National Association of Insurance Commissioners

2016 Workers' Compensation Large Deductible Study

NAIC/IAIABC Joint (C) Working Group

2016

National Association of Insurance Commissioners

The NAIC is the authoritative source for insurance industry information. Our expert solutions support the efforts of regulators, insurers and researchers by providing detailed and comprehensive insurance information. The NAIC offers a wide range of publications in the following categories:

Accounting & Reporting
Information about statutory accounting principles and the procedures necessary for fi ling financial annual statements and conducting risk-based capital calculations.

Consumer Information
Important answers to common questions about auto, home, health and life insurance — as well as buyer's guides on annuities, long-term care insurance and Medicare supplement plans.

Financial Regulation
Useful handbooks, compliance guides and reports on financial analysis, company licensing, state audit requirements and receiverships.

Legal
Comprehensive collection of NAIC model laws, regulations and guidelines; state laws on insurance topics; and other regulatory guidance on antifraud and consumer privacy.

Market Regulation
Regulatory and industry guidance on market-related issues, including antifraud, product fi ling requirements, producer licensing and market analysis.

NAIC Activities
NAIC member directories, in-depth reporting of state regulatory activities and official historical records of NAIC national meetings and other activities.

Special Studies
Studies, reports, handbooks and regulatory research conducted by NAIC members on a variety of insurance related topics.

Statistical Reports
Valuable and in-demand insurance industry-wide statistical data for various lines of business, including auto, home, health and life insurance.

Supplementary Products
Guidance manuals, handbooks, surveys and research on a wide variety of issues.

Capital Markets & Investment Analysis
Information regarding portfolio values and procedures for complying with NAIC reporting requirements.

White Papers
Relevant studies, guidance and NAIC policy positions on a variety of insurance topics.

For more information about NAIC publications, visit us at:

http://www.naic.org//prod_serv_home.htm

© 2016 National Association of Insurance Commissioners. All rights reserved.

ISBN: 978-1-59917-953-7

Printed in the United States of America

No part of this book may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording, or any storage or retrieval system, without written permission from the NAIC.

NAIC Executive Office
444 North Capitol Street, NW
Suite 700
Washington, DC 20001
202.471.3990

NAIC Central Office
1100 Walnut Street
Suite 1500
Kansas City, MO 64106
816.842.3600

NAIC Capital Markets
& Investment Analysis Office
One New York Plaza, Suite 4210
New York, NY 10004
212.398.9000

Table of Contents

© 2016 National Association of Insurance Commissioners

Table of Contents (continued)

© 2016 National Association of Insurance Commissioners

Executive Summary

After discussion and consideration of recent workers' compensation insurer insolvencies, the growth of the large deductible market and the increased number of workers affected by large deductibles, the NAIC/IAIABC Joint (C) Working Group was charged in 2015 to provide an update to the 2006 *Workers' Compensation Large Deductible Study.* This paper is intended to educate readers on the use, business practices and potential risks of large deductible policies in workers' compensation.

The paper focuses on six areas:

- Employer insurance buying trends.
- Solvency concerns.
- Claims.
- State filing requirements.
- Special considerations for workers' compensation underwriters.
- Unique concerns of professional employer organizations (PEOs).

Unlike the original study, which was designed largely by regulators for regulators, the 2016 study has focused on providing a snapshot of the large/mega-deductible landscape. It is intended to serve as a resource for all affected parties, including employers, workers' compensation insurance underwriters, injured workers, advisory organizations, guaranty funds, PEOs and regulators. More than 180 of these parties participated in 43 conference calls dealing with large deductible issues. By including a diverse array of contributors from each of these segments, the 2016 study provides a comprehensive overview of large deductibles and the issues attached to successfully underwriting and regulating these accounts. Using the 2006 study as a resource, this update is intended to complement the original work product by considering recent developments in the use of large deductibles. This product is intended to be a practical guide for regulators, insurance underwriters and employers using deductible products.

The NAIC/IAIABC Joint (C) Working Group's 2006 *Workers' Compensation Large Deductible Study* and a 2015 study published by the Katie School of Insurance and Financial Services at Illinois State University[1] clearly spell out many of the problems associated with the underwriting of workers' compensation on a large deductible basis. These studies also cite examples of abuse of the underwriting process by some employers, PEOs and insurance companies. Because these papers have clearly defined the issues, and even recommended possible solutions, the authors of this study have chosen to focus on what underwriters and properly run PEOs are doing to underwrite large deductible business successfully. This report also discusses recent legislation enacted by some states to address past abuses, as well as some possible solutions proposed by the National Conference of Insurance Guaranty Funds (NCIGF).

Recommendations

The authors recommend referring the following questions to the Financial Condition (E) Committee for consideration by the appropriate National Association of Insurance Commissioners (NAIC) task force or working group:

- Whether the existing reporting framework under Notes to Financial Statements, Note 31 – High Deductibles should be enhanced by additional disclosures or replaced with a framework that books policy reserves on a gross basis and establishes explicit standards for credit for anticipated deductible reimbursements.
- Whether the existing risk-based capital (RBC) charges associated with large deductible business need to be enhanced to ensure that they properly reflect both the risk associated with reserves that

[1] In August 2015, the Katie School of Insurance and Financial services released a study titled "The Role of Large Deductible Policies for PEOs in the Failures of Small Workers' Compensation Insurers." This study examines the way in which large deductible plans are used to manage certain workers' compensation risks and how, in certain instances, the use of these programs led to unfavorable results for insurance companies and their claimants. It provides various statistical data and case studies, along with recommendations on how this business may be managed effectively. Readers who would like to learn more are invited to review this work. The Katie School study is available at *http://business.illinoisstate.edu/katie/industry/research.shtml*.

are unsecured or under-secured and the risk that adverse development of reserves that are currently recognized might result in reimbursable losses that exceed the collateral.

- Whether other types of loss-sensitive programs, such as retrospective rating plans, should also be subject to some or all of the standards that apply to large deductible programs.

The specific recommendations are as follows:

- Enact legislation establishing financial requirements for large deductible workers' compensation coverage, including the following:

o A definition of large deductible coverage that includes traditional policies subject to endorsements or side agreements that shift risk back to the employer.
o Size and financial strength requirements for insurers writing large deductible policies.
o Limitations on the risk employers may retain, relative to their financial capacity.
o Requirements for collateral, including prohibitions against commingling it with other assets of the insurer or pledging it for other competing purposes.

A statute with these provisions has been enacted in Illinois.[2]

- Recommend the Financial Condition (E) Committee be charged to develop RBC standards associated with large deductible business, and ensure that they reflect not only the risk associated with any anticipated reimbursements that are unsecured or under-secured, but also the risk that adverse reserve development might result in losses within the deductible that exceed the collateral that is currently deemed to be adequate.
- Require the insurer's staff to evaluate the creditworthiness of policyholders. Where indicated, the underwriting department should bring in the other resources, such as the finance department.
- Enact legislation that governs the rights and duties of the various parties regarding deductible business in insolvencies; the NAIC and the NCIGF have both developed model language on this point.
- If regulators detect that a company with this type of business may be financially troubled, regulators could conduct a special examination. Such examination would be conducted by an examiner with expertise in this business and could be paid for by the guaranty association.
- Recommend the Financial Condition (E) Committee consider establishing qualifying thresholds that, if exceeded, would require reporting to the regulator. Such a procedure would enable regulators to conduct a special examination, if warranted.
- In those states that do not already have such language, provisions should be enacted that are substantially similar to the text below, which would permit the collection of large deductible reimbursements from insureds:

"The Guaranty Association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer."

If you have comments after reviewing the paper, please forward them to:

David Keleher, ARM, CPCU, AIM, CIC
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197
dkeleher@naic.org

[2] Illinois Senate Bill 1805 was enacted in August 2015. (Appendix I)

© 2016 National Association of Insurance Commissioners

Introduction

After discussion and consideration of recent insolvencies, the growth of the large/mega-deductible market and increased number of workers affected by large/mega-deductibles, the NAIC/IAIABC Joint (C) Working Group was charged in 2015 to provide an update to the 2006 *Workers' Compensation Large Deductible Study*. This study is intended to educate on the use, business practices and potential risks of large deductible policies in workers' compensation.

Although well-managed large deductible programs are an integral component of the modern workers' compensation insurance marketplace, large deductible programs also create added risk. They are complex arrangements, and their success depends on the employer's fulfillment of its obligation to reimburse all claims within the deductible. If the employer has misjudged its ability to fulfill that obligation, or is simply unlucky, the financial consequences to the employer could be catastrophic, and the employer's inability to pay could have a cascading impact on the financial health of the insurer.

In order to manage this risk successfully, insurers and regulators must have a clear understanding of the nature and size of the insurer's exposure Additionally, they must ensure that there are adequate measures in place to limit and mitigate the risk of the employer's failure to pay, as well as ensure injured workers will receive benefits in compliance with state law.

This paper focuses on six areas:

- Employer insurance buying trends.
- Solvency concerns.
- Claims.
- State filing requirements.
- Special considerations for workers' compensation underwriters.
- Unique concerns of PEOs.

Background

In the spring of 2015, members of the International Association of Industrial Accident Boards and Commissions (IAIABC) and the NAIC met during the National Council on Compensation Insurance (NCCI) Annual Issues Symposium. An overall strategy for completion of the study was discussed, and volunteers were solicited to work on various modules proposed for study.

Unlike the original study, which was designed largely by regulators for regulators, the 2016 study focuses on providing a snapshot of the large/mega-deductible landscape. It is intended to serve as a resource for all affected parties, including employers, workers' compensation insurance underwriters, injured workers, advisory organizations, guaranty funds, PEOs and regulators. More than 180 of these parties participated in 43 conference calls dealing with large deductible issues. By including a diverse array of contributors from each of these segments, the 2016 study provides a comprehensive overview of large deductibles and the issues attached to underwriting and regulating these accounts successfully. Using the 2006 study as a resource, this update is intended to complement the original work product by considering recent developments in the use of large deductibles. This product is intended to be a practical guide for regulators, insurance underwriters and employers using deductible products.

The 2006 NAIC/IAIABC Joint (C) Working Group's *Workers' Compensation Large Deductible Study* and a 2015 study published by the Katie School of Insurance and Financial Services at Illinois State University[3] clearly spell

[3] In August 2015, the Katie School of Insurance and Financial services released a study titled "The Role of Large Deductible Policies for PEOs in the Failures of Small Workers' Compensation Insurers." This study examines the way in which large deductible plans are used to manage certain workers' compensation risks and how, in certain instances, the use of these programs led to unfavorable results for insurance companies and their claimants. It provides various statistical data and case studies, along with recommendations on how this business may be

out many of the problems associated with the underwriting of workers' compensation on a large deductible basis. These studies also cite examples of abuse of the underwriting process by some employers, PEOs and insurance companies. Because these papers have clearly defined the issues, and even recommended possible solutions, the authors of this study have chosen to focus on what underwriters and properly run PEOs are doing to successfully underwrite large deductible business. This report also discusses recent legislation enacted by some states to address past abuses, as well as some possible solutions proposed by the NCIGF.

How Does a Large/Mega-Deductible Policy Work?

A large/mega-deductible policy is similar to an ordinary workers' compensation policy in that the insurance carrier is obligated to pay the claim in full. However, in a large/mega-deductible policy, the carrier seeks reimbursement from the employer for the deductible amount for each claim.[4] For example, if a roofer falls and incurs $2 million in medical costs and the employer has a $100,000 large deductible policy, the insurer will pay the claim in full ($2 million) and seek $100,000 from the employer.

What is a Large or Mega-Deductible in Workers' Compensation?

The study group wrestled with this question and determined that there is no uniform definition of "large deductible" or "mega-deductible" among the states or insurers. For example, in Nevada, any deductible of more than $25,000 must be reported to the state. In other states, a workers' compensation deductible of more than $100,000 is considered a large deductible. The real key is what the insurance underwriter considers a large deductible. In the study group's research, it was found that many companies define a large deductible as $100,000 or more and a mega-deductible to be more than $750,000 per claim, but other resources set the mega-deductible threshold as high as $10 million. Although mega-deductibles may require more underwriting and regulatory oversight than other large deductible policies, the difference is one of degree rather than of kind, so this study will refer to them generally as "large deductibles.".[5]

Why Do Employers Find Large Deductible Policies Attractive?

Employers who effectively use these policies experience premium reductions, tax savings, and increased control over costs and workplace safety:

- Deductibles encourage employer participation in safety activity because they have a more direct financial stake in claims.
- When losses do occur, large deductibles give the employer a financial incentive to do everything possible to get the employee back to work as soon as possible.

If employers create safer workplaces and reduce accidents, they benefit from the significant premium savings that large deductibles provide.

Concerns of Ill-Advised Use of Large Deductibles

Research by the study group revealed that when large deductibles are written for employers that are weak financially or use deductibles that are inappropriate for their size, there can be several unintended consequences:

---

managed effectively. Readers who would like to learn more are invited to review this work. The Katie School study is available at *http://business.illinoisstate.edu/katie/industry/research.shtml*.

[4] After the insurer has begun making payments under a covered workers' compensation claim, the insurer is entitled to pursue the insured/employer for reimbursement of payments made up to the deductible amount, regardless of the total value of the claim and regardless of whether the claim has been closed.

[5] In conversations with workers' compensation regulators, concern was expressed that mega-deductibles were perceived as unsecured self-insurance policies. Some evidence has been provided by the Nevada Division of Insurance that the sizes of the largest deductibles on the market have increased over time. (See Appendix D.) However, the study group is not aware of any systematic study that has been performed regarding the loss experience of mega-deductible policies in particular or whether mega-deductible policies are associated with a greater risk of insurer insolvency or non-payment of workers' compensation claim benefits, as compared to large deductible policies. The study group considers these to be important questions for future research to consider.

- Injured employee care and reimbursement can be affected.
- The employer's costs can actually increase.
- If the employer cannot meet its financial obligations to the insurance company, carrier insolvencies might occur, disrupting coverage for numerous other insureds and their injured workers.

This paper will address these concerns, but the study group emphasizes that while there have been a few problems with a limited number of underwriters and employers, including PEOs, using large deductibles, for the most part, this is a vibrant segment of the workers' compensation market.

The focus of the study has been to capture the actions of underwriting companies and employers, including PEOs, that are doing the business in a proper and ethical manner and to share their best practices as a learning tool for other companies considering using large deductibles as an underwriting/risk-management tool.

Workers' Compensation Statistical Data

The study group attempted to develop statistical data about current buying trends in workers' compensation. Members of the study group contacted insurance associations, insurance brokers and workers' compensation advisory organizations, with the following results:

- Associations and brokers contacted confirmed there is a trend for employers moving toward the selection of large deductible workers' compensation programs.
- The NCCI was able to provide aggregated deductible policy information for policy years 2011, 2012 and 2013 representing its entire 36 jurisdiction states and for the independent bureau state of Indiana. This did not include information from the independent bureau states of California, Delaware, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Carolina, Pennsylvania and Wisconsin. Also, no information was included for the monopolistic fund states. California data will be discussed separately.

It should be noted that for the three policy years (2011–2013), the NCCI aggregated deductible information representing an average of 2.7 million policies and $24 billion in premium for each year in the data sample. For these reasons, the group believes the NCCI data is credible.

Trends Identified

- The use of deductibles in workers' compensation is relatively stable.
- About 22% of all workers' compensation premium dollars paid by employers are for deductible policies. For the three policy years, the percentage of total premium for policies with a deductible program as compared to policies without a deductible program is as follows:

Policy Year	Percentage of Total Premium
2011	22.5% Policies with Deductible Programs
2012	21.4% Policies with Deductible Programs
2013	21.2% Policies with Deductible Programs

- Approximately 92% of policies do not have a deductible program. The NCCI data showed the following deductible program results for the three policy years:

Policy Year	Percentage of Policies with Deductible Program	Percentage of Policies with Small Deductible Program (<$100,000)	Percentage of Policies with Large Deductible Program (>= $100,000)
2011	8.02%	4.34%	3.68%
2012	8.25%	4.48%	3.77%
2013	8.59%	4.69%	3.90%

- For policies with a deductible program, less than half have deductibles of $100,000 or more. The breakdown of small and large deductibles is as follows:
    - Approximately 54% of policies represent deductible programs of less than $100,000.
    - Approximately 46% have deductibles of $100,000 or more.
- The number of policies written with a mega-deductible (a deductible of at least $10 million or more) is extremely small. NCCI data included 699 policies in this category in 2011, 836 policies in 2012 and 778 policies in 2013. This represents an average of 0.03% of total policies written, 0.26% of total premium and 1.73% of total incurred losses.

Readers are encouraged to review the tables found in Appendix B for additional statistical data.

California Data

Because California has one of the largest premium volumes for workers' compensation, with nearly $15 billion in written premium in 2013, the study group asked the Workers' Compensation Insurance Rating Bureau of California (WCIRB) to provide statistical information about the use of large deductibles in the state.

The data revealed that 36.3% of written premiums in 2013 were for large deductible programs with a deductible of at least $100,000. This is considerably higher than the 22% reported for other states by NCCI. The data reveals that there has been tremendous growth in the number of insureds selecting large deductibles in California. The following table shows the data for the latest available years.

	(1)	(2)	(3)	(4)
Policy Year	Percentage of Policies with a Deductible Program	Percentage of Policies with a Deductible Program Less Than $100,000	Percentage of Policies with a Deductible Program Greater Than $100,000	Count of Polices with a Deductible Greater Than $750,000
2011	2.3%	0.4%	1.8%	5,844
2012	2.7%	0.5%	2.2%	6,816
2013	3.1%	0.5%	2.5%	8,160

Note: The WCIRB stated that the above data is taken from insurers that are reporting deductible data on unit statistical reports. Not all insurers are reporting complete deductible data on unit statistical reports. See the WCIRB information in Appendix C for additional details.

Solvency Concerns

Introduction

In large deductible arrangements, the employer is obligated to reimburse for all claims up to the deductible amount. Insurers are liable for claims within the deductible even if they have not received reimbursement by the deductible policyholder. The reimbursement obligation is an asset that offsets that liability, and the asset is only as good as the collateral that backs it. If the employer's obligation is unsecured or under-secured, then the value of the reimbursement obligation is only as good as the employer's credit. Furthermore, the nature of a workers' compensation claim is that the benefit may be payable over years or even a lifetime (often referred to as having a "long tail"). Thus, successful collection depends on the employer's credit—not just now, but years, and perhaps decades, into the future—as the claim payments fall due. If the employer fails to pay for any reason, the insurer incurs an unexpected liability, and the failure of the claim reimbursement mechanism has been a significant factor in a number of insurer insolvencies.

When the insurance company becomes insolvent and the responsibility for claims handling is transferred to the guaranty fund, the receiver and the guaranty association must deal with issues such as the following:

- Insurer commingling of collateral with general assets of the estate.
- Collection of reimbursements of claims within the deductible.
- Collateral that is under the control of an entity other than the insolvent insurer.

© 2016 National Association of Insurance Commissioners

- Situations where the carrier and insured (in recent insolvencies, often a PEO) are both insolvent.
- Claims on collateral by the bankruptcy estate of the insured.
- Insureds with questionable creditworthiness or unmanageably high deductibles.
- Insufficient, poor quality or nonexistent collateral.
- Difficulties in transition of claims to the guaranty association due to poor claim management and recordkeeping, often by a third-party administrator (TPA) that was inadequately supervised by the carrier.

This chapter will provide a brief overview of current law regulating deductible programs, describe the role of guaranty funds, provide case studies illustrating some of the current issues and offer some suggestions for better management of these products on a prospective basis.

Current State of the Law

In most states, there is little guidance governing the rights and obligations of the parties when an insurance company with a large deductible portfolio becomes insolvent. One approach to the problem could be called the "secured claim" approach, which places the highest importance on the principle that claims within the deductible are primarily the obligation of the policyholder. Under this approach, deductible reimbursements are earmarked to pay those claims, and any collateral posted by or on behalf of the policyholder is held to ensure that those claims are paid. Accordingly, when the guaranty association takes on the responsibility of paying a claim within the deductible, it earns the benefit of the reimbursement due from the policyholder, and the right to draw on the collateral if necessary, or to initiate a draw by the receiver, for the benefit of the guaranty fund.[6]

Another approach could be called the "reinsurance" approach, which places the highest importance on the principle that the insurer's obligation to pay all covered claims and the policyholder's obligation to reimburse the insurer are unconditional and that each is independent of the other. Under this approach, deductible reimbursements are a general asset of the estate so that large deductible policies and guaranteed cost policies are essentially identical from the guaranty fund's perspective, and the guaranty fund only benefits from the deductible reimbursements in proportion to its share as a creditor of the estate. The NAIC has largely taken the second approach. Under the *Insurer Receivership Model Act* (#555), Section 712—Administration of Loss Reimbursement Policies, the receiver has the right to collect all deductible reimbursements, drawing on collateral as necessary. All such payments are general assets of the estate. Any reimbursements paid to the guaranty association are treated as early access distributions and offset from future recoveries from the estate. However, the receiver also has the option to enter into an agreement under which the policyholder takes on responsibility for claims within the deductible, directly or through a TPA, and any such claims remain off the books of both the estate and the guaranty fund. It should be noted that no state has enacted the reinsurance approach embodied in Model #555. The NCIGF approach, on the other hand, has had some success in state legislatures, as the paragraph below demonstrates. Further, some states may have concerns about the impact of the Model #555 approach on statutory deposit requirements in California.[7]

Eight states currently have statutes in place: California, Illinois, Indiana, Michigan, New Jersey, Pennsylvania, Texas and Utah.[8] Most of these states follow the NCIGF approach and have amended their insurance liquidation acts to clarify the following when to secure competing claims such as deductible amounts owed the insurer and retroactive premium balances: 1) the ownership of the deductible reimbursements or collateral drawdowns; 2) claims-handling matters; 3) collection responsibility; and 4) allocation of collateral. New Jersey has handled this matter through an amendment to its workers' compensation law. In addition, legislation was recently enacted in Illinois that would regulate collateral requirements for smaller insurance companies offering large deductible programs and limit the size of per-claim deductible amounts to 20% of the insured's net worth.[9]

The Role of the Guaranty Funds and Projected Costs of Recent Large Deductible Insolvencies

[6] The NCIGF has adopted model legislation codifying this approach, which is available online at *http://ncigf.org/media/files/Large_Deductible_Model_as_Adopted_August_22_2013.pdf*.
[7] See Cal. Ins. Code § 11691.
[8] Enacted statutes may be viewed at *http://ncigf.org/policyleg*.
[9] See Illinois SB 1805.

© 2016 National Association of Insurance Commissioners

P/C guaranty funds pay covered claims when an insurance company is found to be insolvent and ordered into liquidation. Funding for guaranty fund payments comes from remaining insurance company assets, assessments from solvent insurers and, in some states, deposits collected from insurers to secure their obligations. Insurance company assessments are recouped via various mechanisms, including rate increases, policy surcharges and tax offsets. Ultimately, most assessment costs are borne by policyholders and the public.

In almost all states, there is no statutory cap for guaranty fund coverage of workers' compensation claims. The benefits are paid in full in accordance with policy terms and state workers' compensation law. Many states do have net worth limitations that would either permit the guaranty fund to recover payments from certain high net worth insureds or exclude such claims in the first instance.[10]

Normally, a guaranty fund will pay the injured worker's claim on a large deductible policy from dollar one. Unless state law requires a different process, the guaranty fund will seek to recover amounts within the deductible through the deductible reimbursement collection process and will work with the receiver to draw down the collateral securing these reimbursements if necessary. Especially when there is no applicable law in place, confusion—and sometimes disputes—arise about who has the right (or duty) to collect the deductible reimbursements, who has the right to any collateral in place to secure the deductible (along with other insured obligations) and who has claims-handling responsibility. (Often, pre-liquidation deductible claims are handled by a TPA or other entity, not necessarily the insurer.) There are often competing claims for the collateral, or it is insufficient or nonexistent.

Exhibit 1 illustrates four insolvencies in which collateral was diverted for purposes other than the payment of large deductible claims. In one case, the collateral was commingled with general assets of the insurance company, making it difficult to determine how much of the remaining funds should be considered security for large deductible claims. In another, the collateral was controlled by a managing general agent with its own claims against the collateral. In both situations, the available collateral secured only about one-third of guaranty association paid claims and reserves. Disputes and competing claims will almost certainly reduce the amount recovered by the guaranty associations even further.

Exhibit 1

Estate	Guaranty Association-Incurred Losses Paid as of Year-End 2014
Freestone	$124 million
Imperial Casualty and Indemnity	$40 million
Park Avenue	$75 million
ULLICO	$385 million
Total	$624 million

To date, the combined total early access for these estates has been less than $24 million. This means $601 million was charged back to guaranty association members and/or their policyholders through special assessments.

Case Studies Illustrating Common Issues Encountered in Recent Insolvencies

Asset Issues

Insolvencies of both the Credit General Companies (1999 and 2000) and Reliance Insurance Company (October 2001) raised issues about the character of the deductible reimbursement asset. The core question concerned whether the deductible was a general asset of the estate or whether it should be remitted in full to the guaranty associations to the extent of their claim payments.[11]

[10] A complete summary of guaranty association laws is available from the NCIGF at *www.ncigf.org*.
[11] See *Koken v. California Insurance Guarantee Association*, Petition to Declare Deductible Reimbursements are General Assets of the Estate, filed June 3, 2003. Available at *www.reliancedocuments.com/pdfs/595.pdf*.

© 2016 National Association of Insurance Commissioners

Complications related to deductible programs arose again in the Legion Insurance Company/Villanova Insurance Company and PHICO Insurance Company liquidations. The issues in Pennsylvania were somewhat resolved by the enactment of statutory liquidation act provisions that specifically addressed large deductible assets and liabilities in insurance insolvencies.[12] However, sorting through deductible issues in large, complex cases remains a daunting task, even with legislative parameters in place.

More recently, insolvent companies with large deductible workers' compensation business include: the Park Avenue Property and Casualty Insurance Company/Imperial Casualty and Indemnity Company liquidation (Nov. 18, 2009, and May 12, 2010); the Freestone Insurance Company liquidation (April 28, 2014); and the Ullico Casualty Company liquidation (May 30, 2013).

In the case studies below, PEOs are the primary insureds, and the injured workers involved are employees co-employed by the PEO and injured at PEO client worksites.

Collection Issues

In *Oklahoma v. Staffing Concepts*,[13] the liquidator for the Park Avenue/Imperial estates sought to collect large deductible reimbursements owed by the insured for claims paid by the guaranty associations. The court dismissed the suit, ruling that the liquidator lacked standing to pursue these recoveries because the guaranty associations paid the claims and had an independent right to collect salvage and subrogation recoverables. This led to a costly appeal process, which was ultimately resolved by settlement. Additional issues raised on appeal included whether the collected amount is a general asset of the estate or an asset that should inure to the benefit of the guaranty associations to the extent of their claim payments.

Insured and Insurer Both Insolvent/High Deductible Amount for Small Leasing Employer

In *Terminal Transport, Inc. v. Minnesota Insurance Guaranty Association*,[14] the opinion of the court nicely sums up the fact pattern in play: Because Terminal was a fairly small business, it contracted with a PEO, Oxygen Unlimited LLC, for human-resource services. Oxygen handled payroll, withholding, garnishment and state taxes; it employed workers and leased them to Terminal; and it arranged for insurance coverage, including a workers' compensation policy. Oxygen purchased the workers' compensation policy from Imperial Indemnity and Casualty Insurance Co. for the period of March 31, 2009, through Jan. 1, 2010. This policy included a deductible of $1 million, which reduced the premium paid by Oxygen and the human-resource costs billed to Terminal.

An employee was injured while working for Terminal during the policy coverage period and submitted a workers' compensation claim. Although Oxygen assured Terminal that it would handle the matter, it went out of business, and Imperial was declared insolvent by the state of Oklahoma before the claim was paid.

The claim was ultimately tendered to the Minnesota Insurance Guaranty Association but was denied because of a provision in the Minnesota statute that excludes "any claims under a policy written by an insolvent insurer with a deductible of $300,000 or more [or] that portion of a claim that is within an insured's deductible."[15]

Notably, the policy contained a provision making Terminal "jointly and severally liable for all deductible amounts under this Policy." Terminal had argued that the PEO's inability to pay left the insurer responsible for providing first-dollar coverage and guaranty fund protection would be available to Terminal and its workers, but the court ruled that the joint and several liability clause made Terminal subject to the deductible reimbursement obligation in the same manner as the PEO, even though Terminal was described as a "fairly small business," for which a $1 million deductible would clearly be inappropriate.

---

[12] See PA ST 40 P.S. § 221.23a.
[13] CIV-12-409-C; [Western District Court of Oklahoma] January 24, 2014.
[14] No. A14-1284, Hennepin County District Court, April 20, 2015.
[15] This statute is unusual. In most states, a guaranty fund would pay any workers' compensation claim regardless of deductible and seek reimbursement from the deductible collection or collateral drawdown. In states where guaranty fund coverage of claims within the deductible is excluded or uncertain, policymakers may consider enacting legislation clarifying that unpaid claims under large deductible policies have the same unlimited guaranty fund coverage as other workers' compensation policies.

A similar situation arose in *Brogano v. Ameron Homes*.[16] The claimant suffered injuries to his spine while lifting a box of construction debris. He was an employee of Ameron Homes, a client of Business Personnel Solutions, an employee leasing company with a workers' compensation policy with what became known as Park Avenue Property and Casualty Insurance Company. The court found that "*not known to the litigants at the time*," the policy contained a $250,000.00 deductible. Business Personnel Solutions ceased operations in January 2011. The PEO, and later a related entity known as Service Provider Group, paid benefits for a period of time, but Service Provider Group ceased paying on May 4, 2012, having concluded that it had no legal obligation on the claim. Business Personnel Solutions/Service Provider Group administered the claim as an employer but held no Florida license to act as a TPA.

Financial Reporting and RBC

One way to monitor the adequacy of an insurer's solvency related to a large deductible is to understand how deductible programs are reported on its financial statements. The following section describes the rules for how they are commonly reported.

Liability for large deductible policies under statutory accounting principles is governed by *SSAP No. 65—Property and Casualty Contracts*. SSAP No. 65 recognizes that "because the risk of loss is present from the inception date, losses on large deductible policies must be reserved throughout the policy period, not over the period after the deductible has been reached." However, SSAP No. 65 treats the exposure for claims under the deductible as "credit risk, not underwriting risk," and provides that large deductible reserves "shall be established net of the deductible," except when "any amount due from the insured has been determined to be uncollectible."[17] Notes to Financial Statements, Note 31 – High Deductibles addresses this off-balance-sheet risk by requiring insurers to disclose the amount of reserve credit that has been recorded for large deductibles on unpaid claims and the amounts that have been billed and are recoverable having due regard for confidentiality and trade secret preservation.

It is important to note that SSAP No. 65 proceeds from the premise that "state laws generally require the [insurer] to fund the deductible and to periodically review the financial viability of the insured and make an assessment of the suitability of the deductible plan to the insured."[18] Relatively few states actually have enacted such laws at this time.

There is a diversity of views as to whether this accounting framework is sufficient to provide a clear enough picture of large deductible risk. Some observers believe this framework, which reports losses net of large deductible layers, is consistent with the fact that the insurer has no underwriting risk associated with the deductibles and is consistent with the accounting treatment for ceded reinsurance balances and anticipated salvage/subrogation recoveries; therefore, no major reporting changes are required. These observers also point out that SSAP No. 65 requires disclosure in the notes to the annual statement of: 1) the amount of the reserve credit recorded for large deductibles on unpaid claims; and 2) the amounts that have been billed and are recoverable on paid claims. They conclude that a new "gross" reporting approach is unnecessary because a financial analyst can readily identify both the "gross" and "net" exposure, as well as the total amount of the deductible reimbursements to which the insurer is entitled.

These observers add that the recent problems observed in the workers' compensation market arise from participants that are thinly capitalized or otherwise unsuitable for purchasing large deductible policies. While much attention has been focused on the failures of certain PEOs that purchase these large deductible policies, none of the suggested alternative reporting approaches would address the problems underlying these failures. Imposing additional reporting requirements upon the insurer will not prevent mismanagement or abuse by employers. Therefore, in their view, the costs placed on well-run programs by more burdensome reporting and more stringent accounting standards would outweigh any benefits.

Others disagree. Some believe that net reporting cannot accurately describe this risk, no matter how thoroughly it is supplemented by off-balance-sheet disclosures. They note that SSAP No. 65 itself begins its analysis of large

[16] State of Florida, Division of Administrative Hearings, Office of the Judges of Compensation Claims, Sebastion/Melbourne District Office, Order dtd. Feb. 14, 2014. Available on request.
[17] SSAP No. 65, ¶¶ 35–36.
[18] *Id.* ¶ 34.

© 2016 National Association of Insurance Commissioners

deductible plans by acknowledging that they "differ from self-insurance coupled with an excess of loss policy."[19] Net reporting, in their view, is appropriate only for an excess insurer, which assumes no liability below the deductible. From this perspective, large deductible policies are more like reinsurance.[20] In both cases, the insurer has incurred an unconditional first-dollar liability, but has transferred that risk to another party that has made an equally unconditional promise to hold the insurer harmless. Accounting for reinsurance recognizes both the first-dollar liability and the risk transfer by booking the policy liability on a gross basis and then providing an offsetting credit for the reinsurance.

In the case of reinsurance, credit is only granted to the extent that the reinsurance is secured by collateral, unless the reinsurer is subject to direct regulatory oversight as a licensed, accredited or certified reinsurer. An analogous credit for deductible reimbursements would not have to apply the identical standards, and a more flexible approach, following the principles on which the recent Illinois legislation is based, would mitigate the impact on responsible, soundly underwritten programs. Such an approach would continue to grant credit for all deductible reimbursements unless specific disqualifying events have occurred, but would limit the credit to the available collateral, as is currently done with unlicensed reinsurers, if the employer has defaulted on its reimbursement obligations, the insurer or the employer has failed to meet specific financial strength benchmarks, or the insurer's large deductible exposure is disproportionate to its size. The collateral standards could also be more flexible than those in the *Credit for Reinsurance Model Law* (#785) or the *Credit for Reinsurance Model Regulation* (#786), incorporating current commercially reasonable practices and disqualifying only those types of collateral that experience has demonstrated to be risky. Regulators should also consider whether it might be necessary to have different collateral standards for PEO policies than for policies covering the insured employer's own business operations.

It should also be noted that because the fundamental purpose of a gross reporting requirement would be to provide a clearer picture of the risk, any such reporting framework must be transparent to financial analysts so that they can easily match the credit to the underlying liabilities, rather than simply reporting the deductible reimbursement as an asset. Some have suggested an alternative approach of presenting the deductible reimbursement as a contra-liability, rather than an as asset. This approach would combine reporting of gross and net liabilities for large deductible policies within a single section of the liabilities page within the NAIC annual and quarterly financial statements. The reserve for losses, gross of workers' compensation large deductibles, could be accompanied by a presentation of a contra-liability representing the credit for deductible reimbursements. This contra-liability would be expressed as a negative loss reserve. The sum of these entries would be the reserve for losses, net of workers' compensation large deductibles, and would be identical to the current basis on which loss reserves are reported in the NAIC annual and quarterly financial statements. Under this approach, other relevant entries within the NAIC annual and quarterly financial statements, including total liabilities within the balance sheet and reserves net of reinsurance within Schedule P, could remain calculated on the basis of liabilities net of large deductibles, as is currently the case.

A third approach to consider would be to keep deductible reimbursements off the balance sheet but significantly strengthen Note 31 – High Deductibles. The current requirement to report "unpaid claims" is ambiguous because it does not clearly encompass incurred but not reported (IBNR) claims, and insurers' reporting practices appear to be inconsistent. This could be clarified by changing it to a requirement to report "unpaid losses and to itemize those unpaid losses between case reserves and incurred but not reported (IBNR)." A requirement to report the amount of collateral held could also be added, perhaps itemized by the type of collateral and itemized by employer, along with the losses, for single risks above some specified threshold.[21]

When evaluating these solutions, it is essential to have a clear understanding of the nature of the problem. The premise that the exposure below the deductible is credit risk, and not underwriting risk, assumes that it must be one or the other, but both types of risk must be considered. The presence of credit risk is self-evident because an insurer issuing a large deductible policy incurs no losses below the deductible unless the employer is unable to

[19] Id.

[20] One regulator has observed that there is no real difference between a large deductible program and a fronting program that cedes the same losses back to the employer's captive, if the insurer requires the captive to provide a parental guaranty from the employer. Under the credit for reinsurance laws, the parental guaranty would not count as acceptable collateral, so credit would only be granted to the extent that hard assets were pledged to back the captive reinsurance.

[21] Reviewers have expressed concern this reporting requirement would compromise the confidentiality of individual insureds and would inappropriately make public a customer list of the insurer.

© 2016 National Association of Insurance Commissioners 13

pay. However, that is equally true of ceded reinsurance. In both cases, the existence of the bad debt depends on the counterparty's ability to pay, but if the debt does go bad, its impact depends on the underlying insurance liabilities, and that is underwriting risk. Furthermore, just as a reinsurer's creditworthiness is significantly affected by underwriting risk, so is an employer's. When evaluating an employer's suitability for a large deductible program and the amount of collateral to require, underwriters must carefully consider both the employer's financial strength and the overall loss exposure, within the deductible as well as above it. This is particularly important in the case of PEOs with large deductible programs because:

- The PEO's financial success or failure could depend in significant part on its ability to determine its exposure to claims within the deductible[22] with enough accuracy to include an adequate provision for that risk in the fees it charges it clients.
- The PEO's surplus cushion required by law, when such requirements exist at all, is $150,000 or less, which can be less than the per claim deductible on the PEO's workers' compensation policy.

While there is no consensus on a specific solution, there is strong agreement among participants in this study that the issues raised are important. Any action on these issues falls within the responsibilities and expertise of the Financial Condition (E) Committee and its task forces, and should be referred there for thorough and careful consideration. In addition to the accounting framework, we recommend that the Financial Condition (E) Committee also review the RBC charges associated with large deductible business to ensure that they reflect not only the risk associated with any anticipated reimbursements that are unsecured or under-secured, but also the risk that adverse reserve development might result in losses within the deductible that exceed the collateral that is currently deemed to be adequate. Consideration should also be given to risks arising from other types of loss-sensitive programs, especially retrospectively rated coverage where the adjustments are calculated on a paid loss basis, because some paid-loss retro plans are functionally indistinguishable from large deductible plans once they have entered the retrospective adjustment period.

Recommendation

The group recommends referring the following questions to the Financial Condition (E) Committee for consideration by the appropriate task force:

- Whether the existing reporting framework under Notes to Financial Statements, Note 31 – High Deductibles should be enhanced by additional disclosures or should be replaced with a framework that books policy reserves on a gross basis and establishes explicit standards for credit for anticipated deductible reimbursements.
- Whether the existing RBC charges associated with large deductible business need to be enhanced in order to ensure that they properly reflect both the risk associated with reserves that are unsecured or under-secured and the risk that adverse development of reserves that are currently recognized might result in reimbursable losses that exceed the collateral.
- Whether other types of loss-sensitive programs, such as retrospective rating plans, should also be subject to some or all of the standards that apply to large deductible programs.
- Whether the NAIC should establish qualifying thresholds that, if exceeded, would require reporting to the regulator. Such a procedure would enable regulators to conduct a special examination, if warranted.

Proposed Solutions to Address Issues with Large Deductible Business in Insolvency

Large deductible programs are a part of the modern insurance marketplace. No appropriate solution would manage problems in an insolvency context at the expense of thwarting profitable, well-run programs that respond to a consumer need. The following suggestions seek to both prevent large deductible-related problems that could potentially lead to company failure and to help ensure that appropriate assets secure deductible business when insolvency does occur. Further, the solutions seek to clarify rights and duties of the parties in an insurance insolvency with large deductible business.

[22] A PEO insured under a large deductible policy presents unique circumstances in that the PEO's deductible reimbursement obligations derive primarily from the claims arising from the operations of the PEO's clients, rather than the PEO itself.

© 2016 National Association of Insurance Commissioners

The specific recommendations are as follows:

- Enact legislation establishing financial requirements for large deductible workers' compensation coverage, including the following:

o A definition of "large deductible coverage" that includes traditional policies subject to endorsements or side agreements that shift risk back to the employer.
o Size and financial strength requirements for insurers writing large deductible policies.
o Limitations on the risk employers may retain, relative to their financial capacity.
o Requirements for collateral, including prohibitions against commingling it with other assets of the insurer or pledging it for other competing purposes.

A statute with these provisions has been enacted in Illinois.[23]

- Recommend the Financial Condition (E) Committee be charged to develop RBC standards associated with large deductible business, and ensure that they reflect not only the risk associated with any anticipated reimbursements that are unsecured or under-secured, but also the risk that adverse reserve development might result in losses within the deductible that exceed the collateral that is currently deemed to be adequate.
- Require the insurer's staff to evaluate the creditworthiness of policyholders. Where indicated, the underwriting department should bring in the other resources such as the finance department.
- Enact legislation that governs rights and duties of the various parties regarding deductible business in insolvencies. The NAIC and the NCIGF both have developed model language on this point.
- Conduct a special examination if regulators detect that an insurance company with this type of business may be financially troubled. Such examination would be conducted by an examiner with expertise in this business and could be paid for by the guaranty association.
- In those states that do not already have such language, enact provisions substantially similar to the text below, which would permit the collection of large deductible reimbursements from insureds.

"The Association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer."[24]

Claims Challenges Arising from Large Deductible Policies

Timely and accurate payment of statutory benefits is an essential component of the "grand bargain" achieved in the passage of the first workers' compensation plans more than 100 years ago. In order to guarantee this certainty, workers' compensation claims practices are regulated by state law. Regulation safeguards the interests of injured workers by guaranteeing that medical and indemnity benefits are paid in accordance with state law.

In the U.S., employers generally have two options for securing workers' compensation coverage: 1) buying a workers' compensation insurance policy; or 2) becoming self-insured. The fundamental difference between insurance and self-insurance is who bears the ultimate financial obligation to pay a claim. With an insurance policy, insurers are responsible for paying all current and future claim liabilities. In self-insurance, employers are responsible for paying all current and future claim liabilities. In discussions at the IAIABC, workers' compensation regulators have expressed concern that the use of large deductible policies confuses these concepts and creates opportunities for abuse.[25] This section discusses issues that have been raised with claims payment and handling practices for large deductible policies.

According to a survey conducted by the IAIABC, large deductible policies in most states are allowed on a "first dollar" coverage basis. This means an insurer will adjust and pay for all workers' compensation claims and seek

[23] Illinois Senate Bill 1805 was enacted in Illinois August 2015. (See Appendix I.) It sets out collateral requirements for large deductible programs for certain insurers and calls for an evaluation of the risk retention capability of employers using these programs.
[24] See NCIGF Model.
[25] As part of their compliance activities, the Idaho Industrial Commission has found multiple employers who thought they were "self-insured" when, in fact, they had a large deductible policy in place. Regulators from other states shared similar concerns during committee discussions.

reimbursement, up to the deductible amount, from the employer. The following is an example of statutory language from Kansas:

K.S.A. 44-559a: The insurer shall pay all or part of the deductible amount, whichever is applicable to a compensation claim, to the person or medical provider entitled to the benefits conferred by the workers' compensation act and seek reimbursement from the insured employer for the applicable deductible amount.

The following is another example of statutory language from Kentucky that describes "first dollar" coverage obligations.

K.A.R.304.13-400: If the employer policyholder chooses a deductible policy pursuant to subsections (1) and (2) of this section, the insurer shall pay the deductible amount initially and the employer policyholder shall be liable to the insurer, at the time and in the manner prescribed by the insurer, for the amount of the deductible paid by the insurer for benefits paid pursuant to KRS Chapter 342.

Claims handling under large deductible arrangements is diverse. Some insurers manage and adjust claims from large deductible policies in-house. Many other insurers contract with a TPA to manage claims from large deductible policies. Regulators have shown interest in the claims handling practices in large deductible policies out of concern that employers are directly managing and paying claims. Payment of claims outside of the insurance mechanism can lead to inaccurate benefits paid to the injured worker, non-filing of statistical reports that results in incorrect rate filings, and poor understanding of occupational hazards and risks. An employer benefits from this arrangement, as directly paid claims would not be included in loss calculations (and the subsequent experience modifications derived from same), which translates into future premium savings.

To understand these issues, it is helpful to understand how some insurers handle their large deductible accounts. Insurers that use a TPA will set up an escrow account that is used to pay claims. The escrow account is funded by the employer and maintains a minimum balance that is predetermined by the insurer and employer. The amount is generally equal to a certain number of months of estimated paid losses. Escrow accounts take advantage of modern financial services to increase administrative efficiency and better manage cash flow. In these arrangements, the TPA has a master services agreement in place with the insurer and employer that governs the actions of all parties. The insurer, the TPA and the employer are required to remain in compliance with all federal, state and local laws, including any regulatory reporting requirements to state workers' compensation agencies. These financial arrangements are not intended to avoid claims payment, management or reporting requirements.

Those states that explicitly call for "reimbursement" may not see the use of employer-funded escrow accounts as in compliance with state law, as the insurer is not **directly** paying first-dollar coverage. Both Arkansas[26] and Idaho[27] issued bulletins that explained direct payment of benefits by employers under large deductible arrangements to be in violation of law. Arkansas resolved this issue with a subsequent bulletin that describes in full the criteria that must be satisfied to use loss escrow accounts in compliance with state law.[28]

> If the insured desires to use the services of a third-party claims administrator, the provisions of the *Registration and Regulation of Third-Party Administrators* (#1090) and related state laws should be

[26] Arkansas Bulletin 10-2009 from the Arkansas Insurance Department stated: "Some employers and insurers are operating under the mistaken impression that Ark. Code. Ann. 11-9-813, which authorizes insurers to offer deductibles to policyholders, also authorizes an employer to make direct payment on claims under the deductible amount. The law simply does not allow for such direct payments, WITH OR WITHOUT A VALID DEDUCTIBLE PROGRAM." [sic]

[27] June 2015 letters to Idaho workers' compensation insurance carriers, TPAs, workers' compensation policyholders and other parties stated: "A third-party administrator (TPA) who adjusts claims under a workers' compensation deductible program acts as an agent of the insurer, not the employer. The majority of TPA programs use a loss escrow account which is used to make payments within the deductible layer. These escrow accounts must be funded by the insurance carrier, not the employer. TPAs may not wait for loss-funding to pay benefits due."

[28] The bulletin reiterates multiple times that the insurer must immediately replenish the loss escrow account if it is not replenished timely by the employer. In addition, it notes: "The employer must report all claims to the TPA for payment and must not pay any amounts within the deductible outside of the funding arrangement provided for in the contracts between the TPA and the insurer."

© 2016 National Association of Insurance Commissioners

followed. Specifically, this issue is addressed by Section 11—Workers' Compensation; Agreements and Communication between Employers, TPAs and Insurers:

Section 11 A. (6) If the TPA receives funds directly from the employer or co-employer for claims or claims handling expense, then the master services agreement must provide for uninterrupted claims handling in the event that the employer or the co-employer stops paying the TPA for any reason.

Reporting

It is critically important that the insurer is made aware of all claims incurred by the policyholder. This is the only way the insurer can accurately calculate its loss reserves and accurately adjust its collateral holdings. Delayed reporting by the employer can leave the insurance carrier under-reserved. This could lead to the insolvency of the insurer and leave losses to be paid by the state guaranty fund. Also, the insurer may be subject to fines and penalties for late reporting claims to the states and statistical agents, which it may be unable to recover from the insured that submitted the late report.

All states require the insurer or employer to report workers' compensation claims to the appropriate state agency. Claim reporting is important because it allows the states to monitor benefit delivery, including timeliness and accuracy of payments. Research suggests underreporting is a concern for workers' compensation claims in general, but little is known about the extent of underreporting related to large deductible policies.

Some state insurance regulators have expressed increased concern of non-reporting or under-reporting in these policy arrangements. In the past year, Idaho has investigated several cases of non-reporting. In these cases, an injured worker calls the Idaho Industrial Commission looking for assistance to resolve an issue including late benefit payments, lower-than-expected benefit payments or disputed benefit payments with the employer. When the state attempts to reference the claim in its database, it finds that the claim has not been reported.

The states also have discovered non-reporting of large deductible claims by reviewing the claims history of an employer in the state. If they find no reported injuries over a 12- to 18-month period for an employer with a significant number of employees, it may indicate self-payment of claims and noncompliance with state reporting requirements. An audit of this kind requires the workers' compensation agency to determine which employers have a large deductible policy. This information is generally not reported to the agency in proof of coverage records.

The workers' compensation agency could use its enforcement authority, generally involving penalty fines on either the employer or insurer to ensure compliance with state law. An example from Kansas of a typical enforcement action is:

K.S.A. 44-557 – The repeated failure of any employer to file or cause to be filed any report required by this section shall be subject to a civil penalty for each violation of not to exceed $250.

The states have not indicated significant enforcement actions against insurers or employers for non-reporting or under-reporting. It is difficult to track and would require dedicated staff and technology resources.

Employer Insolvency

Employer bankruptcy can present a significant challenge in claims management and payment. Insurers will ask for at least a 48-hour notice before issuance of a bankruptcy filing. Upon notice of a filing, the insurer must evaluate how to proceed. In Chapter 11 reorganization, the employer is still required to reimburse payments that fall within the deductible amount. Under Chapter 7 liquidation, the insurer may need to access collateral to continue uninterrupted claims payments. In all instances, an insurer must have procedures in place to maintain an adequately funded escrow account.

Insurer Insolvency

Similarly, insurer insolvency can be a significant challenge for workers' compensation regulators that monitor benefit payments. State insurance departments monitor insurance company financial status and can petition the court to place an insurer into liquidation, rehabilitation or conservatorship. Upon notice from the state insurance

department about an insurer insolvency, the guaranty fund begins preparing to transfer and process claim records. The guaranty funds will work with the appointed conservator to pre-pay claims for a certain period of time (typically 60 days) so that benefits continue during the transfer process.

When the guaranty fund takes over the handling of claims, it may encounter difficulties. The guaranty fund can run into problems securing access to records from the company, its TPA or any other vendors, and the data may be of poor quality. The guaranty fund must analyze claim files that may have incomplete or inaccurate coordination. This transfer and review process takes time and may lead to some delay in benefits to an injured worker. Examples of this were previously discussed in the "Solvency Concerns" section.

State Approaches

The use of large deductible policies is not new in workers' compensation. The 2006 *Workers' Compensation Large Deductible Study* enumerated many of the same challenges with large deductibles as addressed herein. The states have taken a variety of different approaches to address ongoing concerns with the practice.

State insurance regulators interested in improving law and practice for large deductible policies should understand the extent of use in their states. Regulators should understand that the introduction of changes to statute or regulations may be met with resistance from employers and/or insurers in the state.

Insurers should have a master services agreement in place that clearly outlines the responsibilities of all parties funding, paying and managing claims. If they follow the guidelines identified in Guideline #1090, processes will presumably be in place to ensure claim payments continue uninterrupted. If this practice is followed, it may address concerns about claim management and practices.

State Laws and State Reporting Requirements

The states take a variety of approaches when dealing with large deductible workers' compensation policies. As mentioned in the "Introduction" section, the Nevada Division of Insurance requires form NDOI-1112 for any deductible policy written with a deductible of $25,000 or more. In other states, the law only requires reporting of deductible policies with deductibles of at least $100,000. Many states allow unique rating rules and discounts to apply to accounts with a workers' compensation premium of at least $100,000. A few states have included provisions in their laws requiring the insurance company to adjust any claims and then seek reimbursement from the employer/policyholder. A few states mention requirements for collateral and whether claims must be reported on a gross versus net basis.

Regulations affecting deductible workers' compensation policies are under review in several states. Readers should check with the state they are studying to determine existing laws and pending legislation.

Informational Filings, a Nevada Regulator's Perspective

The Nevada informational filings are straightforward, containing identifying information regarding the insurer and insured, the size of the deductible, the policy period, the location of the Nevada claims office and a contact person at that claims office. All of this information, as well as several related items, can fit onto a single page, can be submitted electronically in entirety and requires minimal data entry on the division's part.

The informational filings are expected to be submitted no later than 60 days after the large deductible policies to which they pertain become effective. This allows rapid identification of the fact that such policies are present on the market, as well as trends in the issuance of large deductible policies. The division does not need to wait before losses emerge in order to understand how the market is changing. Furthermore, the division would be aware of a contact person with whom to follow up regarding any individual policy, if necessary.

Although the data elements required are basic, they can be aggregated and segmented in informative ways. For instance, the Nevada Division of Insurance has been able to track trends in sizes of deductibles over time, numbers of large deductible policies issued in each time period, and any remarkable observations regarding insurers, insureds or types of insureds involved in large deductible programs. Internal analysis conducted by the Nevada Division of Insurance has also been able to consider large deductible policies issued to PEOs and/or clients of PEOs in particular.

© 2016 National Association of Insurance Commissioners

The informational filings allow rapid identification of situations where the designation of a large deductible policy might not apply. For instance, the Nevada Division of Insurance used the filings to identify policies with $1 billion deductibles that, in practice, are identical to self-insurance in that the possibility of a single workers' compensation claim resulting in more than $1 billion in payouts is exceedingly remote. In a situation of this sort in 2014, the insured for which the $1 billion deductible was proposed was instead required to register in Nevada as a self-insured employer for workers' compensation purposes.

The informational filings enable Nevada to rely on data directly in its possession and under its control, instead of waiting for a financial examination or market conduct examination to access and analyze such data. The latter approach—waiting for an examination—offers only a limited form of access, given that the aforementioned examinations are only conducted at periodic intervals (or, for market conduct examinations, as necessary). Informational filings submitted directly to the insurance regulatory body enable a more efficient flow of information to those analyzing the data, instead of relying on the examiners as intermediaries.

Using the information contained in the NDOI-1112 reports, Nevada is better able to understand the market for large deductibles in the state. The chart developed by the Nevada Division of Insurance found in Appendix D reflects large deductible buying trends in Nevada over the past several years.

Insurance Company Perspective

Often the data contained in the reporting form required by Nevada could be secured from the advisory organization (NCCI or state rating bureaus) reporting data on behalf of the insurance company. Some have suggested that state insurance regulators could use the IAIABC Proof of Coverage (POC) standard to receive deductible information on policies. The POC standard is generally used to report policy information to the state workers' compensation division or commission and not to the state insurance department. If POC is used, a state should consider an inter-agency data-sharing agreement to provide the insurance department with the information it needs. Conversely, any deductible information collected by the insurance department may be helpful to the workers' compensation agency.

Insurers have no issues with providing regulators the information they need to monitor and analyze the utilization of large deductibles. However, insurers caution against the development of more state-specific forms. Many larger deductible programs have exposures in most, if not all, approved states. Unique forms for each state submitted to each bureau can be onerous.

Special Considerations for Workers' Compensation Underwriters'

The underwriting process for accounts written with a large deductible or mega-deductible has many things in common with the underwriting of a self-insured account, or an account written on a retrospective plan basis.

In each of these types of program, the underwriter should evaluate:

- Five years of currently valued loss information, including loss development information.
- The financial strength of the policyholder.
- The quality, liquidity and stability of value of collateral supporting the deductible selected.
- The policyholder's involvement in safety and loss control activities.
- The policyholder's role in the claims-handling process.

Understanding the Account

One key to properly underwriting any account is developing a thorough understanding of the account's past history, its present operations and financial condition, and its future operations plans.

The underwriter needs to secure complete and accurate past loss information, including losses paid within any deductible or self-insured retention the policyholder had in the past; the farther into the past, the more accurate the picture can be formed. This loss information needs to be adjusted to current-day values using, at a minimum, appropriate loss development and IBNR factors. This analysis will normally be completed by a qualified actuary. This process should also include a review of past loss control activity the policyholder may have implemented and

how successful such programs were in reducing the frequency and/or severity of claims. For example, the underwriter could review, if available, Occupational Safety and Health Administration (OSHA) logs, company loss runs, past audits and/or retroactive adjustments, etc.

Once the policyholder's past history has been evaluated, the underwriter should evaluate the policyholder's present situation. Valuable comparative questions to consider include:

- How do current payrolls and employee counts compare to those in previous years?
- Has there been any change in the management of the policyholder?
- Does current management support an aggressive safety program?
- Does current management advocate strong return-to-work programs, including light-duty programs?
- Does current management support the use of managed care clinics to keep costs in check?
- Does current management understand that each and every claim, regardless of size and/or severity, must be reported to the insurance carrier or the insurance carrier's third-party claims administrator—not handled and paid directly by the policyholder?[29]
- Are supervisors and managers held financially accountable for losses in their department?

Underwriters should also realize that the above-described evaluation process provides only a snapshot of the insured's operations and, therefore, should be periodically refreshed to evaluate whether the policyholder's exposures and financial condition have changed. If so, carriers should consider whether attendant changes to premium deposits and collateral requirements are appropriate.

Underwriters implementing this "past, present and future" underwriting process will need to consider several aspects of accounts during the initial underwriting process and during the subsequent management of the large/mega-deductible account. While the process may vary by underwriting company, it is recommended the following best practices be considered.

Underwriting Pre-Review

The study group recommends large/mega-deductible account underwriting include substantial pre-review by underwriting company staff members or hired consultants. This pre-review would provide the underwriter with the following key information:

- **Current financial information**: If the account is publicly traded, this would include U.S. Securities and Exchange Commission (SEC) Form 10-K (annual) and Form 10-Q (quarterly) financial reports. If privately held, audited financial statements should be collected.
- **Description of operations and payroll classifications**: The goal here is to accurately reflect the exposures when establishing the premium deposits. If new classes have been added, a detailed explanation of what changes have occurred should be supplied.
- **Past loss history**: Past loss information, including losses paid within the deductible, is critical. This should include both paid and reserved claims going back at least five years and, where possible, any actuarial analysis of this history.
- **Safety program**: Accounts large enough to be written with large/mega-deductibles should have written safety programs, including strong evidence of upper management support for their implementation.

[29] Please note that there are certain circumstances under which an employer may have the legal right to pay a claim directly. For example, under Missouri Statute § 287.957, employers appear to have the right to pay directly medical-only claims that do not exceed $1,000. Per the NCCI Statistical Plan Manual (2008 Ed.): "The Missouri Employer Paid Medical Program option is available, which allows employers to pay for medical claims up to defined limits based on the Policy Effective Date. Refer to NCCI's *Basic Manual for Workers' Compensation and Employers Liability Insurance* for specific program application details.

- For policies effective prior to Aug. 28, 2005, the Missouri Employer Paid Medical Program option allows employers to pay for medical-only claims up to $500.
- For policies effective Aug. 28, 2005, and after, the Missouri Employer Paid Medical Program option allows employers to pay for medical claims up to $1,000 when the time lost from work (indemnity) is limited to the first three days or less of disability."

Other states may have similar statutes, rules, or regulations that should be considered.

© 2016 National Association of Insurance Commissioners

Financial Analysis

- **Initial financial review**: While some financial data will be collected during the pre-review stage, this is just the start of the financial analysis process. Underwriters need to understand the potential liabilities their underwriting company will assume should the policyholder not be able to meet its deductible reimbursement responsibilities and/or become insolvent. It is highly recommended that underwriting companies invest in staff, or contract with external consultants, who are qualified to evaluate the credit risk they are assuming when writing large/mega-deductible polices. Underwriters must demand enough current financial information to properly evaluate the account, whether it is publicly traded or privately held. Ideally, this will usually include an actuarial analysis of the ultimate claims amounts and an allocation of that ultimate value to the deductible portion and to the excess.
- **Ongoing analysis**: It is critical to make sure that deposit premiums and collateral held are kept in alignment with current exposures. An analysis of several recent insolvencies revealed that holding inadequate collateral appears to have been a contributing factor. This is discussed in the "Solvency Concerns" section.

Collateral

- **Amount of collateral**: The amount of collateral held by the insurance company should be determined through a detailed analysis conducted by the insurer. The analysis typically takes into account a variety of factors including, but not limited to: the insured's financial status; the anticipated payment pattern of losses; existence and attachment point of an aggregate deductible; "loss pick," meaning an estimate of the insured's liability at the selected retention; and the expected development above and below the deductible sufficient to secure the carrier against the potential deductible reimbursement liability assumed by the insured. The key is selecting the appropriate estimate of liability subject to retention based on historical account loss trends when developed to full expected levels. This analysis is normally conducted by a qualified actuary.
- **Quality of collateral**: Collateral held by the insurer needs to be of "high quality," meaning it has great liquidity and stability of value, so it can be drawn upon immediately if the policyholder fails to reimburse the insurer for deductible payments.
- **Conditions for collateral**: Collateral should meet the following conditions:
    - It should be in a form that would be insulated from being included in the estate of a policyholder that goes bankrupt.
    - It should be "evergreen." The collateral should automatically renew until written notice of termination is provided.
    - It should be irrevocable. This means it cannot be cancelled without permission of the debt holder (insurer).
    - If a surety bond, it should: 1) not be cancellable without prior notice to the carrier; and 2) be issued by a surety authorized to do business in the state and whose A.M. Best financial condition is at least A-V.
    - If a letter of credit (LOC), it should be issued by a financial institution with an office physically located within the U.S. and whose deposits are federally insured.
    - Cash or securities should be held in trust by a third party or by the insurer for the express purpose of securing the policyholder's obligation under the large deductible agreement.

Cancellation Considerations

The following cancellation-related issues should be considered:

- State laws should permit cancellation of a deductible policy when the policyholder fails to meet collateral obligations or reimbursable deductible payments. If the insured fails to deliver the promised collateral or reimburse for deductible amounts, the insurer should be able to get "off the risk." This can avoid situations where the insurer would face substantial financial risk should the insured fail to reimburse the insurer for losses within the deductible. In addition, this gives the insurer leverage over an employer who is attempting to "game" the system by paying its premiums but failing to provide collateral or paying reimbursement expenses. If a state does not currently permit the cancellation of the policy when an insured fails to either post collateral or

© 2016 National Association of Insurance Commissioners

reimburse for deductible losses and related allocated loss adjustment expenses, steps should be taken to pass laws or regulations to allow the insurer to cancel the policy.

- In the case of a mid-term cancellation, the insurer should be allowed to offset outstanding deductible reimbursement amounts against the unearned premium. When a premium finance company (PFC)[30] is involved, however, certain states require unearned premium resulting from cancellation to be remitted directly to the PFC, even if there are outstanding deductible reimbursement amounts due and owing from the insured to the insurer. This can create substantial financial risk to the insurer. States should consider passing laws that allow the insurer to be protected by not passing the unearned premium back to the PFC.

Summary

Underwriters that offer products with large/mega-deductible features should consider an account's past, present and future financial condition when evaluating the risk. Applying the basic best practices listed above is just one condition to becoming a successful underwriter in the large deductible market. Successful underwriters also will apply additional proprietary underwriting standards reflecting their unique company financial strength and underwriting expertise.

Unique Concerns of PEOs

With increased regulation and complex employee-related matters, many small to mid-size companies are turning to PEOs for assistance. Many PEOs provide workers' compensation for their clients and worksite employees as part of a comprehensive solution. Often, large deductibles are utilized by the PEO. The unique nature of the PEO relationship imposes additional considerations.

What is a PEO?

PEOs enter into contractual arrangements establishing co-employment relationships with their clients and become the W-2 employer of all covered employees. PEOs are recognized as employers in state statute in nearly 40 states and in the majority of others through state regulation or guidance. These various state PEO recognition, licensing or registration acts create statutory PEO employer status that recognizes the PEO as co-employer of the covered employees. The laws and regulations provide clarity regarding the specific rights and responsibilities of a PEO, as well as those of a client employer that has entered into a PEO arrangement.

PEOs, as co-employers, generally provide a comprehensive suite of services and benefits. These include: paying the employees; remitting and withholding payroll taxes; maintaining workers' compensation coverage; and sponsoring employee benefit programs. PEOs provide an assigned human relations professional to act as the primary point of contact for day-to-day human resources issues and challenges; offer consulting services for worksite safety, which typically includes drug-free workplace administration and OSHA compliance consultation; and manage ongoing employee relations issues such as leaves of absence.

Often, PEOs provide clients with education and guidance in the areas of regulatory compliance, workers' compensation and employee relations, among other things. By sharing the employment responsibilities with their clients, PEOs allow business owners to focus on their business in order to develop, innovate and expand, all while partnering with an organization that will educate and assist them with employment-related compliance matters.

How Are PEOs Regulated?

In the nearly 40 states that regulate PEOs, the framework generally follows the National Association of Professional Employer Organization's (NAPEO) PEO Model Act, which codifies rights and duties of PEOs and

[30] A PFC is a lender that pays the premium to the insurance company on behalf of the insured and collects the premium from the insured in installments. PFCs charge interest to the insured policyholder for the use of its capital.

their clients and establishes standards for the PEO industry, including consumer protections.[31] The NAPEO is the largest trade association in the PEO industry.

The PEO Model Act distinguishes between professional employer services and temporary help services. "Professional employer services" are defined to mean the service of entering into co-employment relationships under the PEO Model Act in which all or a majority of the employees providing services to a client, or to a division or work unit of a client, are covered under the PEO agreement. A co-employment relationship is a relationship that is intended to be an ongoing relationship with a specific client rather than a temporary or project-specific relationship. It also makes a distinction between the PEO industry and temporary help services companies.

"Temporary help services" under the PEO Model Act are defined to mean services consisting of a person or company that recruits and hires its own employees; finds other organizations that need the services of those employees; and assigns those employees to perform work at or services for the other organizations to support or supplement the other organizations' workforces, or to provide assistance in special work situations such as, but not limited to, employee absences, skill shortages, seasonal workloads, or special assignments or projects. A temporary help services company customarily attempts to reassign the employees to other organizations after they finish each assignment.

Although some of the recent workers' compensation insurer insolvencies involved temporary help services companies or staffing agencies, as well as PEOs, the scope of this section is limited to addressing concerns and best practices concerning PEOs. It is important to understand the distinction between these business models and the co-employment relationship that differentiates PEOs from other labor service arrangements.

The PEO Model Act establishes registration requirements and provides a regulatory structure that regulates/governs PEOs that are doing business in the state. Among other things, it establishes minimum financial capacity requirements for registration. There are positive working capital and/or positive net worth requirements based on audited financial statements, with a bond, LOC or securities of equal value to cover any gap.

The positive working capital or net worth requirements, combined with the requirement for audited annual financial statements, provide regulators an opportunity to leverage this information to investigate when warning signals may affect the financial position of a PEO. In addition to the audited annual financial statements, three states—Florida, North Carolina and South Carolina—require their registered PEOs to file unaudited quarterly financial statements. For example, North Carolina's PEO licensing department has engaged an outside audit firm to conduct a review of a PEO's financial condition when there is a concern that the PEO may be in a hazardous financial condition.

The audited financial statement requirement is a significant one for PEOs involved in large deductible workers' compensation programs. The audit firms should be expected to review carefully the adequacy of collateral/reserves of PEOs with large deductible programs, because the adequacy of reserves/collateral has a direct impact on whether the audit firm can issue an unqualified opinion using generally accepted accounting principles (GAAP). A qualified opinion could immediately trigger an investigation and review in a state that licenses PEOs and requires audited financial statements.

Voluntary Compliance/Self-Regulation

Voluntary Federal Certification

On Dec. 19, 2014, President Barack Obama signed the Tax Increase Prevention Act of 2014. Included in this law was the Small Business Efficiency Act (SBEA), NAPEO's top federal legislative priority. The SBEA became effective Jan. 1, 2016. Among other things, and similar to state regulatory requirements, the SBEA creates a certification process for PEOs that gives certified PEOs (CPEOs) the clear statutory authority to collect and remit federal employment taxes.

The importance of the SBEA, in the context of this report, is the financial and reporting requirements of the SBEA:

[31] Attached as Exhibit E is a chart identifying various state laws and regulation, including which state agencies oversee PEO activity.

- A CPEO must maintain a bond in an amount greater of $50,000 or equal to 5% of the CPEO's federal employment tax liabilities for the previous year (not to exceed $1 million).
- A CPEO must prepare and provide the Internal Revenue Service (IRS) with annual independent financial statements audited and prepared by a certified public accountant (CPA).
- A CPEO must provide quarterly assertions to the IRS regarding payment of all employment taxes.

Although the federal certification is not required for PEOs, it is believed that this will serve as a standard in the industry, as clients and prospects will look for the certification. Additionally, carriers underwriting PEOs may request the certification in order to write a large deductible policy.

Self-Regulation Within the PEO Industry

In addition to state and federal law, many members of the industry choose to follow internal standards and guidelines established by the Employer Services Assurance Corporation (ESAC) and the Certification Institute. The ESAC provides a voluntary program of accreditation and financial assurance for PEOs based on ongoing independent certification of compliance with comprehensive financial, ethical and operational standards. The Certification Institute provides a voluntary program of PEO risk management certification, which focuses on workplace safety and claims risk management. This program is focused on helping control a PEO's, and a carrier's, workers' compensation costs by establishing industry-specific risk-management best practices, developed by the collaborative efforts of insurance carriers, PEO industry risk managers and insurance brokers. To become certified, a PEO must adhere to these practices, which are validated on an annual basis in order to retain the certification.[32] Regulators and underwriters may find ESAC standards of value in regulating the PEO industry and in evaluating the risk when writing PEO workers' compensation large deductible policies.

Financial Soundness

The ESAC has been certifying PEO compliance and providing assurance for more than 20 years without a single financial default by an accredited PEO. The ESAC currently accredits PEOs, from new startups to large public companies, which in total serve clients representing more than $70 billion in annual employee wages. Currently, 17 states accept ESAC certification of PEO compliance in lieu of all, or part, of the state's PEO registration or licensing requirements.[33]

All matters pertaining to the accreditation or compliance of PEOs are decided solely by the ESAC's independent directors, who are former regulators with experience relevant to PEO operations. ESAC certification is more comprehensive and stringent in some respects than state registration standards. Over the past 20 years, the ESAC has identified the following key factors to be the most important indicators of the financial reliability of a PEO. These factors are briefly described below:

- **Broader definition of controlling persons and diligent investigation**: It is important to ensure that each PEO is owned or managed by controlling persons with a verifiably reliable business and personal track record.
- **Multi-entity, multistate compliance monitoring**: The ESAC monitors compliance of all PEO entities under common control, regardless of the state in which they operate.
- **Combined or consolidated financial statements coupled with cross guaranties**: The ESAC looks at audited financial statements covering all PEO entities under common control on a combined or consolidated basis. For purposes of monitoring PEO solvency and early detection of developing financial problems, a combined or consolidated financial statement accompanied by cross guaranties by each entity of the liabilities of all other entities under common control (and a parent guaranty of each subsidiary where applicable) has proven to be a reliable compliance monitoring approach.
- **Accurate reporting of working capital**: PEOs are focused on cash flows to effectively and efficiently conduct business. Therefore, reliable financial monitoring of PEO working capital is essential to ensure that there are no errors or omissions in the reporting of current assets and current liabilities. If there are

[32] *www.certificationinstitute.org/peo-wc-best-practices/.*

[33] Arkansas, Colorado, Connecticut, Florida, Indiana, Ohio, Oklahoma, Louisiana, Montana, Nebraska, Rhode Island, Tennessee, Texas, Utah, Vermont, West Virginia and Wisconsin. (See Exhibit F.)

multiple PEO entities under common control, the adequacy of working capital needs to be verified on either a combined or consolidated basis.

- **Ensuring reliable payment of key fiduciary employer responsibilities**: The ESAC requires the opinion by an independent CPA of all major PEO employer payment obligations by all PEO entities under common control, regardless of where they operate. But, even more important, the ESAC closely monitors the earnings, working capital and net worth of all accredited PEO entities under common control on a combined or consolidated basis, with all such entities providing cross guaranties of the other entities' liabilities.[34]

The ESAC also verifies an accredited PEO's compliance with important operational standards.[35] Operational standards 2, 3, 7 and 9 may be of particular interest to workers' compensation regulators.

Enforcement of ESAC Standards

A key element in the ESAC's ability to enforce PEO compliance with its standards is the fact that its surety carrier requires that accredited PEOs report their clients to the ESAC and notify them of changes in client contact information on an ongoing basis. Each PEO provides the ESAC with the contractual right to notify its clients of the termination of the PEO's accreditation. This provides the ESAC and each PEO client with an early warning system that has successfully prevented any financial losses due to an accredited PEO's failure to perform its fiduciary responsibilities for more than 20 years.

Unique Underwriting Concerns for PEOs

In addition to the underwriting standards recommended in the "Special Considerations for Underwriters" section, there are unique considerations for PEOs.

Incomplete Underwriting Data

In order to properly underwrite a PEO, it is important that the underwriter consider the nature and targeted clientele of the PEO. Some PEOs focus on unique industries (e.g., technology, law, health care, etc.), while others focus on a broad array of clients. An underwriter should understand the business standards of the PEO as part of the underwriting process. This may include evaluating the PEO's business underwriting processes, its current book of business and its overall growth rate. Additionally, initial underwriting and evaluation of the book of business, processes, etc., is not sufficient. A diligent carrier should periodically evaluate the book of business and processes throughout the relationship. Additionally, the carrier may consider requiring notification to the extent the clientele or worksite employee count exceeds a certain percentage in growth. Carriers may also wish to have client-level documentation in order to properly evaluate the ongoing risk. Client-level reporting enables both the PEO and the carrier to properly characterize the client experience prior to, and during, the relationship. It also allows subsequent carriers that evaluate the client in the event of a termination of the PEO relationship to properly evaluate the risk to ensure proper coverage.

Financial Analysis

Because carriers have responsibility to pay the claim first and next collect the deductible from the insured, it is important that they assess the ability of the PEO to compensate them for the large deductibles in the event that claims are incurred. Evaluating the financials of the entire entity (not just the PEO registered in a certain jurisdiction) and its corporate structure are necessary to determine whether the PEO can reimburse the carrier for deductible losses. It is recommended that the underwriters look at audited financials following GAAP. The ESAC financial certification may also be a positive indicator in the underwriting process. It is in a carrier's best interest to evaluate the financials of its clients periodically throughout the relationship.

Carriers should also be prudent concerning their own ability to withstand a large deductible claim, because they must pay the claim and seek reimbursement. Regulators may consider whether carriers must have a certain level

[34] *www.accessesac.org/regulators/compliance-verification*.

[35] A complete listing of ESAC operational standards is included in Appendix H. For more information, visit *www.accessesac.org/esac/standards-and-procedures*.

of surplus (an example suggested in recent legislation has been $200 million[36]) and a certain rating through a reputable rating agency (e.g., A.M. Best rating of A- or better has been proposed in recent legislation).

Workforce Safety Standard Guidelines

PEOs often provide clients with consultative services concerning workplace safety standards. As part of the underwriting process, it is helpful to investigate the level of assistance and monitoring PEOs perform with respect to their clients. Many PEOs perform on-site inspections prior to, or shortly after, engaging a client. This should be considered as part of the underwriting process.

Employee Classification and Makeup (Initial and Ongoing Audits)

Worksite employee classification is a key factor in the success of a PEO and underwriting of a workers' compensation policy. It is important to understand the employees covered in order to properly evaluate the risks of insuring a PEO. Classification of independent contractors, full-time, part-time and type of work are all key factors in a proper underwriting analysis. Underwriters should consider periodically auditing the worksite employee classifications, as well as whether the mix of type of employee classification has changed substantially over time. Underwriters should take great care when determining whether to enter into a relationship with PEOs that cover only part of the client's worksite employees, as there may be gaps in coverage or risk that is assumed despite the fact that it may not be included in the original assessment.

Some PEOs take on other PEOs as clients. This practice is often referred to as "piggybacking." Similar concerns might arise when PEOs choose to contract with staffing agencies either exclusively or as a large portion of their book of business. Underwriters should consider whether there is a sufficient control over the safety and workplace of the worksite employees under the staffing agency. Further, whether the staffing agencies with whom the PEO contracts are limited to certain industries or a broad array correlates to the risk assessment of the insurance relationship. The broader the industries serviced by the staffing, the more difficult it is to underwrite and properly evaluate the risk. Additionally, staffing agency worksite employees may go from one job classification to another, causing a fluctuating risk profile for the PEO. Periodic audits of PEOs, their clients and worksite employee makeup are critical. Many PEOs will not partner with staffing agencies for the reasons discussed above. Underwriters and regulators who come across this practice should carefully consider the risk-management practices of the PEO before permitting such behavior or underwriting such risk.

Inquiry into Affiliated PEO Entities

Underwriters must evaluate the entire PEO and its related entities to ensure that the entity being considered for insurance is financially reliable. Additionally, to the extent that a PEO has an interest in an insurance carrier, it may be inappropriate for that carrier to be the sole insurer of a large/mega-deductible policy. Due to licensing, business structure requirements or other reasons, PEOs may have affiliated entities in different states. It is necessary for the carrier to have a complete corporate picture, including of other entities currently or recently owned or controlled by the primary owners of the PEO being evaluated. This would help the carrier evaluate whether there has been recent risky or insolvent financial experience across entities.

Insufficient Collateral

As discussed in the "Special Considerations for Underwriters" section and the "Solvency Concerns" section, sufficient collateral is essential for the protection of the solvency of the carrier and the ultimate protection of the worksite employees. Therefore, the discussion below speaks only to unique considerations of a PEO as it relates to collateral.

Collateral Generally

As discussed in the "Solvency Concerns" section, the nature of workers' compensation claims is long tail. A PEO that appropriates cash flow at the time of underwriting of a large deductible workers' compensation may not maintain sufficient surplus to cover longer-term losses. The ability to access the collateral, even in the event of

[36] Illinois Insurance Code §155.44.

insolvency/bankruptcy, will be key. Although many PEOs do engage in voluntary regulation of their financial and claims practices, all PEOs are not required to maintain certain reserves or account for potential long tail losses indefinitely. As discussed in the "Solvency Concerns" section, some recent insolvencies have related to a failure by the underwriter and the PEO to properly plan for large and long tail claims. In some cases, the PEO viewed its ability to secure a large deductible workers' compensation policy as a short-term means of income generation with no long-term planning. Insurers that consider underwriting PEOs for large deductible workers' compensation claims should carefully review the financial practices, evaluate the collateral and ability to access long term and the overall tenure and experience of the PEO in financial management.

Re-Evaluation of Collateral

PEOs may merge with other PEOs and shrink or grow rapidly depending on the market. It is essential the carrier be able to evaluate and adjust collateral as needed. Contractual notification requirements and periodic financial, employee and client audits should mitigate the potential for insufficient collateral. Additionally, personal LOCs—or even corporate LOCs when there is a shared ownership/affiliation between the PEO and carrier—are inappropriate. Collateral should be of a nature that is readily liquid and stable in value and not in the nature of real estate, personal property, art, etc.

PEOs that become insolvent or file for bankruptcy pose unique concerns for insurance carriers that write large deductible workers' compensation coverage for them. Because the carrier is initially responsible for the payment of any workers' compensation claims, a PEO that is unable to reimburse a carrier for claims payment could put the solvency of the insurer at risk. Understanding the financial position of a PEO—including its financial reserving, claims processing and administrative fee collection practices—is key to assessing the risk and nature of appropriate collateral. Many PEOs collect administrative fees to cover all costs associated with the co-employment relationship. Part of the administrative fee may go to engaging a TPA to process claims, benefits-related costs and services to clients for human resource management, etc. A carrier contemplating underwriting a large deductible workers' compensation policy for a PEO may consider reviewing such fees and may consider the allocation of such fees across the business to determine the level and nature of collateral necessary.

Claims/Deductible Concerns

Regulators and representatives of guaranty funds have expressed concerns about the ability of a PEO to pass all or a portion of the large deductible to a client. Despite disclosure, the client may not contemplate the actual risk of being subject to even a smaller portion of a large workers' compensation deductible. For example, a small cleaning company with 15 employees is unlikely to be able to sustain a $100,000 reimbursement obligation in the event an employee suffers a significant injury on the job. Regulators should evaluate whether they believe this practice, with or without disclosure, is appropriate. Additionally, underwriters should consider this practice when determining whether the client has sufficient and accessible collateral.

Third-Party Administrators

Because of the employment relationship and administrative burdens of managing multiple workers' compensation claims, many PEOs (and other insureds) use a TPA to manage the claims. Although some states have financial, licensing/registration and other requirements for TPAs, others do not. Therefore, carriers should take care in establishing standards for when a TPA may be used (including financial, claims management and reporting standards). Carriers may require only certain select TPAs be used or allow choice within certain guidelines. Regulators may require workers' compensation contract provisions that TPAs must meet to satisfy their claims adjudication responsibilities. Even if the carrier selects the TPA, the carrier should perform periodic audits of the TPA so the carrier has a complete picture of claims reporting activity and reserving practices. It is also recommended that the carrier monitor the financial health of the TPA to be sure claims escrow deposits are adequate and being paid out to injured workers as planned.

PEOs would be well-served to perform internal self-audits to ensure that they are aware of emerging claim trends and to make sure all loss time and serious medical injury claims within the deductible limits are being reported on a timely basis.

Concluding Remarks

© 2016 National Association of Insurance Commissioners

While this study has shed some new light on the questions raised in the 2006 study, many of the issues still remain. Brokers and insurance underwriters continue to offer large deductible policies to employers that are attracted by the significant premium savings over other risk-management tools. Employers continue to pledge to reimburse underwriters for deductibles that can be as large as $999 million per claim. In the majority of cases, the large deductible product written for the employer is suitable for the employer, given its past claims history and financial strength. But, in some cases, large deductibles are being written for employers that simply do not understand the risks they are assuming or do not have the financial ability to reimburse the underwriter when payment is due. Regulators continue to be concerned that some of the plans might be considered unregulated self-insurance.

The larger insurance underwriters that participated in this study believe that existing financial review standards used to evaluate potential large deductible insureds are adequate and that further regulation should not be discussed. Guaranty associations believe regulations are inadequate and make collecting collateral difficult in the event of a carrier insolvency. Workers' compensation system administrators believe the huge premium reductions granted to large deductible policyholders reduce the premium taxes and assessments necessary to operate the workers' compensation system. While stakeholders debate the issues, additional carrier insolvencies have taken place. It is time to move forward.

Next Steps

The NAIC/IAIABC Joint (C) Working Group will forward its recommendations to the Property and Casualty Insurance (C) Committee and the Financial Condition (E) Committee for consideration. There the debate over the need for additional regulation will be continued.

The NAIC/IAIABC Joint (C) Working Group is hopeful this paper improves the understanding of how large deductible policies are used throughout the U.S. workers' compensation market. This effort enhanced communication among stakeholders, which is the first step in addressing challenges that may arise.

© 2016 National Association of Insurance Commissioners

List of Appendices

Appendix A: Study Group Member List
Appendix B: NCCI Large Deductible Data Exhibits
Appendix C: WCIRB Data Exhibits
Appendix D: Nevada Large Deductible Table
Appendix E: PEO Statute Regulation Chart
Appendix F: ESAC State Chart
Appendix G: ESAC Financial Standards
Appendix H: ESAC Operational Standards
Appendix I: Illinois Law 1805

© 2016 National Association of Insurance Commissioners

Study Group Participant List

NAIC/IAIABC Joint Working Group Members

Full Name	Company
Mr. William Lacy	Arkansas Insurance Department
Mr. Ronald A. Dahlquist	California Department of Insurance
Mr. George B. Bradner	Connecticut Insurance Department
Ms. Jennifer Wolf Horesh	IAIABC
Mr. John Gatlin	Illinois Department of Insurance
Ms. Robin Coombs	Kentucky Department of Insurance
Mr. Robert A. Wake	Maine Bureau of Insurance
Ms. Angela Nelson	Missouri Department of Financial Institutions & Professional Registration
Ms. Joan W. Dutill	Missouri Department of Financial Institutions & Professional Registration
Mr. Gennady Stolyarov II	Nevada Dept. of Business & Industry Division of Insurance
Ms. Tracy Klausmeier	Utah Insurance Department

Interested Regulator

Name	State
Ms. Carol Stiffler	Arkansas Insurance Department
Mr. Thomas Taggart	Connecticut Insurance Department
Ms. Cyndi Cooper	Florida Office of Insurance Regulation
Ms. Robin Coombs	Kentucky Department of Insurance
Mr. Charles Hansberry	Louisiana Department of Insurance
Mr. Warren Byrd	Louisiana Department of Insurance
Mr. James Mills	Oklahoma Insurance Department
Mr. Michael R. Shinnick	Tennessee Department of Commerce & Insurance
The Honorable Michael D. Riley	West Virginia Offices of the Insurance Commissioner

Interested Parties

Name	Company
Mr. Steven Politis	Alcott HR Group LLC
Mr. Robert F. DiUbaldo	ACE Group
Ms. Robyn S. Crosson	ADP TotalSource
Mr. Tom Glasson	AIG
Mr. Arunesh Sohi	AIG
Ms. Sandra J. Robinson	American Guaranty Fund Group
Mr. Bruce Wood	American Insurance Association (AIA)
Mr. Steven A. Bennett	American Insurance Association (AIA)
Ms. Nancy R. Treitel-Moore	Liberty Mutual
Mr. Thomas Jenkins	Locke Lord Bissell & Liddell LLP
Ms. Farrah Fielder	NAPEO
Ms. Barbara F. Cox	National Conference on Ins. Guaranty Funds (NCIGF)
Ms. Mona T. Carter	National Council on Compensation Insurance (NCCI)
Mr. Edward Marynowitz	National Council on Compensation Insurance (NCCI)
Ms. Rita Nowak	Property Casualty Insurers Association of America (PCI)
Mr. David Kodama	Property Casualty Insurers Association of America (PCIAA)
Mr. Glen Distefano	SUNZ Insurance Company
Ms. Jessica Mayer	Travelers Insurance Company
Mr. Mike Ignatowicz	Travelers Insurance Company
Mr. John Zillmer	Zurich

© 2016 National Association of Insurance Commissioners

This deductible information has been prepared for the NAIC Workers Compensation Task Force (C), Large Deductible Working Group. The following table includes summarized information based on unit statistical data for all NCCI states for Policy Year 2011.

The table displays the following information:

- Total number of unit reports for each year, along with the Total Premium and Total Incurred Losses
- Percent and number of unit reports with a deductible program—Grouped based deductible size
- Percent of unit reports without a deductible program

Policy Categories	Number of Policies	%	Total Premium	%	Total Incurred Losses*	%
Number of Policies reported without a deductible program	2,512,008	91.98%	$18,180,210,720	77.53%	$8,251,923,861	58.74%
Policies with a Per Claim/Accident Deductible greater than or equal to $10,000,000	699	0.03%	$137,040,558	0.58%	$255,092,740	1.82%
Policies with a Per Claim/Accident Deductible of $5,000,000 to $9,999,999	2,495	0.09%	$291,977,656	1.25%	$482,257,662	3.43%
Policies with a Per Claim/Accident Deductible of $1,000,000 to $4,999,999	22,278	0.82%	$947,247,422	4.04%	$1,512,316,126	10.77%
Policies with a Per Claim/Accident Deductible of $500,000 to $999,999	25,505	0.93%	$722,330,324	3.08%	$1,097,156,822	7.81%
Policies with a Per Claim/Accident Deductible of $100,000 to $499,999	49,484	1.81%	$1,042,520,052	4.45%	$1,246,168,296	8.87%
Policies with a Per Claim/Accident Deductible less than $100,000 and other unspecified programs	118,626	4.34%	$2,127,400,750	9.07%	$1,203,202,919	8.56%
Total Number and Percentage of Policies Reported with a Deductible Program (Small or Large) and other unspecified programs**	219,087	8.02%	$5,268,516,762	22.47%	$5,796,194,565	41.26%
Total	2,731,095	100%	$23,448,727,482	100%	$14,048,118,426	100%

*Total incurred loss amounts do not reflect deductible reimbursements to the carrier from the insured.

**These numbers reflect all per Claim/Accident deductible policies and other unspecified programs, including small deductible policies with deductibles of $100,000 or less.

© 2016 National Association of Insurance Commissioners

This deductible information has been prepared for the NAIC Workers Compensation Task Force (C), Large Deductible Working Group. The following table includes summarized information based on unit statistical data for all NCCI states for Policy Year 2012.

The table displays the following information:

- Total number of unit reports for each year, along with the Total Premium and Total Incurred Losses
- Percent and number of unit reports with a deductible program—Grouped based deductible size
- Percent of unit reports without a deductible program

Policy Categories	Number of Policies	%	Total Premium	%	Total Incurred Losses*	%
Number of Policies reported without a deductible program	2,578,049	91.75%	$19,704,765,626	78.59%	$8,199,218,402	57.47%
Policies with a Per Claim/Accident Deductible greater than or equal to $10,000,000	836	0.03%	$27,214,163	0.11%	$243,495,622	1.71%
Policies with a Per Claim/Accident Deductible of $5,000,000 to $9,999,999	2,323	0.08%	$224,021,876	0.89%	$446,989,303	3.13%
Policies with a Per Claim/Accident Deductible of $1,000,000 to $4,999,999	25,304	0.90%	$960,507,657	3.83%	$1,688,546,085	11.84%
Policies with a Per Claim/Accident Deductible of $500,000 to $999,999	24,667	0.88%	$714,072,692	2.85%	$1,147,973,970	8.05%
Policies with a Per Claim/Accident Deductible of $100,000 to $499,999	52,741	1.88%	$1,112,963,902	4.44%	$1,255,707,919	8.80%
Policies with a Per Claim/Accident Deductible less than $100,000 and other unspecified programs	125,794	4.48%	$2,328,729,899	9.29%	$1,285,404,667	9.01%
Total Number and Percentage of Policies Reported with a Deductible Program (Small or Large) and other unspecified programs**	231,665	8.25%	5,367,510,189	21.41%	$6,068,117,566	42.53%
Total	2,809,714	100%	$25,072,275,815	100%	$14,267,335,968	100%

*Total incurred loss amounts do not reflect deductible reimbursements to the carrier from the insured.

**These numbers reflect all per Claim/Accident deductible policies and other unspecified programs, including small deductible policies with deductibles of $100,000 or less.

© 2016 National Association of Insurance Commissioners

This deductible information has been prepared for the NAIC Workers Compensation Task Force (C), Large Deductible Working Group. The following table includes summarized information based on unit statistical data for all NCCI states for Policy Year 2013*.

The table displays the following information:

- Total number of unit reports for each year, along with the Total Premium and Total Incurred Losses
- Percent and number of unit reports with a deductible program—Grouped based deductible size
- Percent of unit reports without a deductible program

Policy Categories	Number of Policies	%	Total Premium	%	Total Incurred Losses**	%
Number of Policies reported without a deductible program	2,348,670	91.41%	$18,559,764,100	78.84%	$7,408,306,675	57.56%
Policies with a Per Claim/Accident Deductible greater than or equal to $10,000,000	778	0.03%	$23,471,795	0.10%	$213,942,354	1.66%
Policies with a Per Claim/Accident Deductible of $5,000,000 to $9,999,999	2,142	0.08%	$155,750,830	0.66%	$405,812,869	3.15%
Policies with a Per Claim/Accident Deductible of $1,000,000 to $4,999,999	24,099	0.94%	$804,066,175	3.42%	$1,479,993,052	11.50%
Policies with a Per Claim/Accident Deductible of $500,000 to $999,999	23,557	0.92%	$622,014,420	2.64%	$961,283,385	7.47%
Policies with a Per Claim/Accident Deductible of $100,000 to $499,999	49,688	1.93%	$1,026,610,877	4.36%	$1,198,105,625	9.31%
Policies with a Per Claim/Accident Deductible less than $100,000 and other unspecified programs	120,371	4.69%	$2,350,383,178	9.98%	$1,203,226,563	9.35%
Total Number and Percentage of Policies Reported with a Deductible Program (Small or Large) and other unspecified programs***	220,635	8.59%	$4,982,297,275	21.16%	$5,462,363,848	42.44%
Total	2,569,305	100%	$23,542,061,375	100%	$12,870,670,523	100%

*Data for Policy Year 2013 includes policies with effective dates from January through November. The first unit reports for December were not due to be reported to NCCI at the time the data for this report was extracted.

**Total incurred loss amounts do not reflect deductible reimbursements to the carrier from the insured.

***These numbers reflect all per Claim/Accident deductible policies and other unspecified programs, including small deductible policies with deductibles of $100,000 or less.

© 2016 National Association of Insurance Commissioners

WCIRB California®
Objective.Trusted.Integral.

1221 Broadway, Suite 900
Oakland, CA 94612
Voice 415.777.0777
Fax 415.778.7007
www.wcirb.com
wcirb@wcirb.com
David M. Bellusci
Executive Vice President
& Chief Actuary

March 23, 2016

By Email Only

Patricia Hein
Attorney IV
Government Law Bureau
California Department of Insurance
45 Fremont Street, 21st Floor
San Francisco, CA 94105

RE: Requested Data on Large Deductibles

Dear Ms. Hein:

This letter augments the information we provided on March 8 with the additional information you requested.

The table below shows the proportion of total statewide premium on large deductible policies (policies with a deductible of $100,000 or more) as reported on the WCIRB's Large Deductible Data Call. As requested, we've also included the total reported written premium of all insurers and those writing large deductible policies.

Policy Year	Written Premiums of Large Deductible Policies for Insurers Submitting the WCIRB Large Deductible Data Call	Written Premiums of All Insurers	Percentage
2011	4,110,378,275	11,537,540,282	35.6%
2012	4,720,437,714	13,027,399,856	36.2%
2013	5,439,410,025	14,966,136,809	36.3%

Additionally, as included in the March 8 summary, we have also computed the percentages of policies (i) with a deductible program (which includes policies with deductible specified by a dollar amount or percentage) in Column 1 below, (ii) with a small deductible (less than $100,000 deductible) in Column 2 below, and (iii) with a large deductible (greater than or equal to $100,000 deductible) in Column 3 below based on reported unit statistical data. Finally, as requested, we've also shown a count of policies by year reported to the WCIRB as involving a deductible greater than or equal to $750,000 in Column 4 below.

© 2016 National Association of Insurance Commissioners

WCIRB California®
Objective.Trusted.Integral.

Patricia Hein
California Department of Insurance
March 23, 2016

	(1)	(2)	(3)	(4)
Policy Year	Percentage of Policies with a Deductible Program	Percentage of Policies with a Small Deductible Program (<$100,000)	Percentage of Policies with a Large Deductible Program (>=$100,000)	Count of Policies with a Mega Deductible Program (>=$750,000)
2011	2.3%	0.4%	1.8%	5,844
2012	2.7%	0.5%	2.2%	6,816
2013	3.1%	0.5%	2.5%	8,160

As noted in the March 8, 2016 summary, this information is based on unit statistical data from insurers that are reporting complete deductible data on unit statistical submissions. Since the WCIRB has been collecting deductible data on unit statistical reports for only a few years (this data is not used in the WCIRB's ratemaking processes), not all insurers are yet reporting complete deductible data on unit statistical reports. In Columns 1 to 3 in the table above, the claim counts used in both the numerator and denominator are based only on the insurers who reported complete deductible data.

As requested, we have provided the unit statistical data underlying the above table from the insurers providing deductible information. Attached Exhibits 1, 2 and 3 show the data underlying the above information for policy years 2013, 2012 and 2011, respectively.

Let me know if there is anything else we can provide.

Sincerely,

David M. Bellusci
Executive Vice President,
& Chief Actuary

DMB:meg

cc: Ron Dahlquist, CDI
Brenda Keys, WCIRB
Tony Milano, WCIRB
Larry Law, WCIRB

© 2016 National Association of Insurance Commissioners

Policy Year 2013

Counts | **Premium**

Market Share of Insurers Reporting Complete Deductible Data:	Total Premium of Insurers Reporting Complete Deductible Data	Statewide Premium	Market Share
	11,413,036,259	15,026,973,265	76.0%

The following information is based on insurers reporting complete deductible data:

Deductible Policy Count	Total Policy Count	Percentage of Policies with a Deductible Program	Premium From Deductible Policy	Total Premium	Percentage of Premium with a Deductible Program
16,593	534,205	3.1%	3,610,137,292	11,413,036,259	31.6%

Small Deductible Policy Count (<100,000)	Total Policy Count	Percentage of Policies with a Small Deductible Program (<100,000)	Premium From Small Deductible Policy (<100,000)	Total Premium	Percentage of Premium with a Small Deductible Program (<100,000)
2,737	534,205	0.5%	128,961,178	11,413,036,259	1.1%

Large Deductible Policy Count (>=100,000)	Total Policy Count	Percentage of Policies with a Large Deductible Program (>=100,000)	Premium From Large Deductible Policy (>=100,000)	Total Premium	Percentage of Premium with a Large Deductible Program (>=100,000)
13,420	534,205	2.5%	3,444,028,645	11,413,036,259	30.2%

Mega Deductible Policy Count (>=750,000)	Total Policy Count	Percentage of Policies with a Mega Deductible Program (>=750,000)	Premium From Mega Deductible Policy (>=750,000)	Total Premium	Percentage of Premium with a Mega Deductible Program (>=750,000)
8,160	534,205	1.5%	2,235,239,002	11,413,036,259	19.6%

© 2016 National Association of Insurance Commissioners

Policy Year 2012

Counts | **Premium**

Market Share of Insurers Reporting Complete Deductible Data:

Total Premium of Insurers Reporting Complete Deductible Data	Statewide Premium	Market Share
9,780,550,526	13,313,546,455	73.5%

The following information is based on insurers reporting complete deductible data:

Deductible Policy Count	Total Policy Count	Percentage of Policies with a Deductible Program	Premium From Deductible Policy	Total Premium	Percentage of Premium with a Deductible Program
14,129	522,638	2.7%	3,172,137,343	9,780,550,526	32.4%

Small Deductible Policy Count (<100,000)	Total Policy Count	Percentage of Policies with a Small Deductible Program (<100,000)	Premium From Small Deductible Policy (<100,000)	Total Premium	Percentage of Premium with a Small Deductible Program (<100,000)
2,532	522,638	0.5%	97,186,950	9,780,550,526	1.0%

Large Deductible Policy Count (>=100,000)	Total Policy Count	Percentage of Policies with a Large Deductible Program (>=100,000)	Premium From Large Deductible Policy (>=100,000)	Total Premium	Percentage of Premium with a Large Deductible Program (>=100,000)
11,310	522,638	2.2%	3,051,969,652	9,780,550,526	31.2%

Mega Deductible Policy Count (>=750,000)	Total Policy Count	Percentage of Policies with a Mega Deductible Program (>=750,000)	Premium From Mega Deductible Policy (>=750,000)	Total Premium	Percentage of Premium with a Mega Deductible Program (>=750,000)
6,816	522,638	1.3%	1,961,380,041	9,780,550,526	20.1%

© 2016 National Association of Insurance Commissioners

Policy Year 2011

Counts | **Premium**

Market Share of Insurers Reporting Complete Deductible Data:

Total Premium of Insurers Reporting Complete Deductible Data	Statewide Premium	Market Share
8,275,477,180	11,582,915,284	71.4%

The following information is based on insurers reporting complete deductible data:

Deductible Policy Count	Total Policy Count	Percentage of Policies with a Deductible Program	Premium From Deductible Policy	Total Premium	Percentage of Premium with a Deductible Program
11,910	513,048	2.3%	2,442,873,912	8,275,477,180	29.5%

Small Deductible Policy Count (<100,000)	Total Policy Count	Percentage of Policies with a Small Deductible Program (<100,000)	Premium From Small Deductible Policy (<100,000)	Total Premium	Percentage of Premium with a Small Deductible Program (<100,000)
2,084	513,048	0.4%	76,318,084	8,275,477,180	0.9%

Large Deductible Policy Count (>=100,000)	Total Policy Count	Percentage of Policies with a Large Deductible Program (>=100,000)	Premium From Large Deductible Policy (>=100,000)	Total Premium	Percentage of Premium with a Large Deductible Program (>=100,000)
9,159	513,048	1.8%	2,347,351,186	8,275,477,180	28.4%

Mega Deductible Policy Count (>=750,000)	Total Policy Count	Percentage of Policies with a Mega Deductible Program (>=750,000)	Premium From Mega Deductible Policy (>=750,000)	Total Premium	Percentage of Premium with a Mega Deductible Program (>=750,000)
5,844	513,048	1.1%	1,481,098,352	8,275,477,180	17.9%

© 2016 National Association of Insurance Commissioners

Largest 20 Nevada Large-Deductible Workers' Compensation Filings Made in Each Year (2005-2014)

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014*
10,000,000	40,000,000	17,500,000	17,500,000	50,000,000	50,000,000	250,000,000	1,000,000,000	200,000,000	75,000,000
5,000,000	40,000,000	17,500,000	17,500,000	10,000,000	10,000,000	100,000,000	1,000,000,000	25,000,000	50,000,000
5,000,000	40,000,000	10,000,000	10,000,000	10,000,000	10,000,000	75,000,000	75,000,000	20,000,000	25,000,000
5,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	50,000,000	50,000,000	20,000,000	20,000,000
5,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	50,000,000	25,000,000	17,500,000	20,000,000
3,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	14,000,000	17,500,000	17,500,000
3,000,000	10,000,000	10,000,000	5,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	17,500,000
2,500,000	8,500,000	10,000,000	5,000,000	10,000,000	5,000,000	10,000,000	10,000,000	10,000,000	14,000,000
2,000,000	5,000,000	5,000,000	5,000,000	10,000,000	5,000,000	10,000,000	10,000,000	10,000,000	10,000,000
2,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	10,000,000	10,000,000	10,000,000	10,000,000
2,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	10,000,000	10,000,000	10,000,000	10,000,000
2,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	10,000,000	10,000,000	6,000,000	10,000,000
2,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	10,000,000
2,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	10,000,000
2,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	10,000,000
2,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	10,000,000
2,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	10,000,000
2,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	6,000,000
2,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000
2,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000

Color-Coding Key	<$5M	$5M to <$10M	$10M to <$25M	$25M to <$50M	$50M to <$100M	$100M to <$1B	$1B or Greater

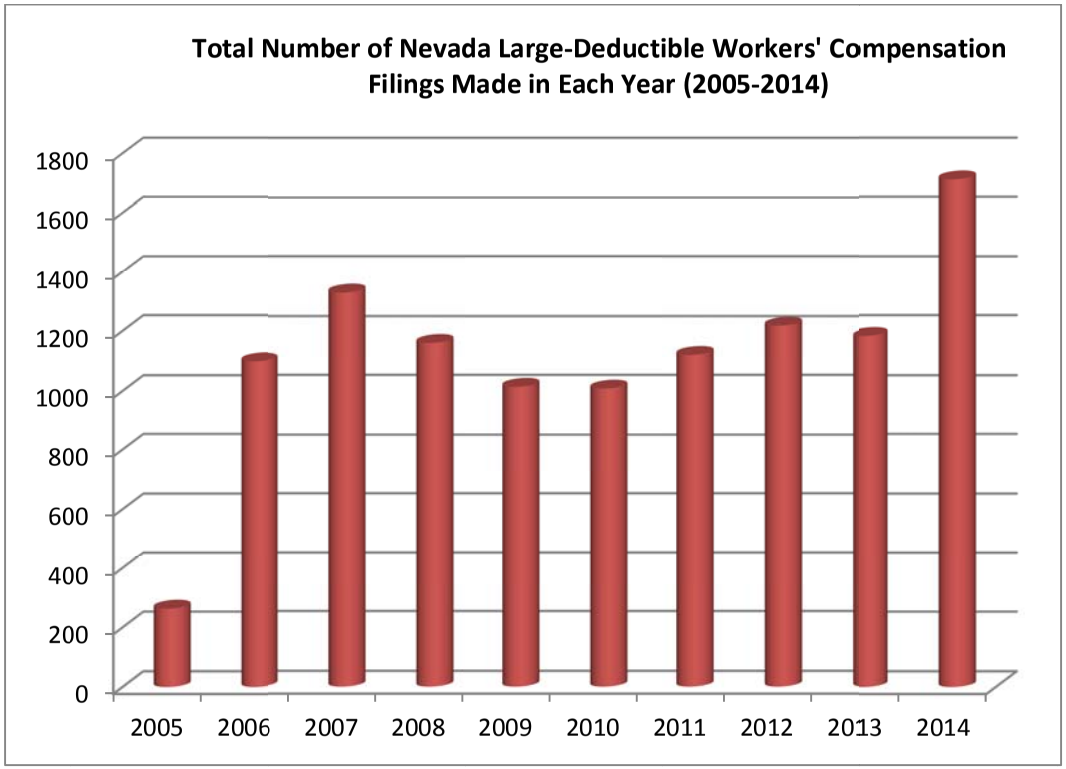
* **Note:** A filing made in 2014 for a $1 billion deductible was disapproved by the Division of Insurance on the grounds that such a deductible amount would be equivalent to self-insurance, and so the employer would need to be registered as a self-insured employer.

Provided by the Nevada Division of Insurance – March 12, 2015

© 2016 National Association of Insurance Commissioners

© 2016 National Association of Insurance Commissioners

Total Number of Nevada Large-Deductible Workers' Compensation Filings Made in Each Year (2005-2014)									
2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
263	1100	1332	1163	1013	1007	1123	1221	1183	1712



Provided by the Nevada Division of Insurance – March 12, 2015

© 2016 National Association of Insurance Commissioners

State	Regulated	Statute/Regulation/Bulletin	Regulating Agency	Audit Reporting Required	Other Financial Reporting Requirements	Net Worth/Positive Working Capital
Alabama	Yes	Alabama Professional Employer Organization Registration Act, Ala. Code §§25-14-1 et seq.	AL Dept. of Labor, Workers' Compensation Division, PEO Registration Office	Yes		Net worth not less than $100,000
Alaska	No					
Arizona	Delayed	Ariz. Rev. Stat. §§23-561 et seq.delayed until June 30, 2013 by Laws 2013, First Special Session, Chapter 2				
Arkansas	Yes	Arkansas PEO Act § 23-92-401, et. seq.	AR Dept. of Insurance, Compliance Division	Yes	Quarterly Financial Reporting	Net worth not less than $100,000
California	Yes, for a few specific industries	Garment: California Code of Federal Regulations, Title 8, Ch. 6, Sub. Ch. 8, §13633; Car Wash: California Code of Federal Regulations, Title 8, Ch. 6, Sub Ch. 11, §13680 et seq.-see also DLSE 667	For garment and car wash: CA Dept. of Industrial Relations, Div. of Labor Standards Enforcement, Licensing and Registration Unit	No		
Colorado	Yes	Colorado Employment Security Act § 8-70-114	CO Dept. of Labor and Employment, Unemployment Insurance Employer Services	Yes		Amount sufficient to secure unemployment insurance premiums, as determined by the department
Connecticut	Yes	PEO Act, Connecticut Gen. Stat. Ch. 566A, §31-221 et seq.	CT Dept. of Labor, Wage and Workplace Standards Division	Yes		Net worth not less than $150,000
Delaware	No					
Florida	Yes	Employee Leasing Act, Fla. Stat., TitleXXXII, Part XI, §§468.520-35; Fl. Admin. Code Rule 61G7	FL Dept. of Business and Professional Regulation, Board of Employee Leasing Companies	Yes	Quarterly Financial Reporting	Net worth not less than $50,000; positive working capital
Georgia	No	Although see: O.C.G.A. §34-7-6 and Rules of GA Dept. of Labor Employment Security Law ch. 300-2-7-07				
Hawaii	Yes	Haw. Rev. Stat. 373L-1 et seq.	HI Dept. of Labor and Industrial Relations, Professional Employer Organization Program	No		
Idaho	N/A	Although see: PEO Recognition Act, Idaho Code Ann. §§44-2401 et seq.	None, although see Idaho Dept. of Labor	No		
Illinois	Yes	Employee Leasing Company Act, 215 IL Code Section 113	IL Dept. of Insurance	No		
Indiana	Yes	Ind. Code 27-16-1 et seq.	IN Dept. of Insurance	Yes		Positive working capital
Iowa	N/A	Although see: Contractor Registration Law, Iowa Code, Chapter 91C	For contractor registration: IA Division of Labor, Contractor Registration	No		
Kansas	Yes	Kansas Professional Employer Organization Registration Act, Kan. Stat. Ann. 2014 Supp. §§44-17-101 et seq.	KS Insurance Department	Yes		Positive working capital
Kentucky	Yes	Ky. Rev. Stat. 342.615	KY Dept. of Workers' Claims, Div. of Security and Compliance, Dept. of Workers' Claims	No		

© 2016 National Association of Insurance Commissioners

Louisiana	Yes	La. Rev. Stat. Ann. §§23:1761-1767	LA Dept. of Insurance, Agent Licensing Div. and also LA Workforce Commission, Tax Liability and Adjudication Unit, Employee Leasing Program	No		
Maine	Yes	Title 32 M.R.S.A. Chapter 125 §14051 et seq.	Dept. of Professional & Financial Regulation, Bureau of Consumer Credit Protection	No		
Maryland	No					
Massachusetts	N/A	Although see: 430 CMR 5.01-5.13	MA Labor and Workforce Dev., Dept. of Unemployment Assistance	No		
Michigan	Yes	Michigan Professional Employer Organization Regulatory Act, Act 370 of 2010, §§338.3721 et seq.	MI Dept. of Licensing and Regulatory Affairs (LARA)	Yes		Working capital not less than $100,000
Minnesota	Yes	Minn. Stat. Ann. §79.255	MN Dept. of Commerce, Insurance Division	No		
Mississippi	N/A	Although see: Miss. Code Ann. §27-7-305 for withholding tax surety bond	For tax withholding: MS Dept. of Revenue			
Missouri	N/A	Although see: Mo. Regs CSR §8-10-4.160; Mo. Rev. Stats. §288.032.1	For tax withholding and client listing: MO Dept. of Revenue, MO Dept. of Employment Security	No		
Montana	Yes	Montana Professional Employer Organizations and Groups Licensing Act, Mont. Code Ann. §§39-8-101 et seq.	MT Dept. of Labor and Industry, Employment Relationships Div.; Workers' Compensation Regs. Bureau	Yes	Quarterly Financial Reporting	Net worth not less than $50,000; positive working capital
Nebraska	Yes	Professional Employer Organization Registration Act, Neb. Rev. Stat. §§48-2701 et seq.	NE Dept. of Labor, Office of Labor Standards - PEO	Yes		Working capital not less than $100,000
Nevada	Yes	Nev. Rev. Stat. §§616B.670 et seq.	NV Dept. of Business and Industry, Div. of Industrial Relations, Workers' Compensation Section, Employer Compliance Unit	Yes		Positive working capital
New Hampshire	Yes	N.H. Rev. Stat. Ann. §§277-B et seq.	NH Dept. of Labor, Employee Leasing	Yes	Quarterly Financial Reporting	Working Capital not less than $100,000
New Jersey	Yes	N.J. Stat. Ann. §§34:8-67, et. seq.	NJ Dept. of Labor and Workforce Development, Div. of Employer Accounts	Yes	Quarterly Financial Reporting	Positive working capital
New Mexico	Yes	Employee Leasing Act, N.M. Stat. Ann. §§60-13A-1, et seq.	NM Regulation and Licensing Dept., Employee Leasing Program	No		
New York	Yes	New York Professional Employer Act, N.Y. Labor Law §§31-915-924	NY Dept. of Labor, Div. of Labor Standards, Permit and Certificate Unit	Yes	Quarterly Financial Reporting	Net worth not less than $75,000
North Carolina	Yes	North Carolina Professional Employer Organization Act, N.C. Gen. Stat. §§58-89A-1 et seq.	NC Dept. of Insurance, Financial Evaluation Div., Special Entities Section - PEO Unit	Yes	Quarterly Financial Reporting	Positive working capital
North Dakota	Yes	N.D. Cent. Code §§43-55-01 et seq.	ND Secretary of State	No		

Ohio	Yes	Ohio Rev. Code Ann. §§4125.01 et seq.	Ohio Bureau of Workers' Compensation, PEO Unit	Yes		Positive working capital
Oklahoma	Yes	Oklahoma Professional Employer Organization Recognition & Registration Act, Okla. Stat. Ann. Title 40 O.S. §§600.1 et seq.	OK Ins. Dept., Financial Div.	Yes	Quarterly Financial Reporting	Net worth not less than $50,000
Oregon	Yes	Or. Rev. Stat. Ann. §§656.850 et seq.	OR Dept. of Consumer and Business Services, Workers' Compensation Div.	No		
Pennsylvania	N/A	PEOs are recognized generally as an employer but PA has not enacted licensing requirements. Although see: Professional Employer Organization Act PL 946, No. 102, which pertains to some PEOs.	Dept. of Labor and Industry	No		
Rhode Island	Yes	Professional Employer Organizations Act of 2004, R.I. Gen. Laws §§5-75-1 et seq.	RI Dept. of Revenue, Div. of Taxation	No		
South Carolina	Yes	S.C. Code Ann. §§40-68-10 et. seq.	SC Dept. of Consumer Affairs, PEO Licensing and Regulation	Yes	Quarterly Financial Reporting	Net worth not less than $50,000; positive working capital
South Dakota	N/A	Although see: S.D. Administrative Rules §§64:06:02:89 et seq. See also: S.D. Code Ann. §§58-33-93 et seq.	SD Dept. of Revenue; SD Dept. of Insurance	No		
Tennessee	Yes	Tennessee Professional Employer Organization Act, Tenn. Code Ann. §§62-43-101 et seq.	TN Dept. of Commerce and Insurance, Employee Leasing Regulatory Program	Yes	Quarterly Financial Reporting	Positive working capital
Texas	Yes	Tex. Labor Code Ann. §§91.0012 et seq.	TX Dept. of Licensing and Regulation, Professional Employer Organizations	Yes		Working capital not less than $50,000 (or more, proportional to number of covered employees)
Utah	Yes	Professional Employer Organization Licensing Act, Utah Code Ann. §§31A-40-101 et seq.	State of UT Insurance Dept., Company Licensing	Yes		Working capital not less than $100,000
Vermont	Yes	Employee Leasing Companies, Vt. Stat. Ann. Title 21, Chapter 12, §§1031-1043	VT Dept. of Labor, Employee Leasing Program	Yes		Net worth not less than $100,000
Virginia	Yes	Va. Code Ann. §65.2-803.1	VA Workers' Compensation Commission; Bureau of Ins. of the State Corp. Commission	No		
Washington	N/A	Although see: RCW §50.04.298, regarding PEOs. See also: WAC §§192-300-200 et seq. regarding PEOs and unemployment taxes.	WA Employment Security Dept.	No		
Washington, D.C.	N/A			No		
West Virginia	Yes	W. Va. Code Ann. §§33-46A-1 et seq.	State of WV, Offices of the Insurance Commissioner, Financial Conditions Div.	Yes		Working capital not less than $100,000
Wisconsin	Yes	Wis. Stat. §§202.21 et seq.	WI Dept. of Financial Institutions	Yes		Working capital not less than $100,000
Wyoming	N/A	Although see: WY Code Ann. §§27-3-101 et seq. regarding unemployment compensation.	WY Dept. of Workforce Services	No		

© 2016 National Association of Insurance Commissioners

Appendix F

States Accepting ESAC Accreditation in Lieu of All or Part of PEO Registration/Licensing (as of 5/2015)

State	Statutory Authorization	Regulation/Rule Authorization	Accreditation Accepted*
Alabama	None	None	No
Alaska	PEO registration/licensing not required		
Arizona	PEO registration/licensing not required		
Arkansas	Yes	Yes	Yes
California	PEO registration/licensing not required (except for garment making industry)		
Colorado	Yes	Yes	Yes
Connecticut	Yes	None	Yes
Delaware	PEO registration/licensing not required		
DC	PEO registration/licensing not required		
Florida	None	Authorizing Accredited PEOs satisfy FL reporting requirements via ESAC	Yes
Georgia	PEO registration/licensing not required		
Hawaii	None	None	No
Idaho	PEO registration/licensing not required		
Illinois	None	None	No
Indiana	Yes	Yes	Yes
Iowa	PEO registration/licensing not required		
Kansas	Yes	None	No
Kentucky	None	None	No
Louisiana (LWC)	Yes	None	Yes
Louisiana (DOI)	Yes	Yes	Pending
Maine	None	None	No
Maryland	PEO registration/licensing not required		
Massachusetts	None	None	No
Michigan	Yes	None	No
Minnesota	None	None	No
Mississippi	PEO registration/licensing not required		
Missouri	PEO registration/licensing not required		
Montana	Yes/limited	None	Yes/limited
Nebraska	Yes	Yes	Yes

© 2016 National Association of Insurance Commissioners

Nevada	Yes	None	No
New Hampshire	Yes	Yes	No
New Jersey	Yes	Yes	No
New Mexico	None	None	No
New York	None	None	No
North Carolina	Yes	None	No
North Dakota	None	None	No
Ohio	Yes	Yes	Yes/implementing full
Oklahoma	Yes	None	Yes
Oregon	None	None	No
Pennsylvania	None	None	No
Rhode Island	Yes/limited	None	Yes/limited
South Carolina	None	None	No
South Dakota	PEO registration/licensing not required		
Tennessee	Yes	None	Yes
Texas	Yes	Yes	Yes
Utah	Yes	Yes	Yes
Vermont	Yes/limited	None	Yes/limited
Virginia	None	None	No
Washington	PEO registration/licensing not required		
West Virginia	Yes	Yes	Yes
Wisconsin	Yes	Yes	Yes
Wyoming	PEO registration/licensing not required		

*ESAC accreditation accepted for all or part of PEO registration/licensing requirements. Contact JMcCoggins@ESACmail.org for details.

Employer Services Assurance Corporation

Standards and Procedures for ESAC Accreditation and Client Assurance Program Participation

(Effective September 2015)

One Financial Centre, Suite 327
650 S. Shackleford Road
Little Rock, Arkansas 72211-3503

(501) 219-2045
info@ESACmail.org
www.AccessESAC.org

© 2016 National Association of Insurance Commissioners

Financial Standards

1) **Adjusted Net Worth Requirement:** An Accredited PEO must have Adjusted Net Worth in an amount which is the larger of $100,000 or five percent of Total Adjusted Liabilities as demonstrated by a Schedule of Net Worth included as part of its audited financial statements and interim financial statements in a form prescribed by ESAC.

2) **Positive Working Capital Requirement:** An Accredited PEO must maintain an adequate level of financial liquidity as demonstrated by maintaining Positive Working Capital. Provided however, an Accredited PEO may have Working Capital that is not Positive Working Capital for a period not to exceed six consecutive months so long as current liabilities are not more than two times current assets and the PEO maintains Positive Quick Working Capital. A calculation of the PEO's Working Capital and Quick Working Capital shall be included as part of its audited financial statements and interim financial statements as required by ESAC's application and accreditation maintenance procedures. Notwithstanding the above financial liquidity requirements, all Applicants for accreditation must be able to demonstrate Positive Working Capital, and an Applicant shall not be eligible for the Positive Quick Working Capital exception as part of the initial qualification for accreditation. Applicants and Accredited PEOs must maintain the level of financial liquidity necessary for licensure or registration in the states in which it operates.

3) **Requirements for Calculation of Net Worth and Working Capital:** An Accredited PEO's net worth and working capital must be made in full compliance with generally accepted accounting principles (GAAP) for a combined or consolidated statement of the financial condition of all PEO entities under common control and including a proper accounting of all transactions with non-PEO Affiliates and related parties including Controlling Persons, Captives, trusts and variable interest entities (see FASB Statement 167). Such calculation of net worth and working capital shall not include as an asset any amount of receivable due to be paid to the Accredited PEO from a trust or captive operated for the exclusive benefit of the Accredited PEO or any receivable from an Affiliate, Controlling Person or related party Entity unless evidence of collectability acceptable to ESAC is provided. Any affiliated party receivable must also comply with the requirements of Financial Responsibility Standard #6.

4) **Alternative Compliance Method for Adjusted Net Worth and Positive Working Capital Requirements:** In lieu of an Accredited PEO meeting the Adjusted Net Worth and financial liquidity standards specified above, the PEO may provide a guaranty, irrevocable letter of credit, surety bond or other security, in all cases acceptable to ESAC and in sufficient amount to offset any deficiency. Provided however, a guaranty will not be acceptable to satisfy a deficiency unless the PEO submits adequate evidence that the guarantor has sufficient net worth and liquidity in the sole judgment of ESAC to satisfy the obligation of the guaranty. The deficiency being covered by the guaranty shall not exceed 25% of the amount required to meet ESAC net worth and liquidity standards. Such guaranty shall be in a form provided by ESAC (Exhibit C). Annual audited financial statements of the parent corporation or other guarantor must be submitted to ESAC in the same manner as required for the PEO by ESAC's accreditation maintenance procedures.

   If an Accredited PEO chooses to submit an irrevocable letter of credit to offset any deficiency, such irrevocable letter of credit will be acceptable so long as: (a) ultimate responsibility for repayment of any sums disbursed under the letter of credit is not an obligation of the PEO or any Affiliated PEO; (b) the letter of credit contains an "evergreen" clause, which automatically renews the letter of credit unless the issuer notifies the PEO and ESAC by 60 days prior written notice of the decision not to renew; and (c) the letter of credit is issued by a financial institution authorized to do so under applicable state or federal banking laws.

5) **Requirements Applicable to Tax Liabilities and Self Funded or Loss Sensitive Insurance or Employee Benefit Arrangements:**

   a. An Accredited PEO must have adequate financial reserves for all state and federal tax liabilities incurred but unpaid and for all plans of Self Insurance or Partial Self Insurance, for all Fully Insured health and workers' compensation insurance policies or plans that are not Fully Funded (i.e. Loss Sensitive), and for any other employee benefit plans maintained as permitted by state law that are not Fully Insured and Fully Funded. These types of insurance programs include but are not limited to Self Insured plans, Partially Self Insured plans, minimum premium plans, captive plans, large deductible plans, and retrospective rating plans where the maximum financial liability to the Accredited PEO is not Fully Funded by current premium payments, and any trust through which employee benefits are provided other than a Fully Funded trust that exclusively provides retirement benefits in connection with a retirement plan qualified under Section 401(a) of the Internal Revenue Code. The Financial Reserves for such insurance and benefit plans shall be equal to the estimated Ultimate Liability for such plans, based upon generally accepted actuarial methods, including but not limited to incurred but not reported claims, incurred but unpaid claims, future claims development, retrospective premium

© 2016 National Association of Insurance Commissioners

adjustments, inflationary trends and the degree of risk. A Certified Actuary, who is independent of the PEO and is a member of the American Academy of Actuaries, must opine as to the reasonableness of the financial reserves recorded on the Accredited PEO's financial statements for such insurance and benefit plans at the end of each fiscal year, unless one or a combination of the following apply:

i. The policy(ies) or plan(s) of workers' compensation insurance are Fully Insured by a licensed insurance carrier(s) and the Accredited PEO provides ESAC the annual confirmation of the carrier's estimate of the PEO's Ultimate Liability for both the current and all prior policy years. The PEO is responsible for providing a carrier confirmation letter from each current or former workers' compensation carrier for which there is any potential remaining claim liability or any such carrier that continues to hold collateral for a potential claim liability. The written confirmation(s) must be transmitted in writing on the carrier(s)' letterhead and signed by an authorized corporate manager or officer in a manner that is consistent with the content and form of Exhibit F; or

ii. The policy(ies) or plan(s) of insurance are Fully Insured by a licensed insurance carrier(s) and the Accredited PEO provides ESAC with a copy of the policy of insurance or other legal contract between the Accredited PEO and the insurance carrier(s) that specifies the Ultimate Liability of the Accredited PEO under the policy or plan of insurance and the Accredited PEO demonstrates to ESAC in its sole discretion that the Accredited PEO's financial statements include financial reserves for such policy or plan equal to or in excess of the policy's or plan's Ultimate Liability;

iii. The reserves for the portion of loss-sensitive insurance policies or plans with respect to dental, vision and/or prescription drugs, not covered by other applicable medical coverage at all times are equal to or greater than 125% of the prior calendar quarter's total reported claims for dental and vision plans and equal to or greater than 125% of the prior calendar month's total reported claims for prescription drugs. A written certification by the third party claims administrator or insurance carrier(s) must be submitted along with the PEO's audited financial statements attesting to the amount of the prior calendar quarter's total reported claims for dental and vision plans and the amount of the prior calendar month's total reported claims for prescription drugs and attesting that all such reported claims have either been paid by the response date of the third party claims administrator or insurance carrier or that as of such date the third party claims administrator or insurance carrier has sufficient funds to pay such reported claims.

An Accredited PEO must submit along with its quarterly financial statements: (i) a certification by management that financial reserves for all policy(ies) or plan(s) of insurance subject to the requirements of this Financial Responsibility Standard #5 have been estimated and adjusted if necessary for such quarterly financial statements and, if requested by ESAC, provide a description of the methods and a copy of the computations and workpapers used to estimate the Ultimate Liability of all plans of self-insurance or loss-sensitive insurance plans or policies; and (ii) an attestation of management that such plans were operated in compliance with Financial Responsibility Standard #5 at all times during the reporting period.

(Note: Upon request, ESAC will provide Applicants and Accredited PEOs with a list of qualified actuaries knowledgeable of PEO operations and ESAC requirements if an actuarial opinion is required.)

b. Notwithstanding the provisions of the requirements of this Financial Responsibility Standard #5 or any other ESAC Standard, an Accredited PEO shall at all times operate any plan of medical, dental, vision and/or prescription drug insurance and workers' compensation insurance in compliance with applicable state and federal law. For any medical insurance plan that is not Fully Insured by a duly licensed insurance company as evidenced by a certificate of insurance acceptable to ESAC, an Accredited PEO shall demonstrate the Plan's compliance with applicable state and federal law by providing ESAC with an opinion letter from an AV-Rated law firm in which the attorney writing the opinion has demonstrated expertise in ERISA law and in applicable state law related to employee welfare benefit plans in the states in which the Accredited PEO is operating the non-Fully Insured plan.

c. Adequate reserves as required pursuant to Section 5.a. above shall be reflected on the Accredited PEO's financial statement unless it is demonstrated to the satisfaction of ESAC that the Accredited PEO is not legally liable for the satisfaction of such plan's liabilities.

d. Any amount due from such a plan shall be deemed an affiliated party receivable.

e. If an Accredited PEO has such a plan whose financial statements are audited, the Accredited PEO shall submit a copy of such audited financial statements to ESAC as part of the Accredited PEO's annual submittal of its own audited financial statements.

© 2016 National Association of Insurance Commissioners

6) **Affiliated Party Receivable Reporting Requirements:** A receivable from an Affiliate ("Affiliated Party Receivable"), other than an Affiliated Party Trade Receivable, must be excluded from a PEO's assets for purposes of meeting ESAC financial standards, unless:

   a. The receivable is a loan receivable that meets the following four criteria:

      i. Such receivable has never been a trade receivable,

      ii. Such receivable is evidenced by a promissory note or similar instrument bearing a reasonable rate of interest,

      iii. Such receivable is amortized in substantially equal payments of principal and interest over not more than 60 months from the date of original advance, and

      iv. Such receivable is not past due or otherwise in default as of the reporting date.

   b. The receivable is immaterial because its exclusion would not result in a failure to meet net worth or liquidity standards; or

   c. The PEO submits additional documentation that verifies to the satisfaction of ESAC the authenticity and collectability of the receivable for purposes of complying with ESAC's standards.

   Any portion of an Affiliated Party Receivable that qualifies as an asset under the above provisions and is due within one year of the reporting date may be treated as a current asset. Any portion of an Affiliated Party Receivable that qualifies as an asset under the above provisions and is due within ninety days of the reporting date may be counted as a quick asset.

   If the total amount of Affiliated Party Receivables otherwise treated as assets exceeds 33% of the Accredited PEO's reported Net Worth as of the reporting date, the Accredited PEO's Net Worth shall be reduced by the amount of Affiliated Party Receivables exceeding this 33% limitation unless:

   a. The parent is a publicly-traded company with Positive Working Capital and a Net Worth of at least 10% of its total liabilities; or

   b. The Accredited PEO provides ESAC with audited consolidated financial statements in which the Affiliate's financial statements are consolidated with those of the Accredited PEO. In such case, the consolidated entities must meet ESAC financial standards on a consolidated basis. Each non-PEO Entity included in the consolidated financial statements must execute a cross guaranty agreement in a form acceptable to ESAC guaranteeing the liabilities of each PEO Entity.

   For purposes of being included as a current asset in computing Working Capital, an Affiliated Party Trade Receivable must be incurred in the ordinary course of business as part of a written service agreement, and as of the reporting date: (i) not be past due or otherwise in default; and (ii) not be more than 60 days old.

7) **Imminent Material Risk Provision:** An Accredited PEO shall maintain its financial condition and operations in a manner that does not present an imminent material risk, including a Presumed Imminent Material Risk, to the financial soundness of such PEO or to ESAC's Client Assurance Program. "Presumed Imminent Material Risk" is present with regard to the financial condition of an Accredited PEO when the PEO's quarterly (or monthly, if applicable) financial report shows a negative net income, which net loss, if it reoccurred in the next two like reporting periods, would result in a violation of one or more of ESAC's Financial Responsibility Standards, absent any curative action by the PEO, unless ESAC determines, in its sole discretion, that the subject net loss is a cyclical or isolated event that will not reoccur within the next two like reporting periods. An Accredited PEO shall be in violation of this standard at such time as ESAC provides written notice to the PEO that ESAC has determined, in its sole discretion, that an imminent material risk exists. However, if in such written notice, ESAC grants the PEO a time period within which to submit a corrective action plan, a violation of this standard shall occur upon (i) the expiration of such time period without the submission of such a plan or (ii) the rejection by ESAC, in its sole discretion, of a corrective action plan timely submitted by the PEO. In the event ESAC accepts a corrective action plan, the PEO shall be in violation of this standard if ESAC determines, in its sole discretion, that the PEO has failed to maintain the requirements of such corrective action plan and provides written notice of such finding to the PEO and the PEO fails to cure such deficiency within five (5) business days of receipt of the notice.

© 2016 National Association of Insurance Commissioners

Additional Requirements Concerning Audited Financial Statements

8) **Audit Requirements:** Annual financial statements must be prepared in accordance with general accepted accounting principles ("GAAP") and accompanied by an unqualified audit report issued by an independent CPA, who is a member of the AICPA and who has an unmodified report from the most recent peer review by the AICPA Peer Review Board.

9) **Requirements for Reporting:** Where audited consolidated or combined financial statements are submitted to ESAC by a PEO or PEO Group, the consolidated or combined entities must meet ESAC financial standards on a consolidated or combined basis, further demonstrated by the accompanying submissions of a Schedule of Net Worth and computations of Working Capital and Quick Working Capital, along with the audited consolidated or combined financial statements. If a PEO Group in which each PEO has the same fiscal year does not have audited consolidated or combined financial statements, but each PEO member of the PEO Group has audited financial statements, then such PEO Group shall submit separate audited financial statements for each PEO member of the PEO Group. Regardless of the form of financial statements submitted, each PEO member of the PEO Group shall provide ESAC with a cross guaranty agreement in a form acceptable to ESAC guaranteeing the liabilities of all other PEO Entities included in the PEO Group. All PEO Entities under common control must be accredited. If an Accredited PEO or Accredited PEO Group is relying on the financial statements of a parent entity for compliance with ESAC's Financial Standards, the parent entity shall provide ESAC with a parent guaranty agreement in a form acceptable to ESAC guaranteeing the liabilities of all PEO Entities included in the PEO Group.

10) **Interim Financial Statements.** An accredited PEO shall provide interim quarterly financial statements and complete ESAC's Schedule of Net Worth and the computations of Working Capital and Quick Working Capital, both of which are available online as part of ESAC's Quarterly Reporting System. Interim financial statements shall meet the same financial standards and requirements as the annual audited financial statement, except the interim statements are not required to be reviewed or audited by an independent CPA. Interim statements shall be submitted by the PEO or PEO Group to ESAC on a consolidated or combined basis, and in a form prescribed by ESAC. Notwithstanding the requirements of this section, an Accredited PEO must also comply with all state registration or licensing financial reporting requirements, including the requirement in some states that the PEO submit a separate audited financial statement or consolidated supplemental schedule on each PEO entity authorized to do business in that state.

11) **Captive Audit Requirements:** For purposes of meeting ESAC Adjusted Net Worth and Positive Working Capital standards as specified in Financial Standards #1 and #2, a Captive that insures any risk of an Accredited PEO must be audited at least annually and a copy of the audited statements provided to ESAC as part of the PEO's annual submittal of audited financial statements.

    The financial condition of the Captive shall be considered by ESAC for purposes of determining the adequacy of recorded liabilities of the Accredited PEO and for calculating Adjusted Net Worth and Working Capital and Quick Working Capital. Such consideration may include, without limitation, whether the Captive has sufficient assets and cash flow to pay its liabilities, including claims attributable to the Accredited PEO, in the ordinary course of its business as such liabilities become due and payable, such that the Ultimate Liability with respect to claims attributable to the Accredited PEO can be satisfied from: (i) the assets and cash flow of the Captive available for such claims, and (ii) the recorded liability of the Accredited PEO. Such consideration may also include the potential liability of affiliates of the Accredited PEO with respect to the Captive and the effect of such potential liability on any assets of the Accredited PEO, including receivables from such affiliate.

    In connection with the submission of its audited financial statements, an Accredited PEO, any of whose risk is insured through a Captive, shall clearly identify and tie back to such audited financials and the audited financial statements of the Captive the PEO's Ultimate Liability with respect to the risk insured through the Captive as of the reporting date and shall identify the amount and location of such liability included in the PEO's balance sheet.

    A Captive that insures any risk of an Accredited PEO must be domiciled in and subject to the regulation of an approved jurisdiction, as evidenced by the listing of approved jurisdictions for Captives as maintained on the ESAC website. An Accredited PEO that desires to utilize a Captive not domiciled in and subject to the regulation of an approved jurisdiction may utilize such a Captive only upon approval of ESAC, which approval shall not be unreasonably withheld if the proposed jurisdiction provides adequate regulatory oversight as determined by ESAC in its sole discretion.

12) **Related Party Transaction Reporting:** An Accredited PEO's financial statements shall reflect all Affiliated Party Transactions whereby the value or cost of any goods, services or benefits provided by or to the PEO shall be fully and accurately recorded in accordance with Financial Responsibility Requirement 6 and generally accepted

© 2016 National Association of Insurance Commissioners

accounting principles, including an adequate footnote description of the nature of the transaction. Without limitation, this requirement shall be applicable to any receivables, payables, provision of goods or services, or sharing of employees or other resources between an Accredited PEO and a Controlling Person or an Affiliate of the Accredited PEO or a Controlling Person or any independent entity operated primarily for the benefit of an Accredited PEO or its clients or employees.

13) **Disclosure to Auditor:** An Accredited PEO shall provide its auditor at the time of engagement to audit the PEO's fiscal year end financial statements with a copy of ESAC's Financial Responsibility Standards.

14) **Startup Provision Concerning Audited Financial Statements:** An Applicant PEO, which has not had sufficient operating history to provide ESAC with audited financial statements based upon at least 12 calendar months of PEO operations, shall demonstrate to ESAC's satisfaction that the PEO will have sufficient capitalization at all times from the date of accreditation, demonstrating compliance with Financial Responsibility Standards 1, 2 and 7. Prior to accreditation, the Applicant shall provide ESAC with projections of monthly cash flow and profit-loss for the initial 12 months of PEO operations following accreditation. After accreditation, the accredited PEO shall provide ESAC with monthly updates of its 12-month projection of cash flow and profit-loss, along with the PEO's monthly internal financial statements, until the PEO can provide ESAC with an audited financial statement covering at least 12 calendar months of PEO operations that demonstrate compliance with Financial Responsibility Standards 1, 2 and 7. Refer to Initial Application Procedure #10 for additional information.

Insurance Coverage, Guaranty and Surety Bond Requirements

15) **Insurance Coverage:** An Accredited PEO must carry the following minimum amounts of insurance coverage:

	Errors & Omissions Coverage (for PEO Internal Operation)		Fidelity Coverage (for PEO Internal Operation)		
PEO Total Annual Wages	Minimum Coverage*/Type	Maximum Deductible	Minimum Coverage*/Type	Maximum Deductible	Umbrella Liability Coverage
0 to 25 million	$500,000	$25,000	$250,000	$25,000	$1 million
25 to 100 million	$1 million	$50,000	$500,000	$25,000	$1 million
100 to 250 million	$1 million	$100,000	$1 million	$25,000	$2 million
250 to 500 million	$2 million	$100,000	$1 million	$25,000	$3 million
Above 500 million	$3 million	$250,000	$1 million	$25,000	$5 million

*Coverage limits should be both per occurrence and in the aggregate.

16) **Parent Guaranty:** An Accredited PEO that chooses to submit consolidated financial statements of a parent corporation, and a Separately Branded PEO, must submit a guaranty by the parent of all the obligations of the PEO (or PEO Group), executed in favor of the clients, worksite employees, insurers, and taxing authorities thereof.

17) **Cross Guaranty:** Each Affiliated PEO of a PEO Group, other than a Separately Branded PEO, must submit a cross guaranty of all the obligations of each other Affiliated PEO in the PEO Group, executed in favor of the clients, worksite employees, insurers, and taxing authorities thereof. Within each group of Separately Branded PEOs, each Separately Branded PEO must submit a cross guaranty of all the obligations of each other Separately Branded PEO in the group, executed in favor of the clients, worksite employees, insurers, and taxing authorities thereof.

18) **Surety Bond:** An Accredited PEO must qualify at all times for an individual surety bond underwritten by a surety that is duly licensed in all states. This bond will be held by the Employer Services Trust for the benefit of the PEO's clients, employees and taxing authorities and must be in an amount equal to the greater of:

(i) 5% of the Accredited PEO's total federal and state employment tax liability* for the preceding calendar year as imposed by USC 26 Subtitle C and applicable laws of all states of operation, rounded up to the nearest $50,000 and not to exceed $1,000,000; or

(ii) $250,000.

* For these purposes, state employment tax liability means all taxes payable to a state by an employer that are either dependent on wages paid or withheld from employees.

© 2016 National Association of Insurance Commissioners

Additional Financial Responsibility Standards

19) **Surety Bond Qualification:** An Accredited PEO must at all times meet the financial underwriting standards for bonding by ESAC's surety for purposes of meeting the requirements of ESAC accreditation as set forth in these Standards and Procedures. These bonding requirements must be met based on the surety's underwriting without the PEO posting cash or cash equivalents that could otherwise reduce the surety's risk and the value of the surety's financial underwriting.

20) **Demonstrated History of Financial Responsibility:** An Accredited PEO, its Controlling Persons and Affiliates must have a demonstrated history of responsible financial management of their business and personal affairs. Accreditation shall be denied to a PEO if the PEO, a Controlling Person or an Affiliate thereof has documented incident(s) of failing to meet personal or business financial responsibilities unless ESAC in its sole discretion determines that the incident(s) are not relevant due to the nature and/or the time since occurrence.

21) **Timely Payment of PEO Employer Responsibilities:** An Accredited PEO shall pay in a timely and accurate manner all Accredited PEO Worksite Employee wages, state and federal payroll taxes, employee benefit plan contributions, and workers' compensation and health insurance premiums for all plans of insurance sponsored or co-sponsored by the PEO and shall provide to ESAC the quarterly confirmation of such payments by an independent CPA. Such confirmation may be in the form of an Examination Level Attestation and/or Agreed-Upon Procedures as specified in Exhibit E.

;

© 2016 National Association of Insurance Commissioners

Employer Services Assurance Corporation

Standards and Procedures for ESAC Accreditation and Client Assurance Program Participation

(Effective September 2015)

One Financial Centre, Suite 327
650 S. Shackleford Road
Little Rock, Arkansas 72211-3503

(501) 219-2045
info@ESACmail.org
www.AccessESAC.org

© 2016 National Association of Insurance Commissioners

accounting principles, including an adequate footnote description of the nature of the transaction. Without limitation, this requirement shall be applicable to any receivables, payables, provision of goods or services, or sharing of employees or other resources between an Accredited PEO and a Controlling Person or an Affiliate of the Accredited PEO or a Controlling Person or any independent entity operated primarily for the benefit of an Accredited PEO or its clients or employees.

13) **Disclosure to Auditor:** An Accredited PEO shall provide its auditor at the time of engagement to audit the PEO's fiscal year end financial statements with a copy of ESAC's Financial Responsibility Standards.

14) **Startup Provision Concerning Audited Financial Statements:** An Applicant PEO, which has not had sufficient operating history to provide ESAC with audited financial statements based upon at least 12 calendar months of PEO operations, shall demonstrate to ESAC's satisfaction that the PEO will have sufficient capitalization at all times from the date of accreditation, demonstrating compliance with Financial Responsibility Standards 1, 2 and 7. Prior to accreditation, the Applicant shall provide ESAC with projections of monthly cash flow and profit-loss for the initial 12 months of PEO operations following accreditation. After accreditation, the accredited PEO shall provide ESAC with monthly updates of its 12-month projection of cash flow and profit-loss, along with the PEO's monthly internal financial statements, until the PEO can provide ESAC with an audited financial statement covering at least 12 calendar months of PEO operations that demonstrate compliance with Financial Responsibility Standards 1, 2 and 7. Refer to Initial Application Procedure #10 for additional information.

Insurance Coverage, Guaranty and Surety Bond Requirements

15) **Insurance Coverage:** An Accredited PEO must carry the following minimum amounts of insurance coverage:

	Errors & Omissions Coverage (for PEO Internal Operation)		Fidelity Coverage (for PEO Internal Operation)		
PEO Total Annual Wages	Minimum Coverage*/Type	Maximum Deductible	Minimum Coverage*/Type	Maximum Deductible	Umbrella Liability Coverage
0 to 25 million	$500,000	$25,000	$250,000	$25,000	$1 million
25 to 100 million	$1 million	$50,000	$500,000	$25,000	$1 million
100 to 250 million	$1 million	$100,000	$1 million	$25,000	$2 million
250 to 500 million	$2 million	$100,000	$1 million	$25,000	$3 million
Above 500 million	$3 million	$250,000	$1 million	$25,000	$5 million

*Coverage limits should be both per occurrence and in the aggregate.

16) **Parent Guaranty:** An Accredited PEO that chooses to submit consolidated financial statements of a parent corporation, and a Separately Branded PEO, must submit a guaranty by the parent of all the obligations of the PEO (or PEO Group), executed in favor of the clients, worksite employees, insurers, and taxing authorities thereof.

17) **Cross Guaranty:** Each Affiliated PEO of a PEO Group, other than a Separately Branded PEO, must submit a cross guaranty of all the obligations of each other Affiliated PEO in the PEO Group, executed in favor of the clients, worksite employees, insurers, and taxing authorities thereof. Within each group of Separately Branded PEOs, each Separately Branded PEO must submit a cross guaranty of all the obligations of each other Separately Branded PEO in the group, executed in favor of the clients, worksite employees, insurers, and taxing authorities thereof.

18) **Surety Bond:** An Accredited PEO must qualify at all times for an individual surety bond underwritten by a surety that is duly licensed in all states. This bond will be held by the Employer Services Trust for the benefit of the PEO's clients, employees and taxing authorities and must be in an amount equal to the greater of:

(i) 5% of the Accredited PEO's total federal and state employment tax liability* for the preceding calendar year as imposed by USC 26 Subtitle C and applicable laws of all states of operation, rounded up to the nearest $50,000 and not to exceed $1,000,000; or

(ii) $250,000.

* For these purposes, state employment tax liability means all taxes payable to a state by an employer that are either dependent on wages paid or withheld from employees.

© 2016 National Association of Insurance Commissioners

Operational Standards

Requirements Concerning Legal Compliance

1) **Conformity with all Applicable Laws:** An Accredited PEO and its Controlling Persons (a) shall operate in conformity with all applicable laws and regulations, including but not limited to required state and federal licensing, certification and registration relative to PEO activities; (b) shall not engage in any deceptive trade practices; (c) shall not engage in misrepresentations of employer obligations and liabilities; and (d) shall have a history free of such misrepresentations, illegal activities, willful or repeated violation of laws, acts of moral turpitude, and willful or repeated violations of PEO licensing and/or registration laws and related regulations. In reviewing such history, the Board may give consideration to mitigating circumstances and the severity of the offense.

2) **PEO Shall Not Represent Itself as a Seller of Insurance:** An Accredited PEO shall not represent or imply that it is a seller of insurance in any of its sales and marketing materials or activities or engage in any activity that constitutes the sale of insurance except through duly licensed insurance producers.

Requirements Concerning Sales, Marketing and Client Service Materials

3) **Client Service Agreement Requirements:** The agreement documenting the terms of all PEO Service Arrangements shall be in writing and shall include the following:

   a. An allocation of the rights and responsibilities of the PEO and the client with respect to the co-employment of the worksite employees;

   b. The PEO shall have responsibility to pay wages to worksite employees and to withhold, collect, report and remit applicable payroll taxes with respect to worksite employee wages; provided “wages” shall not include any obligation between a client and a worksite employees for compensation beyond or in addition to the worksite employee’s salary, draw or regular rate of pay, unless the PEO has expressly agreed to assume liability for payment of such compensation;

   c. The PEO shall have responsibility to make payments for employee benefits for worksite employees to the extent the PEO has assumed responsibility for such benefits in the PEO Service Arrangement;

   d. The PEO shall have a right to hire, discipline, and terminate a worksite employee, as may be necessary to fulfill the PEO’s responsibilities under applicable law and the PEO Service Arrangement; provided that the client shall also have a right to hire, discipline, and terminate a worksite employee;

   e. A specific allocation to either the client or the PEO of the responsibility to obtain workers’ compensation coverage for worksite employees as required by applicable law, from a carrier licensed to do business in the state(s) in which services are performed by the worksite employees;

© 2016 National Association of Insurance Commissioners

f. The rights and responsibilities of the PEO and the client with respect to service fees, terms of payment, effective date and termination; and

g. Any other provisions required by applicable law to be included in a PEO Client Service Agreement.

4) **Written Acknowledgement from Worksite Employees:** An Accredited PEO shall obtain from all worksite employees a written acknowledgment that they understand the nature of their employment relationship with the PEO and voluntarily accept such employment. Such acknowledgment may be included as part of another document or form executed by worksite employees, or it may be a separate document used exclusively for this purpose.

5) **Employment Policies & Procedures:** An Accredited PEO shall provide all worksite employees with written employment policies and procedures, although such policies and procedures may be supplemented with, or modified, to reflect specific policies and procedures applicable at each client worksite.

6) **Termination Notices:** In the event of termination of a PEO Service Arrangement, an Accredited PEO shall provide timely written notice of termination of employment from the PEO directly to any affected worksite employee. While the PEO's client may also provide notice, such client notice to terminated employees does not satisfy the Accredited PEO's responsibility to provide notice of termination.

7) **Sales and Other Information Must be Free of Misrepresentation:** Whether communicated verbally or in writing within sales and marketing materials, sales proposals, client invoices and the like, information provided to Clients and prospective Clients by Accredited PEOs shall not contain incorrect or misleading information.

Requirements Concerning Insurance Coverage

8) **Self Insured Benefit Plan Requirements:** An Accredited PEO that maintains a Self Insured employee welfare benefit plan (e.g. group health insurance), if permitted by state and federal law, must meet the following minimum requirements:

a. The plan must have adequate excess loss insurance coverage if necessary to prevent material adverse impact on the financial condition of the PEO;

b. The plan must use a third party claims administrator ("TPA") licensed as required by state law;

c. The Self Funded nature of the plan must be adequately disclosed to each eligible worksite employee;

d. Adequate financial reserves for the plan must be maintained in compliance with Financial Responsibility Standard number 5; and

e. Plan assets, including participant contributions, must be held in trust for the exclusive benefit of participants and beneficiaries. The trust requirement is applicable to any Self Insured employee welfare benefit plan maintained by the PEO, whether funded through a cafeteria plan or not; provided that a flexible spending account maintained pursuant to a cafeteria plan shall not be considered a Self Insured employee welfare benefit plan for the purpose of this trust requirement.

f. If the plan provides major medical coverage, the PEO must provide a written opinion from qualified outside legal counsel, acceptable to ESAC in its sole discretion, which specifically describes, to ESAC's satisfaction, the basis for counsel's opinion that the plan complies with all applicable law and with ESAC's requirements, specifically including ESAC's Financial Responsibility Standard No. 5.

9) **Workers' Compensation Requirements:** An Accredited PEO shall be responsible for ensuring that workers' compensation coverage is provided for every worksite employee to the extent required by state law. Such coverage shall be obtained from carriers or through plans of insurance admitted or otherwise approved by the states where the worksite employees perform their primary duties and shall be provided pursuant to coverage provisions of state law. A PEO may allow its client to cover the assigned worksite employees under the worksite employer's policies or plans of insurance, if permitted or required by state law, so long as the PEO obtains a certificate of coverage or policy endorsement naming the PEO as a certificate holder or, if required by state law, an additional insured. Under such circumstances, the PEO shall be responsible for ensuring that coverage is, in fact, provided for all assigned worksite employees. In states that permit employers to obtain alternatives to workers' compensation insurance, a PEO may do so, provided the alternative coverage meets or exceeds the statutory minimum coverage required by the state and a written disclosure of the nature and limitations of the coverage, including exposure to tort suits, if applicable, is provided to all clients affected by the coverage.

© 2016 National Association of Insurance Commissioners

Other Operational Requirements

10) **Establish and Maintain Prudent Credit Policy:** An Accredited PEO shall adopt and enforce payment and credit policies and monitoring procedures that represent reasonable practices and procedures within the industry that are prudent with respect to the financial condition of the PEO.

11) **Interference with National Labor Relations Act Prohibited:** An Accredited PEO shall not knowingly use the PEO/Client relationship to help the Client evade or avoid its obligations under the National Labor Relations Act or any collective bargaining agreement.

12) **PEO Shall Not Offer Non-PEO Services:** An Accredited PEO shall not contract with a client to provide any Employment-Related Service other than through a PEO Service Arrangement. If a non-PEO Employment-Related Service is offered, it must be provided through a separate subsidiary or Affiliated Entity of the Accredited PEO.

13) **Affiliation with a Non-Accredited PEO:**

a. **General Rule.** Except as provided in this standard, an Accredited PEO shall not be an Affiliate with a non-Accredited PEO.

b. **Notice Requirements.** An Accredited PEO shall provide written notification to ESAC within ten (10) business days of the effective date of any transaction in which the Accredited PEO becomes an Affiliate with a non-Accredited PEO. Within ten (10) business days of the effective date of such a transaction, such Accredited PEO shall notify its affected clients of the transaction in a form satisfactory to ESAC and shall provide ESAC with evidence satisfactory to ESAC that such notice was sent to clients. A client of the Accredited PEO shall be treated as an affected client, if as a result of the transaction, either the ownership control of the Accredited PEO has changed or the services provided to such clients have changed materially or are reasonably expected to change materially in the foreseeable future.

c. **Acquisition by Accredited PEO, Affiliate or Controlling Person.** If the transaction is an acquisition, directly or indirectly, by (I) the Accredited PEO, (II) an Affiliate of the Accredited PEO, or (III) a Controlling Person of the Accredited PEO of a substantial interest in a non-Accredited PEO, substantially all of the assets of a non-Accredited PEO, or a transaction having similar effect, the following provisions shall apply:

i. **Initial Required Actions.** Within thirty (30) days of the effective date of such a transaction, such Accredited PEO shall:

1. Remit to ESAC an expense reimbursement fee for each separate non-Accredited PEO that became an Affiliate of the Accredited PEO as a result of the transaction and a Controlling Person fee for each new Controlling Person; and

2. Provide notice of any changes in Controlling Persons with the submission of applications for any new Controlling Persons; and

3. Provide ESAC the terms of the transaction and information concerning any new Affiliates of the Accredited PEO on such form as ESAC may prescribe.

ii. **Transactions in which non-Accredited PEOs Cease to Exist.** If the merger of an Accredited PEO and one or more non-Accredited PEOs, or the acquisition of the assets of one or more non-Accredited PEOs by the Accredited PEO, or a transaction that otherwise has the result that after the transaction, there are no non-Accredited PEOs that are Affiliates of the Accredited PEO the Accredited PEO shall:

1. Merge or co-mingle any of the financial affairs of the non-Accredited PEO into the Accredited PEO as of the effective date of the transaction, and, no later than 90 days after the effective date of the transaction, the Accredited PEO shall submit a pro-forma balance sheet and computation of Adjusted Net Worth, Working Capital, and Quick Working Capital, indicating the impact of the merger on its financial position as of the effective date of the transaction. Subsequent financial statements for the Accredited PEO shall be submitted at the time required by accreditation maintenance procedures.

2. Bring the affairs and operations of the merged non-Accredited PEO into compliance with ESAC operating standards not specifically required by applicable state or federal laws within 12 months following the effective date of the transaction.

iii. **Transactions in which non-Accredited PEOs Continue to Exist Post-Transaction.** If one or more non-Accredited PEOs are Affiliate(s) of the Accredited PEO after the transaction:

© 2016 National Association of Insurance Commissioners

1. The Accredited PEO shall cause each non-Accredited PEO that is an Affiliate of the Accredited PEO to apply for accreditation within 90 days of the effective date of the transaction;

2. Until each non-Accredited PEO that is an Affiliate of the Accredited PEO becomes accredited, the Accredited PEO shall:

   a. Continue to operate as a separate Entity with respect to each such non-Accredited PEO;

   b. Market and provide its services under a separate and distinct trade name from each such non-Accredited PEO and not allow any non-Accredited PEO to use the trade name of the Accredited PEO in any manner in sales and marketing or in client service or otherwise use the name of the Accredited PEO in a manner that implies that such Entities are affiliated;

   c. Not guarantee or otherwise share in or be responsible for the liabilities of any non-Accredited PEO;

   d. Not participate in any benefit or group workers' compensation insurance policy or plan held, sponsored or co-sponsored by any non-Accredited PEO or in which any non-Accredited PEO also participates, nor allow any non-Accredited PEO to cover clients or worksite employees by a workers' compensation policy or plan, a benefit plan or group insurance program sponsored or co-sponsored by the Accredited PEO; and

   e. Not engage in the transfer of clients from Accredited PEOs to any non-Accredited PEO or vice versa or allow a client obtained by either of the Entities to be signed or serviced under a PEO arrangement with the other Entity.

3. In the event any non-Accredited PEO does not become accredited within 180 days from the effective date of the transaction, the Accredited PEO must either (i) cease to be an Affiliate of the non-Accredited PEO, or (ii) cease to be an Accredited PEO as of the expiration of such 180 day period.

d. **Acquisition of Controlling Interest in Accredited PEO by non-Accredited PEO, its Affiliate, or Controlling Person(s) and Other Transactions not Described in Paragraphs 13b and c.** If the acquisition of a controlling interest in an Accredited PEO by a non-Accredited PEO, its Affiliate or Controlling Person(s), or any other transaction not described in paragraphs 13b and c results in one or more non-Accredited PEOs becoming an Affiliate of the Accredited PEO, the following provisions shall apply:

   i. **Initial Required Actions.** Within thirty (30) days of the effective date of such a transaction, such Accredited PEO shall:

      1. Remit to ESAC an expense reimbursement fee for each separate non-Accredited PEO that became an Affiliate of the Accredited PEO as a result of the transaction and a Controlling Person fee for each new Controlling Person;

      2. Provide notice of any changes in Controlling Persons with the submission of applications for any new Controlling Persons;

      3. Provide ESAC the terms of the transaction and information concerning any new Affiliates of the Accredited PEO on such form as ESAC may prescribe; and

      4. Provide ESAC with security in a form acceptable to ESAC, determined in its sole discretion, in an amount equal to the amount of financial assurance provided by ESAC to the clients and employees of the Accredited PEO, which security shall remain in effect until such time as all non-Accredited PEOs that are Affiliates of the Accredited PEO have become accredited.

   ii. **Additional Requirements.** The following provisions shall apply as set forth below:

      1. Each non-Accredited PEO that is an Affiliate of the Accredited PEO shall apply for accreditation within 90 days of the effective date of the transaction;

      2. Until such time as each non-Accredited PEO that is an Affiliate of the Accredited PEO becomes accredited, the Accredited PEO shall:

         a. Continue to operate as a separate Entity with respect to each such non-Accredited PEO or an Affiliate of any non-Accredited PEO, which shall prohibit without limitation, commingling funds of the Accredited PEO with a non-Accredited PEO or an Affiliate of any non-Accredited PEO;

© 2016 National Association of Insurance Commissioners

withdrawal of funds of the Accredited PEO by a non-Accredited PEO or an Affiliate of any non-Accredited PEO; and the transfer of assets by the Accredited PEO to or for the benefit of a non-Accredited PEO or an Affiliate of any non-Accredited PEO;

b. Make from its own accounts all payments of employment taxes, employee benefit premiums and contributions, and workers' compensation premiums of the Accredited PEO directly to the taxing authority, insurance carrier or plan administrator, as the case may be;

c. By the 20th day of the following month, provide ESAC with a monthly certification signed by all Controlling Persons and a verification by an independent CPA of the timely and accurate payment of all payroll taxes, employee benefit contributions and insurance premiums of the Accredited PEO in a manner acceptable to ESAC;

d. Market and provide its services under a separate and distinct trade name from each such non-Accredited PEO and not allow any non-Accredited PEO to use the trade name of the Accredited PEO in any manner in sales and marketing or in client service or otherwise use the name of the Accredited PEO in a manner that implies that such Entities are affiliated;

e. Not guarantee, assume or otherwise share in or be responsible for the liabilities of any non-Accredited PEO or an Affiliate of any non-Accredited PEO;

f. Not participate in any benefit or group workers' compensation insurance policy or plan held, sponsored, co-sponsored, issued or provided by any non-Accredited PEO or an Affiliate of any non-Accredited PEO or in which any non-Accredited PEO or an Affiliate of any non-Accredited PEO also participates, nor allow any non-Accredited PEO or an Affiliate of any non-Accredited PEO to cover clients or worksite employees by a workers' compensation policy or plan, a benefit plan or group insurance program sponsored or co-sponsored by the Accredited PEO;

g. Not engage in any merger, combination or similar transaction in which the separate legal existence of the Accredited PEO ceases;

h. Not engage in the transfer of clients from Accredited PEOs to any non-Accredited PEO or an Affiliate of any non-Accredited PEO or vice versa or allow a client sold by either of the Entities to be signed or serviced under a PEO arrangement with the other Entity; and

i. Comply with all other *Standards* and *Procedures* required for maintaining accreditation, including the timely submission of any and all information requested by ESAC regarding Affiliates and Controlling Persons of Affiliates.

3. In the event any non-Accredited PEO that is an Affiliate of the Accredited PEO does not become accredited within 180 days from the effective date of the transaction, the Accredited PEO must either (i) cease to be an Affiliate of non-Accredited PEO, or (ii) cease to be an Accredited PEO on the expiration of such 180 day period.

iii. **Cessation of Accreditation.** If a transaction involves the merger of an Accredited PEO into another entity other than an Affiliate or a transaction having a similar effect, the Accredited PEO shall cease to be accredited on the effective date of the merger. Similarly, if the PEO ceases to do business because it has sold all or substantially all its assets, the Accredited PEO shall cease to be accredited on the effective date of the sale.

14) **Reportable Practices:** An Accredited PEO shall not engage in a legal, financial or operational practice ("Practice") that has been designated as a "Reportable Practice" by ESAC, unless the Accredited PEO provides written evidence acceptable to ESAC in its sole discretion that such Reportable Practice as practiced by the PEO is not reasonably likely to result in a material risk to the financial or operational viability of the Accredited PEO. An Accredited PEO shall have the responsibility to provide timely written notice to ESAC of any "Reportable Practice" in which the Accredited PEO engages or plans to engage.

Where a question of law is involved, acceptable evidence may include a written opinion of a qualified legal counsel, acceptable to ESAC in its sole discretion, which specifically opines that it is more likely than not that the Reportable Practice complies with Applicable Law. At a minimum the opinion must: (i) be addressed to the Accredited PEO or to ESAC; (ii) be written on the letterhead of qualified outside legal counsel engaged in the practice of an area of law specifically applicable to the Reportable Practice in question; and (iii) set forth in reasonable detail the assumed facts upon which the opinion is based and an analysis of the Applicable Law as it relates to the Reportable Practice as practiced by the Accredited PEO. "Applicable Law" shall include (i) an

© 2016 National Association of Insurance Commissioners

existing statute of a jurisdiction to which the Accredited PEO is subject, (ii) a regulation or ruling of an agency with regulatory authority governing the PEO or the Reportable Practice, or (iii) a reported decision of a court of competent jurisdiction.

A Practice shall be designated as a Reportable Practice by ESAC's Board of Directors if the Board determines in its sole discretion that the Practice: (i) potentially represents a material risk to the safety and financial soundness of an Accredited PEO or a material risk to ESAC's financial assurance program and (ii) is not otherwise specifically covered by another ESAC standard. ESAC's determination that a Reportable Practice is or is not reasonably likely to result in a material risk to the financial or operational viability of the Accredited PEO shall in no way be considered or interpreted as an endorsement of or rejection of the Reportable Practice.

15) **ESAC Client Assurance Program Participation Required:** An Accredited PEO shall participate in the Client Assurance Program by executing a Participation Agreement (Exhibit A, as may be amended from time to time) and shall maintain with ESAC a current list of all clients, updated at least monthly, including such information as ESAC shall require, to enroll clients in the Client Assurance Program and provide information required by state licensing and registration. All clients reported to ESAC shall automatically be covered by the Client Assurance Program so long as such client(s) shall remain a client of the Accredited PEO.

16) **Internal Controls:** An Accredited PEO shall establish and maintain adequate internal controls as reasonably required to prevent acts of infidelity by either owners or employees and to maintain its financial and operational integrity.

17) **Record-Keeping Practices:** An Accredited PEO shall be able to provide to regulatory agencies in each applicable jurisdiction and to insurance carriers the following minimum information upon request:

    a. The name, address and tax I.D. number of any client added or terminated within 10 business days, or as required by state law.

    b. Payroll data by client, client SIC number, and workers' compensation classification code.

    c. A listing of all worksite employees covered by workers' compensation insurance by client worksite location and by classification code.

    d. Workers' compensation certificates of insurance, or certificates of alternative coverage where permitted by state law.

© 2016 National Association of Insurance Commissioners

AN ACT concerning insurance.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Insurance Code is amended by adding Section 155.44 as follows:

(215 ILCS 5/155.44 new)

Sec. 155.44. Financial requirements; large deductible agreements for workers' compensation insurance.

(a) An insurer shall:

(1) require full collateralization of the outstanding obligations owed under a large deductible agreement by using one of the following methods:

(A) a surety bond issued by a surety insurer authorized to transact business by the Department and whose financial strength and size ratings from A.M. Best Company are not less than "A" and "V", respectively;

(B) an irrevocable letter of credit issued by a financial institution with an office physically located within the State and the deposits of which are federally insured; or

(C) cash or securities held in trust by a third party or by the insurer and subject to a trust

agreement for the express purpose of securing the policyholder's obligation under a large deductible agreement, provided that if the assets are held by the insurer those assets are not commingled with the insurer's other assets; and

(2) limit the size of the policyholder's obligations under a large deductible agreement to no greater than 20% of the total net worth of the policyholder at each policy inception, as determined by an audited financial statement as of the most recently available fiscal year end.

© 2016 National Association of Insurance Commissioners

(b) As used in this Section, "insurer" means any insurer authorized to issue a workers' compensation policy covering risks located in this State that has an A.M. Best Company rating below "A-" and does not have at least $200,000,000 in surplus.

(c) As used in this Section, "large deductible agreement" means any combination of one or more policies, endorsements, contracts, or security agreements which provide for the policyholder to bear the risk of loss of $100,000 or greater per claim or occurrence covered under a policy of workers' compensation insurance and which may be subject to the aggregate limit of policyholder reimbursement obligations.

(d) Except when approved by the Director of Insurance, any insurer determined to be in a financially hazardous condition pursuant to Article XII 1/2 or XIII of this Code by the Director of Insurance in this State or the equivalent in any

other state is prohibited from issuing or renewing a policy that includes a large deductible agreement.

(e) This Section applies to large deductible agreements issued or renewed by any insurer on or after January 1, 2016.

Section 99. Effective date. This Act takes effect on July 1, 2015.

M