

WORKERS' COMPENSATION LARGE DEDUCTIBLE STUDY

**By the
NAIC/IAIABC Joint Working Group**

Preface

Workers' compensation is based on a series of promises made by the Legislature to the workers and employers in each state. Workers are promised a fast, reliable and fair system of benefits, free from the uncertainty and delay of the tort system, in exchange for relinquishing the ability to sue their employer for potentially large amounts, including noneconomic damages. Employers are promised a limitation on their liability, making the cost of doing business predictable and saving them from catastrophic loss, in exchange for strict liability for all workplace injuries. Both promises are implemented through insurance, which is mandatory for all employers doing business in the state, with limited exceptions.¹ This is the context in which we must evaluate the realities of large deductible policies, as they are currently being used.

Large deductible policies came into existence after the workers' compensation market crisis in the late 1980s and early 1990s. During that time, "assigned risk pools," or other state instituted insurers of last resort, grew to be major insurers of employers that could not get required coverage from private insurers. These pools had large operating losses. Assessments on private insurers to support pool losses became a significant pricing factor. Since then, the usage of large deductibles has increased to the point where, in 2002, the NCCI reported that 31.4% of "manual-equivalent premium"² was written using a deductible of \$100,000 or greater. (This was for 36 states in which the NCCI had complete data. See Appendix 1 for details.) Clearly, large deductible policies are now a major factor in the workers' compensation marketplace.

This is an area where the cooperative efforts of workers' compensation regulators and insurance regulators are particularly valuable, since large deductible policies impact the two regulatory roles in very different ways, so that their shared insights are essential in order to develop a coherent picture. Accordingly, this study on large deductible policies has been commissioned by the NAIC/IAIABC Joint Working Group, established by the National Association of Insurance Commissioners (NAIC) and the International Association of Industrial Accident Boards and Commissions (IAIABC) to enhance communications on issues of mutual interest, particularly those involving the interaction of workers' compensation and labor laws with insurance laws.

¹ All but two states have programs under which qualifying employers can be granted permission to self-insure their workers' compensation obligations under strict state monitoring and regulation. In addition, in many states, participation in the workers' compensation system is voluntary for certain categories of employers. However, except in Texas, these categories are extremely limited and for the most part are confined to very small employers.

² Payroll times carrier manual rates, without modification for schedule rating, deductible credits, or experience rating modifier. See Appendix 2. This measure should provide good comparability from state to state.

Please note –

There are other coverage mechanisms, such as retrospectively rated coverage, that allow the employer to retain a substantial portion of its workers' compensation risk. Throughout this paper, many of the issues that are discussed are not unique to large deductible insurance, although they may be more of a problem or may take on a different significance with large deductible policies. It would be a distraction for most readers to repeat this point, paragraph after paragraph, throughout much of the document. The reader will be reminded of this commonality only in particularly pertinent areas, and in the "Findings and Recommendations" section.

Section 1 – A Description of Large Deductibles

Large deductible policies are designed to give employers that are willing to retain most of the risk an option that reduces their insurance costs without depriving employees of the certainty of insured benefits. When large deductible policies operate as intended, they provide the best of both worlds – the employer gets cost savings from quasi-self-insurance, while its employees remain fully insured.

Above the deductible threshold, a large deductible policy protects the employer from catastrophic losses; below the threshold, the policy protects workers from the risk that the employer will default on its share of the claims obligations. This protection is provided by a unique feature of workers' compensation deductibles. In contrast to general practice in other lines of insurance, an insurer issuing a workers' compensation policy with a deductible clause makes the same unconditional promise made by all workers' compensation insurers: all valid claims arising out of injuries occurring within the policy period will be paid according to state benefit laws.

First-dollar liability to workers distinguishes "deductible" policies from "excess" policies. For purposes of this paper, an "excess policy" will mean any policy in which the insurer is only liable for claims in excess of a specified attachment point. Excess policies are intended to be used only by authorized self-insurers, either for their own protection or as part of the security required by regulators.

The distinction between "large" deductibles and small deductibles is largely a difference of degree. It is important for purposes of this paper primarily because the concerns raised by deductible policies are more significant when more money is at stake.³ Often, however, the marketplace does draw a fairly bright line, because the two products are geared to different markets and, where permitted by state law, large deductibles tend to be very large indeed (i.e., \$100,000 would be the low end of the range for a large deductible policy.) On the whole (in states that permit both options), large deductible coverage and self-insurance share the same base

³ Some states have statutory criteria. In Maine, for example, a "large deductible policy" is defined as "a workers' compensation policy written with a per occurrence deductible in excess of \$5,000 or a medical deductible in excess of \$500." 24-A M.R.S.A. § 2392(12). However, this definition is only used for the specific purpose of calculating a particular policy surcharge that is no longer in effect. Massachusetts has very specific criteria for rating and handling of experience for small, medium and large deductibles. Regulation 211 CMR 113.00.

of relatively large employers. Moreover, an insurer considering an application for a large deductible policy and a regulator considering an application for approval to self-insure face similar concerns about the applicant's financial condition and similar desires for the posting of adequate security.

However, insurers have flexibility, and different insurers follow different criteria, so some employers that would not qualify as self-insurers may be able to find an insurer that is willing to write a large deductible policy. Some notable examples have included employee leasing companies and professional employer organizations, which have often been able to obtain large deductible master policies even though many states allow few, if any, of these entities to self-insure. Conversely, obtaining large deductible coverage is a matter of marketplace negotiation, and meeting objective financial and workplace risk criteria is no guarantee that a particular employer in a particular year will be able to find a carrier willing to write a large deductible policy on satisfactory terms.

The distinction between large deductible and small deductible policies will generally be reflected in the cost of the insurance coverage as compared to the employer's overall workers' compensation expenses. For large deductible coverage, the premium will typically be significantly less than the claims payments, and it is common for the employer to be responsible for 100% of the actual claims in any given year.⁴ Thus, a significant component of the risk that the insurer assumes is the employer's credit risk, which a prudent insurer will address by making the employer's financial condition a major factor in the underwriting process and often by requiring the employer to post collateral or provide some other security for the payment of claims within the deductible.

Often, however, self-insurance regulators impose more stringent requirements for securing payment of the risk retained by the employer, both in terms of the percentage and confidence level of potential losses that must be secured and the kind of security that is required. This is often the key factor in an employer's choice between large deductible coverage or other high retention plan and self-insurance with an excess policy. Current market conditions for surety bonds are tight, with the cost of a bond running about three percent or more of the amount of the bond. On top of this, some sureties require letters of credit to secure the risk of default on claims.

The following language, taken from a policy form currently in use in the market, describes the framework of the "typical" large deductible policy:

Example of Deductible Clause: *We will pay benefits and damages that are covered under this policy. We will only seek reimbursement for those amounts that are within the applicable deductible shown above. You will reimburse us promptly for any deductible amounts and all Allocated Loss Adjustment Expenses that we have advanced. The Each*

⁴ Indeed, if the policy were to include an aggregate deductible that is routinely pierced, it would raise concerns of regulatory arbitrage similar to those raised by financial reinsurance and low-attachment employee benefit stop loss coverage. In other words, it would be highly likely that the real purpose of such a deductible would not be to transfer risk back to the employer, but rather to avoid reporting a portion of the premium by labeling it as loss reimbursement. This is an extreme case of concerns that are discussed at more length in Section 6 below.

Workers' Compensation Occurrence Deductible is the most you will pay for benefits required of you by the Workers' Compensation Law resulting from one Occurrence. The Aggregate Deductible is the most you will pay for the sum of all deductible amounts payable by you for all Occurrences during the policy period.

It is important to understand that not all large deductible policies follow this paradigm, and this is where many of the regulatory issues arise. In particular, although the terms of this policy require the insurer to pay all claims directly, and then the employer reimburses the insurer, such requirements are not universal, and even when they appear in the policy they are sometimes ignored in practice.⁵ In order for the policy to qualify as true "large deductible" coverage as most states view it, the insurer must be obligated to make first-dollar claim payments, but exactly how universal that fundamental obligation is, and how unconditional, has occasionally been put to the test in various contexts. These and other issues will be discussed more fully in the sections that follow.

Section 2 – An Outline of Possible Issues, Concerns, and Problems with Large Deductibles

As noted above, when large deductible policies function as designed, they can provide valuable flexibility in the market. Employers can decide exactly how much of their risk they want to retain and, to the limited extent permitted by state law, the terms for the oversight of the employer's performance of its obligations can be negotiated between the employer and the insurer. The insurer's general accountability for payment of all benefits that are due should eliminate the need for direct regulatory oversight of each individual employer and the risk it retains.

Unfortunately, however, experience demonstrates that large deductible policies do not always function as designed. When they do not, the consequences may include gaps in coverage, financial problems for insurers, problems with claims administration, and the loss of essential information on workplace safety and actuarial data for ratemaking. Furthermore, there are some inherent difficulties with integrating the flexible design of large deductible policies into a system that relies heavily on a variety of standardized processes.

When the employer assumes substantial financial risk from possible workers' compensation losses, an inability to pay claims can be either the cause or the effect of financial problems. Sections 3 and 4 examine what can happen if the employer or the insurer becomes insolvent. In contrast to self-insurer bankruptcies, where the claimant is an unsecured creditor and must depend on the performance of the various safety nets that have been put in place, the bankruptcy of an insured employer should typically have no effect on the payment of claims, since the vast majority of states, perhaps all states,⁶ require a workers' compensation insurer to assume a direct obligation to the claimant for payment of benefits. This applies to large deductible coverage as well as to conventional first-dollar coverage.

⁵ Which was how the policy quoted above became available as reference material, having landed on the author's desk as part of a complaint file.

⁶ The survey responses are inconclusive.

Because the insurer's underlying obligation to assure full statutory coverage is fundamental to large deductible policies, serious problems would arise if an insurer were to issue an excess policy in place of a large deductible policy, and the policyholder failed to pay claims below the attachment point. To avoid this, this document recommends that states review their laws to make sure that the insurer's obligation to pay all valid claims from the first dollar is unconditional, even if there is fraud or other misconduct on the part of the employer, and that the contract must be reformed to include this obligation if the policy language is defective. Furthermore, even when the insurer does have an unconditional legal obligation, there may be a hardship to claimants if the employer has been paying the claims directly and suddenly stops. It may take some time for the insurer to take corrective action, and in the worst case depending on the state, the insurer might even have grounds to challenge the validity of the claim, or other creditors might seek to have the bankruptcy court block enforcement of the claim.

However, the reason the claimant is protected the vast majority of the time when the employer fails to perform on its obligations under a large deductible policy is that the risk is borne by the insurer. Typically, a prudent insurer will protect itself against this surety-like exposure by underwriting the credit risk from the applicant for this coverage and requiring letters of credit or other means of securing recoupment of the deductible. Absent these precautions, the insurer exposes itself to financial stress from defaults, especially if a macroeconomic downturn affects the solvency of many of its policyholders simultaneously. Large deductible policies leverage a high volume of claims relative to a small premium. Thus, it is no coincidence that some of the recent high-profile insurance insolvencies involved carriers with substantial books of questionably underwritten large deductible business.

If an insurer issuing large deductible policies becomes insolvent, for that or any other reason, uncertainties about the status of recoverable reimbursements may complicate the distribution of the insurer's estate. This is of concern to guaranty funds and their member insurers, but fortunately should not affect the injured workers, since large deductible policies have the same level of guaranty fund protection in most states as conventional first-dollar policies, in contrast to excess policies and surety bonds. In addition, workers' compensation claims are exempt from the maximum payment limits that otherwise apply to guaranty fund claims, in almost all states. Section 4 discusses the exceptions and how they can be addressed.

As these examples suggest, most of the drawbacks of large deductible policies revolve around the problems that can arise when insurers do not have current knowledge of all the claims against policyholders. This is the topic of Section 5. Improper claims practices have the potential to compromise the protections the claimant has under the state's workers' compensation laws and the employer's workers' compensation policy. They may also damage the integrity of the reporting systems used for ratemaking and for monitoring workplace safety. Evaluating the extent of the problem is hard because reporting violations, by their nature, rarely get reported. We know of no published studies that have tried to measure the extent of non-reporting by employers, and Section 5 makes some suggestions to address this shortcoming.

Another area where difficulties can arise, as discussed in Section 6, is taxes and assessments, including residual market support. Insureds in this market sector are large enough that there is a significant level of claims payments each year that must be regarded as inevitable. An insurer writing a traditional policy will treat claims within this "working layer" as a foregone conclusion

and price the loss expectation at 100 cents on the dollar. With a large deductible policy, the employer pays the same dollars for those claims, but they are no longer “premium” dollars – they are spent instead on claims reimbursements (or payments, if self-administration is occurring). Thus, if the tax and assessment structures place an undue significance on how these dollars are labeled, the system becomes open to abuse. However, it is one thing to recognize that the figure reported as “premium” may not accurately track an employer’s expected losses. It is quite another thing to be able to quantify the difference between the two concepts, and it is even more challenging to construct an equitable framework for taxes and assessments across a spectrum that encompasses conventional first dollar coverage, large deductibles, retrospective rating, and self-insurance. In order to accomplish this task, it is necessary to find a way to identify which differences between the various types of workers’ compensation coverage should be disregarded for these purposes and which differences should be taken into account, a way to decide how much weight these differences should be given, and a way to measure them with reasonable accuracy.

Section 7 deals with underwriting, ratemaking, and regulatory approvals. From an insurer’s perspective, the large deductible risk has similarities to a retrospectively rated policy, a self-insurer’s excess policy, or even a reinsurance treaty. The focus of rate setting is on quantifying the catastrophic layer of the risk. As noted earlier, the underwriting process must also take into account the employer’s creditworthiness, and careful consideration needs to be given to how to enforce the employer’s obligation to pay claims within the deductible. Since deductible reimbursements are not technically considered “premium,” state laws may be worded in a way that deprives the insurer of the ability to cancel if the employer defaults, or places a more restrictive burden of proof on the insurer. The most important protection for the insurer is to make sure there is collateral; trust arrangements and letters of credit are common security mechanisms, and are required in some states. Regulators should take care that any such side agreements between the insurer and employer do not violate requirements that the policy form itself embody the “entire contract.”

Given the customized nature of this coverage, a formulaic application of manual rates is unlikely to be a sufficient basis for pricing large deductible policies, so rating flexibility is essential for effective implementation of a large deductible program. Despite the high degree of standardization for workers’ compensation rates, most states are amenable to providing a greater degree of rating flexibility. In addition, the incentives provided by the experience rating structure are somewhat less relevant when the employer is responsible for reimbursing most claim payments, and in states that allow negotiated rates for “large” commercial policyholders, most large deductible policyholders will qualify. There may also be some room for creativity in the terms of the large deductible endorsement, although regulators must ensure that it does not undercut any of the protections provided to claimants by the basic workers’ compensation policy to which it is attached.

In this regard, it is recommended that states examine their laws and regulations to ensure that exempt commercial policyholder (ECP), large risk or consent-to-form provisions cannot be used to diminish the insurer’s obligation to guarantee full coverage, from the first dollar to the full extent of the employee’s statutory entitlement to benefits. Similarly, the surplus lines market cannot be an option because of the need to regulate the policy terms and to provide guaranty fund protection to claimants. States should also ensure that claims handling is adequately regulated.

Some states have extended their third-party administrator (TPA) laws to cover workers' compensation administrators, and it is recommended that all states consider this approach.

Section 8 discusses the financial reporting questions presented by large deductible coverage, which center on how to deal with loss reimbursements and the effects of their not being treated as "premium" for financial reporting purposes. Some suggestions are made for improving the information captured in the Annual Statement completed by all insurers. On the ratemaking side, the mismatch between exposures and premiums is addressed. Current ratemaking methodologies take these issues into account, but their accuracy is only as good as the accuracy of the underlying data reporting, which is also relied upon for a variety of other purposes. There is a discussion of possible techniques for evaluating whether there is a significant problem with data quality, and if so, its nature, extent, and possible remedies.

Finally, Section 9 addresses the issues that can arise when professional employer organizations (PEOs) or employee leasing companies purchase large deductible policies. The NAIC/IAIABC *Report on Employee Leasing and Professional Employer Organizations* warned against potential regulatory problems that might arise from the practice of issuing a single "master policy" covering all clients of an employment services outsourcing firm on a blanket basis, and noted that blending a master policy with high deductible coverage requires special attention. When the PEO takes on the responsibility for the deductible, the result from the client's perspective is similar to a fronting arrangement.⁷ The client and worksite employees have first-dollar coverage from the insurer, so that if the PEO should fail, the insurer remains responsible to the client and its claimants. However, it is the PEO that takes on most of the risk of loss for injuries at the client's worksite, and the fees the PEO charges the client must reflect that risk, in addition to all the other services provided by the PEO. The mixture of large deductible policies and outsourcing firms requires careful attention on the part of both regulators and insurers.

Section 3 – Employer Insolvency Considerations

For rock solid public policy reasons, an insurance policy, with or without a deductible, should protect injured workers in the event of employer insolvency. Nevertheless, the bankruptcy of the employer who insures with a large deductible policy may, depending on the protections of state law, present risks for the injured worker and the employer's insurer, as compared to an employer with a policy that has no deductible or a self-insured employer.

When an employer declares bankruptcy, several things happen. The Bankruptcy Code imposes an automatic stay of adjudication and filing of any "action or proceeding against the debtor ... or to exercise control over property of the estate."⁸ If the employer is reorganizing under Chapter 11, the employer is required to keep appropriate workers' compensation coverage for injuries to workers injured after the filing of the bankruptcy petition.⁹ The Court sets a date by which all claimants must file a "proof of claim" before the Bankruptcy Court or be barred from the

⁷ It differs from the usual fronting arrangement, between an insured, an insurer, and a reinsurer, in that there is no privity of contract between the client and the insurer, and the PEO is not in the business of insurance.

⁸ 11 U.S.C. § 362

⁹ 28 U.S.C. § 959(b)

distribution of assets. The Court approves a reorganization plan or liquidation plan and all claims that were or could have been brought against the debtor are discharged, except to the extent that the plan provides for payment of those claims in whole or part.

When an insured employer declares bankruptcy, the insurance policy persists as an independent obligation to the beneficiaries, whether or not the insurer has been paid in full for the coverage. Workers injured while the policy was in force (both before and after the petition is filed) look to the insurer for payment.¹⁰ If the employer continues to function under Chapter 11 reorganization, it is compelled to keep appropriate coverage in place, and payments for the period of coverage after the petition is filed are made from the estate on an ongoing basis as administrative expenses. Similar arrangements are made if an employer that is liquidating continues some operations as part of the winding-down process.

When a self-insured employer enters bankruptcy, the employer may already be in default on its claims payments at the time of the petition, and workers' compensation claimants with pre-petition injuries become general unsecured creditors of the estate. General unsecured creditors have the lowest priority under the Bankruptcy Code, and if paid at all, are likely to receive a percentage of payment of the liquidated debt that is significantly lower than other classes of creditors. This low priority status applies not only to the overdue payments, but also to any to future payments on those claims.

Furthermore, disputes related to pre-petition claims are typically subject to the automatic stay. However, bankruptcy court orders may lift the stay and authorize payment of pre-petition workers' compensation claims. Even if they do not, regulator-held security is not swept into the debtor's bankruptcy estate, and, if sufficient, can be used to pay claims. In some states, there is also a self-insurer's guaranty fund to act as a safety net for payment of claims. For post-petition operations, 28 U.S.C. § 959(b) requires Chapter 11 debtors to comply with state workers' compensation requirements for future claims by maintaining self-insured status or by purchasing insurance, and states may require the employer to post adequate security as a condition of continued authorization to self-insure.

When a large deductible policyholder declares bankruptcy, the protections for the worker and insurer may depend upon the state and upon the claims servicing arrangement in effect. On paper, the insurer's obligation to pay claims under a large deductible policy is the same as the insurer's obligation to pay claims under a policy without a deductible. However, as discussed in Chapter 5, the reality on the ground may be different. Claim payments may be interrupted if the employer stops paying a TPA that is handling its claims. Benefit checks may bounce if the employer stops funding the account from which claims are paid. In such situations, once the insurer is identified and notified of its obligations, payments *should* resume smoothly and the

¹⁰ If the policy is cancelled for nonpayment of premium and the employer continues to operate without insurance before going into bankruptcy, workers injured after the effective date of the cancellation may be left with no meaningful recourse. However, some states, such as California, Minnesota and Wisconsin, have funds to pay for the claims of illegally uninsured employers.

large deductible policy *should* once again function as intended, with the insurer bearing the credit risk.¹¹

A bulletin from the Nevada Insurance Department clarifies the insurer's obligations in the event of policyholder bankruptcy:

Insurers writing any deductible programs will be responsible for the payment of all medical and indemnity costs, including first dollar, for all covered workers' compensation losses. Insurers will be reimbursed by employers for the losses paid which are under the deductible or the portion of any loss paid under the deductible. In no case may a workers' compensation claim be denied because of the failure of the employer to pay his deductible. If an employer fails to pay his deductible, the insurer may amend the policy to eliminate the deductible and the deductible discount. (Bulletin 00-003, July 28, 2000)

This credit risk may be a substantial risk for the insurer. For any unpaid claims reimbursements, the insurer is a general creditor of the estate. Even if the insurer has obtained collateral, access to that collateral may require litigation in the bankruptcy court. If the employer files a Chapter 11 reorganization petition, the insurer may not be allowed to cancel the policy, and prevent the accrual of additional deductible liability, due to the anti-discrimination provisions of the Bankruptcy Code,¹² and when policy cancellation is permitted, state law may postpone the effective date.

Once there is a dispute, the bankruptcy process could impair the claimant's rights, despite the language in the policy guaranteeing payment by the insurer. Although a workers' compensation claimant has the right to proceed directly against the employer's insurer in some states, in other states the employer is a necessary party to any dispute over workers' compensation benefits. For pre-petition injuries, in states where the employer is a necessary party to any dispute, this means the claim dispute is subject to the automatic stay. With a policy without a deductible, this is essentially a technicality – since the debtor's estate is not affected either way by the outcome of the workers' compensation proceeding, the automatic stay is either ignored without objection or is lifted as a matter of course. However, with large deductible or retrospectively rated coverage, the estate may have a significant interest in the reimbursement obligation that will be incurred, and the claimant may be at the mercy of the bankruptcy court's broad discretion whether or not to grant relief from the stay "for cause."¹³

¹¹ Such was the case of the Montgomery Ward bankruptcy. The California Dept. of Industrial Relations noted:

In October, DIR filed additional objections to Montgomery Wards' plan to further delay payment of insured workers' compensation claims. As a result, the company agreed to turn over payment of all insured claims to the insurance carriers that wrote large deductible workers' compensation insurance policies for them. Under the policies, Montgomery Wards was to fund the first \$500,000 of every claim.

"Under California law the carrier is responsible to pay the entire claim including any deductible amount," Duncan explained, "and collect back the deductible from the employer if it can. In this case, the carriers will pay the insured claims and stand in line with other creditors in the hope of getting some deductible amounts reimbursed to them." – Dept. of Industrial Relations, bulletin, "DIR intervenes on behalf of workers' compensation claimants in Montgomery Ward bankruptcy," Dec. 16, 1997.

¹² 11 U.S.C. § 525

¹³ 11 U.S.C. § 362(d)(1)

The above potential problems lead us to make the following recommendations. First, state laws should be examined to assure that proper notice from an injured worker to the employer, or a TPA, equates to notice to the insurer. This would void any insurer attempt to deny coverage on account of an employer failing to report a claim in a timely fashion. Second, remove any state laws that defeat (or cloud) the injured worker's direct right of action against the bankrupt employer's workers' compensation insurer, whether first dollar, retrospective, or deductible. Excerpts from Nebraska law¹⁴ that accomplish these objectives are shown below:

Dealing with bankruptcy and the injured employees right to proceed against the insurer:

No policy of insurance against liability arising under the Nebraska Workers' Compensation Act shall be issued unless it contains the agreement of the insurer that it will promptly pay to the person entitled to the same all benefits conferred by such act, and all installments of the compensation that may be awarded or agreed upon, and that the obligation shall not be affected by the insolvency or bankruptcy of the employer or his or her estate or discharge therein or by any default of the insured after the injury, or by any default in the giving of any notice required by such policy, or otherwise. Such agreement shall be construed to be a direct promise by the insurer to the person entitled to compensation enforceable in his or her name.

Ensuring that notice to the insured is notice to the insurer:

All policies insuring the payment of compensation under the Nebraska Workers' Compensation Act shall contain a clause to the effect (a) that as between the employer and the insurer the notice to or knowledge of the occurrence of the injury on the part of the insured shall be deemed notice or knowledge, as the case may be, on the part of the insurer...

Section 4 – Insurer Insolvency Considerations

In all states without monopolistic state funds, the insolvency of an insurer writing workers' compensation insurance triggers the guaranty fund system or some other mechanism. (This paper shall refer to all such mechanisms as "guaranty funds," even though that is not their structure in all states.) The insolvency of an insurer and the process by which a state guaranty fund assumes the handling of claims is complex. This paper will not examine the entire process, but will focus on those aspects of the process that are more likely to be a consideration with large deductible workers' compensation insurance.

The most important question is whether there are any limitations of guaranty fund coverage for the injured worker when workers' compensation coverage has been provided on a large deductible form. For most states, the answer to that question is "no," but the exceptions warrant discussion. The most common exception, although it is not necessarily problematic, affects coverage for employers that exceed a certain net worth. As large deductible policyholders will typically have a relatively high net worth, this provision will apply to many of them. The reason

¹⁴ These are excerpted from Section 48-146(1), with references to "risk management pools" removed.

that this provision is not generally problematic is that, in most of these jurisdictions, it does not affect coverage for the injured worker because the guaranty fund remains obligated to ensure that workers' compensation claimants (and other third-party claimants) are paid in full. In these jurisdictions, all that happens is that the guaranty fund will seek reimbursement from large deductible policyholders for claims paid to injured employees, both those above and below the policy's deductible amount.

There are ten jurisdictions that don't cover all workers' compensation claims in full, but only three of these have limitations that apply specifically to large deductible policies:

- Puerto Rico and the Virgin Islands apply \$150,000 and \$50,000 per-claim limitations, respectively, to workers' compensation claims. This limit applies to all workers' compensation claims, whether under a large deductible policy or a policy without a deductible.
- Arkansas and Indiana apply \$300,000 and \$100,000 per-claim limits, respectively, to workers' compensation claims. This limit also applies to all workers' compensation claims, whether under a large deductible policy or a policy without a deductible. These states also exclude coverage for claims for policyholders with net worth of more than \$50 million. The net worth provisions in these states are different than most because their effect is to exclude coverage for claims by or against policyholders whose net worth exceeds the statutory limit, rather than pay for the claim and then seek reimbursement from the insured. Note that while such net worth provisions would be more likely to affect employees of large deductible policyholders, there would not be better coverage for such employees if coverage were written without a deductible.
- Illinois, Missouri and New Hampshire exclude coverage for policyholders with a net worth exceeding \$25 million, with provisions similar to those in Arkansas and Indiana.
- Iowa and Minnesota exclude all claims within any deductible or self-insured retentions, and also exclude all coverage on policies with deductibles exceeding \$200,000 and \$300,000, respectively.
- Nebraska excludes all claims within the deductible amount, but covers claims in excess of the deductible. As long as the employer remains solvent, the injured worker can look to the employer to pay claims, but this still may put injured workers in the position of needing to deal with an entity that has not been approved to handle claims (i.e., is not an approved self-insurer). Of course, there is also the peril that the employer may not remain solvent for the potentially long duration of all claims that it may be obligated to pay.

The nature of these exclusions prompts several observations:

- The remedy for these deficiencies does not involve the NAIC's adoption or amendment of a model law. The NAIC already has a model covering these matters, and it does not have these deficiencies. The problems are with the laws in the specific states.

- The mechanics of insurance coverage may create complications if an exclusion or limitation on guaranty fund protection applies, since the deductible clause in the policy – as discussed from a different perspective in Section 5 – may not necessarily give the claimant the right to file a claim directly against the insurer. Ultimately, state workers’ compensation laws make the employer responsible if there is no valid insurance, but those provisions are rarely invoked against insured employers so enforcement might not be straightforward.
- Net worth requirements are not necessarily problematic, but they should be accompanied by provisions that workers’ compensation claims should be paid by the guaranty fund with reimbursement sought from the policyholder. Otherwise, an employer that has not been approved as a self-insurer may be placed in that role, plus it leaves open the danger that a once-solvent employer will later become insolvent and have unpaid workers’ compensation claims outstanding against it. In this regard, should the state not want to adopt the NAIC model, the following excerpt may serve as an example of language that could be used:

“For policyholders exceeding the statutory net worth, the Association shall pay the full amount of covered claims for benefits under workers’ compensation coverage notwithstanding the policyholder’s net worth, but the Association has the right to recover the payments from the policyholder.”

- The provisions in Iowa, Minnesota and Nebraska law excluding coverage for deductible policies raise similar concerns, and the response to these concerns should be similar, with provisions that covered workers’ compensation claims are paid by the guaranty fund and reimbursement is then sought from the policyholder. In this regard, should the state not want to adopt the NAIC model, the following excerpt may serve as an example of language that could be used:

“The Association shall pay the full amount of covered claims for benefits under workers’ compensation coverage notwithstanding the policyholder’s deductible or self-insured retention, but the Association has the right to recover the payments made under the deductible or self-insured retention from the policyholder.”

- The four jurisdictions with caps on workers’ compensation recoveries for individual employers should reconsider them. Such caps are typical of claims for other than worker’s compensation, but place a hardship upon an innocent party (the injured worker) that had nothing to do with the selection of the insurer than eventually became insolvent.

As these are guaranty fund (insurance) matters, it is recommended that the Chair of NAIC’s Workers’ Compensation (C) Task Force draft letters to each of the jurisdictions discussed in the preceding bullets. The letters will outline the nature of the concerns with the individual states’ laws.

There is one other way in which gaps in guaranty fund protection might arise, and that is where coverage is written by a captive insurer or some other specially chartered insurer that is exempt from guaranty fund participation. This is one reason the Risk Retention Act and typical captive insurer acts do not allow the issuance of direct workers’ compensation coverage, and states with

captive laws should review them to ensure that this problem cannot arise. However, the use of a captive insurer does not pose the same problems when it does not provide direct statutory coverage. There may be an appropriate role for captives in the workers' compensation market when there is a licensed fronting company with guaranty fund protection and the purpose for using the captive is to provide a sophisticated, financially strong employer with access to international reinsurance markets and/or the ability to retain risk in a manner that adequately recognizes incurred losses for tax purposes and sets aside pre-tax dollars to pay for them.

The reimbursements that insured employers are bound to remit to their insurer are the aspect of large deductible coverage of the most interest to guaranty funds. Should reimbursements for claims paid by the guaranty funds¹⁵ be treated as reimbursements to the guaranty funds or simply as assets of the estate? The impact of this question is significant, because it affects guaranty fund assessments and the recoveries by claimants with claims not covered by guaranty funds. Treating these reimbursements as assets of the estate has the undesirable effect of increasing guaranty fund assessments (which are often funded by premium tax offsets or otherwise borne by insurance consumers) and the desirable effect of increasing the amounts received by claimants with claims that states have excluded from guaranty fund protection. The question of public policy then becomes whether this is desirable and fair.

At this writing, the question of the handling of deductible reimbursements is the subject of active litigation. This paper will take no position on the proper outcome of that litigation.

The litigation provides a strong indication, however, that legislation to clarify the proper handling of these reimbursements needs to be considered by the states, giving due regard to the public policy questions discussed in the prior paragraph. Reacting to these concerns, several states have recently passed such legislation. Pennsylvania has passed Senate Bill 815 while Illinois has passed HB 5928. In both cases, the legislation applies to pending and future insolvencies, with the result that the guaranty funds' exposure on large deductible policies mirrors that of the insolvent insurer. The legislation provides that:

- Large deductible collateral is not an asset of the estate;
- Payment by an insured of claims within the deductible, either directly or through a TPA, extinguishes those claims, with no further obligation on the part of or charge to the guaranty fund, and
- Guaranty funds receive the benefit of other insured claim obligations (for example, the insured obligation to reimburse for deductibles) to the extent the guaranty funds pay large deductible claims.

¹⁵ There is a wrinkle here that should not be overlooked by policymakers. At the time that a guaranty fund takes over an insurer, there will probably be reimbursements that are already due the insurer arising from claims that the insurer had already paid. The arguments that guaranty funds make with respect to the claims that they pay after they take over the estate would not necessarily hold for reimbursements by policyholders for claims that were previously paid by the insurer and were not paid by the guaranty fund. This has not led to abuses in the past, as guaranty funds have not pursued reimbursements for claims paid by the insurer prior to liquidation, but it is a technical point that should be considered when possible legislation in this area is drafted.

An open question regarding insurer insolvency and guaranty funds relates to claims that have been handled by the employer without the insurer's knowledge.¹⁶ In this circumstance, the guaranty fund may be unaware of such claims when it takes over the insurer's claims administration. Then, if the employer fails to pay amounts due and the injured employee initiates litigation, there appears to be the chance that the guaranty fund may deny coverage, as the claim was not submitted in a timely fashion. This would not absolve the employer of responsibility (either for the amounts over or under the deductible), but this may be of little solace to the injured worker if the employer has become insolvent as well. Such an occurrence has yet to be documented and its frequency is unknown, but it is noted that the laws of some states provide that notice to the employer is considered to be notice to the insurer. Such laws would appear to be of value to the injured employee in the scenario just described, although it may be necessary to clarify guaranty fund statutes as well.

Section 5 – Deductible Policyholder Claims

Most regulators believe, with different levels of conviction and different legal authority, that claims under deductible policies are reported to insurers and adjusted by their staff/agents in the same way as for non-deductible policies. Notwithstanding the regulators' demands or hopes, it has been observed that employers can assume varying degrees of responsibility for handling claims, with varying degrees of knowledge and consent of the insurers. Self-administration of a claim has two subcomponents upon which we will focus:

- Degree of self adjusting of claims (all, some, or completely outsourced to a TPA)
- Degree of coordination and reporting with the primary insurer

Each presents very different sets of regulatory concerns. On the first bullet point, if a qualified and properly directed person (TPA or in-house adjuster) handles a large deductible policy claim, then the efficiency and quality of benefit administration should be roughly comparable to cases where the primary insurer adjusts the claim. On the second bullet, an insurer's lack of knowledge of a worker's claim and its characteristics is likely to have a more dangerous and far-reaching effect on the smooth function of the workers' compensation insurance system. These concerns will be discussed at length later.

In January 2003 the IAIABC surveyed its members concerning the utilization of large deductible policies.¹⁷ The majority of the states responding suggested that the large deductible policies that were authorized in their states required that the insurer adjust and pay the loss and then bill the

¹⁶ Two situations are possible here and both situations have been known to occur, but it is unknown how often they occur. One situation is where – without any knowledge by the insurer – the employer hides a claim or claims from the insurer and/or the insurer's TPA, presumably because the employer wants to obtain a lower experience modifier or believes that this will result in more favorable underwriting. The other situation is where the insurer knows that the employer handles some of its claims without reporting them and agrees to or at least condones this practice. In this situation, while the insurer may know that there are outstanding claims, it won't know the details on them.

¹⁷ "Online Survey of State WC Agencies Regarding Large Deductible Insurance Policies," IAIABC, Spring, 2003.

policyholder for the amount paid, to the deductible limit. This suggests that the intended practice for large deductible policies is for the claims to be handled by the insurance company writing the policy and paid out of the insurer's general operating funds. This is not unlike the beginning point for a workers' compensation policy without a deductible. The insurance company writes the policy and handles the claim. However, the actual handling of claims in large deductible policies often involves not only the insurance company, but also a TPA, which may be engaged by either the insurer or the employer. The extent and significance of these activities, especially self-administration of claims, has been debated: some find it a matter of significant concern, while others maintain either that employer involvement in claims handling is not a common practice or that it is no greater with large deductible policies than with other policies.

Given the central importance of reporting and how large deductibles can contribute to claims adjustment and reporting problems, a second survey was done by the IAIABC in June 2004. That survey demonstrated that workers' compensation regulators widely shared the belief that non-reporting of claims, especially medical-only claims, was a practice in their state. The degree of the nonreporting was a matter of opinion, since the regulators had no systematic evidence. Opinions varied widely, with the most common opinion being that non-reporting affected less than 10 percent of lost time claims. As to the primary culprits in non-reporting, the survey showed that workers' compensation regulators did not consider large deductible policyholders as the worst offenders. Rather, smaller employers that are experience rated were thought to be the most likely to not report lost time claims. A few respondents in the January survey did have strong feelings about large deductible policyholders acting as de facto self-insureds.¹⁸

Deviations from policy language for large deductible policyholders –

As stated above, the typical deductible policy requires the insured to reimburse the carrier for amounts under the deductible. This is designed to protect the claimant, and may be mandated by state law.¹⁹ It is different from a standard deductible in other lines of insurance, where the insured pays first and the carrier pays after the deductible is met. Regardless of the policy language, some agents have been found selling large deductible policies to their clients as though claims were to be paid by the employers out of pocket, citing not only the lower up-front cost, but also the ability to avoid experience modifications attributable to claims within the deductible limits.²⁰ Some of the nation's largest workers' compensation carriers vehemently deny²¹ that they market policies this way, or condone agent or employer behavior in non-reporting of claims.

¹⁸ A typical comment from the survey read, "Large deductible policies tend to cause the employers to act as self-insured, even though they have not qualified as such. Also, it tends toward out of state adjusting, which is prohibited, and it tends toward having the claims adjusted by employees who are not licensed adjusters and therefore are often not fully informed about Idaho requirements. We see deficiencies in reporting initial claims, changes in status, and first payment checks."

¹⁹ For example, Maine law requires that "The deductible form must provide that the claim must be paid by the applicable insurer, which must then be reimbursed by the employer for any deductible amounts paid by the carrier. The employer is liable for reimbursement up to the limit of the deductible." 24-A M.R.S.A. § 2385(3).

²⁰ See, for example, the testimony in *In the Matter of the Enforcement of the Workers' Compensation Act with respect to Montoya Construction*, NM WCA No., 2002. How widespread this practice might be is the subject of ongoing debate.

Perhaps the difference in the survey responses and reported regulatory problems stem from how clearly states define the responsibilities of large deductible employers and their insurers – and how they enforce these rules. States are quite different with how closely they specify the responsibilities of the insurer in paying workers' compensation claims within the deductible limits. The Colorado Insurance Dept. in a March 2, 2003 bulletin made it clear that policy language must clarify the insurer's ultimate financial responsibility vis-à-vis the employee-claimant. However, like other similar bulletins, it was silent on employer payment of claims:

Pursuant to § 8-44-105,C.R.S., every large deductible policy shall contain a provision stating that the insurer is liable to pay workers' compensation benefits directly to the employee or the employee's dependents, in the event of death. All other provisions in § 8-44-105, C.R.S., are applicable to large deductible policies.

Additionally, the forms require the insurance carrier to be responsible from the first dollar, but this does not always happen in practice. In addition to expressly banning self-administration and payment of claims by an employer under a large deductible policy, Oregon adds a specific enforcement responsibility for the carrier:

An insurer which issues a workers' compensation insurance policy with a large deductible provision must file such provision with the Director for approval as required by ORS 742.003. The provision must satisfy the following requirements:

(1) A large deductible provision must clearly and prominently state that the insured employer must report all workers' compensation insurance claims to the insurer and the insurer retains responsibility to administer claims and to pay all costs and expenses.

(2) A large deductible provision must state that the insurer will delete the provision effective not more than ten (10) days following discovery that an insured employer has on three occasions within the policy period known of but not reported a workers' compensation insurance claim to the insurer or has on any occasion within the policy period made direct payment of claim costs. The provision may further state that the insurer will cancel the policy with notice pursuant to ORS 656.427 or that the insurer will delete the provision retroactively to the date of the offense with penalties stated in the provision. When a large deductible provision is deleted, the premium for any remaining portion of a policy term will be computed using the rating plans applied by the insurer to the policy prior to deductible credits except that any system of expense gradation applied by the insurer to similar policies must be used.... (Oregon Admin Rule 836-054-0210)

As an indication of the lack of clarity and strength of regulatory positions, most state web sites do not explicitly mention or discuss the obligations of employers and carriers to report claims in the context of large deductible policies. This lack of clearly articulated rules may contribute to employer and agent boldness in skirting the expressed preferences of carriers to have all claims reported.

²¹ Liberty Mutual has asserted at several meetings of the NAIC/IAIABC Working Group that they expressly prohibit employer payment of claims.

As illustrations of reporting breakdowns that have occurred between employers and insurers:

- In one situation that involved the bankruptcy of an employer insured by a large deductible policy, issued by a solvent carrier and administered by a TPA, the claims for the insured employer were stopped until the TPA was able to work out an agreement with an excess carrier. The excess carrier identified by the TPA was not the carrier that wrote the large deductible policy. So, in this case it was clear that the insurance carrier that provided the large deductible policy never paid on any of the claims. If the insurance carrier had maintained first dollar responsibility, as required by the forms, then there should have been no disruption in the payments.
- In another case, claim checks began bouncing after the employer went bankrupt, and the insurer did not take over responsibility for the claims until regulators intervened to remind the insurer of its obligations.

As mentioned in Section 7 of this paper, one of the possible arrangements that can occur involves a side agreement between the insured and a TPA. As part of the agreement, the TPA will pay the claims and be reimbursed by the employer. In practice, the reimbursement occurs through a fund that is maintained for the payment of claims. The insured will make deposits into the fund and the TPA will use that money to pay claims. In the above examples, this appears to be the arrangement agreed to between the employer, TPA *and insurer*. It explains why the bankruptcy of the insured impacted the payment of claims. To the extent that there is doubt about the insurer's obligation to pay the deductible amounts, regardless of the behavior of the employer in paying the benefits, the arrangement starts to become more like self insurance with excess insurance only. As recommended again later, any ambiguity about the insurer's "first dollar" obligations should be defeated by clear law and strong enforcement.

Anecdotally, employers engaged paying their own claims under a deductible may refer to themselves as self insured, presumably because they perceive that they are bearing the bulk of the financial responsibility. Their worker-claimants may not know who the insurer of record really is. With TPAs handling claims, the experience of some regulators has shown that it is not uncommon for the employer and/or TPA to refer to the employer as being "self-insured." Additionally, the insurance carrier that wrote the policy may also sometimes refer to the employer as "self-insured" or indicate that the employer has an excess policy, which is common for self-insured employers. When statements as these are made, this relationship is likely to be further evidenced through an examination of the claims handling activities of the parties involved.

If there are any doubts about modifications to the insurance contract for workers' compensation with respect to first dollar coverage, it may be a wise public policy measure to void any deviations or manuscripting of a standard workers' compensation policy. For example, in a November 7, 2002 directive from the Oregon Workers' Compensation Division, the state makes responsibility clear:

“Regardless of the terms of the policy, insurers are responsible for all workers’ compensation claims costs of employers for whom the insurer has issued a guaranty contract. Employers must report all claims to the insurer, including claims whose costs do not exceed the deductible threshold. Insurers remain responsible for all claims administration, including direct payment to claimants and service providers, or contracting with TPAs.

The law states that “A guaranty contract issued by an insurer shall provide that the insurer agrees to assume, without monetary limit, the liability of the employer, arising during the period the guaranty contract is in effect, for prompt payment of all compensation for compensable injuries that may become due to subject workers and their beneficiaries.” (OAR 656.419(1) In addition, “Coverage of an employer under a guaranty contract continues until canceled or terminated as provided by ORS 656.423 or 656.427.” (ORS 656.419 (5))”

Missouri offers extensive guidance on the language allowed under large deductible policies and asserts:

As is the case in other states where deductible plans are authorized, the insurance company retains the ultimate responsibility for the payment of compensable claim.²²

Conflict of interest with lump-sum settlements –

Large deductible policies can create a conflict of interest between the insurer and the employer when possible lump-sum claim settlements are considered. This arises in part because the insurer generally has exclusive control over the settlement but the settlement is often largely or entirely financed by the employer. Although it would be a breach of the insurer’s duties under the policy to settle a claim generously because it is not the insurer’s own money, it is not easy to monitor and enforce such obligations. More fundamentally, even when the insurer acts in good faith to settle a claim at its fair present value, the settlement still works to the advantage of the insurer and the detriment of the employer whenever the expected sum of all payments to an injured worker appears likely to exceed the deductible threshold, because deductibles are defined in terms of the total amount paid, irrespective of the timing. If the amount of the lump-sum exceeds the deductible threshold, then the disadvantage to the employer is that it will pay its entire deductible amount right away, rather than over a period of many years. If the amount of the lump-sum is less than the deductible threshold, even though the sum of the expected payments would be in excess of the deductible threshold (through the action of discounting such payments to present value), then the insurer pays nothing and the policyholder loss is equal to the current value of the insurer’s otherwise expected payments.

In general, a good working relationship and prior understandings between the insurer and the employer should minimize these problems (as the insurer generally won’t want to lose the business), but it is a conflict that exists nevertheless. In noting this, it is acknowledged that exactly the same conflict exists with paid loss retrospective rating plans if the per-claim limitations are high enough.

²² Susan Schulte, Chief P&C Section, Dept. of Insurance, “Modified Guidelines for Deductible Workers’ Compensation Policies,” January 31, 2002. The very same language, along with other guidance, also appears in a bulletin by Director Jay Angoff, February 9, 1993.

The extent of unauthorized self-administration of claims by employers –

The major large deductible question left unanswered by this paper is, “to what extent and degree are large deductible policy holders taking responsibility for the adjudication and payment of their own claims within the deductible amounts?” For years there has been a persistent suspicion that a large number of employers subject to experience rating and individually applied loss sensitive rating plans have not reported all of their claims, especially minor claims. Under some circumstances, insurance rating plans create a financial incentive not to report small claims, and there is now software that allows employers to calculate how a given claim payment can be expected to affect their premium.²³ Anecdotal evidence abounds on claims that erupt to reveal breaches of good claims practices discovered long after the injury was reported to an employer who failed to report the case to the insurer or agency. Despite the importance of this issue for many parts of the workers’ compensation system, it is amazing that no study has ever been published that purports to measure the degree of employer nonreporting. Thus, many feel that critics have blown anecdotal evidence out of proportion.

The remainder of this section will deal with claims-related issues that can occur, with extensive coverage of those that can occur when self-administration of claims occurs. This treatment will seem heavy-handed to those that believe that self-administration is rare, but it serves the purpose of emphasizing the serious problems that can happen and the importance of minimizing their incidence.

Claims reporting –

The absence of objective evidence forces conjecture on the consistency with which employers report claims to their insurer, for large deductibles and other types of insurance contracts.²⁴ If a large deductible policyholder or the TPA handling its claims doesn’t report all claims to the insurer, then the loss experience for the employer will not be effectively captured. As a result, the employer’s subsequent experience modifiers will fail to properly reflect its loss experience, and classification ratemaking for its class of business will be distorted, affecting other policyholders.

Perhaps as insidious is the failure of employers adjusting their own claims to report them to the appropriate statistical clearinghouse. Since claims trends are used not only for ratemaking but also for a multitude of policy decisions, from benefit adequacy to administrative resource allocation, any market phenomenon that creates inaccuracy detracts from the administrative efficiency of the system. Interestingly, the decentralized nature of the reporting system that exists under large deductible policies (used as described) makes it virtually impossible to

²³ This software is created for risk management purposes but can be used as a sort of “radar detector.” In some case, its use by dishonest employers can actually improve compliance, since as with tax shelters, there is often an exaggerated perception of the costs of compliance as compared to the costs of evasion, so that non-reporting employers sometimes end up paying more in benefits than they save in premiums.

²⁴ Only two IAIABC survey respondents asserted that claim reporting on large deductible policies in their state is comparable to reporting on policies where no deductible applied. Interestingly, a substantial number of respondents indicated that they did not know whether reporting was comparable.

determine how much underreporting is taking place.²⁵ As noted earlier, there is a good deal of speculation about the extent of the phenomenon and workers' compensation administrators are unsure about its extent. The June 2004 survey of IAIABC members suggests that the underreporting is no different than what occurs with other forms of workers' compensation policies.²⁶ However, there are others who argue that the nature of agreements between the parties involved in a large deductible policy add to the likelihood of underreporting.

Some employers that are covered by a large deductible will enter into agreements with TPAs and properly report the injury to the TPAs. When the agreement is between the employer and the TPA, and not the insurer and TPA, there may be some question as to how effectively the TPA reports injuries to the carrier.²⁷ In fact, at least one regulator has learned during the course of compliance investigations that some insurance carriers will refer to employers that use TPAs to handle their large deductible claims as self-insureds and have no knowledge of claims submitted by the insured. However, as with employer reporting to insurers, there is no good evidence on the extent of failure of TPAs to report to the responsible insurer. Recent insolvencies clearly involved poor reporting by some TPAs to the insurers, but these were insurers which were obviously not managing this aspect of their operation very well. The extent to which this practice continues in current markets is unknown.

Claims handling –

When the employer does not strictly adhere to the policy language requiring the insurer to pay losses,²⁸ it opens the door to a number of claims handling abuses that can come back to haunt the employer, its insurer and the state regulator. It has been suggested that amateurs doing their own claims adjusting make amateur mistakes. Where an employer attempts to pay claims directly,

²⁵ Moreover, since the very features of a large deductible policy that make it attractive to an employer may act as a statistical selection mechanism, the artifact in the resulting claims statistics may cover significant trends and information about discernible classes of employers.

²⁶ Although the cost of failing to report claims is greater if the insurer would otherwise be paying the claim, the benefit of suppressing the employer's experience mod is also greater if the employer is paying for first-dollar coverage.

²⁷ Here is an excerpt from a letter sent to the Nebraska Workers' Compensation Court by a prominent TPA showing such an arrangement: "Please be advised that effective September 30, 2003, (Employer name withheld) has contracted with (TPA name withheld) to administer new workers' compensation claims." Note that the agreement is between the employer and TPA, not the TPA and insurer. This is even more significant in Nebraska because it has adopted a version of the NAIC's model TPA act with provisions that include workers' compensation and prohibit agreements between employers and TPAs for workers' compensation claims, except where the employer is an approved self-insurer.

²⁸ The fact that state law requires the insurer to pay losses rather than allow the policyholder to administer claims is not clear from the insuring agreement. The NCCI's standard policy provides "We will pay promptly when due the benefits required of you by the workers' compensation law" and it also provides, "Tell us at once if injury occurs that may be covered by this policy." Yet it also provides, "Do not voluntarily make payments, assume obligations or incur expenses, *except at your own cost.*" While there are legitimate reasons for this sentence and legitimate payments that could be made by employers (e.g., to pay for lost wages during waiting periods using sick leave), the italicized language in this sentence could also make a person wonder. Regardless of the policy language, the fact remains that a person failing to comply with policy provisions is not breaking a law simply because of that fact. Rather, for a law to be violated, there must be a law that specifically prescribes or prohibits a given action.

rather than report them to the carrier, there are many opportunities for innocent (and intentional) errors in claims handling. Absent the oversight that occurs when an employer is approved to self-insure, there is no assurance that an employer is aware of the details of workers' compensation law and the requirements for claims reporting to the state statistical clearinghouse. Similarly, employers may be unaware of specific statutory provisions concerning health care provider choice, prohibition of ex parte contact with treating health care providers, retention of positions while being paid indemnity benefits, provisions prohibiting retaliation for making a claim, etc.

There is a better understanding on the part of experienced adjusters of those claims that need to be paid whereas an inexperienced person may be more inclined not to pay. Plus, an insurance company adjuster is less likely to be influenced by employment relationships between the employer and claimant, which have no impact on the claim. An inexperienced adjuster is less likely to be able to determine whether proposed medical treatments are reasonable and necessary and what the correct computation of a compensation rate is for an injured worker. Insufficient time and energy may be spent on adjusting, resulting in inadequate control of medical costs or inattention to returning the worker to work. Even if the employer tries to adjust the claim competently and fairly, ignorance of the nuances of state court decisions, regulatory provisions, and statutes can cause good faith mistakes. The fact that only a very small percentage of approved self-insured employers choose to handle their own claims adjustment is only further testament to the difficulty for an employer to efficiently and effectively manage its own claims. Thus, while it is unknown how often unauthorized self-administration of claims actually occurs, it is relatively easy to say that it is an ill-advised practice for both the employer and its employees.

An additional set of factors is potentially more serious. Delay of medical treatment, in some circumstances, exacerbates the injury, resulting in greater long-term disability. Where the employer attempting to adjust its own claims gets "over its head" with respect to the workers' medical condition, significant permanent harm could occur. Similarly, various state laws contain provisions that can operate to bar a claim, if procedural requirements are not met.²⁹ Where the employer is unsophisticated (or malicious), inadequate or incorrect information concerning the workers' rights can be disseminated in a manner that would constitute unfair claims processing practices if perpetrated by an insurer. Unless laws effectively protect employees' rights when an employer or TPA fails to transmit the report of a claim or injury to the insurer, workers' complaints may sometimes not occur until after the workers' rights have been lost. Many states' laws appear to provide this protection, but there appear to be no universally adopted provisions that assure that this protection exists in all states.

It may be argued that these concerns can be removed if a licensed TPA (in those jurisdictions where TPAs are licensed to handle workers' compensation claims) handles the claims for the insured. However, as mentioned previously, if the contract to handle and administer claims is between the employer and TPA, and not the TPA and insurer, then there is some concern whether

²⁹ Notably, statutes of limitations can act as complete bars to a claim, as can statutes requiring initial notice of injury in states where notice to the employer does not suffice. From the claimant's perspective, the same problem can occur when the employer's insurance policy requires timely reporting to the carrier, and the state allows the carrier to include a provision under which the employer's failure to comply may defeat coverage.

the insurer who is legally responsible for the claims will ever be made aware of their responsibility. Once again, this arrangement begins to look like unregulated self-insurance. This is even more apparent when the TPA handling the claim is an affiliate of the insured. In these instances the insured essentially reports injuries to itself and uses its own money to pay claims.

Unregulated self-insurance –

Under the regulatory schemes of the various states, an applicant for the privilege of self-insurance has to demonstrate sufficient resources to assume its own risk of loss with reasonable certainty of payment. Most states further require adequate excess coverage, the placement of security theoretically sufficient to fulfill its obligations to injured workers, an acceptable mechanism for professional claims handling, and an adequate safety program. A large deductible policy can be viewed as an alternative private-sector mechanism for self-insurance, with the insurer's underwriting taking the place of the state's approval process and the insurer's first-dollar claim guarantee taking the place of the state-administered security mechanisms.

But is this alternative always adequate? When a large deductible policyholder "self-insures" by adjusting and paying its own claims, it does so without the protections relating to claims administration that a regulated self-insurer must demonstrate. Insolvencies in recent years have uncovered examples of thinly capitalized employers that were able to obtain large deductible policies with limits that could not be satisfied from liquid assets in the event that the business closed its doors. While it may be argued that this should be of no concern due to the liability of the insurer, a review of the bankruptcy discussion in Section 3 will show that there are indeed concerns should the insured become insolvent. In the worst instance, the insurance company carrying the risk for a PEO may never be aware of the extent of its claims liabilities if it does not know who all the clients are.

When an employer can obtain the benefits of self-insurance without the costly investment in security or administrative oversight compliance, the market creates economic pressure on legitimate self-insurers to purchase large deductible policies. In this sense, large deductibles offer an alternative to traditional self-insurance for those employers attracted by the prospect of avoiding compliance costs or regulatory oversight. The motivational set that gives rise to the choice does not, however, necessarily bode well for the injured worker looking for fast, fair, and correct claims handling. Specifically, if an employer is able to find an insurer that will allow it to administer its own claims,³⁰ then this may result in claims being handled by persons without adequate claims handling skills that may also have the ability to bring unreasonable pressures to bear on an injured worker to accept less favorable treatment than may be properly due under the workers' compensation law.

As noted above, it is difficult to expose the practice of direct payment of benefits by policyholders under large deductible policies. Since these injuries are "off the books" unless the deductible is exceeded or a dispute arises, it is difficult for the administrative agency to become aware of most violations of the provisions requiring the insurer to be on the claim from first

³⁰ It is clear that many insurers would refuse to enter into such a relationship, but the volume of complaints received by compensation commissions gives evidence that not all insurers are so disciplined.

dollar.³¹ Since there is no way to assure that the worker is properly informed of his or her rights, the common expectation that disputes will arise and be adjudicated at the workers' compensation agency if improper claims practices occur becomes less reliable.

When regulators do obtain information that an employer is misusing a large deductible policy, there appear to be some difficulties in pursuing enforcement actions. The public does not understand that there is a problem when the employer is "paying its own claims" and significant enforcement action can be politically unpopular. The enforcement situation is complicated by significant lack of clarity in enforcement responsibilities.³² Even where the issue has come to light because the worker has not received benefits to which he/she is due, the ensuing court dispute may devolve into an orgy of finger pointing, involving the employer, insurer, insurance producer, worker, and any party alleged to have allowed or encouraged direct payment of benefits.³³

Summary

Some regulators believe that large deductible policies may exacerbate a tendency present in employers to self-administer their claims in order to save insurance or other claims administration costs. Self-administered claims present major problems: 1) poor outcomes for the claimant if the claim is not handled properly; 2) loss of data for ratemaking, research, and system performance monitoring; and 3) regulatory complications to resolve questions, confusion, and disputes that arise from improperly handled claims. Even if the employer uses a qualified TPA, these problems may still arise, either because the TPA has a contract with the employer to handle the claims or is affiliated with the employer.

Both insurance regulation and self-insurance regulation strive to assure that injured workers will be paid promptly and fairly. To the extent that large deductible practices avoid such regulation and blur the lines of responsibility, there will be problems and concerns remaining unresolved. While there is no evidence that large deductible policyholders are more likely to self-administer claims and/or to failure to report these claims to their insurer, it would nevertheless appear to be good regulatory practice to establish clear-cut laws prohibiting these undesirable practices and appropriate sanctions for employers detected violating the laws (and insurers found complicit in such practices).

³¹ "In theory, our state requires the insurer to be reimbursed by employer for deductible amounts. As a practical matter, this may not be occurring in some (or many) instances." (Comments received from a workers' compensation agency in response to a survey of the states.)

³² A series of questions were asked in the IAIABC survey concerning the responsible agency for enforcement action in a variety of circumstances. There are significant differences between states, and significant confusion within some states as to what agency has enforcement responsibility for various scenarios. Interestingly, a common answer for many of these questions was that **either** the insurance department or workers' compensation agency had jurisdiction, leaving open the significant probability that confusion about responsibilities will impact enforcement efforts.

³³ See, for instance, *In the Matter of the Enforcement of the Workers' Compensation Act Against Steven Young*, NM WCA No., 2002.

Section 6 – Equity Issues relating to Taxation and Funding of Residual Markets

Workers' compensation premiums and losses are taxed or assessed for close to a hundred different purposes in the U.S., using a variety of procedures and formulae. This section will describe many of these mechanisms and discuss the impact of large deductible coverage from three perspectives:³⁴

- Equity – using the term for these purposes in a narrow sense – are similarly situated taxpayers treated in a similar fashion?
- Proportionality – are differently situated taxpayers treated differently, to the extent that the differences are relevant? Are the right people being taxed, and is the amount they are charged commensurate with the purpose of the tax?
- Incentives – What activities are encouraged by the mechanism for calculating the tax liability, and what activities are discouraged?

Ideally, the goal is for taxpayers to pay their fair shares, and if certain behavior allows taxpayers to reduce or avoid their tax liabilities, it should be behavior that either is considered intrinsically desirable (as with “sin taxes” or tuition tax credits), reduces the need for the tax (as with “user fees”), or both (as with special assessments on occupational death claims).³⁵ Of course, the notion of paying one's fair share raises an obvious question – fair share of what? Since many of the charges discussed here in the context of workers' compensation coverage are designated as special purpose assessments, that designated purpose should give us at least the beginnings of an answer, but as we will see, there is still room for controversy even in this context.

Note that these three perspectives, though somewhat different, are interrelated. For example, any framework that treats similarly situated taxpayers differently invites regulatory arbitrage. This will generally be a counterproductive incentive structure, unless one has to actually do something socially productive in order to claim entitlement to the more favorable classification. Therefore, even where reasonable minds can differ over the “natural” base for a particular tax or assessment, we can still often gain considerable insight by comparing how the different alternatives affect employers with nondeductible workers' compensation insurance, large deductible workers' compensation insurance, retrospectively rated insurance, and traditional self-insurance. Would one group be unduly favored or disfavored? What incentives do employers have for choosing or rejecting a particular type of risk financing, and are those incentives consistent with the purpose of the assessment?

³⁴ Although this inquiry is phrased in terms of “taxes,” the same concepts are equally applicable to residual market assessments and similar fees charged in the private sector.

³⁵ A classic example of a “dual purpose” charge, although it is not a tax or assessment, is experience rating. Insurers use experience rating because loss history correlates with future risk, and many state laws make experience rating mandatory in order to give employers an incentive to reduce their accident frequency.

This document will examine the following major funding needs:

- (a) Taxation for general revenue purposes;³⁶
- (b) Taxes and assessments to support general administration of workers' compensation laws, safety inspection, education and assistance to employers and employees;
- (c) Taxes and assessments to support second injury funds;
- (d) Taxes and assessments to support vocational rehabilitation funds;
- (e) Taxes and assessments to support a wide variety of special funds related to the execution and operation of the workers' compensation system, and
- (f) Support of residual markets.

Sometimes a state will require that taxes or assessments be directly passed on to policyholders through a separate policy charge. While this appears likely to affect public perception, this paper will not treat the use or lack of use of this mechanism. In addition, this paper will not discuss whether certain taxes or assessments may subject insurers domiciled in the state to retaliation or not. These are both important topics, and should be considered whenever a state examines its tax and assessment structures, but these topics do not relate directly to the subject matter of this paper, which is to examine the effects of large deductible policies upon states' systems of taxes and assessments.

Ideally, each funding need can be targeted to the economic sector that creates or benefits from the activities and costs to be covered by those funds. Unfortunately, this is not an easy task. One must deal with the cost, availability and timing of the possible measures of exposure or losses. In addition, when paid losses are used as a basis of taxes or assessments, insurers must cope with requirements to set aside reserves for the probable payment of additional taxes or assessments in the future. For instance, calendar year written premiums, earned premiums, and total paid and incurred losses are available from insurance company Annual Statements on the following March 1st of each calendar year. (All current Annual Statement State Page figures are net of deductible premium credits and net of deductible losses.) If one of these measures is better correlated than any other measure, then it will be available on March 1st. Ah, if only it were so simple!

The use of exposures and losses is complicated because they can be measured in many ways. Insurers regularly divide losses into medical and indemnity losses, and they regularly sort medical and indemnity losses into policy year and accident year³⁷ buckets. (Appendix 2 provides an in-depth discussion of the common measures of premium and losses. The reader unfamiliar with the differences between calendar year premium, standard premium, and policy year premium or between accident year losses and calendar year losses is advised to read Appendix 2.) The advantage to using some of these more complex measures would be that taxes and assessments could be more closely matched with the types of losses and the periods of time

³⁶ Perhaps other tax bases would be more equitable, but it is beyond the scope of this paper to question whether premium taxes should be collected for general revenue purposes.

³⁷ The notion of "accident year" is customarily used only for losses. It would be possible to create a more sophisticated measure of matching premiums to accident year losses than simple calendar year earned premiums, but it would involve computations beyond those that are typically undertaken.

that generated them. The disadvantage to using these measures is that it may take longer for these types of data to be available and, at least in some cases, the additional complication may not result in significantly greater equity in taxes and assessments.

It is generally also more equitable to identify funding bases that minimize the differences in taxes and assessments between similar employers that choose different means to finance their workers' compensation costs. The exception to this principle occurs when the costs generated by an employer change when it changes its means of financing its workers' compensation costs. For instance, an employer wouldn't be expected to generate more or less demand upon a vocational rehabilitation system based on whether it was insured without a deductible, insured with a large deductible, or if it was self-insured. In contrast, the demands generated by self-insured employers upon insurance guaranty funds should be less than those generated by employers that are insured without a deductible.³⁸

With this background, this document will address the funding considerations for different types of taxes and assessments. It will pay attention to whether the employer that is paying the tax or assessment (directly or indirectly) is insured without a deductible, insured with a deductible, insured through a retrospective rating plan, or individually self-insured.

Section 6(a) Taxation for general revenue purposes –

Taxes are collected for general revenue purposes because the government needs money to conduct its business. Typically, such taxes are expressed as a percentage of direct written premiums reported in the Annual Statements of insurers, often after being reduced by the amount of paid dividends.

At the two extremes, compare a very large employer that obtains first-dollar coverage with a similar large self-insured employer that only purchases an excess policy with a large retention, plus a surety bond. Obviously, the self-insured employer will pay far less in traditional premium taxes than will the employer with a first-dollar insurance policy. Which is fairest? Some people will feel that special taxes in lieu of premium taxes on self-insured employers are fairest, while others will take the opposite position. This document will offer no judgments on that question, but one must be aware of the differences that occur and the various potential bases of taxation that could be used, and how they might apply to employers depending on whether the employer is insured without a deductible, insured with a retrospective rating plan, insured with a large deductible, or individually self-insured.

Taxation creates incentives to modify business behavior. While this document will not attempt to address the "equity" of premium taxes for general revenue purposes, the observation is nevertheless offered that a tax on written premiums will be considerably greater for employers written on nondeductible forms and employers written on retrospectively rated policies than for employers written on large deductible forms or employers that are self-insured.

³⁸ Although most states have some sort of self-insurance guaranty fund, such funds are independent of the insurance guaranty fund, whose exposure arises primarily out of surety bonds and excess policies. In some states these lines are not covered at all, and where covered the per-claim limits, especially for surety bonds, typically aggregate all claims against a self-insurer into a single guaranty fund claim.

If the “justification” given for this distinction between employers written on nondeductible forms versus those that are written on large deductible forms or are self-insured is that the latter are really transferring much less risk, then this explanation fails to justify any difference between retrospectively rated employers and employers that are self-insured or written on large deductible policies. Depending on the deductibles and rating values that are selected, the risk transfer and the risk assumed by the employer are very similar with these different loss financing mechanisms. Absent some compensating factor, the implication is that the employer written with a retrospectively rated insurance policy is being overtaxed relative to an employer written with a large deductible or that is self-insured. In addition, one certainly cannot justify a large deductible policyholder paying less in taxes than both self-insured employers and those written using nondeductible forms.

Another wrinkle occurring with large deductible policies that is difficult to justify occurs with employee leasing firms and PEOs, which might purchase coverage for their many clients on large deductible policies. The clients pay premium-like amounts that are comparable with nondeductible premiums charged by insurers, yet the state will only be able to collect premium taxes on the much smaller large deductible premium paid by the PEO. This same “loophole” will apply to any premium-based taxes or assessments, and to any loss-based assessments that don’t add back the losses paid under deductibles.

Section 6(b) Taxes and assessments to support general administration of workers’ compensation laws, safety inspection, education and assistance to employers and employees –

Each state typically has one or more separate and distinct agencies that play a role in the administration of its workers’ compensation law. There is no consistent pattern in how tasks are allocated to different entities. For example, a special agency can be set up to adjudicate disputes and another set up to hear only appeals from administrative hearings. About ten states have safety agencies that assume responsibility for enforcement of the federal OSHA Act. Vocational and rehabilitation services are extremely varied in their delivery and organizational settings.

Much of the work falling to workers’ compensation administrative agencies correlates with the number of compensable claims. This includes such activities as the monitoring, reporting and recording of claims, addressing claimant questions and the handling of disputes. Some agency costs are relatively fixed, with little direct connection to claims. Examples of such activities include the handling of general inquiries, rulemaking and public policy, and administration of safety and education programs. Even then, the differences for nondeductible policyholders between premium-based or loss-based taxes and assessments are probably unimportant. Rather, the primary equity issue is typically whether self-insured and large deductible policyholders are paying their fair shares versus employers written on retro and first-dollar coverage forms.

Premium-based funding has one overwhelming advantage for most employers – it is easy to find a relatively reliable measure of premium written by each insurer operating in the state. The premium base is reported on the insurer’s annual report, and is subject to accounting crosschecks. Premium-based funding has its drawbacks, however, even when there is no consideration of the basis of obtaining funds from self-insureds. One equity argument might be that premium only approximately correlates with workloads created for the state agencies on a year-to-year and

insurer-to-insurer basis. Some insurers consistently run higher loss ratios than others, and insurance cycles mock the connection between premiums collected and losses incurred.

Another problem is that large deductible policyholders are undercounted by an unadjusted premium-based approach.³⁹ One response to this is to adjust the net premiums upward for large deductible policyholders so that a gross⁴⁰ funding basis is used for them. The question is, how? Absent a tightly regulated rating environment, one cannot really say what the gross premium for a large deductible policyholder would be. States with a tightly regulated rating environment could simply use filed rating factors, but if a state without a tightly regulated rating environment were to choose to use a premium basis, then it would appear to be most equitable for the responsible regulator to promulgate factors to be used to adjust the premiums for various deductible levels upward to a gross basis that is comparable with policies written without a deductible. One interesting possibility would be to use standard premiums for premium-based taxes and assessments. Such premiums are unaffected by the presence or absence of a large deductible. Of course, the caveat applying to this paragraph as well as the rest of the discussion is that laws will need to allow for such activities.

A premium-based funding approach, while it may be adjusted to be reasonably equitable for all insured employers, does not address the issue of equity with self-insureds. Some other basis of funding must be found for self-insurers. Common state responses to this include the use of an imputed premium for self-insurers, either from their losses or from the application of rates or loss costs plus an expense load to the payrolls of the self-insured.

Another basis of funding of these needs – one that does not artificially create an advantage for self-insureds or large deductible policyholders – is to use some measure of losses. While gross incurred losses might be more appropriate, the problem with incurred losses is that a significant degree of self-judgment is involved in the establishment of the values for unpaid losses, which are a significant proportion of incurred losses. In fact, calendar-year incurred losses can actually be negative in some years, when reserves from prior years turn out to have been overestimated. Paid losses are not subject to the same arguments, but one problem with paid losses is that paid loss figures relate to accidents that happened at various times over past years. This could lead to inequitable situations for employers that switch back and forth between insured and self-insured status.⁴¹

The most serious problem with using paid losses as a basis of taxes or assessments, however, is that it creates requirements for insurers to set aside reserves for the payment of taxes or

³⁹ This problem can also occur when fronting occurs. The insurer may write a fronted policy (either deductible or nondeductible) for an artificially low premium on account of reinsurance placed through a captive affiliated with the employer. In this case, a funding approach that uses actual premiums will not reflect an appropriate basis of taxation or assessment. (These uses of fronting arrangements may run afoul of state laws, but complete coverage of that subject would be beyond the scope of this paper.)

⁴⁰ “Gross” losses refer to the full value of losses, not reduced for deductibles or, in the case of self-insureds, by recoveries from excess policies. “Gross” premiums refer to premiums without a credit for a deductible.

⁴¹ This problem may not be as serious in practice as might otherwise appear possible. The reason for this is that it is not easy to qualify as a self-insured in most states, so those employers seeking self-insured status often have a lot of reasons for pursuing that option and are not likely to switch back and forth on a regular basis.

assessments on losses to be paid in future years. AICPA SOP 97-3 provides that if taxes or assessments are based on paid losses, then a reserve must be established because an insurer can expect to pay additional assessments in the future. Taxes and assessments based on premiums or imputed premiums do not suffer this disadvantage.

Other approaches may involve taxing or assessing insurers (hence indirectly taxing or assessing employers covered by insurance) one way and taxing or assessing self-insured employers in another way. The question that still remains is whether insured employers or self-insurers are advantaged. Unless the state has chosen to encourage or discourage insurance or self-insurance, it would appear that employers should not be motivated either to insure or to self-insure in order to gain a tax advantage. In fact, one approach is to use paid losses to distribute funding needs between insured and self-insured employers, and then to use premiums or imputed premiums (premiums before deductible credits) to spread the taxes or assessments on insured employers among insurers.

On balance, taxes and assessments to support workers' compensation agencies and related safety and education activities should be selected after careful consideration of practicality, equity, and whether there is a desire by policymakers to encourage or discourage one form of risk financing over another. A movement away from paid losses as a basis of taxes and assessments – as it would eliminate the need for an extra reserving requirement – would be desirable if a reasonable basis of premiums or imputed premiums can be developed so that deductible policyholders will share the burdens fairly. In any event, however, there appears to be no justification in having smaller taxes and assessments for these purposes from large deductible policyholders than from self-insured employers and from nondeductible policyholders.

Section 6(c) Assessments to support second injury funds –

The considerations involved with financing a second injury fund may produce different preferred approaches depending on whether the fund is active or in runoff, and depending on whether it attempts to be fully funded or has substantial unfunded liabilities. With substantial unfunded liabilities, the use of premiums or imputed premiums can result in different insurers being forced to shoulder the burden.

If substantial unfunded liabilities exist and the decision is made that these unfunded liabilities are properly borne by insurers who wrote the business in the past, then a more sophisticated allocation of assessments based on losses can offer the ability to more closely tie in the assessments with the years, insurers and/or employers out of which the losses arose. A loss-based assessment can also eliminate questions of equity between insured and self-insured employers. It also avoids questions of equity with large deductible policyholders if gross losses are utilized. When losses are used as a funding base, indemnity losses would be more appropriate than total losses because second injury fund claims are related only to indemnity claims. There may not be a significant degradation in equity, however, if total losses are used instead of indemnity-only losses. Consideration could also be given to looking to accident year contributions to calendar year claim payments, because otherwise new insurers will need pay for old claims or second injury funds in runoff. A caveat to this suggestion is that it could become increasingly difficult to track older accident years and to assign them to currently operating

insurers. The degree of sophistication that is justified may be a function of the size of the unpaid second injury fund losses, as well as the motivation to use a paid loss-based approach.

To be sure, there are policy issues behind assessments; there are issues of administration, and there are practical issues relating to the impact of assessments be examined in addition to AICPA SOP 97-3. For instance, Kentucky encountered serious problems with very large second injury fund liabilities in the early 1980's. At the time, the second injury fund covered second injuries (with a very broad law) and a percent of all occupational disease claims. The assessment was based on losses. It had some strange consequences on the market. One fairly large insurer had some truly bad results so that its assessment represented about 2/3 of its premium.

A second injury fund represents significant challenges with regard to equity if unfunded liabilities are large. Should the burden be carried by past policyholders and insurers that generated the losses, or should it be shouldered by current insurers and policyholders, which are presumably easier to assess? The answers to these questions are beyond the scope of this document. The most equitable and appropriate funding basis will depend on those answers, but similar principles apply to these determinations as apply to other determinations: self-insureds should be assessed on a basis that has them paying their fair share, and large deductible premiums or losses should be assessed on a gross basis, as the chance of an employer with a large deductible to access the second injury fund will not be reduced on account of a deductible. In addition, unless some element of "fairness" between insurers and years with a substantially underfunded situation is perceived as dictating that assessments be based on losses, it is wise for policymakers to recognize the insurance industry's legitimate preference for assessments based on premiums and/or imputed premiums.

Section 6(d) Assessments to support vocational rehabilitation funds –

All state workers' compensation laws allow for some vocational and rehabilitation services to injured workers. Typically these services are for more severely injured workers who nevertheless have the potential to successfully return to their pre-injury earnings after the end of their healing period. The bulk of the cost is paid directly by insurers or self-insurers as a claims cost, e.g., tuition, books, fees, mileage, and indemnity payments while in a formal training program. However, certain vocational assessment, planning and counseling services must be provided by specialists who work with the injured worker.

The funding and equity issues for vocational rehabilitation funds are different and somewhat simpler than second injury funds owing to the timing of the claims, plus the fact that vocational rehabilitation funds are ongoing in nature. Complicating the picture is the fact that some states use internal agency staff to provide services, others shift the cost to federally funded vocational rehabilitation agencies, and others have privatized much of the service delivery and cost. The quicker payouts make it less important to deal with timing equity for vocational rehabilitation assessments than for second injury fund assessments.

Vocational rehabilitation claims have one similarity to second injury claims; namely, that they are generated by indemnity losses. This would argue for an indemnity loss-based assessment structure, but the effective differences of assessing on an indemnity-only basis (versus total losses) may not justify the extra expense to obtain losses in this form. Of course, if losses in this

form are already being obtained for a second injury fund, then that consideration may be of no consequence. Similarly, if accident year records are not also being obtained for second injury fund purposes, then it is questionable whether it would be worth the extra expense to obtain losses on an accident year basis.

With a loss-based assessment, the issue of equity between large deductible policyholders and other policyholders is addressed by using gross losses. Similarly, the equity issue between self-insured employers and insurers would be addressed using loss-based assessments. Yet vocational rehabilitation doesn't involve the problems with substantial unfunded liabilities, as can be the case with second injury funds, which sways the argument in favor of recognizing the insurance industry's desire to be taxed on premiums or imputed premiums, perhaps with paid losses being used only to assure equity between insured employers and those that are self-insured. One recommendation of this paper is that deductible losses and imputed premiums (or a similar measure) be reported on insurers' Annual Statements, which would allow the use of imputed premiums for those jurisdictions that want to avoid the imposition of an extra reserve requirement upon insurers.

Section 6(e) Assessments to support a wide variety of special funds related to the execution and operation of the workers' compensation system –

There is a very broad range of special funds, much broader than those that have been specifically mentioned. Just a few of the variations include:

- COLAs for Permanent Total Disability
- Permanent Total Disability benefits – (IN, AR)
- Uninsured Employer Funds – (CA, WI, MN)
- Coal Workers' Pneumoconiosis Funds – (KY, WV)
- Self-Insured, Insured, and Group Guaranty Funds
- Reemployment Funds – (ME, OR)
- Reopened Case Fund – (NY)
- Fisherman's Fund – (AK)
- Asbestosis Funds – (IN, WA)
- Supersedeas Funds – (DE, PA, WV)
- Federal Programs – Black Lung and Beryllium

The variety of purposes and funding sources for these special programs are very heterogeneous. Only a few broad generalizations can be made:

- These funds often have very specialized funding mechanisms not based on premiums or losses;
- They are generally for the benefit of narrowly defined occupations, and
- They are often designed to respond to specific types of injury situations.

The variety and narrow impact of these funds makes it convenient to eliminate them from the broad discussion here of taxes and assessments for the broader purposes of maintaining workers' compensation systems. Nevertheless, a study of the discussions of the "mainline" types of

workers' compensation funds may provide useful insights to policymakers considering equitable taxation bases for one of these more unique funds.

Section 6(f) Support of residual markets –

Just as other funding-related issues have been sensitive for workers' compensation agencies, residual market issues have been sensitive for insurance departments. Employers insured in assigned risk plans don't like to pay substantially higher rates than those charged to employers in the voluntary market. On the other hand, employers insured in the voluntary market certainly don't want to pay substantially higher rates to subsidize residual market mechanisms. This document won't analyze problems with residual markets in general; rather, it will analyze the effect of large deductible plans on those residual market mechanisms where any shortfalls must be subsidized by insurers writing business in the voluntary market (and again, ultimately by the employers with voluntary coverage).

Prior to the early 1990s, large insured employers had commonly been written on retro plans. During the late 1980s and early 1990s, however, there was a workers' compensation market crisis that resulted in, among other things, assigned risk plans writing much larger volumes of business than ever before. As these plans were generally underpriced, there arose the necessity in many states for large assessments to subsidize the losses they incurred. The methodology for these assessments in NCCI states and in other states with similar plans was to levy these assessments upon insurers in proportion to their direct written premiums. Thus, an insurer was assessed 100 times as much for a policyholder whose retrospectively rated policy had a \$1,000,000 premium than for a small business with a \$10,000 premium.

The result was that retro plans without some form of recognition of residual market loads (RMLs) became "sure losers" for insurers that were forced to pay a percentage of these premiums to subsidize assigned risk plans.⁴² Merely building the residual market load (RML) into the rate level failed to capture the necessary loading for these subsidies from large employers written using retrospective rating plans, because only a small portion of the retrospective premium was determined as a function of manual rates. Several creative approaches followed, one of which was the widespread introduction of large deductible policies. A primary motivation – perhaps the primary motivation – for the development of large deductible plans was so that insurers wouldn't charge large policyholders as much to support the residual market.⁴³ One can argue the equity of this arrangement at length, but the fear that many insurers and some regulators had was that many large policyholders, including perhaps some that were less fit, would simply opt for self-insurance to completely escape burdens to support assigned risk plans.

In discussing the equity of assessments for assigned risk plans, it is difficult to identify the parties that benefit from and/or should be responsible for supporting the residual market. To some

⁴² Some states have had non-self-supporting residual markets all of the time, and all states have had non-self-supporting residual markets some of the time, particularly in extreme hard market cycles.

⁴³ Clearly, however, additional factors continued to make large deductibles attractive. RMLs largely went away during the mid 1990's, but the volume of business written under large deductible policies continued to grow. Reasons for this growth may have included other tax and assessment breaks for large deductible policyholders, as well as the opportunity (whether allowed by regulators or not) to control or self-pay losses.

extent, it can be argued that no one benefits except for the employers that are insured by the residual market, with the conclusion that the residual market should be self-supporting with no subsidies. To some extent, it can be argued that the entire jurisdiction benefits, because it allows employers to stay in business, and may reduce the incidence of employers operating illegally without insurance. The benefit-to-society-as-a-whole argument would imply that self-insured employers and employers insured using large deductible policies should also support the assigned risk plan.

At this writing, a typical situation is one in which self-insureds do not support the residual market mechanism at all. Large deductible policyholders support the residual market mechanism in proportion to their net premiums, and first-dollar and retrospectively rated policyholders support it in proportion to their total premiums. On its face, this seems like an inequitable funding basis. As referenced before, a fairness-related argument can be made to exclude self-insured employers, but there does not appear to be any argument that can defend large deductible policyholders getting a substantial break in comparison to otherwise similar employers written on retrospectively rated policies. Rather, a pragmatic view is that the laws creating support mechanisms for the assigned risk plans did not contemplate or anticipate the emergence of large deductible policies.

Factors arguing in favor of the current preferences for large deductible policyholders are: (1) the policyholder is buying less “insurance” than a policyholder without a deductible; (2) large deductible policyholders are employers that are less likely to be written in assigned risk plans, and (3) it is in the public interest not to unreasonably motivate mid-sized employers, some of which may not be ideal candidates for self-insurance, to go to self-insurance as a means to avoid supporting the residual market. While these are relatively strong arguments, they don’t justify the lack of a similar treatment for retrospectively rated policyholders. Of course, because of the relatively tougher treatment thus accorded retrospectively rated policyholders, the market has shifted away from the use of retro plans, perhaps so much so that it is merely a distraction to discuss them in many jurisdictions.

In summary, the reduced residual market support required of large deductible policyholders is viewed by many as having been a primary motivation for the creation of large deductible products. While this paper has provided background on the question of whether this reduction is equitable or in the public interest, it will nevertheless not opine on whether the current preferences for large deductible policyholders are equitable or in the public interest. There are clearly strong arguments on both sides of these questions.

Tax & assessment summary –

The tax and assessment laws of many states have not been updated or updated completely to recognize the impact of large deductibles. While it is easy (and correct) to proclaim that states should consider the impact of large deductibles upon their tax and assessment structures, the diversity of fund structures across the many jurisdictions means that a “one size fits all” answer isn’t likely to work or be accepted. Ideally, a tax and assessment structure should try to be understandable, maximize equity, minimize cost, avoid opportunities for undesirable manipulation, obtain a predictable flow of funds, and provide whatever business motivation the jurisdiction may choose. Clearly, the enthusiasm of employers to purchase and insurers to offer

large deductibles would diminish if all taxes and assessments were shared equally by first dollar, retrospective and large deductible insurance policies.⁴⁴

While lower taxes for large deductible policies for general revenue purposes is acceptable to some or many, this opinion does not prevail for taxes and assessments that support workers' compensation administration and benefit funds. Such funds may achieve the greatest equity between large deductible and other policyholders by utilizing either paid losses (including deductible losses reimbursed by policyholders) or by utilizing some measure of the full exposure presented by large deductible policies. A disadvantage to either of these approaches is that the information necessary to utilize them is not contained on Annual Statements provided by insurers. As such, the recommendation is made that an exhibit be added to Annual Statements to show both of these quantities for workers' compensation insurance. This will have several benefits. It will provide information of interest to workers' compensation administrators and insurance departments. It will provide the information necessary to adopt tax and assessment bases that recognize the full exposure of large deductible workers' compensation policies. It will make it easier for insurers to report these quantities, as instructions and the methodology will be contained in Annual Statement instructions, be consistent from jurisdiction to jurisdiction, and can be cross-checked with information submitted to advisory organizations and rating bureaus.

Of course, with both paid losses and imputed (or "grossed up") premiums or loss costs available, the question becomes which of these two measures is superior. In terms of equity, the question can go either way, with premiums (or loss costs) being attractive for many administrative and benefit funds, although paid losses may have more appeal for some the support of second injury funds with substantial unfunded liabilities. But the use of paid losses creates an additional reserving burden for insurers that isn't created when premiums or imputed premiums are used, which may make imputed premiums a more attractive funding mechanism even for second injury fund obligations. Insurers are likely to be more receptive (i.e., be more likely to want to write coverage in a state) when their tax and assessment obligations are subject to little uncertainty, which is not the case with paid losses as a tax or assessment base. For this practical reason, this paper leans towards the use of written premiums, including the use of imputed premiums for large deductible policyholders, for funding that had previously been accomplished through the use of paid losses. This will require additional Annual Statement reporting to administer properly.

Section 7 – Rating and Underwriting of Large Deductible Workers' Compensation Insurance

Underwriting considerations –

The intention of insurance regulators and workers' compensation administrators is that large deductible workers' compensation policies should provide employees with exactly the same coverage for accidents and injuries as policies without deductibles. The difference, of course, is

⁴⁴ As anecdotal illustration of this, insurers in Wisconsin, through the Wisconsin Compensation Rating Bureau, filed twice for large deductible programs in the 1990s. Both times the requests were withdrawn when the Insurance Commission suggested that all assessments would have to be based on standard premium before the application of discounts, dividends, and deductibles.

that the risk is primarily assumed by the policyholder, which is obligated to reimburse the insurer for claims falling underneath the deductible amount(s).

Risk-wise for the employer and for the insurer, there are only subtle differences in principle between a large deductible plan and a retrospectively rated policy or self-insurance (if an excess policy including an aggregate retention plus a surety bond are purchased from the same insurer). Examples can be developed using options available in many jurisdictions to make these three approaches virtually identical from the perspective of risk financing, both for the employer and the insurer. As such, the underwriting considerations for insurers that apply to these three approaches are very similar.

With a prospective large deductible policyholder, the insurer will identify rating classifications and payrolls in the same fashion that it would for a nondeductible account. It will look at hazards, loss control and loss experience as it would for a nondeductible policyholder, but it will particularly focus on the potential for serious claims that may exceed the deductible amount. Perhaps the biggest difference of these options from the insurer's viewpoint is the credit risk under large retro and deductible policies. Unlike providing excess insurance, the insurer must: 1) adjust claims, 2) report loss data to statistical agents, and 3) assume the risk of not being timely paid by the employer for their retained losses.

The large deductible endorsement –

The policy is written using a standard workers' compensation policy, but with a deductible endorsement attached. Such endorsements are typically⁴⁵ subject to filing and approval requirements (but note comments relating to ECPs later in this section) and provide for employer reimbursement of claims paid by the insurer under the deductible amount, but do not provide for any differences in how the insurer will adjust and settle the claims. There may or may not be an aggregate deductible limit.

Exempt commercial policyholder (ECP) or Large Risk Rating Option (LRRO) provisions –

A number of states have ECP and/or LRRO provisions (although perhaps not using those labels) that allow insurers to negotiate rates and/or contract terms with large commercial policyholders. Such provisions, if they apply to workers' compensation without any exception, would have the potential to allow contract amendments to affect the handling of claims, the reimbursement for losses, security and other arrangements. It is thus noted that, if some arrangements that might otherwise be made using this flexibility would be unsatisfactory to the state, then the state's rules and regulations allowing such activity should be so amended. See *Agreements outside of the insurance contract*, which follows shortly.

⁴⁵ The characterization of "typically" requires explanation. The research underlying this document did not include a review of approved endorsements by all insurers in all states. As such, while characterization of "typically" represents an understanding of common market and regulatory practice, there can be no certainty that contrary endorsements approved by state insurance regulators do not exist. It is even more difficult to make safe generalizations because the National Council on Compensation Insurance (NCCI) and state bureaus have not filed endorsements for use in large deductible programs. The possible application of exempt commercial policyholder (ECP) flexibilities to coverage forms makes it even more uncertain whether large deductible generalizations are safe.

Financial arrangements and security –

The laws of most states contemplate a large deductible arrangement where the insurer first pays claims and then seeks reimbursement from the policyholder. As one might expect, however, insurers are typically unwilling to extend significant amounts of unsecured credit to policyholders, which is what they would be doing if they made themselves liable for the payment of all claims under the deductible amount without some form of security to assure that they will be repaid. Various deposit, trust or LOC arrangements are common and at least one state (New Jersey) requires them. Annual Statement accounting (see Section 8) provides a minor penalty in the form of nonadmitting a portion of any amounts due from policyholders that have not been secured. There are issues, however, regarding whether such arrangements are subject to state policy form filing requirements. These issues are discussed under *Agreements outside of the insurance contract*, which follows.

Agreements outside of the insurance contract –

One significant forms-related issue is that there are sometimes agreements *outside of the insurance contract* – that is, they are not specifically referenced within or attached to the insurance contract – established between the insurer, the employer and perhaps a TPA or another party. This is an issue because insurance laws typically require the filing of the policy forms and accompanying endorsements used to write workers' compensation insurance. Writing policies with unapproved forms, providing benefits different than those specified in the policy (which simply references the workers' compensation law), or charging the policyholder anything not specified in the contract are prohibited. Anti-rebate laws are a common example of these prohibitions, where insurers and their agents are prohibited from providing or offering any valuable consideration that is not specified in the policy. Also common are provisions that prohibit additional charges to policyholders that are not specified in the policy. But what of agreements between the policyholder and the insurer that, while they do not specifically provide insurance, relate directly and importantly to an insurance policy issued by the insurer? Does the law applying to such agreements differ from other endorsements or amendments that are attached to insurance contracts?

If an insurer agrees to use and pay for a particular TPA of the policyholder's choosing, that would clearly be a valuable consideration to the policyholder. A similar arrangement, except where the policyholder pays the TPA's administrative charges, would be a valuable consideration to the insurer. Similarly, an agreement by the policyholder to place funds in an account for the payment of claims under a deductible amount would also be a valuable consideration for the insurer. The observation is that agreements of this nature between the policyholder and the insurer (and that might also involve a TPA) are clearly valuable considerations to one party or the other and are not independent of the insurance policy. The conclusion is that such agreements, tied to the insurance contract, but done "on the side," are problematic in view of state laws that require the filing of insurance contracts and all amendments.

This discussion would not be complete without noting that large deductible policyholders in a few states are subject to exempt commercial policyholder (ECP) or similar regulatory schemes that allow insurers flexibility in coverage provisions as well as pricing. ECP and other large risk

provisions are diverse between the states, but it is possible that large policyholders may be able to use them to enter into non-filed agreements with insurers regarding TPAs and collateral. The question then becomes, in those states where ECP or other large risk provisions apply to workers' compensation insurance, is whether a regulatory loophole exists that needs to be plugged.

As employers eligible for large deductible coverage are almost uniformly candidates for significant pricing flexibility of some form, it would appear incongruent for regulators to insist upon form-filing control of various collateral and deposit agreements between insurers and such large policyholders. Thus, while it appears that form filing laws are properly interpreted to extend to large deductible collateral and deposit agreements in general, there does not appear to be any significant public or regulatory interest to be served by the regulation of such agreements for large deductible policyholders, except perhaps in states that require some minimum level of collateral arrangements.

Taking this one step further, in states where unamended ECP or similar allowances permit large deductible policyholders to enter into such arrangements without the need to use filed forms, it is recommended that no attempt should be made to extend regulation to such arrangements. States where large deductible policyholders are not eligible for such policy form flexibility should consider changes to allow such activities to occur without unnecessary regulation. Recent insolvencies demonstrate that it is prudent for insurers to have adequate collateral for the payment of claims under deductible amounts; regulators should not discourage such arrangements by means of regulation unless there is some public purpose to be served by such regulation.

The situation with unfiled TPA agreements involves a different set of regulatory considerations. While flexibility granted under ECP and other large risk provisions may also allow insurers and employers to enter into unfiled TPA agreements, this can be problematic. If such agreements involve the selection of a specific TPA where the employer reimburses the TPA for administrative expenses, then this can be a problem because such payments would be for services provided in conjunction with the insurance contract and should generally be recorded, reported and taxed as premiums. Another set of considerations with side agreements relating to TPAs relates to the setting of claims handling standards and the general supervision of the TPA. Insurers, which are licensed by the state to pay workers' compensation claims, should be primarily responsible for the claims handling standards utilized by TPAs. The selection, supervision and payment of a TPA by an entity that has not been authorized to handle claims (i.e., is not an insurer, an approved self-insurer, or a licensed administrator or adjuster) are seen as problematic.

Extending TPA acts to workers' compensation will address many of these concerns by establishing minimum standards and introducing direct regulatory oversight of claim administration. It is not necessarily problematic that an employer and an insurer agree to the use of a specific TPA, as long as the insurer maintains control of the TPA and benefit payments are made on the insurer's checks.⁴⁶ Yet it is seen as problematic to have contracts or agreements directly between a TPA and an employer (other than an approved self-insurer), because then

⁴⁶ Situations have been encountered where TPAs write checks from the employer, not the insurer, and employees and even their counsel have been fooled into thinking that the employer is self-insured.

supervision of the TPA and its claims handling pass from an insurer (which is licensed and examined) to an employer that has not been approved to self-administer its claims. While the recommendation is thus made that states consider bringing workers' compensation insurers within the scope of their TPA laws⁴⁷, it must be stressed that this process should involve consideration of the reasonable interests of employers, especially those with unusual situations.

The recommendation is also made that states review any forms filing exemptions or other provisions for flexibility for large policyholders to assure that such exemptions do not allow employers to enter into TPA-related agreements with insurers or TPAs outside of form filing laws⁴⁸ and/or contrary to public policy. It is not contrary to public policy for the insurer and employer to agree that the insurer uses a particular TPA for the employer's claims, but this should be subject to insurer control and claims handling standards provided by the insurer.

A complication that this regulatory approach may entail is when a large employer is self-insured in some states and has insurance (large deductible or otherwise) for its operations in other states. In such situations, the employer may desire to have all of its claims handled by the same TPA. Unless the TPA is not licensed or has been found to be undesirable by a state, there seems to be little reason to make it difficult for an insurer to agree with a large employer to use the same TPA as is being used by the employer as a TPA in those states where it is approved to self-insure. This statement does not mean that regulatory oversight should be lifted for such situations, but only that the state's regulation of these situations should not seek to go beyond what is necessary to protect the interests of the insured's employees in that state.

Cancellations and nonrenewals –

Some state laws regarding cancellations and nonrenewals may require revision to recognize large (and small) deductibles. A common provision in state cancellation and nonrenewal laws is that a more abrupt cancellation or nonrenewal is allowed (usually upon ten days notice although some states provide a longer period in the case of workers' compensation coverage) for nonpayment of premium. Deductible reimbursements are not premiums, however, so it is possible that insurers may be placed in a difficult position in some states and need to rely upon an argument that failure to reimburse is a material breach of policy obligations, which is more difficult to prove and may require a longer advance notice period. In either case, of course, cancellation is only possible if the policy language itself provides for that remedy. To the extent that state laws allow it, it is certainly reasonable for deductible endorsements to give insurers the ability to quickly cancel and/or nonrenew when a policyholder fails to reimburse deductible amounts in a timely fashion. It is recommended that state laws that do not allow prompt cancellation for failure to reimburse deductible claims be revised, including clarification that nonpayment of deductible reimbursements from an earlier policy is a valid ground for cancellation of the current policy.

⁴⁷ Several states (e.g., Maine and Nebraska) have done so.

⁴⁸ Agreements between the insurer and TPA that don't involve the insured employer would not require filing. Rather, agreements between the employer and either the insurer or the TPA would be generally subject to policy form filing laws.

Claims handling arrangements –

As discussed previously, the handling of claims is typically not changed by the endorsement used to amend the policy, but “side agreements” regarding TPA handling of claims have appeared to be relatively common, at least for some insurers. These “side agreements” and the arrangements that they relate to have proven to be a source of problems for workers’ compensation administrators and may also contribute to data reporting problems. At this writing, it is unknown how common these problems may be. There are several types of arrangements that can be hypothesized:

- (a) The insurer handles and pays all claims. The employer then reimburses the insurer.
- (b) A TPA under the direct control of the insurer pays claims on behalf of the insurer. The checks are written on the insurer’s account and the data reporting that is handled by the TPA is the same that the insurer would do if it were handling the claims directly. This is entirely shared on a real-time or prompt basis with the insurer by the TPA. The employer reimburses the insurer for claims paid, not the TPA.
- (c) The TPA is selected by and is under the general control of the employer. The employer reimburses the TPA for claims. The TPA provides the insurer with whatever reports that have been agreed upon, but insurer involvement may be minimal except for claims that appear likely to exceed the deductible amount. (Note that there are likely to be premium tax issues involved here if the employer reimburses the TPA for anything more than paid claims.)
- (d) The TPA is owned by the employer or by another entity within the employer’s ownership structure. The significance of this relates to the degree of control that the employer may have over the TPA, possibly to the point of self-administration. The possible difference between this and self-administration is that the state may have better control over the qualifications of the persons that are handling claims, in states where TPAs are regulated. (Note that there are also likely to be premium tax issues involved here if the employer reimburses the TPA for anything more than paid claims.)
- (e) The employer pays for some or all of its small claims. It may or may not report these to the insurer.
- (f) A variation between (b), (c), (d) and (e) is utilized. It appears that there may be quite a few variations.

It appears that arrangement (a) is what most regulators believed they were getting when they first approved large deductible arrangements. Clearly, arrangement (b) can be structured to be nearly identical to (a). The problems and the more serious questions begin to occur when elements of (c), (d) and/or (e) are introduced. The essential conflict is that many employers want to have a hand in managing their own workers’ compensation claims, yet compensation and insurance regulators do not want unqualified entities handling claims or having an undue influence in their handling. There are also concerns about the quality of data and information with these

arrangements that will be reported back for purposes of experience modifiers, ratemaking and oversight by the state.

Amendment of the NAIC's TPA Model Act –

The NAIC's TPA Model Act deals with TPAs and life and health insurance, but does not touch upon P&C insurance. A prior version of the Model Act included a drafting note suggesting that states consider extending the scope of their TPA acts to workers' compensation coverage,⁴⁹ but this was deleted in the NAIC's Model Act in early 2001. The discussion surrounding this action indicated that the drafters thought that the TPA Model Act was applicable only to life and health insurance, and that property and casualty insurance should fall under the MGA Model Act. Nothing in these discussions evidenced any awareness of workers' compensation or its claims handling practices.

A recommendation is made to extend the TPA Model Act to workers' compensation. This would have the effect of requiring contracts between insurers and TPAs, and to assure that claims handling is done subject to claims handling standards provided by the insurer, not the employer. It would have (or should have) the effect of reinforcing the prohibition of contracts between TPAs and insured employers for the handling of workers' compensation claims. (An exception should be made in the Model Act for those employers that have been approved as self-insureds.) Many of the issues raised in this paper deal with situations where an employer, rather than the insurer, contracts with a TPA to handle workers' compensation claims. In such situations, where supervision largely falls to the employer and/or benefit checks are drawn on the employer's account, it is made very difficult to distinguish this from unauthorized self-insurance. (Arguably, in fact, it *is* unauthorized self-insurance, except with an insurance company somewhere far in the background.)

As amendments to the NAIC's TPA Model Act are considered, the challenge will be to avoid limitations to legitimate activities of the employer. Such challenges are likely to exist where the employer is self-insured in some states and covered under a large deductible or a retrospectively rated policy in other states. Absent objections to a specific TPA, there should be little reason why regulators should not want an employer to be able to have its claims for all states serviced by the same TPA. This may involve a contract with the TPA in states where an employer is approved as a self-insured.

Thus, as amendments to the NAIC's TPA Model Act are considered with regard to workers' compensation, and as these considerations include legitimate employer interests, this will require that consideration be given to the proper way for these interests to be met. In this regard, the observation is made that the insurance contract is intended to be the entire agreement between the insurer and the policyholder. That is, regulators are likely to encounter difficulties if they allow insurance policies that don't cover the entire agreement between the employer and the insurer. This observation extends to such things as collateral agreements and agreements regarding TPAs. While this paper makes the observation that states should seek to exempt collateral agreements

⁴⁹ Some states, such as Nebraska and Maine, have done so in their TPA acts. See *Neb.Rev.Stat. §§44-5801 to 44-5816* and Maine's *24-A M.R.S.A. §§ 1901(1)*. The scope of both of these acts extends to workers' compensation self-insurance.

from forms regulation (as it would serve no purpose), the same observation *does not* apply to agreements *between insurers and employers* concerning claims handling and/or TPAs. There is most definitely a public interest involved with assuring that claims made by injured workers are handled properly. It should be made clear, however, that this statement does not extend to agreements between insurers and TPAs (which, while they would be required to fulfill the TPA Model Act, would not need to be filed), or to agreements between employers and TPAs (which should not exist with regard to states in which the employer is not authorized to self-insure).

Regulation of rates –

The regulation of rates for large deductible policies varies from state to state. In most states, large deductible plans are subject to rate filing requirements, but such states often allow greater flexibility in the filed rating plans for large deductibles. A few states have chosen to deregulate large deductible rates completely, while others require rate filings without any additional rating flexibility. Superimposed over this in most states, so-called “exempt commercial policyholder” (ECP) or Large Risk Rating Option (LRRO) provisions may effectively provide rate deregulation for large policyholders written under these plans. Depending on the thresholds in a state, rate deregulation of some sort may apply to nearly all large deductible policyholders.

While the preceding description holds true most of the time, miscellaneous differences abound from state-to-state, insurer-to-insurer and policyholder-to-policyholder. Differences in experiences and philosophy from state to state result in miscellaneous differences in what states will or won't approve.

Other unusual large deductible arrangements –

There have been some rather creative formulations of deductible programs in the marketplace since the 9/11 attack. One version is sometimes called a “split deductible,” in which a given level of retention applies to any event for which fewer than a specified number of deaths or claims are involved, and a second (substantially higher) retention comes into play for more extreme events. Another variation sets different deductible amounts per business location, generally giving higher deductible levels to those locations with greater concentrations of workers and/or perceived to be at greater risk for some potential hazards such as terrorism.

A variation discovered by the guaranty funds in connection with Legion Insurance Company was that a large deductible policy was written in a relatively “normal” fashion, but that the employer also purchased a “deductible reimbursement policy.” (In the case of Legion, the reimbursement policy was purchased through an offshore affiliate, which is a complicating factor for the guaranty funds and may run afoul of surplus lines statutes, but may not be important for this discussion.) The objectionable characteristic about this approach is that it could be used as a mechanism for arbitrage. Insurers could write employers that are really not retaining any risk, or are not maintaining a large amount of risk, but do so with the appearance that there is a large deductible policy (which would be the statutory policy) plus some other reimbursement policy that might not be considered workers' compensation coverage. In many states, this could be a means to gain additional rating flexibility and it would also be likely to have premium tax implications in most states. Presumably, this device might be routinely used when it was

advantageous to the employer from the standpoint of taxation, frustrating the state's attempt to collect adequate revenues and distribute the burden fairly.

It should be noted that a deductible reimbursement policy written by an employer's captive insurer can have a legitimate use as a means for the employer insured with a large deductible to account for the losses that it is incurring and to set up reserves for unpaid losses.⁵⁰ However, lest regulators believe that there are no opportunities for arbitrage with captives, it should be cautioned that a captive could obtain reinsurance from an insurer affiliated with the insurer writing its large deductible policy. This would amount to little more than a deductible reimbursement policy of the sort attributed to Legion in the preceding paragraph.

Because of these problems and possible problems, it is recommended that deductible reimbursement policies be disapproved and (to the extent that this can be accomplished) that insurers writing large deductible policies not be allowed, either directly, through affiliates, or through reinsurance, from assuming any of the financial risk which the employer is ostensibly retaining in the form of a large deductible.

This discussion would not be complete without at least a side discussion of the controversy that this position caused during the drafting of this paper. At least one major insurer as well as the American Insurance Association (AIA) expressed concern with regard to the paper's position in opposition to deductible reimbursement policies. Yet, as the discussions unfolded, it became apparent that the deductible reimbursement policies that the insurers were talking about were not being used as this paper viewed deductible reimbursement policies, but were instead being used as a means of attaching a price to the risk of default for those policyholders that were not completely covering their unpaid losses with some form of collateral. With one example involving a major insurer, the policy used had language that described a relationship identical to that cited with the Legion companies. The difference was that the insurer used unfiled side agreements that kept the employer from using the policy in the fashion that it would appear that it could be used. In fact, given the accounting "disconnects" cited elsewhere in this paper, some of these company practices may result in a better accounting of the insurer's loss liabilities. Thus, with regard to deductible reimbursement policies that aren't being used as such, the problem appears to be with regard to misunderstandings caused by unfiled side agreements. It is thus recommended that this subject be addressed by the NAIC's Workers' Compensation (C) Task Force when it addresses collateral agreements, TPA arrangements and large deductible approval standards generally.

Section 8 – Large Deductible Effects on Annual Statement Reporting, Data Collection and Ratemaking

Most non-NCCI U.S. jurisdictions follow ratemaking⁵¹ and data collection procedures that are similar to those utilized by the NCCI. As such, the comments on data collection and ratemaking

⁵⁰ Captives, self-insurance and tax laws are beyond the scope of this paper, but it is generally accepted that tax management is one of the primary motivating factors for the establishment of captives.

⁵¹ Please note that the NCCI files rates in some jurisdictions and loss costs in other jurisdictions. As most NCCI filings are for loss costs, the remainder of this paper will refer to procedures for loss costs, but they are easily extrapolated to apply to rates for those jurisdictions where the NCCI still files rates.

in this section will relate to the NCCI, with the implication that these generalizations often apply reasonably well to most other jurisdictions.

Annual Statement reporting –

For purposes of Annual Statement accounting, deductible reimbursements are not considered premium.⁵² As such, premiums booked on insurers' Annual Statements do not include large deductible loss reimbursements. This is in contrast to loss reimbursements under retrospectively rated policies, which are considered to be premium.

The Annual Statement accounting situation is more complicated for losses. The accounting for deductible reimbursements is philosophically similar in some respects to the accounting for salvage and subrogation ("S&S") recoveries, but it certainly isn't identical. The table on the next page discusses accounting procedures for large deductible recoveries and contrasts them to the accounting procedures for S&S.

⁵² One state – California – has attempted to collect premium taxes on gross premium amounts, but has not prevailed in litigation as of this writing. The scope of this analysis, however, is Annual Statement accounting. The fact that Annual Statements call for premiums and losses on a net basis does not necessarily imply that state tax laws should be written or interpreted on a net basis. That is a separate decision states must make based on public policy considerations. However, state law should clearly define what the taxable premium is, and any differences from Annual Statement premium should be intentional and unambiguous.

Large Deductibles	Salvage and Subrogation	Discussion
Note – within the context of this document, <i>expected</i> and <i>expectation</i> are used in their mathematical sense, which is generally consistent with the way in which actuaries evaluate Annual Statement loss reserves.		
<p>REPORTING – The reserve credit for “high deductibles” (which might include lines of insurance other than workers’ compensation) is shown in the Notes to the Annual Statement. See instruction #31. The credit shown is not line, state or year-specific. The reserve credit is included (but not separately) on the Assets page as “Amounts Receivable Relating to Uninsured Plans.”</p>	<p>REPORTING – S&S recovered on paid losses is shown in column 10 of Part 1 of Schedule P and S&S expected to be recovered on unpaid losses is shown in column 23 of Schedule P. Schedule P separates WC from other lines and is year-specific, but not state-specific.</p>	<p>There is nothing in the Annual Statement that identifies deductible recoveries or S&S recoveries on a state-specific basis.</p> <p>Note that the amounts that have been recovered on “high deductible” policies are not shown, because there are not separate Schedule P columns for this business. Note also that there is no explicit provision for reporting S&S anticipated to be recovered on paid losses.</p>
<p>Unpaid losses are booked net of the deductible. The exception to this statement is that “no reserve credit shall be permitted for any claim where any amount due from the insured has been determined to be uncollectible.” Note that this uncollectibility refers to any amount due from the insured, not just those amounts due on account of paid losses under the specific large deductible WC policy under consideration. Note also that there is no penalty with regard to unpaid losses for insurers with policyholders that do not have these obligations secured in some fashion.</p>	<p>Unpaid losses are booked net of <i>expected</i> recoveries on unpaid losses.</p>	<p>Large deductible accounting does not appear to be conservative with regard to the establishment of these reserves. Absent SSAP 65, one might expect insurers to book gross losses less <i>expected</i> recoveries. As losses can take a long time to be paid for workers’ compensation, it is reasonable to expect that some employers will eventually become insolvent and some of these deductible amounts will become uncollectible. Yet SSAP 65 directs that the reduction in reserves should reflect all deductible amounts, not just the insurer’s <i>expectation</i> of recoveries.</p>
<p>For policyholders that have an amount that is uncollectible, unpaid losses are booked on a gross basis, without reduction for possible recoveries from the policyholder.</p>	<p>n/a</p>	<p>This represents Annual Statement accounting conservatism.</p>
<p>Paid losses under the deductible amount that have been billed, are not past due and appear to be collectible shall be established as an admitted asset. The exception to this statement is that a minimum of 10% of the amounts due shall be booked as a nonadmitted asset to the extent that they have not been collateralized.</p>	<p>Technically, S&S <i>expected</i> recoveries arising out of paid losses could be booked as a nonadmitted asset, but this is not done as a general practice. (Because of their nature, it is difficult to imagine situations where S&S recoverables would be secured and perhaps thus eligible to be considered as an admitted asset.)</p>	<p>Typical statutory accounting rules (see SSAP 6) that relate to the aging of various premium obligations and amounts due from agents do not apply because deductible reimbursements appear to be outside the scope of SSAP 6.</p>

Given the significant interest of states in knowing total paid and incurred losses for large deductible policyholders, and given the significant amount of workers' compensation business that is being written on these forms, it is recommended that an additional Annual Statement exhibit be developed to show these amounts on a state-by-state basis. The information is of a nature that would be handy to see on the State Page, but the State Page is already crowded with 13 columns. Thus, at least for statements printed on paper, it appears advisable to have a separate exhibit to contain this information. It could provide information on paid, unpaid and incurred amounts. In addition, it could provide premium-related information, including some measure of the gross exposures being insured on large deductible policies, without the substantial discounts allowed for assuming a large deductible. This information, coupled with paid loss information (necessary to compare insured employers with self-insured employers) could be used by the states for more equitable taxes and assessments for workers' compensation insurance.

Data collection and ratemaking issues –

Statistical data collection (e.g., unit statistical reporting and loss reporting to industrial commissions) is driven by the needs for data, one of which is for ratemaking, and ratemaking techniques are limited by the detail, timeliness, quantity and quality of the available data. Standard NCCI procedures for evaluating loss costs work with several sets of data. As a bit of a simplification, the NCCI uses large deductible data for classification ratemaking but not for overall rate level changes. Detail on individual claims is not collected for financial aggregate data, which is used primarily in the determination of overall rate level changes. In contrast, current data collection procedures for classification ratemaking data are designed to provide essentially the same data for workers' compensation insurance policies written on a large deductible basis, including individual loss detail, as for policies written on a non-deductible basis. The only difference is that policies written on a large deductible basis are separately identified so that data developed from them can be segregated from other data.

It is beyond the scope of this paper to address the merits of these choices, but it is noted that classification ratemaking could be done without using large deductible data (instead of being included) and that large deductible data could be included in the determination of overall loss cost changes (instead of being excluded).

Of course, it is one thing for statistical plans and data collection procedures to call for the same collection of large deductible data as for nondeductible data, and it may be quite another thing to ensure that the information is actually reported in that fashion. A significant concern expressed by some has been that insurance statistical reporting and reporting to workers' compensation agencies are being adversely affected by employers that are handling some or all of their own claims. The extent to which this is happening is still uncertain. Interestingly, the surveys conducted by the NAIC / IAIABC Joint Working Group found only a small degree of such concern from insurance departments, but a much more significant degree of concern by IAIABC participants. As the ultimate sources of claim data are essentially the same for insurance and industrial commission use, this causes one to ask the question of whether insurance regulators are simply not yet aware of the problems that exist?

Representatives of the NCCI and the NCIGF have also noted data reporting problems with TPAs, but are quick to note that it would be incorrect to say that TPAs are problematic generally. Rather, it appears that when data reporting problems occur with TPAs, they are the result of inadequate insurer oversight. As was noted above in Section 7, it is recommended that TPA acts be extended to include workers' compensation insurance. This would require that TPAs operate under the oversight of an insurer, not an employer (except where the employer is an approved self-insurer). Especially if insurers are responsible for data reporting specifications, this should help address the data collection problems that appear to have occurred more often when insurers are not directly involved,⁵³ in addition to addressing other concerns discussed elsewhere in this paper.

The most significant study done to date of data reporting patterns was recently completed by California's Workers' Compensation Insurance Rating Bureau (WCIRB).⁵⁴ That study found no significant differences in pure premium, but there were detectable differences in paid and incurred loss development patterns. As a generalization, large deductible claims were subject to greater paid and incurred loss development. If there were no differences between the policyholders covered under large deductible policies and other policies, then this would mean that insurers were somewhat slower to realize the full value of claims handled under large deductible policies and it might mean that they were somewhat slower to pay such losses⁵⁵. The differences, however, were not dramatic and the conclusion of the report was that, "there was no strong evidence that differences in loss development, claim disposal and severity patterns can be attributed to the underreporting of claims of large deductible policies because differences in industry mix or types of risks may also play a significant role..." In brief, the jury is still out on the question of differences in data reporting, but it does not appear that the overall magnitude of such differences is dramatic.

To the extent that data quality problems or differences may exist with large deductible policyholders, then the ratemaking impact will not be upon overall loss cost levels, as large deductible experience is excluded from these determinations, but it will be likely to degrade the quality of classification ratemaking.⁵⁶ Loss cost indications for classes with a large volume of large deductible experience will be underestimated with the result that classes without a large volume of large deductible experience will be pay higher rates that their true loss experience merits.⁵⁷

⁵³ Data communication between TPAs and insurers would also be enhanced if insurers and TPAs both generally adhered to uniform data reporting standards and definitions. The Insurance Data Management Association (IDMA) worked to develop such standards, but encountered problems with getting TPAs to consider conversion to such data standards.

⁵⁴ Item AC02-03-03, Actuarial Committee Agenda, meeting of 6/30/2004.

⁵⁵ An alternative explanation would be that claims are being paid as promptly as others, but that payments made by TPAs and reimbursed by employers may be slower to be reported to insurers. This would be quite possible, especially when dollars under deductible thresholds don't flow through an insurer's accounts, but are only reported to them after the fact by a TPA.

⁵⁶ This statement characterizes NCCI ratemaking procedures and is true in most states, but not all.

⁵⁷ This is to say that the rate relativities for class codes without much large deductible insurance will be assigned a large than fair share of the overall state losses.

Apart from ratemaking, some states use workers' compensation loss data for safety monitoring, planning, statistical and enforcement programs. To the extent that financial aggregate data is used, the elimination of large numbers of losses will distort interstate and time series comparisons. To the extent, however, that the data used is developed from the unit statistical (classification ratemaking and experience rating) data system, then biases should not exist unless data quality is a problem.

The obvious solution to these concerns – if problems exist – would be to take steps to resolve data reporting deficiencies. After all, such deficiencies would affect information being reported to industrial commissions as well. In this regard, it is instructive to examine NCCI edits (i.e., procedures for identifying and further examining unusual results) that may flag situations where claims are not being reported. In this regard, the reader should note that the NCCI has changed its edits during the period of time that this paper was drafted. NCCI edits after February 2004 include:

- An edit identifies units⁵⁸ on submission with premiums of at least \$250,000 and loss ratios of less than 1%. This edit uses premiums *before credits* so that the existence of a large deductible policy won't mask the true size of the policyholder. The insurer must correct a unit flagged in this manner before it will be used for experience rating or ratemaking. The only way "around this" for an insurer is for the insurer to individually certify that the report is correct. The NCCI has stated that it will monitor such certifications to look for any patterns of abuse (as such certifications should be rare).
- The NCCI conducts a periodic analysis of all carrier unit statistical data, during which it looks for unusual trends in low claim counts relative to premium size. This is based on a curve fit of expected claims by premium size. In the event that the NCCI determines there may be an issue, NCCI works directly with the identified carrier to solve any systemic issues and obtain corrections.
- The aggregate claim frequency by carrier, state, and policy period is examined to determine if a particular carrier has unusual experience. This provides an alternative method for NCCI to identify possible under-reporting that includes policies at lower levels of premium.

These approaches do not simply focus on large deductible policies. Rather, they look at all units received by NCCI. In this manner, NCCI can also potentially identify under-reporting on large deductible policies that may have been incorrectly coded as full coverage, in addition to other causes of under-reporting such as system problems and TPA issues.

A question that regulators must ask is whether these edits represent an acceptable balance between: 1) the expense and inefficiency introduced by forcing insurers to do additional work to verify the accuracy of good data and 2) the need to minimize incorrect data that is accepted into the experience rating and ratemaking data stream. The proper balance and methods for edit checking is beyond the scope of this report.

⁵⁸ A "unit" is an annual report for a given policyholder. It shows payrolls and losses by class code. Small medical losses may be lumped together, but other losses are reported individually. "Unit reports" are the basic data element for NCCI experience rating and classification ratemaking.

As regulators mull these questions, they must consider the nature of the problems that they most suspect and that they are most concerned about. One potential data reporting problem is an insurer with a TPA that fails to report any claims at all. It appears that NCCI edits will have a good chance of catching problems of this nature, although it is possible that the NCCI could do a better job here if carriers were to specifically report units when TPAs are involved and identify the TPA.

Another data reporting problem (which has ramifications that go well beyond data reporting) will occur with employers that self-administer small claims “under the table”. NCCI experience rating gives primary weight to claims of less than \$5,000, with greater weight given to indemnity payments than to medical payments;⁵⁹ thus, there is an economic motivation⁶⁰ for employers to pay claims that settle for less than \$5,000 or perhaps not a great deal more. An employer that does this would still report more serious cases and may even report some smaller ones as well, but this activity would clearly be harmful to data users (and sometimes to the injured employee!). The observation is made that NCCI edits do not appear well suited to detect such activities. NCCI edits could detect suspicious patterns of claims size distributions, but these could probably only be part of a multi-pronged approach to detect self-administration of claims.

As was discussed in Section 5 of this paper, self-administration of claims is not easy for anyone to detect, except from hindsight when claims payment problems come to the attention of regulators. The insurer is in the best position to detect self-administration of claims, but the authors have doubts regarding the will of some carriers to proactively combat self-administration by their policyholders. Claims adjusters for insurers look at the claims they are assigned, not to claims that they are not assigned. Underwriters tend to be rushed and are unlikely to look for something that may not appear likely to harm the insurer.⁶¹

Self-administration of claims may be caught by chance by a regulator or an insurer, but one indication to an insurer of employer self-administration of claims – especially from a large deductible policyholder that has a lower-than-expected frequency of claims – is when there is a somewhat longer than average report lag from the employer to the insurer. Perhaps claims don’t get reported until after some treatment has already occurred. This is an area where the insurer, and not the NCCI, must bear the burden. The NCCI first gets a unit report at six months

⁵⁹ In all but the eight NCCI states that did not approve the change, the current experience rating plan gives 30% of the weight to medical-only payments that it gives to indemnity payments. This represents a change from an earlier experience rating plan in which there was not any reduction in weight for medical claim payments. Although there were clear actuarial justifications for this amendment to the NCCI’s prior plan, one must note that the NCCI’s prior experience rating plan anecdotally resulted in a much higher level of self-administration of small medical-only claims. This revision largely removed the attractiveness of this practice for nondeductible policyholders, but the economic motivation still exists for large deductible policyholders.

⁶⁰ The incentives for employers to self-pay as a means of manipulating experience modifications are subject to a variety of considerations including the employer’s assigned credibility, loss development and other “on-level” factors in effect in any given state(s).

⁶¹ This appearance is deceiving. Self-administration of small claims will produce an experience modifier that is lower than it should be and thus makes the risk looks more attractive to the insurer, but above and beyond the concealed claim frequency risk, self-administration increases the chance that the insurer may end up paying more on a claim that is bungled in its early stages.

following the expiration of a policy. These reports don't show incident to report times or anything else that would meaningfully detect reporting delays (versus the substantial reporting delay that may occur if there are problems with a TPA) that may indicate employer self-administration of claims.

It appears that meaningful detection of employer self-administered claims may not be possible without audits by regulators.⁶² In this regard, the NCCI and other state bureaus can provide assistance, as they can furnish information on large deductible policyholders. This information can include unit statistical experience, which may help the regulator identify employers that appear to have claim characteristics in line with employer self-administration. The regulator can then examine insurer underwriting files (to see if there is any explicit acquiescence with regard to self-administration of claims) as well as insurer claim files to see if somewhat longer claim reporting lags are common.

While these ideas may get an auditor started, it should be clear that it won't be easy to detect every violation. As was discussed in Section 5, it amounts to looking for things that are not reported. That can be tough. States may wish to use their fraud units instead of claims or market conduct examiners for this reason. The authors of this paper do not pretend to have expertise in the detection of fraud.

The recommendation is made that specific tests be developed for inclusion in the NAIC's *Market Conduct Examination Handbook* to detect employer self-administration and TPA nonreporting of claims. The decision whether to include fraud personnel in such work would then be left to the developers of those tests and, in practice, to the market conduct examiners that would be checking for such violations.

Of course, it would be much easier to simply stop using large deductible experience for classification ratemaking. To the extent that large deductible policyholders are predominantly very large policyholders, there may be actuarial merit in disregarding this experience or giving it less weight for classification ratemaking purposes, but that would be a technical actuarial issue beyond the scope of this document. Nevertheless, classification ratemaking is not the only purpose for which statistical data is used, and above and beyond the statistical issues, the integrity of the benefit system depends on the consistent and timely reporting of workplace injuries. Thus, regardless of the extent to which actuaries may be able to survive working with poorer data in their determination of classification loss costs, there can be no question that substandard reporting of workplace injuries and loss experience will create problems and should not be tolerated. Industrial commissions need this data; it is necessary for time series analyses of compensation systems' performance; it is necessary for experience rating, and it is also of value for ratemaking.

Section 9 – PEOs and Large Deductibles

The availability of standard non-deductible workers' compensation policies for PEOs and employee leasing firms has traditionally been limited. Adding a large deductible to a PEO's

⁶² As was discussed in Section 5, this responsibility may lie with either the workers' compensation or the insurance agency, or both, or there may be confusion.

policy adds complexity and may make it even more problematic for insurers to underwrite. Put simply, an insurer writing a large deductible for a PEO will want to make money on the excess limits risk that it intends to assume, and it will also want to avoid losing money through a possible PEO default on claims that fall under the deductible. This latter consideration makes PEOs difficult to underwrite unless the insurer has solid assurance that it will be able to maintain adequate security for claims under the deductible amount and a clear sense of how much claims exposure it has taken on.

In theory, therefore, PEOs with large deductible master policies should rarely cause problems in the marketplace, since one would not expect an insurer to consider issuing a large deductible policy to an outsourcing firm unless it had ironclad collateral and strict underwriting control over the outsourcing firm's client base. Indeed, both insurers and PEOs currently report that underwriting standards are so high that the market for this type of coverage has practically dried up for many sectors of the PEO industry, especially for smaller PEOs. However, during the last soft market cycle, there was a significant niche market for the sale of large deductible master policies to PEOs and employee leasing companies.⁶³ Underwriting standards were not always so rigorous, and the results in many cases were unfortunate.

It is important to understand the nature of the risk assumed by a PEO with a master policy and a large deductible. Deductibles in this market can range from \$100,000 to \$500,000 and beyond. Clearly, small employers individually are not able to assume that level of risk. Therefore, under a large deductible master policy issued to a PEO, the PEO does not charge the cost of each client's deductible reimbursements back to that client.⁶⁴ Instead, the PEO charges each client up front, not only for the PEO's costs of coverage and workers' compensation related services, but also for the client's share of the PEO's anticipated deductible reimbursement obligations⁶⁵ – and that will be the bulk of what the client pays the PEO for coverage.⁶⁶ However, since the client is also an "employer" by contract or by operation of law, it should be clearly spelled out in the policy that the PEO, and only the PEO, is responsible for the deductible reimbursements. The National Association of Professional Employer Organizations (NAPEO) is unaware of any large

⁶³ A significant volume of PEO and employee leasing activity is based in states shown in Appendix 1 as having a high proportion of large deductible premium.

⁶⁴ For the same reason, it is unlikely that a PEO would ever obtain large deductible coverage on any basis other than a master policy basis, except when the individual policies can be written in a manner that make the PEO rather than the client responsible for the deductible reimbursement. When this is the case, the same considerations apply as for master policies.

⁶⁵ There have been examples of employee leasing companies that have charged low fees by billing their existing clients on a "pay as you go" basis, ignoring their true incurred losses and using current client charges to fund their current deductible reimbursement payments arising out of prior-year incurred losses. Such an arrangement cannot be sustainable, and when it is attempted, the long tail of the workers' compensation risk makes this approach a disaster waiting to happen. Insurers can minimize the threat of such irresponsible management by sound underwriting and insistence on appropriate collateral when they issue large deductible policies.

⁶⁶ This is not meant to suggest that the client buys "coverage" as such. It is common for a PEO to charge its clients a single comprehensive fee rather than itemizing particular costs such as workers' compensation coverage, except where separate charges are required by law. However, the workers' compensation liability a PEO assumes as a co-employer is one of the most significant costs it incurs (after the employee payroll itself) and thus must be given particular consideration in determining the fee charged to its clients.

deductible policies issued on any other basis, but as with other standard practices affecting large deductible coverage, adherence to these practices cannot simply be taken for granted. Regulators must therefore take care that the policy language does not open the door for an insurer to surprise the client with the news that it might be liable for deductible reimbursements if the PEO cannot or does not pay.

The PEO's assumption of the risk of claims within the deductible means that the PEO must analyze its development patterns, estimate its expected losses, select an appropriate safety margin and discount rate, and then allocate anticipated costs among its clients in a manner that allows it to remain competitive in the marketplace. If the PEO predicts its deductible reimbursement obligations correctly, the PEO makes a profit. If the PEO significantly underestimates these costs, then it could suffer a significant loss.

Up to a point, therefore, there is a significant resemblance – when viewed from the perspective of the relationship between the PEO and the client – between a PEO selling client employers the protection provided by a co-employment relationship that is insured by a large deductible master policy, and an insurer selling workers' compensation coverage to small employers that is backed by excess reinsurance with comparable attachment points. However, there are crucial differences from a regulatory perspective between a PEO assuming its clients' workers' compensation risk through purchasing a large deductible policy as an insured, and an insurer assuming similar risk by issuing statutory coverage while purchasing reinsurance with comparable attachment points. In the large deductible situation, the insurer provides more than just catastrophic "reinsurance" to the PEO. It is also accountable for guaranteeing first-dollar coverage to each of the PEO's claimants. The insurer's capital is on the line, and the guaranty fund in turn stands behind the insurer. This gives states more flexibility in determining the appropriate regulatory safeguards.

It is important to understand that a PEO does not simply provide workers' compensation "coverage" to its clients. Although the details may vary somewhat by state, it is fair to generalize that a PEO assumes the obligation (by contract and often also by law) to purchase workers' compensation insurance for those that it co-employs.⁶⁷ Thus, the PEO is covering its own co-employees (that are also co-employed by their clients). It does not issue insurance policies to its client employers. It is also important to remember that a PEO's workers' compensation expenses on behalf of its clients include not only the cost of claims within the deductible and insurance beyond the deductible, but also the cost of such additional services as safety programs, case management, and return to work programs. PEOs have observed that assuming claims risk through large deductible programs gives them more of an incentive to provide these services to their clients, since they can recoup investments in loss control through

⁶⁷ According to NAPEO, twenty-six states now recognize a PEO (or employee leasing company) industry as a valid workers' compensation policyholder by statute. These states are Arizona, Arkansas, Colorado, Florida, Georgia, Idaho, Illinois, Kentucky, Louisiana, Maine, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, and Virginia. Illinois deems the PEO a "joint employer" by statute but does not expressly address policy structure in the statute. The North Carolina General Assembly has passed legislation (Senate Bill 20), currently on the Governor's desk that will authorize the PEO industry to maintain policies on an MCP basis. In addition, legislation has introduced in Iowa, SB 3138/1319 and Alabama H.B. 765 that will recognize the PEO industry for workers' compensation policyholder purposes.

the savings in claims costs. Although insurers often also offer loss control services, for the same reasons, the PEO's role as co-employer and its in-depth involvement in multiple aspects of its clients' operations may place it in a superior position to provide an effective risk management program for its clients.⁶⁸

However, states that choose to allow PEOs to purchase large deductible coverage need to keep in mind that the involvement of a licensed insurer does not automatically solve all the problems that might arise, and there are still a number of issues that might require enhanced oversight. Most obviously, what risks does this type of coverage pose for the financial health of the insurer? In principle, with one exception, the risks assumed with a PEO account are not all that different from the insurer's perspective than the risks assumed with any other large deductible account. The one qualitative difference in the nature of the risk can be a significant one – as PEOs add and shed clients, the business can be expected to change both the size of its payroll and the nature of its (already unusually heterogeneous) worksite operations.⁶⁹

While responsible PEOs that are in it for the long haul will be forced by the market to exercise the same underwriting and pricing discipline as insurers, the long tail has made issuing workers' compensation coverage attractive to gamblers who were not necessarily in it for the long haul, not to mention out-and-out Ponzi scams. This is not by any means intended to cast aspersions on PEOs – these are the same concerns that make eternal regulatory vigilance necessary in the licensed insurance market.

Furthermore, even when the insurer is adequately secured or has sufficient capital to absorb the cost, one cannot simply say it is the insurer's problem, and not the public's, if the PEO underprices the fees it charges its clients and becomes insolvent as a result. Workers' compensation coverage is not the only service provided by PEOs. Even with workers' compensation claims fully backed by an insurer, a major PEO insolvency could have a devastating impact on employees and client employers.⁷⁰ This certainly makes it a matter of public interest how the PEO charges its clients for workers' compensation coverage and how the

⁶⁸ NAPEO has indicated that many PEOs employ significant risk selection, workplace safety, and loss control expertise on staff and that determining the fees required to cover large deductible exposures and other PEO service expenses is more straightforward than it might appear. PEOs generally obtain and examine prior year loss runs, experience rating information and OSHA accident logs when evaluating prospective clients. The PEO will also conduct a confirmation of payroll and classifications. In addition, the PEO's experience with similar clients and impact of its loss control programs will be considered. All of this information is utilized in addressing the fees to be charged for PEO services. The independent Certification Institute (www.CertificationInstitute.org) offers (with NAPEO's support and insurer participation) a voluntary certification for PEOs that seek to demonstrate compliance with established risk management best practices.

⁶⁹ Although there is some annual variation, NAPEO data indicates that an annual client retention rate of 84% is typical for its members. While this is a respectable figure, it nevertheless allows for significant changes in clientele over the periods of time relevant for experience rating, especially when a PEO is growing rapidly.

⁷⁰ It is imaginable that an insurer could want to structure a large deductible policy so that clients are jointly liable with the PEO for deductible reimbursements. At this time, the authors are unaware that this has ever been attempted. While it would provide some protection to the insurer, it would transform the business relationship of the PEO and its clients to something similar to that of an assessment insurer, which is something that is likely that most clients would not comprehend at the outset or want to enter into. The recommendation is made that such policy forms and arrangements should be disapproved if they are proposed to insurance departments.

PEO secures the risk it assumes, because when a PEO bears the lion's share of its clients' workers' compensation exposure, this could be the PEO's single most significant point of financial vulnerability.

An especially hazardous situation would occur if a PEO were allowed to use a small affiliated insurer to write a large deductible policy. The premium to the insurer would thus be minimized, which would have the apparent effect of putting little capital strain on the insurer. If claims were handled by TPAs, there would also be little administrative burden on the insurer. The PEO and the insurer, collectively, would assume the clients' full workers' compensation exposure, but only a small portion of that risk would show up on the insurer's books. The remainder would represent a substantial off-balance-sheet commitment by the insurer to its owner, the PEO, for payment of claims within the deductible should the PEO default on its reimbursement obligations. The danger is that should the PEO become insolvent, either from its assumption of workers' compensation risk or for some other reason (e.g., health benefits), then its affiliated insurer would be likely to fail along with the PEO. At that point, the guaranty fund would be obligated to pay benefits to client employers, yet it would have no meaningful recourse to be reimbursed under the large deductible, as the PEO would also be insolvent.⁷¹

Regulators must also consider other issues in addition to solvency concerns. There is an extensive network of consumer protection laws governing insurance sales and marketing. Should these laws or something similar apply when workers' compensation coverage is included as part of the services provided by a PEO? What about the impact on the rating system when PEOs can set their own prices for coverage? Although many PEOs use the client's manual rates as a guide in establishing client service fees, they are not required to do so. While most states have moved away from strict rate regulation in favor of a more competitive system, many states still mandate the use of experience rating by insurers because of the incentive it provides the employer to maintain a safe workplace. To some degree, these issues arise with master policies even when they are issued on a guaranteed cost basis – although the PEO's cost of coverage for a guaranteed cost policy is a fixed amount established by the insurer, and it is established on the basis of each client's manual rates, the PEO is not obligated to rate its clients on the same basis, and the insurer will typically use a single experience modification factor for the PEO as a whole, leaving it up to the PEO how that will be passed through to the clients.

The use of a large deductible policy by a PEO also raises concerns because the amounts the clients would otherwise pay to insurers as workers' compensation premiums are instead paid to PEOs. Since these amounts are not insurance premiums, they are not subject to premium-based taxes and assessments, and the amount paid by the PEO to the insurer as large deductible premium is a considerably lesser amount. Similar concerns were discussed in Section 6 of this paper in the context of large employers, and PEOs magnify these concerns by applying these same reduced taxes and assessments to small and mid-sized client employers in states that permit the issuance of master policies to PEOs. On the other hand, to the extent that it is smaller employers that are being treated inequitably, PEOs can level the playing field, and in areas where

⁷¹ Alternatively, if the insurer were chartered under a captive law that exempted it from guaranty fund participation, the client employers and the unpaid claimants would be the ones left without recourse. This is a particularly sharp illustration of the reasons, discussed above in Section 4, why captive insurers should not be permitted to write direct workers' compensation insurance.

favorable treatment for large employers is justified by administrative efficiencies or economies of scale, PEOs can make some of the same efficiencies and economies available to smaller employers.

In general, the concerns arising out of large deductible policies to PEOs will become moot for those states that adopt the suggestion of the NAIC/IAIABC paper on PEOs and require the issuance of separate coverage for each client employer, for example, under a multiple coordinated policy arrangement. But for the reasons discussed above, those states that choose to permit master policies must carefully evaluate whether they should also allow such policies to be written on a large deductible basis, and if so, what additional regulatory safeguards might be warranted.

Findings and Recommendations

Large deductibles represent an intermediate economic strategy between self-insurance and complete loss transfer to an insurer. They have proven to be attractive to many medium-sized and large employers. The reasons for this attraction have not, however, always been consistent with the goals of state workers' compensation administrators and insurance regulators, and problems and concerns have arisen that must be adequately addressed. In this regard, generalizations become difficult because of state-to-state differences.

Each state has its own regulations and attendant costs for self-insurance of employers' workers' compensation responsibilities. Likewise, as this report has shown, states vary on the specificity of their legal protections for claimants and employers under large deductible insurance. Thus, no blanket statements can be made about the attractiveness of large deductible plans from the perspective of insurance or WC regulatory agencies. Among other factors, it depends on the laws in place and the resources expended by insurance regulators and workers' compensation administrators to enforce them. With these caveats, adequate attention to the following recommendations should resolve many of the concerns and demonstrated problems that states have experienced with large deductible insurance:

1. *This paper recommends that state statutes clearly indicate that any policy of insurance represented as covering an employer's obligations under the state workers' compensation act shall be conformed to workers' compensation laws regarding the insurer's obligations for full coverage of claims.* These obligations should be enforceable notwithstanding any agent or insurer representation manuscripted on the policy or verbally. Specifically, large deductibles or any other risk sharing arrangement between the employer and the insurer should not reduce or eliminate the ultimate obligation of the insurer to pay all claims from the first dollar of coverage to ultimate statutory benefit levels. This obligation should hold notwithstanding the insolvency of the employer or breaches of other contract provisions, until such a time the contract is duly cancelled. To this end, the Nebraska statute, cited in section 3, represents a good model of such statutory protection. In addition, language similar to the statutory language cited in Chapter 3 from Nevada affirming the responsibility of carriers to pay claims from the first dollar, even in the event of bankruptcy of the policyholder, are very important protections. Insurers should not be authorized to issue excess policies, where the insurer is not responsible for claims below the stated retention level, to any employer that is not approved as a self-insurer, and the insurer should

bear the risk of claims obligation if it issues an excess workers' compensation policy to a nonqualifying employer.

Recommended NAIC activities – none.

Recommended IAIABC activities – Review the IAIABC Proof of Coverage EDI protocol to determine if additional confirmations are required for large deductible policies to determine if state contract language has been used.

2. *Any coverage restrictions by guaranty funds (i.e., for large deductible policies or for policyholders exceeding a certain net worth) should still involve administration and payment of all claims by the guaranty fund, but with the employer being billed back by the guaranty fund for any such amounts that it has expended.* The guaranty funds in most states cover the full amount of all workers' compensation claims for large employers and those arising under large deductible policies. This is viewed as the preferred arrangement. Some states have provisions that treat either large policyholders or policyholders with large deductibles differently. This paper takes no position on those provisions except to recommend that guaranty funds be required to pay claims, from first dollar up, on behalf of such large employers and then seek reimbursement from the employer. Negation of coverage and turning the claims over to the employer would be disruptive; there is the hazard that employer insolvency may result in unpaid claims to injured workers, and this would also result in claims handling by an employer that has not been approved as a self-insurer. States should also ensure that captive insurers or other insurers that do not participate in state guaranty funds are not permitted to write workers' compensation policies issued to satisfy statutory coverage requirements.⁷² Please note that this recommendation applies to more than just large deductibles, and includes any instance in which the insurer is obligated to pay from the first dollar.

Recommended NAIC activities – It is recommended that the Chair of NAIC's Workers' Compensation (C) Task Force be charged to draft letters to each of the jurisdictions discussed in Section 4 of this paper. The letters will outline the nature of the concerns with the individual states' laws.

Recommended IAIABC activities – Support the NAIC activities above.

3. *It is recommended that states review their workers' compensation laws to assure that, to the fullest extent possible, an employee's benefits and rights to benefits will not be compromised when the employee reports a claim or injury to the employer or the TPA handling claims, but the employer or TPA fails to properly report the claim or injury to the*

⁷² Specific exceptions to this recommendation can be warranted in those situations where a state has created some form of special charter insurer with substantial authority to assess members or policyholders for deficits. An example of this is the Maine Employers' Mutual Insurance Company, which has its own guaranty fund-like protection in the form of policyholder assessments.

*employer's insurer.*⁷³ Injured workers should not have their benefits compromised by the actions of an insured employer that attempts to handle a claim on its own. Any defect in reporting of a claim by an employer or by a TPA handling claims for the employer should not operate as a bar when an employer becomes impaired or when an insurer becomes impaired and guaranty funds must take over payments. In addition, guaranty fund provisions should not penalize claims that are made late because the worker had been misled into believing that an employer was self-insured. Some states (e.g., Nebraska) have laws that provide that notice to the employer is considered to be notice to the insurer. While a provision of this nature would fulfill this recommendation, a state considering such a law change should review the impact of such a change on other laws, including various penalty-related provisions, to assure that penalties are not levied against an innocent insurer when the employer is solely responsible for the violation and the insurer has not been negligent or complicit. Please note that this paper does not oppose provisions that might allow an insurer or guaranty fund to seek reimbursement from an employer when the insurer or guaranty fund ultimately becomes liable for increased costs arising out of a claim that an employer had attempted to handle. Please note also that this recommendation applies to more than just large deductibles.

Recommended NAIC or IAIABC activities – none. The burden of action falls upon the individual states.

4. *States should review their statutes to clarify – and reinforce as necessary – the obligation of the insurer to receive and adjust the claims of its policyholders.* It appears to be the opinion of most state insurance and workers' compensation regulators that it is not legal for an employer to handle its own workers' compensation claims, with the usual exception of approved self-insurers. Yet the state laws that are relied on for this conclusion are not uniform, and in many cases are not especially clear. States should consider whether their legal framework makes the insurer a statutory party to a workers' compensation claim, or whether the insurer is merely the agent of the employer. It is especially weak for a state to rely solely upon the fact that approved policy forms do not provide for self-administration of claims. Absent licensing of adjusters, what prohibits an insurer from agreeing with an employer that the employer will adjust the employer's claims on behalf of the insurer?⁷⁴ It

⁷³ In general, this should not represent significant problems in terms of documentation of these facts in those situations where an employer or a TPA has made payments on a claim, because then a paper trail will exist. Problems would be more likely to exist when an employee had received a verbal denial of a workers' compensation claim by an employer. Even here, however, there is the likelihood that some medical treatment would have been received and that some attempt would have been made by medical providers to determine whether workers' compensation coverage applies. Health insurers will similarly follow up to determine whether injuries are work-related. Nevertheless, it should be noted that there might be situations where the production of relevant documentation by the injured worker may represent a challenge. For instance, in Maine, 39-A M.R.S.A. §§ 301 and 302 preserve the employee's rights to benefits if the employee reports the injury within 90 days to any official of the employer, to the employee's supervisor, or to any on-site health care provider, or "if it is shown that the employer or the employer's agent had knowledge of the injury." And yes, this has led to litigation and generated case law when the notice was given orally or when no affirmative notice was given but the accident had witnesses.

⁷⁴ Even in states where adjusters are licensed, the employer's staff could be exempt from licensure if they are not treated as adjusting claims "on behalf of the insurer" because the state's laws treat the employer as the party in interest.

is beyond the scope of this paper to attempt an analysis of individual state insurance and workers' compensation laws on this subject, but it is suggested that states that do not desire to allow self-administration of claims review their laws to determine the specific legal basis for this prohibition. Please note that this recommendation applies to more than just large deductibles.

Recommended NAIC or IAIABC activities – none. The statutory language to accomplish such changes to workers' compensation laws would probably be quite simple; the difficult task falling to the individual states is to determine whether their laws adequately prohibit this activity without changes.

5. *Insurance departments should review their approval standards and procedures to assure that undesirable practices are not allowed (or apparently allowed) owing to regulatory loopholes, shortcomings in regulatory oversight, or a lack of clarity in the applicable law.* In particular, if employer self-administration of claims is illegal or otherwise considered contrary to public interest in a state, then it is important the state review its ECP or similar large risk provisions to assure that this practice cannot be allowed (or apparently allowed) on account of these flexibilities. Please note that this recommendation applies to more than just large deductibles.

Recommended NAIC or IAIABC activities – The Workers' Compensation (C) Task Force should be charged to develop approval guidelines for large deductible policies (endorsements) and to itemize those aspects of the workers' compensation insurance contract that should not be exempted from filing for policyholders subject to ECP (or similar) treatment. In conjunction with work addressing recommendations dealing with TPAs and collateral agreements, this effort should include an examination of any agreements that could be made without filing, as well as an examination of agreements that have tended to be made without filing, but where filing or a greater degree of regulatory oversight appears advisable.

6. *There should be clear understanding and agreement between state agencies that handle workers' compensation and those that handle insurance as to their responsibilities in the area of workers' compensation enforcement.* In many situations, the division of responsibilities is relatively obvious, but this clear delineation of responsibilities may be less common in the specific instance of detection and enforcement involving illegal self-administration of claims. (Note that the agency in the best position to *detect* illegal activities may not always be the agency that is best situated to *enforce* sanctions arising out of these illegal activities.) At least one agency needs to be responsible; it is especially important that there is an understanding between the two agencies when both are potentially responsible. Please note that this recommendation applies to more than just large deductibles.

Recommended NAIC or IAIABC activities – none. This is something that must be done on a state-by-state basis.

7. *Audit and examination procedures of state agencies for claims payment and overall compliance with law should explicitly include steps to detect, investigate, and record unlawful self-payment of claims by employers. These procedures should be sensitive to possible instances of insurance producers that encourage this activity, either in conjunction with large deductible policies or with experience rated policies where such self-payment may be seen as a way to achieve lower experience modifications.* There are widely varying perceptions of the incidence of unauthorized settlements of claims by employers other than approved self-insured employers. Some perceive that this practice is isolated, while others perceive that it is relatively pervasive among both large deductible policyholders as well as other policyholders affected by experience rating. While it is possible that some variation in perceptions may arise from differences in the incidence of this practice from state to state, this doesn't appear likely to be an adequate explanation. This uncertainty is only exacerbated because there appear to be few states, if any, that have procedures in place to attempt to detect this practice in their oversight of workers' compensation claims handling (either by the state's insurance or the workers' compensation agency). As noted previously, this practice is likely to be problematic when it occurs and it would be especially problematic if it were widespread. Thus, it is recommended that detection of employer self-payment of claims be a subject of examinations and/or data analysis by the state agency (insurance or workers' compensation) with authority in this area. The recommendation relating to understanding and coordination between the agencies is especially applicable to this endeavor. Please note that this recommendation applies to more than just large deductibles.

Recommended NAIC activity – The Market Conduct (D) Committee should be charged with exploring whether cost-effective examination procedures can be developed that would assist in detecting self-payment of claims by experience-rated employers and the non-reporting of claims by TPAs for individual large policyholders. These procedures should be sensitive to the self-payment of smaller claims by experience-rated policyholders that are attempting to influence their experience rating. These procedures should provide for follow-up with insurance producers handling accounts where such activities are discovered, as producer involvement may be likely. These procedures should be sensitive to possible differences in state laws, some which may clearly allow the examination of the handling of claims by individual employers and some which may make this activity difficult.

As the current incidence of unlawful self-administration is unknown, it is recommended that the procedures developed to detect such problems attempt first to concentrate on insurers, policyholders and/or situations where some indication exists that such problems are occurring. This will provide some experience in dealing with these issues and may also help to indicate the true extent to which these activities are occurring. At these times, this process should then be reevaluated, not only with regard to the effectiveness of the examination tools in their detection of self-administration of claims, but also to determine whether the resources expended to detect such self-administration are well spent in view of the extent to which problems are found. To the extent that such problems are found to be relatively common, then more resources may need to be devoted to detection and enforcement, while the failure of market conduct activities to detect significant amounts of

self-administration – even though this may also indicate that such detection mechanisms are of limited utility – should result in less resources being devoted to such activities.

Recommended NAIC / IAIABC Joint Working Group activity – The Joint Working Group should monitor the progress of the (D) Committee’s activities in this regard and provide assistance as may be appropriate.

8. *It is recommended that the NAIC TPA Model Act be extended to apply to workers’ compensation and that only insurers and approved self-insurers can contract with TPAs for the handling of their claims.* The TPA Model Act provides a number of safeguards applying to the administration of health claims that would be advantageous in the workers’ compensation area as well. Several states (e.g., Maine and Nebraska) have applied this protection to workers’ compensation. Please note that this recommendation applies to more than just large deductibles. Please note also that it is acknowledged that establishing appropriate limitations on the employer’s role may not be a simple task, as situations (e.g., multi-state employers that are self-insured in some states but not in others) exist where employers will have a legitimate interest in the selection of the TPA, reporting provided by the TPA or with other issues. Thus, the recommendation should be viewed as the general direction for the NAIC to take, but it should not be viewed as something where exceptions are unlikely to be warranted.

Recommended NAIC activity – The NAIC’s Workers’ Compensation (C) Task Force should be charged with the consideration of amendments to the Model TPA Act to extend it to workers’ compensation claims.

Recommended IAIABC activity – none.

9. *It is recommended that those states that have not recently reviewed their workers’ compensation tax and assessment structures with the view of recognizing the effects of large deductible insurance should do so.* The breadth and complexity of tax and assessment issues make sweeping statements difficult. In addition, there will be differences of opinion with regard to “fairness” beyond those differences driven purely by self-interest. Nevertheless, several statements are safe, however. The first and most important is that large deductible policies make a big difference in Annual Statement premiums and losses. The second is that the reserve requirements associated with taxes and assessments on paid losses have caused the insurance industry to prefer premiums or imputed premiums (premiums “grossed up” to recover deductible credits) as a basis for taxes and assessments that specifically support workers’ compensation administration or benefit funds.⁷⁵

⁷⁵ The industry’s position regarding the use of imputed premiums as a basis of taxation when taxes are levied for general revenue purposes is more complex. In general, the industry would oppose “grossing up” premiums for purposes of general revenue premium taxes. Aside from arguments of “fairness,” this would create an incentive for employers insured under large deductible forms to self-insure, and some employers insured under large deductible forms may not be the best of candidates for self-insurance. The appeal of this logic would evaporate in a state that levied comparable revenue-generating taxes upon self-insured employers, but this is not a common approach among the states.

Recommended NAIC or IAIABC activity – none. These are issues that need to be resolved in the political arenas of the individual states.

10. *Insurance regulation of large deductible workers' compensation should prohibit arrangements through which the employer purchases a large deductible workers' compensation policy and then purchases a separate policy (i.e., a "deductible reimbursement policy") that insures amounts falling under the deductible.* The primary reason for this recommendation relates to the need to avoid arbitrage, where an insurer and/or employer may be able to obtain a more favorable treatment for taxes or assessments by using the large deductible policy as a facade. Other reasons for recommending disapproval include the harm that this practice can have on financial and statistical reporting, and the potential use of this device as a means to evade rate regulation.

Several additional comments apply:

- This recommendation does not apply to the employer that "purchases" a deductible reimbursement policy from an affiliated captive insurer, where the deductible reimbursement policy isn't used to service claims or to demonstrate financial responsibility. As long as the captive doesn't purchase reinsurance, especially reinsurance from an insurer affiliated with the insurer providing its large deductible policy, then this activity can be viewed as a legitimate means for the employer to capitalize its liabilities for losses that have occurred but that take years to pay.
- This recommendation should not be interpreted as a recommendation that loss portfolio transfer policies be disapproved. A loss portfolio transfer policy is different from a deductible reimbursement policy. The former covers for past unpaid losses that were retained by the employer in some fashion, while the deductible reimbursement policies addressed by this recommendation cover for prospective losses that would otherwise be retained by the employer.
- This recommendation should not be interpreted as a recommendation for disapproval of surety bonds applying to losses retained by the employer under a large deductible policy. A surety bond is different from a deductible reimbursement policy. A surety bond does not "insure" the employer for its deductible losses under a large deductible policy; rather, it provides assurance to the large deductible insurer that it will be reimbursed for deductible losses, either by the employer or by the insurer writing the surety bond. Any payments made under a surety bond become obligations that the employer (as obligor) is obligated to reimburse to the surety on a dollar-for-dollar basis. In contrast, a deductible reimbursement policy reimburses the employer or its large deductible insurer for deductible amounts paid or payable to its large deductible insurer. The writer of the deductible reimbursement policy is compensated by the employer's payment of premiums, rather than being reimbursed for loss payments that it must make. As an aside, although this report does not recommend against the issuance of a surety bond by the same insurer (group) writing the large deductible policy, and the report notes that such a practice may possibly have bookkeeping advantages (subject to further study by the Casualty Actuarial Task Force), it is noted that this practice would

be a very hollow means of satisfying a state's requirement that the employer provide security for its obligation to reimburse the insurer for losses under the deductible amount.

- The motivation for this recommendation largely goes away if a state can manage to treat employers insured with large deductibles and other policyholders equally for taxes and rating, but this appears likely to be a difficult task, and one that may not be cost-effective generally.
- The motivation to avoid rate regulation should be nonexistent or relatively weak for large workers' compensation policyholders, as rate regulation for such policyholders should generally allow considerable flexibility. In addition, most large private employers voluntarily opt to assume some of their own risk, so it appears relatively unlikely that they will need to develop something that gives the appearance that they are assuming their own risk when, in fact, they are willing to do so.
- This paper does not support any specific degree of rate regulation, and if the only apparent reason that insurers seek to use this coverage device is to avoid rate regulation, then the regulator should reconsider whether that rate regulation is in the public interest.

Recommended NAIC or IAIABC activity – While this is largely a set of actions that need to be taken by individual state insurance departments through their approval process, the approval guidelines to be developed in response to recommendation 5 in this report should address this concern.

11. *State cancellation and nonrenewal restrictions applying to workers' compensation should recognize failure to reimburse deductible payments under deductible policies as grounds for cancellation.* While such cancellations should only be prospective and not apply to injuries that have already occurred as of the effective date of cancellation, insurers should nevertheless be able to cancel for nonreimbursement of deductible amounts in much the same manner as they are able to cancel for nonpayment of premium. The law should also make clear that nonpayment of deductible reimbursements from an earlier policy is a valid ground for cancellation of the current policy.

Recommended NAIC or IAIABC activity – none. Unless the NAIC decides to adopt a model cancellation law for workers' compensation policies or expand the scope of existing model laws, this is something that needs to be done to cancellation laws at the level of the individual state. To some extent, this is an area where one would expect insurance trade associations to have the most interest. Regardless of their origin, regulators should support such changes when they are presented, and include them in appropriate legislative amendment packages as the opportunity may present itself.

12. *States should find ways to exempt collateral agreements from form filing requirements except where this is already being accomplished through ECP or similar large risk flexibility.* Agreements relating to collateral and reimbursement accounts directly relate to and are customarily a condition for issuance of a policy, and are thus generally subject to policy form filing requirements except where ECP or similar large risk provisions allow such agreements to be negotiated without the necessity for the filing of the language of the agreements. That is not to say that such agreements are commonly filed, because that isn't the case. Notwithstanding this interpretation of current laws, there is little reason for the detail of these agreements to be subject to regulatory oversight.

Recommended NAIC or IAIABC activity – none. The recommendation is made that states find ways to exempt collateral agreements from form filing requirements except where this is already being accomplished through ECP or similar large risk flexibilities. The means to accomplish this is going to vary from state to state, and no NAIC model directly addresses this. To the extent that individual states can exempt collateral agreements from forms filing requirements, they should do so.

13. *Especially in those states where agreements between employers and TPAs are legal, the states should be careful to require the filing of all agreements between insurers and employers relating to the handling of claims by TPAs.* The same legal reasoning that applies to collateral agreements also applies to agreements between employers and insurers relating to TPAs. Agreements between employers and insurers with regard to TPAs directly relate to and are customarily a condition for issuance of a policy, and are thus generally subject to policy form filing requirements except where ECP or other large risk provisions allow such agreements to be negotiated without the necessity for the filing of the language of the agreements. Also, as is the case with collateral and reimbursement accounts, the observation is made that such agreements are commonly not filed in spite of the law. However, in contrast to the observations and recommendation made with regard to collateral agreements and reimbursement accounts, there are significant reasons for regulatory concern relating to many aspects of these agreements. Extension of the TPA Model Act to workers' compensation would address many of these concerns, but it would not be a complete response, in part because the form filing oversight that should otherwise be applicable may be rendered ineffectual by large risk provisions that do not specifically recognize large deductible concerns. It is not seen as a problem if an insurer agrees to utilize a specific acceptable TPA for a given policyholder, but large risk flexibility should not allow the employer to have claims paid in a fashion that makes it appear that the employer is a self-insurer. Regulatory concerns are also raised if the employer has the authority to dictate claims settlement standards or to disapprove settlements,⁷⁶ and large risk laws should not be used to insulate these areas from oversight. Please note that this recommendation applies to more than just large deductibles.

Recommended NAIC & IAIABC activities – Changing the NAIC's TPA model is a necessary step in the right direction, as is the review by individual states of their large risk

⁷⁶ This is not intended to take a position on whether employers should have any explicit rights to contest claims settlements by insurers for their employees, but such influence or rights (if any) should be only those allowed by law, and not achieved through subterfuge.

provisions to assure that they have not left a loophole. The recommendation that market conduct examinations be extended to cover TPA activity and the possibility of unauthorized self-administration of claims is necessary to address this as well.

14. *Annual Statement reporting should be amended to show workers' compensation losses under the deductible threshold on a state-by-state basis.* For workers' compensation (only), this would include columns showing paid, incurred and unpaid deductible losses, and written, earned and perhaps unearned actual deductible premiums. In addition, the page would also show premiums on a basis that is reflective of the total exposure for policyholders without credit for deductibles. These could be calculated using payrolls and bureau or state-provided rates or loss costs. The same basis of calculation would not necessarily need to be used for every state. Rather, an attempt should be made to use whatever is most efficient for insurers in the individual states, which will probably be a function of the insurers' statistical reporting practices for that state. There would be several purposes for this reporting. States would have a clearer picture of their total insured marketplace and the portion of its risk being retained under deductible forms. In addition, it would allow for more equitable taxes and assessments to support of workers' compensation funds and administration using a basis other than paid losses. While state-specific reporting is contemplated, this reporting should probably not be on the State Page, as columns showing deductible losses would create a mismatch between premiums and losses. In addition, the current State Page is already crowded.

Recommended NAIC activities – The Casualty Actuarial (C) Task Force should be charged to consider this change, the many related details, and to develop an appropriate proposal for NAIC consideration.

15. *Further study should be done with regard to apparent "disconnects" in accounting requirements for loss recoveries under large deductible programs.* Current instructions call for insurers to book losses net of deductibles for most policyholders rather than net of expected deductible recoveries. When there is an amount past due for a policyholder, the insurer must book the gross amount of losses, in spite of the expectation that some recoveries are likely to occur. Then, as unpaid amounts are written off, they are booked as credit losses, and not as Schedule P and State Page losses. At this time, no specific accounting changes are being recommended, but it is instead recommended that the Casualty Actuarial (C) Task Force be charged to examine the reserving and booking of losses due to policyholder default so that there is consistency in the handling of these losses over their lifetimes. This study should include an examination of the accounting of so-called deductible reimbursement policies when they are not used as such, but are instead used as collateral.

Recommended NAIC activities – The Casualty Actuarial (C) Task Force should be charged to consider this subject and, if necessary, develop an appropriate proposal for NAIC consideration.

16. *Guaranty fund laws should be changed or clarified to assure that reimbursements by employers for claims paid by guaranty funds under deductible plans go to the guaranty fund instead of simply becoming assets of the estate.* At this writing, there is litigation with regard to whether these reimbursements should be treated as reimbursements to the guaranty funds or become assets of the insurer's estate.⁷⁷ This paper takes no position on the proper outcome of such litigation under current laws, but observes that treating these reimbursements as assets of the estate rather than as reimbursements to the guaranty funds will have the effect of increasing guaranty fund assessments (or offsets), while benefiting claimants for those lines of business and types of losses that are not afforded guaranty fund coverage. It would result in policyholders for lines of insurance and types of claims not covered by guaranty funds to receive more than they would have in the absence of a guaranty fund, inconsistent with the philosophy of guaranty fund laws that choose to guarantee recoveries for some lines of insurance but not for others. Clearly, however, the presence of litigation and the questions of public policy call for this issue to be visited and, at a minimum, clarified.⁷⁸

Recommended NAIC activities – The NAIC's Financial Condition (E) Committee should be charged to develop clarifications and/or changes to the model guaranty fund laws so that reimbursements from employers for deductible claims paid by guaranty funds are treated as reimbursements to the guaranty funds and not as assets of the insurer's estate.

17. *States should avoid licensing an insurer controlled by or in some way affiliated with a PEO if that insurer would be able to write a large deductible workers' compensation policy for the PEO.* This would represent a substantial risk of a joint PEO/insurer insolvency in which the guaranty fund will be burdened to pay all claims on a first-dollar basis for all of the PEO's clients, yet the guaranty fund will probably be unable to obtain meaningful reimbursements from the defunct PEO. If the insurer is chartered as a captive or is otherwise exempt from guaranty fund participation, and the state allows such insurers to write direct workers' compensation business, clients and injured workers could be left with no protection at all.

It is therefore recommended that states avoid the licensing of insurers that are owned or controlled by a PEO or an employee leasing firm.

Recommended NAIC or IAIABC activities – Since the NAIC is endeavoring to develop more uniform standards for insurer licensing, this issue should be considered by the National Treatment Working Group.

⁷⁷ The same issue arises in principle with retrospective rating, but payments on retrospectively rated policies are clearly considered premiums and the legal ramifications of this may be different even if the public policy ramifications are not.

⁷⁸ If legislators make the public policy decision that employer reimbursements of amounts paid by the guaranty fund should go directly to the guaranty funds, then it should be noted that the same treatment of employer claim reimbursements may not be proper for reimbursements arising out of claims paid by the insurer prior to the time that it was taken over by the guaranty fund.

Policy Year 2002 Manual-Equivalent Premiums						
	(1)	(2)	(3) = (1) + (2) + (5)	(4) = [(2) + (5)] / (3)	(5)	(6) = (2) / [(2)+(5)]
State Code	Units without a deductible or with deductibles less than \$100,000	Units with deductibles of at least \$100,000	Totals	% of Manual Premium reported as High Deductible	after Deductible Credit for Units with deductibles of at least \$100,000	Large Deductible Discount
AL	501,280,467	279,843,112	879,285,938	43.0%	98,162,359	74.0%
AK	230,185,720	33,974,923	285,307,767	19.3%	21,147,124	61.6%
AZ	636,066,263	144,801,664	829,110,706	23.3%	48,242,779	75.0%
AR	274,502,557	92,949,286	408,019,058	32.7%	40,567,215	69.6%
CO	1,158,000,647	341,415,024	1,633,846,895	29.1%	134,431,224	71.7%
CT	646,153,912	180,782,845	893,555,601	27.7%	66,618,844	73.1%
DC	152,494,314	28,358,753	197,152,814	22.7%	16,299,747	63.5%
FL	4,029,741,852	2,139,579,419	6,816,094,548	40.9%	646,773,277	76.8%
GA	1,214,338,042	476,878,641	1,862,166,884	34.8%	170,950,201	73.6%
HI	285,306,873	52,786,851	355,742,359	19.8%	17,648,635	74.9%
ID	270,265,461	36,400,395	319,187,592	15.3%	12,521,736	74.4%
IL	2,720,061,727	757,814,355	3,826,525,511	28.9%	348,649,429	68.5%
IN	822,004,904	230,264,192	1,163,846,342	29.4%	111,577,246	67.4%
IA	431,190,902	115,035,654	587,873,848	26.7%	41,647,292	73.4%
KS	362,326,870	96,170,790	492,514,288	26.4%	34,016,628	73.9%
KY	401,452,581	160,158,090	611,570,666	34.4%	49,959,995	76.2%
LA	921,167,885	306,602,588	1,385,784,182	33.5%	158,013,709	66.0%
ME	265,248,536	34,205,768	313,528,888	15.4%	14,074,584	70.8%
MD	583,043,134	198,622,076	874,822,249	33.4%	93,157,039	68.1%
MS	370,041,882	117,097,396	545,712,040	32.2%	58,572,762	66.7%
MO	1,021,625,025	264,901,197	1,415,177,619	27.8%	128,651,397	67.3%
MT	231,360,815	19,982,266	262,055,443	11.7%	10,712,362	65.1%
NE	274,842,374	79,563,146	381,896,922	28.0%	27,491,402	74.3%
NV	457,964,145	132,887,987	634,551,912	27.8%	43,699,780	75.3%
NH	295,849,149	76,938,740	403,635,190	26.7%	30,847,301	71.4%
NM	208,200,796	57,072,209	282,305,095	26.2%	17,032,090	77.0%
NC	1,203,975,535	350,720,863	1,706,344,445	29.4%	151,648,047	69.8%
OK	669,132,216	183,970,924	939,471,364	28.8%	86,368,224	68.1%
OR	699,790,387	50,713,262	777,308,862	10.0%	26,805,213	65.4%
RI	246,119,617	41,030,855	304,433,449	19.2%	17,282,977	70.4%
SC	469,359,754	159,537,673	686,290,429	31.6%	57,393,002	73.5%
SD	114,606,770	23,645,916	146,248,859	21.6%	7,996,173	74.7%
TN	907,504,341	478,576,244	1,515,482,674	40.1%	129,402,089	78.7%
UT	335,449,211	69,398,690	436,207,575	23.1%	31,359,674	68.9%
VT	156,156,906	25,723,658	189,590,218	17.6%	7,709,654	76.9%
VA	728,804,007	228,038,296	1,030,881,606	29.3%	74,039,303	75.5%
Total	24,295,615,577	8,066,443,748	35,393,529,838	31.4%	3,031,470,513	72.7%

Note to table: “Manual-equivalent” premiums are payrolls times carrier manual rates prior to the application of various credits, including insurer credits for large deductibles. A threshold of \$100,000 was used for all states.

This table is for 36 states where NCCI collects data and had complete data and does not contain data from a number of large states (e.g., California, New York and Pennsylvania). Wisconsin, which is not shown on this table, does not allow large deductibles for workers’ compensation.

Common Measures of Premiums and Losses

This appendix will first describe common measures of premiums and losses. Following those descriptions, which will not include any mention of large deductibles and their effects, a few paragraphs will discuss the effects of large deductibles upon these premium and loss measures.

Written & earned premiums – *Written premiums* are those that have been written or booked by an insurer during a specified period of time. *Earned premiums* for a period of time represent the proportional amount of policies' premiums for the period of time that a policy is in effect. For instance, if a \$1000 policy is written mid-year, then all \$1000 of that premium is credited as *written premium* during that year, but only \$500 of that premium is *earned* during that period of time. The other \$500 of *earned premium* from that policy will be credited to the next year, even though none of the *written premium* may fall within the next year.

Annual Statement (calendar year) written & earned premiums – The reader may note that the term “written or booked” used in the preceding explanation of written and earned premiums is a little vague. What about the policy that is effective on 12/31/XX, but isn't finally booked until a few months later? What about audit premiums? What about premium development,⁷⁹ which is usually upward? Typically, there are two ways in which written and earned premiums are expressed, either *calendar year* or *policy year*. With *calendar year* written premiums, all premiums that are booked during a calendar year are attributed to that year, regardless of the inception date of the policy. So if a policy is effective on 12/31/XX, but doesn't get booked until several months later, then its premium is shown as *calendar year* written premium in year XX+1. Audit adjustments are treated similarly. If a policy runs from 1/1/XX through 12/31/XX, but the audit doesn't occur until several months later, the audit adjustment (upward or downward) is shown as *calendar year* written premium for year XX+1. *Calendar year* earned premiums are the written premiums booked during the year, plus the booked premiums that have not been earned (are “unearned”) as of the end of the year, minus the booked premiums that were unearned as of the end of the prior year. The key thing to remember with calendar year written and earned premiums is that they contain adjustments for corrections or changes to prior years' premiums that are booked during the current year.

Annual Statement treatment of dividends – Annual Statement state pages show dividends paid separately from premiums. For the purpose of collecting taxes on written premiums, it is common for states to reduce written premiums by the amount of dividends paid, but it is easy to do things either way because dividends are shown separately.

Standard premium – *Standard premium* is a term that pops up in ratemaking. It is calculated on a policy-by-policy basis, and is defined in a way that is intended to produce the same result for an employer regardless of who insures the employer. For each class code on a policy, it is the

⁷⁹ The combined effect of audit and other premium adjustments is usually upward, so insurers' calendar year premiums that omit consideration of premium development tend to be slightly underestimated. To compensate, some insurers will adjust their calendar year premiums to reflect anticipated premium development, even though no actual transaction such as an audit adjustment has been run through the books. Such premium development is sometime referred to as “EBNR” – earned but not reported/recorded.

product of the payrolls for each class times the unmodified bureau rate applying to each class times the applicable experience modifier. For a policy or group of policies, the standard premiums for each applicable code are added together to produce the *standard premium* for that policy or group of policies. In states where loss costs are filed instead of rates, loss costs are used instead of rates in this calculation; some loss cost states compensate for this in whole or part by specifying a “generic” profit and expense multiplier. The important thing is to note what is not included in the calculation. Expense constants are not added in, size-of-risk discounts are not applicable, “deviations” (in states where the bureau files rates) are not applied, and various schedule rating and similar credits or debits are not applied.

Paid & incurred losses – A loss is said to be an *incurred loss* as soon as it happens (i.e., as soon as the worker is injured), while the loss (or a portion of it) becomes a *paid loss* only after it has been paid. For instance, a death claim for a worker with dependents may be a \$300,000 *incurred loss* as soon as it happens, but it may only be a \$10,000 *paid loss* by the end of the first year. While the concept of *paid* versus *incurred* is relatively simple, it is more complex to address the period of time to which the *paid* or *incurred* loss is assigned. Some additional concepts necessary to analyze these issues are explained below. When considering paid versus incurred losses as a basis of taxation, several factors should be noted. In particular, although incurred losses are conceptually more accurate, paid losses are an objective accounting item, while incurred losses involve a considerable degree of judgment by the insurer in the setting of loss reserves.

Annual Statement (calendar year) paid & incurred losses – *Calendar year paid losses* are those losses that are booked as paid during the calendar year. Unless there are errors or reporting delays (e.g., as might occur with a TPA), there is little reason why the paid losses booked during a calendar year should be significantly different from actual payments during the year. In practice, the differences are so small that they are not a matter for concern. *Calendar year incurred losses* are defined as the *calendar year paid losses*, plus the year-end reserves for unpaid losses (including reserves for losses that may have occurred but are yet to be reported), minus the year-end reserves for unpaid losses for the prior year. This means that *calendar year incurred losses* are not just the losses actually incurred during that year – they also include all reserve adjustments or corrections (upward or downward) for losses incurred in all prior years. In workers’ compensation, because losses often take many years to pay, and because total unpaid losses from all past years are often several times the amount of incurred losses in the most recent year, corrections and adjustments from prior years are often the controlling factor in whether or not an insurer’s current year’s *calendar year incurred losses* appear high or low.

Accident year paid & incurred losses – For most usages, including many or most ratemaking usages, calendar year incurred losses are an unsuitable measure of incurred losses because the effect of newly reported losses and reserve adjustments from prior years will result in calendar year incurred loss figures that are substantially different than the estimated losses that actually happened during the year. In these cases, the most common “solution” is to use *accident year* paid and incurred losses. With *accident year* losses, all loss amounts, both paid and unpaid, are assigned to the year in which the underlying accident actually occurred. As a result, the losses assigned to a given year are the truest possible estimation of those losses that actually occurred during the year. The complicating factor to *accident year losses* is that they will change from

evaluation date to evaluation date, as previously unpaid losses are paid, previously unreported losses are now reported and reserve estimates on previously reported claims change. While calendar year incurred losses at the end of the calendar year are known with certainty (unless there have been bookkeeping errors), *accident year losses* will typically change with each subsequent evaluation. This is known as *loss development*.

Policy year premiums and paid & incurred losses – Another way that both premiums and losses can be associated to a specific and common period of time is to associate all premiums and losses to the inception year of the policy that is generating the premium or loss. Classification ratemaking exclusively uses policy year data, and policy year data is also commonly used by bureaus for the determination of overall rate or loss cost levels. The advantage to policy year data versus accident year data is that the goal of ratemaking is to predict losses on a policy year basis, and policy year data provides a precise match of exposures with their corresponding losses. The advantages to accident year data are that accident year data is available sooner – the most recently available policy year will inherently be about six months older than the most recently available accident year.

Large Deductible Effects on Premium and Loss Measures

Insurance company Annual Statement State Pages are the most commonly used source of premiums and losses for workers' compensation tax and assessment purposes. A workers' compensation policy or group of workers' compensation policies written on a large deductible basis will yield significantly different numbers on the Annual Statement State Page than would have been the case if the policy or policies had been written on a non-deductible basis. Written and earned premiums will be shown net of deductible credits, and such credits are typically quite large. Unless a large deductible policyholder becomes insolvent and the insurer goes unreimbursed for losses under the deductible amount, paid and incurred losses will also be net of the deductible amounts. As a result, any taxes or assessments based upon Annual Statement State Page premiums or losses will collect substantially less money from employers that move from non-deductible policies (whether retrospectively rated or otherwise) to large deductible policies.

Standard premiums are typically not reported to states, but they are collected by bureaus and are used for ratemaking purposes. Standard premiums are unaffected by large deductible credits.

Similarly, losses reported to bureaus for classification ratemaking purposes are reported such that results can be determined on both a net and a gross basis, but none of the regular reports of financial aggregate data that go to most insurance departments as a matter of course include losses falling under large deductible amounts. There is no reason that a state cannot also ask for gross losses and/or losses falling under these deductible amounts – in fact, some states (i.e., Florida and Nebraska) have asked for them. Of course, if there are data quality problems (i.e., from non-reporting) with large deductible insurance, then the fact that insurance data can be reported on either basis will be of little utility, as it will merely be incorrect data reported in different ways.