JUDICIAL BRANCH WORKERS' COMPENSATION PROGRAM ADVISORY COMMITTEE
Minutes of the Business Meeting—April 10, 2015
Judicial Council of California – Sacramento
Fourth Floor, Veranda Rooms A and B
2860 Gateway Oaks Drive, Suite 400
Sacramento, California 95833

FRIDAY, APRIL 10, 2015
OPEN MEETING (RULE 10.6(A))—BUSINESS MEETING AGENDA

Advisory Body Members Present:	Ms. Tania Ugrin-Capobianco, Chair, Ms. Cindia Martinez, Ms. Colette Bruggman, Ms. Jeanine Bean, Ms. Michelle Hafner, Ms. Richard Feldstein, Ms. Shelia Tolbert, Ms. Stephanie Cameron, Ms. Stephanie Cvitkovich, Mr. John Zeis, Mr.
Advisory Body Members Absent:	Ms. Brenda Lussier, Mr. David Yamasaki, Ms. Jamie Lau, Ms. Elisha Allen, Ms. Heather Capps
Others Present:	Mr. Greg Trout, Ms. Angela Bernard, Ms. Jacquelyn Miller, Mr. Michael Harrington, Mr. Mark Priven, Mr. Jeff Johnston, Mr. Jon Paulsen, Mr. Dominic Russo, Ms. Lynn Cavalcanti, Ms. Tricia Baker, Mr. Patrick Fuleihan, Ms. Diane Wratten, Ms. Linda Cox, Ms. Lisa Bartlow, Ms. Jade Vu, Mr. Patrick Farrales, Mr. Zlatko Theodorovic, Ms. Lucy Fogarty, Ms. Pat Haggerty, Mr. Steven Chang, Ms. Krystal Hess, Ms. Erin Allen, Enrique Estacio (on behalf of Ms. Kimberlie Turner)

I. OPEN MEETING

Call to Order
Ms. Linda Cox called the meeting to order at 9:00 a.m. in Veranda Rooms A and B on the fourth floor of the Sacramento office of the Judicial Council of California (JCC).

II. PUBLIC COMMENT

Written Comments Received

No written comments were received.

III. INFORMATION ONLY ITEMS (NO ACTION REQUIRED)

ITEM 1: ARRIVAL; CONVENE MEETING/OPENING REMARKS/AGENDA REVIEW; WRITTEN COMMENTS

Linda Cox's Remarks
Ms. Linda Cox thanked the participants for their visit at this annual meeting. She noted that due to the size of the group that it may be necessary to meet again before the next annual meeting. Ms. Cox also noted that there are additional decisions to make in preparation for the next fiscal year.

NO COMMITTEE ACTION.

ITEM 2: INTRODUCTIONS

Greg Trout's Remarks Regarding Bickmore

Bickmore began working with the Judicial Council of California about one year and one-half ago when they were selected to replace the previous administrator and broker. Bickmore is a firm of 110 employees that has operated out of Sacramento for 30 years. Bickmore's focus has been on public entities, public entity risk management programs, and self-insurance programs. Bickmore is the leading consultant that provides actuarial advice, claims management systems, risk management systems, and risk control. Mr. Trout provided details regarding his professional background which included the CSAC Insurance Authority from which the Judicial Branch Workers' Compensation Program (JBWCP) program evolved. Currently in California there are 90 other programs like the JBWCP's, such as school district, city and county pools.

The JBWCP compares to Bickmore's other clients in that it falls near the middle range with their large client pools having near $100 million in revenue each year. One of Bickmore's largest clients is the University of California, which includes all campuses. They also have other state agency clients, such as the Department of Workers' Compensation. As a result they are very familiar with the public sector, whether that is the state, local, or county government.

Tricia Baker's Remarks Regarding AIMS

Acclamation Insurance Management Services (AIMS) began working with the JBWCP in July 2014 and were able to fully take over all claims and as the new third party administrator (TPA) effective October 1, 2014. Ms. Baker's regular duties are to transition new clients into AIMS. She has also acted as the Interim Program Manager for the JBWCP account in order to work on the transition process with the JBWCP. Patrick Fuleihan has recently joined AIMS as the Interim Program Manager.

When AIMS took over the JBWCP program's open claims inventory they anticipated 1,170 open claims; however, 1,340 open claims were transferred. This difference was due to several reasons including the bid numbers were completed six months before AIMS had taken over the JBWCP account. This would have caused the open inventory to increase. In addition, Ms. Baker advised that October 2014 was one of the largest reporting months that the JBWCP has had with 75 new claims being reported.

While the industry standard is to have 150 claims per examiner, this program only allows for 130 claims per examiner. This lower case load sets up AIMS for success because the examiners are better able to manage their claims. AIMS estimated that they needed nine examiners to handle the anticipated open claims; however, after further review they actually need 10 examiners. When AIMS took over, they were able to close many claims which brought the case load down to 1,296 open claims at the end of January, 2015. This claims volume still requires10 examiners. When AIMS triaged claim files, they also had to confirm the information, determine if the previous action plans remained valid or if they needed to change, determine the current claim status and develop new action plans and set diaries and work with the courts on a plan of action in moving the claims forward. To further bring down the inventory, AIMS examined expenses related to the usage of outside vendors, such as field investigators and nurses. During the triage of claims, AIMS determined that they could close 27 nurse case management assignments that were no longer required.

A standard company goal is to close as many cases as it opens, which would be a 100 percent closure ratio. Between the beginning of October 2014 and the end of January 2015, AIMS had a closure ratio of 132 percent with 250 new claims that were compared to the 284 closed claims. When the 29 reopened claims were added to the newly opened claims, totaling 279 open claims, AIMS still had a closure ratio of 101 percent. Additionally, AIMS has denied 22 claims (9%), delayed 19 claims (8%) due to compensability, and approved 209 claims (83%) – all of which fell within industry standards as a normal ratio.

Regarding the reporting of new claims, there are three ways to report it to AIMS: (1) fax the completed form to AIMS, (2) visit the 5020 website and directly enter the claim information, or (3) call the new 24-hour injury hotline call center. This call center directly and simultaneously enters the injury information into the 5020 website, so the injured worker receives his or her claim number and report immediately.

Currently AIMS is still interviewing and recruiting qualified examiners. AIMS were authorized to hire a tenth examiner who will not be assigned to a specific court. They will work behind the scenes and assist the Claims Examiners on every court and work on special projects as needed. In the event of vacations, maternity leaves or if an Examiner leaves, this position will step into the vacancy thus eliminating any down time on any desk.

NO COMMITTEE ACTION.

IV. DISCUSSION AND POSSIBLE ACTION ITEMS

ITEM 3: NEW THIRD PARTY CLAIMS ADMINISTRATION VENDOR, AIMS

Diane Wratten's Remarks Regarding AIMS Services and Accomplishments

Ms. Wratten is responsible for computer access, information, reports, and anything else related to the claims data. Ms. Wratten has worked with Bickmore, the JCC and the AIMS operation team to collect JBWCP claims data to input and convert it into the AIMS system. AIMS also scheduled additional meetings with the courts, so that they were included in the transition process. This ensured that the courts' needs were heard and met.

AIMS is currently standardizing all occupational codes for the JBWCP organizational structure. They will be advancing and expanding the current JBWCP structure to building and department level. The expansion will provide more accurate claims data reporting. The JBWCP will then have a more thorough understanding of which department to allocate risk management resources in order to reduce losses. This also allows AIMS to have a better understanding of the JBWCP, a better reporting system and manage claims more efficiently. As a result of the information sharing process, AIMS will have a more global view of the JBWCP.

Ms. Wratten also reported on the many AIMS accomplishments that were achieved during the transition process. First, In November and December 2014, AIMS held two open houses – one in Northern California and one in Southern California. AIMS sister company, Allied Managed Care, also attended. Allied Managed Care handles AIMS utilization review, medical bill review, nurse case management and manages the Medical Provider Network (MPN). These open houses gave AIMS the opportunity to provide the courts with training on how to enter new claims and run routine claims reports.

Second, AIMS has created online, hands-on training webinars for all of the courts. AIMS trained 114 users on the system. AIMS continue to offer these trainings on an ongoing basis. For example, when an individual needs assistance or a refresher course with the AIMS system or if a new employee needs training.

Lastly, AIMS actively monitors who has access to their system to ensure that only those people who need access to the system have access. They also send out a quarterly report to the courts via E-mail to verify who has access, what level of access they have, and what their titles are for verification and termination as needed.

> *FOLLOW UP*
> AIMS would like the JBWCP to provide them with names of new and discharged employees as the information becomes available.

Tricia Baker's Remarks Regarding AIMS Accomplishments

AIMS scheduled Claims Examiner trainings with staff and discussed customer service, policies and procedures, how to enter notes into the claims systems and training on how to use their paperless system. Ms. Cox also gave a separate presentation to the Claims Examiners regarding the JBWCP which provided them with historical and current information regarding the California courts.

AIMS implemented their pharmacy benefits program. During the transition from the prior Third Party Administrator (TPA) to AIMS, the prior TPA could not provide social security numbers until the actual data transferred. This was difficult because the pharmacy program needed social security numbers to issue cards to injured workers. As a result, AIMS could not prepare any cards in advance. Once AIMS received the raw data for 1,300 files they had to input all of this date within six weeks in order to distribute cards to injured workers. In the interim, AIMS sent all of the injured workers pre-welcome letters that provided them with AIMS contact information, basic instructions and when their old cards would be deactivated and their new cards activated. Once AIMS did receive the data, they were able to input all of the information within three weeks instead of six weeks as anticipated. The new pharmacy benefits program can now electronically ask for authorization and bill, which has greatly improved the timeframe for injured workers to obtain their prescribed medication.

AIMS had worked with Allied Managed Care to construct the framework for AIMS' MPN. AIMS was able to receive input from all of the courts on preferences and that information was incorporated into the customization. Thirty-nine courts now participate in the MPN. The MPN helps control the medical costs and includes contracted physicians who help maintain quality care within established policies and procedures. The MPN became effective in March 2014, and AIMS hopes to have all injured workers currently treating outside the MPN moved into the network within 60 to 90 days.

Ms. Baker next spoke about additional changes that have taken place since AIMS came on board with the JBWCP. AIMS has a nurse review and triage all new claims as a form of early intervention.

Once the new claims are triaged the reports are provided to the manager and supervisor who will review and determine if the claim should be referred for medical case management. If it is determined that nurse case management services are needed the court will be consulted for their concurrence as to the specific task goal, length of service and associated costs.

The last change is the claim file documentation. AIMS has claim file templates that include litigation strategies, plans of action and more basic detail to ensure that all issues are addressed. The templates require the Claims Examiner to input more detailed information including a plan of action every 90 days. The Claims Supervisors also review claims within established timeframes to identify any roadblocks that are preventing this claim from moving forward or closing.

Diane Wratten's Remarks Regarding Future Improvements
Ms. Wratten then spoke about future improvements of AIMS. AIMS will be providing a list of the past three years claims data – open and closed – so that these claims can be reassigned to their proper organizational structure in the JBWCP's new court location hierarchy. This reorganization will allow for better reporting, managing of claims and understanding of the losses for follow up risk management activities. AIMS' goal is to begin this process in May 2015, and it will take effect once AIMS has finished expanding the JBWCP's hierarchy. AIMS is also differentiating between the courts based on their size and potentially with regional locations of the courts. Once completed this would allow AIMS to compare like-sized courts with other like-sized courts. Lastly, Ms. Wratten thanked the JBWCP for their help, assistance and cooperation.

Patrick Fuleihan's Remarks Regarding Joining the Program
Mr. Fuleihan thanked the JBWCP and is excited to participate in this program. He stated that transitioning is a work in progress and it takes time, but he is going to make this program the best program that it can be.

Linda Cox's Remarks Regarding AIMS' Program Administrator
Ms. Cox stated that one of the key components of this program was to have a person from AIMS fully dedicated to act as the program administrator to oversee the AIMS team assigned to the JPBWCP program.

QUESTIONS ASKED

What is the role of Allied Managed Care?
Ms. Baker stated that Allied Managed Care is an AIMS sister company. They perform utilization and medical bill review as well as nurse case management services.

In situations of delays in treatment, is the examiner or Allied Managed Care the best route?
Ms. Baker and Mr. Fuleihan together answered that Allied Managed Care does perform many of AIMS authorizations, but the examiners have a certain level of authority, so it hard to say without looking at an individual case itself. If anyone would like a claim reviewed Mr. Fuleihan is available to determine the reasons for the delay. As a note, utilization review has five days to make a medical determination and fourteen days if they are not presented with all of the relevant information.

NO COMMITTEE ACTION

ITEM 4: PRESENTATION OF DRAFT ACTUARIAL REPORTS (*ACTION REQUIRED*)

Mr. Harrington of Bickmore gave a brief overview of actuarial terminology which included definitions for "Incurred Loss," Allocated Loss Adjusting Expense (ALAE)", "Unallocated Loss Adjusting Expense (ULAE)," "Incurred but Not Reported (IBNR)," and "Ultimate Loss."

Mr. Harrington explained that the two goals of the actuarial study are to determine: (1) how much does one owe for claims that have already been incurred (outstanding claims liabilities), and (2) how much money does the JPWCP need to keep the program running for the next fiscal year (funding/allocation). Mr. Harrington reviewed the loss development of the trial courts and state judiciary separately with the committee.

PRESENTATION OF ACTUARIAL RESULTS FOR OUTSTANDING CLAIMS LIABILITIES

TRIAL COURTS

When Mr. Harrington performed last year's review of the trial court program, the development for **incurred losses** (paid and case reserves) from 2000-01 through 2013-14 was expected to be $13.8 million for all years. However, in performing the actuarial review this year, it was determined that the actual loss development was $14.6 million. As a result, the trial courts' incurred loss increased $840,000 more than was expected in the prior year's report.

There are factors to take into consideration for the difference between expected and actual incurred losses one of which is that the prior TPA estimated the amounts differently than AIMS and may have had a different philosophy in their reserving practices. For this reason, Mr. Harrington looked at the trial court's paid loss development.

For **paid losses**, last year's actuarial study showed that from 2000-01 through 2013-14 the paid losses were expected to be $13.97 million. However the actual paid losses were $14.1 million which resulted in a paid loss of about $143,000 more than was estimated in the prior year report.

Mr. Harrington reviewed the trial court's **ultimate losses** shown in this year's study. When conducting last year's review, the actuary expected ultimate losses from 2000-01 through 2013-14 to be $214.8 million. The actual ultimate loss was $214.1 million which is a $716,000 decrease from the prior year report.

Mr. Harrington reviewed the **total outstanding liabilities** for the trial courts. The total reserves (case reserves plus IBNR plus TPA costs) from 2000-01 through 2013-14 increased from $74.53 million shown the prior report to $76.29 million, resulting in an increase of $1.76 million.

QUESTIONS ASKED

In 2002-2004, why was the estimated ultimate loss so much higher than later years where the loss has plateaued?

Mr. Harrington explained that in 2003-2004 there were workers' compensation reforms enacted specifically SB899, by the legislature which reduced benefits throughout the state. This made the process less profitable for lawyers to get involved in dealing with claims and made it less worthwhile for claimants to file claims because the benefits were reduced Because of the reduced benefits the new claims being filed decreased in frequency resulting in a 25 percent immediate decrease in costs.

Is it common in older years for the change in ultimate loss to be a negative number?
Mr. Harrington explained that the more claims linger the more they will cost, so older years may have a higher ultimate loss but as claims are resolved the costs will come down. However, Bickmore has seen cases where the older years develop more adversely and the more recent years develop better than expected. Next year, the reported loss numbers will carry more weight because AIMS will have been adjusting claims for at least one full year.

JUDICIARY

Last year's review of the judiciary program showed **incurred loss** development (paid and case reserves) from 2000-01 through 2013-14 was expected to be $631,000. However, in performing the actuarial review this year, it was determined that the actual loss development was $249,000 resulting in a decrease of $382,000. Because the actual loss was less than the expected loss, this was very favorable to the judiciary and it showed that the judiciary is headed in a good direction.

For **paid losses**, last year's actuarial study showed that from 2000-01 through 2013-14 the judiciary's paid losses were expected to be $938,000. However the actual paid losses were $704,000 which is a decrease of $$234,000 from the estimates in prior year report.

Mr. Harrington reviewed the judiciary's **ultimate losses** shown in this year's study. When conducting last year's review, the actuary expected ultimate losses from 2000-01 through 2013-14 to be $20.6 million. The actual ultimate loss was $20.27 million which is a $337,000 decrease from the prior year report.

Mr. Harrington reviewed the **total outstanding liabilities** for the judiciary. The total reserves (case reserves plus IBNR plus TPA costs) from 2000-01 through 2013-14 decreased from $5.96 million shown the prior report to $5.86 million, resulting in a decrease of $96,000 which is very positive for the judiciary.

TRIAL COURTS AND JUDICIARY COMBINED

Mr. Harrington presented an exhibit showing the outstanding liabilities (loss and ALAE) for the trial courts and state judiciary combined as of June 30, 2015 to be $75.9 million. When the ULAE component is added, the total is $82.1 million. This exhibit also shows increases at various confidence levels.

QUESTION ASKED
The total ultimate loss for 2013-2014 is almost $15 million, so do we know how much was paid in premiums that year?
Mr. Harrington responded that there is a difference between the total ultimate loss numbers and the allocations. The court allocations used the expected cash payments for the year, so when the premiums were set in the past, only a portion was related to that year and the remainder is related to the previous years. Historically, there was not a direct connection between the funding amount that goes into the court allocations and total ultimate loss.

For informational purposes Mr. Harrington presented two more exhibits comparing:

- Ultimate cost projections for new claims occurring between 7/1/2015 and 6/30/2016 ($16.4 million for the trial courts and $824,000 for the judiciary; and
- Projected payments that will be made between 7/1/2015 and 6/30/2016 for all claims – all years ($14.3 million for the trial courts and $780,000 for the judiciary.

PRESENTATION OF ACTUARIAL RESULTS FOR MEMBER PREMIUM ALLOCATIONS, 2015-16

Mr. Harrington gave the committee an overview of the JBWCP allocation model – what costs are allocated and the method in which those costs are allocated. Using the **cash flow funding** bases, the allocation components for **both the trial courts and judiciary** are loss and ALAE payments of $15.1 million, TPA fees of $2.25 million, excess premiums of $480,114 (trial courts only), and consulting and brokerage fees of $465,591, for a total of $18.34 million.

QUESTIONS ASKED

Can the actuarial report on the allocations be presented to the Judicial Council without first addressing the fund balance, fund reserves, or solvency of the program?

Ms. Cox answered that information will be presented to the Judicial Council in difference segments. The actuarial report discussing the total value of the program will be presented and accepted and then the court allocations will be presented as well for approval

In the projection and allocations is there is no reduction for any investment income?

Mr. Harrington replied that if you reflected investment income in the funds, then you can discount your reserves. Ms. Pat Haggerty added that the investment is held in a state investment money fund. This money, $51,000, is held in the fund balance and remains within this program and continues to grow with interest in a positive direction.

COMMITTEE ACTION

Michelle Hafner motioned to accept the actuarial report and present it to the Judicial Council. Shelia Tolbert seconded that motion. No one opposed. No one abstained.

ITEM 5: DISCUSSION OF PROGRAM FUNDING ALTERNATIVES (ACTION REQUIRED)

Mr. Harrington explained the differences between two funding method options: (1) **Cash Flow Funding** where premiums are charged to cover the *cost of claims paid* in a given fiscal year, and (2) **Ultimate Cost Funding** where premiums are charged to cover the *ultimate cost to claims occurring* in a given fiscal year. The current method used by JBWCP is the Cash Flow Funding method.

The total cash flow funding for 2015-16, combining the trial courts and judiciary is $18.34 million. This represents total amount expected to be paid between July 1, 2015 to June 30, 2016 for all claims and program expenses. Overall, the program has liabilities of about $82 million

and assets of about $51 million. This program is strongly funded for any projected short-term cash flow scenarios for about the next 20 years; however, in the long term the program is not fully funded.

The gap between program assets and program liabilities keeps increasing because the addition of new claims per year is higher than what is collected using the cash flow funding basis. Bickmore has recommended two program funding goals to close this gap. First, the short-term goal is to prevent the gap from increasing. Second, the long-term goal is to eliminate the gap and fully fund the program.

Bickmore recommends a change from Cash Flow Funding to Ultimate Cost Funding for FY15-16 because (1) without such a change, the gap between the program assets and liabilities will increase each year, (2) this is the standard best practice for pooled self-insurance programs, and (3) this is the accepted practice for risk enterprise funds.

QUESTIONS ASKED

How long has the Cash Flow Funding method been in place?
Mr. Harrington answered that to his knowledge it has been in place since the existence of the program.

Is there a five year history of the gap?
Mr. Harrington answered that at this time there is no historical report on the gap.

Mr. Harrington presented exhibits showing the cost to fund the 2015-16 program year on an ultimate cost basis. The allocation components for **both the trial courts and judiciary** are loss and ALAE payments of $17.1 million, TPA fees of $2.25 million, excess premiums of $480,114 (trial courts only), and consulting and brokerage fees of $465,591, for a total of $20.45 million. This is approximately $2.1 million more than funding on a cash flow basis.

Mr. Harrington informed the committee that historically the judiciary has not purchased excess insurance because the costs of such coverage have been unreasonably high. However an option has been presented for the judiciary to purchase excess insurance for 2015-16 at reasonable cost compared to what has been offered in prior years. The net cost to the judiciary to purchase this coverage would be $270,000. If it is decided to purchase the coverage this amount the judiciary's 2015-16 funding would also be increased by that amount.

In summary, a change to the ultimate cost funding method would achieve the program's **short-term** funding goal of preventing the gap between assets and liabilities from growing.

Looking to the future, the change to ultimate cost funding this year addresses the goal of preventing the asset to liability gap from growing but does not close the gap. The next step is to reduce the gap to the point where the program is fully funded. Bickmore recommends addressing this over the course of the 2015-16 year by developing a long term plan for reducing the gap. This plan would be brought to the committee for review and adoption and potentially implemented with the calculation of the 2016-2017 program premiums. It is expected that a funding plan will take a multi-year approach in order to ultimately achieve the funding goal.

QUESTION ASKED

Is there any reason why the JBWCP would not want excess insurance for the judiciary?

Mr. Harrington answered that the judiciary was grandfathered in without excess insurance and there has not been a claim anywhere near a catastrophic loss. If the excess insurance were purchased, losses would be capped if a catastrophic claim over $2 million occurred.

Mr. Trout added that the excess insurance responds not only to individuals, but also to events, such as if there were a strong earthquake where many workers were injured. In the past a reasonable quote was never obtained and it was never a good time to purchase the excess coverage. This is a good time to obtain a reasonable quote and purchase excess insurance coverage.

Ms. Cox added that in prior years, excess insurance was not provided for the judiciary because the quotes received were unreasonably priced for the JBWCP to provide that coverage. However, the JBWCP has received a reasonable quote for FY15-16, so now is the opportune time to propose this action to move forward toward along with a fully funded workers' compensation program. This would enable the JBWCP get acclimated to paying for this additional amount of excess insurance for the judiciary and to take advantage of the lower cost.

QUESTIONS ASKED

If an earthquake struck San Francisco, how would excess insurance apply to so many entities that are affected?
Mr. Paulsen answered that the excess program covers all of the members, so it acts as an entity that is responsible for the group members and the rest of the pool, but the policies for the trial courts and judiciary are separate.

As a committee should we look more holistically at ways to reduce the gap before we change our methodology?
Ms. Ugrin-Capobianco answered that they would like to move on from the cash flow funding method so that they can be fully funded. The committee needs to be more proactive and begin dealing with this gap now rather than wait and do it one year from now.

Mr. Trout stated that there has been a $4 million gap in collecting the funding in just the last two years, so now is the time to address this and start closing the gap.

Mr. Harrington then stated that the ultimate funding would not only bring the JBWCP to where Bickmore recommends it should be. Even without looking at a longer history pattern of the gap, you can see that the payments are developing worse in recent years. The gap is not going to recover without taking action now and or will continue to grow.

Mr. Feldstein stated that it is critical to deal with this now because this is not the only gap that the trial courts have to deal with, so the sooner that the JBWCP can move forward to address this gap, then the more favorable the decisions will be.

Why was the excess insurance quote received by JBWCP at a lower rate this year than it was quoted last year? And how do we know that it is not a teaser rate?

Mr. Paulsen answered that the large commercial excess insurers do not offer teaser rates. The insurance quote is valid for two years with an option to lock in the rate for the second year as long as the losses do not worsen. The insurance carrier would not have provided Merriwether with an amount that they were not comfortable with.

COMMITTEE ACTION
Cindia Martinez motioned to use the Ultimate Cost Funding method with the amendment to approve the increase in cost for the 15-16 fiscal year' by $2.1 million and to also include the purchase of excess insurance to the judiciary. Jeanine Bean seconded that motion. No one opposed. Michelle Hafner and Stephanie Cvitkovich abstained.

ITEM 6: LUNCH – PRESENTATION ON THE WORKERS' COMPENSATION INDUSTRY STATUS AND TRENDS

Mark Priven explained the industry status and trends. In California, employers have paid more than employers in other states for workers' compensation. Injured workers in California have been paid less than injured workers in other states. Labor and management had gotten together to negotiate how to bring these two together. One method used to complete this goal was to take expenses out of the situation, such as frictional costs.

QUESTION ASKED
Why was there a drastic difference in closure rates?
Mr. Priven answered that Workers' compensation was reformed so that no one in the new system is worse off than when he or she have entered under the old system. A few of the reforms were an adjustment for age and the use of an independent medical review system. Since the reforms have been in place claims have closed at record pace.

When the JBWCP was compared to the rest of the public sector self-insurers in California statewide, the JBWCP faired very favorably. The JBWCP was either at the same as the other public sector self-insurers or at the same level for incurred costs per claim.

When the JBWCP was compared to the rest the country regarding frequency of claims, California had a much higher claim frequency than compared to the rest of the states. California had roughly the same amount of OSHA injury claims, but almost 50 percent more permanent disability claims than other states. When broken down all regions of California with the exception of Los Angeles, are aligned with the national average.

Regarding cumulative and repetitive motion injury claims, the JBWCP as a whole had a high frequency of claims. Since 2008, the Bay Area's claims had plateaued; however, the Los Angeles area has steadily increased. This showed that culture and environment may have been contributing factors because the Bay Area and Los Angeles area operate under the same rules, yet the Los Angeles area had more claims.

When the JBWCP was compared to California as a whole regarding cumulative and repetitive motion injury claims (including those who are not only self-insurers), it favored quite well. When the percentage of claims was examined by the type of injury, the JBWCP had a higher percentage than the Workers' Compensation Insurance Rating Bureau of California (WCIRB) for

CT/repetitive injures and slip/trip/falls. The JBWCP had a lower percentage of claims than the WCIRB for strains and the other catch-all category. This was expected because the JBWCP is mostly office-based positions, rather than field-based positions where these types of injuries are more likely to occur.

NO COMMITTEE ACTION.

ITEM 7: STATUS REPORT ON THE PROGRAM YEAR 2015-2016 EXCESS INSURANCE RENEWAL (DISCUSSION)

Jon Paulsen presented the status report for the 2015-2016 excess insurance renewal. Currently, only the trial court, not the judiciary, purchases excess insurance. It is at a $2 million self-insured retention with a $50 million limit. If a catastrophic claim were filed with the trial courts, they would pay the first $2 million and the excess insurance company would pay the remainder up to $50 million. This is an occurrence-based insurance, not per claimant... For example, if there were a single occurrence such as an earthquake that injured multiple workers at once, the trial courts would still only pay the first $2 million of the claim.

Next, Mr. Paulsen reviewed premium estimates received by various companies that offer excess insurance policies. Currently, Safety National has offered very competitive terms, while he also expects Arch Insurance to also offer competitive terms. Safety National offered the trial courts a renewal at a zero percent increase to the rate which is a $2 million deductible with a $50 million limit. Safety National also offered the same terms, but with separate policies to the judiciary.

QUESTION ASKED
Why do the trial courts and judiciary need to be looked at separately?
Mr. Paulsen answered that he does not believe you must look at them separately. If they are looked at separately, then each the trial courts and the judiciary have their own policy that they can turn to for greater coverage if a catastrophic event occurs. Ms. Cox added that premiums could increase because the judiciary is a higher risk since it is in an area that is prone to earthquakes and where the majority of workers are located. As a result, it may be less expensive to keep polices separate. Historically the policies have always been separate because the funding mechanisms are different for the trial courts as opposed to the judiciary.

FOLLOW UP
Ms. Hafner would like to see an excess insurance premium quote for both the trial courts and judiciary combined into a single policy and also quotes for separate policies.

NO COMMITTEE ACTION.

ITEM 8: JBWCP REVIEW (DISCUSSION)

Ms. Cox reviewed the memorandum of coverage. This will be issued to the members and it sets forth provisions for workers' compensation coverage pursuant to California law. This will provide an understanding of who is covered, the coverage period, subrogation, and coverage disputes.

Next, Ms. Miller discussed the workers' compensation oversight services provided by Bickmore. Judicial Council staff member, Lisa Bartlow provides oversight of the claims TPA. Both Ms. Miller and Ms. Bartlow are available to assist the members in understanding the workers' compensation system and coordinate the complex cases at AIMS. They participate in claim reviews and they have resources available to members that are outside of AIMS, such as identifying ergonomics situations.

Ms. Miller also developed and implemented a spot-check program. She will review 25 claims from the courts to ensure there is compliance with 19 measurable and specific areas such as the ability to accommodate modified duties.

QUESTION ASKED
Is there any support from Bickmore to identify why the claims are so high?
Ms. Cox answered that she and Mr. Fuleihan can look into the data and identify which types of claims were submitted and see from where they coming. She can work with Mr. Johnston at Bickmore in the risk control department to see if he has any ideas that may be of assistance to the courts.

Ms. Miller stated that because the JBWCP had transitioned TPA's last year, only a technical audit was performed, not a managed care audit. However, for 2015-2016, both a technical and managed care audit will be performed. The managed care audit will evaluate the services provided by Allied regarding managed care services. They will be evaluated by encounters or referrals made. This will be done June 1, 2015 with AIMS. The technical claims audit will begin July 15, 2015 at AIMS. This will provide the opportunity to determine if any areas need improvement and to focus resources on those areas.

QUESTION ASKED
Are there a targeted number of cases to review?
Ms. Miller answered that there will be 100 encounters for the managed care audit and 112 files for the technical audit. This allows for two files per court to be evaluated. If a court does not have any cases to review, then Bickmore will audit additional cases at courts that have a larger number of cases.

Ms. Cox then reviewed the member survey results. This survey focused on the members' experience regarding the transition of TPA services. A total of 41 courts participated in the survey and 72 percent responded. Overall, 15 courts (37%) responded that the transition was seamless with no disruptions, 21 courts (51%) felt there were some bumps along the way, and five courts (12%) report that they encountered issues. The comments regarding the transition expressed concern about adjuster turnover and that claims data transfer seemed to take longer than expected.

Furthermore regarding the helpfulness of the communications, 26 courts (64%) said that the communications regarding the transition were very helpful, 14 courts (34%) said it was somewhat helpful, and one court (2%) said it was not helpful. And 38 courts (93%) said that the communications were frequent enough. Additionally, 36 courts (88%) said they were satisfied with the claim adjusters' responsiveness and communication, while only five courts (12%) said they were not satisfied. This survey is done once every year.

NO COMMITTEE ACTION.

ITEM 9: FOCUS AND GOALS FOR THE FUTURE (DISCUSSION)

Mr. Johnston discussed the focus and goals of the future with respect to loss control services.. A customized on-line portal of safety and loss control resources has been created specifically for the courts. It includes highlighted loss control programs such as ergonomics and safety communications, which also include customized yet basic and time manageable, training videos, sessions, and webinars.

Lastly, Ms. Cox discussed the master agreement ergonomic evaluation phases. She explained that the first phase that the JBWCP has worked on a master agreement for ergonomics to get statewide consistency and gain control over how evaluations are done. And phase two is to obtain controlled pricing of common ergonomic equipment and seek percentage rate discounts.

NO COMMITTEE ACTION.

ITEM 10: CLOSING COMMENTS AND DISCUSSION

No comments received.

NO COMMITTEE ACTION.

V. ADJOURNMENT

This meeting adjourned at 2:37 p.m.

VI. CLOSED SESSION (CAL. RULES OF COURT, RULE 10.75 (D) (2))

This meeting was called to order at 3:00 p.m. and adjourned at 3:37 p.m.

Parliamentary Procedures for the Judicial Council of California

APPROVED BY THE JUDICIAL COUNCIL ON DECEMBER 14, 2012

Contents

Parliamentary Procedures for the Judicial Council of California

I. Introduction

These parliamentary procedures are a set of rules for conducting business at Judicial Council meetings.

II. Establishing a Quorum

A quorum is defined as the minimum number of members of the body who must be present at a meeting for business to be legally transacted. The Judicial Council abides by a rule providing that a quorum is one more than half the *voting* members. Because there are 21 voting members on the council, there must be 11 voting members present to legally transact business. Even if the council has a quorum to begin the meeting, it can lose the quorum during the meeting when a member departs. When that occurs, the council loses its ability to transact business until and unless a quorum is reestablished.

III. The Role of the Chair

While all members of the council should know and understand the rules of parliamentary procedure, it is the Chair who is charged with applying the rules in the conduct of the meeting. The Chair, for all intents and purposes, makes the final ruling on the rules every time he or she states an action. In fact, all decisions by the Chair are final unless overruled by the council itself.

Because the Chair conducts the meeting, normally the Chair will play a less active role in the debate and discussion than other members of the council. This does not mean that the Chair should not participate in the debate or discussion. The Chair as a member of the council has the full right to participate in the debate, discussion, and decision making of the council. However, the Chair should generally look to other council members to make or second motions.

IV. Voting Requirement for Judicial Council Action

To take any substantive action, a majority of all voting members of the Judicial Council must vote in favor of the action. (See Gov. Code, § 68508.) Because there are 21 voting members on the council, there must be a quorum of at least 11 members voting to take any action, and a vote on a substantive motion (as defined below) requires 11 affirmative votes to pass.

Advisory members of the council may make or second motions and may fully participate in discussion and debate, but are not counted for purposes of quorum, and may not vote. (See Cal. Rules of Court, rule 10.3(b).)

V. Motions in General

Motions are made in a simple two-step process. First, the Chair should recognize the council member. Second, the member makes a motion by preceding his or her desired approach with the

words, "I move . . . ." A typical motion might be: "I move that we adopt the committee's recommendation."

The Chair usually initiates the motion by doing one of the following:

1. Inviting the council members to make a motion. "A motion at this time would be in order."

2. Suggesting a motion to the members. "A motion would be in order that we adopt the committee's recommendation."

3. Making the motion. As noted, the Chair has every right as a council member to make a motion, but should normally do so only if he or she wishes to make a motion on an item but is convinced that no other member is willing to step forward to do so at a particular time.

After a vote is taken, the Chair should announce the result of the vote as well as the vote count. For example, the Chair might say: "The motion to create a five-member working group to develop parliamentary procedures for the council has passed. The vote was 11 in favor, 9 opposed, and 1 abstention." By announcing the result and the vote count, the Chair clarifies what the council has done for the benefit of the council and the public. Rather than making the announcement, the Chair may ask the Secretary to announce the result of the vote as well as the vote count.

A. Substantive Motions

There are three substantive motions that are the most common and recur often at meetings:

The basic motion. The basic motion is the one that puts forward a decision for the council's consideration. A basic motion might be: "I move that we create a five-member working group to develop parliamentary procedures for the council."

The motion to amend. If a member wants to change a basic motion that is before the body, he or she would move to amend it. A motion to amend might be: "I move that we amend the motion to have a ten-member working group." A motion to amend takes the basic motion that is before the council and seeks to change it in some way. The council would first vote on whether the motion should be amended. If that motion passes, the council would then vote on the motion itself as amended.

The substitute motion. If a member wants to completely do away with the basic motion that is before the council and put a new motion in its place, he or she would move to make a substitute motion. A substitute motion might be: "I move that we impose a moratorium against appointing new working groups."

Motions to amend and substitute motions are often confused. But they are quite different, and their effect (if passed) is also quite different. A motion to amend seeks to retain the basic motion on the floor, but modify it in some way. A substitute motion seeks to throw out the basic motion on the floor and substitute a new and different motion for it. The decision on whether a motion is really a motion to amend or a substitute motion is left to the Chair. So if a member makes what that member calls a motion to amend, but the Chair determines that it is really a substitute motion, the Chair's designation governs.

The basic rule of substantive motions is that they are subject to discussion and debate. Accordingly, basic motions, motions to amend, and substitute motions are all eligible for full discussion by the council. The debate can continue as long as council members wish to discuss an item, subject to the decision of the Chair that it is time to move on and take action.

For a substantive motion to pass, it requires the affirmative concurrence of a majority of voting members of the council. In other words, 11 voting members of the council must vote in favor of a substantive motion for it to pass. An abstention does not constitute a vote in favor of a motion.

The order in which various motions are considered is addressed in section VI, Multiple Motions Before the Judicial Council, on pages 5–6.

B. Friendly Amendments

A "friendly amendment" is a practical parliamentary tool that is simple, informal, saves time, and avoids bogging down a meeting with numerous formal motions. It works as follows: During the discussion on a pending motion, it may appear that a change to the motion is desirable or may win support for the motion from some members. When that happens, a member who has the floor may simply say, "I would like to suggest a friendly amendment to the motion." The member suggests the friendly amendment, and if the maker and the person who seconded the motion pending on the floor accept the friendly amendment, that now becomes the pending motion on the floor. If either the maker or the person who seconded rejects the proposed friendly amendment, the proposer can formally move to amend.

C. Procedural Motions

In contrast to the substantive motions described above, which result in the council voting whether to take action, there are several types of procedural motions. These motions differ from substantive motions in both the applicability of the rule of free and open debate on motions and in the number of votes required to pass the motions. The procedural motions, all of which indicate a desire of the council to move on, are *not* debatable. Thus, when the motion is made and seconded, the Chair must immediately call for a vote without debate on the procedural motion.

As for votes on these motions, while substantive motions require the concurrence of 11 voting members, procedural motions require either a majority or a two-thirds vote (depending on the motion) of voting members who are present. For example, if 15 voting members are present, 8 votes are required to pass a motion that requires a majority vote, and 10 votes are required to pass a motion that requires a two-thirds vote. (The counting of votes is discussed in greater detail in section VII, Counting Votes, on pages 7–8.)

Procedural motions that require a **majority vote** include:

Motion to adjourn. This motion, if passed, requires the council to immediately adjourn to its next regularly scheduled meeting. It requires a simple majority vote of those present and voting to pass.

Motion to recess. This motion, if passed, requires the council to immediately take a recess. Normally, the Chair determines the length of the recess, which may be a few minutes or an hour. It requires a simple majority vote of those present and voting to pass.

Motion to fix the time to adjourn. This motion, if passed, requires the council to adjourn the meeting at the specific time set in the motion. For example, the motion might be: "I move we adjourn this meeting at 5 p.m." It requires a simple majority vote of those present and voting to pass.

Motion to table. This motion, if passed, requires discussion of the agenda item to be halted and the agenda item to be placed on "hold." The motion can contain a specific time in which the item can come back to the council: "I move we table this item until our regular meeting in October." Or the motion can contain no specific time for the return of the item, in which case a motion to take the item off the table and bring it back to the council will have to be taken at a future meeting. A motion to table an item (or to bring it back to the council) requires a simple majority vote of those present and voting to pass.

Procedural motions that require a **two-thirds vote** include:

Motion to object to consideration of an item. Normally, such a motion is unnecessary since the objectionable item can be tabled or simply defeated. However, when members of a body do not even want an item on the agenda to be considered, then such a motion is in order. It requires a two-thirds vote of those present and voting to pass.

Motion to limit debate. The most common form of this motion is to say: "I move the previous question" or "I move the question" or "I call the question" or simply "Question." As a practical matter, when a member calls out one of these phrases, the Chair can expedite things by treating it as a "request" rather than as a formal motion. The Chair can then simply inquire, "Is there any further discussion?" If no one wishes to discuss it further, the Chair can proceed to a vote on the underlying matter. On the other

hand, if even one council member wishes further discussion and debate on the underlying matter, the Chair must treat the "call for the question" as a motion and proceed accordingly.

When a council member makes such a motion, he or she is really saying, "I've had enough debate. Let's get on with the vote." When such a motion is made, the Chair should ask for a second, stop debate, and vote on the motion to limit debate. Note that a motion to limit debate could include a time limit. For example: "I move we limit debate on this agenda item to 15 minutes." A motion to limit debate requires a two-thirds vote of those present and voting to pass.

D. Motions to Reconsider

There is a special and unique motion that requires a separate explanation: the motion to reconsider. A tenet of parliamentary procedure is finality. After vigorous discussion, debate, and a vote, there must be some closure to the issue. Thus, after a vote is taken, the matter is deemed closed, subject only to reopening if a proper motion to reconsider is made and passed.

A motion to reconsider is a procedural motion that requires only a majority vote of those voting members who are present to pass, but there are two special rules that apply only to the motion to reconsider.

First is the matter of timing. A motion to reconsider must be made at the meeting at which the item was first voted upon. A motion to reconsider made at a later time is untimely.

Second, a motion to reconsider may be made only by a member who voted *in the majority* on the original motion. If such a member has a change of heart, he or she may make the motion to reconsider. (Any other council member may second the motion.) If a member who voted *in the minority* seeks to make the motion to reconsider, it must be ruled out of order. The purpose of this rule is finality. If a member of the minority could make a motion to reconsider, the item could be brought back to the council again and again, which would defeat the purpose of finality.

If the motion to reconsider passes, then the original matter is back before the body, and a new original motion is in order. The matter may be discussed and debated as if it were on the floor for the first time.

VI. Multiple Motions Before the Judicial Council

There can be up to three motions on the floor at the same time. The Chair can reject a fourth motion until he or she has addressed the three that are on the floor and has resolved them. This rule has practical value. More than three motions on the floor at one time tends to be too confusing and unwieldy for most everyone, including the Chair.

When there are two or three motions on the floor (after motions and seconds) at the same time, the vote should proceed *first* on the *last* motion that was made. So, for example, assume the first motion is a basic motion to appoint a 5-member working group to develop parliamentary procedures for the council. During the discussion of this motion, a member might make a second motion to amend the basic motion so that a 10-member working group would be appointed instead of a 5-member working group. And perhaps, during that discussion, another member makes yet a third motion as a substitute motion to impose a moratorium against appointing new working groups. The proper procedure would be as follows:

First, the Chair would address the third (the last) motion on the floor, the substitute motion. After discussion and debate, a vote would be taken on the third motion. If the substitute motion *passed*, it would be a substitute for the basic motion and would eliminate it. The first motion would be moot, as would the second motion (which sought to amend the first motion), and the action on the agenda item would be completed on the passage by the council of the third motion (the substitute motion). No vote would be taken on the first or second motions.

Second, if the substitute motion failed, the Chair would address the second (now, the last) motion on the floor, the motion to amend. The discussion and debate would focus strictly on the amendment (whether the committee should be 5 members or 10 members). If the motion to amend *passed*, the Chair would now move to consider the main motion (the first motion) *as amended*. If the motion to amend *failed*, the Chair would now move to consider the main motion (the first motion) in its original format, not amended.

VII. Counting Votes

A. Number of Votes Needed to Take Action

As noted above, for substantive motions, a minimum of 11 voting members must be present to constitute a quorum, and a minimum of 11 votes are needed to pass such substantive motions. For procedural motions, a minimum of 11 voting members must be present to constitute a quorum, and there must be either a majority vote or a two-thirds vote of voting members, depending on the motion, to pass such procedural motions.

When a majority vote is needed to pass a motion, one vote more than 50 percent of those voting is required. If a two-thirds vote is needed to pass a motion, there is a formula to determine how many affirmative votes are required. The simple rule of thumb is to count the “no” votes and double that count to determine how many “yes” votes are needed to pass a particular motion. So, for example, if 6 members vote “no,” then the “yes” vote of at least 12 members is required to achieve a two-thirds majority vote to pass the motion.

In the event of a tie vote, the motion always fails because an affirmative vote is required to pass any motion. For example, if the vote is 10 in favor and 10 opposed, with 1 member absent, the motion is defeated.

B. Abstentions

Members sometimes prefer to abstain from voting. Members who abstain are counted for purposes of determining whether there is a quorum, but the abstention votes on the motion are treated as if they do not exist. In other words, an abstention is not treated as either a "yes" vote or a "no" vote.

C. Examples

Here are a few examples to illustrate vote-counting under different circumstances:

Majority Vote Counting

Assume that 21 voting members of the council are present to vote on a substantive motion, which requires 11 votes to pass. If the vote on the motion is 11 to 10, the motion passes. If the motion is 10 to 10 with 1 abstention, the motion fails because the abstention is not counted as a "yes" vote.

Assume that 18 members are present and voting on a procedural motion that requires only a majority vote to pass (as opposed to 11 votes). If the vote is 10 to 8, the motion passes. If the vote is 9 to 9, the motion fails. If the vote is 9 to 8 with 1 abstention, the motion fails because 10 votes are required for the motion to pass (one vote more than 50 percent). Once again, the abstention vote is counted only for the purpose of determining quorum, but on the actual vote on the motion, it is as if the abstention vote did not occur.

Two-Thirds Vote Counting

Assume 21 members are present and voting on a motion that requires a two-thirds vote to pass. If the vote is 11 to 10, the motion fails for lack of a two-thirds majority. If the vote is 18 to 3, the motion passes with a clear two-thirds majority. If the vote is 13 to 8, the motion fails. Using the formula discussed above, the "no" votes are counted and doubled to determine whether there are enough "yes" votes to constitute a two-thirds majority. If the vote is 13 to 6 with 2 abstentions, the motion passes because the abstentions are treated as if they don't exist, and with 6 "no" votes, 12 votes are needed to pass the motion. Therefore, the motion passes with 13 votes.

Abstention

To cast an "abstention" vote, a member either votes "abstain" or says "I abstain." However, if a member votes "present," that is also treated as an abstention. The member is essentially saying, "Count me for purposes of a quorum, but my vote on the issue is abstain." In fact, any manifestation of intention to vote neither "yes" nor "no" on the pending motion may be treated by the Chair as an abstention.

Absence

Can a member vote "absent" or "count me as absent?" The ruling on this is up to the Chair. The better approach is for the Chair to count this as a vote to abstain if the person does not actually

leave the boardroom. If, however, the member leaves the boardroom and is actually absent, the Chair should count the member as absent. That, of course, may affect the quorum.

VIII. Alternative Methods of Voting

A. Voting by Proxy

Voting by proxy is not permitted. A Judicial Council member, therefore, may not authorize another person to vote on his or her behalf.

B. Attending Meetings and Voting by Telephone or Teleconference

Council members are permitted to attend meetings and vote by telephone or teleconference.

C. Early Voting

On occasion, a voting member of the Judicial Council may be unable to attend a council meeting or must depart before the presentation of a discussion item or the ensuing exchange is completed. Subdivision (c) of rule 10.5 (Notice and agenda of council meeting) defines the term "business meetings" as meetings "at which a majority of voting members are present to discuss and decide matters within the council's jurisdiction." The rule contemplates that members will be present for a discussion of the agenda item. Accordingly, a council member is not permitted to vote before the discussion about the agenda item has ended.

IX. Courtesy and Decorum

The rules of order are meant to create an atmosphere where council members and the public can attend to business efficiently, fairly, and with full participation. At the same time, it is up to the Chair and the council members to maintain common courtesy and decorum. It is always best for only one person at a time to have the floor, and it is always best for every speaker to be first recognized by the Chair before speaking.

The Chair should ensure that discussion and debate of an agenda item focuses on the item and the policy in question. The Chair has the right to cut off discussion that diverges from the agenda item.

Debate and discussion should be focused, but free and open. In the interest of time, the Chair may, however, limit the time allotted to speakers, including council members.

Council members should not interrupt the speaker. There are, however, exceptions. A speaker may be interrupted for the following reasons:

Privilege. The proper interruption would be to say, "Point of privilege." The Chair would then ask the interrupter to "state your point." Appropriate points of privilege relate to anything that would interfere with the normal comfort of the meeting. For example, the room may be too hot or too cold, or a blowing fan might interfere with a person's ability to hear.

Order. The proper interruption would be to say, "Point of order." Again, the Chair would ask the interrupter to "state your point." Appropriate points of order relate to anything that would not be considered appropriate conduct of the meeting, such as the Chair moving on to a vote on a motion that permits debate without allowing that discussion or debate.

Appeal. If the Chair makes a ruling with which a member of the body disagrees, that member may appeal the ruling of the Chair. For example, if the Chair deems a motion to be a substitute motion and a member considers it to be a motion to amend, the member may appeal that ruling. If the motion is seconded and, after debate, it passes by a simple majority vote, the ruling of the Chair is deemed reversed. The motion to appeal the ruling of the Chair is considered a procedural motion.

Call for orders of the day. This is simply another way of saying, "Let's return to the agenda." If a member believes that the council has drifted from the agenda, such a call may be made. It does not require a vote. If the Chair discovers that the agenda has not been followed, the Chair simply reminds the council members to return to the agenda item properly before them. If the Chair fails to do so, the Chair's determination may be appealed.

Withdraw a motion. During debate and discussion of a motion, the maker of the motion on the floor, at any time, may interrupt a speaker to withdraw his or her motion from the floor. The motion is immediately deemed withdrawn, although the Chair may ask the person who seconded the motion if he or she wishes to make the motion, and any other member may make the motion if properly recognized.

X. Recess and Adjournment

Unless there is an objection, the Chair may recess the council meeting for a definite period of time and may adjourn the meeting.

Judicial Branch Workers' Compensation Program (JBWCP)

Mission Statement

The mission of the Judicial Branch Workers' Compensation Program (JBWCP) is to protect the interests of the program participants (trial court judicial officers, employees and jurors; the Supreme Court justices and employees; the six District Courts of Appeal Justices and employees; employees of the Habeas Corpus Resource Center, members of the Commission on Judicial Performance, employees of the AOC; and retired judges on assignment) and eligible injured workers. The JBWCP strives to achieve this by ensuring timely and accurate claims' adjudication collaborating to assess program successes and opportunities for improvement; and proactively implementing cost-containment efforts and cost-effective interventions.

Goals

The goals of the JBWCP include the following:

- Provide oversight of all program vendors to promote administrative efficiency;
- Ensure the timely and accurate adjudication of claims;
- Collaborate with medical providers to obtain appropriate treatment and return injured workers to gainful employment as soon as they are able;
- Develop and implement useful resources, tools, and procedures for the program participants to ensure efficient and effective claims monitoring;
- Foster an understanding of JBWCP priorities, initiatives, and results through outreach and collaboration;
- Analyze claims data to identify trends and mitigation opportunities to contain costs and manage outcomes and
- Provide financial stewardship to ensure adequate funding for the program through the use of annual actuarial loss projections and consistent application of premium/cost allocation to all program participants.

www.courts.ca.gov/jbwcp.htm
jbwcp@jud.ca.gov

Judicial Branch Workers' Compensation Program (JBWCP) Advisory Committee

Purpose

Makes recommendations to the council for improving the statewide administration of the Judicial Branch Workers' Compensation Program (JBWCP) and makes recommendations on allocations to and from the Judicial Branch Workers' Compensation Fund.

Background

The Judicial Branch Workers' Compensation Program (JBWCP) Advisory Committee succeeds the Judicial Branch Workers' Compensation Oversight Committee, formerly a subcommittee of the Trial Court Budget Advisory Committee. It was created in 2001 to assist trial courts with the then-newly-established workers' compensation program. The workers' compensation program is no longer limited to the trial courts: it has expanded to include all judicial branch entities except the Superior Court of California, County of Los Angeles.

Mission

The mission of the JBWCP Advisory Committee is to protect the interests of the program participants and eligible injured workers. Participants of the program include the following judicial branch entities:

State Judiciary

The state judiciary consists of approximately 108 justices and 1,634 employees of the:

- Supreme Court of California
- California Judicial Center Library
- Courts of Appeal
- Habeas Corpus Resource Center
- Commission on Judicial Performance
- Judicial Council of California

Trial Courts

- Superior Courts of California, excluding Los Angeles (comprised of approximately 12,507 employees)

Judicial Officers

- Superior Court judges (comprised of approximately 1,603 judges)

It strives to achieve its mission by ensuring timely and accurate claims' adjudication; collaborating to assess program successes and growth opportunities for improvement; and proactively implementing cost-containment efforts and cost-effective interventions.

The advisory committee is charged with the following responsibilities:

- Determine JBWCP priorities and initiatives, and ensure results through outreach and collaboration;
- Oversee all program vendors to promote administrative efficiency;
- Provide financial stewardship to ensure adequate funding for the program through the use of annual actuarial loss projections and consistent application of premium/cost allocation to all program participants.
- Ensure the timely and accurate adjudication of claims;
- Implement the necessary procedures to obtain appropriate treatment and return injured workers to gainful employment as soon as they are able;
- Develop useful resources, tools, and procedures for the program participants to ensure efficient and effective claims monitoring;
- Identify trends and mitigation opportunities to contain costs and manage outcomes.

Relevant Legislative Mandates

- Rule 10.350. Workers' compensation program
- Rule 10.67. Judicial Branch Workers' Compensation Advisory Committee
- Rule 10.11. Executive and Planning Committee
- Government Code Section 68114.10
- Labor Code Section 3700
- California Government Code Section 71623.5

JBWCP – AIMS SERVICE GUIDELINES

Activity	Process	Modifications/Changes	Date	Approved	Date
Program Information	**Caseload:** TPA shall provide qualified staff such that those working with JBWCP claims will have manageable caseloads. To achieve this, it is recommended that each Examiner maintain a caseload of 130 open indemnity claims. The supervisor shall not carry a caseload. **Scheduled Reports:** AIMS will determine standard reports to be issued to each JBWCP Member. AIMS will issue standard, scheduled (monthly) reports to Members by 10 calendar day of the month. AIMS will issue identified standard reports to the JBWCP Program Manager, Representative and Consultant by the 5th working day of the month. AIMS will develop a monthly report identifying those claims set up with in the month with "unidentified" or "unassigned" categories. The report is to be submitted to the Consultant by the 5th working day of the month. **Claim File Documentation:** All activity, contact, notification, reconciliation, referrals, verification, etc., shall be clearly documented in the computer notepad and maintained in the applicable claim file. A copy of all written documentation, notices, letters, reports, etc. will be maintained in the applicable claim file. This requirement shall apply to all standards contained in this section of the Agreement.	Supervisors will		JBWCP TEAM/AIMS AGREED 12/17/14	08/29/14

	Use of electronic claim files is appropriate only with assurance all claim file documentation can be recreated in hard copy as requested and access provided to the electronic claim files. • Case Closure – Future Medical Files With the exception of claims for Hearing Loss that include a requirement to provide Hearing Aids, claims awarded future medical care, in which there has been no medical care or benefits provided in the last 12 months can be administratively closed unless there is documentation of upcoming medical care expected within the next 12 months. Claims for Hearing Loss in which there is a future medical award requiring provision of Hearing Aids may be administratively closed if there are is no medical care provided or benefits paid in the last 24 months unless there is documentation of upcoming medical care or benefits expected within the next 12 months. All future medical files must remain readily accessible and cannot be destroyed or deleted from the claims system. • Supervisors will review all claim files for claims adjusters with the exception of Sr. Level Adjusters, prior to closure to assure all issues are properly addressed and resolved and that file documentation including claims data is accurate.			03/04/15	

	Supervisors will review claims for Sr. Level Adjusters prior to closure on Litigated claims to assure all issues are properly addressed and resolved and that file documentation including claims data is accurate. **Claim Review Protocols**: Claim Review Schedules will be confirmed with each Program Member. • Supervisors are expected to schedule claim reviews directly with the respective trial court in accordance with the Claim Review Schedule. • The Supervisor is required to inform the JBWCP Program Manager and Consultant of all claims reviews regardless of whether or not they attend. • The JBWVP Program Manager should be involved in reviews if the Member has claims that also entail personnel/HR matters. • Examiners are expected to present the claim summaries in a concise manner and have available any and all pertinent case development details. For example: Med/Legal exam dates and results, major • diagnostic study dates and results, past legal proceeding dates and results and upcoming WCAB dates. • AIMS Claim Status Report is to be provided on every case reviewed and will be completed by the Examiners. • Claim Status Report will be e-mailed to the Member and JBWCP Program Manager and the Consultant at least one week prior to the scheduled review. • Information on companion cases should be included, even if the companion cases were not specifically referenced in the claim list.				

	• Defense attorney participation in the Claim Review should be on an as needed basis and with approval. o Defense attorney WILL NOT bill either the claims file or the JBWCP for their participation in the review o The presentation of the review information remains the responsibility of the Examiner o The defense attorney's participation will be to provide subject matter expertise as requested **Coverage:** JWBCP will provide coverage dates for each Program Member. Examiner shall verify the coverage period and that coverage was provided to the member by JBWCP on the date of injury or illness in accordance with member program dates and governing documents. If applicable, Examiner shall exercise due diligence in joining applicable co-defendants. All activity to verify coverage and join co-defendants shall be clearly documented in the computer notepad. **Customized Profile:** Each Program Member will be contacted to discuss the claim handling protocols and identify any specific needs. AIMS will develop a profile outlining Member specific requirements. **Forms:** AIMS shall provide all forms necessary for the processing of benefits or claims information including: The Employer's Report of Injury (5020), DWC Form 1, medical service orders, return-to-work slips, lost time information reports, vouchers, checks and other related forms. The cost			Revised 02/04/15	

	of providing these forms shall be included within the AGREEMENT price. **Human Resources Liaison(s):** If a claim is filed by a court contact staff member, AIMS will also ensure that system access to their individual workers' compensation claim will be inaccessible. Should assignment to a different adjuster become necessary for confidentiality purposes, this will be accommodated within the JBWCP assigned adjusters. **Jurors:** • **Grand Jurors** are not covered under this program. Examiners are required to communicate to court contacts that Grand Jurors are not covered under the JBWCP and should be directed to the applicable county. Claims Examiners should report related issues to the JBWCP Program Manager and the Consultant. • **Trial Court Jurors** are covered under the JBWCP and are associated with their respective trial court Member. Examiners should be aware of the distinction between Grand Jurors and Trial Court Jurors. **Legally Uninsured:** The JBWCP does not file an annual report with SIP. The JBWCP is legally uninsured per LC 3700. For purposes of SIP, the JBWCP has the same status as the state. TPA generated reports will be based on the fiscal year which is 7/1 – 6/30, unless otherwise specified. **Member Issues/Concerns:** Examiners must notify their supervisor, Account Manager and JBWCP Program Manager and Consultant if a program issue arises.				

	• Program structure issue examples include: requests for loss control services, questions related to court charge back costs, training for topics like ADA or FMLA, problems with their system access or report needs; and challenges with an Examiner. • If an Examiner believes that a file may be been mishandled by a previous TPA of county, they will notify their immediate supervisor who will review the claim and discuss their findings with the Account Manager or Consultant. • At no time should the Examiner discuss their thoughts regarding the prior's TPA's work product with the trial court or claimant. The Account Manager should discuss potential concerns with Consultant and the JBWCP Program Manager. **Run-off Claims:** • The trials courts became independent employers as of 1/1/2001 when they separated from the counties. • The Trial Courts have the choice to join the JBWCP and did so at different times. • The responsibility for "run off" claims may differ by court. Questions concerning the liability of run-off claims shall be directed to the JBWCP Program Manager. o Please note that the JBWCP Program Manager is responsible for making the counties "whole" on the payments they have made for trial court workers' compensation losses prior to joining the JBWCP.				

	• The JBWCP has assumed liability for all injuries on or after 1/1/2001. Any issues of contribution between a court and a county are negotiated on a program-wide basis between the particular county and the JBWCP Program Manager. • Settlement of "run-off" claims o If a settlement has been reached between the JBWCP and a county, there will be a Memorandum of Understanding (MOU) outlining the process in the event there are potential contribution issues on an individual claim basis or more. o If the settlement has not been resolved between the county and the JBWCP Program Manager and a county initiates contribution efforts on an individual file basis, the initial response should be to inform the inquirer that contribution issues are generally resolved on a program-wide basis and that the county's Risk Management or County Counsel Departments, as appropriate, should be directed to initiate dialogue with the JBWCP Program Manager in the event the county is interested in pursuing. o Such inquiries should be directed to the county and inform the JBWCP Program Manager and Consultant. If the party seeking contribution is unwilling to proceed accordingly, Examiners should provide the related information to the Consultant and the JBWCP Program Manager for follow up with the				

	county in an appropriate manner. • If the county has a file in its possession that it is believed to be the responsibility of the JBWCP, the county should contact the JBWCP Program Manager to initiate the process to have the file(s) and related data transferred into the program. **Scanning:** Mail is scanned in to the AIMS system on a daily basis and indexed directly to the appropriate examiner for review and action. Examiners will review their scanned mail daily. Original documents are maintained for 60 days. _____ **Staffing Changes:** The JBWCP Program Manager and Consultant are to be notified by the Account Manager when Examiner of Supervisor changes occur. Notifications should occur within 72 hours of the TPA's notice. • Communication will include a list of the affected entities and any known service issues with a particular Member. Service issues shall be discussed with the JBWCP Program Manager and Consultant before communicating with the Member(s) involved. Based on the discussion, the JBWCP Program Manager will advise if the communication will come from the JBWCP Program Manager or from the TPA.				

	• If communication will be made by the TPA, the communication will include: a basic transition plan, contact information and direction during the transition, assurance that the claims supervisor will be monitoring the claims during the transition, and that the court will have the JBWCP Program Manager's and Consultant's support during the transition.				
Claims Handling	**<u>Employer's First Report/Claim Set Up:</u>** All Employer's First				

JBWCP – AIMS SERVICE GUIDELINES

Process	Report of Injury Forms shall me maintained in the claim file in accordance with company standards for efficiency, documentation and statutory requirements. The Employers' First Report of Injury is privileged information and is beyond the power of subpoena. <u>All claims will be set up in the Claims System within one (1) working day of receipt.</u> The date of injury shall control the processing of the claim and benefits due. • All new 5020 Employer's First Reports will be received via web imported portal and will be completed by the Claims Set up Coordinator. Report shall be e-mailed to Examiner, Supervisor, Nurse and Client. • Claims Examiner will complete the four- point contact per company policy and client requirements. • The Supervisor will review all new losses received for an initial assessment of severity, compensability and subrogation issues. • The Claims Management System will set an automatic supervisor diary for seven (7) days following claim entry to confirm that all contacts/issues on the claim have been addressed. (i.e. benefit provisions, notices, subrogation, etc.) • Medical Only claims will be transitioned to Indemnity status following management review when the claim has been open 6 months and/or has an Incurred value of $7,500. Management review of the file supporting transition or the determination to remain at Medical Only status will be clearly documented in the File Notes.			Revised 02/04/15	

	Compensability Investigation: **Contacts:** The Examiner shall contact the primary Member contact by e-mail within twenty-four (24) hours of receiving a new claim to confirm receipt of the claim and to review any concerns the Member may have regarding the claim; regardless of the claim type. All claims' notes must be entered in the claims system within 24 hours. • The Examiner will review all first reports of injury within 24 hours of reporting and make the initial contacts with the Employee, Treating Doctor and Employer. The Employee and Treating Doctor will be informed they will be contacted within 3 business days by a Triage Nurse. If the Employee is initially unwilling to communicate with the Triage Nurse, the Examiner will discuss the value and benefit of the communication, document the claims file accordingly and notify the Triage Nurse. • An injured worker shall be contacted by phone within one (1) working day of notification in our office of lost time on all claims. • On all non-litigated indemnity files on total temporary disability, modified duty and/or any change of status every fourteen (14) days. • On all non-litigated indemnity files with any unresolved issues, subsequent contact with the injured worker shall occur as needed or at intervals not to exceed every thirty (30) days. **Compensability (AOE/COE):**			10/15/15 REVISION	

	Investigations: All questionable claims shall be investigated in a prompt, thorough and legal manner to determine compensability or to validate issues in question. <u>The examiner is to identify the need for investigation and refer case for same within three (3) days from receipt of claim or knowledge of questionable issues giving rise to the need for investigation.</u> All investigative firms sub-contracted should be professionals who specialize in the area of the investigation required. Client authorization shall first be obtained before initiating any field investigation. The authorization will be documented in the notepad section of the claims file. • Member/Member notification will include information on what vendor has been assigned, who will need to be interviewed, the next steps to be taken in the investigation and the estimated timetable for completion. • All claims requiring an investigation shall be documented as such in the claim file, with an explanation of the issues, the reasons for the investigation and the objective of the investigation. • All investigative assignments (either oral or written) shall be documented by completion of the approved investigation assignment sheet. The assignment will be documented in the claims system. • All investigative assignments shall be made in accordance with any client protocols or special procedures. • All investigative assignments will refer to the JBWCP Approved Vendor List unless otherwise instructed.			10/05/15	

	• All investigative assignments requiring an employee's statement should request ONLY THE LAST 4 DIGITS of their Social Security number for identification.				
Communications	Examiners must place an out-of-office message on their e-mail and phone to inform Member contacts when they will be away from their desk for 24 – 48 hours. • They must also provide the name and contact information for the person covering their desk. • Examiners must inform program participants when they will be away from the office for more than 48 hours and provide an interim contact person. If an Examiner has an unplanned absence, the supervisor is responsible for making contact with the Member primary contact as well as updating the Examiner's voice mail. • Outgoing voicemail messages are to be updated on a daily basis. They must always provide the identity and contact information for the person covering the individual Examiner's desk. • Voicemail and e-mails must be returned the day they are received, but in no event longer than 24 hours. • Examiners must inform the JBWCP Program Manager and Consultant of all catastrophic, death potentially fraudulent, potential 132a or Serious & Willful claims and WCAB hearings upon notice of such information. • Every effort should be made to meet completion deadline commitments. If a deadline CANNOT be met, the Examiner must advise the Member contact				

	of the updated completion date. o For example, the Examiner commits to contacting a provider or communicating a status to a trial court contact. But, the provider is out of the office. The Examiner would need to call or e-mail the trial court contact and let them know that the provider was out of the office and give an updated timeframe for completion. **Denials:** All claims which are to be delayed or denied, pending a compensability decision shall be done in keeping with all applicable statutory rules and regulations (and/or case law). All delays and denials shall be approved by the supervisor. Authority to delay or deny a claim shall first be obtained from the client. Denials will be discussed with the member/Member prior to issuing the denial. • All denials shall be documented in the file to providing the reasoning or legal basis for the denial. • All denials shall have the denial wording prepared for the official denial letter by the Examiner. All of the necessary approvals shall be documented on the original working document and in the notepad. • All denials should be approved by the Supervisor and Manager. **Ergo Evaluations:** Requests for ergonomic evaluations from the primary treating physician, panel qualified medical or			Revised 02/18/15	

	agreed medical examiner will be referred to an outside consultant. The selection of the consultant will be discussed with the JBWCP member. All Ergo Evaluations will be referred to the JBWCP Approved Vendor list unless otherwise instructed. The Claims Examiner will direct the consultant regarding the protocol for the assignment in terms of reporting instructions and recommendations for equipment. Ergo evaluation reports and requests for equipment will be reviewed by the adjuster and supervisor. Basic office equipment such as pens, staplers, etc. . . (equipment to be used by other Court staff) should be paid directly by the Court. Equipment specific to the individual's injuries will be paid from the claims file. Questions regarding the appropriateness of payment of equipment will be escalated to JBWCP management. **Excess Recoveries:** Any excess reimbursements must be credited to the applicable file and include documentation in the activity notes to include: amount of recovery, additional recovery still owed by the excess carrier and efforts undertaken to seek that recovery. **Excess Reporting:** • Any initial report to excess insurance must receive supervisor review and all initial excess reports must be copied to the JBWCP Program Manager and Consultant. • Please refer to the Excess Insurance schedule to ensure initial reports for the respective Member have been met in accordance with the appropriate policy				

	period. (Reporting is at 50% of retention or other criteria as outlined in the policy, such as death, paralysis, etc.) **Fiscal Year:** July 1st – June 30th **Litigation:** • Should a claim become litigated, please refer to the individual Member instructions for the Member's choice of counsel and communication guidelines. • Assignment of legal defense counsel should NOT be automatic upon receipt of notice of litigation from the claimant. • Claims supervisor will review and decide which cases are to be assigned to outside counsel in conjunction with the JBWCP Administrator and/or designee. • The Examiner is expected to maintain control of the legal aspect of the claim and the defense attorney will be expected to follow the direction of the Examiner. • If there are no specific instructions, the Examiner is to use their best judgment on choice of counsel. • Examiners are expected to maintain close contact with both the Member and defense counsel during litigation proceedings. • Provide JBWCP Administrator and/or designee with a monthly report of all litigated claims. A report will be issued to the JBWCP Representative listing all notices of Representation/Litigation received within the month. • AIMS will supply the JBWCP Representative with a				

	search link to all Legal Correspondence received. • The JBWCP Representative will have access to their own Litigation Diary to monitor/review files as needed. • Provide e-mail copy of all legal correspondence and sub rosa reports to JBWCP Administrator and/or designee. **Plan of Action:** Each claim file shall contain the Examiner's Plan of Action outlining the strategic steps to be taken to bring the claim to conclusion. Action plans must be updated at least every forty-five (45) calendar days, allowing a two week grace period for completion on active indemnity claims upon which indemnity benefits are being paid or are at issue, or whenever a material event has occurred that will significantly affect the outcome of the claim. Action Plans must be updated at least every one hundred eighty (180) calendar days, allowing a two week grace period for completion on future medical claims. The Account Manager shall provide a past due and no future diary report each month to identify any files that have fallen off diary. Such Action Plans will be identified as such in the computer notepad. **Reserves:** AIMS, Inc. maintains a commitment to excellence in claims administration and service to our clients. An integral component of quality claims management is the accurate and realistic assessment of the financial exposure of each case. This critical process is known as reserving. It is the responsibility of the Examiners, Adjusters and Supervisors to establish and maintain appropriate reserves on				

	all claims. Although precise reserving is not always possible when a claim is first reported, developments in the injury, facts or liability picture will dictate the course of reserve. It is therefore, an ongoing process which requires an alert and timely response to the facts that are developed. Reserves will be based upon probably outcome and case resolution. It is understood Self-Insurance Plans reserving guidelines are not a requirement of the JBWCP program. File documentation must support the reserves established on every file. • Initial reserves will be set within five (5) business days from the date the claim is received. Reserves must include a detailed evaluation documented in the system Reserve Worksheet. • Reserves will be evaluated at: o 45 days diary review o At the ninety (90) day from date of receipt and every ninety (90) days thereafter o When the Examiner receives information that may significantly alter the course or cost of the claim – in these cases, the reserves review will not be delayed until the next diary date o Ten (10) days from receipt of medical information or a report indicating a change the status of the claim (extending disability, finding or permanent residuals, etc.) o Upon notice of any fact which influences the				

	dollar value of the claim o All reserves setting or changes are to be accompanied by a reserve worksheet o In cases where there is apportionment of permanent disability, reserves should be reduced to the appropriate exposure only where legal apportionment has been established o In reserving lifetime medical awards, realistic estimates of future medical needs will be evaluated. Use of the Life Expectancy (LE) guidelines will be used as appropriate, with file documentation supporting reserving below LE guidelines as needed. The following Corporate reserving ranges apply: Claims Assistant: $ $75,000 Claims Examiner: $75,000 $250,000 Senior Examiner: $250,000 $500,000 Claims Manager: $500,000 $750,000 Acct. Manager: $500,000 $750,000 Corp. Exec: $750,000 $2,000,000 President/CEO AIMS: Over $2,000,000				
	<u>Settlement Requests:</u> • Settlement requests shall be submitted in writing and				

	should be on the JBWCP standardized settlement request form. • Each request will include a summary of the claim, an explanation/rationale for the recommended settlement amount; claim cost to date and projected cost. All settlement requests will be forwarded to the Supervisor for review and approval, PRIOR to submission to the Member contact. Upon submission of the settlement request to the Member contact, the Examiner is to copy the request to their Supervisor. The Supervisor is then responsible for following through in a timely manner with the Examiner on whether or not the Member contact has responded and the settlement authority has been acted upon. The Account Manager will provide a weekly SAR report to the JBWCP Representative. • Due to the varying approval processes within each Member, the necessity to provide a Member with a settlement outline and request as soon as possible is imperative. There should at no time be a request made a day before or the day of a formal appearance at the WCAB. • All settlement requests must be coordinated through the Examiner. Must be on the JBWCP SAR form. Defense counsel is not to request authority directly, without involvement of the Examiner. **AIMS does not have settlement authority.** **<u>Subrogation:</u>**			10/05/15	

	• Every effort will be made to identify and pursue subrogation recovery at the onset of the claim investigation. • Once subrogation potential is identified, the Examiner should discuss the recovery with the respective Member contact and document the decision to pursue and rationale for same in the claim activity notes. • In many cases, court subrogation will be pursued with the respective county. Should the court contact be unable to provide the appropriate county contact for subrogation notice, Examiners should contact their supervisor for assistance. • Should county subrogation be identified but pursuit of recovery is decided against by the court contact, the Examiner should immediately notify the claim supervisor and Account Manager. The issue will be discussed and brought to the JBWCP Program Manager for direction. • The claim file notes will contain specific information regarding the identification and pursuit of subrogation issues, including documentation of the decision not to pursue recovery. **Sub Rosa (Surveillance) Investigations:** Consideration of surveillance/sub-rosa investigations must be discussed with the member/Member prior to assignment. Copies of the reports should be sent to the JBWCP Administrator and/or designee via e-mail only. A list of all sub rosa investigation reports received within the month will be provided to the JBWCP Representative, with the reports available to view in the AIMS system.				

Sub-rosa/surveillance is designed to develop evidence to verify unsubstantiated facts or activities of injured workers (i.e. the employer/client or other credible party advises that the injured worker is worker somewhere else or engaging in activities that are in conflict with the injury or work restrictions; working while receiving temporary disability benefits, etc.)

- All sub rosa/surveillance assignments should include the precise type of activity required with a specific time limitation for the assignment.

Investigation Reports Distributed to Physicians: To maintain the confidentiality of the investigative reports, distribution of these reports to treating or evaluating physicians must be done on a case by case basis and ONLY AFTER documented discussion with the Claims Supervisor.

Supervisor Diary Guidelines: When a supervisor is reviewing a file, the supervisor will include an activity note documenting their review, findings and any action items needed and the expected date of their next review. Below are guidelines for supervisor diary review:

Indemnity Initial Review	Within 14 days of claim receipt
Indemnity Subsequent Review	Within 30 days of initial Supervisor review
Indemnity Subsequent Review	Within 90 days of claim receipt
Active Indemnity Cases over $50,000 incurred	Every 90 days

Revised 06/11/15

	Active Indemnity Cases under $50,000 incurred Every 180 days Future Medical Cases Every 180 days				
Financial Process/Protocols	• The JBWCP Program Manager and Consultant should be notified of payments over $25,000 for funding purposes – Examiners will notify their Supervisor who will then notify the JBWCP Program Manager and Consultant. No payments to vendors will be authorized and/or made without a claimant name and claim number on the invoice. • Agreed Medical Examiner (AME) bills will be paid in full, with the exception of laboratory or testing charges which will be subject to fee schedule through Bill Review. • Panel Qualified Medical Examiner (PQME) bills will be subject to fee schedule through Bill Review. **Permanent Disability Advances:** All lump sum Permanent Disability Advances WILL BE reviewed and approved by the AIMS Supervisor. Following approval of the Advance, the Court will be contacted to discuss the plan to provide the Advance, the purpose and advantage or risk of providing the Advance. The Supervisor's approval and discussion with the Court will be documented in the Claims file. Any concerns expressed by the Court regarding the Advance will require immediate notification of the JBWCP Program Manager and Consultant. **Stale Check Process:** This procedure describes the events that occur once a check issued from a trust account is 180 days			JBWCP/AIMS	03/04/15 11/12/14

	outstanding and has become stale dated. • Once a check is determined to be stale dated, the Senior Trust Accountant places a stop payment with the bank and prints out the stop payment confirmation. • The stop payment confirmation with the check information is then forwarded to the Claims Analyst who reverses the check in NavRisk, the Risk Management Information System (RMIS). • Once the check is reversed in NavRisk, the Claims Analyst informs the Senior Trust Accountant, who then forwards the check information to the Worker's Comp Branch Manager requesting he/she research why the check was stale dated and if it needs to be reissued. • The claims team will research the checks and reissue each check as appropriate and update the Senior Trust Accountant. • If a stale dated check can't be reissued and was not a duplicate check, then the check will be escheated to the State of California. **Overpayments:** Examiner shall be responsible for attempting the collection of any overpayment of any benefit. In the event the TPA is unable to collect the overpayment, the TPA may be responsible to reimburse JBWCP for the amount of the overpayment if the basis for the overpayment relates to an error or errors by the TPA. Attempted recovery will be documented in the claims file. Any overpayment not recovered will NOT BE credited against "new and further" disability without the approval of JBWCP. Overpayments which have not been recovered will be				

	evaluated by the TPA for reimbursement to JBWCP. Provided a monthly report to the JBWCP Program Administrator and/or designated staff of overpayments that indicates a plan of action for reimbursement. **Penalties and Self Imposed Increases:** Late payment of all benefits must include the self-imposed increase in accordance with California law. TPA will provide JBWCP with a quarterly listing of any administrative penalties/increases paid the quarters ending March 31, June 30, September 30 and December 31. The report shall designate the party responsible for the penalty/increase. If the penalty/increase was the responsibility of the TPA, TPA shall issue a check payable to JBWCP for reimbursement of the penalties/increases. The check and report shall be submitted to JBWCP by the 20th of the following month after the quarter ends.				
Managed Care Process	**AMC Medical Case Management Services:** • **Nurse Triage**: Initial early medical review of injury and treatment needs • **Telephonic Nurse Case Management**: Proactive oversight of treatment and return to work (RTW) activities • **Field Nurse Case Management**: On-site nurse intervention, with injured worker (IW), providers, Employers, Clients. (Task assignments). **Medical Case Management:**				

	• Case Management will be assigned according to case management protocols. 4 point contacts will be completed with assessment of any barriers with an action plan to address the barriers and bring file to resolution. The Official Disability Advisor will be used to document RTW guidelines. • Examiner recommendations for case management WILL be discussed with the Member if medical issues are significant, claimant recovery is not progressing, or the claimant becomes TD at any point during the life of the claim. The Examiner WILL advise the Member of the additional cost of MCM services and discuss the benefits and risks of utilizing MCM services, thereby engaging the Member in the decision to assign MCM services. This discussion will be specifically noted in the Claims File. If the Member is in agreement with the recommendation for case management, the Examiner should refer to the case to case management services. **<u>Transition of Medical Case Management Services:</u>** **<u>Existing Case Management:</u>** Claims Examiner will review existing Telephonic and Field cases to determine the need for continued case management. Any cases with anticipated or Actual inpatient or outpatient surgeries will be referred to either TCM or FCM depending on the complexity of the surgery, preexisting conditions, DME and home health coordination or assessment of other				11/13/14

	barriers. Cases identified with high narcotic usage will also be referred for Telephonic Case Management for discussion of medications with provider and to obtain control of medication usage. **<u>Medical Exams:</u>** • If an employee requests a PQME but does not follow through in scheduling the PQME within the stated time frames, the Examiner is to contact the Member contact and discuss if the TPA should schedule the appointment for the employee. • If the PQME is cancelled or the employee is a no show, the Examiner will contact the Member contact and discuss if they should reschedule the appointment for the employee. • Upon receipt of a medical report that provides work restrictions, permanent and stationary status or discharge from care, the Examiner is required to provide this information to the Member contact within 24 hours. • Medical Only claims that involve Permanent Work Restrictions will be included in this notification to the Member contact. **<u>Medical Provider Network (MPN)</u>**: The Medical Provider Network (MPN) is an elective network decided by the individual court. The JBWCP utilizes the AIMS – AMC MPN.				

	• Judiciary Program does not participate in the MPN.
	• Claims Management offices have been given a matrix of courts participating in the MPN.
	• MPN providers can be found via website that will be provided once we file the plan.
	  o Anthem Blue Cross is in place for all courts that are not participating in the TPA MPN.
	  o AMC MPN is part of the Anthem Blue Cross Network but has been customized to meet the needs of JBWCP.
	  o Any Member questions regarding tailoring the providers contained within the MPN should be directed to the JBWCP Program Manager, Consultant and to the Program Account Manager.
	
	Contact information will be provided.
	
	<u>Nurse Case Management Goals:</u>
	
	• The Claims Examiner remains in control of the file and provides the direction to Nurse Case Management staff.
	• Case Management goal is to assure the best possible care upfront and help transition to return to work.
	• Case Managers will work closely with the claims staff and report any significant changes within 24 hours.
	• The Claims Examiner is the primary point of contact for communications with the Member.
	• Facilitate care, motivate and educate the injured employee on injury and RTW.
	• Obtain restrictions and facilitate transitional return to work.
	• Address RTW guidelines with provider and discuss				

	treatment options. • Coordinate services for injured worker. • Communicate with Claims Examiner. • Identify barriers and provide solutions. • Assure safe and timely return to work. • Assist with file resolution. **Nurse Triage overview:** • The Examiner will review all first reports of injury within 24 hours of reporting and make the initial contacts with the Employee, Treating Doctor and Employer. The Employee and Treating Doctor will be informed they will be contacted within 3 business days by a Triage Nurse. If the Employee is initially unwilling to communicate with the Triage Nurse, the Examiner will discuss the value and benefit of the communication, document the claims file accordingly and notify the Triage Nurse. The Triage Nurse will contact the Employee and the Treating Doctor and document the claim file within 3 business days. • Nurse interviews the IW and/or medically evaluates the first report of injury and any available medical document. Nurse completes the AMC Triage template. • Nurse will instruct the IW on where to go for treatment which are pre- selected by the JBWCP Member in advance • Nurse will obtain availability of transitional work and description of injured workers job duties. • Nurse will review the Official Disability Advisor RTW and ACOEM for treatment guidelines • Nurse will complete assessment of information received				10/15/15 REVISION

	• Nurse forwards AMC Triage template to the JBWCP Member within 30 minutes of completing the document • Triage nurse will assign to appropriate level of Nurse Case Management if necessary based on pre-selected TCM or FCM nursing Triggers • Triage Nurse will document activities in AlliedConnect management software real-time and claims system **Telephonic Case Management Triggers:** TCM Referral Criteria – A TCM assignment will be considered in the following cases. • Lost time claims without a planned or anticipated partial or full return to work date. • Cases in which there is no planned or anticipated return to work. • Anticipated or Actual inpatient or outpatient surgery of any type. • Claims with PT or Chiropractic care over 18 visits and continued on TTD. • Multiple body part injuries. • Back injuries with radiculopathy. • Claims that are not showing improvement with conservative care after three (3) months. • All claims with prior injury history to same or related body part and/or current open claim. • Med only cases with three (3) months of restricted duty without full RTW discussion. • Return to work at restricted or modified duty with no progression to regular duty.				

	• Prior claim, same body part with Permanent Disability rating. • Conditions unsubstantiated by objective findings (e.g., myofascitis, chronic fatigue, fibromyalgia, thoracic outlet syndrome, reflex sympathetic dystrophy). • Prior workers' compensation claim with same mechanism of injury, month of injury or body part within the prior two (2) years. • All Cases with prescription for narcotics will be referred to TCM • Outpatient Hospitalization **TCM and FCM Protocols:** • Case Manager (CM) will initiate services within 24 hours of referral. • CM will contact the medical provider, injured worker, employer and examiner within 48 hours of receipt of referral. • First progress report must include: o Brief description of the accident/injury. o Date of next medical exam, diagnostic testing, surgeries, etc. o MTUS guidelines and ODG guidelines for treatment and RTW. o Current work status to include any restrictions. o Medical notes substantiating off-work status. o Medical Provider's anticipated RTW date. o Diagnosis, prognosis and treatment plan. o Specific Nurse Case Management action plan with target dates. o Identification of unrelated treatments,				

	conditions and barriers to RTW. • The initial evaluation is completed within seven (7) business days from referral. • Progress Reports will be completed every thirty (30) days or significant activity. • Appointment updates to Examiner within 24 hours of appointment. • 24 hour updates on any significant file changes: RTW modified or full duty, anticipated surgery or anything that may impact file. • Closure Report to be completed upon file closure within five (5) days • CM cases will be staffed with Claims Examiner and Supervisor when case reaches ninety (90) days of service. The staffing must include: o TCM goals for resolution. o Action oriented plans with timeframes. o Expected outcomes. o Projected Closure dates. Claim Notes will be documented in Claim system and AlliedConnect **<u>TCM and FCM Closure Criteria:</u>** • Injured worker has successfully RTW full duty. • Injured worker has RTW in a permanent modified position. • Injured worker is declared P&S. • Claim is denied. • No impact on file. • Request from Claims Examiner. **<u>Field Case Management Triggers:</u>**				

	• Initial stages of a catastrophic or serious injuries • Surgical cases with serious complicating factors, such as diabetes, infections, blood clots. • Amputations, other than digits • Spinal cord injuries • Head injuries • Burns, third degree • Psych claims • Prolonged recovery or extended disability as identified by the Claims Adjuster • Non-compliant injured worker as identified by the Claims Adjuster • Uncooperative treating physician as identified by the Claims Adjuster -assign to obtain or clarify treatment plan • Inpatient hospitalization **<u>Telephonic Case Management – Re-referral:</u>** Cases that were initially closed Triage only or closed in TCM may be re-referred for telephonic case management. Claims examiner will review file to determine need for case management. Examiner will discuss with Program Member will assign to either TCM or FCM depending on the severity of case, anticipated surgery, clarification of treatment requested. Case Manager will complete 4 point contact with examiner, employer, provider and employee. Case Management reports to include medical treatment plan, next appointment date, work status and any barriers to recovery with case management recommendations. Nurse case manager will use standard of care guidelines to facilitate optimum recovery and RTW. The nurse will track all lost time, modified and RTW dates within NavRisk. If the injured				

	worker has lost more than 60 days of lost time from work or if there are other barriers to recovery or RTW noted the case should be strongly considered for Field Base Case Management. Reporting will be completed after every appointment or significant activity. Case management will be closed after case resolution or information requested on Task assignments are completed. Staffing with claims examiner and supervisor will be completed at 90 day intervals and will be noted in the claims system. **TCM and FCM Closure Criteria:** • Injured worker has successfully RTW full duty. • Injured worker has RTW in a permanent modified position. • Injured worker is declared P&S. • Claim is denied. • No impact on file. • Request from Claims Examiner. **The Following is Posted in Serranus for Court Locations To Review With Regards to the Case Management:** **Nurse Triage**: • The Examiner will review all first reports of injury within 24 hours of reporting and make the initial contacts with the Employee, Treating Doctor and Employer. The Employee and Treating Doctor will be informed they will be contacted within 3 business days by a Triage Nurse. The Triage Nurse will contact the Employee and the Treating Doctor and document the claim file within 3 business days.				10/15/15 REVISION

	Nurse contact is made with the intention of assessing the severity of injury, claimant's response to injury and co-morbidity factors. The Case Manager will review the treatment plan and compare to national standards of care. The Case Manager will identify barriers to recovery and identify optimal lengths of medical care and disability based on diagnosis. **<u>Telephonic Case Management:</u>** Nurse will perform 4 point contact; injured worker, court HR contact noted on location specifics and provider to assess the severity of injury, claimant's response to injury and co-morbidity factors. Nurse must contact the court HR noted on the court location specifics to see if contact with the employee's direct supervisor is allowed and to obtain information on modified or alternative work availability. The Nurse Case Manager will contact the treating provider, injured worker and employer and provide an assessment of information gathered and document and barriers or impediments for resolution of case and RTW. Nurse will discuss treatment options with provider and assure employee understands the treatment and expectations. Nurse will report after every appointment or any significant activity. Nurse will facilitate treatment and work toward RTW. Case staffing will take place every ninety (90) days with Examiner and Claims Supervisor. **<u>Field Case Management</u>**:				

This service can be either task or full case management services and will include case management with return to work coordination for the cases that require in person contacts with the medical providers and injured worker. Nurses shall coordinate with the Claims Examiner to perform 4 point contact; injured worker, court HR contact noted on location specifics and provider to assess the severity of injury, claimant's response to injury and co-morbidity factors. Nurse must contact the court HR noted on the court location specifics to see if contact with the employee's direct supervisor is allowed.

The field will make onsite visits with provider to clarify treatment options, discuss treatment protocols, facilitate treatment and assure and address questions form employee. The nurse will track all lost time, modified and RTW dates within NavRisk.

The Case Manager will assess the impact of Field Case Management Services and will recommend case closure when claimant has been returned to full duty work or the Case Manager is unable to impact the claim any longer. Case Management reports will be done monthly or with significant activity. Regular staffing will be performed with the Field Case Manager, Manager and Claims Examiner on a regular basis every ninety (90) days

Pricing:

Triage	$85.00 per h

	Telephonic Case Management	$90.00 per hour				
	Field Case Management	$95.00 per hour				

Utilization Review (UR) Criteria:

ADDENDUM 1
Approval of Medical Requests AMC Standard

Requested Authorization	Claims Representative APPROVAL Level	Send to Utilization Review
Diagnostic Testing	MRI's and x-rays	All repeat diagnostics – 2nd MRI
		Bone scans CT Exams CT/Myelogram CT/Discogram
		EEG, SSEP (Somatosensory potential), VEP (Visual evoked potential) (brain)

		EMG/NCV – and all surface EMG testing (SEMG)
		ECSWT (extracorpeal shockwave therapy) – *Ask UR for appropriate CPT code for this therapy; ask Bill Review company for cost not covered by fee schedule*
	All carpal tunnel evaluations – *If no pre-existing problems or co-morbidity factors*	All carpal tunnel evaluations if IW has diabetes, is pregnant or any co-morbidity factors – pre-existing – obese; extensive use of hands for hobbies
	Stress test/EKG for presumptive heart cases	Any other questionable diagnostics
		Sleep studies
Blood Work	Routine blood work to monitor side effects of medications RX on long term basis; blood work to monitor risk factors (ex. Lipid panel) in presumptive cases	Complex blood chemistry panel to rule out "add-on" or "sequelae diagnosis"
Durable Medical Equipment (DME)	Hearing aids for hearing loss claims – Provided there is documentation of hearing loss data at acceptable audiometric levels at 500, 1000, 2000 and 3000 Hz using ANSI standards	Tens Unit – Purchase or rental – Interferential muscle stimulators units such as H wave therapy devices and 4 channel IF devices
		Custom DME

		Bone growth stimulators
		Cervical or lumbar traction devices – Motorized or pressurized
	All DME less than $800.00 (Send to UR if it is exercise equipment less than $500.00	All DME priced greater than $800.00 OR DME supply requests if DME purchase date is older than one (1) year from date of the original RX
	Adjusters may authorize the following DME by Procedure: Cervical Surgery Shoulder Surgery Back Surgery	 Cervical Collar Walker 3 and 1 Commode Shower Chair Reacher Transportation Cervical Bone Growth Stimulator Shoulder Immobilizer/Sling Cold Therapy Unit Shoulder CPM Shower Chair Back Brace

		Walker Elevated Commode or Toilet Seat Extender Tub Seat, bench or shower chair to use in the bathtub or shower Long-handle Reacher/Hip Kit includes Sock Aid, Reacher, Sponge, Toilet Aide Hospital Bed Spinal Bone Growth Stimulator
	Knee Surgery	Walker with wheels Cane Crutches Cold Therapy Unit Knee CPM Knee Brace Wheel Chair
	Wound Care	Gauze Bandage Tape Dressing
	Foot Surgery	Bracing Knee Scooter Crutches
Pharmaceuticals	Oral medications under six (6)	Oral medications prescribed in

	months OR oral medications prescribed by Agreed Medical Evaluator or Defense Qualified Medical Evaluator within two (2) years of the first RX of the medications Medications for treatment of presumptive cases with future award OR medications prescribed for preventative treatment of first aids and/or exposure cases (see diagnosis)	excess of 6-12 months, excluding over the counter Oral medications prescribed by Agreed Medical Evaluator or Defense Qualified Medical Evaluator greater than two (2) years from first RX of the medications Medications for "add on conditions" such as sexual dysfunctions ex. Viagra, opiates, appetite suppressants, weight loss, herbal medication, psyche medications, etc.
	Simple injections administered by treating physicians such as Toradol or shots provided in an Simple injections administered by treating physicians such as Toradol or shots provided in an Emergency Room setting such as Demerol or Morphine Initial steroid/anesthetic	Repeated injections – Narcotic injections done in a doctor's setting Repeated injections – Narcotic injections done in a doctor's setting All Synvisc, Supartz, Hyaluronic Acid injections, trigger point injections, epidural injections –

	injections for tendinitis/bursitis NOTE: SEND TO UR – Demerol and Morphine shots done in a doctor's setting	first and repeats, facet injections, any radiofrequency procedure and Botox
Physical Medicine – PT, OT, Chiro, Acupuncture & Massage	All passive or active therapy for no more than six (6) visits Initial post-op PT six (6) visits	All passive or active therapy exceeding six (6) visits
		Work hardening
		All non-medical exercise or treatment programs such as reflexology, aerobics, Pilates, gym memberships, personal trainers, aquatics, etc.
Specialty Referrals/Consults	All initial Orthopedic referrals	Psych evaluations, testing's & treatment
	For cases involving head injuries/trauma, it is okay to refer to neurologist upon recommendation of treating physician at initial consult	Specialty referrals to Neurosurgeons, Neurologists, Rheumatologists, etc.
		All Pain Management/Functional Restoration & Detox Program
		Chemical Dependency Program
		Gastric bypass or lap band surgery
Surgeries		All surgical procedures both outpatient and inpatient – clarify the length of stay, need

		for asst. surgeon, DME, meds, home health nursing care requirements depending on the type of surgery IDET procedures Implantable devices (spinal cord stimulator and morphine pump)
Extended Duration of Medical Care		All claims with conditions unsubstantiated by objective findings such as RSD (Reflex Sympathetic Dystrophy) or CRPS (Complex Regional Pain Syndrome) – treatment for chronic fatigue, fibromyalgia & myofascitis
		Concurrent review or retro review of non-emergency hospitalizations, non-emergency transfers, ambulatory surgery care centers Concurrent review or retro review of transfer level of care from acute setting to rehab
Ancillary Services		Home health care/aide Nursing Care – short term/long term care, assistance for support, custodial/driving/shopping

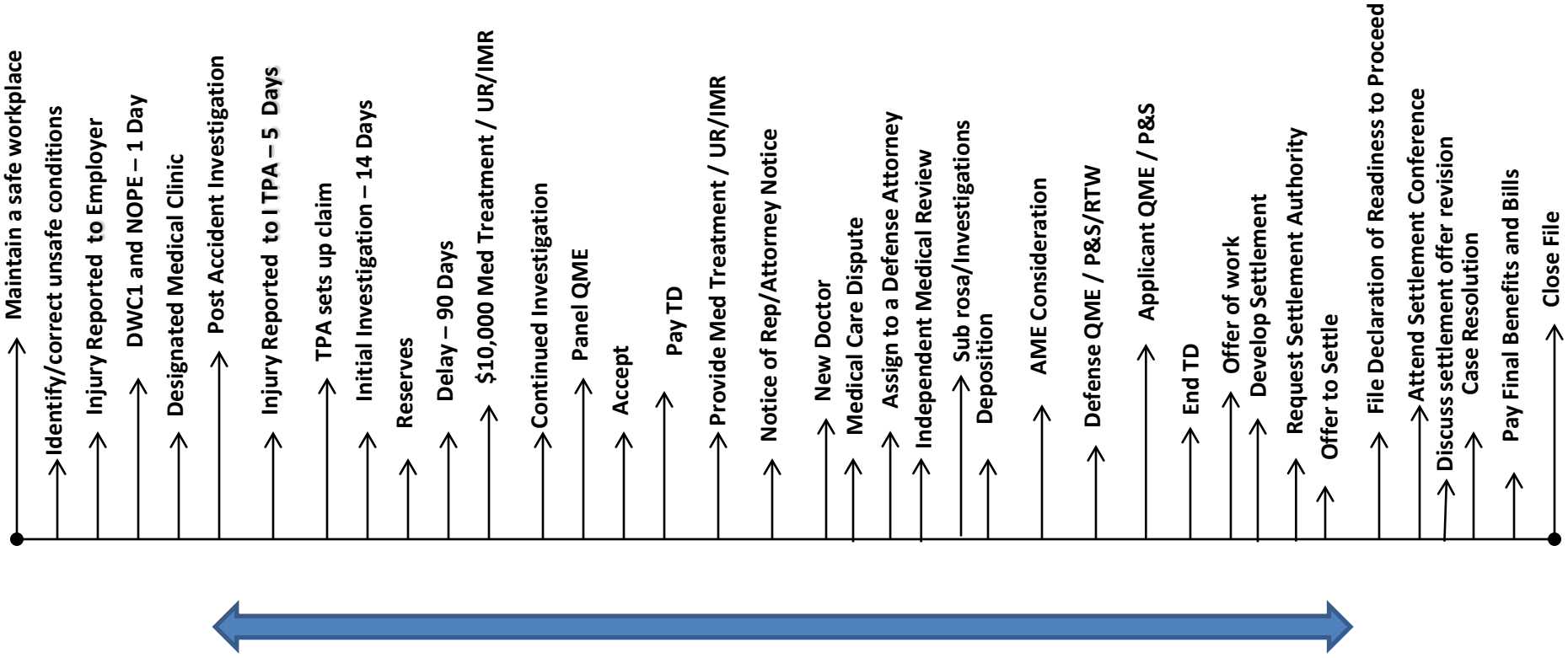
		Might need CPT codes or pre-negotiated price
Others		Weight loss programs
		Biofeedback
		Non-emergency dental services
		All computerized muscle testing
		All uncommon or experimental services or devices
		Drug dependency treatment

	Utilization Review Services: Utilization Review services are provided at AMC Sacramento office. Type of Review: UR – Inpatient/Outpatient, Retrospective and/or Concurrent Cost: $85.00 Flat Rate Physician Advisor Review Cost: $225.00 Flat Rate				
	Pharmacy Services: • The JBWCP members use TMESYS pharmacy network program for all prescription drugs. The program is a proprietary network owned by PMSI (recently purchased by Helio Corporation and a name change is expected this fall. The network name TMESYS will remain unchanged). • First Fill forms are provided by the JBWCP entity at the time of injury				

	• Claim Examiners shall designate a new claim as pharmacy eligible based on the following criteria: 1. AOE/COE is admitted 2. Treatment is active ▪ The cards are sent out automatically via an electronic interchange between AIMS and the pharmacy program when a file is reported to AIMS, the electronic reporting is sent out at the end of the working day. PMSI processes the file and mails out pharmacy card information within 24 hours. 1. Cards are automatically closed the following work day when the examiner closes the file, documents the claim status with a Compromise and Release, or denies the file. The updated claim data is part of the daily eligibility file sent to PMSI. 2. The examiner has the ability to update the pharmacy				

	website to request new cards, turn off cards or block medications and doctors as needed. 3. All narcotic medications that fall outside of the pharmacy formulary are sent to Nurse Case Management as an early intervention program to review prevent addiction issues.				

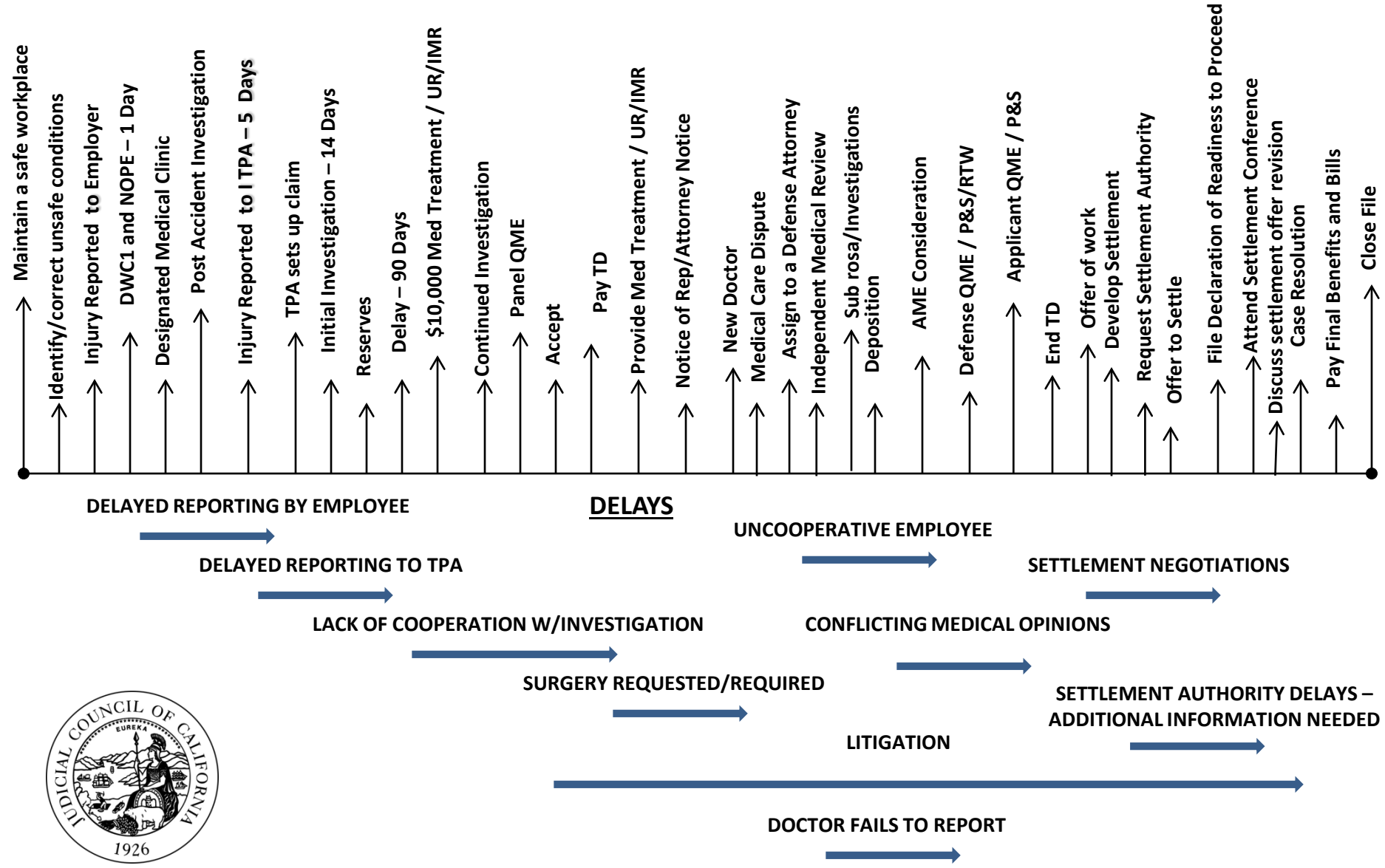
Life Of A Claim



Approximately Two Years

JUDICIAL COUNCIL OF CALIFORNIA
EUREKA
1926

Life Of A Claim



Claims Settlement Policy & Procedure (Sample 1)

I. BACKGROUND

Workers' Compensation benefits are mandated and established by State law. All claims involving permanent disability must be finalized through the Workers' Compensation Appeals Board (WCAB). There are three primary settlement types:

- STIPULATIONS WITH REQUEST FOR AWARD:

  Used to settle the employee's claim based upon written agreements of the parties. This agreement may or may not provide for an award of lifetime medical benefits. This type of settlement is primarily utilized for settling claims where the claimant remains an employee of the employer.

- COMPROMISE & RELEASE

  A type of settlement which includes a payment to the employee in addition to any Compensation which is payable in exchange for the employee's release of the employer from any future liability for payments as specified in the agreement. This type of settlement is primarily used when the claimant is no longer an employee of the employer and is utilized to finalize all issues.

- FINDINGS & AWARD

  This type of settlement is issued by a WCAB Judge at the conclusion of an Appeals Board trial. The parties are bound to the Findings issued by a Judge. The only recourse an employer has is to Petition For Reconsideration by the Appeals Board.

II. POLICY STATEMENT

CHWCA's contracts Claims Administrator will negotiate settlements with the injured worker and any attorneys involved in the case. The primary settlement options will either be Stipulations with Request for Award or Compromise and Release. Settlement of claims through C&R may be desirable because of its finality. A C&R Settlement not only allows the closing of a file and eliminates future claims handling costs, but also eliminates financial reserves being held to cover anticipated future benefit payments.

It shall be the policy of CHWCA to resolve claims through C&R when economically feasible to do so. Member Authorities shall have input and be a part of the claims settlement process as outlined below.

III. SETTLEMENT AUTHORITY LEVELS

Level 1: $1 to $10,000 – Claims Administrator

CHWCA's third party Claims Administrator shall be granted settlement authority of up to $10,000 on any claim. However, the Claims Administrator shall advise the Member Authority of any settlement within this level prior to settlement offer.

Level 2: $10,000 to $50,000 – Program Consultant & Claims Administrator

CHWCA's Program Consultant and Claims Administrator shall be granted authority for claim settlements between $10,001 and $50,000. In the even the Program Consultant and Claims Administrator disagree on a settlement within this range, the Executive Committee shall review the matter and grant authority as appropriate.

The Program Consultant will ensure that the Member Authority is kept informed regarding the claim and will take into consideration the Member's desires in any settlement process. However, the Program Consultant shall keep the best interests of other CHWCA members paramount in any decision.

Level 3: $50,0001 and above – Executive Committee

The Executive Committee shall have authority for claim settlements above $50,001. The Program Consultant and Claims Administrator shall have reviewed the proposed settlement agreement and shall set forth the reasons for such settlement for review and consideration by the Executive Committee. The Member Authority shall be advised in advance of the recommended action and shall be allowed to indicate its position to the Executive Committee prior to a final decision.

IV. DISPUTES

Any claim settlement decision made by CHWCA may be appealed by a Member Authority.

A Member Authority appeal within the Level 1 ($1 - $10,000) shall be made to the Program Consultant, who shall act as the arbitrator. The decision of the Program Consultant shall be final.

A Member Authority appeal of a claim within Level 2 ($10,001 - $50,000) shall be appealed to the Executive Committee. The decision of the Executive Committee shall be final.

Level 3 claims are not subject to appeal.

Settlement Authority Policy (Sample2)

<*name*> is a risk-sharing, self-insured program providing first dollar workers' compensation coverage to its members. All claims costs, including settlements, are paid from the Program's pooled funds. As such, no claim involving exposure to <*name*> funds shall be settled without prior authorization from JPA Name. That notwithstanding, the <*name*> Executive Committee does hereby delegate the following levels of settlement authority:

1. Settlement authorization for claims with settlement value less than $25,000 shall be delegated to the Claims Administrator;
2. Settlement authorization for claims with settlement value between $25,001 and $99,999 shall be delegated to the Program Director;
3. Settlement authorization for claims with settlement value of $100,000 or higher will require the authorization of the Executive Committee.

All potential settlements will be communicated to both the employer involved and the Program Administrator prior to settling the claim.

Judicial Branch Workers' Compensation Advisory Committee
Settlement Authority Considerations

Workers' Compensation claims for the JBWCP are administered through the Judicial Branch Workers' Compensation Program (JBWCP) by a third party administrator (TPA) Acclamation Insurance Management Services (AIMS).

Under authority of the JBWCP, AIMS manages all workers' compensation claims for the Program with oversight from the Judicial Council Human Resources staff along with the risk management consultant, Bickmore. In addition, California court oversight and the management of workers' compensation claims and court cases is provided by the Workers' Compensation Appeals Board (WCAB). The WCAB promulgates rules on policy, manages court cases and approves all litigated and non-litigated workers' compensation settlements.

Current practice requires AIMS to present settlement recommendations to the members for approval. Each member of the JBWCP has a different process for reviewing and authorizing settlements. While all settlement recommendations presented to the members should outline all of the claim details and provide, there can be some confusion or lack of understanding regarding various settlement opportunities.

There are two ways to settle a workers' compensation claim:

1. Compromise & Release – this is a type of settlement which may close a workers' compensation claim in its entirety and will usually provide the claimant with a lump sum payment. In most cases, the claimant is then responsible for payment for their future medical care. This settlement must be approved by a workers' compensation judge.

   If the claimant is Medicare eligible, then the settlement must include a Medicare set-aside analysis (MSA). There is an additional cost to obtain the analysis of approximately ($2500) that is charged to the claim file. Any claim involving a MSA could substantially make settling the claim by this method cost prohibitive.

   Settlement by Compromise and Release with or without an MSA should only be considered on an as needed basis based on the claim status and not as a general rule simply because an employee is no longer employed by the courts. If there has been no medical treatment for at least one year the claim file may be administratively closed.

2. Stipulation with Request for Award – this is a type of settlement where an agreement is reached regarding an issue in dispute. This usually references the level of Permanent Disability resulting from an industrial injury or illness. In these cases, the Stipulation with Request for Award settlement will be based upon a level of Permanent Disability outlined in the Permanent Disability Rating Schedule (PDRS). This settlement is referred

to as a “scheduled” settlement and will provide guidance on the provision of future medical benefits. A settlement like this must be approved by a workers’ compensation judge.

Establishing a uniform settlement authority process will allow a consistency in settlement of all cases within the JBWCP as well as provide for planning and timing of case resolution. Creating a uniform settlement authority may consider many options, including:

- Creating a formal settlement request document;
- Requiring a settlement conference between the claims adjuster and the JBWCP member to discuss the specifics of the settlement as well as the impact to the member and the JBWCP program;
- Determining a settlement response timeline;
- Establishing a settlement authority level by JBWCP members; and
- Identify cases which may require additional authority
    - Authority required from Advisory Committee;
    - Authority required from Excess Carriers.

As with any new process, consideration should be given to:

- What will be accomplished by this change:
- What training will be required to implement the change;
- Will the process be measured to determine if it is successful
    - How will the process be measured?

Judicial Branch Workers' Compensation Program (JBWCP) Service Providers

Acclamation Insurance Management Services (AIMS)

Originally founded in 1973 as Leonard J. Russo Insurance Services, Inc., this privately owned organization is incorporated in the state of California and has been administering property/liability and workers' compensation claims continuously for over forty-two (42) years. In January 1990, the current corporate name, AIMS, was assumed to better reflect the diverse nature of our product offering.
AIMS corporate values include integrity, discipline, vision, excellence, financial responsibility, and respect.

AIMS is committed to great client service at every level. It is every employee's responsibility to:

- Listen for understanding
- Show empathy
- Find solutions
- Anticipate needs
- Follow through on commitments

AIMS works in partnership with the JBWCP to achieve optimal results from their workers' compensation program. To learn more about AIMS, please visit their website: http://www.aims4claims.com.

Role of the Third Party Administrator

AIMS provides workers' compensation claims administration services for the JBWCP. AIMS is a third-party administrator (TPA). TPAs are companies that self-insured employers and permissibly un-insured government employers commonly contract with to administer the claims administration process. The process of properly and effectively administering claims is very complex as there are numerous actions that must be taken by specific mandated deadlines. The claims reserving process is governed by a wide body of law and court cases, effectively providing benefits and facilitating the process by which an injured worker returns to work. Often, this will have a direct effect on controlling the costs associated with the employer's workers' compensation program. Oversight of a TPA is the responsibility of the Division of Industrial Relations, Office of Self Insurance Programs (OSIP).

The JBWCP is permissibly un-insured and is not subject to the OSIP guidelines. However, the OSIP guidelines and requirements are considered for the administration of claims. The program's claims administration is reviewed regularly by: the JBWCP administrator, the risk consultant, the TPA, and the JBWCP Advisory Committee. Adjustments are made regularly to the program's Service Guidelines as needed to ensure continued effective claims administration.

AIMS and the JBWCP

AIMS became the JBWCP's claims administrator on July 1, 2014. AIMS took on the administration of the JBWCP's claims in October of 2014, and have now been responsible for the full administration of the program for a full year.

At the time of contract agreement, AIMS proposed a staffing model that they felt appropriate for the administration of the JBWCP. However, it has been necessary to adjust the proposed staffing model to better fit the needs of the program. The current contract needs to be amended to reflect the necessary adjustments. In addition, it has become necessary to consider one additional claims assistant to support ten claims examiners would be beneficial for the effective administration of claims and allow for an improved ratio of support staff per claims adjuster. The addition of one staff person would affect the following:

- Decrease turnaround time to ensure industry best practices and the program services guidelines are being met more effectively;
- Support the ongoing changes in claims handling as indicated in the Service Guidelines, the increase in independent medical reviews requests, and upcoming industry changes, such as revised benefit notices;
- Allow examiners to spend time developing more in-depth rationales and plans of action; and
- Provide more efficiency and accuracy in processing tasks.

The program administration is seeking the Committee's approval to amend the agreement with AIMS so that it is renewed on a fiscal year basis, and to add one additional claims assistant as outlined above. This will result in an increase to the overall cost of the contract by 3.2 percent over the remaining years of the contract (see attached AIMS Increase doc.).

Bickmore Risk Services

Bickmore is the largest independent, full-service risk management consulting firm in the Western United States and has nearly 30 years of experience in virtually all types of public entity self-insured and un-insured public programs.

The firm consults with public and private entities in 40 states. Bickmore's 113 employees include self-insurance program managers, certified public accountants, litigation management attorneys, credentialed actuaries, certified workers' compensation specialists, risk control specialists, claims consultants, and risk management information experts. Visit the Bickmore and Associates website for more information.

Bickmore and the JBWCP

Bickmore provides risk management consulting services, including subject matter experts for claims administration and TPA oversight, actuarial valuation of the program's liabilities, and best practices for managing a pooled program. Bickmore analyzes JBWCP trends and develop metrics to inform and aid in the mitigation of the cost of workers' compensation losses for all JBWCP members. They highlight trends, strengths, areas for improvement, or risks that may impact all members. Bickmore is excited to continue their work with the JBWCP.

The current contract was up for renewal on October 31, 2015. In order to retain the ability to continue to pay for the necessary services provided by Bickmore, Bickmore agreed to amend the contract for a limited term, effective November 1, 2015 through June 30, 2016. The needs of the program will need to be considered prior to the next contract renewal period. Proposed changes to the agreement will be presented at the spring meeting.

		Persons		Amount		
	Rate	Current	Proposed	Current	Proposed	Increase
Account/Program Manager	$ 20,001.62	1	1	$20,001.62	$20,001.62	$0.00
Claims Manager	$ 17,788.36	1	0	$17,788.36	$0.00	($17,788.36)
Claims Supervisor	$ 15,915.90	1	2	$15,915.90	$31,831.80	$15,915.90
Senior Claims Examiner	$ 12,246.07	9	9	$110,214.63	$110,214.63	$0.00
Claims Examiner	$ 7,864.33	1	1	$7,864.33	$7,864.33	$0.00
Claims Representative	$ 7,857.59	2	3	$15,715.18	$23,572.77	$7,857.59
Monthly Amount				$187,500.02	$193,485.15	$5,985.13
Annual Amount				$2,250,000.24	$2,321,821.80	$71,821.56
2- year Amount				$4,500,000.48	$4,643,643.60	
Remaining Years of contract (assume all options exercised)						7
Increase/Decrease over the remaining years						$502,750.92

	Annual Amounts
Current Claims Administration Services	$2,250,000.24
Other Services	$12,499.76
Current Contract Amount	$2,262,500.00
Increase/Decrease (Claims Administration Services)	$71,821.56
Percentage Increase/Decrease	3.2%

TIMELINE FOR 2016 ANNUAL AGENDA PROCESS
Executive and Planning Committee (E&P)
(Advisory bodies whose work focuses on projects and administrative issues.)
[Responsible staff in brackets]

Wednesday, 10/7/2015	**[E&P and RUPRO staff]** Comm/Comm Meeting: Provide advisory body staff with information about the 2016 annual agenda process.
Wednesday, 10/7/2015 – Friday, 3/4/2016	**[Advisory body staff (staff to advisory bodies for which E&P has oversight)]** With advisory body chairs, develop draft annual agendas. Discuss with CJER staff any projects that include elements pertaining to education (see *CJER Committee Guidelines on Proposals From Other Advisory Committees*). Consult with other offices regarding projects that require collaboration with resources from those offices.
Monday, 3/7/2016	**[Advisory body staff]** Submit draft annual agendas to E&P staff in Word format (to allow commenting and editing).
Tuesday, 3/8/2016 – Friday, 3/25/2016	**[E&P staff and advisory body staff]** Refine draft annual agendas after considering comments and suggestions from E&P staff.
Monday, 3/28/2016	**[Advisory body staff]** Submit revised, final draft annual agendas to E&P staff in Word format.
Friday, 4/1/2016	**[E&P staff]** Post final drafts of the annual agendas on the MOODLE site and send e-mail to notify E&P, the Administrative Director, and three Judicial Council Chiefs that they are available for review. Send hardcopies to those who have requested them.
Wednesday, 4/13/2016 (tentative)	**[E&P staff plan/implement; advisory body staff support chair and contribute]** E&P Meeting (in-person, the day before the April Judicial Council meetings): E&P discusses each advisory body's annual agenda with its chair and principal staff.
Thursday, 4/21/2016	**[Advisory body staff]** Submit to E&P staff final annual agendas incorporating any changes requested by E&P.
Monday, 5/2/2016	**[E&P staff]** Submit request to Webcontent to have the final versions of the annual agendas posted on Serranus website. Save final annual agendas on Shared drive (S:).
Friday, 5/6/2016	**[E&P Staff]** Draft CNU blurb announcing the posting of the annual agendas. Submit the draft blurb to Communications staff.
Tuesday, 5/10/2016	**[E&P and Communications Staff]** CNU Announcement: Posting of annual agendas on Serranus website. Send by e-mail memo from E&P chair to advisory body chairs and staff notifying them of the posting.
June 2016	**[E&P staff plan/implement; advisory body staff attend and contribute]** Comm/Comm Meeting: Debrief regarding the 2016 annual agenda process.

Advisory Body Name
Annual Agenda—2016
Approved by E&P/RUPRO/JCTC (select one): _____

I. ADVISORY BODY INFORMATION

Chair:	
Staff:	
Advisory Body's Charge: *[Insert charge from Cal. Rules of Court, or the specific charge to the Task Force.]*	
Advisory Body's Membership: *[Insert total number of members and number of members by category.]*	
Subgroups/Working Groups: *[List the names of each subgroup/working group, including groups made up exclusively of advisory body members and joint groups with other advisory bodies, and provide additional information about the subgroups/working groups in Section IV below. To request approval for the creation of a new subgroup/working group, include "new" before the name of the proposed subgroup/working group and describe its purpose and membership in section IV below.[1]]* *Subgroup or working group name:*	
Advisory Body's Key Objectives for 2016: *[An objective is a strategic aim, purpose, or "end of action" to be achieved. Enter as bullet points the advisory body's objectives for the coming year.]*	

[1] California Rules of Court, rule 10.30 (c) allows an advisory body to form subgroups, composed entirely of current members of the advisory body, to carry out the body's duties, subject to available resources, with the approval of its oversight committee.

II. ADVISORY BODY PROJECTS

#	Project[2]	Priority[3]	Specifications	Completion Date/Status	Describe End Product/ Outcome of Activity
1.	*[Be specific about what the project entails and what it is expected to accomplish. If the proposal is for rules or forms, include the number of new or amended rules and new or revised forms. Note any subgroups/working groups involved]*		Judicial Council Direction *[Judicial Council directive/strategic plan goal/operational plan objective/rule of court/charge and explain connection to this project]*: Origin of Project: *[include information about the origin of the project, for example, is it required by statute or Judicial Council direction, did it result from a suggestion from a court, judge, or attorney; etc.]* Resources: *[include any specific resource needs, such as Education, OERS, etc.]* Key Objective Supported: *[indicate which key objectives from section I, if any, the project supports]*	*[Include status and projected completion date, or state "Ongoing" if applicable]*	
2.			Judicial Council Direction: Origin of Project: Resources:		

[2] All proposed projects for the year must be included on the Annual Agenda. If a project implements policy or is a program, identify it as *implementation* or *a program* in the project description and attach the Judicial Council authorization/assignment or prior approved Annual Agenda to this Annual Agenda.

[3] For non-rules and forms projects, select priority level 1 (must be done) or 2 (should be done). For rules and forms proposals, select one of the following priority levels: 1(a) Urgently needed to conform to the law; 1(b) Urgently needed to respond to a recent change in the law; 1(c) Adoption or amendment of rules or forms by a specified date required by statute or council decision; 1(d) Provides significant cost savings and efficiencies, generates significant revenue, or avoids a significant loss of revenue; 1(e) Urgently needed to remedy a problem that is causing significant cost or inconvenience to the courts or the public; 1(f) Otherwise urgent and necessary, such as a proposal that would mitigate exposure to immediate or severe financial or legal risk; 2(a) Useful, but not necessary, to implement statutory changes; 2(b) Helpful in otherwise advancing Judicial Council goals and objectives.

#	Project[2]	Priority[3]	Specifications	Completion Date/Status	Describe End Product/ Outcome of Activity
			Key Objective Supported:		
3.			Judicial Council Direction: Origin of Project: Resources: Key Objective Supported:		
4.			Judicial Council Direction: Origin of Project: Resources: Key Objective Supported:		
5.			Judicial Council Direction: Origin of Project: Resources: Key Objective Supported:		
6.			Judicial Council Direction: Origin of Project: Resources:		

#	Project[2]	Priority[3]	Specifications	Completion Date/Status	Describe End Product/ Outcome of Activity
			Key Objective Supported:		

III. STATUS OF 2015 PROJECTS:

[List each of the projects that were included in the 2014 Annual Agenda and provide the status for the project.]

#	Project	Completion Date/Status

IV. Subgroups/Working Groups - Detail

Subgroups/Working Groups: *[For each group listed in Section I, including any proposed "new" subgroups/working groups, provide the below information. For working groups that include members who are not on this advisory body, provide information about the additional members (e.g., from which other advisory bodies), and include the number of representatives from this advisory body as well as additional members on the working group.]*

Subgroup or working group name:

Purpose of subgroup or working group:

Number of advisory body members on the subgroup or working group:

Number and description of additional members (not on this advisory body):

Date formed:

Number of meetings or how often the subgroup or working group meets:

Ongoing or date work is expected to be completed: