REPORT OF THE
WORKERS' COMPENSATION COMMISSION ON

TIMING OF RESOLUTION OF WORKERS' COMPENSATION CLAIMS AND EMPLOYEE LEASING

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 13

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WORKERS' COMPENSATION COMMISSION

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MEMORANDUM

TO: The Honorable Governor James S. Gilmore, III
Members of the General Assembly

FROM: Virginia R. Diamond, Chairman

DATE: December 21, 1998

Pursuant to House Joint Resolution 186, attached is the Workers' Compensation Commission's report on the Timing of Resolution of Workers' Compensation Claims, and Employee Leasing.

Virginia Workers' Compensation Commission

Written Report to the Governor and General Assembly
of the Commonwealth of Virginia

Timing of Resolution of Workers' Compensation Claims (Part I) and Employee Leasing (Part II)

Legislature Reference Number
House Joint Resolution 186

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TIMING OF RESOLUTION OF WORKERS' COMPENSATION CLAIMS

PART I
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I. EXECUTIVE SUMMARY

House Joint Resolution 186 directed the Workers' Compensation Commission to "study ways to expedite the receipt of workers' compensation benefits for employees injured on the job." The Resolution noted that "unnecessary delay in providing an employee or his dependents with the compensation they are entitled to under the law is unconscionable and is antagonistic to the legislative intent of the Act," and "can lead to unnecessary loss of property, further health problems, family discord and strife, and personal financial crisis."

Growth of the Workers' Compensation System

The Commission's challenge is to adapt its procedures to the increasingly large and complex case load.

The Commission processes approximately 200,000 accident reports each year, including nearly 60,000 of which involve at least seven lost work days and more than $1,000 in medical expense. Parties file approximately 20,000 applications for hearings.

Litigation has grown in numbers and complexity. Deputy Commissioners decided 4,178 cases in 1996. This is up from 3,938 in 1986, and 2,857 in 1976. These cases are longer than cases in previous decades, and involve extensive discovery. By increasing the number of Deputy Commissioners, the Commission has prevented a significant increase in the length of time for resolving cases. The average length of time from application to Opinion after an on-the-record determination is 115 days, compared to 189 days for an evidentiary hearing. In 1991, the length of time was 187 days for the evidentiary docket.

Parties may appeal Deputy Commissioner Opinions to the Full Commission, and in 1996 the Full Commission decided 1,623 cases. This compares to 914 cases in 1986, and 297 cases in 1976. The average length of time from a review request to a Full Commission decision is 179 days. In 1991 the length of time for issuance of a Review Opinion was 146 days.

Parties may appeal Full Commission decisions to the Court of Appeals. In 1997 there were 335 such appeals, and the average length of time involved is about 200 days from appeal to decision.

Commission Initiatives to Expedite the Process

The Commission is committed to resolving claims as quickly as possible, and has adopted several initiatives to expedite the process. They include:

1. Upgrade of Computer System - The Commission has invested in a major upgrade of its information system to achieve efficiencies in claims processing, better networking capabilities among the regional offices, and increased options for interaction with the public including electronic filing and a Web page.

2. Emergency Case Docket - Cases involving a demonstrated hardship, upon the agreement of parties, can be heard on an emergency basis in Richmond in the Commission's newly constructed second courtroom.

3. Mediation - The Commission will adopt mediation procedures for issues which lend themselves to mediation.

4. Ombudsman - The Commission has created a new position, Ombudsman, to facilitate better understanding of the system and better communication between the parties.

5. Public Education - The Commission is expanding its public seminars, brochures, and Telephone Response Unit to improve public understanding of procedures.

6. Staff Attorneys - To assist with the growing Review caseload, the Commission has created the position of Staff Attorney. Staff Attorneys are experienced practitioners who assist Commissioners in Opinion research and drafting.

7. Decision on Acceptance or Rejection of Claims - The Commission currently sends out a twenty-day Order to the employer/insurer seeking either an acceptance or denial of the claim. If no response is received, this is followed-up with a ten day Order. The Commission will streamline this process by sending out only the twenty-day Order, after which the case will be referred immediately to the docket if there is no response.

II. INTRODUCTION

House Joint Resolution 186 ("HJR 186")[1], adopted during the 1998 General Assembly session, directed the Virginia Workers' Compensation Commission (the "Commission") to conduct a study of the time frames involved in resolving workers' compensation claims, and to report on initiatives available to the Commission to expedite the resolution of claims. HJR 186 refers to the public's interest in the prompt processing of claims and the encouragement of voluntary payments.

The Commission engaged in an intensive self-study of the various stages in the procedures of the agency, scrutinizing each department for ways to move the process more efficiently and expeditiously. In addition to seeking input from Commission staff, the agency communicated with representatives of insurance companies, third party administrators, employers, rehabilitation providers, and employee representatives. Attorneys who practice before the Commission also provided suggestions in response to a survey. The Commission retained the services of a computer consulting firm to study its data processing system, and to make recommendations regarding expansion of computer related services to the public.

This report summarizes the findings of the agency's self-study, and details the initiatives the Commission is undertaking to fulfill its mission of providing expeditious and fair handling of workers' compensation claims.

III. THE ROLE OF THE COMMISSION IN HISTORICAL CONTEXT

A. *The Virginia Workers' Compensation Commission*

The policies and procedures of the Commission are largely determined by the provisions of the Virginia Workers' Compensation Act (the "Act").[2] The Act defines the composition of the Commission, specifies the powers and responsibilities of the Commissioners, and establishes guidelines and limitations for compensating injured workers. The primary role of the Commission is to administer the provisions of the Act, including mediating disputes between the parties, conducting hearings for disputed claims, and reviewing appeals from the evidentiary and on-the-record hearings.

The Commission administers not only the Workers' Compensation program, but also the Crime Victims' Compensation Program, the Uninsured Employer's Fund, the Medical Costs Peer Review Program, the Second Injury Fund, and the Birth-Related Neurological Injury Compensation Fund. These other activities are outside the scope of HJR 186 and were not studied for this report.

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[1] See Appendix, page A1.

[2] Code § 65.2-100 *et. seq.*

The Commission relies on other agencies which also play vital roles in the compensation system. The State Corporation Commission's Bureau of Insurance is responsible for rate-making issues, assigned risks, and overall regulation of insurers. The Department of Labor and Industry is responsible for occupational health and safety issues. The Attorney General's Office defends the Uninsured Employer's Fund and provides collection assistance for the agency.

The Commission is authorized to make rules that are consistent with the Act to carry out its administrative responsibilities and to define procedures and responsibilities for employers, insurers, and employees. The Commission also acts as a court of competent jurisdiction in hearing contested claims. Commissioners and Deputy Commissioners decide cases and appeals.

The provisions of the Act governing insurance and the reporting of accidents by employers, their insurers, and self-insured employers are mandatory. Violators are subject to fines. Knowingly and intentionally failing to comply with the insurance requirements of the Act is a Class Two misdemeanor.

B. *Growth of the Workers' Compensation System*

During the course of the century, since the Act was adopted in 1919, the system, and the economic context, have evolved considerably. Whereas in 1919 there were fewer than 11,000 accidents reported, almost 200,000 accidents were reported in 1997. Initially, the jurisdiction of the Act was limited to employers with eleven or more employees. Now the Act covers employers with three or more employees -- over three million workers and 98% of Virginia's working population. The Commission currently houses 500,000 active files.

The Commission processed nearly 34,000 voluntary agreements on initial claims in 1997 and adjudicated more than 5,000 cases at the hearing or Deputy Commissioner level. This compares to fewer than 4,000 hearings in 1986, and fewer than 3,000 hearings in 1976.

The length and complexity of cases also have grown. Whereas discovery was rarely used in the early 1980s, interrogatories and depositions of parties, witnesses, and medical care providers are now part of most cases.

The Full Commission decided more than 1,400 cases in 1997. In 1986 the Full Commission reviewed approximately 900 cases. A decade earlier the Commission heard fewer than 300 appeals. As the case load has grown, so has the judicial and administrative staff. There are currently eighteen Deputy Commissioners, with an agency staff of 170.

In Virginia, overall medical and indemnity costs for workers' compensation have declined since 1993, but had increased steadily until that time. In 1996, total workers' compensation benefits paid by private insurers and self-insured employers equalled approximately

$368,461,395.[3] Settlements of workers' compensation cases in 1997 were valued at almost $111,000,000, involving nearly 4,900 claims.

IV. BENEFITS AND GENERAL PROCEDURES UNDER THE ACT

A. *Introduction*

The Commission is responsible for processing, managing and adjudicating all workers' compensation claims in Virginia. In addition to processing new claims, the agency has continuing responsibility for managing the ongoing, or open, claims previously established. In the context of ongoing claims, issues are frequently presented to the Commission for resolution by employers' applications for hearing, or by workers' claims for additional benefits. An employer files an application to initiate a change in a claimant's benefit status. Workers file change in condition claims for additional benefits.

Responsibility for processing workers' compensation claims and employer's applications at the Commission involves two types of management functions: administrative and judicial. Administrative management functions include opening a claim file, entering the workers' compensation award, and maintaining the physical file. Judicial management involves adjudicating disputed claims and oversight of undisputed claims.

To analyze each step in the process of handling workers' compensation claims, it is useful to review generally the benefits and procedures specified by the Act.

B. *Benefits under the Act*

The Act provides for medical benefits and wage loss indemnity benefits. Generally, medical benefits, which are payable for as long as necessary, may include payment for physicians' services, hospital, and other necessary medical treatment. Wage loss indemnity benefits are calculated based on 66⅔% of the employee's pre-injury weekly wage, and generally are limited to 500 weeks.

The medical benefit award is now made for the life of the employee as long as the treatment sought is reasonable, necessary, and causally related to the industrial accident.[4] Medical benefits may include payment for physicians' services, chiropractic care, hospitalization, and other necessary medical treatment. The term "medical attention" also covers medical supplies and travel expenses for medical visits.

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[3] See Appendix, pages A4 and A5.

[4] Code § 65.2-603.

In addition, the employer or insurer must provide any prosthetic devices and therapeutic appliances, as well as home modification, if necessary. The total of these appliances and modifications may not exceed $25,000. In 1998, the General Assembly excluded wheelchairs from this $25,000 limitation.

The Act also provides for wage loss indemnity benefits. These benefits are primarily intended to replace the wages of injured workers while they are unable to work or are working for less than their pre-injury average. Benefits for temporary total and temporary partial incapacity, permanent total and permanent partial incapacity, and death are based on loss of earnings.

Indemnity benefits are calculated by averaging the weekly wages of the injured worker for the fifty-two week period immediately preceding the date of injury.[5] The maximum amount of the average weekly wage for which the employee is reimbursed is subject to a maximum weekly rate, ascertained annually by the Commission. The minimum compensation rate is set at twenty-five percent of the state-wide average weekly wage, or the employee's actual wage, whichever is less. In 1919, the compensation rate was not less than $5.00 per week or more than $10.00 per week, based upon one-half of the employee's average weekly wage. Currently, the maximum compensation rate is $534.00 per week, and the minimum is $133.50.

Temporary total benefits are due to workers who are unable to work in any capacity as a result of the work injuries.[6] Temporary partial benefits are paid to workers who have returned to work in a capacity which pays less than their pre-injury job. Temporary partial benefits compensate for the difference between the pre-injury and post-injury wages.[7]

Permanent total disability benefits are paid for the lifetime of the injured worker. A small percentage of injured workers actually qualify for this benefit. It is available to those who have a severe brain injury and are permanently unemployable in gainful work, those who have lost both arms, hands, feet, legs, eyes, or any two thereof as a result of the work injury, or who are for all practical purposes totally paralyzed.[8]

Benefits for permanent partial disability are scheduled losses which are provided for the loss of use or loss of function of a part of the anatomy, or for disfigurement. Such losses are "scheduled" because a fixed weekly benefit value is placed on body members by a schedule set out in the Code for which an injury has caused a total or partial loss of use.[9]

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[5] Code § 65.2-101.

[6] Code § 65.2-500.

[7] Code § 65.2-502.

[8] Code § 65.2-503.

[9] Code § 65.2-503.

Temporary total and permanent total disability benefits, as well as death benefits for which payments continue for more than one year, may be supplemented by a cost-of-living adjustment. If an employee's combined benefit under workers' compensation and the Federal Old Age Survivor and Disability Insurance Act is less than eighty percent of his or her average monthly earnings before the injury, the employee is eligible for a cost-of-living supplement.

The amount of the supplement is based on the increase (or decrease) in the Consumer Price Index from one calendar year to the next. This supplement is not self-executing and requires the employee file a change-in-condition application so that eligibility for this supplement may be determined.[10]

The Act also includes provisions for vocational rehabilitation training services to injured workers. Vocational rehabilitation focuses on returning injured workers to gainful employment. Often this is to the same job or industry. If the resultant injuries do not allow for return to the same job or industry, vocational rehabilitation concentrates on preparing injured workers for employment in another occupation.[11]

Death benefits are awarded if an injured worker's death occurs as a result of the compensable injury and within nine years of the date of injury. These benefits are available to dependents who are wholly or partially dependent upon the employee's earnings at the time of the death. Dependents wishing to claim death benefits must do so within two years of the injured employee's death. Effective July 1, 1998, the General Assembly increased the burial expense allowance from $5,000 to $10,000 and increased the transportation expense allowance from $500 to $1,000.[12]

C. *General Procedures under the Act*

With regard to general procedural requirements, Virginia is an "award state." This means that claims that are not disputed by employers are to be memorialized in an Award entered by the Commission. Disputed claims that are determined to be compensable under the Act also result in an Award.

Changes in the status of an Award are made when the parties submit forms that memorialize their agreement. If the parties do not agree about changes in the status of an Award, the Commission may hear the parties' arguments and determine if a change in the Award is appropriate. An employer seeking to terminate an existing Award is required to file an application for a hearing. An employee seeking new or modified benefits under an existing Award is required to file a claim requesting a hearing--a change-in-condition claim.

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[10] Code § 65.2-709.

[11] Code § 65.2-603.

[12] Code § 65.2-511 - 517.

The Act contains many statutes of limitations, each of which are subject to exceptions. Generally, initial claims by employees must be filed within two years of the accident, or within two years of the date of the communication to the employee of the diagnosis of an occupational disease. Notice of an accident to the employer must be given within thirty days of the accident, and sixty days after communication for a disease. Change in condition claims for additional benefits or to modify an Award must be made within two years of the date the claimant last received compensation. Temporary total disability for change-in-condition claims are limited to ninety days before the claim is filed. Claims for permanent disability benefits must be filed within three years of the date the claimant last received compensation. If an employee refuses suitable employment proffered by the employer, he or she must "cure" this refusal within six months.

Claims for coal miners' pneumoconiosis, byssinosis, asbestosis, and HIV have varying statutes of limitations with respect to both diagnosis and exposure.

Requests to review a Deputy Commissioner's Opinion must be made within twenty days from receipt of the Opinion. Notice of an appeal from a review by the Full Commission must be filed with the Court of Appeals within thirty days after receipt of the Review Opinion.

The complexity of the substantive and procedural provisions of the Act, and the numerous potential issues for dispute, have produced a large and complex body of case law that guides the various levels of the Commission in its processing of these cases.

V. CLAIMS PROCESSING BY THE COMMISSION

A. *Introduction*

In general, the Commission's involvement in an employee's benefits occurs in one of two ways: either when there is no award, which occurs soon after a workplace injury; or when there is an existing award. In cases in which no award has been entered, the Commission opens a claim file, notifies the parties of their responsibilities, and either processes an Award or adjudicates disputes concerning the claim.

In cases in which an award has been entered, the Commission re-opens the existing claim file, notifies the parties of what they should then do, and either processes a new or modified Award or adjudicates new disputes. We will first discuss the Commission's procedures for initial claims, and then discuss the Commission's procedures for claims having Awards.

B. *Administering Benefits: Procedures Following Injury*

1. Claim File Initiation

The Commission opens a file for each employee about whom the Commission receives notice of injury in a workplace accident. The Commission is officially apprised of such injuries, thus triggering the file-opening process, in one of two ways: either through a claim for benefits filed by a claimant; or a First Report of Accident filed by an employer.

Claims processing and management is initiated at the Commission in the First Report Unit. This Unit creates a claim file after the Commission receives either the Employer's First Report of Accident or the Claim for Benefits form filed by the claimant. Claimants' claims are afforded priority by the First Report Unit.

a) *Report of Accidents by Employer*

Employers are required to report to the Commission all workplace accidents.[13] The Commission divides accidents into two categories: minor and major. A minor accident involves less than $1,000 in medical costs or results in fewer than seven days of incapacity. Minor accidents are reported monthly on Form 45A. The information from the Form 45A is entered into the Commission's computer system and can be retrieved.

When a claim is established from an Employer's First Report of Accident form, the First Report Unit determines further appropriate action based upon information found on the form. The Employer's First Report of Accident includes a space where the insurer may code its reason for filing the report. This coding system allows the Commission to determine the insurer's initial position with respect to a claim.

The criteria for filing a First Report form are: (1) lost time exceeds seven days; (2) medical expenses will exceed $1,000; (3) compensability is denied; (4) issues are disputed; (5) accident resulted in death; (6) permanent disability or disfigurement may be involved; or (7) a specific request is made by the Commission. The form 45A, a report of minor injury, is adequate notice to the Commission for accidents that do not meet these criteria.

In 1997, there were 147,101 minor injuries reported, and 57,661 major injuries reported. Of these, 33,773 resulted in the submission of agreement forms, which the Commission processed as "Awards of Benefits." An Award of Benefits

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[13] Code § 65.2-600.

provides for payment to an injured employee of workers' compensation benefits under the Act.

b) *Employees' Claims for Benefits*

After the report of an injury, the Commission mails to the injured employee a guide that provides information on his or her rights under the Act. In the case of a minor injury, the Commission mails "A Brief Guide to Workers' Compensation for Employees (Minor Injury Cases)." This guide does not have a Claim for Benefits form but is otherwise essentially the same as the guide sent in more serious cases.

After notice of a major injury, the Commission sends the claimant a booklet entitled "A Brief Guide to Workers' Compensation for Employees," which includes a Claim for Benefits form and a brief description of the Virginia Workers' Compensation Act. The Commission also mails a notification letter, commonly called the "blue letter," to the injured worker, the insurer, and the employer. This letter informs the parties of the file number and lists any additional information which is needed. The blue letter provides additional guidance to the injured worker.

If an employee notifies the Commission of a workplace accident, the Commission immediately opens a file and assigns a claim number. The First Report Unit begins the process of matching the claim filed by the employee with the Employer's First Report of Accident. If the employer's Report has not been filed, the Unit contacts the employer to request it.

2. Referral to the Claims Examination Department

The Claims Examination Department is the Unit within the Commission which determines whether claims are referred to the hearing docket, or whether they can be resolved through agreement forms. The Claims Examination Department, which consists of nine claims examiners, processes approximately 59% of all claims through agreement forms, without the need to be referred to the hearing docket. In 1997, 33,773 awards were entered involving non-contested claims for benefits

This department also responds to the nearly 400 calls that are made to the Commission daily. These telephone calls concern either general information about workers' compensation, or specific information about the status of a claim.

a) *Request for Medical Reports*

The Commission first reviews a claim for completeness. If the claim cannot be processed because it lacks certain critical elements, such as signature or

name of employer, it is returned and the claimant or attorney advised of the deficiency.

Rule 1.1 of the Commission states in pertinent part, "An original claim will not be docketed until medical evidence to support the claim is filed." When a claim is not supported by medical evidence, the claims examiner issues letters notifying the employee that a case cannot be referred to the hearing docket until the necessary information is received.

b) *Twenty Day Orders to the Insurers*

With most claims, the Claims Examination Department sends a Twenty Day Order to the employer/insurer, inquiring whether the claim is accepted or denied, and if denied, a reason for denial. The Order is a checklist form that was created to help the Commission determine whether a case can be resolved or what type of hearing is necessary. The Order is enforced through a show cause hearing. The response of the insurer is not legally binding on the parties because Rule 1.5 of the Rules of the Commission provides that the response is not considered a part of the hearing record.

If the insurer does not respond within twenty days, a second Order is sent, requiring a response within ten days. If there is still no response, the Commission refers the case to the hearing docket and issues a Show Cause Order for failure to respond. If an insurer provides the requested information within the appropriate periods, the examiner works with the parties to resolve the case.

The Commission has identified some factors causing a delayed response by insurers. In the past several years, the insurance industry has undergone major restructuring, including mergers, consolidation of offices, and downsizing. In the past, most insurance claims examiners handling Virginia workers' compensation claims were located within Virginia. It is now common for out-of-state offices to handle Virginia claims. Sometimes it is time-consuming to locate the appropriate office.

There is also a growing use of third-party administrators that handle certain aspects of a client company's claims. As a result, the Twenty Day Order often does not arrive at the appropriate party handling the case until several weeks have elapsed. The Commission has held a number of meetings with insurers to discuss ways to remedy this situation. Commission initiatives in this regard are discussed below in section VI(G).

3. Referral From the Claims Examination Department

If a claim is not contested and the parties reach agreement, the Claims Examination Department refers the file to the Awards Unit for the processing of a Memorandum of Agreement ("MOA"). If a claim cannot be resolved and voluntary payment will not be made, the claim is referred either to the evidentiary hearing docket or to the dispute resolution docket. Through electronic referral, the claims examiner assigned to handle the claim initially refers the claim either to a regional office, if that is the geographic area in which the accident occurred, or to one of ten deputies who conduct hearings in Richmond or a geographic area serviced by the Richmond office. The file is then transferred to the Deputy Commissioner's office and the case scheduled for hearing.

a) *Awards*

If the insurer or employer accepts the claim, the Commission processes a Memorandum of Agreement executed by the parties, and enters an award. The MOA identifies the parties' agreement about the details of the claimant's benefit payment. The MOA sets out the amount of each periodic compensation payment[14] to the claimant and the period for which such compensation may be paid.

The insurer or employer prepares the MOA and then sends it to the claimant or the claimant's representative for execution. After the claimant signs the MOA, he or she returns it to the insurer. The insurer then completes its execution of the document and sends it to the Commission for entry. Once received by the Commission, the MOA is processed by the Commission's Awards Unit.

Entry of the MOA by the Commission creates an "open award" to the claimant. Under an open award, an insurer is obligated to continue paying benefits as described in the MOA until the award is terminated. An open award can be ended in one of two ways: the claimant's execution of an Agreed Statement of Fact; or the employer's filing an appropriate application to terminate benefits.

A number of initiatives to expedite the entry of Awards are discussed below in section V(D).

[14] Compensation is normally paid weekly with lump sum payments made for accrued arrearages.

b) *Hearings*

When an insurer disputes compensability, the Commission's internal system of formal adjudication is triggered. If the insurer denies the claim, the claims examiner sends the file to the hearing docket for adjudication of the contested issues. The file may also be sent to the hearing docket if the insurer persists in a failure to provide the information requested by the Commission. In 1997, the process initiated by the filing of a claim until the claim was docketed for a hearing took approximately fifty days.

The hearing docket is essentially divided in two parts. The dispute resolution docket processes those cases in which oral evidence likely is unnecessary. The parties are given an opportunity to present evidence and argument in a summary fashion for expedient determination. A Deputy Commissioner determines these cases "on the record." Litigants are notified that their case has been selected for such a determination, and are given the opportunity to object to this procedure. These cases are decided by submission of documents and written statements.

In 1997, 1,711 claims were referred to the dispute resolution docket in an average of forty-five days from the date of application. On average, the length of time from the filing of an application to the issuance of the Opinion is 115 days.[15]

The second docket is the evidentiary docket. The evidentiary docket affords litigants an opportunity to present evidence through witness testimony. A Deputy Commissioner is assigned files referred to the evidentiary docket and presides over a hearing, in which testimony is recorded. Deputies are authorized to subpoena witnesses, administer oaths, and examine books and records relating to a proceeding.

In 1997, 8,624 claims were referred to the evidentiary hearing docket in an average of 49 days. Of the 3,446 opinions following evidentiary hearings in 1997; the average length of time between application and an evidentiary hearing was 106 days, followed by a decision in an average of thirty-four days.[16] This 140 day period compares to 187 in 1991.

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[15] See Appendix, page A6.

[16] See Appendix, pages A7 and A8.

The Commission currently has eighteen Deputy Commissioners.[17] There are two at the Alexandria office; two at the Virginia Beach office; and one each at the Harrisonburg office, Roanoke office, and Lebanon office. The remaining eleven Deputy Commissioners are based in the Richmond office and hear cases there and at additional hearing sites throughout the Commonwealth.

Generally, hearings are scheduled for one-half hour. If a case is going to take longer than one-half hour, the parties are to notify the Commission immediately. If the docket has not been filled for that day, the case may not need to be rescheduled. However, because discovery has not always been completed, the Commission may not be notified until ten or fewer days prior to the hearing date. The case may be required to be continued until another date. Hearings consist simply of witness testimony, not legal argument. Medical care providers are not required to attend hearings because their medical records are automatically introduced into the record. Opening and closing statements are not allowed.

Written Opinions are issued for both on-the-record determinations and evidentiary hearings.[18] The Deputy Commissioner makes findings of fact and conclusions of law deciding all relevant issues that are in dispute.

4. Settlements

At any point in the process, the parties may submit to the Commission for approval a Petition and Order to settle the case. In 1997, the number of cases settled and resolved by compromise settlement was 4,899, representing a total value of $110,537,248. In 1987, the number of settled cases was 2,029, representing a total value of $33,183,146.[19] A Deputy Commissioner reviews settlement documents and approves the settlement if deemed in the best interest of the claimant.[20]

5. Review by the Full Commission

An Award entered by the Commission's Awards Unit, an Order approving a compromise settlement, and a final Order entered by a Deputy Commissioner can be appealed to the Full Commission. Request for review must be made within twenty days from the date the party receives the award or order.

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[17] See Appendix, page A9.

[18] See Appendix, page A10.

[19] See Appendix, page A11.

[20] Code § 65.2-701(C).

After a request for review is filed, a transcript of the hearing before the Deputy Commissioner is prepared and sent to the parties, if requested. A briefing scheduled is issued to the parties. The party requesting review has fifteen days to file a written statement in support of its position on review. The other party is then given twenty-five days from the date of the original notice.

The review opinion is drafted by one Commissioner and reviewed by the other Commissioners. In fewer than 5% of cases, one Commissioner dissents from the majority opinion. Oral argument takes place one day a month, and is granted when there are novel issues or where the case is complex. In 1997, on average, 166 days elapsed between the time a request for review was filed and the time the review opinion was issued.

In 1996, 1,623 cases were appealed from the Deputy Commissioner level to the Full Commission. This compares to 914 cases in 1986 and 297 in 1976. To remain current, the Commission must issue thirty Opinions per week. When these figures are expressed as a percentage of opinions initially issued by Deputy Commissioners, there is a discernible upward trend. The reviews in 1996 represented 31.3% of the opinions issued by Deputy Commissioners compared to 23.2% in 1986 and 10.4% in 1976.[21]

Full Commission review opinions are, in turn, appealable as a matter of right to the Virginia Court of Appeals. In 1996, 356 cases were appealed to the Court of Appeals, whereas in 1987, 188 cases were appealed.[22] Finally, the Supreme Court of Virginia may hear cases appealed from the Court of Appeals, but does so only in very limited circumstances, and then at its discretion.[23]

C. *Administering Benefits: Procedures Following Awards*

Following the entry of an initial award, the insurer or claimant may request a hearing to adjudicate additional issues which arise from a change in the circumstances. Such changes range from a change in the claimant's employment or medical status to the necessity of medical treatment and appropriateness of vocational rehabilitation. If the insurer and claimant reach an agreement, agreement forms may be submitted directly to the Awards Unit. If not, an employee's claim and an employer's application are treated differently.

1. Employee's Claim

An employee's "change-in-condition" claim is treated like an initial claim for benefits. The claim is referred to a claims examiner, who reviews the claim for

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[21] See Appendix, page A12.

[22] See Appendix, page A13.

[23] Code § 17.1-411.

supporting documentation. The examiner also initiates correspondence with the opposing party to determine whether it is in agreement with the change in condition. If disputed, the examiner refers the claim to the hearing docket for an evidentiary hearing or to the dispute resolution docket for an on-the-record determination.

2. Employer's Application

If an employer wishes to terminate benefits under an open Award because the claimant is able to work, has failed to cooperate with vocational rehabilitation or medical treatment, has refused suitable employment, or on other grounds, the employer must file a change-in-condition application.

An employer's change-in-condition application[24] is subject to stricter requirements than a claimant's claim. These technical requirements mandate that the application be in writing, under oath, state the grounds relied upon, and state the date through which compensation was last paid under the current award. The employer also must submit sufficient evidence for the Commission to have probable cause to believe that the change in condition has actually occurred.

The reason for the stricter requirements is that employers can suspend compensation payments during the time the application is litigated. The probable cause standard affords claimants the appropriate due process prior to suspension of benefits. The employee has fifteen days to object to the suspension of benefits pending a hearing. The claims examiner examines the evidence presented with the application and determines if there is probable cause to suspend benefits. If probable cause is found, the case is referred to either the hearing docket or the dispute resolution docket. If the application is denied, the employer must resume payments immediately.[25] Employers' change in condition applications are dismissed or referred to the docket within twenty-two days.

D. *Expediting Entry of Awards*

In general, the Awards Unit performs its functions efficiently. Routine agreements for compensation are typically processed in less than a week. The Unit also audits payments and frequently identifies instances in which insurers failed to pay compensation benefits in accordance with the Commission's awards. Audits result in employees receiving their full entitlement to compensation benefits. Judicial awards are quickly entered into the computer data base, resulting in the timely identification and correction of errors and a current and reliable data base.

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[24] See Appendix, page A14.

[25] A decision to deny a change-in-condition claim or application may be reviewed by the Commission much like a hearing decision may be reviewed.

After a thorough examination of the Award Unit's procedures, the Commission implemented seven efficiency measures in 1998. Additionally, the Commission identified ways to improve awards processing in the future.

1. Correction of Clerical Errors in Judicial Opinions

When the study began, the Awards Unit delayed, for at least thirty days, the entry of judicial awards into the database, to allow any review petitions to reach the file and to uncover errors. The Commission changed the process requiring intermediate processing of such awards. Upon the discovery of clerical error, the responsible Deputy Commissioner or Commissioner is notified immediately. This procedural modification results in the timely correction of most clerical errors in judicial awards, obviating the need for unnecessary requests for review, and resulting in the quicker commencement of compensation payments.

2. Modification of Form Award Language

The Commission's study identified that the wording of form awards issued by the Awards Unit was sometimes ambiguous. To promote consistency and to avoid ambiguity, the Commission adopted form language for awards. This language is currently used in Commission Opinions.

3. Mailing Copies of Awards to all Interested Parties and Their Attorneys

The Commission has undertaken revision of its database and obtained the necessary equipment to insure that awards are sent to all parties, including defense counsel, using revised document language and the new equipment.

4. Delay in the Acceptance or Rejections of Agreements and in the Entry of Awards

The efficiency study showed that substantial delays in awards occurred because the Awards Unit's attempts to correct errors were inefficient. In response, the Commission adopted detailed procedures to guide the Awards Unit in dealing with deficient agreements submitted by the parties. The new procedures require that all agreements be either accepted or rejected without delay. To avoid prejudice to either party, the awards Unit now enters the award and simultaneously notifies the parties of any significant clerical errors that have been corrected. If a party determines that the award is improper, the party may move to vacate or to modify the award.

5. Audit of Insurer Payments upon the Termination of an Award

The Awards Unit seeks to verify that the insurer has paid compensation benefits in accordance with the Commission's award. The Commission's study identified several

situations in which the substantial time expended was not justified because it failed to result in additional payments to claimants. Consequently, the Awards Unit will limit detailed audits of (1) overpayments, (2) old awards, or (3) information not verifiable by the insurer.

E. *The Telephone Response Unit*

The Commission's Telephone Response Unit handles approximately 370 to 400 calls every day, seeking information either of a general nature or regarding a particular claim. Call length varies dramatically depending upon the nature of the call. Simple inquiries by potential claimants, employers, or insurers requesting Commission forms are generally handled in under one minute. Likewise, calls by parties to an existing claim requesting an update as to the status of the claim are frequently handled in one minute or less, although status inquires may often result in further questions taking more time for response. More complex questions, such as those from claimants who are seeking guidance and advice as to appropriate procedures or processes, frequently take up to four or five minutes or longer.

In August 1998, the Commission acquired a toll-free number which will allow people from around the Commonwealth to call the Commission at no charge.

In order more efficiently to handle the volume of calls, the Commission has restructured the Unit and increased the number of individuals answering calls from three to ten. This change was accomplished by using existing staff members more efficiently, not by adding staff. Specialized training for the staff has taken place and will continue periodically.

VI. COMMISSION INITIATIVES TO ENHANCE EFFICIENCY

A. *Introduction*

As a result of the Commission's ongoing review of its processes and from what was learned through this study, the Commission has undertaken several initiatives to promote more efficient administration of workers' compensation claims. These steps range from relatively simple actions, such as minor modifications of claims examination rules, to more substantial moves, such as an emergency case docket and the creation of an Ombudsman position.

B. *Data Processing Department*

In the fall of 1997, the Commission undertook a study of its computer system. The resulting report revealed that the current computer system has major deficiencies, including lack of capacity, lack of integration of components, and outdated equipment, resulting in repair difficulties and frequent shutdowns. Another concern identified by this study was the Commission's "Year 2000" non-compliance, which may stop the information systems from working, or corrupt data and generate inaccurate information.

One limitation identified by the computer systems study is the inability of the Commission's scanners to handle bulk imaging. A legal file must be placed into the scanner manually, one page at a time, rather than through a bulk feeder. Another limitation involves the tremendous amount of "form" mail processed by the Commission. Under the present system, once a letter has been generated by the system, there is no provision for Commission personnel to customize the letter. Other problems include the inability to enter certain information in the claims database, such as date of death, difficulty in switching between screens, and the inability to use the system to calculate data.

The Commission's current wiring, networks, hardware,and software are outdated and require replacement or upgrading to resolve these concerns. The Commission presently is undergoing rewiring, and hardware is being replaced, including the servers and desktop computers. Networks are being installed in the regional offices, allowing more than one person in an office to connect to Commission systems. The imaging system is being replaced with a more modern system. Software is being written to address the "Year 2000" problem. Finally, the present multitude of incompatible "platforms" are being replaced with integrated platforms that are designed to work together and are well supported.

Another area for improvement in the Commission's data processing capability involves the ability to communicate with the public electronically. As indicated above, the servers are presently not networked to the outside world and do not have the capacity to be so. Thus, the Commission is not able to utilize the Internet to provide information and assistance to the public.

Moreover, the Commission believes that its present systems would benefit substantially from electronic enhancements. System upgrades will also facilitate increased use of electronic filing of documents. For example, the First Report Unit creates over 50,000 new claim files a year. Eighty percent of these files begin with the receipt, in the mail, of a written First Report of Accident form. Unit personnel review the form and generate letters requesting any additional necessary information. Over 1,000 reports a month require such follow-up correspondence. Personnel also manually "key in" the data, as well as any additions and corrections. Electronic assistance, through modern communications software, could impact this process significantly. Such assistance would be designed to eliminate errors, provide system-mediated review for missing information, and eliminate the need for Unit personnel to key the reports into the system.

The Commission anticipates that the system upgrade will be completed by the summer of 1999.

C. *Public Education*

1. Seminars

The Commission has engaged in a series of initiatives designed to increase knowledge of the workers' compensation system. This year, a seminar held for claims adjusters and employer and employee representatives was attended by about 500 people

on June 10, 1998, and received extremely positive evaluations from attendees. This day-long seminar covered the Act's responsibilities with regard to the filing of forms, time limits, and notification requirements. The Commission will offer more seminars in 1999, and will present smaller programs throughout the Commonwealth, in cooperation with the Labor Studies Center of Virginia Commonwealth University.

2. Publications

The Commission is expanding its production of educational publications to provide clear information on aspects of the workers' compensation system. In addition to its "Brief Guide to Workers' Compensation" and its "Employer's Guide to Workers' Compensation," the Commission is publishing booklets on such topics as "Employee's Guide to Workers' Compensation Hearings" and "Guidelines for Vocational Rehabilitation."

3. Web Site

The Commission's technology upgrade will enable it to establish a Web site. This will serve as an additional educational resource.

D. *Mediation*

The Commission will more thoroughly develop its mediation program. In certain cases, Deputy Commissioners may offer to mediate an issue through a telephonic conference call.

E. *Staff Attorney Positions*

The Commission has created Staff Attorney positions to assist with the review of files and drafting of Review Opinions. Although in previous years the Commissioners have employed law clerks to assist them with legal research, the clerks were traditionally law students or recent graduates. The Commission has created these new positions to attract more experienced and seasoned practitioners. The Commission will continue to develop and expand the Staff Attorney program.

F. *Emergency Case Docket*

The Commission has decided to institute an "emergency case docket" that provides for hearing cases on short notice if there is a hardship and agreement from both parties. A Deputy Commissioner will be on-call one day each week to hear such cases either in person or by telephone.

The Commission has built a second courtroom in Richmond, which is utilized regularly for hearings, and which also will be made available for this emergency docket.

G. *Streamlining of Twenty-Day Order Process*

Currently, the Commission sends insurers a twenty-day order asking whether a claim is accepted or denied and, if denied, the reasons for the denial. If the insurer has not responded within the twenty day period, a claims examiner issues a second letter notifying the insurer of its failure to respond and giving the insurer an additional ten days to submit the information. If there is still no response, the claim is forwarded to the hearing docket, if there is sufficient medical documentation in the file, and a show cause order issued against the insurer for failing to respond.

A survey of more than eighteen major insurers and third-party administrators indicated that their internal guidelines for determining, in a typical case, whether to accept a claim is fourteen days. Therefore, the Commission has decided to eliminate the second ten-day response period and the reminder letter. If an insurer fails to respond to the initial twenty-day order, the case immediately will be referred to the hearing docket. Failure to respond will be noted in the Commission's system and show cause orders issued to those insurers that show a pattern or practice of failing to respond to the twenty-day orders.

H. *Commission Ombudsman*

The Commission has created a new position, an "Ombudsman." The Ombudsman will help parties clarify, and if possible resolve, disputes without the necessity of a hearing.

In many cases, disagreements between employees and employers/insurers are the result of lack of communication, lack of documentation of medical treatment, or lack of information. The Ombudsman will be able to facilitate the exchange of information and the gathering of documents so that many, if not all, issues can be resolved. The Ombudsman will also be an educational resource for parties who have questions about the system.

VII. CONCLUSION

This study of the agency's operations, and input from a wide range of interested parties, has resulted in a series of initiatives the Commission will undertake to resolve claims as quickly as possible.

The Commission is committed to achieving the mission of resolving claims expeditiously and fairly. The Commission will continue to review and analyze its program in order to maximize its efficiency and effectiveness in serving the Commonwealth.

PART I
APPENDIX

HOUSE JOINT RESOLUTION NO. 186

Requesting the Workers' Compensation Commission to study ways to expedite the receipt of workers' compensation benefits for employees injured on the job.

Agreed to by the House of Delegates, February 17, 1998
Agreed to by the Senate, March 10, 1998

WHEREAS, under the terms of the Virginia Workers' Compensation Act (the Act) both employer and employee surrender former rights and gain certain advantages; and

WHEREAS, the Act imposes a legal obligation to financially compensate an employee or his dependents for injury or death arising out of and in the course of employment without regard to fault as to the cause of the injury or death; and

WHEREAS, any unnecessary delay in providing an employee or his dependents with the compensation they are entitled to under the law is unconscionable and is antagonistic to the legislative intent of the Act; and

WHEREAS, such delays could be avoided by eliminating the causes of time-consuming administrative process at the Commission, incurred in determining such matters as employer liability allotment in the case of leased employees; and

WHEREAS, the unacceptable delays may be avoided by encouraging employers to make voluntary payments as currently permitted under the Act; and

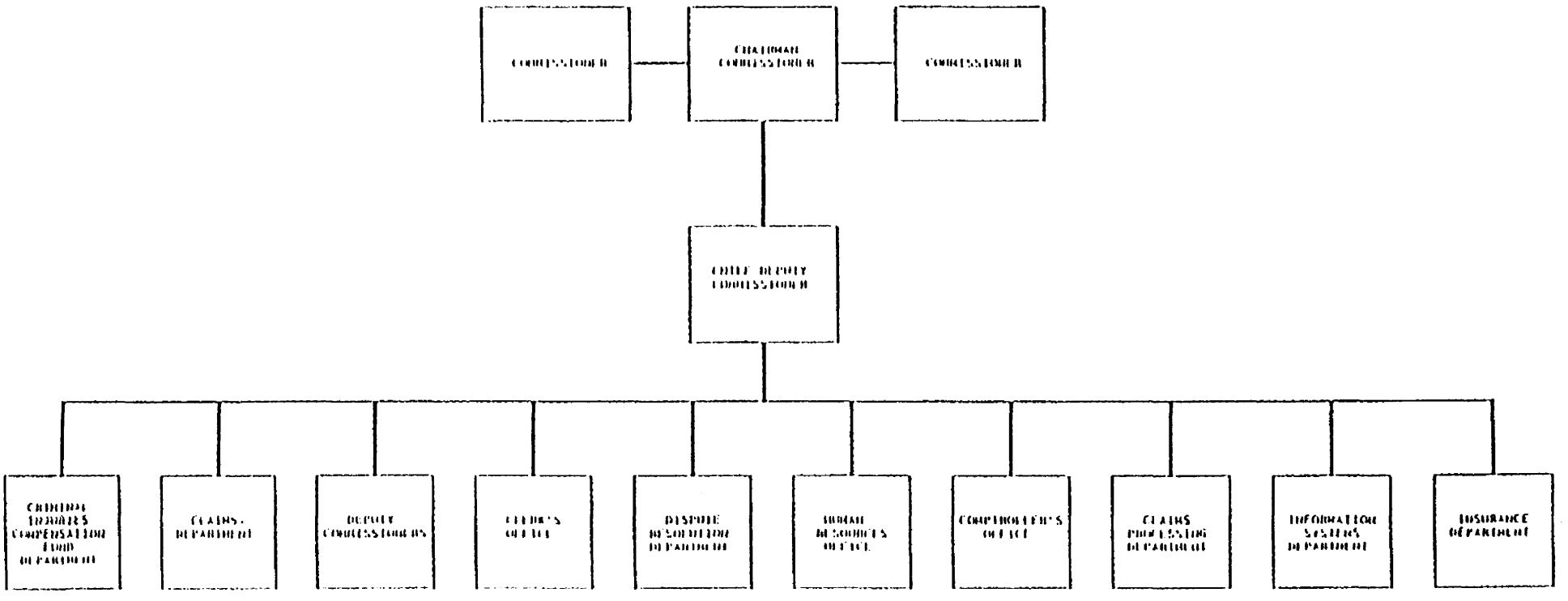
WHEREAS, such unacceptable delays may also be the result of the limited resources of the Commission, and the present case load may warrant the addition of more staff and personnel to expedite claims and ease the suffering caused by unnecessary delay; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Workers' Compensation Commission be requested to study ways to expedite the receipt of workers' compensation benefits for employees injured on the job. Such study shall include recommendations that will serve to provide benefits in a more timely manner to injured employees, including (i) encouraging voluntary payments by employers and (ii) increasing the effectiveness of the Commission staff and personnel to better handle the increasing caseload.

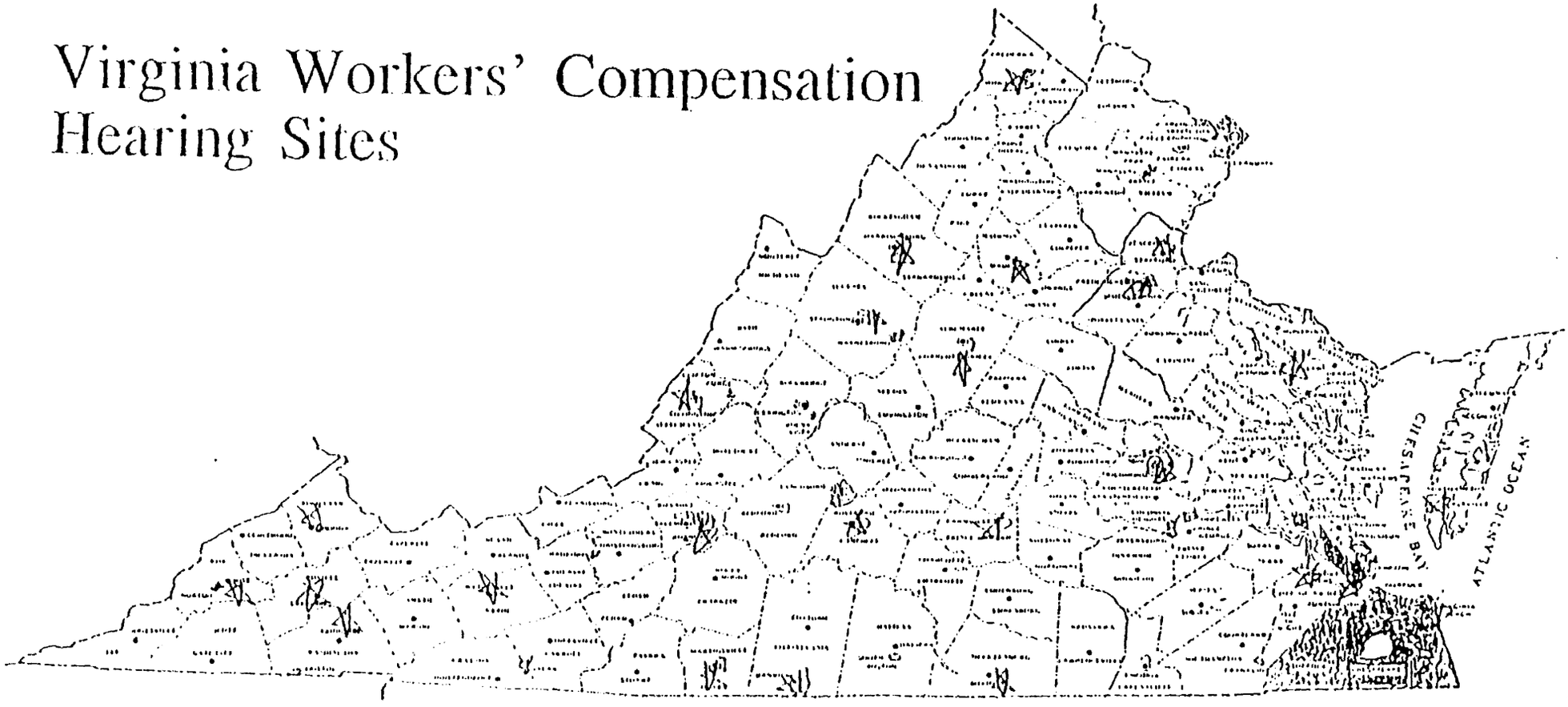
All agencies of the Commonwealth shall provide assistance to the Commission for this study, upon request.

The Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

VIRGINIA WORKERS' COMPENSATION COMMISSION



Virginia Workers' Compensation Hearing Sites



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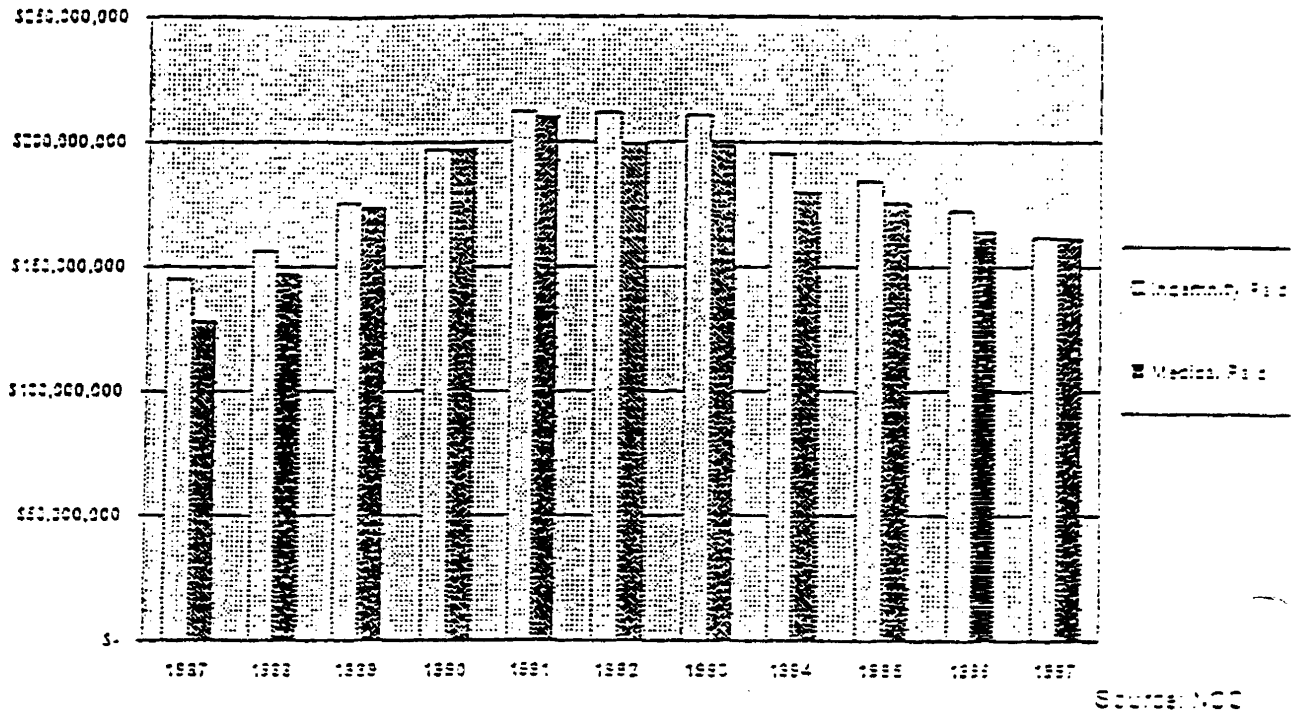
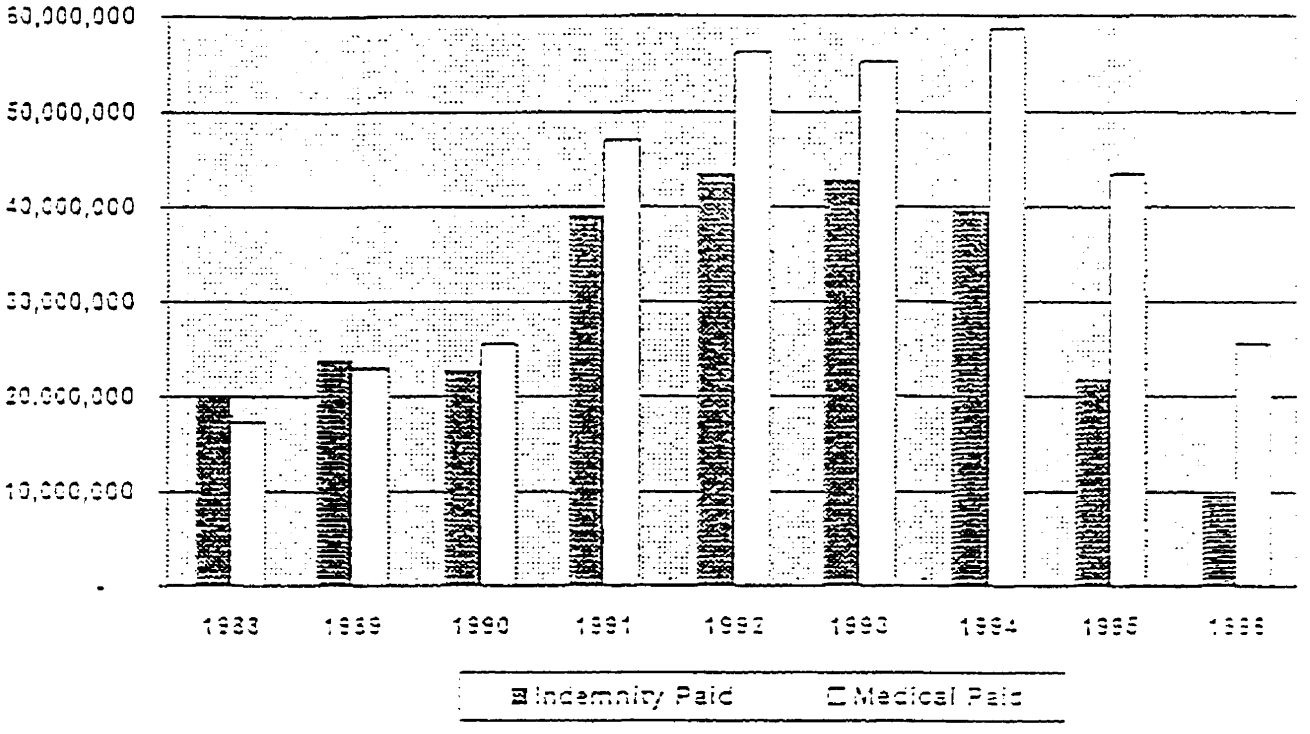


Source: NCC

Virginia Workers' Compensation Paid Losses by Self-Insured Employers



Time Frames for Dispute Resolution Docket
1997

From:	To:	Days:
Application Filed	Referral to Docket	45
Referral to Docket	Opinion Issued	70
Opinion Issued	Request for Review	13
Request for Review	Review Opinion Issued	166
Review Opinion Issued	Request for Appeal	30
Request for Appeal	Court of Appeals Opinion Issued	202

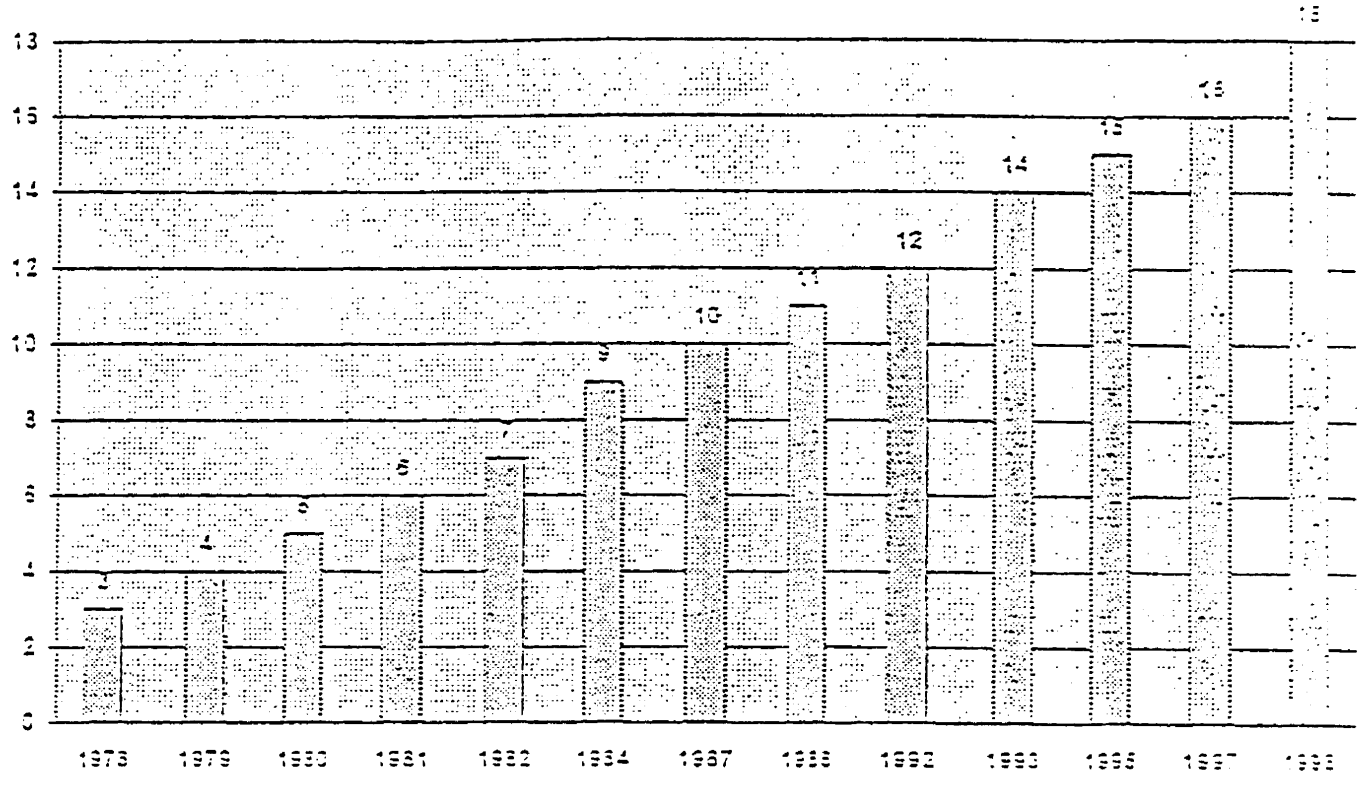
Time Frames for Evidentiary Docket
1997

From:	To:	Days:
Application Filed	Referral to Docket	49
Referral to Docket	Hearing	106
Hearing	Hearing Opinion Issued	34
Hearing Opinion Issued	Request for Review	13
Request for Review	Review Opinion Issued	166
Review Opinion Issued	Request for Appeal	30
Request for Appeal	Court of Appeals Opinion Issued	202

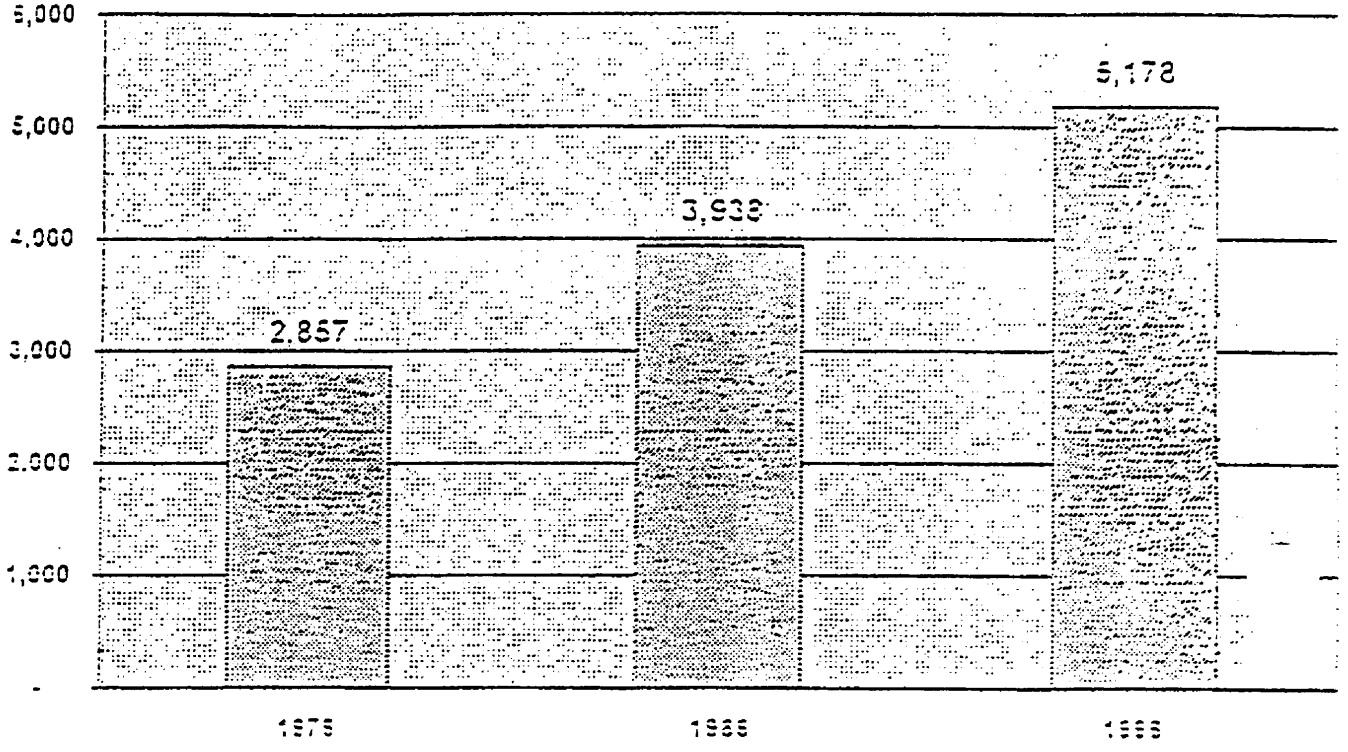
Time on Docket
1991 - 1997

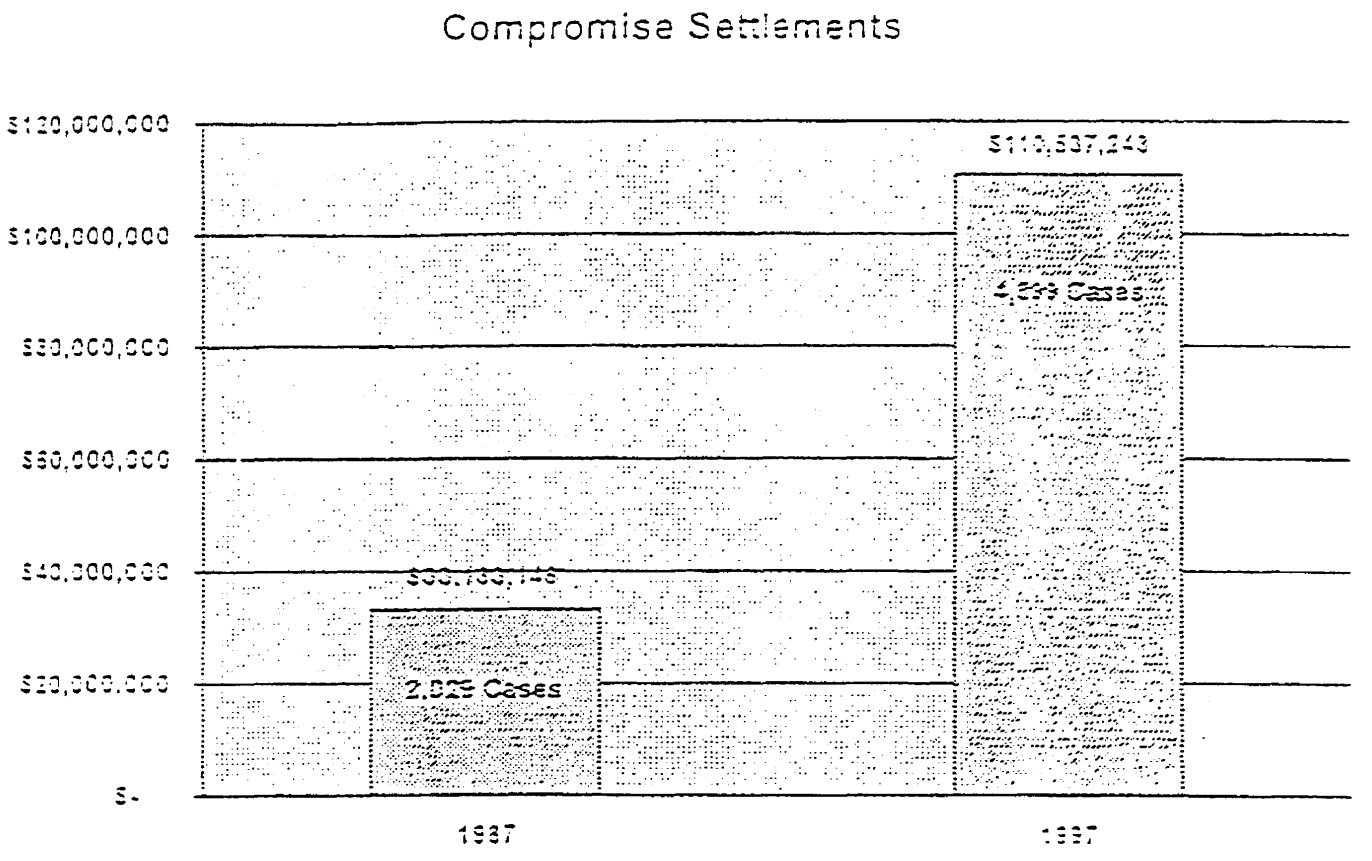
Year	Referral to Opinion	Opinion to Review
1991	187 days	146 days
1992	169 days	140 days
1993	148 days	164 days
1994	144 days	116 days
1995	137 days	136 days
1996	142 days	154 days
1997	140 days	179 days

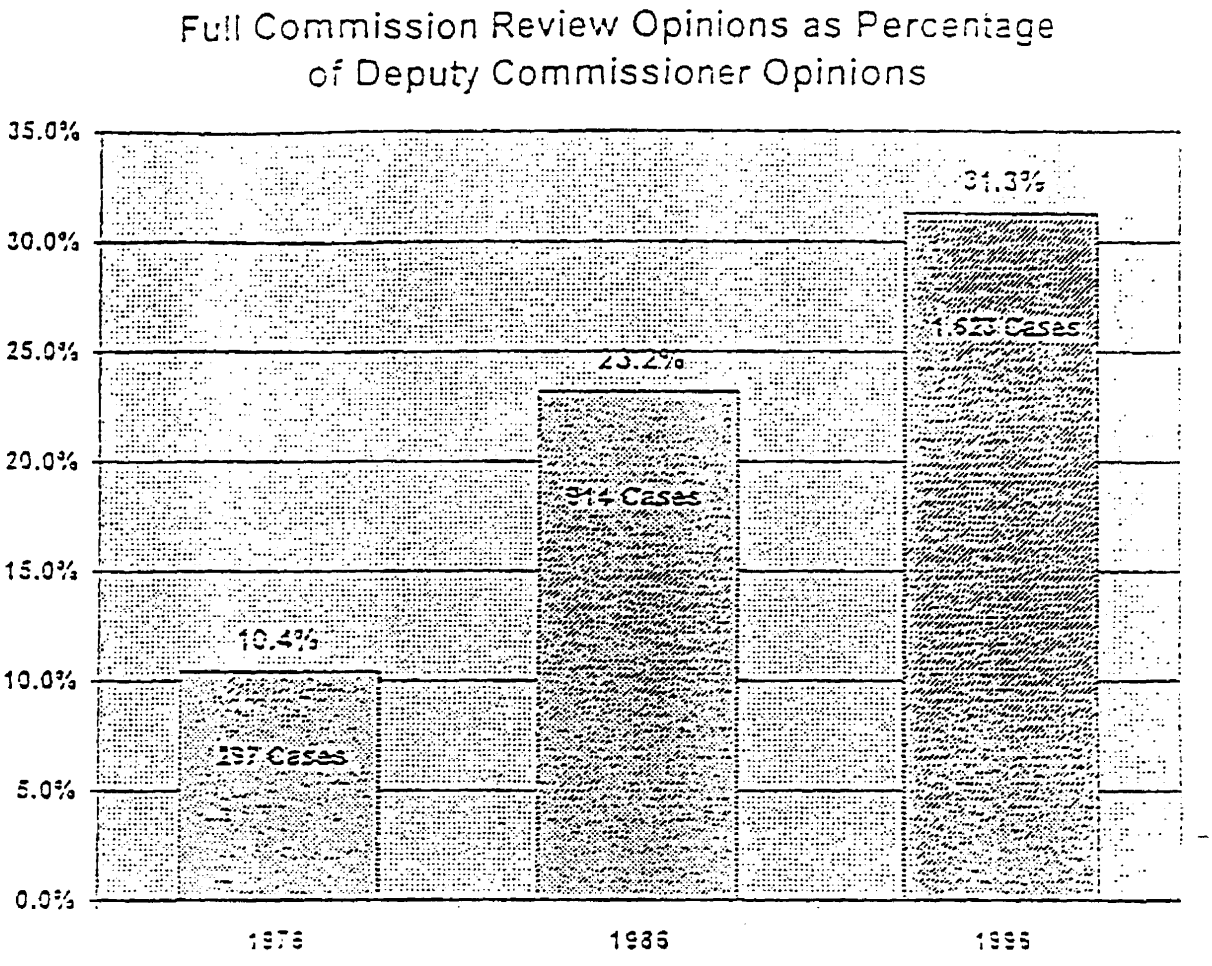
Number of Deputy Commissioners

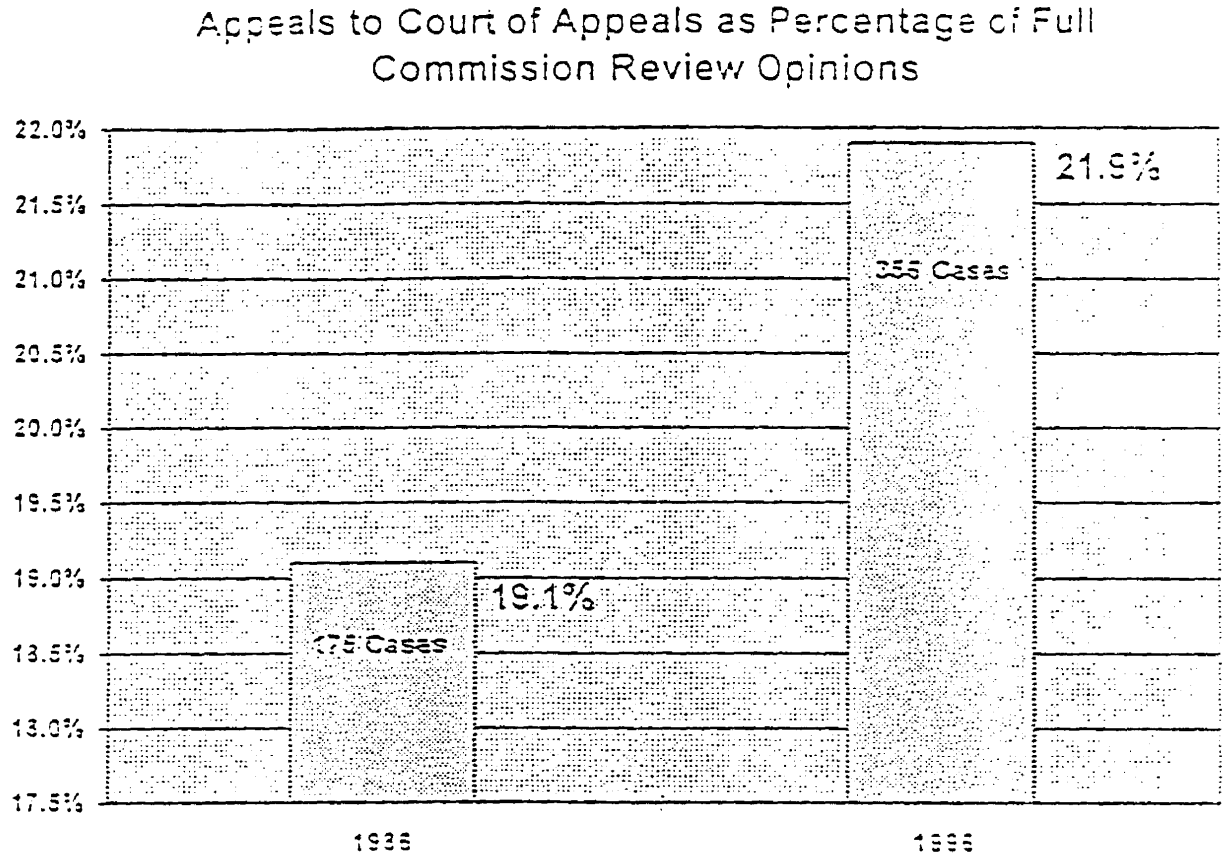


Deputy Commissioner Opinions

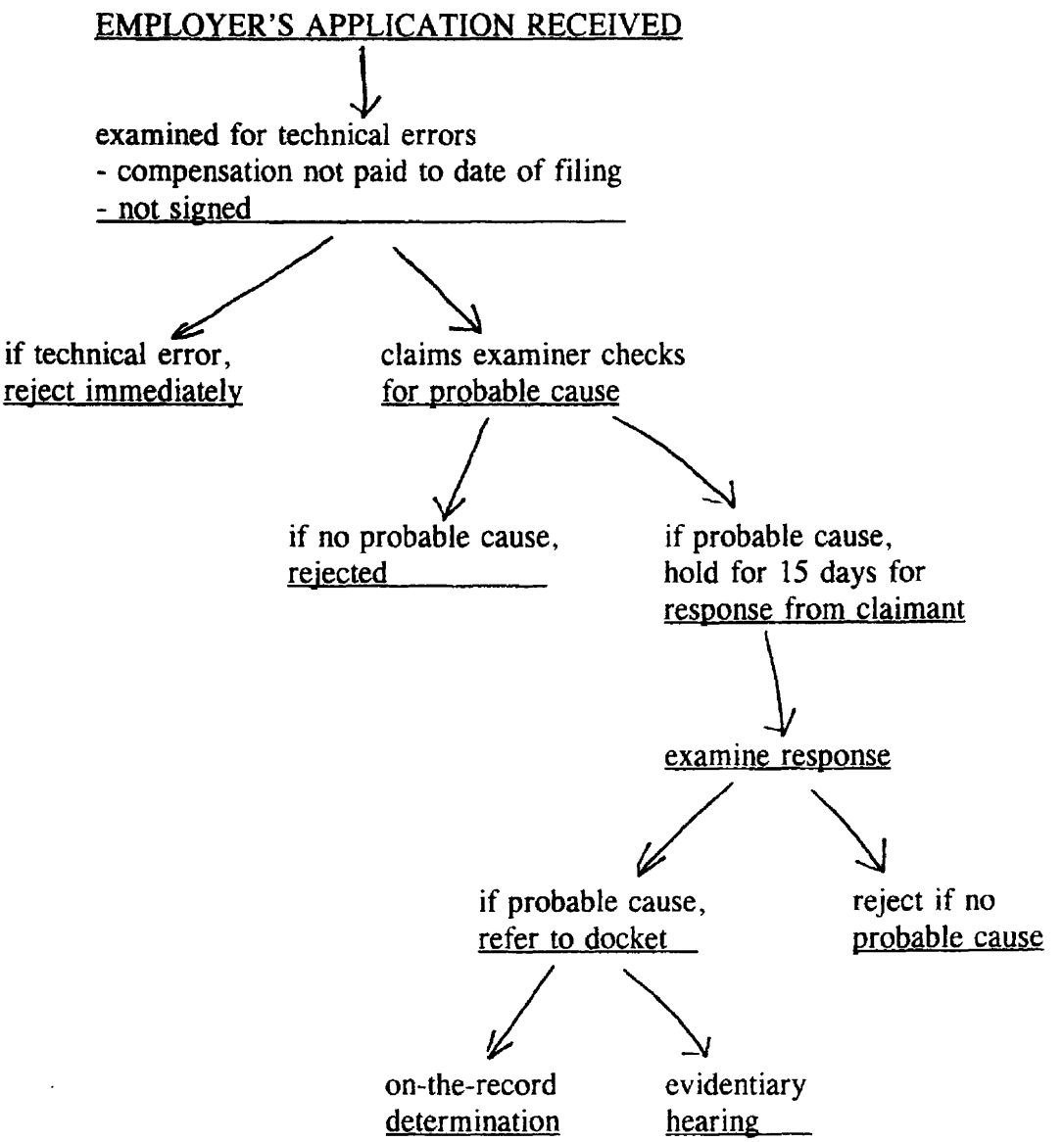



Compromise Settlements
$120,000,000
$100,000,000
$80,000,000
$60,000,000
$40,000,000
$20,000,000
$-
$110,537,243
4,393 Cases
2,025 Cases
1987
1997


Full Commission Review Opinions as Percentage of Deputy Commissioner Opinions
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
10.4%
197 Cases
23.2%
914 Cases
31.3%
1,623 Cases
1978
1986
1995


Appeals to Court of Appeals as Percentage of Full Commission Review Opinions
22.0%
21.5%
21.0%
20.5%
20.0%
19.5%
19.0%
18.5%
18.0%
17.5%
19.1%
175 Cases
21.9%
356 Cases
1998

Procedures for Employer Applications



PART II
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PART II

EMPLOYEE LEASING

I. EXECUTIVE SUMMARY

A Professional Employer Organization ("PEO") is a business entity that provides personnel related services to its clients through a series of agreements. The PEO and client enter into a contractual relationship by which the employees of the client are effectively transferred to the employment of the PEO. The PEO then leases the employees back to the client in exchange for fees.

Under the terms of a standard PEO-client agreement, the client delegates substantially all of its personnel administration functions to the PEO. The PEO administers payroll, collects and transmits tax withholdings, pays unemployment taxes, and creates and generally administers personnel policies and procedures. These agreements also contemplate that the PEO will obtain and maintain workers' compensation insurance coverage for the employees placed with the client. The client pays to the PEO fees calculated to cover these costs and to provide the PEO with an appropriate return on its investment.

It is important to distinguish PEOs from temporary employment agencies. Where temporary agencies place employees for discrete assignments for a relatively short period, the PEO "leases" employees to the client for the length of the contractual relationship. The placement is for an indefinite period, and the working relationship between the PEO and the client, with respect to the employees, is more intricate and involved. The relationship becomes one that the industry considers "co-employment."

PEOs are a relatively recent addition to the business environment. In the 1980s, PEOs began to increase in number and size, as small to medium sized employers turned to alternative means of doing business for various reasons.

The Commission's study of this industry indicates that the relationships existing among a PEO, its clients, and the employees represent a departure from traditional normative employment standards. As a result, questions arise as to the applicability in this context of existing statutes and regulations which presume continuance of traditional employment structures. The Commission's study and present experience have identified several distinct areas of concern with regard to operation of the PEO-client relationship in the current workers' compensation environment. These issues are summarized in the discussion which follows.

Liability for Workers' Compensation Benefits and the Obligation to Obtain Insurance

There are two distinct questions presented under the Virginia Workers Compensation Act (the "Act") by the PEO-client relationship. The first inquiry is the identity of the party that is liable for the payment of workers' compensation benefits. The second is a determination of the party that is obligated or permitted to obtain insurance to secure payment of those benefits.

Liability for Workers' Compensation Benefits

The Act imposes liability for benefits upon "employers." Code Section 65.2-101 states that an "*Employer* includes (i) any person . . . and any individual, firm, association or corporation . . . using the services of another for pay. . . If the employer is insured, it includes his insurer so far as applicable." PEOs and their clients assert that their contractual arrangements give rise to a co-employment relationship. Characteristics of that relationship objectively viewed tend to establish that there is a blurring of the identity of the "employer" in such relationships. This redefinition of "employer" can create conceptual difficulties in administering the liability provisions of the Act.

The Virginia Court of Appeals addressed this in Virginia Polytechnic Institute v. Frye,[1] where the court found that liability for benefits should be imposed upon the client of a "labor broker." The court applied traditional common-law principles of control in the employment relationship to find that the client, VPI, was the "employer" who would be liable for benefits under the Act. This decision is relevant in assessing such liability in a PEO-client relationship.

Extension of the Exclusive Remedy Provision of the Act

Closely related to the liability question is the issue of who should benefit from the exclusive remedy provision found in Code Section 65.2-307.[2] This provision effectively bars all common law remedies an injured employee may have against the employer liable for workers' compensation benefits. In the context of PEO-client relationships, the question of which party enjoys immunity from suit arises, given the nature of the contractual arrangement.

In Metro Machine Corp. v. Mizenko,[3] the Supreme Court of Virginia found that both a temporary employment agency, against whom an injured employee collected benefits, and its client, for whom the employee rendered services, were entitled to the protection of Code Section 65.2-307. In arriving at this result, the Court cited the common-law "borrowed servant" doctrine. Although the Court did not address the issue in the specific context of a PEO-client relationship, the court's rationale reflects the protection afforded any entity denominated an employer.

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[1] 6 Va. App. 489, 371 S.E.2d 34 (1988). See Appendix B.

[2] That Section states in its entirety:

> The rights and remedies herein granted to an employee when his employer and he have accepted the provisions of this title respectively to pay and accept compensation on account of injury or death by accident shall exclude all other rights and remedies of such an employee, his personal representative, parents, dependents or next of kin, at common law or otherwise, on account of such injury, loss or service or death.

[3] 224 Va. 78, 419 S.E.2d 632 (1992). See Appendix B.

Some states have judicially construed their exclusive remedy provisions as specifically extending to PEOs, using a rationale similar to that used by our Supreme Court in Mizenko. In some states, judicial recognition of a co-employment relationship existing between a PEO and its client leads to the extension of the exclusive remedy provision to include the PEO. Other states have legislatively extended the exclusive remedy provision specifically to include PEOs. These approaches are discussed in more detail in the report.

Which of the Parties Should be Permitted or Obligated to Obtain Insurance?

PEOs offer to obtain and maintain insurance on behalf of the client, as part of their package of services. Sometimes, the PEO procures a master policy issued to itself insuring all its "employees" placed with all its clients. Other times, the PEO obtains multiple policies, each covering an individual client. These arrangements trigger the insurance underwriting concerns discussed in this report. They also present questions under the mandatory insuring requirements of the Act.

Code Section 65.2-800 states that "[e]very employer subject to the compensation provision of this title shall insure payment of compensation to his employees in the manner hereinafter provided." Section 65.2-801(A) also states that "[e]very employer subject to this title shall secure his liability thereunder." The Virginia Workers' Compensation Commission's consistent and well-established administrative interpretation of these provisions requires that an employer maintain a policy in which it is the named insured.[4]

By law, the Commission is notified every time an insurance policy is canceled or non-renewed. Notification triggers an inquiry to the employer regarding insurance status. Upon receipt of every claim, the Commission verifies coverage for the named employer. In either situation, the Commission will be unable to verify insurance coverage on behalf of the PEO client when the client is not the named insured and may result in a civil penalty assessed against the client under Code Section 65.2-805.

A number of states have adopted legislation regarding coverage patterned after the Model Act created by the National Association of Insurance Commissioners. Under the Model Act, the client of the PEO is responsible for purchasing and maintaining the insurance. However, this statute also provides that the PEO may procure a master policy issued to it where it is registered with the state Commissioner of Insurance under the PEO registration and licensing provisions.

States that have addressed the issue legislatively have taken different approaches, adopting the Model Act or a variant. It is important to note that under the Commission's current interpretation of the relevant provisions of the Act, a legislative change would be required in order for the mandatory insuring requirement to be satisfied by a policy issued to the PEO.

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[4] Gulbranson v. C.F.W. Contracting, VWC File No. 186-27-49 (October 15, 1998) See Appendix, page A3a.

Regulation of the PEO Industry

Several states have enacted legislation and regulations addressed specifically to the PEO industry. These regulatory schemes require registration of PEOs with various state agencies, including state Bureaus of Insurance. Many of these statutes are patterned after the NAIC Model Act. Licensure and registration permits regulation of the terms under which workers' compensation insurance policies are issued and the premium rates that are applied.

Typically, these statutes require that an entity operating as a PEO be licensed with the state agency regulating insurance. The process requires that the entity disclose to the agency certain financial information and information pertaining to past operations and ownership of the entity.

II. INTRODUCTION

A. *Authority*

At its 1998 session, the Virginia General Assembly adopted House Joint Resolution 186 requiring the Virginia Workers' Compensation Commission (the "Commission") to study the current status of the employee leasing situation in Virginia. This industry is built upon contractual arrangements between business entities known as Professional Employer Organizations ("PEOs") and their clients who contractually delegate to the PEO substantially all of their personnel functions. The relationship between the PEO and its clients frequently is referred to as "employee leasing."

B. *Methodology*

The Commission used a variety of research methods to conduct this study. Methods ranged from personal interviews to statutory and regulatory research. Input was sought from a variety of sources, including local and national organizations representing the PEO industry and domestic and foreign state regulatory agencies.

C. *What is a PEO?*

1. Definition

The PEO industry is a relatively recent addition to the business environment. In the 1980s, PEOs began to increase in number and in size, as small to medium sized employers turned to alternative methods of doing business to lower costs. Employee leasing was designated as a major issue of the 1990s by the National Association of Insurance Commissioners (NAIC) and the International Association of Industrial Accident Board Commissioners (IAIABC) Joint Committee. Although PEO clients range in size, the average client employs eighteen people at the inception of its contractual relationship with the PEO. The largest PEO employs 120,000 persons. Today, there are approximately 2,500 PEOs in the United States.

Generally speaking, the PEO and the client enter into a contractual relationship under which the PEO assumes responsibility for the following:

- payment of client employee wages;
- collection and payment of employment taxes to state and federal authorities;
- compliance with applicable state and federal reporting and recordkeeping requirements;
- hiring, firing, and reassigning client employees; and

- other specified employment related functions consistent with the contract including employee benefits, insurance, workplace safety monitoring and instruction, and others.

To accomplish these objectives, the contractual arrangement provides that the entire work force of a client is transferred to the PEO, and the PEO and client enter into what the industry terms a relationship of "co-employment" with respect to the workers "leased" to the client.

2. PEOs Contrasted with Temporary Employment Agencies

Although sometimes confused with temporary employment agencies ("temp agencies"), PEOs function in a manner quite different from temp agencies. The contract with a temp agency anticipates that the temporary workers are assigned specific tasks for a limited time. The temp agency is vested with discretion in deciding which worker to send to the client and when that particular worker should be used to fill that assignment. Thus, the client of the temp agency is likely to view temporary workers as relatively fungible, rather than contemplating an extended relationship with a particular worker.

In contrast, the client of a PEO contemplates extended relationships with specific workers who often were the client's direct employees before its association with the PEO. The client enters into the contractual relationship with the PEO simply as a means of expeditiously administering personnel matters. The PEO does not have the same latitude in making placement decisions as does the temp agency.

D. ***Overview of Issues***

PEO-client relationships present unique questions as to their status under existing statutory schemes. Of particular concern to the Commission's study are the issues arising under the Virginia Workers' Compensation Act with regard to insurance coverage for workers' compensation liability.

This report does not address issues within the jurisdiction of the Bureau of Insurance, but only those issues within the purview of the Workers' Compensation Commission. The report also discusses the Model Act of the National Association of Insurance Commissioners, and legislation adopted by other states.

1. Model Act

In 1991, The National Association of Insurance Commissioners adopted model legislation (the "Model Act") specifically aimed at resolution of insurance issues implicated by the PEO industry. The Model Act, and its accompanying regulations, are designed "to ensure that an employer who leases some or all of its workers properly obtains workers' compensation insurance coverage for all of its employees, including

those leased from another entity; and that a premium is paid commensurate with exposure and anticipated claim experience.[5] The Model Regulation acknowledges that the "basic rule" under workers' compensation statutes is that the client is responsible for purchasing and maintaining a standard workers' compensation policy and that the exposure and experience of the client are used in determining the appropriate premium.

The Model Regulation allows for two exceptions to this basic rule: a master policy purchased by a PEO, or a multiple coordinated policies scheme. A PEO may purchase a master policy in the voluntary market if the PEO is registered with the Commissioner of Insurance. The insurer "may take all reasonable steps to ascertain exposure under the policy and collect the appropriate premium." This includes requiring a "complete description" of a PEO's operations.[6] Multiple coordinated policies are available to PEOs whose clients are in the assigned risk pool.

The Model Act also addresses an issue that arises upon cancellation of a policy in a PEO's name: experience modification factors. When the employee leasing arrangement is terminated in cases in which the PEO provided workers' compensation insurance for the client under a master policy, the Model Regulation provides guidance for developing an experience rating for the client. While the client was covered under the PEO's master policy, its experience was commingled with that of all the other clients to calculate an experience rating for the PEO as a whole. In these situations, "the experience of the lessee [client] shall be developed and reported by the insurer, to the extent possible. . . ." However, "if suitable payroll and loss experience is not reported, then the lessor's [PEO's] experience modification factor will apply to the lessee [client] for up to three (3) years or until such time as the lessee [client] qualifies for development of its own experience modification."

2. Other States

States that have addressed this issue in a comprehensive legislative manner typically do so by specifically assigning the client responsibility for workers' compensation coverage. In this way, it is difficult, if not impossible, for a client to manipulate loss experience by contracting with a PEO. Other states have adopted a hybrid approach. For example, under Utah law, the client is considered the employer of leased employees for purposes of the requirement that employers provide workers' compensation coverage for their employees. A PEO may procure a "master" policy for its clients, thereby allowing the PEO to utilize its own, as opposed to its clients', experience modification factor. Each client, however, must be listed as an additional

[5] NAIC Employee Leasing Model Regulation Section 1. See Appendix, page A1b.

[6] NAIC Employee Leasing Model Regulation Section 4. See Appendix, page A1b.

insured on an endorsement to the master policy, allowing premiums to be calculated accurately.[7]

In Florida, an "employee leasing company" is considered the employer of those employees leased to a client and is "responsible for providing workers' compensation coverage." A PEO's license is dependent upon its making available, to its workers' compensation carrier, information on each client company. Such information includes a listing, by classification code, of all employees provided to each client, as well as total wages, by classification code, for each client.[8]

Illinois law provides that a policy covering client employees that is written in the name of a PEO must separately schedule, for each client, the experience of the employees leased to the client. If, at the inception of an employee leasing contract, a client's experience modification factor exceeds the PEO's experience modification factor by 50%, then the client's experience modification factor must be used. The law specifically provides that the client is ultimately responsible for providing workers' compensation coverage to the client employees.[9]

III. REGULATION OF THE PEO INDUSTRY

A. *Introduction*

Next, we will address government regulation of PEOs. We will use as a foundation for our analysis an examination of the Model Act and relevant legislation enacted in Texas and Florida. These examples all involve, as a starting point, the requirement that PEOs register with the state and maintain a license.

B. *The Model Act*

The Model Act provides a thorough analysis of several issues involving government regulation of the PEO industry. One is whether employee leasing companies should be licensed. The stated purpose of the Model Act is delineated in the September 17, 1991, minutes of the Commercial Lines-Property and Casualty Insurance (D) Committee: "[T]he purpose of the Model Act was to require employee leasing agencies [PEOs] to register with the insurance commissioner. The purpose of the Model Regulation is to regulate the terms under which policies are issued and premium rates are applied to employee leasing companies [PEOs]."

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[7] Utah Code Ann. Section 35A-3-103(3)(a) (Supp. 1998). See Appendix B.

[8] Fla. Stat. Ann. Section 468.529 (West Supp. 1998). See Appendix B.

[9] Ill. Ann. Stat. Ch. 215, para. 113/25, 113/30 & 113/35 (Smith-Hurd Supp. 1998). See Appendix B.

The Model Act requires that all entities that lease employees register with the Commissioner of Insurance before becoming eligible for issuance of a workers' compensation policy. Registration requires that the PEO disclose the following: the name of the PEO; the address of the principal place of business of the PEO and the address of each office located within the state; the taxpayer or employer identification number; every name under which the PEO has operated in the past five years, as well as the names of predecessor entities, successors or alter egos; a list of every individual or entity that owns more than a 5% interest in the PEO; and a list of every cancellation or nonrenewal of workers' compensation insurance issued to the PEO or a predecessor in the last five years, to include the dates and reasons for cancellation.[10]

These registration requirements allow the Commissioner of Insurance to track each PEO to insure that it is not being used to avoid payment of premiums. This also allows for tracking of the principal employees of each entity so that a PEO cannot close one day when the experience rating gets bad enough to make premiums prohibitively expensive and open the next day under a different name.

The Model Act also provides that any PEO that has had a workers' compensation policy terminated in any jurisdiction within the past five years because of a determination that the employee leasing arrangement was being utilized to avoid premiums will not be eligible for registration or will have its registration terminated.[11] In addition, criminal penalties are imposed for any entity or any employee of any entity that knowingly utilizes or participates in an employee leasing arrangement for the purpose of depriving one or more insurers of lawful premiums.[12]

C. *Texas*

Texas law addresses the unique ramifications of the PEO industry.[13] The Texas PEO licensing statute is more restrictive than the Model Act when determining the qualifications of a PEO for licensure or registration. While the Model Act looks to any person who has greater than a five percent share of ownership, Texas looks to owners with either direct or indirect control of greater than twenty-five percent of the voting shares and to any person who "possesses the authority to set policy and direct management" of a PEO and any person "who is employed, appointed, or authorized" by a PEO "to enter into a contract with a client company

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[10] NAIC Leasing Registration Model Act Section 1. See Appendix, page A1a.

[11] NAIC Leasing Registration Model Act Section 1 (B). See Appendix, page A1a.

[12] NAIC Leasing Registration Model Act Section 3. See Appendix, page A1a.

[13] At a minimum, each state requires PEOs, as businesses, to qualify to do business in their respective jurisdictions before undertaking to secure leasing agreements. As will be discussed, some states utilize this initial licensing procedure to obtain additional information unique to PEOs in order to address many of the issues raised in this Report.

on behalf of the company." These people are defined by the Texas statute as being "controlling" persons.[14]

To qualify for a license in Texas, every person defined as a controlling person must be at least eighteen years of age and "have educational, managerial, or business experience relevant to: (1) operation of a business entity offering staff leasing services; or (2) service as a controlling person of a staff leasing services company." In addition, a background check is performed on each individual applicant for a license and each controlling person of each applicant. The investigation "must include: (1) the submission of fingerprints for processing through appropriate local, state, and federal law enforcement agencies; and (2) examination by the department of police or other law enforcement records maintained by local, state, or federal law enforcement agencies.[15]

An additional set of requirements for licensure in Texas pertains to the net worth of the PEO. The net worth requirements are graduated based upon the number of leased employees and range from $50,000 to $100,000. The net worth computation requires "adequate reserves for all taxes and insurance, including reserves for claims incurred but not paid and for claims incurred but not reported under plans of self-insurance of health benefits." Documents used to establish net worth must not be dated "earlier than nine months before the date on which the application is submitted" and must be "prepared or certified by an independent certified public accountant.[16]

D. *Florida*

In Florida, PEOs are regulated under a comprehensive statutory scheme. Like Texas, Florida's licensing scheme is more restrictive than the Model Act. For example, each "controlling person" of a PEO is required to maintain a license. A controlling person is defined as someone who controls, directly or indirectly, fifty percent or more of the PEO's voting securities. A controlling person also is someone who possesses the authority to "cause the direction of the management or policies" of a PEO or who is able to enter into a contractual relationship with a client on behalf of the PEO.[17]

Background investigations, including submission of fingerprints, are required of each license applicant. The Florida Board of Employee Leasing Companies has ruled that certain incidents impede an applicant's ability to obtain a license, including directly or indirectly being involved in business operations that are considered "detrimental to clients." Such detrimental

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[14] Tex. Lab. Code Ann. Section 91.001 (West 1996). See Appendix B.

[15] Id. Section 91.012-.013.

[16] Id. Section 91.014.

[17] Fla. Stat. Ann. Section 468.520 (West Supp. 1998). See Appendix B.

operations include violating state or federal payroll, tax, wage and hour, or workers' compensation laws, failing to comply with laws relating to employee health benefits, and failing to comply with occupational safety.[18]

Additionally, Florida imposes a $50,000 net worth requirement on applicants and requires all PEOs to submit annual financial statements to the PEO licensing board. Depending on the size of the PEO, these financial statements must be either "audited" or "reviewed" by a certified public accountant.[19]

E. *Self-Insurance*

Virginia Code Section 65.2-801 provides that one of the ways in which an employer may satisfy the mandatory insuring requirement is to be a "member in good standing of a group self-insurance association licensed by the State Corporation Commission." Section 65.2-802 delineates the requirements for licensure as a group self-insurance association. If PEOs are permitted to enter into transactions to satisfy the mandatory insuring requirement on behalf of itself and its clients, the question of whether they may do so by a self-insurance plan arises.

There is no specific statutory or regulatory provision in Virginia which would deny PEOs a self-insurance option. Other states that have legislated in this area, however, have addressed this issue explicitly. For instance, California expressly allows PEOs to be self-insured.[20] In contrast, South Carolina specifically prohibits self-insurance arrangements in this context.[21] This issue may be appropriate for legislative action in Virginia.

IV. LIABILITY FOR BENEFITS AND RESPONSIBILITY FOR PROCURING INSURANCE

A. *Introduction*

The contractual relationship between a PEO and its client presents unique questions as to liability for workers' compensation benefits. These relationships require a reexamination of traditional employment concepts. Because, under Virginia's workers' compensation scheme, "employers" are liable for benefits and must procure workers' compensation insurance, a new definition of what is now commonly identified as the "employer" may be required to address these liability concerns.

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[18] Fla. Admin. Code Ann. Rule 61G7-5.001 (1998). See Appendix B.

[19] Id. Rule 61G7-5.0031- .0032.

[20] Cal Labor Code Section 3602 & 3700 (West Supp. 1998). See Appendix B.

[21] S.C. Code Ann. Section 40-68-120(A) (Law. Co-op. Supp. 1998). See Appendix B.

This section will focus on several issues. First, the issue of allocation of liability for benefits paid under the Act is addressed. This includes a discussion of who is considered an "employer" under the Act and a summary of a case of the Virginia Court of Appeals that addresses this question in the specific context of "labor brokers." This section also presents synoptical information on the extent to which the "exclusive remedy[22] provisions of workers' compensation statutes from other states have been extended to protect PEOs as well as their clients from common law remedies.

Second, the issue of who is responsible for procuring and maintaining workers' compensation insurance is discussed. Covered in this discussion is a detailed analysis of current Commission procedures regarding insurance and identification of issues related to such procedures that are implicated by the PEO industry. Also included is a comparison of state legislation on this issue and an examination of the related issues in the temporary employment agency situation.

B. *Is the PEO or the Client the "Employer" that is Liable for Benefits?*

1. Introduction

The Virginia Workers' Compensation Act was passed in 1918 and is considered "to be in the nature of a compromise between employer and employee to settle their differences arising out of personal injuries."[23] The Act enables businesses and their workers to establish certainty in an area that could otherwise be murky:

> Under [the Act] there is no doubt or uncertainty as to the right of recovery or the amount thereof. The damage resulting from an accident is treated as a part of the expense of the business and to be borne as such, as much as the expense of repairing a piece of machinery which has broken down.[24]

The "differences" that typically arise in a workplace injury revolve around who is responsible for the injury. The Act undertakes to resolve these differences in advance of workplace accidents in a manner that is said to be "greatly to the advantage of the employee."[25]

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[22] Briefly, this concept appears generally in workers' compensation statues and operates to exclude common-law remedies the injured worker may have against his or her employer as a result of the workplace accident, and limiting the right of recovery to those remedies provided by workers' compensation.

[23] Humphrees v. Boxley Bros. Co., 146 Va. 91, 135 S.E. 890 (1926).

[24] Id.

[25] "By [the Act] the question of the negligence of the employer is eliminated, the common law doctrines of the assumption of risk, fellow servants, and contributory negligence are abolished, and the rules of evidence are laxly enforced . . . ." Id.

An insured employer's liability is placed by the Act upon the insurer. The Commission, in its role of enforcing the Act, generally treats the employer and its insurer as a single, unified party. The Act actually defines an employer as including its insurer.[26] Thus, underlying the Act is a recognition that the relationship between an employee and employer directly involves the employer's insurer, although in most cases the employee does not know the identity of the insurer.

2. Current Virginia Law

a) *Who is an Employer?*

The Act sets forth the following definition of an employer: "*Employer* includes (i) any person . . . and any individual, firm, association or corporation . . . using the services of another for pay . . . . If the employer is insured, it includes his insurer so far as applicable."[27] Thus, the Act clearly seeks, by this broad definition of "employer," to provide the maximum protection possible to persons injured while working for another. This protection, however, is not without limit. For example, employers are not liable under the Act if they employ fewer than three employees.

The Act also limits protection by not providing benefits to all persons injured at the workplace. For example, it is the injured person's burden to prove that he or she was an "employee" at the time of the injury. Under the Act, an "employee" is defined as follows:

> *Employee* means: Every person, including a minor, in the service of another under any contract of hire or apprenticeship, written or implied, except (i) one whose employment is not in the usual course of the trade, business, occupation or profession of the employer or (ii) as otherwise provided in subdivision 2 of this definition.[28]

The Act goes on to exclude certain categories of working persons, including casual employees, domestic servants, and certain farm laborers, among others.

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[26] Va. Code Section 65.2-101. See Appendix B.

[27] Id.

[28] Id.

The Supreme Court of Virginia has held that the Act does not undertake to change the employer/employee relationship; rather, it leaves intact tha relationship as it was at common law.[29] At common law, four elements are considered in determining whether an employer-employee relationship exists: (1) selection and engagement of the employee; (2) payment of wages; (3) power of dismissal; and (4) the power of control of the employee's action.[30] "Power of control" is the most significant element bearing on the question.

Thus, if the party for whom the work is being done may not only prescribe what the result shall be, but also direct the means and methods by which the worker shall do the work, the former is an employer, and the latter an employee. But if the party for whom the work is being done may specify the result only and the worker may adopt such means and methods as he or she chooses to accomplish that result, then the latter is not an employee.[31]

b) *Is a PEO a "special employer"?*

In general, an employer under the Act is responsible for benefits for injured workers who can establish that, at the time of a workplace injury, they were under the "control" of the employer.[32] Virginia courts have not specifically addressed whether a PEO's client may avoid its liability as an "employer" under the Act.

The Virginia Court of Appeals addressed the issue of whether a relationship with a "labor broker" nullified workers' compensation liability of an entity that was already an "employer" within the meaning of the Act and thus subject to its requirements. In VPI v. Frye,[33] a worker, Mannon, was employed by a contractor who had received a contract with VPI to maintain its grounds and buildings. The worker suffered a fatal injury while assigned to work at VPI.

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[29] Crowder v. Haymaker, 164 Va. 77, 79, 178 S.E. 803, 804 (1935).

[30] Stover v. Ratliff, 221 Va. 509, 511, 272 S.E.2d 40, 42 (1980).

[31] County of Spotsylvania v. Walker, 25 Va. App. 224, 230, 487 S.E.2d 274, 277 (1997).

[32] As will be discussed in greater detail below, such employers are also responsible for complying with the reporting and insurance requirements of the Act. For example, the Act provides that "[e]very employer subject to the compensation provisions of this title shall insure the payment of compensation to his employees in the manner hereinafter provided." Va. Code Section 65.2-800. The failure to file with the Commission annual proof of compliance with these provisions "shall" result in the assessment against the employer of a civil penalty from $500 to $5,000. See Appendix B.

[33] Virginia Polytechnic and State University v. Frye T/A Home Improvement, 6 Va. App. 589, 371 S.E.2d 34 (1988). See Appendix B.

Mannon's widow filed a claim for death benefits under the Act. In affirming the determination of the Commission that VPI was liable under the Act as Mannon's "special employer," the Court found persuasive that "VPI exclusively and completely controlled Mannon's employment to the extent that Frye was prohibited from coming on campus to supervise his employees" and that "[h]ow Mannon performed on site work was directed by VPI."

VPI argued that, even if it was Mannon's special employer, Frye should be held liable as a labor broker who agreed to and did secure workers' compensation liability insurance. In assessing this argument, the court noted that "[a] number of states, by either judicial decision or statute, have adopted rules to govern the labor broker situation. Particularly, when the labor broker agrees to provide workers' compensation coverage, they have held that the labor broker is the liable employer."[34] The court noted that most of these states have adopted statutes providing that liability is joint and several between dual employers. In contrast, the Virginia Act "does not provide for shared liability and our case law clearly places responsibility on the special employer."[35]

The holding in Frye greatly impacts a PEO and its client where the PEO agrees to obtain worker's compensation insurance. As was true in Frye, the employee's work will normally be directed almost exclusively by the client with whom the employee is placed. The relationship between a PEO and its client would appear to be substantially similar to that existing between VPI and Frye, and thus the Frye decision would be germane to determining the effect of any contractual obligation on the part of the PEO to provide workers' compensation insurance.

c) *Are PEOs entitled to benefit from exclusive remedy principle?*

Pursuant to Code Section 65.2-307, the workers' compensation remedy is an injured employee's sole recourse against his or her employer.[36] Where the

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[34] 6 Va. App. At 594, 371 S.E.2d at 37 (citing White v. Extra Labor Power of Am., 221 N.W.2d 214 (Mich. Ct. App. 1974); Bilotta v. Labor Pool of St. Paul, Inc., 321 N.W.2d 888 (Minn. 1982); Ettlinger v. State Ins. Fund, 206 N.Y.S.2d 739 (N.Y. App. Div. 1960); Ishmael v. Henderson, 286 P.2d 265 (Okla. 1955)).

[35] Id. In rejecting VPI's argument, the court also relied on Code Section 65.2-300, which provides that "no contract or agreement . . . shall in any manner operate to relieve any employer in whole or in part of any obligation created by this title." The court noted that the parties may, however, enter into an appropriate indemnification agreement to accomplish their intentions.

[36] That section states, in its entirety:

> The rights and remedies herein granted to an employee when his employer and he have accepted the provisions of this title respectively to pay and accept compensation on account of injury or death by accident shall exclude all other rights and remedies of such employee,his personal representative, parents, dependents or next of kin, at common law or otherwise, on

injury is one covered by the Act, this section operates to extinguish all other remedies against the employer that might have been available to the worker.[37] The employee, however, generally retains other common-law, as well as statutory, remedies against strangers to the employment relationship. The issue of whether a PEO is also entitled to immunity should be addressed in any legislation relating to the PEO industry.[38]

3. How have other states dealt with the issue of whether the PEO or the client is liable?

a) *Introduction*

States that have addressed the issue of PEO liability have done so in various ways. Those that have extended the exclusivity principle by judicial interpretation adopt the "borrowed servant" doctrine.[39] Under the borrowed servant doctrine, an employee, who is directly employed by one employer, may become the employee of a second employer, for purposes of workers' compensation, when the employee's service is transferred to the second employer. Other states have handled the problem with comprehensive legislation. This Report will take up examples of each approach.

b) *Judicial approach*

In Brown v. Aztec Rig Equipment,[40] the Texas Court of Appeals decided a case in which an injured employee filed a negligence action against an employer, Aztec, and a PEO, Administaff. The agreement between Administaff and Aztec required that Administaff "furnish and keep in full force and effect at all times . . . workers' compensation insurance covering all Administaff employees furnished to [Aztec]." With regard to the allocation of duties, the agreement provided that "Administaff handled administrative matters relating solely to personnel management while Aztec directed and supervised the details

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account of such injury, loss of service, or death.

[37] See, e.g., Griffith v. Raven Red Ash Coal Co., 179 Va. 790, 20 S.E.2d 530 (1942).

[38] Other states' legislation typically addresses this issue specifically, as will be discussed below.

[39] In Metro Machine Corporation v. Mizenko, 244 Va. 78, 419 S.E.2d 632 (1992), the Virginia Supreme Court held that, in the temporary employment setting, the exclusivity provision of the federal workers' compensation statute also bars an action by a borrowed servant against a borrowing employer. The decision appears to assume that the exclusivity provision would also bar such an action against the lending entity. See Appendix B.

[40] 921 S.W.2d 855 (Tex. Ct. App. 1996). See Appendix B.

of work to be done in furtherance of its business and provided necessary tools and equipment."

The Texas court found that this arrangement created a co-employment relationship and that both Aztec and Administaff were entitled to the protection of the exclusive remedy provision of the Texas Workers' Compensation Act.[41] The court intimated that employment pursuant to the borrowed servant doctrine was tantamount to joint employment.

c) *Statutory approach*

Other states have specifically addressed this issue by statute. For instance, in Florida, a PEO is considered to be the employer of record and thereby benefits from the exclusive remedy provisions of the workers' compensation statute.[42] New Hampshire has specifically legislated that a PEO and its client are both entitled to the benefit of the exclusive remedy.[43]

After the decision in Brown v. Aztec Rig Equipment, Texas enacted comprehensive legislation governing the PEO industry. Under that legislation, a PEO licensed under the state's licensing and registration requirement is considered to be a co-employer with the client, and both are entitled to invoke the exclusive-remedy provision.[44] Other states have enacted similar statutory provisions extending the workers' compensation bar to cover PEOs.[45]

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[41] Tex. Lab. Code Ann. Section 408.001(a) (West 1996) provides as follows:

> Recovery of workers' compensation benefits is the exclusive remedy of an employee covered by workers' compensation insurance coverage or a legal beneficiary against the employer or an agent or employee of the employer for the death of or a work-related injury sustained by the employee. See Appendix B.

[42] See Fla. Stat. Ann. Section 468.529 (West Supp. 1998). See Appendix B.

[43] See N.H. Rev. Stat. Ann. Section 277-B:10 (Supp. 1997). See Appendix B.

[44] See Tex. Lab. Code Ann. Section 91.042 (West 1996). See Appendix B.

[45] See, e.g., Ark. Code Ann. Sections 23-92-315 & 11-9-105 (Michie 1992); Or. Rev. Stat. Section 656.018(4) (Supp. 1998); S.C. Code Ann. Sections 40-68-70, -75, and 42.1-540 (Law. Co-op. Supp. 1997); Utah Code Ann. Section 34A-2-105 (Supp. 1998). See Appendix B.

C. *Is the PEO or the client responsible for procuring insurance?*

1. Introduction

The issue of whether a PEO may be deemed an employer for workers' compensation liability is related to the issue of who is responsible for procuring and maintaining workers' compensation insurance. Employers are required to secure their workers' compensation obligations, either through insurance, self-insurance, or other established methods that show an employer's solvency.[46] A typical workers' compensation insurance policy is straightforward, deferring, for the most part, to state law.[47]

2. Current Virginia Law and Practice

a) *Statute*

With respect to Virginia's mandatory insuring requirement, Code § 65.2-800(A) provides that "[e]very employer subject to the compensation provisions of this title shall insure payment of compensation to his employees in the manner hereinafter provided." An employer who fails to comply with the statutory insuring requirement is subject to a civil penalty of between $500 and $5,000.[48]

The obligations of Code § 65.2-800(A) can only be met by one of the three ways authorized under Code § 65.2-801(A): by purchasing a workers' compensation insurance policy issued through a private insurer; by being certified by the Commission as an individual self-insurer; or by becoming a member of a licensed group self-insurance association.

There is no provision in the Act that permits one employer to satisfy its workers' compensation insurance obligation by including its employees under another company's policy. While a PEO and a client could contract for the PEO to pay for the employer's workers' compensation policy, the current Commission

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[46] In Virginia, the Workers' Compensation Commission regulates whether an employer qualifies as a self-insurer. After qualification, the Commission continues to monitor compliance.

[47] For example, NCCI's form workers' compensation policy, which has been approved for use in Virginia, provides that the insurer "will pay promptly when due the benefits required of [the insured] by the workers' compensation law." Workers Compensation and Employers Liability Policy, NCCI No. WC 00 00 00 A (April 1, 1992).

[48] Va. Code Section 65.2-805. See Appendix B.

interpretation of Code § 65.2-801(A) requires that the employer, not the PEO, be the named insured.[49]

b) *The Commission's role*

The Commission monitors compliance of the employer's obligation to maintain insurance through a set of comprehensive procedures. Section 65.2-804B requires that a carrier give the Commission thirty days' notice whenever an insurance policy under the Act is to be canceled or non-renewed. This notice initiates a Commission inquiry designed to enforce the Act's insurance provisions. A Commission inquiry may also follow receipt of a document originating a claim for benefits.[50] When the Commission receives a document initiating a claim, its first action is to verify insurance coverage for the employer identified in the originating document.[51]

Following receipt of the notice of cancellation or non-renewal, the Commission initiates a process in which the insurer and the employer must provide information necessary to determine whether there will be coverage after the effective date of the cancellation. Similarly, upon the opening of a claim file, the Commission investigates whether the named employer is insured.

If the employer does not provide the requested information or is found not to be insured, a subpoena is issued to the employer for the required coverage information. Ultimately, if the employer does not provide a sufficient response, a show cause order is issued to the employer. This order directs the employer to appear before the Commission at a specific date and time at a hearing to explain why coverage has not been obtained. Following the hearing, an order may be entered levying a civil penalty of $500 to $5000 if the employer failed to maintain coverage.[52]

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[49] In Gulbranson v. CFW Contracting, VWC File No. 186-27-49 (October 15, 1998), the Commission found that Code Section 65.2-800(A) requires an employer, as opposed to its PEO, "to have in effect a policy on which it is the named insured." See Appendix, page A3a.

[50] Claims are initiated when the Commission is first notified of a work place injury. Such notification may be made either when the employer files its First Report of Accident Form, or when the claimant files an initial claim for benefits.

[51] The injured worker, however, frequently views the client as being his employer and gives the client's name and not that of the PEO in the initial application. When the Commission attempts to verify coverage, it finds in its database that the client is not insured.

[52] During fiscal year 1998, the Commission processed 20,104 notices of cancellation resulting from employers' failure to pay premiums. There were an additional 10,716 notices of cancellation processed for various reasons other than non-payment of premiums. In processing these cancellations, the Commission issued the following documents: 42,333 initial inquiry letters; 15,352 second inquiry letters where there was no response to the initial

C. *Interaction between PEOs and the Commission*

This discussion frames an important issue as to who, in the PEO-client relationship, should be permitted or obligated to obtain and maintain workers' compensation insurance. Under the Commission's interpretation of Virginia law, it is "employers" who must comply with the mandatory insuring requirement of Code Section 65.2-800.[53]

3. How have other states handled the issue of who may satisfy the obligation to get insurance?

a) *Introduction*

This issue of who may satisfy the client's obligation to maintain current insurance has been resolved in various ways. The Model Act, promulgated by the NAIC, provides a basic framework for analyzing this issue. Other states' legislation also is helpful

b) *The Model Act*

The Model Act and its regulations acknowledge that the "basic rule" under the workers' compensation act is that the client is responsible for purchasing and maintaining a standard workers' compensation policy. The Model Regulation allows for two exceptions to this basic rule: a master policy purchased by a PEO or a multiple coordinated policies scheme.[54] A PEO may purchase a master policy in the voluntary market if the PEO is registered with the Commissioner of Insurance. Multiple coordinated policies are available for those PEOs whose clients are compelled to acquire policies through the residual market, or assigned risk pool.

The Model Regulation contains other requirements, much like those implicated by a standard voluntary policy. For example, failure to comply with the Model Regulation is grounds for cancellation or nonrenewal of a policy. Under the Model Regulation, if a PEO has received notice of cancellation or nonrenewal, it "shall notify by mail, within fifteen (15) days of the receipt of notice, all of the lessees [clients] for which there is an employee leasing

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letter; 7,096 orders directed to employers and carriers to provide coverage information; and 5,179 special inquiry letters where the proffered response was not sufficient. During this same time period, 1,662 files were transferred to the dispute resolution department for issuance of a show cause order and subsequent docketing for hearing.

[53] In Gulbranson v. CFW Contracting, VWC File No. 186-27-49 (October 15, 1998), the Commission found that Code Section 65.2-800(A) requires an employer, as opposed to its PEO, "to have in effect a policy on which it is the named insured." See Appendix, page A3a.

[54] NAIC Employee Leasing Model Regulation Section 4. See Appendix, page A1b.

arrangement covered under the to-be-canceled policy."[55] Therefore, the individual lessees or clients are ensured to receive notice.

c) *Florida*

Under the Florida Employee Leasing Company Act, a PEO is responsible for providing workers' compensation insurance covering leased employees. The PEO is also required to make specific disclosures pertaining to each client's workforce to the PEO's workers' compensation insurance carrier. Notice by the PEO must be provided to the insurer and to the Florida Division of Workers' Compensation whenever an employee leasing contract is terminated.[56]

d) *Texas*

Texas has enacted legislation specifically directed to the PEO industry.[57] Under the Texas law, an "employee provider firm" has the option of securing workers' compensation insurance for its clients. If it does so, it is required to purchase a "master" workers' compensation policy and submit a separate endorsement for each client. Each client's unique experience modification factor is utilized in calculating premiums on the master policy, except that, after a client has been under contract with a PEO for more than two years, the PEO's experience modification factor is used.[58]

e) *Oregon*

Under Oregon law, a PEO is responsible for procuring workers' compensation coverage for a client, unless the client has a policy covering the leased employees. If the PEO procures the coverage, or if it terminates coverage, it must notify the Oregon Department of Consumer and Business Services. The

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[55] NAIC Employee Leasing Model Regulation Section 5. See Appendix, page A1b.

[56] Fla. Stat. Ann. Section 468.529 (West Supp. 1998). See Appendix B.

[57] Prior to the enactment, however, this same issue of the effect of the PEO being the named insured arose in the course of litigation. In Brown v. Aztec Rig Equipment, discussed earlier, the agreement between an employee leasing company, Administaff, and a client, Aztec, required that Administaff "furnish and keep in full force and effect at all times . . . workers' compensation insurance covering all Administaff employees furnished to [Aztec]." A policy was issued to Administaff, and included an alternate employer endorsement that provided that "this endorsement applies only with respect to bodily injury to [Administaff's] employees while in the course of special or temporary employment by the alternate employer." The plaintiffs alleged that, because Aztec was not the named insured, Aztec did not have workers' compensation coverage. The court rejected that argument, stating that "[t]he manner in which the insurance is paid is immaterial, so long as there is a compensation policy in force." The court found that "Aztec had workers' compensation coverage through Administaff." See Appendix B.

[58] Tex. Lab. Code Ann. Section 91.042 (West 1996). See Appendix B.

termination may not occur in fewer than thirty days from the notice. The issue of accurate determination of risk is not addressed by the Oregon statute.[59]

f) *Maine*

While Maine has adopted a comprehensive legislative scheme regulating PEOs, the statute defers to the Maine Superintendent of Insurance to determine whether a PEO may procure workers' compensation insurance for a client in the PEO's name. If it is determined that PEOs may provide such insurance, certain statutory guidelines apply. For example, a client's experience modification factor must be used in the policy procured by a PEO for the first three years of the employee leasing contract.[60]

g) *California*

California, which has not enacted comprehensive PEO legislation, allows client companies to secure their workers' compensation obligations by agreement with PEOs. In such cases, both clients and PEOs benefit from the employers' exclusive workers' compensation remedy provisions. California law also provides that an agreement to provide workers' compensation coverage may not be made "for the purpose of avoiding an employer's appropriate experience rating."[61]

4. The Model Act

The Model Act and Regulation distinguish between a PEO and a temp agency. They define a "temporary help service" as "a service whereby an organization hires its own employees and assigns them to clients for a finite time period to support or supplement the client's work force in special work situations such as employee absences, temporary skill shortages and seasonal workloads."[62]

This is contrasted with the PEO, which is defined as "an arrangement, under contract or otherwise, whereby one business or other entity leases all or a significant number of its workers from another business. Employee leasing arrangements include, but are not limited to, full service employee leasing arrangements, long-term temporary arrangements, and any other arrangement

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[59] Or. Rev. Stat. Section 656.850 (Supp. 1998). See Appendix B.

[60] Me. Rev. Stat. Ann. tit. 32, Section 14055(2) (West Supp. 1997). See Appendix B.

[61] Cal. Labor Code Section 3602(d) (West Supp. 1998). See Appendix B.

[62] NAIC Employee Leasing Model Regulation Section 3 (A). See Appendix, page A1b.

which involves the allocation of employment responsibilities among two or more entities."[63]

V. CONCLUSION

The Commission's study of the PEO industry, conducted pursuant to House Joint Resolution 186, delineated several major issues. These issues arise from the unique characteristics of the contractual relationship between a PEO and its client and include complex questions involving issues regulated by both the Virginia Workers' Compensation Commission and the State Corporation Commission's Bureau of Insurance. This report addresses issues involving liability for workers' compensation benefits and the manner of compliance with the mandatory insuring requirement found in the Virginia Workers' Compensation Act. Virginia case law and legislation in other jurisdictions provide some guidance for resolution of these issues. Clarification may be needed, however, by way of legislation.

The Commission also discovered that some jurisdictions specifically regulate the PEO industry. Such legislation frequently requires that PEOs register with an appropriate state agency and obtain a license. The Model Act drafted by the National Association of Insurance Commissioners, as well as enactments by other states, provide relevant paradigms should this type of regulatory system be considered in Virginia.

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[63] Id. Texas has a more detailed discussion of who qualifies as a leased employee than the Model Act. The Texas statute includes a definition of an "assigned employee" which incorporates the same concepts expressed in the Model Act. The "assigned employee" refers to an employee under a staff leasing services arrangement for work to be performed in Texas. "Assigned employee" expressly excludes an employee hired to "support or supplement a client company's workforce in a special work situation." The special work situation is defined as an employee absence, a temporary skill shortage, seasonal workload and a special assignment or project. Texas also includes a definition of an independent contractor. An "independent contractor" is paid by the job, is free to hire additional people to assist at his discretion and is not working exclusively for one party, in other words, is free to work for others or to send additional people to work for others. Temporary help is also defined. The definition of temporary help mirrors the exclusions delineated in the definition of assigned employee.

PART II
APPENDIX A

PART II
APPENDIX B

Available from the Virginia Workers' Compensation Commission by Request

1. *Virginia Statutes*
   - a. *Insurance*
     - i. § *38.2-218*
     - ii. § *38.2-1822*
     - iii. § *38.2-1823*
     - iv. § *28.3-1908(C)*
   - b. *Workers' Compensation Act*
     - i. § *65.2-101*
     - ii. § *65.2-800*
     - iii. § *65.2-801*
     - iv. § *65.2-804*
     - v. § *65.2-805*
     - vi. § *65.2-813*
     - vii. § *65.2-820*
     - viii. § *65.2-821*
2. *Arkansas Statutes*
   - a. *Subchapter 3 - Arkansas Employee Leasing Act*
   - b. *Workers' Compensation Act § 11-9-105*
3. *California Statutes*
   - a. *Labor Code § 3602*
   - b. *Labor Code § 3700*
4. *Florida Statutes and Rules*
   - a. *Chapter 468, Part XI - Employee Leasing Companies*
   - b. *Rules Chapter 61G7 - Board of Employee Leasing Companies*
   - c. *Workers' Compensation Act § 440.11*

5. *Illinois Statutes*
   a. *Act 113 Employer Leasing Company Act*

6. *Maine Statutes*
   a. *Professions and Occupations Chapter 125 Employee Leasing Companies*

7. *New Hampshire Statutes*
   a. *Chapter 277-B Employee Leasing Companies*
   b. *Workers' Compensation Act § 281-A:5*

8. *Oregon Statutes*
   a. *Workers' Compensation Act §656.018*
   b. *Worker Leasing Companies § 656.850 - 656.990*

9. *South Carolina Statutes*
   a. *Chapter 68 Regulation of Staff Leasing Services*
   b. *Workers' Compensation Act § 42-1-540*

10. *Texas Statutes*
   a. *Staff Leasing Services Act, Title 2, Labor Code, Subtitle E Regulation of Certain Occupations, Chapter 91*
   b. *Administrative Rules of the Texas Department of Licensing and Regulation, 16 Texas Administrative Code, Chapter 72*
   c. *Title 132A, Article 9100 Texas Department of Licensing and Regulation*

11. *Utah Statutes*
   a. *Workers' Compensation Act § 34A-2-103*
   b. *Workers' Compensation Act § 34A-2-105*

12. *Virginia Cases*
   a. *Virginia Polytechnic Institute & State Univ. v. Frye t/a Home Improvements, 6 Va. App. 589, 371 S.E.2d 34 (1988)*
   b. *Metro Machine Corp. v. Mizenko, 244 Va. 78, 419 S.E.2d 632 (1992)*

13. *Texas Case*
   a. *Brown v. Aztec Rig Equipment, 921 S.W.2d 855 (Tex. Ct. App. 1996)*