PINNACOL ASSURANCE

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303.361.4000 / 800.873.7242
pinnacol.com

December 31, 2019

Honorable Jared Polis, Governor
Members of the General Assembly
Colorado State Capitol
Denver, CO 80203

Dear Governor Polis and Members of the General Assembly:

Pursuant to C.R.S. §8-45-122, attached please find Pinnacol Assurance's Report to Colorado Policymakers on 2018 Data. Per the statute, the report contains the following information:

(a) Number of policies held by Pinnacol
(b) Total assets of Pinnacol
(c) Amount of reserves
(d) Amount of surplus
(e) Number of claims filed
(f) Number of claims admitted or contested within the twenty-day period pursuant to section 8-43-203, specifying the number of contested claims that are medical only and those that are indemnity claims
(g) Number of medical procedures denied
(h) Amount of total compensation each executive officer or staff member receives, including bonuses or deferred compensation
(i) Amount spent on commissions
(j) Amount paid to trade associations for marketing fees
(k) All information relating to bonus programs
(l) Any other information the CEO deems relevant to the report

** All data is as of year-end 2018.*

The introduction to the report also highlights Pinnacol's focus and commitment to policyholders, injured workers and the Colorado community. Additional financial information may be found in the appendices to this document.

If you have any questions concerning the information in this report, please contact me at 303.361.4000.

Sincerely,

Philip B. Kalin
President and CEO

cc:
Sen. Leroy Garcia, Senate President
Sen. Chris Holbert, Senate Minority Leader
Rep. KC Becker, Speaker
Rep. Patrick Neville, House Minority Leader
Sen. Angela Williams, Chair, Senate Business, Labor and Technology Committee
Sen. Rhonda Fields, Chair, Senate Health and Human Services Committee
Rep. Tracy Kraft-Tharp, Chair, House Business Affairs and Labor Committee
Rep. Susan Lontine, Chair, House Health and Insurance Committee
Colorado Legislative Council Library

PINNACOL ASSURANCE

Report to Colorado Policymakers on 2018 Data

Dec. 23, 2019

pinnacol.com

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Introduction

Pinnacol has provided workers' compensation insurance to Colorado employers, regardless of risk, since 1915. We ensure workers receive wage replacement and the medical care they need when they're injured on the job, and we protect their employers from potentially catastrophic losses. Today, we cover more than 56,000 businesses and more than 900,000 employees across the state.

After 104 years in business, we're continuing to explore new and better ways to serve our policyholders and their employees, and thus, transforming Pinnacol into the insurance company of the future. We embody our mission of providing caring protection to Colorado businesses and their employees by putting customer service at the center of everything we do. By evolving our technology and using the principles of human-centered design, we're effectively responding to our customers' habits and desires and providing better service. We sit down with customers—agents, policyholders and injured workers—to watch how our processes work (and sometimes don't) for them. The innovations we subsequently create spring from those customers' needs, not our assumptions. Some recent innovations that have emerged from this work include:

- **Cake Insure**: Our digital subsidiary has shortened the time required to buy a small business work comp policy from days down to less than three minutes using proprietary algorithms and artificial intelligence.
- **Mileage reimbursement enhancements**: By offering online tools as well as streamlining our internal processes, we've shortened the time between when an injured worker submits a reimbursement form and when Pinnacol distributes their check from approximately 10 days to approximately one day.
- **OSHA recordkeeping app**: When a policyholder reports a claim, it's now automatically imported into Pinnacol's recordkeeping app. Three Occupational Safety and Health Administration (OSHA) forms are then automatically populated and available, helping policyholders navigate a cumbersome process.

Focusing on policyholder and injured worker satisfaction

As a result of our customer-centered approach to all facets of our business, our customer satisfaction has reached unprecedented levels. Cake's fall 2019 Net Promoter Score (NPS) was 74; Pinnacol's was 53. Both scores are much higher than the industry standard in the mid-30s.

Pinnacol takes great pride in the caring service we provide to injured workers, and it shows in our injured worker satisfaction scores. Every year for the past four years, Pinnacol's average injured worker satisfaction score has been higher than any of our competitors' scores. And in November 2019, our injured worker satisfaction score reached an all-time high of 4.41 out of 5.

Keeping Colorado workers safe

Pinnacol has the largest, most experienced team of safety consultants in Colorado, including experts in industrial hygiene and ergonomics. Our team also features specialists in industries like construction, oil and gas and health care. Our consultants spend more than 35,000 hours every year helping employers across the state keep their workplaces safe. We also have hundreds of safety resources available to our policyholders at no cost, including webinars, posters and sample documents. Many of these materials are available for download whenever an employer needs them.

Caring for injured workers

In 2018, Pinnacol received nearly 44,000 claims. Only 3 percent of those were contested (denied) in 2018, most often because the injury was determined to be not work-related.

We are proud that, in 2018, the Division of Workers Compensation recognized Pinnacol for our exemplary claims service. We resolve claims 17 percent faster than competitors, and the Division's data shows that 97 percent of our claims are paid timely (the nearest competitor is at 89 percent), and 95 percent are paid accurately.

Developing the workforce of tomorrow

Like every other business, Pinnacol faces challenges in recruiting and retaining high-caliber staff. So growing our own team members is appealing. We're now entering into our third year of partnership with CareerWise Colorado, a statewide apprenticeship program. We believe in this model so much that we currently have 27 apprentices—more than any other employer in Colorado—and have onboarded our third cohort of students. Our apprentices stay with us for three years. During their junior and senior years of high school they spend two to three days a week at our office getting paid, hands-on work experience; they may transition to working for us full time after they graduate. When they complete their apprenticeships, each will have earned up to 40 hours of debt-free college credit and a nationally-recognized industry certification. We've already hired five apprentices from our first cohort as full-time employees at Pinnacol.

Supporting our employees

2018 marked the third consecutive year Pinnacol has made *The Denver Post*'s Top Workplaces list. We're also proud that the Colorado Women's Chamber of Commerce awarded Pinnacol the "Innovation Award" for employee- and family-friendly practices such as health and wellness programs, PTO donation and assist programs, and compensation models that ensure gender pay equity.

Investing in Colorado

As the leading provider of worker's compensation insurance in Colorado, we recognize our impact on the state and its economy. Our commitment extends beyond our customers and their employees. With customers in all 64 Colorado counties, we spread our efforts across the state to help nonprofits large and small.

In 2018, Pinnacol awarded grants totaling more than $550,000 to 32 Colorado nonprofits to help keep its policyholders' employees safe and healthy, provide rehabilitative care to those who are injured, and ensure Colorado has a robust business climate and the workforce it needs. Our grants funded organizations and programs such as the Colorado Safety Association, the Spinal Cord Injury Recovery Project, and Associated General Contractors' apprenticeship program for the construction trades.

Through the employee-led Pinnacol in Action program, 80 percent of Pinnacol's 600+ employees volunteered with a nonprofit in 2018, spending more that 6,400 hours serving the community. Participation in the program is voluntary, and employees are free to lend a hand to organizations that are meaningful to them. They shared their time and talents with groups such as the Denver Health Foundation, the Food Bank of the Rockies and the National Sports Center for the Disabled.

One of the initiatives of which we are most proud is the Pinnacol Foundation, which in 2018 awarded more than $450,000 in scholarships to 97 children whose parents were seriously injured or killed in a work-related accident in Colorado, whether or not Pinnacol was the insurer on the claim. The students applied their scholarships to traditional two- and four-year college programs as well as accredited vocational institutions. Since the Foundation was created in 2000, it has awarded almost $5 million to nearly 600 students in every corner of the state.

Maintaining financial stability to benefit Colorado businesses

Pinnacol has decreased rates and issued general dividends to our policyholders each of the last five years. In 2018, we reduced rates by an average of 7.4 percent and distributed general dividend checks totaling $50 million to our customers. In 2019, we reduced rates by an average of 10 percent and distributed $70 million in general dividend checks.

Managing expenses, carefully stewarding our financial resources, applying disciplined underwriting practices, and focusing on managing risks to our investment portfolio, allow us to maintain our financial stability and guarantee the payment of benefits to injured workers and their dependents that may span years or even decades. This commitment has resulted in an A- (Excellent) rating from insurance rating agency A.M. Best and a BBB+ rating from Standard & Poor's. Also, Aon recognized Pinnacol in the 2019 "Ward Top 50" of best-performing property and casualty insurance carriers in the U.S., placing us in the top two percent of the nearly 3,000 property and casualty carriers evaluated by the company for the second time in a row.

In 2018, Pinnacol received a clean audit of its financial statements, as conducted by independent auditors (KPMG) contracted by the Colorado Office of the State Auditor. The full audit report is attached in Appendix B. In addition, the recent financial examination of Pinnacol released by the Division of Insurance in December 2019 did not have any findings.

Required reporting per C.R.S. §8-45-122 - All data as of Dec. 31, 2018

Policy Count: 56,179
Pinnacol's policies-in-force (active) as of Dec. 31, 2018 were slightly increased from 2017 (increase of 342 policies) while premium grew by $6.14M or 1 percent despite a 7.39 percent rate decrease.

Total (Admitted) Assets: $2,872,602,313
Pinnacol's total assets grew by 1.37 percent over year-end 2017. The change was driven primarily by positive net income and operating cash flow as well as an increase in the value of invested assets. Pinnacol's investment portfolio emphasizes high quality, taxable bonds, supplemented by a smaller portfolio of equities, high-yield debt and alternative investments. It is overseen by an investment committee including outside professionals as well as members of Pinnacol's board.

Reserves: $920,568,000
Our reserves represent the financial obligations of Pinnacol to pay injured workers' expected future benefits and related claims expenses, as determined by a contracted third-party actuarial firm (Milliman). Pinnacol's total reserves decreased by .27 percent over year-end 2017, primarily due to fewer claims per premium dollar.

Surplus: $1,290,998,081
Our surplus is equity to cover unexpected claims/losses and economic fluctuations, as well as other risks. It is, essentially, our rainy day fund. Pinnacol's surplus grew by 1.1% over year-end 2017. It is important to recognize that, because Pinnacol is not allowed to participate in the state's insurance guaranty fund, our surplus serves as our own guaranty fund. Every year the board sets a surplus target range based on A.M. Best Capital Adequacy Ratio.

Colorado's strong economy and Pinnacol's attention to its operating performance helped drive positive net income, which is consistently the biggest driver of surplus growth for Pinnacol. Our surplus also reflects our share of PERA's unfunded liability, which has grown as PERA has changed its actuarial and investment assumptions.

Claims filed in 2018: 43,610

Claims required by statute to be admitted or denied within 20 days and notice provided to the Colorado Division of Workers' Compensation (DOWC): 4,768

Contested claims that are medical-only: 1,209

Contested claims that are indemnity claims: 85

The number of claims Pinnacol admitted or contested (denied) within 20 days decreased by 9.72 percent in 2018 compared to 2017. In 2018, we provided notice to the DOWC of 11 percent of claims, somewhat less than the 12-14 percent figure in recent years.

The total number of claims Pinnacol contested (denied) and reported to the DOWC decreased in 2018 from 2017 by 8 percent. The number of contested indemnity claims increased by 6 claims and the number of contested medical-only claims decreased by 118 claims. Pinnacol's most common basis for contesting claims in 2018 was due to an injury not being work-related or the need for further investigation.

Here is a more complete picture of key data elements for 2018 with explanations to follow.

Claims processed with no filing required with DOWC	=	38,824 (89 percent)
Claims admitted within 20 days with DOWC	=	3,492 (8 percent)
Claims contested (denied) within 20 days with DOWC	=	1,294 (3 percent)
Subtotal of items 2 and 3	=	4,786
Total claims in fiscal year 2018	=	43,610 (100 percent)

Item 1: No Filing Required: Claims that are minor in nature; the injured worker has not sustained a permanent disability, disfigurement, or lost time from work in excess of three calendar days/shifts. These claims are processed by Pinnacol and do not require a filing of admission or contest with the DOWC. These claims represent 89 percent of all claims received by Pinnacol in 2018.

Item 2: Admitted Claims: There were 3,492 claims (8 percent of total claims in 2018) admitted within 20 days with DOWC.

Item 3: Contested Claims:
The 1,294 contested claims (3 percent of total claims in 2018) stemmed from one or more of the following reasons:

- Injury or illness was not work-related – 710 (55 percent)
- Pending further investigation or information – 298 (23 percent)
- Other – 107 (8 percent). This category includes such things as no insurance policy or the injured worker is covered by another carrier.

Items 2 and 3: Admitted or Contested within 20 days: Claims that are more complex in nature require a formal filing with the DOWC of "contested" or "admitted." It should be noted that not all contested claims are ultimately denied; many may initially be contested initially based on the need for more information within the 20-day window, the time in which compensability must be determined.

Claims where the injured worker has sustained one of the following require a formal filing of "contested" or "admitted" with the DOWC:

- The injured employee contracted an occupational disease
- The injured employee was found to have a permanent disability due to the injury
- The injury or occupational disease resulted in lost time from work for the injured employee in excess of three shifts or calendar days

As noted above, the number of claims that fall into these two categories (11 percent) was slightly below the range of 12-14 percent of total claims filed for the last few years.

Medical procedures denied: 2,888
Pinnacol's percentage of medical procedures denied compared to total bills received was 0.48 percent for 2018. The most common reason for denying medical procedures that require prior approval from Pinnacol is the procedure was found not to be medically necessary.

Medical procedures denied are in accordance with Rule 16 of the Colorado Division of Workers' Compensation's Rules of Procedure. Some medical procedures require prior approval from the insurance company. Once a request for prior authorization is received, Pinnacol has seven business days to inform the medical provider and the injured worker that we will pay or deny payment for the procedure.

H. Amount of total compensation each executive officer or staff member receives, including bonuses or deferred compensation

Title	2018 Total Compensation
President and CEO	$972,268
Chief Customer Officer (promoted from Senior Vice President, Insurance Operations 6/1/2018)	$489,434
Vice President, General Counsel and Corporate Secretary	$470,131
Vice President, Strategic Development	$420,330
Vice President, Chief Investment Officer	$384,929
Chief Financial Officer	$365,303
Vice President, Human Resources	$365,306
Vice President, Agency Relations and Safety (promoted from Assoc Vice President, Underwriting 9/1/2018)	$239,158
Vice President, Chief Information Officer	$347,413
Vice President, Communications and Public Affairs	$324,073
Vice President, Chief Marketing Officer	$266,318
Vice President, Operations (promoted from Assoc Vice President, Customer Experience 6/1/2018)	$253,912
Average total compensation for 9 Associate Vice Presidents	$240,637

I. Amount spent on commissions: $82,426,324

J. Amount paid to trade associations for marketing fees: $164,410

K. Information related to bonus programs
See Appendix A

L. Other information the CEO deems relevant to the report
See Appendix B

Note: Sources for all items except H and the Appendices are the 2018 Pinnacol Annual Statement, the Pinnacol Assurance Key Factor Report, the General Ledger Account (60511-100 — Advertising Expenses — Association Marketing) and other internal reports.

Appendix A

Information related to bonus programs

PINNACOL ASSURANCE

EXECUTIVE PERFORMANCE PLAN
(As Amended and Restated January 1, 2018)

SUMMARY

The Executive Performance Plan ("Performance Plan") is hereby amended and restated effective for Plan Years commencing on or after January 1, 2018. The Performance Plan is intended to recognize the achievement of major company objectives and individual objectives, measured on an annual basis.

This Performance Plan appropriately emphasizes individual and group accountability for making specific contributions to Pinnacol Assurance's overall business results. Based on Board of Directors of Pinnacol Assurance ("Board") approval, the Performance Plan will be finalized and communicated to Executive Staff. A relatively short decision-result cycle should be attainable (first quarter of the following year) to determine award payout following Board approval.

PLAN DESCRIPTION

Plan Year – The Plan Year shall be a calendar year.

Performance Measures – Awards are paid under this Performance Plan for meeting or exceeding annual performance objectives for pre-established company metrics for the Plan Year, as set forth by the Board.

Eligibility – This Performance Plan will only apply to the following positions, each of which will be considered an Eligible Employee: CEO, Vice Presidents, and Associate Vice Presidents. An Eligible Employee who is hired on or after October 1 of a Plan Year is not eligible to participate in the Performance Plan for the year of hire.

Incentive Award Plans – Eligible Employees will have incentive award plans based on meeting major company objectives and individual objectives related to Pinnacol Assurance's annual business plan. For Vice Presidents and Associate Vice Presidents, the amount of an award under this Performance Plan, if any, is subject to the approval of the CEO and then ultimately the Board. For the CEO, the amount of an award under this Performance Plan, if any, is subject to the approval of the Board.

Determination of Payment

1. Eligible Employees Other Than the CEO

   The CEO shall make a determination as soon as practicable after the end of the Plan Year as to whether each Eligible Employee (other than the CEO) has met his or her individual objectives and whether the company objectives have been met. The CEO shall make an initial determination as to the award that each such Eligible Employee is eligible for under this Performance Plan for the Plan Year. The Board shall then approve the amount of all awards (the date of such approval being the "Initial Determination Date" with respect to such Eligible Employee). The "Determination" of an award by the Board, as well as the decision as to whether to make any such award, and the amount, if any, of such award, shall be in the sole discretion of the Board. Determination means the Board has passed a resolution approving or denying a bonus award as well as the amount of any such award.

2. CEO

The Compensation Committee of the Board (the "Committee") shall make a determination as soon as practicable after the end of the Plan Year as to whether the CEO has met his individual objectives and whether the company objectives have been met. The Committee shall make an initial determination as to the award that the CEO is eligible for under this Performance Plan for the Plan Year. The Board shall then approve the amount of the final award (the date of such approval being the "Initial Determination Date" with respect to the CEO). The Determination of an award by the Board, as well as the decision as to whether to make any such award, and the amount, if any, of such award, shall be in the sole discretion of the Board. Determination means the Board has passed a resolution approving or denying a bonus award as well as the amount of any such award.

3. Subsequent Adjustment Due to Error

The Board may increase or decrease the amount of an award subsequent to an Initial Determination Date (a "Subsequent Adjustment Due to Error"), provided, however, that a Subsequent Adjustment Due to Error shall only be made because of a mathematical error, an adjustment to results as described below under "Company Objectives," or upon the determination of the Board that a metric or criterion used to compute an award had been determined in error. The date on which the Board approves a Subsequent Adjustment Due to Error shall be a Subsequent Determination Date with respect to such adjustment.

4. Determination Dates

The Initial Determination Date with respect to a Plan Year shall be on or after January 1 of the calendar year immediately following the Plan Year but no later than the May 31 of the calendar year immediately following such Plan Year. Any Subsequent Determination Date with respect to a Plan Year shall be no later than the September 30 of the calendar year immediately following such Plan Year.

Payment – Payment of an award, or of a Subsequent Adjustment Due to Error that increases an award, shall be made within 2-1/2 months of the Initial Determination Date (with respect to the award) or within 2-1/2 months of the Subsequent Determination Date (with respect to the Subsequent Adjustment Due to Error). In the event that a Subsequent Adjustment Due to Error reduces an award that has already been paid, Pinnacol Assurance may recoup such Subsequent Adjustment Due to Error from the recipient of an award by reducing the compensation otherwise payable to such recipient within sixty (60) days of the Subsequent Determination Date (including, but not limited to, regular compensation, bonuses, commissions, or severance pay and any amount of such Subsequent Adjustment Due to Error that Pinnacol Assurance has not recouped from such compensation shall be paid by the recipient to Pinnacol Assurance on the sixtieth (60^{th}) day following the Subsequent Determination Date. This paragraph applies whether or not such recipient has remained an Eligible Employee.

Vesting – An Eligible Employee who is not employed by Pinnacol Assurance on a Determination Date (whether an Initial or Subsequent Determination Date) forfeits all rights to an award (or an increase in an award in the case of a Subsequent Adjustment Due to Error) for the Plan Year to which such Determination Date relates. An Eligible Employee who is employed by Pinnacol Assurance on an Initial or Subsequent Determination Date is fully vested in the award (or an increase in an award, in the case of a Subsequent Adjustment Due to Error) granted on such Initial or Subsequent Determination Date.

Allocation of Award Under Each Plan – Incentive awards will be earned as follows once the Board has determined that an Eligible Employee has met the criteria for an individual award, which for all Performance Plan participants shall be based 90% on achievement of company objectives and 10% on Individual Strategic Goals.

Eligible Employee's Performance Plan Award Range (% of Base Salary)

	Threshold	Commendable	Maximum
Associate Vice Presidents	20.0%	32.5%	45.0%
Senior Vice President and Vice Presidents	22.5%	37.5%	52.5%
CEO	32.24%	45.67%	59.10%

Award Payout Calculation

Individual worksheets will be prepared for each Eligible Employee. Pinnacol Assurance will use the following factors in determining the amount of the award once the threshold criteria are met:

1. Company Objectives

Annual targets for Combined Ratio Before General Dividends, New Business Policyholder Satisfaction, Original Premium Retention, Injured Worker Satisfaction, and Individual Strategic Goals (each as defined or described below) will be established by the Board. Projected as well as past performance will be factored into the formula for establishing company objectives.

A. "Combined Ratio Before General Dividends" is the combined ratio results for insurance operations, excluding other income/expense, as determined by the company's financial statements. The numerator of the ratio is total expenses (all losses incurred, loss adjustment expenses, underwriting expenses and safety group dividends). The denominator of the ratio is net underwriting premiums earned (underwriting premiums earned minus program dividends (but not minus general dividends).

B. "New Business" will be based upon the premium generated by policies that are new business to Pinnacol Assurance during the Plan Year.

C. "Businesses Covered" will be based upon the number of businesses covered at December 31st of the Plan Year.

D. "Original Premium Retention" will be based on the average percentage of premium Pinnacol Assurance retains during the Plan Year.

E. "Policy Holder Net Promoter Score" will be based on the score of the "how likely are you to recommend Pinnacol" question contained in the service quality surveys of customers (policyholders) sent during the Plan Year. The new promoter score is calculated by taking the number of promoters (responses of 9 & 10) and subtracting the number of detractors (0 – 6).

F. "Injured Worker Satisfaction" will be based on the average score of the overall satisfaction question contained in the statutory surveys of injured workers for surveys sent during the Plan Year.

G. "Individual Strategic Goals" will be based on the total score of the leadership competencies established by the Board. The Board will evaluate the CEO's performance, the CEO will evaluate the Vice Presidents performance and the Vice Presidents will evaluate the Associate Vice Presidents for this measure.

The weighting of the objectives shall be:

- Combined Ratio - 60%
- New Business: 4%
- Businesses Covered: 3%
- Original Premium Retention - 4%
- Policy Holder Net Promoter Score - 4 %
- Injured Worker Satisfaction - 5%
- Individual Strategic Goals: 20%

2. Discretionary Adjustment

The CEO may review additional issues or concerns regarding any award with the Committee prior to final award approval by the full Board.

The final results pertaining to any objective may be adjusted at the discretion of the Board, based on the recommendation of the Committee, to account for unforeseen or uncontrollable events. Such adjustments will be made to assure that the results of this Performance Plan are a fair reflection of the business performance of Pinnacol Assurance. Unforeseen or uncontrollable events may include, without limitation, adverse court rulings, imposed regulatory costs and/or revenue reductions, significantly better than expected performance results, and Board-approved budget adjustments.

3. Calculation of the Award Amount

A. If the actual result is between two measurements (i.e., threshold and commendable or commendable and maximum) then the award will be linearly interpolated to match the actual result, but not to exceed the maximum award for that performance measure.

B. If an Eligible Employee has been employed in an eligible position for less than the full twelve calendar months of the Plan Year and was hired prior to October 1 of the Plan Year, the award will be calculated based on the Eligible Employee's base salary on December 31 of the Plan Year or if the Eligible Employee moves from an Eligible Position to a non-eligible position, on the Eligible Employee's base salary on the last day in the eligible position in the Plan Year, in either case prorated based on the number of months in the eligible position.

C. If an Eligible Employee has been employed in more than one classification eligible for an award under this Performance Plan (e.g., as both an Associate Vice President and a Vice President) during a Plan Year, the award will be calculated based on the Eligible Employee's base salary in each eligible classification, using the base salary on the day prior to any eligible classification change during the year and the base salary on December 31 of the Plan Year in the additional eligible classification, in each case prorated based on the number of months in the eligible classification and multiplied by the Eligible Employee's Performance Plan Award Range for each eligible classification.

D. The principles of B. and C. above are illustrated by the following examples.

Dakota is hired (or promoted) on July 1 into an AVP position with a base salary of $100,000 per year. He performs at a commendable level for the Plan Year.

Dakota's award = $50,000 x 32.5% = $16,250

Montana is an AVP on January 1 with a base salary of $100,000 per year. She is promoted to a VP with a base salary of $150,000 on July 1. She performs at a commendable level for the Plan Year.

Montana's award = ($50,000 x 32.5%) + ($75,000 x 37.5%) = $44,375

Section 409A

All payments contemplated by this Plan are intended to qualify as "short-term deferrals" as such term is defined in Treasury Regulation Section 1.409A-1(b)(4) and this Performance Plan shall be administered and construed accordingly. To the extent that any such payment is not a short-term deferral, this Performance Plan is intended to otherwise comply with Section 409A of the Internal Revenue Code of 1986, as amended, the Treasury Regulations promulgated thereunder, and any administrative guidance or judicial decisions with respect thereto ("Section 409A") and shall be administered and construed accordingly. It is the intention of Pinnacol Assurance that payments under this Performance Plan not be subject to the additional tax or interest imposed pursuant to Section 409A. To the extent such potential payments or benefits are or could become subject to Section 409A, Pinnacol Assurance may amend this Performance Plan with the goal of giving Eligible Employees the economic benefits described herein in a manner that does not result in such additional tax or interest being imposed. It is the intention of Pinnacol Assurance that no person shall be considered to have a legally binding right to any award under this Performance Plan at any time prior to an Initial Determination Date that relates to an award, or, in the case of a Subsequent Adjustment Due to Error that provides for an increase to an award, prior to such Subsequent Determination Date. Each payment described in this Performance Plan shall be a separate payment and a separately identifiable payment to the maximum extent permitted by Section 409A.

Pinnacol Assurance reserves the right to add, change, end, or suspend this Performance Plan at any time, with or without notice. This document shall not be construed as a contract of employment, nor does it restrict the right of Pinnacol Assurance to discharge the employee or the right of the employee to terminate his or her employment at any time.

Pinnacol Assurance has evidenced its adoption of the Pinnacol Assurance Investment Executive Performance Plan (As Amended and Restated January 1, 2018) effective January 1, 2018, by the signature of its duly authorized officers.

PINNACOL ASSURANCE

By: _____

Name: Terrence Love

Title: Chief Legal and Comp Resources Officer

Date: 12-22-17

PINNACOL ASSURANCE

By: _____

Name: Barbara Brannen

Title: VP of HR

Date: 12-26-17

Appendix B

Other information the CEO deems relevant to the report:
Annual financial statement audit report
Rule 16 of the Colorado Division of Workers' Compensation
Rules of Procedure

PINNACOL ASSURANCE

Statutory-Basis Financial Statements and
Supplemental Schedules of Investment Information

December 31, 2018 and 2017

(With Independent Auditors' Report Thereon)

LIMITATIONS ON DISCLOSURE OF INFORMATION CONTAINED IN THIS DOCUMENT

The enclosed report is being distributed to you at this time for your information in accordance with Colorado Revised Statutes (CRS).

SECTION 2-3-103 (2) states in part:

> All reports shall be open to public inspection except for that portion of any report containing recommendations, comments, and any narrative statements, which is released only upon the approval of a majority vote of the committee (emphasis supplied).

SECTION 2-3-103.7 (1) states in part:

> Any state employee or other individual acting in an oversight role as a member of a committee, board, or commission who willfully and knowingly discloses the contents of any report prepared by, or at the direction of, the Office of the State Auditor prior to the release of such report by a majority vote of the committee as provided in Section 2-3-103 (2) is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than five hundred dollars (emphasis supplied).

COSA – 201 10/2006

LEGISLATIVE AUDIT COMMITTEE
2018 MEMBERS

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Chair

Representative Lori Saine
Vice Chair

Representative Rod Bockenfeld
Senator Rhonda Fields
Representative Tracy Kraft-Tharp
Senator Paul Lundeen
Representative Dafna Michaelson Jenet
Senator Jim Smallwood

Office of the State Auditor Staff

Dianne E. Ray
State Auditor

Kerri Hunter
Deputy State Auditor

Crystal Dorsey
Contract Monitor

KPMG LLP
Contract Auditors

An electronic version of this report is available at
www.Colorado.gov/auditor

A bound report may be obtained by calling the
Office of the State Auditor
303.869.2800

Please refer to report number 1810F when
requesting this report

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Geraldine A. Lewis-Jenkins
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PINNACOL ASSURANCE
2017 BOARD OF DIRECTORS

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PINNACOL ASSURANCE

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PINNACOL ASSURANCE

Report Summary

Authority and Purpose/Scope of the Audit

This audit is conducted under the authority of Section 8-45-121(2) of the Colorado Revised Statutes (C.R.S.), which authorizes the State Auditor to conduct an annual financial audit of Pinnacol Assurance (Pinnacol or the Company) and contract with an auditor or firm of auditors, having the specialized knowledge and experience. The primary purpose of our engagement is to audit the statutory-basis financial statements of Pinnacol as of and for the year ended December 31, 2018, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States, and to express an opinion on those statutory basis financial statements and the supplemental schedules of investment information. The objective of an audit conducted in accordance with such standards is to obtain reasonable, but not absolute, assurance about whether the statutory basis financial statements are free of material misstatement.

The financial statements of Pinnacol are prepared in accordance with statutory accounting principles prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado (hereinafter referred to as statutory basis financial statements, or financial statements in accordance with statutory accounting principles). Accordingly, they are not designed to present, and do not present, the financial position or results of operations in accordance with U.S. generally accepted accounting principles.

In the course of our audit, we examined, on a test basis, evidence supporting the amounts and disclosures in Pinnacol's statutory basis financial statements as of and for the year ended December 31, 2018.

Audit Opinion and Report

As we are issuing an opinion on the statutory basis financial statements in conformity with accounting principles prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado, we have modified our financial statement opinion to include an adverse opinion on accounting principles generally accepted in the United States of America (GAAP).

We issued a report on Pinnacol's compliance and internal control over financial reporting based on an audit of the financial statements performed in accordance with Government Auditing Standards. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be deficiencies, significant deficiencies, or material weaknesses. A deficiency in internal control over financial reporting exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A significant deficiency is a deficiency, or combination of deficiencies, in internal control over financial reporting that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. A material weakness is a deficiency, or combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis.

We noted no matters involving the internal control over financial reporting and its operation that we consider to be material weaknesses.

Summary of Current Year Findings and Recommendations

There were no reported findings and recommendations resulting from the audit for fiscal year 2018.

Summary of Prior Year Findings and Recommendations

There were no reported findings and recommendations resulting from the audit for fiscal year 2017.

PINNACOL ASSURANCE

Description of Pinnacol Assurance

December 31, 2018

Pinnacol Assurance (Pinnacol or the Company) was established as a political subdivision of the State of Colorado (the State) under provisions of the Workers' Compensation Act of Colorado (Title 8, Article 45 of the Colorado Revised Statutes, as amended) to operate as a domestic mutual insurance company for the benefit of injured employees and dependents of deceased employees in Colorado. As required under state law, Pinnacol provides an assured source of workers' compensation insurance to Colorado employers. Pinnacol shall not refuse to insure any Colorado employer or cancel any insurance policy due to the risk of loss or amount of premium, except as otherwise provided in Title 8, Article 45, C.R.S., as amended.

Pinnacol is controlled by a nine member board of directors, which is appointed by the Governor with the consent of the Colorado Senate. The board of directors has control over all monies of Pinnacol and is restricted to use such monies only for the purposes provided in Title 8, Article 45, C.R.S., as amended. The board of directors appoints a chief executive officer who is vested with full power and jurisdiction over the administration of Pinnacol. Pinnacol is not an agency of state government. The State retains no liability on the part of Pinnacol and no State monies are used for Pinnacol operations. All revenue, monies, and assets of Pinnacol belong solely to Pinnacol. The State of Colorado has no claim to, nor any interest in, such revenue, monies, and assets and shall not borrow, appropriate, or direct payments from such revenue, monies, and assets for any purpose.

Cake Insure, Inc. (Cake) was incorporated on September 20, 2017. Cake is a wholly-owned subsidiary of Pinnacol and helps small businesses quote and purchase a workers' compensation insurance policy from Pinnacol. Cake is a digital platform designed to market, underwrite, and service small direct policyholders that are not considered high risk. With the launch of Cake, Pinnacol became subject to Title 10, Article 3, Part 8 of the C.R.S., Insurance Holding Company Systems, which requires additional report filings with the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado. Pinnacol holds 100% of the voting shares ownership in Cake. An "Insurance Holding Company System" is two or more affiliated persons, one or more of which is an insurer.

Policyholders' Surplus

Pinnacol had policyholders' surplus of $1,290,998,000 and $1,276,308,000 as of December 31, 2018 and 2017, respectively. The increase in surplus is primarily related to current year net income, offset by the change in unrealized capital gains.

KPMG LLP
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1225 17th Street
Denver, CO 80202-5598

Independent Auditors' Report

The Members of the Legislative Audit Committee and
Pinnacol Assurance Board of Directors:

Report on the Financial Statements

We have audited the accompanying financial statements of Pinnacol Assurance, which comprise the statutory statements of admitted assets, liabilities, and policyholders' surplus as of December 31, 2018 and 2017, and the related statutory statements of operations and changes in policyholders' surplus, and cash flow for the years then ended, and the related notes to the statutory financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with statutory accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 1 to the financial statements, the financial statements are prepared by Pinnacol Assurance using statutory accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado, which is a basis of accounting other than U.S. generally accepted accounting principles. Accordingly, the financial statements are not intended to be presented in accordance with U.S. generally accepted accounting principles.

The effects on the financial statements of the variances between the statutory accounting practices described in Note 1 and U.S. generally accepted accounting principles, although not reasonably determinable, are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the variances between statutory accounting practices and U.S. generally accepted accounting principles discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles paragraph, the financial statements referred to above do not present fairly, in accordance with U.S. generally accepted accounting principles, the financial position of Pinnacol Assurance as of December 31, 2018 and 2017, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, and policyholders' surplus of Pinnacol Assurance as of December 31, 2018 and 2017, and the results of its operations and its cash flow for the years then ended, in accordance with statutory accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado described in Note 1.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information included in the supplemental schedule of investment risks interrogatories and supplemental summary of investment schedule are presented for purposes of additional analysis and are not a required part of the financial statements but is supplementary information required by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated May 22, 2019 on our consideration of Pinnacol Assurance's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Pinnacol Assurance's internal control over financial reporting compliance.

KPMG LLP

Denver, Colorado
May 22, 2019

PINNACOL ASSURANCE

Statutory-Basis Statements of Admitted Assets, Liabilities, and Policyholders' Surplus

December 31, 2018 and 2017

(In thousands)

Admitted Assets		2018	2017
Cash and invested assets:			
Bonds at adjusted carrying value, fair value of $2,099,192 in 2018 and $2,060,910 in 2017 (note 4)	$	2,129,597	2,017,524
Preferred stock at adjusted carrying value, fair value of $7,927 in 2018 and $8,232 in 2017 (note 4)		7,924	8,158
Common stock at fair value, adjusted cost of $387,760 in 2018 and $409,072 in 2017 (note 4)		447,357	544,752
Mortgage loans on real estate (note 4)		15,024	—
Real estate at cost – net of accumulated depreciation of $17,196 in 2018 and $15,776 in 2017		15,984	16,854
Cash, cash equivalents, and short-term investments		73,492	76,899
Other invested assets (note 4 and note 9)		92,944	70,490
Receivables for securities sold		1,317	842
Total cash and invested assets		2,783,639	2,735,519
Uncollected premiums		35,689	35,161
Earned but unbilled premiums		32,485	43,610
Funds held by or deposited with reinsurers		2,182	1,792
Electronic data processing equipment – at cost – net of accumulated depreciation of $8,772 in 2018 and $8,003 in 2017		495	985
Receivables from subsidiaries and affiliates		172	751
Accrued investment income		17,940	15,893
Total admitted assets	$	2,872,602	2,833,711
Liabilities and Policyholders' Surplus			
Reserve for unpaid losses and loss adjustment expenses:			
Reserve for unpaid losses (note 2)	$	813,072	815,521
Reserve for unpaid loss adjustment expenses (note 2)		107,496	107,574
Total reserve for unpaid losses and loss adjustment expenses		920,568	923,095
Unearned premiums		83,113	83,431
Advance premiums		11,029	10,786
Dividends payable to policyholders		103,478	78,600
Commissions payable		39,617	39,307
Structured settlement liability (note 3)		386,352	384,790
Payable to subsidiaries and affiliates		58	24
Credit balances due policyholders		8,953	8,566
Payable for securities purchased		4,430	5,183
Other liabilities		24,006	23,621
Total liabilities		1,581,604	1,557,403
Surplus notes (note 7)		100,000	100,000
Special surplus fund for unfunded pension benefits (notes 1 and 7)		407,510	350,883
Unassigned policyholders' surplus (note 7)		783,488	825,425
Total liabilities and policyholders' surplus	$	2,872,602	2,833,711

See accompanying notes to statutory-basis financial statements.

PINNACOL ASSURANCE

Statutory-Basis Statements of Operations and Changes in Policyholders' Surplus

Years ended December 31, 2018 and 2017

(In thousands)

		2018	2017
Underwriting income:			
Premiums earned	$	631,755	625,619
Deductions:			
Losses incurred (note 2)		303,206	303,662
Loss adjustment expenses incurred (note 2)		74,775	79,047
Other underwriting expenses incurred		152,720	152,004
Total underwriting deductions		530,701	534,713
Net underwriting gain		101,054	90,906
Investment income:			
Net investment income earned (note 4)		83,380	77,446
Net realized capital gain (note 4)		9,825	17,890
Total investment income		93,205	95,336
Other income (loss):			
Provision for uncollectible premiums		(3,442)	(2,595)
Structured settlement expense (note 3)		(10,828)	(7,908)
Other income		921	856
Dividends to policyholders		(72,355)	(52,430)
Net income		108,555	124,165
Change in nonadmitted assets		538	(1,898)
Change in net unrealized gains on investments		(83,513)	67,692
Correction of an error (note 1x)		(10,890)	—
Policyholders' surplus – beginning of year		1,276,308	1,086,349
Policyholders' surplus – end of year	$	1,290,998	1,276,308

See accompanying notes to statutory-basis financial statements.

PINNACOL ASSURANCE

Statutory-Basis Statements of Cash Flow

Years ended December 31, 2018 and 2017

(In thousands)

		2018	2017
Cash flow from operations:			
Premiums collected – net of reinsurance	$	628,256	629,312
Losses and loss adjustment expenses paid – net of reinsurance and deductibles		(380,509)	(395,326)
Other underwriting expenses paid		(153,444)	(141,056)
Dividends paid to policyholders		(47,478)	(48,474)
Investment income received, net of investment expenses paid		84,711	80,757
Miscellaneous proceeds		921	857
Net cash provided by operations		132,457	126,070
Cash flow from investments:			
Proceeds from sale, maturity, or redemption of investments:			
Bonds		392,213	493,543
Stocks		91,469	99,597
Other invested assets		9,245	6,114
Miscellaneous proceeds		—	842
Total proceeds from sale or redemption of investments		492,927	600,096
Cost of investments acquired:			
Bonds		(520,217)	(609,754)
Stocks		(54,746)	(72,400)
Mortgage loans on real estate		(15,024)	—
Other invested assets		(30,506)	(27,802)
Miscellaneous proceeds (applications)		(1,777)	(1,182)
Total investments acquired		(622,270)	(711,138)
Net cash used in investments		(129,343)	(111,042)
Cash flow used in financing and miscellaneous sources:			
Cash used in other miscellaneous sources		(6,521)	(2,927)
Net cash used in financing and miscellaneous sources		(6,521)	(2,927)
Net (decrease) increase in cash, cash equivalents, and short-term investments		(3,407)	12,101
Cash, cash equivalents, and short-term investments – beginning of year		76,899	64,798
Cash, cash equivalents, and short-term investments – end of year	$	73,492	76,899

See accompanying notes to statutory-basis financial statements.

(1) Nature of Operations and Significant Accounting Policies

(a) Organization

Pinnacol Assurance (Pinnacol or the Company) was established under provisions of the Workers' Compensation Act of Colorado (Title 8, Article 45 of the C.R.S., as amended), as a political subdivision of the State of Colorado, to operate as a domestic mutual insurance company for the benefit of injured employees and dependents of deceased employees. Pinnacol provides insurance to employers operating within the State of Colorado (the State) not otherwise insured through private carriers or self-insurance.

Pinnacol is controlled by a nine member board of directors, which is appointed by the Governor with the consent of the Senate. In accordance with the applicable statutes of the State, the administration of Pinnacol is under the direction of a chief executive officer, appointed by the board of directors. Pinnacol is not an agency of the State and the State retains no liability on behalf of Pinnacol and no State monies are used for Pinnacol operations.

Cake Insure, Inc. (Cake) was incorporated on September 20, 2017. Cake is a wholly-owned subsidiary of Pinnacol and helps small businesses quote and purchase a workers' compensation insurance policy from Pinnacol.

(b) Basis of Presentation

The accompanying statutory basis financial statements of Pinnacol have been prepared in accordance with accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado (the Division). Prescribed statutory accounting practices (SAP) are those practices that are incorporated directly or by reference to state laws, regulations, and general administrative rules applicable to all insurance enterprises domiciled in a particular state. Colorado has adopted the National Association of Insurance Commissioners' (NAIC) statutory accounting practices, which are codified in the NAIC's *Accounting Practices and Procedures Manual* (the Manual). Therefore, compliance with the Manual is a prescribed accounting practice. In the preparation of the accompanying statutory basis financial statements, the Company has followed NAIC guidelines and has not utilized any practices considered to be permitted practices.

Statutory accounting practices contained in the Manual vary in some respects from accounting principles generally accepted in the United States of America (GAAP). The more significant differences between SAP and GAAP are as follows:

- Policy acquisition costs, such as commissions, premium surcharges and other expenses directly related to the cost of acquiring new business are expensed as incurred, while under GAAP, they are deferred and amortized over the policy term to provide for proper matching of revenue and expense.

- Investments in debt securities are generally carried at amortized value, while under GAAP, they would be carried at fair value. For GAAP, changes in fair value in bonds go through net investment income.

- Pinnacol's investment in preferred stock of Cake, a subsidiary, is reported at the lower of cost or fair value. Under GAAP, it would be included in the consolidated financial statements and all significant intercompany balances and transactions would be eliminated in consolidation.

- Short term investments, which include investments with maturities at the time of acquisition of one year or less, are included with cash and cash equivalents in the accompanying statutory basis financial statements, while under GAAP, only investments with maturities at the time of acquisition of three months or less are included with cash and cash equivalents.

- Assets are reported under NAIC SAP at "admitted asset" value and "nonadmitted" assets, or those items not meeting the definition of an asset, are excluded through a charge against policyholders' surplus, while under GAAP, all assets are reported on the balance sheet, net of any required valuation allowance. Nonadmitted assets at December 31, 2018 and 2017 comprised the following (in thousands):

		2018	2017
Receivables	$	16,551	16,894
Fixed assets		280	578
Prepaids		2,874	2,771
Total nonadmitted assets	$	19,705	20,243

- The reserve for losses and loss adjustment expenses (LAE) is reported net of reinsurance, while under GAAP, the balance sheet reports reinsurance recoverable, including amounts related to losses incurred but not reported, as assets.

- The surplus note is reported as a component of surplus, increasing policyholders' surplus under NAIC SAP. Under GAAP the surplus note is recorded as long term debt. The related interest expense may not be accrued under NAIC SAP until approved for payment by the commissioner of the state of domicile while under GAAP, the interest expense is recorded as incurred.

- Governmental Accounting Standards Board (GASB) Statement No. 68, *Accounting and Financial Reporting for Pensions*, which is effective for fiscal years ended June 30, 2014 or later, requires employers that are part of a cost sharing multiple employer pension fund to record their portion of the unfunded liability, while under NAIC SAP, the employer must only record the cost of the contribution and any liability for any contributions due and unpaid.

- Governmental Accounting Standards Board (GASB) Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*, which is effective for fiscal years ended June 30, 2017, and requires employers that are part of a cost sharing multiple employer OPEB plan to record their portion of the net OPEB liability, while under NAIC SAP, the employer must only record the cost of the contribution and any liability for any contributions due and unpaid.

The effect of the differences between statutory basis of accounting and generally accepted accounting principles, although not reasonably determinable, is presumed to be material. Pinnacol is a political subdivision of the State and as such would follow all applicable Governmental Accounting Standards Board (GASB) pronouncements.

(c) Use of Estimates

The preparation of statutory basis financial statements in accordance with accounting practices prescribed by the Division requires management to make estimates and assumptions that affect the

reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the statutory basis financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include the internal structured settlement liability, the reserves for unpaid losses and loss adjustment expenses, the earned but unbilled premiums asset, as well as the allowance for uncollectible premiums, among others. Actual results could differ from those estimates and such differences could be significant.

(d) Investments

Investments are recorded on the trade date. Bonds and preferred stocks are stated at amortized value or fair value, based on their NAIC designation, and are adjusted for other than temporary declines in fair value. Mortgage loans on real estate are carried at the outstanding principal balance, less any allowances for credit losses. Common stocks, mutual funds, and common trust funds are carried at fair value. Other invested assets, including partnerships, are recorded at the underlying audited equity value. For those investments in which the audited financial statements are not available in a timely manner, the unaudited equity value is used. Unrealized capital gains on common stocks, preferred stocks, mutual funds, and common trust funds are reported as a direct adjustment to policyholders' surplus. Common stocks and preferred stocks in an unrealized loss position for both years are recorded as other than temporarily impaired (OTTI) and are recorded as a realized loss in the statutory basis statement of operations in the period in which they occur.

Bond premium or discount is recognized using the effective interest method taking into consideration specified interest and principal provisions over the life of the bond. Bonds containing call provisions are amortized to the call or maturity value or date that produces the lowest asset value.

Gains and losses on investments sold are realized in operations and are computed using the specific identification method.

Prepayment assumptions for purposes of recognition of income and valuing of loan backed bonds and structured securities were obtained from widely accepted models with inputs from major third party data providers. Model assumptions are specific to asset class and collateral type and are regularly evaluated and adjusted where appropriate. The prospective adjustment method is used to value all loan backed securities.

Real estate includes land, the building on the land, and capitalized building improvements used in conducting the Company's business. Land is carried at cost. Building and capitalized building improvements are carried at cost less accumulated depreciation. The cost of the building and capitalized improvements is depreciated over an estimated useful life of 30 years using the straight line method. Depreciation expense was approximately $1,419,000 and $1,418,000 for the years ended December 31, 2018 and 2017, respectively, and is included in net investment income earned in the statutory basis statements of operations and changes in policyholders' surplus.

(e) Investment in subsidiary

Cake was incorporated on September 20, 2017 as a subsidiary of Pinnacol. Pinnacol purchased 2,000,000 voting shares of preferred stock in Cake on September 28, 2017. Pinnacol's ownership percentage in Cake is 100%.

Pinnacol does not consolidate their financial results with Cake. Pinnacol and Cake issue standalone financial statements that are each independently audited.

Perpetual preferred stock of Cake is reported at the lower of book value or fair value. Cake preferred shares are not publicly priced. Therefore, the per share cost is being used by Pinnacol for carrying value and fair value for the year in which the preferred stock of Cake was purchased and is confirmed by the NAIC's Securities Valuation Office (SVO).

(f) Cash, Cash Equivalents, and Short-Term Investments

For purposes of the statement of cash flow, cash, cash equivalents, and short term investments include cash on deposit, money market funds, and other investments with maturities of one year or less at the date of acquisition.

As of December 31, 2018, cash, cash equivalents, and short term investments of approximately $73,492,000 include $(3,670,000) of book overdrafts, $67,200,000 of cash equivalents, and $9,962,000 of short term investments. As of December 31, 2017, cash, cash equivalents, and short term investments of approximately $76,899,000 include $(3,095,000) of book overdrafts, $79,794,000 of cash equivalents, and $200,000 of short term investments.

(g) Receivables for Securities Sold

As of December 31, 2018 and 2017, receivables for securities sold were approximately $1,317,000 and $842,000, respectively. Receivables for securities arise when sales of securities are recorded as of the trade date. A receivable due from the custodian is established when a security has been sold, but the proceeds from the sale have not yet been received. Receivables for securities not received within 15 days from the stated settlement date are nonadmitted. There were no nonadmitted receivables for securities sold in 2018 or 2017.

(h) Uncollected Premiums

Uncollected premiums are reported net of allowances for uncollectible and nonadmitted balances. Certain receivables are not admissible for statutory accounting purposes.

All receivables for canceled policies and billed receivables that relate to balances outstanding for a period exceeding 90 days are not admissible according to the Manual.

Pinnacol independently estimates the realizable amounts of premiums receivable and records an allowance for any uncollectible balances that were not already non-admitted. During 2018 and 2017, Pinnacol recorded a provision of approximately $3,442,000 and $2,595,000, respectively, for premiums receivable due to the unlikelihood of ultimate collection thereof. These amounts are reflected as provision for uncollectible premiums in the accompanying statutory basis statements of operations and changes in policyholders' surplus.

A significant portion of Pinnacol's premium receivable balances at December 31, 2018 and 2017 were from companies operating in the construction and services industries in Colorado. The construction industry represents approximately 39% of premiums earned as of December 31, 2018 and 37% as of December 31, 2017. The services industry represents approximately 38% of premiums earned as of December 31, 2018 and 40% as of December 31, 2017, with all other individual industries constituting the remainder of premiums receivable balances.

(i) Earned but Unbilled Premiums

Earned but unbilled premiums represent a receivable or liability for changes in earned premium and audit premiums, which are amounts due from or to policyholders after the respective policy period has

expired based on payroll audits performed by Pinnacol. A liability is included as a component of credit balances due policyholders. Such amounts are estimated by Pinnacol based upon internal calculations using historical premium data. Pinnacol recorded a net estimated earned but unbilled premium receivable in 2018 and 2017 of approximately $32,485,000 and $43,610,000, respectively.

(j) Credit Balances Due Policyholders

Credit balances due policyholders represent excess premiums or are amounts due to policyholders. Generally, credit balances due policyholders are applied to future premium obligations of policyholders. For 2018 and 2017, such amounts are approximately $8,953,000 and $8,566,000, respectively.

(k) Electronic Data Processing Equipment

Electronic data processing equipment is recorded at cost, less accumulated depreciation, and depreciated on a straight line basis over an estimated useful life of three years. Net book value of these assets at December 31, 2018 and 2017 was approximately $495,000 and $985,000, respectively. Related depreciation expense of approximately $769,000 and $969,000 was incurred during 2018 and 2017, respectively, and is included in LAE and other underwriting expenses incurred in the statutory basis statements of operations and changes in policyholders' surplus.

(l) Office Furniture, Equipment, Software, Art, and Leasehold Improvements

Office furniture, equipment, software, art, and leasehold improvements are recorded at cost and depreciated on a straight line basis. Equipment and software are depreciated over an estimated useful life of three years. Office furniture, art, and automobiles are depreciated over an estimated useful life of five years. Leasehold improvements are depreciated over the shorter of the term of the lease or the useful life. In accordance with the Manual, these are nonadmitted assets. The net book value of these assets at December 31, 2018 and 2017 was approximately $280,000 and $578,000, respectively. Related depreciation expense of approximately $240,000 and $530,000 was incurred in 2018 and 2017, respectively, and is included in LAE and other underwriting expenses incurred in the statutory basis statements of operations and changes in policyholders' surplus.

(m) Safety Group Dividend Program

Pinnacol has a safety group program whereby policyholders who are members of the program are entitled to a dividend based on established criteria. Pinnacol paid out safety group dividends of $2,717,000 in 2018 and $2,303,000 in 2017. As of December 31, 2018 and 2017, safety group dividends payable of $3,289,348 and $3,651,000, respectively, are included in dividends payable to policyholders. These dividends are not declared from surplus nor are they recorded as a direct reduction to policyholders' surplus. The dividends are recorded as dividends to policyholders in the statutory basis statements of operations and changes in policyholders' surplus.

(n) Individual Loss Control Dividend Program

Pinnacol has an individual loss control dividend (ILCD) program that is designed for policyholders who are committed to effective loss control in their business operations. If the policyholder meets the minimum premium requirements and pays an additional 5% premium charge as a buy in to the plan, the policyholder may receive a reduction of premium based on the policy premium and the loss ratio. Pinnacol paid out ILCDs of $17,769,000 in 2018 and $16,483,000 in 2017. As of December 31, 2018 and 2017, ILCDs payable of $30,061,000, and $24,882,000, respectively, are included as dividends payable to policyholders in the statutory-basis statements of operations and changes in policyholders' surplus.

(o) General Policyholder Dividends

The Board of Directors, at its discretion, determines the amount of general policyholder dividends to be declared, based on Pinnacol's overall experience and financial condition. Pinnacol has declared general policyholder dividends to its policyholders in good standing of approximately $70,000,000 in 2018 and $50,000,000 in 2017. This is included in dividends payable to policyholders.

(p) Reserve for Unpaid Losses and Loss Adjustment Expenses and Structured Settlement Liability

The reserve for unpaid losses and loss adjustment expenses represents management's best estimate of ultimate net cost of all reported and unreported losses incurred through December 31, 2018 and 2017. The reserve for unpaid losses and loss adjustment expenses is estimated by management, which uses an independent third party actuary to provide estimates based on individual case basis valuations and statistical analyses. Those estimates are subject to the effects of trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management believes the reserve for unpaid losses and loss adjustment expenses is adequate. These estimates are continually reviewed and adjusted, as necessary, as experience develops or new information becomes known. Such adjustments are included in losses incurred or loss adjustment expenses incurred within the statutory basis statements of operations and changes in policyholders' surplus in the period such information becomes known. Subrogation claims (claims against third parties) are recognized as a reduction of losses incurred when collections are received.

Internal structured settlement liabilities represent obligations to claimants and dependents on cases that have been closed by contract. The discounted reserve for internal structured settlements is estimated by management, which uses an independent third party actuary to provide estimates based on these obligations.

(q) Revenue Recognition and Unearned Premiums

For certain policies, earned premium is recorded on an installment basis to match the billing frequency stated in the policyholder contract with a provision for amounts earned but unbilled. Earned premium for all other contracts is recognized using the daily pro rata method over the period the policy is effective.

Unearned premiums represent amounts either collected or billed and due from policyholders at December 31, 2018 and 2017 but unearned at that date as they pertain to subsequent policy periods. Unearned premiums billed, which relate to policy effective dates subsequent to December 31, 2018 are not included in the unearned premiums balance, but are included as advance premium if the related cash is collected. Unearned premiums are computed on a daily pro rata basis over the effective period of the policies.

(r) Premium Deficiency Reserve

A premium deficiency reserve is recognized by recording an additional liability for the deficiency, which results when anticipated future loss, loss adjustment expense, commissions, other acquisition costs and maintenance costs exceed the recorded unearned premium reserve, any future installment premiums on existing policies, and anticipated investment income. The change in this reserve is recorded as a component of other underwriting deductions.

Pinnacol recorded a premium deficiency reserve of $0 at December 31, 2018 and 2017. Pinnacol considered anticipated investment income at 3.5% when evaluating the premium deficiency reserve for 2018.

(s) Multiemployer Pension Plans and Other Postretirement Benefits

Pinnacol participates in the State Division Trust Fund (SDTF), a cost-sharing multiple-employer defined benefit pension and health care trust fund plan administered by the Public Employees' Retirement Association (PERA). SDTF provides retirement, disability, and survivor benefits. All employees of Pinnacol are members of the SDTF.

As a participant in a multiple-employer pension plan and health care trust fund, Pinnacol recognizes as net pension cost and net postretirement benefit cost the required contribution for the period and as a liability any contributions due and unpaid.

(t) Reinsurance

Ceded reinsurance transactions are accounted for based on estimates of their ultimate cost. Losses incurred, loss adjustment expenses incurred, and the reserve for loss adjustment expenses are reported net of reinsured amounts in accordance with the Manual. Premiums earned are reported net of reinsurance (note 5).

(u) Taxes

As a political subdivision of the State of Colorado, Pinnacol is generally not subject to federal or state income taxes under a specific exemption granted under Section 501(c) of the Internal Revenue Code; nor is Pinnacol subject to property tax or sales and use taxes. However, Pinnacol is subject to income taxes on any net income that is derived from a trade or business regularly carried on and not in furtherance of the purposes for which it was granted exemption. No income tax provision has been recorded as the net income, if any, from any unrelated trade or business, in the opinion of management, is not material to the financial statements taken as a whole.

Pinnacol is not subject to a premium tax pursuant to Section 8-45-117(3), C.R.S. However, Pinnacol is subject to a surcharge on premiums pursuant to Section 8-44-112(1)(a), C.R.S. The surcharge is based on a rate established by the Colorado Department of Labor and Employment Division of Workers' Compensation annually, approximately 1.00% and 1.03% at December 31 2018 and 2017, respectively. Such amounts are included in other underwriting expenses incurred.

(v) Surplus Note

Pinnacol issued a $100,000,000 surplus note on June 25, 2014. Before issuing this debt, the Company obtained approval from the Commissioner of the Division for the transaction and approval to classify the debt as a component of policyholders' surplus.

(w) Special Surplus Fund for Unfunded Pension Benefits

Pinnacol participates in a cost sharing multiple-employer defined benefit pension plan administered by PERA. PERA has a net pension liability which represents the unfunded pension benefits. Statutory accounting does not allow Pinnacol's portion of the net pension liability to be recorded as a liability but allows a company to establish a special surplus fund to provide for contingencies. GASB No. 68, *Accounting and Financial Reporting for Pensions* is effective for fiscal years beginning after June 15, 2014. The statement requires cost-sharing employers participating in defined benefit plans to record their proportionate share of the collective net pension liability in their GASB financial statements. PERA provides Pinnacol with the audited schedule of employers' allocations and net pension liability. The total pension liability used to calculate the net pension liability is determined by an actuarial valuation as of December 31, 2016. PERA uses standard update procedures to roll-forward the total pension

liability to December 31, 2017. A discount rate of 4.72% is being used. PERA also provides the employer allocation percentage for purposes of calculating Pinnacol's proportionate share of the collective net pension liability.

(x) Immaterial Correction of an Error

During 2018, Pinnacol corrected the methodology in the calculation and reporting of earned but unbilled premiums (EBUB). It was determined that the use of earned premium rather than written premium as the basis for the calculation would result in a more accurate estimate. As of December 31, 2017, surplus was overstated by $10,890,000 and the receivable for EBUB premiums was overstated by $10,890,000. The adjustment is immaterial to Pinnacol's surplus as of December 31, 2018 and 2017.

(y) Application of Recent Statutory Accounting Pronouncements

During 2018 there were no substantive revisions to statutory accounting that were applicable to Pinnacol, and therefore, there were no substantive revisions adopted by the Company.

(2) Unpaid Losses and Loss Adjustment Expenses

Unpaid losses and loss adjustment expenses (both allocated and unallocated) represent management's best estimate of the ultimate medical and indemnity net cost of all losses and loss adjustment expenses that are incurred but unpaid at year end. Such estimates are based on individual case estimates for reported claims and actuarial estimates for losses that have been incurred but not reported. Any change in probable ultimate liabilities is reflected in losses incurred or loss adjustment expenses incurred within the statutory basis statements of operations and changes in policyholders' surplus in the period such determination is made.

The estimated ultimate cost of losses is based on historical patterns and the expected impact of current socioeconomic trends. The ultimate settlement of claims will not be known in many cases for years after the time a policy expires. Court decisions and federal and state legislation between the time a policy is written and the time associated claims are ultimately settled, among other factors, may dramatically impact the ultimate cost. Due to these factors, among others, the process to estimate loss and loss adjustment reserves at a point in time cannot provide an exact forecast of future payments. Rather, it produces a best estimate of liability as of a certain date. Management believes the currently estimated reserves to be adequate. While the ultimate liability may differ from the current estimate, management does not believe the difference will have a material effect, either adverse or favorable, on Pinnacol's financial position or results of operations.

Unpaid Losses and Loss Adjustment Expenses

Activity in the liability for unpaid losses and loss adjustment expenses in 2018 and 2017 is summarized as follows (in thousands):

	Unpaid losses and loss adjustment expenses	
	2018	2017
Balance at January 1	$ 923,095	935,712
Additional amounts incurred related to:		
Current year	431,225	432,960
Prior years	(53,243)	(50,251)
Total incurred	377,982	382,709
Reductions relating to payments for:		
Current year	134,677	131,868
Prior years	245,832	263,458
Total paid	380,509	395,326
Balance at December 31	$ 920,568	923,095

During the year ended December 31, 2018, the provision for unpaid losses and loss adjustment expenses for insured events of prior years was reduced by $299,075,000 to $624,020,000. This reduction includes payments for unpaid losses and loss adjustment expenses of approximately $245,832,000 and a $53,243,000 reduction in reserves for prior year unpaid losses and loss adjustment expense. This decrease is generally the result of ongoing analysis of recent loss development trends and better than expected development. Pinnacol's claims continue the trend of favorable development that has been evident for a number of calendar years. When the actual selected ultimate cost of an accident year's claims is less than the original estimate, favorable development is recorded. This favorable development resulted from initiatives to improve claims handling practices and reduce claims handling expenses when prudent and a reduction of ultimate claim frequency in Colorado. Pinnacol management continually evaluates the estimated ultimate cost of all accident years and on a calendar year basis adjusts to the best estimate available, favorable or unfavorable, in the current period. At the end of the current year, the amount of reserve credit recorded for high deductibles on unpaid losses was $2,952,000. Such reduction is collateralized generally with letters of credit for the benefit of Pinnacol. Pinnacol received $6,989,556 and $7,133,000 in subrogation as of December 31, 2018 and 2017, respectively. There were no significant changes in methodologies or assumptions used in calculating the reserves.

(3) Internal Structured Settlements

Pinnacol has an internal structured settlement program in which it retains the liability for settlements to claimants rather than purchasing annuities from third parties. This liability has mortality risk and is discounted using a market rate. The internal structured settlement liability is actuarially valued. The internal structured settlement liability is reported as a financing liability separate from unpaid losses and loss adjustment expenses on the statutory-basis statements of admitted assets, liabilities, and policyholders' surplus.

Activity in the liability for internal structured settlements in 2018 and 2017 is summarized as follows (in thousands):

	2018	2017
Beginning balance	$ 384,790	378,736
Amounts incurred:		
Change in valuation	10,828	7,908
Amounts paid	(26,166)	(25,377)
New internal structured settlements	16,900	23,523
Ending balance	$ 386,352	384,790

Pinnacol uses an annuity quote that is based upon an estimated discount rate as a basis for the paid claim amount. As such, the liability should be discounted at a market rate. The discount rate applied to internal structured settlement liabilities is 2.5% at December 31, 2018 and 2017.

The amount of the discount for unpaid internal structured settlements as of December 31, 2018 and 2017 is approximately $148,736,000 and $152,555,000, respectively. The discount amounts for internal structured settlement reserves at December 31, 2018 and 2017 are distributed over the years in which the losses were incurred as follows (in thousands):

2018		2017	
Loss year	Discount	Loss year	Discount
Prior	$ 96,240	Prior	$ 101,024
2008	9,816	2008	10,336
2009	9,853	2009	10,414
2010	5,113	2010	5,591
2011	6,728	2011	7,149
2012	4,207	2012	4,320
2013	5,331	2013	5,287
2014	6,116	2014	6,019
2015	3,271	2015	1,979
2016	1,484	2016	418
2017	540	2017	18
2018	37		—
Total	$ 148,736	Total	$ 152,555

(4) Investments

Estimated fair value of investments in bonds and equities is based on quotations provided by widely accepted third party data providers. In 2018 and 2017, Interactive Data Corporation (IDC), Reuters, and Markit Partners were used to obtain fair market values. Additionally, in 2018 and 2017, the fair value of certain common trust funds were primarily determined by net asset value and common stock warrants were primarily determined by a widely accepted third party vendor, followed by a hierarchy using broker/dealer quotes, Bloomberg, Yield Book analytic model, and a benchmark to index model. Prior month price is used only when information is limited or unavailable.

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(a) Bonds

The Securities Valuation Office (SVO) of the NAIC assigns designations of bonds from 1 to 6. Bonds with designations of 1–2 are stated at amortized value using the interest method. Bonds with designations of 3–6 require the bond to be carried at the lower of amortized value or fair value, with any related unrealized loss reported in policyholders' surplus.

During 2018 and 2017, Pinnacol had investments in long term bonds, which the SVO assigned a 3 or higher designation. Carrying values are equal to the lower of amortized value or fair value for these bonds.

The carrying value and the fair value of investments in long term bonds in 2018 and 2017 are summarized as follows (in thousands). The carrying value includes investment grade bonds that are reported at amortized value and low rated bonds that are reported at the lower of cost or fair value:

	2018			
	Carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
Government obligations:				
Nonloan-backed bonds	$ 115,041	2,886	(730)	117,197
Loan-backed bonds	6,253	204	—	6,457
U.S. political subdivisions:				
Nonloan-backed bonds	11,247	384	(46)	11,585
Loan-backed bonds	—	—	—	—
U.S. special revenue:				
Nonloan-backed bonds	49,939	1,543	(505)	50,977
Loan-backed bonds	382,534	550	(9,438)	373,646
Industrial and miscellaneous:				
Nonloan-backed bonds	1,220,548	10,535	(33,777)	1,197,306
Loan-backed bonds	213,588	948	(2,821)	211,715
Hybrid Securities:				
Nonloan-backed bonds	6,704	54	(185)	6,573
Loan-backed bonds	—	—	—	—
Bank Loans:				
Nonloan-backed bonds	123,743	330	(337)	123,736
Loan-backed bonds	—	—	—	—
	$ 2,129,597	17,434	(47,839)	2,099,192

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	2017			
	Carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
Government obligations:				
Nonloan-backed bonds	$ 103,710	4,115	(487)	107,338
Loan-backed bonds	11,945	500	—	12,445
U.S. political subdivisions:				
Nonloan-backed bonds	11,268	691	(24)	11,935
Loan-backed bonds	—	—	—	—
U.S. special revenue:				
Nonloan-backed bonds	51,227	3,588	(81)	54,734
Loan-backed bonds	349,008	1,168	(2,846)	347,330
Industrial and miscellaneous:				
Nonloan-backed bonds	1,241,051	37,378	(3,848)	1,274,581
Loan-backed bonds	241,708	3,082	(125)	244,665
Hybrid Securities:				
Nonloan-backed bonds	7,607	275	—	7,882
Loan-backed bonds	—	—	—	—
	$ 2,017,524	50,797	(7,411)	2,060,910

The book/adjusted carrying value and estimated fair value of investments in long term bonds at December 31, 2018, by contractual maturity, are shown in the following table (in thousands). Investments such as mortgage backed securities have been allocated based on the original maturity date at issuance. Contractual maturities may differ from actual maturities because the borrower may have the right to call or prepay obligations with or without call or prepayment penalties.

	2018	
	Book/adjusted carrying value	Fair value
Due in one year or less	$ 126,822	125,650
Due after one year through five years	703,554	698,065
Due after five years through ten years	884,821	866,314
Due after ten years	414,400	409,163
	$ 2,129,597	2,099,192

Proceeds from sales of investments in long term bonds during 2018 and 2017 were approximately $125,208,000 and $227,717,000, respectively. Realized gains on long term bonds of approximately $2,270,000 and $4,885,000 and realized losses of approximately $(3,001,000) and $(1,908,000) were recognized during 2018 and 2017, respectively.

(Continued)

The following table provides the length of impairment for those investments in long term bonds with an unrealized loss as of December 31, 2018 (in thousands):

Description of securities	Less than 12 months		12 months or greater		Total	
	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses
U.S. government	$ 23,712	(206)	56,946	(524)	80,658	(730)
U.S. political subdivisions	—	—	2,411	(46)	2,411	(46)
U.S. special revenue	115,798	(1,831)	226,148	(8,112)	341,946	(9,943)
Industrial and miscellaneous	792,596	(26,184)	285,326	(14,912)	1,077,922	(41,096)
Hybrid securities	6,307	(254)	63	(12)	6,370	(266)
Bank loans	110,858	(5,404)	8,677	(710)	119,535	(6,114)
Total	$ 1,049,271	(33,879)	579,571	(24,316)	1,628,842	(58,195)

The following table provides the length of impairment for those investments in long term bonds with an unrealized loss as of December 31, 2017 (in thousands):

Description of securities	Less than 12 months		12 months or greater		Total	
	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses
U.S. government	$ 40,156	(258)	30,741	(229)	70,897	(487)
U.S. political subdivisions	2,453	(24)	—	—	2,453	(24)
U.S. special revenue	183,505	(1,142)	79,568	(1,785)	263,073	(2,927)
Industrial and miscellaneous	277,899	(2,460)	141,478	(3,233)	419,377	(5,693)
Hybrid securities	522	(6)	496	(5)	1,018	(11)
Total	$ 504,535	(3,890)	252,283	(5,252)	756,818	(9,142)

(b) Loan-Backed and Structured Securities

Loan backed securities are stated at amortized value or fair value based on their NAIC designation. The prospective method is used to value mortgage backed securities. Prepayment assumptions for single class and multiclass mortgage backed/asset backed securities were obtained from widely accepted models with inputs from major third party data providers. Any loan backed and structured securities in an unrealized loss position were reviewed to determine whether an OTTI should be recognized at year end. At December 31, 2018 and 2017, Pinnacol did not recognize any OTTI on loan backed securities. Loan backed and structured securities in an unrealized loss position as of year-end,

(Continued)

stratified based on length of time continuously in these unrealized loss positions, are as follows (in thousands):

	2018	
	Aggregate amount of unrealized loss	Aggregate fair value of securities with unrealized loss
Less than twelve months	$ 3,863	249,730
Twelve months or longer	8,390	242,482
	$ 12,253	492,212

(c) Equities

Unrealized gains on investments in common stocks, mutual funds, and common trust funds are reported as a component of policyholders' surplus. For any decline in the fair value of equities which is determined to be other than temporary, the resulting OTTI loss is recognized in the statement of operations. OTTI of common stocks, mutual funds, and common trust funds result in the establishment of a new, adjusted cost basis for such investments. The original cost, adjusted cost, gross unrealized gains (measured against adjusted cost), and fair value of common stocks, mutual funds, and common trust funds are summarized as follows (in thousands):

	Original cost	Adjusted cost	Gross unrealized gains	Fair value
December 31, 2018	$ 426,489	387,760	59,597	447,357
December 31, 2017	$ 445,397	409,072	135,680	544,752

The Company is a member of the Federal Home Loan Bank (FHLB) of Topeka. Through its membership, the Company may borrow an amount which is dependent on the market value and risk related to investments that are held at FHLB. The Company has not conducted any borrowings with the FHLB as of December 31, 2018. As a requirement of the membership, Pinnacol owns FHLB Class A and Class B Capital Stock. In 2018, these assets totaled $500,000 and $10,000, respectively.

(d) Mortgage Loans on Real Estate

The Company held $15,024,000 of commercial mortgage loans at December 31, 2018. Mortgage loans on real estate consist entirely of domestic commercial collateralized loans and are carried at their unpaid principal balances adjusted for any unamortized premiums or discounts, origination fees, provision allowances, and foreign currency translations. Interest income is accrued on the unpaid principal balance for all loans, except for loans on non-accrual status. Premiums, discounts, and origination fees are amortized to net investment income using the effective interest method.

A third-party manager actively manages the Company's mortgage loan portfolio by completing ongoing comprehensive analysis of factors such as debt service coverage ratios, loan-to-value ratios, payment status, default or legal status, collateral property evaluations, and general market conditions. On a quarterly basis, the Company reviews any provided credit quality risk indicators in its internal assessment of loan impairment and credit loss.

Management's periodic evaluation and assessment for mortgage impairments is based on delinquency status, internally derived fair value, as well as credit concern status based on known and inherent risks in the portfolio, adverse situations that may affect the borrower's ability to repay, the fair value of the underlying collateral, composition of the loan portfolio, current economic conditions, loss experience, and other relevant factors. Risk is mitigated primarily through first lien collateralization, guarantees, loan covenants, and borrower reporting requirements. Since the Company does not hold uncollateralized mortgages, loans are generally not deemed fully uncollectible. Any remaining unrecoverable amounts are written off during the final stage of the foreclosure process.

Loan balances are considered delinquent when payment has not been received based on contractually agreed upon terms. The accrual of interest is discontinued when concerns exist regarding the realization of loan principal or interest. The Company resumes interest accrual on loans when a loan returns to current status or under new terms when loans are restructured or modified.

At December 31, 2018, the Company did not have any troubled, impaired, or delinquent mortgage loans, or any reason to believe payments would be uncollectible on any existing loans.

(e) Other Invested Assets

Investments in partnerships are stated at the underlying audited equity value. For those investments in which the audited financial statements were not available by the March 1, 2019 statutory annual statement filing deadline, the unaudited equity value was used. These assets totaled $92,944,000 and $70,490,000 in 2018 and 2017, respectively. The Company has contributed $83,928,000 in net capital (capital contributions – capital distributions) since investing in partnerships and may be responsible for up to an additional $116,191,000.

(f) Impairment of Investments

The Company writes securities down to fair value that it deems to be OTTI in the period the securities are deemed to be so impaired. The Company records write-downs as realized capital losses and adjusts the cost basis of the securities accordingly. The Company does not adjust the revised cost basis for subsequent recoveries in value.

The assessment of whether an OTTI occurred is based upon management's case by case evaluation of the underlying reasons for the decline in fair value. Management considers a wide range of factors, as described below, regarding the security issuer and uses its best judgment in evaluating the cause of the decline in its estimated fair value and in assessing the prospects for near term recovery. Inherent in management's evaluation of the security are assumptions and estimates about the operations and future earnings potential of the issuer.

Considerations used by the Company in the impairment evaluation process include, but are not limited to, the following:

- Fair value is significantly below cost.

- The decline in fair value is attributable to specific adverse conditions affecting a particular instrument, its issuer, an industry, or geographic area.
- The decline in fair value has existed for an extended period of time.
- A debt security has been downgraded by a credit rating agency.
- The financial condition of the issuer has deteriorated.
- A change in future expected cash flow has occurred.
- Dividends have been reduced or eliminated or scheduled interest payments have not been made.
- The ability and intent to hold investments until recovery, including consideration of the investment manager's discretion to sell securities.
- The present value of projected cash flows expected to be collected is less than amortized value of loan-backed and structured securities.

While all available information is taken into account, it is difficult to predict the ultimate recoverable amount from a distressed or impaired security.

At December 31, 2018 and 2017, 9.03% and 10.4% of long term bonds held by the Company were rated non-investment grade, respectively. At December 31, 2018 and 2017, the Company had approximately $58,123,000 and $9,056,000, respectively, of unrealized losses related to its long term bonds. The unrealized losses on securities are primarily attributable to fluctuations in market interest rates and changes in credit spreads since the securities were acquired.

(g) Other-Than-Temporary Impairment

During 2018 and 2017, the Company recognized $4,620,000 and $1,689,000, respectively, in OTTI on long term bonds, $31,000 and $8,000, respectively, in OTTI on preferred stock, and $8,128,000 and $2,255,000, respectively, in OTTI on common stocks, mutual funds, and common trust funds.

(h) Fair Value Measurements

The Company has categorized its assets and liabilities that are reported on the statutory basis statements of admitted assets, liabilities, and policyholder's surplus at fair value into the three-level fair value hierarchy. The three-level fair value hierarchy is based on the degree of subjectivity inherent in the valuation method by which fair value was determined. The three levels are defined as follows.

- Level 1 – Quoted Prices in Active Markets for Identical Assets and Liabilities: This category, for items measured at fair value on a recurring basis includes common stocks, preferred stocks and money market mutual funds. The estimated fair value of the equity securities within this category are based on quoted prices in active markets and are thus classified as Level 1.
- Level 2 – Significant Other Observable Inputs: This category for items measured at fair value on a recurring basis includes bonds and common stocks which are not exchange traded. The estimated fair values of some of these items were determined by independent pricing services using observable inputs. Others were based on quotes from markets which were not considered actively traded.
- Level 3 – Significant Unobservable Inputs: This category for items measured at fair value includes common stocks, common stock warrants, preferred stocks, and bonds. The estimated fair value of

common stock warrants and bonds was determined by internal ratings in the absence of observable inputs.

At the end of each reporting period, the Company evaluates whether or not any event has occurred or circumstances have changed that would cause an instrument to be transferred between Levels 1 and 2. This policy also applies to transfers into or out of Level 3 as stated below. During the current year, no transfers between Level 1 and 2 were required.

The following table represents (in thousands) information about the Company's financial assets measured at fair value in Level 3 as of December 31, 2018.

	Fair value measurements – Level 3 December 31, 2018						
Assets	Beginning balance January 1, 2018	Amortization accretion	Current realized net income	Change in unrealized surplus	Purchases/ Transfers into Level 3	Sales/ Settlements/ Transfers Out of Level 3	Ending balance December 31, 2018
Bonds - bank loans	$ 2,035	18	(176)	(620)	16,949	(2,654)	15,552
Perpetual preferred stocks	20	—	(9)	—	—	—	11
Common stocks-Industrial and miscellaneous	236	—	(11)	111	374	(66)	644
Total assets	$ 2,291	18	(196)	(509)	17,323	(2,720)	16,207

The following table represents (in thousands) information about the Company's financial assets measured at fair value in Level 3 as of December 31, 2017.

	Fair value measurements – Level 3 December 31, 2017						
Assets	Beginning balance January 1, 2017	Amortization accretion	Current realized net income	Change in unrealized surplus	Purchases/ Transfers into Level 3	Sales/ Settlements/ Transfers Out of Level 3	Ending balance December 31, 2017
Bonds							
Bank loans	—	56	(190)	163	6,078	(4,072)	2,035
CDOs/CBOs/CLOs	—	—	—	7	1,000	(1,007)	—
All other bonds	2,187	2	(41)	22	27	(2,197)	—
Total bonds	2,187	58	(231)	192	7,105	(7,276)	2,035
Perpetual preferred stocks	—	—	(8)	—	28	—	20
Common stocks-Industrial and miscellaneous	159	—	(45)	86	160	(124)	236
Total assets	$ 2,346	58	(284)	278	7,293	(7,400)	2,291

(Continued)

The following table presents (in thousands) information about the Company's financial assets measured at fair value on a recurring basis for accounting purposes as of December 31, 2018 and 2017, respectively, and indicates the fair value hierarchy of the valuation techniques utilized by the Company to determine such fair value:

	Fair value measurements – recurring basis December 31, 2018			
Assets	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**	**Total**
Common stocks				
Industrial & miscellaneous	$ 111,324	—	644	111,968
Common trust funds	—	55,031	—	55,031
Mutual funds	280,358	—	—	280,358
Total common stocks	391,682	55,031	644	447,357
Perpetual preferred stocks	320	—	11	331
Money market mutual funds	67,200	—	—	67,200
Total assets	$ 459,202	55,031	655	514,888

	Fair value measurements – recurring basis December 31, 2017			
Assets	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**	**Total**
Common stocks				
Industrial & miscellaneous	$ 131,561	—	236	131,797
Common trust funds	—	79,088	—	79,088
Mutual funds	333,867	—	—	333,867
Total common stocks	465,428	79,088	236	544,752
Perpetual preferred stocks	—	—	20	20
Short-term bonds & cash equivalents	24,000	199	—	24,199
Total assets	$ 489,428	79,287	256	568,971

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Certain assets are measured at fair value on a nonrecurring basis quarterly or more frequently if events dictate that the carrying value of the asset may not be recovered. These assets include bonds held at fair value with an NAIC designation of 3–6 and redeemable preferred stocks held at fair value with an NAIC designation of RP3–RP6. There were bonds with these designations where the fair value was less than amortized value, which resulted in an unrealized loss of $9,221,000 at December 31, 2018 and $2,984,000 at December 31, 2017.

The following table reflects (in thousands) the fair values and admitted values of all admitted assets and liabilities that are financial instruments excluding those accounted for under the equity method as of December 31, 2018 and 2017, respectively. The fair values are also categorized into the three level fair value hierarchy as described above.

	December 31, 2018				
Type of financial instrument	**Fair value**	**Admitted value**	**Level 1**	**Level 2**	**Level 3**
Financial instruments-assets:					
Long-term bonds					
Bank loans	$ 123,736	123,742	—	104,900	18,836
CDOs/CBOs/CLOs	66,993	68,396	—	65,995	998
Private placements	52,602	54,474	—	—	52,602
All other bonds	1,855,861	1,882,985	—	1,834,518	21,343
Total long-term bonds	2,099,192	2,129,597	—	2,005,413	93,779
Preferred stocks					
Perpetual preferred	331	331	320	—	11
Perpetual preferred-subsidiary Cake	7,571	7,571	—	—	7,571
Redeemable preferred	25	22	25	—	—
Total Preferred stocks	7,927	7,924	345	—	7,582
Common stocks					
Industrial & miscellaneous	111,968	111,968	111,324	—	644
Common trust funds	55,031	55,031	—	55,031	—
Mutual funds	280,358	280,358	280,358	—	—
Total Common stocks	447,357	447,357	391,682	55,031	644
Mortgage Loans	15,024	15,024	—	—	15,024
Cash, cash equivalents and short-term investments	73,492	73,492	63,530	9,962	—
Other - Affiliated non-collateral loan	4,000	4,000	—	—	4,000
Total assets	$ 2,646,992	2,677,394	455,557	2,070,406	121,029

(Continued)

Type of financial instrument	December 31, 2017 Fair value	Admitted value	Level 1	Level 2	Level 3
Financial instruments-assets:					
Long-term bonds					
Bank loans	$ 135,218	133,626	—	118,496	16,722
CDOs/CBOs/CLOs	35,171	34,900	—	35,171	—
Private placements	29,535	29,232	—	—	29,535
All other bonds	1,860,986	1,819,766	—	1,846,639	14,347
Total long-term bonds	2,060,910	2,017,524	—	2,000,306	60,604
Preferred stocks					
Perpetual preferred	485	422	465	—	20
Perpetual preferred-subsidiary Cake	7,571	7,571	—	—	7,571
Redeemable preferred	176	165	176	—	—
Total Preferred stocks	8,232	8,158	641	—	7,591
Common stocks					
Industrial & miscellaneous	131,797	131,797	131,561	—	236
Common trust funds	79,088	79,088	—	79,088	—
Mutual funds	333,867	333,867	333,867	—	—
Total Common stocks	544,752	544,752	465,428	79,088	236
Cash, cash equivalents and short-term investments	76,899	76,899	60,720	16,179	—
Total assets	$ 2,690,793	2,647,333	526,789	2,095,573	68,431

(i) Investment Income

Major categories of net investment income for the years ended December 31, 2018 and 2017 are summarized as follows (in thousands):

	2018	2017
Investment income:		
Corporate and miscellaneous bonds	$ 72,771	66,848
U.S. government bonds	2,893	2,736
Cash and other investments	1,314	464
Real estate	5,691	5,983
Other invested assets	2,654	3,237
Mortgage Loans	185	—
Equity securities	15,636	16,081
Surplus note interest expense	(8,625)	(8,625)
Investment expenses	(9,139)	(9,278)
Net investment income earned	83,380	77,446
Net realized capital gain (loss):		
Corporate and miscellaneous bonds	(5,352)	1,294
U.S. government bonds	—	(6)
Equity securities	15,177	16,602
Net realized capital gains	9,825	17,890
Net investment income	$ 93,205	95,336

(Continued)

(5) Reinsurance

Ceded Reinsurance – Pinnacol purchases excess of loss reinsurance with two layers and terrorism coverage. The reinsurance coverage for individual workers' compensation accidents was as follows:

- Layer 1 – Limit of $20,000,000 in excess of retention of $20,000,000 per occurrence
- Layer 2 – Limit of $40,000,000 in excess of retention of $40,000,000 per occurrence
- Terrorism Only – Limit of $50,000,000 in excess of retention of $80,000,000 per occurrence

Management is not aware of any loss nor did the Company record any loss great enough to attach to these layers during any of the prior policy periods.

Reinsurance contracts do not relieve Pinnacol of its obligations, and a failure of the reinsurer to honor its obligations could result in losses unreimbursed to Pinnacol. Pinnacol evaluates and monitors the financial condition of its reinsurers to minimize its exposure to loss from reinsurer insolvency. Management of Pinnacol believes its reinsurers are financially sound and will continue to meet their contractual obligations.

Pinnacol uses Lloyd's Syndicates as part of its ceded reinsurer program. The Syndicates are generally not rated by AM Best. The remaining reinsurers had the following AM Best ratings at December 31, 2018:

Reinsurer	AM Best Rating
Arch Reinsurance Company	A+
Endurance Specialty Insurance Limited	A+
The Cincinnati Insurance Company	A+
Partner Reinsurance Company Ltd.	A
Lloyd's Syndicate 2003 (Catlin Underwriting Agencies Limited)	A
Lloyd's Syndicate 3000 (Markel Syndicate Management Limited)	A

Assumed Reinsurance – Pinnacol has entered into assumed reinsurance contracts that allow the Company to provide insurance coverage under the workers' compensation provisions of other states for the employees of Colorado companies who work outside of Colorado (Other States Coverage). Effective March 1, 2004, Pinnacol executed a reinsurance contract with Argonaut Insurance Company (a California corporation) for Other States Coverage. The contract was canceled in 2010; however, Pinnacol will continue to pay existing claims in accordance with this reinsurance agreement until these claims are closed or these risks are transferred. As the Company entered into a reinsurance agreement in 2010 with Zurich American Insurance Company, there were no gaps in coverage. This agreement was still in effect as of December 31, 2018. The Other States Coverage contracts are designed as 100% quota share arrangements with Pinnacol acting as the assuming company. Premium revenue is recognized pro rata over the period the policy is effective.

Funds have been placed on deposit as collateral with Argonaut Insurance Company and Zurich American Insurance Company in the amount of $2,182,000 and $1,792,000 in 2018 and 2017, respectively.

Pinnacol held unearned premium reserves related to assumed business of $919,000 and $811,000 for the years ended December 31, 2018 and 2017, respectively. Pinnacol had loss and loss adjustment expense reserves related to assumed business of $26,024,000 and $27,003,000 for the years ended December 31, 2018 and 2017, respectively.

(Continued)

The following reinsurance activity has been recorded in the accompanying statutory-basis financial statements (in thousands):

		2018	2017
Direct premiums written	$	623,848	620,980
Premiums ceded		(1,325)	(1,336)
Premiums assumed		8,914	8,340
Net premiums written	$	631,437	627,984
Direct premiums earned	$	624,274	618,554
Premiums ceded		(1,325)	(1,336)
Premiums assumed		8,806	8,401
Net premiums earned	$	631,755	625,619
Direct losses incurred	$	300,001	300,649
Losses ceded		—	—
Losses assumed		3,205	3,013
Net losses incurred	$	303,206	303,662
Direct loss adjustment expenses incurred	$	73,108	77,982
Loss adjustment expenses ceded		—	—
Loss adjustment expenses assumed		1,667	1,065
Net loss adjustment expenses incurred	$	74,775	79,047

(6) Employee Benefits

(a) Defined-Benefit Pension Plan through the State of Colorado

Pensions – Pinnacol participates in the State Division Trust Fund (SDTF), a cost-sharing multiple-employer defined benefit pension fund administered by the Public Employees' Retirement Association of Colorado (PERA). The net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions, pension expense, information about the fiduciary net position and additions to/deductions from the fiduciary net position of the SDTF have been determined using the economic resources measurement focus and the accrual basis of accounting. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

During the 2018 legislative session, the Colorado General Assembly passed significant pension reform through Senate Bill (SB) 18-200: Concerning Modifications to the Public Employees' Retirement Association Hybrid Defined Benefit Plan Necessary to Eliminate with a High Probability the Unfunded Liability of the Plan Within the Next Thirty Years. Governmental accounting standards require the net pension liability and related amounts of the SDTF for financial reporting purposes be measured using the plan provisions in effect as of the SDTF's measurement date of December 31, 2017. As such, the following disclosures do not include the changes to plan provisions required by SB 18-200.

Plan Description – All Pinnacol employees are provided with pensions through the SDTF-a cost-sharing multiple-employer defined benefit pension plan administered by PERA. Plan benefits are specified in Title 24, Article 51 of the C.R.S., administrative rules set forth at 8 C.C.R. 1502 1, and

applicable provisions of the federal Internal Revenue Code. Colorado State law provisions may be amended from time to time by the Colorado General Assembly. PERA issues a publicly available comprehensive annual financial report that can be obtained at https://www.copera.org/investments/pera-financial-reports

Benefits provided – PERA provides retirement, disability, and survivor benefits. Retirement benefits are determined by the amount of service credit earned and/or purchased, highest average salary, the benefit structure(s) under which the member retires, the benefit option selected at retirement, and age at retirement. Retirement eligibility is specified in tables set forth at C.R.S. § 24-51-602, 604, 1713, and 1714.

The lifetime retirement benefit for all eligible retiring employees under the PERA benefit structure is the greater of the:

- Highest average salary multiplied by 2.5% and then multiplied by years of service credit.
- The value of the retiring employee's member contribution account plus a 100% match on eligible amounts as of the retirement date. This amount is then annuitized into a monthly benefit based on life expectancy and other actuarial factors.

In all cases the service retirement benefit is limited to 100% of highest average salary and also cannot exceed the maximum benefit allowed by federal Internal Revenue Code.

Members may elect to withdraw their member contribution accounts upon termination of employment with all PERA employers; waiving rights to any lifetime retirement benefits earned. If eligible, the member may receive a match of either 50% or 100% on eligible amounts depending on when contributions were remitted to PERA, the date employment was terminated, whether 5 years of service credit has been obtained and the benefit structure under which contributions were made.

Benefit recipients who elect to receive a lifetime retirement benefit are generally eligible to receive post retirement cost-of-living adjustments (COLAs), referred to as annual increases in the C.R.S. Benefit recipients under the PERA benefit structure who began eligible employment before January 1, 2007 receive an annual increase of 2%, unless PERA has a negative investment year, in which case the annual increase for the next three years is the lesser of 2% or the average of the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) for the prior calendar year. Benefit recipients under the PERA benefit structure who began eligible employment after January 1, 2007 receive an annual increase of the lesser of 2% or the average CPI-W for the prior calendar year, not to exceed 10% of PERA's Annual Increase Reserve (AIR) for the SDTF.

Disability benefits are available for eligible employees once they reach five or more years of service credit and are determined to meet the definition of disability. The disability benefit amount is based on the retirement benefit formula shown above considering a minimum 20 years of service credit, if deemed disabled.

Survivor benefits are determined by several factors, which include the amount of earned service credit, highest average salary of the deceased, the benefit structure(s) under which service credit was obtained, and the qualified survivor(s) who will receive the benefits.

Contributions – Eligible employees and Pinnacol are required to contribute to the SDTF at a rate set by Colorado statute. The contribution requirements are established under C.R.S. § 24-51-401, *et seq*. Eligible employees are required to contribute 8% of their PERA-includable salary. The employer contribution requirements for Pinnacol are summarized in the table below:

	For the Year Ended 12/31/18	For the Year Ended 12/31/17	For the Year Ended 12/31/16
Employer contribution rate (includes 1.02% allocation to the Health Care Trust Fund – see note 6c) [1]	10.15%	10.15%	10.15%
Amortization Equalization Disbursement (AED) as specified in C.R.S. §24-51-411 [1]	5.00	5.00	4.60
Supplemental Amortization Equalization Disbursement (SAED) as specified in C.R.S., §24-51-411 [1]	5.00	5.00	4.50
Total employer contribution rate [1]	20.15%	20.15%	19.25%

[1]Rates are expressed as a percentage of salary as defined in C.R.S. § 24-51-101(42).

Employer contributions are recognized by the SDTF in the period in which the compensation becomes payable to the member and Pinnacol is statutorily committed to pay the contributions to the SDTF. Employer contributions recognized by the SDTF from Pinnacol were $12,627,000 and $12,030,000, for the years ended December 31, 2018 and December 31, 2017, respectively. These contributions met the contribution requirement for each year.

(b) Voluntary Tax-Deferred Retirement Plans

Plan Description – Employees of Pinnacol that are also members of the SDTF may voluntarily contribute to the Voluntary Investment Program, an Internal Revenue Code Section 401(k) defined contribution plan administered by PERA. Title 24, Article 51, Part 14 of the C.R.S., as amended, assigns the authority to establish the Plan provisions to the PERA Board of Trustees. PERA issues a publicly available comprehensive annual financial report for the Program. That report can be obtained at https://www.copera.org/investments/pera-financial-reports.

Funding Policy – The Voluntary Investment Program is funded by voluntary member contributions up to the maximum limits set by the Internal Revenue Service, as established under Title 24, Article 51, Section 1402 of the C.R.S., as amended. In addition, Pinnacol has agreed to match employee's elective contributions into the PERA 401(k) Plan at 50% up to the first 6% of employees' elected deferrals. Employees are immediately vested in their own contributions, employer contributions and investment earnings. For the years ended December 31, 2018 and 2017, Pinnacol contributed approximately $1,556,000 and $1,449,000, respectively, in matching contributions to the PERA 401(k) Plan. Pinnacol also offers a 457 deferred compensation plan.

(Continued)

(c) Defined Benefit Other Postemployment Benefit (OPEB) Plan

OPEB Plan – Pinnacol participates in the Health Care Trust Fund (HCTF), a cost-sharing multiple-employer defined benefit OPEB plan administered by PERA.

Plan Description – The HCTF is established under Title 24, Article 51, Part 12 of the C.R.S., as amended. Colorado State law provisions may be amended from time to time by the Colorado General Assembly. Title 24, Article 51, Part 12 of the C.R.S., as amended, sets forth a framework that grants authority to the PERA Board to contract, self-insure and authorize disbursements necessary in order to carry out the purposes of the PERACare program, including the administration of the premium subsidies. The HCTF provides a health care premium subsidy to eligible participating PERA benefit recipients and retirees who choose to enroll in one of the PERA health care plans. PERA issues a publicly available comprehensive annual financial report that can be obtained at https://www.copera.org/investements/pera-financial-reports.

Funding Policy – Pinnacol is required to contribute at a rate of 1.02% of PERA-includable salary for all PERA members as set by statute. Pinnacol's contribution is included in the contribution rate of 20.15% in Note 6(a). No member contributions are required to the HCTF. The contribution requirements for Pinnacol are established under Title 24, Article 51, Part 4 of the C.R.S., as amended. The apportionment of the contributions to the HCTF is established under Title 24, Article 51, Section 208(1)(f) of the C.R.S., as amended. For the years ending December 31, 2018 and 2017, Pinnacol contributions to the HCTF were approximately $639,000 and $609,000, respectively, equal to the required contributions for each year.

(d) Other

Health and Welfare Trust – Effective January 1, 2010, Pinnacol entered into certain self-funded benefit programs with its vendors for healthcare, dental care, and vision care and established a separate legal trust for administrative purposes. In 2018, Pinnacol also entered into a guaranteed cost program with one of its two healthcare vendors. Pinnacol withholds monthly premium from its employee participants' payroll checks and uses these premiums and the employer contribution amounts to fund the trust account. These premiums are used to reimburse medical claims paid by the third party vendors for the self-funded programs or pay premiums to the healthcare vendor for the guaranteed cost program. Employer contributions in 2018 and 2017 were $6,661,000 and $7,721,000, respectively.

Accrued Paid Leave – Pinnacol employees may accrue paid time off based on their length of service subject to certain limitations on the amount that will be paid upon termination or taken in future periods. Paid time off is recorded as an expense and a liability at the time the paid time off is earned. The estimated liability for cumulative accrued paid time off of approximately $2,811,000 and $2,609,000 at December 31, 2018 and 2017, respectively, is included in other liabilities in the statutory basis statements of admitted assets, liabilities, and policyholders' surplus.

(7) Policyholders' Surplus

Pinnacol declared general policyholder dividends in 2018 of $70,000,000 and 2017 of $50,000,000 and subsequently paid them in March 2019 and March 2018. General policyholder dividends are a component of other income.

The Division monitors a company's "risk based capital" in assessing the financial strength of an insurance company. Pinnacol's level of surplus exceeds the "company action level" of risk based capital, which is approximately $180,870,000 for 2018.

A surplus note in the amount of $100,000,000 was issued on June 25, 2014, to an unaffiliated third party in exchange for cash. Each payment of principal and interest on the surplus note may be made only with the prior approval of the Division and only to the extent Pinnacol has sufficient policyholders' surplus to make such payment. The interest on the unpaid principal amount of this note will be paid in semiannual installments at the rate of 8.625% per annum. In 2018, $8,625,000 of interest was paid on the note and recorded as investment expense. The note, which is subordinate to the prior payment of all other liabilities of the Company, will be due and payable twenty years from the issuance date, with an optional pre-payment date in whole or part in fifteen years with no penalty. The surplus note was issued to partially cover Pinnacol's estimated proportionate share of PERA's unfunded liability for vested service of Pinnacol employees and retirees. This liability is not required to be recorded in the statutory basis financial statements as of December 31, 2018, but it reduces the capital adequacy assessments of outside rating agencies, such as A.M. Best. In accordance with the note agreement, Pinnacol may apply the proceeds for general corporate purposes.

The surplus note agreement contains customary affirmative and negative covenants and requires that Pinnacol maintain certain specified ratios and thresholds. Among others, these covenants include maintaining a maximum writing ratio, debt to capitalization ratio and interest coverage ratio. Management believes that at December 31, 2018 Pinnacol is in compliance with such covenants, ratios and thresholds.

The Company participates in a cost-sharing multiple-employer defined benefit pension plan administered by PERA. PERA has a net pension liability which represents the unfunded pension benefits. The funded portion of PERA's total pension liability as of December 31, 2017 is 43.2%. The Company has a special surplus fund to identify its portion of the unfunded pension benefits. Based on information provided by PERA as of June 30, 2018, the Company's special surplus fund for the unfunded pension benefits has increased by $56,627,000 from $350,883,000 in 2017 to a new balance of $407,510,000 for 2018. The discount rate is 4.72%. There are no limitations for using the special surplus fund for policyholders, injured workers or other creditors.

(8) Commitments and Contingencies

The Company has made total commitments of $116,191,000 to provide additional funds as needed to the following partnerships:

Partnership Name		2018
NB Pinnacol Asurance Fund LP	$	90,000,000
Entrust Permal Special Opportunities Fund IV Ltd		7,026,000
Blackstone Tactical Opportunities Fund II LP		5,238,000
North Haven Credit Partners LP		4,842,000
NB Strategic Co-Investment Partners III LP		3,396,000
Warburg Pincus Private Equity XII LP		2,461,000
GCM Grosvenor Opportunistic Credit Fund IV Ltd		1,675,000
Kayne Credit Opportunities Fund LP		1,173,000
Blue Ocean Income Fund LP		380,000
TOTAL	$	116,191,000

Lawsuits arise against the Company in the normal course of business. Contingent liabilities arising from litigation and other matters are not considered material in relation to the financial position of the Company.

At December 31, 2018 and 2017, Pinnacol had a letter of credit for the benefit of Argonaut Insurance Company under an assumed reinsurance agreement for approximately $6,297,000 and $7,468,000, respectively. This reinsurance agreement allows Argonaut Insurance Company to draw upon the letter of credit, which is 100% collateralized, at any time to secure any of Pinnacol's obligations under the agreement. Included in long term bonds and money market securities are amounts held as collateral for the letter of credit of approximately $10,300,000 and $13,595,000, compared to a requirement of $6,297,000 and $7,468,000, as of December 31, 2018 and 2017, respectively.

At December 31, 2018 and 2017, Pinnacol had a trust for the benefit of Zurich American Insurance Company under an assumed reinsurance agreement. This reinsurance agreement allows Zurich American Insurance Company, the beneficiary, to claim the trust assets at any time to secure any of Pinnacol's obligations under the agreement. Included in long term bonds are amounts held in the trust of approximately $41,065,000 and $45,006,000, compared to a requirement of $39,000,000 as of December 31, 2018 and 2017.

Pinnacol is contingently liable for approximately $41,270,000 of claims closed by the purchase of annuities from life insurers for structured settlements. Pinnacol has not purchased annuities from life insurers under which the Company is payee, and therefore, no balances are due from such annuity insurers.

Pinnacol is aware of an unfunded net pension liability. If Pinnacol were to partially or fully leave the PERA program, the unfunded net pension liability for the vested service of Pinnacol employees and retirees would become immediately due to PERA. Title 24, Article 51, Section 316 of the C.R.S. requires a company to calculate the reserve transfer necessary when an employer disaffiliates from PERA. The formula to calculate the termination liability differs significantly from the formula used to calculate Pinnacol's share of the unfunded pension obligation under GASB 68. Therefore, the amount of a possible termination liability is unknown but is expected to exceed $100,000,000. Currently, the possibility of the Company partially or fully leaving the PERA program is remote and would require legislative action.

(9) Related Party Transactions

Pinnacol purchased preferred stock in a non-insurance subsidiary, Cake, for $10,000,000 on September 28, 2017 in exchange for 2,000,000 preferred shares. In 2017, Cake purchased software and intellectual property from Pinnacol in the amount of $5,598,000, which exceeded the amount capitalized by Pinnacol by $2,429,000. Because of common control between Pinnacol and Cake, the excess was recorded as a deemed dividend, reducing the cost basis of Pinnacol's investment in Cake to $7,571,000. In September 2018, Cake repurchased all outstanding common stock, which increased Pinnacol's voting ownership in Cake from 90% to 100%. There was no change to the 2,000,000 preferred shares owned by Pinnacol.

Effective April 30, 2018, there is a loan agreement between Pinnacol and Cake. Cake, as the borrower, can draw down up to $4,000,000 over a period of up to two years at an interest rate of LIBOR plus 3.00%. This loan amount was fully funded as of December 31, 2018. Interest is due upon maturity, and there is no pre-payment penalty. This loan is a component of other invested assets.

Under a program administrator agreement approved by the Division, Cake writes policies for Pinnacol through its digital platform that potential policyholders can utilize to receive a quote and bind a policy. Pinnacol makes payments to Cake monthly as policies are generated. During 2018, Pinnacol paid $385,000 in program administrator fees.

Under a management service agreement approved by the Division, Pinnacol provides certain personnel services to its subsidiary for a set monthly fee and receives reimbursement for costs Cake incurred. During

(Continued)

2018, Pinnacol received $5,779,000 in management fees and reimbursed costs from its subsidiary. The management fees offset various expenses in the income statement.

At December 31, 2018 Pinnacol reported $58,000 due to subsidiary for commissions due Cake as an agent. Pinnacol also reported $237,000 due from subsidiary, including $172,000 for management fees and reimbursable expenses under the management service agreement and $65,000 for accrued loan interest.

There were no transactions with affiliates in amounts that exceeded 0.5% of the total admitted assets of Pinnacol.

(10) Subsequent Events

The Board of Directors declared general dividends on October 31, 2018 in an amount to be approximately $70,000,000. The final dividend amount of $70,000,000 was confirmed by the Board in February 2019 and subsequently paid in March 2019.

Subsequent events have been evaluated through May 22, 2019, the date these statutory basis financial statements were available to be issued.

SUPPLEMENTAL SCHEDULES OF INVESTMENT INFORMATION

(See Independent Auditors' Report)

PINNACOL ASSURANCE

Supplemental Schedule of Investment Information
Investment Risks Interrogatories

Year ended December 31, 2018

(In thousands)

1. Pinnacol's total admitted assets as reported on page 2 of its annual statement are: $ 2,872,602
2. The following are the ten largest exposures to a single issuer/borrower/investment by investment category, excluding: (i) U.S. government securities, U.S. government agency securities, and those U.S. government money market funds listed in the Appendix to the *Purposes and Procedures Manual of the NAIC Securities Valuation Office (SVO)* as exempt, (ii) property occupied by Pinnacol, (iii) policy loans, and (iv) asset types that are investment companies (mutual funds) and common trust funds that are diversified within the meaning of the Investment Company Act of 1940 (Section 5(b) (1)).

	Issuer	Description of exposure	Amount	Percentage of total admitted assets
2.01	FNMA POOLS	LONG TERM BONDS	$ 241,498	8.407%
2.02	FHLMC	LONG TERM BONDS, COMMON STOCK	81,554	2.839
2.03	FREDDIE MAC	LONG TERM BONDS, COMMON STOCK	29,447	1.025
2.04	FANNIE MAE	LONG TERM BONDS	17,662	0.615
2.05	GUGGENHEIM PRIVATE DEBT FUND NOTE ISSUER 2.0, LLC	OTHER LONG-TERM ASSETS, LONG TERM BONDS	20,554	0.716
2.06	FGLMC POOLS	LONG TERM BONDS	13,890	0.484
2.07	PETROLEOS MEXICANOS	LONG TERM BONDS, COMMON STOCK	12,238	0.426
2.08	ALPHABET INC	LONG TERM BONDS, COMMON STOCK	11,950	0.416
2.09	WELLS FARGO	LONG TERM BONDS, COMMON STOCK	11,646	0.405
2.10	CAKE INSURE, INC	OTHER LONG-TERM ASSETS, PREFERRED STOCK	11,571	0.403

3. Pinnacol's total admitted assets held in bonds and preferred stocks by NAIC designation are:

NAIC Designation	Amount	Percentage of total admitted assets
Bonds:		
NAIC-1	$ 1,488,257	51.809%
NAIC-2	462,844	16.112
NAIC-3	81,301	2.830
NAIC-4	89,590	3.119
NAIC-5	16,722	0.582
NAIC-6	845	0.029
Preferred stocks:		
P/RP-1		—
P/RP-2		—
P/RP-3	319	0.011
P/RP-4	23	0.001
P/RP-5	7,571	0.264
P/RP-6	11	0.000
	$ 2,147,483	

4. Assets held in foreign investments are $284,057 and assets held in foreign-currency-denominated investments are $0, which is approximately 9.9% and 0.000% of Pinnacol's total admitted assets, respectively.

5. The following represents aggregate foreign investment exposure categorized by NAIC sovereign designation:

Foreign investment assets

NAIC Designation	Amount	Percentage of total admitted assets
Countries designated NAIC-1	$ 244,548	8.513%
Countries designated NAIC-2	32,344	1.126
Countries designated NAIC-3 or below	7,165	0.249
	$ 284,057	

(Continued)

PINNACOL ASSURANCE

Supplemental Schedule of Investment Information
Investment Risks Interrogatories

Year ended December 31, 2018

(In thousands)

6. The following represents the largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

Foreign investment assets

NAIC Designation	Country	Amount	Percentage of total admitted assets
Countries designated NAIC-1:			
Country 1:	CAYMAN ISLANDS	$ 66,657	2.320%
Country 2:	AUSTRALIA	31,520	1.097
Countries designated NAIC-2:			
Country 1:	MEXICO	22,533	0.784
Country 2:	INDONESIA	3,503	0.122
Countries designated NAIC-3 or below:			
Country 1:	BRITISH VIRGIN ISLANDS	6,993	0.243
Country 2:	BARBADOS	96	0.003
		$ 131,302	

7. Aggregate unhedged foreign currency exposure is $0, which is approximately 0.000% of Pinnacol's total admitted assets.

8. The following represents aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

Foreign-Currency-Denominated investment assets

NAIC Designation	Amount	Percentage of total admitted assets
Countries designated NAIC-1	$ —	—%
Countries designated NAIC-2	—	—
Countries designated NAIC-3 or below	—	—
	$ —	

9. The following represents the largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

Foreign-Currency-Denominated investment assets

NAIC Designation	Country	Amount	Percentage of total admitted assets
Countries designated NAIC-1:			
Country 1:		$ —	—%
Country 2:		—	—
Countries designated NAIC-2:			
Country 1:		—	—
Country 2:		—	—
Countries designated NAIC-3 or below:			
Country 1:		—	—
Country 2:		—	—
		$ —	

10. The following represents the ten largest nonsovereign (i.e., nongovernmental) foreign issues:

Issuer	NAIC Designation	Amount	Percentage of total admitted assets
10.01 PETROLEOS MEXICANOS	2	$ 12,238	0.426%
10.02 UBS AG STAMFORD CT	1	10,905	0.380
10.03 BNP PARIBAS SA	1	10,766	0.375
10.04 ACTAVIS FUNDING SCS	2	8,803	0.306
10.05 MACQUARIE GROUP LTD	1	8,593	0.299
10.06 JOHNSON CONTROLS INTL PL	2	8,535	0.297
10.07 CREDIT SUISSE GROUP AG	2	8,518	0.297
10.08 SCENTRE GROUP TRUST	1	7,030	0.245
10.09 SINOPEC GRP OVERSEA 2015	1	6,969	0.243
10.10 PETRONAS CAPITAL LTD	1	6,964	0.242

See accompanying independent auditors' report.

(Continued)

PINNACOL ASSURANCE

Supplemental Schedule of Investment Information
Investment Risks Interrogatories

Year ended December 31, 2018

(In thousands)

11. Assets held in Canadian investments are less than 2.5% of Pinnacol's total admitted assets.
12. Amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01	Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets?		Yes [ ]	No [X]
12.02	Aggregate statement value of investments held in investments with contractual sales restrictions	$	88,944	3.096%
	Largest three investments held in investments with contractual sales restrictions:			
12.03	GCM GROSVENOR OPPORTUNISTIC CREDIT FUND IV, LTD	$	10,139	0.353%
12.04	NB PINNACOL ASSURANCE FUND LP		9,910	0.345
12.05	ENTRUST SPECIAL OPPORTUNITIES FUND III LTD		9,603	0.334

13. The following are the ten largest equity interests (including investments in the shares of mutual funds, preferred stocks, publicly traded equity securities, and other securities and excluding money market and bond mutual funds listed in the Appendix to the Purposes and Procedures Manual of the NAIC Securities Valuation Office (SVO) as exempt or Class 1):

	Issuer		Amount	Percentage of total admitted assets
13.01	HARDING LOEVNER INTERNATIONAL EQUITY FUND & EMERGING MARKETS FUND	$	46,787	1.629%
13.02	BLACKROCK EQUITY INDEX FUND B CTF		39,673	1.381
13.03	WESTWOOD INCOME OPPORTUNITY FUND		37,056	1.290
13.04	VANGUARD INST INDEX FUND		34,558	1.203
13.05	DODGE & COX INTERNATIONAL STOCK FUND		30,202	1.051
13.06	T. ROWE PRICE INSTITUTIONAL SMALL-CAP STOCK FUND		29,185	1.016
13.07	GMO BENCHMARK-FREE ALLOCATION FUND-III		25,560	0.890
13.08	FRANKLIN INTERNATIONAL GROWTH FUND		21,941	0.764
13.09	FIRST EAGLE OVERSEAS FUND		19,916	0.693
13.10	MORGAN STANLEY INSTITUTIONAL FUND		17,641	0.614

Items 14 through 23 are not applicable.

See accompanying independent auditors' report.

PINNACOL ASSURANCE

Supplemental Schedule of Investment Information
Summary Investment Schedule

December 31, 2018

(In thousands)

Investment categories	Gross investment holdings* Amount	Gross investment holdings* Percentage of gross investment holdings	Admitted assets as reported in the annual statement Amount	Admitted assets as reported in the annual statement Percentage of total admitted assets
Bonds:				
U.S. Treasury securities	$ 99,068	3.6%	$ 99,068	3.6%
U.S. government agency obligations (excluding mortgage-backed securities):				
– Issued by U.S. government agencies		—		—
– Issued by U.S. government-sponsored agencies		—		—
Non U.S. government (including Canada, excluding mortgage-backed securities)	15,973	0.6	15,973	0.6
Securities issued by states, territories, and possessions and political subdivisions in the U.S.:				
– States, territories, and possessions general obligations		—		—
– Political subdivisions of states, territories, and possessions and political general obligations	11,247	0.4	11,247	0.4
– Revenue and assessment obligations	49,939	1.8	49,939	1.8
– Industrial development and similar obligations		—		—
Mortgage-backed securities (includes residential and commercial MBS):				
Pass-through securities:				
– Issued or guaranteed by GNMA	2,546	0.1	2,546	0.1
– Issued or guaranteed by FNMA and FHLMC	349,484	12.6	349,484	12.6
– All other		—		—
CMOs and REMICs:				
– Issued or guaranteed by GNMA, FNMA, FHLMC, or VA	36,757	1.3	36,757	1.3
– Issued by non-U.S. government issuers and collateralized by mortgage-based securities issued by above		—		—
– All other	83,477	3.0	83,477	3.0
Other debt and other fixed income securities (excluding short term):				
– Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	1,187,144	42.6	1,187,144	42.6
– Unaffiliated non-U.S. securities (including Canada)	293,962	10.6	293,962	10.6
– Affiliated securities		—		—
Equity interests:				
– Investments in mutual funds	280,358	10.1	280,358	10.1
Preferred stocks:				
– Affiliated	7,571	0.3	7,571	0.3
– Unaffiliated	353	0.0	353	0.0
Publicly traded equity securities (excluding preferred stocks):				
– Affiliated		—		—
– Unaffiliated	110,891	4.0	110,891	4.0
Other equity securities:				
– Affiliated		—		—
– Unaffiliated	56,108	2.0	56,108	2.0
Other equity interests including tangible personal property under lease:				
– Affiliated		—		—
– Unaffiliated		—		—

(Continued)

PINNACOL ASSURANCE

Supplemental Schedule of Investment Information
Summary Investment Schedule

December 31, 2018

(In thousands)

Investment categories	Gross investment holdings* Amount	Gross investment holdings* Percentage of gross investment holdings	Admitted assets as reported in the annual statement Amount	Admitted assets as reported in the annual statement Percentage of total admitted assets
Mortgage loans:				
– Construction and land development	$	—%	$	—%
– Agricultural		—		—
– Single-family residential properties		—		—
– Multifamily residential properties	8,903	0.3	8,903	0.3
– Commercial loans	6,121	0.2	6,121	0.2
– Mezzanine real estate loans		—		—
Real estate investments:				
– Property occupied by Company	15,984	0.6	15,984	0.6
– Property held for production of income		—		—
– Property held for sale		—		—
Contract loans		—		—
Derivatives		—		—
Receivables for securities	1,317	0.0	1,317	0.0
Securities lending		—		—
Cash, cash equivalents, and short-term investments	73,492	2.6	73,492	2.6
Other invested assets	92,944	3.3	92,944	3.3
Total invested assets	$ 2,783,639	100.0%	$ 2,783,639	100.0%

* Gross investment holdings as valued in compliance with NAIC *Accounting Practices and Procedures Manual*.

Note: Reinsurance Interrogatories are excluded as they are not applicable.

See accompanying independent auditors' report.

KPMG LLP
Suite 800
1225 17th Street
Denver, CO 80202-5598

Independent Auditors' Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

The Members of the Legislative Audit Committee and
Pinnacol Assurance Board of Directors:

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, the financial statements of Pinnacol Assurance, which comprise the statutory statements of admitted assets, liabilities, and policyholders' surplus as of December 31, 2018, and the related statutory statements of operations and changes in policyholders' surplus and cash flow for the year then ended, and the related notes to the statutory financial statements, and have issued our report thereon dated May 22, 2018. Our report on the financial statements includes an adverse opinion on U.S. generally accepted accounting principles because the financial statements are prepared using statutory accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado, which is a basis of accounting other than U.S. generally accepted accounting principles. Our report on the financial statements also includes an unmodified opinion on the financial statements in accordance with statutory accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado, which is a basis of accounting other than U.S. generally accepted accounting principles.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered Pinnacol Assurance's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Pinnacol Assurance's internal control. Accordingly, we do not express an opinion on the effectiveness of Pinnacol Assurance's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

KPMG

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Pinnacol Assurance's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Pinnacol Assurance's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Pinnacol Assurance's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

KPMG LLP

Denver, Colorado
May 22, 2019

KPMG LLP
Suite 800
1225 17th Street
Denver, CO 80202-5598

The Members of the Legislative Audit Committee and
Risk and Audit Committee of the Board of Directors
Pinnacol Assurance
Denver, Colorado

Ladies and Gentlemen:

We have audited the financial statements prepared in accordance with statutory accounting principles prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado of Pinnacol Assurance (the Company) as of December 31, 2018 and 2017 and for each of the years then ended, and expect to issue our report thereon under date of May 22, 2019. Under our professional standards, we are providing you with the accompanying information related to the conduct of our audits.

Our Responsibility under Professional Standards

We are responsible for forming and expressing an opinion about whether the financial statements, that have been prepared by management with the oversight of the Pinnacol Assurance Risk and Audit Committee of the Board of Directors (Pinnacol Risk and Audit Committee), are presented fairly, in all material respects, using accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado, which practices differ from U.S. generally accepted accounting principles. We have a responsibility to perform our audit of the financial statements in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial statement audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. In carrying out this responsibility, we planned and performed the audit to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether caused by error or fraud. Because of the nature of audit evidence and the characteristics of fraud, we are to obtain reasonable, not absolute, assurance that material misstatements are detected. We have no responsibility to plan and perform the audit to obtain reasonable assurance that misstatements, whether caused by error or fraud, that are not material to the financial statements are detected. Our audit does not relieve management or the Pinnacol Risk and Audit Committee of their responsibilities.

In addition, in planning and performing our audit of the financial statements, we considered internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control.

We also have a responsibility to communicate significant matters related to the financial statement audit that are, in our professional judgment, relevant to the responsibilities of the Pinnacol Risk and Audit Committee in overseeing the financial reporting process. We are not required to design procedures for the purpose of identifying other matters to communicate to you.

Other Information in Documents Containing Audited Statutory Financial Statements

Our responsibility for other information in documents containing the Company's financial statements and our auditors' report thereon does not extend beyond the financial information identified in our auditors' report, and we have no obligation to perform any procedures to corroborate other information contained in these documents.

The Members of the Legislative Audit Committee and
Risk and Audit Committee of the Board of Directors
Pinnacol Assurance

Accounting Practices and Alternative Treatments

Significant Accounting Policies

The significant accounting policies used by the Company are described in note 1 to the financial statements.

Unusual Transactions

There have been no unusual transactions that we are aware of that need to be disclosed to you.

Qualitative Aspects of Statutory Accounting Practices

We have discussed with the Pinnacol Assurance Risk and Audit Committee and management our judgments about the quality, not just the acceptability, of the Company's statutory accounting principles as applied in its financial reporting. The discussions generally included such matters as the consistency of the Company's statutory accounting policies and their application, and the understandability and completeness of the Company's financial statements, which include related disclosures.

Management Judgments and Accounting Estimates

The preparation of the financial statements requires management of the Company to make a number of estimates and assumptions relating to the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the period. Those judgments are ordinarily based on knowledge and experience about past and current events and on assumptions about future events. Significant accounting estimates reflected in the Company's 2018 statutory basis financial statements include the following:

Reserve for Unpaid Losses and Loss Adjustment Expenses is based on an analysis of historical paid and incurred claims. To assist management in estimating the liability for unpaid losses and loss adjustment expenses, Pinnacol retains the assistance of an actuarial consulting firm. We evaluated the key factors and assumptions used to develop the reserve for unpaid losses and loss adjustment expenses, including possible management bias in developing the estimate, in determining that the reserve for unpaid losses and loss adjustment expenses is reasonable in relation to the financial statements as a whole.

Structured Settlement Liability is based on mortality risk and is discounted using a market rate. Pinnacol discounts internal structured settlement liabilities on a tabular basis using a discount rate of 2.5% for 2018. The discount rate is based on an estimate of expected investment yield and considers the risk of adverse deviation in the future from such yield. To assist management in estimating the internal structured settlement liability, Pinnacol retains the assistance of an actuarial consulting firm. We evaluated key factors and assumptions used to develop the structured settlement liability, including possible management bias in developing the estimate, in determining that the structured settlement liability is reasonable in relation to the financial statements as a whole.

Earned but Unbilled Premiums Asset is based on an analysis of internal calculations using historical premium data, including audit premium data. We evaluated key factors and assumptions used to develop the earned but unbilled premiums asset, including possible management bias in developing the estimate, in determining that the earned but unbilled premiums asset is reasonable in relation to the financial statements as a whole.

KPMG

The Members of the Legislative Audit Committee and
Risk and Audit Committee of the Board of Directors
Pinnacol Assurance

Uncorrected and Corrected Misstatements

Uncorrected Misstatements

In connection with our audit of the Company's financial statements, we have not identified any significant financial statement misstatements that have not been corrected in the Company's books and records as of and for the year ended December 31, 2018 and have communicated that finding to management.

Disagreements with Management

There were no disagreements with management on financial accounting and reporting matters that would have caused a modification of our auditors' reports on the Company's statutory financial statements.

Management's Consultation with Other Accountants

To the best of our knowledge, management has not consulted with or obtained opinions, written or oral, from other independent accountants during the year ended December 31, 2018.

Significant Issues Discussed, or Subject to Correspondence, with Management

Major Issues Discussed with Management prior to Retention

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with the Pinnacol Risk and Audit Committee and management each year prior to our retention by the Legislative Audit Committee as the Company's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Immaterial Correction of an Error

Management recorded an immaterial correction of an error as described in note 1 to the financial statements. Management identified an error in the methodology used to calculate the earned but unbilled premiums estimate. During 2018, management corrected the methodology by using earned premium rather than written premium as the basis for the calculation. As of December 31, 2017, surplus was overstated by $10,890,000 and the receivable for EBUB premiums was overstated by $10,890,000. The adjustment is immaterial to Pinnacol's surplus as of December 31, 2018 and 2017 and was appropriately corrected through surplus in 2018.

Material Written Communications

The following material written communications between management and us have been provided:

1. Internal legal letter
2. Management representation letter

Significant Difficulties Encountered during the Audit

We encountered no significant difficulties in dealing with management in performing our audit.

Independence

We are not aware of any additional relationships between our firm and the Company and persons in a financial reporting oversight role at the Company that may reasonably be thought to bear on independence.

KPMG

The Members of the Legislative Audit Committee and
Risk and Audit Committee of the Board of Directors
Pinnacol Assurance

Confirmation of Audit Independence

We hereby confirm that as of May 22, 2019, we are independent accountants with respect to the Company under all relevant professional and regulatory standards.

* * * * * * *

This letter to the Legislative Audit Committee and Pinnacol Risk and Audit Committee of the Board of Directors is intended solely for the information and use of the Legislative Audit Committee, Pinnacol Risk and Audit Committee of the Board of Directors and management and is not intended to be and should not be used by anyone other than these specified parties. However, upon release by the Legislative Audit Committee, the report is a public document.

Very truly yours,

KPMG LLP

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

7 CCR 1101-3
WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 16 UTILIZATION STANDARDS

16-1 STATEMENT OF PURPOSE

In an effort to comply with the legislative charge to assure the quick and efficient delivery of medical benefits at a reasonable cost, the Director (Director) of the Division of Workers' Compensation (Division) has promulgated these utilization standards, effective January 1, 2020. This Rule defines the standard terminology, administrative procedures, and dispute resolution procedures required to implement the Division's Medical Treatment Guidelines and Medical Fee Schedule.

16-2 STANDARD TERMINOLOGY FOR RULES 16, 17, AND 18

(A) Ambulatory Surgical Center (ASC) – licensed as an ambulatory surgery center by the Colorado Department of Public Health and Environment.

(B) Authorized Treating Provider (ATP) – may be any of the following:

(1) The treating physician designated by the employer and selected by the injured worker;

(2) A health care provider to whom an authorized treating physician refers the injured worker for treatment, consultation, or impairment rating;

(3) A physician selected by the injured worker when the injured worker has the right to select a provider;

(4) A physician authorized by the employer when the employer has the right or obligation to make such an authorization;

(5) A health care provider determined by the Director or an administrative law judge to be an ATP;

(6) A provider who is designated by the agreement of the injured worker and the payer.

(C) Billed Service(s) – any billed service, procedure, equipment, or supply provided to an injured worker by a provider.

(D) Billing Party – a service provider or an injured worker who has incurred authorized medical costs.

(E) Certified Medical Interpreter - certified by the Certification Commission for Healthcare Interpreters or the National Board of Certification for Medical Interpreters.

(F) Children’s Hospital – federally qualified, and certified by the Colorado Department of Public Health and Environment.

(G) Convalescent Center – licensed by the Colorado Department of Public Health and Environment.

(H) Critical Access Hospital (CAH) – federally qualified, and certified by the Colorado Department of Public Health and Environment.

(I) Day – defined as a calendar day unless otherwise noted. In computing any period of time prescribed or allowed by Rules 16 or 18, the parties shall refer to Rule 1-2.

(J) Free-Standing Facility – an entity that furnishes healthcare services and is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or provider–based entity.

(K) Hospital – licensed by the Colorado Department of Public Health and Environment.

(L) Long-Term Care Facility –federally qualified, and certified by the Colorado Department of Public Health and Environment.

(M) Medical Fee Schedule – Division's Rule 18, its exhibits, and the documents incorporated by reference in that Rule.

(N) Medical Treatment Guidelines – the medical treatment guidelines as incorporated into Rule 17.

(O) Over-the-Counter Drugs – medications that are available for purchase by the general public without a prescription.

(P) Payer – an insurer, self-insured employer, or designated agent(s) responsible for payment of medical expenses. Use of agents, including but not limited to Preferred Provider Organizations (PPO) networks, bill review companies, Third Party Administrators (TPAs), and case management companies, shall not relieve the self-insured employer or insurer from their legal responsibilities for compliance with these Rules.

(Q) Prior Authorization – assurance that appropriate reimbursement for a specific treatment will be paid in accordance with Rule 18, its exhibits, and the documents incorporated by reference in that Rule.

(R) Provider – a person or entity providing authorized health care service, whether involving treatment or not, to a worker in connection with work-related injury or occupational disease.

(S) Psychiatric Hospital – licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

(T) Rehabilitation Hospital Facility – licensed as a rehabilitation hospital by the Colorado Department of Public Health and Environment.

(U) Rural Health Clinic Facility – federally qualified, and certified by the Colorado Department of Public Health and Environment.

(V) Skilled Nursing Facility (SNF) – licensed as a skilled nursing facility by the Colorado Department of Public Health and Environment.

(W) Telemedicine – two-way, real time interactive communication between the injured worker, and the provider at the distant site. This electronic communication involves, at minimum, audio and video telecommunications equipment. Telemedicine enables the remote diagnoses and evaluation of injured workers in addition to the ability to detect fluctuations in their medical condition(s) at a remote site in such a way as to confirm or alter the treatment plan, including medications and/or specialized therapy.

(X) Veterans' Administration Medical Facilities – all medical facilities overseen by the United States Department of Veterans' Affairs.

16-3 RECOGNIZED HEALTH CARE PROVIDERS

(A) Physician and Non-Physician Providers

(1) For the purpose of this Rule, recognized health care providers are divided into the major categories of "physician" and "non-physician." Recognized providers are defined as follows:

(a) "Physician providers" are those individuals who are licensed by the State of Colorado through one of the following boards:

(i) Colorado Medical Board;
(ii) Colorado Dental Board;
(iii) Colorado Podiatry Board;
(iv) Colorado Optometry Board, or
(v) Colorado Board of Chiropractic Examiners;

Only physicians licensed by the Colorado Medical Board may be included as individual physicians on the employer's or insurer's designated provider list required under § 8-43-404(5)(a)(I).

(b) "Non-physician providers" are those individuals who are registered, certified, or licensed by the Colorado Department of Regulatory Agencies (DORA), the Colorado Secretary of State, or a national entity recognized by the State of Colorado as follows:

(i) Acupuncturist (LAc) – licensed by the Office of Acupuncture Licensure, Colorado Department of Regulatory Agencies;

(ii) Advanced Practice Nurse (APN) – licensed by the Colorado Board of Nursing; Advanced Practice Nurse Registry;

(iii) Anesthesiologist Assistant (AA) – licensed by the Colorado Medical Board, Colorado Department of Regulatory Agencies;

(iv) Athletic Trainers (ATC) –licensed by the Colorado Department of Regulatory Agencies;

(v) Audiologist (AU.D. CCC-A) – licensed by the Office of Audiology and Hearing Aid Provider Licensure, Colorado Department of Regulatory Agencies;

(vi) Certified Registered Nurse Anesthetist (CRNA) – licensed by the Colorado Board of Nursing;

(vii) Clinical Social Worker (LCSW) – licensed by the Board of Social Work Examiners, Colorado Department of Regulatory Agencies;

(viii) Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) Supplier – licensed by the Colorado Secretary of State;

(ix) Marriage and Family Therapist (LMFT) – licensed by the Board of Marriage and Family Therapist Examiners, Colorado Department of Regulatory Agencies;

(x) Massage Therapist (MT) – licensed as a massage therapist by the Office of Massage Therapy Licensure, Colorado Department of Regulatory Agencies.

(xi) Nurse Practitioner (NP) – licensed as an APN and authorized by the Colorado Board of Nursing;

(xii) Occupational Therapist (OTR) – licensed by the Office of Occupational Therapy, Colorado Department of Regulatory Agencies;

(xiii) Occupational Therapist Assistant (OTA) – licensed by the Office of Occupational Therapy, Colorado Department of Regulatory Agencies;

(xiv) Orthopedic Technologist (OTC) – certified by the National Board for Certification of Orthopedic Technologists;

(xv) Pharmacist – licensed by the Board of Pharmacy, Colorado Department of Regulatory Agencies;

(xvi) Physical Therapist (PT) – licensed by the Physical Therapy Board, Colorado Department of Regulatory Agencies;

(xvii) Physical Therapist Assistant (PTA) –certified by the Physical Therapy Board, Colorado Department of Regulatory Agencies;

(xviii) Physician Assistant (PA) – licensed by the Colorado Medical Board;

(xix) Practical Nurse (LPN) – licensed by the Colorado Board of Nursing;

(xx) Professional Counselor (LPC) – licensed by the Board of Professional Counselor Examiners, Colorado Department of Regulatory Agencies;

(xxi) Psychologist (PsyD, PhD, EdD) – licensed by the Board of Psychologist Examiners, Colorado Department of Regulatory Agencies;

(xxii) Registered Nurse (RN) – licensed by the Colorado Board of Nursing;

(xxiii) Respiratory Therapist (RTL) – certified by the National Board of Respiratory Care and licensed by the Office of Respiratory Therapy Licensure, Colorado Department of Regulatory Agencies;

(xxiv) Speech Language Pathologist (CCC-SLP) – certified by the Office of Speech-Language Pathology Certification, Colorado Department of Regulatory Agencies; and

(2) Upon request, health care providers must provide copies of license, registration, certification, or evidence of health care training for billed services.

(3) Any provider not listed in section 16-3(A)(1)(a) or (b) must comply with section 16-6, Prior Authorization when providing all services.

(4) Referrals:

(a) A payer or employer shall not redirect or alter the scope of a referral to another provider for treatment or evaluation of a compensable injury. Any party who has concerns regarding a referral or its scope shall advise the other parties and providers involved.

(b) All non-physician providers must have a referral from a physician provider managing the claim (or NP/PA working under that physician provider). A physician making the referral to any listed or unlisted non-physician provider shall, upon request of any party, answer any questions and clarify the scope of the referral, prescription, or the reasonableness or necessity of the care.

(5) Use of PAs and NPs in Colorado Workers' Compensation Claims:

(a) All Colorado workers' compensation claims (medical only or lost time claims) shall have an "authorized treating physician" responsible for all services rendered to an injured worker by any PA or NP.

(b) For services performed by an NP or a PA, the authorized treating physician must counter-sign patient records related to the injured worker's inability to work resulting from the claimed work injury or disease, and the injured worker's ability to return to regular or modified employment, as required by §§ 8-42-105(2)(b) and (3). The authorized treating physician also must counter-sign Form WC 164. The signature of the physician provider shall serve as a certification that all requirements of this rule have been met.

(c) The authorized treating physician must evaluate the injured worker within the first three visits to the physician's office.

(A) Out-of-State Provider

(1) Relocated Injured Worker

(a) Upon receipt of the "Employer's First Report of Injury" or the "Worker's Claim for Compensation" form, the payer shall notify the injured worker that the procedures for change of provider, should s/he relocate out-of-state, can be obtained from the payer.

(b) A change of provider must be made:

(i) Through referral by the injured worker's authorized treating physician; or

(ii) In accordance with § 8-43-404(5)(a).

(2) Referred Injured Worker

In the event an injured worker has not relocated out-of-state but is referred to an out-of-state provider for treatment or services not available within Colorado, the

referring provider shall obtain prior authorization from the payer as set forth in section 16-6. The referring provider's written request for out-of-state treatment shall include the following information:

(a) Medical justification prepared by the referring provider;

(b) Written explanation as to why the requested treatment/services cannot be obtained within Colorado;

(c) Name, complete mailing address and telephone number of the out-of-state provider;

(d) Description of the treatment/services requested, including the estimated length of time and frequency of the treatment/service, and all associated medical expenses; and

(e) Out-of-state provider's qualifications to provide the requested treatment or services.

16-4 REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES

When an injury or occupational disease falls within the purview of Rule 17, Medical Treatment Guidelines and the date of injury occurs on or after July 1, 1991, providers and payers shall use the medical treatment guidelines, in effect at the time of service, to prepare or review their treatment plan(s) for the injured worker. A payer may not dictate the type or duration of medical treatment or rely on its' own internal guidelines or other standards for medical determination. Initial recommendations for a treatment or modality should not exceed the time to produce functional effect parameters in the applicable Medical Treatment Guidelines. When treatment exceeds or is outside of the Medical Treatment Guidelines, prior authorization is required. Requesters and reviewers should consider how their decision will affect the overall treatment plan for the individual patient. In all instances of denial, appropriate processes to deny are required.

16-5 NOTIFICATION

(A) The Notification process is for treatment consistent with the Medical Treatment Guidelines that has an established value under the Medical Fee Schedule. Providers may, but are not required to, utilize the Notification process to ensure payment for medical treatment that falls within the purview of the Medical Treatment Guidelines. Therefore, lack of response from the payer within the time requirement set forth in section 16-5(D) shall deem the proposed treatment/service authorized for payment.

(B) Notification may be made by phone, during regular business hours.

(1) Providers can accept verbal confirmation; or

(2) Providers may request written confirmation of an approval, which the payer should provide upon request.

(C) Notification may be submitted using the "Authorized Treating Provider's Notification to Treat" (Form WC 195). The completed form shall include:

(1) Provider's certification that the proposed treatment/service is medically necessary and consistent with the Medical Treatment Guidelines.

(2) Documentation of the specific Medical Treatment Guideline(s) applicable to the proposed treatment/service.

(3) Provider's email address or fax number to which the payer can respond.

(D) Payers shall respond to a Notification submission within five (5) business days from receipt of the request with an approval or a denial of the proposed treatment.

(1) The payer may limit its approval to the number of treatments or treatment duration specified in the relevant Medical Treatment Guideline(s), without a medical review. If subsequent medical records document functional progress, additional treatment should be approved.

(2) If payer proposes to discontinue treatment before the maximum number of treatments/treatment duration has been reached due to lack of functional progress, payer shall support that decision with a medical review compliant with section 16-7(B).

(E) Payers may deny the proposed treatment only for the following reasons:

(1) For claims which have been reported to the Division, no admission of liability or final order finding the injury compensable has been issued:

(2) Proposed treatment is not related to the admitted injury;

(3) Provider submitting Notification is not an ATP, or is proposing for treatment to be performed by a provider who is not eligible to be an ATP;

(4) Injured worker is not entitled to proposed treatment pursuant to statute or settlement;

(5) Medical records contain conflicting opinions among the ATPs regarding proposed treatment;

(6) Proposed treatment falls outside the Medical Treatment Guidelines.

(F) If the payer denies Notification under sections 16-5(E)(2), (5) or (6) above, the payer shall notify the provider, allow the submission of relevant supporting medical documentation as defined in section 16-6(E), and review the submission as a prior authorization request, allowing an additional seven (7) business days for review.

(G) Appeals for denied Notification by a provider shall be made in accordance with the prior authorization appeals process outlined in 16-7(C).

(H) Any provider or payer who incorrectly applies the Medical Treatment Guidelines in the Notification process may be subject to penalties under the Workers' Compensation Act.

16-6 PRIOR AUTHORIZATION

(A) Granting of prior authorization is a guarantee of payment in accordance with Rule 18, RBRVS, and CPT® for the services/procedures requested by the provider pursuant to section 16-6(E). Prior authorization may be requested using the "Authorized Treating Provider's Request for Prior Authorization" (Form WC 188) or, in the alternative, shall be clearly labeled as a prior authorization request.

(B) Prior authorization for payment shall only be requested by the provider when:

(1) A prescribed service exceeds the recommended limitations set forth in the Medical Treatment Guidelines;

(2) The Medical Treatment Guidelines otherwise require prior authorization for that specific service;

(3) A prescribed service is identified within the Medical Fee Schedule as requiring prior authorization for payment; or

(4) A prescribed service is not identified in the Medical Fee Schedule as referenced in section 16-8(C).

(C) Prior authorization for a prescribed service or procedure may be granted immediately and without a medical review. However, the payer shall respond to all prior authorization requests in writing within seven (7) business days from receipt of the provider's completed request, as defined in section 16-6(E). The duty to respond to a provider's request applies regardless of who transmitted the request.

(D) The payer, unless it has previously notified said provider, shall give notice to the provider of these procedures for obtaining prior authorization for payment upon receipt of the initial bill from that provider.

(E) To complete a prior authorization request, the provider shall concurrently explain the reasonableness and the medical necessity of the services requested, and shall provide relevant supporting medical documentation. Supporting medical documentation is defined as documents used in the provider's decision-making process to substantiate the need for the requested service or procedure. The following documentation is required:

(1) An adequate definition or description of the nature, extent, and necessity for the procedure;

(2) Identification of the appropriate Medical Treatment Guideline, if applicable; and

(3) Final diagnosis.

(F) The Division recommends payers confirm in writing, to providers and all parties, when a request for prior authorization is approved.

(G) If, after the service was provided, the payer agrees the service was reasonable and necessary, lack of prior authorization does not warrant denial of payment. However, the provider is still required to provide, with the bill, the documentation required by section 16-6(E) for any unlisted service or procedure for payment.

16-7 DENIAL OF A REQUEST FOR PRIOR AUTHORIZATION

(A) If an ATP requests prior authorization and indicates in writing, including reasoning and relevant documentation, that he or she believes the requested treatment is related to the admitted workers' compensation claim, the insurer cannot deny solely for relatedness without a medical opinion as required by section 16-7(B). The medical review, IME report, or report from an ATP that addresses the relatedness of the requested treatment to the admitted claim may precede the prior authorization request, unless the requesting physician presents new evidence as to why this treatment is now related.

(B) The payer may deny a request for prior authorization for medical or non-medical reasons. Examples of non-medical reasons are listed in section 16-11(B)(1). If the payer is denying

a request for prior authorization for medical reasons, the payer shall, within seven (7) business days of the completed request:

(1) Have all the submitted documentation under section 16-6(E) reviewed by a "physician provider" as defined in section 16-3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physician providers performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review prior authorization requests for medications without having received Level I or Level II accreditation.

(2) After reviewing all the submitted documentation and other documentation referenced in the prior authorization request and available to the payer, the reviewing provider may call the requesting provider to expedite communication and processing of prior authorization requests. However, the written denial or approval still needs to be completed within the seven (7) business days specified under this section.

(3) Furnish the provider and the parties with a written denial that sets forth the following information:

(a) An explanation of the specific medical reasons for the denial, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion.

(b) The specific cite from the Medical Treatment Guidelines, when applicable;

(c) Identification of the information deemed most likely to influence the reconsideration of the denial when applicable; and

(d) Documentation of response to the provider and parties.

(C) Prior Authorization Appeals

(1) The requesting party or provider shall have seven (7) business days from the date of the written denial to provide a written response to the payer. The response is not considered a "special report" when prepared by the provider of the requested service.

(2) The payer shall have seven (7) business days from the date of the response to issue a final decision and provide documentation of that decision to the provider and parties.

(3) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(D) An urgent need for prior authorization of health care services, as recommended in writing by an ATP, shall be deemed good cause for an expedited hearing.

(E) Failure of the payer to timely comply in full with section 16-7(A), (B), or (C) shall be deemed authorization for payment of the requested treatment unless the payer has scheduled an independent medical examination (IME) and notified the requesting provider of the IME within the time prescribed for responding set forth in section 16-7(B).

(1) The IME must occur within 30 days, or upon first available appointment, of the prior authorization request, not to exceed 60 days absent an order extending the deadline.

(2) The IME physician must serve all parties concurrently with his or her report within 20 days of the IME.

(3) The insurer shall respond to the prior authorization request within five business days of the receipt of the IME report.

(4) If the injured worker does not attend or reschedules the IME, the payer may deny the prior authorization request pending completion of the IME.

(5) The IME shall comply with Rule 8 as applicable.

(F) Unreasonable delay or denial of prior authorization, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

16-8 REQUIRED USE OF THE FEE SCHEDULE

(A) All providers and payers shall use the Medical Fee Schedule to determine the maximum allowable payments for any medical treatments or services within the purview of the Workers' Compensation Act of Colorado and the Colorado Workers' Compensation Rules of Procedure, unless one of the following exceptions applies:

(1) If billed charges are less than the fee schedule, the payment shall not exceed the billed charges.

(2) The payer and an out-of-state provider may negotiate reimbursement in excess of the fee schedule when required to obtain reasonable and necessary care for an injured worker.

(3) Pursuant to § 8-67-112(3), the Uninsured Employer Board may negotiate rates of reimbursement for medical providers.

(B) The fee schedule does not limit the billing charges.

(C) Payment for billed services not identified or identified but without established value in the Medical Fee Schedule shall require prior authorization from the payer pursuant to section 16-6, except when the billed non-established valued service or procedure is an emergency or a payment mechanism under Rule 18 is identifiable, but not explicit. Examples of these exception(s) include ambulance bills or supply bills that are covered under Rule 18 with an identified payment mechanism. Similar established code values from the Medical Fee Schedule, recommended by the requesting physician, shall govern the maximum fee schedule payment.

16-9 REQUIRED BILLING FORMS, CODES, AND PROCEDURES

(A) Medical providers shall use only the billing forms listed below or their electronic reproductions. Any reproduction shall be an exact duplication of the form(s) in content and appearance. If the payer agrees, providers may place identifying information in the margin of the form. Payment for any services not billed on the forms identified in this

Rule may be denied. However, the payer shall comply with the applicable provisions set forth in section 16-11.

(1) CMS (Centers for Medicare & Medicaid Services) -1500 shall be used by all providers billing for professional services, durable medical equipment (DME) and ambulance services, with the exception of those providers billing for dental services or procedures. Health care providers shall provide their name and credentials in the appropriate box of the CMS-1500. Non-hospital based ASCs may bill on the CMS-1500, however an SG modifier must be appended to the technical component of services to indicate a facility charge and to qualify for reimbursement as a facility claim.

(2) UB-04 - shall be used by all hospitals, hospital-based ambulance/air services, Children's Hospitals, CAHs, Veterans' Administration Medical Facilities, home health and facilities meeting the definitions found in section 16-2, when billing for hospital services or any facility fees billed by any other provider, such as hospital-based ASCs.

(a) Some outpatient hospital therapy services (Physical, Occupational, or Speech) may also be billed on a UB-04. For these services, the UB-04 must have Form Locator Type 013x, 074x, 075x, or 085x, and one of the following revenue code(s):

- Revenue Code 042X Physical Therapy
- Revenue Code 043X Occupational Therapy
- Revenue Code 044X Speech/Language Therapy

(b) CAHs designated by Medicare or Exhibit # 3 to Rule 18 may use a UB-04 to bill professional services if the professional has reassigned his or her billing rights to the CAH using Medicare's Method II. The CAH shall list bill type 851-854, as well as one of the following revenue code(s) and Health Care Common Procedure Coding System (HCPCS) codes in the HCPCS Rates field number 44:

- 0960 - Professional Fee General
- 0961 - Psychiatric
- 0962 - Ophthalmology
- 0963 - Anesthesiologist (MD)
- 0964 - Anesthetist (CRNA)
- 0971 - Professional Fee For Laboratory
- 0972 - Professional Fee For Radiology Diagnostic
- 0973 – Professional Fee - Radiology - Therapeutic
- 0974 - Professional Fee - Radiology - Nuclear
- 0975 - Professional Fee - Operating Room
- 0981 - Emergency Room Physicians
- 0982 - Outpatient Services
- 0983 - Clinic
- 0985 - EKG Professional
- 0986 - EEG Professional
- 0987 - Hospital Visit Professional (MD/DO)
- 0988 - Consultation (Professional (MD/DO)

All professional services billed by a CAH are subject to the same coding and payment rules as professional services billed independently. The

following modifiers shall be appended to HCPCS codes to identify the type of provider rendering the professional service:

GF Services rendered in a CAH by a NP, clinical nurse specialist, certified registered nurse, or PA
SB Services rendered in a CAH by a nurse midwife
AH Services rendered in a CAH by a clinical psychologist
AE Services rendered in a CAH by a nutrition professional/registered dietitian
AQ Physician services in a physician-scarcity area

(c) No provider except those listed above shall bill for the professional fees using a UB-04.

(3) American Dental Association's Dental Claim Form, Version 2019 shall be used by all providers billing for dental services or procedures.

(4) With the agreement of the payer, the ANSI ASC X12 (American National Standards Institute Accredited Standards Committee) or NCPDP (National Council For Prescription Drug Programs) electronic billing transaction containing the same information as in (1), (2) or (3) in this subsection may be used.

Dispensing pharmacies and pharmacy benefit managers shall use NCPDP Workers' Compensation/Property and Casualty (P&C) universal claim form, version 1.1, for prescription drugs billed on paper. Physicians may use the CMS-1500 billing form as described in section 16-9(A)(1).

(5) Bills for services incident to medical services, such as language interpreting or injured worker mileage reimbursement, may be submitted by invoice or other agreed-upon form.

(B) International Classification of Diseases (ICD) Codes

All provider bills shall list the ICD-10 Clinical Modification (CM) diagnosis code(s) that are current, accurate, specific to each patient encounter, and preferably include the Chapter 20 External Causes of Morbidity code(s). If ICD-10-CM requires a seventh character, the provider must apply it in accordance with the ICD-10-CM Chapter Guidelines provided by the Centers for Medicare and Medicaid Services (CMS). The ICD-10-CM diagnosis codes shall not be used as a sole factor to establish work-relatedness of an injury or treatment.

(C) Providers must accurately report their services using applicable billing codes, modifiers, instructions, and parenthetical notes listed in the Medical Fee Schedule; the National Relative Value File, as published by Medicare in the April 2019 Resource Based Relative Value Scale (RBRVS); and the American Medical Association's Current Procedural Terminology (CPT®) 2019 edition. The provider may be subject to penalties for inaccurate billing when the provider knew or should have known that the services billed were inaccurate, as determined by the Director or an administrative law judge.

(D) National provider identification (NPI) numbers are required for workers' compensation bills; providers who cannot obtain NPI numbers are exempt from this requirement. When billing on a CMS-1500, the NPI shall be that of the rendering provider and shall include the correct place of service codes at the line level.

(E) Timely Filing

Providers shall submit their bills for services rendered within 120 days of the date of service or the bill may be denied unless extenuating circumstances exist. For claims submitted through electronic data interchange (EDI), providers may prove timely filing by showing a payer acknowledgement (claim accepted). Rejected claims or clearinghouse acknowledgment reports are not proof of timely filing. For paper claims, providers may prove timely filing with a signed certificate of mailing listing the original date mailed and the payer's address; a fax acknowledgment report; or certified mail receipt showing the date the payer received the claim. All timely filing issues will be considered final 10 months from date of service unless extenuating circumstances exist.

Injured workers shall submit requests for mileage reimbursement within 120 days of the date of service or reimbursement may be denied unless good cause exists.

Extenuating circumstances may include, but are not limited to, delays in compensability being decided or the provider has not been informed where to send the bill.

16-10 REQUIRED MEDICAL RECORD DOCUMENTATION

(A) The treating provider shall maintain medical records for each injured worker when billing for the provided services. The rendering provider shall sign the medical records. Electronic signatures are accepted.

(B) All medical records shall legibly document the services billed. The documentation shall itemize each contact with the injured worker. The documentation also shall detail at least the following information per contact or, if contact occurs more than once per week, detail at least once per week:

(1) Patient's name;

(2) Date of contact, office visit or treatment;

(3) Name and professional designation of person providing the billed service;

(4) Assessment or diagnosis of current condition with appropriate objective findings;

(5) Treatment status or patient's functional response to current treatment;

(6) Treatment plan including specific therapy with time limits and measurable goals and detail of referrals;

(7) Pain diagrams, where applicable;

(8) If being completed by an authorized treating physician, all pertinent changes to work and/or activity restrictions which reflect lifting, standing, stooping, kneeling, hot or cold environment, repetitive motion or other appropriate physical considerations; and

(9) All prior authorization(s) for payment received from the payer (i.e., who approved prior authorization, services authorized, dollar amount, length of time, etc.).

(C) All services provided to patients are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not made timely. In this event, the documentation will need to be amended, corrected, or entered after rendering the service. Amendments, corrections, and delayed entries must comply with Medicare's widely accepted recordkeeping principles as outlined in the April 2018 Medicare Program Integrity Manual Chapter 3, section 3.3.2.5. (This section does

not apply to patients' requests to amend records as permitted by the Health Insurance Portability and Accountability Act (HIPAA)).

(D) Authorized treating physicians must sign (or counter-sign) and submit to the payer, with their initial and final visit billings, a completed "Physician's Report of Workers' Compensation Injury" (Form WC 164) specifying:

(1) The report type as "initial" when the injured worker has his or her initial visit with the authorized treating physician managing the total workers' compensation claim (generally the designated or selected physician). If applicable, the emergency department (ED) or urgent care authorized treating physician for this workers' compensation injury also may create a Form WC 164 initial report. Unless requested or preauthorized by the payer to a specific workers' compensation claim, no other authorized physician should complete and bill for the initial Form WC 164. See Rule 18 for required fields.

(2) The report type as "closing" when the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim determines the injured worker has reached maximum medical improvement (MMI) for all covered injuries or diseases, with or without permanent impairment. See Rule 18 for required fields. If the injured worker has sustained a permanent impairment, item 10 also must be completed and the following information shall be attached to the bill at the time of MMI:

(a) All necessary permanent impairment rating reports, including a narrative report and appropriate worksheets, when the authorized treating physician managing the total workers' compensation claim of the patient is Level II Accredited; or

(b) Referral to a Level II Accredited physician requested to perform the permanent impairment rating when a rating is necessary and the authorized treating physician managing the total workers' compensation claim of the patient is not determining the permanent impairment rating.

(3) At no charge, the physician shall supply the injured worker with one legible copy of the completed Form WC 164 at the time the form is completed.

(4) The provider shall submit to the payer the completed Form WC 164 no later than 14 days from the date of service.

(E) Providers other than hospitals shall provide the payer with all supporting documentation at the time of billing unless the parties have made other agreements. This shall include copies of the examination, surgical, and/or treatment records. Hospitals shall provide documentation to the payer upon request. Payers shall specify what portion of a hospital record is being requested (for example, only the ED chart notes, in-patient physician orders and chart notes, x-rays, pathology reports, etc.).

(F) In accordance with section 16-11(B), the payer may deny payment for billed services until the provider submits the relevant required documentation.

16-11 PAYMENT OF MEDICAL BENEFITS

(A) Payer Requirements for Processing Medical Service Bills

(1) For every medical service bill submitted by a provider, the payer shall reply with a written notice or explanation of benefits (EOB). If the payer reimburses the exact

billed amount, identification of the patient's name, the payer, the paid bill, the amount paid and the dates of service are required. If any adjustments are made, the payer's written notice shall include:

(a) Name of the injured worker;

(b) Specific identifying information coordinating the notice with any payment instrument associated with the bill;

(c) Date(s) of service(s), if date(s) was (were) submitted on the bill;

(d) Payer's claim number and/or Division's workers' compensation claim number, if one has been created;

(e) Reference to the bill and each item of the bill;

(f) Notice that the billing party may submit corrected bill or appeal within 60 days;

(g) For compensable services related to a work-related injury or occupational disease the payer shall notify the billing provider that the injured worker shall not be balance-billed;

(h) Name of insurer with admitted, ordered or contested liability for the workers' compensation claim, when known;

(i) Name, address, e-mail (if any), phone number and fax of a person who has responsibility and authority to discuss and resolve disputes on the bill;

(j) Name and address of the employer, when known; and

(k) Name and address of the third party administrator (TPA) and name and address of the bill reviewer if separate company when known; and

(l) If applicable, a statement that the payment is being held in abeyance because a hearing is pending on a relevant issue.

(2) The payer shall send the billing party written notice that complies with sections 16-11(A)(1) and (B) or (C) within 30 days of receipt of the bill. Any notice that fails to include the required information is defective and does not satisfy the 30-day notice requirement set forth in this section.

(3) Unless the payer provides timely and proper reasons set forth by sections 16-11(B)-(D), all bills submitted by a provider are due and payable in accordance with the Medical Fee Schedule within 30 days after receipt by the payer.

(4) If the payer discounts a bill and the provider requests clarification in writing, the payer shall furnish to the requester the specifics of the discount within 30 days including a copy of any contract relied on for the discount. If no response is forthcoming within 30 days, the payer must pay the maximum Medical Fee Schedule allowance or the billed charges, whichever is less.

(5) Date of receipt of the bill may be established by the payer's date stamp or electronic acknowledgement date; otherwise, presumed receipt is presumed to

occur three (3) business days after the date the bill was mailed to the payer's correct address.

(6) Unreasonable delay in processing payment or denial of payment of medical service bills, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

(7) If the payer fails to make timely payment of uncontested billed services, the billing party may report the incident to the Division's Carrier Practices Unit to be used during an audit.

(8) Payers shall reimburse injured workers for mileage expenses as required by statute or provide written or electronic notice of the reasons for denying reimbursement within 30 days of receipt.

(B) Process for Denying Payment of Billed Services Based on Non-Medical Reasons

(1) Non-medical reasons are administrative issues. Examples of non-medical reasons for denying payment include the following: no claim has been filed with the payer; compensability has not been established; the provider is not authorized to treat; the insurance coverage is at issue; typographic, gender or date errors in the bill; failure to submit medical documentation; unrecognized CPT® code.

(2) If an ATP bills for medical services and indicates in writing, including reasoning and relevant documentation that he or she believes the medical services are related to the admitted WC claim, the payer cannot deny payment solely for relatedness without a medical opinion as required by section 16-11(C). The medical review, IME report, or report from an ATP that addresses the relatedness of the requested treatment to the admitted claim may precede the received billed service, unless the requesting physician presents new evidence as to why this treatment is now related.

(3) In all cases where a billed service is denied for non-medical reasons, the payer shall send the billing party written notice of the denial within 30 days of receipt of the bill. The written notice shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being denied, if submitted on the bill;

(b) If applicable, acknowledgement of specific paid items submitted on the same bill as denied services;

(c) Reference to the bill and each item of the bill being denied; and

(d) Clear and persuasive reasons for denying the payment of any item specific to that bill, including the citing of appropriate statutes, rules, and/or documents supporting the payer's reasons.

Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the 30-day notice requirement set forth in this section.

(4) Prior to modifying a billed code, the payer must contact the billing provider and determine if the code is accurate. If the payer disagrees with the level of care

billed, the payer may deny the claim or contact the provider to explain why the billed code does not meet the level of care criteria.

(a) If the billing provider agrees with the payer, then the payer shall process the service with the agreed upon code and shall document on the EOB the agreement with the provider. The EOB shall include the name of the person at the provider's office who made the agreement.

(b) If the provider disagrees, then the payer shall proceed according to section 16-11(B) or (C), as appropriate.

(5) If, after the service was provided, the payer agrees the service was reasonable and necessary, lack of prior authorization does not warrant denial of payment.

(6) When no established fee is given in the Medical Fee Schedule and the payer agrees the service or procedure is reasonable and necessary, the payer shall list on the EOB one of the following payment options:

(a) A reasonable value based upon the similar established code value recommended by the requesting provider, or

(b) The provider's requested payment based on an established similar code value.

If the payer disagrees with the provider's recommended code value, the denial shall include an explanation of why the requested fee is not reasonable, the code(s) used by the payer, and how the payer calculated/derived its maximum fee recommendation. If the payer is denying the medical necessity of any non-valued procedure after prior authorization was requested, the payer shall follow section 16-11(C).

(C) Process for Denying Payment of Billed Services Based on Medical Reasons

When denying payment of billed services based on medical reasons, the payer shall:

(1) Have the bill and all supporting medical documentation reviewed by a "physician provider" as defined in section 16-3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physician providers performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. After reviewing the supporting medical documentation, the reviewing provider may call the billing provider to expedite communication and timely processing of the medical bill.

(2) In all cases where a billed service is denied for medical reasons, the payer shall send the provider and the parties written notice of denial within 30 days of receipt of the bill. The written notice shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being denied, if submitted on the bill;

(b) If applicable, acknowledgement of specific paid items submitted on the same bill as denied services;

(c) Reference to the bill and each item of the bill being denied;

(d) Clear and persuasive medical reasons for the decision, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;

(e) The specific cite from the Medical Treatment Guidelines, when applicable; and

(f) Identification of the information deemed most likely to influence the reconsideration of the denial, when applicable.

(3) Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.

(4) If the payer is denying the medical necessity of any non-valued procedure provided without prior authorization, the payer shall follow the procedures given in sections 16-11(C)(1) and (2).

(D) Process for Appealing Billed Service Denials

(1) The billing party shall have 60 days from the date of the EOB to respond to the payer's written notice under section 16-11(A)–(C). The billing party's timely response must include:

(a) A copy of the original or corrected bill;

(b) A copy of the written notice or EOB received;

(c) A statement of the specific item(s) denied;

(d) Clear and persuasive supporting documentation or reasons for appeal; and

(e) Any available additional information requested in the payer's written notice.

(2) If the billing party responds timely and in compliance with section 16-11(D)(1), the payer shall:

(a) When denying for medical reasons, have the bill and all supporting medical documentation and reasoning reviewed by a "physician provider" as defined in section 16-3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physician providers performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. After reviewing the documentation and response, the reviewing provider may call the billing provider to expedite communication and timely processing of the medical bill.

(b) When denying for non-medical reasons, have the bill and all supporting documentation and reasoning reviewed by a person who has knowledge

of the bill. After reviewing the provider's documentation and response, the reviewer may call the provider to expedite communication and timely processing of the medical bill.

(3) If before or after conducting a review pursuant to section 16-11(D)(2), the payer agrees with the billing party's response, the billed service is due and payable in accordance with the Medical Fee Schedule within 30 days after receipt of the billing party's response. Date of receipt may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the response was mailed to the payer's correct address.

(4) After conducting a review pursuant to section 16-11(D)(2), if there is still a dispute regarding the billed services, the payer shall send the billing party written notice of denial within 30 days of receipt of the response. The written notice shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being denied, if submitted by the provider;

(b) If applicable, acknowledgement of specific paid items submitted on the same bill as denied services;

(c) Reference to the bill and each item of the bill being denied;

(d) An explanation of the clear and persuasive medical or non-medical reasons for the decision, including the name and professional credentials of the person performing the medical or non-medical review and a copy of the medical reviewer's opinion when the denial is for a medical reason; and

(e) The explanation shall include the citing of statutes, rules and/or documents supporting the payer's reasons for denying payment.

(5) Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.

(6) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts. The parties shall do so within 12 months of the date the original bill should have been processed in compliance with section 16-11, unless extenuating circumstances exist.

(E) Retroactive review of Medical Bills

(1) All medical bills paid by a payer shall be considered final at 12 months after the date of the original EOB unless the provider is notified that:

(a) A hearing is requested within the 12 month period, or

(b) A request for utilization review has been filed pursuant to § 8-43-501.

(2) If the payer conducts a retroactive review to recover overpayments from a provider based on medical reasons, the payer shall have the bill and all supporting documentation reviewed by a "physician provider" as defined in

section 16-3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physician providers performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. The payer shall send the billing party written notice that shall include all notice requirements set forth in section 16-11(A)(1) and also shall include:

(a) Reference to each item of the bill where payer seeks to recover overpayments;

(b) Clear and persuasive medical reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and

(c) Evidence that these payments were in fact made to the provider.

(3) If the payer conducts a retroactive review to recover overpayments from a provider based on non-medical reasons, the payer shall send the billing party written notice that shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:

(a) Reference to each item of the bill where payer seeks to recover overpayments;

(b) Clear and persuasive reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and

(c) Evidence that these payments were in fact made to the provider.

(4) In the event of continued disagreement, the parties may follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(F) An injured worker shall never be required to directly pay for admitted or ordered medical benefits covered under the Workers' Compensation Act. In the event the injured worker has directly paid for medical services that are then admitted or ordered under the Workers' Compensation Act, the payer shall reimburse the injured worker for the amounts actually paid for authorized services within 30 days after receipt of the bill. If the actual costs exceed the maximum fee allowed by the Medical Fee Schedule, the payer may seek a refund from the medical provider for the difference between the amount charged to the injured worker and the maximum fee. Each request for a refund shall indicate the service provided and the date of service(s) involved.

(G) To the extent not otherwise precluded by the laws of this state, contracts between providers, payers and any agents acting on behalf of providers or payers shall comply with section 16-11.

(H) Onsite Review of Hospital or Other Medical Charges

(1) The payer may conduct a review of billed and non-billed hospital or medical facility charges related to a specific workers' compensation claim.

(2) The payer shall comply with the following procedures:

Within 30 days of receipt of the bill, notify the hospital or other medical facility of its intent to conduct a review. Notification shall be in writing and shall set forth the following information:

(a) Name of the injured worker;

(b) Claim and/or hospital or other medical facility I.D. number associated with the injured worker's bill;

(c) An outline of the items to be reviewed; and

(d) If applicable, the name, address and telephone number of any person who has been designated by the payer to conduct the review (reviewer).

(3) The hospital or other medical facility shall comply with the following procedures:

(a) Allow the review to begin within 30 days of the payer's notification;

(b) Upon receipt of the patient's signed release of information form, allow the reviewer access to all items identified on the injured worker's signed release of information form;

(c) Designate an individual(s) to serve as the primary liaison(s) between the hospital or other medical facility who will acquaint the reviewer with the documentation and charging practices of the hospital or other medical facility;

(d) Provide a written response to each of the preliminary review findings within ten (10) business days of receipt of those findings; and

(e) Participate in the exit conference in an effort to resolve discrepancies.

(4) The reviewer shall comply with the following procedures:

(a) Obtain from the injured worker a signed information release form;

(b) Negotiate the starting date for the review;

(c) Assign staff members who are familiar with medical terminology, general hospital or other medical facility charging and medical records documentation procedures or have a level of knowledge equivalent at least to that of an LPN;

(d) Establish the schedule for the review which shall include, at a minimum, the dates for the delivery of preliminary findings to the hospital or other medical facility, a ten (10) business day response period for the hospital or other medical facility, and the delivery of an itemized list of discrepancies at an exit conference upon the completion of the review; and

(e) Provide the payer and hospital or other medical facility with a written summary of the review within 20 business days of the exit conference.

16-12 DISPUTE RESOLUTION PROCESS

When seeking dispute resolution from the Division's Medical Dispute Resolution Unit, the requesting party must complete the Division's "Medical Dispute Resolution Intake Form" (Form WC 181) found on the Division's web page. The items listed on the bottom of the form must be provided at the time of submission. If necessary items are missing or if more information is required, the Division will forward a request for additional information and initiation of the process may be delayed.

When the request is properly made and the supporting documentation submitted, the Division will issue a confirmation of receipt. If, after reviewing the materials, the Division believes the dispute criteria have not been met, the Division will issue an explanation of those reasons. If the Division determines there is cause for facilitating the disputed items, the other party will be sent a request for a written response due in ten (10) business days.

The Division will facilitate the dispute by reviewing the parties' compliance with Rules 11, 16, 17, and 18 within 30 days of receipt of the complete supporting documentation; or as soon thereafter as possible. In addition, the payer shall pay interest at the rate of eight percent per annum in accordance with § 8-43-410(2), upon all sums not paid timely and in accordance with the Division Rules. The interest shall be paid at the same time as any delinquent amount(s).

Upon review of all submitted documentation, disputes resulting from violation of Rules 11, 16, 17 and 18, as determined by the Director, may result in a Director's Order that cites the specific violation.

Evidence of compliance with the order shall be provided to the Director. If the party does not agree with the findings, it shall state with particularity and in writing its reasons for all disagreements by providing a response with all relevant legal authority, and/or other relevant proof upon which it relies in support of its position(s) concerning disagreements with the order.

Failure to respond or cure violations may result in penalties in accordance with § 8-43-304. Daily fines up to $1,000/day for each such offence will be assessed until the party complies with the Director's Order.

Resolution of disputes not pertaining to Rule violations will be facilitated by the Division to the extent possible. In the event both parties cannot reach an agreement, the parties will be provided additional information on pursuing resolution and adjudication procedures available through the Office of Administrative Courts. Use of the dispute resolution process does not extend the 12 month application period for hearing.