

# PROPOSED RULEMAKING

## DEPARTMENT OF LABOR AND INDUSTRY

[ 34 PA. CODE CH. 125 ]

### Workers' Compensation; Individual Self-Insurance

The Department of Labor and Industry (Department), Bureau of Workers' Compensation (Bureau), proposes the following amendments to Chapter 125, Subchapter A (relating to individual self-insurance), to read as set forth in Annex A. This rulemaking updates and clarifies the standards and procedures which govern the processing of applications for and the administration of self-insurance for individual employers under the Workers' Compensation Act (act) (77 P. S. §§ 1—1041.4, 2501—2506 and 2701—2708) and the Pennsylvania Occupational Disease Act (Occupational Disease Act) (77 P. S. §§ 1201—1603).

#### *Statutory Authority*

This proposed rulemaking is published under the authority in sections 305(a) and 435(a) of the act (77 P. S. §§ 501 and 991(a)) and section 2205 of The Administrative Code of 1929 (71 P. S. § 565).

#### *Background*

Under section 305(a) of the act (77 P. S. § 501(a)) and under section 305 of the Occupational Disease Act (77 P. S. § 1405), an employer liable for the payment of benefits under those acts may be granted an exemption from the necessity of insuring the payment of its liability with an authorized insurer. The grant of an exemption, which is commonly referred to as self-insurance status, is based on the employer demonstrating to the Department that it has the financial ability to pay the compensation provided under the acts. Subchapter A addresses technical issues such as the application procedures for self-insurance by individual employers, the materials and information that must be provided with the application, minimum requirements to be considered for self-insurance, factors used in assessing the financial ability to self-insure, financial security and excess insurance requirements and requirements to service a self-insurer's claims.

These regulations were adopted on October 13, 1995, and have seen only very limited regulatory amendments in the last 13 years. The most recent regulatory amendments followed the act of June 24, 1996 (P. L. 350, No. 57), which among other things amended sections 305 and 802 of the act (77 P. S. §§ 501 and 1036.2) and added section 819 of the act (77 P. S. § 1036.19) affecting matters relating to the requirements for self-insurance. The Department then amended, in pertinent part, §§ 125.2 and 125.9 (relating to definitions; and security requirements) at 28 Pa.B. 5459 (October 24, 1998).

By this proposed rulemaking, the Department seeks to increase clarity and consistency through the introduction of new standard terms that may be used throughout the regulations, to provide more objective standards for qualifying for and maintaining self-insurance status, and to improve and strengthen the Department's ability to efficiently and effectively monitor and regulate workers' compensation self-insurance in this Commonwealth.

On November 14, 2005, the Department held a stakeholder meeting to discuss this proposed rulemaking. All

791 employers self-insured in this Commonwealth as well as the 335 employers in runoff status were invited to the meeting. Subsequently, the Department received written comments from Henry L. Martin, of National Fuel Gas Distribution and Richard White, of Wegman's Food Markets, Inc.

Additionally, the following individuals made presentations at the meeting: Gregory Gross, of Whirley Industries; Kimberly Rzomp, of Summit Health; Patrick Larkin, of Brokerage Professionals, Inc.; Jonathan H. Rudd, Esquire, on behalf of Royal Ahold; and Lou Ann Kauffman, of the Pennsylvania State System of Higher Education.

All comments and suggestions have been reviewed and considered.

#### *Summary of Proposed Regulations*

The Department proposes to amend § 125.1 (relating to purpose) to clarify existing language.

The Department proposes to amend § 125.2 (relating to definitions) to clarify existing language, to delete the existing definition of "excess insurer," and to include definitions of the following terms: "active self-insurer," "adequate accident and illness prevention program," "authorized retention amount," "catastrophic loss estimation," "default multiplier," "default multiplier-calculated security factor," "excess indemnity insurance," "excess insurance," "financial ability to self-insure," "investment grade long-term credit or debit rating," "liability limit," "long-term credit or debit rating," "maximum quick asset exposure amount," "minimum funding amount," "minimum security amount," "nonprocurement registration number," "non-workers' compensation insurer," "NRSRO," "self-insurance loss portfolio transfer policy," "special retention amount," "standard retention amount," "workers' compensation excess insurance," "workers' compensation excess insurance recoveries" and "workers' compensation insurer."

The Department proposes to amend § 125.3 (relating to application) so that the section better reflects the application requirements. The Department proposes to replace the existing affidavit requirement with a verified statement. Under § 125.3(b), the Department proposes to allow renewal applicants to file their application 3 months before the expiration of the current permit, which is 1 month earlier than under the current language. Under § 125.3(c)(1), the Department specifies the application fees required for affiliates or subsidiaries who file a consolidated application under § 125.4 (relating to application for affiliates and subsidiaries). The Department proposes to amend § 125.3(c)(2)(i) to require that the monetary values presented in the financial statements must be in United States dollars and that the text must be in English, as well as to require that parent companies provide consolidated financial statements for both themselves and their subsidiaries. The Department proposes to amend § 125.3(c)(5) and (6) to require that loss information must be filed on each employer requesting self-insurance for an initial application, and that a report on incurred loss must be filed on each self-insurer for a renewal application. Also, proposed § 125.3(c)(6) allows applicants that have retained an actuary to submit that actuary's report with the application.

The Department proposes to add requirements that applicants include evidence of long-term credit or debt

ratings, if any, in § 125.3(c)(9), as well as a listing of all Pennsylvania workers' compensation claims previously incurred as a self-insurer in § 125.3(c)(8). This will replace existing language related to the OSHA No. 200 report, which has not been utilized since the promulgation of Chapter 129 (relating to workers' compensation health and safety). The Department proposes to amend § 125.3(d) to require applicants to provide all data, information, explanations, corrections and missing items regarding an application within the time period prescribed in writing by the Bureau. Otherwise the application will be deemed withdrawn and a renewal applicant will have to obtain insurance coverage by the expiration of such time period. The Department proposes to amend § 125.3(e) to clarify that the Bureau will not issue a decision on an application until all data, information, explanations, corrections and missing items have been submitted. The Department also proposes to clarify existing language and reference currently recognized auditing standards where applicable.

The Department proposes to amend § 125.4 to allow for a variation in the submission of audit reports and financial information for applicants that are subsidiaries of a foreign parent company. The Department proposes to delete the provision in subsection (a) requiring that a parent company of a consolidated program be incorporated under the laws of a state of the United States, because this incorporation requirement is extended to all applicants in § 125.5 (relating to preliminary requirements). The Department also proposes to delete the requirement that a Bureau form be used by an applicant to delete an affiliate or subsidiary from a consolidated permit, because a specific form for this purpose is unnecessary.

The Department proposes to amend § 125.5 to require, for enforcement purposes, that an applicant must be incorporated or organized under the laws of a state of the United States, as well as to require that the applicant must have an adequate accident and illness prevention program under Chapter 129. The Department proposes to delete existing language in § 125.5(b)—(d), because this information is addressed in § 125.6 (relating to decision on application).

The Department proposes to amend § 125.6(a) to add new paragraphs which set forth objective standards that an applicant must satisfy to demonstrate its financial ability to self-insure, including that the applicant has adequate financial capacity and adequate financial health. The criteria for adequate financial health depends upon whether the applicant is a public or private employer. For a private employer, the Department proposes to require an investment grade long-term credit or debt rating, or a long-term credit or debt rating that it is one grade below investment grade as issued by a rating organization or estimated by the Bureau. This will ensure that a private employer applicant which is approved to self-insure will have adequate, current financial health to meet its obligations, including its self-insurance liability, into the reasonably foreseeable future. The Department also proposes to add language in § 125.6(a) to grandfather existing self-insurers who do not meet the rating requirements under certain conditions.

The Department also proposes to amend § 125.6(a) to streamline the factors to be considered in assessing an application. The Department further proposes to clarify the information, standards and procedures pertaining to initial decisions, compliance with conditional approvals, issuance of permits, reconsideration requests and deci-

sions, and appeals from reconsideration decisions to standardize and streamline the process and identify the necessary time frames involved.

The Department proposes to reduce the time period for compliance with conditional approvals in § 125.6 from 60 to 45 days. The Department proposes to modify the hearing procedures following a reconsideration decision to replace the *de novo* hearing process with an appeal hearing process that will be conducted according to these regulations and 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure) to the extent not specifically superseded by these regulations.

The Department proposes to amend § 125.7 (relating to permit) to clarify the nature and applicability of the automatic extension of an existing permit, providing safeguards for renewal applicants where the Bureau fails to issue an initial decision on a renewal application before the permit's expiration, or where a renewal applicant is in the process of timely satisfying conditions set forth in the Bureau's decision at the time an existing permit is set to expire.

The Department proposes to rescind § 125.8 (relating to denial of renewal application) because it currently contains information that is duplicated in § 125.6.

The Department proposes to amend § 125.9 (relating to security requirements) to clarify existing language and to replace the use of the outdated security constant with the new term, minimum security amount. The Department will also modify the requirements relating to the forms of acceptable security, the procedures for posting and replacing security and the methods for calculating security amounts. The Department also proposes to add requirements for stand-by arrangements with claims service companies in the event of a default.

The Department proposes to amend § 125.9(b)(3) to delete Alaska and Hawaii as states in which a bank's branch office may issue a securing letter of credit to the Bureau, because time zone differences hamper the Bureau's ability to promptly draw down a letter of credit with a bank located in these states. The Department proposes to amend § 125.9(b)(3)(iii) to require a trustee of a letter of credit trust to obtain a Commonwealth of Pennsylvania Nonprocurement registration number to facilitate the transfer of the proceeds of a letter of credit from the Commonwealth to a trustee, and to allow the Bureau to draw down on a letter of credit and use the proceeds to finance the maintenance of a letter of credit trust arrangement should a self-insurer fail to do so. The Department proposes to amend the various methods for calculating the required amount of security for private employers under § 125.9(d) to set forth in detail the factors for calculating security depending upon the status and duration of the private employer's self-insurance program.

The Department also proposes to add a specific security discount table in § 125.9(l), based on the self-insurer's investment grade long-term credit or debt rating, if any, pursuant to which all security amounts calculated under subsection (d) may be discounted. The Department further proposes to replace the language in § 125.9(f) permitting present value discounting of liability projected in an actuary's report, which may result in an inadequate security amount, with language allowing the Bureau to use the overall experience of all self-insurers or of self-insurers in the self-insurer's industry in its selection of loss development factors under certain circumstances.

The Department also proposes to amend § 125.9(g) to clarify that the Bureau may make adjustments and use alternative methods other than loss development for calculating a self-insurer's required security amount in certain situations, and to amend § 125.9(j) to allow for a phase-in of any increased security requirements under subsection (d) over a period of up to 2 years. It also amends § 125.9(k) to specify the circumstances under which the Bureau may release a runoff self-insurer of the obligation to provide security.

The Department proposes to amend § 125.10 (relating to funding by public employers) to focus on short-term solvency rather than long-term reserves by requiring public employers to maintain sufficient dedicated cash reserves to meet payments over the next year for benefits and expenses in order to self-insure. The Department proposes to amend § 125.10(a) to provide that a public employer must maintain a dedicated asset account, which no longer needs to be a trust fund, and include the Commonwealth but not certain runoff self-insurer public employers who do not meet the threshold for average annual payout of benefits on self-insurance claims. The Department proposes to delete the current language in § 125.10(b) and (c) regarding long-term reserves and to add new subsections (b) through (e) which set forth in detail the various methods and factors for calculating the required asset level of a public employer's dedicated asset account depending upon the status and duration of the public employer's self-insurance program.

The Department proposes to amend § 125.11 (relating to excess insurance) to replace the current requirements and limits of excess insurance with new language addressing excess insurance in terms of adequate financial capacity and the coverage of a possible catastrophic loss. Under § 125.11(a), the Department proposes to add the requirement that, where excess insurance is required to demonstrate adequate financial capacity, the applicant's retention amount must at least equal its authorized retention amount and the applicant's liability limit of its insurance must be in an amount acceptable to the Bureau to cover adequately a catastrophic loss. The Department proposes to delete existing requirements for aggregate excess insurance found in § 125.11(b), as these requirements are no longer necessary. The Department also proposes to delete existing language in § 125.11(c)(1), because it currently contains information that is duplicated in the definitions of "excess indemnity insurance" and "workers' compensation excess insurance."

The Department proposes to amend § 125.12 (relating to payment, handling and adjusting of claims) to require self-insurers to notify the Bureau when they change claims handling or adjusting arrangements, whether self-administered or administered by a registered claims services company. The insurers will also have to provide a summary of the self-insurer's claims data to the Bureau, upon request, to explain discrepancies or problems that may arise due to the change in claims handling responsibilities.

The Department proposes to amend § 125.13 (relating to special funds assessments) to include the Uninsured Employers Guaranty Fund as one of the listed special funds for which a self-insurer is liable to pay assessments. That fund was newly established in sections 1601—1608 of the act (77 P. S. §§ 2701—2708) by Act 147 of 2006, which was signed into law on November 9, 2006. The Department also proposes to allow the Bureau to require a self-insurer to retain the services of its certified

public accountant to resolve questions about the accuracy of annual compensation payments reported by the self-insurer.

The Department proposes to amend § 125.15 (relating to workers' compensation liability) to clarify existing language, including specific reference to self-insurance loss portfolio transfer policies.

The Department proposes to amend § 125.16 (relating to reporting by runoff self-insurer) to clarify existing language regarding the timing, format and contents of the runoff report, and to specify the procedure for a runoff self-insurer to request adjustment of its security amount.

The Department proposes to amend § 125.17 (relating to claims service companies) to set forth the continuing obligation of claims service companies to assist the self-insurer and the Bureau in providing data and information on the self-insurer's claims serviced by that company.

The Department proposes to amend § 125.19 (relating to additional powers of Bureau and orders to show cause) to explain the procedures by which the Bureau may address changes in the financial condition of active self-insurers and violations of the act and this subchapter. The Department proposes to add subsection (a) to set forth procedures whereby the Bureau may review the qualifications for self-insurance, and revoke an existing permit, where necessary, for active self-insurers whose financial condition declines before the expiration of an existing permit. Under paragraph (1), the Bureau will issue a letter to the self-insurer outlining its concerns. The Department further proposes to add specific language pertaining to the Bureau's ability to suspend or revoke a permit following the issuance of an order to show cause, which will proceed in the manner set forth in the order to show cause provisions contained within Chapter 121 (relating to general provisions), when a self-insurer unreasonably fails to pay compensation for which it is liable or fails to submit any report or pay any assessment made under the act.

The Department proposes to amend § 125.20 (relating to computation of time) to adjust the manner in which a period of time will be computed under this chapter to be consistent with the time computation provisions under Chapter 121.

The Department proposes to add § 125.21 (relating to self-insurance loss portfolio transfer policy) to establish procedures and guidelines for the transfer of a self-insurer's workers' compensation liability to an insurance carrier through the use of a self-insurance loss portfolio transfer policy.

#### *Affected Persons*

Active self-insurers, runoff self-insurers and employers applying for self-insurance in the future will all be affected by this proposed rulemaking in various degrees. The procedural amendments will affect all categories of self-insurers and applicants for self-insurance. A number of the substantive amendments, including those relating to loss development calculations and security discounts, will affect existing private sector self-insurers. New and existing public sector self-insurers also will be affected by the amendments to funding requirements. Self-insurance claims services companies, sureties and trustees will also be impacted by this proposed rulemaking.

#### *Fiscal Impact*

Private employer applicants with a strong financial rating will likely see no significant, direct impact to their overall costs from the current regulations. These appli-

cants could possibly experience reduced costs, due to the greater security discounts proposed for employers having strong financial ratings. Private employer applicants with lesser financial ratings, however, could experience some increase in costs as a result of the changes to security and excess insurance requirements.

The vast majority of public sector applicants would realize substantially reduced funding requirements under the proposed regulations. The Bureau estimates that required funding amounts would decline by an average of 49% under the proposed regulations for 35 of the 55 public self-insurers. Of the remaining 20, eight public employers with existing funding requirements would be required to increase their workers' compensation funding by an average of 77%, amortized over a 6-year period. Another eight public employers who do not have funding requirements under the existing regulations would have such requirements under the proposal. However, these employers would experience no practical change since they voluntarily maintain funding accounts that meet or exceed the proposed funding requirements. Four additional public employers who do not currently fund any of their outstanding liability would have to make annual deposits into dedicated accounts of up to 5% of their prior year's payment of compensation for up to 6 years.

Some additional costs resulting from the requirement that the trustee maintain a standby arrangement with a claims service company are likely for those posting a letter of credit as security. Those costs would vary, but could be as much as a few thousand dollars.

Some one-time additional costs associated with the implementation of the proposed amendments are likely for the Bureau. The costs, which will not be substantial, would mostly result from the reprogramming of the computer system used to monitor self-insurers and to decide applications.

#### *Reporting, Recordkeeping and Paperwork Requirements*

The major reporting, recordkeeping and paperwork requirements resulting from these proposed amendments are as follows:

- An active or runoff self-insurer is required to annually file, in electronic format prescribed by the Bureau, a listing of its open and closed claims incurred after the effective date of these amendments.
- An active or runoff self-insurer may be required to file with the Bureau summary data on its claims when it changes claims handling arrangements.
- A security or letter of credit trustee is required to show that it maintains a standby arrangement with a claims services company.

#### *Effective Date*

These proposed amendments will take effect when published as final-form regulations in the *Pennsylvania Bulletin*.

#### *Sunset Date*

No sunset date is necessary for the proposed regulatory amendments. The regulations are continuously monitored by the Workers' Compensation Advisory Council and by the Bureau in the day-to-day handling and processing of individual self-insurance applications. If needed, corrections can be initiated based on information obtained by these operations.

#### *Public Comment and Contact Person*

Interested persons may submit written comments to the proposed rulemaking to George Knehr, Chief, Self-Insurance Division, Bureau of Workers' Compensation, Department of Labor and Industry, Chapter 125 Regulations—Comments, P. O. Box 15121, Harrisburg, PA 17105 or gknehr@state.pa.us. Written comments must be received within 30 days of the publication of this proposed rulemaking in the *Pennsylvania Bulletin*.

#### *Regulatory Review*

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on April 20, 2009, the Department submitted a copy of this proposed rulemaking and a copy of a Regulatory Analysis Form to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the Senate Committee on Labor and Industry and the House Labor Relations Committee. A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey any comments, recommendations or objections to the proposed rulemaking within 30 days of the close of the public comment period. The comments, recommendations or objections must specify the regulatory review criteria which have not been met. The Regulatory Review Act specifies detailed procedures for review, prior to final publication of the rulemaking, by the Department, the General Assembly and the Governor of comments, recommendations or objections raised.

SANDI VITO,  
*Secretary*

**Fiscal Note:** 12-85. No fiscal impact; (8) recommends adoption.

#### **Annex A**

#### **TITLE 34. LABOR AND INDUSTRY**

#### **PART VIII. BUREAU OF WORKERS' COMPENSATION**

#### **CHAPTER 125. WORKERS' COMPENSATION SELF-INSURANCE**

#### **Subchapter A. INDIVIDUAL SELF-INSURANCE.**

#### **§ 125.1. Purpose.**

This subchapter is promulgated under section 435 of the act (77 P. S. § 991) to provide regulatory guidelines for the uniform and orderly administration of self-insurance for individual employers. This subchapter ensures full payment of compensation when due to [ **employees** ] **employees** of self-insured employers and to their dependents under the act and the Occupational Disease Act.

#### **§ 125.2. Definitions.**

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

*Act*—The Workers' Compensation Act (77 P. S. §§ 1—[ **1038.2** ] **1041.4, 2501—2506 and 2701—2708**).

*Active self-insurer*—A self-insurer that is not a runoff self-insurer.

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*Adequate accident and illness prevention program*—A determination by the Bureau under Chapter 129 (relating to workers' compensation health and safety) that an applicant's accident and illness

prevention services fulfill the program and service requirements as stated in that chapter.

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*Aggregate excess insurance*—Insurance under which [ provides that ] the [ excess ] insurer pays on behalf of or reimburses a self-insurer for its payment of benefits on claims incurred during a policy period in excess of the retention amount to the [ excess ] insurer's [ limit of ] liability limit and that meets the requirements of § 125.11(b) (relating to excess insurance).

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*Authorized retention amount*—A retention amount that is equal to or is less than a self-insurer's maximum quick assets exposure amount or the current standard retention amount, whichever is less, or the special retention amount approved by the Bureau.

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*Cash flow protection amount*—The maximum amount of benefits a self-insurer pays over a 2-year period on an occurrence without reimbursement from [ an excess ] a nonworkers' compensation insurer or a workers' compensation insurer under a specific excess insurance policy with a per year per occurrence cash protection plan.

*Catastrophic loss estimation*—The greater of the following:

(i) The largest number of employees usually working at one time at the largest location in this Commonwealth in terms of the applicant's employment, or the employment of any of its affiliates or subsidiaries under a consolidated permit under § 125.4 (relating to application for affiliates and subsidiaries), multiplied by the current Statewide average weekly wage multiplied by 500.

(ii) The current Statewide average weekly wage multiplied by 5,000.

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*Default multiplier*—A multiplier calculated by the Bureau, and published annually in the *Pennsylvania Bulletin*, based upon the Bureau's analysis of the total costs and expenses to liquidate defaulted self-insurers' claims compared to those self-insurers' average annual benefits payments in years preceding the defaults, as derived from the experience of the Self-Insurance Guaranty Fund and of sureties and others paying the claims of defaulted self-insurers.

*Default multiplier-calculated security factor*—The self-insurer's average annual payout of benefits, net of workers' compensation excess insurance recoveries, over the last 3 completed calendar years multiplied by the default multiplier.

\* \* \* \* \*

*Excess indemnity insurance*—Aggregate excess insurance or specific excess insurance that does not meet the definition of workers' compensation excess insurance but that is provided by a workers' compensation insurer or a nonworkers' compensation insurer that possesses an A.M. Best rating of A- or better or a Standard & Poor's insurer financial strength rating of A or better or a comparable rating of another NRSRO.

[ *Excess insurer*—An insurance company authorized to transact the class of insurance listed in section 202(c)(14) of The Insurance Company Law of 1921 (40 P. S. § 382(c)(14)). ]

*Excess insurance*—Excess indemnity insurance or workers' compensation excess insurance.

*Financial ability to self-insure*—Possession of adequate financial capacity and adequate financial health, as specified in § 125.6(a) (relating to decision on application).

\* \* \* \* \*

*Investment grade long-term credit or debt rating*—A long-term credit or debt rating identified as investment grade by the NRSRO that issued it.

*Liability limit*—The maximum amount of benefits for which a nonworkers' compensation insurer or a workers' compensation insurer indemnifies a self-insurer under an excess insurance policy.

*Long-term credit or debt rating*—A measurement by a NRSRO of an applicant's willingness and intrinsic capacity to meet its long-term financial commitments as the commitments become due, exclusive of the effects of any guaranties, insurance or other forms of credit enhancements or legal priorities on any of the applicant's financial obligations.

\* \* \* \* \*

*Maximum quick assets exposure amount*—Five percent of an applicant's average year-end quick assets amount for its last 2 completed fiscal years.

*Minimum funding amount*—The lower of the following:

(i) The current Statewide average weekly wage multiplied by 1,000.

(ii) The retention amount of the applicant's current or any proposed excess insurance, if applicable.

*Minimum security amount*—The lower of the following:

(i) The current Statewide average weekly wage multiplied by 1,000.

(ii) The retention amount of the applicant's current or any proposed excess insurance, if applicable.

*NRSRO*—A designated Nationally-recognized statistical rating organization of the United States Securities and Exchange Commission or its successor.

*Nonprocurement registration number*—An identification number issued by the Commonwealth, Department of General Services, Central Management Vendor Unit, to entities who may receive payments from the Commonwealth that are not associated with a contract or purchase order.

*Nonworkers' compensation insurer*—An insurance company authorized to transact any class of insurance under the Insurance Company Law of 1921 (40 P. S. §§ 341—991.2361) other than the insurance under section 202(c)(14) (40 P. S. § 382(c)(14)), or an insurance company designated as an eligible surplus lines insurer as defined in section 1602 (40 P. S. § 991.1602).

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**Quick assets**—The sum of an applicant's cash, cash equivalents, current receivables and marketable securities or, if the applicant is a public employer who uses fund accounting, the total of the applicant's general fund assets.

**Retention amount**—

(i) The maximum amount of benefits a self-insurer pays without reimbursement from the [excess] non-workers' compensation insurer or the workers' compensation insurer under an aggregate excess insurance policy or under a specific excess insurance policy which does not include an annual cash flow protection plan.

(ii) The term also includes the lower of the maximum amount of benefits a self-insurer pays on each occurrence without reimbursement from the excess insurer[, if any,] or the cash flow protection amount under a specific excess insurance policy which includes an annual cash flow protection plan.

\* \* \* \* \*

[ **Security constant**—The Statewide average weekly wage multiplied by 300. ]

**Self-insurance**—The privilege granted to an employer which has been exempted by the Bureau from insuring its liability under section 305(a) of the act (77 P. S. § 501(a)) and section 305 of the Occupational Disease Act (77 P. S. § 1405).

**Self-insurance loss portfolio transfer policy**—A policy of insurance accepted by the Bureau as meeting the requirements of § 125.21 (relating to self-insurance loss portfolio transfer policy) under which a self-insurer transfers liability incurred as a self-insurer to a workers' compensation insurer.

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**Special retention amount**—A retention amount that exceeds the applicant's maximum quick assets exposure amount or the standard retention amount requested by the applicant and approved by the Bureau based on a determination that the applicant has sufficient quick assets to easily liquidate all losses from a catastrophic event at the requested greater retention amount. For an applicant whose self-insurance status began before \_\_\_\_\_ (Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.), this may also be based on a determination that the requested retention amount is less than or is approximately equal to the retention amount of the applicant's excess insurance in effect on \_\_\_\_\_ (Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.).

**Specific excess insurance**—Insurance under which [provides that] the [excess] insurer pays on behalf of or reimburses a self-insurer for its payment of benefits on each occurrence in excess of the retention amount to the [excess] insurer's [limit of] liability limit and that meets the requirements of § 125.11(b) (relating to excess insurance).

**Standard retention amount**—The retention amount generally required for a self-insurer's excess insurance published annually by the Bureau in the *Pennsylvania Bulletin* that is based on a retention amount commonly used by current self-insurers and determined appropriate by the Bureau.

**Workers' compensation excess insurance**—Aggregate excess insurance or specific excess insurance provided by a workers' compensation insurer that includes the premium collected for the insurance in data used by the Workers' Compensation Security Fund set forth in the Workers' Compensation Security Fund Act (77 P. S. §§ 1051–1066) to calculate assessments against workers' compensation insurers to finance the operations of that fund.

**Workers' compensation excess insurance recoveries**—Payments made to a self-insurer under a policy of workers' compensation excess insurance or payments receivable under a policy of workers' compensation excess insurance in the future that the insurer has agreed in writing that it is liable to pay.

**Workers' compensation insurer**—An insurance company authorized to transact the class of insurance listed in section 202(c)(14) of The Insurance Company Law of 1921.

### § 125.3. Application.

(a) An applicant shall file an application on a form prescribed by the Bureau. [Questions] All questions on the application shall be answered [thoroughly and] completely and accurately with the most recent information available. A rider may be attached if more space is necessary. The application shall be signed by the applicant, or if a corporation, an officer of the corporation[, and attested to]. The application, including any attached riders and applicable forms, shall be verified as set forth on the application[. Attached riders and applicable forms enclosed with the application shall be verified to in the sworn affidavit requested on the application], subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities).

(b) Initial applications shall be filed with the Bureau no later than 3 months prior to the requested effective date of self-insurance. Renewal applications shall be filed with the Bureau no later than [2] 3 months prior to the expiration of the current permit.

(c) With the application, the applicant shall include:

(1) The nonrefundable statutory fee in the amount of \$500 for initial applicants or \$100 for renewal applicants required [by] under section 305(a) of the act (77 P. S. § 501(a)), payable to the "Commonwealth of Pennsylvania." A statutory fee is required in the amount of \$500 [for initial applicants or \$100 for renewal applicants is required] for each affiliate or subsidiary [included] being initially added or in the amount of \$100 for each affiliate or subsidiary renewing under a consolidated application under § 125.4 (relating to application for affiliates and subsidiaries).

(2) Its [Security] Securities and Exchange Commission (SEC) Form 10-K for the last complete fiscal year, if applicable. The SEC Form 10-K does not serve as a substitute for the full completion of the application form.

(3) Its latest audit report issued by a licensed certified public accountant or accounting firm. The report [shall] must cover the last complete fiscal-year period immediately prior to the date of application. If the most current audited period precedes the application date by more than 6 months, the applicant's latest SEC Form 10-Q or

unaudited interim financial statements [ **shall** ] **must** be submitted. The audit report [ **shall meet the following criteria** ] **must include the following**:

(i) [ **It shall include financial** ] **Financial** statements which are presented in conformance with applicable generally accepted accounting principles as promulgated by the Financial Accounting Standards Board or the Government Accounting Standards Board or with international [ **accounting** ] **financial reporting** standards promulgated by the International Accounting Standards Board. **The monetary values presented in the financial statements must be in United States dollars and the text of the financial statements and their accompanying notes must be in the English language. If the applicant is a parent company, consolidated financial statements of the applicant and its subsidiaries shall be provided.**

(ii) [ **It shall state** ] **A statement that the audit [ meets the reporting requirements defined either in the applicable ] was conducted in accordance with generally accepted auditing standards [ promulgated by the AICPA or the applicable generally accepted governmental auditing standards promulgated by the Comptroller General of the United States in "Government Auditing Standards," referred to as the Yellow Book ] in the United States or in accordance with the standards of the Public Company Accounting Oversight Board (United States) or the International Standards on Auditing. An unqualified or qualified opinion shall be stated on the most recent audited financial statements.**

(4) **Audit reports covering the applicant's second and third most recent complete fiscal-year periods prior to the date of the application, if an initial application. If audit reports covering those periods are not available, financial statements reviewed by a certified public accountant in accordance with standards established by the [ AICPA ] American Institute of Certified Public Accountants covering the second and third most recent complete fiscal year periods will be accepted.**

(5) **A report of the [ applicant's ] paid and incurred workers' compensation loss experience in this Commonwealth under each of the 3 complete policy years prior to the application of each employer requesting self-insurance, if an initial application. [ Affiliates' paid and incurred workers' compensation loss experience shall be submitted if applicable. ] The loss information for each policy year shall be valued within 3 months prior to the date of the submission of the application.**

(6) **A report on a form prescribed by the Bureau stating the costs of claims incurred by [ the applicant ] each employer requesting self-insurance by annual periods and projecting the total value of its outstanding liability under the act and the Occupational Disease Act, if a renewal application. [ Applicants are encouraged, but not required, to have their projection of outstanding liability prepared by an actuary ] **A renewal applicant that has retained the services of an actuary to project the total value of its outstanding liability may submit the actuary's report with its application.****

(7) **A report for each employer requesting self-insurance on a form prescribed by the Bureau summa-**

**rizing the existence of the accident and illness prevention program required under section 1001(b) of the act (77 P. S. § 1038.1) and regulations promulgated thereunder[ , if a renewal applicant ] .**

(8) [ **At the direction of the Bureau, an applicant's annual summaries of occupational injuries and illnesses, OSHA No. 200, if the applicant is required to keep Occupational Safety and Health Administration records. ] **A listing for each employer requesting self-insurance, in a Bureau-prescribed electronic format, of the employer's Pennsylvania workers' compensation claims incurred as a self-insurer, including claims currently in litigation, and information such as payments and reserves on each claim. The listing must include:****

(i) **All opens claims at the time of submission.**

(ii) **All claims closed in the past if these claims are available. If a listing of all claims closed in the past is not available, the listing must at least include all claims closed on or after \_\_\_\_\_ (Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.)**

(iii) **Case reserves provided in the listing must be established according to instructions prescribed by the Bureau.**

(9) **Written verification of the applicant's current long-term credit or debt ratings, if any.**

(d) **The applicant shall provide additional data [ and ], information and explanation that the Bureau deems pertinent to its review of the application based on the factors enumerated under § 125.6(a) (relating to decision on application), and shall make any corrections determined necessary by the Bureau, and provide any items under subsection (c) determined missing or insufficient by the Bureau. The applicant shall provide the data [ and ], information, explanation, corrections or missing items within the time period prescribed by the Bureau[ , which will be reasonable based on the extent and availability of the data and information required ]. If the applicant does not provide the data, information, explanation, corrections or missing items within the time period prescribed in writing by the Bureau, the application will be deemed withdrawn. A renewal applicant that does not provide the data, information, explanation, corrections or missing items within the time period prescribed in writing by the Bureau shall obtain workers' compensation insurance coverage effective the expiration of that time period and shall provide evidence of the coverage to the Bureau no later than the coverage's effective date.**

(e) **The Bureau will not [ begin its review of ] issue a decision on the application under § 125.6 (relating to decision on application) until the application [ and the required supporting materials as outlined in this section ], including all items required under subsection (c) and all additional data, information, explanation and corrections under subsection (d), have been submitted.**

\* \* \* \* \*

**§ 125.4. Application for affiliates and subsidiaries.**

(a) **An affiliate or subsidiary may be included under an application submitted by another affiliate or its parent**

company [if the parent company or affiliate is incorporated under the laws of a state of the United States] by providing information and data on the affiliate or subsidiary on a form prescribed by the Bureau. The related entities will be included under one consolidated permit if the application is approved. A written request shall be made [on a form prescribed by the Bureau] by the applicant to [add or] delete an affiliate or a subsidiary [to or] from a consolidated permit after its issuance.

\* \* \* \* \*

(d) If an affiliate or subsidiary not included under a consolidated application as outlined in subsection (a) wishes to self-insure, it shall submit an application in its own name and provide its own audit reports in the manner indicated in § 125.3 (relating to application). The Bureau may require the parent company to furnish appropriate financial information within a [reasonable] time [according to the extent and nature of the requested information] period prescribed by the Bureau.

(e) If the applicant is a direct or indirect subsidiary of a parent company that is not incorporated or organized under the laws of a state of the United States, the applicant may submit its parent company's consolidated audit report and an unaudited consolidated balance sheet of the applicant's financial condition, or other financial information on the applicant that the Bureau deems pertinent to its review of the application, to satisfy the financial reporting requirements of § 125.3(c), provided the parent company's audit report complies with the § 125.3(c)(3)(i) and (ii).

#### § 125.5. [Minimum] Preliminary requirements.

(a) An [initial] applicant [must] shall have been in business for at least 3 consecutive years prior to application.

(b) [A private employer applicant shall demonstrate that 10% of its quick assets or 20% of its cash and cash equivalents at the end of 2 of the last 3 fiscal-year periods exceed a proposed cash flow protection amount or the proposed retention amount of its aggregate excess or specific excess insurance, whichever is less] An applicant shall be incorporated or organized under the laws of a state of the United States.

(c) [A public employer applicant shall demonstrate that 10% of its general fund quick assets at the end of 2 of the last 3 fiscal-year periods exceed a proposed cash flow protection amount or the proposed retention amount of its aggregate excess or specific excess insurance, whichever is less] Each employer requesting self-insurance shall have an adequate accident and illness prevention program.

[(d) Subsections (b) and (c) do not apply to applicants which are not required to obtain specific excess insurance under § 125.11 (relating to specific excess insurance and aggregate excess insurance) nor to applicants which are self-insured prior to October 14, 1995.]

#### § 125.6. Decision on application.

(a) The application of an applicant which meets the requirements of § 125.5 (relating to [minimum] preliminary requirements) will be approved if the Bureau determines that the applicant has demonstrated[, with reasonable certainty, the ability to meet all obligations under the act and the Occupational Disease Act] that it possesses the financial ability to self-insure.

(1) An applicant shall demonstrate that it has adequate financial capacity by showing one of the following:

(i) The retention amount of the applicant's current or proposed excess insurance equals or is less than its authorized retention amount.

(ii) The applicant's catastrophic loss estimation is equal to or is less than its maximum quick assets exposure amount.

(2) An applicant shall demonstrate that it has adequate financial health, as follows:

(i) If a public employer, the applicant satisfies or will satisfy the requirements established for it under § 125.10 (relating to funding by public employers).

(ii) If a private employer, the applicant's level of financial stability, solvency and liquidity is such that it satisfies one of the following:

(A) The applicant possesses an investment-grade long-term credit or debt rating, or such a rating that is one generic rating classification below investment grade.

(B) For applicants who do not receive a long-term credit or debit rating by an NRSRO, the Bureau estimates that the applicant would merit an investment grade long-term credit or debt rating, or a rating that is one generic rating classification below investment grade, if it were rated.

(C) An applicant that was approved to self-insure as of \_\_\_\_\_ (Editor's Note: The blank refers to the effective date of adoption of this proposed rule-making.) that possesses an actual or Bureau-estimated long-term credit or debt rating more than one generic rating classification below investment grade shall be deemed to possess adequate financial health if its generic rating does not decline further. This exception will no longer apply if the applicant's actual or Bureau-estimated long-term credit or debt rating increases to one generic rating classification below investment grade or higher.

(b) The Bureau will [include] consider the following [factors] information in assessing an applicant's financial ability to [meet those obligations] self-insure:

(1) The [audit opinion required under § 125.3(c)(3) (relating to application).] applicant's level of financial health based upon its long-term credit or debt rating, if any, or upon an evaluation by the Bureau of one or more of the following:

(i) The applicant's financial statements, which may include comparisons of the applicant's financial ratios to general or to industry ratios and cash flow analysis.



(ii) Public documents and reports filed with other state and Federal agencies including the United States Securities and Exchange Commission.

(iii) Other financial analysis information provided to or considered by the Bureau.

(2) The [length of time that the applicant has been doing business under its present corporate identity] amount of the applicant's quick assets at the end of its last 2 completed fiscal years as shown on the audited financial statements provided to the Bureau under § 125.3 (relating to application).

(3) The [applicant's overall solvency, identified as its ability to meet its financial obligations as they come due] terms, conditions and limits of the applicant's existing or proposed excess insurance.

(4) [The applicant's organizational structure and management background.] For a public employer, its ability to satisfy or its past history in satisfying the requirements established under § 125.10.

[ (5) The nature of the applicant's operations and its industry.

(6) Financial analysis appropriate for the particular applicant, including for example, industry ratio and cash flow analyses.

(7) The applicant's debt ratings from National financial rating agencies, if any.

(8) The applicant's workers' compensation loss history and insurance history.

(9) The applicant's potential financial workers' compensation obligations, including average expected claims and maximum possible loss as limited by the excess insurance coverage obtained by the applicant, if any.

(10) The applicant's claims administration history and compliance with the act, the Occupational Disease Act and this part.

(11) The existence and adequacy of the applicant's accident and illness prevention program required under section 1001(b) of the act (77 P. S. § 1038.1(b)) and regulations thereunder.

(b) (c) If the [Bureau's assessment] Bureau finds under subsection (a) [is] that the applicant [can meet its obligations] possesses the financial ability to self-insure, it will send to the applicant [a preliminary approval notice of] an initial decision approving the application and a list of conditions as set forth under subsection [ (d) ](c)(2) that [shall] must be met before the applicant will be issued a permit. The Bureau [may] will issue a permit to a renewal applicant [subject to] at the time of the initial decision when the renewal applicant [complying] is currently in compliance with the conditions set forth by the Bureau.

[ (c) ] (1) An applicant has [60] 45 days from the receipt of the [preliminary approval notice] initial decision approving the application to comply with the conditions set forth by the Bureau.

(i) The applicant may toll the [60] 45-day compliance period by filing a request for a conference or notifica-

tion of its intent to submit additional written information under subsection [ (f) ] (e).

(ii) An applicant may be granted a 30-day extension to meet the conditions if the applicant requests an extension in writing [to the]. The Bureau must receive the extension request within the initial [60] 45-day compliance period.

(iii) [The application of an] Unless a timely reconsideration is initiated under subsection (e), when the applicant [which] does not meet the conditions within this compliance period, the application will be deemed [withdrawn] denied.

(iv) A renewal applicant that does not meet the conditions within this compliance period and that has not timely initiated the procedures outlined in subsection (e) shall obtain workers' compensation insurance coverage effective the expiration date of the compliance period and provide evidence of the coverage to the Bureau no later than the coverage's effective date.

[ (d) ] (2) The applicant will be issued a permit [which is effective no sooner than 15 days] after all of the following [has] have been filed with the Bureau:

[ (1) ] (i) Security in an amount as set forth in § 125.9 (relating to security requirements) or funding as set forth in § 125.10 [ (relating to funding by public employers) ].

[ (2) ] (ii) A certificate providing evidence [of] that the applicant has obtained excess insurance [as required by the Bureau] coverage with limits set forth under § 125.11(a) (relating to excess insurance), if required.

[ (3) ] (iii) A guarantee agreement executed by its parent company or an affiliate as set forth in § 125.4 (relating to application for affiliates and subsidiaries), if required.

(iv) Contact information on the claims services company or in-house staff that will be handling the applicant's claims.

[ (4) ] (v) Documents relating to any other requirement set by the Bureau to protect the compensation rights of [employees] employees.

[ (e) ] (d) If an applicant does not meet the requirements of § 125.5 or if upon review [of the pertinent data] under subsection (a) the Bureau finds that the applicant has not demonstrated [its ability to meet its obligations, it will] that it possesses the financial ability to self-insure, [it will] the Bureau will send to the applicant [a preliminary denial notice of] an initial decision denying the application. The [notice] initial decision will state the documents, [evidence and other data] data, information, explanation and corrections received from the applicant or otherwise reviewed or considered by the Bureau in rendering its [preliminary determination] initial decision. A renewal applicant shall obtain workers' compensation insurance coverage effective no later than 30 days after its receipt of an initial decision denying the renewal application and shall provide evidence of the coverage to the Bureau no later

than the coverage's effective date, unless the applicant has timely initiated the procedures outlined in subsection (e).

(e) The applicant may request a conference with the Bureau to submit additional materials to support its application or the alteration of the conditions required in the initial decision, or to challenge the accuracy of underlying calculations made or data considered by the Bureau in its decision or conditions. The applicant may also notify the Bureau of its intention to submit these materials directly in writing without a conference. The Bureau must receive a request or notification within 20 days of the date of the Bureau's initial decision.

(1) Upon its receipt of the request or notification, the Bureau will schedule a conference. If a conference is not requested, the Bureau will establish a deadline, not to exceed 30 days from the Bureau's date of receipt of the notification, for the submission of the additional materials.

(2) The prior permit of a renewal applicant that has filed a timely request for a conference or notification of intent to submit additional materials will be automatically extended under the prior conditions established by the Bureau beyond the permit's original expiration date until the Bureau issues a reconsideration decision on the renewal application under subsection (f).

(f) [ The applicant may request a conference with the Bureau upon receipt of the Bureau's preliminary approval notice or denial notice. A conference request shall be made in writing within 20 days after the receipt of the preliminary notice. At the conference, the applicant may present additional evidence or data to support its application or the alteration of the conditions required in the preliminary approval notice. The applicant may present that information to the Bureau in writing, or in person, or both ] After a conference or the receipt of additional materials, the Chief of the Self-Insurance Division of the Bureau will review the entire record of the application and will issue a reconsideration decision on the application.

(1) The applicant shall have 30 days from its receipt of a reconsideration decision approving an application to comply with any conditions set forth by the Bureau in that decision.

(i) Unless a timely appeal is filed under subsection (g), when the applicant does not meet the conditions within this 30-day period, the application will be deemed denied.

(ii) A renewal applicant that does not meet the conditions within this 30-day period shall obtain workers' compensation insurance coverage effective the expiration of the compliance period and shall provide evidence of the coverage to the Bureau no later than the coverage's effective date, unless the applicant has timely initiated the procedures outlined in subsection (g).

(2) Upon the issuance of a reconsideration decision denying a renewal application, the renewal applicant shall obtain workers' compensation insurance coverage effective no later than 30 days after its receipt of the reconsideration decision and shall provide evidence of the coverage to the Bureau no

later than the coverage's effective date unless the applicant has timely initiated the procedures outlined in subsection (g).

(g) [ After a conference and the receipt of written submissions, the Chief of the Self-Insurance Division of the Bureau will promptly review the entire record of the application and will issue a reconsideration decision on the application.

(h) ] An applicant shall have the right to appeal a reconsideration decision issued under subsection [ (g) with the ] (f). The Bureau must receive the appeal within 30 days of the [ receipt ] date of the reconsideration decision. The prior permit of a renewal applicant that filed a timely appeal shall be automatically extended under the prior conditions established by the Bureau beyond the permit's original expiration date, until a presiding officer issues a written decision on the appeal. Untimely appeals will be dismissed without further action by the Bureau.

(1) The Director of the Bureau will assign the appeal to a [ hearing ] presiding officer who will schedule a [ de novo ] hearing on the appeal from the [ initial ] reconsideration decision. [ The applicant will receive reasonable ] The presiding officer will provide notice to the parties of the hearing date, time and place.

(2) The hearing will be conducted [ in a manner to provide the applicant and the Bureau the opportunity to be heard. The hearing officer will not be bound by strict rules of evidence. Relevant evidence of reasonably probative value may be received into evidence. Reasonable examination and cross-examination of witnesses will be permitted ] under this subsection and 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure) to the extent not superseded in paragraph (6). The presiding officer will not be bound by strict rules of evidence.

(3) [ Testimony will be recorded and a full record kept of the proceedings. The Bureau and the applicant will be provided the opportunity to submit briefs addressing issues raised ] Hearings will be stenographically recorded. The transcript of the proceedings will be part of the record.

(4) [ Following the close of the record, the hearing officer will promptly issue a written decision and order. The decision will include relevant findings and conclusions, and state the rationale for the decision. The decision will be served upon the applicant, the Bureau and counsel of record. The decision will include a notification to the applicant and the Bureau of further appeal rights to Commonwealth Court ] The presiding officer will issue a written decision and order under 1 Pa. Code Chapter 35, Subchapters G and H (relating to proposed reports; and agency action) to the extent not superseded in paragraph (6). The presiding officer will determine whether the Bureau abused its discretion or acted arbitrarily under this subchapter in the reconsideration decision. The applicant has the burden to prove that the Bureau abused its discretion or acted arbitrarily in the reconsideration decision.

(5) **[The applicant or the Bureau,]** A party aggrieved by a decision rendered **[on an appeal]** by the presiding officer, may **[file a further]** appeal the decision to Commonwealth Court.

**(6) This subsection supersedes 1 Pa. Code §§ 35.131, 35.190, 35.201, 35.211—35.214 and 35.221.**

**[(i)] (h)** An applicant which has been denied self-insurance may reapply after an annual audit report is published subsequent to the latest one submitted with the denied application.

#### **§ 125.7. Permit.**

(a) A permit is issued for 1 year, except that the Bureau may shorten or extend the effective period of a permit by not more than 6 months to facilitate the filing of timely audit reports with the next renewal application.

(b) If the Bureau fails to issue **[a] an initial** decision with respect to a renewal application **under § 125.6 (relating to decision on application)** prior to the expiration of the permit for the prior year, the prior permit **[shall]** will be automatically extended **under the prior conditions established by the Bureau beyond the permit's original expiration date**, until a **[final]** decision on the renewal application is **[made]** issued by the Bureau. This automatic extension applies only in cases **[where]** when the renewal application has been timely filed under § 125.3 (relating to application) **and the applicant has submitted or is submitting all data, information, explanation, corrections and missing items, or has corrected or is correcting inaccurate data, within the time period prescribed in writing by the Bureau.**

(c) If a renewal applicant's permit for the prior year expires while the applicant is in the process of satisfying conditions set forth in an initial or reconsideration decision, the prior permit will be automatically extended beyond its original expiration date, pending satisfaction of the conditions within the time period prescribed in writing by the Bureau.

**§ 125.8. [Denial of renewal application] (Reserved).**

**[The applicant shall immediately secure workers' compensation insurance coverage upon the preliminary denial of a renewal application unless the applicant has initiated the procedures outlined under § 125.6 (f)—(h) (relating to decision on application). The applicant shall provide to the Bureau a certificate of insurance evidencing workers' compensation coverage within 30 days following receipt of a final decision denying its renewal application.]**

#### **§ 125.9. Security requirements.**

(a) This section applies to self-insured employers except the Commonwealth and political subdivisions. A private employer shall provide security in an amount as set forth in subsection (d). An instrumentality of the Commonwealth shall provide security in **[the minimum]** an amount **[of the security constant]** equal to the minimum security amount rounded upward to the nearest hundred thousand or in a greater amount as determined by the Bureau to protect **[employees]** employees and their dependents against temporary interruptions in the payment of benefits by the self-insurer. The security required in this section is not a substitute

for the applicant demonstrating its financial ability to **[pay compensation under the act and the Occupational Disease Act]** self-insure. A self-insurer's security may be adjusted annually or more frequently as determined by the Bureau.

(b) The following forms of security are acceptable:

(1) A surety bond on a form prescribed by the Bureau issued by a company authorized to transact surety business in this Commonwealth by the Insurance Department.

(i) **[The]** At the time of the issuance of the bond, the surety company shall possess a current A. M. Best Rating of **[B+]** A- or better or a Standard **[and]** & Poor's insurer's financial strength rating **[of claims paying ability]** of A or better or a comparable rating by another NRSRO.

(ii) The self-insurer shall replace the bond with a new bond issued by a surety company with an acceptable rating or with another acceptable form of security if the surety company's highest rating falls below **[the acceptable rating]** an A. M. Best Rating of B+, a Standard & Poor's insurer's financial strength rating of A- or a comparable rating by another NRSRO after the bond is issued. If the bond is not replaced within **[60]** 45 days, the Bureau will have discretion to draw on the surety bond and deposit the proceeds with the State Treasurer to secure the self-insurer's liability **and to revoke the current permit if the bond exclusively secures claims currently being incurred against the self-insurer.**

(iii) An active self-insurer that does not post another bond or another acceptable form of security to cover claims currently being incurred against the self-insurer, after the surety of a bond that exclusively secures the claims provides notification of its intention to terminate the bond, shall obtain workers' compensation insurance coverage effective the bond's termination date. The self-insurer shall provide evidence of the coverage to the Bureau no later than the coverage's effective date.

(2) A security deposit held under a trust agreement prescribed by the Bureau and maintained for the benefit of **[employees]** employees of the self-insurer:

(i) The deposit **[shall]** must consist of cash; bonds or other evidence of indebtedness issued, assumed or guaranteed by the United States of America, or by an agency or instrumentality of the United States; investments in common funds or regulated investment companies which invest primarily in United States Government or Government agency obligations; or bonds or other security issued by the Commonwealth and backed by the Commonwealth's full faith and credit.

(ii) The securities **[shall]** must be held in a Commonwealth chartered bank and trust company or trust company as defined in section 102 of the Banking Code of 1965 (7 P.S. § 102) or a Federally-chartered bank or foreign bank with a branch office and trust powers in this Commonwealth.

(iii) **The trustee shall maintain a standby arrangement with a claims service company for the administration and the payment of the self-insurer's claims on behalf of the trust in the event**

**of the self-insurer's default on its liability. Evidence of the standby arrangement shall be provided annually to the Bureau.**

(3) An irrevocable letter of credit using language required by the Bureau issued by and payable at a branch office of a commercial bank located in the continental United States [ , Alaska or Hawaii ]. The letter of credit [ shall ] must state that the terms of the letter of credit automatically renew annually unless the letter of credit is specifically nonrenewed by the issuing bank 60 days or more prior to the anniversary date of its issuance[ : ].

(i) At the time of issuance of the letter of credit, the issuing bank or its holding company shall have a B/C or better rating or 2.5 or better **credit evaluation** score by **Fitch Ratings, as successor to the rating services of Thomson BankWatch**, or the issuing bank shall have a **CD or long-term issuer credit** rating of BBB or better or a **short-term issuer credit rating of A-2 or better** by Standard & Poor's [ Corporation ] or a **comparable rating by another NRSRO**.

(ii) The self-insurer shall replace the letter of credit with a new letter of credit issued by a bank with an acceptable credit rating or with another acceptable form of security if [ a ] the **issuing bank's highest** rating falls below the acceptable rating **outlined in subparagraph (i)** after the letter of credit is issued. If the letter of credit is not replaced within [ 60 ] 45 days, the Bureau will draw on the letter of credit and will deposit the proceeds to secure the self-insurer's liability.

(iii) The applicant shall execute **and maintain** a trust agreement on a form prescribed by the Bureau with a Commonwealth-chartered bank and trust company or trust company as defined in section 102 of the Banking Code of 1965 or a Federally-chartered bank or foreign bank with a branch office and trust powers in this Commonwealth. **The bank and trust company or trust company shall have a nonprocurement registration number.** The trust agreement will accommodate proceeds from a letter of credit drawn on by the Bureau. **The Bureau may draw down on a letter of credit posted by a self-insurer to finance the maintenance of the trust arrangement if the self-insurer fails to maintain this arrangement.**

(iv) The trustee of the trust agreement required under subparagraph (iii) shall maintain a standby arrangement with a claims service company for the administration and the payment of the self-insurer's claims on behalf of the trust in the event of the self-insurer's default on its liability and the deposit of the proceeds of the letter of credit in the trust fund. **Evidence of the standby arrangement shall be provided annually to the Bureau.**

(c) Affiliates included under a consolidated permit under § 125.4(a) (relating to application for affiliates and subsidiaries) must be included together under the forms of security provided. For purposes of this section, affiliates [ included under a consolidated permit are considered to be one self-insurer ] that are runoff self-insurers are considered to be active self-insurers if they were included under a consolidated permit with affiliates that remain active self-insurers.

(d) The amount of security required of [ self-insured ] private employers is **determined** as [ described ] set forth in paragraphs (1)—[ (4) ] (6).

(1) For a new self-insurer, the Bureau will determine the **initial** amount of security [ . **The initial security will** ], to be calculated as follows:

(i) **An amount** no less than **two times** the amount of the applicant's total greatest annual insured incurred workers' compensation losses in this Commonwealth during the **last 3 [ complete ] completed** policy years prior to its application [ plus ], or the **minimum** security [ constant and rounded ] amount, whichever is greater.

(ii) **Discounted by the percentage outlined under subsection (i) for the applicant's highest current long-term credit or debt rating, if any.**

(iii) **Rounded** upward to the nearest hundred thousand.

(2) For those **active self-insurers** who have been approved [ for self-insurance ] to self-insure for more than 1 year but less than 3 years, the amount of security is [ the ] calculated as follows:

(i) **The greater of [ that ]:**

(A) **The amount** outlined in paragraph (1) [ or 100% ].

(B) **One hundred percent** of the **Bureau's calculation of the self-insurer's undiscounted** outstanding liability based on loss development, net of workers' compensation excess insurance recoveries [ , as adjusted by its history of loss development by the Bureau or as projected by an actuary, plus the security constant and rounded ].

(ii) **Discounted by the percentage outlined under subsection (I) for the applicant's highest current long-term credit or debt rating, if any.**

(iii) **Rounded** upward to the nearest hundred thousand.

(3) For those **active self-insurers** who have been approved [ for self-insurance ] to self-insure for 3 or more years, the amount of security is [ 100% ] calculated as follows:

(i) **One hundred percent** of the **Bureau's calculation of the self-insurer's undiscounted** outstanding liability based on loss development, net of workers' compensation excess insurance recoveries, [ as adjusted by its history of loss development by the Bureau or as projected by an actuary, plus ] or the **minimum** security [ constant and rounded ] amount, whichever is greater.

(ii) **Discounted by the percentage outlined under subsection (I) for the applicant's highest current long-term credit or debt rating, if any.**

(iii) **Rounded** upward to the nearest hundred thousand.

(4) [ Notwithstanding this subsection, the Bureau may require security in an amount greater than outlined in this section if it finds that the security resulting from the description in paragraphs (1)—(3) would not be adequate to secure fully and guarantee the payment of incurred and future benefits to each self-insurer's employes. ] When multiple affiliates are included under a consolidated

permit, the required amount of security for the consolidated program is calculated as follows:

(i) The sum of each individual affiliate's required amount of security as calculated under the applicable paragraphs above but excluding the effects of any rounding or minimum applicable to the individual affiliates, or the minimum security amount, whichever is greater.

(ii) Discounted by the percentage outlined under subsection (l) for the applicant's highest current long-term credit or debt rating, if any.

(iii) Rounded upward to the nearest hundred thousand.

(5) For runoff self-insurers, the amount of security is calculated as follows:

(i) One hundred percent of the Bureau's calculation of the runoff's undiscounted outstanding liability based on loss development, net of workers' compensation excess insurance recoveries.

(ii) Discounted by the percentage outlined under subsection (l) for the runoff's highest current long-term credit or debt rating, if any.

(iii) Rounded upward to either:

(A) The nearest ten thousand if the Bureau's calculated undiscounted outstanding liability, net of workers' compensation excess insurance recoveries, discounted by the percentage outlined under subsection (l) for the runoff's highest current long-term credit or debt rating, if any, is \$50,000 or less.

(B) The nearest hundred thousand.

(6) When multiple runoff self-insurers are included under one security instrument, the required amount of security is calculated as follows:

(i) The sum of each individual runoff self-insurer's required amount of security as calculated under paragraph (5) but excluding the effects of any rounding applicable to the individual runoff self-insurers.

(ii) Discounted by the percentage outlined under subsection (l) for the runoff self-insurers' highest current long-term credit or debt rating, if any.

(iii) Rounded upward to either:

(A) The nearest ten thousand if the Bureau's calculated undiscounted outstanding liability, net of workers' compensation excess insurance recoveries, discounted by the percentage outlined under subsection (l) for the runoffs' highest current long-term credit or debt rating, if any, is \$50,000 or less.

(B) The nearest hundred thousand.

(e) [ A self-insurer wishing to refute the Bureau's adjustment of its outstanding liability by its history of loss development may do so by providing a report prepared by an actuary. ] The Bureau may consider the analyses and projections of a report prepared by an actuary retained by a self-insurer. The Bureau is not required to accept or use the actuary's analyses or projections in calculating its projection of the self-insurer's outstanding liability under subsection (d).

(f) [ Only a projection of a self-insurer's outstanding liability prepared by an actuary may be discounted to present value. The present value dis-

count rate will be no more than the current yield of a 30-year United States Treasury bond. ] The Bureau may incorporate or use the overall Commonwealth's workers' compensation experience of insured or self-insured employers in the self-insurer's industry or of all insured or self-insured employers in its selection of loss development factors under subsection (d) if the claim volume or experience of the self-insurer is not sufficient to be considered fully credible based on generally accepted actuarial procedures. The loss development factors selected by the Bureau and its other judgments in its calculation of a self-insurer's outstanding liability will be sufficiently conservative to ensure the adequate provision of security.

(g) The Bureau may make any adjustments to the loss development procedures under subsection (d) it deems appropriate under the circumstances, or it may use methods other than loss development it determines to be reasonable to calculate the amount of the self-insurer's outstanding liability, if the Bureau believes that a self-insurer has changed its reserving methodology in such a way as to invalidate loss development factors based on past experience. [ The Bureau may further require the self-insurer to obtain the services of an actuary to project its outstanding liability or require an appropriate party to conduct an audit of the self-insurer's claims reserves. ]

(1) The Bureau may substitute the self-insurer's default multiplier-calculated security factor for the outstanding liability amount based on loss development in calculating the self-insurer's required amount of security if the Bureau believes that the paid, incurred or case reserve data reported under § 125.3 (relating to application) or under § 125.16 (relating to reporting by runoff self-insurer) is substantially inaccurate and cannot be accurately replaced within a reasonable period of time.

(2) In applying the default multiplier-calculated security factor, the Bureau may adjust a self-insurer's annual payout of benefits to correct any material underpayment of benefits the Bureau believes results from the self-insurer's failure to pay compensation for which it is liable during the evaluation period or if the Bureau finds that the factor would inadequately estimate the self-insurer's outstanding liability, including liability from a significant infusion of claims.

\* \* \* \* \*

(i) The Bureau may reduce the amount of security required of a self-insurer under subsection (d) to no less than the minimum security [ constant ] amount rounded upward to the nearest hundred thousand if the self-insurer establishes a funding trust to provide a source of funds for the payment of its liability. A self-insurer may elect to establish a funding trust or it may be required by the Bureau to establish a funding trust where the Bureau determines that a dedicated source of funds is needed to further ensure the timely payment of the self-insurer's liability. In either case, the following conditions shall be met:

(1) The trust agreement [ shall ] must be in a form prescribed by the Bureau.

(2) The trust assets [ shall ] must be held in a Commonwealth chartered bank and trust company or trust company as defined in section 102 of the Banking

Code of 1965 or a Federally chartered bank or foreign bank with a branch office and trust powers in this Commonwealth.

(3) The value of the trust fund [shall] must be adjusted at least annually to the required funding level as determined by the Bureau [or an actuary].

(j) A self-insurer with security [as of October 14, 1995,] which is less than the level of security required by subsection (d) may be permitted to phase in the level of required security over a maximum of [3] 2 years. The Bureau will determine the terms of the phase-in period, including the length of time and the annual [adjustments] phase-in amounts.

(k) [The Bureau will not grant a request for a reduction in or release of security by a runoff self-insurer until at least 1 year has passed since the termination of its self-insurance status or the runoff self-insurer provides a certificate of insurance evidencing that its self-insurance liability has been assumed by an authorized workers' compensation carrier. Requests shall be supported by a report prepared by an actuary projecting the runoff self-insurer's outstanding workers' compensation obligation, a claims reserves analysis prepared by an appropriate party or a certificate of insurance evidencing assumption of self-insurance liability. The Bureau will consider but is not bound by the findings of the reports in deciding security reduction or release requests.] The Bureau may release a runoff self-insurer of its obligation to provide security if either of the following occurs:

(1) The runoff self-insurer provides evidence that its liability was assumed under a self-insurance loss portfolio transfer policy.

(2) If the runoff self-insurer made no payments on its liability over the past 2 years, all claims against the runoff self-insurer are closed and the runoff self-insurer presents evidence acceptable to the Bureau that it is unlikely that any new claims will be filed or that any closed claims will be reopened.

(l) The [amount of security required of a self-insurer under subsection (d)] shall be discounted by 40% and rounded upward to the nearest hundred thousand if the [following discount percentages shall be applied in calculating a self-insurer's required amount of security under subsection (d)] based on the highest long-term credit or debt rating of the self-insurer or of the affiliate guarantying the self-insurer's liability: [is rated Aaa or Aa by Moody's Investors Services or AAA or AA by Standard & Poor's Corporation. The amount of security required of a self-insurer under subsection (d)] shall be discounted by 20% and rounded upward to the nearest hundred thousand if the debt of the self-insurer or of the affiliate guarantying the self-insurer's liability is rated A or Baa by Moody's Investors Services or A or BBB by Standard & Poor's Corporation. A self-insurer receiving one of the discounts outlined in this subsection shall increase its security to the amount required under subsection (d) as limited by this subsection, if applicable, if the debt rating of the self-insurer or of its guarantying affiliate is downgraded to below the rating qualifying it for the discount.]

#### Security Discount Table

<i>Moody's Investors Service</i>	<i>Standard &amp; Poor's, Fitch Ratings, or Dominion Bond Rating Service</i>	<i>Security Discount</i>
Aaa	AAA	75%
Aa1	AA+	65%
Aa2	AA	60%
Aa3	AA-	55%
A1	A+	45%
A2	A	40%
A3	A-	35%
Baa1	BBB+	25%
Baa2	BBB	20%
Baa3	BBB-	15%
Ba1 and lower	BB+ and lower	0%

(m) [Termination of self-insurance status may not relieve a runoff self-insurer from the obligation to provide security under this section, including the obligation to provide additional security due to increases in the value of its outstanding liability.] The Bureau may revise the table in subsection (l) through publication of a notice in the *Pennsylvania Bulletin*, to assign security discount rates for revisions to the long-term credit or debt ratings of the outlined NRSROs or for the long-term credit or debt ratings of other NRSROs.

#### § 125.10. Funding by public employers.

(a) A self-insured public employer shall establish and maintain a [trust fund] dedicated asset account to provide a source of funds for the payment of benefits and other obligations and expenses relating to its self-insurance program. [The trust agreement shall be in a form prescribed by the Bureau.] This section does not apply to [the Commonwealth] a runoff self-insured public employer whose average annual payout of benefits on self-insurance claims over its last 3 completed calendar years, net of workers' compensation excess insurance recoveries, is less than the current Statewide average weekly wage multiplied by 100.

(b) [For a public employer whose self-insurance status began or begins on or after October 14, 1995, the funding level of the trust fund established under subsection (a) shall be maintained at a level which is at least equal to the self-insurer's outstanding liability.] For a new self-insured public employer and for an active self-insured public employer that has been self-insured for less than 3 consecutive years, the required asset level of the dedicated asset account established under subsection (a) is calculated as follows:

(1) An amount greater than or equal to 20% of the public employer's modified manual premium calculated in accordance with § 125.202 (relating to definitions) or the minimum funding amount, whichever is greater.

(2) Discounted by the percentage outlined under § 125.9(l) (relating to security requirements) for the self-insurer's highest current long-term credit or debt rating, if any.

(3) The dedicated asset account must equal the above prescribed asset level no later than 30 days before the effective date of the public employer's initial permit and may not be reduced below this asset level for the first 3 years of self-insurance.

(c) For an active self-insured public employer that has been self-insured for more than 3 consecutive years but less than 7 consecutive years, the required asset level of the dedicated asset account established under subsection (a) is calculated as follows:

(1) An amount greater than or equal to the greater of the following:

(i) The self-insurer's greatest annual payout of benefits since its initial approval to self-insure, net of workers' compensation excess insurance recoveries, plus 20% of that annual payment amount.

(ii) The minimum funding amount.

(2) Discounted by the percentage outlined under § 125.9(l) for the self-insurer's highest current long-term credit or debt rating, if any.

(3) The dedicated asset account must be equal to or exceed the prescribed asset level 120 days before the beginning of the self-insurer's next fiscal year or at a later date agreed to by the Bureau.

(4) The Bureau may adjust the self-insurer's greatest annual benefit payout amount to correct any material underpayment of benefits the Bureau believes is the result of the self-insurer's failure to pay compensation for which it is liable during the evaluation period.

(d) For an active self-insured public employer that has been self-insured for 7 or more consecutive years, the required asset level of the dedicated asset account established under subsection (a) is calculated as follows:

(1) An amount greater than or equal to the greater of the following:

(i) The self-insurer's average annual payout of benefits over its three most recent completed calendar years, net of workers' compensation excess insurance recoveries, plus 20% of that average payment amount.

(ii) The minimum funding amount.

(2) Discounted by the percentage outlined under § 125.9(l) for the self-insurer's highest current long-term credit or debt rating, if any.

(3) For good cause shown, the Bureau may permit an active self-insurer, who is self-insured on \_\_\_\_\_ (*Editor's Note:* The blank refers to the effective date of adoption of this proposed rulemaking.) and whose existing workers' compensation account or trust fund is funded below the required level under subparagraphs (i) and (ii), to phase-in compliance with the required funding amount of this subsection within a time period prescribed by the Bureau. The following also apply to this arrangement:

(i) The phase-in must not diminish the injured workers' guaranty of benefits or provide inad-

equated funding for the proper administration of the self-insurer's claims or for the timely payment of other obligations relating to the self-insurance program.

(ii) The self-insurer shall make annual deposits into the dedicated asset account in the minimum amount of 5% of its payout of benefits in the prior calendar year, or \$100,000, whichever is greater.

(iii) During the phase-in period, the self-insurer may not withdraw any assets from the dedicated asset account without the approval of the Bureau until the required funding level of the account under paragraphs (1) and (2) is met.

(iv) If the asset level of the self-insurer's dedicated asset account remains below the required level under paragraphs (1) and (2) after six annual deposits under clause (A), thereafter the required asset level of the account established under subsection (a) is calculated as follows:

(A) The actual asset value of the dedicated asset account at the time of the sixth annual deposit under clause A divided by the amount required under paragraphs (1) and (2) at that time.

(B) Multiplied by the amount required to be in the designated asset account under subparagraphs (1) and (2) for the current year.

(4) The dedicated asset account must equal or exceed the prescribed asset level 120 days before the beginning of the self-insurer's next fiscal year or at a later date agreed to by the Bureau.

(5) The Bureau may adjust the self-insurer's average annual payout of benefits to correct any material underpayment of benefits the Bureau believes is the result of the self-insurer's failure to pay compensation for which it is liable during the evaluation period.

(e) For a runoff self-insured public employer, the asset level of the dedicated asset account established under subsection (a) is that outlined under subsection (d), except that the minimum funding amount does not apply.

[ (c) For a public employer whose self-insurance status began prior to October 14, 1995, the funding level of the trust fund established under subsection (a) shall be maintained at a level which is at least equal to the difference between the self-insurer's outstanding liability as of a date determined by the Bureau following October 14, 1995, and its current outstanding liability or at a level which is greater than this amount as determined by the Bureau due to the financial condition or the workers' compensation loss experience or funding history of the self-insurer. ] (f) If a public employer self-insurer does not possess an investment grade long-term credit or debt rating, the Bureau may require that the asset level of its dedicated asset account established under subsection (a) be greater than that outlined under subsection (b), (c) or (d), in any amount which the Bureau determines will guaranty that the self-insurer will have sufficient funding to meet fully its claims payments and other obligations and expenses relating to its self-insurance program as they come due over the self-insurer's next fiscal year.

§ 125.11. [ Specific excess insurance and aggregate excess ] Excess insurance.

(a) [ A self-insured private employer with quick assets of less than the Statewide average weekly wage multiplied by 200,000 or with cash and cash equivalents of less than the Statewide average weekly wage multiplied by 100,000 or a self-insured public employer with general fund quick assets of less than the Statewide average weekly wage multiplied by 50,000 shall obtain specific excess insurance with a liability limit acceptable to the Bureau and a retention amount or cash flow protection amount which is less than 10% of its quick assets. The Bureau may waive this requirement upon written request if the self-insurer demonstrates that it has sufficient financial strength and liquidity to assure that all obligations under the act and the Occupational Disease Act will be promptly met without the protection of an excess insurance policy. ] An applicant whose catastrophic loss estimation is greater than its maximum quick assets exposure amount shall obtain aggregate excess insurance or specific excess insurance with a retention amount that is no more than its authorized retention amount and a liability limit acceptable to the Bureau to provide an adequate level of protection to cover the losses from a catastrophic event.

(b) [ Aggregate excess insurance may be obtained by a self-insurer. The Bureau will not recognize a contract or policy of aggregate excess insurance in considering the ability of an applicant to fulfill its financial obligations under the act and the Occupational Disease Act unless the contract or policy complies with subsection (c).

(c) The ] A contract or policy of [ aggregate ] excess insurance [ or specific excess insurance, or both, shall ] must comply with the following:

(1) [ It shall be issued by an excess insurer which possesses an A. M. Best Rating of B+ or better or a Standard and Poor's rating of claims paying ability of A or better.

(2) ] It [ shall ] must state that it is not cancelable or nonrenewable unless written notice by registered or certified mail is given to the other party to the policy and to the Bureau at least 45 days before termination by the party desiring to cancel or not renew the policy.

[ (3) ] (2) It [ shall ] must state that if a self-insurer is unable to make benefit payments under the act and the Occupational Disease Act due to insolvency or bankruptcy, the excess carrier shall make payments to other parties involved in the paying of the self-insurer's liability, as directed by the Bureau, subject to the policy's retentions and limits.

[ (4) ] (3) It [ shall ] must state that the following apply toward reaching the retention amount in the excess contract:

\* \* \* \* \*

[ (5) ] (4) It [ shall ] must state that it applies to any losses of a self-insurer under the act and the Occupational Disease Act [ ; it ]. It may not exclude coverage for any categories of injuries or diseases compensable under the act and the Occupational Disease Act.

[ (d) ] (c) A certificate of the excess insurance obtained by the self-insurer [ shall ] must be filed with the Bureau together with a certification that the policy fully complies with subsection [ (c) ] (b).

§ 125.12. Payment, handling and adjusting of claims.

\* \* \* \* \*

(c) A self-insurer shall notify the Bureau when it changes arrangements for the handling or adjusting of its claims, including the initiation, modification or termination of self-administration arrangements or the initiation, termination, expiration or modification of services with a registered claims services company. Upon the Bureau's request, the self-insurer shall forward to the Bureau a summary of data on its claims, such as cumulative payments sorted by year of loss, in a Bureau-prescribed format and in a time-frame agreed to by the Bureau if the Bureau determines that this data is necessary to maintain the integrity of past data on the claims filed or to rectify or explain discrepancies or questions raised by the data summary.

§ 125.13. Special funds assessments.

(a) A self-insurer is responsible for the payment of assessments to maintain funds under the act, including:

\* \* \* \* \*

(5) The Uninsured Employers Guaranty Fund.

\* \* \* \* \*

(c) A self-insurer shall keep accurate records of compensation paid on a calendar year basis, including payment for disability of all types, death benefits, medical benefits and funeral expenses, for the purposes of assessments under the act and the Occupational Disease Act. The records [ shall ] must be available for audit or physical inspection by Bureau [ employes ] employees or other designated persons, whether in the possession of the self-insurer or a service company. If the Bureau has a reasonable basis to question the annual compensation payments reported by the self-insurer, it may require the self-insurer to retain the services of the self-insurer's licensed certified public accounting firm to audit the data reported to provide confirmation or make necessary adjustments.

§ 125.15. Workers' compensation liability.

(a) Notwithstanding the terms of a guarantee and assumption agreement executed under § 125.4(b) (relating to application for affiliates and subsidiaries), a self-insurer or a runoff self-insurer remains liable for workers' compensation on injuries or disease exposures occurring during its period of self-insurance. With application to and permission from the Bureau, liability can be transferred to another employer. Liability also may be transferred [ to a company authorized to write workers' compensation insurance in this Commonwealth if the employer gives written notice to the Bureau within 10 days of the transfer ] through a self-insurance loss portfolio transfer policy.

(b) A self-insurer which liquidates or dissolves shall transfer its liability to a third party, subject to the approval of the Bureau, or shall [ insure its liability with a company authorized to write workers' compensation insurance in this Commonwealth ] obtain a self-insurance loss portfolio transfer policy covering the liability.



(c) If a self-insurer sells or divests a part of itself, self-insurance coverage ends for the separated parts on the date of separation. The self-insurer remains [ **responsible** ] **liable** for claims incurred against the separated part occurring up to the date of separation unless the Bureau approves [ **an alternative arrangement for the payment of** ] a request to transfer the self-insurer's liability to another entity.

**§ 125.16. Reporting by runoff self-insurer.**

(a) A runoff self-insurer shall file an annual report with the Bureau by a date prescribed by the Bureau on a prescribed form.

(b) The runoff report [ **shall** ] **must** include a [ **list of the runoff self-insurer's open cases, the reserves on those cases, the administrator of those cases and the runoff self-insurer's payout for workers' compensation benefits in the preceding calendar year** ] listing in a Bureau-prescribed electronic format of the runoff's Pennsylvania workers' compensation claims, including all claims currently in litigation, and information such as payments and reserves on each claim. The listing must include all opens claims at the time of submission and, if available, all claims closed in the past. If a listing of all claims closed in the past is not available, the listing must at least include all claims closed on or after \_\_\_\_\_ (*Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.*). Case reserves provided in the listing must be established according to the Bureau's instructions. This report [ **shall** ] **must** be filed until all cases incurred during the runoff self-insurer's period of self-insurance are closed for at least 2 years.

(c) A runoff self-insurer that is a private employer shall make any request for the adjustment of its amount of security in writing when it submits its runoff report. If the runoff self-insurer disagrees with the Bureau's decision on the request, it may request reconsideration of this decision under § 125.6(e) (relating to decision on application).

**§ 125.17. Claims service companies.**

\* \* \* \* \*

(c) The claims service company shall employ at least one person on a full-time basis who has the knowledge and experience necessary to service claims properly under the act and the Occupational Disease Act. A resume covering that person's background [ **shall** ] **must** be attached to the registration form of the claims service company.

(d) A claims services company whose engagement to handle or adjust the claims of a self-insurer is terminating or expiring, or has terminated or expired, shall provide reasonable assistance to the self-insurer and the Bureau in providing data and information on the claims serviced to maintain the integrity of past data on the claims filed with the Bureau, to rectify or explain discrepancies or questions on the claims data raised by the Bureau, or to address other related issues identified by the Bureau.

**§ 125.19. Additional powers of Bureau and orders to show cause.**

[ **In addition to the powers enumerated elsewhere in this subchapter, the act and the Occupational**

**Disease Act, the Bureau will have the authority, after notice and opportunity for hearing, to suspend a self-insurer's permit, to issue cease and desist orders and to order corrective actions if a self-insurer is in violation of this subchapter, the act or the Occupational Disease Act.** ] (a) If the Bureau has reason to question whether a self-insurer continues to maintain the financial ability to self-insure during the pendency of a permit, authorized under section 305(a)(3) of the act (77 P. S. § 501(a)(3)) and under section 305 of the Occupational Disease Act (77 P. S. § 1405), it may issue a letter to the self-insurer noting the reasons for its concerns and outlining the documents, data and information upon which the Bureau's concerns are based. The following also apply:

(1) The Bureau's letter is treated for procedural purposes as if it were an initial decision denying a renewal application under § 125.6(d) (relating to decision on application).

(2) When the Bureau determines that the self-insurer no longer possesses the financial ability to self-insure, the self-insurer's current permit will be revoked, unless the self-insurer timely initiates the procedures outlined under § 125.6(e)—(g).

(3) The self-insurer shall obtain workers' compensation insurance coverage effective no later than 30 days after its receipt of a notice of revocation by the Bureau and provide evidence of the coverage to the Bureau no later than the coverage's effective date.

(b) The Department may serve upon a self-insurer an order to show cause why its self-insurance status should not be suspended or revoked under section 441(b) of the act (77 P. S. § 997(b)) for unreasonably failing to pay compensation for which it is liable, or for failing to submit any report or to pay any assessment made under the act.

(1) The order to show cause proceedings are governed by provisions in Chapter 121 (relating to general provisions), found in § 121.27 (relating to orders to show cause).

(2) The self-insurer shall obtain workers' compensation insurance coverage effective no later than 30 days after its receipt of an order revoking or suspending its self-insurance status and provide evidence of the coverage to the Department no later than the coverage's effective date.

**§ 125.20. Computation of time.**

[ **Unless otherwise provided, reference to the term "days" in this subchapter means calendar days. For purposes of determining timeliness of filing and receipt of documents transmitted by mail, 3 days shall be presumed added to the prescribed period. If the last day for filing a document is a Saturday, Sunday, legal holiday or a day on which the Bureau's offices are closed, the time for filing shall be extended to the next business day. Transmittal by mail shall mean by first-class mail.** ] Except as otherwise provided by law, in computing a period of time prescribed or allowed by this chapter, the day of the act, event or default after which the designated period of time begins to run may not be included. The last day of the period so computed shall be included, unless it is Saturday,

Sunday or a legal holiday in this Commonwealth, in which event the period shall run until the end of the next day which is neither a Saturday, Sunday nor a holiday. A part-day holiday shall be considered as other days and not as a holiday. Intermediate Saturdays, Sundays and holidays shall be included in the computation.

**§ 125.21. Self-insurance loss portfolio transfer policy.**

A self-insurance loss portfolio transfer policy must comply with all of the following:

(1) The insurance carrier must be a workers' compensation insurer.

(2) The policy must provide statutory coverage limits and state that the insurer is responsible to defend, adjust and handle all open, reopened and incurred but not reported claims against the self-insurer for the period of time covered by the policy.

(3) The policy must be retrospective, providing coverage for a consecutive period of time of self-insurance.

(4) The policy must be noncancelable by either the insurance carrier or the self-insurer for any reason.

(5) The amount of annual compensation paid by the insurance carrier on any claims assumed under

the policy must be included as compensation paid on the data reports filed with the Insurance Department.

(6) The insurance carrier must include the premium received on the policy in the amount of net written workers' compensation premium it annually reports to the Insurance Department or to the National Association of Insurance Commissioners.

(7) The insurance carrier must notify existing claimants with injuries or diseases covered by the policy that it has assumed liability for the payment and handling of their claims.

(8) The insurance carrier must file the policy with a rating organization approved by the Insurance Commissioner and identify it as a special self-insurance loss portfolio transfer policy. The insurance carrier should not report statistical information on claims assumed under the policy to the rating organization.

(9) The insurance carrier must enter an appearance with the appropriate workers' compensation judge, the Workers' Compensation Appeal Board and any appellate court on each pending claim in adjudication against the self-insurer for injuries or disease exposures occurring during the time period covered by the policy.

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