

GUIDELINES FOR THE FILING OF WORKERS' COMPENSATION "LARGE DEDUCTIBLE" POLICIES & PROGRAMS

Background: For an exhaustive treatment of large deductible workers' compensation insurance, see the NAIC/IAIABC white paper, *Workers' Compensation Large Deductible Study*. The intent of these guidelines is to give states suggested approval guidelines for large deductible policies and programs that are consistent with that detailed study, and to give a few comments on the reasoning behind some of them. Unfortunately, the *Large Deductible Study* has become dated in some respects (TPA-related matters being the prime example), which means that the reader should supplement that background material with a review of relevant NAIC activity since then.

Status of these "Guidelines": During the time that these guidelines were under development, the NAIC decided that issues previously being addressed through the adoption of model laws and regulations would instead be addressed by the adoption of "guidelines" if there was not a widespread feeling among NAIC membership that the NAIC should strongly encourage adoption by the states of the law or regulation on a uniform basis. Accordingly, many items that were previously under development as model laws or regulations were reclassified as "guidelines." This document, however, was never intended for adoption as a regulation or law ("model" or otherwise). Rather, it was (and is) intended to be adapted by the individual state to its laws and then to become part of the state's (often informal) set of published approval standards. While parts of this document may cause a state to consider law changes, no attempt is contained herein to draft any suggested statutes or regulations.

Conformance to State Laws: As referenced in the preceding paragraph, the suggested requirements will need to be modified by individual states as necessary to conform to specific state laws. For instance, some states have laws that restrict the eligibility of some employers for these programs, or that prescribe deductible amounts, or that require specific forms, or that require or prescribe collateralization. Particularly in light of the disfavor with which so-called "desk drawer rules" are viewed, individual states are encouraged to add or delete material from this document in order to make their own review guidelines consistent with the individual state's laws. Each state is then encouraged to make its version of this document freely available through whatever means that the state uses to communicate its approval standards.

Situations in which these guidelines are most likely to require amendment include (a) if state law requires the employer to post collateral in order to obtain large deductible coverage; (b) if state law allows insured employers to self-administer claims or to have any formal right to deny or protest claims; (c) if state law includes PEO provisions that may require amendment of these guidelines where they refer to a PEO; (d) if state law restricts the sale of large deductible coverage to employers of a minimum size or has other requirements of a similar nature, (e) if state law has rate filing requirements or restrictions on allowable rates, and (f) if state law has provisions relating to TPAs, which are likely to vary from state to state especially as/if/when TPA-related laws are revised to recognize workers' compensation. This list is not intended to be all-inclusive. Typically, states are well aware of unique provisions in their laws that would give rise to exceptions.

Deductible size: These approval standards and other requirements have only been written to apply to so-called "large" deductibles, not to small deductibles allowed (or required in some cases) as an option by some states' laws. While there is no attempt in this document to distinguish these "small" deductibles from "large" deductibles, there is generally a clear distinction in the marketplace. "Small" deductibles are typically no more than \$5000 or \$10,000 and may be for medical losses only. "Large" deductibles are typically at least \$100,000 (although some states have approved "large" deductibles as low as \$25,000), and \$1,000,000 deductibles are not uncommon. They will always or almost always apply to combined medical and indemnity losses.

Rates & statistical reporting: These guidelines do not address rate filing requirements. Each state will need to review its own laws to determine applicable rate filing standards and requirements. These guidelines do,

however, recognize that accurate statistical reporting is essential to the integrity of the ratemaking process, and one of the objectives of these requirements is to ensure that experience incurred under these policies can be reported to the NCCI or other state bureau on a basis that preserves information on classifications, payroll and total losses.

– Suggested Filing Requirements –

- (1) Insurers are neither obligated to offer large deductible policies, nor to offer them to all customers in all amounts that the insurer might file or that these guidelines might allow.
- (2) Under a large deductible policy, the insurer (or TPA on its behalf) must handle the defense and settlement of all claims as if no deductible applies. The policy must provide that the insurer shall pay all deductible amounts directly to the person or health care provider entitled to the benefit pursuant to the law, with deductible amounts paid by the insured employer to the insurer or its TPA. The insurer's obligation to pay claims shall not be eliminated if the employer fails in its obligations to reimburse the insurer or its TPA. Termination of the policy only terminates the insurer's obligation for injuries incurred after the policy period, and shall not affect obligations for injuries prior to the cancellation or expiration of the policy.
- (3) All costs borne by the employer must be in the form of payments to the insurer or its TPA. The employer must not pay anything to claimants, doctors, attorneys or any entity other than the insurer or its TPA to settle workers' compensation obligations or to pay for associated settlement costs. *(State exceptions may occur with "first aid" costs or in the occasional instance where the policyholder is a hospital or has the capability to provide emergency on-site treatment for injuries.)*
- (4) Rights of the employer to contest, control, approve or disapprove claim settlements must be consistent with those allowed by state insurance and workers' compensation laws. In many or most states, such rights are limited or do not exist. Provisions that appear to give the employer additional rights to control, approve or disapprove payments or settlements should not be allowed when they conflict with state law, either in policies or in TPA agreements. *(Explanation: Applicability of these statements will depend upon state law. In a number of states, the workers' compensation law gives the employer some ability to dispute a workers' compensation claim that its insurer intends to pay. Even in such states, however, an endorsement to this effect is usually unnecessary as this right vests to the employer without any policy endorsement being necessary. As such, provisions of this nature are generally discouraged because, if they are not illegal, then they are probably unnecessary.)* The comments in this section are not intended to preclude an insurer or TPA from agreeing with the policyholder to provide detailed or extensive claim reporting or notification procedures, as long as those procedures are not inconsistent with state law. It is not unreasonable to expect large policyholders to want more frequent reporting with greater detail than is common with small policyholders that only have infrequent claims.
- (5) Given the likelihood that many policyholders will not have a detailed knowledge of state law and interpretations thereof, it is strongly advisable that contracts include specific language complying with items (2), (3) and (4), to ensure that these items are clearly understood, rather than relying on the statutory obligations of the insurer or a generic conformance clause.
- (6) Prompt payment of all amounts owed to the insurer is one of the policyholder's most important contractual obligations. Some of the states that allow relatively quick (e.g., ten days) cancellation for nonpayment of premium explicitly recognize nonpayment of a deductible reimbursement as a ground for accelerated cancellation on the same basis. In states without explicit provisions in their laws to

address nonpayment of deductible reimbursements, this should be viewed as a ground for cancellation under laws permitting cancellation for “substantial breach of contractual duties” or similar statutory language. It is also recommended that states allow the insurer to have the right to offset unpaid deductible amounts against unearned premiums, if any, in the event of cancellation of the policy.

- (7) Coverage written under these forms is customarily considered workers’ compensation coverage for Annual Statement reporting, workers’ compensation law, and insurance laws. It is not necessary that these items be mentioned in a manual page for the insurer, but nothing should be approved that states or suggests otherwise.
- (8) Typically, large deductible policies will be developed by the attachment of a large deductible endorsement to an otherwise standard workers’ compensation policy. Large deductible policies are still considered statutory policies (as opposed to excess workers’ compensation policies, which are written for approved self-insureds, and are typically not considered statutory policies), so the large deductible endorsement must not purport to negate any statutorily required provisions. Should an insurer file an entire large deductible *policy form*, instead of an endorsement, the regulator must take care to see that all statutory provisions are included.
- (9) The policy must specify the nature of the losses for which the employer must reimburse the insurer, or reimburse the TPA on the insurer’s behalf. The deductible amount may be any one of the following:
 - (a) Benefits only;
 - (b) The sum of benefits and actual LAE or ALAE; or
 - (c) Benefits only, but the employer is liable to reimburse actual LAE or ALAE in addition to the deductible applying to the benefits.
 - (d) Any reasonable pro-ratio of LAE or ALAE between the insurer and the employer is acceptable.

Employers’ liability coverage may be included with any of the above. *(Some state laws may not allow all of these options and this language will then need to be restricted accordingly.)*

- (10) The policy must specify whether the deductible is per-person or per-accident. The most common form of deductible (per-accident for accidental injury and per-person for disease) is acceptable; unique proposals should be considered on their merits.
- (11) Even in states that otherwise exempt large deductible workers’ compensation insurance from rate filing requirements, manual pages and/or other documentation should be filed to assure that policies are written in accordance with these guidelines and any specific state laws. Individual risk filings should not be necessary and are not recommended.
- (12) Some states have laws, regulations or other practices that exempt policyholders of a certain size or premium from various aspects of form or rate regulation. In these states, it is likely that most or all large deductible policyholders will qualify. When exemptions from form approval apply, care should be taken that these exemptions may not be used to evade or alter the statutory requirements for workers’ compensation policies. In particular, policyholders and insurers may not be given the ability to reduce benefits in any way, and employers may not be given rights to adjust or administer claims, nor to control a TPA or adjuster, except to the limited extent as may be permitted under Items 25 and 26.

This recommendation is not intended to imply that that states should limit large risk flexibilities otherwise granted for workers' compensation rates or premium payment provisions. To the contrary, Item 21 in these guidelines recommends that states grant policyholders and insurers considerable flexibility in the negotiation of collateral and deposit arrangements.

- (13) Policy rating must preserve and use usual payroll and classification information and require the use of audited payrolls after policy expiration. In other words, rating that does not use standard workers' compensation rating classifications and actual audited payrolls should not be allowed. The reason for this is to preserve data and data quality associated with these policies. Although it is typically not necessary for the large deductible endorsement or manual pages to mention this, all deductible losses, including those that are reimbursed by the employer, are still reported to the bureau and used for experience rating purposes. Anything in a filing that appears to allow the non-reporting of losses should be disapproved.
- (14) An insurer may offer an endorsement to limit the aggregate amount to be reimbursed by the employer under the deductible provision due to claims arising during the policy period. This coverage must be included on the same policy as the rest of the workers' compensation coverage, and not offered as a separate policy.

The reason for this recommendation is that this separate policy would probably be reported as liability insurance and not as workers' compensation, and various assessment bases for residual markets and other compensation-specific assessments would be adversely and unfairly affected. It follows that exceptions to this recommended disapproval policy could be considered if RMLs are minimal or not applicable for a state, and the state has assessment mechanisms for workers' compensation that use something other than net premiums. Exceptions might also be considered for so-called "basket aggregate" policies when the rules filed with the program provide assurance that the net workers' compensation large deductible premium will be much larger than the charge for expected workers' compensation losses under the "basket aggregate" policy.

- (15) If aggregate stop-loss protection is provided, the policy must provide for proration of any aggregate retention limits in the event of cancellation by the insurer unless the aggregate limits are a function of the audited exposure. However, the policy may state that proration of the aggregate retention limit will not occur in the event of cancellation due to nonpayment or other serious breach of contract. These "serious breaches" would need to be detailed in the cancellation provisions. (*Explanation: Without this provision, an insurer that cancels a policy mid-term, as it neared the aggregate limit, would avoid providing the coverage that the employer had paid for when it purchased an aggregate maximum limit.*)
- (16) The manual rules must state that coverage is to be provided only when the financial impact of the retention amount (that is, the effect of the deductible, subject to any aggregate provided on the policy) will remain uninsured by the policyholder. That is, anything that appears to involve so-called "deductible reimbursement policies" or that otherwise insures these same exposures should be questioned and not approved. "Deductible reimbursement policies" applying to workers' compensation insurance should also be disapproved, but fully addressing this problem goes beyond the scope of the workers' compensation form approval process, as insurers in the past have used surplus lines or health insurers to write this coverage to avoid this prohibition. The application of this section is not, however, intended to prohibit:
- (a) An employer from procuring unreinsured deductible reimbursement insurance from a valid captive insurance arrangement,

- (b) A bona fide loss portfolio transfer policy, where an insurer picks up a book of unpaid past incurred claims on a one-time basis, or
- (c) A surety bond purchased at arms' length from an unaffiliated insurer used to guarantee reimbursement of claims paid by the insurer under a large deductible arrangement. (A surety bond of this nature purchased from an affiliated insurer would not be a meaningful transfer of credit risk and could be used to "play games.")

(Explanation: The story here is a bit complex, but the primary reason for this guideline is to avoid arbitrage, where an insurer and/or employer may be able to obtain a more favorable treatment for taxes or assessments by using the large deductible policy as a façade. Other reasons for disapproval of this practice includes the harm that this practice can have on financial and statistical reporting, and the potential use of this device as a means to avoid regulation. Readers who are not familiar with the reasons why these situations need to be avoided are advised to read the relevant sections of the full Study.)

- (17) Provisions that would allow the insurer to cancel the large deductible endorsement, but otherwise keep the policy in force and cause the policy to revert to a "guaranteed cost" contract, should be unacceptable unless there is agreement from the employer. However, provisions similar to retro provisions dealing with employer insolvency may be included in the policy, and can be extended to nonpayment situations. Such provisions could allow an insurer to value all claims on an incurred basis for the purpose of making a claim against a financially distressed employer's LOC, surety bond, or receiver.
- (18) (This section only applies to states that utilize loss-based assessments.) Difficulties are likely to arise when an insurer wishes to recoup loss-based assessments from the policyholder on a dollar-for-dollar basis. While this is fair in principle, it can become very complicated to apply correctly, especially if such assessments are not uniform percentages collected year after year. For an assessment on paid losses that is levied on a sporadic basis, a proper assessment technique would require:
 - (a) The insurer would wait until after the end of each year – which would be after the time that it would have otherwise billed for most of the losses,
 - (b) The insurer would then determine whether a loss-based assessment is being made,
 - (c) The insurer would then apply the tax rate to all paid losses during the prior year and,
 - (d) Then, long after the policyholder has reimbursed the insurer for the losses, the insurer would bill for the tax.

Thus, for states where assessments on paid losses are not the same percentage year after year, it would be much easier to simply add an additional amount to the premium for an average amount of loss-based assessments and not charge for actual assessments. In addition to being reasonably fair, this procedure will also be far simpler from a billing and statistical reporting standpoint.

- (19) The premium tax status of policyholder payments (i.e., whether they are considered taxable as premiums or not) is the subject of state law or interpretations of state law, and should typically not be part of a rate or form filing. Accordingly, reviewers should be alert to anything in a filing that appears to be an attempt to shelter payments by the policyholder from premium taxes or workers' compensation assessments. The total cost to the policyholder of the set of agreements constituting the large

deductible arrangement is premium, except to the extent that the law clearly provides that certain payments may legally be considered as something other than premiums. This exception will almost always include reimbursements for losses paid. In some states, it may also apply to loss adjustment and other administrative expenses paid to the TPA, but it will rarely, if ever, include payments such as reimbursements of taxes or assessments by the policyholder. Reports have been received, however, of policyholders seeking to shelter other payments, and analysts should be aware of this possibility within the context of their specific state's laws.

- (20) A few states require insurers to obtain collateral from policyholders to assure that the insurer will eventually be reimbursed as losses are paid. Even in states without such requirements, however, it is an unusual account where the insurer does not require collateral of some nature to assure that it will be reimbursed for loss payments. The reason for these requirements and practices is that, if the policyholder becomes bankrupt, the insurer will still be obligated to provide full statutory benefits to injured workers, even if it will not be reimbursed for those claim payments. Thus, it is only prudent for an insurer to protect itself against the possibility of policyholder insolvency or noncompliance.

Collateral and prefunding arrangements, when they exist, are a substantial part of the total agreement between the policyholder and the insurer. A collateral agreement makes no sense without an accompanying coverage agreement, and the insurer will usually not agree to provide coverage without an accompanying collateral agreement. It can therefore be argued that the entirety of such collateral agreements should be considered part of the insurance policy and thus be subjected to state laws requiring the filing of insurance policies and all endorsements and amendments thereto.

Deeming the collateral agreements to be subject to filing requirements would, however, be awkward. Collateral agreements will often involve a third party (e.g., a bank) and may sometimes relate to more than a single workers' compensation policy written for a period of one year. The same statement is true for prepayment arrangements.

It is therefore recommended, instead of applying state form filing laws to the collateral or prepayment agreements themselves, that when such arrangements exist, a reference to the insurers' collateral or prepayment requirements should be a required part of the large deductible endorsement. The primary reason for this recommendation is practicality, and not a lack of regulatory authority in this area. This recommendation differs from the *Large Deductible Study*, which would have applied form filing laws to collateral agreements, though frequently subject to large risk exemptions.

While the non-filing of collateral agreements should generally cause few problems, the situation would be very different if an insurer attempted to change premium calculations or to amend cancellation or other policy provisions through provisions contained in collateral agreements – or in any other side agreement, for that matter. The policy should constitute the entire contract of insurance between the policyholder and the insurer, and an allowance for separate collateral agreements can only be acceptable if insurers keep these agreements limited to the details of handling the policyholder's collateral.

In summary, as long as no problems arise to cause the regulator to change this approach, this document recommends:

- (a) Exempt the collateral agreement from form filing requirements, regardless of the size of risk, but only if the scope of the collateral agreement is narrowly confined to the handling and maintenance of collateral. If the insurer wants the collateral agreement to cover more than that, then it will need to be filed.

- (b) When collateral is required, the large deductible endorsement must refer to the existence of the collateral agreement and provide that collateral must be maintained in accordance with that agreement.

At this writing, problems and abuses in this area do not appear to be a subject of significant complaints. Should problems develop in the future, or should states have requirements or limitations regarding collateral agreements that they wish to apply, then the best recourse may be a requirement for these to be mentioned in the insurer's accompanying manual pages. Rulemaking authority may be another possible alternative to the application of form filing laws.

- (21) As just discussed, it is common and prudent for an insurer to require collateral when writing a large deductible policy. The amount, adequacy, and especially any lack of collateral are important concerns for actuaries and financial examiners that are evaluating the liabilities of an insurer. Notwithstanding the importance of collateral, this document recommends that states not require insurers' large deductible filings to include a requirement that collateral be posted unless the state has a law to this effect. Presumably, an insurer would only write a large deductible account without collateral in return for a higher price or for accounts (e.g., a governmental entity) where the chance of default was believed to be remote. This is not to discourage an insurer's filing from including a requirement for collateral, only to note that such a requirement should not be a condition for approval unless the state has a law to this effect.
- (22) Even when not required by state law, states may wish to consider minimum standard premium size, payroll, net worth, or other provisions of this nature for risks to be written on a large deductible policy. If states implement such minimums, it is recommended that they also consider accompanying exceptions for policyholders that post adequate collateral (e.g., no less than the amount of the deductible, although insurers may routinely require greater amounts of collateral).
- (23) If the insurer making the large deductible filing is owned or controlled by a large employer in the state, then careful consideration should be given to disapproving any large deductible filing for the insurer unless its manual rules include a provision that it will not write large deductible coverage for that employer or an affiliated entity without adequate, high-quality security. The reason for this admonition is that it would otherwise be possible for the insurer and the employer or affiliated entity to accumulate substantial unfunded liabilities and, should the employer become bankrupt, then the affiliated insurer would likely become bankrupt as well, leaving the state's guaranty fund to pay the losses. This potential concern may be especially strong if the entity involved is a PEO, as the exposure of a PEO can change significantly on short notice when clients are added, a bankrupt PEO's assets are likely to fall well short, and the client employers will typically not be (and should not be) obligated to reimburse the guaranty funds for obligations of the PEO's estate.
- (24) As referenced above, unique issues arise when the policyholder on a large deductible policy is a PEO. While agreements between the PEO and its clients are beyond the scope of a policy filing or the filing of manual rules, nothing contained in the policy or in the manual rules should permit or imply that, in the event that the PEO becomes unable to reimburse losses paid by the insurer, that the clients of the PEO will then become liable to reimburse these losses. This would not be appropriate because of the nature of the PEO-client relationship and because individual clients of the PEO are typically not going to be of sufficient size that they can assume the size of losses that are involved with a large deductible.
- (25) Policies written for a policyholder with a contract or agreement with a TPA must be endorsed to reflect the existence of this agreement. At a minimum, this endorsement must: name the TPA; include the responsibility (if any) of the policyholder to pay the TPA; identify the insurer's ability to terminate the

Guidelines for the Filings of Workers' Compensation
Large Deductible Policies & Programs

TPA agreement; state that the policyholder cannot switch TPAs without the prior consent of the insurer; and provide for actions in case of nonpayment or policyholder default.

- (26) The insurer must still be responsible for setting claims handling standards if it uses a TPA or an independent adjuster to handle claims. Except in states that provide that insured employers may adjust claims, a large deductible policy should not be used to give the employer the ability to adjust its own claims. (Limited exceptions may be considered with the agreement of the state's workers' compensation commission, but it is unlikely that state workers' compensation commissions will have much interest in approving exceptions. A possible exception may involve policyholders that had recently been approved self-insurers, but are now purchasing insurance. The workers' compensation commission may approve such an exception to ease the transition for the formerly self-insured employer.)

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

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