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The Role of Large Deductible Policies for PEO’s in the Failures of Small Workers’ Compensation Insurers

By James R. Jones CPCU, AIC, ARM, AIS

Executive Director, Katie School of Insurance & Financial Services at Illinois State University

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Executive Summary

This study examines the way in which large deductible plans in some instances were abused by some employers at the expense of injured workers. It also considers owner abuse of these plans. Additionally, the failure of insurers, auditors, and actuaries to understand the credit risk of large deductible plans, which are inadequately collateralized, contributes to these problems. Studies conducted by regulators, legislators and other experts are reviewed for this study. Recommendations are based on these prior studies, recent investigations of insolvencies, and an analysis of their causes.

An examination of the underwriting guidelines (detailed in this study) by well-known insurers illustrate that large deductible policies, involving professional employer organizations, can be underwritten responsibly and have sustainable profitability. However, the insurers featured in this study significantly deviated from responsible underwriting and claims administration standards, oftentimes for the benefit of owners, or managers, at the expense of workers and employers. The case studies included at the end of this paper of actual insurers, and the circumstances surrounding their failures, highlight the important causes of these insolvencies.

The study reveals that the financial problems of troubled insurers being supervised by state insurance departments, could be avoided through a better disclosures by auditors, better disclosure and understanding of

the credit risk by actuaries, more secure collateral, collateral that is more accessible to the insurer instead of the Managing General Agent, and better monitoring of the workers' compensation large deductible insurance claims within the deductible. Having better disclosure of the existence of these deductibles and their collateral through interrogatories in the insurance statutory accounting filings could assist the auditors, actuaries, and examiners in performing their work.

Regulatory and legislative actions may also be required to significantly reduce these insolvencies in the future. Smart regulation that reflects the already the disciplined approach taken by larger, well-managed insurers and PEOs, would be valuable, while not imposing onerous additional restrictions on responsible companies. The title of the study with the focus on large deductibles with PEOs by small insurers is a deliberate and an important distinction. The risk associated with a large deductible policy well-underwritten by a \$26 billion insure, that works with a well-managed PEO, is a completely different risk than a large deductible policy with poorly managed PEO, offered by an insurer with only \$200 million in surplus. The insolvencies examined since 2006 all involved insurers with less than \$500 million in surplus (below the current threshold for ORSA).

Why This Study Is Important

Workers' compensation insurance is designed to protect injured workers and their families from the financial consequences of workplace injuries. Unfortunately for thousands of these workers across the country, this protection is delayed or compromised by mismanagement and the questionable practices of some employers. Stakeholders adversely affected by this include injured workers and their families, taxpayers, employers, insurers, regulators, legislators, and state guaranty funds.

Society recognizes the need for workers to be able to promptly receive medical care to help them return to work, and wages to pay their families' living expenses. This system functions well. However, this study points out that recent insolvencies of small insurers have made this protection uncertain for many workers.

Insolvencies of workers' compensation insurers since 2007 affected more than 27,000 workers' compensation claims and may ultimately approach \$2 billion in losses. (Appendix A lists the workers' compensation insurers, the number of claims, the amount of loss reserved at time of insolvency, and the amounts paid or expected to be paid.). These claims came from workers at more than 4,000 employers doing business in nearly every state in the U.S.

Although this study did not undertake a determination of the causes of ALL of these insolvencies, the role of precipitous growth, especially through professional employer organizations (PEOs) and Managing General Agencies (MGAs), was found in many of these insolvencies, and turns out to be a statistically reliable predictor of failures. For example, there were more than 10,000 claims representing over \$508 million in unpaid compensation stemming just from the two cases highlighted at the end of this paper which involved PEOs, MGAs, generating precipitous premium growth. The unpaid claims of insolvent workers' compensation insurers not only affect the lives of those injured workers making claims, but all the employees of insolvent insurers and businesses that cannot continue their operations because of these failures. The cost of these insolvencies is eventually borne by the remaining insurers and their policyholders. As a result, the payments of guaranty associations for these losses, ultimately come at the expense of the public.

Every attempt was made to make this study factual and objective. However, the recommendations made in this paper may generate concerns among numerous professionals, regulators, associations, and companies because the causes of these failures have numerous antecedents.

Background of this Study

Following a series of workers' compensation insurer insolvencies related to large deductible plans, the National Conference of Insurance Guaranty Funds (NCIGF)—a non-profit, member-funded association that provides national assistance and support to the property and casualty guaranty funds located in each of the 50 states and the District of Columbia—saw a need for further study of the issue examining the underlying causes of these insolvencies. The NCIGF provided technical assistance and support for this study.

Workers' Compensation Insurance and Insolvencies

Workers' compensation insurance is a unique insurance coverage. Unlike other types of insurance, workers' compensation insurance is created by statute to provide prompt reimbursement of medical expenses and lost wages to injured workers, regardless of fault. Workers' compensation statutes were designed to provide a remedy for injured workers without the cost of proving liability under common law. Workers' compensation insurance provides certain and immediate relief to injured workers. Consequently, many of the defenses that an employer (and its insurer) might have, are not valid in workers' compensation claims.¹ Unlike other lines of insurance that place the burden of paying claims under a deductible amount squarely on the insured, laws require workers' compensation insurers to drop down and pay for claims within an insured's deductible amount if the insured does not pay or fails to reimburse the insurer for payment in accordance with contract terms.

The unique nature of workers' compensation means that there may be unique causes of workers' compensation insurer insolvencies. Although there are dozens of factors contributing to these insolvencies—ranging from poor corporate governance to regulatory oversight, which are all deserving of attention—the following factors (especially in combination) have been identified as having the potential to cause these workers compensation insurer insolvencies:

- Inadequate collateral posted by the employer using large deductible policies;
- Employers that control the claims handling for injured workers through Third Party Administrators where the insurer has limited access to claims information; and
- Cross-ownership of PEO employers and insurance companies used to provide workers' compensation to the PEO.
- Pursuit of aggressive growth strategies by insurers through MGAs and PEOs.

The following addresses each of these factors in detail.

Large Deductible Policies and Collateral²

Large deductible plans (typically plans with deductibles greater than \$500,000)³ are designed to give employers the ability to retain most of the risk related to paying workers' compensation benefits in exchange for greatly reduced insurance premiums, while still providing employees the certainty of insured benefits. A unique and important feature of a large deductible policy is that the workers compensation insurer retains the liability to pay claims from dollar one. It is different than excess insurance coverage with a self-insured retention amount,

¹ Principles of Workers' Compensation Claims, Jones 2nd Edition AICPCU

² This section regarding large deductible plans relies extensively on 1) The 2006 NAIC Workers' Compensation Large Deductible Study conducted by the NAIC/IAIABC Joint Working Group, and NAIC Guideline #1970 Guideline for Filing Workers' Compensation Large Deductible Policies and Programs. NAIC 2008

³ States define the term "large deductible" in different ways. In fact, some statutory definitions define it as \$5,000 per occurrence deductible. For purposes of this paper the term is used for deductibles that create credit risks to the insurer if the PEO becomes bankrupt.

which would only provide coverage beyond a specified amount of loss retained by the insured (the attachment point).

Employers can decide how much of the risk they want to retain and will negotiate the amount with an insurer, and can even negotiate the terms of oversight provided by the insurer with respect to the performance of its contractual obligations. With a large deductible policy, it is common to design the plan in a way that the employer would expect to be responsible for 100 percent of its claims in a typical year (assuming the actuarial assumptions hold up). This means that there is an (often undetected) credit risk if the employer does not have the financial wherewithal to pay the claims.

One of the reasons that employers choose large deductible plans over self-insurance is because self-insurance regulation imposes much more stringent requirements for securing payment of the claims, both in terms of the percentage and valuation of potential losses that must be secured by the employer as opposed to what is required under large deductible plans. It has been suggested in some studies that large deductible plans act, in some situations, as unregulated self-insurance where the insurers' underwriting guidelines take the place of the state's approval process for self-insurance. (Appendix B shows a comparison of the differences between self-insurance requirements and a large deductible plan in Florida.)

The high level of discretion in the use of large deductibles permitted for insurers and employers to negotiate things such as oversight, credit underwriting, the withholding of collateral and handling of claims, provides an opportunity for fraud and abuse. This occurs when insurers are mismanaged and overly focused on growth, and/or in situations where the insurer and employer are closely related parties.

What Happens to Claims When an Employer with a Large Deductible Fails?

Employers sometimes fail. Sometimes they fail because of mismanagement or changing market conditions affect their business model, and sometimes they fail by design. What happens when the employer, such as a PEO, with a large deductible policy, that was supposed to pay the claims within the deductible amount is no longer able to do so? Some of the following consequences may occur when large deductible policies do not function as designed:

- Claims payments for injured workers are delayed;
- Coverage gaps may develop;
- Insurers may suffer financial problems (as a result of paying for claims that they did not expect to pay and did not charge for in their premiums or hold sufficient collateral); and
- The administration of claims can become problematic if the employer had poor record keeping, and controlled the reserving for losses and payment of claims through a TPA.

When claims administration is controlled (nearly exclusively) by the employer, then important information about the claims and the liabilities of the insurer that is responsible for paying these claims is compromised. This information is essential for paying claims, reserving losses, appropriately pricing and rating risks, and for underwriting.

Although it may appear that the injured workers of failed employers are seamlessly protected by the insurer that then pays the claims owed by the employer that is no longer able or willing to pay, the reality is not so bright. Unpaid, or extensively delayed claims, following an employer failure, may occur for several reasons:

- 1) The insurer may not have easy access to the claim information to pay the claims. The claim information may be held with a third party administrator (TPA) that has no contract with the insurer, but only with the (now defunct) employer. This lack of control by the insurer is considered a significant issue by regulators and legislators who have studied the problem. Unfortunately, one motive for keeping the complete claims information away from insurers is to distort the loss picture and control their reported claim payouts and reserves through the control over the TPA. This lack of access prevents insurers from having a complete understanding of the liabilities incurred by the employer and, consequently, the potential for claims obligations that may have to be borne by the insurer. The case studies presented found employers with exceptionally low loss ratios for several years (which by itself is not unusual for large deductible workers' compensation programs during the first few years). However, these cases illustrate how precipitously losses can mount and quickly lead to bankruptcy.
- 2) Claim payments may be stopped because the employer stops paying the TPA for handling the claims.
- 3) Benefits checks may be issued but bounce because the employer stops funding the account (in the situation where the employer has agreed to pay claims from dollar one).
- 4) Even if the insurer had required the employer to set aside collateral to pay claims, access to that collateral may require litigation.
- 5) Even if the policy wording stipulates that the insurer pay claims directly, the reality may be much different. The NAIC Large Deductible Study found that side agreements between the insurer and the PEO employer, contradicted policy wording. For example a PEO sometimes designs the coverage using side agreements that allow for all claims administration to be made directly by employer, without insurer involvement, and work more like a self-insurance plan with an excess policy.

Finally, if the insurer is smaller and a significant part of its income comes from an employer with a large deductible plan (or several employers placed with the insurer by the same Managing General Agent (MGA) with the same inferior standards), then the insurer itself may not have sufficient capital to withstand the collapse of the employers. This occurred in many of the cases observed in this study, because these insurers did not collect the premiums to pay the claims, and also did not require and secure adequate collateral, or have access to the collateral posted by the employer (because of litigation or because it is being held by the MGA).

The Effect of Side Agreements on Data Collection with Large Deductible Workers' Compensation Insurance

The intention of insurance regulators and workers' compensation administrators is that the large deductible workers' compensation policies should provide employees with exactly the same coverage for accidents and injuries as policies that do not have deductibles. The reality is that *side agreements made outside of the policy contract may make these policies perform more like self-insurance with an excess policy*. The difference between large deductible policies and excess insurance is that with large deductibles the insurer is presumed to adjust the claims, report the loss data to statistical agents, and assume the risk of not being paid in a timely manner by the employer. With excess policies the insurer only steps in when the losses occur above the agreed-upon attachment point (losses in excess of preset amount). The underwriting would be different for these because the insurance exposure for the carrier is only above the specified amount. However, because of the side agreements made to allow the employer and its TPA to handle claims within the deductible, some insurers may underwrite large deductible policies in a similar fashion to excess policies. In doing this they often do not properly consider the credit risk that would normally be given considerable weight in underwriting and rating a large deductible policy. Unfortunately this credit risk is sometimes overlooked by actuaries providing their actuarial opinions and public auditors providing their opinions.

Most U.S jurisdictions follow ratemaking and data collection procedures that are similar to those utilized by the National Council on Compensation Insurance (NCCI). TPAs should, in theory, be as accurate and accountable for proper recording of workers' compensation data as insurers. The NCCI, and industry experts who have studied this issue have expressed concerns about improper data reporting when there is inadequate insurer oversight of the TPA⁴ (as is the case when the TPA reports to the employer instead of the insurer, which seems to be the case in many of the workers' compensation insurer insolvencies observed since 2007.) The consequence is that loss cost indications for classes with a large volume of large deductible experience will be understated, with the result that those classes without a large deductible experience will unfairly pay higher rates than their loss experience merits (because these class codes will be assigned a disproportionately larger share of the actual overall losses).

Apart from ratemaking, this data is used for safety monitoring, planning, and statistical and enforcement programs. Inaccurate reporting distorts data and discourages safety, and makes comparisons among states, or among classes, more difficult over time.

Special Considerations for PEOs and Large Deductible Policies

A **professional employer organization** (PEO) is a firm that provides a service under which an employer can outsource employee management tasks such as employee benefits, payroll and workers' compensation, recruiting, risk/safety management, and training and development. The PEO hires a client company's employees, thus becoming their employer of record for tax purposes and insurance purposes. The client then pays a fee for this service and "borrows" back its employees. Both employers have a relationship with the worker. This practice is known as co-employment. Unlike temporary or other employment staffing services, the PEO does not typically provide new workers to the client. The National Association of Professional Employer Organizations (NAPEO) defines co-employment as the contractual allocation and sharing of employer responsibilities between a PEO and its client. PEOs take on multiple and often very diverse risks. This is because PEOs can add and shed these risks during the policy period, without insurer approval. Consequently, the PEO model deserves special consideration when using large deductibles because the underlying risks, including credit risks, may change dramatically.

Although some PEOs have been questioned for dubious practices, responsible PEOs can provide valuable expertise in managing human resources that the small business could not ordinarily afford. According to the NAPEO, there around 700 PEOs operating in 50 states, with 2.5 million people involved in the PEO arrangements with employers. The average client is a small business with fewer than 20 employees. Through a PEO, the employees of small businesses gain access to big-business benefits such as retirement plans; health, dental, life, and other insurance; dependent care; and other benefits they might not typically receive as employees of a small company. PEOs continue to grow in popularity. A survey conducted by the Florida Association of Professional Employment Organizations in 2010 found that PEOs provided more than 69,000 companies with nearly 900,000 worksite employees, representing a payroll in excess of \$25 billion.⁵

One of the assertions made by PEOs is that they can help small businesses reduce their workers' compensation insurance costs.⁶ Competent PEOs achieve this by focusing on workplace risk management, safety programs and good human resources practices. Unfortunately, recent events suggest that some PEO owners do not achieve workers' compensation savings through value-added services, but instead use opaque, questionable, abusive and even illegal practices to limit their payments to workers.

⁴ Work Comp Large Deductible Study, NAIC 2006 p. 41

⁵ The Florida Association of Professional Employer Organizations (FAPEO) 2010 Census Brochure

⁶ <http://www.napeo.org/peoindustry/industryfacts.cfm>

As late as 2006, PEOs with large deductible master policies were considered by some regulators to pose few problems because it was believed that “one would not expect an insurer to consider issuing a large deductible policy to an outsourcing firm unless it had ironclad collateral and strict underwriting control over the outsourcing firm’s client base.”⁷ Since the time that opinion was written, several workers’ compensation insurers have become insolvent, including many insuring PEOs, where the collateral turned out to be illusory and the underwriting in soft markets led to weaker controls and less discipline by some insurers in underwriting PEOs.

As mentioned earlier, in a large deductible situation, the insurer provides more than just catastrophic reinsurance to the PEO. It is also accountable for guaranteeing first dollar workers’ compensation insurance coverage to each of the PEO’s injured workers. The insurer’s capital is on the line for all claims incurred by the PEO. As PEOs add and shed clients through various market cycles, the PEOs’ client businesses can be expected to change both in the size of their payroll and the nature of their (already heterogeneous) worksite operations and hazards. For PEOs operating under one master policy as the insured, taking on these new clients is tantamount to the PEO having the underwriting authority to bind new business coverage. Similar to a Managing General Agent (MGA), they have the “underwriting pen” (in insurance parlance). Exacerbating the problem is that they may also have the “claims pen” (either by controlling the claims reported to the TPA, or by controlling the TPA as a related entity.)

While responsible PEOs with sustainable business models will exercise discipline, the long tail nature of workers’ compensation coverage makes it attractive to gamblers who seek a quick return by underpricing the risk and then exiting the PEO business before the losses catch up to it. Some may even operate outright “Ponzi schemes” with illusory coverage where the client pays a fee to the PEO that includes insurance, but the PEO pockets the money and only pays for part of the claims before exiting and leaving the clients to pay for the claims.

This might be viewed as “just an employer problem or just the insurers’ problem” especially in the case of well-capitalized insurers that can absorb the loss without the risk of becoming insolvent. However, the insidious, devastating consequences of a PEO related insurer insolvency make it a matter of public interest. The insured workers’ claims are not seamlessly paid but instead incur delays and additional costs. The client loses all of the other services provided by the PEO as well as the workers’ compensation coverage. Client companies are forced to scramble to find services and benefits for their employees. A rash of PEO insolvencies might even have the potential to disrupt the workers’ compensation market for certain classes of business accustomed to obtaining workers’ compensation through a PEO arrangement.

In addition to solvency issues related to these abusive practices of providing illusory coverage, regulators should consider that a number of consumer protection laws governing insurance sales and marketing may also be violated as the PEO may obscure premium rates as the amounts paid to PEOs by client companies are fees, in lieu of insurance premiums. The revenue implications for states is that they do not receive insurance premium taxes. The NAIC, the NCCI, insurance legislators, and insurers, all have specifically addressed the issue of PEOs. The following summarizes their work on this topic.

The NAIC and PEOs

In 1991 the NAIC proposed a model act that addressed the potential for manipulating the workers’ compensation experience rating system while acknowledging the complication for PEOs and their insurers in attempting to bring on multiple clients with varying accident experiences. The proposed regulation included a provision that 1) leasing companies must be registered with any state where they do business; 2) that they have multiple coordinated policies; and 3) that the insurer in a master policy arrangement must be able to generate the information necessary to establish an accurate experience factor for a client that leaves a leasing arrangement.

⁷ Work Comp Large Deductible Study. NAIC 2006 p. 45.

Although the proposed model act was only enacted by a handful of states, it became the catalyst of future action. In 2008, the NAIC adopted model guidelines for the regulation of workers' compensation insurance in PEO arrangements. The entire guidelines are found on both the NAIC website and the NAPEO website. Upon adoption, these guidelines became the national recommended basis for insurance regulations concerning workers' compensation in PEO arrangements. In 2009, the NAIC released an exposure of an implementation paper to accompany the guidelines and to assist states in understanding various issues related to adopting any or all of the guidelines. NAPEO participated in developing that paper, which is still being formalized.

The NAIC's Guidelines for Regulation and Legislation on Workers' Compensation Coverage for PEO Arrangements (Guideline #1950) dealt with coverage gaps, experience modifications, and the use of the residual market. It mandated the use of multiple coordinated policies for PEOs in the residual market and contemplated three types of coverage in the voluntary market: master policy, multiple coordinated policy, and client-based policy. The guidelines addressed many of the issues of experience rating and proof of coverage that have arisen in PEO arrangements. In that regard, the guidelines are lengthy and detailed, and suggest a number of notice requirements for PEOs. The guidelines propose two types of coverage situations—a "full workforce" and a "partial workforce" PEO arrangement. In the former, the PEO and its carrier would assume full workers' compensation liability for all workers at a client company. In a "partial workforce" PEO arrangement (where only co-employees are covered), the PEO and its carrier must confirm the existence of client coverage for employees not co-employed by the PEO and may not continue the PEO arrangement in the absence of such coverage.

[The NAIC and the Use of Large Deductible Policies by PEOs](#)

The Workers' Compensation Large Deductible Study (2006), cited earlier in this paper, made several recommendations for the use of large deductible policies by PEOs. The following lists some of those recommendations:

- Insurer must be responsible from first dollar to ultimate benefits level
- Any coverage restrictions by guaranty funds should still require payments and then billing to the employer for monies paid
- Insurers, not employers, must handle claims
- State laws should be clear that self-administration of claims is contrary to the public interest
- Only insurers and approved self-insurers should be able to contract with TPAs for claims administration
- Deductible reimbursement policies should be prohibited
- Failure to reimburse deductible payments should be grounds for cancellation
- Require the filing of all agreements between insurers and employers relating to handling of claims by TPAs
- Annual statement reporting should be amended to show workers' compensation losses under the deductible amount
- Avoid licensing an insurer controlled or affiliated with a PEO if that insurer would be able to write a large deductible for the PEO
- Change and clarify guaranty funds laws to assure the reimbursement by employers for claims paid by the guaranty funds go to the guaranty funds instead of simply becoming assets of the estate

Some of these recommendations have been adopted in states. However, the thorny issue of large deductibles used by PEOs, arguably the most significant instrumentality for abuse and fraud, has not been widely adopted. Many of these recommendations, had they been in place, may have prevented the insolvencies that occurred post-2006. Following significant effort by the NAPEO, the International Association of Industrial Accident Boards

and Commissions (IAIABC)-NAIC Working Group Study of Large Deductible Workers' Compensation Policies dropped a recommendation that PEOs not be allowed to use large deductible workers' compensation policies.⁸

NCCI and PEOs

The National Council on Compensation Insurance (NCCI) has published three studies on workers' compensation and PEOs. The latest study by their chief economist, Harry Shuford, specifically set out to address some of the negative assertions made against PEOs. In one conference presentation⁹, he stated that getting rid of the tarnished reputation of PEOs was similar to "getting chewing gum out of your hair." However, despite the reputational issue, many of his findings showed the favorable value of PEOs in the workers' compensation system. He urged the industry and regulators not to just speculate about PEOs but to investigate.

Perhaps the most insightful part of the study related to how different PEOs are from each other. Although the title of his presentation was "Don't Just Speculate, Investigate", the unspoken message was, when you investigate, differentiate. PEOs are very different in size, geographic reach, and even business models. For example, nearly half of the PEO market is represented by five PEO companies, and the 15 largest PEO companies comprise approximately two-thirds of the market. Large multi-state PEO risks outperform the overall market, while single state PEOs and PEOs operating in two to three states lag behind. The diversity of income sources is another consideration. PEOs that have income from multiple service sources are different (and less risky) than PEOs that provide value to clients solely by providing cheaper workers' compensation coverage.

Shuford addressed the questionable practice of "scrubbing experience mods" to achieve artificially lower rates, by noting that nearly 90 percent of PEO clients do not qualify for experience mods.

Another NCCI study pointed out an interesting finding about claims that were made under a large deductible policy. According to this study, claims made under large deductible policies had significantly more loss development in the excess layers than claims under other policies (i.e., small deductible policies or guaranteed cost policies).¹⁰ This finding served to confirm suspicions that there may be inaccuracies with loss reserves established for claims with large deductible policies. Undoubtedly, this concern was why so many recommendations have been made to improve the quality and reliability of the claims data developed from loss experience under these policies.

One important service that the NCCI performs with respect to PEO/employee leasing arrangements is establishing Policy Rules and Reporting Requirements, Client Data Reporting Requirements, and the Application of Experience Rating Modification. These requirements may vary by state. Excerpts from the Illinois requirements include:

- A need for the experience of employees leased to client(s) to be separately maintained by the employee leasing company.
- A need to specifically deal with a client that leaves an employee leasing arrangement. This means maintaining records to be able to separate client data and use such data to calculate the client's own

⁸ Information based on NAPEO website. A statement by the NAPEO chairman can be found at http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CCQqFjAB&url=http%3A%2F%2Fwww.napeo.org%2Fmembers%2Fwickmanelecfin.pdf&ei=REWvVly_JMT8yQTTtYLQCQ&usg=AFQjCNHeb-NIW3pmLKix9I1Bz10ZDHi_4w

⁹ AIS Conference Presentation by Harry Shuford, Practice Leader and Chief Economist, May 16, 2013. "**Don't Just Speculate, Investigate! The Story Behind the PEO Study**"

¹⁰ Workers' Compensation Excess Loss Development, NCCI 2011

experience rating modification. The insurer has a number of requirements such as conducting audits and reporting separate client data to NCCI after termination of Employee Leasing arrangements.

Appendix C details all of the entire requirements.

NCOIL and PEOs

The National Conference of Insurance Legislators (NCOIL) meets to propose model legislation on insurance issues¹¹. Similar to NAIC, which proposes model act regulations, NCOIL proposes model legislation for states to adopt and/or modify for their own particular circumstances. In 2007 NCOIL proposed model legislation regarding Workers' Compensation Insurance Coverage in Professional Employer Organization (PEO) Relationships and made specific recommendations. The legislation was reviewed again in 2013. Many of the same issues identified by the NAIC, especially related to record-keeping of payroll and claims, were identified by legislators. The model legislation was proposed to address these and other issues and concerns. Some of the main points of the proposal include:

- Establishing a legal definition of a PEO (especially as it relates to the practice of “staff leasing” and differentiating it from temporary worker services);
- Requiring PEOs to register with the state as a condition precedent for an insurer to be able to write a workers' compensation policy for the PEO;
- Requiring the licensed insurer to be responsible for the payment and administration of all workers' compensation claims;
- Confirming the need for the PEO to maintain separate payroll records and separate records of work-related injuries and illnesses for each Client company, and to report these in a timely and ongoing manner to its insurer;
- Confirming the need for the insurer to report all loss and payroll information to the designated advisory organization in a manner approved by the commissioner [or other state official if appropriate] that identifies the Client and allows the calculation of an accurate experience rating for the Client on an ongoing basis

Insurer Responses to PEOs

It is worth noting that many well-known insurers successfully write PEO businesses. It's valuable to consider how these insurers underwrite PEOs and to assess how these successful insurers manage the risks of PEOs. These insurers have insights and best practices to help avoid financial losses that occur when insurers do not properly underwrite the PEO business.

The following highlights some of the underwriting requirements made by one large insurer in considering writing the PEO business. Of note is the fact that the insolvent carriers did not use similar underwriting guidelines, did not require similar claims data transparency, accepted risks that would be ineligible, and used large deductible policies in middle-market PEOs. Some may argue that these guidelines would only apply to risks placed in the voluntary market. It is worth noting that the recommendations made by NAIC related to claims administration data accuracy and reliability with respect to the use of large deductibles, is already addressed by many insurers engaging in good business practices. This suggests that for insurers, complying with NAIC recommendations would not be onerous, and would only serve to prevent the less competent insurers from taking on inappropriate risks.

The following show the guidelines considered by one successful PEO insurer.¹²

¹¹ <http://www.ncoil.org/other/ModelLawsResolutions.htm>

¹² <http://www.zprogramsmatch.com/program.aspx?program=WCompPEO>

Ineligible risks:

- Less than 3 years in business
- Predominantly blue-collar client list
- Accounts heavily weighted in construction or transportation

Submission Requirements

- Complete and thorough list of current active client companies of PEO including name, client #, payroll by class code and state, employee count, and detailed description of all operations including any unusual operations or coverage.
- Five years of currently valued loss information from carrier or TPA, broken down to client company and claimant level
- Five years of audited payroll summary
- Detailed explanation of all losses above \$25,000
- Completed supplemental Underwriting Assessment forms
- Organizational chart and résumés of key management
- Description of marketing plan
- Financial statements: middle-market PEOs should have three years of reviewed and compiled or management-generated comprehensive financial statements, including income statements, balance sheets, and if available, a statement of cash flows. Qualifying PEOs for Large Risk PEO programs should have three years of audited financial statements.

Middle-Market PEO Eligible Risks

- Accounts are typically written on a guaranteed cost basis with “first dollar coverage” or with a small deductible. Larger accounts can be written on an incurred loss retro in states where filings support.
- Solid management team with proven expertise in the PEO industry
- Management commitment to underwriting and safety
- Ability to accurately and clearly describe underlying client company exposures
- Transparent, tangible loss history and credible financial history

The brokers that work with these carriers represent their PEO clients best by making sure the client fully understands the risks associated with large deductible policies, and making sure their clients have sustainable business models.

Collateral Requirements

As mentioned several times, collateral requirements are essential to addressing the issue of large deductibles. The following illustrate common collateral requirements that successful brokers include in their communications to PEO clients considering large deductible plans:

- 1) Collateral Required
 - a. **Letter of credit (LOC)** - Issuing bank typically requires security for the LOC and, depending on relationship, could be as much as \$1 for \$1.
 - b. **Cash** - Carriers may not like this option because, depending on where cash is held (such as with an MGA), it may not be readily accessible
 - c. **Collateral trust money** is put into a trust account for the benefit of the carrier.

- d. **Deductible reimbursement policy** - An offshore contract that reimburses the Carrier as claims are paid. Client pays premium into the policy to fund the claims.
- 2) Standard Premium Required for LD Plans
 - a. Most require \$500,000
 - b. Some carriers require \$750,000
 - 3) Data Needed
 - a. Historical loss & payroll information.
 - b. Minimum of five years data – the more data the better for loss projection.
 - c. Expected losses must be known in order to decide feasibility of program.
 - d. Current financials
 - e. Critical information to decide the feasibility of security of the program.
 - 4) Tax Issues
 - a. Deductible expenses include fixed costs, paid claims fees, paid claims
 - b. For tax purposes, loss reserves to pay claims within the large deductible plan, are not deductible by IRS guidelines. Thus a broker's client's tax bill in the first two-three years of a paid loss program will be higher due to the non-deductible nature of claims reserves. This may cause a cash flow issue if the client has to provide cash to secure the LOC.

The purpose of including examples of these communications and underwriting guidelines is NOT to suggest that these must be followed rigidly by all insurers. In fact, the insurance marketplace is at its most valuable when there is freedom and competition to underwrite based on market needs. However, these guidelines do suggest that successful insurers recognize and address the issues identified by other stakeholders in the system, and regulations and legislation that mirror the discipline of the underwriting of these companies would not appear to be onerous for an insurer to implement. Insurers should have the ability to deviate from these guidelines while at the same time have a way to address those deviations, so as not to place the firm at risk for insolvency, and leave injured workers with delayed or reduced claim payments.

Deficiencies in Auditor and Actuarial Opinions

The insolvencies also illustrated some significant deficiencies in the audit and actuarial practices. At the end of Case Study 1 is a section entitled, "What the auditors and actuaries missed" which provide examples of practices that could be improved.

For example, related party transactions and potential credit risks need to be fully disclosed in opinions. Traditional audit "red flags" such as paying dividends during times of poor financial performance, should be noted. It appears that the internal controls related to reserving were weak. These weakness should be noted in the audit. The collateral which was supposed to be held by the PEOs to pay claims within the large deductible amount was often intermingled with operating funds without sufficient recognition of this by the auditors. Actuaries rely on auditors to ensure the voracity and accuracy of these controls in establishing their estimates of reserves, and the potential risk of material adverse deviation.

Actuaries reviewing reserves of small insurers with large deductible policies, should review and comment on the credit risk of PEOs which could materially adversely impact the reserve estimates. This was not always done.

Actuaries also have numerous tools and techniques that could be employed in assessing reserves that currently are not used. For example, actuaries could use machine learning algorithms to examine company variables to predict if an insurer faces the risk of insolvency. For these insolvencies, decision tree methods known as Bagging

and Random Forest produced the best results. For example, had machine learning algorithms been employed for these recent insolvencies, out of seventeen companies, the “Random Forest” method would have predicted the failures two years prior to insolvency and would have only misclassified one. The top five variables from both the Bagging method and the Random Forest models are: the growth of Net Premiums written, the growth of Loss and Loss adjusted expense reserves, the direct premium written, workers compensation’ loss and loss adjusted expense reserve and the percent of direct premiums written by MGA’s . This study found the following results with respect to the measure of predictability for each variable.

Variable	Predictability Measure (The higher the value the more accurate the variable is in predicting WC insurer insolvency)
NPW Growth Rate	9.8
Loss and LAE Reserve Growth Rate	8.2
DPW	6.0
WC Loss and LAE Reserve Growth Rate	5.9
Percentage of Premium Revenue from MGAs	5.8
NPW	3.4
WC DPW	3.0
Exp. Ratio	2.3
Combined Ratio	1.65
WC NPW	0.2
Net Commissions Ratio	-(2.6)

These results are impressive and this study show that tools known by actuaries such as machine learning algorithms can be used to identify reserving and insolvency risks. The criticism lodged against actuaries is that the tools and techniques known and understood by them are not always used in reserving, because they are not required by “standard practice”, and going beyond that standard might cause an actuarial firm to lose a client (insurer management), even if the reserving could be made more accurate, and beneficial to non-managerial stakeholders.

Continuing Legal Issues; Legislative Response

A few guaranty funds have been successful in requiring the borrowing employer’s insurer to pay claims in situations where the PEO co-employer insurer fails through use of the “other insurance” provision which requires “other insurance” to be exhausted first before the guaranty fund pays. With respect to such claims, the amount potentially at issue could be substantial. The principle was that an employer’s workers’ compensation insurance policy must cover all of the insured’s employees. In fact, most workers’ compensation acts prohibit the withdrawal of an individual employee from insurance coverage, and prohibit an employer and its insurer from selectively omitting an employee from the coverage of a policy. A borrowed employee becomes the employee of the borrowing employer to whom he has been loaned. In short, guaranty funds assert that a borrowing employer’s workers’ compensation insurance policy must cover any and all borrowed employees.

A 2012 court decision in Illinois challenges the guaranty fund’s ability to recover from the insurer of the borrowed employer. The court ruled that the Illinois Insurance Guaranty Fund was not entitled to recover from the borrowing employer’s insurer under the “other insurance” provision. The court acknowledged the statutes

and cases cited above, but nevertheless reached a result based on what the statutes “don’t require”—that is, duplication in coverage by the borrowing employer and loaning employer. The court found that the Legislature could not have intended “absurdity, inconvenience, or injustice” by requiring duplication of coverage from both the loaning and borrowing employers.¹³ The court’s decision places in question the ability of guaranty funds to collect on tens of millions of dollars of payments for PEO claims.

Another legal issue relates to the ability of PEOs to self-insure. For example, in California (per WorkersCompensation.com), Labor Code section 3701.9 was added in 2012 as part of SB 863. This provision prohibits temporary services employers (TSEs) and leasing employers (LEs) from self-insuring their workers’ compensation liability. These entities that were self-insured in 2012 when SB 863 was passed had to become insured by January 1, 2015. The concern addressed by section 3701.9 is that a self-insured staffing company may grow rapidly during a calendar year without a concomitant increase in its workers’ compensation self-insurance deposit. Self-insured employers do not pay insurance premiums; instead, they post a security deposit each year. A self-insured employer would not have to increase the security deposit for its increased payroll until the following year, unlike a typical employer with workers’ compensation insurance, which is required to pay an increased premium on newly hired employees as soon as they are hired. When a self-insured employer’s security deposit is insufficient, the obligation for the loss falls on the Self-Insurers’ Security Fund (Fund) (§§ 3742, 3743) and other self-insured employers may be charged a pro rata share of the funding necessary to meet the obligations of an insolvent self-insurer.

Related-Party Transactions and Cross-Ownership of Employers with Third Party Administrators (TPAs) and/or Insurers

From the background presented, it is easy to see the potential problem of having employers control the TPAs for long-tail workers’ compensation claims. There is an incentive for the affiliated TPA to intentionally understate its claims and loss liabilities, and under-report claims to the insurer as a way of keeping rates artificially low. Unfortunately, the under-reporting or under-reserving of claims may not be known until the firm becomes insolvent. For the employer owners with nefarious intent, the TPA provides the instrumentality for the Ponzi scheme. As mentioned earlier, it becomes difficult for the insurer to step in and pay claims of a defunct employer when the claims were controlled by the employer affiliated with the TPA. Ultimately, consumer and worker protections may be compromised by a TPA closely affiliated with an employer.

Regulators must also consider the especially financially hazardous situation when an employer uses a small, affiliated insurer to write a large deductible policy. A simple internet search will yield examples of affiliated insurers with statements on their websites such as the following:

“X Insurance company was founded specifically for Professional Employer Organizations, Staffing Companies and large companies”¹⁴

“XX is an experienced workers compensation provider covering an expansive spectrum of industries through our affiliated professional employer (PEO)”

¹³ *Illinois Ins. Guar. Fund v. Virginia Sur. Co., Inc.*, 2012 IL App (1st) 113758 at ¶¶ 19, 20, 22.

¹⁴ Google search conducted August 1, 2015 found these examples. These are illustrative examples that such insurers with PEO specific missions exist. Absolutely no analysis of these insurers was conducted by the author to ascertain the financial viability of these insurers. They are NOT on the list of recent insolvencies that were the target of this study.

If insurers with this kind of mission utilizes a large deductible, than a hazard exists in that the employer's premium might be minimized, at the expense of the insurer's capital requirements and the underwriting could be lax and less objective (in fact that may be part of the attraction). Consequently the reported risk on the insurer's financial statements may reflect only a percentage of the ultimate exposure, as a substantial amount could be off-balance sheet commitments by the insurer to its employer owner.

If the employer is bankrupted, the employer owners and the affiliated insurer could seek bankruptcy protection. This is in fact the situation that has occurred with several companies, including those presented in Case Studies within this paper.

At some point the state guaranty fund would normally be asked to step in and pay the claims of the insolvent insurer. The fund would have no meaningful recourse to be reimbursed under the large deductible, as the employer is already insolvent. Although state guaranty funds may help pay claims of insurers that become insolvent, their existence should not be viewed as "the" solution for abuses of the system and subsequent insurer solvencies, any more than the FDIC should be considered as the solution to bank fraud.

The first case study illustrates the problem associated with related party transactions. The second illustrates the problem with pursuing a growth strategy with an MGA, and providing poor oversight of the underwriting. In all of the cases the collateral posted was not accessible to pay claims. In the first case the related entity did not properly collateralize the large deductible. In the second case with Ullico, the MGA, Patriot received the collateral and then did not make it available to pay claims when the insurer became insolvent.¹⁵ In addition to these two cases there have been other similar cases of insurer failures with large deductibles and significant PEO involvement with the insurer. For example, Park Avenue Property and Casualty wrote ONLY PEOs and staffing companies. It had only about 30 policyholders. A detailed explanation of these policyholders, their exposure, and their collateral is included at the end of the first case study. In addition, Pegasus and Southern Eagle had affiliated PEO with intermingled collateral. In the case of Southern Eagle, the collateral was a promissory note from the PEO owner.¹⁶

Recommendations of Multiple Stakeholders Regarding PEOs

All of the recommendations and responses by key industry stakeholders including regulators, legislators, and insurers, indicated that the potential for fraud and abuse exists in the PEO model. All of the responses attempted to differentiate the reputable firms from the ones that were more likely to have abusive practices. The common themes include:

1. Making sure that if large deductibles are used, there is sufficient collateral to pay the claims
2. Making sure that the insurer has access to the collateral (rather than just the MGA)
3. Making sure that insurers control the claims information
4. Making sure to protect injured workers from delays, coverage gaps, and insurer insolvencies
5. Making sure there is state registration and review of the PEO's management especially for related-party transactions with insurers and MGAs.

Despite the apparent consensus of opinion by so many industry stakeholders, numerous problems and legal issues still persist. Part of the challenge is that large insurers, with a history of insuring reputable PEOs, do not see the need for more regulation. To address this, one recommendation is to differentiate the smaller insurers that write less than \$500 million of annual direct written premium. The rationale is that larger insurers would

¹⁵ See Case No 8392-VCN in the Court of Chancery of the State of Delaware April 9, 2015. IL Insurance Guaranty Fund's Motion for Leave to Intervene

¹⁶ These three insurer examples were presented on July 8th at NCIGF legal conference in San Francisco.

need to comply with the Own Risk Solvency Act (ORSA), which ostensibly would identify and address these types of credit risks that could lead to insolvency.

Some more detailed recommendations include:

- Requiring insurers to report large deductibles policies to their statutory accounting financial statement filings, to assist auditors and actuaries in assessing credit risk with the large deductible
- Making many of the voluntary reporting requirements of PEOs, currently done by PEOs as “best practices” mandatory in every state

Case Studies of Small Workers Compensation Insurer Insolvencies Involving PEOs with Large Deductibles

The following case studies are actual cases of insurer insolvencies. The cases presented highlight many of the areas of concern expressed earlier in this paper. Some of the common problems found in both cases include:

- Unrecognized significant contingent liability because of the credit risk of PEOs with large deductible policies in relation to surplus of insurer
- Unrecognized incentives for under-reporting and under-reserving claims
- Lack of adequate controls and oversight by the insurer

The cases highlight two areas of concern. The first case study, Dallas National (aka Freestone), highlights the problems associated with related party transactions where the PEO controls the TPA, MGA and insurer and orchestrates the financial transactions through these different entities. At the end of this case other cases such as Park Avenue, which had related party transactions are highlighted, but in less detail.

The second case involved ULLICO Casualty Company. ULLICO is different from the previous cases in that it did not have the same related party transactions, but it did have an emphasis on aggressive growth that led to poor underwriting. The manner in which the growth was achieved, through MGAs that did not appear to have a stake in the long term financial outcome of the insurer, is valuable to understand. Unlike the first set of cases where the profit motives of the owner/manager of the related entities were paramount, in these second set of cases, the short term profit motives of multiple unrelated parties, each serving their own interests, were instrumental in the company's downfall. At the end of these case, other similar cases are presented, but in less detail.

Many of the problem issues identified throughout this study can be found in these cases.

Case Study 1: Dallas National Insurance Company (aka: Freestone Insurance Company)

The following is a case study of an insurance company that ended up in liquidation. The purpose of this case study is to illustrate some of the significant risks associated with related entities, and underwriting professional employer organizations, especially those with large deductible insurance policies. The facts in this case are taken from statutory actuarial opinions, independent auditors' reports, legal and administrative proceedings, and the SNL financial database. Citations are used to indicate the sources used for gathering the information for this case study. This case study reflects the personal analysis of the author, and the author's opinion is based on this information.

History of Dallas National¹⁷

Dallas National Insurance Company was the surviving corporation of the merger of Dallas Fire Insurance Company into Dallas National (previously California Indemnity Insurance Company) effective December 31, 2005. Dallas National was controlled by DNIC Insurance Holdings, Inc. which was 100% owned by Charles David Wood, Jr.

California Indemnity Insurance Company (CIIC) was incorporated in California in 1987. Mr. Wood acquired CIIC on September 30, 2005. Prior to the sale, CIIC was redomesticated from California to Texas. On December 6, 2005, CIIC amended its Articles of Association, changing its name from CIIC to Dallas National Insurance Company.

Dallas Fire commenced operations in July of 1962. The company was initially licensed to write General Liability business in the state of Texas. Dallas Fire started writing Workers' Compensation (WC) business in Texas in 2002. In December 2005, Dallas Fire Insurance Company was merged into Dallas National.

Dallas National Insurance Company wrote Occupational Accident and Property coverage in Texas, General Liability coverage in 22 states and workers' compensation coverage in 39 states. In 2006 about 80 percent of its business was workers' compensation, but by 2011 that percentage was almost 100 percent.

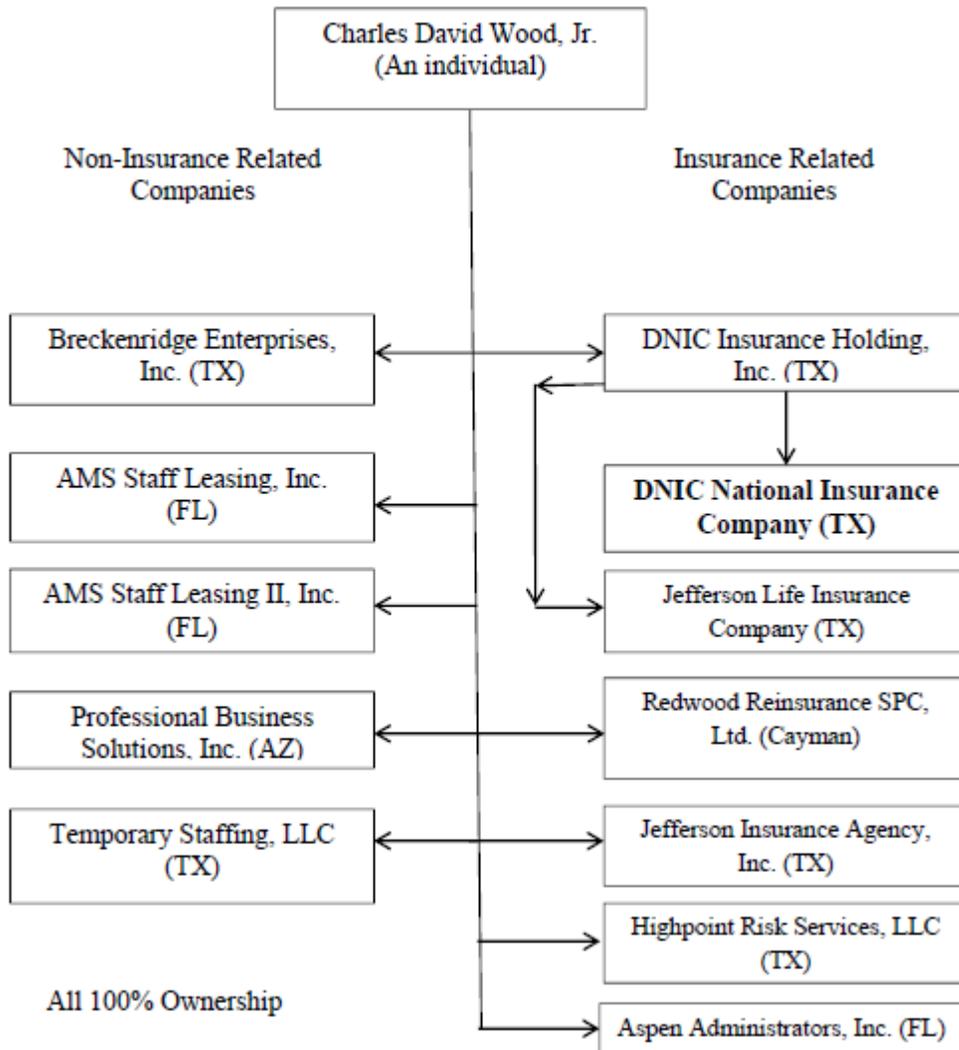
Although DNIC was not licensed to do business in Florida for most of its existence, it did assume Florida workers' compensation insurance losses through a reinsurance agreement with Companion Property and Casualty Insurance Company. In this agreement, Companion agreed to cede DNIC 100 percent of the workers' compensation losses placed through entities related to DNIC. For the policies the DNIC called "Temporary Staffing Accounts", written by its DNIC-affiliated PEO, AMS Staff Leasing, Companion would write the policies under its name, and then transfer 100 percent of the risk to DNIC. Consequently, DNIC had a significant workers' compensation exposure in Florida.

In December of 2007, Dallas National added outside directors to its board of directors, including the Banking Commissioner for the State of Oklahoma; a former Insurance Commissioner for Arkansas; a former insurance executive and workers' compensation expert; a business executive from Florida; and a retired Deputy Commissioner of Finance from the Texas Department of Insurance. The stature of this board, with former regulators, was chosen to provide additional credibility to the company as the insurer became more national.

¹⁷ Much of this section comes from the Texas Department of Insurance website.
https://apps.tdi.state.tx.us/pcci/pcci_show_profile.jsp?tdiNum=96027

One of the issues related to Dallas National’s ultimate demise is the issue of related entities. Exhibit 1 illustrates the related parties in this case.¹⁸ This issue of related entities has caused the demise of several workers’ compensation insurers, insuring PEOs with large deductible policies.

Exhibit 1- Chart of Dallas National Insurance Company and Related Companies



An explanation of how these related entities affected the stability of Dallas National is important in understanding the underlying causes, and the need for additional oversight of these arrangements. The following synopsis of the Delaware Department of Insurance Report on Examination of Dallas National (Dated September 30, 2013) helps to explain what occurred in the five-year time period from January 2007 through December 2011 that led to insolvency:

- The insurer shared facilities, personnel, and computer equipment with AMS Staff Leasing. The insurer operated under a claims services agreement with Aspen Administrators to provide all administrative

¹⁸ Excerpted from Delaware Dept. of Insurance Examination. 2011.

services in regard to workers' compensation and general liability claims. Aspen was the only "material and significant" Third Party Administrator (TPA)¹⁹.

- Although only about 3 percent of the workers' compensation premium came from staffing and PEO companies owned by shareholders of the insurer, the insurer entered into an agreement with Highpoint, a Managing General Agency (MGA) that produced master policies with AMS Staff Leasing firms (I and II) with large deductible insurance policies. The Delaware examination revealed that endorsements for the collection of collateral were missing and collateral from these AMS firms had not been remitted to the insurer (at the time of the examination). **(The issue of collateral and the need to maintain collateral to pay claims was mentioned in the accompanying paper. This is a thorny issue that is still unresolved and surfaces as a problem in almost all the insurer insolvencies with large deductible policies.)**

Dallas National's Financials²⁰

The following financial information for DNIC illustrates a common characteristic of workers' compensation: long tail lines (meaning losses are slow to develop and pay out over many years), with large loss development patterns (meaning that the ultimate amount of claims owed years later may be multiples of the amounts initially reported in the accident year). This characteristic is something that insurance producers commonly explain to PEO clients when they are contemplating a large deductible plan. It is one reason that prudent insurers that use large deductible plans require five years of loss history. This characteristic also makes it hard to compare PEO loss ratios, which include large deductible plans, to insurer loss ratios, because they include so many artificially low loss ratios from early years when loss development is not fully understood and accounted for. Exhibit 2 presents a trend in some key data for the five years before the disciplinary action was taken by the insurance department.

Exhibit 2- Key Financial Information

Year	Net Admitted Assets	Capital and Surplus	Gross Written Premiums	Net Income (Loss)
2007	\$256,655,078	\$87,966,798	\$108,510,859	\$23,154,569
2008	\$258,282,160	\$84,545,500	\$84,105,093	\$7,506,061
2009	\$289,412,689	\$88,518,316	\$72,358,674	(\$823,580)
2010	\$323,507,466	\$87,888,209	\$132,078,757	\$2,811,894
2011	\$326,685,392	\$64,197,327	\$117,506,471	(\$20,728,220)
2011 Reconciled		(\$4,706,181)		

Although the net income seemed to vary, and the surplus appeared steady until 2011, the underlying reserves told a story of increasing liabilities. These were the reserves being reported by management. However, there the underlying information tells another story that many consider to be much more insidious. Exhibit 3 illustrates the issue of increasing claims reserves in both absolute terms and in relative terms to the overall capital and surplus.

Exhibit 3- Key Reserving Information

Reserves by LOB from Sch P (\$000) (annual only)	2008 Y	2009 Y	2010 Y	2011 Y	2012 Y

¹⁹ 2011 Examination by the Delaware Department of Insurance p. 14

²⁰ 2011 Examination by the Delaware Department of Insurance

Workers' Compensation Reserves	22,611	34,509	93,282	115,118	124,192
Reserves / Capital and Surplus	109.35	124.71	192.73	304.94	351.92

The Underlying Problems

As significant as the drop in surplus reported in 2011 was, (nearly 25 percent), this turned out to be dramatically understated. The true reconciled loss in surplus from 2010 to 2011 was \$92,594,390 instead of nearly \$24 million reported. This left the company with a negative surplus and nearly \$5 million in the red. A reasonable question might be what happened in 2010? However, that reasonable question assumes that there must have been some catastrophic shock loss. The reality was that \$68,903,507 was a negative adjustment to surplus and this adjustment was due to factors that occurred over several years, such as:

1. **Unfavorable loss and Loss Adjusting Expense (LAE) development subsequent to the examination date for years 2011 and prior years**
2. **Collateral (from AMS) was deemed uncollectible in connection with its higher deductible workers' compensation policies, and**
3. **Off-book deductible losses that were not reported from AMS to the TPA (Aspen)**

As mentioned in the accompanying paper, the issue of collateral on large deductible workers' compensation policies is of critical importance. It proved to be so in this case, as well. As previously stated, a policyholder is responsible for all claims within the deductible. Under SSAP No. 65, the insurer is supposed to pay the claims from the first dollar, and then get reimbursed from the policyholder. Considering this credit risk, many states' insurance laws require the collection of the collateral to be based on the ultimate actuarial reserve calculations and require insurers to attach a policy endorsement to the master policy, requiring the payment of the collateral by the policyholder.

In this case, Dallas National had two master policies with AMS and AMS Staff Leasing II. The following is excerpted from the actuarial firm's opinion included in the examination:

- The endorsement requiring the collection of collateral was not attached from 2010 and beyond;
- Dallas National's parent, David Wood, failed to pay or reimburse the company for amounts owed by AMS;
- After efforts to collect or get reimbursed, Dallas reduced its held collateral to reimburse itself for amounts billed to AMS;
- A deficiency occurred because the collateral account was drawn down and AMS refused to fund it according to actuarial determined reserve calculations;
- The actuarial opinion did not catch the issue with collateral (management may not have communicated to their actuary that the collateral was not adequate or collectible); and
- Dallas did not establish a receivable from AMS for losses and loss adjusting expenses (as required by SSAP No. 65, paragraph 37)

These issues alone accounted for \$50,249,156 of the \$68 million negative adjustment.

In addition to the problems stemming from the PEO, AMS, several other problems were discovered with the insurer's affiliated TPA, Aspen, including:

- **Mischaracterization of certain open claims as being closed;**
- **Deficiency in timely reporting of claims; and**
- **Incorrect application of certain deductible amounts**

In May of 2012, A.M. Best Co. downgraded the financial strength rating of Dallas National to B- (Fair) from B (Fair) and credit rating to "bb-" from "bb". The ratings agency said the action was the result of Dallas National's

deteriorated and unfavorable risk-adjusted capitalization following volatility in its underwriting performance²¹. A week later, Southport Lane, a New York–based private equity firm, announced that through its subsidiary Lonestar Holdco LLC, it would acquire Dallas National Insurance Co. In the announcement, Southport’s CEO stated, “We are committed to providing additional capital to strengthen Dallas National and provide further security to policyholders. This acquisition underscores our long-term strategic interest in building a significant presence in the insurance sector.”²²

In March of 2013, Dallas National redomesticated to Delaware and subsequently the agreement with the TPA, Aspen, was terminated. All of the directors and officers were asked to resign. The new company terminated the affiliated agreements with Highpoint Risk Services, and later that year its agreement with AMS staff leasing. In February 2014 it changed its name to Freestone Insurance Company. In April 2014 it was placed in receivership for rehabilitation in Delaware, and in August of 2014 it was placed in liquidation.

The financial toll is still being calculated, but the human toll is that more than 2,000 injured workers, their families, and employers, were left to figure out how to collect over \$123 million in workers’ compensation claims owed to them.

The Florida Administrative Hearing²³

In 2008, an administrative hearing was held in Florida because the Florida Insurance Department denied DNIC the right to do business in that state. The Department deemed Charles David Wood, Jr. to be “untrustworthy,” and “had good reason to believe” he acted in bad faith. Some underlying reasons for their findings included:

- Wood’s TPA, Aspen, did not meet requirements for timely payment of claims;
- Wood’s PEO, AMS Staff Leasing, failed to report claims to its insurer;
- The failure of the PEO to report claims skewed rate making, and had potential to lead to inappropriate filings;
- The 100 percent reimbursement reinsurance agreement Dallas National had with Companion P & C Insurance Company (cited earlier in the case), was an illegal “fronting agreement”; and
- The business relationships between Dallas National and its affiliates were not deemed to be “at arm’s length” and were to the detriment of Dallas National. They shared offices as well as ownership, and this “commingling” of people and funds could lead to weak controls and could ultimately leave the insurer with insufficient assets to satisfy its obligations to injured workers.

The company’s management denied these assertions, and Dallas National brought in an expert, a Fellow of the Casualty Actuarial Society and Member of the American Academy of Actuaries to refute the assertion made by the state’s examiner, who was not an actuary. DNIC’s expert defended the reserving methodology used by Dallas National and its appointed actuary, Milliman, and claimed that the insurance department’s employee was overstating the claim liabilities. The administrative court found in favor of Dallas National Insurance Company and recommended that the Office of Insurance Regulation (OIR) issue a license to the company.

This took place six years prior to the liquidation of Dallas National Insurance Company. Charles David Wood, Jr. claimed that the department denied his application because of a vendetta against him. Wood’s assertion was that Florida’s Insurance Commissioner was seeking revenge because of a previous conflict in which another company was caught spying on the commissioner (earlier in the 1990s during the commissioner’s time as a

²¹ Insurance Journal. <http://www.insurancejournal.com/news/southcentral/2012/05/23/248672.htm>

²² Insurance Journal. <http://www.insurancejournal.com/news/southcentral/2012/05/31/249572.htm>

²³ The information contained in this addendum was excerpted from the public documents of the Administrative Hearing of Dallas National Insurance Company v. Office of Insurance Regulation, the state of Florida Case 08-5624.

regulator) and Wood made a large loan to that business, after the business had been caught in the spying incident.²⁴

What the Auditor and Actuaries Missed

Although the direct cause of this insolvency is mismanagement, there were likely items that the auditors and actuaries could have detected. Whether these would have prevented the insolvency, is speculative, but as an educational exercise it is worth noting how the auditor and actuarial opinions could have been improved.

First, an audit probably should have caught, at a minimum, the missing policy endorsements (requiring that payment of the collateral by the policyholder). Auditors look at such things on a test basis, and often the sample size is very small; however, even a small sample size would have caught this issue. The auditors should have considered this to be a risky client, given the corporate structure and all of the related party transactions. Higher risk translates to changing the "nature, extent, or timing" of testing to increase the chances an audit will detect any material misstatements. While the auditors may have been mollified by the increases in workers' comp. reserves each year, that is, if the auditors expressed concerns to management, management may have assured them that they were addressing the issue by increasing the reserves. Unfortunately it turns out that the reserves were still inadequate and thus the actuarial opinion should also be examined for inaccuracies.

Two main causes of the very significant deterioration of net income were decreasing premiums and policy fees earned, and a significant increase in "losses incurred." Auditing textbooks (and the Becker CPA Exam Review class), emphasize that an audit provides an opinion on past results, and a "clean" (unqualified) opinion does not mean that a company is a good investment. The auditors are giving an opinion on historical information, not advising as to whether a company would be a good investment. HOWEVER, auditors are required to assess a company's ability to continue as a "going concern" for the subsequent 12 months. The auditors may have had some concerns, given the deterioration in net income and the net loss in 2009, but still gave an unqualified opinion. Many times audit firms have been criticized (and sued) for giving an unqualified opinion when in fact a company goes under the next year. Perhaps the most flagrant issue which was not addressed was the significant dividends being paid out while the company's financial situation was deteriorating. This should have been a "red flag" that required additional scrutiny, and explanation in the report.

Besides the auditors missing key concerns, the original actuary Dallas National appointed had evidently not considered in his opinion the issue of collateral and the potential for contingent liability. New management hired another actuarial firm (Bickerstaff Whatley Ryan & Burkhalter) that noted as a "Relevant Comment" that "Contingent liability exists with respect to large deductible workers' compensation business in the event policyholders are unable to meet their obligations". The actuarial firm specifically addressed the issue with management, which advised that "they know of no uncollected recoveries." In 2011 the Delaware Department of Insurance hired INS consultants to help in examination of the company. In its opinion, the INS actuary stated, "Due to the claims data issued with the Company's affiliated claims administrator, Aspen, it was determined that material and systematic weaknesses existed to such an extent that underlying loss data was not reliable..."²⁵ This issue, along with the lack of collateral, turned out to be the undoing for Dallas National. Management is supposed to disclose related parties in the footnotes and the auditors also audit the footnotes. In this case, they were disclosed. However the original actuary either did not see this, or ignored it, and in either case, did not comment on the risks of such related entities.

²⁴ <http://www.tampabay.com/blogs/venturebiz/content/dallas-insurer-sues-fla-insurance-chief-vendetta-tied-st-pete-scandal-90s>

²⁵ 2013 DE Dept. of Insurance Examination p. 35 and p. 37. Management's booked reserves were materially different from the estimates made by the company's appointed actuary, Milliman.

Imperial Fire and Casualty, which it seized less than a year later. “We were just not aggressive enough in our scrutiny of this transaction.”

Similar to Dallas National, Imperial Fire and Casualty also had former insurance commissioners and regulators on its board. Mr. Donelon said the presence of former insurance commissioners on Imperial’s board may have been “a positive influence” in his staff’s decision to approve Southport’s application. The issue of corporate governance is beyond the scope of this study but an important consideration.

The Case of Park Avenue Property and Casualty

Although there are several examples of failures involving related-party transactions, perhaps the most well-known involves Park Avenue Property and Casualty. The Park Avenue insolvency affected over 2,000 workers with over \$77 million in claims.

“Complicated By Design”

The following background provides the complicated but not atypical history of Park Avenue. Many of these carriers have similar circuitous routes to their current corporate structure. Several attorneys and regulators have suggested that they are “complicated by design” making them difficult to follow, and giving pause to potential prosecutors who may have the burden of explaining the transactions to a jury.

According to the Oklahoma Insurance Department, Providence Insurance was sold on Jan. 29, 2009, to Park Avenue Insurance Co., and renamed Park Avenue Property and Casualty Insurance Co. PAPC was controlled by Jerry Lancaster, Derek Lancaster, Deron Lancaster, Aaron Lancaster and Jan Schindler, and was liquidated by the OID in late November 2009.

The department alleges that Jerry Lancaster bought shares in another Oklahoma domestic insurance company, Banclnsure Inc., with proceeds from the sale of Providence/PAPC. That transaction was effected through another PAPC subsidiary (named Imperial), affiliate Eagle Insurance Agency, which is also owned by Jerry Lancaster.

Lancaster subsequently arranged to have himself and an associate at Imperial, Terry McCullar, named to Banclnsure’s board. Later, according to the department, Eagle Insurance Agency “began issuing workers’ compensation policies under Banclnsure’s name in California,” without Banclnsure’s knowledge or authorization.

According to the OID, the Providence/PAPC purchase was accomplished via “several complex agreements between Providence, Imperial and several financial institutions.”

Among other things, the department says that the parties had planned to use a \$56 million bond portfolio as collateral for a loan to Providence’s future purchaser. Use of the bond portfolio would have required OID approval, which was neither sought nor granted, and “would have instantly made Providence insolvent,” the department alleges.

The insurance department also alleged that at least one principal of Imperial—Jerry Lancaster, vice chairman— withheld information about a federal injunction prohibiting Lancaster from participating in ERISA business due to fiduciary proprieties, in violation of Oklahoma law.³⁰

³⁰ <http://www.okaro.org/Community/Company+Records/1850.aspx>.

The Role of PEOs in Park Avenue’s Insolvency

Exhibit 4 below shows the 29 PEOs policyholders that made up Park Avenue’s book of business. Column 2 is the amount that the Guaranty Association paid out for claims within the deductible (WID). (Keep in mind that these are NOT the type of claims that the actuarial opinions refer to regarding risk of the potential claims that may EXCEED the deductible. These are the “dollar one” claims within the deductible that the insurer becomes responsible for when the PEO fails. This is the amount paid to date, but Column 4 represents the total exposure (in essence the credit risk). The remarkable column is the percentage of collateral to the exposure the company had for claims WITHIN the large deductible amount.

Column 5 uses the term “Intermingled Collateral” because Park Avenue had no separate accounts segregating the collateral to pay claims from the funds it used for its operational expenses. (This was permitted by the side the agreements made with the PEOs). Thus there was insufficient funds to cover the “collateral” that they were supposed to be holding for claims owed within the large deductible amount. This illustrates the reasons for the suggestion that collateral needs to be not only segregated but in a form such as a letter of credit, or a trust account held by a bank. Column 6 dramatically illustrates how underfunded many of the PEO collateral accounts were (aside from the issue of being intermingled). The highlighted PEOs held less than 50 percent. Notice that several PEOs had claims in which there was NO collateral at all. On average the PEOs held less than a third of the collateral needed.

Exhibit 4- Claims Paid By Guaranty Association With Large Deductible and Collateral Held By PEOs³¹					
Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
PEO	GA Total Paid WID	GA Total Reserves WID	GA Total Exposure WID	Intermingled Collateral ³²	Collateral as % of Exposure WID
PEO 1	\$1,072,467	\$15,291	\$1,087,757	\$1,000,000	91.90%
PEO 2	\$732,199	\$157,206	\$889,404	\$375,000	42.20%
PEO 3	\$5,557,352	\$654,004	\$6,211,357	\$6,410,158	103.20%
PEO 4	\$2,455,682	\$441,372	\$2,897,054	\$362,500	12.50%
PEO 5	\$1,795,079	\$893,013	\$2,688,091	\$0	0.00%
PEO 6	\$685,537	\$14,732	\$700,269	\$300,000	42.80%
PEO 7	\$4,346,175	\$1,118,897	\$5,465,073	\$750,000	13.70%
PEO 8	\$10,553,632	\$4,626,729	\$15,180,361	\$2,250,000	14.80%
PEO 9	\$415,341	\$68,015	\$483,356	\$339,200	70.20%
PEO 10	\$1,862,653	\$0	\$1,862,653	\$1,200,000	64.40%
PEO 11	\$470,496	\$250,419	\$720,915	\$708,335	98.30%
PEO 12	\$138,292	\$16,048	\$154,339	\$449,919	291.50%
PEO 13	\$0	\$0	\$0	\$0	
PEO 14	\$483,705	\$149,652	\$633,356	\$300,000	47.40%
PEO 15	\$54,726	\$78,781	\$133,508	\$220,131	164.90%
PEO 16	\$345,518	\$40,588	\$386,106	\$250,000	64.70%
PEO 17	\$14,835,453	\$3,814,897	\$18,650,349	\$3,000,000	16.10%

³¹ Information developed by Locke Lord LLC based on publicly available information.

³² The term “Intermingled Collateral” refers to collateral which is not separated or truly held as collateral. The term has been used in several cases but in this case it was used in the case in Oklahoma entitled in district court in OK by the receivers of Park Avenue Property and Casualty and Imperial Casualty and Indemnity v. Howard Leasing CJ-2012-1292.

PEO 18	\$0	\$0	\$0	\$0	
PEO 19	\$0	\$0	\$0	\$0	
PEO 20	\$3,580,096	\$294,478	\$3,874,575	\$1,000,000	25.80%
PEO 21	\$1,837,901	\$1,402,417	\$3,240,318	\$1,500,000	46.30%
PEO 22	\$590,443	\$0	\$590,443	\$250,000	42.30%
PEO 23	\$452,479	\$30,372	\$482,851	\$0	0.00%
PEO 24	\$1,001,059	\$616,747	\$1,617,806	\$1,000,020	61.80%
PEO 25	\$455,020	\$70,835	\$525,856	\$150,000	28.50%
PEO 26	\$1,577,439	\$555,833	\$2,133,271	\$1,000,000	46.90%
PEO 27	\$0	\$0	\$0	\$0	
PEO 28	\$269,431	\$40,084	\$309,515	\$250,000	80.80%
PEO 29	\$333,641	\$30,716	\$364,357	\$0	0.00%
Total	\$55,901,815	\$15,381,126	\$71,282,941	\$23,065,262	32.40%

Case Study 2: ULLICO Casualty Company (UCC)

On March 10, 2013, the Delaware Chancery Court ordered [ULLICO Inc.](#) subsidiary workers compensation unit [ULLICO Casualty Co.](#) into rehabilitation as its surplus fell below zero. In May the court ordered the Insurance Commissioner to liquidate [ULLICO Casualty Co.](#) As reported in SNL news that day, ULLICO Casualty's claims activity in the fourth quarter of 2012 had been "much greater than anticipated," resulting in a significant boost to incurred-but-not-reported, or IBNR, workers' comp reserves. The company also reduced the reserve credit taken for large deductible contracts with certain workers' comp policyholders over a "reasonable doubt" about future collectability of outstanding balances.

“Does anyone else have injured workers who are not getting refills of medications approved due to the Ullico liquidation? One patient’s TPA claims adjuster has stated to the pharmacy there is no one to approve the refill. The denial of medication refills can cause harm to those patients...”

- Leeseeker

“Whoever you are, and whatever your place in this system please recognize that this is certainly unfortunate, but so is the loss to all those who worked for Ullico, or had money invested, or will otherwise be at a complete loss of income to pay rent or buy food and may also be in very bad shape because of this, whatever the cause.

-Ozzie

--Excerpts from Workers’ Compensation Forums, following the insolvency of ULLICO.³³

These two short online postings on a forum for workers’ compensation illustrate the human toll of insurer insolvencies. The following is the story of ULLICO’s demise.

History

ULLICO Casualty Company (UCC) was incorporated by the Union Labor Life Insurance Company in 1979 in the state of Delaware. UCC is a wholly owned subsidiary of ULLICO Inc. The company marketed its products through key brokers and Managing General Underwriters (MGUs). MGUs market and distribute workers’ compensation insurance and other commercial lines of business. The MGU has the authority to bind coverage and therefore can accept the risks on behalf of ULLICO. The company used the services of various third party administrators (TPAs) to perform claims handling for workers’ compensation.

ULLICO Casualty performed unexceptionally through many of its years. From 2000 to 2005 it experienced a decline in premium and underwriting income. In August of 2003 a new CFO, Mark Singleton, was recruited to help turn around the company. He was promoted to CEO in 2006 to lead a new growth strategy for the company. The company did experience growth immediately after he took over. Singleton resigned in April 2009. Table 1 shows the growth in net premiums written for ULLICO. One key question is how did the company grow so fast in such a short time? A related question is, did this growth strategy cause ULLICO’s undoing? Table 2 provides an overview of other key financials, including the decline in the Risk-Based Capital (RBC) ratio.

³³ <http://forums.workcompcentral.com>

Table 1: Percentage Increases in Net Premium Growth from 2005–2012								
Year	2005 Y	2006 Y	2007 Y	2008 Y	2009 Y	2010 Y	2011 Y	2012 Y
Growth NPW (%)	(3.44)	16.34	25.72	62.70	75.20	31.48	(0.02)	8.20

Table 2: ULLICO Casualty Company (2005–2012) Key Financials								
Key Financial Measures	2005 Y	2006 Y	2007 Y	2008 Y	2009 Y	2010 Y	2011 Y	2012 Y
Income (In \$000)								
Net Premiums Earned	23,623	26,127	34,439	53,925	95,592	129,923	136,059	152,669
Net Loss and LAE Incurred	12,204	12,912	18,653	29,332	58,644	80,667	126,581	202,928
Net Underwriting Expense Incurred	11,508	11,602	15,575	24,593	39,693	49,979	47,376	46,685
Leverage								
Net premiums written / Average C&S	51.13	46.29	61.05	92.20	117.56	140.43	131.21	248.85
Risk-Based Capital (TAC/ACL RBC)								
Risk-Based Capital Ratio (RBC)	765.32	995.86	606.54	676.46	446.01	382.85	308.20	(135.31)

Understated Loss Reserves

The company reported net underwriting losses in every quarter of 2011 and 2012, and the amount of red ink spilled increased through all four reporting periods of 2012. Approximately \$74.8 million of its \$96.9 million 2012 net underwriting loss hit in the fourth quarter of the year as the company materially boosted its reserves. Data reported on Schedule P, Part 2 of the company's annual statement indicated that ULLICO Casualty experienced unfavorable prior-year development of incurred net losses and defense and cost-containment expenses of \$54.9 million in the workers' compensation business line and \$72.5 million, overall. The vast majority of the unfavorable workers' comp reserve development pertained to accident years 2009 through 2011, according to Schedule P data.

In 2011, Towers Watson conducted the actuarial analysis of the reserves of ULLICO. The actuary stated in her disclosure that there were no significant risks that could result in Material Adverse Deviation (which she defined as 20 percent of surplus). The following year in 2012, after the surplus fell below zero and the risks were finally recognized, the actuary still believed that the restated reserves were accurate.

“My opinion makes no provision for future emergence of new classes of losses or types of losses not sufficiently represented in the Company’s historical data.” That sentence represents a systemic failure of the analysis of reserves. Actuaries conduct a review of the reserves focused on historical data (a retrospective view), and do not typically consider a more forward-looking approach that considers changes in the underlying risks. Such a perspective requires examining changes in business strategies, additions of new risks, underreporting losses on current risks, or any of a myriad of issues that might be detected by a broader analysis. (Note: Actuaries are quite capable and trained to perform this forward-looking analysis and do so when it involves pricing, but they do not typically apply these skills to reserves analysis for their clients.)³⁴

The extent to which the liabilities were underreported with ULLICO can be seen through the claims information received by the California Insurance Guaranty Association from the Liquidator.

- Outstanding Loss Reserves at Liquidation for California claims: \$97,359,000. These were the loss reserves reported initially to the guaranty fund.
- Outstanding Loss Reserves + Paid to date for California claims at 6/30/2014 (roughly one year past liquidation): \$178,544,000. This represents what the guaranty fund paid and then posted for reserves a year after liquidation.
- Outstanding Loss Reserves + Paid to date for California claims at 12/31/2014: \$188,128,000. This is an update only six months later.

These numbers indicate the significant underreporting of the liabilities by the insurer³⁵.

The same issue that exists with the actuarial opinion also exists with financial regulators. The NAIC even states, “The IRIS Ratios and the Financial Analyst Team Reports depend on the accuracy and standardization of the annual financial statements of the filings of insurers. The tools cannot identify a misstatement of financial condition or a financial statement not prepared in the proper or complete format.”³⁶

Interestingly, the 2010 ULLICO Management Discussion (a formal filing made to NAIC) reflecting on 2010 results, noted a 41 percent increase in reserves for workers’ compensation (\$21.3 million), which they attributed to “business growth,” even though the earned premiums only grew 35 percent and loss development for workers’ compensation was due to a bankruptcy of a policyholder (Yellow Cab), which had a large deductible policy.

This insolvency left 7,812 workers with \$384,903,620 in pending claims.

ULLICO presents an example of an insurer, which through a desire to grow business rapidly, sacrificed its traditional underwriting discipline, and accepted risks it did not fully understand. The use of large deductible plans, combined with this lack of managerial oversight of its MGA, combined to lead to ULLICO’s failure.

Other Similar Cases³⁷

Lumbermen’s Underwriting Alliance (LUA), which issued large deductible workers’ compensation plans for professional employer organizations, among other insurance lines, has been put into rehabilitation according to [a Missouri Department of Insurance](#) announcement.

³⁴ Actuaries may suggest that they would conduct this IF the audit firms detect and report on these changes in their reports.

³⁵ One possible explanation for the underreporting is that the insurer may have kept the reserves based on a “net” of deductible basis. This still should have required some notation by the actuary, especially if the reserves are that materially different on a net basis.

³⁶ NAIC IRIS Ratio Manual

³⁷ Excerpted from <http://www.workerscompensation.com/compnewsnetwork/news/21489-are-insured-peo-s-with-large-deductibles-a-growing-problem.html>

LUA specializes in providing property and casualty insurance to the forest products industry, generally consisting of lumber and sawmill operations. Over time, LUA expanded its offerings, and therefore its membership, to a broader range of industries and insurance coverages. By 2014, LUA was providing property allied lines, inland marine, earthquake, and workers' compensation coverage to assisted living facilities and the food processing industry, as well as the forest products industry. LUA also issued large deductible workers' compensation plans for professional employer organizations (PEOs).

Lumbermen's faced financial difficulty when one of its largest PEO insureds, TS Employment, failed to fully fund collateral obligations and filed Chapter 11 bankruptcy. The Chapter 11 bankruptcy filing for New York-based TS Employment listed the IRS as a creditor with \$95.2 million in taxes owed, according to court records. Corporate Resource Services is TS Employment's only client. New York-based Corporate Resource Services ranks as the 22nd-largest U.S. staffing firm, based on 2013 revenue. TS has up to 30,000 employees for whom it processes payroll, according to court filings.

"Throughout LUA's more than 110-year history, we have worked hard to build a reputation of integrity, trust and reliability," stated Jan Carlsson, President and Chief Executive Officer. "I want to assure the market that we are committed to remaining accessible and responsive to our policyholders during this voluntary supervision period and beyond. LUA has taken the necessary step of entering into a voluntary supervision period due to a sudden and unanticipated Chapter 11 Bankruptcy filing by TS Employment Services, Inc., a Tri-State affiliated company with whom LUA has had a customer relationship for more than eight years. LUA provided workers' compensation coverage for Tri-State, which offers payroll processing and revenue billing services as a professional employer organization (PEO). TS Employment Services was forced into bankruptcy when it was unveiled that the company had "material, unpaid federal payroll tax liability." Mr. Carlsson noted that as a result of TS Employment's filing, "Tri-State's ability to continue to meet its financial obligations to LUA has been placed in question."

Rehabilitation is a legal step taken by the court to protect policyholders by preserving the company's assets. John Huff, director of the Missouri Department of Insurance, was named receiver by the court. The move allows him to take over operations of the company. Huff will now attempt to correct existing problems, continue operations of Lumbermen's, maintain policyholder accounting and develop a plan of rehabilitation or petition the court for liquidation, according to the department. Policies will continue pursuant to their terms and conditions, and policyholders must continue making premium payments to keep insurance coverage intact, according to the department... "Putting Lumbermen's into rehabilitation allows us to ensure the company's assets are handled properly so that claims are paid as fully as possible," Huff said.

Lumbermen's, , had approximately 3,000 policyholders and 6,080 open workers' compensation claims, with the largest number of claims in California. (EmploymentLawAcademy.com) Many other insurers listed in Appendix A suffered from similar mismanagement and understatement of reserves.

Appendix Items

- A. List of Insolvent Workers' Compensation Employers 2008–2014
- B. Comparison of Large Deductible Plan Policyholders to Individual Self-Insured Entities
- C. Employer Leasing Arrangements, Reporting, and Rating Requirements.

APPENDIX A: List of Insolvent Workers' Compensation Insurers 2008–2014. Source: National Conference of Insurance Guaranty Funds (Claim Counts) and SNL database (Reserves).

Company	# of WC Claims	Year Prior to Insolvency	Worker Comp Reserves one year prior to insolvency	Guaranty Funds Paid and Reserved as of 12/31/2014
Aequicap Insurance Company Total	571	2007	\$ 10,526,641	\$ 31,258,858
Atlantic Mutual Insurance Company Total	1,560	2008	\$ 146,518,750	\$ 191,089,364
CAGC Insurance Company Total	85	2010	\$ 11,681,640	\$ 10,667,928
Centennial Insurance Company Total	650	2008	\$ 48,845,270	\$ 92,370,045
Commercial Mutual Insurance Co Total	21	2003	\$ 9,762,180	\$ 5,734,039
Cornerstone Mutual Insurance Co Total	79	2003	\$ 9,762,190	\$ 14,765,959
Eastern Casualty Insurance Company Total	356		\$ 40,298,086	\$ 50,618,645
First Commercial Insurance Total	1,212	2007	\$ 36,173,350	\$ 59,983,124
Freestone Insurance Company Total	2,388	2011	\$ 124,294,000	\$ 123,832,068
Frontier Insurance Company Total	260	2010	\$ 45,510,440	\$ 56,435,289
Georgia Restaurant Mutual Total	8	2007	\$ 3,054,000	\$ 3,379,272
Georgia Timber Harvesters Mutual Captive Total	12	2007	\$ (15,000)	\$ 3,172,718
Gibraltar National Insurance Co. Total	85	2007	\$ 637,000	\$ 2,267,683
Imperial Casualty & Indemnity Insurance Total	905	2007	\$ 17,475,000	\$ 36,022,892
Insurance Corp of NY Total	15	2008	\$ 20,334,045	\$ 4,158,251
Lumbermens Mutual* Total	6,968	2010	\$ 542,095,730	\$ 542,095,730*
Park Avenue Property & Casualty Total	2,039	2007	\$ 37,334,190	\$ 77,332,053
Pegasus Insurance Company Total	629	2008	\$ 3,381,000	\$ 7,693,254
Red Rock Insurance Company Total	187	2012	\$ 29,657,000	\$ 9,370,757
Reinsurance Co. of America Total	158	2007	\$ 9,214,000	\$ 8,442,765
Southeastern U.S. Insurance Inc. Total	1,054	2007	\$ 35,110,000	\$ 57,023,769

Southern Eagle Insurance Company Total	458	2009	\$ 8,450,000	\$ 13,029,689
The Insurance Company of NY Total	14		\$ 1,021,424	\$ 616,613
Ullico Casualty Company Total	7,812	2010	\$ 73,361,000	\$ 384,903,620
Valor Insurance Company Total	-			
Grand Total	27,526		1,167,125,0730	\$1,693,986,710
<p>“*” Lumbers GA paid and reserved amount is stated the same because the case is so new and reserve reckoning as not yet occurred.</p>				

APPENDIX B- Comparison of Large Deductible Plan Policyholders to Individual Self-Insured Entities in Florida

	Employee Leasing (PEO) / Large Deductible Policyholders	Individual Self Insurers
Regulator	Board of Employee Leasing Companies within the Department of Business and Professional Regulation	Department of Financial Services – Division of Workers’ Compensation
Statutes	Chapter 468, Florida Statutes	Chapter 440, Florida Statutes
Rules	FAC 61G7	FAC 69L5
Capital Requirements	<p>\$50,000 initial and greater than \$0 ongoing</p> <ul style="list-style-type: none"> <i>No distinction is made for risk-bearing(large deductible) and non-risk-bearing entities</i> <p>An applicant for an initial employee leasing company license shall have a tangible accounting net worth of not less than \$50,000. An applicant for initial or renewal license of an employee leasing company group shall have an accounting net worth or shall have guaranties, letters of credit, or other security acceptable to the board in sufficient amounts to offset any deficiency. Each employee leasing company shall maintain an accounting net worth and positive working capital, as determined by generally accepted accounting principles.... In determining the amount of working capital, a licensee shall include adequate reserves for all taxes and insurance, including plans of self-insurance or partial self-insurance for claims incurred but not paid and for claims incurred but not reported.</p>	<p>Greater of \$10 million or 3 times standard premium</p> <p>Most recent audited Financial Statements shall show a Net Worth of the greater of \$10 million or three (3) times Standard Premium.</p> <p>69L-5.225</p> <p>Current self-insurers that no longer meet the net worth requirements must post a qualifying security deposit in an amount equal to 150% of the actuarially determined outstanding loss reserves, discounted to present value, using a 4% discount rate</p> <p>440.38(2) F.S.</p>

	<p>468.525(3)(b) (c) (d)</p> <p>Capital deficiencies can be offset with a guaranty.</p> <p>61G7-5.005</p>	
Security Deposit	NONE	<p><u>Current Investment Grade Credit Rating</u> - Minimum \$100,000;</p> <p><u>Less than Investment Grade Credit Rating</u> – amount equal to the greater of the actuarially determined outstanding loss reserves discounted to present value, using a 4% discount rate, or the actuarially determined outstanding loss reserves forecasted to a date one year in the future, discounted to such forecasted date using 4% discount rate as calculated in its Actuarial Report.</p> <p>To be maintained until there is no remaining value to its workers’ compensation claims and the statute of limitations has run out on closed claims. To be held by the FSIGA or the Department (DFS) exclusively for the benefit of workers’ compensation claimants. Security Deposit to consist of either (1) surety bond; or (2) irrevocable letter of credit.</p> <p>69L-5.218</p>
Workers’ Compensation Insurance	<p>Guaranteed Cost OR Large Deductible policies</p> <p>Per occurrence retention limit: NONE</p> <ul style="list-style-type: none"> <i>No distinction is made for risk-bearing (large deductible) and non-risk-bearing entities</i> 	<p>Specific excess workers’ compensation insurance policy</p> <p>Per occurrence retention limit: No more than \$500,000 or 1% of the self-insurer’s Net Worth as shown on latest audited financial statements, whichever is greater (rounded to the nearest \$50,000).</p>

	<p>Claim Adjusting: Insurer adjusters or Qualified Servicing Entities approved by the Department (DFS) contracted and managed by the insurer.</p> <p>Required to file with board a full description of workers' compensation self-insurance benefit plan and incorporate all assets and liabilities of any trust established for funding in its financial statements. <i>61G7-9.001</i></p>	<p>Higher retention must be approved by the Department (DFS).</p> <p>Excess carriers must be subject to the protection afforded by the Florida Workers' Compensation Insurance Guaranty Association or the Department (DFS) may accept policies issued by insurance companies that have current financial strength and size ratings from A.M. Best Company of not less than "A-" and "VII," respectively.</p> <p><i>69L-5.219(1)(a) & (b) & (c)</i></p> <p>Claim Adjusting: Qualified Servicing Entities approved by the Department (DFS) or in-house servicing approved by the Department</p> <p><i>69L-5.216</i></p>
<p>Financial Statement Reporting Requirements</p>	<p>Required for Employee Leasing Company with gross payroll of \$2.5 million or more, no later than 120 days from fiscal year end</p> <p><i>468.525(3)(e) / 61G7-5.0031</i></p> <p>Regulatory requirement: GAAP statements audited using GAAS</p> <p>No later than 75 days after end of each calendar quarter, statement affirming that it is maintaining positive working capital and accounting net worth, and has adequate reserves to pay, when due, all</p>	<p>Required for all self-insurers no later than 120 days from fiscal year end</p> <p><i>69L-5.209</i></p> <p>Regulatory requirement: Audited using GAAS unless exempted before 1/1/1997</p> <p>Financial strength to ensure the timely payment of all current and future claims</p> <p>Financial Statements shall show Net Worth of the greater of \$10</p>

	<p>payroll taxes, workers' compensation and health insurance premiums, and amounts due under any plan of self-insurance or partial self-insurance along with balance sheet and income statement for the quarter.</p> <p><i>61G7-10.001</i></p>	<p>million or three (3) times standard premium</p> <p><i>69L-5.209</i></p>
Claim Liability Reporting	<p>Each audited or reviewed financial statement shall include Form EL-4516 disclosing no additional claim liabilities for guaranteed cost policies or the actuarial methodology used to calculate claim reserves, including IBNR. <i>61G7-10.0012</i></p>	<p>Workers' Compensation Liabilities: Form DFS-F2-SI-20 due no later than 120 days from fiscal year end</p> <p><i>69L-5.207</i></p> <p>If credit rating is less than investment grade, an Actuarial Report is due within 120 days of fiscal year end or within 90 days from date requested. Shall include a forecast of loss reserves to a future date.</p> <p><i>69L-5.210</i></p>
Licensing	<p>Department (DBPR) shall license any applicant the board certifies is qualified. <i>468.527</i></p>	<p>Florida Self-Insurers Guaranty Association reviews applicants for membership in the association and recommends approval or denial to the Department (DFS) based on financial strength and ability to ensure the timely payment of all current and future claims.</p> <p><i>440.385(3) (b) 6. & 7.</i></p> <p>Department (DFS) approves FSIGA recommendations unless it finds clear and convincing evidence that the recommendation is erroneous. <i>440.38(1)(b)</i></p>
Acquisition (change of ownership) requirements	<p>License cannot be transferred or assigned. Must apply for a new license if acquirer not already licensed.</p> <p><i>468.5245</i></p>	<p>If majority of assets and/or stocks are purchased by a Successor Entity and the Current Self-Insurer can no longer provide Financial Statements in its own name, then Current Self-Insurer's authorization shall be revoked unless the successor entity becomes a current</p>

	<p><i>NOTE: The sale of the majority of business assets is allowed and subject to board approval. The original licensee remains licensed and subject to regulation, but it is uncertain as to what becomes of the liabilities in these transactions. Of particular concern are the large deductible claim liabilities.</i></p>	<p>self-insurer or the authorization is terminated. Application for self-insurance authorization by Successor Entity must be made within 30 days of the effective date of the acquisition or restructuring.</p> <p>69L-5.209(3)</p> <p>The successor entity as defined in 440.385(1)(b), F.S shall acknowledge liability for payment of the Former Self-Insurer’s self-insured workers’ compensation liabilities by providing a written statement executed by a senior executive officer of the Successor Entity.</p> <p>69L-5.209(5)</p>

APPENDIX C- Employee Leasing Arrangements Policy, Reporting and Rating Reqs.

**EMPLOYEE LEASING ARRANGEMENTS ¹
POLICY, REPORTING, AND RATING REQUIREMENTS IN ILLINOIS
AS OF August 26, 2013**

STATE	ILLINOIS
NCCI Filing(s)	Item 01-IL-99 (Circular IL-99-01)
Policy Requirements (Voluntary and Residual Market)	The employee leasing company is required to register with the Illinois Insurance Department before becoming qualified as self-

	<p>insured through the Illinois Workers' Compensation Commission Self-Insurance Department for workers' compensation or becoming eligible for a workers' compensation and employers' liability insurance policy. The employee leasing company and client(s) must secure coverage under a master policy². When a master policy is written to cover leased employees and is issued to the employee leasing company, the clients must be identified on the policy by the attachment of the Illinois Employee Leasing Endorsement. The endorsement must:</p> <ul style="list-style-type: none"> • Indicate that the policy provides coverage for leased employees • Provide that coverage under the endorsement will be limited to the named insured's employees leased to the clients • Indicate that the experience of employees leased to client(s) will be separately maintained by the employee leasing company
<p>Policy Reporting Requirement (Voluntary and Residual Market)</p>	<p>The one-digit Employee Leasing Policy Type Code must be reported on the Header Record (Record Type 01). Refer to Part  for details.</p>
<p>Endorsement Requirements</p>	<ul style="list-style-type: none"> • WC 12 03 03 A – For an employee leasing policy providing coverage for the leased workers of specified client company(ies). • WC 12 03 04 – For a client policy limiting coverage for non-leased workers. • WC 12 03 05 – For an employee leasing policy providing coverage for non-leased workers and excluding coverage for workers leased to clients.
<p>Employee Leasing Company Client Data Requirements (Voluntary and Residual Market)</p>	<p>The Employee Leasing Company is required to:</p> <ul style="list-style-type: none"> • Maintain accounting and employment records relating to all employee leasing arrangements for a minimum of four calendar years • Maintain addresses of each office it maintains at the principal place of business • Separately maintain the experience of employees leased to clients • Maintain sufficient data by client to permit calculation of experience rating modification for each client • Provide modification or payroll and loss information to a client upon request

	<ul style="list-style-type: none"> Notify its insurer of any terminated employee leasing arrangement within 30 days before termination or upon termination
<p>Insurer Client Data Reporting Requirements (Voluntary and Residual Market)</p> <p>When a client leaves an employee leasing arrangement...</p>	<p>...separate client data will be developed and reported. Such data will be used in the calculation of former client's experience rating modification.</p> <p>The insurer is required to:</p> <ul style="list-style-type: none"> Provide proof of coverage to the employee leasing company and its clients within 30 days of coverage being effected or changed Audit policies within 90 days of effective date Conduct additional audits thereafter Compare a client's experience rating modification to the employee leasing company's experience rating modification at the inception of the employee leasing arrangement Report separate client data to NCCI after termination of Employee Leasing arrangement Report subsequent or corrected client data to NCCI for the continuance of experience rating
<p>Experience Rating Production (Voluntary and Residual Market)</p> <p>When a client leaves an employee leasing arrangement...</p>	<p>...the carrier must extract client data from the policy. Section 215 ILCS 113/25 requires experience rating modification for a former client to be produced using its own experience. In order to produce the experience rating modification for the client, the data must be reported on Form NC2745 (experience rating form for former clients of labor contractors). The employee leasing company experience rating modification is also revised to remove client data reported on Form NC2745.</p>
<p>Application of Experience Rating Modification (Voluntary and Residual Market)</p> <p>At inception of an employee leasing arrangement...</p>	<p>...a client's experience rating modification will be used to calculate its portion of premium if the client's experience rating modification exceeds the employee leasing company's experience rating modification by 50%. Additional assessment (Employee Leasing Rating Adjustment) will be applied for a period of two years.</p>
<p>Application of Experience Rating Modification (Voluntary and Residual Market)</p> <p>When a client leaves an employee leasing arrangement...</p>	<p>...and its data is reported, an experience rating modification will be developed and applied to its new policy.</p>
<p> = Content Requires Authentication</p> <p>¹ Also known as Professional Employer Organization Arrangements.</p>	

² Master Policy is issued in name of employee leasing company. It entails commingled data of multiple clients reported via single unit report.