WORKERS' COMPENSATION (C) TASK FORCE

Workers' Compensation (C) Task Force. Dec. 6, 2009, Minutes
NAIC/IAIABC Joint (C) Working Group Dec. 5, 2009 Minutes (Attachment One)
Press Release Oct. 22 Frank Neuhauser Regarding 24-hour Coverage (Attachment One-A)
Professional Employer Organization Model Law (C) Working Group, Nov. 6, 2009, Minutes (Attachment Two)
PEO Implementation Commentary, Sept. 22, 2009 Draft (Attachment Three)

Draft: 12/14/09

Workers' Compensation (C) Task Force
San Francisco, CA
December 6, 2009

The Workers' Compensation (C) Task Force met in San Francisco, CA, Dec. 6, 2009. The following Task Force members participated: Merle D. Scheiber, Chair (SD); William W. Deal, Vice Chair (ID); Linda S. Hall represented by Sarah McNair-Grove (AK); Jim L. Ridling represented by Charles Angell (AL); Jay Bradford represented by Bill Lacy (AR); Steve Poizner represented by Christopher Citko and Ron Dahlquist (CA); Thomas R. Sullivan represented by Jon Arsenault (CT); Michael T. McRaith represented by John Gatlin (IL); Sandy Praeger represented by Ted Clark (KS); Sharon P. Clark represented by William Nold (KY); James J. Donelon represented by Ed O'Brien (LA); Ralph S. Tyler, III represented by Randy Johnson (MD); Mila Kofman represented by Eric Cioppa and Bob Wake (ME); John M. Huff represented by Angela Nelson (MO); Ann Frohman represented by Alan Wickman (NE); Roger A. Sevigny represented by Kent Dover (NH); Scott J. Kipper represented by Marie Holt (NV); Kim Holland represented by Kathie Stepp (OK); Teresa Miller represented by Rae Taylor (OR); Joseph Torti, III represented by Paula Pallozzi (RI); Randy Moses (SD); Kent Michie represented by Neal Gooch (UT); Alfred W. Gross represented by Mary Bannister (VA); and Jane L. Cline represented by Mary Jane Pickens (WV).

1. Draft "Implementation Commentary"

Mr. Wake announced that during the Nov. 6 Professional Employer Organization Model Law (C) Working Group conference call, a motion was passed to move the Sept. 22 draft professional employer organization (PEO) "Implementation Commentary" to the Workers' Compensation (C) Task Force in order to allow greater public exposure. The Working Group had finished drafting the document, he said, but there could be some minor changes from suggested comments received during a final Task Force exposure period.

The "Implementation Commentary" was drafted to be a companion document to the adopted 2007 NAIC *Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements* (#1950)—PEO Guidelines. It was believed that the companion paper was needed to assist states, professional employer organizations, and the insurance industry in implementing a regulatory framework consistent with the PEO Guidelines.

Bill Schilling (National Association of Professional Employer Organizations—NAPEO) suggested that the comment period be limited so that the draft might be ready for consideration of adoption by the Task Force during the 2010 Spring National Meeting. Director Scheiber agreed and suggested the comment period be closed 30 days prior to that national meeting, to allow time to consider any comments received and to prepare the final document for consideration of adoption.

Upon motion by Mr. Wake, and second by Mr. Wickman, the Task Force voted to bring the draft "Implementation Commentary" (Attachment Three) under the Workers' Compensation (C) Task Force's purview to enhance its public exposure—with a comment period to be open until 30 days prior to the 2010 Spring National Meeting.

Mr. Wake asked that any comments on the exposure draft be e-mailed to him, with copy to Bob Card (NAIC), no later than Feb. 24, 2010.

2. State of the Line Annual Report

Barry Llewellyn (National Council on Compensation Insurance—NCCI) provided a comprehensive review of workers' compensation based on information gathered and analyzed by his advisory organization. The review encompassed 2008 and prior workers' compensation results, workers' compensation premium drivers, workers' compensation loss cost drivers, and current data pertaining to the workers' compensation residual market. Among findings reported were the following:

- Workers' Compensation Results: Net written premiums continued to decline in 2008—$39 billion in 2008 (preliminary) compared to $44.2 billion in 2007. Employer workers' compensation costs as a percentage of total compensation (private industry)—1.7% in 2008 compared to 1.9% in 1998. Calendar year combined ratio for private carriers was the same for 2008 (preliminary) as for 2007—101%. By further comparison, for the years 1990 through 2008, the high was 123% in 1991 and low 93% in 2006. For 2001, 122% (1.9% due to 9/11). Accident year combined ratio for private carriers was 100% in 2008 (preliminary) compared to 96% in 2007. By further comparison, for the years 1999 through 2008, the high was 143% in 1999 and low 87% in 2005. Investment returns remain below historical average—10% for 2008 (preliminary) compared to 12.7% in 2007. By further comparison, for period 1990 through 2008, the high was 21.3% in 1998 and low 10% in 2006 and 2008.

- Workers' Compensation Premium Drivers: Impact of discounting on premium (private carriers) was -6.8% in 2008 (preliminary) compared to -4.6% in 2007. By further comparison, for the period 1991 through 2008, the high was +2.1% in 2004 and low -23.2% in 1999. Average approved bureau rates/loss costs was -1.7% in 2009 (states approved through 4/17/09) compared to -3.1% in 2008 and -6.6% in 2007 and 2004 through 2009 (cumulative) was -25.2%.

- Workers' Compensation Loss Drivers: Indemnity claim costs continue to grow (average indemnity cost per lost-time claim) — +5.0% in 2008 (preliminary) compared to +3.4% in 2007. Medical claim costs continue to grow in 2008 (average medical cost per lost-time claim) — +_6.0% in 2008 (preliminary) compared to +5.8% in 2007. Medical losses are more than half of total losses (all claims, NCCI states)—medical 58% and indemnity 42% in 2008 (preliminary). This compares with 53% medical and 47% indemnity in 1998; 46% medical and 54% indemnity in 1988. Lost-time claim frequency continues to decline— -4.0% in 2008 (preliminary) and -2.6% in 2007. For the period 1991 through 2008, there was a cumulative change of -54.9%.

- Workers' Compensation Residual Market (NCCI-serviced workers' compensation residual market pools as of Dec. 31, 2008): Residual market premium volume declines—$0.7 billion in 2008 (preliminary) compared with $1.0 billion in 2007. Residual market combined ratios—114% in 2008 (preliminary) compared to 112% in 2007. Residual market underwriting results—$-105 million in 2008 (preliminary) compared to $-119 million in 2007. Residual markets depopulated—$500.8 million in 2008 compared to $999.5 million in 2004 (-50%).

Mr. Llewellyn concluded that positives are: industry's capital position; workers' compensation underwriting results; that frequency continues to decline; and that residual market depopulation continues. He cited the negatives as low investment returns continuing to put pressure on underwriting results, potential reform erosion, medical costs still above inflation, uncertain political fallout from federal action, and the underwriting cycle.

3. H.R. 635 Update

Mr. Card provided a brief overview of H.R. 635. The proposed federal bill, introduced by U.S. Rep. Joe Baca (D-CA), would establish a National Commission on State Workers' Compensation Laws. The bill would require a proposed commission to take the following actions: 1) Review the findings and recommendations from a 1972 Report of the National Commission on State Workmen's Compensation Laws; 2) Study and evaluate state workers' compensation laws in order to determine if such laws provide an adequate, prompt and equitable system of compensation for injury or death arising out of or in the course of employment; and 3) Study and evaluate whether additional remedies should be recommended to ensure prompt and good-faith payment of benefits and medical care to injured workers and their families.

Mr. Card said the there are now 13 co-sponsors for H.R. 635. The latest co-sponsors include Rep. Emanuel Cleaver (D-MO), Rep. John Conyers (D-MI), Rep. Bob Filner (D-CA), and Rep. Mary Jo Kilroy (D-OH). Among those opposing the legislation are American Insurance Association, National Association of Professional Insurance Agents, National Conference of Insurance Legislators, Property Casualty Insurers Association of America, and the U.S. Chamber of Commerce. The proposal remains in the House Committee on Education and Labor, with no hearing currently scheduled. Mr. Card said the NAIC would continue to follow the bill and will notify the Task Force if chances for its passage improve.

Director Scheiber asked Mr. Card what the NAIC position is on H.R. 635. Mr. Card replied that he had received a written reply regarding that question from Amanda Yanek (NAIC), which indicated that state insurance regulators have statutory authority over only parts of the workers' compensation world—namely solvency and the rates and policy form language. The commission bill is concerned with the workers' compensation benefit structure, which is the purview of the state workers' compensation administrators—not insurance regulators. Thus the NAIC has not taken a position either for or against the bill. Joe Bieniek (NAIC) said the statement was derived from an NAIC Government Relations Leadership Council meeting—with the intent that the NAIC take no position on H.R. 635.

4. Model Law Review (C) Working Group

Mr. Card said that in 2010, the Model Law (C) Working Group will review the *Twenty-Four Hour Coverage Pilot Project Model Act* (#960) to recommend whether it should be deleted, amended, or left the same. The Working Group was recently reformed for this purpose. Director Scheiber appointed Randy Moses (SD) as chair of the Working Group.

5. NCOIL Independent Contractor Model Law

Mr. Cioppa announced that NCOIL had adopted its "Construction Industry Workers' Compensation Coverage Act" (NCOIL Independent Contractor Model Law) Nov. 22. Prior to this adoption, comments on the draft NCOIL Independent Contractor Model Law had been provided to that organization through a subgroup of the NAIC/IAIABC Joint (C) Working Group. The subgroup held conference calls Nov. 3 and Nov. 4, before submitting comments Nov. 12 to NCOIL for consideration during the NCOIL annual meeting. Both Director Scheiber and Executive Director Greg Krohm (International Association of Industrial Accidents Boards and Commissions—IAIABC) signed the letter providing the comments.

Mr. Cioppa said NCOIL did not accept the NAIC comments. He said the NAIC and IAIABC felt that the NCOIL Independent Contractor Model Law had some significant issues, and many of the statements made in the adopted model could be considered highly controversial. For example, in general the model law would require principal contractors, intermediate contractors and subcontractors to carry workers' compensation insurance—regardless of the number of employees. The model law was restricted to apply only to the construction industry, although the original drafting had proposed a broad-based workers' compensation bill dealing with all employments. Mr. Cioppa encouraged those present to review the NCOIL adopted model provided in the meeting materials.

Susan Nolan (NCOIL) stated that she thought her organization had produced a good model. Seven NCOIL conference calls took place for drafting the model law, with not much time for comment between calls. She noted that her office received many comments from members of the NAIC/IAIABC Joint (C) Working Group. She noted that experienced legislators worked on the NCOIL draft, and there seemed to be much agreement among them that the adopted model would be very valuable to the states.

Mr. Wickman asked if Ms. Nolan would clarify the coverage requirements under Section 3 of the NCOIL Independent Contractor Model Law, as he was not clear if a sole proprietor (e.g., plumber) would be required to cover himself for workers' compensation under the model, or would just have to have workers' compensation coverage for his employees—if any. Ms. Nolan said the intent is to require that the sole proprietor have workers' compensation coverage when working for someone else, but not when performing work on his or her own property.

Mona Carter (NCCI) stated that at first, the legislators drafting the model believed all workers should be covered, even though they might be sole proprietors working alone without any employees. Then, as the model progressed, it was determined that the emphasis should be placed on the general or principal contractor—to be held responsible for ensuring that any workers or subcontractors under their control were covered for workers' compensation (e.g., via certificates of insurance for subcontractors).

Ms. Nolan emphasized that through Section 3, the workers' compensation liability flows upstream to the general or principal contractor. Ms. Carter added that every state has an opportunity to review the model. No longer will a general or principal contractor not be responsible for workers' compensation of any workers on their job site.

Director Scheiber urged regulators who are considering adoption of the model to review it thoroughly and compare it with current state statutes.

6. Revised Third Party Administrator (TPA) Guidelines

Mr. Wickman said a revision of the draft TPA Guidelines is to be distributed to members of the Task Force and the Large Deductible Study Implementation (C) Working Group in the next few days. The packet of information includes two draft versions (one including and one not including workers' compensation), copies showing tracked changes and a cover letter. He explained that the original intent of the draft TPA Guidelines was essentially to rewrite the current NAIC Statute (model law #90, adopted in 1977) by including workers' compensation. But as the draft guidelines evolved, it became clear that further updating was necessary—including some changes pertaining to health insurance. He said the current model would be replaced by the draft guidelines once they are adopted by the NAIC. Mr. Wickman said the revision includes a number of changes pertaining to health insurance that have been suggested through the Regulatory Framework (B) Task Force. He added that after many months of consulting with that Task Force and receiving e-mail correspondence from the health insurance industry, the draft appears satisfactory to them and is ready to move forward.

Mr. Wickman said the next step is to hold a Large Deductible Study Implementation (C) Working Group conference call in late January 2010 to review the changes made. Once the Working Group is satisfied with the changes, the draft would be forwarded to the Producer Licensing (EX) Task Force for review. After that, the draft would be presented for consideration of adoption by the Workers' Compensation (C) Task Force—perhaps as early as the 2010 Spring National Meeting.

Upon motion by Mr. Wickman, and second by Mr. Cioppa, the Task Force voted to present the revised draft TPA Guidelines through the Large Deductible Study Implementation (C) Working Group to the Producer Licensing (EX) Task Force for review. Mr. Wickman sought this motion as a matter of protocol for sending the draft through the Working Group to another task force.

Director Scheiber expressed interest in seeing this project completed by the Workers' Compensation (C) Task Force during the 2010 Spring National Meeting. He asked Mr. Card to let him know when the Large Deductible Study Implementation (C) Working Group completed its review of the draft TPA Guidelines so that he might assist in some way when presenting the draft to the Producer Licensing (EX) Task Force.

7. Adoption of Working Group Materials

The Task Force reviewed the draft summary of the Large Deductible Study Implementation (C) Working Group; the minutes of the NAIC/IAIABC Joint (C) Working Group Dec. 5 meeting (Attachment One); and the minutes of the Professional Employer Organization Model Law (C) Working Group Nov. 6 conference call (Attachment Two). Upon motion by Mr. Wickman, and second by Ted Clark, the Task Force adopted the minutes and the summary.

Having no further business, the Workers' Compensation (C) Task Force adjourned.

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Draft: 12/14/09

NAIC/IAIABC Joint (C) Working Group
San Francisco, CA
December 5, 2009

The NAIC/IAIABC Joint (C) Working Group of the Workers' Compensation (C) Task Force met in San Francisco, CA, Dec. 5, 2009. The following Working Group members participated: Eric Cioppa, Co-Chair (NAIC—ME); Bill Lacy (NAIC—AR); Christopher Citko (NAIC—CA); Mark Franklin (NAIC—CT); Robin Westcott (NAIC—FL); John Gatlin (NAIC—IL); Ted Clark (NAIC—KS); Bob Wake (NAIC—ME); Tammy Lohmann (NAIC—MN); Angela Nelson (NAIC—MO); Alan Wickman (NAIC—NE); Linda Baum (NAIC—NJ); Marie Holt (NAIC—NV); Kathie Stepp (NAIC—OK); Rae Taylor (NAIC—OR); Paula Pallozzi (NAIC—RI); Michael Bertrand (NAIC—VT); and Bill Kenny and Mary Jane Pickens (NAIC—WV).

1. Draft Implementation Commentary

Mr. Wake presented the Sept. 22 exposure draft "Implementation Commentary" of the NAIC Professional Employer Organization Model Law (C) Working Group. The purpose of the "Implementation Commentary" is to assist the states, professional employer organizations (PEOs) and the insurance industry with implementing a regulatory framework consistent with the NAIC *Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements* (#1950)—NAIC PEO Guidelines.

The draft Implementation Commentary includes the following sections (and two appendices): Executive Summary; Historical Background of the Guidelines; Some Legal Issues Relating to Implementation; and Specific Issues Related to the Guidelines. Among the specific issues addressed are those pertaining to the statutory-regulatory framework of PEOs, master policies and experience rating, proof of coverage, pricing, exclusive remedy, residual market issues, improper extensions of coverage (piggybacking), self-insurance, and loss-sensitive coverage.

Mr. Wake said the adopted NAIC PEO Guidelines make some significant changes in the way PEOs are regulated—particularly in the policy area. The guidelines therefore offer some challenges, both in understanding how the new regulatory process will work and the extent to which parts of the new guidelines interact with each other. He noted that a state may have unintended consequences if it adopts some sections but not others in the guidelines. Therefore, he said, it was decided it was important to draft, as a companion document, the Implementation Commentary to explain what the NAIC PEO Guidelines do and what the principle issues are both for regulators and private stakeholders, because the guidelines require changing the way business has been done. He said that most notably, in this regard, the draft guidelines focus on the importance of tracking coverage at the client level, even in master policy situations for purposes that include experience rating, data reporting, proof of coverage, and establishing the inception and termination of coverage. He added that master policy arrangements now would require that each client be an additional insured who would obtain a certificate of coverage. He said that from the industry standpoint, the issue of biggest concern is how to implement master policy data reporting at the client level for experience rating and other statistical purposes.

Mr. Wake said the Working Group essentially completed its review of the draft Implementation Commentary during the NAIC Fall National Meeting, although some minor changes were made after that date and some discussion may still ensue regarding how to improve readability of Appendix B, titled *NCCI Alternatives and Technical Supplement on Data Reporting*. However, during the Nov. 6 Working Group conference call, a motion was made and passed to advance the draft Implementation Commentary to the Workers' Compensation (C) Task Force during the NAIC Winter National Meeting with the understanding that the draft should remain open for comment and possible revision through Feb. 24, 2010. The date was chosen to allow 30 days before the NAIC 2010 Spring National Meeting for comments received to be considered and any further changes made before the Workers' Compensation (C) Task Force considers adoption of the draft in at the meeting. Mr. Wake asked that any comments on the exposure draft be e-mailed to him, with copy to Bob Card (NAIC), no later than Feb. 26, 2010.

Mr. Wickman questioned whether the Professional Employer Organization Model Law (C) Working Group would have a purpose after NAIC adoption of the Implementation Commentary. He explained that current PEO issues have now been addressed through the Working Group's efforts through the development of the PEO Guidelines and now the Implementation Commentary. However, he said, the Professional Employer Organization Model Law (C) Working Group will want to keep on top of future developments in this area, so perhaps should remain—at least for some time—as a group of the NAIC. Mr.

Card noted that the Workers' Compensation (C) Task Force 2010 charges state that one of the Professional Employer Organization Model Law (C) Working Group's duties is to "follow changes in the professional employer organization marketplace." Therefore, the Professional Employer Organization Model Law (C) Working Group has the authority under the 2010 charges to continue (albeit inactive) at least through that year.

2. NCOIL Independent Contractor Model Law

Mr. Card said the NCOIL Independent Contractor Model Law Subgroup met by conference call on several occasions to provide the National Conference of Insurance Legislators (NCOIL) with comments on that organization's draft "Construction Industry Workers' Compensation Coverage Act" (NCOIL independent contractor model law). NCOIL adopted its independent contractor model law Nov. 22, during the NCOIL Annual Meeting.

Mr. Cioppa observed that NCOIL apparently did not accept any of the changes proposed by the Subgroup. Mr. Wickman and Mr. Kenny agreed with that assessment. Mr. Kenny added that he had attended the NCOIL meeting, which considered adoption of the independent contractor model law, but did not recall hearing much discussion about the model or interest in accepting any of the language proposed through joint efforts of the NAIC and IAIABC.

Mr. Cioppa reflected that many of the statements made in the adopted NCOIL independent contractor model law could be considered highly controversial. For example, in general the model law would require principal contractors, intermediate contractors and subcontractors in the construction industry to carry workers' compensation insurance—regardless of the number of employees. The model law was also restricted to apply only to the construction industry, although the original drafting had proposed a broad-based workers' compensation bill dealing with all employments. Mr. Cioppa encouraged those present to review the adopted copy provided in the meeting materials.

Mr. Wickman observed that the adopted model will probably be of greatest regulatory interest to the state workers' compensation administrative agencies, but he noted that the construction industry would also be very interested, as construction costs would likely increase if the model is adopted by states in its present form. He added that many concerns identified in the model might be cleaned up by a state before making law changes.

Mr. Citko mentioned that California had recently required roofers to obtain workers' compensation insurance to be able to receive a C39 license to operate in that capacity in the state. He said that sole proprietors, while having to obtain workers' compensation coverage, could opt not to cover themselves. Most of these policies, he added, are being written by the California Workers' Compensation Insurance Fund.

Ms. Taylor said Oregon passed a law two and a half years ago that allowed certain contractors to be exempt from workers' compensation. However, effective July 10, 2010, Oregon will require that, to become licensed in that capacity, these same contractors obtain workers' compensation coverage. The new licensing law will require that individual owners (e.g., sole proprietors) be covered for workers' compensation along with any of their employees. She added that the licensing requirement change is expected to cause an influx of workers' compensation policies to be written through the Oregon assigned risk plan.

Mr. Cioppa concluded this discussion by mentioning that Mr. Card should be contacted if anyone would like a copy of the Subgroup comments sent to NCOIL Nov. 12.

3. Independent Contractor Trucking Issues Focus Group Update

Mr. Wickman said the Independent Contractor Trucking Issues Focus Group update ties in with NCOIL's Nov. 25 announcement regarding the adoption of that organization's independent model law. As part of that announcement, NCOIL had stated: "As an offshoot of the model, the NCOIL Workers' Compensation Committee has been charged in 2010 to examine the use of independent contractors in the trucking and transportation industries." Mr. Wickman said that in October 2008, the Focus Group e-mailed a letter to a number of trucking industry and related organizations to try to identify and understand workers' compensation practices in the trucking industry that seem unfair. This was an effort to solicit information, not to develop a model law or write a major white paper. He said the replies received primarily suggested legislative changes to overcome abuses such as those arising when a business wants to call workers (drivers, primarily) something other than employees in order to avoid the costs of workers' compensation.

Mr. Wickman asked what steps the Focus Group should now take—in light of the NCOIL announcement to begin drafting a trucking industry independent contractor model law. He surmised that further work by the Focus Group would now seem to depend on what NCOIL does regarding the announcement. Mr. Cioppa said he believed that if NCOIL was going ahead with drafting a trucking industry independent contractor model law, then he did not believe the Focus Group should try to move forward.

Mr. Card said he would contact NCOIL to discuss that organization's timetable and scope for drafting a trucking industry independent contractor model law. He would notify Mr. Cioppa and Mr. Wickman of his findings so that a sound decision could be made regarding future Focus Group activities.

4. NAIC Large Deductible Study Implementation Working Group Update

Mr. Wickman said the Large Deductible Study Implementation Working Group did not meet this quarter, as the draft Third-Party Administrator (TPA) Guidelines was recently revised with health insurance changes made in accordance with those proposed by the NAIC Regulatory Framework (B) Task Force. While the primary purpose for drafting the TPA Guidelines—which is expected to replace the current NAIC statute (model law #90)—was to add workers' compensation, the draft additionally provided some updating from the current model that pertained to health insurance. A revised draft, which will be released for comment shortly after the Winter National Meeting, will be presented in two versions. One version will include workers' compensation and one version will not. The purpose of the two versions is to allow a state to choose the version it finds most appropriate to its needs.

Mr. Wickman noted that the Regulatory Framework (B) Task Force had been critical of many health insurance changes proposed through the draft, but seems satisfied with the latest revision, which will be distributed soon.

Mr. Wickman said he plans to hold a Large Deductible Study Implementation (C) Working Group conference call in late January 2010 to consider the recent changes made to the draft TPA Guidelines and, once any remaining issues have been resolved, submit the revised draft to the Producer Licensing (EX) Task Force for review. Upon receiving final comment back from the Producer Licensing (EX) Task Force the revised draft will be presented for consideration of adoption to the Workers' Compensation (C) Task Force—possibly during the 2010 Spring National Meeting.

5. Workers' Compensation Large Deductible Subgroup Update

Mr. Wickman said the Workers' Compensation Large Deductible Subgroup of the Casualty Actuarial and Statistical (C) Task Force has been evaluating whether a preferable method could be developed for assessing workers' compensation large deductible premiums. States today usually base large deductible policy assessments on direct written premiums net of deductible, but some states assess based on paid losses that then add back deductible losses. Mr. Wickman reported that the subgroup is currently creating a summary to present, but also to recommend against the use of direct premiums net of deductible credits.

6. H.R. 635 Update

Mr. Card provided a brief overview of H.R. 635. The proposed federal bill, introduced by U.S. Rep. Joe Baca (D-CA), would establish a National Commission on State Workers' Compensation Laws, which would: 1) review the findings and recommendations from a 1972 Report of the National Commission on State Workmen's Compensation Laws; 2) study and evaluate state workers' compensation laws in order to determine if such laws provide an adequate, prompt and equitable system of compensation for injury or death arising out of or in the course of employment; and 3) study and evaluate whether additional remedies should be recommended to ensure prompt and good faith payment of benefits and medical care to injured workers and their families.

Mr. Card said there are now 13 co-sponsors of H.R. 635, including: Rep. Emanuel Cleaver (D-MO), Rep. John Conyers (D-MI), Rep. Bob Filner (D-CA), and Rep. Mary Jo Kilroy (D-OH). The following entities are among those opposing the legislation: American Insurance Association, National Association of Professional Insurance Agents, National Conference of Insurance Legislators, Property Casualty Insurers Association of America, and the U.S. Chamber of Commerce. The proposal remains in the House Committee on Education and Labor, with no hearing currently scheduled. Mr. Card said the NAIC would continue to follow the bill and will notify the Working Group if chances for its passage improve.

7. Consider Working Group Activities for 2010

Mr. Cioppa asked what new projects the Working Group might consider for next year. He presented an e-mail received Dec. 4 from Greg Krohm, Ph.D. (IAIABC co-chair) suggesting possible projects, such as a paper on the ramifications of federal health care reform on workers' compensation; a critique of the Oct. 22 press release by Frank Neuhauser (University of California, Berkeley) (Attachment One-A) that proposes rolling workers' compensation into general health insurance as 24-hour coverage; and an exploration of the literature on why workers' compensation medical cost rates are escalating more than general health costs.

Of these suggestions, the 24-hour coverage suggestion was the most discussed. Mr. Card mentioned that the Model Law Review (C) Working Group of the Workers' Compensation (C) Task Force will review the 1994 NAIC adopted *Twenty-Four Hour Coverage Pilot Project Model Act* (#960) next year. This review will be conducted to determine if the model should be deleted, amended, or left the same. Mr. Card said the Model Law Review (C) Working Group has already been formed to pursue this analysis and make recommendations back to the Task Force in 2010. He added, however, that input from the NAIC/IAIABC Joint Working Group may prove very helpful to the Model Law Review (C) Working Group, should efforts be combined in some way.

Ms. Taylor mentioned that Oregon had tried a 24-hour program in the 1990s, but could not get it to work satisfactorily. Mr. Cioppa and Mr. Citko said their states also had tried unsuccessfully to conduct a 24-hour program in the 1990s. Mr. Citko suggested that decisions involving 24-hour coverage be postponed until after regulators are able to determine what changes the federal government may be making to health insurance. Mr. Cioppa asked that further thoughts on 2010 activities for the Working Group be e-mailed to Mr. Card for later consideration.

8. Next Working Group Meeting

The next Working Group meeting will be in Nashville during the IAIABC All Committee Conference April 19-21, 2010.

Having no further business, the NAIC/IAIABC Joint (C) Working Group adjourned.

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SANTA BARBARA . SANTA CRUZ

Embargoed for release:
12:00 noon, October 22, 2009

Contact: Frank Neuhauser
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Summary

A study to be released on Thursday by researchers at the University of California, Berkeley finds substantial differences between the administrative cost of delivering medical treatment through the current private health insurance system and other payers for medical treatment, particularly workers' compensation. The study, "**Comparing the costs of delivering medical benefits under group health and workers' compensation—An answer to financing universal coverage?"** was funded under a grant from the California Healthcare Foundation in Oakland CA. The authors find integrated medical care, often called "24-hour care," would improve the efficiency of medical delivery, greatly reduce administrative costs, and potentially offer savings sufficient to cover a large fraction of the cost of universal coverage.

Findings

Administrative cost of insurance

- In California, based on review of all rate filings by insurers between 1999 and 2009, the administrative cost of delivering medical treatment for occupational injuries and illness through workers' compensation insurance is between 52% and 57% of insurance premiums.
- A review of aggregate data on 37 other states finds similar, possibly higher, administrative costs for workers' compensation.
- The comparable cost for private health insurance, according to the Centers for Medicare and Medicaid Services, averaged 12.4% of premiums.

Savings under 24-hour care

- Integrating occupational and non-occupational medical treatment under the more efficient health insurance system would reduce administrative costs and produce large one-time savings from switching insurance models.
- Nationally, savings in the first 10 years would be between $490 billion and $560 billion.
- In California, integration would produce savings in the first 10 years of $100 billion to $120 billion

Paying for universal coverage

- Using prior estimates of covering the uninsured, the study projects the ten-year cost of universal coverage to be between $715 billion and $1,870 billion nationally.
- Depending on the ultimate cost of universal coverage, the authors estimate the savings from 24-hour care could cover 26% to 78% of the cost of covering the uninsured.

The study cautions that 24-hour care is difficult to implement in the absence of near universal coverage for the working-age population. However, the savings from integration would cover a substantial fraction of extending coverage to the currently uninsured..

The study is based on a detailed review of all rate filings between 1999 and 2007 by insurers writing workers' compensation coverage in California and rate filings by the Workers' Compensation Insurance Rating Bureau of California (WCIRB) for the same years. National estimates also use data available from the National Academy on Social Insurance (NASI), a non-partisan, non-profit research institute in Washington, DC and the National Council on Compensation Insurance, Inc. (NCCI) a private firm that acts as the rating bureau for 37 states.

Note to reporters: the full study and appendices are available from the lead author, Frank Neuhauser, frankn@berkeley.edu or 510-643-0667

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Professional Employer Organization Model Law (C) Working Group
Conference Call
November 6, 2009

The Professional Employer Organization Model Law (C) Working Group of the Workers' Compensation (C) Task Force met via conference call Nov. 6, 2009. The following Working Group members participated: Robert Wake, Chair (ME); Becky Harrington (AR); Mark Franklin and Tom Taggart (CT); Dick Cook (KS); Alan Wickman (NE); Janice Moskowitz (NV); Kathie Stepp (OK); and Tonya Gillespie (WV).

1. Chair's Opening Remarks

Mr. Wake explained that the distributed Sept. 22 draft "Implementation Commentary: Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements" (PEO Implementation Commentary) replaced the earlier version dated Sept. 13 that had been reviewed by the Working Group and the Workers' Compensation (C) Task Force during the Fall National Meeting. Other than some minor changes, he said, the drafts are the same. While the Sept. 22 draft PEO Implementation Commentary had been distributed several weeks prior to this conference call, no comments on it were received.

Mr. Wake expressed optimism that the Working Group might therefore adopt the Sept. 22 draft during the conference call. He noted that Noreen Vergara (NAIC) had stated in an Oct. 22 e-mail that she did not see a problem with attaching the PEO Implementation Commentary to the Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (NAIC PEO Guidelines). She said it could also be adopted as a separate white paper—subject either way to final adoption by the Joint Executive (EX) Committee/Plenary. Mr. Wake therefore believed that when the draft PEO Implementation Commentary was adopted, a decision would also need to be made regarding whether it be added as an appendix to the NAIC PEO Guidelines or stand alone as a white paper.

2. Working Group Discussion

Mr. Wickman implied that while the draft PEO Implementation Commentary appeared very close to adoption, he was concerned that Appendix B, titled "NCCI Alternatives and Technical Supplement on Data Reporting," may need further work. He had intended to provide comment on Appendix B, but had not been able to get to that prior to the conference call. The changes he was planning to suggest for Appendix B were generally minor; however, he would like to see the appendix made more expansive and reader friendly. Mr. Wickman emphasized that he did not want to delay adoption of the draft if no other impediments were observed.

Bill Schilling (National Association of Professional Employer Organizations—NAPEO) said he was concerned that the Sept. 22 draft Implementation Commentary had not been exposed long enough for comments from all parties that may be impacted. In particular, he mentioned that adequate exposure should be provided to interested parties, state insurance regulators, and International Association of Industrial Accident Boards and Commissions (IAIABC) members—not just to those involved directly with the Working Group. Bob Card (NAIC) mentioned that the Sept. 22 draft PEO Implementation Commentary had been posted on the NAIC Web site shortly after being received from Mr. Wake, which allowed opportunity for comment.

Mona Carter (National Council on Compensation Insurance—NCCI) agreed with Mr. Wickman that the options presented in Appendix B may lead to some confusion and may need to be revised. She said her advisory organization might add some questions before each option to help guide regulators in their selection. Based on recent discussions with insurance regulators, NCCI had been developing questions about the options. Mr. Schilling agreed that some revision to Appendix B as suggested by Mr. Wickman and Ms. Carter was in order and that prefacing options with questions as suggested by Ms. Carter may be beneficial to the states in choosing a proper data reporting approach.

3. Motion

Mr. Wickman made the following multi-part motion:

- That the draft PEO Implementation Commentary be moved from the Working Group to the Workers' Compensation (C) Task Force during the Winter National Meeting.
- That the Workers' Compensation (C) Task Force be asked to properly expose the draft PEO Implementation Commentary as suggested by Mr. Schilling and allow time for additional comments for possible revision, especially in regard to Appendix B.
- That the Workers' Compensation (C) Task Force would not be expected to consider adoption of a revised PEO Implementation Commentary until it meets during the 2010 Spring National Meeting.

Upon motion by Mr. Wickman and second by Mr. Franklin, the Working Group adopted the entire multi-part motion and the PEO Implementation Commentary. Once the PEO Implementation Commentary is adopted by the Workers' Compensation (C) Task Force, the draft will be considered for adoption by the Property and Casualty Insurance (C) Committee, and finally—probably during the second national meeting of 2010—the Joint Executive (EX) Committee/Plenary.

Mr. Wake added that upon consideration of PEO Implementation Commentary adoption by the Workers' Compensation (C) Task Force, a Task Force decision should also be made regarding whether the draft is to become an appendix to the NAIC PEO Guidelines or stand alone as an NAIC white paper.

Having no further business, the Professional Employer Organization Model Law (C) Working Group adjourned.

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Implementation Commentary
(9/22/09 Working Group Draft)

GUIDELINES FOR REGULATIONS AND LEGISLATION ON WORKERS' COMPENSATION COVERAGE FOR PROFESSIONAL EMPLOYER ORGANIZATION ARRANGEMENTS

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Executive Summary

This Implementation Commentary is designed to assist states, PEOs, and the insurance industry to implement a regulatory framework consistent with the "Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements" ("Guidelines") adopted by the NAIC in 2007, which are attached as Appendix A. The Commentary provides a framework for considering the Guidelines and provides additional information concerning:

- The historical background of the Guidelines, including an overview of professional employer organization (PEO) arrangements;
- Differences between the Guidelines and earlier regulatory approaches;
- Statutory and structural considerations for implementation; and
- Key issues that may be essential for successful implementation.

The PEO business model for employment services outsourcing has continued to expand nationwide.[1] While employment services outsourcing and the concept of co-employment involve a number of issues for states, one significant issue is how state workers' compensation systems adapt to address the requirements of this method of doing business. Presently, there is a broad disparity among states in how they regulate these and other outsourcing arrangements. The existing statutory frameworks in some states may not directly or adequately address issues related to workers' compensation, while other states are devoid of any significant statutory provisions.

The Guidelines are designed to provide the states with a possible regulatory framework for addressing the most significant workers' compensation issues that have arisen to date in PEO relationships, with an emphasis on a clear allocation of the respective rights and responsibilities of PEOs, clients, and insurers. In some cases the Guidelines seek to clarify or codify current best practices, while in others, they mandate some significant changes from the *status quo*. The purpose of this commentary is to provide additional insight from the working group that developed the Guidelines.

I. Historical Background of the Guidelines

The Guidelines are the culmination of over eighteen years of experience, effort, and deliberation by the NAIC, with input from the International Association of Industrial Accident Boards and Commissions ("IAIABC"). The Guidelines, as adopted in 2007, are a successor to a model statute and regulation of far more limited scope adopted by the NAIC in 1991. The Guidelines draw heavily upon the 2002 Report on Employee Leasing and Professional Employer Organizations produced by the NAIC-IAIABC Joint Working Group, on input from that Joint Working Group, and on over three years of deliberation and work by the NAIC Professional Employer Organization Model Law (C) Working Group of the NAIC Workers' Compensation Task Force.

This historical overview is designed to provide a context for those who are seeking to use the Guidelines as a basis for statutory and regulatory actions. While the Guidelines pertain only to the issue of workers' compensation in PEO situations, an understanding of the broader context of the evolution of PEOs and of these Guidelines should assist those using them.

A. Origins of the PEO Industry and the Initial Regulatory Responses

The PEO industry began its evolution in the 1970's as the employee leasing industry. Initially, it involved a client terminating its entire workforce, a leasing company employing that workforce, and then the leasing company providing that same workforce back to the client as leased employees. The idea was for the leasing company to be "the employer" or general employer of the workers, who would be working for the client company as "borrowed servants." Unlike traditional

[1] The National Association of Professional Employer Organizations (NAPEO) estimates that the PEO industry has grown to $68 billion in gross revenues in 2008. One source for information about the PEO industry is the NAPEO web site at www.napeo.org

staffing entities which would provide additional temporary workers to a client for specific needs such as seasonal work or filling in for absences, and then reassign those workers to another client when the need was over, this new concept involved entire workforces on a long-term basis.

The concept was designed to allow the client to focus on the core business of its enterprise and to leave the employment-related issues to the leasing company, which could save costs through economies and efficiencies of scale usually only available to larger enterprises. The leasing company maintained that as the employer of the leased workers it was both able to and also required to secure workers' compensation for the worksite employees leased to a client. However, the concept was also susceptible to abuse. As the 2002 NAIC-IAIABC Report stated:

> There are many reasons for entering into employment services outsourcing agreements. Many businesses become employment services outsourcing clients because they find it to be an efficient way to obtain high quality administrative services, and many of these outsourcing companies have worked hard to develop professional standards for the industry. However, other employment services outsourcing arrangements have been motivated by factors ranging from exploitation of loopholes in rating rules to outright fraud.

In particular, a widespread abuse observed by regulators was the use of employee leasing arrangements for "mod laundering" – that is, the employee leasing company would claim that as a brand new employer, its workers' compensation premium should not be affected by the accident experience of its clients before they had joined the employee leasing arrangement. The opaque, poorly documented nature of some employee leasing arrangements also fostered shell games, in which workers and worksites fell into gaps where neither the client nor the leasing company was paying the premium for the exposure. Occasionally, the leasing company simply charged its clients for insurance it never bought.

Over time, it was generally agreed that "employee leasing" was a misnomer for what factually transpired in the service relationship. From the employees' perspective, their boss was still the client, which continued essentially the same employment relationship with the employees as before. On the other hand, most states recognized that the service firm did also enter into an employment relationship with the employees. Thus, both businesses had employment duties, which were shared and allocated according to the terms of the service contract between the service firm and the client.

Because of these facts, the initial "fire and lease back" concept of employee leasing has largely been abandoned and replaced by the "co-employment" relationship used by today's PEOs. Under this concept, employer responsibilities are shared or allocated between the client and the PEO by contract (and in some states by law). Most states now recognize both the PEO and the client as having employer responsibilities with regard to a worksite employee.

Nonetheless, the movement of workers' compensation responsibilities for these employees from client to a leasing company and back or from leasing company to leasing company had a major impact on the experience rating system.

Under traditional rating rules, a client customarily lost its experience factor because its entire workforce was absorbed into the leasing company's larger workforce and became insured under a master policy covering the leasing company. As noted earlier, this system allowed unscrupulous leasing companies to offer high-risk, high-experience-factor clients a lower premium by moving the workforce into a leasing company with a lower experience modifier, often a recently organized (or reorganized)[2] company with a "unity" modifier, meaning no adjustment for experience. Experience rating concerns were the principal focus of the 1991 NAIC model act and regulation, which mandated that:

> 1) leasing companies must be registered with any state where they did business;
>
> 2) a leasing company must use a multiple coordinated policy arrangement in the residual market instead of a master policy; and
>
> 3) an insurer in a master policy arrangement must be able to generate the information necessary to establish an accurate experience factor for a client that left a leasing arrangement.

[2] Although the rating rules are designed to prevent employers from reorganizing with a clean slate whenever adverse experience develops, through provisions that combine the experience of predecessor and successor employers, the complexities in the employee leasing relationship and the structure of employee leasing companies as service providers rather than "bricks and mortar" businesses provided more opportunities for employee leasing companies and their clients to evade these rules by disguising continuity of operations.

B. Development and Objectives of the Guidelines

As the leasing industry grew and evolved into the PEO industry,[3] the initial NAIC models proved inadequate. Experience rating issues continued to be a problem and additional regulatory concerns were identified. As a result a second study was undertaken by the Joint NAIC-IAIABC Committee, the NAIC rescinded the 1991 models, and the present Guidelines were developed.

Several fundamental decisions were made by the NAIC Working Group at the outset, which guided development of the Guidelines:

1. Limited Scope – While the Working Group recognized that there are multiple state law and regulatory issues related to PEOs (including other insurance issues such as health benefits), the Guidelines would be limited solely to the issues of workers' compensation.

2. Multiple Options – The group recognized that there was significant variation across the states with regard to workers' compensation in PEO arrangements. Some states had adopted the initial NAIC models (or a variant of those models), some states required PEOs to use multiple coordinated policies in both the residual and voluntary markets, and other states allowed master policy arrangements in the name of the PEO or leasing company. The group decided to provide guidance that could be adapted and used for any or all of these situations.

3. Voluntary versus Residual Markets – The Working Group, recognizing the peculiar responsibilities of the residual market, opted to maintain the requirement of a multiple coordinated policy or client-based policy in the residual market. Greater flexibility is allowed under the Guidelines for insurers and insureds in the voluntary market as long as essential requirements for coverage, experience, and notice are met.

4. Implementation Commentary – Because of the complexity of the Guidelines, the need to address a number of issues legislatively, and the fact that the Guidelines address only the workers' compensation aspects of PEO arrangements, it was decided to issue a companion paper to the Guidelines to give state regulators and legislators additional context for implementation.

Significant changes had occurred in both the PEO industry and in state regulation between the development of the first NAIC model rule and act in 1989-1991 and the efforts of the Working Group in 2003-2007. In 1991, only four states[4] had any kind of statutory scheme to regulate the PEO (then employee leasing) industry. By the NAIC adoption of the Guidelines in 2007, thirty-two states[5] had enacted some form of registration or licensing legislation for the industry. While some of these statutes are limited in scope, most of the more recent statutes are more comprehensive and provide significant legislative guidance as to the definition and treatment of the PEO industry. Some specifically address workers' compensation issues and virtually all recognize a PEO as an employer for purposes of workers' compensation.

As work on the Guidelines proceeded, the Working Group recognized the importance of looking from the ground up at the tripartite relationship among the PEO, the client, and the insurer, and carefully considering the contractual and financial obligations that each of them has toward each of the other two. As a result, the Guidelines have addressed several areas where the Working Group determined that existing laws and practices needed to be changed, or where vague situations needed to be clarified, including:

- A formal, documented obligation by the insurer to the client.

[3] Over time, this type of arrangement has become known as a professional employer organization (PEO) co-employment arrangement where both the PEO and the client have certain employer obligations.

[4] Arkansas, Florida, Maine, and Utah.

[5] AL, AZ, AR, CA, CO, FL, IL, IN, KY, LA, ME, MA, MN, MT, NV, NH, NJ, NM, NY, NC, ND, OH, OR, PA, RI, SC, TN, TX, UT, VT, VA, and WV.

- Termination of one co-employer's coverage does not automatically terminate the other co-employer's coverage, especially when there has not been sufficient notice.

- Clear recognition of a payment structure under which the client's obligation is to pay fees to the PEO, and the PEO's obligation is to pay premium to the insurer.

- Coverage issued through a PEO must cover the client's full workforce, unless the client has other coverage that provides full "catch-all" protection for any employees who are not co-employed by the PEO.

- Experience must be reported at the client level on an ongoing basis, not just when the client leaves the PEO.

- An experience modification factor will be calculated for all experience-rated clients, even in situations where the insurer and PEO choose to calculate premium on the basis of the PEO's experience.

- Disclosure requirements so that clients clearly understand their rights and responsibilities.

II. Some Legal Issues Relating to Implementation

A. Existing Law

One of the first issues for a state to consider, when seeking to use or implement the Guidelines, is to assess the status of current state law with regard to PEOs and employer status. The Guidelines are structured as a regulation, but state law must provide a proper statutory foundation in order to be able to adopt all or part of the Guidelines as a regulation. In many states, certain provisions contained in the Guidelines may be more cleanly adopted as statutes, while other states may have concerns about delegation of too much authority to an administrative agency. In addition, some provisions go beyond the traditional bounds of insurance regulation, such as the requirement for a PEO to provide clear and conspicuous written notice to clients if the PEO is not assuming responsibility for workers' compensation coverage. Although providing PEO services without workers' compensation coverage is not the norm, it is not an insurance transaction, it is the absence of an insurance transaction. Thus, unless the insurance regulator has already been given general regulatory authority over PEOs, or the Legislature has otherwise specifically addressed the issue, it would not ordinarily trigger the jurisdiction of the insurance regulator.

For these reasons, it is necessary for each state to analyze its individual situation to determine which provisions contained in the Guidelines are best addressed by directly making those changes to state law, and which provisions are best addressed through enabling language so that the state can adopt the Guidelines provisions through rulemaking.[6] It is important to consider these issues carefully, with due regard for possible unintended consequences. For example, some states, when implementing the 1991 recommendation to prohibit master policies in the residual market, phrased their laws in the form "a master policy shall be issued in the voluntary market," which would appear to prohibit the issuance of multiple coordinated policies in the voluntary market.

In states where "delegation of authority" issues are not substantial, one possible approach is to adopt broad enabling language, such as the following:

[6] As the Drafting Note to Section 1 explains: "These guidelines are presented in the form of a regulation; however, some provisions may be more appropriately enacted as legislation in some states. Agencies promulgating regulations based upon these guidelines should ensure that statutes regulating PEOs or employee leasing arrangements, statutes regulating workers' compensation insurance, or other applicable law grant them adequate rulemaking authority. In states where another agency has regulatory jurisdiction over PEOs, the commissioner should consider jointly promulgating regulations with that agency. Agencies promulgating regulations or drafting legislation based upon these guidelines should also ensure that insurers, PEOs and regulators have adequate resources and infrastructure in place to make compliance feasible, including but not limited to the necessary information systems and the necessary reporting mechanisms for data and proof of coverage."

The Commissioner may adopt regulations establishing the terms and conditions governing the provision of workers' compensation insurance coverage for workers in a professional employer organization arrangement.

An informal survey of state insurance department counsel indicates that most states believe they would have the legal authority to take such an approach. However, some state constitutions or administrative procedure acts would require a more detailed delegation of authority, and states might also have public policy reasons for wanting to address some aspects of the Guidelines more explicitly by statute. There are also additional questions that each state must address:

- Is there an existing registration or licensing system that can be used for (or must be considered when adopting) the registration and reporting requirements?
- Are there existing definitions of PEOs or leasing companies that should or must be used, or that ought to be changed?
- How do existing statutes, regulations, and rating rules governing all employers apply to employers involved in "co-employment" relationships?
- Must statutory provisions be added or modified in order to allow for the Guidelines to be promulgated as a regulation or to make the regulatory approach effective?

The provisions for the exclusivity of the workers' compensation system for workplace injuries is a classic example of the last point, where changes in law may be needed and cannot be accomplished by regulation alone. Traditional statutes do not address employee leasing or PEOs from an exclusive remedy standpoint. Failure to address this by statute can lead to circumvention of the exclusive remedy and breed the types of litigation that workers' compensation was designed to prevent.

B. Key Issues Beyond the Scope of the Guidelines

The Guidelines relate only to workers' compensation insurance issues. A state considering updating its regulation of PEOs through adoption of the Guidelines should consider whether or not it wishes to approach this area through a comprehensive statute addressing the regulation of the PEO industry, or a global effort to ensure that existing pieces of legislation are consistent with one another and gathering them into a single regulatory scheme, rather than piecemeal rulemaking addressing a limited set of issues against the background of existing law.[7] This is a policy decision that should be addressed with the state Legislature, and should depend in part on how recent and how thoroughly integrated the existing regulatory framework is.

As a part of this process, states should consider how well their existing laws address issues that were identified by the Working Group as being beyond the scope of the Guidelines. These include:

- Concerns raised by cross-ownership of insurers and PEOs.
- Whether adjustments need to be made in existing state law for taxes and assessments when large deductible policies are issued to PEOs.
- Whether compulsory coverage laws and proof-of-coverage laws need to be amended to clarify the status of PEOs and their clients.
- Whether laws need to be amended to address the employee status and opt-out rights of the owners of client businesses when those owners become PEO co-employees (what one regulator has called the "auto-leasing" problem).

[7] NAPEO, the largest trade association of the PEO industry, has actively promoted registration of PEOs and regulation of the industry. It has developed a model act that contains a comprehensive registration scheme, but its workers' compensation provisions are limited and address only a part of the Guidelines.

III. Specific Issues Related to the Guidelines

Rather than presenting a detailed section-by-section analysis of the Guidelines, this paper focuses on the issues that the authors of the Guidelines identified and how the Guidelines need to be applied in addressing those issues.

A. Statutory-Regulatory Framework for PEOs

A professional employer organization performs a wide range of employment-related services, some of which involve significant amounts of money. These services are relied on by its clients, by employees, by insurers, and by government agencies, and the impact can be devastating if a large PEO becomes insolvent, fails to meet its obligations, or buys insurance and pays taxes based on incorrect information. For these reasons, there is a broad consensus among all interests involved, including leading PEO representatives, that PEO services should be a regulated industry.

There is no consensus, however, as to what form this regulation should take. Should PEOs be licensed or should they be required only to register? Should there be financial requirements and supervision, and if so, what should the requirements be? Almost any regulatory option one could imagine has been used by at least one state.[8]

As noted earlier, one of the first and most fundamental questions the Working Group addressed was whether to propose a regulatory framework for PEOs. As important as the issue is, the Working Group concluded that it was not the appropriate body to set comprehensive standards, as its jurisdiction and subject matter expertise was limited to workers' compensation. The former NAIC Model Act, adopted in 1991, set up a limited-purpose registration process, requiring a PEO to be registered in order to be issued a master workers' compensation policy or be covered under multiple coordinated policies. However, there was a strong consensus that such a piecemeal arrangement was not desirable, but rather that regulation of PEOs should be comprehensive in scope, involving not only workers' compensation insurance but also other areas, including substantive workers' compensation law, health insurance, unemployment compensation, taxation, and solvency.

Some of these issues are within the purview of other NAIC Committees or the IAIABC, and the Working Group has briefed those bodies and encouraged them to stay involved in these matters. Other essential elements of comprehensive PEO oversight are beyond the jurisdiction of both insurance and workers' compensation regulators. Therefore, the Guidelines are based on the premise that some sort of legislation already exists – as it does in most states – that defines what a PEO is, requires PEOs to be registered or licensed by the state, and recognizes some form of co-employment relationship (either by statute or case law). Section 4 of the Guidelines then provides that workers' compensation coverage may only be provided through a PEO arrangement if the PEO is properly registered – insurers are prohibited from issuing master policies to unregistered PEOs or entering into multiple coordinated policy agreements with them, and Section 15 provides for administrative enforcement by the insurance commissioner.

The Guidelines attempt to recognize the diversity of state laws currently regulating PEOs, and include a number of drafting notes to provide guidance. Drafting notes to Sections 1 and 15 suggest that if a different state agency has regulatory jurisdiction over PEOs, the regulations implementing the Guidelines should be promulgated jointly by that agency and the Insurance Commissioner. If a state does not currently register or license PEOs, and does not enact such a requirement at the time it implements the Guidelines, a drafting note to Section 4 suggests that as a fallback, the regulation could require a limited-purpose registration similar to the 1991 Model Act. Similarly, Subsection 3(H) appears in two versions, one for use in states that already have a statutory definition of "PEO," incorporating the statutory definition by reference, the other version spelling out an explicit definition for use in states that need one.

Other potential inconsistencies between current state laws and the Guidelines are less likely to have a substantive impact on the Guidelines, but still need to be addressed in some manner.[9] Implementation of the Guidelines is a good occasion for states to review their current regulatory frameworks for PEOs to see if changes should be made and to evaluate how the

[8] Currently, the most common state regulators of PEOs or employee leasing companies are insurance departments (AR, IL, IN, LA, ME, NC, OK, and WV); labor departments (CO, CT, MT, NH, NJ, NY, VT); or the industrial or workers' compensation commissions (AL, KY, NV, OH, OR, VA).

[9] A majority of states have existing provisions addressing workers' compensation in PEO arrangements (some using the older "employee leasing" terminology).

Guidelines best fit. As recognized in various drafting notes, changes to the Guidelines to adapt to the state's structure and terminology may be necessary. In particular, references to "registration" of PEOs need to be changed to "licensing" in states that require licensure, the term "PEO" needs to be modified if the state uses some other terminology such as "employee leasing," and references to co-employees need to be changed in states that do not recognize co-employment.

B. Master Policies and Client-Level Experience Rating

As indicated above, the issue that originally prompted the concern of insurance regulators and workers' compensation regulators related to the inability of experience rating systems to track experience of individual employers when they became clients of employee leasing firms (later PEOs). Much of this concern is eliminated with multiple coordinated policies, because current insurance statistical and data handling structures have the ability to track experience from separate coordinated policies and to produce experience ratings using all of the client employers' past experience. The fundamental challenge has been "master policies," where multiple client employers are covered under a single policy issued in the name of the PEO.

For this reason, the Working Group gave serious consideration to recommending that master policies be prohibited entirely. However, because of the potential efficiencies that could be realized from the master policy model, representatives of the PEO and insurance industries strongly urged the Working Group to consider whether there was a way to permit master policies that could satisfy regulatory concerns. The Working Group therefore took as its starting point the recommendation in the 2002 NAIC-IAIABC White Paper that the only acceptable alternative to prohibiting master policies would be:

> allowing master policies but with client-specific notice requirements and payroll, loss and other data reporting requirements that would give the client a status similar to that of an individual insured under a group policy.
>
> If the latter approach is taken, careful attention must be paid to the need to guarantee that coverage cannot be terminated or materially altered by the insurer or by the employment services outsourcing company without reasonable advance notice to the client. It is also important to maintain and report accurate and up-to-date information in sufficient detail to permit the calculation of meaningful client-specific experience ratings and verification of proof-of-coverage on the client level. In practice, this may be a moot point, since insurers and employment services outsourcing companies may not consider the master policy a worthwhile option if client-by-client recordkeeping and reporting are unavoidable.[10]

Despite the skepticism that had been expressed, the Working Group and the interested persons were able to reach consensus on a regulatory framework for master policies. In particular, the Guidelines require experience reporting at the client level and the production of experience ratings on an ongoing basis for every client of sufficient size to be eligible for experience rating. This requires two essential enhancements to the current system. One is the ability to identify each client workforce as a discrete unit of coverage, even if coverage is provided to the PEO on a master policy and the client does not purchase a separate policy.[11] This is primarily a regulatory issue, and is one of a number of reasons the Guidelines have adopted a "certificate of coverage" requirement, under which each client is issued a coverage document outlining its rights and obligations under the master policy and clearly establishing both the identity and status of the client and the inception and termination dates of coverage.[12] This has occasionally been a source of misunderstanding because of the traditional usage of the term "certificate of insurance" in the context of property and casualty insurance industry. Like the certificates issued by

[10] NAIC-IAIABC Joint Working Group *Report on Employee Leasing and Professional Employer Organizations* at 32.

[11] Section 11 of the Guidelines requires that all loss reporting be conducted in a manner that will allow for the experience rating of the client to be maintained on a stand-alone basis.

[12] Specifically, the certificate must: specify the effective date of the client's coverage and the expiration expiration date of the underlying master policy (with a renewal certificate issued when the master policy is renewed); provide that coverage shall continue as long as the master policy and the PEO agreement between the PEO and the client both remain in force, spelling out any exceptions; and provide that termination of coverage without replacement requires 30 days' advance notice to the client. Subsection 7(D).

insurers under group life and health policies, this is a legally binding coverage document, not just a representation of the status of coverage at some point in time, and has the effect of making the client an additional insured under the policy.[13]

The other essential element of an improved experience rating system is an effective data reporting infrastructure. This is also necessary to make proof of coverage ("POC") function effectively at the client level, but it is not something that can be established simply by legislative or regulatory decree. What is mandated must actually be feasible, and those implementation issues are discussed below in *"Data Reporting."*

Although the Guidelines require the maintenance of separate experience modification factors for each client that is subject to experience rating, they do not mandate the use of those factors when setting premium rates for PEO coverage in the voluntary market. Although a prudent insurer could be expected to consider this information, the Guidelines leave the ultimate decision to the agreement of the parties. One reason for providing this flexibility is that in some situations, if a PEO has a relatively stable or homogeneous client base, the PEO's aggregate experience might provide meaningful information that client level experience does not provide, because the individual client experience will be more volatile and less credible, especially for smaller clients, some of which may be too small to be subject to experience rating at all. Another reason a PEO is not necessarily merely the sum of its clients is that the PEO's risk management activities might also have an impact on anticipated losses, hopefully for the better. The enhanced data reporting requirements under the Guidelines can help carriers evaluate whether or not a PEO is providing effective loss control services.

The Guidelines also make provision for experience rating in split workforce situations, because the PEO co-employees and the client's direct hire employees will, according to the Guidelines, have the same experience modification factor, but they may have very different risks, especially if the PEO takes on only the safest or most hazardous work units. In these situations – especially if separate experience modification factors cannot be calculated with reasonable accuracy – insurers are allowed to use their reasoned underwriting judgment.[14] The Guidelines also prohibit splitting a client's risk between the residual and voluntary market, an arrangement that has caused problems in the past.[15]

In order to implement an experience rating plan that complies with the Guidelines, adoption of regulations may not be all that needs to be done. It will be necessary to ensure that the state's workers' compensation advisory or rating organization has submitted a compatible experience rating plan, and it will also be necessary to review the experience rating statutes for possible inconsistencies. In particular, any provision that might be construed as mandating the treatment of the PEO as "the employer" for experience rating purposes will need to be revised, and if the state chooses to adopt the provisions allowing the parties to choose an alternative experience rating methodology in the voluntary market, the mandatory experience rating provisions need to accommodate that flexibility by giving the Commissioner sufficient authority through the rulemaking process or the rating plan approval process.

C. Lack of Coverage, Gaps in Coverage, and Proof of Coverage

Coverage gaps and omissions are anathema to the workers' compensation ethic. Insurance regulators and workers' compensation administrators agree that the structure of the workers' compensation system should make gaps and omissions in coverage nearly impossible. A well-designed POC system is one essential tool in preventing coverage failures, which should virtually never occur once a business has been identified by the system as having employees.

One of the Working Group's most pressing concerns, as it developed the Guidelines, was the awareness that the traditional approach to coverage for PEO arrangements has given rise to several sources of coverage failures:

- Tracking a client in and out of a PEO arrangement: Traditionally, coverage has been reported in the name of the policyholder, which is always the PEO in the case of a master policy and might be the PEO in the case of a multiple coordinated policy arrangement. Unless the POC system also tracks coverage at the client level, it will lose track of an employer when it becomes the client of a PEO, and will be unaware of the existence of a new business that

[13] Subsection 7(B).

[14] Subsection 12(B).

[15] Subsection 6(D).

becomes a client of a PEO immediately upon its creation. While this might be unimportant when the employer remains a fully covered client of the PEO, it can become a problem when the PEO-client relationship comes to an end while the client's business continues. At that point, a POC system that has not been tracking the client will have no way to know that there is an active, operating employer out there whose workers' compensation coverage has terminated, unless and until the former client obtains replacement coverage.

- Disputes over client status: If a master policy provides generic coverage to all the unnamed clients of the PEO, it may be unclear and open to dispute whether a particular employer was a covered client. Even when there are clear records demonstrating that a PEO-client relationship existed, they might not be sufficient to establish conclusively when the relationship began, when it ended, or whether it was in place at the time of the accident.

- Split workforce arrangements: A client employer may choose to engage a PEO for only a specified segment of its entire workforce. Ordinarily, all of an employer's employees within the state are covered under a single policy, but the split employment arrangement results in split coverage when some work units are covered through the PEO and others are not. This can give rise to coverage disputes if the status of a particular employee is not clear. There is also the danger that the state's compensation administrator will receive a POC report from the PEO's insurer, but not realize that the coverage is only for some of the client's employees, and thus allow the client to operate with the rest of its workforce uninsured. Therefore, when split workforce coverage is permitted, the POC system must not only track the coverage at the client level, but must also identify which work units are covered under the policy and whether that coverage is partial or complete.

- "Orphan" employees: One of the most common and dangerous types of split workforce arrangements is unintentional (or at least is not the stated and acknowledged intent of the parties). The parties intend for all of the client's employees to be co-employed by the PEO, so in theory, there is full coverage even if the policy's terms limit coverage to the PEO's co-employees. However, because there is only one policy, if there is anyone who is not covered through the PEO, then that employee is not covered at all. The most common danger here is the employee who is not treated as an employee, and whose existence might even be unknown to the PEO and/or its insurer – this might be someone who is held out by the client (often in good faith) to be an independent contractor, or someone who is employed by an uninsured subcontractor of the client. If the policy were issued directly to the client, it would clearly cover all employees of the client, whether or not disclosed to the insurer. However, if the policy is issued to the PEO, these employees risk falling through the cracks because they were never employed by the policyholder. There are also cases where there is no dispute that the worker was employed by the client, but the PEO's insurer disputes whether the necessary steps were taken for the worker to be hired by the PEO, especially in the case of casual employees such as day laborers who might not have been placed upon the PEO's payroll.

- Insolvency: Another factor that increases the risk of coverage disputes is the insolvency of the PEO, the client, or an insurer. If the PEO becomes insolvent, its insurer may use the PEO's failure to comply with its obligations as a basis for contesting coverage. Often, in these cases, the situation is made worse because existing law generally gives the PEO the responsibility of notifying individual clients. When the PEO is already out of business, or generally defaulting on all of its other obligations, the clients are unlikely to be receiving the notice to which they are entitled. If the insurer becomes insolvent, the receiver or the guaranty fund may take a fresh look at the validity of categories of claims the insurer had been paying routinely, especially if PEO losses are perceived as a contributing factor in the insolvency. The receiver will also be cancelling coverage, and clients may not receive this notice in a timely manner when the PEO is the named insured. And in split workforce arrangements, the coverage difficulties already noted earlier are complicated not only by the increased likelihood that any claim that can possibly be contested will be contested, but also by the possibility that even when it is uncontested that the insolvent insurer would clearly have been responsible for the claim in the ordinary course of operations, a guaranty fund will argue that there is also another insurer on the same risk and that secondary insurer should pay in preference to the guaranty fund.

The Guidelines provide regulatory language (or statutory language in states that enact these provisions by statute) to respond comprehensively to these potential sources of gaps or omissions. It must be emphasized, however, that these protections are incomplete unless the state's POC laws and the advisory organization's POC data system provide a mechanism that effectively tracks coverage at the client level. In addition, there must also be an effective mechanism for verifying that PEOs doing business in the state are properly insured, which can be accomplished through either the PEO registration process, some type of two-tier POC system for PEO arrangements that simultaneously tracks worksite employers and a separate PEO category, or a combination of the two approaches. Currently, many states with comprehensive PEO regulation mandate

separate reporting by a PEO of incoming and exiting clients. This might be considered as a part of or supplement to the present POC system.

Two important new safeguards against coverage failures established by the Guidelines are:

- The certificate of coverage mechanism discussed earlier, which when properly implemented by insurers and regulators ensures that even under a master policy, each client's coverage has a clearly established inception and termination date, with adequate advance notice to both the client and the POC system before a client's coverage can be terminated or replaced.[16]

- A presumption that a PEO's policy ordinarily provides full workforce coverage to all covered clients, meaning that coverage during the relationship is equivalent to the coverage a client would have under a stand-alone policy.[17] The PEO's insurer does have the right to issue a policy that limits the scope of coverage to PEO co-employees, but only a full-workforce policy can be used to satisfy the clients' coverage obligations,[18] so there is an expectation that PEOs and their clients will only be interested in non-full-workforce coverage when they intend from the outset that the PEO arrangement will only cover a portion of the client's workforce.[19]

The provision making full-workforce coverage the norm and more limited coverage the exception was one of the most controversial decisions made by the Working Group. Insurers objected that making them cover any unknown employees of a PEO's clients would undermine the certainty they seek when they deal with the PEO. Regulators acknowledged this point, but ultimately decided that an essential feature of the workers' compensation system is that somebody must take responsibility for ensuring that there are no orphan employees. If it is not the PEO's insurer, then it must be the client's insurer, and reasonable steps must be taken to verify that the client does indeed have an insurer that provides the same all-inclusive coverage that any traditional statutory workers' compensation policy provides for all employees, whether or not listed on the employer's payroll.[20] The client's representation that it has no direct hire employees is not sufficient; after all, if it were sufficient, the PEO's insurer would have no qualms about writing full-workforce coverage in the first place.[21]

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[16] West Virginia took a different approach in its new PEO law. Under the Guidelines, an insurer issuing a master policy has no responsibility to a client if no certificate of coverage or its equivalent was ever issued by or on behalf of the insurer, unless the insurer is in some way responsible for the failure to issue the certificate. The PEO is obligated to give clear written notice to the client if it provides PEO services without providing workers' compensation coverage, Paragraph 4(C), but if the PEO fails to comply, it is the PEO that bears the liability to the client, not the insurer that did not provide the coverage. By contrast, under West Virginia's "stopgap" provision, the PEO's insurer is responsible if the client has no other coverage. *See* W. Va. Code St. R. § 85-31-6.1. These provisions do not bar the insurer from pursuing indemnification from any solvent party that may be at fault.

[17] Paragraph 7(A)(1): "If the PEO agreement with a covered client is a full work force PEO agreement [as defined in Subsection 2(E)], the policy or certificate shall cover all PEO co-employees and shall also cover any other obligations of the client under [insert appropriate statutory reference] to the same extent as if the client had obtained a direct purchase policy in this state."

[18] Subparagraph 7(A)(2)(b), which also makes an exclusion for the client's direct hire employees unenforceable if the insurer has reported the policy to the POC system. A drafting note advises states to allow non-full-workforce policies to be reported as secondary coverage if a state's POC system tracks both primary and secondary coverage.

[19] The Guidelines contain a drafting note allowing for a "Designated Workplaces Exclusion Endorsement" in this situation where allowable under existing law and regulation. However, under such an exclusion, the client must maintain separate coverage for the workplace in question.

[20] Subparagraph 7(A)(2)(a): "A PEO's insurer may not issue or renew coverage with a direct hire exclusion unless it obtains satisfactory evidence demonstrating that the client has coverage for all of its other workers' compensation liabilities."

[21] Subparagraph 7(A)(2)(e).

Moreover, even if it issues a limited policy, a PEO carrier becomes liable under the Guidelines for full-workforce coverage if it does not promptly issue notice of termination after learning that the client's coverage has been cancelled or is otherwise not in effect. This provision does not address every potential gap in coverage, however, because it does not apply in a situation where the PEO carrier is not aware of the cancellation or termination of a client's policy. After considerable debate and consideration of input from carriers, the drafters of the Guidelines concluded that a cross-notice provision they had originally proposed was unfeasible, and that the offending client would have to bear the consequences of being treated as an uninsured employer.[22] The Guidelines also include provisions for the uninterrupted payment of benefits if the insurers dispute who is responsible for a claim (the client's insurer is provisionally responsible, subject to reimbursement by the PEO's insurer if the dispute is resolved in favor of the client's insurer),[23] and for situations where a PEO agreement is terminated but the workers covered by the PEO continue as employees of the client[24] or where there are two insurers and one becomes insolvent.[25]

D. Notice and Cancellation of Coverage for PEOs and Clients

Workers' compensation coverage is a mandatory requirement for almost every business in almost every state in the United States. It is essential, therefore, that employers who are clients of PEOs receive timely notice before their coverage is terminated without their consent. In a PEO arrangement, the client usually relies on coverage purchased by a third party (the PEO). Because the client remains fully responsible for workers' compensation benefits for its employees, the consequences for the client can be disastrous if that coverage can be terminated without the client's advance knowledge.

This is especially true in PEO relationships, because if a PEO should terminate its co-employment of the client's employees, the client would almost certainly continue its operations as the sole employer of its workers. Doing so without coverage would violate state workers' compensation requirements and be illegal. As a result, the client would be exposed to penalties for operating without insurance, possibly including closure of the business, and exposure to both workers' compensation and tort liability for workplace accidents. Recovery of any resulting losses or penalties from the PEO is likely to be uncertain, slow, and difficult at best. In fact, there would be no prospect of meaningful recovery where the PEO itself has failed and there is no one left to pay a judgment, which unfortunately is one of the situations where the normal communication procedures are at the greatest risk of breaking down.

The 1991 NAIC Model Employee Leasing Regulation tried to address this issue by requiring the PEO to notify all of its clients within 15 days after receiving notice that its workers' compensation policy will be cancelled or nonrenewed. However, this left PEO clients with seriously diminished rights, as compared to employers who purchased coverage directly. It also left unaddressed the issue of termination of the PEO arrangement and placed notice issue in the hands of the PEO rather than the carrier.

Under standard workers' compensation policies and practice and typical state insurance laws, if an insurer fails to give its policyholder timely notice of cancellation or nonrenewal, the termination is invalid and the policyholder remains fully insured. However, where the policyholder is the PEO, or even if the policyholder is the client but its address of record is "care of the PEO," the insurer can comply with its own legal obligations without any guarantee that any notice will actually get to the client. Furthermore, under some scenarios the client could already be without coverage before the PEO was required to give notice under the 1991 Model.

An essential element of the Guidelines is to address what should be one of the client's most valuable rights – continued coverage until adequate notice of cancellation is provided.

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[22] It should be noted that this approach also creates a risk of exposure for the uninsured employer fund, in states that have them. West Virginia has decided that concerns such as these outweigh the burden of holding the PEO's insurer responsible for the ongoing verification of client coverage.

[23] Subparagraph 7(A)(2)(d). In West Virginia, on the other hand, the PEO's insurer is responsible in these situations. *See* W. Va. Code St. R. §§ 85-31-6.1 & -6.2.

[24] Subparagraph 7(A)(2)(f).

[25] Subparagraph 7(A)(2)(g).

The Working Group concluded that the insurer must be responsible for notice in every case where the client is dependent on receiving timely notice in order to maintain coverage.[26] The insurer can still delegate this function to the PEO, but if that process breaks down, then the insurer must provide extended coverage to the client, subject to applicable premium charges, for the duration of the statutory notice period. Nothing in the Guidelines prevents the insurer from holding the PEO responsible for any failure to comply with its contractual duties, nor from requiring the PEO to post security for the performance of its obligations, but the insurer may not seek recourse from the client for the PEO's default.

For these reasons, cancellation or nonrenewal of a client's coverage is not valid unless either:

- 30 days' advance notice has been delivered to both the client and the POC system. If termination is initiated by the PEO, this notice may be delivered by the PEO (with notice to the insurer);

- The client initiates or affirmatively consents to the termination. However, the Guidelines expressly prohibit circumventing restrictions on involuntary termination through such devices as documents authorizing the PEO to cancel coverage "voluntarily" on the client's behalf;[27] or

- The PEO has replaced coverage with no break in coverage and provided advance notice to the insurer, the client, and the POC system. This exception only applies if valid replacement coverage has actually been obtained. In that case, any dispute over the cost or other terms of the replacement may be sorted out between the actual parties to the dispute without worrying that the client might go bare.

The relationship between the PEO and the insurer, on the other hand, is closer to the traditional insurer-policyholder relationship, and therefore raises fewer unique issues that need to be addressed in the Guidelines. Accordingly, the Guidelines explicitly provide that "A master policy or a coordinated policy may be cancelled or nonrenewed by the insurer on the same grounds and subject to the same conditions as any other workers' compensation insurance policy." It is important to keep in mind, however, that for the reasons discussed earlier, even though the PEO's default on its obligations may result in loss of coverage for the clients, there must be timely notice before that loss of coverage can be effective, and notice to the PEO can never substitute for notice to the clients. Indeed, if the client's coverage must be terminated for reasons beyond the client's control, it is all the more important that the client be given ample time to obtain appropriate replacement coverage.

The Guidelines therefore expressly contemplate that even after cancellation or nonrenewal has taken effect as between the insurer and the PEO, the insurer might still have a continuing obligation to cover the client. If that happens, the insurer must implement some other mechanism for providing coverage to the client, and may bill the client directly for that coverage. This situation is especially likely to arise in states that allow expedited cancellation of workers' compensation policies for nonpayment.

A drafting note to the Guidelines advises that "If applicable state law permits involuntary termination of workers' compensation coverage upon shorter notice in some or all situations, states may consider modifying this provision accordingly." The statutory basis for expedited cancellation of a policy is usually nonpayment of premium. However, states should recognize that nonpayment by the PEO to the insurer does not constitute fault on the part of the client, which may be having similar difficulties of its own if the PEO has stopped performing its obligations. The Guidelines make clear that a client's failure to pay fees when due to the PEO does not constitute nonpayment of premium.[28]

This raises another important issue not adequately addressed by the 1991 Model – responsibility for premium payment. The essence of the PEO coverage model, whether it is implemented through a master policy or multiple coordinated policies, is that the PEO is responsible for paying the premium to the insurer. In turn, the PEO charges fees to the clients that are intended to be sufficient to cover its cost of workers' compensation insurance and all other services provided by the PEO. When the insurer has accepted that the PEO is serving this role, the client is entitled to rely on that acceptance unless and until the insurer has notified the client that any future bills must be paid directly to the insurer. Therefore, the Guidelines provide that for coverage provided under a master policy or multiple coordinated policy agreement, the insurer's only recourse is against the PEO – if the PEO defaults on its obligations, the client is protected against being billed a second time

[26] Section 10.

[27] Subsection 10(E).

[28] Subsection 8(A).

for workers' compensation coverage after it has already paid the PEO in full. The need for the insurer to pursue recovery from the PEO may pose difficulties for the insurer, but they can often be mitigated by obtaining adequate security in advance.

But what if the client has not paid the PEO in full? The client's obligation to the PEO is important, but it is a contractual matter between the PEO and the client. Because of the broad and varied scope of PEO services, which extend to matters well outside the scope of insurance departments, the Working Group did not support the regulation of PEO fees. The Working Group considered, but did not favor, a proposal to treat the PEO as a payment intermediary with workers' compensation premiums itemized and billed separately. As a result, fee regulation under the Guidelines is limited to disclosure requirements and prohibitions against insurance-related misrepresentation (See *"Pricing"* below).

This means that fee disputes and termination disputes between clients and PEOs cannot be resolved through the insurance department's administrative processes. The nature of the PEO-client relationship makes it unrealistic to require good cause for termination, let alone to require the PEO to maintain a client against the PEO's will if good cause is lacking.[29] And without regulated fees or pass-through billing of insurance premium, the complexity of the claims and counterclaims that might occur makes it inappropriate to treat fee disputes as similar to premium disputes. Accordingly, the Working Group did not adopt the PEO industry's request to allow expedited cancellation for nonpayment of PEO fees, in states that allow expedited cancellation for nonpayment of premium. However, some states allow expedited cancellation for fraud, and those states should consider whether cases involving fraud committed by the client would be within the scope of the Drafting Note on expedited cancellation.

Another termination issue that the 1991 Model does not address is the nature of the insurer-employer relationship under a multiple coordinated policy arrangement. Should the client have the right to convert its policy to a direct purchase policy if it leaves the PEO, or should leaving the PEO be a valid ground for terminating the client's coordinated policy? Some regulators felt that an insurer ought to make the same full-year commitment when it issues a coordinated policy covering a business as it does when it issues a direct purchase policy. However, insurers replied that in the voluntary market, participation in a multiple coordinated policy arrangement through a PEO is often an essential condition for their acceptance of the risk, and termination of that arrangement represents a material change in circumstances that justifies termination of coverage. The insurer might not even have an applicable rating plan for direct purchase coverage for that class of business.

Based on those considerations, the Guidelines provide that the client should not have a legal right to convert to direct purchase coverage if the PEO relationship terminates. The insurer has the option to allow this, but it should also have the option to terminate coverage once adequate notice can be provided. This means that if the PEO relationship is terminable at will at any time, then the insurance policy might be as well, but the insurer's obligation to provide full statutory notice means the client is left with time to shop for replacement coverage and is in essentially the same position as if it had not joined the PEO in the first place. It should be noted that because cancellation of coverage must be initiated by the insurer, the process depends on the PEO giving timely notice to the insurer. Until this happens, the client continues to be covered and the PEO continues to be responsible for the premium.

Of course, if the Guidelines conflict with applicable cancellation statutes, then the statute must prevail. If termination of the PEO relationship is not considered a breach of a valid contractual condition or a sufficiently material change to justify cancellation under applicable state law, a drafting note to the Guidelines recognizes that those states must either amend the statute to provide a new permitted ground for cancellation, or revise their regulation to conform to the statute by mandating conversion to direct purchase coverage in lieu of cancellation.

E. Policy Forms

As we have seen, the Guidelines require a number of changes in the terms of the insurer-insured relationship, and also in how some of the existing terms are documented. This will require changes to the policy forms, and careful review by regulators. In addition, many of the existing standardized forms and endorsements developed by advisory organizations have been in place in substantially similar form for many years, and in some cases the language reflects terminology, such as "employee

[29] Although the Guidelines prohibit the cancellation of workers' compensation coverage until adequate notice has been provided, they expressly acknowledge that other PEO services may cease immediately upon termination of the PEO agreement to the extent permitted by law, and require this to be disclosed to the client. Paragraph 4(D)(3).

leasing," that is no longer in widespread use. If a significant number of states adopt an approach substantially similar to the Guidelines, the use of standard language will be helpful to all stakeholders, especially insurers, PEOs, and clients that do business on an interstate basis. This means the standardized endorsement language currently in place will need to be updated, and new standard forms will need to be developed: in particular, multiple coordinated policy agreements and master policy certificates of coverage. Insurers, PEOs, producers, clients, and regulators should all be working with the advisory organizations in this process.

F. Data Reporting

In order for workers' compensation administrators and insurance regulators to maintain the experience rating and POC systems discussed in the previous sections, both they and the rating agencies or advisory organizations must have the statistical data essential to enforce and monitor the workers' compensation system. The statistical data must be sufficient to enable the state's compliance administrator to efficiently identify whether an employer within the state has the coverage required by law, and track the employer's claim experience and benefit payments. The method of coverage chosen by an employer must be reported to the compliance administrator as proof that the protection exists on that job site, and subsequent changes to that method must also be reported. For experience rating, subsection 11(A) of the Guidelines requires all loss and payroll reporting to be "conducted in a manner that identifies both the PEO and the client, and enables the calculation of experience modification factors" at the client level.

It was generally acknowledged during the development of the Guidelines that data reporting is not a significant issue where coverage is client-based (that is either through a stand-alone client-based policy or through a multiple coordinated policy arrangement where each client is identified on a separate policy). The main data issues appear to relate to master policies, or to multiple coordinated policies that are in the name of the PEO and do not adequately identify the individual client or do not adequately enable the reporting of client level data needed for experience rating and POC systems. Concerns have also been expressed about the reporting of multiple coordinated policies when the policies are issued with the PEO rather than the client as the principal named insured, which is an option expressly permitted by the Guidelines as long as it is done "in a manner that clearly specifies the identities of the PEO and client and clearly describes the scope of coverage."[30] Subsection 11(A) of the Guidelines mandates that all such data be maintained and reported by carriers at the client level, regardless of whether coverage involves a multiple coordinated policy arrangement or a master policy,[31] but does not dictate how this is to be done.

There was significant debate as to the nature of the data reporting issue, who was responsible, and how to resolve the difficulty. Various carriers said they were able (or were not able) to provide client-based data, rating agencies said they were (or were not) able to handle the data in PEO arrangements, and states indicated varying levels of sophistication with regard to data collection or use. These technical issues are important, but establishing the necessary technical infrastructure is beyond the scope of the Guidelines. Instead, an effort was made to identify the goals of the Guidelines based upon an assumption that the technical issues could be resolved.

The root of these technical issues is that present industry standards for the reporting and collection of data are based on separate policies for each employer. These standards support the constant exchange and use of data from carriers' systems to data collection organizations, and subsequently, to many states' compliance systems. While some industry standards have changed to assist in the complex reporting of PEO-related data, the ability to make significant changes has been limited both by cost considerations and the need to be careful about preserving current capabilities for exchanging data. Additional requirements or changes to industry standards are meaningful responses only if compliance is technically feasible. A significant challenge with reporting and tracking client level data is that clients can be added or terminated during the policy period, or move from one PEO relationship to another. These activities make it challenging to report and track individual client experience and coverage without separate policies and without substantial changes to industry standards and major costs.

The Workers *[sic]* Compensation Policy Reporting Specifications (WCPOLS) system, the electronic data entry system jointly created by the nation's rating agencies, has for many years included a functionality that can identify whether or not a workers' compensation policy is related to a PEO arrangement. Similarly, the National Council on Compensation Insurance

[30] Subsection 7(E).

[31] Subsection 7(J); *see also* Sections 11 and 12.

(NCCI), the country's largest advisory and rating organization and POC provider, has developed and implemented an MCP model that is widely used in the residual market. However, issues still remain as to how information on voluntary market policies is provided to and processed by rating agencies and users. For example, it is reported that the "PEO-related policy" flag is not used consistently, for example, and this information is not sufficient by itself to allow client-level data to be tracked effectively.

According to NCCI, a number of issues continue to be significant when determining how compliance requirements can be met and addressed. Under the 1991 model, the delivery methodology chosen for creation of an experience modification for a company leaving what was then called an employee leasing arrangement was the filing of a paper report and a manual calculation. Time has proven that to be both unreliable and inefficient.

Currently an increasing majority of states statutorily recognize both a PEO and its clients as employers for purposes of workers' compensation. The Guidelines themselves provide the potential for multiple means of providing coverage in a PEO arrangement.[32]

One solution may be to develop some form of system for master policy situations that parallels the multiple coordinated policy framework for reporting data. This would require both carriers and rating agencies to be able to segregate data for clients of PEOs as if each had an individual policy. Carriers that are engaged in PEO coverage indicate a willingness to provide this client-level data, as do the PEOs themselves. NCCI has provided a technical supplement outlining various alternative mechanisms for reporting and compiling this information.[33] However, it has warned that any option requiring significant changes to industry standards, including operating and reporting systems, would be difficult to implement and costly to the industry.

While insurers and rating agencies have historically managed their data systems to respond to both regulatory and industry needs, it is the states' ultimate responsibility to determine what data they need and what they will require their rating agencies to do. Where possible, the Guidelines have attempted to generate greater rather than less flexibility, providing a clear mandate to provide both the states and the rating agencies the data that will allow experience rating programs and POC systems to operate at the client level, but without micromanaging the details of system design. There is, nevertheless, certain basic information that must be collected for both the PEO and its clients:

- Employer identification – This includes the name of the employer and any FEIN or SSN associated with the employer.
- Location – This includes the actual address of the client, and not just the mailing address of the PEO.
- Payrolls & Classifications – Payrolls must be assigned to appropriate class codes on a client-by-client basis, with the ability to identify the PEO that is involved.
- Loss data – The same loss data that is required for all other policyholders, in a form that can be attributable to both the client and the PEO.
- Coverage information – This includes policy dates, the nature of the policy, states that are covered*, etc.*

Regulators, and many within the industry, contend that this is information a well-managed insurer would want to collect anyway, and therefore ought to be the wave of the future. One current impediment – the fact that some carriers issuing master policies simply do not track coverage at the client level in the first place – should vanish once the Guidelines' certificate-of-coverage requirements are in force. Carriers must also recognize that issuing coverage on a master policy basis is an option, not a necessity, and if they are unable to issue master policies in compliance with state laws and regulations consistent with the Guidelines, then they can switch to multiple coordinated policies, as some states currently require.[34]

Given that a large majority of states now statutorily recognize PEOs as employers for workers' compensation (and that number is growing rather than shrinking) and that the PEO concept of co-employment is likely to continue, the states and the requisite stakeholders (workers' compensation administrators, rating agencies, carriers, and PEOs) will need to work cooperatively to address system issues. In particular, this includes a nationwide effort to coordinate the evolution data collection and processing in a consistent and cost-effective manner. At least for a period of time, states seeking to adopt laws

[32] Section 3.

[33] See Appendix B.

[34] *See, e.g.,* N.J. Admin. Code, Title 12, § 16-24.6.

and regulations consistent with the Guidelines may find themselves having to deny carriers the ability to write PEO coverage on a master policy basis until they can have sufficient assurance that client-specific data to support POC and experience rating systems will be reported.

G. Exclusive Remedy

Workers' compensation was designed as a mandatory (in most states) no-fault system to guarantee compensation to a worker injured on the job and, in return, protect the employer from protracted litigation or extraordinary liability for normal worksite injuries. Employers are required to buy workers' compensation coverage (or in the case of self-insurance, provide it themselves under regulatory oversight), and the insurance or self-insurance is required to cover all worksite injuries. The worker gains certainty of coverage for worksite injury but (except in certain egregious situations) gives up the right to sue in tort for those injuries. The workers' compensation system has become the "exclusive remedy" for recovery if the employer complies with its obligation to maintain coverage.

In most states (either by law or by interpretation), this exclusive remedy has been extended to protect employers that borrow workers from liability if the employer supplying the workers provides workers' compensation insurance.[35] However, it is not always clear that this applies in the case of a "co-employment" relationship. Such clarification is necessary, because allowing the worker the option to collect the statutory workers' compensation benefits from the co-employer whose name is on the insurance policy or to sue the other co-employer for the same incident and injury would defeat the nature of the no-fault system. Both co-employers have agreed upon an arrangement that guarantees the availability of workers' compensation benefits, so both deserve the benefit of the exclusive remedy.

In implementing the Guidelines, it is recommended that a state review its workers' compensation provisions to assure that the exclusive remedy provision will prevent "double dipping" or create an incentive for more litigation that could undermine the purpose of exclusive remedy. The Working Group, when drafting the Guidelines, recognized that this was a statutory rather than regulatory issue, and that the applicable statutes are generally found in the workers' compensation laws rather than the insurance laws.

In the case of a PEO relationship (or co-employment model), does state law clearly provide that both the PEO and PEO client are entitled to exclusive remedy protection?[36] Or is the exclusive remedy only extended to the party obtaining insurance coverage? Absent a provision clarifying the entitlement of both co-employers to the exclusive remedy, a state runs the risk that a business that chooses to avail itself of PEO services will thereby expose itself to tort lawsuits for workplace injuries even though the business has been careful to make sure that full workers' compensation protection is available through the PEO. In the worst case, the client might be exposed to a "double-dip" lawsuit after the injured worker has already received workers' compensation benefits! (Or conversely, a PEO that does not provide workers' compensation coverage could expose itself to tort liability for its clients' workplace injuries even though it has provided only administrative services to its clients.)

States with more comprehensive PEO acts have routinely dealt with this issue when enacting that legislation.[37] If such a provision is not already in place, it should be added to the state's workers' compensation statute. This may require a

[35] Under this protection, for example, a client using temporary staff personnel would be afforded the exclusive remedy protection of the temporary employment service's workers' compensation coverage for injuries sustained during a temporary worker's assignment to the client.

[36] The Indiana Code, for example, provides at IC 27-16-9-2 "The protection of the exclusive remedy provisions of IC 22-3-2-6 and IC 22-3-7-6 apply to the PEO, the client, and each covered employee and other employee of the client regardless of whether the PEO or the client is responsible to obtain the worker's compensation coverage for the covered employees under the professional employer agreement."

[37] For example, the New York Professional Employer Act provides that "Both the client and the professional employer organization shall be considered the employer for the purpose of coverage under the workers' compensation law and both the professional employer organization and its client shall be entitled to protection of the exclusive remedy provision of the workers' compensation law irrespective of which entity secures and provides such workers' compensation coverage." New York Labor Code, Article 31, § 922 at paragraph 4.

cooperative effort of the insurance department with a state workers' compensation commission or labor department, depending upon which agency is responsible for administering the state's workers' compensation system.

H. Residual Market Issues

What should be the recourse if a PEO is unable to obtain voluntary coverage, either for its own employees or for those workers that it co-employs with its clients? At first glance, it might seem obvious that the PEO should be entitled to coverage in the residual market. However, the Working Group recognized that this is not the only way coverage can be issued. The PEO needs to be able to purchase coverage for its own home office employees on the same basis as any other employer, but as long as each client retains the right to purchase its own residual market coverage, the PEO does not absolutely need the right to buy coverage for all its clients.

Therefore, the Working Group concluded that it is appropriate to allow the residual market to impose some minimum standards on PEOs that could not be applied to other employers. If a PEO is in good standing, it has the right to purchase residual market coverage on a multiple coordinated policy basis, just as it can under the 1991 Model Regulation and existing residual market plans. However, Section 6 of the Guidelines includes provisions under which the residual market may determine (subject to the PEO's right to appeal to the Commissioner) that a PEO is not in good standing and coverage for the clients' workforces must be purchased by the clients themselves:

- If the PEO or an affiliate owes past-due premium or otherwise does not meet the general qualifications for residual market coverage;
- If the PEO is unable to demonstrate the financial capacity to comply with its obligations under the multiple coordinated policy agreement; or
- If the PEO has been barred by regulators or found to have unfit management or ownership.

In addition, as discussed above in *"Experience Rating,"* an unimpaired ability to enter into split workforce PEO arrangements may give the PEO and clients an incentive to "dump" the riskiest components of the clients' workforces into the residual market, or for a PEO to buy voluntary market coverage for its best clients and "dump" the others. Therefore, Subsection 6(D) of the Guidelines makes split workforce arrangements ineligible for residual market coverage, and gives the residual market the authority to deny or surcharge coverage if a PEO splits its client base.

A final issue that needed to be addressed in order to construct a nationwide model is that different states make residual market coverage available in different ways. Therefore, the Guidelines include two different versions of Section 6, one to be used in states with an assigned risk/ servicing carrier program, the other to be used in states with a single statutory carrier of last resort. The Guidelines presume that such a carrier also has the authority to write voluntary market coverage, so states with a single carrier that only provides involuntary coverage should adjust the language accordingly.

I. Pricing

The Guidelines impose no requirement that the PEO itemize the workers' compensation portion of its billings to its clients.[38] Paragraph 4(D)(2)[39] requires the PEO to provide specific notice that the premium obligation of coverage provided through the PEO is that of the PEO alone and not the client.

[38] As discussed earlier, the Guideline drafters considered, but rejected, a proposal to require pass-through billing of premium. There was significant feeling that amounts charged clients for the workers' compensation services elements of PEO services should be reflective of the costs of workers' compensation coverage, but the ultimate agreement was that this is a commercial and market issue.

[39] "The PEO shall have a written agreement with the client, signed by the client before coverage becomes effective, including clear and conspicuous provisions … Explaining that while the coordinated policy or certificate of coverage is in force, the PEO will be responsible for paying all premium obligations, including any

Although itemized charges for workers' compensation are not required, the PEO may choose to provide them. In that case, the PEO has the obligation to be fair and accurate. It cannot, for example, advertise below-market workers' compensation coverage if its true costs are higher and it conceals the difference elsewhere in its bill. Subsection 4(F) of the Guidelines requires that a PEO "not make any materially inaccurate, knowingly or recklessly misleading, or fraudulent representations to the client of the cost of workers' compensation coverage."

In situations where a PEO itemizes the costs of workers' compensation, Subsection 4(F) requires that any such statement of costs be within defined bounds unless otherwise approved by the Commissioner.[40] This is of particular concern when the PEO assumes responsibility for most or all of the claims costs under a large-deductible or retrospectively rated policy and adopts its own "rating" methodology for recovering those claims costs from its clients. In some states, legislation might be necessary in order to give the Commissioner the authority to impose such restrictions, because they could be viewed as direct regulation of PEO fees and thus beyond the jurisdiction of insurance regulators. If a statutory amendment is proposed, it might logically be included in either the state's insurance rate regulatory act or its PEO act. Including the language in the PEO act allows the imposition of sanctions on a noncompliant PEO, and depending upon the structure of laws already on the books, Section 4 of the Guidelines can essentially be "lifted" from the regulation and placed in the state's PEO act substantially intact. The state's rating law may be a less appropriate place for these provisions, as the PEO is not an insurance company, but a cross-reference in the insurance laws may be necessary in order to give the Commissioner the necessary rulemaking authority.

J. Improper Extensions of Coverage (Piggybacking)

Subsection 7(C) of the Guidelines is designed to limit coverage of a master policy to only one PEO or one PEO group. It also prohibits extension of coverage under a master or coordinated policy to another PEO, employee leasing company, temporary service agency or other entity in the business of employment services outsourcing. This provision is designed to prevent "piggybacking" and provides an additional argument for a comprehensive legislative/regulatory approach to PEOs in any given state. It addresses an issue raised by the NAIC/IAIABC Joint Working Group Report of 2002.

The classic "piggybacking" scenario occurs when PEO A, which has a master policy, then co-employs all of the employees and worksite co-employees of PEO B, thus seeking to extend coverage to PEO B's co-employees and clients. This represents a significant increase in the insurer's exposure, without any new underwriting by the insurer and possibly without even the payment of additional premium. There are variations on this scheme, but the purpose is the same: to extend the insurance coverage beyond that originally intended or contracted for. In one common variant, PEO A claims to have acquired PEO B, and asks its insurer to add PEO B to the policy, when the "purchase" is a sham transaction that does not really transfer actual ownership and control.

The drafters designed this provision not only to address piggybacking, but also to prevent a PEO contract with a client temporary staffing agency that in turn provides employees on a temporary basis to other clients. It was felt that having the on-site client employer more than one level removed from the employer securing coverage was too problematic.

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audit adjustments and policyholder assessments, and will be entitled to any premium refunds. The written agreement shall further explain that although the PEO will charge fees to the client that reflect or include the cost of coverage, these fees are not considered insurance premium obligations of the client. If there is a policy deductible, the written agreement shall further explain that the PEO is responsible for reimbursing the insurer for the deductible and may not seek recovery from the client.

[40] "If the PEO charges the client an itemized amount for workers' compensation coverage, the PEO shall provide the client with a good faith estimate of the actual cost of coverage and an accurate and concise description of the basis upon which it was calculated and the services that are included. Without the prior approval of the commissioner, a PEO may not charge a client an itemized amount for workers' compensation coverage that is:

(1) Materially inconsistent with the actual amounts charged by the insurer or reasonably anticipated loss-sensitive charges;
(2) In conflict with the terms of the uniform classification system; or
(3) Materially in conflict with the terms of the uniform experience rating plan."

On the other hand, this provision is not intended to prohibit a legitimate acquisition of one PEO by another; of a PEO providing services to an HR consulting or other entity that does not provide workers or W-2 co-employment services to client companies; or of a commonly owned PEO group procuring common coverage. However, pursuant to Subsection 7(C): "For a master policy to be issued to a PEO group, all covered PEOs must be combinable for experience rating purposes, each member of the group shall execute a cross-guarantee of the premium payment obligations of the other members, and each covered PEO shall be expressly named as an insured PEO before the effective date of coverage."

The effectiveness of Subsection 7(C) is enhanced by a state's adoption of the Guidelines' recommendation for registration or regulation of PEOs generally. Once a state has a requirement for registration or licensing of PEOs doing business in the state, it is easier to identify PEOs, know their insurance relationships, and to prevent these types of improper extensions of coverage.

K. Self-Insurance

One fundamental question that arises, if a state recognizes a PEO as an employer, is whether the PEO should be allowed to self-insure its workers' compensation exposure on the same basis as other employers? Currently, some states permit self-insurance by PEOs and others do not.

The Working Group was concerned that a PEO self-insurance program is not true "self-insurance" as that term is commonly understood. In effect, a self-insured PEO is really insuring its clients, and allowing a PEO to self-insure would leave the clients and workers with no other recourse if the PEO failed, or would create unacceptable risk for the self-insurance guaranty fund in states that have such a fund. Therefore, the Working Group decided not to propose self-insurance by PEOs as one of the options for coverage in Section 3. Subsection 3(B) contemplates the possibility that a client might be allowed to self-insure (because not all PEO arrangements give the PEO responsibility for workers' compensation coverage), but not a PEO.

A drafting note to Section 3 acknowledges that some states permit self-insurance by PEOs and that states desiring to maintain such coverage will need to modify the Guidelines accordingly. However, a drafting note suggests that any states considering self-insurance:

> should seriously consider basing such authorization upon licensure as an alternative risk-bearing entity, similar to laws allowing licensure for multiple-employer welfare arrangements and group self-insurance pools, and upon compliance with standards substantially similar to those established by these guidelines for insurers issuing master policies.

L. Loss-Sensitive Coverage

The self-insurance question involved extensive discussions among the Working Group and interested parties concerning the nature of the risk assumed by a PEO with regard to workers' compensation. This risk differs from the risk ordinarily assumed by the employer that self-insures or has a loss-sensitive coverage plan. For a traditional employer, the workers' compensation risk is inherent in its operations, while for a PEO, the risk is assumed from its clients by contract (along with other employment-related risks). The client remains the owner of the operating business where the injury would occur. If a traditional employer self-insures or has a loss-sensitive arrangement, the self-insurance program is pure expense. Self-insurance "pays off" if it is cheaper than buying standard insurance, but the employer can never actually make a profit, only reduce the expense or suffer a loss.

By contrast, a PEO in a loss-sensitive arrangement must estimate its clients' likely workers' compensation losses, and collect payments from the clients that are sufficient to cover the expected losses and the expenses of operating the program. If the PEO manages the workers' compensation elements of its contract successfully and the losses are better than expected, the PEO makes a profit. If losses and expenses (adjusted to present value) are equal to the payments collected, this element of the PEO's operations break even. And if the clients' losses are significantly worse than expected, the PEO will incur a loss.

This analysis initially led some of the regulators on the Working Group to oppose any arrangement in which the PEO was involved in its clients' coverage on any other basis than as a pure intermediary between the clients and a licensed insurer. The industry's response and that of some carriers was that it was healthy for a PEO to assume some or all of its clients' risk,

because that gave the PEO an economic incentive to operate good risk management programs, so that a PEO was not simply financing coverage but actually improving the operations of its clients' workplaces. In this regard, the industry argued that the PEO's position was not that of an insurer, but that as a co-employer with multiple touch points with the workforce (payroll, human resources, benefits, health, and compliance) it had far greater abilities to invest in and manage risk management that a client did. A PEO, it was argued, was in a better position than the traditional insurer to improve safety, manage return to work, identify fraudulent claims, and address workers' compensation issues.

A consensus emerged on the Working Group that it should be permissible for a PEO to take on some degree of insurance risk. It was noted that the states already allow fronting arrangements in which unlicensed entities can assume insurance risk – as long as a licensed insurer assumes responsibility by issuing the primary policy, the insurer is then permitted to cede the risk to an unlicensed reinsurer, subject to reporting requirements and rules against taking accounting credit for unsecured reinsurance.

Regulators recognized that the rationale for prohibiting self-insurance does not necessarily apply to loss-sensitive coverage, because there is a significant difference between the risk that a PEO assumes under a large deductible or retrospectively rated policy issued by a licensed insurer and the risk that a PEO assumes under a self-insurance program. With loss-sensitive insurance coverage, a licensed insurer has assumed full responsibility for all payments due under the policy, whether or not the PEO is willing and able to fulfill its obligations to the insurer, in the same manner as a fronting insurer that passes the risk to an unlicensed reinsurer.

Therefore, the Working Group determined that loss-sensitive coverage should be permitted as long as adequate safeguards are in place. For loss-sensitive coverage, the safeguards established by the Guidelines are designed to ensure that the contract is exactly what it purports to be: an informed bargain between a willing insurer and a willing PEO to allocate risk between each other, without shifting those risks to third parties. As in the context of other issues, the most essential regulatory requirement in the Guidelines is that the insurer must make and honor an unconditional commitment to cover the clients and the workers.

Likewise, when the client has paid the appropriate fees up front, the PEO may not hit the client with additional charges down the road if claims experience goes sour. Beyond those restrictions, the focus is on transparency, making sure that all parties have all the information they need to make an informed decision. Transparency extends to regulatory reporting as well. Subsection 11(D) of the Guidelines requires specific reporting by all insurers, foreign as well as domestic, in the domestic PEO market, and by domestic insurers on their nationwide PEO business. The content of the report is to be specified by the Commissioner, and a drafting note contemplates that it will include information on the rating methodologies, security arrangements, and reinsurance arrangements used, allowing regulators to evaluate whether PEO arrangements pose any material financial risk to the insurer.

Conclusion

The Guidelines are the result of a lengthy effort by regulators and interested parties to address a number of concerns that have arisen in PEO arrangements over the years. While the PEO industry has been largely successful in providing coverage and other services to many businesses on a long term basis, this record of success has not been universal. It has become apparent that the PEO relationship creates a variety of complications in areas such as proof of coverage, experience rating, and notice, and open up opportunities for abuse that require enhanced regulatory oversight.

Some states have addressed PEO issues more comprehensively than others. Some have adopted systems that work particularly well for them and others are looking to adopt regulations or revise regulations already in place. The ultimate goal of all the states is to preserve a workers' compensation system where all workers are properly covered and claims are handled promptly and correctly. Additional goals are to preserve competition in the market place in an effort to keep workers' compensation rates low and, to the extent possible, continue to move coverage from the residual to the voluntary market. To this end the Guidelines have sought to provide flexibility while addressing issues that have arisen in the past.

It has become clear that in each state, the issue is not simply one of the regulatory needs of the insurance regulatory agency. Action should include other important stakeholders in the process – the workers' compensation administrative agency and/or adjudicator, the advisory organization or rating agency, the insurance carriers involved in the PEO markets, and PEOs themselves. All of them should be involved in the process of developing those regulations necessary for that state while also striving to assure some commonality for data-reporting and exchange of information nationwide.

Implementation of these Guidelines may take time. They may require legislative efforts. They may also require a phased approach over time. However, the Working Group believes that the end result will be a better workers' compensation system for all.

Appendix A

[Insert current official version of Guidelines here.]

Appendix B

NCCI Alternatives and Technical Supplement on Data Reporting

Purpose of Proof of Coverage (POC) and Experience Rating Data

Workers' compensation administrators and insurance regulators rely on POC and statistical data to enforce and monitor the workers' compensation system. For states that recognize the PEO and their clients as co-employers, compliance programs and regulations need to consider the impact of insurance coverage as it relates to the PEO and the client employer. Regardless of the existence of a PEO or employee leasing arrangement, the integrity of experience rating and POC programs must be effectively maintained with statistical data that is:

- Sufficient to enable the state's compliance administrator to efficiently track and identify whether an employer within the state has the coverage required by law to ensure that injured employees' claims will be processed and the required benefits paid. At a minimum, POC data must identify the worksite employer's name, location, covered work units, and date of inception/cancellation/termination of coverage.

- Detailed enough to allow for the accurate reporting and tracking of payroll and losses attributable to the worksite employer, and enabling the calculation of experience modification factors at the client level.

Master Policy Considerations

The Guidelines support the master policy model when the following conditions are met:

- Client-specific notice requirements and payroll, loss, and other data reporting requirements give the client a status similar to that of an individual insured employer while insured under a master policy;

- Current insurance statistical and data reporting structures have the ability to track client experience and produce client experience ratings using all of the client employers' past experience, whether or not that experience is from the master policy;

- The insurer or the PEO cannot terminate or materially alter coverage without reasonable advance notice to the client;

- Insurers maintain and report data in sufficient and accurate detail to permit the calculation of meaningful client-specific experience ratings and verification of POC on the client level;

- Experience ratings are produced on an ongoing basis for every client that is eligible for experience rating;

- Ability to identify each covered client's workforce as a discrete unit of coverage under the master policy;

- The master policy adopts a "certificate of coverage" requirement, under which each client is issued a coverage document outlining its rights and obligations under the master policy and clearly establishing both the identity and status of the client and the inception and termination dates of coverage.

Considering these conditions, the Master Policy could be issued using the following structure:

- Standard workers' compensation policy (master policy) is issued to the PEO, as the primary named insured;

- Each client company of the PEO is listed as an additional named insured (as provided in Subsection 7(B) of the Guidelines);

- Information page schedules are attached to the master policy to identify each client company's name, FEIN, and job location;

- Each client company is issued a "certificate of insurance" coverage document outlining its rights and obligations under the master policy that clearly establishes both the identity and status of the client, and the inception and termination dates of coverage;

- Each client workforce is identified as a discrete unit of coverage, and corresponding endorsements are attached to specify notice requirements, and policy conditions for each client company covered under the master policy;

- Experience modification factor applicable to the master policy would include the combined experience of the PEO and each client company, including any past experience;

- Pricing and experience rating rules may be adjusted to allow for the combinability of experience and combination of premiums and eligibility for discounts, such as large deductible programs, retrospective rating, and group modification factor.

Data Reporting Options for the Master Policy

The root of the technical problems with obtaining client-level data under a master policy is that present industry standards for the reporting and collection of data are based on the issuance of a separate policy for each employer. These standards support the constant exchange and use of data from carriers' systems to data collection organizations, and subsequently, to many states' compliance systems. The existence of a separate policy identifies the employer as a potential candidate for experience rating and results in the submission of unit statistical data that provide the payroll and losses of the employer used in the experience rating calculation. While some industry standards have changed to assist in the complex reporting of PEO-related data, the ability to make significant changes to the current system is limited both by cost considerations and the need to preserve current capabilities for exchanging data. Adding requirements or changing industry standards is only meaningful if compliance is technically feasible.

Following are two Master Policy options for the reporting of client-level detail. To consider coding changes and system implementation, an 18 to 24 month industry lead time would be required. Should any of these alternatives be considered (or possibly others), it is important to take into account the full range of data reporting and experience rating challenges presented by the Master Policy when client-level detail is required. Both options require the reporting of unit reports for each client that can be linked together for experience rating purposes; the major difference between the options relates to how policy (and POC) data is reported. A third option presented is to convert the current manual reporting system to electronic form. This would support reporting under the 1991 NAIC Model Regulation, but would not be consistent with the Guidelines.

Option 1—Single master policy issued with the reporting of separate client policy and unit data

Data Reporting Requirements

Option 1 sets up a data reporting system for master policy situations that parallels the multiple coordinated policy framework. Separate policy data for each client company and the PEO would be reported as if separate client policies were issued. Separate unit data (payroll and loss) for each client would also be reported, thereby allowing for the reporting and maintenance of client level experience, in addition to the calculation of a group modification factor based on the combined experience of the PEO and its clients. This option would require the reporting of data in sufficient detail to permit the calculation of meaningful client-specific experience ratings, upon termination of a PEO agreement, and verification of POC at the client level. Additionally, policy reporting would need to be sufficient to identify the connection between all the client level policies to ensure that the separate unit data would also be rolled up to the PEO master policy level.

Option 2—Single master policy issued with the reporting of single policy data and separate client-level unit data (Multiple Coordinated Units)

Data Reporting Requirements

Option 2 attempts to support the continuation of reporting a single master policy, but requires the reporting of separate unit data (payroll and loss) for each client. It utilizes the single PEO Master policy and requires multiple coordinated units to be reported. With Option 1, both client-level policy and unit data would be reported; however, with Option 2, only client-level unit data would be reported. As a result, Option 2 would require more detailed

policy reporting requirements and the expectation of multiple unit reports for a single master policy. This option would call for significant changes to industry standards, including operating and reporting systems, and might be difficult to implement and costly to the industry.

Option 3—Electronic Reporting of Former Client Experience Rating Data

Currently, when a client leaves a master policy, the PEO carrier reports the client's payroll and loss data to NCCI for experience rating purposes on a hard copy form through a manual process. Option 3 automates the current experience rating manual process, so that carriers would be able to electronically report and collect the individual data of former client companies to NCCI. This option supports the 1991 NAIC Model Regulation, which requires submission of client-level data only after the termination of an employee leasing arrangement; however, it would require changes in industry standards, additional costs, and may prove inadequate if business limitations exist for accurate and timely maintenance and reporting of client-level payroll and losses. This option does not address the maintenance of client-level data while the client is part of the master policy, and therefore is not consistent with the Guidelines.

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