-agent or insurance company underwriter to report any large payroll fluctuations during the policy term. Corrected payroll estimates during the policy term can help minimize the possibility of a large premium audit bill or a large return premium, which can significantly affect the cash flow of a business.

Employers need to be aware that workers' compensation insurers generally have the right to audit payroll records during the policy period and within three years after the policy period ends. Usually this right is reserved for the final audit, but an insurance company can conduct interim audits

as well. Failure to comply with an insurance company's audit can lead to the cancellation or non-renewal of a policy, and insurance companies can use all legal means at their disposal to collect outstanding premiums. In addition, an employer that fails to allow an insurer audit may be liable to pay a total premium equal to three times the estimated policy premium. Further, the WCIRB can promulgate experience modifications using reported losses but excluding unaudited payroll, which typically results in an increased experience modification from the prior years'. It is important to be aware that the deliberate under-reporting of payroll is considered insurance fraud and can be prosecuted to the fullest extent of the law. The WCIRB also has the right to conduct an audit of an employer's payroll records, which allows it to evaluate the accuracy of the payroll audit performed by the insurer.

Does the CDI Handle Workers' Compensation Claim Issues?

It is important to note that most disputes between injured workers and workers' compensation insurers do not come under the jurisdiction of the CDI [1]. The DWC assists employers and employees with workers' compensation claims. If an employer or employee has a question or concern regarding a workers' compensation claim, he/she can contact the DWC's Information and Assistance Unit.

When disputes arise regarding a workers' compensation claim, the DWC's Information and Assistance Unit can assist an unrepresented injured worker in resolving the dispute. If the Unit is unable to resolve the dispute, a formal Application for Adjudication (dispute resolution) can be filed with the DWC. The Information and Assistance Unit may be able to help an injured worker file the Application with the DWC unless an attorney has been retained. The DWC has exclusive jurisdiction over workers' compensation claim disputes.

[1] In specific instances, CDI does investigate the fraudulent submission or denial of workers' compensation claims (California Insurance Code Section 1871.4).

An employer or employee can contact the DWC using the information provided in the "Resources" section of this brochure. The "Resources" section includes specific contact information for the Information and Assistance Unit and DWC. Also, an employer should be able to discuss any general workers' compensation claims issue with its broker-agent or discuss a specific claim with the claims adjuster who has been assigned to handle the claim by the workers' compensation insurer.

What Workers' Compensation Issues Does the CDI Handle?

The CDI primarily deals with rating and underwriting issues involving workers' compensation insurance. Consumers can contact the CDI with a variety of workers' compensation rating and underwriting concerns.

The following is a list of common consumer issues under the jurisdiction of the CDI regarding workers' compensation insurance:

- Insurer compliance with filed rates
- Rating errors
- Classification and experience modification disputes
- Failure to provide loss history reports
- Cancellation and nonrenewal notices
- Audit disputes
- Dividend plans
- Broker-agent handling
- Insurance fraud

Title 10, California Code of Regulations (CCR) Sections 2509.40 – 2509.78 list detailed procedures for disputing experience modifications and classification assignments, including appeals to the CDI. Please contact the CDI through the information given in the "Talk to Us" section of this brochure when you experience workers' compensation rating and underwriting difficulties. In most cases, we can assist consumers in resolving workers' compensation issues regarding rating and underwriting. If it is determined that the CDI does not have jurisdiction, we will refer consumers to the appropriate state agency for assistance.

Also, it is important to contact the CDI regarding any suspected workers' compensation fraud. Fraud reports can be filed with the CDI on an anonymous basis. The more complete and credible the information, the greater the chance of apprehending and prosecuting those involved in workers' compensation fraud.

Frequently Asked Workers' Compensation Questions

Q: What is a loss reserve?

A: Insurance companies use loss reserves to evaluate the monetary worth of each claim. A loss reserve is an estimated amount of money that the insurance company sets aside, or earmarks, to pay for a claim. It is usually up to a claims adjuster to set the loss reserve, utilizing judgment

and experience from prior, similar claims. Adequate loss reserves help determine how much money an insurance company must have in surplus to meet current, emerging, and future claims obligations. Insurance companies must report workers' compensation loss reserves, along with other claim reporting information, to the WCIRB, as this information is used by the WCIRB to calculate experience modifications. Poor loss reserve practices can put an insurance company in financial jeopardy, as both overestimating and underestimating loss reserves (to fund potential obligations) can lead to a misallocation of funds required to pay out claims, and creates an inaccurate picture of an insurer's financial obligations. When there are not enough funds reserved to meet future obligations, an insurer's solvency will be negatively impacted.

Conversely, if too many funds are reserved, the experience modification may become inflated, leading to the need to unfairly raise the insureds' premiums. Since maintaining insurer solvency is of high importance, loss reserves must be as accurate as possible and revised regularly based on the most current claims information available.

Q: How does an employer request a workers' compensation premium and loss history report?

A: Workers' compensation premium and loss history reports (commonly referred to as loss runs) must be requested in writing by the policyholder or by the policyholder's authorized broker-agent. The insurance company has 10 business days to comply with this request under the following circumstances outlined in California Insurance Code Section 11663.5: (1) the policy is cancelled or nonrenewed; (2) the policyholder requests the information within 60 days prior to the renewal date of an existing policy; (3) the policyholder's current insurer's rating is downrated by a nationally recognized insurance rating service to a financial rating below secure or good or to a rating that would negatively impact the ability of the policyholder to conduct its business operations; and (4) the policyholder's current insurer is conserved by the department or is ordered to cease writing business.

If an insurance company fails to comply with a written request for loss runs under the provisions of California Insurance Code Section 11663.5, contact the CDI for assistance by using the information provided in the "Talk to Us" section located at the end of this brochure.

Q: What is a minimum premium?

A: Insurance companies have minimum premium amounts in place to cover the expenses involved in issuing and servicing policies. When the payroll of a company is small, it is possible that the premium generated from the premium calculation will be very low. If the calculated premium is so low that the insurer cannot meet even basic expenses, it is not a sound financial practice to insure the risk, as the insurer would be losing money before any claim had occurred. By setting a minimum premium, an insurance company determines the smallest acceptable premium that it is willing to charge in order to accept a risk. Each insurance company must file its minimum premium requirements with the CDI as part of its rating plan.

Q: What happens when an employer cancels a policy during the policy year?

A: When an employer cancels a workers' compensation policy in the middle of a policy year (mid-term) in order to secure insurance with another company or to close a business, the insurance company will return any unexpired, or unearned, premium on a pro rata basis, unless the insurer discloses to the policyholder in accordance with California Insurance Code Section 481(c) that cancellation will be on a short rate basis. A short rate is an administrative penalty assessed to the policyholder for failure to complete the contracted term of insurance. An insurance company may charge a minimum premium for the cancelled policy if the short rate cancellation amount is less than the minimum premium in order to cover expenses. If an employer experiences problems with a cancellation or a premium refund issue, it can contact the CDI by using the information available in the "Talk to Us" section of this brochure.

Q: How does the insolvency of an insurance company affect outstanding claims?

A: Fortunately, there is protection for both employers and employees when a workers' compensation insurer becomes insolvent. The Insurance Commissioner oversees the conservation and liquidation of California insurance companies under appointment of the courts. The Conservation and Liquidation Office (CLO) of the CDI is responsible for handling the details of conservation and liquidation. Because the payment of workers' compensation claims is crucial, the CLO works very closely with the California Insurance Guarantee Association (CIGA) to help ensure the timely payment of claims. This helps to relieve the burden employers and employees experience when

an insurance company becomes insolvent. CIGA acts as a safety net and guarantees that claim payments will continue to be made whether or not the insolvent insurance company's liquidated assets are enough to cover claims. For more information on the conservation and liquidation process, contact the CDI through the information available in the "Talk to Us" section of this brochure. Also, the "Resources" section of this brochure contains contact information for CIGA.

Q: What exactly is a dividend plan?

A: A dividend plan is a type of rating plan that allows an employer to share in the profits of its workers' compensation insurer in the form of a dividend. Because the employer participates in the profits of the insurer, dividend plans are often referred to as participating insurance policies. There are various types of dividend plans with different provisions and requirements. Under these types of plans, the payment of a dividend is typically contingent upon the profitability of the insurer, and may also be contingent upon the loss experience of a particular insured. An employer interested in pursuing other options to prospective rating (please see the "Prospective Rating" paragraph under the "How Is Workers' Compensation Premium Calculated?" section), should contact its broker-agent for discussion and further information. All dividend plans must be submitted along with all other rating plan information to the CDI for approval.

Q: Can an insurance broker-agent or insurance company guarantee the amount of a future workers' compensation dividend?

A: The California Code of Regulations (CCR) clearly states that broker-agents or insurance companies cannot guarantee or in any way promise the payment amount of future workers' compensation dividends (see Title 10, Chapter 5, Subchapter 3, Article 9, Section 2504). A broker-agent, or other company representative, can provide past dividend payment amounts for illustration purposes, but the policyholder dividend statement cannot directly or indirectly imply the amount of future dividend payments. If an employer feels that a broker-agent or company representative is in any way misrepresenting its dividend plan, especially by directly or indirectly promising future dividend results, the employer should contact the CDI immediately through the information provided in the "Talk to Us" section of this brochure.

Q: What can an employer do if there is a dispute regarding a workers' compensation classification code?

A: If an employer questions its workers' compensation insurance company's assignment of a classification code, the employer should contact the broker-agent or insurance company underwriter for a discussion and/or explanation of the classification code in question. If an insurance company changes a classification code that results in an increased premium, the insurance company must inform the employer of the change in writing within 30 days in accordance with California Insurance Code Section 11753.1(b) (unless the reclassification is the result of a CDI regulation or under the authority of the Insurance Commissioner). If there continues to be a dispute regarding an existing or reclassified code, the employer can file a written complaint with its insurer, and if the employer still does not obtain any relief, it can file an appeal with the CDI. (Please see the contact information listed in the "Talk to Us" section.) Similarly, if an employer wants to dispute a classification decision made by the WCIRB, the employer can file a written inquiry with the WCIRB. If the inquiry is denied or is not responded to within 90 days, the employer may pursue its dispute by serving the WCIRB with a Complaint and Request for Action (CRFA). If the CRFA is rejected or not acted upon within 30 days, the employer can contact the CDI and file an appeal. (Please note the contact information for the WCIRB can be found in the "Resources" section of this brochure.) Finally, refer to the "What Workers' Compensation Issues does the CDI Handle?" section of this brochure for related information on the appeals process for classification and experience modification issues.

Glossary

Agent
A licensed individual or organization authorized to sell and service insurance policies for an insurance company.

Agreed Medical Evaluator (AME)
A physician who may be selected by the parties, when an injured worker is represented by an attorney, to assess any disputed medical-legal issues.

Binder
A short-term agreement that provides temporary insurance coverage until the policy can be issued or delivered.

Broker
A licensed individual or organization who sells and services insurance policies on behalf of the insured employer.

Broker-agent
A licensed individual who can act as an agent representing one or more insurers, and also as a broker dealing with one or more insurers representing the insured employer's interests.

Cancellation
The termination of an in-force insurance contract by either the insured or the insurer before its normal expiration date.

Claim
Notice to an insurance company that a loss has occurred that may be covered under the terms and conditions of the policy.

Claims Adjuster
In workers' compensation, the person who evaluates and handles workers' compensation claims and determines the amounts to be paid under the policy terms.

Commercial Lines
Insurance coverages for businesses, commercial institutions, and professional organizations, as contrasted with personal insurance.

Commission
A portion of the policy premium that is paid to an agent by the insurance company as compensation for the agent's work.

Conditions
The portion of an insurance contract that sets forth the rights and duties of the insured and the insurer.

Consequential Bodily Injury
In workers' compensation, special circumstances can arise when a work-related injury causes some sort of non-work-related injury.

Coverage
Protection that is provided under an insurance policy.

Declarations (DEC) Page
Usually the first page of an insurance policy that contains the full legal name of the insurance company, the policy number, effective and expiration dates, premium payable, the amount and types of coverage, and the deductibles, if any. May also be referred to as the Information Page.

Deductible
The amount of the loss that the insured is responsible to pay before benefits from the insurance policy are payable.

Dual Capacity
In workers' compensation, an employer may be liable two ways to an employee who incurs bodily harm on the job as a result of using a product or service produced by that employer. The employee is eligible for workers' compensation benefits and may also sue the employer because of the defectiveness of the injuring product or service.

Earned Premium
The portion of the policy premium paid by an insured that applies to the expired portion of the policy and has been allocated to the insurance company's loss experience, expenses, and profit year-to-date.

Effective Date
The starting date of an insurance policy; the date the policy goes into force.

Endorsement
"Endorsement" or "endorsement form" means a form, agreement or document that amends, adds to, subtracts from, supplements, or revises a policy form and is attached to a policy form to be effective.

Exclusion
A contractual provision in an insurance policy that denies or restricts coverage for certain perils, persons, property, or locations.

Experience Modification
A rating factor, which is expressed as a percentage, that is used to adjust the workers' compensation premium of qualifying employers. An experience modification compares the loss or claims history of the insured employer to all other employers in the same industry that are similar in size. Generally, an experience modification of less than 100% reflects better-than-average experience, and an experience modification of more than 100% reflects worse-than-average experience.

Expiration Date
The termination date of coverage as indicated on an insurance policy.

First Party
The policyholder (insured) in an insurance contract.

Flat Cancellation
Cancellation that takes place on the policy effective date. No premium charge is made; however, other charges (i.e., service) may apply.

Fraud
An intentionally deceptive act committed to obtain an unfair or unlawful advantage. Fraud usually involves monetary gain.

Frequency
The number of times a loss occurs.

Hazard
A circumstance that increases the likelihood or potential severity of a loss.

Indemnity
In a property and casualty contract, the objective is to restore an insured to the same financial position after the loss that the insured had prior to the loss. In the most basic sense, indemnity is compensation for a loss.

Independent Adjuster
A person or organization that provides claims adjusting services to different insurers on a contract basis.

Insurance
A method of shifting risk from a person, business, or organization to an insurance company in exchange for the payment of premium. The insurance company commits to be responsible for covered losses.

Insured
The policyholder(s) entitled to coverage under an insurance policy.

Insurer
The insurance company that issues insurance and agrees to pay for losses and provide covered benefits.

Judgment Rating
A rating modification (either decrease or increase) that is based on the underwriter's experience, best judgment, and analysis in classifying and underwriting a particular type of risk.

Lapse
In property and casualty insurance, a lapse is the termination of a policy because of a failure to pay premium when due, or when an employer's policy ends without the employer having new coverage to replace it.

Liability Insurance
Coverage for a policyholder's legal liability resulting from injuries to other persons or property damage.

License
A certificate of authority issued by the CDI to an insurer, agent, broker, or broker-agent to transact insurance business.

Limits of Insurance
The maximum amount of benefits the insurance company agrees to pay in the event of a loss.

Managing General Agent (MGA)
An agent contractually authorized by an insurance company to manage all or part of the insurer's business activities. An MGA can manage the marketing, underwriting, policy issuance, premium collection, appointing and supervision of other agents, claims payments, and reinsurance negotiations of an insurance company.

Material Misrepresentation
A factual falsification made in such a manner that the insurance company would have refused to insure the risk if the truth had been known at policy issuance.

Misquote
An incorrect estimate of an insurance premium.

Nonpayment of Premium
Failure by the policyholder to pay the premium on a policy or pay the installment premium payments due on a policy.

Nonrenewal
The termination of an insurance policy on its normal expiration date.

Occupational Accident
A work-related accident that injures an employee.

Occupational Disease
An illness contracted as a result of employment-related exposures and conditions.

Occupational Hazard
A condition in an occupation and surrounding work environment that increases the peril of accident, illness, or death.

Occurrence
A liability insurance policy that covers claims arising out of occurrences that take place during the policy period, regardless of when the claim is filed.

Personal Line
Insurance written on the personal and real property of an individual (or individuals) to include such policies as homeowners' insurance and personal auto insurance, as contrasted with commercial lines.

Policy
A contract that states the rights and duties of the insurance company and the insured.

Premium
The monetary payment that an insured makes to an insurance company in exchange for the contract indemnifying the insured against potential loss. Simply put, this is the payment made by the insured to keep an insurance policy in effect.

Producer
A term used by the insurance industry to refer to agents, brokers, broker-agents, and solicitors.

Pro Rata Cancellation
A cancellation of a policy by an insurance company that returns the unearned premium to the policyholder (the portion of the premium for the remaining time period that the policy will not be in force).

Provisions
The statement of policy conditions in an insurance policy.

Qualified Medical Evaluator (QME)
Appointed and regulated by the DWC's Medical Unit, a QME assesses an injured worker's permanent impairment and limitations and evaluates a wide variety of disputed medical-legal issues. Often, a QME performs a separate medical evaluation when the treating physician's assessment is disputed.

Quotation
An estimate of the cost of insurance based on the information supplied to the agent, broker, broker-agent, or the insurance company.

Regulations
Requirements developed by a state agency, including the CDI, that implement laws passed by the legislature. Regulations go through a public comment process and must be approved by the state Office of Administrative Law.

Reinstatement
The restoration of a lapsed or cancelled policy.

Renewal
The continuation of an insurance policy (offer of renewal) into a new term from the same insurance company that issued the existing policy.

Schedules for Rating Permanent Disabilities
The schedules that are used to determine the percentage of permanent disability of an injured worker.

Schedule Rating
A method of pricing property and liability insurance. Schedule Rating uses debits and credits to modify a base rate figured by the special characteristics of the risk exposure. Insurers develop Schedule Rating because actuarial experience shows a direct relationship between certain physical characteristics and the possibility of loss. All schedule rating plans must be filed with the CDI.

Second Party
The insurance company in an insurance contract.

Resources

California Department of Industrial Relations
Division of Labor Standards Enforcement
Headquarters:
1515 Clay Street, Room 401
Oakland, CA 94612
Phone: 510-285-2118
Web site: www.dir.ca.gov/dlse/dlse.html

Division of Workers' Compensation (DWC)
1515 Clay Street, 17th Floor
Oakland, CA 94612
Mailing Address:
PO Box 420603
San Francisco, CA 94142
Phone: 510-286-7100
Website: www.dir.ca.gov/dwc/dwc_home_page.htm

Division of Workers' Compensation (DWC)
Information and Assistance Unit
Phone: 800-736-7401

Division of Workers' Compensation (DWC)
Uninsured Employers Benefits Trust Fund
Los Angeles Claims Unit: 213-576-7300
Oakland Claims Unit: 510-286-7067

Division of Workers' Compensation (DWC)
Subsequent Injuries Benefits Trust Fund
Sacramento Unit: 916-928-4601

Division of Workers' Compensation (DWC)
Medical Unit
PO Box 71010
Oakland, CA 94612
800-794-6900
Website: www.dir.ca.gov/dwc/MedicalUnit/imchp.html

California Department of Industrial Relations
Office of Self Insurance Plans (OSIP)
11050 Olson Drive, Suite 230
Rancho Cordova, CA 95670
Phone: 916-464-7000
Fax: 916-464-7007
Website: www.dir.ca.gov/osip

California Department of Industrial Relations
Workers' Compensation Appeals Board
There are 24 district offices and satellites located in CA
Recorded information: 800-736-7401
Website: www.dir.ca.gov/dwc/dir2.htm

California Insurance Guarantee Association (CIGA)
PO Box 29066
Glendale, CA 91209-9066
Phone: 818-844-4300
Website: www.ciga.org

State Compensation Insurance Fund (State Fund)
P.O. Box 8192
Pleasanton, CA 94588
Phone: 888-782-8338
Website: www.statefundca.com

Workers' Compensation Insurance Rating Bureau (WCIRB)
1901 Harrison Street, 17th Floor
Oakland, CA 9612
Phone: 888-CA-WCIRB (888-229-2472)
Fax: 415-778-7272
Website: www.wcirb.com

Policyholder Ombudsman
Workers' Compensation Insurance Rating Bureau
1901 Harrison Street, 17th Floor
Oakland CA 94612
Attn: Policyholder Ombudsman
Phone: 415.778.7159
Fax: 415.371.5288
Email: ombudsman@wcirb.com
Twitter: @wcirbombud

Led by Insurance Commissioner Ricardo Lara, the California Department of Insurance is the consumer protection agency for the nation's largest insurance marketplace and your best resource for honest and impartial answers to insurance questions. Knowledgeable insurance professionals are available through our consumer hotline. Call 1-800-927-HELP (4357) or visit www.insurance.ca.gov to view all of our consumer information guides and insurance resources. These tools are available to consumers free of charge.

Filing a Complaint (Request for Assistance)

CDI is committed to protecting your rights. Many questions can be answered over the phone. If we are unable to resolve the issue over the phone, you can file a Request for Assistance form by mail or online on our website. The system will allow you to attach copies of all necessary documents, such as policies, canceled checks and correspondence. Some examples of the issues the Department may be able to help with include:

- Improper Denial of Claim
- Cancellation or non-renewal of a policy
- Delay in settlement
- Alleged misappropriation of premiums paid
- Alleged misrepresentation by an Agent/Broker or solicitor
- Unfair underwriting practices
- Dishonest or deceptive insurance sales tactics

Contact Us

Consumer Assistance Hotline:
1-800-927-4357
TTY 1-800-482-4833
Visit us on the web at:
www.insurance.ca.gov
To order additional materials contact
Community Relations & Outreach at:
crob@insurance.ca.gov

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