

Nebraska Filing Requirements for Worker's Compensation "Large" Deductibles

Except as specifically noted, these approval standards and other requirements apply only to so-called "large" deductibles, NOT too small medical deductibles. (Nebraska workers' compensation law requires that small medical deductibles - \$500, \$1,000, \$1,500, \$2,000, and \$2,500 – be offered to any insured that requests them.)

- (1) Insurers are not obligated to offer "large" deductibles or to offer them in all amounts that these rules might allow.
- (2) In no event shall a deductible of less than \$50,000 be offered or written under the "large" deductible law.
- (3) The insurer must handle the defense and settlement of all claims as if no deductible applies. All costs borne by the employer must be in the form of premium payments and loss or ALAE reimbursements to the insurer. The employer must not pay anything to an entity other than the insurer or TPA acting on behalf of the insurer through a contract in fulfillment of workers' compensation obligations. The insurer is the ultimate responsible party. If an independent adjusting service handles claims, any billings from this service must be to the insurer, not the employer.

Any provisions referring to the ability of the insurer to "advance" money to the employer are unacceptable, as the insurer must pay all losses, loss-adjustment expenses, and taxes or assessments directly. Provisions that appear to give the employer the right to control, approve or disapprove payments or settlements are not allowable.

- (4) Coverage written under these forms is to be considered workers' compensation coverage for annual statement reporting, workers' compensation, and insurance

laws, and, using premium after deductible credits, as a basis of assigned risk assessments or assignments¹

- (5) The deductible amount that the employer must reimburse may be any one of the following:
- (a) Benefits only;
 - (b) The sum of benefits and actual ALAE; or
 - (c) Benefits only, but the employer is liable to reimburse actual ALAE in addition to the deductible applying to the benefits
 - (d) Any reasonable pro-ration of ALAE between the insurer and the employer is acceptable

Employers' liability coverage may be included with any of the above.

- (6) The law is not specific on whether deductibles must be per-person or per accident. The "normal" form of deductible (per accident for accident injury and per person for disease) is acceptable. Other proposals will be considered on their merits.
- (7) Deductibles shall only be made available where the "basis premium" exceeds \$125,000. "Basis premium" is defined to be the sum of projected payrolls (for all states where coverage applies) times rates that will be in effect at policy inception, with all-expense discounts and modifiers applying except for deductible credits or ECP modifications.²
- (8) To arrive at premium thresholds, it is acceptable to combine payrolls for employers under common ownership, provided that all such related employers

¹ As of writing, no such assessments or assignments apply, but it is always possible that this may change in the future.

² Virtually all policyholders with a "basis premium" that exceeds \$125,000 will qualify for treatment as an exempt commercial policyholder (ECP) under Chapter 73. For ECPs, insurers may apply credits or debits to workers' compensation insurance in addition to their filed rates, but such additional ECP credits or debits shall not be used in the determination of the maximum allowable deductible.

are written under the same policy and subject to the same deductible for Nebraska losses. It is NOT mandatory, however, to policies and it is not necessary to combine their payrolls to meet minimum size requirements to apply any deductible provided.

- (9) A policy shall not be written with a deductible to exceed 40% of the “basis premium.” If, however, the final audited payrolls show that the deductible exceeded 40% of what the premium would have been on a non-deductible basis, this does not imply that the deductible which was in effect must be changed retroactively. The provisions of the policy will continue to apply.
- (10) Rate credits for deductibles are allowed to be determined on a judgment basis. While a filing of manual pages needs to be made that will assure that policies are written in accordance with Nebraska law, the manual pages do not need to include a schedule of deductible credits. Individual risk filings are not necessary.
- (11) Even though guide rating is allowed, as described above, policy rating must preserve and use usual payroll and classification information and require the use of audited payrolls after policy expiration. In other words, a “flat charge” rating that does not rely upon standard workers’ compensation rating classifications and audited payrolls are not allowable.
- (12) Deductibles must apply to all losses (or all losses + ALAE) on a medical + indemnity basis, regardless of any characteristics of the claim. (For instance, claims arising from aircraft accidents are not to be subject to a different deductible amount than claims arising from other accidental injuries.)
- (13) Insurers may offer an endorsement to limit the aggregate amount to be reimbursed by the employer under the deductible provision due to claims arising during the policy period. This coverage must be included in the same policy as the rest of the workers’ compensation coverage.
- (14) If an aggregate stop-loss is provided by the policy and the employer’s retention limit is a flat amount, or if flat minimum retention is used in a “greater of” fashion

in conjunction with a retention limit that is a function of audited payrolls and premiums, then this flat annual amount must not be less than the “basis premium.” This requirement notwithstanding, the policy must provide for proration of any flat aggregate retention limits in the event of cancellation by the insurer. Exception: the policy may state that proration of the aggregate retention limit will not occur in the event of cancellation due to nonpayment or other serious breaches of contract. These “serious breaches” would need to be detailed in the cancellation provisions.

If the employer’s aggregate retention limit is a function of audited premiums or payrolls, without a flat minimum being used, then the applicable coverage formula must not be designed to yield a smaller annual retention than the “basis premium.” In this case, however, if it occurs that audited payrolls would produce a pre-deductible premium that is less than the “basis premium,” then it is not unacceptable if the calculated retention turns out to be less than the minimum target otherwise specified in this paragraph.

- (15) The manual rules must state that coverage is to be provided only when the financial impact of the retention amount (that is, the effect of the deductible, subject to any aggregate provided on the policy) will remain uninsured.
- (16) We have seen proposed provisions that would allow the insurer to cancel the large deductible endorsement, but otherwise keep the policy in force, causing the policy to revert to a “guaranteed cost” contract. Such an amendment to the policy is unacceptable on a retroactive basis and can be made on a going-forward basis only with agreement from the employer. This statement notwithstanding, provisions like retro provisions dealing with employer insolvency may be included in the policy and can be extended to nonpayment situations. Such provisions could allow an insurer to value all claims on an incurred basis for the purpose of making a claim against the employer’s LOC or receiver.

(17) Without modification to address annuity-type settlements, an insurer can find itself in the situation where it needs to bill an employer monthly or quarterly for 20, 30, or more years, until an annuitant dies, remarries, or the payments finally sum to the deductible amount. If an insurer wishes to simply ignore this rare situation – fine, we will approve that. If, however, an insurer wishes to address this situation, then there are quite a few complications. The discussion shown on the next several pages, up to the bold-face reference to **REQUIREMENT**, can be ignored if you choose not to specifically address annuity-type settlements. But we recommend that you look at it.

Settlement (by commutation) of reimbursements due the insurer

Lump-sum settlements

“Large” deductible workers’ compensation contemplates reimbursement to the insurer after payment has been made on behalf of the employer. An advantage to this arrangement, as opposed to retrospective rating, is that the employer doesn’t need to agree with loss reserves that the insurer has established. A shortcoming, however, is that certain annuity-type losses may require the insurer to bill the insured on a monthly or quarterly basis for an extended period.

When annuity-type claims occur under a retrospectively rated contract, it is common for the employer and insurer to eventually agree that a given retrospective premium calculation is to be considered final. In this fashion, while the insurer must still send out regular checks to the claimant, the necessity of annual billings to the employer (to settle reserve changes) is eliminated. In addition, the settlement with the employer can fairly reflect the time value of money.

The situation is more complicated in the case of employers written under “large deductible” policies, but a parallel agreement would be acceptable. An employer and insurer could agree to a final settlement based on the sum of the present values of expected future payments after such expected payments have first been limited by the

deductible amount. This is to be distinguished from applying the deductible limit to the sum of the present values of future claim payments.

An example can serve to illustrate the last two sentences in the prior paragraph. Suppose that an insurer is obligated to pay \$10,000 annually for the life of a widow. The present value of these expected payments is \$120,000 and the deductible is \$100,000. Under these circumstances, if the insurer seeks to reach a final settlement with the employer without undertaking a lump-sum settlement of the actual claim, then a fair reimbursement settlement should be for less than \$100,000. Basically, it would be the present value of 10 annual payments of \$10,000, which will be less than \$100,000 because of interest and mortality.

None of the above applies when an insurer settles an annuity-type claim with the claimant on a lump sum basis. In this case, unless the insurer has special provisions in the contract (and, to date, we've never seen any proposed one), the insured would be liable for the amount of the settlement up to the deductible provision, without reduction for either the time value of money or for the other contingencies.

Clearly, it is the case that an insurer can leave itself open to accusations of bad faith if it attempts to settle a claim with ordinary annuity-type benefits on a lump-sum basis. The insurer may stand to benefit to the detriment or potential detriment of the powerless policyholder. And, in both cases, the policyholder is likely to be quite unappreciative.

What we believe would be fairest, and what we would wish to encourage, would be a provision something like the following, using the usual "we/you" language:

- If, absent the "lump-sum" settlement, the claim would involve defined periodic payments, and
- If the sum of these periodic payments, is not discounted for the time value of money, mortality, remarriage, and other contingencies, potentially could have exceeded the deductible amount, then

The amount which you must reimburse us for this “lump-sum” settlement shall be determined in the following manner:

- First, paid losses, unpaid losses which are certain, and potential unpaid losses which sum to an amount equal to the deductible shall be identified, then
- The unpaid amounts so identified shall be reduced actuarially to recognize the time value of money and, to the extent applicable, mortality, remarriage, and other contingencies; and then
- The unpaid amounts, so reduced, shall be summed

Actuarial and other presumptions for these calculations shall be the same as those used by us to determine the actual amount paid to settle the claim.

Comment 1: We aren't proud of this wording; we hope that somebody else can do better

Comment 2: A similar formula could also be used to address the “reimbursement settlement” questions raised earlier, except that “reimbursement settlements” can be negotiated in advance, which makes this unnecessary.

REQUIREMENT: Manual pages and forms which are in conflict with the approval standards described on the preceding pages must be changed to obtain approval. This may be done on a “Nebraska Exception” basis. In addition, insurers must acknowledge that they have been notified of the statistical considerations outlined below:

- (1) The insurer must provide complete statistical reporting of all incurred claims (“unit data”) to the NCCI so that the NCCI’s experience rating and classification ratemaking can be done without degradation. This means that reserves must be established for individual claims that are not immediately settled, even though the insurer may anticipate that the claim will ultimately settle for less than the deductible amount.
- (2) The insurer must be able to provide aggregate financial data to the NCCI for deductible policies on a gross basis; that is as if no deductibles applied. This will be a special NCCI call for Nebraska

- (3) Nothing in deductible arrangements may alter reports received by the Nebraska Workers' Compensation Court.
- (4) Premium taxes: All amounts collected by insurers (which must be exactly the same as the amounts spent by employers) pursuant to deductible insurance contracts are to be considered as premium except:
- a. Loss amounts reimbursed by employers to insurers, and
 - b. ALAE reimbursed by employers to insurers
- (5) Workers' Compensation Trust Fund³Assessments: These assessments, whenever they are collected, will be 2% of losses (not losses + ALAE) paid during the calendar year, including losses reimbursable under deductible plans. (This includes "large" deductible plans as well as the NCCI-filed medical-only "small" deductible plan.)

Insurers must be able and will be required to report losses paid on behalf of employers pursuant to deductible forms as a supplement to premium tax forms submitted to the Department of Insurance. Tax forms promulgated by the Department require the reporting of losses paid that would have been reported as part of the annual statement on page 15 if no WC deductible provisions are applied.

Rating Recoupment for Workers' Compensation Trust Fund and RML Charges Addendum to Approval Standard

In the filings received since we promulgated filing standards for large deductibles, our requests for rating examples uncovered certain types of rating errors for virtually all insurers. Specifically, these errors involved improper recognition of assessments. We noted that policy forms that proposed recoupment of actual assessments and residual market loads all involved overcharges.

³ This fund combined the formerly separate Vocational Rehabilitation and Second Injury Funds. While statutory provisions applying to second injury claims no longer apply, old claims are still being run off.

As such, we disapprove of any forms that would recoup actual assessments. This addendum is intended to explain why we decided to disapprove of such forms. The mechanics of doing this properly would be cumbersome, and not a single proposal to date has shown correct rating and billing procedures to accomplish this feat. Rather than working at great lengths with insurers to design procedures that we expect would be misapplied anyway, we believe it is better to disapprove forms that propose actual recoupment. We believe that the simpler alternative, which is for insurers to reflect these costs in their premium charges, is also the better alternative.

Specifically, we have seen the following problems:

- (1) Difficulties arise when the insurer wishes to recoup actual loss-based assessments. While this is fair in principle, it becomes very complicated to apply correctly. The actual means of collecting the Workers' Compensation Trust Fund is an assessment of paid losses on an erratic basis. To collect this assessment properly from deductible insureds would require:
 - a. The insurer must wait until after the end of each year – which would be after they have otherwise billed for most of the losses,
 - b. The insurer must then determine whether a loss-based assessment is being made,
 - c. The insurer must then apply the 2% tax rate to all paid losses during the prior year and,
 - d. Then, long after the policyholder has reimbursed the insurer for the losses, the insurer must bill for the 2% tax applying

For deductible insureds, it would be best to add an additional amount to the tax load for an average amount of loss-based assessments and not charge for actual assessments. In addition to being reasonably fair, this procedure is simpler from a billing and statistical reporting standpoint. Proposals to pass "actual" assessments back to the insured will be disapproved for the reasons just mentioned.

(2) Some insurers have also proposed to pass the costs for actual RML's back to the insured. This would also be very cumbersome for billing purposes – worse than assessments for second injury and vocational rehabilitation. Given this difficulty, plus the fact that Nebraska's RML's have been very low⁴

⁴ As of this writing, the voluntary market has no responsibility for shortfalls that may occur in Nebraska's assigned risk business, but it is possible that this could change in the future.