Training Manual – IC-1 Information Report Purpose of Guide

This guide is intended to provide the preparer sufficient information to correctly complete this report. It is also intended to provide guidance to the responsible self-insurance officials certifying to the accuracy, completeness and reasonableness of disclosures made therein. In this regard, one of the presumptions of granting the privilege of self-insurance is that the self-insured Maryland employer has the management systems and controls in place to comply with the workers compensation laws and regulations and to provide adequate and timely reports on the cost of claims. Failure to do so can result in the loss of the self-insurance privilege.

Authority

The principal provisions of the law governing workers' compensation self-insurance in the State of Maryland are set forth in Maryland Annotated Code, Labor and Employment Article (LE) § 9-404 and 405. Specifically, the reporting provisions are LE § 404(i) and § 405(e).

Under the regulatory authority granted to the Commission, the principal reporting requirements are further defined as the submission of an annual audit report, an annual Information (Claims) Report and a tri-annual actuarial report. These provisions are set forth in the Code of Maryland Regulations Title 14.09.14.04 and 14.09.13.08. The Commission has prescribed the use of Form IC-1 – Annual Information Report to satisfy the claims reporting provision of the Code.

The Commission has adopted a fiscal year cycle for the submission of the IC-1 report. Each year at the end of June or first week of July, the Commission announces the availability of the updated IC-1 form on its website and its submission due date of September 1. Each self-insurer is granted the option of using a cutoff date for claims data of up to six months from June 30 as long as it is consistently applied from year to year.

The information that is vital in the discussion of the Self-Insurer program and the completion of the IC-1 Information Report is found in the **Code of Maryland Regulations (COMAR) - Title 14 Independent Agencies; Subtitle 09 WCC. Chapter 13 – Individual Employer Self-Insurer – Rule .01 through Rule .12.**

For a more detailed examination of the rules you can go to the Workers' Compensation Commission home page at www.wcc.state.md.us. Click on the "Claims & Adjudication" drop down window. Proceed to COMAR/Maryland Register Online; click on COMAR

Online, click on Search a specific Title; click on 14 independent agencies; enter 14.09.13.08. These **Reporting Requirements** address the specific reporting obligations of the Self-Insurers. They are also presented below in detail.

Rule .08 - Reporting Requirements: A.

Financial Reports.

(1) A self-insurer shall file an annual audited financial report and 10K reports, if applicable, with the Commission within 120 days of the end of the reporting period. An extension may be granted upon written request of the Commission.

2) The self-insurer shall submit interim reports as requested by the Commission. **B. Claims Reports.**

(1) A self-insurer shall maintain true and accurate records of workers' compensation paid and incurred costs and case reserves on each claim in indemnity, medical and allocated costs paid and reserves for each claim. This information shall be provided annually to the Commission or more frequently if requested by the Commission.

(2) Reports submitted by a service company or third-party administrator on behalf of the self-insurer shall be treated as if they were submitted by the self-insurer directly. **C. Penalty.**

(1) After notice and opportunity for a hearing, the Commission may assess an individual employer self-insurer that the commission finds to be in violation of this regulation a fine not exceeding $1,000 for each violation.

(2) Failure to pay a fine assessed under this section may result in revocation of self-insurance status. **D. Reserves.**

A self-insurer shall evaluate and maintain adequate records of the past, present, and future liability of all claims incurred under its self-insurance program, including their closed and current claims in addition to reserves for future anticipated costs. Future anticipated costs shall represent the expected total cost of compensation over the life of each claim, based on all available information at the valuation date. Annually required reserves reports

shall also include estimates of incurred but not reported costs applicable to open claims, closed claims and claims which have occurred, but have not yet been reported.

E. Change In Ownership or Financial Condition.

(1) A self-insurer shall notify the Commission within 30 days of a change in majority ownership. Existing parental guarantees may not be released until an acceptable replacement guarantee is received by the acquiring parent company.

(2) A self-insurer or parent guarantor that amends its organizational documents to change its identity, status, or business structure, including merger, acquisition, and disposition, shall promptly notify the Commission in writing. All legal agreements and instruments that obligate the self-insurer, guarantors, excess carrier, or security provider shall be updated by the provider within 30 days. The Commission may request copies of documents or information considered necessary to determine whether an action has affected the ability of the employer to self-insure.

F. Bankruptcy and Closure.

A current or former self-insurer shall notify the Commission within 10 days by certified mail, return receipt requested, of a petition for bankruptcy or closure filing and shall provide an updated claims report as defined in Regulation .08B of this regulation.

The balance of this manual focuses on the proper information to complete the annual **Information Report (IC-1) t**he purpose for the requested information (instructions for the online completion of IC-1 are provided under separate cover at the end).

Understanding the IC-1

SECTION I – Corporate or Organization Data

The Commission may have a need to contact those individuals who have authority to speak for the organization in the areas specified. Accordingly, the name, title, address, telephone number, fax and email address should be entered. It is the practice of the Commission staff to observe corporate protocol and contact the official listed as the corporate program director or State contact before contacting any of the other listed officials. ***When there is a change in any of these officials or their location and contact information, the Commission should be notified within 60 days of the change.***

a. **Organization's Contact Person in Maryland –** Multi-State employers who operate their workers compensation program on a decentralized basis should list

the responsible individual in the local or regional office for the Maryland program. If the program is centralized, list the individual in the corporate office responsible for Maryland workers' compensation activities.

b. **Organization's In-house Legal Counsel –** It may be necessary for the Commission's Counsel to communicate with the organization's Counsel, in particular, where security and other agreements are being considered or an adjustment to the approved self-insurance plan is necessary.

c. **Organization's Chief Financial Officer –** The Commission staff may need to discuss financial statement or conditions, security and excess requirements with the CFO or his/her designee.

SECTION II – Workers' Compensation Commission Representative

Self-Insured employers who use third party administrators (TPA) to handle and adjust claims in Maryland shall provide the name, address, phone, fax and e-mail address of the TPA representative authorized to speak to the Commission on behalf of their client. If the organization also uses a Maryland lawyer (firm) to represent and appear before the Commission on disputed claims, only the TPA information should be provided. If the program is administered internally and local counsel is used to handle and adjust claims before the Commission, the information on the responsible internal administrator should be disclosed.

If either the corporate contact person or local administrator are not responsible for the content on the IC-1 report. The contact information for the preparer of the IC-1 report should be disclosed separately in an attachment to the report.

The Commission does not separately approve TPA for claim administration in Maryland. The Commission holds the self-insurer accountable for any errors or non-compliant activities of their administrator. **The Commission must be informed prior to the change in a plan administrator to include name, address, telephone, fax and email address as well as the effective date of takeover and whether the new administrator will be handling all claims or just those from date of takeover.**

SECTION III – Participating Subsidiary/Payroll Office

Any subsidiary or affiliate in Maryland that has a separate FEIN should be separately approved for self-insurance and listed in this section. Any time the name of the unit is different than that of the parent and an employee/claimant could list that name as his/her employer they should be separately approved as a self-insured subsidiary. Subsidiary entities with no employees need not be approved for self-insurance and should not be listed here. If the self-insured employer has other entities in Maryland that are covered under a commercial policy, the names, addresses and FEIN numbers should be listed in an attachment to this report. The parent or subsidiary may have employees located in different facilities throughout the State. Section IX b. requires a listing of these locations. For each subsidiary listed, identify the principal work classification, as an example- If the principal classification is: nursing-home health, public & traveling-all employees use code 8835 (The NCCI Workers' Compensation Work Comp Class Codes may be used and can be found at the following site: http://www.workerscompensationshop.com/workers_compensation_class_codes.htm), # of employees: 40; # all other employees (non-nursing or health service employees): 10. The employee count should be as of the end of the reporting period.

SECTION IV – Payroll Data

The Commission collects payroll data for two purposes. The Fiscal Services Division uses Form A-02 annual Report of Payroll to calculate an assessment on insurers and self-insures for the operation of the Commission. (LE § 9-316). The IC&R Division collects this data to use in the evaluation of loss experience.

For purposes of this report the reported payroll should be the sum of the gross payroll reported to the Maryland Department of Unemployment Insurance during the 4 quarters of the reporting period. The number of employees should be the 12-month average calculated from the reported employment on the Quarterly Unemployment Report. The gross payroll should be the same as that reported on the A-02 report unless the reporting period for the IC-1 is different than fiscal year ending June 30.

"Types of Work Performed" refers to the work performed in Maryland locations only. There are instances where the activities of a multi-state employer may vary by State. For

example, a multi-state manufacturer may not have production facilities in Maryland but only administrative and research activities. This information can have an impact on the evaluation of security requirements along with the actual loss experience.

SECTION V – Claims Data

a. Maryland Annotated Code, LE § 9-707 requires employers to report all loss time injuries to the Commission within 10 days of the accident. Since many injuries occur that do not require loss time of 3 days or more, most employers elect to report most injuries including medical only to the Commission on Form SF-1, First Report of Injury or Illness. The number of SF-1's issued during the reporting period should be reported on this line.

b. Maryland Annotated Code, LE § 9-704 and § 9-709 sets forth the time limitations for an employee to file a claim. An injured worker cannot be paid workers compensation benefits until a claim is filed whether disputed or not. (COMAR 14.09.06.01) Form C-40, Claim Filing Acknowledgement, also provides the right to dispute the injured worker's claim based on specified contesting issues. The number of C-40's received during period should be reported here.

c. Injuries reported in (a.) above may not all involve loss time, medical or compensation. The count of claims with injuries, and paid or incurred losses, during the period should be readily available on the loss run for the period and agree with the number of internal claims set up to track losses on the injuries.

SECTION VI – Reserves*

There are two related accounting authorities that have established standards for the recording and reporting of loss contingencies. The expectation is the self-insurer will follow the applicable principles set forth in these documents when estimating ultimate loss liabilities. They are FASB Statement No. 5 Accounting for Loss Contingencies (Commercial Enterprises and Not-For-Profits) and GASB No. 10 – Accounting and Reporting for Risk Financing and Related Insurance Issues (Government Agencies)

a. Ultimate loss net of payments:

There are two categories of loss reserves. (1) Those losses which are known and can be reasonably estimated on a claim-by-claim basis (b. below) are referred to as open

reserves, and (2) those losses not yet known but can be reasonably predicted using primarily actuarial estimates to derive at the ultimate loss liability estimate and is commonly referred to as estimates of Incurred But Not Reported (IBNR) losses. IBNR losses are not known by the employer/insurer until years after the accident has occurred. Examples are claims that have been closed but must be reopened due to worsening condition. Some liability claims may be filed long after the event that caused the injury to occur. Asbestos-related diseases, for example, do not show up until decades after the exposure. IBNR also refers to estimates made about claims already reported but where the full extent of the injury is not yet known. Insurance companies and self-insurers should regularly adjust reserves for such losses as new information becomes available.

Under COMAR 14.09.13.06(C)(2), the Commission requires the submission of an independently prepared actuarial estimate of ultimate loss liability every three years. On the two intervening years, the self-insurer may use alternative methods to derive an ultimate loss estimate such as those used in the audited financial statements. The auditors for larger organizations usually rely on independently prepared actuarial reports on an annual basis. The Commission will accept such estimates in the off years. If such reports are based on a multi-state estimate, a logical and reasonable allocation formula can be used. If the independent auditors do not use an actuarial estimate, the Commission will accept whatever method used by the auditors as long as it conforms to the two accounting authorities cited above. Another method is an internally prepared (or TPA prepared) actuarial estimate. Estimates that vary substantially from the ratio of open reserves to ultimate loss liability, as computed in the year the actuarial study was completed, require explanation. A footnote should be provided in the accompanying documentation describing the method used and any major variation with prior year report. The amount reported here should be the sum of open reserves plus an IBNR estimate net of any expected excess or third-party reimbursements.

b. Total value of open claim liability (case reserves) for all years:

This amount is the total of all unpaid losses net of any excess or third-party payments. These estimates are expected to include known, reasonably predictable outcomes for the life of the claim as soon as it can be evaluated for future permanency and medical treatment. For example, LE § 9-927 sets forth compensation award amounts where loss

of limb occurs. While the injured worker may be receiving temporary benefits, it is expected that a reserve will be made for a permanent disability award and for major surgery if applicable. Waiting for the claimant's attorney to file for permanency or major surgery before a reserve is established is not considered a timely reserving practice if the nature and extent of the injury liability could have been predicted earlier in whole or in part. Failure to make adequate and timely reserves on active claims can result in substantial increases in security requirement. Consistent patterns in under reserving can be cause for termination. The Commission's determination of the adequacy of reserves will be based on the reserve established as of the cutoff date for the IC-1 report only. The individual claims on which reserves have been established should be verifiable to the accompanying loss run.

SECTION VII – Incurred Losses:

The Commission considers incurred losses by year of accident as opposed to paid losses by year of payment more predictive of future loss trends and, in most instances, uses this data to calculate security requirements. Most claims involving permanency have a life cycle of 3 to 5 years. It is also understood the nature and extent of the injury cannot always be predicted at the outset, therefore, claim development loss adjustments must be made in subsequent years to provide for the ultimate expected loss on each claim. The table provided in this section shows incurred losses for each of 3 years as adjusted for cost or loss adjustments by year.

a. Current Year: Incurred Losses (Paid and Reserves) recorded on Workers' Compensation claims resulting from injuries or occupational disease that occurred in the current year. The date of accident not the date the claim was filed controls the period in which the loss should be reported. This information should be supported by the accompanying loss run data submitted with this report. The "Originally Reported" column and "Total Incurred as Adjusted" for current year should always be the same amount.

b. First Prior Year: As a claim matures, there will be adjustments to add or change expected losses. The amount in the "Originally Reported" column for this year's report should be the same as the "Total Incurred as Adjusted" column in the previous

year's IC-1 - "Current Year" column. The amount entered into the "Adjustments To Prior Year" column should be the sum of all adjustments made during the current year to reported prior year claim losses. The "Total Incurred as Adjusted" column amount should be the total accumulated losses for accidents occurring in the previous year. This amount should agree with the total accumulated losses reported in the accompanying loss run. If the amount in the "Total Incurred as Adjusted" column is not equal to the sum of column a. and b, and explanation should be attached to this report.

c. **Second Prior Year:** The amount in the "Originally Reported" column for this year's report should be the same as the "Total Incurred as Adjusted" column in the previous year's IC-1 - "First Prior Year" row. The amount entered into the "Adjustments To (Second) Prior Year" column should be the sum of all adjustments made during the current year to losses on accidents occurring in the second prior year to this reporting period. The "Total Incurred as Adjusted" column amount for the second prior year should the total accumulated losses for accidents occurring in the second previous year. This amount should agree with the total accumulated losses reported in the accompanying loss run. If the amount in the "Total Incurred as Adjusted" column is not equal to the sum of column a. and b, an explanation should be attached to this report.

SECTION VIII – Excess Coverage and Security Deposit Information

COMAR 14.09.13.06 and .07 governs the requirements for security and excess insurance. The amount of coverage and security is determined by the Commission. Excess retention cannot be more than 5 percent of equity or unrestricted net assets and limits cannot be less than 20 times the retained amount. In this regard, the Commission may require amounts beyond the minimums when conditions warrant. COMAR 14.09.13.06(C)(1) sets forth the 6 factors considered in establishing the amount of security required by the Commission to secure the payment of employee claims. The reliability, timeliness and reasonableness of data reported to the Commission under VI and VII above is the critical component of this determination. Complete information for **ALL** fields. The appropriate response should be one of the following: Amount; N/A; Yes or No. Aggregate limits in excess policies refer to the aggregate limit of liability of the policy holder on payments in a policy period. Amounts in excess of the aggregate limit are paid by the excess carrier. Not all excess policies have provision for aggregate coverage.

a. Amount of risk retained by self-insurer: (Dollar amount or "0")

b. Excess workers compensation policy limits: (Dollar amount or "0". If statutory, enter 999,999).

c. Does your excess insurance provide for an annual aggregate limit? (Yes or No) If so, what is the annual aggregate amount? (Dollar amount or "0")

d. Name of Excess Carrier: Name or Leave Blank

e. Do you have umbrella coverage applicable to workers' compensation? (Yes or No) If yes, enter (dollar amount).

f. Amount of surety bond, security on deposit or letter of credit: (dollar amount or "0")

g. Provide name of issuer of security instrument.

SECTION IX – Additional Information

a. – j. Complete information for **ALL** sections. State None or N/A if such is the case. (Provide any applicable documentation)

a. Loss Run(s) – This document provides the detail of claims since the inception of self-insurance or 20 years whichever is shorter. The run must list each claim for the most immediate 5 years and an annual summary for each year thereafter. The loss run must provide the following information on each open and closed claim:

(1) Internal Claim Number

(2) Claimant's Name

(3) Date of accident

(4) Commission Claim Number, If Applicable – (Not all claims are submitted to the Commission). Loss time claims in excess of three days must be submitted to the Commission.

(5) Status (Opened or Closed)

(6) Paid Losses (Amount) – Compensation, Medical Other, Total

(7) Incurred Losses (Amount) – Compensation, Medical Other, Total

(8) Reserves (Amount) – Compensation, Medical Other, Total

The Loss Run should be arranged by year based on date of accident. Each column should be subtotaled by year. After year 5, only subtotal for each of the previous years should be provided.

Totals for all reported years should be provided for each column.

The Incurred Loss amount total for each of the 3 most recent years should agree with the amount reported in Section VII. Similarly, the total reserve amount should agree with the amount reported in Section VI(b). Anytime the loss run totals do not agree with the reported amounts in Section VI and VII an explanation needs to be attached. It is assumed that all claims listed on the loss run have been reviewed for adequacy of reserves as of the report cutoff date.

Most loss runs may contain other data such as location of worker, brief description of injury etc. This data need not be eliminated before submission to the Commission. In the past, the Commission has accepted various forms of data transmission. The preferred method of submission of loss runs is on CD and in an Excel, Access or Word file. It can also be e-mailed.

b. Employee locations. List all regional, division, local and store worksites in Maryland where the number of employees is greater than ten (10) and include the number of employees at each worksite.

c. Copy of current contract with TPA, if applicable. If the previously submitted contract is still in effect, it need not be resubmitted.

d. A list of claims on which issues were filed during the reporting year by the claimant's attorney requesting the assessment of penalties. If none, so state.

e. A list of claims on which the Commission assessed penalties during the year. If none, so state

f. A statement whether there has been any change in the reporting period in accounting for WC costs as a result of auditor or internal recommendations or decision. If none, so state.

g. A list of the states in which you are self-insured for WC; and the number of states in which you have employees but are not self-insured.

h. Certificate of Status. A certificate of status for any domestic or foreign corporation doing business in the State of Maryland can be obtained at the following website **www.dat.state.md.us.** A certificate should be submitted for the TPA only, if applicable.

i. Number of independent contractors and associated payroll covered by the self-insurance program. It is expected that before self-insured employers do business in

Maryland with an independent contractor or subcontractor who has employees, they will require a Certificate of Insurance that includes Workers' Compensation. Coverage for all Maryland employers can be verified online by accessing **www.wcc.state.md.us.** Then go to Public Online Services and then select Employer Coverage Verification Inquiry. It is expected that all employers in Maryland will satisfy themselves that the individuals and firms with whom they do business are in compliance with the Maryland Workers Compensation coverage requirements. Self-insured employers should be particularly alert to the practice of reporting contract employees on Form 1099 and excluding them from their workers compensation program. The self-insured employer could be found liable for any claim wherein the so called "independent contractor" is determined to be in an employer-employee relationship because of the control exercised over the independent contractor's work activities. The self-insured employer should seek the advice of counsel on such matters. In this regard, self-insured employers can extend coverage to any contract employees as long as it is disclosed in the application and periodic reporting of payroll to the Commission.

CERTIFICATION (Online submissions accepted as certification in lieu of signatures)

A. The self-insured employer is liable for the accuracy, completeness, timeliness and reasonableness of disclosures and representations made to the Commission in this report regarding its self-insurance program. Therefore, it is expected that the self-insurer will create and maintain a system of internal control that ensures compliance with the laws and regulations under which the program operates. The principal components of the control environment should be:

(a) The parties responsible for the certification process should be trained and qualified personnel including third party administrators.

(b) There should be written procedures covering key policies. (c) There should be a system of authorization and approval for all transactions and reserves in place.

(d) There should be a separation of duties and responsibilities to minimize the potential for collusive activities.

(e) There should be documented computerized and other support systems that produce complete and accurate reports and

(f) An internal review process that periodically determines that the program is operating as intended.

B. The self-insurer should consider appointing a certifying official who has knowledge of the subject matter, including Maryland workers compensation law and regulations and reporting requirements as they relate to the organization's self-insurance program; background or experience in working with information contained in the annual Information Report; holds a position high enough in the organization to have knowledge and responsibility for the internal control system over the program and can certify to the integrity of the system producing the annual Information Report; has the delegated authority to represent the organization on self-insurance matters and to take corrective action where conditions dictate. It is expected that the IC-1 certifying official should be either the corporate Workers' Compensation Program Director or higher-level manager.

C. Errors and omissions found in this report by the Commission and its representatives could result in any one of the following actions: (1) The assessment of a penalty under
COMAR 14.09.13.08(C), (2) an increase in security under COMAR 14.09.13.06 Security Deposit Determinations, or (3) an order of termination under LE § 405(f) Revocation of Approval.