CIC | INSURANCE COMPANY OPERATIONS

LEARNING GUIDE

THE NATIONAL ALLIANCE
for Insurance Education & Research

Insurance Company Operations

DESIGNATED

CERTIFIED INSURANCE COUNSELOR

Certified Insurance Counselor

PROGRAM

Agency Management

Commercial Casualty

Commercial Multiline

Commercial Property

Insurance Company Operations

Life & Health

Personal Lines

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Insurance policy forms, clauses, rules, court decisions, and laws constantly change. Policy forms and underwriting rules vary across companies.

Contents

A Letter from William J. Hold, President/CEO

We know that choosing the right professional development programs to strengthen your career can be challenging. There are many options for you to choose from; so how can you be sure that your time, efforts, and money are being invested and not wasted?

By partnering with The National Alliance, you can rest assured that you are also making the best educational choice for your career—no matter what step of your learning path you are on.

For the last 50 years, our designations have been regarded throughout the industry as symbols of quality and trust. Our practical insurance and risk management courses are taught by active insurance practitioners, include policies and forms currently used in the field, and guide you through real-world scenarios to give you a deeper understanding of what your clients are facing today. The knowledge and skills you develop in any one of our courses (or designation programs) can be put to use immediately.

You will build long-lasting relationships with your clients and stay ahead of industry trends, emerging risks, and products that are constantly evolving in our dynamic market. You will have access to the industry's latest learning materials and be the first to hear about new courses. With a learning path customized to fit your needs, you will be better equipped to protect your clients.

Have no doubt that your success is our priority. Whether you are new to your career or a seasoned professional, you are about to embark on a wonderful professional development journey. Thank you for choosing The National Alliance for Insurance Education & Research as your guide toward a thriving career.

Let's take the first step.

William J. Hold, M.B.A., CRM, CISR

President/CEO

To the Participant

Welcome to Insurance Company Operations, part of the Certified Insurance Counselors designation program. This program will provide you with the core knowledge and tools you need in your work as a highly trained insurance counselor.

A Certified Insurance Counselor is recognized as someone knowledgeable in all areas of insurance. As a participant in The National Alliance program of study, it is expected that you will not only gain knowledge that will give you greater success in your work, but that you will be challenged to make integrity, innovation, inspiration, and imagination part of your daily practice.

As experts in their fields, TNA faculty, consultants, and academic directors—each with a commitment to assist you in your efforts to achieve standards of excellence—have contributed to the content of this course. In this course you can expect:

- engagement in the learning process
- clear learning objectives supported by essential content
- activities designed to strengthen understanding
- exposure to real-world examples and contexts

As representatives of The National Alliance (TNA), we take great pleasure in welcoming you to this program and to our organization. We are committed to helping you become a successful Certified Insurance Counselor.

Resources

As a participant of the course, you have access to numerous online resources, including:

- an extensive glossary of insurance terms
- “Speaking From Experience” videos
- Study Guide

Type the following address into your browser: **scic.com/ICOresources** to access your ICO resources

Program Overview

The following is an at-a-glance view of the contents of this learning guide. Here, you will find section goals as well as specific learning objectives for every section.

Section 1: Executive and Financial Management

Section Goal

In this section, you are introduced to terminology common to discussions of insurance company operations. In addition to becoming familiar with critical terms and fundamental concepts, you will gain a "big-picture" understanding of the various facets, activities, and concerns of the operations within an insurance company.

Learning Objectives:

1.1 Define strategy, strategic planning, and strategic plan.

1.2 Evaluate how the executive management team applies marketplace analysis and value proposition to determine capital structure and surplus requirements to formulate a strategic plan.

1.3 Evaluate the benefits of a company's organizational structure and differentiate them, given the company type, funding sources, and profit objectives.

1.4 Define and explain value, vision, and mission statements and their effect on company culture.

1.5 Relate risk tolerance and risk appetite to decision making within an insurance company.

1.6 Summarize the considerations a company employs to determine its location and operations.

1.7 Compare and contrast the purposes of STAT and GAAP accounting.

1.8 Explain the influence of actuarial services upon the financial impact of reserving, including IBNR (incurred, but not yet reported) losses, in an executive financial analysis.

1.9 Calculate and explain the importance of three types of profitability ratios.

1.10 Distinguish between internal and external communication and explain the value of each to the strategic plan.

1.11 Differentiate the audits necessary to support regulatory compliance.

1.12 Describe the various technologies necessary in an insurance company, including general ledger, billing, business intelligence, communication, and security.

Section 2: Product Development

Section Goal

In this section, you will come to understand the product development process that occurs within an insurance company.

Learning Objectives:

2.1 Identify the information the product development department uses to establish their tactical plan.

2.2 Apply the five-step process used in the product development process to design and implement a product.

2.3 Evaluate the effectiveness of a product development team's use of the actuarial process to determine the price and performance of a product.

Section 3: Underwriting

Section Goal

In this section, you'll learn about the steps, tools, and structure used by insurance company underwriting departments. In addition, you'll gather information about the impact of market cycles, as well as the purpose of reinsurance and loss control. This section will conclude with a look at premium audits and the technology needed to support the underwriting process.

Learning Objectives:

3.1 Identify and explain the steps in the underwriting process.

3.2 Describe tools used in the underwriting process.

3.3 Identify the considerations in structuring an underwriting department.

3.4 Define the two market cycles and provide characteristics of each.

3.5 Given an example, determine the type of reinsurance necessary and explain its use.

3.6 Evaluate the need for loss control in the underwriting process and justify its use.

3.7 Identify the functions of a premium audit and defend its use.

3.8 Justify the selection of specific technology used in the underwriting process.

Section 4: Claims Management

Section Goal

In this section, you'll learn about the claims management process—from planning to managing to technology.

Learning Objectives:

4.1 Incorporate claims management considerations into a plan to support the company's strategic plan.

4.2 Determine specific considerations with each step of the claims process and explain them.

4.3 Evaluate a claim in regard to the roles of subrogation and salvage.

4.4 Analyze the problem of fraud from the perspective of a special investigative unit and consider the appropriate solution.

4.5 Defend the value of litigation management to the insurance company.

4.6 Predict possible outcomes when an insurance company acts in bad faith.

4.7 Give examples of the considerations for a CAT (catastrophe) plan and evaluate their importance.

4.8 Understand claims technologies and how they impact the success of a claims department and the insurance company.

Section 5: Product Distribution

Section Goal

In this section, you will learn how insurance products move from the development process to distribution. Critical factors of internal and external relationship management will take center stage and you'll also explore the technology available to support the sales and marketing functions.

Learning Objectives:

5.1 Defend the need for the corporate marketing and sales management departments' involvement in the implementation of the strategic plan.

5.2 Compare various methods used to create the brand.

5.3 Differentiate between the various methods of distribution and determine where they are most effective.

5.4 Identify different areas of relationship management and their effects on sales and growth.

5.5 Evaluate methods intended to support policyholder services.

5.6 Compare technologies available to sales and marketing departments.

How to Use this Learning Guide

The learning guide you are using in this course is like all the learning materials published by The National Alliance; it has been written and authenticated by industry experts.

Each section in this learning guide shares the same features.

A title identifies each section.

Section 2: Product Development

Strategy Implementation

The company takes actions to implement its objectives and goals.

To execute its strategic plan, a company:

- allocates resources

Once the executive management team has completed step 1 in the strategic planning process—strategy formulation, it is ready for step 2—strategy implementation. Now is the time for the implementation of the tactical plan within each department.

The tactical execution will involve carrying out all the specific actions or initiatives, defined with clear purpose, timeline, and KPIs (key performance indicators).

Members of the product develop... department work clos... ...other depart... ...ios ar...

Section text supports specific learning objectives.

Learning Objective 1

Identify the questions, steps, and processes the executive management team will employ to analyze marketplace factors, internal capabilities, and goals to create an effective strategic business plan.

Companies, including insurance companies, can only function successfully with effective leadership. The **executive management team (EMT)** performs critical functions within a leadership framework. They are responsible for managing the company's core business operations as a whole, which requires strategic planning of various development and department processes, monitoring financial matters, and ensuring the business objectives are met.

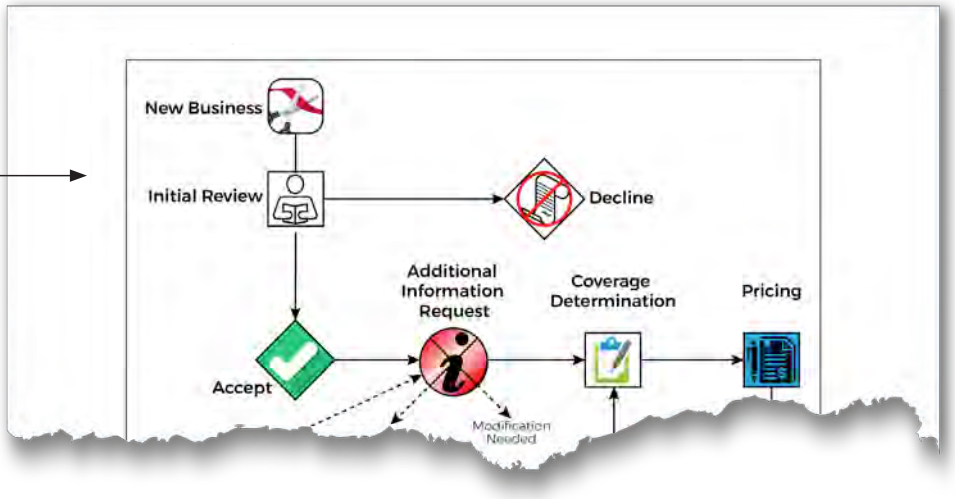
The executive management team understands that capital is critical to the survival of the insurance company, since coverage must be supported by policyholder surplus. With this fundamental principle in mind, the EMT undertakes strategic planning. Once planning is complete and business operations are underway, financials will be created and ...ed and a board of directors will be selected to oversee the company's ...

Important terms are boldfaced. The terms also appear in the Glossary of Terms.

In order to meet regulatory guidelines, P&C insurers must maintain certain levels of **capital** (a large sum of money used to start a business or which is invested to make more money) to support the ability to write new policies and maintain existing policies. This capital is a financial cushion that dictates the insurer's capacity. Large numbers of losses, called **frequency**, or large dollar losses, called **severity**, can diminish an insurer's capacity, causing it to increase rates, seek investment capital, purchase more reinsurance, reduce its exposure, or a combination of these and other techniques. Reducing exposure is accomplished by non-renewing policies in areas where the company may have too many policies. This process, known as **exposure management**, is performed continually by insurers.

Rating agencies, such as A.M. Best, Demotech, and others, assist regulators, agents, and consumers by setting financial standards and assigning alpha-numerical ratings related to those standards. Each rating agency has its own way of measuring financial health. That said, there is still no guarantee that a company will remain financially solvent. In addition to rating agencies, insurers must file detailed financial statements each year with state regulators. For property and casualty companies, these detailed statements are called "**yellow books**" because the cover is required to be yellow.

Visuals such as diagrams, graphs, and tables support the text.



Each section concludes with a summary.

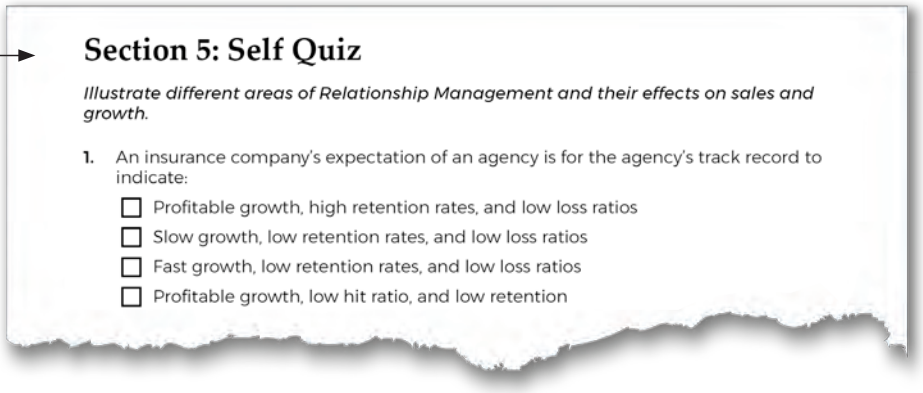
Summary

To support the success mapped out in the Executive Strategic Plan, the new and existing product lines must be advertised and distributed. Corporate Marketing develops the advertising strategies that will reflect the goals of the plan, as well as the Values, Vision, and Mission of the company. A company's brand emerges from this reflection of the company culture and the direction the EMT wants to take the company. Marketing identifies who the customer is: is it the agent or is the agent a business partner and the insured is the mutual customer of the agent and the company.

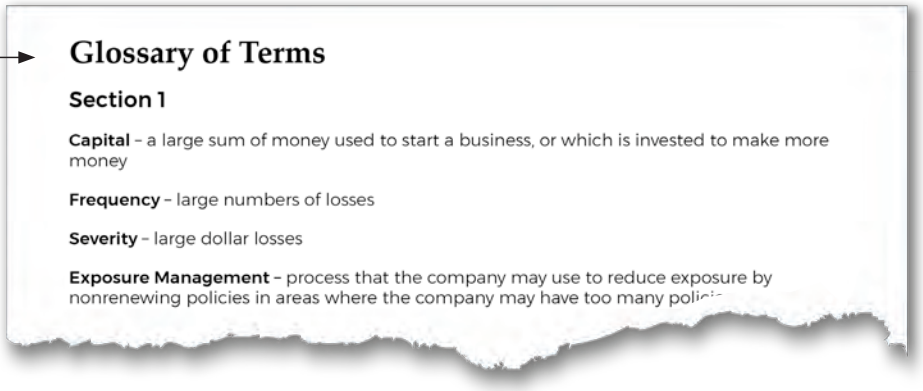
Corporate Marketing considers every possible touchpoint with a consumer. These can be overt or even subliminal. External communication can be with customers, agencies, regulators, and others and is critical to consumers' positive perceptions of the company. These communications include ads, customer response, annual repo[illegible]me up with

Knowledge Checks help you test your understanding before moving forward.

Each section closes with a quiz to help you assess your learning.

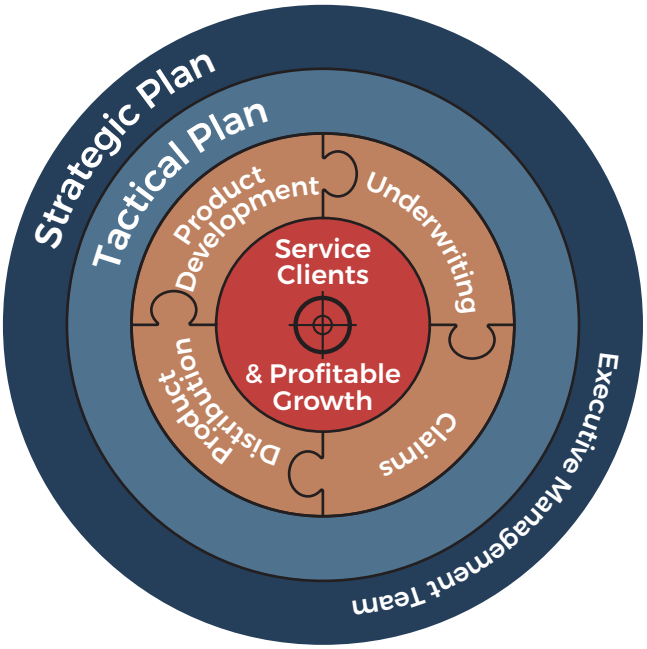


A Glossary of Terms puts the learning resource's special vocabulary in one, easy-to-use location.



A Look Inside the ICO Program

The CIC Insurance Company Operations (ICO) Course is designed to navigate the issues, decisions, processes, and resources of operating an insurance company. You will be able to visualize the departmental connections and understand how important it is that they all work together to accomplish the strategic plans of the company. This program has been broken down into five primary sections describing the key departments' operations:



Executive and Financial Management;

Product Development;

Underwriting;

Claims Management;

and Product Distribution.

While various insurance companies may not necessarily break their operations down into these five specific areas or be limited by just these areas, there is no doubt that every company must have a methodology for creating them.

From a high level, the executive management team tops the organizational chart and is responsible for the strategic direction of the insurance company. The product development group is responsible for developing the forms, rules, and rates that will be used for the products the company will offer, monitors profitability, and makes changes as needed. The underwriters accept or reject submissions, price each risk, and evaluate the performance of these risks to achieve profitability. The claims management department is where the proverbial "rubber meets the road" by interpreting policies and handling claims that arise from the products the company sells in the marketplace. The product distribution team works diligently to develop advertising information and work within the distribution systems set forth. Even though each of these departments has its own specific functions, they must all work together within the framework of the strategic business plan in order to be successful.

Section 1: Executive and Financial Management

Section Goal

In this section, you are introduced to terminology common to discussions of insurance company operations. In addition to becoming familiar with critical terms and fundamental concepts, you will gain a "big-picture" understanding of the various facets, activities, and concerns of the operations within an insurance company.

Learning Objectives:

1.1 *Define strategy, strategic planning, and strategic plan.*

1.2 *Evaluate how the executive management team applies marketplace analysis and value proposition to determine capital structure and surplus requirements to formulate a strategic plan.*

1.3 *Evaluate the benefits of a company's organizational structure and differentiate them, given the company type, funding sources, and profit objectives.*

1.4 *Define and explain value, vision, and mission statements and their effect on company culture.*

1.5 *Relate risk tolerance and risk appetite to decision making within an insurance company.*

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1.11 *Differentiate the audits necessary to support regulatory compliance.*

1.12 *Describe the various technologies necessary in an insurance company, including general ledger, billing, business intelligence, communication, and security.*

The property and casualty (P&C) insurance industry is one of the most highly regulated industries in the world—and rightfully so. It is the backbone of many financial transactions that take place. The industry supports consumers and businesses by providing protection against risks from both first-party property losses and third-party liability suits, among others. By pooling premiums to pay for losses incurred by policyholders, insurance companies can provide necessary coverage at a fraction of the cost of potential losses.

According to the National Association of Insurance Commissioners, there are over 2,500 P&C insurance companies in the US. Collectively, insurance companies and their related activities contribute approximately three percent of the country's gross domestic product (GDP) and provide jobs to almost 650,000 people across the nation. In addition, the P&C industry pays out tens of billions of dollars each year in property losses related to catastrophes, on top of the everyday losses that occur in any given year. Insurance is also regulated at the state level, adding complexity to the industry. There are 51 jurisdictions in the US, each with its own nuances regarding regulation. That's an important consideration as the insurance company seeks to balance its internal and external constraints.

In order to meet regulatory guidelines, P&C insurers must maintain certain levels of **capital** (a large sum of money used to start a business or which is invested to make more money) to support the ability to write new policies and maintain existing policies. This capital is a financial cushion that dictates the insurer's capacity. Large numbers of losses, called **frequency**, or large dollar losses, called **severity**, can diminish an insurer's capacity, causing it to increase rates, seek investment capital, purchase more reinsurance, reduce its exposure, or a combination of these and other techniques. Reducing exposure is accomplished by non-renewing policies in areas where the company may have too many policies. This process, known as **exposure management**, is performed continually by insurers.

Rating agencies, such as A.M. Best, Demotech, and others, assist regulators, agents, and consumers by setting financial standards and assigning alpha-numerical ratings related to those standards. Each rating agency has its own way of measuring financial health. That said, there is still no guarantee that a company will remain financially solvent. In addition to rating agencies, insurers must file detailed financial statements each year with state regulators. For property and casualty companies, these detailed statements are called "**yellow books**" because the cover is required to be yellow.

As you can imagine, all of this regulation is designed to protect the consumer of the insurance product—the insured. Without proper regulation, consumers could easily be taken advantage of by unscrupulous players in the insurance marketplace.

Strategic Planning

Learning Objective:

1.1 Define strategy, strategic planning, and strategic plan.

Companies, including insurance companies, can only function successfully with effective leadership. The **executive management team (EMT)** performs critical functions within a leadership framework. They are responsible for managing the company's core business operations as a whole, which requires strategic planning of various development and department processes, monitoring financial matters, and ensuring the business objectives are met.

The executive management team understands that capital is critical to the survival of the insurance company, since coverage must be supported by policyholder surplus. With this fundamental principle in mind, the EMT undertakes strategic planning. Once planning is complete and business operations are underway, financial statements will be created and maintained and a board of directors will be selected to oversee the company's interests.

Key questions to consider in the strategic planning process:

In a highly regulated business where the products may vary only slightly, it is crucial for an insurance company to have a clear strategic business plan that will effectively and efficiently deploy its resources to meet or exceed its goals.

Let's take a closer look at the concepts leading to the creation of a strategic business plan: strategy, strategic plan, and strategic planning. See the diagram for more clarification about the differences.

Strategy

- Thoughtful, deliberate plan of action
- Chooses to be clear about the company's direction in relation to what's happening in a dynamic environment
- Answers the question "How?" as in "How will we achieve our aim of creating and nurturing a successful insurance company?"

Strategic Planning

- The process used to create the strategic plan
- Runs an ERM* analysis, which determines risks and opportunities
- Conducts a SWOT* analysis and helps answer these questions: "Where are we now? Where are we going? How will we get there?

Strategic Plan

- The formulated roadmap that describes how the company executes its chosen strategy
- Provides answers from initial SWOT
- Includes values, vision and mission statements.

*ERM stands for "enterprise risk management"; SWOT stands for "strengths, weaknesses, opportunities, and threats." Both types of analyses will be discussed in greater detail later in this section.

The development of the plan starts with a variety of information, such as organizational values, market trends, regulatory guidelines, competitive analysis, and risk appetite. The EMT then uses that information to look at where they are going, such as the adjustment or development of values, vision, and mission statements; and making financial projections. Then, the EMT uses the information to conduct specific actions, which eventually result in a **strategic business plan**.

This section will examine:

- various kinds of information that go into the strategic planning process
- some of the action items that occur in order to develop a strategic business plan.

Although we will look at different information and actions separately, keep in mind that the process isn't always linear, and a single action may incorporate a variety of information. In fact, many of these actions will occur at the same time.

Strategic Planning—An "In and Out" Process

Where are we now?	Where are we going?	How will we get there?
• Organizational values • Existing market Market trends • Business objectives • Competitors • Risk appetite	• Development of values, vision, and mission statements • Market analysis • SWOT analysis • ERM analysis • Financial projections • Resource allocations • Performance metrics	• A strategic business plan that reflects what the company wants to be and whom it wants to serve

Knowledge Check

Directions: Explain the difference between strategy, strategic planning, and strategic plan. What are the questions the EMT must answer before it starts the strategic planning process? What sources of information will be needed to answer these questions?

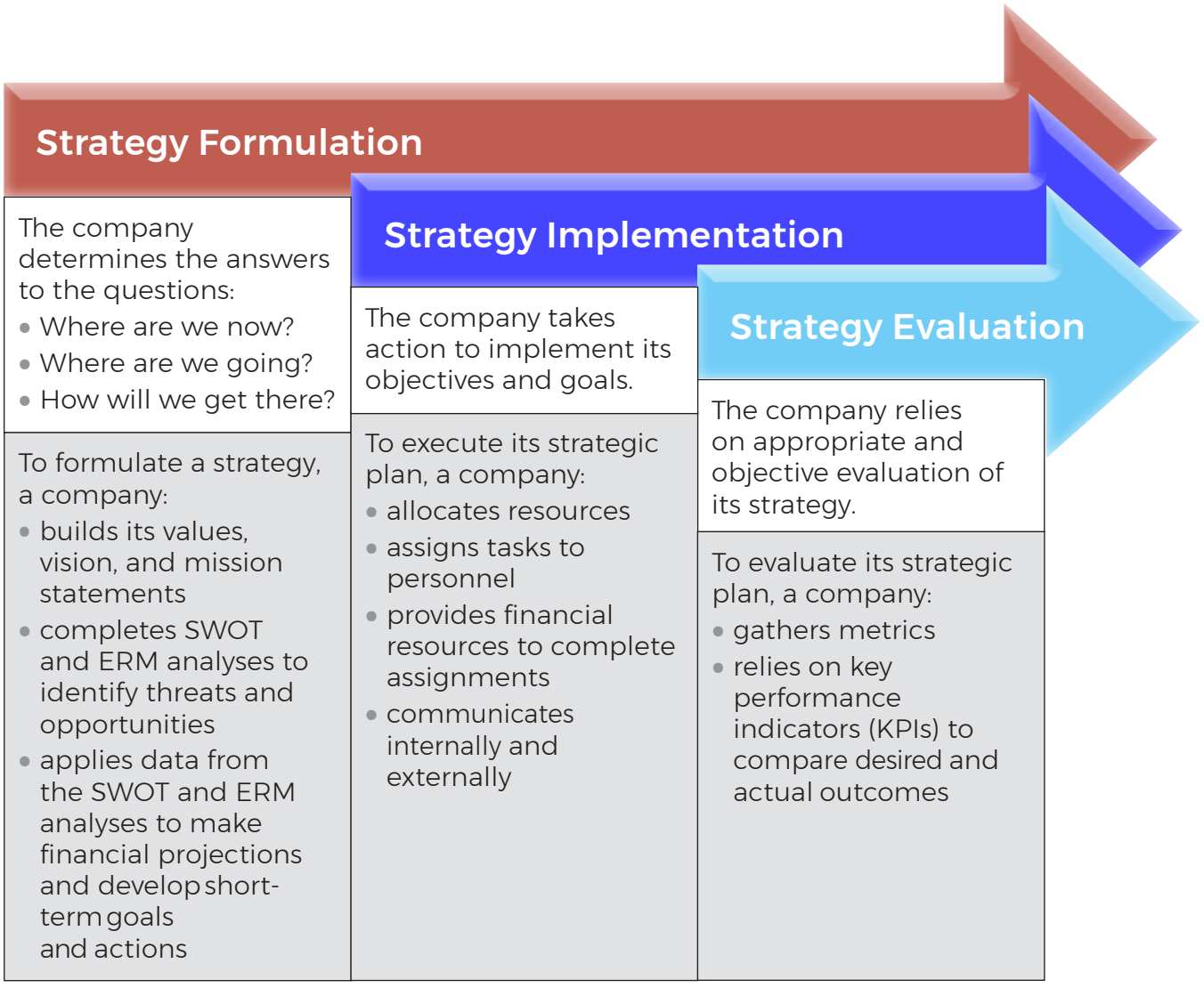
Strategic Management

Learning Objective:

1.2 *Evaluate how the executive management team applies marketplace analysis and value proposition to determine capital structure and surplus requirements to formulate a strategic plan.*

The Strategic Management Process

We simplified the strategic planning process, as an "In and Out" process. The **strategic management** process has three interdependent steps: 1) strategy formulation; 2) strategy implementation; and 3) strategy evaluation. This process builds on the preliminary strategic planning process and takes action on the agreed upon strategy.



Let's examine the three steps of the strategic management process.

Step 1: Strategy Formulation

Strategy formulation is the first step in the process where the EMT decides what it wishes to build and asks: where are we now, where are we going, and how will we get there? The strategic planning and management steps may overlap or be expanded on in the management phase of the strategic plan.

To formulate a strategy, a company:

- completes SWOT and ERM analyses to identify threats and opportunities
- applies data from the SWOT and ERM analyses to make financial projections and develop short-term goals and actions.
- builds its values, vision, and mission statements.

SWOT (Strengths, Weaknesses, Opportunities, and Threats) Analysis and ERM (Enterprise Risk Management) Analysis

A SWOT analysis has four components: two are internally focused and two are externally focused.

With an internal focus, the executive management team focuses on the company's strengths and weaknesses (SW). While assessing weaknesses can be difficult, the exercise gives good insight into what may need to be accomplished as the company seeks to grow and change.

With an external focus, the executive management team seeks opportunities (O) and gives careful thought to potential threats (T), such as competition. External issues include issues that the company will have no control over.

Occasionally, an **enterprise risk management** (ERM) analysis is used as part of the review of external threats. ERM analysis focuses not only on external issues that can impact a company from a competitor standpoint, but also the likelihood of other occurrences that may have serious impact on its ability to meet strategic goals. Examples include regulatory issues, economic issues, global natural disasters—which affect reinsurance availability and pricing, pandemics, and cyber-attacks.

Marketplace Evaluation

An early step in developing a strategy is understanding the marketplace. The EMT takes two steps to complete the "how" process. First, it determines where gaps exist in the marketplace. Where are the customers who need to be served and what do they need? Second, the team determines how those needs can best be served.

Sustainable Competitive Advantage

Once the team completes its marketplace evaluation, the next logical step is to determine the company's **sustainable competitive advantage**. A sustainable competitive advantage includes all of the things that will distinguish the company from other companies in the eyes of its target customers.

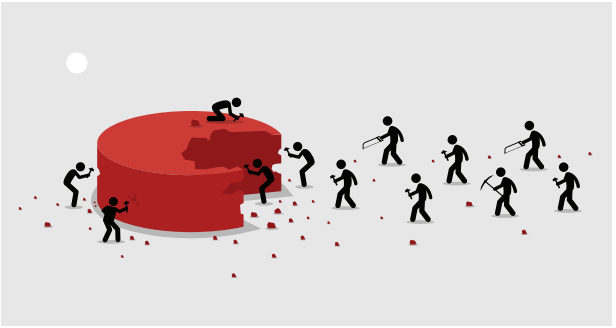
Example: Pricing and product stability, ease of doing business, or financial incentives are all elements that can contribute to a company's sustainable competitive advantage.

The EMT recognizes that the company's business strategy is important to its sustainable competitive advantage. What will set the company apart? What will differentiate it from and improve upon what other companies bring? The answer could be as simple as one thing—product availability.

Example: Imagine being a member of the EMT. You recognize that other companies in a given area are unwilling to provide wind coverage. Your team is willing to write coverage for an exposure other companies choose not to provide.

Resource Allocation

Strategic planning management includes making decisions regarding resource allocation. Resources include both capital and personnel.

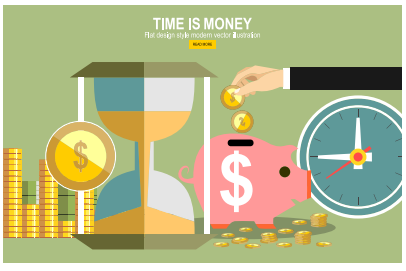


Capitalization is a major factor in what coverage and how much coverage can be written. Capital structure, surplus requirements, and investment sources must be carefully considered. These may vary by type of company formation, regulatory jurisdiction, and lines of business offered.

Personnel, or people, must also be allocated. Effective management of staffing needs is critical. The EMT must identify necessary organizational structure.

Long-term Value

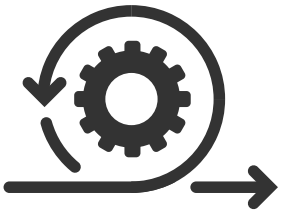
Finally, the EMT must develop a long-term strategy. That is, they must create a plan that maximizes the company's long-term value. In part, that's because long-term projections are necessary to raise the capital necessary to start a company. Long-term value is also important to regulators, shareholders, subscribers, and policyholders who need to know that the insurance company is going to be in the market for a



considerable time. Strategic planning and clever management anticipates and responds to a dynamic, changing environment.

Once the SWOT analysis and ERM processes are complete, the EMT establishes the approach it believes will enable success. The team identifies long-term objectives and sets related priorities. These objectives and priorities lead to financial projections, or anticipated results (as would be recorded in a **pro-forma financial statement**—to be discussed in greater detail later in this section), which lead to action plans to implement the goals and objectives.

Step 2: Strategy implementation



After a strategy has been formulated, it is implemented, or put into action. The company must begin to move toward accomplishing its strategic objectives and goals. The implementation process assumes that the company has, or will, secure the necessary internal and/or external resources. Strategy implementation includes the development of action steps that will be part of the tactical plans carried out by each department.

Similarly, strategic implementation requires effective internal and external communications.

Employees are the target of internal communication, while other stakeholders are the focus of external communication. As the company implements its strategic plan, additional resources may need to be allocated.

Step 3: Strategy Evaluation

Once a strategic plan is in motion, the EMT must monitor actions and analyze results to determine if the team's objectives are being realized. Proper objective evaluation requires clear standards. Performance measures and financial assessments must be established so the EMT can compare actual results to established standards and goals. This allows the company to evaluate and revise, if necessary.

Knowledge Check

Directions: What tools can the executive management team use to identify marketplace readiness and value propositions to determine capital structure, surplus requirements, and investment sources?

_____

_____

_____

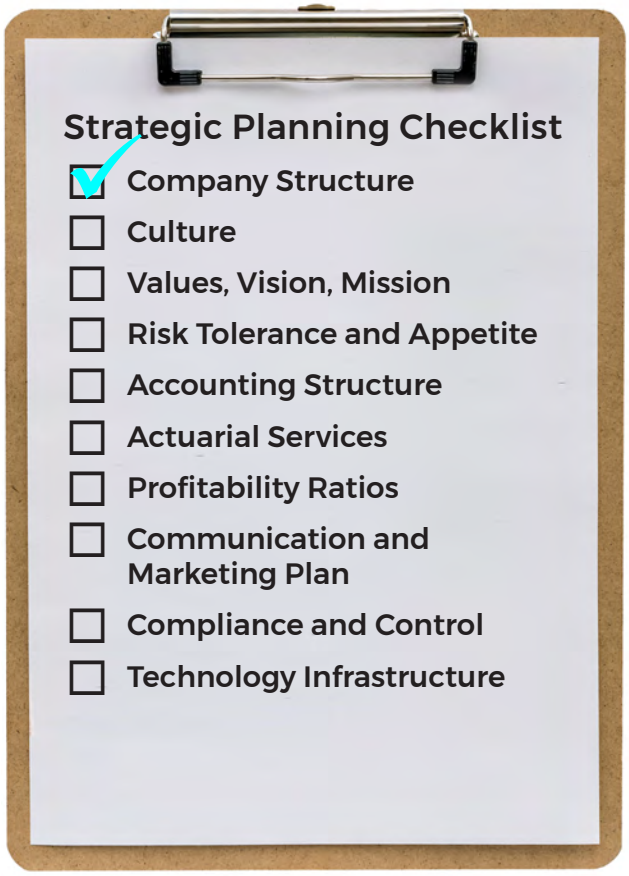
_____

Organizational Structure

Learning Objective:

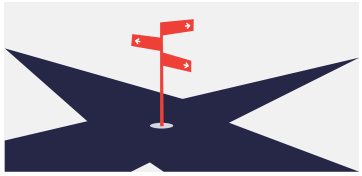
1.3 *Evaluate the benefits of a company's organizational structure and differentiate them, given the company type, funding sources, and profit objectives.*

You may want to use the checklist shown here as a guide as you examine the topics in this section. Members of a company's EMT deliberate on each item in the list as part of their strategic planning process.



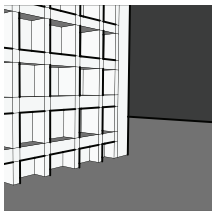
Selecting a Company Structure

The first item in the checklist refers to organizational structure.



Company structure is directly related to funding sources and profit objectives. While a variety of company structures exist, we will focus on these four primary insurance company structures: stock, mutual, reciprocal, and hybrid.

Structure 1: The Stock Insurance Company



A **stock insurance company** is an incorporated insurance company owned by **stockholders**. Stockholders are investors in the organization. Stock companies can be held privately or traded publicly. Publicly traded companies have their stock sold on one of the exchange companies (NYSE or NASDAQ).

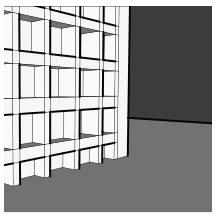
The stockholders of the company elect the corporation's board of directors. The stockholders and board members may or may not be policyholders. Since stockholders are investors in the company, they are looking for return on their investments. The primary objective of a stock company is to make a profit for its stockholders. Profits can be shared in the form of dividends at defined periods, the increase in value of the stock over time, or both.

Stock insurance companies have some unique characteristics. Capitalization of the company is relatively easy. All that is needed—with certain exceptions—is willing investors. In addition, stock companies have access to capital markets, meaning they have access to investors willing and ready to infuse additional capital for shares of ownership. For publicly traded companies, this can mean additional stock offerings to either individual or institutional investors.

Mergers and acquisitions (M&A) within the stock structure are less difficult than in other company structures. With the approval of regulators, transactions can be in cash, stock, or any combination. Branding can also be easier because access to capital is easier, since capital can be used as the funding source for the advertising dollars branding requires.

Stock insurance companies have more pressure on **topline growth**. Topline growth is the increase in written premium month-over-month. Investors generally look at topline growth as an indicator of the bottom-line results. Strong sales and a growing topline help drive stock prices up. Recall that a stock company's primary responsibility is to its stockholders, not its policyholders. This does not mean that stock companies aren't concerned about policyholders—the opposite is true. Retention of existing customers is an important driver of topline growth.

Structure 2: The Mutual Insurance Company



Like a stock insurance company, a **mutual insurance company** is also an incorporated insurance company. Funding to start the mutual can come from loans or surplus notes, or from prospective policyholders. A mutual company is owned by its policyholders. The objective of the mutual company is to provide insurance coverage at or near the actual cost of doing business. If there is any money left over at the end of a fiscal year in the form of profits or surplus, the company may return the money to policyholders in the form of a dividend. Or it may use the surplus to reduce future premiums.

Mutual insurance companies have many unique characteristics. There are no stockholders, placing the focus on the bottom line. As a result, there is less pressure on day-to-day results. Some mutual insurance companies have been around for hundreds of years, giving the company structure the advantage of being stable and having longevity in the market.

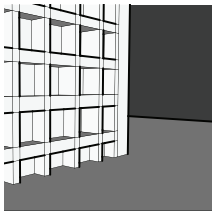
Growth and expansion for mutual companies can be a bit more difficult. Surplus must be built up over time. Since there are no stockholders, investment capital is not available. Mergers and acquisitions can be more difficult because there is no stock to exchange and policyholders own the company.

Mutual Insurance Holding Companies (MIHCs)

As noted above, it is difficult for a mutual insurance company to expand because profits may be returned to the policyholders (who own the company) as dividends. Since the mutual cannot sell shares of stock to raise capital, it must rely on retention of profits from underwriting operations or investment income to increase capital. In 1995, the idea of **mutual insurance holding companies (MIHCs)** was introduced in several state legislatures. Until then, the only option for the mutual insurance company was to merge with another mutual insurance company, or to "demutualize," meaning it would cease to be a mutual and convert to a stock insurance company. The processes of merger and demutualization can be very involved, expensive, and may require a lengthy regulatory review. By 1998, twenty-one states and the District of Columbia had passed legislation allowing domestic mutual insurance companies to reorganize by forming MIHCs.

Under a mutual holding company structure, two new entities are formed: a **mutual holding company**—a non-stock corporation which is the holding company parent; and a **stock holding company**—a subsidiary of the mutual holding company. The original mutual insurance company is converted into a stock insurance company and is controlled by the stock holding company. Ownership of the mutual holding company is retained by the policyholders, including any potential dividend rights. Participation by non-members is prohibited in the mutual holding company. An intermediate stock holding company is formed and the majority of the voting stock is owned by the mutual holding company. The former mutual insurance company is converted to a stock company and the policyholders' contracts and contract rights are now provided by the stock insurance company. Now, the stock intermediate holding company can facilitate an initial public offering (IPO) and may hold interests in affiliated businesses. This allows the insurance company access to capital markets so it can secure the necessary capital to fund expansion.

Structure 3: The Reciprocal Insurance Company



A **reciprocal insurance company**, or simply, reciprocal, is the third company structure.

A reciprocal, also known as an interinsurance exchange, is a group of individuals or organizations who join together into an unincorporated association. The purpose of these individuals or organizations, called subscribers, is to insure one another. This is an insurance application of the "one for all, and all for one" mantra.

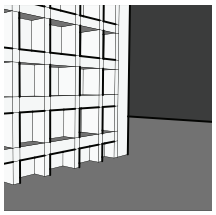
Reciprocals have their own unique characteristics. Because subscribers insure one another, they are both insureds and insurers. There is much less pressure on profits, since they try to operate as close to the cost of doing business as possible. They are also much easier to capitalize. The cost of assets that have a long lifespan can be spread out over a period of time.

Most reciprocals offer coverage to a specific niche or single line of business; however, that is not always the case. There are at least two large reciprocals that offer multiple lines

of insurance. Subscribers make premium deposits when initially purchasing coverage, along with signing a subscriber's agreement that outlines the terms of the interinsurance exchange. The reciprocal is managed by an attorney-in-fact who oversees the operation of the company. This can be a person or an organization.

It can be easier for reciprocals to enter into the market because state insurance regulation of reciprocals may be different than other company types in regard to capitalization requirements. That said, it is generally more difficult for reciprocals to raise additional capital.

Structure 4: Hybrid Structures



Through the use of holding companies—sometimes several holding companies—multiple companies of varying structures operate across the globe including selling property and casualty insurance, life insurance, banking, and investment and financial planning under one company group. This hybrid structure allows the company group to be made up of stock, mutual, reciprocal, and other insurance company structures.

Boards of Directors

Two of the company structures described above—the stock insurance company and the mutual insurance company—have boards of directors. Reciprocals have advisory committees that act in the same fashion as boards of directors. The purpose of a board of directors is to make certain that owners' interests are protected. Stock insurance company boards are elected by the stockholders. Mutual insurance company boards are elected by policyholders. Reciprocal advisory committees are elected by the subscribers.

Every board member has three primary obligations:

1. **Duty of Care** – Directors must make prudent decisions using due diligence, gathering all relevant facts before making decisions.

2. **Duty of Loyalty** – Directors must always keep the interests of the organization the primary focus. Self-interest must be put aside. A duty of loyalty may include disclosure of conflicts of interest.

3. **Duty of Obedience** – Directors must be careful to follow the organization's bylaws, stated purpose, and applicable laws.

A board's size and makeup will vary by a company's type (private versus public) and size. Smaller, closely held companies may not require or desire expertise in certain areas. The process of nominating and approving board members may be less formal. Board members may not be truly independent and may provide actual decisions on how the organization is run.

In contrast, larger organizations and publicly traded companies will use a much more formal approach. While the actual number of board members will vary by the size of the company, expertise is important. Typically, these board members are running, or have run, very successful companies and may be on other company boards. The nominating committee of the board will vet the candidates, but the stockholders or policyholders will elect them.

Once a board is established, it will then decide on board committees, and members will be assigned to those committees by the chairman. While committees will vary based on the complexity of the organization, typical board committees include:

Audit committee:	compliance and control audits are reported directly to the audit committee of the board;
Nominating committee:	vets and nominates prospective board members and officers of the company, which are then elected accordingly;
Governance committee:	assures the board is in compliance with the requirements of the company's bylaws;
Finance committee:	oversees the company's investments and recommends salary and bonus arrangements for officers of the company.

Investment Oversight

A board's finance committee is responsible for overseeing the company's investment strategy. The committee works closely with the executive management team to establish the types of investments the organization will make.

There are limitations on how assets can be invested. The investment portfolio must comply with regulation by the various departments of insurance (DOIs) and the National Association of Insurance Commissioners (NAIC). The NAIC suggests model regulation, but each state insurance department can modify the regulation and run it through the state's legislative process to make it law.

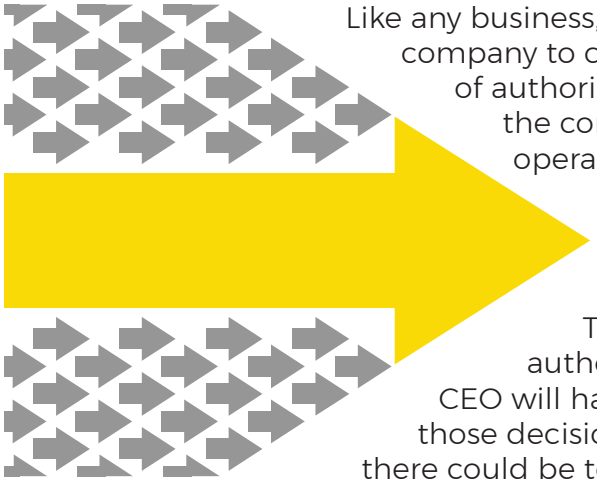
In addition to DOIs, rating agencies such as AM Best, Demotech, Moody's, Standard & Poor's, and others, can adjust their financial ratings of a company based on its investment portfolio. As you will see from the financial exercise in this section, investment income is reported separately from underwriting income.

Insurance companies are required to hold investment-grade securities—no penny stocks or junk bonds. They are not free to invest assets in certain ways. In the past, real estate was allowed to be included on a company financial statement as an asset. After the real estate collapse in the 1990s, real estate was no longer allowed to be used to invest policyholder surplus. The main point is the investment portfolio must be extremely secure and well-balanced.

One final note on investments: in the insurance industry, claims are generally cyclical. Since reserves are set aside for when payment is needed, they must be invested in short-term investment products in order to supply funds as they are needed to pay claims. Consequently, maturities must be laddered, meaning they must have staggered maturity dates.

Many board members come from businesses that are not like the insurance industry. That creates a learning curve for new board members. Industry-specific pricing and statutory accounting practices are two key areas that may require training for new directors.

The Board's Role in Leadership



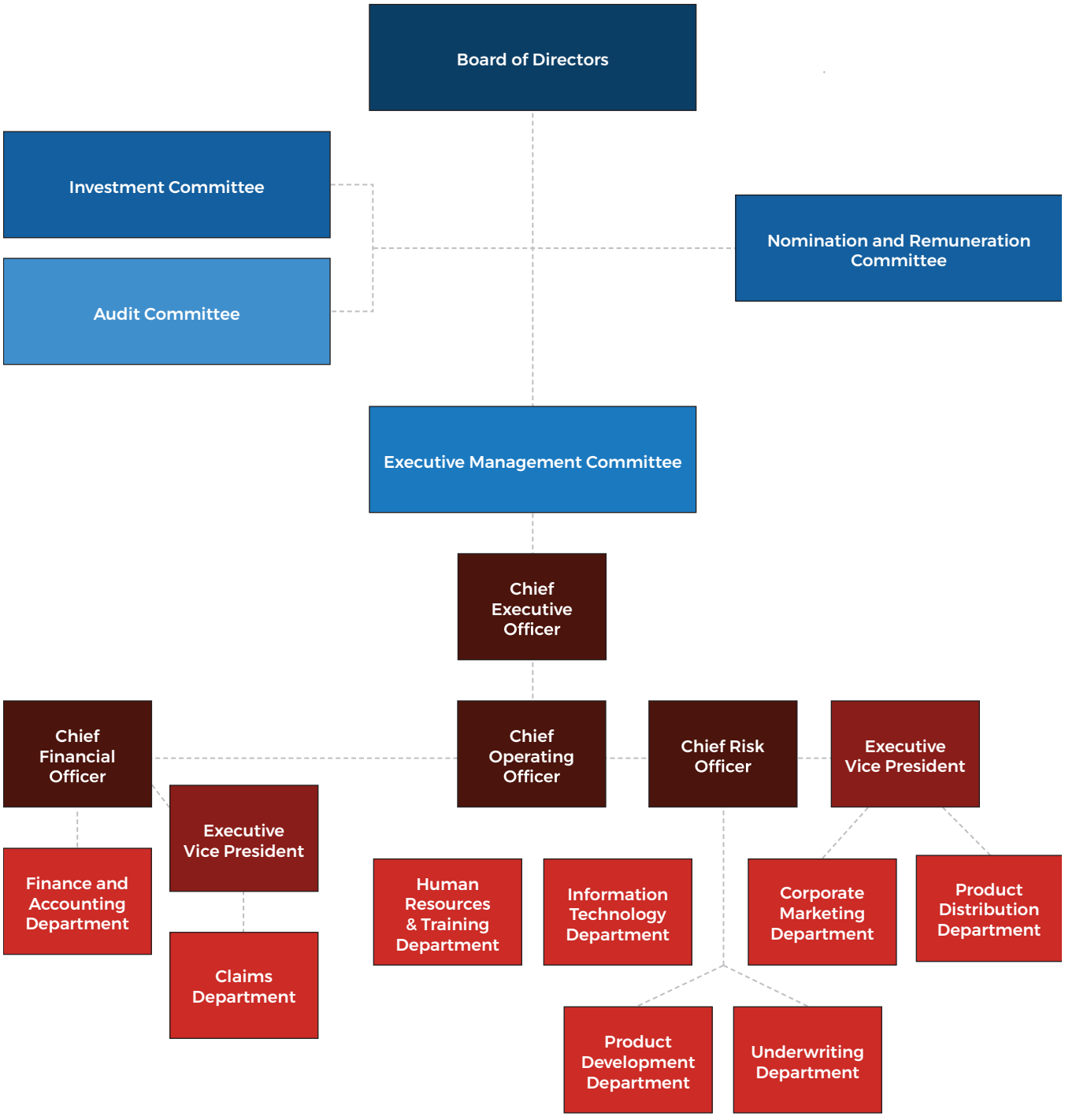
Like any business, leadership structure varies somewhat from company to company. That said, hierarchy is critical to the flow of authority and accountability. There must be officers of the corporation who are responsible for the day-to-day operation of the insurance company.

The board of directors provides oversight to that leadership structure.

The chief executive officer (CEO) has the overall authority to make decisions for the company. A good CEO will have strategically placed officers to help make those decisions. Depending upon the size of the company, there could be ten or more executives. Typical executive positions include:

- Chief Executive Officer
- President
- Chief Financial Officer
- Chief Claims Officer
- Chief Underwriting Officer
- VP—Sales & Marketing
- VP—Claims
- VP—Information Technology
- VP—Product Management

Below is a sample organizational chart.



Knowledge Check

Directions: Identify and describe the primary company structures and characteristics.

1. _____

2. _____

3. _____

Culture

Learning Objective:

1.4 Define and explain value, vision, and mission statements and their effect on company culture.

Company Culture

Now let's move to the next items in our check list—construct a **company culture** and create **values, vision** and **mission statements.**

Like people, organizations have "personalities." To some degree or another, corporate environments can be structured or unstructured; traditional or modern; stuffy or relaxed; or something else entirely. Whatever "personality" a company has, it is a reflection of their company's culture—the DNA and backbone that affects nearly every aspect of a company. The culture will have direct impact on aspects of hiring, employee retention, collaboration, communication, productivity, brand, competitive edge, and growth, to name a few. But where does culture come from? How does culture form inside an organization?

Two approaches lead to the construction of the company's culture: passive or active.

The **passive approach** allows a culture to be created over time. Employees observe the behavior and values of management and fellow employees functioning in self-protective mode. Few or no standards regarding acceptable work behavior are established creating an environment which will be prone to change leading to higher levels of instability and inconsistency. Over time, some level of chaos is created, and morale is generally poor. Turnover can be inflated because job satisfaction is low.

On the other hand, an executive management team that deliberately creates culture follows the **active approach.** The leadership team is intentional about deciding acceptable behaviors. In addition, leadership models the behaviors that create the desired culture. Leaders are setting the stage for success when they establish a solid foundation, allowing for positive employee engagement and employee and customer retention, which results in business longevity and growth targets becoming more in sync.

Values, Vision, and Mission Statements

Building statements that articulate the values, vision, and mission for the organization is the first step in deliberately creating a healthy culture. These statements are the who, what, and why of the company—who it is, why it exists, and what it wants to be.

Values Statement

The values statement is a statement of commonly held core values that define the "who" of the organization. It is often referred to as the company's code of conduct. The statement describes the central theme, or top priorities, of the organization's culture. It's used, among other things, as a "measuring stick" in employee hiring and evaluation, and it's a constant reminder of what is expected of every company employee from top to bottom.

These values must be written and shared with all members of the organization. The values statement should be placed in front of everyone so there is a constant reminder of the company's position. The treatment of fellow employees must be modeled and lived out in every situation by every member of the company.

It's also a great indicator to customers and stakeholders of what they can expect when they do business with the company. Values statements can be used in the marketing and branding process. These values should be the cornerstone of every facet of the company.

When you think of values statements, think of words like integrity, honesty, accountability, perseverance, diligence, and responsibility. These words are common in values statements, but there are many more. When the EMT is developing its company's values statement, it must answer a few key questions:

What key values are desired to be the foundation of the company?

- How will these values be defined and implemented?
- Will they inspire everyone to be the best they can be?
- How will they be used in the employee hiring and evaluation process?

Look at these examples:

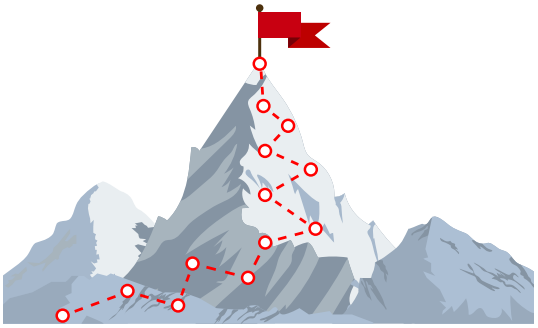
Chick-fil-A: Chick-fil-A's core values comprise customer-first, personal excellence, continuous improvement, working together, and stewardship.

Adidas: Performance sport is the foundation for all we do and executional excellence is a core value of our group. Passion: at the heart of our company—we are continuously moving forward, innovating, and improving. Integrity: We are honest, open, ethical, and fair. People trust us to adhere to our word. Diversity: We know it takes people with different ideas, strengths, interests, and cultural backgrounds to make our company succeed. We encourage healthy debate and differences of opinion.

The Walt Disney Company: Disney declares that their values of innovation, quality, community, storytelling, optimism, and decency, are present in everything they do and help create the unified vision for their workforce.

Vision Statement

The vision statement is aspirational in nature. It's the statement that answers the question "What do we want to be when we grow up?" The vision statement is the light that guides the company to its hopes and aspirations for the future.



Vision statements are the foundation for the development and implementation of a long-term strategic plan. It affects every decision made by those with authority. It also helps a company focus its efforts on strategic opportunities.

Read these examples:

Chick-fil-A: Chick-fil-A's vision statement is "to glorify God by being a faithful steward of all that is entrusted to us. To have a positive influence on all who come in contact with Chick-fil-A."

Adidas: Adidas's vision is "to be the design leaders with a focus on getting the best out of the athletes with performance guaranteed products in the sports market globally."

The Walt Disney Company: Disney's vision statement is "to be one of the world's leading producers and providers of entertainment and information."

Mission Statement

The mission statement is a short but powerful statement regarding the reason an organization exists. It is a "why" statement that states a company's core purpose and overall goal. The mission statement generally deals with the here and now. It identifies a company's operational goal, meaning the products it provides, the market(s) it serves, and its geographical territories. It communicates purpose and direction to employees, customers, vendors, other stakeholders. It differs from the vision statement in that it describes what an organization needs to do in the moment to achieve the vision.

The mission statement is more actionable because it is more specific. It naturally lends itself to the development of short-term goals. Since it describes why an organization exists and how it will compete, the statement allows the leadership team to define understandable goals that fit together to support the mission.

Consider these examples:

Chick-fil-A: Chick-fil-A's mission statement is "to be America's best quick-service restaurant at winning and keeping customers." The emphasis placed in this statement is on the dominant position the company would want to achieve in the sector. Its focus is to refine its brand and services in such a way that it outsmarts all the other players by being second-to-none."

Adidas: The Adidas Group strives "to be the global leader in the sporting goods industry with brands built on passion for sports and a sporting lifestyle. We are committed to continuously strengthening our brands and products to improve our competitive position."

The Walt Disney Company: Disney's mission statement is to "entertain, inform, and inspire people around the globe through the power of unparalleled storytelling, reflecting the iconic brands, creative minds, and innovative technologies that make ours the world's premier entertainment company."

Knowledge Check

Directions: Describe the distinct purpose of each kind of statement: values, vision, and mission.

_____

_____

_____

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Risk Tolerance, Risk Appetite

Learning Objective:

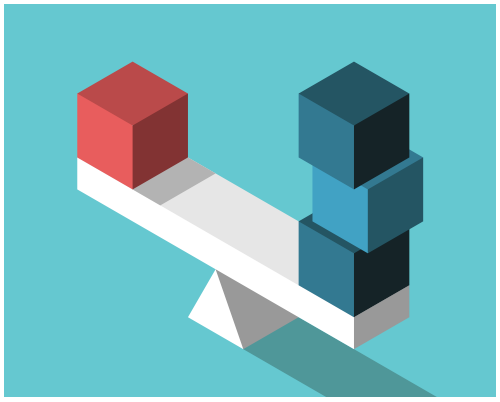
1.5 *Relate risk tolerance and risk appetite to decision making within an insurance company.*

Risk Tolerance and Risk Appetite

Let's look at the new item on the checklist: risk tolerance and appetite and the business decisions the EMT must make as a result of its risk appetite.

When a company's EMT begins to move into the strategy implementation step, which includes decisions about types and lines of business and all the related details, it must first consider what the company's risk tolerance and risk appetite will be. The decisions made in this step, which will be examined in depth here, form the basis of product development—starting the process of designing and pricing products to be delivered to the marketplace.

Risk Tolerance

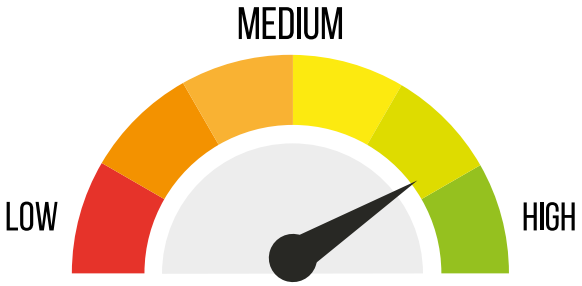


Simply put, **risk tolerance** is the maximum amount of risk a person or organization is willing to assume. An insurance company can have a higher or lower level of risk tolerance. Having a very low tolerance of risk is known as being risk averse.

If the accepted level of risk is too high, executives run the risk of ruin should a catastrophic event take place. If the accepted level of risk is too low, executives run the risk of creating coverage or pricing that is not attractive to the market. The EMT must have a good balance when it comes to risk tolerance.

Risk Appetite

Risk appetite is the maximum amount of risk the organization is willing to accept while striving to meet its strategic and tactical plans. Risk appetite is generally driven by an organization's risk tolerance. It strives to put into motion a prudent version of the company's risk tolerance.



Risk appetite can vary by line of business, whether you're working in a niche or as generalist, by geographical territory, spread and correlation of risk, and other factors. A company that writes commercial auto insurance in multiple areas (sometimes even within a given state), for example, may find some areas more appealing than others. In homeowners' or commercial property lines, there may be zip codes that are open or closed based on a company's appetite to write coverage in those areas.

A company's risk appetite needs to be broad enough to be successful in the markets it wants to target. Certainly, it would not be wise to target construction risks if a company did not have a strong appetite for the use of the additional insured or similar endorsement needed to be a player in that market.

Risk appetite can also be influenced by the capital available to write the line or lines of business a company wants to target. We discussed earlier how important capital is to a company. Without the necessary capital to support its risk appetite, a company is spinning its proverbial wheels. Part of the use of capital may include the use of reinsurance.

Reinsurance will be discussed in more detail in the underwriting section of this course. At this point, it's important to be aware that the proper use of the resource of reinsurance can be a creative method for a company to exercise its risk appetite even if it doesn't have all the necessary capital to support it.

Proper use of management controls is important to the integrity of risk appetite. The executive management team works together to determine levels of authority that will

guide the decision- making process of acceptable risk. After a risk tolerance statement is developed, the team then works through appropriate executive leadership to advise product management and the underwriting of each department of their applicable levels of authority.

Finally, risk appetite is driven by specific metrics, or measurements. Measurements like premium to surplus ratio, loss ratio, expense ratio, and combined ratio—some of which are examined more closely later in the course—are taken into consideration as decisions are made during regular reviews of risk appetite. Risk appetite can be expanded or contracted as needed based on market response and other factors.

Business Decisions Resulting from Risk Appetite

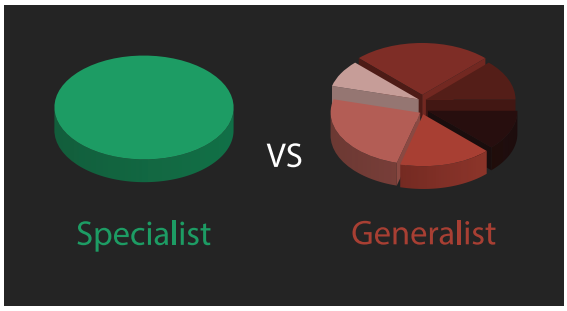
There are a number of decisions the EMT must make which are driven by its risk appetite. These decisions take internal and external constraints.

Single-Line or Multiline

The first decision is whether the company is a single-line or multiline company. A **single-line company** can be much more efficient and effective because it concentrates all of its efforts on that one line of business. It can become the "expert" in that line. However, like most things, there are downsides, as well. If the company relies on that one line only and the market changes, it could lose its market position. For a single-line company, there is no portfolio balance that can be relied upon when market fluctuations occur.

On the other hand, a **multiline company** has the balance it needs to survive during market changes. As we will discuss later in the underwriting section of this course, market cycles for different lines generally do not change together. It's rare that two or more lines of insurance are affected in any given market cycle. That said, personnel expense may be greater since the company cannot count on the same efficiencies. Consider that each line of business will most likely need its own underwriting team.

Specialist or Generalist



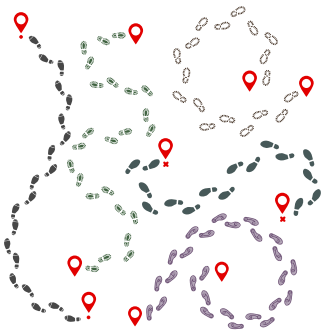
Another decision is whether a company is a specialty, or niche, carrier or a generalist. **Specialist carriers** focus on one or only a few types of risks. Perhaps the company wants to focus on contractor's pollution coverage or directors and officers coverage, for example. Conversely, a **generalist carrier** would write all different types of businesses rather than focusing on specific types.

Yet another decision is whether a company wants to be in personal lines, commercial lines, or both. If a company wants to be in personal lines, which lines within personal will it write? If it's going to write commercial lines, which lines within commercial will it write?

Finally, the executive management team must decide if it has any appetite for other lines, such as financial services, surety, benefits, or life insurance.

Geographic Footprint

Once a decision has been made as to the line or lines of business that a company will write, the company's executive management team must decide *where* it wants to write that business. Will the company write in a single state or multiple states? Will it start out in a single state and expand over time?



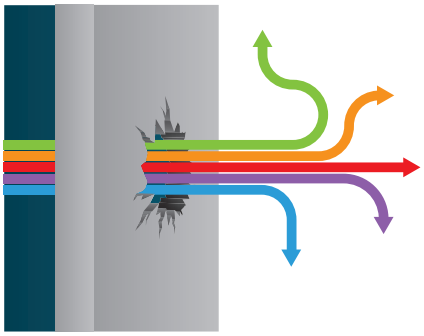
In order to make a wise decision, the EMT will need to do its due diligence. It must first determine what the market need is for the product(s) in the state(s) where it wants to sell. Pricing will be important, but actuaries and product developers make those calculations. Executives need to know that there is room in the marketplace for the company to participate.

Reception by Distribution Sources

In addition, the team needs to consider how receptive agents in those areas are to new companies. Some agents may be skeptical and unwilling to do business with the company. Others, conversely, may be willing to jump right in and become top producers.

The team also needs to consider regulatory and judicial environments, which can be very discouraging.

Barrier to Competition



In the process of making market decisions, the team needs to keep in mind that success in one state does not always guarantee success in another state. Competition can be tougher in some markets than others. A company must be willing to accept any challenges that come along and work through them. If a company chooses to take on a difficult challenge in a specific state and successfully navigates it, that could create a perceived barrier for competitors. Those competitors may see the challenges and may not willing to address them.

Spread of Risk

Companies sometimes may expand to gain spread of risk. **Spread of risk** is created when a company writes policies in all areas of a single state or in multiple states. The larger the area in which a company writes, the greater the spread. Spread of risk helps the company minimize its exposure to a catastrophic event that could affect a majority of their policies at the same time.

Another way to create spread of risk is to add additional lines of business. A company that is currently writing commercial general liability policies may wish to create spread by adding business auto coverage or workers' compensation insurance to its portfolio of products.

In the process of creating spread of risk, a company may expand beyond its core competencies. Writing policies in more than one state requires companies to take into consideration potential differences between state regulations. It also requires the input of underwriters experienced in the nuances of those states. The wider the geographic area, the more diverse the skill set required to write business. Without the proper skill set, the company can create inefficiencies that could damage its reputation with agents and policyholders.

Correlation of Risk

When the states in which a company intends to write business are subject to catastrophic losses, such as hurricane, wildfires, tornadoes, and others, the executive management team must make decisions regarding correlation of risk. **Correlation of risk** is the likelihood that a given catastrophe or different catastrophes will affect more than one territory or state.

Examples of Correlation:

A large hurricane making landfall in Florida and then again in South Carolina is highly probable, thereby creating a high correlation of risk; a large hurricane making landfall in Florida and then again in Texas has a very low probability and, therefore, creates a low correlation of risk.

Example of No Correlation:

A large hurricane making landfall on the Texas Gulf Coast has no correlation to a wildfire across the panhandle of Texas later in the year.

Knowledge Check

What is the relationship between a company's risk tolerance and risk appetite and the EMT's decision-making process?

_____

_____

_____

Other Operational Considerations

Learning Objective:

1.6 *Summarize the considerations a company employs to determine its location and operations.*

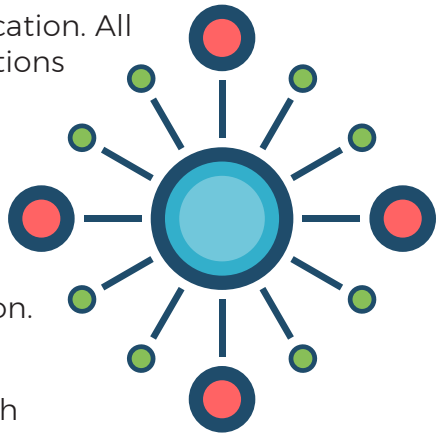
Location and Operations

When making decisions regarding location and operations, there are a number of factors for consideration. Those factors include:

- Lines of business offered
- Centralized or decentralized
- Proximity to markets served
- Regulatory environment
- Judicial environment
- Business environment

- Availability of resources
- Future expansion flexibility

Centralized or Decentralized



Some centralized organizations may only have one primary location. All business is handled out of that single location. Any field operations are incidental and primarily related to sales personnel. Other centralized organizations may have multiple regional offices; however, all decisions are made at the home office level. The more centralized an organization, the higher the risk of bureaucracy. This causes delays in responding to issues outside of the location. Many times, centralized organizations become silos, meaning they focus only on issues at that location. The result can be low inertia and stagnation.

Decentralized organizations have one primary home office with regional or local offices. People making decisions regarding issues specific to the region are on-site and have authority to make those decisions quickly. Since there is generally some level of variation between geographic areas, specific market needs can be addressed by those who are within those geographic areas and possess greater "local" knowledge. Decentralized organizations can have procedural differences in the way they operate. This can create a higher risk that actions will not meet expectations across the organization. In addition, there can be audit and regulatory compliance issues created because of these differences.

Proximity to Markets Served

The markets the company intends to serve will have an effect on locations and operations.

For example, if a company is writing business that is heavily dependent upon reinsurance, it may be better to locate in a hub that has easy access to London and/or Bermuda since the majority of reinsurance carriers are domiciled in one or both of those locations. Reinsurance is primarily a relationship transaction. As a result, it may require several trips by company executives to reinsurers' offices or visits to the company by reinsurers.

On the other hand, if a company is going to focus on agricultural risks, it may be best for the company to locate in, or close to, the Midwest. Although farming and ranching is done in almost every state, there is a particularly large amount done in the Midwest. Being close to customers and agents would be a good strategic move by the executive management team.

Regulatory Environment

There are 51 regulatory departments within the United States. This number doesn't count territories and possessions, which are also regulated. That means there are 51 different ways insurance company regulation is treated.

In order to be an insurance company, a company must first have a state of domicile. This is the state in which it is initially organized and licensed to transact insurance. Before it can write its first policy, the company must meet the capitalization requirements of the state of domicile. That capitalization requirement can vary somewhat.

"**R-Street**" is an organization that rates departments of insurance across the country. In its report card on insurance regulation, it looks at factors, such as politicization, fiscal efficiency, solvency regulation, and underwriting freedom. Companies can review this information as it's updated each year and use it as part of their decision processes.

Once a company is approved, it must then file forms, rules, and rates for regulatory approval.

This is another factor to consider that will be discussed in the product development section of this course. Some states are much easier to do business with than others. Some states require approval of underwriting guidelines, while other states require filing of underwriting guidelines for "advisory" purposes.

Judicial Environment

The legal climate can vary from jurisdiction to jurisdiction. Even within a specific jurisdiction, certain local areas can have different legal climates. The effects of the judicial environment can have a devastating effect on the company from a financial perspective.

As an executive management team evaluates the judicial environment, it looks at statutory laws that are in place and any applicable case law (previous court cases) that affect coverage and claims. How jurisdictions look at bad faith is important. Some jurisdictions recognize first-party bad faith, while others recognize third-party bad faith, and some recognize both. The team also looks closely at defenses that are available for policyholders or the company. The concept of bad faith is discussed in the claims management section.

Certain areas within jurisdictions may have judges and/or juries that are considered exceptionally hostile toward insurance companies. These are areas where verdicts and awards can lean heavily toward the plaintiff and ignore typical interpretations. The American Tort Reform Association publishes an annual report titled "Judicial Hellholes." Many insurance company executives and claims departments review the report after it is published each year.

Business Environment

Taxes and Tax Incentives

During the decision process, an executive management team will evaluate the tax environment. That includes real estate taxes, tax incentives, and whether there is state income tax.

State and local taxes can be costly, depending upon where a company wants to locate. If a company plans to own a building, real estate taxes become an important financial consideration. Taxes should be considered even if a company does not own a structure, business, or personal property.

Some states and/or municipalities offer tax incentives to businesses willing locate in their areas. These incentives can run for multiple years to influence the decision process.

State income tax situations can also be a consideration. While a business itself will not have a tax liability, a state tax does have a negative impact on executives and can drive up the cost of hiring employees.

Cost of Living

Some municipalities can have a very high cost of living. Cost of living affects everything from housing to grocery expense. In areas where the cost of living is higher than the national average, the related salaries of executives and staff must also keep pace. Conversely, in areas were the cost of living is lower than the national average, salaries are lower.

There are instances where companies are located in areas where the cost of living is almost prohibitive for employees. As a result, employees live outside the area, resulting in longer commuting times. This can cause extra strain on employees and drive down work satisfaction. A company must take these factors into consideration when making this important decision.

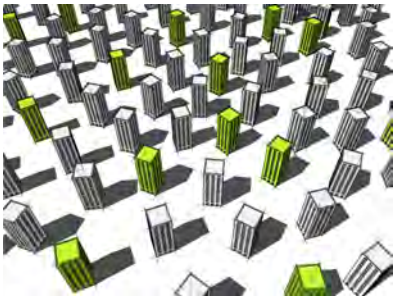
Availability of Resources

Personnel is a key resource for a company. When making a decision regarding location, it's important to understand the talent pool that's available in that area. Experienced personnel can generally only be found in areas that are close to other insurance companies. It's highly unlikely that locating in an area without experienced people will create success. Far too much training time is needed to be productive quickly.

Physical facilities are also important. Buildings that are readily available for occupancy are necessary. Whether owning or leasing, the company cannot afford to wait months before occupying space.

Technology is another important consideration for an insurance company. The availability of information technology (IT) infrastructure is key to getting an operation up and running. If a facility does not have the necessary IT infrastructure, the next consideration is whether there are IT firms that can handle the addition of that necessary infrastructure quickly and accurately.

Future Expansion Flexibility



At certain points in the future, expansion will most likely be necessary. The decision of where to locate operations must take into consideration that need to expand. If a company leases space, there needs to be the option of obtaining more space as the company grows. If a company purchases a building, it must take two things into consideration:

1. Does the new building have room for additions to the structure for future expansion?

2. Should the company purchase a larger structure now, leasing out the space it doesn't use, so it's available as it becomes necessary to expand?

Another option is available: start small and build or purchase a larger building later. This option requires the executive management team to be aware of available property, as well as inflation and other real estate market considerations.

Knowledge Check

Alpha Insurance serves a large clientele of commercial farmers. The company is moving to an agricultural state to be closer to clients and which has no state taxes and offers tax incentives. It also has a favorable regulatory and judicial system. When choosing a city in that state for the main office, what are some other considerations the company might need to make?

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Financial Management

Learning Objective:

1.7 Compare and contrast the purposes of STAT and GAAP accounting.

Establishing an **accounting structure** is the next item on the checklist.

An insurance transaction is a financial transaction. An insurance company accepts a risk of financial uncertainty from the insured in exchange for a premium that is a fraction of the exposure. As such, financial management is extremely important to ensure that funds are available when losses occur.

Financial management is another important cornerstone of a company's operation since it involves every area of the company and supports the measurements needed to analyze success in terms of the strategic plan. Ultimately, financial management is one of the most important factors used in making day-to-day decisions and evaluating where a company is in its journey and what changes it may need to make.

Basic Accounting Structure

Like any business, an insurance company is responsible for the financial accounting operations, and requires structure of how it tracks income and expenses. Accountants prepare financial statements, evaluate the company's financial operations, prepare budgets, and track the money that flows in and out of the company. Typical reporting tracks investment income, premium income, policyholder dividends, operating expenses, and claims.

Part of the basic accounting structure is establishing the **general ledger**. The general ledger includes lines for every transaction that takes place as a company begins to do business. While the general ledger is established in a very detailed manner, over time, it may need to be adjusted as the company adds new expenses or wishes to break down income and expenses in more granular terms.

In addition to setting up the general ledger, it is necessary to establish bank accounts. A company's EMT, along with its board of directors, must decide the number and types of accounts that it needs. In the decision process, the account signatories are established, along with authority levels regarding the dollar amounts that require more than one signature.

Insurers are required by law to file certain financial statements in an annual report to regulators and the investing public. The company's annual statement is based on **statutory accounting principles** (STAT), which differ from **generally accepted accounting principles** (GAAP). If the company is publicly traded, accountants must prepare accounting statements based on GAAP for investors.

Understanding the difference between these two reporting methods requires an understanding of specific frameworks for reporting financials properly. STAT accounting includes income and expenses by state, line of business, and other metrics required by regulators. Also included are premium taxes and agency commissions. While much of this same information is transferred into the GAAP accounting profile, it is reported differently.

Reinsurance transactions, including most ceded premium, ceded commissions, and reinsurance recoverable from post-claim events, must be tracked.

GAAP (Generally Accepted Accounting Practices) Versus STAT (Statutory) Accounting

Up to this point, GAAP and STAT accounting have only been briefly mentioned. A closer look at these types of accounting methods is now necessary.

GAAP Accounting

Most businesspeople are familiar with GAAP accounting. GAAP is a set of rules that consider details, complexities, and legalities of business accounting. The Financial Accounting Standards Board (FASB) uses GAAP as its foundation for comprehensive approved accounting methods and practices. US law requires businesses that release financial statements to the public and publicly traded companies to follow GAAP guidelines.

The purpose of GAAP accounting is to make the process of financial reporting transparent. It uses standardized assumptions, terminology, definitions, and methods. This allows easy comparison of companies to outside parties. The transparency of GAAP enables investors and shareholders to make realistic financial decisions.

Generally speaking, most insurance companies file GAAP financial statements for their policyholders, subscribers, and investors. The Securities and Exchange Commission (SEC) requires publicly traded companies to file GAAP financials.

STAT Accounting

Statutory accounting (STAT) is a set of accounting regulations prescribed by the NAIC for the preparation of the insurance company's financial statements. The primary goal of STAT accounting is to assist regulators in monitoring an insurance company's solvency. STAT was developed based on three pillars:

Conservatism:	Recognition:	Consistency:
The goal is to evaluate in a conservative manner to provide protection for policyholders against potential insolvency	The focus is on liquidity and the company's ability to meet its obligations when they are due.	STAT is applied in a consistent manner in evaluating companies, enabling comparison in a meaningful way.

By making it easier for regulators to consistently monitor solvency, consumers benefit from the transparency and accuracy of the regulatory oversight. At the end of each calendar year, all insurance companies must file extremely detailed financial statements, called "Yellow Books," with their state of domicile.

Fundamental Differences

The following table summarizes the fundamental differences between GAAP and STAT accounting. Let's examine each difference more closely.

Key Differences Between GAAP and STAT

Financial Statements Income:

GAAP: Income is recognized when the sale is made.

STAT: Income is recognized gradually over the policy term; premium is constantly being transferred from unearned premium to earned premium.

Expenses:

GAAP: Expenses are recorded over the term of the policy.

STAT: Expenses are charged against income when the expense is incurred; the expense associated with selling a policy is recorded when the sale is made, although most of the premium is unearned.

Assets:

GAAP: All assets are recognized on the balance sheet.

STAT: Intangible and non-liquid assets (e.g., real property, tax credits) are not recognized on the balance sheet.

Equity Value:

GAAP: Retained earnings are recorded as stockholder equity.

STAT: Retained earnings are recorded as statutory policyholder surplus.

Ratios:

GAAP: Underwriting ratio is calculated by dividing underwriting expenses by net premiums written; when added to the loss ratio, two different combined ratios result.

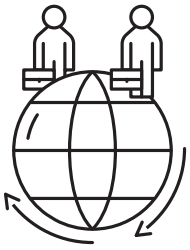
STAT: Underwriting ratio is calculated by dividing underwriting expenses by net premiums earned.

Pro-Forma

A **pro-forma financial statement** is a future-looking document. It is a forecast of what a company intends to write over time. Generally, the pro-forma looks out over the next five years or more.

A lot of detail goes into the pro-forma. It starts by looking at the number of policies a company expects to write by month in the state or states where the company intends to write business. The number then works down the spreadsheet through rows that deal with information like the following:

- New business policy count
- Average premium per policy
- Total new business premium
- New business retention
- Estimated renewal policy count
- Average premium per policy
- Total renewal premium
- Renewal retention
- Total written premium
- Expected loss ratios
- Reinsurance costs
- Other factors



Ultimately, the bottom line shows the capital necessary to support the line of business in a particular state. If there are multiple states, this process is completed for each line of business in each state. The numbers aggregate on a worksheet in the front of the program.

One important factor regarding the pro-forma forecast is that it is filed with the Departments of Insurance in each state where a company writes business. This keeps each state's regulator informed of the company's projected growth as the company seeks continued protection for consumers in each state. If the company under- or over- performs its forecast, it must be prepared to explain the variances to state regulators. This is why the forecast is assembled carefully and thoughtfully, often by a company's entire executive management team. The process may also include leaders from other departments like product development, underwriting, product distribution, claims management, and internal and external actuaries as needed.

Proper financial management dictates that the business plan be monitored monthly or quarterly. As an executive management team reviews the data reported in the financial statements, it makes appropriate changes or seeks to understand why variances exist and what needs to be done to correct them.

Knowledge Check

Directions: Describe the differences between STAT and GAAP accounting and in what situations each is the preferred system.

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Actuarial Services

Learning Objective:

1.8 *Explain the influence of actuarial services upon the financial impact of reserving, including IBNR (incurred, but not yet reported) losses, in an executive financial analysis.*

What Actuaries Do

Next in our list of checklist items is analyzing the **actuarial services**. The insurance actuary is a highly skilled mathematician who computes risk and rates according to probabilities based on statistical data and addresses the measurement and management of risk. In P&C insurance, actuaries determine the adequacy of loss reserves, allocate expenses,

and compile statistics for external state regulatory officials. Integral to all facets of the organization, actuaries are closely engaged with all insurance company departments: underwriting, product development, finance, claims, distribution, and senior management.

While insurance is not the only industry that employs the use of actuaries, most actuaries work in the insurance industry. They help insurance companies determine the financial impact of risks—positive or negative.

Requirements to Be an Actuary

To become an actuary, an individual must meet five requirements—a process that takes years of hard work and dedication. They must:

- ✓ earn a bachelor's degree
- ✓ pass 10 actuarial exams
- ✓ pass several online courses
- ✓ attend conferences
- ✓ meet continuing education requirements

Key Actuarial Responsibilities

Millions of policyholders rely on actuaries to make financially sound decisions. These decisions ensure insurance benefits are available when they are needed. While it is easy to assume that actuaries only work with rates and reserves, they interact with every department within the company.

Actuaries are typically involved in **ratemaking,** or calculating premiums, that policyholders should pay for their insurance. They are also involved in calculating a company's reserves. **Reserves** are the funds a company needs to invest currently in order to pay for future losses.

Many of the regulatory requirements on insurance companies cover reserve requirements. Those requirements are intended to ensure the company's financial integrity and solvency. Actuaries play a vital role in making sure these regulations are met by providing statements of actuarial opinion, or actuarial certification, regarding rate and reserve adequacy with regulators.

Actuaries may provide support through **predictive modeling** and **catastrophe (CAT) management**. Actuaries use these modeling and data analysis techniques to discover predictive patterns and relationships. They use CAT models for pricing and underwriting, as well as solvency and capital management.

Actuaries also support key areas of insurance program options. They:

- assure insured organizations that their insurance premiums and retentions are appropriate (including through market cycles)
- support loss reserve reviews (certifications) required by many types of financial reporting organizations
- conduct loss projections used for forecasting, pricing, and budgeting
- provide cost allocation studies
- contribute to the design of new insurance products as key members of product development teams

While actuaries are integral to all insurance company operations, statutes do not mandate an insurance company have in-house actuarial staff. Actuarial services can be outsourced, but most larger organizations keep the function in-house. As part of their annual review, many companies will have internal reserving practices reviewed by an outside actuarial firm.

Importance of Reserves

Loss reserves and unearned premium reserves are an insurer's two major financial liabilities. Determination of reserves is one of the main responsibilities of an actuary.

Reserves are the amount a company must set aside to pay all future benefits for obligations that already exist, and they are considered liabilities in a company's financial statements.

In other words, they represent the amount of loss an insurance company believes it will ultimately pay out for claims on policies it is currently writing and for policies it has written in previous years. Even if an insurance company decides to discontinue writing insurance policies, it still has to set aside a part of its surplus for loss and loss adjustment expense reserves. Loss payments made in a given accounting period are not only for policies which are written in that period but also for claims from prior exposure periods.

Companies pay considerable attention to their loss reserves. As time goes on and claims are paid, ultimate loss estimates (and therefore reserve estimates) become much more accurate. Every year, as new information becomes known, companies must re-estimate historical loss reserves.

Insurers who under-reserve their losses overstate their income and eventually experience adverse development. **Adverse development** is upward adjustments that must be made to loss expenses when claims are higher than reserves.

Serious under-reserving causes an overestimation of policyholder available capital, making a company's financial health look better than it really is. This can result in regulators mandating a financial solvency exam—or worse, it can result in insolvency.

If a company is too conservative, the results may show a large redundancy in reserves. Insurers who are overly conservative may allot too much of their capital to reserves and be under-leveraged, impacting the ability to write adequate new business.

Types of Reserves

There are two types of reserves actuaries work with: case reserves and IBNR (incurred but not reported) reserves.

1. Case Reserves

When a claim is initially filed, a **case reserve** is established (money is set aside) for payment of that claim. Case reserves for individual claims are generally set by a claims adjuster. This reserve is the best estimate of what the claim will ultimately cost and is based on the information available at that time. As additional information becomes available, the adjuster makes modifications to the reserve amount. Many companies have processes for individual case reserves, including:

- stair-stepping or judgment method
- bulk reserving
- factor or tabular reserves

While the estimate of case reserves will be more reliable than any estimate that includes unreported claims, there is always uncertainty as new developments related to claims change over time. Other claims can be problematic when there is a lag between when they are reported and when cost estimates are made.

2. IBNR (Incurred But Not Reported) Reserves

While claims adjusters set the case reserve on individually reported claims, actuaries look at reserves in aggregate to determine if they sufficiently reflect the total ultimate losses that are expected to be paid out over time. Again, case reserves are normally inadequate for setting estimates of ultimate liability to an organization. Industry experience shows that because case reserves are inadequate, additional **incurred but not reported (IBNR)** estimates are required.

These IBNR loss reserves must be held for claims payments that have been incurred but not reported, for claims that reopen, claims in transit, and for natural development, over time, of known claims. The **bulk reserve**, or gross IBNR, that actuaries are responsible for determining, is composed of four elements:

1) adverse development—the provision for future adjustments of case reserves
2) reopened claims reserve—the provision for claim files that are closed but may reopen

3) incurred but not reported (IBNR)—claims that have occurred but have not been reported to the carrier

4) reported but not recorded (RBNR)—also called pipeline claims, RBNR represent claims that have been reported to the insurer but have not yet been recorded on the insurer's books.

> **Note:** Pure IBNR is the sum of IBNR and RBNR. It is industry practice to simply refer to the bulk reserve, or gross IBNR, as simply IBNR.

IBNR represents the liability for unpaid claims not reflected in the case reserve estimates for individual losses and must be calculated to determine estimates of ultimate loss.

Ultimate losses, therefore, include what has been paid to date, case reserves, and IBNR liabilities. While an adjuster will see the incurred losses (paid losses and case reserves) of all claims, an actuary is charged with adding the IBNR so that the accounts' ultimate losses (paid losses, case reserves AND IBNR liabilities) can be estimated. Ultimate losses are generally calculated for large accounts, territories, classes of business, or any segment of an insurance company's portfolio.

Insurers don't have a stack of cash labeled "case reserve" and another called "IBNR reserve." Instead, each is part of the total reserve, which is treated as a liability on the balance sheet. By making sure the assets are large enough to cover all the liabilities, the company can ensure all reserves are sufficiently covered.

Other Reserves

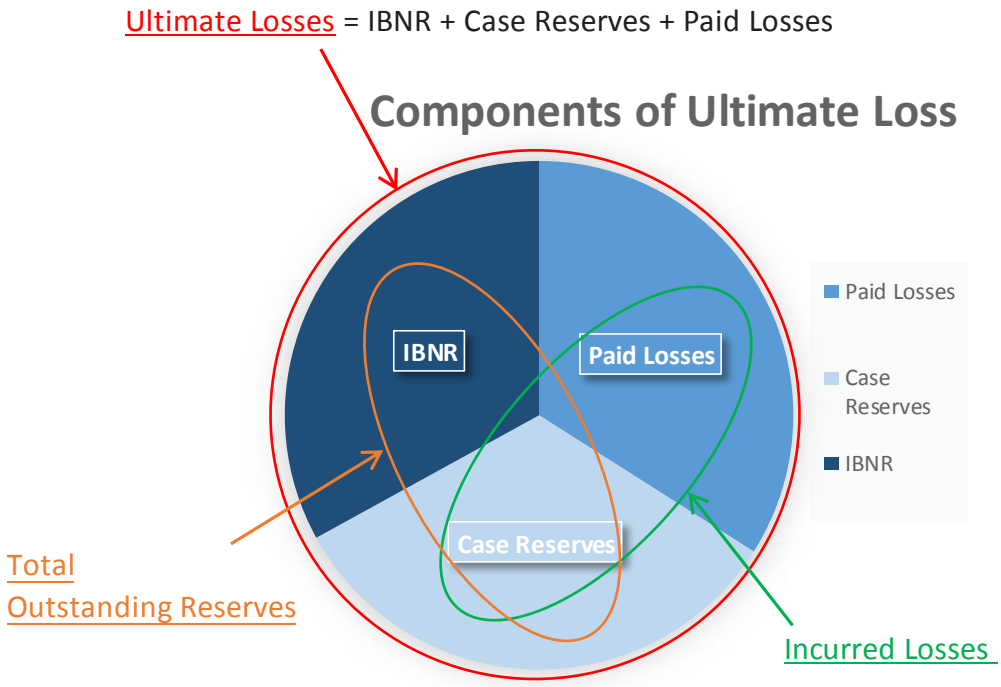
Loss is only part of a total claim cost. There is also a need for reserves for the expenses associated with adjusting losses. Expenses such as investigation, litigation, and administration are included in a separate item called "loss adjustment expenses" or LAE. These reserves can be broken down into **allocated loss adjustment expenses** (ALAE) and **unallocated loss adjustment expenses** (ULAE).

ALAE are expenses that are directly assigned to or arise from a particular claim (expenses go into the claim reserve). An example of ALAE includes court fees and outside council. ALAE cost varies by coverage. ALAE are generally low (approximately 5%) for workers' compensation and higher for general liability (approximately 20–40%). A key objective for all claims organizations is to effectively manage ALAE, minimizing ALAE payouts so the cost of disputing claims is not greater than the cost of accepting them.

ULAE are those expenses not specifically allocated or charged to a particular claim. This includes claim administrative salaries, overhead, rent, and other related adjustments. UALE generally range from 8–15%. These costs are included as underwriting expenses.

The total claims reserve (the one that goes on the balance sheet) holds reserves for known case reserves, IBNR, and ALAE.

Estimating Ultimate Losses and Outstanding Reserves



As mentioned previously, reserves represent the amount of loss an insurance company believes it will ultimately pay out for claims on policies it is currently writing and for policies it has written in previous years. Calculating these reserves is a difficult process, a task actuaries are charged with completing. The starting point for calculating outstanding reserves is to calculate the ultimate losses for the given risk being evaluated (a large account, a given state, a territory, class of business, etc.).

Known loss information is provided by a risk management information system (RMIS). The RMIS provides this information:

- the valuation date for all loss and claim information (01/01/2021);
- the paid losses;
- the incurred losses; and
- the claim counts.

The information we do not know are the IBNR reserves. Actuaries use a methodology known as **loss triangulation** to calculate IBNR reserves. The calculation requires determining the loss development factors (LDFs). LDFs, which are unique to each book of business, state, or line of business, are numerical representations of the IBNR reserves for a risk.

Actuaries use the loss triangulation tool to organize data in order to identify and analyze patterns in the past loss or claim data. Generally, it is preferable to have over five years loss or claim history for the triangles to be meaningful. These loss triangles capture the changes in the ultimate value resulting from natural loss development, or loss and claim growth over time after the initial reserves are established.

If a RMIS system is available, these triangles can be applied to paid losses, incurred losses, or any defined claim type to determine those specific development factors. If a RMIS system is not available, the development factor can be obtained from other sources, such as rating bureaus (e.g., ISO and NCCI), actuarial consultants, an insurance company's agents or brokers, and other related sources (e.g., financial reporting services, such as AM. Best).

The purpose of calculating loss development factors is so they may be applied to a current valuation of incurred losses to determine an estimate of ultimate losses. Again, LDFs are frequently calculated separately for incurred losses, paid losses (determining claim payout timing), and claim counts. They are calculated using period-to-period changes in values on the assumption that current losses will be paid in the same pattern as prior losses with similar time of development. Selected LDFs MUST match with the age of the losses, the risk type, and the deductible limit applied on the losses. Actuaries have tabular tables of thousands of development factors matching risk of all types and development ages. It is critical that they apply the correct factor for a given risk.

Consider these examples:

Loss and Claim Data Provided by RMIS

Loss and Claim Data Provided by RMIS			
Policy Year	**Incurred Losses**	**Claim Count**	**Paid Losses**
2016	665	230	500
2017	670	250	440
2018	625	270	355
2019	550	255	270
2020	460	235	140
Total	**2,970**	**3,755**	**1,705**

Loss Triangle

With the following provided incurred loss triangles, LDFs for our designated risk can be calculated.

Incurred Loss Triangle					
Policy Year	**Months of Development**				
	12	**24**	**36**	**48**	**60**
2016	400	500	575	633	665
2017	421	535	610	670	
2018	439	539	625		
2019	440	550			
2020	460				

Note: Months of development determined by valuation date.

Required Formulas:

- **Ultimate Losses = (Paid Losses + Case Reserves) + IBNR**
- **Ultimate Losses = (Incurred Losses) + IBNR**
- **Ultimate Losses = (Incurred Losses) x LDF**

Total Incurred Loss Development Factors					
Policy Year	Months of Development				
	12 to 24	24 to 36	36 to 48	48 to 60	60 to Ultimate
2016	1.250	1.150	1.101	1.051	xx
2017	1.271	1.140	1.098		xx
2018	1.228	1.160			xx
2019	1.250				xx
2020					xx
Ave PTP Factor	1.250	1.150	1.100	1.051	xx
LDF	1.740	1.392	1.210	1.100	1.047

** The tail factor of 1.047 is provided by an actuary or other sources to estimate all additional development beyond the available data (all losses expected to occur beyond 60 months). Tail factors differ due to variables such as industry average factors, change in third-party administrators (TPAs), or selected time periods.*

** Combining period-to-period factors to determine the development to ultimate factors*

*1.047 x 1.051 = **1.100** 1.100 x 1.110 = **1.210** 1.210 x 1.150 = **1.392** 1.392 x 1.250 = **1.740***

Outstanding Reserve Calculation:

Actuaries will use the loss triangle to first determine period-to period value, meaning the change in development from one valuation period to the next. All average period-to-period factors are determined and then multiplied together to determine the ultimate loss development factor for each valuation period. This is how the IBNR is determined numerically.

Applying the formulas for ultimate loss and outstanding reserves:

- **Ultimate Losses = (Incurred Losses) x LDF**
- **Total Loss Reserve = Ultimate Losses – Paid Losses**

Estimated Outstanding Reserves					
Policy Year	(A X B = C)				(C – D)
	A	B	C	D	E
	Incurred Losses	LDF	Ultimate Losses	Paid Losses	Total Loss Reserve
2016	665	1.047	696	500	196
2017	670	1.1	737	440	297
2018	625	1.21	756	355	401
2019	550	1.392	766	270	496
2020	460	1.74	800	140	660
Total	**2,970**	**xx**	**3,755**	**1,705**	**2,050**

Although this is example is extremely simplistic, it shows there are many challenges with determining outstanding reserve estimates. First, all components of ultimate loss (case reserves, paid losses, and IBNR) change over time with each new valuation period. As each valuation is re-evaluated, the ultimate loss estimate changes. Consequently, reserve estimates change as well. In other words: IBNR development *can* and *will* change—sometimes significantly—as all new information is obtained.

Second, the triangulation concept is predicated on "history repeating itself." It is not valid when significant changes have occurred within the insurance company case reserving philosophy. Additionally, if any mergers, acquisitions, spin-offs, and so forth have occurred during prior periods, data and results can be compromised.

Last, the triangulation process is both an art and a science. There are many qualitative assessments to the data crunching that produce varying reserve estimates. As such, each reserve estimate varies depending on the assigned actuary.

Factors That Determine Reserve Stability

There are many factors to consider when analyzing a company's loss reserves.

Individuality: The changing practices and philosophies of an individual claims adjuster have an overarching impact on the entire reserving process. Claim adjusters set case reserves, and, when combined with the actuarially determined IBNR reserve, represent what will ultimately be paid. If, for instance, claims adjusters are increasing all case reserves by ten percent, this must be taken into account when analyzing the adequacy of both the case reserve and the IBNR reserves. Since most actuarial techniques of analyzing loss reserves place emphasis on past case-incurred reporting patterns, any sudden change will distort the estimates made for IBNR reserves.

Lines of Business and Location: Other factors to consider include the lines of business and the states in which a company sells these policies. Changes within the regulatory and litigious environments in various states cause uncertainty and difficulty in analyzing loss reserve increases. Similarly, states have varying benefit levels with workers' compensation insurance. Just as those changes are factored into the pricing decisions, they must also be included in the reserving decisions, as higher benefits will result in higher future loss payments.

Consistency: At a case reserve level, there are also challenges in maintaining consistency with reserving practices. Outside of the normal and expected day-to-day changes that occur throughout the claims operation, there are more uncommon, yet troubling, reasons why case reserves can be inaccurate, including:

Claims Staff Turnover: There are inherent lost opportunities with all claims files when there is adjuster turnover, which can increase claim costs and lead to reserve adequacy issues. Consider that it usually takes 90 days to recruit and hire a new adjuster, and another 90 days before the recruit cycles through her/his assigned claims inventory. Turnover creates the potential for a long reserve lag on any given file at any given time.

Lack of Training and Experience: Employee education and training are investments, as they support a company's ability to retain quality talent. Investing in an adjuster's continuing education creates higher employee satisfaction, as it demonstrates a company's willingness to prioritize efforts to improve existing employee skills and strive to develop new ones. In addition, well-educated staff give a company a ready pool of candidates to promote when openings occur, again resulting in more employee loyalty.

Outdated Claims Systems: Many departments are working with older systems and methods that are no longer effective or efficient. Utilizing new technology allows real-time access to information, which helps adjusters sort and analyze files more effectively and efficiently. Automation, reserving programs, machine learning, claim analytics, and computer-based intelligence are now automating the reserve process and driving more consistency with the reserving process.

Excessively High Caseloads: Companies can be pushed to increase adjuster caseloads in an effort to reduce operating expenses. Higher caseloads result in oversights in critical areas of the adjustment process over the long term, as workloads are not manageable.

Stable reserves are achieved when the claims reserving process has stable tort/ economic/ legal/benefit conditions, uniform procedures, competent stable employees, low rates of inflation, and higher volumes of similar claims to analyze.

Impact of Reserves to Financials

Loss reserves are generally the largest liability on an insurer's balance sheet and are characterized by a great deal of uncertainty. All insurance companies hold different amounts of reserves for all of their insurance products, regardless of the amount of premium written. The difference and uncertainty lie in the characteristics of the lines of business, which include the litigious nature of the lines or the duration of settlements. For example, auto collision cases settle quickly, so within a few years, the liability is known with a high degree of confidence. For medical malpractice, worker

compensation, and other so-called "long-tail" coverages, losses may not be apparent for some time. The ultimate cost of claims may not be known for years, especially in complex cases that are litigated. It is not uncommon to have a case open for 20+ years, and unfortunately, the largest cases settle last.

These reserve differences are reflected in a type of analysis called "loss development," in which payout patterns for previous years are used to determine how much loss will ultimately be paid and the timing of these payments. Since approximately 70% of insurance company expenses come from claims, accuracy in estimating unpaid reserves is critical to a company's survival.

Policyholder Surplus

An insurance company's annual financial statement is a lengthy and detailed document that shows all aspects of its business. In statutory accounting, the initial section includes a balance sheet, an income statement, and a section known as the "capital and surplus account," which sets out the major components of policyholders' surplus and changes in the account during the year. As with GAAP accounting, the balance sheet presents a picture of a company's financial position at one moment in time, meaning its assets and its liabilities and the income statement provide a record of the company's operating results from the previous period. An insurance company's policyholders' surplus—meaning its assets minus its liabilities—serves as the company's financial cushion against catastrophic losses and as a way to fund expansion.

Policyholder surplus is essentially the amount of money remaining after an insurer's liabilities are subtracted from its assets. In other industries this surplus is known as "net worth" or "owners' equity." It is a measure of underwriting capacity because it reflects the financial resources, or capital, that stand behind every policy written by the insurer.

Policyholder surplus can also be used to pay claims if reserves prove to be insufficient. A weakened surplus can lead to ratings downgrades and ultimately, if the situation is serious enough, to insolvency.

Regulators require insurers to have sufficient surplus to support the policies they issue including all outstanding reserves. The greater the risks assumed, and hence the greater the potential for claims against the policy, the higher the amount of policyholders' surplus required.

Other problems that inadequate reserving can create include:

- Inadequate reserving may attract the attention of regulatory agencies, indicating that the carrier may not be in compliance with capital requirements. Capitalization requirements are used to discourage riskier investments. A capitalization requirement is the amount of liquidity a financial institution must have in its reserves to cover its business operating expenses. The amount usually is determined by taking a fixed percentage of the institution's risk-weighted assets. Insurance companies are required by regulators to maintain minimum capital levels to reduce the risk of insolvency and protect consumers.

- Key investigative and legal strategies that may mitigate exposure are not implemented in a timely fashion (or at all) because management was not aware of potentially large losses that could adversely impact a company's financial stability.
- Reinsurance recovery can be jeopardized if the reinsurer demonstrates it was prejudiced by the delay or failure of the carrier to report a loss that would have met the loss reporting threshold requirements outlined in the reinsurance contract had an accurate reserve been set.

Knowledge Check

Directions: Describe the impact that IBNR reserves have on company financials.

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Calculating with Ratios

Learning Objective:

1.9 Calculate and explain the importance of three types of profitability ratios.

The next checklist item is **profitability ratios**. Like any business, an insurance company must be able to analyze its performance and compare itself to other companies within the industry, and review its actual performance against its plan. Every business uses profitability ratios in that analysis process. The profitability ratios for insurance companies, however, are different from those used in other businesses.

To calculate probability ratios, look at the following equations.

The fundamental equation for the economic relationship of the price of any product is:

$$\text{Price} = \text{Cost} + \text{Profit}$$

Since the insurance industry is different in nature than other businesses, the fundamental equation is slightly different:

$$\text{Premium} = (\text{Losses} + \text{ALAE} + \text{UW Expenses}) + \text{UW Profit}$$

Recall that ALAE (allocated loss adjustment expenses) are those that directly assigned to or which arise from a particular claim. UW is an abbreviation for underwriting.

Core Profitability Ratios

A ratio is an easy assessment of the relationship between two or more numbers. The relationship can show a positive, flat, or negative result. While there are a number of ratios used to analyze insurance company profitability, there are three specific ratios that are utilized more frequently in the measuring process.

1. Loss Ratio

   The loss ratio measures the portion of each premium dollar that is used to pay losses. Historically, most insurance companies monitor and analyze loss ratios as a primary measure of rate adequacy. This can be done by risk, line of business, state, agency, or the company as a whole. Loss ratios include both incurred losses and the ALAE.

$$\text{Loss Ratio} = \frac{\text{Incurred losses} + \text{Loss Adjustment Expenses}}{\text{Earned Premium}}$$

   The higher a loss ratio, the lower the profitability of the book of business being analyzed. The loss ratio does not take underwriting expenses into consideration, only the ratio of losses to earned premium. Depending upon the line of business, even lower loss ratios may result in lack of profitability if the line of business has higher expenses.

   The loss ratio is the simplest measure of performance for an insurance company. It is usually calculated for a given period of time, be it a month, quarter, or year. A loss ratio generally does not include IBNR losses unless specifically noted.

   A loss ratio is generally shown on a calendar year (CY) basis. An annual CY loss ratio begins on January 1 and ends on December 31. The loss ratio may also be shown on an accident year (AY) basis. An accident year loss ratio uses the earned premium, incurred losses, and LAE for the year the policy was issued. The AY method accounts for losses which develop into the future to be assigned to the year in which the policy was issued.

   Generally, when a product development team is calculating rates for a specific line of business, it also develops a target loss ratio that the rates anticipate. The actual loss ratio is then compared to the target loss ratio as one of the key metrics when looking at the performance of a product.

2. Underwriting Expense Ratio

The underwriting (UW) expense ratio measures the portion of each premium dollar used to pay for a company's operating expenses. Loss adjustment expenses that can be directly allocated to a specific claim are not included in this calculation since they are already contemplated in the loss ratio.

The acquisition expense is the most commonly attributed expense in this equation. Acquisition costs or expenses include costs for marketing, advertising, underwriting department costs, and agent commissions. All other operating costs, including executive salaries and board honorariums, are included in the expense portion of this ratio.

The UW expense ratio can be calculated with either earned premium or written premium. Using earned premium is the most conservative method and yields a higher UW expense ratio. This is because earned premium is almost always smaller than written premium. The difference between earned and written premium is discussed later in this section.

In their financial projections, the executive management team has defined expected expense parameters. The UW expense ratio allows the team to make sure expenses are in line with projections. If not, the team may need to either make changes to the process or be prepared to explain the variance to the board.

$$\text{UW Expense Ratio} = \frac{\text{UW Expenses}}{\text{Earned Premium}}$$

3. Combined Ratio

The combined ratio is a primary measure of the profitability of a book of business. It includes functions of the loss ratio and UW expense ratio combined. Losses, LAE (loss adjustment expenses), and UW expenses are added together to make up the top portion of the ratio. The bottom of the ratio is usually the earned premium. Developing the ratio can be accomplished in one of two ways:

A) add the loss and LAE ratio and the UW expense ratio; or

B) use the formula shown below.

$$\text{Combined Ratio} = \frac{\text{Losses + LAE + UW Expenses}}{\text{Earned Premium}}$$

If the combined ratio equals 1, then the company is using 100% of its earned premium to pay for losses and expenses. If the ratio is greater than 1, the company is generating an underwriting loss. If the ratio is less than 1, the company is generating an underwriting profit. Any one of these ratios is not a complete indication that a company is or isn't profitable.

As we discussed earlier, in financial management, the insurance company makes investments. If investment income is good, the company can still be profitable. By the same token, if investment income is negative, it can eat into the underwriting profit and even produce a loss.

It's not uncommon to see companies write certain lines of business where the expected combined ratio equals or exceeds 1. This is more common in lines of business that have long-tail liabilities. While IBNR is included in the reserving and financial calculations, those reserves are invested and produce returns that can more than offset the losses because of the length of time before claims are ultimately to be paid out. In addition, some companies may count on investment income to outpace the combined ratio on short-term liabilities. This strategy is commonly referred to as "cash flow underwriting" and can be dangerous in times when investment income fluctuates substantially.

As a company begins to write business and execute its strategic plan, analyzing key ratios is part of the process of evaluating the plan's success. The calculations also allow an executive management team and board members to compare their company's performance to that of other companies in the industry with similar underwriting appetites and product offerings.

Knowledge Check

Directions: What are the three primary probability ratios?

1. _____

2. _____

3. _____

Communications

Learning Objective:

1.10 Distinguish between internal and external communication and explain the value of each to the strategic plan.

Corporate Marketing

One of the tasks an executive management team undertakes during strategy formulation is creating a marketing plan. This is another item on the checklist.

The team must decide how it will build the company's brand and the method or methods it will use to deliver the message about its products. The company needs to attract its distribution partners and customers. The executive management team will include a corporate marketing structure as part of its strategic business plan.

Corporate marketing can be managed internally or outsourced. Some companies have staff that are trained and experienced in delivering proper messaging to the outside world. Other companies may choose to use the services of third-party organizations that specialize in advertising and branding. It's also possible that a company will use a combination of both.

Recall that a company's values, vision, and mission statements are part of the development of culture within the organization. They are also important in the process of branding.

Branding is the building of an effective strategy that gives the company an edge in the market. It's the promise the company makes to its customers.

Corporate marketing gives the EMT choices regarding different means of advertising and the cost of each so it can make decisions on how to successfully promote the company within budget constraints. There are many choices: radio, television, internet ads, social media, and others. These are all necessary decisions, and it's up to corporate marketing to supply the research and data for those decisions.

Corporate marketing's responsibility also includes communicating with all of the company's stakeholders.

Communications

The twenty-first century has ushered in new and exciting methods and means of communication. One thing that's certain—effective communication is critical to the success of any company. While it's true that there have always been multi-generational challenges present in communications of any sort, new technology brings newer and different challenges. It's important to remember that communication is a dialogue—not a monologue. Listening is a very important part of the communication process. To have a successful organization, the EMT not only needs to get its message out, it needs to receive feedback regarding that message and then act upon that feedback. Communication can be internal or external.

Internal and External Communications

Communication can be internal or external. **Internal communication** occurs among members of the same organization. With internal communication, information must flow strategically to maintain the optimal level of engagement by all employees. This information must flow *up and down* the chain of command to the proper personnel to create efficiencies and engagement. By giving and receiving information, then acting upon it, employees are informed and motivated. Internal value is created by listening to the ideas and concerns of those working hard every day to accomplish even the most mundane tasks that are essential to the company. Employees are much more productive when they feel valued, informed, and heard.

Earlier in this section, we discussed values, vision, and mission statements and their relationships to culture. A company's internal communications are part and parcel to reinforcing those statements and driving the culture among employees who are then able to communicate them through **external communications**. Happy, effective, productive employees communicate positively inside the company and outside it, as well. Positive attitudes are then transferred to customers and stakeholders outside the organization.

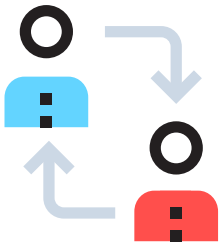
Handling Internal Communications

The larger the organization, the more delegated communications become. A large company may have a department dedicated to communications, both internal and external. Smaller companies may delegate that responsibility to their HR departments. It can also reside within the executive management team.

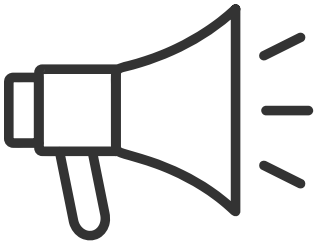
The EMT has one of the largest roles in internal communications—creating culture and brand. As a result, it plays an active part in communicating with the entire employee team. Since the executive management team needs to be heard from and seen on a regular basis, it needs to choose the method or methods of internal communications.

Using a company intranet is a great way to build two-way communication. Keeping in mind that listening can be more important that speaking, executives need to choose methods that allow and encourage employees to participate and voice their concerns and suggestions. In turn, executives must listen to those concerns and suggestions and then implement changes that make sense and that are in line with the company's values, vision, and mission.

Handling External Communications



External communications should flow naturally from internal communications. While external communications are the focus later in this section, it is enough now to say that great external communications are a direct result of internal communications. Happy, productive employees are key to communicating to outside customers and other stakeholders.



As the EMT develops the strategy needed to develop success, it must remember that people are its most powerful and effective tool. Visibility is carried out by a number of methodologies, but communications are the most effective. Keeping employees informed and listening to feedback and suggestions are a recipe for success for any company. If everyone knows the plan and understands what goes on in all areas of the company, productivity is increased, as is job satisfaction.

Knowledge Check

Directions: Explain the difference between internal and external communication.

How does communication impact strategic management?

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Compliance and Control

Learning Objective:

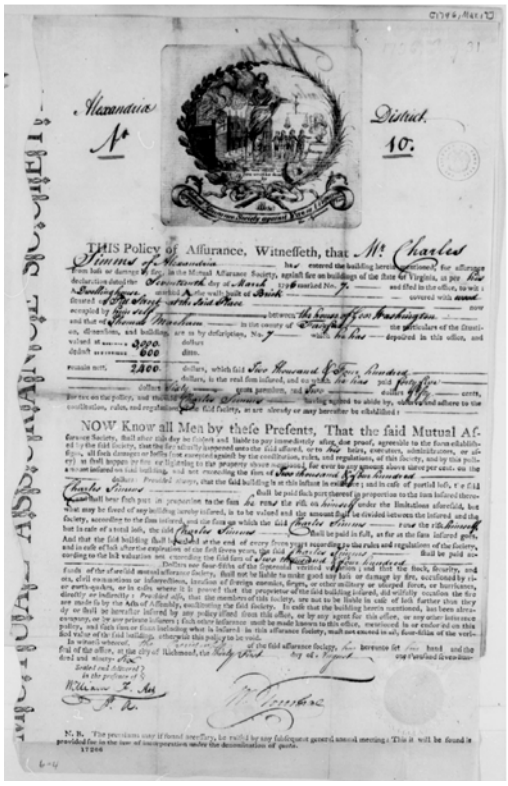
1.11 *Differentiate the audits necessary to support regulatory compliance.*

The next item on the checklist is monitoring **compliance and control**. The insurance industry is one of the most regulated industries in the nation because of its size and financial impact on society. In fact, insurance in the United States is the world's largest market by premium volume. Almost 30 percent of the gross written premiums worldwide are written in the US. Without insurance, much of the country's financial market would not exist. Just the property and casualty industry alone is extremely critical in the risk-bearing economy. Add life insurance, health insurance, and other financial products to that list and you can see the true impact of insurance. Based on that, it stands to reason that regulation is also extremely important.

The History of Insurance Regulation

In 1735, the first insurance company in the United States was formed in South Carolina for the purpose of writing fire insurance. In 1752, Benjamin Franklin helped form an insurance company called Philadelphia Contributionship, a mutual which is still in operation today. The first stock insurance company, Insurance Company of North America, was formed in 1792.

Massachusetts was the first state to enact law requiring insurance companies to maintain adequate reserves. Shortly after that, formal regulation began when New Hampshire appointed its first insurance commissioner. Prior to that, regulation was governed by corporate charter, statutory law, or common law. In 1859, New York State appointed its own insurance commissioner, creating a state insurance department designed to develop comprehensive insurance regulation at the state level.



THIS Policy of Assurance, Witnesseth, that

NOW Know all Men by these Presents, That the said Mutual Af-

From that time forward, the insurance industry was regulated by individual state governments. Each state operated independently to regulate the markets in their states. This was usually done through a state department of insurance or a division of insurance. Since 1869, challenges to the state-based system of regulation have risen from inside and outside the insurance industry. For example, the **McCarran-Ferguson Act** was enacted in 1945. This Act clarified that states should continue to regulate and tax insurance. It also affirmed that state regulation of insurance was in the best interest of the consumer.

In 2010, The Wall Street Reform and Consumer Protection Act of 2010 was enacted. This Act is more widely known at the **Dodd-Frank Act,** named after the sponsors of the legislation. While Dodd-Frank was primarily designed to create new banking and securities reform, it did create the Federal Insurance Office as an information-gathering source to inform Congress on insurance-related matters. The Act also included some reinsurance reform and changed the basis for regulation and taxation of surplus lines companies. Primary regulation of insurance has remained with the states since the enactment of McCarran-Ferguson.

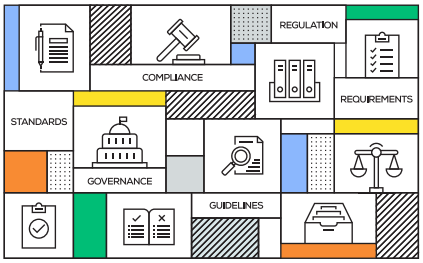
Purpose of Insurance Regulation

The primary reason for the regulation of insurance is consumer protection. Between the financial impact, complexity of insurance contracts, lack of sufficient information for consumers to adequately shop and compare, and the fact that insurance is generally a contract of adhesion, insurance is more heavily regulated. According to the NAIC, the public wants two things from regulators:

1. solvent insurers who are financially able to make good on the promises they have made; and
2. fair treatment of policyholders and claimants.

These two factors create two types of regulation: financial regulation and market regulation. While insurance regulators are elected in some states and appointed in others, they are accessible and accountable to the public. They are also sensitive to local social and economic conditions in their respective states. State insurance regulation is structured around several key functions, which include insurer licensing, agent licensing, product regulation, market conduct, financial regulation, and consumer services. Some of these functions will be discussed in other sections of this course. For the present, we will focus on financial regulation, market conduct, and insurer licensing.

Financial Regulation



Financial regulation is one of the most important protections for the country's insurance consumers. The largest insurance financial database is located at the NAIC and is maintained by state insurance regulators. The database contains all of the quarterly and annual financial filings for every insurance company doing business in the US for over 20 years. In addition to scrutiny by companies like R-Street, mentioned earlier in this section, state financial regulators are subject to peer review through an accreditation process. Each department is required to undergo a comprehensive review by an independent team every five years. This review ensures the department continues to meet certain standards for solvency oversight.

Risk-Based Capital

Risk-Based Capital (RBC) is a method that measures the minimum amount of capital for an insurance company to support its business operations. Size and risk profile are taking into consideration when reviewing RBC because it limits the amount of risk a company can take. The higher the risk, the higher the amount of capital that must be held. RBC is intended to be a minimum regulatory capital standard and is not necessarily the full amount of capital the company should hold to meet its safety and competitive objectives. It is just one of several tools that gives regulators legal authority to take action regarding potential solvency issues.

Risk factors for RBC formulas focus on Asset Risk, Underwriting Risk, and Other Risk. Under the RBC system, regulators have the authority and statutory mandate to take preventive and corrective actions. These actions vary depending on the capital deficiency indicated by

the results of the RBC calculation. The actions are designed to provide for early intervention by the regulator to correct problems before insolvency becomes inevitable.

There are four levels of action that a company can trigger under the formula:

Company action – the insurance company puts a plan in place to correct its RBC prior to regulatory intervention (may include adding capital, reinsurance, merger/acquisition);

Regulatory action – the company action is not effective, and the regulator now works with the company to produce a plan. This may include a Financial Solvency Exam;

Authorized control – the regulator takes control of the company and mandates corrective actions to be taken to preserve the company if possible;

Mandatory control – the company goes into receivership and is liquidated.

Financial Solvency Examination

Each state conducts financial reviews of all companies domiciled in that state. In addition to the annual Yellow Book reports that are filed by those companies, the state regulator does a triannual (every three years) financial exam. The purpose of the financial solvency exam is to ensure that a company's financial position is sound and accurate. The regulator can also decide to do additional financial solvency exams if she/he suspects the company is having financial difficulties.

Market Regulation

Market regulation is designed to ensure that consumers are charged fair and reasonable premiums, have access to products that are beneficial and compliant, and that companies operate in ways that are legal and fair to their customers. The NAIC began the Market Conduct Annual Statement (MCAS) as a method of collecting data related to market conduct. State regulators report information via the MCAS system. In turn, it provides regulators with information not normally available for market analysis. Most states report data to the NAIC, which compiles the data.

Market Regulation Examination

Market conduct examinations occur on a regular basis. Sometimes, however, a market conduct examination is triggered by complaints against an insurer. Market conduct examinations can be performed by each state in which a company writes business. The purpose of the examination is to ensure that a company is following its rules, rates, and forms that are filed, as well as any statutory market requirements of that state. Market conduct exams review producer licensing issues, complaints, types of products sold by insurers, compliance with filed rating plans, claims handling, and other market-related aspects of a company's operations. Violations can lead to improvement recommendations, civil penalties, or suspension or revocation of licenses.

Both financial solvency examinations and market conduct examinations take months to complete. Audit teams from the state department of insurance come into the company's office and review files as part of their audit process. The company must supply the auditors

a secure room where they can do their work. As documents or access to files are requested, the company must grant that access. The gathering of the requested documents can be quite time-consuming for a company. In multi-state insurance companies, it is not uncommon for multiple regulators to be conducting examinations concurrently. The insurance company pays the costs associated with these examinations.

Insurer Licensing

There are approximately 6,000 insurance companies in the US (including territories). Over 2,500 are property and casualty insurers. Before selling products or services, state laws require insurance companies and insurance-related businesses to be licensed. Failing to comply with regulatory requirements can subject a company to fines, as well as suspensions or revocation of a company's license. In addition to the NAIC's Uniform Certificate of Authority Application, a database has been developed to facilitate the sharing of information regarding merger and acquisition filings.

Admitted Insurance Company

When an insurance company is licensed by a state and obtains a Uniform Certificate of Authority, it is known as an "authorized insurer" or an "admitted insurer." Some people refer to these companies as standard market companies. Qualification as an admitted insurer requires a company to file an application. The company must meet specific capitalization requirements, which can vary by state. This process can be lengthy in some states. Admitted insurers must then file rules, rates, and forms in compliance with the insurance regulations where they do business. Customers of admitted companies are usually financially protected from insolvency by a guaranty fund or association. Guaranty funds or associations, however, have limitations as to the maximum claim per policy that is payable.

Non-admitted Insurance Company

A company may wish to avoid some of the more stringent regulatory requirements of admitted companies by choosing to do business as a "non-admitted company." These companies are also referred to as excess and surplus lines companies. In most states, before a non-admitted company can do business, it must first be approved by the Department of Insurance. Surplus lines companies are much nimbler than admitted companies. Rules, rates, and forms are not required to be filed, allowing companies to make changes as needed without regulatory approval. In addition, surplus lines companies are not protected by a guaranty fund or association. As a result, consumers have no protection in the event of insolvency.

Other Reviews

In addition to regulatory compliance, there are a number of other reviews that will need to be completed.

Actuarial Review

Actuarial reviews must be done on an annual basis and are used to certify the company's case and IBNR reserves as part of regulatory reporting. In addition, a company can monitor its case and IBNR reserves monthly, quarterly, or semi-annually, as it chooses. The certification of the annual review can be done by a company actuary or an outside actuary.

Reinsurance Audit

When a company relies on reinsurance, it will need to provide specific reporting which may include the reinsurer auditing certain functions of the company. Reporting will include the number of policies, along with the written premium and limits profiles of those policies.

Auditing can include areas such as claims handling procedures and underwriting practices. This allows the reinsurer to verify that information submitted during the reinsurance negotiation process is accurate.

Internal Audits

All companies have rules and procedures that must be followed. Insurance companies have no shortage when it comes to operating guidelines or best practices. These guidelines establish how an insurance company wants to perform the various functions within the organization. As you learned above, some guidelines reflect requirements set by regulatory authorities. Other guidelines are designed to standardize employee practices for handling insurance transactions.

Even though some procedures are not related to statutory or other formal regulations, failure to follow those procedures or guidelines can be used to establish a basis for bad faith lawsuits. Internal audits are designed to monitor compliance with internal procedures and practices. They also serve to provide feedback to the executive management team and the board of directors regarding areas that are both in and out of compliance. The internal audit uses established processes that measure adherence to the standards set.

Compliance and Control

Internal auditing can be divided into two segments: compliance; and control. Both types of audits use the same general tools. File reviews and work procedure reviews are included in the internal auditing process.

Internal Compliance Audits

Compliance audits check to see whether an insurance company is meeting the regulatory requirements that exist in the territories where the company does business. These audits mirror the examinations that are conducted by regulators. If internal compliance audits are performed properly, there should be no surprises when regulatory examinations take place.

Internal Control Audits

Control audits ensure that a company is following its own defined procedures. Lack of adherence to internal procedures may also result in regulatory penalties. Even if procedures and processes have no impact on insurance regulation, there could be other issues with other regulatory bodies, such as the Internal Revenue Service. Internal control audits are completed at every level of a company.

Internal audits are performed by an independent body. The findings of the audits may be reported to the CEO but are more frequently reported to the audit committee of the board of directors. The results of the audits show how an insurance company is functioning relative to regulatory and internally established requirements. These audits may be completed by internal staff dedicated to internal auditing. Because the internal auditing team generally reports to the board, they act independently with regard to their work. The audits may also be completed by an outside audit firm hired by the insurance company. Financials have to be certified, so an outside accounting audit firm will perform the financial audit.

Knowledge Check

Directions: Use different types of audits to explain the importance of regulatory compliance.

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Technology Management

Learning Objective:

1.12 *Describe the various technologies necessary in an insurance company, including general ledger, billing, business intelligence, communication, and security.*

The Importance of Technology Infrastructure

While decisions regarding technology infrastructure are near the bottom of the checklist, their importance places them at the forefront of the strategic planning process. Just as it's true in many other parts of our lives, technology has taken on an increasingly important role in insurance.

Advancements in technology enable better communication, greater transactional efficiency, and lower cost. We have come to expect features, such as 24-hour availability, customer self-service, instant fulfillment, and other online conveniences. This has changed the way we shop, pay bills, watch movies, hail a ride, schedule travel, rent a house, reserve a restaurant table, and perform many other routine activities. Technology in insurance has advanced in a similar way.

For a carrier, technology provides the digital environment within which the business of insurance is transacted. The technical nature of insurance, such as the features of various coverages, the precision needed in pricing, the collection of data that is required, and the strict regulatory requirements that apply, invites the use of technology. Technology is adept at defining processes, ensuring transactional consistency, and applying internal and external controls.

The Formulation of Technology Strategy

A carrier's technology strategy can be thought of as a combination of two elements—base and strategic.

Base Technology

Base technology refers to technology that is necessary as a requirement of conducting business. These capabilities are needed regardless of the insurer's products, distribution, or business strategy. Some examples of this level of technology include:

Some examples of this level of technology include:

- technology that supports the working environment, including some collection of network capability, email, shared drives, internet, computers, phones, and other basic hardware and software
- a website that represents the public face of the company
- human resource systems, including payroll systems, benefits systems, and recruiting systems
- a policy transaction system that collects necessary information, manages coverage, calculates premiums, and processes policies, endorsements, and renewals
- a billing system to create and deliver bills, collect payments, reconcile with amounts due, and manage cancellations
- technology that supports actuarial, accounting, and finance functions, providing premiums, losses, producer commissions, overhead expenses, taxes, licenses and fees, compiling financial statements, and reporting in various forms to regulators and other stakeholders
- claims technology to receive claims, evaluate them, document investigation and settlement activities, set reserves, and make payments
- a data warehousing environment that stores data and makes it available to various functions of the company

Strategic Technology

The second element of a carrier's technology strategy can be considered strategic technology. **Strategic technology** refers to technology that is unique, dependent upon, and intended to enable an insurance carrier's chosen operating model. The type of insurance, the products sold, the distribution methods used, and other factors influence the type of strategic technology that is needed. One way to identify required technology is by considering the steps in the value chain.

Example: Consider two different companies that operate in different markets. Company 1 sells personal automobile policies directly to consumers and through retail agents. Company 2 sells large property coverage to commercial customers, through insurance agents and brokers.

Company 1 might consider the following technology:

- an easy-to-use user interface that can be used by both retail producers and consumers, or two separate interfaces to collect application information
- a rating system that provides real time rating and responds immediately to users while they are online
- connections to external service providers, such as credit bureaus and state Departments of Motor Vehicles
- direct billing to customers, which might include options such as electronic funds transfer (ETF) and credit cards
- electronic policy delivery upon purchase
- online policyholder self-service
- online claims reporting

Company 2 has different technology needs:

- a submission process which collects the necessary information about property exposures to be insured
- rating flexibility for underwriters to use, based on the individual attributes of each risk and consistent with internal guidelines and legal boundaries
- electronic connections to models that provide estimates of building values and catastrophic risk
- a digital environment where underwriting decision making can be documented
- the capability to provide a formal, legally approved quote letter for business that meets underwriting guidelines
- the ability to provide, upon purchase, a binder to confirm coverage, along with a policy to follow, usually within 30 days
- a billing interface with the producer
- a system that manages loss control inspections
- a system that supports the unique reinsurance needs of large property business

As you can see, while Company 1 and Company 2 might both require some of the same basic technology, their different business strategies and markets create the need for additional technology that is unique to each company's approach.

Additional considerations with regard to formulating technology strategy include:

- The overall cost of technology
- The strategic value of the technology relative to the cost
- The useful life of the technology
- Maintenance costs
- Whether the needed technology is available on the market or whether it is so specialized that it needs to be built internally ("buy versus build")

Effect of Regulation

In February 2017, in response to the growing threat of cyber breaches and in recognition of the large amounts of sensitive and personal information financial companies handle, the New York Department of Financial Services released the **DFS 23 Cybersecurity Regulation.** As a result, the NAIC developed model legislation. Since then, other states have also adopted various forms of cyber security regulation.

DFS 23 imposes a number of requirements on financial services companies, including insurance companies. Requirements of DFS 23 require insurers to:

- establish and maintain a formal cybersecurity program
- create and maintain a formal program of cyber risk assessment
- take defensive action to protect a company's systems and non-public data
- monitor, detect, and respond to cybersecurity events
- designate a Chief Information Security Officer
- perform vulnerability testing of a carrier's systems
- limit user access to non-public information
- institute multi-factor authentication
- encrypt non-public information
- conduct regular cybersecurity awareness training
- create and maintain an incident response plan, which includes reporting cybersecurity events to regulators

The Implementation of Technology Strategy

Once a company has determined the technology infrastructure needed to support its strategy, a technology road-map budget, and schedule can be determined.

One of the first steps in implementing a technology strategy is to determine which parts of the technology must be built and which can be purchased in the market. Technology that can purchased in the market usually has the advantages of being more proven, less risky, and less expensive. The disadvantage is that this technology can be purchased by any carrier and therefore usually does not provide a lasting competitive advantage.

Some capabilities may be needed that are not available to be purchased in the market, or which are so integral to a carrier's strategy that they must be built independently. These technologies are proprietary to the carrier and may represent their "secret sauce."

Historically, carriers used a "waterfall" approach to building technology. The **waterfall approach** is characterized by a large upfront investment, a period of building systems, and eventually—sometimes years later—a large technology release that unveils the finished product. This approach has weaknesses however, including:

- Large projects often run behind schedule and over budget; project managers and teams are reluctant to sound alarms, thinking they can make up time within the remaining schedule left. As a result, management may not have visibility into a struggling project until it's too late to salvage it or change direction.
- Building large pieces of technology over long periods of time often entails making choices along the way. These choices depend on user feedback. But without periodic touchpoints, the feedback loop with users may be weak or missing, resulting in incorrect assumptions and flawed outcomes.
- When a project fails using this approach, carriers have often invested vast amounts of money and have little or no value to show for it.

Because of these disadvantages, many companies have moved away from the waterfall approach to an "agile" approach. The **agile approach** replaces the large upfront investment and the long delivery timelines with a more iterative approach. In this method, the project is divided into smaller portions and work is done over short time frames called "sprints." These sprints are usually less than a month; often they are one- or two-week periods. By delivering small components of value every few weeks

and recalibrating with the users regularly, the risk and pitfalls of the waterfall approach can be reduced significantly.

Technology Considerations

Within each function, the technology needed is determined through a combination of business expertise, technology support, and budgetary considerations.

Some examples of functional technology which must be built include:

Application intake: Every company needs a way to receive applications from prospective customers and enter information into its systems.

Rating and quoting: This involves translating the company's filings and intended rules into a rating algorithm that can be applied to obtain the premium for each individual account.

Forms library: This is a repository of the policy forms representing a carrier's products and is available to customers, along with rules under which they may be applied.

Policy system: This system produces a policy using an insured's information, intended coverage features, specific exposures covered, effective and expiration dates, and pricing.

Billing system: Once a policy is purchased, the premium due must be allocated over installments, if any, and any additional installment fees, taxes, or surcharges must be collected.

Data warehouse: A data warehouse is a repository which stores all of the relevant data for the business written and makes it available as needed to various functions of the company.

Accounting and finance: The primary technology needed for accounting and finance functions is the general ledger.

Actuarial: The actuarial function requires data needed both to price business and to set aside claims reserves for business that has already been written. Both of these objectives involve using past data to predict the future.

Claims: Systems are needed to collect notice of claims, to set reserves and make payments, and to track claims history.

Business Intelligence: A system is needed to provide management with visibility into business performance. It allows management to evaluate questions like:

- Which producers are submitting the most business?
- Where are the products most competitive?
- How is business distributed by state and by line of business?
- Are growth and profitability goals being met?
- Where are the areas of greatest success and where is improvement needed?
- How do actual results compare to KPIs (key performance indicators)?

Other systems that may be needed include systems to schedule, track, and follow up on loss control activities; reinsurance systems to track the premiums and losses subject to reinsurance; and statistical reporting systems which report policy and claim information to statistical agents or regulators.

The Evaluation of Technology Strategy

As with any technology platform, the technology used by insurers must be maintained and must develop in ways that support each company's own growth and evolution. Over time, as a company expands products, improves experience, and manages growth and profitability, its technology systems adapt to changing needs. In addition, as new technology appears, carriers are continually assessing new opportunities to use technology to improve the business.

While this view varies from company to company, technology can be thought of at three levels:

1. **Production support:** This is technology that is fundamental to keeping systems up and running. It includes software support, licenses for a carrier's main systems, bug fixes, and system performance improvement. This area of technology is sometimes referred to as "keeping the lights on."

2. **Maintenance:** This category refers to changes to the systems that are needed during the ordinary course of business, to make minor changes in rates or products, or to keep up with other, routine changes. These changes usually do not require a high level of oversight and tend to be relatively quick, low risk, inexpensive, "no regrets" types of changes. Legal decisions, policy wording updates, new types of exposures, changes in underwriting appetite, and customer-facing improvements create necessary changes in carriers' systems.

3. **Development/investment:** These projects tend to be large and evaluated for cost versus benefit, individually and at a senior level, including potential CEO or Board of Directors' approval. This might include entering a new line of business, entering new states, deploying a new claims system, or creating a new service model.

The assessment of technology is tied directly to the management of a business. Technology is maintained, improved, and replaced based on considerations such as these:

- Does the technology maximize the efficiency of business processes (underwriting, claims, service, or other)?
- Does the technology allow management to monitor the book of business and make changes as needed to ensure continued success in the market and to optimize profitability?
- Does the technology perform at a level needed to be successful in the market (capabilities, response time)?
- Does the technology meet the company's business strategy with regard to products, territory, and scale?

InsureTech

The emergence of insuretech has created significant changes in how carriers monitor, evaluate, and adjust their approaches to technology. **Insuretech** refers to a wide variety of emerging technology and its application in insurance. The lines between traditional technology and insuretech can be blurred, but generally insuretech is characterized by one or more of the following:

- start-up companies
- newly developed technologies, tailored to some part of the value chain
- vendors of data or models that claim to provide more precise pricing, classification, claims fraud detection, or other improvements over traditional approaches
- online platforms offering digital fulfillment for insurance products
- platforms serving emerging digital markets, such as the sharing economy

The insuretech market has accelerated innovation within the technology used in insurance and offers significant potential to continue to change and improve the insurance experience for carriers, producers, and clients.

As you can see, technology is an extremely important part of an insurance company's operations. It's also one of the most expensive infrastructure investments a company will make. The complexity and expense increase substantially depending upon the IT strategy the executive management team pursues.

"Off-the-shelf" systems leased from vendors offer limited customization but are less costly with little up-front investment. Purchasing a vendor's system with customization rights is the next option. It's slightly more costly because of the purchase price and the need for IT personnel, but it gives the company much more flexibility. Finally, building a proprietary system gives a company full control over the functionality of the system, but it is time-consuming to develop and the costliest method, involving a full team of software developers.

Knowledge Check

Directions: What is strategic technology?

_____

_____

_____

_____

Summary

This first two topics of this section are on the executive management team's role in the creation and execution of the company's strategic plan. In addition, it covers the "In and Out" process, SWOT and ERM analyses, and other tools used to assess and formulate an effective and clear strategic plan. All of the executive management team's decisions will limit or allow subsequent choices for ALL of the other aspects of running the organization.

For example, the options available to the people working on product development will be defined by the executive management team, including decisions regarding issues such as types and lines of business, location, and even company culture. In many ways, the products define the company in the marketplace. However, the company structure, resources, appetite for risk, capital, financial standing, regulatory compliance, technology, and communication (both internal and external) affect the product and its delivery. But this is the purpose of a concise strategic plan. It must consider all the overlapping variables that can impact an insurance company.

Section 1: Self-Quiz

Strategic Planning

1. Strategy is a thoughtful deliberate plan of action. Select the word that best describes this process.
   - ☐ What
   - ☐ When
   - ☐ Where
   - ☐ How

Strategic Management

Directions: Circle True or False as it relates to the statement.

Marketplace evaluation includes the following:

1. Determining where gaps exist in the marketplace.

   True **False**

2. Evaluating the current stock market position.

   True **False**

3. Determining where customers are who need to be served.

   True **False**

4. Determining how needs can best be served.

   True **False**

5. Determining geographic areas with the largest populations.

   True **False**

6. Name the three management steps in the strategic management process.

   a. _____

   b. _____

   c. _____

Organizational Structure

1. Match the listed profit objectives listed below om the left with the insurance company organizational structure on the right that most closely fits the profit objective:

Profit Objective	Company Structure
A. Duty to stockholder	_____ Reciprocal
B. Duty to policyholder	_____ Stock
C. Duty to subscriber	_____ Mutual

2. Of the stock, mutual, and reciprocal structures, which most closely matches each characteristic?

Mutual	Reciprocal	Stock

The easiest access to additional funds _____

Has the history of long term-operations _____

Is most capable of merging or acquiring another carrier _____

Has the highest pressure on day-to-day operations to add top-line growth _____

Is the easiest to capitalize _____

Has an objective to operate as close to its cost as possible _____

3. Name three primary obligations of every member of a company board of directors.

   a. _____

   b. _____

   c. _____

Culture

1. Name two common approaches to the construction of a company's culture.

   a. _____

   b. _____

2. Match the correct statement type to its listed definition.

Statement	Definition
A. Mission	_____ What we want to be when we grow up.
B. Vision	_____ Core purpose and goals, in the here and now
C. Values	_____ Commonly held core, the "who"

Risk Tolerance, Risk Appetite

Directions: Circle True or False.

1. A company with a high risk tolerance is known as being risk averse.

   True **False**

2. Risk appetite varies little by line of business or geographic territory.

   True **False**

3. A company's risk tolerance needs to be broad enough to succeed in target markets.

   True **False**

4. Risk appetite is the most risk a company will accept while still striving to reach strategic and tactical plans.

   True **False**

5. Use of management controls has no effect on risk appetite integrity.

   True **False**

6. Name two ways a company can create spread of risk.

   a. _____

   b. _____

7. Risk appetite determines several key company decisions on location and lines of business. List five of those decisions.

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

Other Operational Considerations

1. Carriers need to decide if they will operate in a centralized or decentralized structure. Each approach has pros and cons. Select the structure that applies to the following consequences:

	Centralized	Decentralized
High risk of bureaucracy		
Procedural differences		
Audit/compliance issues		
Slow response to problems		
Local focus only		
Higher risk actions won't meet goals		

2. Name three environments that a carrier needs to address in its strategic thinking.

   a. _____

   b. _____

   c. _____

3. A carrier needs to assess available resources when deciding on a location in which to operate. For each resource listed below, indicate with a Yes or No if it is a resource necessary to operate.

Directions: Circle Yes or No.

Available personnel

Yes **No**

Nearby restaurants

Yes **No**

Available physical facilities

Yes **No**

Public transportation

Yes **No**

Temperate climate

Yes **No**

Technological infrastructure

Yes **No**

Financial Management

1. Name the two financial items that any basic accounting structure tracks.

   a. _____

   b. _____

Directions: Circle True or False.

2. GAAP accounting is required by the National Association of Insurance Commissioners.

True **False**

3. GAAP accounting is required for reports of publicly traded companies.

True **False**

4. STAT accounting is a system unique to insurance accounting.

True **False**

5. GAAP accounting allows investors and shareholders to make realistic financial decisions.

True **False**

6. STAT accounting allows for liberal financial reports.

True **False**

7. STAT accounting focuses on consumer protection.

True **False**

8. GAAP accounting is on an "ongoing operation" basis.

True **False**

9. STAT accounting was developed based on three pillars. Name them.

a. _____

b. _____

c. _____

Actuarial Services

1. Name the two key responsibilities of an actuary in an insurance company.

   a. _____

   b. _____

Directions: Select True or False.

2. Under-reserving can make a company's results look worse.

   True **False**

3. Reserves are funds set aside to pay future benefits for obligations.

   True **False**

4. Case reserves are estimates of what a claim will cost based on information available at the time the reserve is set.

   True **False**

5. ALAE (allocated loss adjustment expenses) are not included in case reserves.

   True **False**

6. Which is most accurate when describing "ultimate loss":

   - ☐ Represents the amount the company believes it will ultimately pay for a loss
   - ☐ Represents the largest loss over the past year for a company
   - ☐ Represents an easy actuarial calculation using current case reserves
   - ☐ Represents an estimated ultimate loss which is the same for all lines of business

Directions: Circle True or False related to the following statement.

Loss triangles are used to:

7. Compute prior claims value changes period-to-period

   True **False**

8. Calculate anticipated future changes in claims value

True **False**

9. Examine a claim for only one year

True **False**

10. Examine only future activities without regard to historic data

True **False**

Directions: Circle True or False.

11. Reserves are usually the largest liabilities on a company balance sheet.

True **False**

12. Reserves differ for different products.

True **False**

13. Reserves for property losses usually last longer until closed.

True **False**

14. Reserves for workers' compensation losses are referred to as "long-tail" claims.

True **False**

15. Reserves have no impact on rates charged for future policies.

True **False**

16. High reserve amounts mean a company needs less surplus to operate.

True **False**

Calculating with Ratios

1. Profitability ratios are based on comparing money going out to money coming in. Below, match the income or expense item on the left to the correct definition on the right.

Income or expense	Definition
_____ Written premium	**A.** Premium collected but not allowed on the books
_____ Earned premium	**B.** Adjusting expenses assigned to a particular claim
_____ ALAE	**C.** Expense considered claim department operation expense
_____ UW expense	**D.** Total of all premium on all in-force policies
_____ ULAE	**E.** General operational expenses of the company
_____ Unearned premium	**F.** Premium collected and on books to meet obligations

Directions: Circle True or False

2. Ratios greater than 1.0: 1.0 indicate a profitable result.

True **False**

3. One number used in a profit ratio is always an "expense" number.

True **False**

4. Profit ratios can be based on either written or earned premium.

True **False**

Communications

Directions: Circle True or False

1. Communication is a monologue, not a dialogue.

True **False**

2. Listening is a very important part of the communication process.

True **False**

3. The EMT needs to receive feedback on a message it presents to others.

True **False**

4. Communication by an insurance company is external only.

True **False**

5. Internal communication plays an active part in communicating culture and brand to all employees.

True **False**

Compliance and Control

1. There are two primary purposes for insurance regulation. Name them.

   a. _____

   b. _____

2. Insurance company audits can be conducted by the insurance company or by an external organization. Internal audits are more likely to measure if the carrier is performing within the prescribed limits. Audits conducted by external organization tend to focus more on the financial status of the carrier. Below is a list of topics commonly subject to audit. Indicate if the topic is subject to a financial audit or a performance audit.

TOPIC	FINANCIAL	PERFORMANCE
Surplus		
Market conduct		
Licensing		
Reserves		
Accounting reports		
Reinsurance		
Internal compliance/ control		

Technology Management

1. In recent years technology has become a more important facet of insurance company operations. Technology advancements have become the expected by the public and have become a "ticket to play" for insurance carriers. Computer assistance can be recognized as serving one of two purposes—either base services or strategic services. Listed below on the left are several services carriers look to technology to handle. For each service, indicate if this is a base or strategic service.

SERVICE	BASE	STRATEGIC
Working environment		
User interface		
Website		
Real time rating		
Payroll/HR		
Third-party services interface		
Policy processing		
Direct Billing/EFT		
Accounting/finance		
Claims		
ePolicy delivery		
Policyholder self service		
Billing		
Building value estimates		
Online Underwriting		
Loss Control Services		
Data Warehouse		

2. Technology systems are those performing in three major areas for insurance carriers. Name these three areas.

   a. _____

   b. _____

   c. _____

3. Implementation of automation systems fall into two techniques. Name these two techniques.

   a. _____

   b. _____

Section 2: Product Development

Section Goal

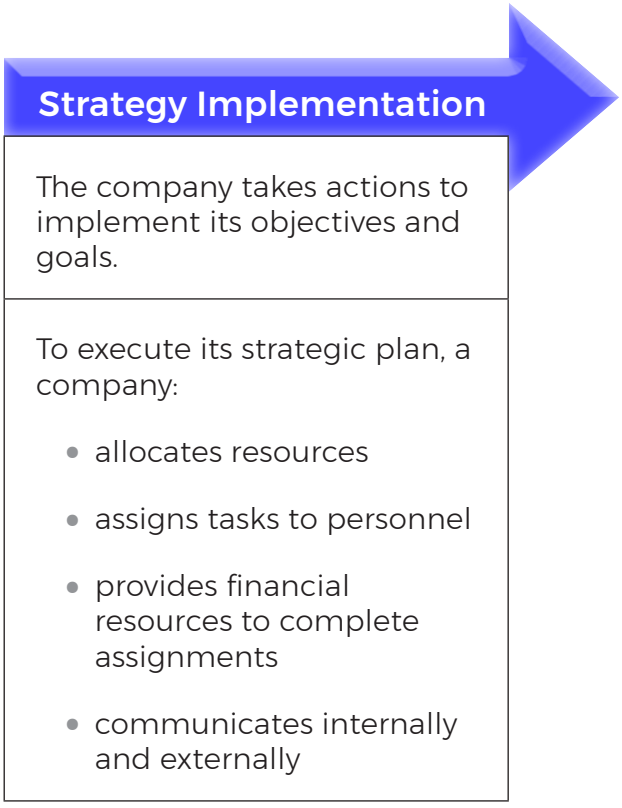
In this section, you will come to understand the product development process that occurs within an insurance company.

Learning Objectives:

2.1 *Identify the information the product development department uses to establish their tactical plan.*

2.2 *Apply the five-step process used in the product development process to design and implement a product.*

2.3 *Evaluate the effectiveness of a product development team's use of the actuarial process to determine the price and performance of a product.*

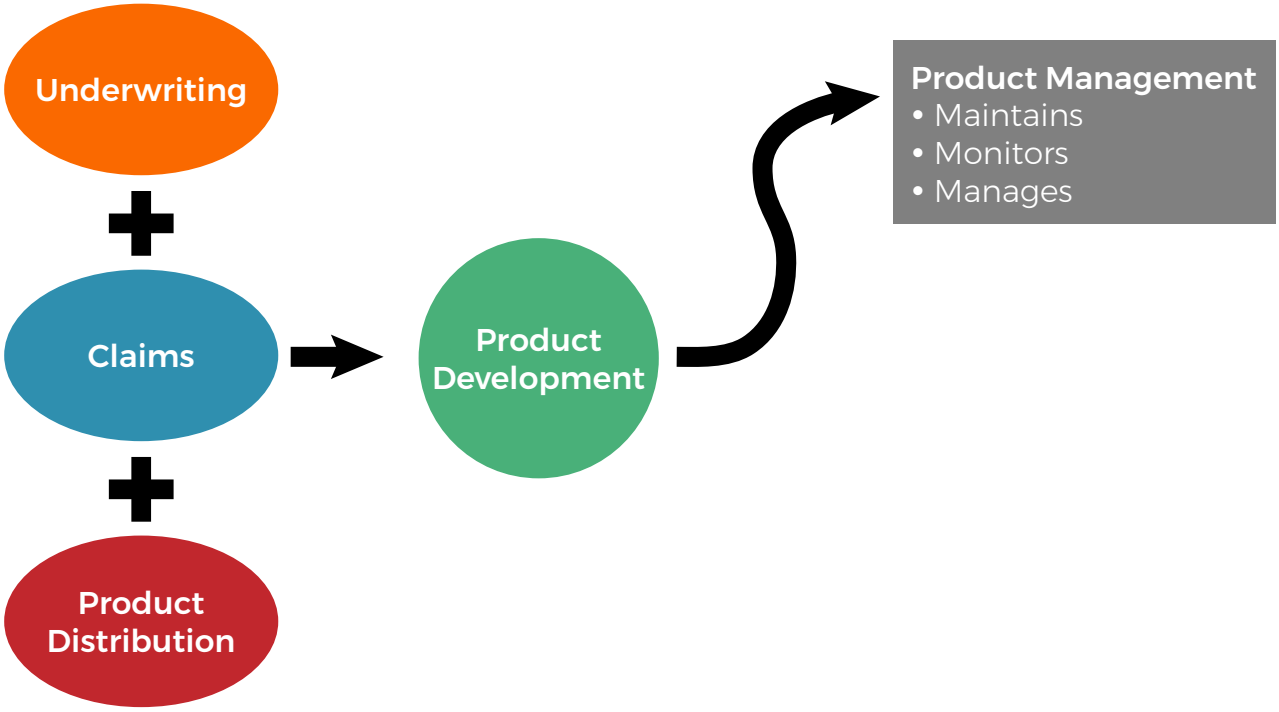


Once the executive management team has completed step 1 in the strategic planning process—strategy formulation, it is ready for step 2—strategy implementation. Now is the time for the implementation of the tactical plan within each department.

The tactical execution will involve carrying out all the specific actions or initiatives, defined with clear purpose, timeline, and KPIs (key performance indicators).

Members of the product development department work closely with colleagues in other departments within the company to design and implement products for the marketplace. They also work collaboratively to measure product performance.

Product development tasks and product management tasks are closely related. In the diagram below, we use three departments to create a simple explanation for the relationship between **product development** and **product management.**



In the diagram, the product development department works with the underwriting, claims, and product distribution departments to create a product. Once the product is in the marketplace, the product management team then monitors its performance and pricing to ensure profitability. Product development can be an independent, stand-alone department, or it may exist within other departments in the company, such as the underwriting department. In many insurance companies product management team members may be part of the company's underwriting division, and a chief underwriting officer will normally hold a position among a company's chief executives.

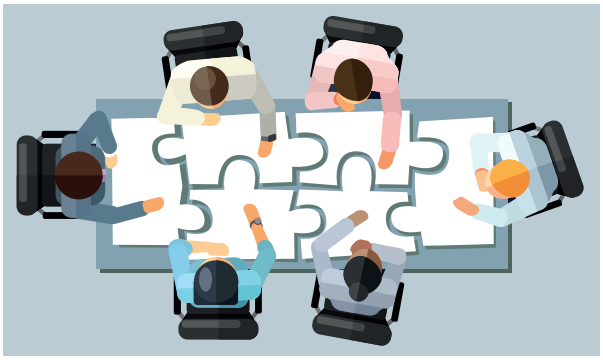
This section begins by discussing how the product development department tactically executes—or implements—the direction provided by the strategic plan. Our discussion will continue with the steps of the product development process, which will include the five-step process used to develop, monitor, and modify products. Finally, we will finish by looking at how the activities of the product development team build on the actuarial process to determine rates.

Developing a Tactical Plan

Learning Objective:

2.1 Identify the information the product development department uses to establish their tactical plan.

Developing a Tactical Plan



The overall strategic plan influences the development of tactical plans. A tactical plan answers "HOW" the strategic plan will be achieved. Often, the tactical plan is broken out into short-term goals, has a narrower focus, and is broken down by departments. Members of the product development team examine a number of topics to help them develop their tactical plan. The team will strive to describe what they will achieve, how it will be accomplished, and who has the responsibility for implementation.

Let's examine these topics and how they affect the product development process in more detail.

Regulatory Environment

Once the EMT reaches a decision as to what and where it wants to write, it is up to the product development department to review any insurance regulations that will affect how the company will operate. This undertaking is necessary to gain the approval of regulators for rules, rates, and forms. While product developers look closely at different filing requirements, underwriters also consider regulatory compliance. To avoid issues related to **market conduct**, a company must follow guidelines and operate completely within parameters established by regulators.

Judicial Environment

As the EMT developed its strategic plan, it reviewed the judicial environment of the states it was considering as potential locations. Now, members of the product development team decide whether to use standardized forms, proprietary forms, or a combination of the two in the development of each product the company will sell. Understanding the judicial environment will help the team accomplish two important things. They can:

- build forms that can withstand challenges to the coverage intended to be provided in the forms, and
- participate in the development of rates.

Risk Appetite

Understanding the company's desired risk appetite developed during the strategic planning process is crucial to the product development process. Underwriting rules and guidelines, along with proper rate development, are critical to aligning with that appetite. Working with actuaries, the product development team builds rates that can cover the pure cost of risk plus projected expenses and desired profits. The team also considers risk appetite when it develops forms and endorsements.

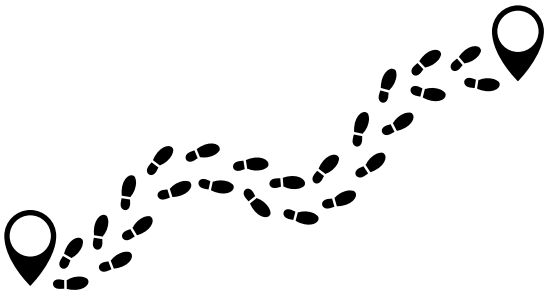
Lines of Business

The EMT considered risk appetite an important factor in its decisions regarding the line(s) of business it desires to write. As the product development team begins the process of developing rules, rates, and forms, it most certainly makes sure that the coverage provided is in line with the company's overall strategic plan.

Working independently of the executive management team, the underwriting department is also careful to adhere to the guidelines developed during strategic planning. Underwriting is the gatekeeper of eligibility. While exceptions may be granted from time to time, the goal is to stay within acceptable margins.

Geographic Footprint

The product development group carefully considers the guidance that emerged during strategic planning regarding geographic footprint. It makes sure it has in place personnel possessing the proper skill sets required to meet the market challenges created by doing business in this footprint.



Example: ABC Insurance has just acquired a company which writes agricultural accounts in a new geographic territory. ABC will need the individuals with knowledge of agricultural exposures in order to meet the unique challenges of this market segment.

Knowledge Check

Directions: Read the excerpt from the EMT's strategic plan. Then select from the list which actions the product development team will pursue. Explain why you chose those actions.

EMT's Strategic Plan Excerpt: Develop and price a product that will better position the company in the Southwest region.

a. Review federal and state rules and regulations in new geographical area.
b. Design a marketing campaign to promote the new product.
c. Meet with actuaries and underwriters to see if risk appetite of EMT for product matches the rates set.
d. Locate personnel will special knowledge in the new product sector.
e. Keep forms the same without reviewing for possible changes.

_____

_____

_____

_____

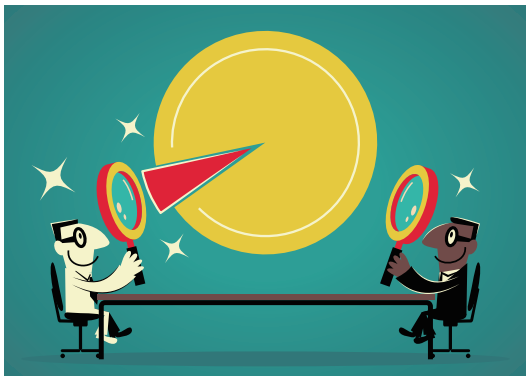
Product Development

Learning Objective:

2.2 *Apply the five-step process used in the product development process to design and implement a product.*

The Product Development Department

The responsibilities of the product development department may vary from company to company. In some companies, the team is responsible solely for the development of insurance contracts. Other companies may include contract development and pricing within the scope of product development activities. Others may include contract development, pricing, and coordination with other departments within the scope of its responsibilities. Start-up and smaller companies may outsource the entire product development process because the required skill set is not available. It's also not uncommon to have the process of product development be a collaboration between the underwriting, claims, sales, and actuarial departments.



Regardless of how the company may structure responsibilities, the purpose of the product development department is twofold: to develop new products to be offered by the company and to maintain its existing products.

From time to time, the EMT may decide to expand its offered lines of business or products. It then becomes the responsibility of the product development department to execute strategies that will support that expansion.

Based on feedback from other departments within the company, the product development group also monitors the impact of emerging risks or trends within the industry. The product development team then communicates these findings to the EMT so new strategic decisions can be made. Emerging exposures may include:

- Ride-share companies, like Uber and Lyft
- On-demand delivery such as Roadie, Task Rabbit, or Door Dash
- Drone exposures
- Cyber exposures
- Autonomous vehicles
- Smart homes

Once the product development team studies these new or emerging exposures, its responsibilities include making modifications to existing forms and creating new endorsements to add or eliminate exposures.

As members of the product development team work to develop and manage products, they must consider the importance of regulatory compliance requirements. Depending upon the state regulatory system, rules, rates, and forms will need to be filed with regulators and possibly approved. Keeping within those guidelines is key to getting approval for new products or product changes in a timely manner.

The product development department is also responsible for establishing and monitoring pricing. Profitable growth is critical to the company's success. Sometimes products are not meant to be competitively priced. A company may desire to write a specialty product to create a niche. That niche may be a class of business that has greater exposure, such as steel erection contractors or auto dismantlers. Greater exposure means higher than average expected losses, and requires higher pricing.

Input from agents and brokers is extremely valuable in fine-tuning the pricing and coverages necessary to keep the product viable in the marketplace.

To be effective, the product management team needs to coordinate with other departments. Launching new or modified products requires timely implementation.

Speed to market is critical to keep the company from losing momentum. New and revised products require coordination with the company's IT department to implement system programming changes. Internal staff, such as claims, underwriting, and sales, must be trained. From there, the agency force needs to be notified and properly trained so they are prepared when questioned by policyholders.

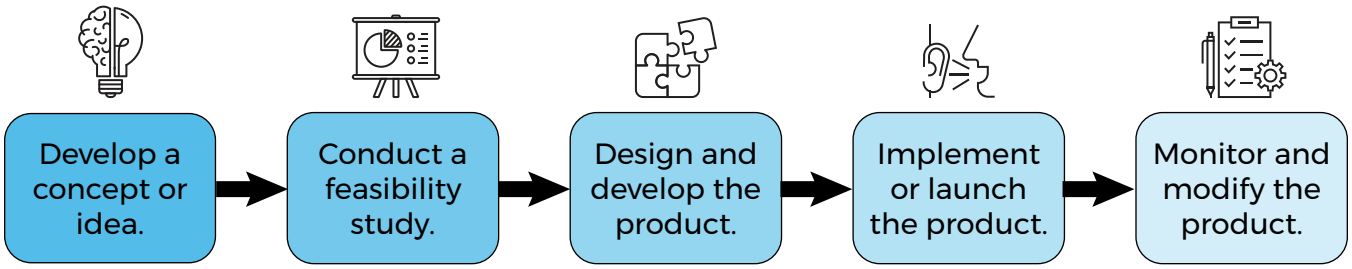
As you can see, the product development department has a big job with lots of "balls in the air" at any moment in time. Each major area of responsibility deserves additional discussion.

Development of New Products

When a company talks about new products, what exactly does that mean? New products can fall in to one of three categories:

- A new line of insurance: Perhaps a company is currently writing personal auto and homeowners' coverage. As a result, they decide to add personal umbrella coverage as a new line of insurance.
- A new product within a line of business: Say a company is currently writing homeowners' coverage but does not offer an HO-4 policy. It later decides that the HO-4 policy could be a profitable product, so the company expands its product offering to include the HO-4.
- Expansion into a new state: Say a company currently writes commercial lines policies in four states and decides to expand the same lines of business into a fifth state.

The act of product development is generally a five-step process. As with similar processes, it is somewhat circular in nature, although we express it here in linear fashion. The steps in the process are:



Let's look at each step more closely.

Step 1: Develop a Concept or Idea.

The concept or idea for a new or expanded product can come from a number of sources. At first, the EMT's strategic plan will be the guide for developing its products as the company begins its startup process. Once its product or products are in the marketplace, a company may receive useful input from both internal and external sources.

Input from Internal Sources

Internal sources that may provide input about products include underwriting, claims, and product distribution departments.

The underwriting team frequently receives requests for new or modified coverages from the distribution force.

The claims department can provide the product development team feedback regarding trends in uncovered claims that the company may want to consider in order to create a competitive advantage.

The product distribution team is the company's "boots on the ground." One of its charges is to collect market intelligence. This team's close and constant contact with agents gives it a unique perspective on coverage or pricing demands in the marketplace and, therefore, can be a source of valuable input.

Feedback from all internal sources is critical to making product adjustments or developing new products.

Input from External Sources

Agents: Agent advisory committees are one external source of helpful information. Many companies have formal committees made up of key agents from across the distribution territories. These agents meet regularly with company management to give feedback regarding product and pricing needs. Other companies may not have formal committees, but may still receive unsolicited feedback from agents within their distribution systems.

Society: another external source is society, in general. Since the product development process is analytical by nature, the product development team constantly monitors societal changes. Advancement in technology (like artificial intelligence) and scientific changes (like climate change) may have an impact on coverage. Emerging trends, as discussed above, may also cause changes in products or pricing.

As ideas and concepts emerge and are discussed, some of them may lend themselves to product changes or new products. That leads to the next step in the process.

Step 2: Conduct a Feasibility Study

Once the product development team has a concept or idea, it must determine if the idea is actually feasible. The team begins collecting market, pricing, and loss data in order to perform an analysis. If a company has its own credible data (a large enough data pool to give a true analysis), it can pull reports from its internal database. If not, it can purchase data from several sources. Industry data may be readily available from the Insurance Services Office (ISO) or the American Association of Insurance Services (AAIS). Data aggregators, such as independent actuarial firms, can also be used in the process. Data aggregators collect data from key competitors and use that data to perform analyses.

Once data analysis is complete and the decision is made to move forward, the product development team assembles a business plan, including a pro-forma statement. The business plan will include competitive analysis, internal capabilities, and pro-forma analysis. The pro-forma statement serves as a forecast of the expected premiums, losses, and capital needed to support the product being developed.

The feasibility study also includes the assembly of a new product development committee made up of internal staff. The committee includes members of other departments whose input will be valuable in putting the framework of the product together. Committee members include representatives from underwriting, product distribution, claims, IT, finance, legal, and other key internal stakeholders. Most companies have multiple ongoing projects in different stages. One of the committee's primary considerations is to determine how to prioritize the new product among other existing projects.

Once a feasibility study is complete and the EMT has agreed to move forward, the next step in the product development process begins.

Step 3: Design and Develop

Now it's time to design and develop the forms, rules and guidelines, and rates that will be used for the product.

Forms

There are two approaches to developing forms: the use of standardized and/or proprietary forms.

- **Standardized forms**

  Forms developed by ISO, AAIS, and NCCI (National Council on Compensation Insurance) are filed for use in all or most states. A company can choose to use these forms as they are or with minor modifications. The ease of regulatory approval is among the advantages of using standardized forms. A second advantage is that the forms are already tested in the marketplace and the courts.

Note: State laws govern workers' compensation (WC) benefits and other provisions; therefore, a NCCI policy cannot be modified since it incorporates the laws of the states activated on the Information Page.

A company also has the option to modify existing ISO or AAIS standardized forms. If a company chooses to make modifications, it has several options. First, it can modify all forms it uses. In this process, the company uses some of the language copyrighted by the organization writing the standard form but modifies the language to create the coverage it desires to provide. Second, it can modify only specific forms and endorsements, making the process more streamlined. Finally, the company can use the standardized forms and complement them by using proprietary endorsements created by the product development group.

- **Proprietary forms**

  A company also has the option of creating proprietary forms. **Proprietary forms**—ones written entirely by the company—do not include any copyrighted language from standardized forms. Company staff can create proprietary forms, or creation can be outsourced to a third party with experience in the process.

  Another way of developing proprietary forms is to acquire forms written by another company. If a company likes certain aspects of another company's forms, it can request copies of those forms from the state regulatory authority. (In most states, these forms must be filed and made accessible to the public, so they are readily available.) The company can then make any necessary modifications, create its own form numbers, and file the forms with the regulator. This method is known as a "me, too" filing because the company is using forms that are similar to forms that have already been approved for use. The filing merely highlights any differences, making them easy for regulators to recognize and analyze.

  If a company is considering developing proprietary forms, there are a number of issues it must contemplate before making a final decision. They include both pros and cons:

Pros

- **Market advantage:**

  Understanding the needs within the market it is seeking to penetrate allows a company to create forms and rates that attract potential insureds.

- **Opportunity for Innovation:**

  Market advantage combined with market intelligence allow a company to potentially offer unique coverages that are not currently offered.

- **Greater flexibility:**

  Creation of proprietary forms allows a company to be much more flexible in form creation because the company can work outside the limitations that exist in standardized forms.

- **Ease of modification:**

  If a company writes its own forms, modifications can be taken care of quickly. Standardized forms are modified by the form's original writer and can take years to be modified. If the writer of a standardized form sees no need for modification, a company has no control.

- **Specify coverage and exclusions:**

  The use of standardized forms forces a company to add endorsements that provide additional coverages or exclusions. By developing its own forms, a company has the flexibility to include those within the form itself.

- **Required resources and skill set:**

  In order to create forms properly, a company needs personnel who have extensive knowledge in the creation of forms that meet both legal and regulatory guidelines. As noted above, this is accomplished with company employees or by outsourcing to firms experienced in form development.

Cons

- **Time consuming:**

  The development of proprietary forms takes time. Forms may go through a number of draft phases and reviews before being approved internally.

- **Regulatory issues:**

  Once a form is filed, it must be reviewed for approval by a state regulator. Since the form is not a standardized form, the review time can be lengthy. In addition, there is a potential for regulatory resistance. As language is reviewed and analyzed, a regulatory authority may ask many questions and suggest changes.

- **Distribution force training:**

  Once a form is approved, members of the Distribution Force must be trained. There may be exclusions that are different than those found in standardized forms. These differences may create resistance from the agents who will be selling it.

- **Lack of historical performance data:**

  Newly created proprietary forms have no historical performance data. This lack of data makes it difficult for actuaries to determine credible rates from the onset. In addition, the Claims Department has no prior coverage interpretation data, making case reserving and coverage determinations more difficult.

- **Judicial interpretation issues:**

  Like historical data, newly written forms have no judicial interpretation history. As much as a company would like to think that it was proactive in writing a form, insurance is really more of a reactive industry. Judicial interpretations can create coverage issues much different from those intended when the form was written.

Rules and Guidelines

Rating rules and underwriting guidelines must be filed with regulatory authorities. Some states require that rules and guidelines be approved by the regulator. In other states, rules and guidelines are filed for advisory purposes only. Either way, these are important documents because if the regulatory authority requires a market conduct exam, the results of the exam will be based on how well the company followed the rules and guidelines as filed.

Rules generally deal with factors that impact the final rates charged to a policyholder. These rules may contain rating factors based on risk classification. They may also contain experience rating plans and the use of scheduled debits or credits. Finally, increased limits factors and deductible credits may also be included in the rating rules.

Underwriting guidelines drive the acceptability of risks that a company wants to write. They also impact any coverage limitations based on the specific characteristics of a given risk.

These guidelines are used to determine product eligibility, territory restrictions, coverage restrictions, and certain classes of business that are ineligible.

Rates

The rates that a company charges for its products must be filed and approved by the regulator in each state where the company does business. Each of the rates submitted requires actuarial support and certification within the filing.

Filing Requirements

Before a product development department can actually file rules, rates, and forms, it must first consider the requirements of each state's insurance regulations. As noted earlier, the process for filing regulations will vary from state-to-state. Those variations are summarized here:

- **Prior approval**

  In states that require prior approval, rules, rates, and forms may not be used until the regulatory authority has approved them for use. The length of approval time may vary based on the state authority, line of business, proprietary versus standardized forms, and other factors.

  Most states have what is known as a "deemer" period—the number of days in which the regulator has to approve or deny a filing. If the regulator does not respond within that period of time (usually 30–60 days), the filing is "deemed" to be approved.

- **Use and file**

  This method is straightforward in its application. A company can begin to use the rules, rates, and forms, and then file them with the regulator for approval. This makes it easy to get the product and/or pricing in the marketplace quickly. There can be a huge downside to this filing method, however, if something in the filing is not approved and changes are required, the company must then issue endorsements or pricing changes to all of the policies it has sold that are subject to the modifications.

- **File and use**

  "File and use" is another very straightforward method of filing. A company files the appropriate information with the regulator. Once it is received, a company can begin using the rules, rates, and forms. Like "use and file," this filing method allows a company to put product and/or pricing in the marketplace quickly. It also has the same downside as "use and file," meaning if a filing is not approved or requires modifications, a company must issue endorsements or change prices.

- **File and no approval**

  A few states allow for filing of rules, rates, and forms with no approval. Other states may allow for "file and no approval" of certain lines of business.

- **Flex rating**

  Some states allow companies to file for rate increases without any approval, provided the rates do not increase above a certain percentage. This allows companies to make small, inflationary rate increases without having to wait for regulatory approval.

- **State-made or bureau-made rates**

  Some states have rating bureaus that develop pricing for certain lines of business within the state. Companies can file their own rates in addition to the bureau rates. This creates a level of complexity for the company. Generally, if the company's rates are higher than bureau rates, the company must either honor the bureau rate or have the insured sign a "consent to rate" form. This form notifies the policyholder that the company's rate is higher, and they are consenting to the higher rate.

- **No file**

  A few states are considered "no file" states. These states have no requirements that rates be filed or approved. However, the regulator does reserve the right to review the rates and disapprove.

- **No rating law**

  Only one state, Illinois, has an "open competition" system. This state has no regulatory requirement for rates to be filed in the voluntary risk market. State antitrust laws still apply if necessary.

Step 4: Implement and Launch

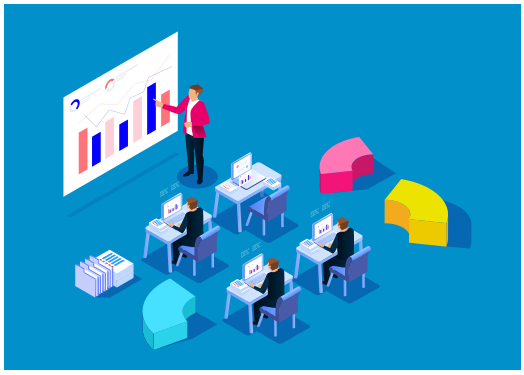
Much of the underwriting and sales processes, as well as the monitoring of key metrics, will be programmed into the company's IT systems. Consequently, implementation will include many meetings with the members of the IT department, given their role in programming the systems with the necessary data and algorithms to rate, underwrite, and issue the products. Testing the programming is also an important part of this process so that any bugs and glitches can be worked out prior to launch.

Once a product or products have been developed, filed, and approved, the next step in the process is to implement and launch. The launch may include support by the executive management team. This allows the distribution force to recognize the importance of the product launch to the company. It also gives the distribution force an opportunity to interact with members of the executive management team. The launch can be done at one central location, in "town hall" formats, or at the company's office.

Implementation and launch involves both internal and external processes. It's important to understand that some of the actions in this step may occur in step 3—design and develop, while others may not occur until the end of this step, just prior to the launch phase.

Training

- Internal: underwriting, claims, customer service, sales
- External: distribution



The internal part of step 4 starts by meeting with members of the executive management team to give them a program overview. The overview includes a review of the completed processes as well as next steps. These next steps may include scheduling the appropriate member or members of the executive management team to help with the launch process.

Members of the product development department work with underwriters to provide product training and to explain the underwriting guidelines that have been filed with the regulator. If supplemental applications have been filed, the underwriters will need to know when they will be needed and the importance of the information to the issuing of coverage.

The claims department also needs training time with the product development group. Products are developed knowing that there will be claims, so a full understanding of a product is imperative to proper claims handling.

Finally, if a company has a customer service department, those team members will need to be properly trained, as well. Whether the customer service department deals with the distribution force, the policyholder, or both, full understanding of coverage, changes, and billing is needed.

Once internal training is completed, external training begins. The company's distribution force needs to understand underwriting guidelines, policy coverages, and endorsements. They will also need to understand the submission process, including any supplemental information that will be necessary to properly underwrite the product or products.

Since external training is part of the launch phase, distribution packages should be made available. These packages should include copies of the forms, rules, rates, guidelines, and marketing and sales information, such as brochures. Also, quick reference guides are always great tools because they consolidate important information on the front and back of a single sheet.

Step 5: Monitor and Modify

The product development process doesn't end once a product is in the marketplace. Now step 5 begins. In this step, the product must be monitored for success, and monitoring may indicate a need for modification. There are a number of areas that are monitored, including:

- **Competition**

  Product developers need to know how a new product is competing with others once it has been launched.

- **Product marketability**

  Given a product's feasibility study, product developers assess whether the new product was actually needed in the marketplace.

- **Customer value**

  Customers must perceive a product as valuable. This doesn't necessarily mean the product sells at the lowest price; it means that the product provides good value for the premium dollar and customers recognize that.

- **Distribution compensation**

  During the feasibility study, the product development team should have looked at the compensation structure of other, similar products in the marketplace. Now they need to determine for sure that the commission offered is fair.

- **Unintended coverage**

  Once claims begin to occur, product developers need to monitor policy interpretation and claims payments. The team needs to understand whether the policy language is being interpreted as planned or if unintended coverage has been created.

- **Claim volume**

  Claim frequency and severity were forecast when the product went through the pricing phase of the product development process. Product developers need to constantly compare actual versus expected losses. In addition, they need to compare actual versus expected frequency and severity of losses.

- **Patience through the premium cycles**

  When a product is new, it takes time to develop enough credible experience to determine if modifications are necessary. Until premium volume builds, a few small losses can make a product look rate-deficient. Patience is necessary during this phase. After a couple of fully-earned premium cycles, trends can be spotted. The premium cycles allow earned premium to catch up to written premium and loss development matures. These trends alert the product development team as to whether action is needed.

Review of Rate Adequacy

Depending upon the line of business, a review of rate adequacy is generally done annually. Regulators may allow a company to make rate adjustments every six months. That said, increases that come too often may cause the regulatory authority to begin to question the company's actuarial practices and why the company needs to increase rates so frequently. The purpose of the review is to make sure a product is performing profitably.

If a review indicates that a product is unprofitable, the product development team needs to take a deep dive into the metrics and other data, where they can search for the source of the lack of profitability. A number of issues could affect profitability, including rates, unintended coverage, and underwriting guidelines. Regardless of the specific issue or issues, problems must be addressed to restore profitability.

If a product is profitable, the product development team may choose to maintain rates, which allows for greater profitability. If the product is profitable but competition is causing the company to write less business, the team may need to consider a rate decrease. This is a difficult decision to make because lowering pricing may lead to unprofitability should losses increase.

Rate Adjustment Considerations

Rate increases and decreases can have huge impacts on a company. Both have positive and negative outcomes, so both must be analyzed thoroughly before making rate changes.

Some lines of business vary more than others. Rate increases are generally never the same for each insured, and the impact on each insured needs to be considered. For example, on a state-wide basis, a 10% rate increase is generally an average rate increase. Some individual insureds could see no increase, while others could see an increase of 20%. A rate increase may create adverse selection, meaning insureds with low losses leave for lower pricing. Meanwhile, those with higher losses may not be able to move, creating a pool of i with higher expected losses.

Rate increases can also reduce a company's retention ratio. Retention ratio can be measured in two ways: premium retention and policy retention. Premium retention allows a company to see how written premium is affected by a rate increase. It is important because it's part of the loss ratio equation. On the other hand, policy retention allows a company to see how many policies it's actually losing as a result of rate changes.

Retention is rarely 100%, but a company can measure its historical retention against retention after a rate increase to measure the increase's impact.

Rate decreases can also have an impact on existing business. When rates decrease, a company's average premium per policy or account also decreases. The product development team must measure the effect on the total book of business. The change in average premium per policy can be overcome by higher retention and higher new business production.

Product Modification

Sometimes a product's performance is unrelated to rates. Instead, it may be related to the product itself. Factors that influence product modification include:

Policy interpretation: If the judicial system interprets coverage differently than from the intent when a form was developed, modification may be necessary. Court decisions, interpretations, and awards can have an impact on both frequency and severity of losses.

Changes in technology: Perhaps new technology has been developed that may give a company an opportunity to offer broader coverage.

Claims experience: Frequency and/or severity may be different than expected. This difference could be positive or negative. The product development team must track the types and nature of claims to determine if coverage is meeting profit expectations. If not, modifications may be necessary.

Industry trends: Data from industry organizations or aggregators can be purchased and used to conduct an industry-wide trend analysis.

Changes in laws: Changes in statutory law can have significant influence on coverage modification. Coverage laws relating to UM/UIM, WC, and other statutory coverages may require product modifications. Emerging exposures such as drones and cannabis may also affect the need for modification.

Regulatory change: Regulatory change can be either insurance industry-related or other industries-related and may lead to necessary modification.

Proactive competitive advantage: A company may desire to modify its product to attract more business by adding coverage that others have not yet offered in order to create a competitive advantage. If a company offers a new, emerging coverage for no additional premium charge, it creates an advantage in the marketplace.

After a full analysis of a product and its performance, the product development team may determine that there is definitely a need for modification or enhancement. Modifications or enhancements can be used in several ways:

- First, modification may be used as a tool to exclude or limit coverage.
- Second, broad interpretation of coverage may expose the need for exclusionary or limiting language in traditional lines of business.
- Finally, enhancements or new products may be developed to provide coverage for emerging exposures.

During the modification process, there may be a need to seek feedback from internal and external partners. Gathering other perspectives assists in the decision-making process.

Once analyzed data reveal that modification or enhancements are necessary, a decision is made, and the whole process begins again.

Knowledge Check

Directions: When an insurance company contemplates development of proprietary forms, name the steps they will engage in to develop that product.

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Product Pricing

Learning Objective:

2.3 Evaluate the effectiveness of a product development team's use of the actuarial process to determine the price and performance of a product.

Pricing

In the process of rate-making, actuaries must come up with the pure cost of risk—the estimated amount of premium that will cover all of the ultimate losses over time. Recall that actuaries use a methodology known as triangulation to determine mathematically the estimated ultimate net loss for each year into the future, based on historical losses.

Now actuaries must take two additional steps. First, they must "trend" or index losses. Indexing is accomplished by factoring in inflation, which takes yesterday's dollars and expresses them based on the value of today's dollar. Once ultimate losses have been converted to today's dollars, actuaries then divide the losses by the exposure base to develop the pure cost of risk. Known as a "loss cost," the calculation looks like this:

Estimated Loss Projection

	(A x B = C)				(C/D)
	A	**B**	**C**	**D**	**E**
Policy Year	Ultimate Losses	Trend Factor	Trended Ultimate Losses	Exposure	Loss Cost
2016	696	1.25	870	570	1.53
2017	737	1.2	884	575	1.54
2018	756	1.15	869	590	1.47
2019	766	1.01	774	610	1.27
2020	800	1.05	840	595	1.41
Average Loss Cost **1.44**					

2021 Projected Exposure (given by HR) = 625

Loss Projection = (2021 projected exposure) x (2021 projected average loss cost)
= 625 x 1.44
= $900

As you can see from this example, once losses are indexed and divided by the exposure base, the loss costs for each year are added and then averaged to create the projected loss cost for the coming year.

Once the product development department has the loss cost, it works closely with the actuarial department to develop a **loss cost multiplier** (LCM). The LCM contemplates underwriting expenses and desired profit. The loss cost is then multiplied by the LCM to determine the final base rate.

Rates are generally based on pooling of risk. **Pooling** is simply aggregating all of the premiums for a specific line of business. Claims are then paid out of the pool of premiums, as well as expenses and profit. The larger the pool, the more accurate the projections of losses (known as the "Law of Large Numbers"). When the pool is too small, all policyholders can be negatively affected by others in the pool.

Pooling Perspectives

In the process of pooling, there are certain factors that can affect the rates charged for different policyholders and the company. The exhibit below shows a list of these factors:

Factors that affect rates from the policyholder perspective include:

- Marital status
- Zip code or rating territory
- Insurance score
- Motor vehicle record
- Prior claims activity
- Loyalty
- Discounts for features that minimize loss (alarm systems, defensive driving courses, sprinkler systems, wind mitigation features)
- Package discounts
- Type of vehicle
- Construction type of building
- Gender and age (these factors are outside the control of the policyholder)

Factors that affect rates from the company perspective include:

- Risk appetite
- Type of coverage
- Underwriting parameters
- Profit appetite
- Type of company (stock, mutual, reciprocal)
- Loss experience
- Regulatory changes*
- Cost of reinsurance*
- Inflation*
- Investment income*
- Public attitude toward insurance*
- Class action lawsuits*
- Competition*

(factors that an insurance company cannot influence directly but are closely tied to the company's operation.)*

Rating Rules

From a commercial lines standpoint, most companies use the ISO classifications manual as part of their rating rules. Generally, each type of risk has an assigned classification code. From there, companies can either use ISO loss costs or develop their own as shown above.

Class loss costs are organized by risk categories which include large groups of risks that have been analyzed in the loss cost development process. These loss costs are used for similar risks within a given rating territory. Because class loss costs are based on large statistical samples, they apply without recognition of characteristics of any specific risk. Class loss costs are often referred to as "manual loss costs." This is because they correspond to the risk classification code from the ISO Classifications Manual

Advantages include the fact that they are updated regularly, always available when needed, and easily lend themselves to automation. Disadvantages include making sure the proper classification is used, higher chances of manipulation, and they do not reflect any special characteristics of a risk. Class loss casts are used for Commercial Property, General Liability, Workers Compensation, and Business Auto coverages.

Some classifications do not have an assigned manual rate. Instead, the classifications manual shows "a" in the column where a loss cost might normally be. When a classification is "a" rated, the loss cost charged is a judgment rate. There is generally a range suggested, and the underwriter chooses a rate based on the facts of the particular risk being insured. Like typical loss costs or rates, "a" rates must comply with regulatory requirements.

Specific loss costs are used for larger, more complicated or diverse property risks. These loss costs recognize risk characteristics and are specific to a particular location and operation. Advantages include the fact that they are unique to a particular building or operation, and they grant credits or apply debits depending on the good or bad characteristics found. Disadvantages include the need for regular updating to reflect any changes in occupancy, operations, or conditions. Since a formal inspection is required if any of these changes, time is needed for scheduling and completion. New loss costs take time for promulgation, as well, so tentative or "a" rates must be used in the interim.

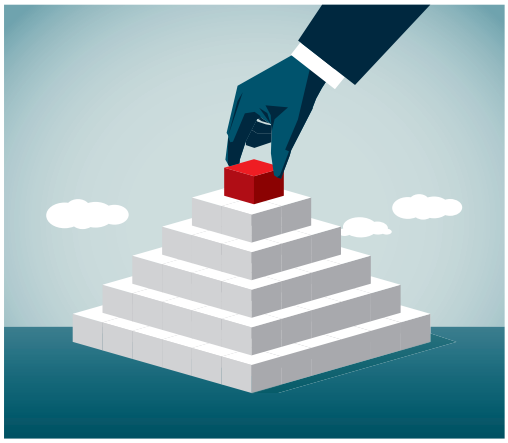
Built up rating can be used for very large commercial risks with credible experience. Loss costs are developed by using the risk's experience and then the company uses its LCM. Built up rating is used in a relatively small number of circumstances because of the size and statistical experience requirement. This type of rating can be used for Commercial Property, General Liability, Business Auto, and Workers Compensation.

Experience rating can be used to develop debits or credits for a specific risk. Since class rating does not take the characteristics of a specific risk into consideration during the rating process, experience rating allows final rates to be tailored to those characteristics. Experience rating takes the individual risks premiums and losses over the last three to five years, compares it to industry average statistics, and develops debits or credits to modify the final price. Generally, experience rating is used for casualty exposures such as General Liability or Business Auto Liability.

Workers Compensation can also be experience rated. Many states employ the use of Experience Modification Factors (experience mods). Criteria for experience mods varies from state to state. Typically, the risk must generate a certain premium dollar threshold over three years or a larger threshold in one year. Workers Compensation rates or loss costs are based on the average experience of each class code. If a risk has better than average experience, it will receive a credit mod and pay less for its coverage. If a risk has worse than average experience, it will receive a debit mod and pay for its coverage. If the risk generates average experience, it will receive a "unity" mod (1.00).

For risks that are smaller and do not qualify for experience rating, other debits and credits are available. For Commercial Property accounts, individual premium modification factors (IRPMs) can be used. For casualty account, scheduled debits and credits may be applied. IRPMs and scheduled debits or credits are tied to risk characteristics on an individual basis. These debits and credits are filed with the company's rules and must only be applied if the characteristics actually exist. The company must maintain a record of the criteria used and the amounts of the debits or credits.

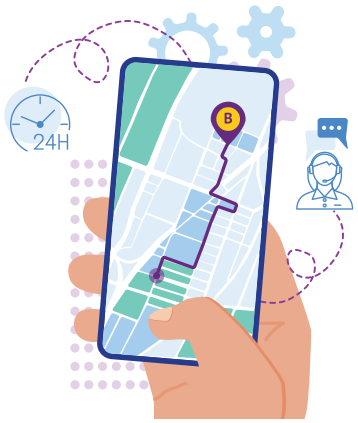
Retrospective rating can be used on larger casualty risks. Retrospective means to look back, which is exactly how it works. A deposit premium is charged to the insured up front. Eighteen to 24 months after the policy expires, the company looks back at the losses that have been paid or incurred that occurred during the policy period. Premiums are then adjusted according to the actual experience. Retrospective rating is generally a contractual relationship between the insured and the company. The contract spells out all the details that will be important to the retro process.



Multivariate rates are used quite often, especially in personal auto coverage. Some companies writing homeowners' policies also use **multivariate rating**. This type of rating is based on the relationship between multiple variables at the same time.

Multivariate rating is also commonly referred to as "tiering." Policyholders are assigned to a "tier" based on the combination of variables determined in the pricing and underwriting process. These variables can include age, gender, marital status, prior policy limits, insurance score, rating territory, and many other combinations. These variables are used to determine pricing based on potential profitability.

Over the last several years, usage-based rating has been used by some companies in the marketplace. Usage-based rating may be used in both personal lines and business auto markets. Data can be collected via an onboard diagnostic tool plugged into a vehicle's computer system, via GPS tracking devices, or with an app downloaded to a mobile device or smartphone. These devices then record the insured's (or insured's employee's) driving habits. Rates are then derived from the data collected.



Once the product development group, in conjunction with the actuarial department, makes decisions related to rating, develops the appropriate forms, and promulgates rules and guidelines, the forms must then be filed with the regulatory authority. Actuaries are critical to this process because rate filings must include actuarial support and certification.

Knowledge Check

When a new product has acquired a claims history, what information does the product development team need from actuaries and how do they get it?

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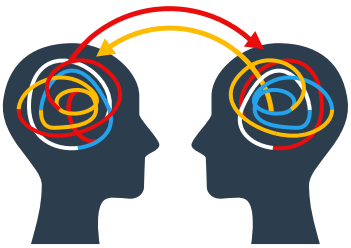
Summary

Section 2 highlights how the product development department implements the executive management team's strategic plan. In this case, the product development team comes up with a tactical plan to allocate resources; find appropriate personnel; check financial resources; further determine risk appetite; review regulations, rates, and forms; and communicate with external and internal sources. The team should follow the five-step product development process: 1) develop a concept or idea, 2) conduct a feasibility study, 3) design and develop the product, 4) implement or launch the product, and 5) monitor and modify the product.

Speaking From Experience

For valuable reinforcement, some important concepts related to the learning objectives in this section, use the following link to access video clips from insurance company professionals actively engaged in these departmental strategies.

scic.com/ICOresources



Section 2: Self-Quiz

Developing a Tactical Plan

Directions: Fill in the blank

A tactical plan answers _____the strategic plan will be achieved.

Directions: Name three factors that affect the decisions on the type of products developed by the product development department.

a. _____

b. _____

c. _____

Product Development

Directions: Circle True or False

The product development team is responsible for establishing and monitoring pricing.

True **False**

Directions: Indicate the correct sequence of the steps in the product development process by numbering the items below.

_____ Implement or launch the product

_____ Conduct a feasibility study

_____ Monitor and modify the product

_____ Develop a concept or idea

_____ Design and develop the product

Directions: Fill in the blank with the term that matches the definition.

_____ is simply aggregating all of the premiums for a specific line of business.

Directions: Select the statement that best describes the roles and responsibilities of product development.

- ☐ Always its own department and is responsible for development of contracts only, but will coordinate with other departments on pricing and distribution.
- ☐ May be its own department or a part of another department and the assigned responsibilities will vary from company to company.
- ☐ Part of the actuarial department as the actuarial department has to determine the price of the newly developed contracts.
- ☐ It has its own department with assigned responsibilities to develop contracts, but Underwriting manages the product.

Directions: Indicate which of the following is included in the development of a new product.

1. A new product in an existing state

Included **Not Included**

2. A new line of business for both existing and new states

Included **Not Included**

3. A new product within an existing line of business in existing states

Included **Not Included**

4. A new product in a new state

Included **Not Included**

5. An existing line of business approved for use in a new state

Included **Not Included**

Directions: Which of the following is an accurate statement about the review of product performance?

- ☐ Once launched, a review of the rates should be conducted after five years to analyze the profitability of a product.
- ☐ If the review process indicates a product is performing profitably, there should be a rate increase consideration.
- ☐ The review process includes monitoring the competition, customer value, and the frequency of claims.
- ☐ Once launched, there is no need to change distribution compensation.

Directions: Indicate which statements are true in regard to rate adjustments. Circle True or False.

1. Rate increases impact all policyholders equally.

True **False**

2. Both increases and decreases in rates impact the retention ratio.

True **False**

3. Rate decreases on existing business result in a lower retention rate.

True **False**

4. Rate increases on existing business may create adverse selection.

True **False**

5. Rate decreases on existing business result in a reduction on the average premium per account.

True **False**

Product Pricing

Directions: Identify whether or not there is a possible need for modification or enhancements of a product in regard to each of the following. Circle Yes or No.

1. Policy interpretation mirrors the intent of the product.

Yes **No**

2. Desire to create a competitive advantage

Yes **No**

3. Data identifies emerging trends for certain industries.

Yes **No**

4. Changes in laws or statutes

Yes **No**

5. Other than insurance, changes in regulations of other industries

Yes **No**

6. Court decisions expand liability beyond the intent of the product.

Yes **No**

7. Claims demonstrate severity and frequency are the same as forecasted.

Yes **No**

Section 3: Underwriting

Section Goal

In this section, you'll learn about the steps, tools, and structure used by insurance company underwriting departments. In addition, you'll gather information about the impact of market cycles, as well as the purpose of reinsurance and loss control. This section will conclude with a look at premium audits and the technology needed to support the underwriting process.

Learning Objectives:

3.1 Identify and explain the steps in the underwriting process.

3.2 Describe tools used in the underwriting process.

3.3 Identify the considerations in structuring an underwriting department.

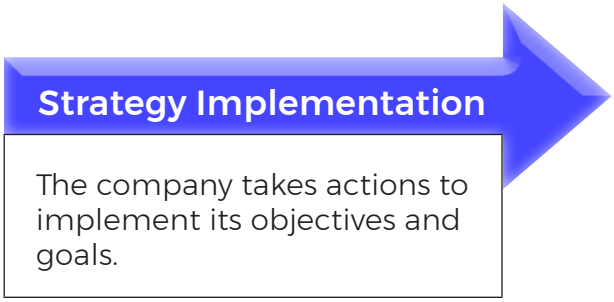
3.4 Define the two market cycles and provide characteristics of each.

3.5 Given an example, determine the type of reinsurance necessary and explain its use.

3.6 Evaluate the need for loss control in the underwriting process and justify its use.

3.7 Identify the functions of a premium audit and defend its use.

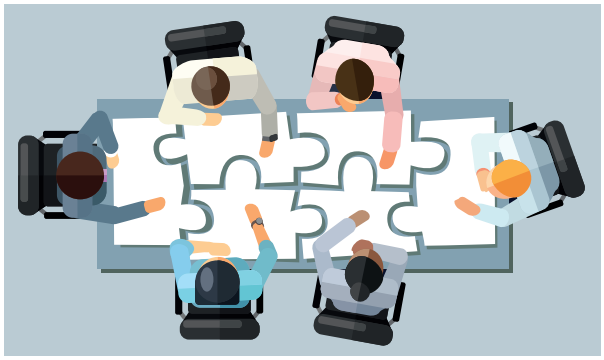
3.8 Justify the selection of specific technology used in the underwriting process.



An underwriting department within an insurance company generally serves two functions. The department:

1. Reviews new business and renewal business including proper risk selection and appropriate pricing.

2. Maintains the company's risk appetite. By maintaining the established philosophy, the underwriting department safeguards the strategic plan and targets the business segments determined during the strategic management process.



The discussion of underwriting begins with an assumption: the product development process is complete. Products have been developed, filed, and launched, and the distribution force is now submitting applications for prospective policyholders. The underwriting department is charged with reviewing, approving, and monitoring all new and renewal business to assure that the risks the company has accepted meet and stay within the guidelines filed by the product development group and meet the tactical and strategic goals of the underwriting group to carry out its part in implementing the strategic business plan. To better understand how these plan components are incorporated, let's examine the underwriting process in detail. The underwriting department will assess what resources and tools to use to implement the strategic plan.

The Underwriting Process

Learning Objective:

3.1 Identify and explain the steps in the underwriting process.

Underwriting New Business

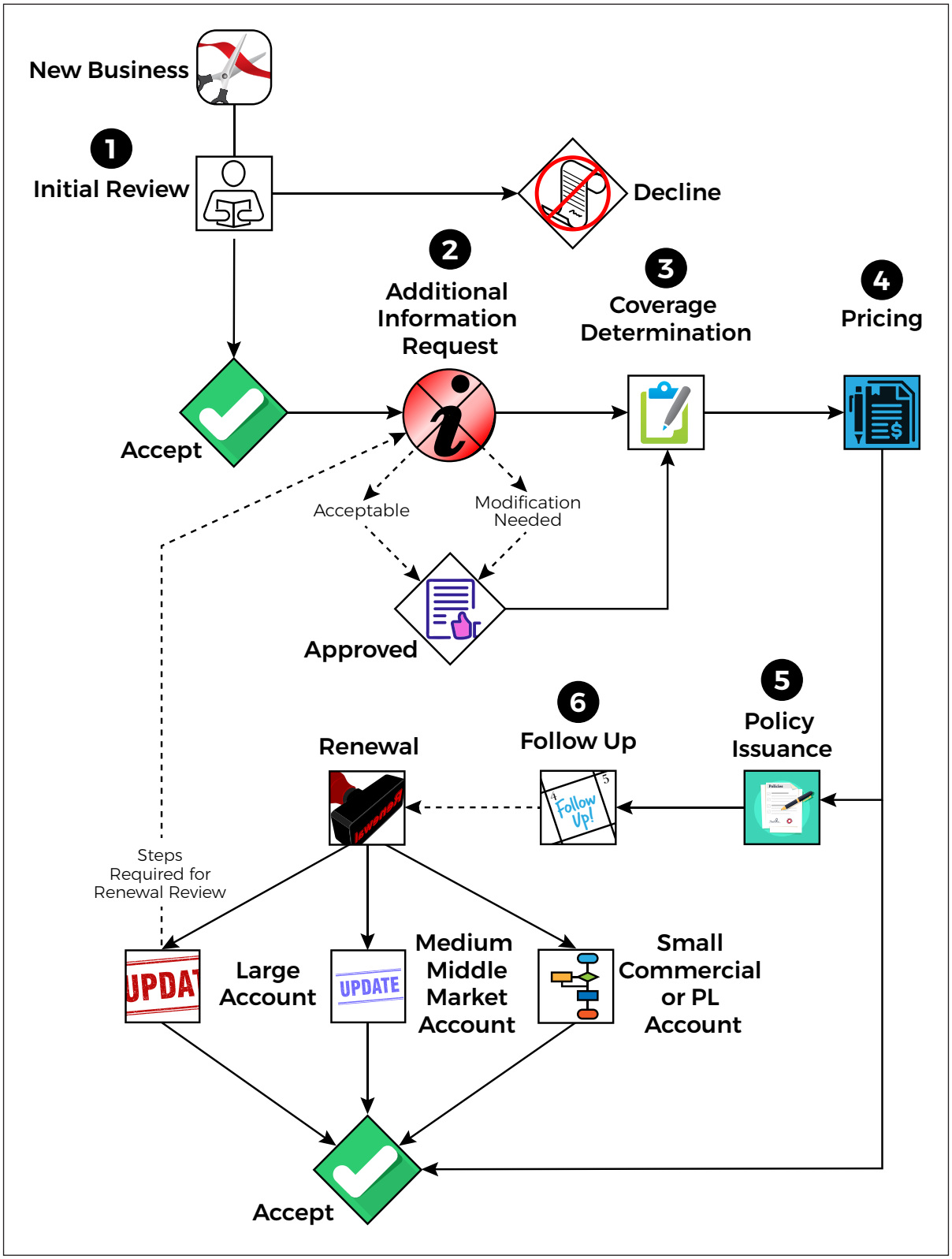
For individuals unfamiliar with how insurance companies operate, underwriting can be a difficult process to grasp. To some it is a mysterious "black box." Others regard the underwriting process as an art more than a science. Certainly, there is a level of discretion involved. Nevertheless, companies follow a methodical approach to underwriting.

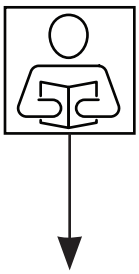
The underwriting function exists to ensure that a carrier is writing business that fits the company's risk appetite determined during strategic planning. The product development department creates programs around this appetite and embeds rules and guidelines within the programs to support the selection of risks. As discussed in the previous section, different companies have different approaches to the insurance business and want to write business in different ways. Some carriers choose to be generalists and offer a broad array of products over a large spectrum of risk classifications. Others choose to take a much narrower, specialist approach and target specific market segments.

The distribution force is responsible for selling products to consumers and collecting all the information a company needs to properly underwrite the business. The information is then submitted to the carrier's underwriting department for evaluation. This is where the underwriting process really kicks in, and there are a number of steps involved.

Steps in the Underwriting Process

The following diagram identifies the six steps in the underwriting process.

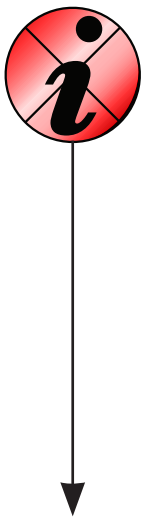




Step 1: Initial Review

Underwriters make an initial review of an insurance application and supporting documents to determine the acceptability of a submission. Standardized ACORD applications are generally acceptable for most lines of business. However, some companies may require proprietary supplemental applications to gain a more complete look at the characteristics of certain risks.

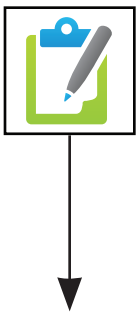
If a risk does not meet a company's guidelines, the underwriter will decline the submission and move on. However, if a submission is within the company's risk appetite, the underwriter will begin a deeper analysis of the risk to determine if it is acceptable as-is, or if modification is needed.



Step 2: Additional Information Request

In this step, an underwriter determines what additional information may be required to properly assess a risk. Some submissions may contain very complete information, including loss runs, pictures, and narratives. In such instances, thorough underwriting can be done immediately. If a submission is less complete, an underwriter will need to request the information necessary from the agent. Receiving incomplete submissions causes delays in the underwriting process.

Applications from agents are not the only resource needed to complete the underwriting process. Other external information may also be necessary. An underwriter may order credit reports, loss control inspections, MVRs, and CLUE (Comprehensive Loss Underwriting Exchange) reports to help with the risk assessment and decision process.



Step 3: Coverage Determination

If a risk meets the company's designated criteria as submitted, the underwriter will approve the submission and move to the rating process. Sometimes marginal submissions are acceptable if coverage modifications are made. The underwriter may suggest deductible options, limits options, limitation endorsements, or other modifications that make the risk acceptable. If the risk does not fit the desired profile and cannot be modified to make it acceptable, the underwriter must decline the risk.

Step 4: Pricing

Once coverage determinations have been made, the underwriter's next step is to set the pricing of the account. Some lines of coverage allow certain levels of discretionary pricing. **Discretionary pricing** refers to the ability of an individual underwriter to credit or debit an account or a portion of an account based on the merits of the risk, program or agency segmentation. Another form of

discretionary pricing is through the use of standard versus preferred programs within a company. Standard company products may be written at manual or prescribed pricing while the preferred program already includes a credit. Agency stratification or segmentation presents another opportunity to provide credit. Many carriers have identified high performing agents and brokers based on profitability, growth, and retention. These agents and brokers thus become eligible for additional credit consideration in recognition of their preferred status.

Commodity lines such as private passenger automobile or homeowners' insurance are usually class rated with no deviations allowed—there is no subjectivity involved, as these lines are heavily regulated.

Step 5: Policy Issuance

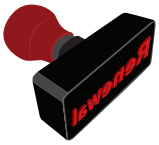
After an agent receives a quote and the insured purchases coverage, policies must be issued. The company is required to deliver the policy to the insured in most cases. These policies are delivered either electronically or mailed to the insured with a copy to the agent. Certain regulators may not allow policies to be delivered electronically.

Step 6: Follow-Up

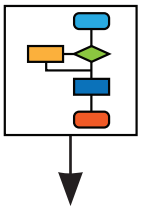
In some cases, policies are written subject to certain conditions, requiring follow up. These could include, for example, receipt of additional information or compliance with loss control recommendations.

Underwriting Renewal Business

Renewal business is handled differently than new business. With renewals, an underwriter has much more information and historic company data available for review purposes. Renewals are the lifeblood of the insurance industry (with the exception of a small subset of accounts that have been unprofitable) because it is less expensive to maintain existing accounts than it is to on-board new ones. Additionally, an underwriter has the comparative luxury of knowing details about renewal risks that they may not have for new business.



Below are the three different methods normally used to underwrite renewal policies, depending on the type of business.



1. Personal lines and small commercial accounts are often referred to as commodity lines. For these accounts, the renewal underwriting process is as automated as possible. These risks may only be reviewed by an underwriter every three to five years, unless a specific trigger requires the need for an interim review, such as loss frequency, a large loss, or a change in exposure.

2. Middle-market accounts and risks where the exposure base changes are updated each year. This is a process in which an agent gives updated information to the underwriter and modifications are made to the renewal policy.

3. Large-account renewal demands a more hands-on underwriting approach. Often the renewal underwriting review is as rigorous as underwriting new business because:

- these risks are large and complex,
- exposures and operations can change over the course of the year,
- pricing may need to be adjusted,
- adverse loss experience may have occurred, and
- they may be subject to reinsurance.

The underwriter may require new applications and may also request an updated inspection.

For small and large carriers who still have products that require underwriter involvement, the individual underwriter is still called upon to make acceptance decisions. As carriers determine their risk appetite, capacity, and establish portfolio strategies to deal with large loss, they typically will draft a set of guidelines or internal rules as a valuable resource for underwriters. The carriers have learned over the years what lines of business have been profitable and which have presented challenges. Based on this experience, underwriting guidelines assist the individual underwriter in the selection and renewal of accounts. It is important underwriters adhere to these guidelines since they are written with the product rules, rates, and forms in mind. To ensure this adherence, companies may have individuals who perform underwriting audits on the business being placed on the books.

Automated policy systems which approve, quote, and issue policies already have these guidelines built into the approval criteria. Even with automated policies, there may be a referral of the policy to an underwriter. Underwriting guidelines permit the underwriters to determine which are acceptable and which not acceptable, resulting in the declination of the individual account.

Underwriting Resources

Learning Objective:

3.2 Describe tools used in the underwriting process.

Most underwriters perform their job within an office environment and seldom, if ever, venture into the field, with the exception of **production underwriters**. In addition to their underwriting responsibilities, production underwriters also manage product distribution. They travel to different insurance agencies to develop agent relationships and promote the company's products and services. Since most underwriters cannot see first-hand the risks that are being submitted for their consideration, they must rely on other tools, resources, and personnel in order to properly evaluate a risk and determine acceptability. There are many resources available to underwriters, and the ones selected depend on the types of reviews needed for individual accounts.

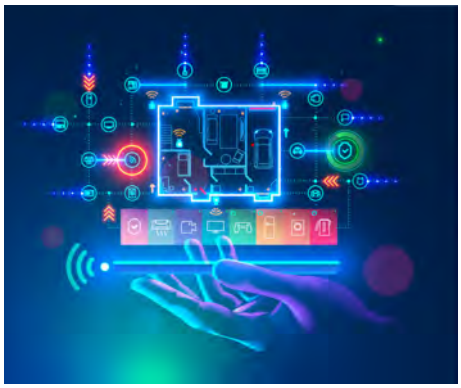
As an example, personal lines risks (personal automobile and homeowners') are the least complex accounts to underwrite. The information required to underwrite these lines properly is readily available electronically and is often delivered automatically to an underwriter, facilitating quick decision making. These resources include:

- motor vehicle reports on drivers
- automobile registrations and vehicle details
- deeds of purchase and sale
- CLUE (Comprehensive Loss Underwriting Exchange) reports
- credit reports
- permit data on home construction and repairs
- aerial imagery
- flood zones
- proximity to fire stations and fire hydrants
- other pertinent information available on various websites

The advent of automated underwriting tools, facilitated by artificial intelligence (AI) and predictive analytics, is transforming commodity lines. Unlike large, complex commercial accounts, the decision-making process with these smaller policies is more objective, lending itself to automation. This frees-up underwriters to spend their time on accounts that are flagged for underwriting review, since AI can handle the black-and-white decisions.

Artificial intelligence (AI) is defined as the theory and development of computer systems able to perform tasks that normally require human intelligence, such as visual perception, speech recognition, decision making, and translation between languages.

Predictive analytics encompasses a variety of statistical techniques from data mining, predictive modeling, and machine learning, that analyze current and historical facts to make predictions about future or otherwise unknown events.



Telematics is another tool that enables a granular examination of personal lines accounts, letting underwriters zero-in on individual risks. For example, tracking devices that are either installed in a vehicle or downloaded via an app onto a smart phone allow a carrier to assess the driving habits of particular drivers, and in some cases, structure premiums around those habits. On the homeowners' insurance side, Internet-of-Things (IoT) devices installed in homes provide real-time information on consumer data like water usage. These devices can monitor and shut off water to a home when excessive flow is detected, potentially averting large, costly water claims. The presence of an IoT device can be used to adjust pricing to reflect the change in exposure.

For commercial lines accounts, the data mentioned above are available along with other robust sources.

Examples include:

- the agent's personal knowledge of an account
- detailed financial statements
- loss runs from prior carriers
- loss control reports
- premium audits
- underwriting tools such as:
  - Best's Hazard Index
  - FC&S bulletins
  - SIC codes
  - NAICS codes
  - OSHA standards
  - IRMI reports

One is not more important than the other. However, collectively, the tools and resources support the underwriter in making informed decisions with more confidence. In fact, the information available will, in most cases, be even more comprehensive than what the underwriters could have obtained on their own.

Knowledge Check

Directions: List the tools and resources that are available to the underwriting department to identify appropriate risks and rewards and align or realign company targets to the tactical plan.

_____

_____

_____

_____

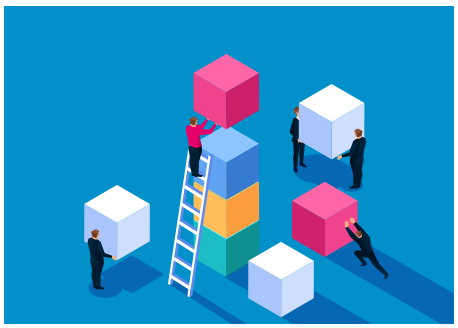
Department Structure

Learning Objective:

3.3 Identify the considerations in structuring an underwriting department.

A company's underwriting department is established and structured based on specific criteria.

Company Size



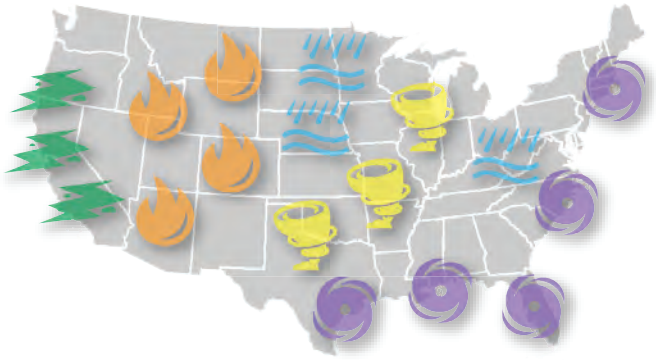
Small insurance companies may have only one a few underwriters within an underwriting department. Limited resources means that these underwriters are generalists out of necessity. They may have to handle multiple lines of business across many states. As a company grows and expands, the resource will need to change.

Large companies may have a centralized home office and regional branch offices. Each will have its own underwriting department. Often the function of underwriters in this context varies depending on whether the individuals work in the home or a branch office. Likewise, the amount of authority granted to these individuals will vary depending on the individual underwriter's job function and experience level. Larger

companies may have the luxury of designating underwriters as specialists in their various market segments and geographical territories.

Geographic Territory

The EMT geographical territory selection influences the types of experience and expertise required within an underwriting department. For example, imagine that a company's geographic territory is a coastal region prone to hurricanes. Underwriting in such a catastrophe-exposed territory requires a level of expertise that is distinctly different from the kind of expertise required in territories exposed to catastrophes like wildfire, earthquake, flood, and tornado or hail.



Another distinguishing factor is the level of understanding of risks associated with urban versus suburban or rural territories. For example, writing an apartment building in the middle of a densely populated urban area is much different than writing a family-owned farm on 1,000 acres of land in a rural territory.

Account Types

Finally, an underwriting team's required skill set is driven by the types of accounts the EMT has decided to target. Underwriting personal lines accounts, for example, requires differing levels of experience and expertise depending upon whether a company is writing mainstream personal lines or high net worth accounts.

Commercial lines accounts not only differ from personal lines, but they also differ based on what segment of the market a company is targeting—small commercial versus middle-market commercial versus large, more complex, commercial accounts.

Finally, if a company works in specialty or niche markets, such as professional or fiduciary liability, it will need an underwriting team with an extremely focused skill set.

Structural Evolution

As a company begins to grow and expand, the departmental needs change. As it changes, it may require a restructure of its underwriting department. Whether it is adding lines of business, expanding into new geographic territories, or both, a company will add new teams to meet demands.

Sometimes growth and expansion occurs as the result of mergers and acquisitions. The impact of the M&A will depend on the organization being acquired. The EMT may choose to operate as one insurance company if both companies have similar risk appetites. If the appetites

are different, it may choose to operate as separate entities. This may be due to the different skill levels needed to underwrite or to keep the risk appetites segregated for operational or other purposes.

The following table lists types of underwriters insurance carriers use and describes the underwriters' functions and their authority levels. Note, however, that the titles and descriptions in the table are not comprehensive. Different insurance companies use various titles for these roles.

Job Title	Area of Responsibility or Expertise	Decision-Making Authority
Underwriter Assistant Underwriter Trainee Underwriter Underwriter I Underwriter II	Responsibilities are typically well defined. For example, they may be aligned with a line of business such as personal versus commercial lines or by new versus renewal business or by class of risk. A specific territory or a territory's size may determine where an individual at one of these levels is assigned.	Authority is defined within each job title and increases as the job title progresses from top to bottom.
Staff Underwriter	People in this position have no line responsibility to agents. Individuals assist management; authorize rules exceptions; conduct internal audits; participate in rate reviews; and interpret rules for other underwriters.	Authority is defined.
Senior/Executive Underwriter	People in these positions may have specialized skill sets and may be more experienced. They serve as mentors; examine new lines of business or niches more closely; and work with other departments within a company.	An individual at this level has greater expertise and so greater authority.
Production Underwriter	People in this position have a higher level of business expertise and are given sales growth objectives in addition to profitability and retention objectives. Individuals may be assigned to specific territories; lines of business; or agents. They may have greater marketing responsibilities and increased service responsibilities. Licensure may be required.	An individual at this level has a higher level of authority than a senior or executive underwriter. The production underwriter makes decisions related to a broader range of risks and often makes on-the-spot decisions, increasing the value and authority of this position.
Specialty Underwriter	Individuals in this position have defined areas of responsibility for a specific class, coverage, or program. They typically have expertise in particular areas, such as large or specialized accounts, technology risks, cyber, trucking, and construction.	The level of authority is specific to the area of specialty.

A company may grant underwriting authority to individuals outside the company. The following table presents examples of external sources and their levels of underwriting authority.

External Resource	Underwriting Authority
Independent Agency Personnel	Independent agency personnel must be granted authority by contract or agreement. Those individuals with such authority follow guidelines established by the company. The option of using this external resource is common for small commercial and personal lines accounts, and non-complex risks.
Exclusive, Direct, Captive Agents	These individuals are closely tied with the insurance company and need to be able to make certain decisions in the process of writing business; therefore, the company grants them underwriting authority.
Marketing Representatives	Individual insurance companies determine the underwriting authority.
Managing General Agent (MGA)	An MGA contract or agreement defines the level of authority.
Risk Specialist/Loss Control Specialist	Individual insurance companies determine the underwriting authority.

Knowledge Check

Directions: Name three considerations when structuring or restructuring the underwriting department.

1. _____

2. _____

3. _____

Market Cycles

Learning Objective:

3.4 Define the two market cycles and provide characteristics of each.

Like many other industries, the insurance industry has historically been subject to significant market cycles. Property and casualty insurance market cycles can be severe, alternating between what are commonly called "hard markets" and "soft markets."

There are many factors that influence the market cycle, both from within and outside the insurance industry.

1. Desire for top-line revenue growth: Top-line growth is generally driven by a desire to gain market share. A company looking for market share will drive hard to write as much business as possible. This is accomplished by allowing greater flexibility within the underwriting guidelines, which allows more marginal risks to be written. A company can also add additional lines of business on existing accounts.

2. Focus on bottom-line profits: Requiring strict adherence to underwriting guidelines and restricting exceptions increases bottom-line profits. A company can also maintain its pricing integrity rather than using discretionary credits to reduce rates artificially. Pricing integrity refers to a company's adherence to actuarially sound premiums despite outside influences, such as competition. Finally, a company can restrict certain classes of business that have the potential to be volatile or less profitable.

3. Success or failure of peer companies within the industry

4. Catastrophic losses

5. Reinsurance availability

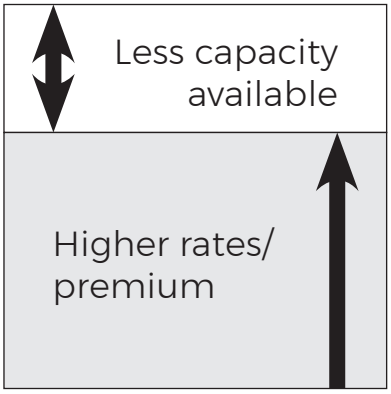
6. Economic influences

Hard Market

A hard market begins when companies begin to raise rates and restrict coverage availability. This is driven by a deterioration in industry-wide bottom-line results. Generally, companies cease making any profits in one or more lines of business and need to take remedial action to restore profitability. Industry unprofitability can be driven by increases in attritional losses (a company's day-to-day losses); litigation and adverse court decisions; catastrophic losses; unavailability of reinsurance; and lack of capital.

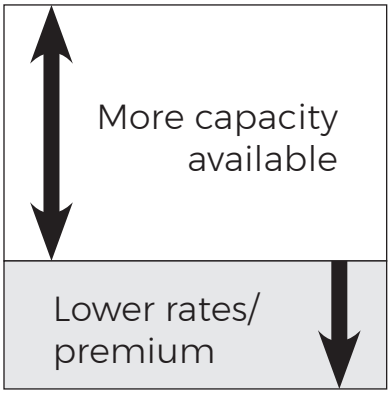
During a hard market, a company may restrict offered coverages, tighten underwriting standards significantly, raise rates, and exit certain segments of business entirely. Often carriers will de-emphasize new business acquisition but will want to retain their existing business. Companies maintain this conservative posture until bottom-line profitability is restored and capital accumulation occurs. Another result of a hard market cycle is the use of excess and surplus lines (E&S) markets for placing risks that admitted markets are canceling to reduce exposure.

Hard Market



Soft Market

Soft Market



A soft market begins when companies have successfully restored profitability and once again have an appetite for top-line growth. Characteristics of a soft market include a relaxation of strict underwriting guidelines, targeted pricing decreases (in order to increase market penetration), and a roll out of new coverages and products. Over time, this activity accelerates, and unsupported price slashing sometimes occurs, causing significant market disruption.

While in a soft market, companies may also gamble on broadening their underwriting eligibility and using relaxed standards in order to capture business in a market that has become increasingly competitive. This is all driven by a desire for revenue growth and increased market penetration. One result of this is that consumers become "price-shoppers" first, regardless of whether a carrier's products are the best fit or if coverages are comparable. When this cycle reaches its bottom, the inevitable result is deterioration in profitability, and the cycle repeats itself.

The Market Cycle

Over time, the length and duration of a market cycle varies and depends on a number of influential conditions. Historically, some soft markets have lasted for many years, leading experts in the insurance industry to wonder if the cycle has been broken and whether the industry is in a "new normal." Inevitably, however, soft markets come to an end, and a hard market takes hold.

As a general rule, the economic pressure on companies to grow causes soft markets to last longer than hard markets. Over the years some companies have boasted that they are going to "bring an end to the market cycle." However, as these companies have found, no one company, no matter how large, can have the kind of influence on a market as diverse and fragmented as the insurance industry.

Due to the various factors influencing the market cycles, it should be noted that sometimes commercial and personal lines market cycles may not coincide. It's even possible that within commercial or personal lines (such as commercial property versus workers compensation, or personal auto versus homeowners), the cycles for some *products* may not coincide.

Knowledge Check

Directions: Name the two types of market cycles and list three characteristics of each.

1. _____

   a. _____

   b. _____

   c. _____

2. _____

   a. _____

   b. _____

   c. _____

Reinsurance

Learning Objective:

3.5 Given an example, determine the type of reinsurance necessary and explain its use.

Most companies purchase some form of reinsurance. Simply stated, reinsurance is "insurance on insurance."

The numbers are staggering when you look at the exposure insurance companies carry. The exchange of premium for risk is pennies on the dollar. A company may not have the level of capital to support the exposure it wants to write. This could be related to a new line of business, a new territory, an exposure to catastrophe, or the run-off of lines it is exiting. This depends, of course, on the strategic plan and the tactical plan the underwriting department has identified to implement it.

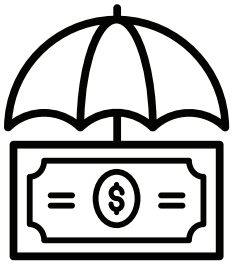
Prior to introducing some conventional reinsurance programs generally used within the industry, three terms need to be defined.

Reinsurance is a contractual arrangement in which one insurance company agrees to insure the assumed liabilities of another insurance company. Others that may use reinsurance are self-insured firms or another reinsurance company.

To "cede" means, roughly, to "give up." Therefore, a **ceding company** is the primary insurance company that is transferring part of its liability to another insurance company.

A **reinsurer** is an insurance company that accepts the liabilities from a ceding company for a stated premium.

Types of Reinsurance Contracts



There are two primary types of reinsurance—treaty reinsurance and facultative reinsurance.

With **treaty reinsurance**, a ceding company and a reinsurer enter into an agreement for certain classes of business that are to be ceded. In the agreement, the reinsurer agrees to accept all risks that qualify under the treaty. This assures the ceding company that coverage is automatically in place for all those classes of business.

Facultative reinsurance is written on a risk-by-risk basis. Each exposure that a company wishes to reinsure is offered to the reinsurer as a single transaction. The reinsurer underwrites each risk the same way the ceding company does—individually when the submission is received. The reinsurer is not obligated to accept any submission. Facultative reinsurance is most commonly used when insuring large property exposures or high hazard risks.

Treaty and facultative reinsurance can be written on a pro rata (proportional) or excess-of-loss (non-proportional) basis. The form of reinsurance written depends on the arrangement by which losses are apportioned between the ceding company and the reinsurer.

Pro Rata Reinsurance

Pro rata reinsurance is an agreement between the ceding company and a reinsurer to share insurance based on an agreed percentage. The agreed percentage applies to both the losses and the premiums paid. In return, the ceding company receives a ceding commission back from the reinsurer, similar to an insurance agency receiving commission on premiums it paid for its business insurance. Since there is typically no occurrence limit under the pro rata agreement, the insurer has a level of catastrophe exposure. That said, many agreements will exclude coverage for certain types of catastrophes, such as tropical systems or earthquakes.

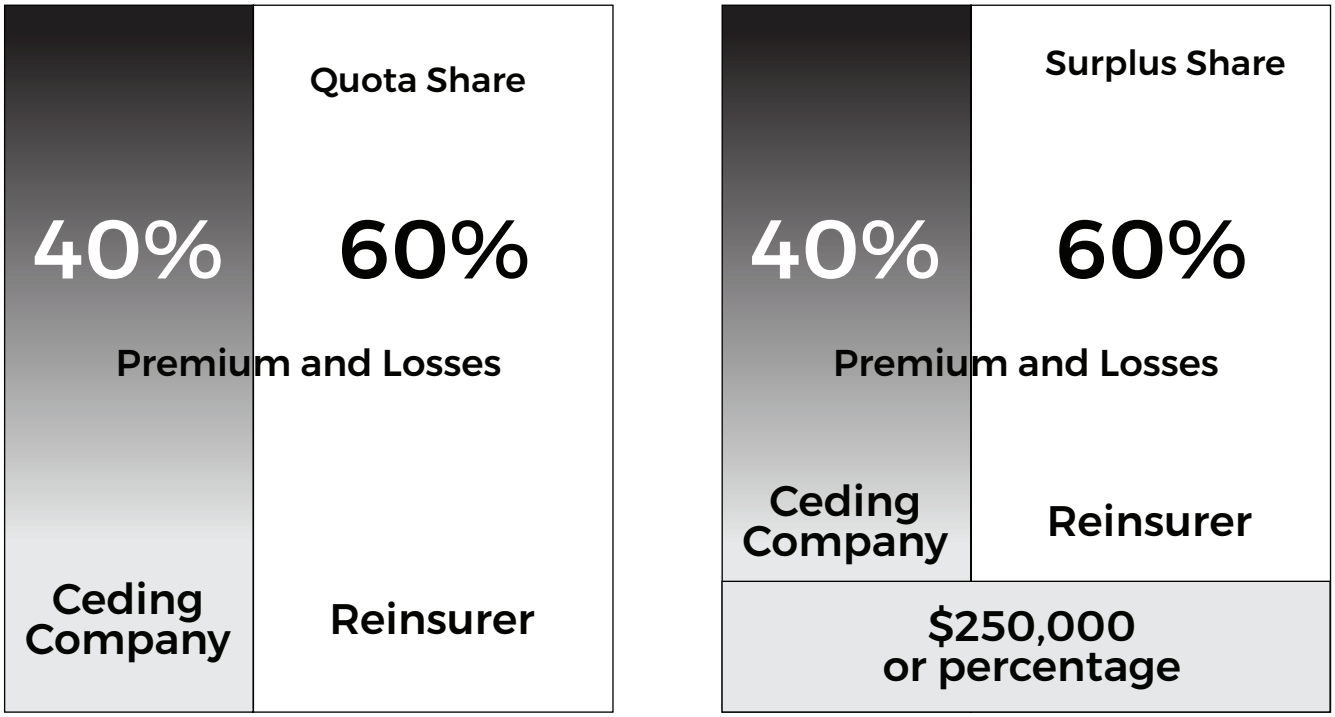
Pro rata reinsurance can be written in one of two forms:

1. **Quota Share**—The ceding company cedes a percentage of every exposure it insures within a class or classes subject to the treaty. Premium and losses are shared according to the percentage stated in the treaty.

2. **Surplus Share**—Similar to quota share, the sharing percentage is stated in the agreement. However, losses are not shared until they exceed a net retention described in the agreement.

Pro rata and excess of loss are basic examples of reinsurance. Actual reinsurance contracts could be (and will be) different percentages and retentions, as well as a combination of the two.

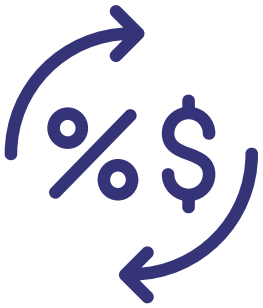
Pro Rata Reinsurance (Proportional)
($1M limit on each example)



Excess of Loss Reinsurance

In an excess of loss reinsurance agreement, a ceding company agrees to retain a certain amount of liability for losses. This liability is known as the company's retention. The reinsurer agrees to indemnify the ceding company for all losses exceeding the retention up to the limit in the agreement. The retention can be expressed as a dollar amount or as a percentage amount. The reinsurer does not participate in a loss until it exceeds the retention amount.

There are three types of excess of loss reinsurance:



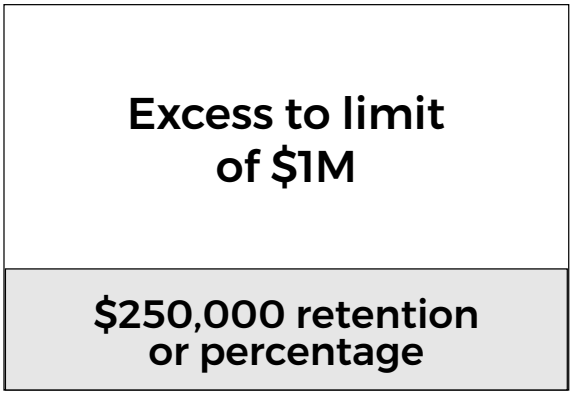
1. **Per risk excess of loss:** The reinsurer pays only when the loss from a specific risk from any one occurrence exceeds a predetermined retention.

2. **Per occurrence excess of loss:** The reinsurer pays only when the aggregate losses from any one defined occurrence exceed the predetermined retention. This is sometimes referred to as catastrophe reinsurance.

3. **Aggregate excess of loss:** The reinsurer pays when the ceding company's aggregate net losses exceed a predetermined amount or proportion of premium income. This is commonly referred to as stop loss or loss ratio reinsurance. In the example below, the ceding company retains the first $250,000 of the loss. The reinsurer responds to the amount that is in excess of the retention until the loss reaches $1,000,000. If the total loss is less than $1,000,000, the reinsurer only pays the amount in excess of the retention. However, if the loss exceeds $1,000,000, the responsibility goes back to the ceding company.

Per Risk

Excess of Loss Reinsurance (Non-proportional)
$750,000 in excess of $250,000 retention



General Uses of Reinsurance

There can be a variety of legitimate and useful reasons why a company would choose to use reinsurance. Carriers that are small, large, and anywhere in between will have a number of treaties and facultative programs in place that they are managing and adjusting on at least an annual basis. Here are some of the reasons why reinsurance is used.

Market Entrance

When an insurance company begins selling a new line of business, the exposure is astronomically greater than the earned premium. Even a relatively small loss can create a loss ratio that must be overcome before that line of business is profitable. Reinsurance allows a company to share risk until the premium volume reaches a certain point or the ceding company gains confidence in unfamiliar coverages.

Stabilizing Loss Experience

Sometimes a company experiences wide variations in financial results from year to year that can create regulatory, shareholder/policyholder, or rating agency problems. Reinsurance can be used to smooth these fluctuations.

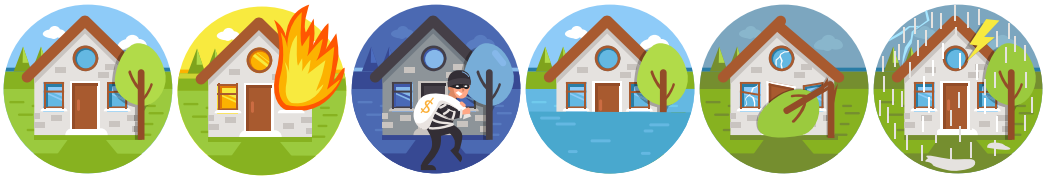
Underwriting Assistance

A company may want to venture into new lines of business or unfamiliar territories. Because they typically deal in many geographical territories and lines of business, reinsurers can provide guidance and counsel.

Increased Capacity

Regardless of size, every insurance company wants to be able to compete in the marketplace. Securing the proper reinsurance may allow a company to increase its ability to write larger lines of business than it would otherwise be able or willing to do. Insurance regulation may prohibit a company from exposing more than 10% of its policyholder surplus on a single risk.

Catastrophe Protection



Catastrophic events can cause devastating losses for an insurance company. These losses can result in decreased earnings and even possible insolvency. Reinsurance can be purchased to alleviate the potential consequences of hurricanes, earthquakes, tornadoes, and wildfires. Even single events such as explosions or improper manufacturing of a particular product can result in catastrophe for an insurance company.

Retirement

An insurance company may decide it no longer wants to write in a certain territory, a class of business, or a book of business. When it retires from writing business, the company has three basic choices. It can choose:

- not to renew any of the business and let it "run off."
- cancel all existing policies and return unearned premiums—if allowed to do so by the regulator.
- purchase portfolio reinsurance.

While many view reinsurance as a means to stabilize loss experience, it can do much more for the primary insurance company. From providing expertise, to catastrophe protection, to retirement of business, reinsurance plays a vital role in the stability and solvency of the insurance company. Assured that its writings are adequately protected, the insurance company has the confidence and ability to invest in its operations or expand into new territories and/or lines of business.

Knowledge Check

According to the tactical plan, the underwriting department has identified a need for new product support and entrance into a new market that is prone to wildfires. What kind of reinsurance would you need. Why?

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Loss Control

Learning Objective:

3.6 Evaluate the need for loss control in the underwriting process and justify its use.

Loss Control Services

Depending upon underwriting guidelines, someone may need to evaluate certain risks on behalf of a company. The evaluation can be an inspection or a risk survey.

Inspections and risk surveys are completed by loss control personnel, that is, individuals possessing expertise in specific risks. These inspections or surveys may be completed by company personnel, outsourced to third-party vendors, or a combination of both.

The titles of personnel providing this service vary by insurance company. Common titles include:

- Loss Control Representative
- Risk Engineer
- Safety Engineer
- Safety Specialist
- Risk Management Specialist

The levels of responsibility for loss control personnel may vary by insurance company, line of business, and account size. Loss control personnel are used primarily in commercial lines. However, some companies may use outside inspection vendors for personal residential risks or high net worth risks.

Loss control can sometimes be a misunderstood function of an insurance company. Some people believe that the job of loss control is to find something wrong with a risk. In fact, the primary function is to determine what an insured does correctly. Although there may be some negatives for every risk a company writes, most of the time, loss control personnel use their expertise to discover characteristics of an insured that have a positive influence on an underwriting decision.

Purpose and Function

Loss control personnel perform risk assessments and underwriting surveys that enhance the underwriting process. Certain types of risks or more complex accounts may require a risk assessment prior to underwriting approval. Others may be required to be completed within the first 30 to 60 days of a policy period.

The purpose of the assessment or survey is to help facilitate an underwriter's risk selection by helping to determine the insurability of a risk. It identifies and evaluates the risk exposures presented by the insured. Once the evaluation is complete, an analyses report is provided to help the underwriter better understand the risk so proper classifications can be assigned.

Loss control personnel provide recommendations to help eliminate or reduce the possibility of loss or to minimize the severity of loss. Some recommendations may require mandatory compliance, while other may be optional. Once recommendations have been made to the insured, loss control personnel follow up to see if the recommendations have been implemented.

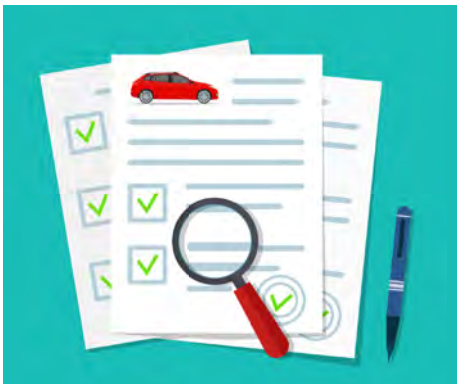
Sometimes insureds will want help completing the recommendations or may desire to improve their safety and loss control methods. Loss control personnel can review analytical data and propose solutions and loss prevention strategies to help them.

When losses occur, the claims department may want loss control personnel to collaborate on loss or post-loss investigations. Since loss control is generally involved in solutions, the collaboration may result in reduced exposure to future losses.

Finally, in addition to insureds, loss control personnel can provide training for insurance company personnel. They can, for example, give underwriters additional training regarding the loss control aspects of specialty or larger commercial risks and the influence of those risks. This allows underwriters to have a greater understanding of the accounts they are involved with.

Accessing Services

Loss control services may be provided with or without a fee structure. Some loss control services are provided with the purchase of a policy. These are sometimes called value-added services. Examples of value-added services are safety materials, basic safety programs, annual safety meetings, OSHA safety training, and inspections and recommendations—all of which are provided free of charge.



Other services are provided on a fee basis. These are services that are offered in addition to the basic services all policyholders receive. Formal safety programs, regular and frequent safety meetings, MVR and background checks, distracted driver training, and other services that are over and above traditional basic services are examples of fee-based services.

Loss control services can also be bundled or unbundled. Bundled services are commonly offered without a separate fee and are offered to all policyholders. Unbundled services are provided through third-party vendors that offer loss control services for a fee. These are generally loss control consultants who specialize in specific areas or industries. They may also be referred to as risk management consultants.

Loss Control Tools

While many of the services provided by loss control personnel are completed by personal inspection, some level of technology usage is also required. Roof and upper-floor inspections are often completed using drone technology, for example. A drone uses software that can zoom in for close inspection of existing damage and can measure a roof to provide roof replacement cost estimates. Water flow sensors are another example of a loss control tool. These sensors are used or recommended for insureds who have exposure from pipes that may leak. Google Earth also provides aerial views of insureds' locations.

Loss control personnel can also access OSHA reports, state safety bureau reports, and other real time risk intelligence. Data related to specific risks allow loss control personnel to perform some level of predictive modeling as part of the services they provide.

Knowledge Check

Directions: Make a case for why loss control can help in these two situations:

1. A policy covering a remote property in rough terrain is up for renewal. The property has not been viewed in a few years. How can loss control personnel or tools help in this scenario?

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2. Several recommendations to lower premium have been made to lessen risk at a commercial property location. How can loss control personnel provide support in this scenario?

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Premium Audit

Learning Objective:

3.7 Identify the functions of a premium audit and defend its use.

Deposit Premiums

Commercial general liability, business auto, and workers' compensation are examples of lines of business in which exposures are estimated when policies are written or renewed. Since premiums are estimated up front, premiums charged are **deposit premiums.**

After a policy period expires, a company must determine the actual exposure for an insured during the time the policy was in force. This determination requires a premium audit.

The purpose of a **premium audit** is to ascertain an actual exposure so the insurance company can collect the premium developed by that exposure. While casualty policies are primarily subject to premium audits, there may be other lines of business that require audits after policy expiration.

Policies subject to premium audits have contract language that provides for such financial reviews. Rules and rates dictate which classes of business may be subject to audit.

These are two critical components of the proper pricing of a risk—classification and estimated premium basis. Both components contribute to pricing integrity and help develop statistical accuracy.

Classification

When a policy is written, a **classification** is developed based on the description of the insured's scope of operation. In some cases, the scope of operation requires only a single classification. In other cases, the scope of operation may include a number of separate, yet similar operations. Once again, most of the time, a single classification most accurately describes the business operations, but there are times an insured will have separate distinct operations that require separate classifications.

Once classifications are determined, the exposure base reflects the most accurate method of pricing the risk. Premiums for workers' compensation and employers' liability policies are based on remuneration. Remuneration is commonly thought to be payroll. While payroll *is* a portion of remuneration, it is not necessarily *all* remuneration. Domestic workers are rated on a per capita basis.

Commercial general liability policies have a number of different exposure bases depending upon the classification of risk.

This table from the ISO *Commercial General Liability Manual* indicates the numbering system used in ISO's *General Liability Classification Manual* for various industry sectors.

Look at this excerpt from the ISO Commercial General Liability Manual.

Business Operations	Class Codes
Manufacturing or processing	Codes 50000–59999
Contracting or servicing	Codes 90000–99999
Mercantile	Codes 10000–19999
Buildings or premises—office or residential occupancy or leased to others	Codes 60000–69999
Miscellaneous	Codes 40000–49999

Estimated Premium Basis

Insurance carriers make every effort to collect an appropriate premium for the liability exposures being insured. This effort relies on two factors. First, the risk must be correctly classified. Next, the risk is assigned a **premium basis** based on that classification. In order to properly assess exposure, the premium basis should accurately reflect the exposure presented. Advisory rating services provide the premium bases (as shown in the following table) to accomplish the goal of collecting the appropriate premium for exposure. The table shows the basis, definition, and application of commercial general liability coverage for various types of operations. The appropriate premium basis is prescribed based on the risk classification shown in this example.

Summary of CGL of Premiums		
Exposure Bases	**Definition**	**Application of Rate**
Admissions	The total number of persons, other than employees of the named insured, admitted to the event insured or to events conducted on the premises whether on paid admissions, tickets, complimentary tickets, or passes.	Per 1,000 admissions
Area	The total number of square feet of floor space at the insured premises, computed as per the *CLM Manual.*	Per 1,000 sq. ft. of area
Each	This basis of premium involves units of exposure, and the quantity comprising each unit of exposure is indicated in the classification footnotes, such as "per person."	

Summary of CGL of Premiums		
Exposure Bases	**Definition**	**Application of Rate**
Gross sales	The gross amount charged by the named insured, concessionaires of the named insured, or by others trading under the insured's name for a) all goods or products, sold or distributed; b) operations performed during the policy period; c) rentals; and d) dues or fees. See the *CLM Manual* for inclusions and exclusions.	Per $1,000 of Gross Sales
Payroll	Payroll means remuneration. Remuneration means money or substitutes for money. See the *CLM Manual* for inclusions, exclusions, and overtime.	Per $1,000 of payroll
Total cost	The total cost of all work let or sublet in connection with each specific project including: 1) the cost of all labor, materials and equipment furnished, used or delivered for use in the execution of the work, however, do not include the cost of finished equipment installed but not furnished by the subcontractor if the subcontractor does no other work on or in connection with such equipment; and 2) all fees, bonuses or commissions made, paid or due.	Per $1,000 of Total Cost
Total Operating Expenditures	Total expenditures (including grants, entitlements, and shared revenue) without regard to source of revenue during the policy period, including accounts payable. See the *CLM Manual* for inclusions, exclusions, and accounting terminology.	Per $1,000 of Total Operating Expenditures
Units	A single room or group of rooms intended for occupancy as separate living quarters by a family, by a group of unrelated persons living together, or by a person living alone.	

Another example is the Business Auto Policy. It has a number of exposures that are rated on an estimated basis, requiring a post-policy period audit. Certain symbols give automatic coverage for vehicles whether or not they are listed on the policy. Some exposures are rated on cost of hire, number of employees, gross sales receipts, or mileage. The actual exposures must be determined for the proper premium charge.

Types of Audits

Audits can be performed in a number of ways. Large insurers may have internal staff dedicated to conducting premium audits. These staff members perform audits on-site wherever a company's insureds are located. Other insurers outsource premium audit functions to a third-party audit firm.

Some insurance companies require insureds of smaller accounts to complete voluntary audits. These insurance companies mail the voluntary audits along with instructions. Insureds fill out the audit forms and then mail them back to their insurance companies.

An insured that uses a payroll vendor may allow that vendor to report its payroll to its insurer.

Some companies that write workers' compensation allow insureds to do monthly self-audits. An insured fills out a form each month indicating the payroll for the previous month and includes a check for the amount of the premium developed. This makes the annual audit a bit easier since the records should match the reports.

Some insurers waive the audit requirement for small accounts. Regardless of the audit method, it simply may not be cost effective to pursue them.

Audit Periods

Generally, the audit period for most policies is annual. An insurance company has the option of going back several years if there has been no previous audit. If the company and the insured prefer to have audits more frequently than annually, that is also an option.

Auditor's Primary Responsibilities

An auditor's primary responsibilities include following industry and the insurance company's rules and procedures. If a company uses ISO classifications, the auditor will also use the *PAAS® (Premium Audit Advisory Service) Classification Guide*, a detailed manual that includes extensive interpretations on the intent and proper application of each classification. The auditor reviews the policyholder's operations to ensure that the business exposures are properly classified. Once the proper classification is determined, the auditor then reviews the books and records and determines the actual premium basis for the audit period.

Final Premium Audit Impact

The final audit is usually completed within 60 to 90 days after a policy expires. Once the final audit is completed, the insurer adjusts the premium based on the classifications and exposures determined by the auditor. The results could be a change in classification, a change in the exposure base, or both. If the exposure base is higher than estimated, the insured will owe an additional premium (AP) for the audit period. On the other hand, if the exposure base is less than estimated, the insured will receive a return premium (RP). Generally, improper classification can create a significant premium audit adjustment since it can impact the rates charged in addition to any exposure changes.

Changes to the expired policy period due to the premium audit may also affect the renewal policy. If classifications and/or exposures have increased, the company will increase the renewal term. This helps the insurer and the insured avoid a large AP or RP on the next year's premium audit.

Knowledge Check

Why are premium audits important? Give a justification for audits for medium and large accounts. How can these audits be carried out in a cost-effective way?

Underwriting Technology

Learning Objective:

3.8 Justify the selection of specific technology used in the underwriting process.

Within an insurance carrier, technology plays a critical role in making products available to customers. Deploying technology enables a carrier to assess customers' risk and exposure, align products to customers' needs, and provide supporting services.

Technology capabilities vary widely, depending on the markets served and the type of distribution used. The design of technology is closely connected to the process and experience that a carrier wishes to create for customers and producers and to the underwriting approach it employs in the products it wishes to sell. The following table shows some of the differences in products that lead to differences in the needed technology:

Market Served	% of Business Processed Using *Only* Technology, i.e., "Straight Through"	Rating and Pricing	Coverages and Product Features
Personal Auto	90%+	Calculations based entirely on rating formulas and algorithmic pricing models	Standardized policy forms
Small Commercial	50%–75%	Calculations based on rating formulas and algorithmic pricing models, with some ability for underwriters to modify based on individual risk characteristics	Standardized policy forms, with some more advanced features which must be selected or filled in for each customer
Large Commercial	0%	A technical price is calculated which the underwriter usually has broad ability to modify based on individual risk exposure, prior losses, and underwriting judgment	Standard forms which may include extensive individual modifications tailored to each risk including individually scripted coverage language

More commoditized lines of business such as personal lines and small commercial are characterized by a large number of small, repeatable transactions. The premium for many of these products is often only a few hundred dollars. Therefore, it is critical for carriers in these markets to process these lines of business as seamlessly and efficiently as possible, to promote ease of doing business, and to keep expenses low. Underwriting is articulated through a system of rules which are programmed into the program, allowing most transactions to be processed without human intervention. This enables real-time response and ensures fair, consistent treatment of large numbers of customers.

In larger commercial lines accounts or more specialized lines of business, the pricing, underwriting and coverage considerations vary greatly from one risk to the other and can be complex. Here, technology automates the more routine elements of the process. But an underwriter, working with a producer, makes the subjective judgments and decisions needed to evaluate risk, weigh options, tailor coverage specifically to each client, and negotiate terms.

As a result, there is no one-size solution that fits all carriers or markets. But there are many common components used to make up the portfolio of technology solutions that a carrier may choose to use.

Policy Management Systems

A policy management system is at the center of the technology suite used for product management and underwriting. The system provides the foundational capability to complete the technical calculations and transactions needed to sell an insurance product to a prospective customer. It is the central point into which application data is received, underwriting is performed, price is calculated, coverage options are made available, policy forms are compiled, and a policy is delivered.

Policy management systems vary significantly for different products and from one carrier to another, but generally they can be thought of as providing capabilities to complete six basic policy transactions: new policies, renewal policies, mid-term changes/endorsements, cancellations, reinstatements, and audits.

Policy management systems generally include the following components:

- **Submission Intake:** The transaction process begins with the application data being entered into a policy management system. This data includes basic information such as the name and address of the insured, information about the exposures to be covered, and the types of coverage requested.
- **Technology Suite:** There is also a suite of technology, often referred to as "upload/download," that provides direct transfer of submission data from an agency management system into a carrier's system. This data is captured in the carrier's policy management system and the resulting output is downloaded electronically back into the agent's system.
- **OFAC:** The Office of Foreign Assets Control (OFAC) is a division of the US Treasury which enforces economic and trade sanctions applicable to other countries. Insurers generally comply with OFAC requirements by automatically checking applicant information against OFAC rules in their systems.
- **Clearance:** Prospective clients may apply for insurance with multiple producers. To avoid providing multiple quotes which may be inconsistent or even competitive with one another to different producers, policy management systems review applications when they are received to determine whether they were previously submitted from another producer.
- **Rating:** The rating process involves collecting application data and applying the rating rules for each product to calculate a price. These rules can be complex and may involve detailed calculations for the myriad options and features that are available within most insurance products.

- **Quoting:** Quoting capability is the means by which a proposed product and premium are offered to a customer. A policy management system summarizes the data used and constructs a binding legal document.

- **Bind/Policy Issuance:** Once a quote has been accepted, a policy management system delivers the supporting documentation which may include a binder confirming coverage and a policy which includes all of the details of coverage: the named insured, the coverages provided, the legal language, and all policy forms which make up the product, as well as notices or other documents that are required by state regulators.

Because policy management systems provide the environment in which insurance products are transacted, they also hold all of the data from those transactions and make that data available to other functions through the insurance carrier. Some examples of that data include policy numbers and effective dates provided to the claims department to verify coverage and premiums; commissions sent to the finance department for financial reporting; and individual risk data supplied to the actuarial department to monitor and adjust rates.

While there are some cases where carriers will choose to build a policy management system themselves, most carriers work with established vendors in the policy management systems market. These systems provide some of the core functions that are needed "off the shelf." Carriers then configure them further for the specific product and underwriting strategy they wish to employ. This approach of buying and customizing usually provides faster speed to market, less cost, and lower execution risk.

Underwriting

While a policy management system provides the transactional capabilities to process business, the decision about which risks meet a carrier's underwriting requirements, as well as the appropriate pricing for each risk, are driven by underwriting and pricing logic incorporated into the system. Depending on the markets served, some of these elements may include:

Predictive modeling: formulas that adjust for individual risk characteristics that are not reflected in the basic rating structure.

Underwriting warnings: Some systems are programmed to trigger a notice to an underwriter based on a set of predetermined business rules. For example, when writing coastal property business, a carrier may have requirements about the minimum deductibles that are required depending on how close the insured location is to the water. These rules may be built into the system to notify the underwriter of the requirements or for personal lines and smaller commercial business, the system may apply these rules automatically.

Internal data: As part of the underwriting process, data from other functions within a company is usually collected for review. This may include claims data to support renewal policies, loss control data to assist with underwriting review of larger commercial accounts, and premium audit data to validate estimates of exposures which change over the course of a policy.

External data: For many products, external data is used in the underwriting process to confirm the information in the application or to supplement the application with additional information to better understand the exposure. For example, for property data, it is common to use external services to validate property values to ensure 100% insurance to value. In some lines of insurance, personal credit may be used. For automobile products, insurers access state Department of Motor Vehicle databases for driver records. The supply of external data and the emergence of new databases and vendors has expanded significantly in recent years and carriers are continually evaluating new ways to improve their understanding of individual risks.

Underwriting controls/governance: Distinct from underwriting guidance, many systems also impose limits on what underwriters are permitted to do, in order to protect a company both from an underwriting risk that is outside of the company's appetite and to ensure regulatory compliance. For example, a policy management system may identify and block classes of business that are excluded by a company's reinsurance program, or it may prevent an underwriter from making a pricing or coverage decision that conflicts with a company's approved filings.

Other Product and Underwriting Technology

In addition to the core systems that deliver the underwriting and policy transaction capabilities, for many types of insurance there is additional technology to support other specific elements of the process:

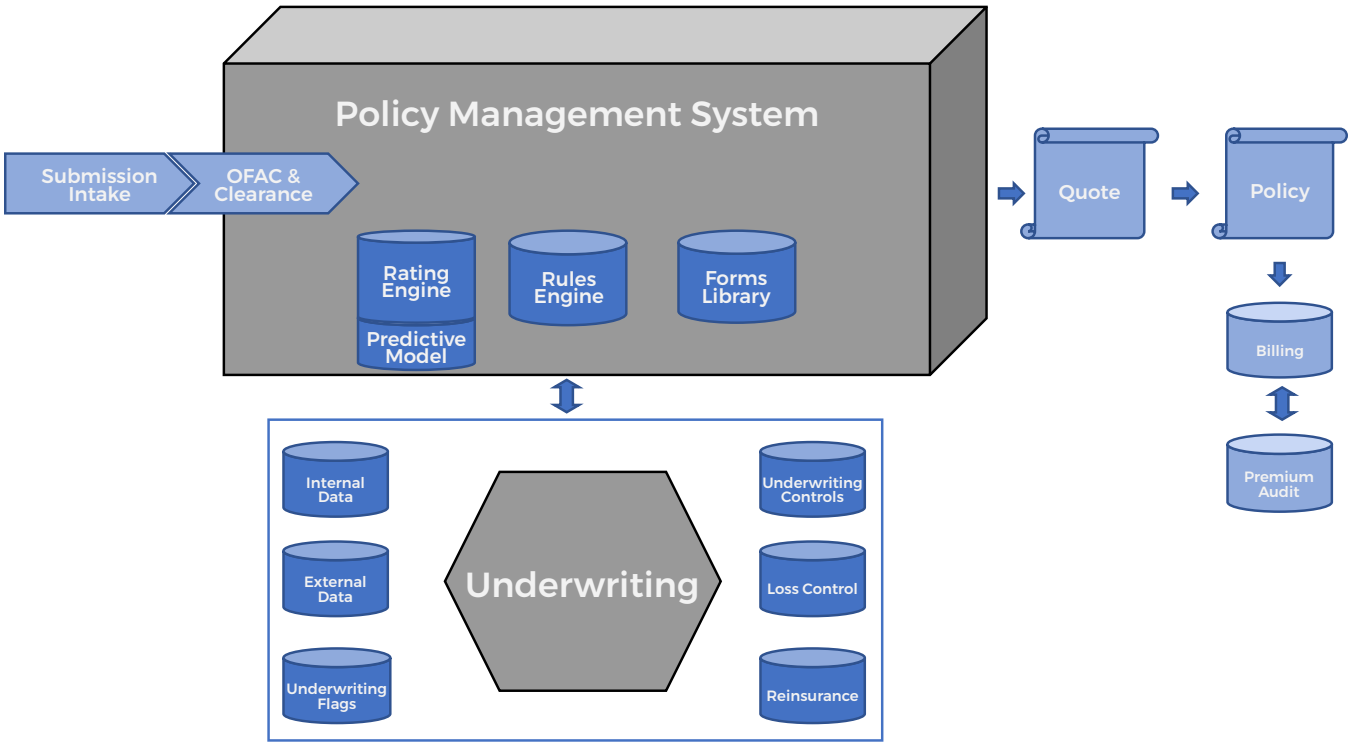
- **Billing Systems:** capture the transaction output of a policy management system and translate those orders into a bill showing the amounts due from, or owed to, a customer. The bill is delivered to the customer identifying the policies and transactions made, the associated premiums, and if applicable, any installments and due dates. If there are multiple policies in force for a customer, many billing systems seek to combine them into a single account bill to create a single, centralized view for the customer.

- **Loss Control Systems:** support the process of loss control used to write commercial business. They automate functions, such as the scheduling of inspections, capture of inspection results, follow-ups on recommended improvements, and creation and tracking of loss control service plans.

- **Premium Audit Systems:** For many commercial policies, the exposure used to calculate the premium at policy inception is an estimate and so must be trued-up at policy expiration through an audit. A premium audit system automates this process. Most systems determine what form the audit will take (mail, phone, online entry, physical visit), and schedule and track the audit, capture the results, and deliver the additional or return premium calculation to the billing system.

- **Reinsurance Systems:** Often, carriers that make use of facultative reinsurance for individual risks use technology to keep track of the business they are writing and the reinsurance they are securing for that business. For example, a company might write a property limit of $50M, with the intent of retaining the first $10M and buying individual facultative reinsurance for the $40M layer above $10M. Carriers use systems to maintain the details of these individual contracts including the insured name, effective dates, location information, the reinsurer and broker (if any), and contract terms. They also keep track of premium paid for the reinsurance, as well as coverage in the event of a claim.

As you can see, the technology used to conduct underwriting and deliver a carrier's products is really a collection of systems, each part working in concert with other parts to complete various steps in the process. Below is a diagram that shows a simple underwriting and product delivery platform with the interaction among the different components.



Knowledge Check

Directions: Describe the reasons and tasks necessary for effective software and hardware systems technology that can handle different kinds of data interfaces within the underwriting department and between other databases, such as that of a reinsurer.

_____

_____

_____

_____

Summary

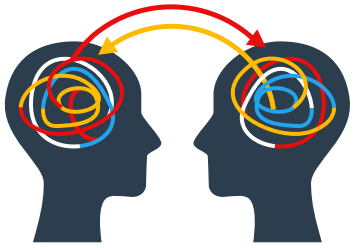
The underwriting department interacts with the product development department and the EMT to implement the company's strategic plan. A tactical plan for the underwriting process is put into motion. It is based on the framework of the six steps in the underwriting process and the tools and resources available to this department. The six steps in the process are as follows: In Step 1, an initial review is conducted to determine acceptability of a submitted "new business" application. Step 2: If a submission is accepted, there is an additional information request (credit reports, loss control inspections, MVRs, CLUE reports, and so on). Step 3 addresses coverage determination (deductible options, limits, endorsements, or other modifications). The policy may still be declined at this point. In the next step, Step 4, pricing is set to reflect the risk involved (discretionary pricing, standard pricing, and preferred program pricing). Commodity lines and some personal lines products are usually regulated or class rated with no changes allowed. Step 5 is policy issuance—by hard copy or electronic, although some regulators do not allow electronic delivery of the policy. The final, and sixth step, follow-up, is a check to see that the client has complied with any conditions set for the policy to be in force. For "renewal business" the steps are simplified. Personal lines and small business account renewals are automated and do not change unless some anomaly triggers a more in-depth review. A closer look is taken at these every three to five years. Middle-market accounts are updated yearly because of exposure-base changes. Agents provide this information to underwriters and modifications are made to the policy. Large account renewals require more care because of their size and complexity, and their exposures change more rapidly. Policy modifications, pricing, reinsurance considerations, and a request for inspection based on loss history make this a longer renewal process.

Underwriting resources and tools for research include official documents, like MVR reports, credit reports, CLUE reports, loss reports, aerial imagery, flood zones, and websites. Also, automated technology systems like artificial intelligence systems, modeling and predictive analysis, and telematics (special tracking and app software) are useful to glean data. New in-house off-the-shelf IT systems can interface with outside and inside data sources, making the access to information more available and automatic. These tools and resources can streamline and impact the structure of the Underwriting department, making it more agile and able to activate and refine the tactical plan for the division. Company size, geographic territory, account types, company evolution and new products, market cycles (hard and soft) and losses can affect the restructuring of a company. Availability of reinsurance is vital to a growing company. Pro rata and excess of loss reinsurance are two types of reinsurance available and are different ways to handle cost and risk. The strategic plan is formulated and the product development and underwriting departments are working together with the EMT to drill down and create their own interconnected tactical plans to implement all the facets of the strategy. The underwriting team will continue to use cutting-edge data technology, agent and broker sources, and other metrics to review the success of the new products and established programs as claims come in.

Speaking From Experience

For valuable reinforcement, some important concepts related to the learning objectives in this section, use the following link to access video clips from insurance company professionals actively engaged in these departmental strategies.

scic.com/ICOresources



Section 3: Self-Quiz

The Tactical Plan and the Underwriting Process

Directions: The six steps to the underwriting process are shown below in random order. Sequentially number the steps in their correct order, beginning with step 1.

	Policy issuance
	Additional information request
	Follow-up
	Initial review
	Pricing
	Coverage determination

Directions: Use the following terms to fill in the blanks.

acceptability	**are not**
accuracy	**certain regulators may not**
all regulators do not	**experience factor found in the underwriting guidelines**
are	**merits of the risk, program, or agency segmentation**

1. Applications from agents _____ the only resource needed to complete the underwriting process.

2. Underwriters make the initial review of the insurance application and supporting documents to determine the _____ of a submission.

3. Discretionary pricing refers to the ability of an individual underwriter to credit or debit an account or a portion of an account based on the _____.

4. _____ allow policies to be delivered electronically.

Directions: Match the type of business with the characteristics of renewal underwriting for that type of business.

A. Personal lines and small commercial lines accounts **B.** Large accounts **C.** Middle-market accounts	_____ are risks where the exposure base changes are updated each year. This is a process in which an agent gives updated information to the underwriter and modifications are made to the renewal policy.. _____ demands a more hands-on approach. Often the renewal underwriting review is as rigorous as new business. _____ are often referred to as commodity lines. For these accounts, the renewal underwriting process is as automated as possible.

Underwriting Resources

Directions: Circle True or False.

1. There are many resources available to underwriters, and the ones selected depend on the types of reviews they need for individual accounts.

True **False**

2. Similar to commercial lines, the underwriting decision-making process for personal and small commercial lines is less objective, thus not lending itself to automation.

True **False**

3. The agent's personal knowledge of an account is a robust source of underwriting information for commercial lines.

True **False**

4. Deeds of purchase, CLUE reports, and data on home construction and repair are all examples of resources used in personal lines underwriting.

True **False**

Directions: Match the following terms with the descriptions:

A. Artificial intelligence **B.** Predictive analytics **C.** Telematics	_____ encompass a variety of statistical techniques, including data mining, modeling, and machine learning that analyze current and historical facts to make assessments about future or otherwise unknown events.
	_____ is defined as the theory and development of computer systems able to perform tasks that normally require human intelligence, such as visual perception, speech recognition, decision-making, and translation between languages.
	_____ is a tool that enables a granular examination of personal lines accounts, letting underwriters zero-in on individual risks. Examples include vehicle tracking devices and devices in homes to provide real-time information.

Directions: For each of the following sources of information, indicate whether they are predominately used in commercial lines or personal lines by putting a C or P after the source of information.

5. CLUE reports _____

6. Premium audits _____

7. Detailed financial statements _____

8. Permit data on home construction and repair _____

9. Tools such as Best Hazard Index, FC&S, and NAICS codes _____

Department Structure

1. Which four of the following is the correct list of specific criteria used to structure an underwriting department?
   - ☐ Company size
   - ☐ Geographic territory
   - ☐ Account types
   - ☐ Structural evolution
   - ☐ Company charter
   - ☐ Legal environment
   - ☐ Distribution force
   - ☐ Investment return

Directions: Indicate with a Yes or No which of the following entities may be granted underwriting authority.

2. Policyholders

Yes **No**

3. Independent agency personnel

Yes **No**

4. Exclusive, direct, captive agents

Yes **No**

5. Marketing representatives

Yes **No**

6. Policyholder's legal counsel

Yes **No**

7. Managing general agents (MGA)

Yes **No**

8. Risk specialist/loss control specialist

Yes **No**

Directions: Circle True or False.

9. Underwriters employed by small insurance companies are typically generalists out of necessity.

True **False**

10. Large insurance companies may have the luxury of designating underwriters as specialists in their various market segments and geographical territories.

True **False**

11. Geographical territory has no influence on the types of experience and expertise required within an underwriting department.

True **False**

12. Underwriting of commercial lines is the same whether it be small commercial, middle-market, or large commercial accounts.

True **False**

13. As a company grows and expands, the underwriting department needs to change.

True **False**

Market Cycles

Directions: Indicate with a Yes or No which of the following factors influence the insurance market cycle.

1. Desire for top-line revenue growth

Yes **No**

2. Focus on bottom-line profits

Yes **No**

3. Success or failure of peer companies within the industry

Yes **No**

4. Catastrophic losses

Yes **No**

5. Reinsurance availability

Yes **No**

6. Economic influences such as interest rates, inflation, and stock market trends

Yes **No**

Directions: For each of the following, indicate which market cycle it best describes—Hard or Soft.

7. Companies begin to raise rates.

Hard **Soft**

8. Companies restrict coverage availability.

Hard **Soft**

9. Companies are in a growth mode.

Hard **Soft**

10. Companies relax their underwriting guidelines.

Hard **Soft**

11. Companies roll out new products and coverages.

Hard **Soft**

12. Companies create a need for the excess and surplus markets.

Hard **Soft**

Directions: Use the following terms to fill in the blanks.

actuarially sound	**growth goals**
bottom-line profitability	**increased**
coverage hunters	**may not**
catastrophic losses only	**price shoppers**
day-to-day losses	**will always**

13. Pricing integrity refers to a company's adherence to _____ premiums despite outside influences.

14. "Attritional" losses refer to a company's _____.

15. During a hard market, companies maintain a conservative posture until _____ is achieved.

16. During a soft market, consumers become _____ first.

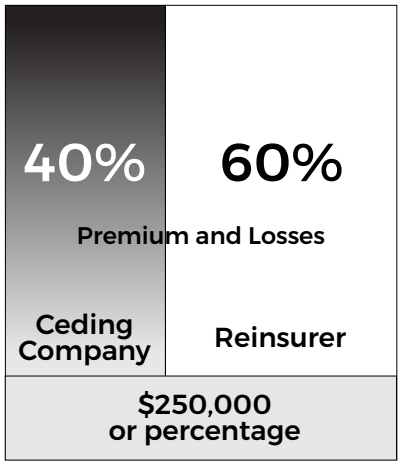
17. Due to the various factors influencing the market cycles, it should be noted that commercial and personal lines market cycles _____ coincide.

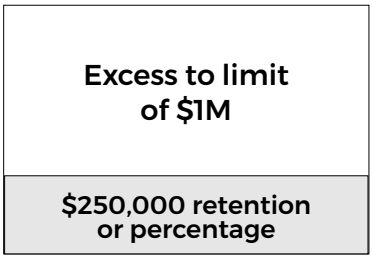
Reinsurance

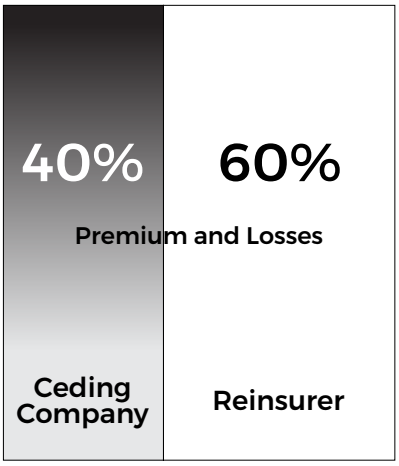
Directions: Match the following seven reinsurance terms with their appropriate definition:

Terms	Definitions
A. Reinsurance **B.** Ceding company **C.** Reinsurer **D.** Treaty reinsurance **E.** Facultative reinsurance **F.** Pro rata reinsurance **G.** Excess of loss reinsurance	_____ A ceding company and a reinsurer enter into an agreement for certain classes of business that are to be ceded. In the agreement, the reinsurer agrees to accept all risks that qualify under the treaty.
	_____ An agreement between an insured and reinsurer to share insurance based on an agreed percentage.
	_____ This reinsurance is written on a risk-by-risk basis. Each exposure that a company wishes to reinsure is offered to the reinsurer as a single transaction.
	_____ A contractual arrangement in which one insurance company agrees to insure the assumed liabilities of another insurance company.
	_____ A ceding company agrees to retain a certain amount of liability for losses. This liability is known as the company's retention. The reinsurer agrees to indemnify the ceding company for all losses exceeding the retention up to the limit in the agreement.
	_____ An insurance company that accepts the liabilities from a ceding company for a stated premium.
	_____ The primary insurance company that is transferring part of its liability to another insurance company.

Directions: The three illustrations shown below represent pro rata quota share, pro rata surplus share, and excess of loss reinsurance. Identify each by placing the appropriate description under each illustration.







Directions: Circle True or False.

1. A company may want to venture into new lines of business or unfamiliar territories. Because they typically deal in many geographical territories and lines of business, reinsurers can provide guidance and counsel.

   True **False**

2. The choice of whether to use treaty or facultative reinsurance is determined by the insurance company's size.

   True **False**

3. Securing the proper reinsurance may allow a company to increase its ability to write larger lines of business than it would otherwise be able or willing to do.

   True **False**

4. Reinsurance allows a company to share risk until the premium volume reaches a certain point or the ceding company gains confidence in unfamiliar coverages.

   True **False**

5. Reinsurance can be purchased to alleviate the potential consequences of hurricanes, earthquakes, tornadoes, and wildfires.

True **False**

6. Apex Insurance Company has an excellent portfolio of coverages and experienced underwriters. Therefore, they do not need reinsurance.

True **False**

7. Sometimes a company experiences wide variations in financial results from year to year that can create regulatory, shareholder/policyholder, or rating agency problems. Reinsurance can be used to smooth these fluctuations.

True **False**

Loss Control

Directions: Select the correct statement from each of the following groups of three.

- ☐ The loss control process is necessary on the review of every commercial risk.
- ☐ Loss control personnel perform risk assessments and underwriting surveys that enhance the underwriting process.
- ☐ The loss control department must sign off on risks of a predetermined premium volume.

- ☐ The purpose of the assessment or survey is to comply with the state department of insurance regulations.
- ☐ The purpose of the assessment or survey is to satisfy reinsurance requirements.
- ☐ The purpose of the assessment or survey is to help facilitate an underwriter's risk selection by helping to determine the insurability of a risk.

- ☐ Some loss control recommendations may require mandatory compliance, while others may be optional.
- ☐ All loss control recommendations are mandatory.
- ☐ All loss control recommendations are optional.

- ☐ All loss control services are automatically provided to policyholders without a fee.
- ☐ Loss control services may be provided with or without a fee structure.
- ☐ Companies typically charge for each and every loss control service provided.

Premium Audit

Directions: Select the correct word or phrase to make the following statements correct.

60 to 90 days	**description of the insured's scope of operation**
90 to 120 days	**estimated premium basis**
actual exposure	**insured's operation**
annual	**owe an additional premium**
be owed a return premium	**semi-annual**
coverage territory	

1. The purpose of a premium audit is to ascertain the _____ so the insurance company can collect the premium developed by that exposure.

2. These are two critical components of the proper pricing of a risk—classification and _____.

3. When a policy is written, a classification is developed based on the _____.

4. Generally, the audit period for most policies is _____.

5. The final audit is usually completed within _____ after a policy expires.

6. If the exposure base is higher than estimated, the insured will _____ for the audit period.

Directions: Circle True or False.

7. General liability uses a number of different exposure bases, depending on the nature of the risk.

True **False**

8. Advisory rating services provide the premium bases to accomplish the goal of collecting the appropriate premium for exposure.

True **False**

9. The *Commercial Lines Manual* provides direction on how to apply the exposure bases.

True **False**

10. For most general liability exposures, the rating is on a per $100 of exposure basis.

True **False**

11. Remuneration means gross sales.

True **False**

12. The Business Auto Policy has a number of exposures that are rated on an estimated basis, requiring a post-policy period audit.

True **False**

Underwriting Technology

Directions: Match the following underwriting technology component terms with the appropriate description in the table.

Component Terms	Descriptions
A. Submission intake **B.** "Upload/ download" **C.** Office of Foreign Assets Control **D.** Rating **E.** Quoting **F.** Binding/ policy issuance **G.** Clearance	_____ The means by which a proposed product and premium are offered to a customer.
	_____ A division of the US Treasury which enforces economic and trade sanctions applicable to other countries.
	_____ The transaction process begins with the application data being entered into a policy management system. This data includes basic information such as the name and address of the insured, information about the exposures to be covered, and the types of coverage requested.
	_____ Once a quote has been accepted, a policy management system delivers the supporting documentation which may include a binder confirming coverage and a policy which includes all of the details of coverage
	_____ Provides direct transfer of submission data from an agency management system into a carrier's system. This data is captured in the carrier's policy management system and the resulting output is downloaded electronically back into the agent's system.
	_____ Prospective clients may apply for insurance with multiple producers. To avoid providing multiple quotes which may be inconsistent or even competitive with one another and belong to different producers, policy management systems review applications when they are received to determine whether they were previously submitted by another producer.
	_____ This process involves collecting application data and applying the rating rules for each product to calculate a price.

Directions: Rank in the correct order from highest to lowest, the lines of business which have the most to least amount of "pass-through" ability due to technology.

Ranking	Lines of Business (shown in random order)
	Small Commercial
	Personal Auto
	Large Commercial

Underwriting Technology

Directions: Choose the underwriting policy management term/tool that matches the description.

Underwriting Management Terms/Tools	Terms/Tools Descriptions
A. Predictive modeling **B.** Underwriting warnings **C.** Internal data **D.** External data **E.** Underwriting controls/ governance	_____ Distinct from underwriting guidance, many systems also impose limits on what underwriters are permitted to do, in order to protect a company both from underwriting risk that is outside of the company's appetite and to ensure regulatory compliance.
	_____ Some systems are programmed to trigger a notice to an underwriter based on a set of predetermined business rules.
	_____ As part of the underwriting process, data from other functions within a company is usually collected for review.
	_____ Data is used in the underwriting process to confirm the information in the application or to supplement the application with additional information to better understand the exposure.
	_____ Formulas that adjust for individual risk characteristics that are not reflected in the basic rating structure.

Section 4: Claims Management

Section Goal

In this section, you'll learn about the claims management process—from planning to managing to technology.

Learning Objectives:

4.1 *Incorporate claims management considerations into a plan to support the company's strategic plan.*

4.2 *Determine specific considerations with each step of the claims process and explain them.*

4.3 *Evaluate a claim in regard to the roles of subrogation and salvage.*

4.4 *Analyze the problem of fraud from the perspective of a special investigative unit and consider the appropriate solution.*

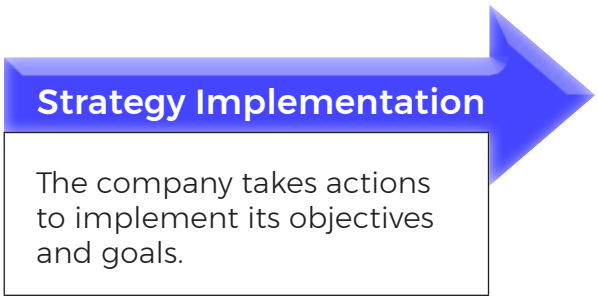
4.5 *Defend the value of litigation management to the insurance company.*

4.6 *Predict possible outcomes when an insurance company acts in bad faith.*

4.7 *Give examples of the considerations for a CAT (catastrophe) plan and evaluate their importance.*

4.8 *Understand claims technologies and how they impact the success of a claims department and the insurance company.*

Tactical Plan for Claims Management



The policies that are sold by the company provide a promise to make payment to or on behalf of the policyholder in the event the policyholder sustains an economic loss as defined by the policy. Some policies include payment for legal defense costs, as well. Depending upon the type of policy, there are one or more parties to the promise. Other parties to the promise can include additional insureds, loss payees, lender loss payees, mortgage holders, and others that have been added to the policy.

When losses occur, it is the job of the claims department to determine if the promise made in the policy has been triggered. That determination involves investigation and interpretation of the policy in light of the circumstances surrounding the claim. Proper claims handling will help ensure that the insurance company meets its financial goals.

Capital is critical to insurance company survival. Recall that actuaries contemplate that claims will occur, and how much money will be paid out when they have completed their complicated mathematical calculations to determine rates and develop IBNR. Part of that calculation includes reserves and payments on claims. Underpayment or overpayment, and/or under-reserving or over-reserving of claims can have a huge impact on the financial health of the organization and create regulatory issues.

The claims department is, of course, like every other department, aware of the EMT's strategic plan and is involved in determining ways to successfully carry it out. The claims team will execute its tactical plan by setting up resources, guidelines, and goals, and monitoring systems to ensure the strategic plan is implemented and current controls are working and meeting expectations. Let's look at this in more detail.

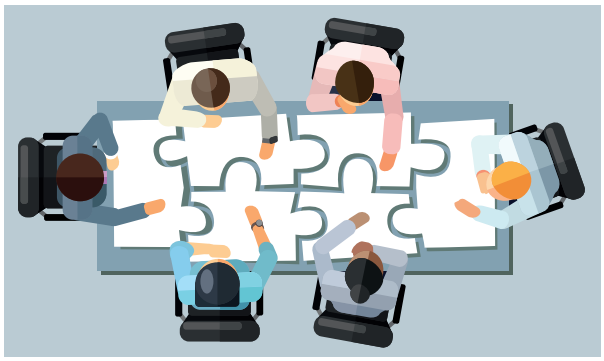
Claims' Tactical Plan

Learning Objective:

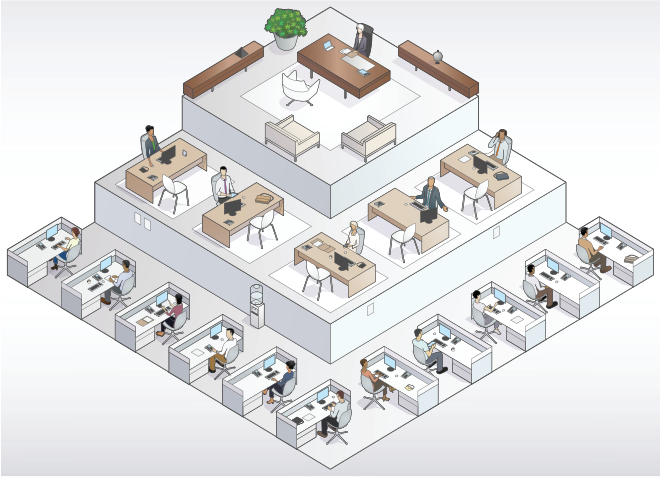
4.1 *Incorporate claims management considerations into a plan to support the company's strategic plan.*

Strategy

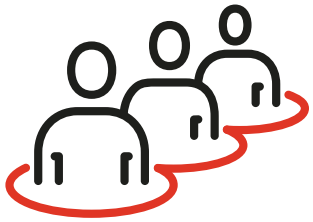
In the formulation of the strategic plan, consideration was given to the fact that the lines of business being written by the company would result in losses that would have to be paid. Resources have been allocated to the handling of claims so now it's up to the claims management team to create and execute ways to meet the goals set by the executive management team.



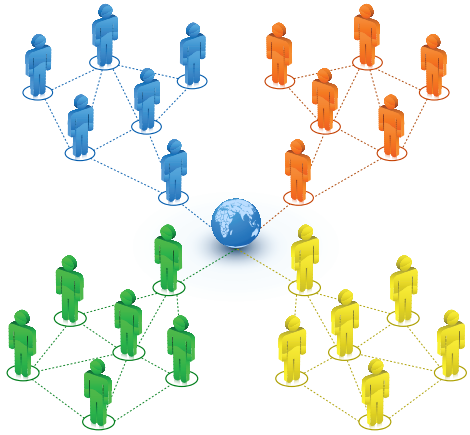
The first consideration will be the allocation of human resources. A claims department cannot execute without people. Structure within the department will need to be decided. How many people, and at what levels, will the department need? The initial number may be small, but management will need to determine the metrics used to help in the decision about when and where to add personnel within the department structure. As the company grows, the claims management team will continue to evolve.



Since it is when a claim is filed that the policyholder finds out how good the company really is, focusing on customer experience is critical. In the formative years of a company, customer experience may reside mainly within the people working in the actual claim process. Understanding how customers perceive the process and the quality of their experience is critical to a company's image. Over time, as the department grows, a separate customer experience team may be developed to follow up and receive feedback from the policyholder after the claim is closed. That feedback is then aggregated and analyzed by the claims management team. When personnel must deal with new product lines, training must also be increased. How well the new products are understood will smooth the roll-out of this part of the strategic plan.



In the property and casualty world, many claims must be handled outside of the office. The claims management team must decide how the field structure will be laid out. At first, a company may use the services of independent adjusting firms or a Third-Party Administrator (TPA). TPAs generally handle the majority of the claims function and may even have some level of draft authority. Independent adjusters typically handle the outside investigation and estimation of damages. Internal staff known as desk adjusters will then take the reports and estimations to determine if and how much the company will pay. As a company grows, it may desire to begin bringing part or all of the outside functions in-house rather than outsourcing to third-parties. At that point, the company begins to use its own employees to handle claims in the field and make payments to the policyholder.



Lines of authority will need to be determined based on rank within the department. Desk adjusters may only have authority to settle small claims. From there, larger claims may require supervisor approval before they can be paid. Eventually, lines of authority will be given all the way up to the claims' VP level. Some companies may require very large claims to be approved by the EMT before being paid out.

Specialty units may also be developed. Certain lines of business, such as excess liability, pollution liability, EPLI (employment practices liability insurance), and other specialty lines will require personnel with specialized experience in handling claims for those lines. Fraud will undoubtedly be an issue at some point, so the company will need to eventually develop a special investigations unit (SIU). Some claims will need to be paid by the company even though they're caused by someone else. The company will pay under the policyholder's policy and then seek reimbursement

from the at-fault party. Recovering those dollars requires the use of a subrogation and salvage department. SIU and subrogation/salvage will be discussed later in this section.

In addition to human resources, the claims management team will need to decide on what technology will be utilized in the reporting, investigation, handling, and closing of claims.

There are many decisions to be made, and all of them are important to the proper functioning of the claims department and the success of an insurance company.

Knowledge Check

Directions: Identify the different kinds of personnel and specialty units needed by the claims department to carry out the tactical plan.

_____

_____

_____

_____

Steps in the Claims Process and Its Strategic Plan

Learning Objective:

4.2 *Determine specific considerations with each step of the claims process and explain them.*

Process Overview

A claims adjuster must complete several steps in the claims process. While each insurance company has its own policies and procedures, claims handling processes are similar regarding the basic steps taken from report to resolution. These steps are as follows:

Note that these steps—report, investigate, verify, evaluate, and resolve—form a convenient acronym: **RIVER.** This acronym can be used to recall each step as we learn about it and why they are important functions in the claims process. It's important to remember that each step is equally as important as the others since they are all critical to the proper handling of a claim file.

Step 1: Claim Reporting (REPORT)

The first step in the claims process is reporting. Proper claim reporting is important to the entire claim process. Consequently, there are goals and significant subsequent steps, customer retention, and finances related to timely reporting.

Prompt reporting is essential when it comes to a claim. Reporting should be timely and accurate, allowing the company to get the initial details into the system as soon as possible. This helps ensure the adjuster can take action to mitigate and stabilize the claim quickly. Timely reporting helps to preserve the details of a loss for accuracy and completeness. Over time—even a short period of time—details can begin to fade, and facts become muddled. For example, taking statements from drivers as soon as possible after an auto accident is optimal. The more days that develop between the accident and when a statement can be secured affect the accuracy of the statement of events. Studies have shown that recounts of these events by a driver can change as time passes. This could be due to drivers forgetting some of the events or the advice of others can misconstrue their memory of the accident.

Most insurance policies contain a provision that advises the insured of their duties in the event a loss occurs. Some policies are general in nature, requiring notice as soon as practicable after the loss. Others may require notice within a certain period of time or even to a specific address noted in the policy. If a lawsuit is brought against the insured, the company must receive a copy of the notice immediately since there is typically a limited number of days to respond to the allegations in the suit. In addition, the insured and any others involved in the claim must cooperate with the insurance company in its investigation and defense.

Example: Section IV—Commercial General Liability Conditions

SECTION IV – COMMERCIAL GENERAL LIABILITY CONDITIONS

2. Duties In The Event Of Occurrence, Offense, Claim Or Suit

a. You must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim. To the extent possible, notice should include:

(1) How, when and where the "occurrence" or offense took place;

(2) The names and addresses of any injured persons and witnesses; and

(3) The nature and location of any injury or damage arising out of the "occurrence" or offense.

b. If a claim is made or "suit" is brought against any insured, you must:

(1) Immediately record the specifics of the claim or "suit" and the date received; and

(2) Notify us as soon as practicable.

You must see to it that we receive written notice of the claim or "suit" as soon as practicable.

c. You and any other involved insured must:

(1) Immediately send us copies of any demands, notices, summonses or legal papers received in connection with the claim or "suit";

(2) Authorize us to obtain records and other information;

(3) Cooperate with us in the investigation or settlement of the claim or defense against the "suit"; and

(4) Assist us, upon our request, in the enforcement of any right against any person or organization which may be liable to the insured because of injury or damage to which this insurance may also apply.

d. No insured will, except at that insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent.

Judicial Interpretation Regarding Prompt Reporting

An insured's failure to follow the condition regarding prompt reporting may result in denial of a claim. There are three primary judicial interpretations when the condition is violated by the insured.

- In some jurisdictions, non-compliance with the condition completely negates coverage.
- In other jurisdictions, non-compliance is interpreted as prejudice against the insurance company's ability to investigate and defend a claim as the result of the late notice. However, the insured may rebut the court's presumption.
- The majority of jurisdictions place the burden on the insurance company to demonstrate its rights were prejudiced before coverage is affected.

While prompt reporting is important regarding claims in all policies, it is of even greater importance in liability policies written on a claims made-and-reported basis. In order for claims to be covered by these policies, they must occur AND be reported during the policy period.

Methods of Reporting

There are several methods of reporting losses to an insurance company. Some agencies, as part of the service they provide to customers, prefer the policyholder call them to report a claim. In turn, the agency completes the "first notice of loss" (FNOL) and forwards it on to the insurance company. They may also enter the information directly into the company's electronic reporting system.

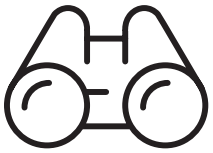
Some agencies, as well as some insurance companies, prefer that the policyholder report a claim directly to the company. In this case, the insured would call the claim reporting telephone number and complete the FNOL with the insurance company's claim personnel. This allows the company to get the information first-hand from the policyholder rather than through another party.

Sometimes claims are reported by third parties. For liability claims, this could be the third-party claimant or an attorney. With first-party claims, this could be an attorney or public adjuster that represents the insured. It could also be another party, such as a water mitigation firm the insured has hired.

Initial Case Reserve

Once the claim is reported and assigned to an adjuster, a case reserve is established. The case reserve could be a factor reserve generated by the claims department's software based on similar past claims. The initial case reserve may also be set manually by the adjuster that is assigned to the claim. As more details are received, the reserve may go up or down in relation to the initial reserve.

Step 2: Investigating a Claim (INVESTIGATE)



Now that the claim has been reported, the adjuster begins the investigation process. Determining whether or not coverage is applicable to a loss is the first step completed by a claims adjuster. The methodology used depends on whether the claim is first-party or third-party in nature.

First-party claims are losses suffered by the insured. These are generally property-related claims. In dealing with a first-party claim, and the adjuster needs to answer several questions to determine if coverage applies.

Insurable interest:

Did the insured have a financial interest in the property at the time the loss occurred?

Policy period:

Did the loss occur or start during the policy period?

Covered property:

Is the property listed on the policy, and does it qualify as covered property according to policy wording?

Policy limits:

Are the limits adequate, and do they meet any applicable insurance to value or coinsurance provisions?

Covered cause of loss:

Was the loss caused by a peril that is covered by the policy, and are there any exclusions or limitations that apply?

Endorsements:

Are there any applicable endorsements that add or delete coverage?

Third-party claims involve claimants who are not insureds but have been injured or had property damaged by an insured. Third-party losses involve the determination of legal liability on the part of the policyholder. As a result, the steps to determine coverage are greater and require more information.

Insured status:

Does the person or organization allegedly involved in the claim qualify as an insured under the policy?

Coverage territory:

Did the occurrence or offense take place in the coverage territory as defined by the policy?

Policy period:

Did the bodily injury, property damage, or personal and advertising injury take place during the policy period?

Exclusions:

Are there any exclusions that apply or any exceptions to the exclusions that grant coverage?

Occurrence:

Was there an occurrence as defined by the policy?

Policy limits:

Are the limits of insurance adequate?

Legal liability:

Is the insured legally liable?

Determining Legal Liability

While the ultimate determination of legal liability belongs to the courts, the adjuster must be able to understand and recognize when the policyholder may be held legally liable in order to settle the claim if needed. There are several ways in which coverage may be determined, and that determination may not always be based on legal liability.

Determination of Coverage	
Covered/with legal liability If a customer slips and falls in a store because the owner or employees did not clean up a spill, the adjuster can make a determination that the insured is legally liable.	**Not covered/with legal liability** A policyholder may be held legally liable for a situation that is not covered by the policy, such as breach of contract or certain pollution losses.
Covered/no legal liability There are certain coverages that require payment regardless of fault, such as medical payments or state-required no-fault coverage.	**Not covered/no legal liability** The policyholder may not be legally liable and no coverage applies.

In the determination process, there are four types of liability that can affect a claim.

1. **Statutory:**

   Statutory liability is created by law. A state's law may establish a standard of care that is required. If that standard of care is violated, it creates legal liability. Statutory law takes precedent over contracts.

2. **Contractual:**

   Contractual liability arises out of the assumption of liability by the parties to the contract. Known as contractual risk transfer, assumption of liability is quite common in agreements. Not all contractual liability assumption is covered by an insurance policy.

3. **Tort:**

   A tort is a civil wrong other than breach of contract. There are several types of tort liability.

   - Negligence:

     Negligence is liability that is based on the failure to exercise the appropriate amount of care given certain circumstances. Sometimes basic negligence is known as the "prudent person rule"—failure to do what a prudent person would do under similar circumstances.

Example: Elements of Negligence

Duty owed: the offending party has a duty owed, such as a duty to safely operate an automobile on the streets
Duty breached: the offending party must have breached that duty, such as running a red light
Damages: there must be damages, such as bodily injury and property damage
Proximate cause: the breach of the duty must be the proximate cause of the damages, such as the running of the light caused a collision that resulted in injuries to another

- Intentional torts

  Intentional torts involve acts that are intentionally committed. The harm they cause may or may not be intentional.

- Strict liability

  Strict liability is generally found in products liability and similar situations. In strict liability situations, it's up to the party subject to strict liability to prove that they were not negligent.

- Absolute liability

  Absolute liability is liability that is imposed without regard to fault. In some jurisdictions, dog bites and swimming pool accidents involving children are examples of situations that can create absolute liability. Others may involve pollution or liquor liability.

During the investigation process it may be required that the company defend the policyholder because of lawsuits. With insurance policies, the duty to defend is much broader than the duty to indemnify or pay on behalf of the insured. The company may need to provide defense even when the insured is not legally liable. When a lawsuit is filed against an insured it can contain a number of allegations. If at least one of the allegations is true and potentially covered by the policy, the insurance company must defend the entire lawsuit.

When determining if potential coverage exists, the adjuster compares the lawsuit with the policy. This process is sometimes referred to as the "four corners test" or the "eight corners test"—the four corners of the policy versus the four corners of the lawsuit. In some jurisdictions, outside evidence and information not contained in the policy or the lawsuit may be considered in determining whether coverage will apply. This is known as the "**extrinsic evidence rule**."

If either of these tests show that none of the allegations trigger coverage in the policy, then the insurance company has no duty to defend. While an adjuster may use deductive reasoning in making some decisions regarding a claim, as noted above, only the court can make the final determination of the policyholder's liability.

Detrimental Reliance

Detrimental reliance occurs when one party is reasonably induced to rely on a promise made by another party. Sometimes, just the act of investigating a claim can create the appearance that coverage exists in the policy in the mind of the policyholder even though there may not be. This is why it's very important for the adjuster to be clear with the policyholder when taking action on a claim.

Example: If the adjuster gives names to the insured of preferred body shops for repair estimates on a vehicle after a collision loss, and the insured does not have collision coverage on their policy, this could be construed as confirming coverage. This creates detrimental reliance if the insured has a shop begin repairs.

When the insured relies on the coverage implication to their detriment, a situation known as **estoppel** is created. According to *Black's Law Dictionary,* estoppel is defined as: "An affirmative defense alleging good-faith reliance on a misleading representation and an injury or detrimental change in position resulting from that reliance." Consequently, the insurance company is "estopped" or stopped from enforcing the exclusion and must provide coverage.

In order to avoid estoppel in situations where the investigation must be completed prior to determining coverage, one of two processes can be used.

The first process is known as a **reservation of rights** letter (ROR). The ROR is a unilateral document, meaning it is only signed by one party—the insurance company. The letter is sent by the insurance company to the policyholder advising them that although there is a question about whether or not a loss is covered, the insurance company will proceed with the investigation of the claim, but reserves its right to deny the claim at a later date.

The second process is known as a **non-waiver agreement**. This document is bilateral—meaning that it is signed by the insurance company and the insured. It's a contract or agreement acknowledging that there is potentially an issue with coverage, but that the investigation of the claim will proceed while the issue is being resolved. The company reserves its right to later deny coverage.

Declaratory Judgments

Sometimes the insurance company will want the court to interpret or clarify policy language prior to making a coverage decision. In this case, the company representatives will request a formal hearing with a judge, allowing the court to give its interpretation. While the court's decision regarding the clarification stands, it does not provide for or order enforcement of the policy.

Outside Services

The investigation process may require resources that involve the services of others. These services may be used in order to obtain additional information that is needed in order for the adjuster to make a proper coverage decision. Outside services could include those of private investigators, cause and origin experts, vocational experts, independent medical examiners, forensic accountants, consulting engineers, and accident reconstructionists.

Impact on Case Reserve

As the investigation process turns up more details, the case reserve may need to be increased as a result of the updated information. Also, the use of outside experts comes at a cost. These costs must be included in the incurred loss calculation as allocated loss adjustment expense (ALAE) since they can be allocated to a specific claim.

Step 3: Verify the Damages (VERIFY)

The next step in the claims process is to verify the damages claimed by the policyholder or the third-party claimant. The documentation needed will vary based on the type of claim.

For first-party property claims or third-party property damage claims, the adjuster will need some form of documentation that the property was owned by the claimant and what the value is. This can include receipts from when items were purchased or repair estimates given.

Time value claims, such as additional living expense, rental value, business income, and any extra expense will require financial information. For example, a homeowner will need to show the costs associated with having to live away from their home during repairs and provide documentation to verify what they would normally have spent. The difference between those two numbers is their additional living expense.

Claims that involve medical services, such as medical payments losses, workers' compensation, or third-party bodily injury losses will require copies of bills and receipts for medical services and treatments. The adjuster will review the reports and receipts and confirm the relationship of the injury to the accident. Sometimes there is a need to verify that the injury is truly related to the loss. If necessary, the adjuster may request an independent medical examination. This may require the use of surveillance, monitoring of social media, and review of previous medical records to rule out preexisting injuries.

The last step in the verification process for property-related claims is the policyholder's **proof of loss**. The proof of loss is a sworn statement by the claimant that is signed and notarized. The proof of loss includes an inventory of the lost or damaged property and its value.

Impact on Case Reserve

The process of adjusting case reserves on the claim will continue with this step. Once the adjuster receives all the necessary information they have requested, they will now be able to adjust the reserve on the claim up or down based on this updated information.

Step 4: Evaluate the Claim (EVALUATE)

At this point, normally, coverage has been determined and the investigation and verification processes are complete. Now it's time to evaluate the claim to determine what will be paid. The critical function of the adjuster is to determine what are the possible outcomes after obtaining all of the facts and details. This requires a thorough review and analysis of the claim. In this process, the adjuster is weighing potential damages, legal liability, and coverage questions. Having policies and procedures in place creates standardization and ensures greater consistency with how claims are handled.

Property Claims

When dealing with first-party property claims, there are factors involved in the equation of how much a company will pay, as shown in the example policy language, shown here. It must determined whether the policy language dictates the settlement to be replacement cost or actual cash value. If no repair or replacement of the property will be made by the insured, the adjuster must understand the difference in the settlement amount. There can also be a variety of outcomes when settling some property claims if the item or items are one of a kind or extremely rare.

Example: Sample property valuation provision—Building and Personal Property Coverage Form

Building and Personal Property Coverage Form

7. Valuation

We will determine the value of Covered Property in the event of loss or damage as follows:

a. At actual cash value as of the time of loss or damage, except as provided in **b., c., d.** and **e.** below.

b. If the Limit of Insurance for Building satisfies the Additional Condition, Coinsurance, and the cost to repair or replace the damaged building property is $2,500 or less, we will pay the cost of building repairs or replacement.

The cost of building repairs or replacement does not include the increased cost attributable to enforcement of or compliance with any ordinance or law regulating the construction, use or repair of any property.

However, the following property will be valued at the actual cash value, even when attached to the building:

(1) Awnings or floor coverings;

(2) Appliances for refrigerating, ventilating, cooking, dishwashing or laundering; or

(3) Outdoor equipment or furniture.

c. "Stock" you have sold but not delivered at the selling price less discounts and expenses you otherwise would have had.

d. Glass at the cost of replacement with safety-glazing material if required by law.

e. Tenants' Improvements and Betterments at:

(1) Actual cash value of the lost or damaged property if you make repairs promptly.

(2) A proportion of your original cost if you do not make repairs promptly. We will determine the proportionate value as follows:

(a) Multiply the original cost by the number of days from the loss or damage to the expiration of the lease; and

(b) Divide the amount determined in **(a)** above by the number of days from the installation of improvements to the expiration of the lease.

If your lease contains a renewal option, the expiration of the renewal option period will replace the expiration of the lease in this procedure.

(3) Nothing if others pay for repairs or replacement.

Most policies to not define actual cash value (ACV). When there is no specific definition within the policy, the term is subject to jurisdictional interpretation. Courts may interpret ACV in one of three ways:

1. **Replacement cost, less depreciation:**

   This method takes the cost of repairs or replacement in today's values and then uses depreciation tables based on the type of property and its expected life span.

2. **Fair market value:**

   This is the amount a willing buyer would pay a willing seller if neither party were under undue constraints.

3. **Broad evidence rule:**

   This method allows for all relevant evidence of the value of the property to be considered in the process of determining ACV.

When settling claims on an ACV basis, the adjuster must consider whether or not labor is depreciable. A depreciable asset is any asset listed for tax and accounting purposes that can be determined to have a loss in value. Some jurisdictions allow for labor to be depreciated while other do not.

ACV can be modified to include settlement on a replacement cost basis in some policies for an additional premium, while other policies automatically include it. In the process of evaluating the claim, the adjuster must take this into consideration, as well as how the policy treats settlement if the damaged property is *not* replaced.

Finally, some jurisdictions have **valued policy laws** that may govern the amount the company pays for structures that are total losses. In some jurisdictions, valued policy laws only apply to the peril of fire, while others apply to all perils covered under the policy. The law may require the company to pay the limit of insurance shown on the policy, even if the property is over-insured. Other jurisdictions may allow the company to repair or replace the structure if it costs less to do so, but require the company to refund the premium difference. These laws are designed to prohibit the insurance company from arguing that the property was over-insured after the loss.

Liability Claims

With liability claims, the degree of negligence for each party is considered in the evaluation process. Allocation of fault is a jurisdictional issue and will vary between contributory negligence and comparative negligence.

Contributory negligence is defined by *Black's Law Dictionary* as: "A plaintiff's own negligence that played a part in causing the plaintiff's injury and is significant enough to bar the plaintiff from recovering damages." In some contributory negligence jurisdictions, even a minor amount of fault by the plaintiff will bar recovery. Other jurisdictions may require a greater degree of negligence before recovery is barred.

Comparative negligence is defined by *Black's Law Dictionary* as: "A plaintiff's own negligence that proportionally reduces the damages recoverable from a defendant." For example: Two parties are involved in an accident. One party is 80 percent at fault while the other party is 20 percent at fault. The party that is 20 percent at fault would have its recovery reduced by 20 percent. Comparative negligence jurisdictions may vary between pure and modified forms. In modified comparative negligence jurisdictions, the claimant may recover their entire loss if their degree of fault is less than a certain percentage.

Another method of apportioning liability that varies among jurisdictions is **joint and several liability**, which involves more than one defendant. In pure joint and several liability, the plaintiff can collect from one member of the group of defendants. This party may sometimes be referred to as the "deep pocket" defendant. In some jurisdictions, the law may provide a potential for contribution. This allows the "deep pocket" defendant to seek recovery from the other parties that are jointly responsible. In modified joint and several liability jurisdictions, the law may apply only to economic damages or to damages below a monetary threshold.

Some jurisdictions recognize only pure several liability. With several liability, each party is solely responsible for its share and not any other defendant's share.

Damages payable can be broken down into two categories: **special damages** and **general damages**. Special damages are also referred to as economic damages. These are damages that are monetary in nature, such as medical bills, property damage, and lost wages. General damages are also referred to as noneconomic damages. These are damages that are not monetary, but juries can assign a dollar amount to them. Examples of general damages include pain and suffering, mental anguish, loss of consortium, and others. Insurance company claim departments use software that compare similar injuries to determine reserves on general damages.

Sometimes the conduct of the insured is particularly egregious and harmful to the plaintiff. In these cases, the adjuster must consider if the court has the potential for awarding punitive damages. Punitive damages are those awarded to punish the insured. How punitive damages are treated varies by jurisdictions. In some jurisdictions they may not be awardable. Other jurisdictions may award punitive damages but bar them from being covered by insurance. The adjuster must also be aware as to how the policy treats punitive damages. Some policies do not exclude punitive damages while others may contain punitive damages exclusions.

Finally, the adjuster needs to understand how the jurisdiction views collateral sources of recovery. Collateral sources of recovery are payments made to the claimant from other policies. Some jurisdictions still recognize the collateral source rule, which prohibits the admission of evidence that the injured party has received compensation from another source or sources. A number of jurisdictions have either altered or partially done away with this common law rule by statute.

Impact on Case Reserve

The process of adjusting case reserves on the claim will continue with this step. Once the adjuster receives all the necessary information they have requested, the reserve will be adjusted up or down based on this updated information. This information is very important in guiding the success of the strategic plan.

Example: Case Study—Impact on Reserving

CASE STUDY – EVALUATION/RESERVING

Your client, Able Construction Corp, is insured under a BAP, CGL and Work Comp policy. One of their employees was driving an insured Ford F150 pickup on company business and was involved in a serious auto accident involving multiple vehicles. Limits on the BAP are 1,000,000 /2,000,000 /1,000,000.

Facts – Able's employee was driving the company owned vehicle to a job site when he failed to stop at a Stop Sign, drove into the intersection and struck a 2013 Dodge delivery van (Claimant #1) owned by Peter's Pies. The Peters Pies truck was pushed across the intersection and rear-ended a 2017 Cadillac XT5 (Claimant # 2) which had stopped at the intersection. The Cadillac had two occupants, the driver and his wife. Able's driver, Paul Klutz was fatally injured.

Liability – investigation concludes that Insured is 100% negligent

Coverage – applicable to policy limits

Claimant #1 – Delivery van was driven by Tom Smith, age 42. Mr. Smith sustained a fractured right femur, fractured right wrist and multiple deep facial lacerations and contusions. He was treated and admitted to Mercy Hospital. He is in his second week and expectations are that he will be discharged to his home next week for continuing recovery. To date Mr. Smith has incurred $25,000 in medical bills. His recovery will involve significant physical therapy and it's anticipated he will miss a minimum of 3 month's work. Damage to the Dodge van is estimated at $10,300. Van cargo was 300 pies, most of which were damaged.

Reserve: BI – _____ PD – _____

Claimant #2 – the occupants of the Cadillac were Dirk and Dania Lightfoot. Dirk is age 55 and Dania is age 50. They are co-owners and operators of the D&D PitStop. A combination convenience store /deli /gas station. Mrs. Lightfoot sustained a whiplash type injury to her neck and a minor concussion.

Aside from general stiffness, Mr. Lightfoot was uninjured. Both were treated and released from Memorial Trauma Care.

Immediately following the accident, the Lightfoot's retained the services of Cheatum, Cheatum and Howe, a high profile, aggressive law firm in your city. Damage to the vehicle is estimated at $16,000.

Reserve: BI – _____ PD – _____

Reserve Issues for discussion:

Claimant #1

BI – will include significant medical bills, PT, lost wages and potential for permanent partial disability. Also, potential for permanent facial scarring.

Initial reserve should be $300,000.

PD – Should include cost of repairs, loss of use of the van and cost to replace the cargo. Initial reserve should be $15,000

Claimant # 2

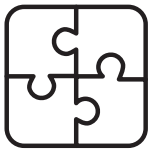
BI – will include medical bills, lost wages, loss of business income and potential loss of consortium. Attorney representation is also a factor. Initial reserve should be $50,000.

PD – will include cost to repair vehicle + loss of use. Reserve should be $18,000

Able Employee

A work comp claim will be established, and reserve established in accordance with fatal benefit level of the applicable jurisdiction.

Step 5: Resolve the Claim (RESOLVE)



Now that the claims department has evaluated the claim and has determined what the settlement should be, it must now bring the claim to its conclusion.

There are four ways of resolving a claim:

- pay in full
- pay in part
- deny without payment
- close without payment

Methods of Handling Claim Differences

Even when the insurance company has determined that coverage exists, and they are willing to pay, there is not always an agreement on the amount of that payment. When disagreements regarding the amount of the claim occur, there are several ways of resolving the issue.

- **Negotiation:** Negotiation involves arriving at a mutually acceptable resolution through back-and-forth conversations. Negotiation can be directly with the policyholder or their representative, such as an attorney or public adjuster
- **Appraisal:** Property policies contain an appraisal condition that allows for resolution of disputes regarding the amount of the loss. The insured and the company each retain their own appraiser. The two appraisers select a third appraiser, called an umpire, the cost of which is split between the insured and the insurance company. An agreement by any two of the three appraisers is the amount that will be paid.

Example: Appraisal—Loss Condition Commercial Property

2. Appraisal

If we and you disagree on the value of the property or the amount of loss, either may make written demand for an appraisal of the loss. In this event, each party will select a competent and impartial appraiser. The two appraisers will select an umpire. If they cannot agree, either may request that selection be made by a judge of a court having jurisdiction. The appraisers will state separately the value of the property and amount of loss. If they fail to agree, they will submit their differences to the umpire. A decision agreed to by any two will be binding. Each party will:

a. Pay its chosen appraiser; and

b. Bear the other expenses of the appraisal and umpire equally.

If there is an appraisal, we will still retain our right to deny the claim.

- **Arbitration:** Arbitration is performed by an outside service provider who assembles a panel of claims experts. The claim file is submitted and reviewed by the experts, who then make a decision. The decision can be binding or non-binding depending on the jurisdiction and the policy language.
- **Mediation:** Mediation involves representatives of the insured and the insurance company who meet to discuss the claim differences. The impartial third-party, known as the mediator, oversees and guides the discussion and assists in settling the dispute. In some jurisdictions, mediation is required before litigation is approved.
- **Litigation:** Litigation involves settling the dispute in the courtroom. Litigation commonly involves a jury, although the parties can choose to allow a judge to make the decision in lieu of a jury trial. Litigation can be public or private. Private litigation allows for the process to be held outside of the court dockets and is usually less formal.

Policy Settlement Provisions

Every policy has a provision regarding how claims are settled. These provisions (clauses) vary among policy types. With liability policies, the question is whether the insured has input regarding how and when the claim can be settled.

Consent-to-Settle: A pure consent-to-settle clause does not allow the insurance company to settle a claim or suit without the prior consent of the insured. This consent is usually required to be in writing. Pure consent-to-settle clauses are rarely seen in today's insurance environment.

Hammer Clause: A more common consent-to-settle clause is known as the "hammer" clause. This term is used when the insurance company reserves the right to charge the insured for differences in the settlement costs if the insured chooses not to consent to the settlement agreeable between the insurance company and the third-party claimant. Depending on the type of policy and market conditions, a "soft hammer" or "velvet hammer" clause may be used. This indicates that the insured will be responsible for a percentage of the additional settlement costs.

Non-Consent or No Participation: This is the type of settlement clause seen most commonly, such as in a Commercial General Liability Policy or a Business Auto Policy. This means the right to settle claims lies with the insurance company, not the insured.

Buy-Out Provision: This is a very uncommon settlement clause and is subject to specific conditions depending on the insurance company. It allows for the insured who disagrees with the insurance company's settlement to take that settlement directly. The insured then handles the defense and settlement of the claim on their own. If the insured settles the claim for less than the insurance company's settlement offer, the insured keeps the difference.

Policies and procedures regarding loss settlement will vary by company and line of business.

Example: Some companies may have preferred vendor lists for auto physical damage or property claims. Some homeowners' insurance companies have begun using "managed repair," a method of settling property claims by requiring the insured to use a specific contractor named in their policy. In automobile claims, repairs on automobiles can take into account the usage of which automobile part will be used in the repair process. The company will either pay the claim in full or pay it in part.

Deny the Claim

If the adjuster determines that there is no coverage under the policy, the claim is denied. Appropriate notice must be sent to the insured citing the specific policy language used to deny coverage. If the company has provided defense but the court has released the insured from liability, the claim will be closed at that time.

Close Without Payment

Some claims may be closed without payment. Property claims that are below the policy deductible or where the insured has abandoned the claim are closed with no payment. Sometimes statutes of limitation apply. These are state statutes that govern the window of time during which a claim can be filed. If the claim is filed beyond that period of time, or the claimant does not continue to pursue the claim, they will be barred from recovery. Construction defect claims are subject to statutes of repose. Depending on the state, after a period of five to ten years from the time the property is conveyed to the owner, the builder is no longer responsible for defects in construction.

Unfair Claims Practices Defined

Any of the following acts by an insurer, if committed in violation of Section 3, constitutes an unfair claims practice:

- Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue
- Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies
- Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies
- Not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear
- Compelling insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them
- Refusing to pay claims without conducting a reasonable investigation
- Failing to affirm or deny coverage of claims within a reasonable time after having completed its investigation related to such claim or claims
- Attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application
- Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured
- Making claims payments to an insured or beneficiary without indicating the coverage under which each payment is being made
- Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form
- Failing in the case of claims denials or offers of compromise settlement to promptly provide a reasonable and accurate explanation of the basis for such actions
- Failing to provide forms necessary to present claims within fifteen (15) calendar days of a request with reasonable explanations regarding their use
- Failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by or required to be used by the insurer are performed in a workmanlike manner

Fair claims practice is vital to the insurance company's reputation. Reputation affects retention and new clients. Personnel should understand how important fair practice is to implementing the strategic plan and the success of the company.

Knowledge Check

Directions: Name the five steps in the claims process. Write a sentence about each step and its importance.

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

Subrogation and Salvage

Learning Objective:

4.3 Evaluate a claim in regard to the roles of subrogation and salvage.

Subrogation

Insurance policies generally contain a provision known as Transfer Of Rights Of Recovery Against Others To Us. This is referred to as the **subrogation provision.** It automatically transfers the right of recovery from the insured to the insurance company when it pays a loss to the insured caused by another party. The policy wording may prohibit the insured from waiving its right of recovery after a loss. Since the policy does not prohibit it, subrogation can be waived prior to the loss. Some property policies allow for waiver of subrogation after a loss in a tenant/landlord situation. Following are some examples of subrogation wording in different policies.

Example: Ability of Insured to Waive Their Rights Varies by Type of Policy

Sample in Commercial General Liability Policy

Transfer Of Rights Of Recovery Against Others To Us

8. If the insured has rights to recover all or part of any payment we have made under this Coverage Part, those rights are transferred to us. The insured must do nothing after loss to impair them. At our request, the insured will bring "suit" or transfer those rights to us and help us enforce them.

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Sample in Workers Compensation And Employers Liability Insurance Policy

G. Recovery From Others

We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the injury. You will do everything necessary to protect those rights for us and to help us enforce them.

Sample in Business Auto Policy

5. Transfer Of Rights Of Recovery Against Others To Us

If any person or organization to or for whom we make payment under this Coverage Form has rights to recover damages from another, those rights are transferred to us. That person or organization must do everything necessary to secure our rights and must do nothing after "accident" or "loss" to impair them.

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Subrogation is important to the insurance company since it allows the company to recover monies it has paid to its insureds. A well organized and efficient subrogation unit can make a significant difference in an insurance company's bottom line.

It's important to note that some policies may allow for the payment of losses on a replacement cost basis. In these situations, recovery by the insurance company is limited to ACV (actual cash value) since third-party property damage claims are only payable on that basis. Still, the insurance company can recover much of what it has paid to the insured.

Once damages are recovered, each party is entitled to recover its payment. Some policies may contain wording that governs the order in which the insured and the insurance company recover from the subrogation proceeds. This is especially important when the insured has a deductible and/or the loss exceeds the policy limits. If the policy does not contain specific recovery language, then the order of recovery will vary by jurisdiction.

There is also a common law form of subrogation. This is a well-respected legal treatise known as the **Made Whole Doctrine** and is defined as follows:

> It is widely held that in the absence of contrary statutory law or valid contractual obligation to the contrary, the general rule under the doctrine of equitable subrogation is that whether an insured is entitled to receive recovery for the same loss from more that one source, e.g., the insurance company and the tortfeasor,* it is only after the insured has been fully compensated for all the loss that the insurance company acquires a right to subrogation.

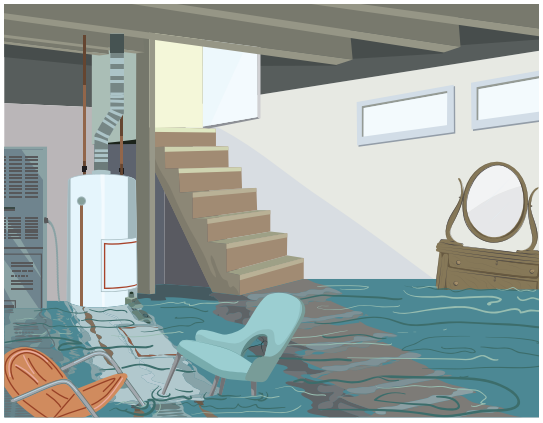
*A tortfeasor is someone who commits a tort.

There are several common occurrences where subrogation takes place. After an insurance company pays a physical damage loss, it will attempt recovery from the at-fault party. Third-party property damage losses may also be paid by the property insurance carrier causing the company to try to recover from the at-fault party.

Success of the subrogation unit is generally measured as a percentage of the losses paid that are subject to recovery.

Salvage

Property that has not been totally lost or destroyed will have some level of value to the insurance company. This property is known as **salvage**. *Black's Law Dictionary* defines salvage as: "The property saved or remaining after a fire or other loss, sometimes retained by an insurance company that has compensated the owner for the loss." After the insurance company pays the insured for a total loss on a vehicle, it takes the vehicle and sells it to a salvage yard. The amount the company receives is the salvage value. That value is used to reduce the amount of the loss for the insurance company.



Salvage may be taken by the insurance company, but it can also be retained by the insured. If the insured retains the property, the amount of the claim payment to the insured will be reduced by the value of the salvage. In some examples, policy language supports salvage. However, under the abandonment clause in the policy, the insured cannot just give damaged property to the insurance company and expect payment on a total loss basis just because they no longer want it.

Example: Salvage may be taken by the insurance company or retained by the insured.

E.Loss Conditions

The following conditions apply in addition to the Common Policy Conditions and the Commercial Property Conditions:

4. Loss Payment

a. In the event of loss or damage covered by this Coverage Form, at our option, we will either:

(1) Pay the value of lost or damaged property;

(2) Pay the cost of repairing or replacing the lost or damaged property, subject to **b.** below;

(3) Take all or any part of the property at an agreed or appraised value; or

(4) Repair, rebuild or replace the property with other property of like kind and quality, subject to **b.** below.

We will determine the value of lost or damaged property, or the cost of its repair or replacement, in accordance with the applicable terms of the Valuation Condition in this Coverage Form or any applicable provision which amends or supersedes the Valuation Condition.

Example: But the insured may not usually abandon property to the insurance company.

E. Loss Conditions

1. Abandonment

There can be no abandonment of any property to us.

Knowledge Check

Directions: In your own words, define the terms subrogation and salvage, and how and when they come into play.

_____

_____

_____

_____

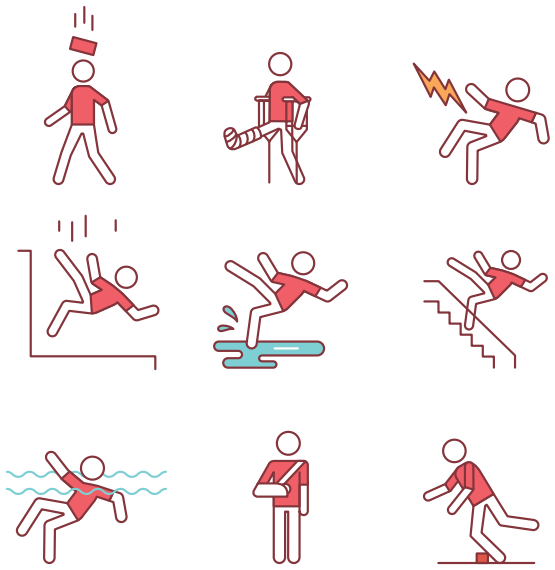
Special Investigations Unit

Learning Objective:

4.4 *Analyze the problem of fraud from the perspective of a special investigative unit and consider the appropriate solution.*

Industry Fraud

According to the Coalition Against Insurance Fraud, approximately ten percent of property-casualty insurance losses and loss adjustment expenses each year are the result of fraud. The Insurance Information Institute estimates that fraud costs the industry over $30 billion each year, while the FBI estimates the cost to be over $40 billion.



What is fraud? Fraud can be divided into to types: hard fraud and soft fraud. **Hard fraud** occurs when an insured or claimant deliberately plans or creates a loss that is covered by an insurance policy in order to receive payment. These losses can be related to theft, slip and fall, staged automobile accidents, or other activities. **Soft fraud** occurs when the insured or claimant exaggerates an otherwise legitimate claim. Inflating the amount of an automobile

physical damage claim to cover the deductible or stating additional items were taken in a burglary are examples of soft fraud.

Special Investigations Unit (SIU)

Most insurance companies make use of a SIU. Some companies outsource SIU activity to third parties while others have fraud units housed within their claims departments. The purpose of a SIU is to identify emerging trends regarding fraud, uncover suspect claims, and conduct investigations in an effort to minimize this multi-billion dollar problem. Using sophisticated technology and skilled investigators, a SIU works to identify, prevent, and deter suspected fraudulent claims. A SIU is usually comprised of individuals with experience in both insurance claims handling techniques, as well as law enforcement experience. Many state insurance departments require insurance companies to have formal, filed fraud investigation protocols.

When an adjuster or a claims supervisor suspects fraud, the claim file is passed on to the SIU for review and investigation. Suspected cases may be identified based on various matrices. These matrices may be completed manually, or they may be automated using software loaded within the claims operating system. This process is designed to look for parameters that indicate a higher likelihood of fraud.

Once the SIU receives the claim file, the SIU personnel assigned will begin the investigation process. As part of the investigation, interviews will be conducted. The interview process will include the policyholder, the claimant(s), any witness(es), and any others that might have knowledge of the circumstances of the claim, including the agent.

Since insurance fraud is a crime, the investigation may include local, state, or federal law enforcement personnel. If fraud is discovered, the suspect or suspects may be arrested, and charges filed.

In addition to law enforcement involvement, if fraud is discovered, the SIU will work with the adjuster and legal counsel to properly deny the claim. The SIU will also notify other departments within the company to coordinate other needed activity, such as policy cancellation.

If the investigation does not turn up any fraud, the claim file is returned to the adjuster. The adjuster then moves forward in the process of resolving the claim.

Knowledge Check

Directions: You are a part of a SIU (special investigation unit) and have been assigned a suspected fraud case. What will you do first? Second? Third?

1. _____

2. _____

3. _____

Litigation Management

Learning Objective:

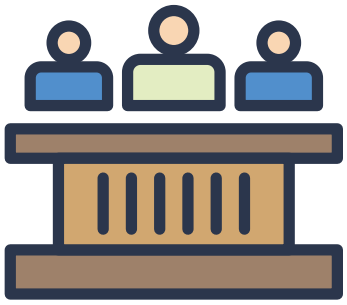
4.5 Defend the value of litigation management to the insurance company.

Litigation Management

Litigation costs are often the largest outside expense for the insurance company. Litigation expense can have a significant influence on the overall financial results of the company. Litigation management is a process that manages the use of litigation and mitigates the associated costs. Litigation management can have a positive effect on the bottom line and make the implementation of the strategic plan more achievable.

When litigation becomes necessary, the adjuster always maintains control of the claim file. The responsibility for the file is never relinquished to defense counsel. While the adjuster should listen to the advice of counsel, the decision as to when settlement is appropriate remains the adjuster's decision. Likewise, decisions regarding moving forward with litigation or the use of alternative dispute resolution, such as mediation or arbitration are also at the adjuster's sole discretion.

Outside Counsel



All insurance companies make use of outside counsel in some facet. Outside counsel is made up of approved panels of attorneys that will represent the company and/or its policyholders when certain claims occur.

When selecting outside counsel, the insurance company should properly negotiate the terms of the agreement. These terms serve as the basis of controlling litigation expense. The agreement should include terms whereby the attorney firm bills its negotiated rates to the tenth of an hour. These expenses should be billed on a monthly basis to the insurance company for each file so that payment of legal expenses can be properly applied to the appropriate claim file. In certain cases, flat charges may be negotiated, when possible, for services such as answering complaints.

A litigation budget should be established within a specified period of time after the firm receives a claim file. This allows the adjuster to properly assign the costs to the claim's ALAE (allocated loss adjustment expense). It's also important for the insurance company to understand which attorney or attorneys will be assigned to its cases. The hourly rates charged will vary based on whether the attorney is a partner or a junior attorney. It's also important for the insurance company to build rapport and relationship with the attorneys assigned. Once the law firm has a case, it should provide regular updates to the adjuster so informed decisions regarding the file can be reached.

Insurance companies may use outside vendors to audit billings from outside counsel. There is also software that can be purchased to perform the billing audits. This is done to assure the company it is not being overcharged for services.

Some insurance companies may hire staff counsel to handle certain claims. This gives the company greater control of expenses since staff counsel are paid salaries rather than billing hourly for their services. Typically, staff counsel is assigned to the more routine cases because they are easily handled and repetitive in nature. More complex or time-consuming cases may still be handled by outside counsel.

Tripartite Relationship

When the insurance company uses outside counsel to defend the insured and the company, a **"tripartite relationship"** occurs. In short, the outside counsel is representing two different parties, thus there are three parties in the relationship. The underlying concept is that the three parties work together to reach a mutually beneficial resolution to the claim. Since the attorney is representing the policyholder, but being paid by the claims department, there can sometimes be a perceived or actual conflict of interest.

Knowledge Check

Directions: Make a case for an insurance company having its own litigation management team.

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_____

Bad Faith

Learning Objective:

4.6 Predict possible outcomes when an insurance company acts in bad faith.

Bad Faith Definition

Black's Law Dictionary defines **bad faith** as: "An insurance company's unreasonable and unfounded (though not necessarily fraudulent) refusal to provide coverage in violation of the duties of good faith and fair dealing owed to an insured. Bad faith often involves an insurer's failure to pay the insured's claim or the claim brought by a third party."

Duty Owed to Policyholders

The insurance company owes its policyholders the duty of fair dealing when handling claims. The duty of fair dealing requires that the insurance company will abide by the contract and will not injure the right of the insured to receive the benefits provided. Fair dealing generally requires that a party cannot act contrary to the "spirit" of the contact. The insurance company must not be unreasonably slow or purposely impede the investigation and settlement of the insured's claim.

Good faith is generally defined as honesty in a party's conduct during the contract or agreement. It is the requirement of the insurance company and its adjusters to be forthright when handling the claim and communicating with the insured.

The duty of good faith and fair dealing is established in common law. The common law is an implied duty in which there is an understanding that good faith and fair dealing will be used in the claims handling process. If the company violates the implied duty, an action for negligence can result from improper claims handling.

Some states have legislation that has been enacted creating statutes that specifically address bad faith. These statutes can be titled as Unfair Claims Practices or Unfair Trade Practices. Whether common law or statutory law, the insurance company must give equal consideration to its interests as well as the interests of the policyholder.

In addition to first-party bad faith—bad faith related to the insured's claim—some states recognize third-party bad faith. This is bad faith in the handling of a third-party claimant's injuries or damages as a result of the insured's negligence.

Following is a list of potential bad faith actions:

- Deceptive practices or deliberate misrepresentations to avoid paying claims;
- Deliberate misrepresentation of records or policy language to avoid coverage;
- Unreasonable litigation conduct;
- Unreasonable delay in resolving a claim or failure to investigate;
- Use of improper standards to deny a claim;
- Failing to maintain adequate investigative procedures or to thoroughly investigate the claim in accordance with the company's procedures;
- Violation of Unfair Claims Practices Acts.

Damages Triggered

When the court finds the insurance company guilty of bad faith, it awards damages to the insured. It's not uncommon for these damages to be in excess of policy limits. The insurance company who denies coverage for a loss cannot later shield itself from damages by arguing it should be protected by a policy limit it wrongfully said did not cover the loss.

The court can also award extra-contractual damages. These are damages that are designed to compensate the injured party for the harm done by the insurance company based on the way it handled the claim. Examples of extra-contractual damages include attorney fees and other litigation costs incurred by the insured, or stress caused by worry over unpaid bills the insurance company should have provided funds to pay.

Impact of Bad Faith on Claims Operations

As said before, reputation is key to the company and to the roll-out of any strategic plan. The claims department interfaces with the public in a striking way. It is the time when the client sees what the insurance company will do for them.

An employee or a department acting in bad faith can devastate a company. This can affect retention of clients and the gain of new ones. The company can face regulatory and legal consequences, as a result. This can affect public perception and the finances of the company on a larger scale, defeating the EMT's strategic plan.

Knowledge Check

Directions: What is the impact of bad faith actions carried out by a claims department? How will it affect the insurance company and its strategic plan?

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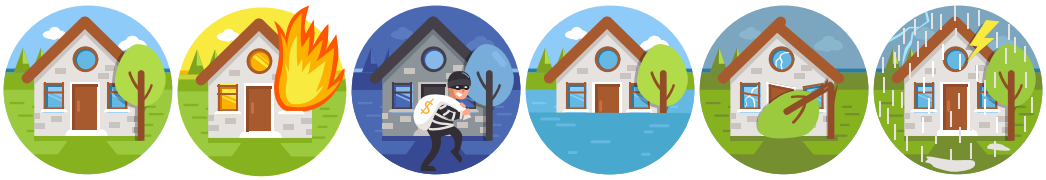
Catastrophe Planning

Learning Objective:

4.7 *Give examples of the considerations for a CAT (catastrophe) plan and evaluate their importance.*

Catastrophe Claim Handling



Regardless of what area of the country the insurance company writes coverage, it is exposed to catastrophe (CAT) losses throughout the year. Hurricanes, blizzards, winter storms, wildfires, tornadoes, earthquakes and others are all examples of catastrophes that can create claims for the insurance company. CAT losses put the greatest amount of strain on the insurance company's claims handling ability. They also create the greatest concern for the policyholder. Consumer satisfaction surveys and studies have shown that the faster the company makes contact with the insured in the claims handling process, the greater the satisfaction with the claims service.

What is a CAT plan? Many state departments of insurance require the insurance company's claims department to file CAT plans each year. The company's CAT plan will vary depending on a number of factors including:

- size of the insurance company;
- geographic location of the insurance company;
- claims department staffing model;
- lines of business written;
- severity and type of claims the insurance company expects to receive.

Components of the plan may need to include:

- What the expected claims volume is based on using geographic information systems;
- What the average reserve will be when a claim is opened;
- How the policyholder will contact the insurance company and what the expected time frame will be for the insured to be contacted by an adjuster;
- How the insurance company will notify agents regarding claims handling procedures;
- Information regarding contracts with firms that specialize in handling CAT claims and how many are contracted;
- How authority levels are or will be established for the CAT adjusters;
- Hiring and training of temporary staff;
- How IT system access will be granted to independent adjusters and temporary staff;
- How the CAT impacts the company's use of preferred contractor programs, preferred body shop programs, and other cost management arrangements;
- How employees will be utilized in the claims handling process;
- How interaction with departments of insurance will be handled;
- Responsibility for securing adjuster accommodations;
- How policy form distribution will be handled;
- Maintenance of service standards for non-catastrophe claims;
- Handling of disputed claims;
- File auditing procedures for compliance with expected standards;
- How social media will be utilized in the claims handling process;
- Criteria for referral to SIU;
- Expectations regarding monitoring and modifying the plan, if needed.

Knowledge Check

Directions: What is a CAT plan and why is it important especially to the claims department when a disaster happens?.

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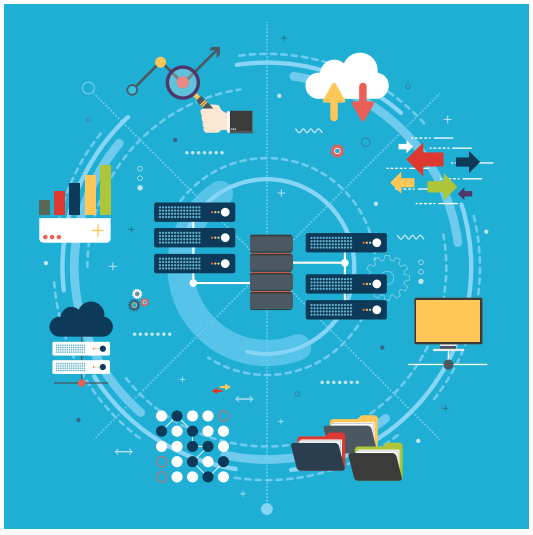
Claims Technology

Learning Objective:

4.8 *Understand claims technologies and how they impact the success of a claims department and the insurance company.*

Claims Technology



The technology used to support the claims function of an insurance company is oriented around the ultimate fulfillment of the promise made in insurance: to respond to a claim from the policyholder consistent with the provisions of the policy.

The nexus of claims technology is the claims system. The claims system is central to the claims function in a similar way to how the policy management system is central to the underwriting and policy issuance process. The claims system enables an insurance company to manage the claims process from the first notice of loss to ultimate settlement. Throughout that process the system interacts with a variety of other functions, both internal and external to the company.

Claims systems typically mirror the claims process, which varies significantly for different types of business. At the highest level, the handling of property claims varies from that of liability claims. Workers' compensation claim handling varies still more.

Going deeper within each type of coverage, there is more diversity still. Within property, the claims process could be as simple as providing payment to a tenant for a piece of furniture damaged by water or it can be much more complex, such as the loss of a manufacturing plant and all of its equipment by fire.

Liability claims also vary significantly in severity. A simple liability claim might involve for example, the scratching of one car by opening the door of another. Or it may have much more complexity in cases where the actions of the insured caused catastrophic injury, or involved breach of a contract, or where defamation or slander is alleged.

For workers' compensation, the focus is on employee injuries, which may be so mild as to have almost no effect at all, or so severe as to result in permanent disability or death. With all of these types of claims, there is the further complication that what looks like a small claim initially may develop over time to become severe. In some cases, many different coverages may be involved, or multiple claimants may be involved.

Claims systems must be adaptable enough to handle this diversity in claim activity and enable claims staff to navigate this complexity in the context of the promises made in the policy—the coverages, the exclusions, the deductibles, the limits, and other policy requirements or terms. In that way, they must be much more flexible than policy systems. Policy systems have something of a fixed universe in terms of the rates, products and coverage options available. Claims systems must be capable of responding to almost anything.

Despite the unpredictability of claims dynamics, most claims systems are relatively similar in structure, which usually includes one or more of the following key functions:

Notice/Input Process

When a claim occurs, the claims system must have a mechanism for that claim to be reported, that is, to receive the **first notice of loss** (FNOL). Companies may allow for this notice to come by phone, to be input into an online portal, to be reported by an agent or broker, or to be received by email or physical mail. The system establishes a new claim, assigns a claim number and permits the person receiving the claim to collect and store preliminary information such as the date and circumstances of the incident, the names of individuals involved and the insured's policy number.

Most systems cross-reference against the policy system to permit the claims staff to access the policy in real time, allowing them to confirm that a policy is in force and inform the claimant of any deductibles and limits which may apply as well as to let them know of any responsibilities they may need to fulfill in the claims process. This cross validation against the policy system is a critical feature of claims technology to ensure that claims are handled consistently with the policy terms.

Claims Triage and Resource Management

Because of the many and varied types of claims that can be received, and the different process used for different circumstances, one of the most important tasks of the claims system early in the process is to assign the claim to the right resources and path to resolution. Property claims must be assigned to property adjusters, liability claims to those skilled in handling legal and liability-oriented matters, and workers' compensation claims to those who are experienced in the unique laws, courts, medical considerations, and compensation dynamics of the workers' compensation world.

This assignment includes matching the complexity of the claim to the skill level of the adjuster and providing for referral and escalation options if a claim exceeds an adjuster's own settlement authority. For some liability and workers' compensation claims, this escalation may extend to outside parties, such as external law firms.

For many small, simple claims, the system may provide auto-adjudication options. Auto-adjudication refers to claims being settled almost entirely by the claims system, without human intervention. Claims systems use a series of rules to determine whether a claim can be settled using the automation alone. This approach increases the speed and efficiency of handling small claims and increases client satisfaction.

A further consideration is case load. It is imperative to manage the case loads of adjusters so they have the time and resources necessary to handle each claim properly. In the case of very complex cases, an adjuster may only have capacity for a few claims at any one time. Adjusters handling very simple claims may have dozens or even hundreds of claims at any given time.

The claims system makes decisions about triage and resourcing through a set of business rules that are part of its programming. By implementing these business rules, allocating claims out, and then sending those claims into the digital environments in which those adjusters work, the right claims land at the desktops of the right people, ready to be investigated and ultimately settled.

Collection, Storage, and Management of Documents

As claims are reviewed, a variety of documents may come and go between the claimant, the claims adjuster, and various third parties, including attorneys, repair shops, experts (such as appraisers, cause and origin, etc.), medical professionals, contractors, and the courts.

Documents may include emails, letters, notes from phone calls, estimates, contracts, expert reports, legal notes and proceedings, photographs, physicians' reports, and medical records.

The claims system provides the central point for storage of these artifacts. In addition, because of the sensitivity of some reports—for example, medical records are subject to state and federal laws regarding confidentiality—the system must not just store these reports, but also have security features in place to ensure that they cannot be accessed by anyone who is not authorized to do so.

Claims Handling and Settlement

The claims process ultimately results in a financial impact—the indemnification of the claimant from the company. Claims costs are the largest category of expense to an insurance company. The management and transactions associated with this expense take place in the claims system.

Claims transactions include the following:

- **Case reserves:** This is the amount the insurance company puts aside for a claim, based on the adjuster's expectation of the ultimate amount the claim will settle for. It is an estimate of the liability the company will carry in its financial records for a particular claim. It is fluid and may increase or decrease as the details of the claim and damages evolve.

- **Paid loss:** This is the amount paid. The claims system must permit the ability to issue a check or ACH (automated clearing house, i.e., electronic) payment to a claimant. The payment might be a partial payment, or it may represent the ultimate settlement of the case.

- **ALAE (Allocated loss adjustment expense):** This item refers to expenses that are directly associated with an individual claim. It does not refer to claims overhead or other general claims expenses. It includes legal expenses, the cost of cleanup, experts' fees, appraisal costs, travel costs, and other similar expenses.

The claims system enables these transactions to take place. The technology permits reserves to be set up and changed, and payments to be made, along with all of the attendant details: the date of the transaction, the reason or any comments, the associated bills, etc.

With these transactions, the claims system interfaces directly with the financial systems of the company. Payments are made from the company's bank accounts. Transactions are recorded in the general ledger of the company. And the claims system passes along the statistical detail needed to complete financial statements, as well as other reporting obligations.

Fraud Detection

As insurers work to settle claims accurately, fairly, and according to the terms of the policy, they must be alert for fraudulent activity. Claims systems include safeguards to identify suspicious activity. They may use specific triggers, such as a large number of occupants involved in an automobile accident. Algorithmic models scan multiple factors and look at the accumulation of those dynamics to identify claims for further investigation. Some claims systems collect external data or scan social media to identify situations where fraud may be occurring.

Knowledge Check

Directions: How does claims technology streamline what the department can do in these areas: input, resources, case type and load, storage and cross-referencing, settlement, and fraud detection.

_____

_____

_____

_____

Summary

The claims department and its management team must create their own tactical plan to dovetail with and support the EMT's strategic plan. It must be responsive to other departments as well. The claims department is key to the success of the strategic plan, both financially and as a front-facing group that interacts with the public in an important way: when a policy if filed, the customer finds out how good the company is. Personnel resources and sourcing are critical to the claims management team in carrying out their implementation of the strategic plan. Number one is the expertise and specialty knowledge of personnel.

There are several steps to the claims process. They are: report, investigate, verify, evaluate, and resolve. You can remember these with the acronym: RIVER. Each of these steps has its own special considerations that will affect the strategic plan and its implementation. Timeliness and accuracy are just a few of those considerations.

The subrogation provision is known as the Transfer Of Rights Of Recovery Against Others To Us. This transfers the right of recovery to the insurance company when it pays a loss to the insured caused by another party. This is known in common law as the Made Whole Doctrine. A subrogation unit can recover monies and make a significant difference to the company's bottom line and its ability to carry out its strategic plan. Salvage is property remaining after the insurance company has compensated the client following a loss that can be appropriated for sale.

A special investigation unit (SIU) is tasked to investigate fraudulent claims by researching databases, reviewing past histories, and conducting interviews. Charges may be filed or dismissed. The SIU is important in identifying trends in fraud that can affect the long-term goals of the company and its plan. Other considerations are reporting, investigation, handling, and closing of claims.

Companies that act in bad faith, especially in the claims operation, can devastate the company's reputation and its future plans. Not only does bad faith have legal and financial ramifications at both state and federal levels, retention of clients and increasing the number of clients will be impossible. Some bad-faith actions are deceptive practices, misrepresentation, delay, improper standards and procedures, and violation of Unfair Claims Practices Acts.

Catastrophe planning for the claims management team must take place to protect customers in a time of disaster and to safeguard the company's ability to respond and have the appropriate reserves. A CAT plan factors in the size of the company, its geographic location, staffing, lines of business, severity and types of claims expected, claims volume, reserve, timely response, notification avenues, IT capacity and security, and staffing training, among others.

Claims technology streamlines what the department can do in these areas: input, resources, case type and load, storage and cross-referencing, settlement, fraud detection, and trend identification. The claims management team and effective execution of its tactical plan are vital to the company in getting feedback on how new product lines are being received and how they are working in the real world. This helps the EMT and other departments evaluate how the strategic plan is working. This evaluation is critical to the plan's well-being. The claims team also can safeguard reserves and mitigate losses by using its special investigation unit, subrogation and salvage, and by careful tracking and resolution of claims.

Section 4: Self-Quiz

Claims' Tactical Plan

Directions: There are several considerations the claims department makes regarding technology. List 3 areas technology will be utilized within the claims department.

1. _____

2. _____

3. _____

Directions: Circle True or False related to the following statement.

Claims are only handled internally within the insurance company.

True **False**

Steps in the Claims Process and its Strategic Plan

Directions: Select the correct sequence of the five steps in the claims process:

- ☐ Reserve, investigate, verify, estimate, resolve
- ☐ Report, interpret, verify, evaluate, resolve
- ☐ Report, investigate, verify, evaluate, resolve
- ☐ Reserve, interpret, verify, estimate, resolve

Directions: There are several different people that can report a loss to an insurance company. Name three

1. _____

2. _____

3. _____

Directions: Identify each of the following statements as True or False

4. Duty to indemnify is broader than duty to defend.

True **False**

5. Defense may be provided for an insured even when the insured is not legally liable.

True **False**

6. An investigation to determine coverage may require resources that involve the services of others, such as a forensic accountant or consulting engineer.

True **False**

7. The established case reserve, including the allocated loss adjustment expense (ALAE), may be impacted by the information discovered during the investigation.

True **False**

Directions: Select the statement that best describes the concept of joint and several liability.

- ☐ Liability that may be apportioned either among two or more parties or to only one of a few select members of the group, at the adversary's discretion.
- ☐ Liability that may be apportioned jointly or separately by policy when a policyholder has more than one policy with different carriers.
- ☐ Liability that is jointly defended by more than one insurance company when several parties file a lawsuit against one or more policyholders.
- ☐ Several persons may either jointly file a lawsuit or file separate lawsuits against the insured for bodily injury or property damage that occurred.

Subrogation and Salvage

Directions: Fill in the blanks in the following statement using the terms provided.

litigation	**paid**
mitigation	**percentage**
owed	**recovery**

1. Success of the subrogation unit is generally measured as a _____ of the losses _____ that are subject to _____.

Directions: Identify each of the following statements as True or False.

2. A subrogation clause grants the right to the insurance company to collect from an at-fault party the money the insurance company paid to or on behalf of the policyholder, unless the policyholder has waived their right of recovery, which is usually required to be waived prior to a loss.

True **False**

3. The condition/requirement for an insured to waive their subrogation rights is the same in all liability policies.

True **False**

4. Property that has not been totally lost or destroyed and which retains some salvage value will apply directly to that claim's loss adjustment calculation.

True **False**

5. Insurance companies may have an option, according to loss conditions, to take all or part of damaged property as salvage.

True **False**

Special Investigations Unit

Directions: Fill in the blanks using the terms provided.

covered	**not covered**
hard	**payment**
legitimate	**soft**
misrepresented	**waivers**

1. _____ fraud occurs when an insured or claimant deliberately plans or create a loss that is _____ by an insurance policy in order to receive _____.

2. _____ fraud occurs when the insured or claimant exaggerates an otherwise _____ claim.

Directions: Circle True or False related to the following statements.

3. A SIU (special investigation unit) is comprised of law enforcement officers who have sophisticated interrogation skills.

True **False**

4. With sophisticated technologies and skilled investigators, the SIU works to identify, prevent, and deter suspect claims.

True **False**

5. All state departments require insurance companies to have a formal SIU with protocols in place for sharing fraud information with other insurance companies.

True **False**

Litigation Management

Directions: Select the accurate statements regarding litigation.

- ☐ If the adjuster makes the decision to litigate, all responsibility and control of the claim file is given to the defense counsel except when outside counsel is used.
- ☐ Outside counsel have greater control of expenses, compared to inside counsel, and are given cases that are easily billed by the hour and resolved quickly.
- ☐ Inside counsel have less control of expenses as they have taken on all claims management responsibility for handling complex and time-consuming cases that have been abandoned by the adjuster.
- ☐ The adjuster makes the decision as to when to settle, when to litigate, and/or when to make use of an alternative dispute resolution, and maintains the control of the file.

Bad Faith

Directions: Check all that apply to the following statements related to bad faith.

- ☐ Established in common law.
- ☐ Often involves an insurer's failure to pay the insured's claim or the claim brought by a third party
- ☐ Use of an improper standard to deny a claim
- ☐ Honesty in a party's conduct during the contract or agreement

Catastrophe Planning

Directions: Check all the factors that impact the insurance company's CAT plans.

- ☐ The type of business written
- ☐ The culture of the insurance company
- ☐ The size of insurance company
- ☐ The type of claims the insurance company expects to receive
- ☐ The number of employees in the underwriting department
- ☐ The geographic location of insurance company

Claims Technology

Directions: Circle True or False related to the following statements.

1. Claims systems typically mirror the underwriting process.

True **False**

2. The claims system enables the company to manage the process from first notice to settlement.

True **False**

3. Claims systems are established to respond to liability claims only.

True **False**

Directions: List three examples of documents that would be collected, stored, and managed as part of the claim process.

a. _____

b. _____

c. _____

Directions: Match the claims transaction on the left to its description on the right.

A. Case reserve	_____ The amount paid
B. Paid loss	_____ Expenses that are directly associated with an individual claim
C. Allocated loss adjustment expense	_____ Amount the insurance company puts aside for a claim

Section 5: Product Distribution

Section Goal

In this section, you will learn how insurance products move from the development process to distribution. Critical factors of internal and external relationship management will take center stage and you'll also explore the technology available to support the sales and marketing functions.

Learning Objectives:

5.1 *Defend the need for the corporate marketing and sales management departments' involvement in the implementation of the strategic plan.*

5.2 *Compare various methods used to create the brand.*

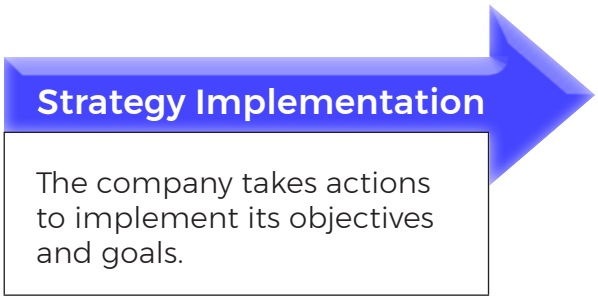
5.3 *Differentiate between the various methods of distribution and determine where they are most effective.*

5.4 *Identify different areas of relationship management and their effects on sales and growth.*

5.5 *Evaluate methods intended to support policyholder services.*

5.6 *Compare technologies available to sales and marketing departments.*

Product Distribution Tactical Plan



Section 1: Executive and Financial Management included some discussion regarding internal and external communication. The executive management team made decisions up-front about the allocation of resources, including people and budgets to market products and drive sales. Now it's the responsibility of the product distribution departments (corporate marketing and sales management) to execute their respective tactical plans in accordance with the direction given by the EMT.

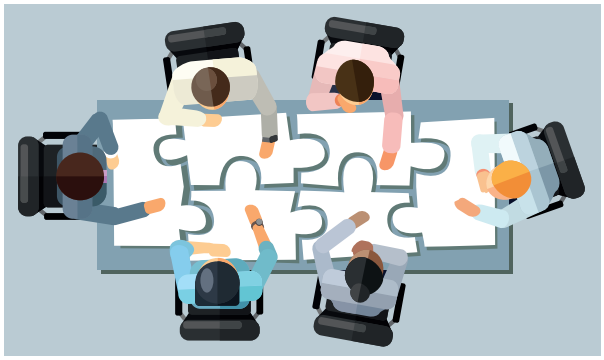
The corporate marketing department will use the EMT's strategic plan to develop marketing tactics that will include advertising, social media, search engine optimization (SEO), and the creation of marketing materials to support the distribution of the company's products. In turn, the sales management team will begin to execute on the chosen method or methods of distribution. In addition, distribution partners must be managed and measured so the EMT can be assured that the plan is being carried out. Let's look at this two-pronged tactical plan in more detail.

Corporate Marketing and Sales Management

Learning Objective:

5.1 *Defend the need for the corporate marketing and sales management departments' involvement in the implementation of the strategic plan.*

Tactical Planning



The corporate marketing and sales management departments have separate tactical plans, yet each plan is somewhat interdependent. In order for the company to achieve the success mapped out in the strategic plan, the products need to be advertised and distributed. Each department is charged with creating the proper action steps to execute its part of the plan. In the cycle of development, both the marketing and distribution teams are brought into planning in the product development stage and continue to have input as the new products and plans are integrated into each department's tactical plans.

Corporate marketing will begin to develop the advertising strategies that will reflect the goals it has set in order to achieve the directives in the overall strategic plan. Recall that the executive management team developed values, vision, and mission statements and those statements are the cornerstone of the company's culture. Corporate marketing must create an image of the company that reflects that culture, thus creating the company's brand.

One of the first questions to be answered for sales management is the age-old question of "who is the customer?" Not only does the answer to that question vary by company, it also varies by whom you ask within the company. Some would insist that the customer is the agent. On the other hand, some would insist that the agent is a business partner and the insured is the mutual customer of the agent and the company. How the company views the agent relationship will drive how the relationship is managed.

Corporate Marketing

Learning Objective:

5.2 Compare various methods used to create the brand.

Corporate Marketing Overview

The corporate marketing group is responsible for influencing consumers. Every message touch-point with a consumer is an opportunity to create an attraction for the company. Even subtle messaging can be retained by consumers. In other words, a person can hear sounds or see images even though they are not focusing on them. These sounds and images are still being registered in the subconscious mind.

The corporate marketing team manages the external messaging and outward appearance of the company. Their job is to take the values, vision, and mission statements and implement an advertising program that takes the internal messaging and focuses it in an outward direction.

External Communication

External communication is the transmission of information from inside the company to persons or organizations outside the company. External communication can be with customers, agencies, regulators, and others. The importance of external communications cannot be overlooked because it has a tremendous impact on how those outside the organization perceive it.

External communication should be intentional; it should have purpose and reason. In many instances, external communication is a two-way process. It's as important to understand feedback as much as it is to provide information. It should be free of errors and jargon and easy to understand.

Proper external communication presents a favorable image of the company. It can provide information about products to customers and agencies. It also can help promote and advertise the company in a positive manner.

External communication includes advertisements, customer response, annual reports, media, brochures, and face-to-face meetings. These are all effective ways to support the company's brand identity.

Branding

In order to draw customers, the company must differentiate itself from other companies in the marketplace. **Brand identity** is the collection of the elements that make the company unique. It is the perception of the company in the eyes of the consumers it is trying to attract. Brand is driven by everything that is public-facing, including logos, graphics, business cards, advertising materials, and much more.

Developing brand identity incorporates both internal and external interaction. Content creators—those within corporate marketing who are responsible for messaging—must truly believe in the brand they are creating. Likewise, the people that interact with the brand (agencies and consumers) must also be able to strongly identify with the brand. Brand and brand identity require several factors to be considered.

Differentiation: The company and brand must be able to be identifiably differently than others in the marketplace that offer similar products.

Recollection: The brand must make an impact visually and mentally on consumers.

Scalability: The brand identity must be able to grow and change as the company evolves.

Complementary touch-points: No matter what advertising medium is used, each touch-point must complement the brand.

Applicability: The brand identity must be very clear for those engaging in content creation.

Advertising

Once corporate marketing creates the basics that will be part of the branding process, it must now begin to "spread the brand." The department must take the directives from the EMT's strategic plan and develop marketing materials and advertising plans to begin getting the company's branding out in front of the public and gain recognition. The team will devise a strategy that will be used to deploy resources to put the brand in the public eye. That methodology is called advertising.

Advertising comes in a number of formats. From billboards to social media, the company is never without a choice as to where and how it finances its advertising campaign. Following are some examples of traditional and newer marketing techniques.

Fliers and Brochures → Whether using them for direct mail campaigns or supplying them to distribution partners as sales material, the use of fliers and brochures is still rampant in today's digital age. Agencies that represent the company can keep supplies in the lobby of offices, give them to personnel to distribute to potential customers when discussing insurance, or even put electronic versions of the materials on the agency website. The power of a hand-out should never be underestimated.

Billboards → There's something to be said about the power of the billboard to break up the monotony of a drive. Whether it's back and forth to work every day or a long trip on a boring highway, billboards are easily seen and will not become obsolete. Today, digital billboards, with messages that can be changed from day-to-day or week-to-week, have replaced older billboards in some areas.

Television and Radio → Whether at home or on the go, people are either watching television or listening to music. Traditional FM radio stations still abound, and people tune in to hear their favorite music. In larger metropolitan areas, traffic updates are a great source to catch the ears of potential customers. Someone may change the station if they don't like a song, but when the traffic report comes on, people listen. Television is much the same way. Local television and cable spots are much less expensive than national advertising, but are still extremely effective at grabbing attention.

Internet Marketing → In today's digital age, the company can target audiences precisely with internet advertising. Internet advertising companies can target down to the zip code level, assuring that people within specific geographic areas will see the company's advertising. In addition, once someone clicks on the advertisement, it will continue to pop up on pages they visit that allow targeted ads.

Social Media → Facebook, Instagram, Twitter, and LinkedIn are just some of the ways the company can communicate its message to customers and prospective customers. Articles, pictures, sales messages, and testimonials are just some of the methods that can be used to create brand identity.

Blogs, Videos, and Vlogs →

Blogs can be used to give information regarding products offered by the company. Blogs, videos, and vlogs can also be used as educational tools to help the general public have a better understanding of the company or to create a more informed customer. Carriers will put these blogs in a format the agencies can co-brand and push out through their social media (Twitter, Facebook, Instagram, etc) accounts to insureds and prospective insureds. While we understand that insurance is not a very popular subject for the average person, when shopping for insurance, information can be very powerful.

Search Engine Optimization (SEO) →

When consumers are searching for information, the internet is the place to go. With so much information at their fingertips, it's important to understand search engines and optimization Corporate marketing will need to use SEO to the company's advantage. Content is one of the main keys to SEO. The company's website needs to contain relevant content written with authority and focus on key words that will be used by the consumer to search for information.

The company can also share advertising costs with its agency distribution network. **Cooperative advertising**, called **co-op advertising** for short, is a great way to get the company's message out in front of consumers on a local basis, as well as adding value to the relationship with its agency partners. With co-op advertising, the agency develops an advertising campaign and discusses it with the company. The advertising is designed to feature the company while also featuring the agency. When the agency and company come to an agreement, the company and agency each share in a percentage of the cost. In most cases, the agency uses company-developed advertising, giving the company the control it needs over the messaging in order to continue to grow its brand identity.

A carrier's marketing department will apply a fair amount of strategy around internal marketing as well. All internal communications, intranet content, "town hall" presentations, etc., are reviewed by the marketing department to make sure a consistent and positive message is portrayed.

Knowledge Check

Directions: What are five important branding factors creatives consider when building a brand? How are these determined in the development process? Which media avenues do you think best support brand awareness?

1. _____

2. _____

3. _____

4. _____

5. _____

_____

_____

_____

_____

Distribution

Learning Objective:

5.3 *Differentiate between the various methods of distribution and determine where they are most effective.*

Distribution Considerations

While the corporate marketing group is developing plans regarding advertising methods and creating promotional material, the sales management team must begin to create the distribution network needed to impact the company's success.

Deciding on the method or methods of distribution to use comes with the consideration of several factors: expense; control, desired market penetration, and scalability.

- **Expense:** The cost of doing business is an important consideration as the company begins to bring its products to the marketplace. If the company decides to sell its products through outside distribution networks, it must consider the cost of compensation, which includes commission and other costs. If the company chooses to market directly to the public, the cost of advertising will be much heavier.
- **Control:** If the company chooses to use outside distribution networks, it must consider what authority level it will allow the members of the networks. It must also consider what level of expertise it will require of those who wish to sell products for the company.
- **Desired market penetration:** Market penetration—how much of the total market the company can claim as their customers—is an important consideration. In order for the company to realize economy of scale (the level at which the company is getting its maximum profitability for its operating costs), it must choose a distribution method or methods that will result in the desired penetration as quickly as possible.
- **Scalability:** Scalability relates to the ability to expand or contract operations as needed. Products may need to be scaled up or back depending upon market conditions and other factors. The company needs to be able to increase or decrease production as needed to meet these market conditions.

Distribution Methods

There are a number of distribution methods available to the company as it brings its products to the marketplace. The company may choose to use more than one method of distribution, thereby giving it a level of market penetration that best fits its needs. These methods include the following:

Independent Agency System: The independent agency system is made up of individual insurance agencies that are independently owned. The use of the independent agency system as a means of distribution is extremely effective when entering into a new territory or expanding within an existing territory. The company enters into a contract with the agency, allowing the agency to transact insurance on behalf of the company. Independent agents typically have a presence in their communities as well as existing, valuable relationships with policyholders, which can be leveraged to afford the company the opportunity to get the market penetration it is looking for.

Using independent agencies is not without its challenges. Because independent agents represent multiple companies, competition for market share between those companies exists. Using the independent agencies may also create additional costs the company did not originally anticipate. Creation of contingent commission plans or profit-sharing plans may be necessary. The company may also be forced to be added to comparative rating software platforms for certain lines of business.

Exclusive Agents: Exclusive agents are those that represent only one company or company group. Since no other companies are represented by these exclusive agents, there is no competition for business within the agency. The use of exclusive agents as the desired distribution method requires the company to offer a broad array of products and maintain competitive pricing for its agents to survive. The challenge, though, is that a carrier's appetite and portfolio of products is typically not broad enough to provide the agent with the array of necessary products (personal lines, commercial lines, life, professional liability, excess and surplus, management liability, surety), so they may need to form relationships with aggregators or MGAs (managing general agents).

When rate action is needed because of pressure from losses, the company must take the distribution force into consideration. Higher rates can make it difficult, if not impossible, for an exclusive agent to maintain his or her book of business. Sales force turnover can be very high when the company's competitive market position is severely impacted as a result of rate increases.

Direct Marketing: Direct marketing uses insurance company employees to sell its products to consumers. The product must either have broad appeal or there must be a means of preselecting customers. Direct marketing requires solicitation efforts that are focused on selected customers. These are generally customers that have a high tendency to purchase coverage on a direct basis and includes both outbound and inbound calls.

Initially, direct marketing can be a very expensive distribution method. Typically, the fixed costs, such as salaries, advertising, direct mail, and others are very high. Over time, revenue will rise and balance the equation, but costs will always impact profitability. In addition, a significant amount of time must be spent to properly screen prospects.

Online Distribution: Online distribution is a form of direct marketing that takes place via the internet. In order to effectively distribute products online, a robust automated quoting system must be developed. This type of distribution system generally lends itself to personal lines coverages.

Prompt follow-up via online chat or telephone contact yields greater success. Customers may not be fully comfortable purchasing completely online. Regardless of the line of business, insurance is still a complex purchase and customers need validation that their purchase is correct. Most customers use online methods for research and product pricing, and many still want to communicate via the phone or face-to-face during the purchasing process.

As mentioned above, some companies use multiple distribution methods, including independent agents, exclusive agents, and online sales.

Knowledge Check

Directions: Name the four different distribution methods. Next, choose two and defend how you would combine them together to maximize benefits and manage cost, control, market penetration, and scalability.

1. _____

2. _____

3. _____

4. _____

_____

_____

_____

_____

Relationship Management

Learning Objective:

5.4 *Identify different areas of relationship management and their effects on sales and growth.*

Relationship Management Overview

Let us say the executive management team has decided the company will distribute its products through the independent agency system. Now it's time for the sales team to appoint and manage the agencies that will make up the distribution system. In order to manage the relationships that are created, field personnel are hired as sales managers.

Over the next few pages the discussion will focus on some key factors that are important in the distribution process. It's up to the sales managers to find, appoint, and develop the relationships necessary for the company to meet its goals. Keep in mind that, sometimes, managing relationships includes rehabilitating the relationship or even terminating it.

Company Expectations of an Agency

In order to effectively distribute its products to customers, the company must take a methodical approach to appointing the agencies that will make up its distribution force. The relationship between the agency and the company is best described as a partnership. The company is going to give the agency the authority to act on its behalf. In return, the company wants to make sure the agency can be trusted with that authority and will act in the company's best interest.

Not every agency is a good prospect for creating a partnership. The company sales representatives must make sure that the agencies seeking appointments meet the established criteria. Following are some of the criteria considered when appointing agencies.

Competent Leadership and Management →

A good agency candidate for appointment is one that is well run. This includes management that is efficient and effective. Agency management personnel, including the agency's principals, must be good communicators. Positive staff environments and a culture that produces happy employees generally reflects open communications with staff, creating an efficient, well-run agency.

Effective Use of Automation →

Generally speaking, an agency that uses automation in an effective way is much more productive. Automation, when used properly, can go a long way in keeping employees productive and customers satisfied with the level of service they receive from the agency.

Track Record of Business Success →

One of the primary characteristics the company is looking for from the agency is profitable growth. Reviewing data from other companies the agency represents is a great way to get an idea about their track record. Profitable growth generally leads to a higher retention ratio, which, in turn, leads to greater growth and profitability for the agency and the company.

Identifiable Sales Culture →

The ideal agency is one that has a culture based on sales. This starts with producers who are focused on consistently bringing in new business to the agency. These producers generally have a high close ratio on new business. In addition, they are very focused on prospecting. Other members of the staff are also focused on selling by recognizing account rounding opportunities and focusing on retention. Higher retention equals faster and more economical growth.

Agency Marketing Plan →

A good prospective agency is one that has a marketing plan and focuses on it. Agencies that just haphazardly write business are usually not as successful as those who have a plan and properly execute it. Doing so indicates they understand what classes of business are wanted by the companies they represent and they intentionally seek out that business.

Knowledgeable and Professional Staff →

The company wants the agencies that represent them to understand insurance in general, and also its products specifically. The field representative should be looking for agencies whose teams are aware of the bottom line and understand its importance. As mentioned above, the members of the agency's team should be focused on sales and retention. It's important that the agencies that represent the company recognize they are the front-line underwriters for new business. As such, they know and understand the company's risk appetite and seek business that fits within the established guidelines.

Commitment to the Company → When reviewing prospective agencies, it's important to know how many other companies are represented and how this company will fit in the mix. It is important to get a feel for what share of the agency's business the company will expect to receive. To that end, it will be the responsibility of the field representative to communicate what will be the company's desired level of commitment and minimum level of commitment. The minimum level will be the amount of premium the company wants just to maintain the agency appointment.

Perpetuation → At some point, the agency principal or principals will be looking to retire. Understanding what the agency's plans are from that point on will be part of the consideration. It's expensive for the company to appoint agencies. If the owners are planning to sell when they retire, there is a great unknown as to what will happen at that point. A agency perpetuation plan, whereby other people within the agency will purchase it and keep it as a going concern will be a positive point in the consideration process.

Timely Accounting Practices → Whether the company uses agency bill or direct bill, assurance that the agency remits money on a timely basis is important. While many companies use direct bill, when return premium creates return commission and there is no offset, the company will need to know that the agency will repay them as required.

Responsibilities of Sales Representative

As part of the sales process, the company has field representatives that are meeting with agencies in the appointment process. These field representatives, also known as sales or marketing representatives, are still deeply involved after the agencies are appointed. Sales representatives have a number of responsibilities they are tasked with, each with equal importance.

Meet production and financial objectives: Once an agency is appointed, the real work begins for the sales representative. The representative must first take on the task of sitting down with the agency principals on a regular basis to review the goals and commitments set in the appointment process. The representative is also responsible for training the agency staff involved with the product. From a sales perspective, this includes helping them understand the features and benefits of the products and what differentiates the company's products from others in the marketplace. After training, regular follow up with the agency is important. The sales representative is the one who conducts the management process of the agencies in their assigned territory to ensure the company is meeting its financial objectives.

Part of that management process includes facilitating the relationship between the agencies and the different departments within the company. Since underwriting plays a critical role in meeting objectives, this is one of the most important relationships to be facilitated. The sales representative should feel free to bring along the underwriter on visits or to encourage the agency personnel to visit the company. From time to time, the sales rep may also be a liaison for billing issues, policy issuance, premium audits, loss control, and claims.

As part of the management of the agency, the sales representative will accountable for driving growth and profitability. They will be responsible for addressing acquisition and retention metrics. Commitments need to be monitored. If numbers are ahead or behind, the sales representative needs to investigate and understand the reasons for the variance.

Territory analysis and management: The sales representative must analyze the performance of the assigned territory on a regular basis. That means constantly reviewing metrics on each individual agency and also on an aggregate basis, looking for trends and deciding if they are specific to an agency, geographic area, or the entire territory.

Part of the evaluation process includes reviewing the number of appointments within the territory. It's up to the sales representative to determine if the appropriate number of agencies are appointed within the territory to meet the company's objectives. That evaluation includes reviewing each agency as to its size, the length of the appointment, and the type of business written with the company. Ultimately, the sales representative will determine if the number of appointments is sufficient or if it needs to be increased or decreased.

The sales representative is also responsible for gathering intelligence about the competition. As the representative visits agencies within the territory, they are gathering information on other companies represented by each agency. That information must then be reported by to sales management so the underwriting and product development teams can decide if changes need to be made to existing products.

Evaluation of agencies: Each agency within a territory must be reviewed and evaluated on a regular basis. Informally, that may occur quarterly as an internal process to assess each agency's performance. At least once a year, the sales representative should have a formal review directly with each agency. This review will include written premium, actual sales to goals, loss ratio, and other metrics set by the company.

Many companies internally rank the agencies they appoint. Depending upon the company, ranking may be a deciding factor in the benefits and services it provides to higher ranking agencies. Those benefits and services could be things like profit sharing or contingent commission arrangements, trips, preferential underwriting treatment, and others.

Recommend rehabilitation: When an agency is not performing up to the standard required in its agreement with the company, the sales representative may need to recommend rehabilitation. There are a number of factors that individually or combined may result in rehabilitation, such as:

- Production: If there is a shortfall in production as compared to the commitment, the sales representative must meet with the agency to determine what is the cause of the shortfall. The sales representative may then help the agent to identify new sources of business that can help make up the shortfall. There may also be marketing assistance, financial incentives, new target markets, or other options to assist the agency.

- Loss ratio: If the agency's loss ratio is too high, an analysis of its book of business will need to be completed. Issues related to severity may or may not present a problem, but a high frequency of claims *is* a clear indicator the book has problems. At that point, the sales representative needs to meet with agency staff to determine if the poor loss ratio is the result of poor selection on the agency's part. It's also possible for relaxed underwriting to be the cause, or in some cases, both. The analysis will show if there is a commonality in the claims that have occurred. The sales representative may need to offer some risk management techniques to improve the loss ratio and reduce future issues.

- Retention: Retaining existing business is always more profitable than writing new business. When retention ratios are higher, growth is more consistent and more profitable. As a result, the sale representative must take the time to determine where lost business is going. One method is to poll insureds that have been lost to see why they left. The company needs to know if the agency is poorly servicing or communicating with the insured, or if the company is to blame as the result of poor service or claims handling or pricing that is not competitive.

Recommend termination: If all attempts at rehabilitation have not been successful, it may be necessary for the sales representative to terminate the relationship between the company and the agency. If that is the only option left, the proper way to handle the termination is to follow the language in the company/agency contract. Language in the contract will govern the amount of notice required for the termination, which may vary depending upon the reason for the termination. The contract language will also speak to when the agency's authority on behalf of the company ends and how long the company will continue to renew policies on behalf of the agency.

Other Agency Services

There are a number of other services that the company may consider offering to its agency partners. Those services include the following:

- **Marketing assistance**
  - Marketing and sales materials as discussed in corporate marketing
  - New product training
  - Quick reference guides and appetite guides
  - Affinity program development (partnerships with associations or franchises offering exclusive pricing, competitive coverage plans, and other services)
- **Account management access**
  - Access to account information for policyholders, including billing, policy information, and claims
  - Ability to quote and submit business electronically
  - Online access to book of business and production reports
  - Online access to accounting, billing, and EFT commissions
- **Mentoring programs**
  - Typically offered as the result of a long-term agency relationship
  - A mentor is assigned to a new producer or newly appointed agent
- **Education and training**
  - Sales training for new producers
  - Account manager/account executive training
  - Technical assistance, including in-house agency training and company-created training modules
  - Subsidies for training paid as a bonus for production, including professional certification programs such as CISR, CIC, and others
- **Financial support**
  - Co-op advertising, where the company shares in the advertising expense related to its products or services offered by the agency
  - New producer loans
  - Lead generation
  - Automation enhancements for the agency
- **Licensing assistance**
  - Handling the licensing/ appointment process for the agency
  - The company may pay for agency or producer licensing with the state regulatory authority

Knowledge Check

Directions: What makes a particular agency a good prospect for an insurance company to partner with in terms of product distribution? Name at least three important aspects of a prospective independent agency.

1. _____

2. _____

3. _____

4. _____

Policyholder Services

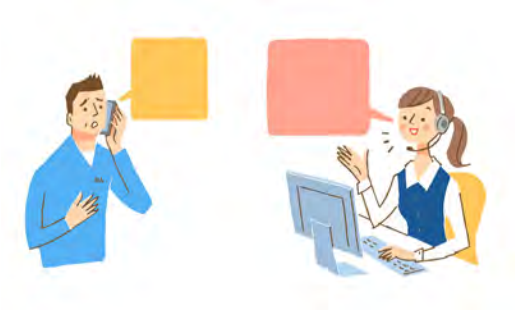
Learning Objective:

5.5 Evaluate methods intended to support policyholder services.

Client Access

In today's world, the company must be able to respond to the policyholder's needs on an expanded basis, including the possibility of 24-hour access. Many companies now offer client interface that allows the policyholder to access their account information and complete limited transactions. Access can include mobile apps, interactive websites, or interactive phone systems. These options allow the policyholders to pay bills, report claims, receive text alerts, view and print policies, and complete minor changes on their policies. In addition to accepting credit card and EFT payments, some companies provide direct deposit for the payment of claims.

Service Centers



Since the late 1990s, some companies have chosen to offer service centers as an option to their agency partners. Service centers were designed to offer policyholder services on behalf of the agency. Generally, they are used for commodity lines, such as personal auto, homeowners', and businessowners' policies. These generally are accounts that produce very little commission, yet are often expensive for agency staff to maintain. Service centers lift the service burden from the agency by handling the smaller administrative issues.

The service center is set up by the insurance company. Employees of the service center directly handle some or all of the service for certain policy types or sizes. Service centers handle typical customer service processes for customers such as phone calls, emails or texts, policy changes, certificates of insurance, and other day-to-day transactions.

Characteristics of a service center agreement include the following:

- Centralized services: services are typically handled by company personnel in a single location.
- Metrics-driven: the agreement between the agency and the service center include service standards that are measured and reported on a monthly or quarterly basis.
- Lower expenses: service centers run on a "shared services" basis, meaning the employees of the service center work for multiple agencies. This sharing of services lowers the cost of doing business for each individual agency.
- Improved customer satisfaction: customer calls are handled immediately by service personnel. Extended hours, including 24/7 service, gives customers the ability to receive service at a time that is convenient for them.
- Options provided: the agency can take advantage of all or part of the services offered by the company. That allows the agency to tailor the agreement to its specific needs.

The effective use of service centers has many benefits for the agency. Using the service center allows the agency to redirect its resources to production, making it more efficient at generating new business. It also allows the agency to focus on larger clients. If the service center offers 24/7 service, the agency benefits from the enhanced customer service. Finally, in the event a disaster occurs, the service center has the resources to continue to service the policyholders even when the agency may suffer a loss from the disaster, thereby strengthening the relationship with the policyholder.

Service centers need technology and people. That means there is a cost involved. So how does the insurance company recoup or offset the cost of a service center? Some companies require a minimum production threshold to be eligible to access the service center. If an agency meets the criteria, costs can be recouped in several ways. One way is the use of flat fees or reduced commissions for policies handled by the center. With some service centers,

the agency receives the full commission when writing the accounts, and the fees or reduced commissions apply at the renewal. Depending upon the size or tenure of the agency, the fees or commission charges may be negotiated or completely eliminated.

The extent of the services offered by the service center may vary by the company offering the services. Some centers may offer service only, while others may also include up-sell and cross-sell functions. Depending on the state insurance regulations of the agency's location, these types of services may require service center personnel to be licensed. For most states, processing non-premium bearing transactions usually doesn't require a license. If services include discussion of coverages, binding, increasing limits, and similar transactions, licensing *will* be required.

The use of service centers by agencies is not without its challenges. Confusion can be created as to who the policyholder is supposed to work with—the company or the agency. While it's not necessarily true, the use of service centers may give the appearance of the agency being cut out of the business equation. The insurance company may end up building brand loyalty with the client at the agency's expense. This means that the insured may follow the company rather than the agency. Finally, if the policyholder's account is split between multiple insurance companies, the service center may handle only the service on policies written with the insurance company sponsor. In that case, the agency would still have to handle the remaining policies, creating additional confusion.

Additional Services Offered

When it comes to policyholder services, there are many opportunities for the company to offer value-added services to attract and retain customers. Those services can include:

- **Disaster Preparedness and Recommendations:** Whether it be through text alerts, email, or social media, the company has the opportunity to communicate with agencies and policyholders alike. When catastrophes and disasters are imminent, direct alerts via email or text can be used to give policyholders specific information about their policies as well as preparedness and safety tips. Social media allows the company to give general information to all of its followers. After the event takes place, the company can continue to communicate with policyholders by giving them information regarding shelters, mobile claim office locations, and other important information they may need.

- **Safety Tips:** Another great value-added service is information regarding safety. Most policyholders are users of the internet. The company can communicate privacy and security tips to help customers protect their privacy and personal information. If the company writes business or personal auto policies, driver and auto safety tips are a great way to provide additional information to customers. Finally, information regarding business and home maintenance safety tips can be communicated, as well.

- **Resources:** The company website, social media, or email can be a great way to provide access to article, videos, blogs, vlogs, etc., to put information into the hands of policyholders.

Knowledge Check

Directions: How do centralized services support agencies in giving access and good service to clients? How can they hinder access and service?

_____

_____

_____

_____

Technology

Learning Objective:

5.6 Compare technologies available to sales and marketing departments.

The Use of Technology to Support Sales/Marketing

The technology used to support sales and marketing efforts primarily focuses on enabling interactions between the insurance company and the external environment. This includes evaluating external markets, conveying externally-facing communications, managing distributors, attracting new customers, and retaining and servicing existing customers.

Because of the externally-facing nature of this technology, it can directly impact the perception of the company in the marketplace and the individual experiences of intermediaries and customers. In addition, the transactions that take place almost always connect with and have an impact on internal functional areas such as underwriting, operations and finance.

Marketing Strategy and Message

A company's marketing approach typically includes the unique value it believes it provides. Technology can play an important role in helping to set strategy, promote the company's external-facing messages, and monitor performance relative to targets.

A company's systems can help to enable this by collecting and exposing data that mirrors the structure of the company.

Example: A company that operates within four profit centers, selling three products through six regional offices and 60 individual marketing territories will likely want to know how each of those individual segments are performing.

By capturing data that reflects the structure in the example, leadership can evaluate where production is the strongest, where additional advertising or training resources are best spent and where financial incentives such as supplemental commission are best used.

Data can also be used to evaluate the best new opportunities for growth. External data can be purchased that shows the number of customers, amount of premium and other similar metrics across various categories. By comparing a company's own data with that of industry data, leadership can understand market share at a granular level and redirect focus toward the largest areas of potential customers.

One of the most familiar areas of technology supporting the marketing function is a company's website. Websites often serve as the first point of contact used by external parties to obtain information about a company. Most companies take great care in designing their websites to provide precisely the look and feel they wish to promote with customers, highlighting their brand and message while providing information such as:

- description of the company
- history and mission
- products offered
- leadership team
- contact options

For many companies, their website also serves as the entry point for individuals to interact with the company privately. These companies provide sign-in capabilities for agents to access their own agency information with the company or for customers to access policies, billing, or other account services. These individual services significantly increase the need for cyber security to ensure that individual personal information is protected, including password requirements, two-step verification, message encryption and a more robust infrastructure to guard against and detect unusual activity.

Agency Management

The technology used to support a company's agents or other intermediaries is intended to enable the important and symbiotic relationship between companies and producers. Depending on the company, the marketing strategy, and the distribution system used, technology capabilities may include:

Producer management system: This type of system evaluates the performance of each producer by line of business or other metrics and provides information about submission activity, quoting success, new premium, and retention levels, and possibly other information such key contacts in the agency, company services that the agent is using, individual incentives, and the VIP status of the agency.

Customer relationship management (CRM) system: A CRM system provides a company with the means to track outreach to agents or customers, including the ability to capture notes, attach emails, and organize and visualize a company's external customer relationship efforts for each producer. Sometimes, the producer management system and CRM are combined into a single system.

Producer self-service: Many companies provide producers with direct access to information about their customers, and in some cases, to some simple transactions, including policy download/printing, issuance of certificates, and simple policy transactions such as address changes.

Business Acquisition and Retention

The technology used to support new business acquisition varies depending on the markets served and the business model used by the company. Some examples of technology used to support new business acquisition include:

- Customer portals: Companies that market without a producer directly to customers create websites which allow potential customers to input their personal information, review coverages, and get a quote. Since these portals are customer-facing, they are intended to be simple to use and the content is designed to explain to customers the complexities of the insurance products they are considering. Some companies may require customers to speak briefly to a customer service representative in order to complete the transaction. In those cases, the technology also must support this hybrid internet/phone approach.

- Agency portals: Many companies provide websites to their agencies to use for submitting business. These websites usually accept the applicant information; offer coverage options; collect underwriting information; and provide rating, downloadable quote letters, and policy documents.

- Upload/download: Agencies have their own agency management systems to store applications, policies, correspondence, and other records pertaining to their clients. In order to ease the application process, some companies provide their producers with "upload/download" technology. This technology uploads application data from the agency's system directly to the carrier's system, and downloads information such as quoting and policy documents back to the agency's system.

- Electronic mailboxes: For some types of business, especially highly specialized business that requires a specific type of underwriter, applications are emailed either to an individual underwriter or to a centralized mailbox. In these cases, the technology may provide an automated reply to the sender letting them know the application was received and, if sent to a centralized mailbox, who the account has been assigned to.

Regardless of how application information is received, the technology used must also interface with other company systems to complete the transaction, such as underwriting systems and the policy management system. In addition, once a transaction is completed, information must be sent to finance systems to record premium, set up billing arrangements, and remit producer commission.

Retention and Policyholder Services

Existing customers may experience a wide range of changes in their insurance needs during the term of a policy. Customers may buy and sell vehicles, properties, or businesses. Commercial lines clients must often provide proof of insurance to meet their own contractual requirements. Policyholders may have questions about their coverage or their bill.

The technology used to receive and process these changes is similar to the process used to receive new business applications—namely a combination of customer and producer portals, upload/download capability, and email, along with phone access to service representatives.

The servicing requests on existing business can be quite diverse. Many companies' technologies will attempt to route requests to the specific team that is most appropriate to the request. For example:

- Questions about coverage and requests to add or delete coverage must be handled by representatives who are licensed to provide insurance advice.

- Requests that are exposure related may be routed to underwriters. For example, a request by a florist to add a dump truck to their policy may need to be reviewed by underwriting. Adding a dump truck may signal that the exposure is not a florist but possibly something else such as a nursery, which might require underwriting approval.

- Simple policy changes are routed to administrative staff who can process such changes at low cost.

- Billing requests are handled by staff who are trained in the billing system and equipped to handle billing questions such as explaining bills, accepting payments over the phone, and confirming payments have been received. Most companies try to route these types of questions first through technology—either a phone system or a website—to reduce the costs of staff needed for simple questions.

Knowledge Check

Directions: Compare and contrast the kinds of technology used by the marketing department to the technologies used by the sales group.

_____

_____

_____

_____

Summary

To support the success mapped out in the strategic plan, the new and existing product lines must be advertised and distributed. Corporate marketing develops the advertising strategies that will reflect the goals of the plan, as well as the values, vision, and mission of the company. A company's brand emerges from this reflection of the company culture and the direction the EMT wants to take the company. The marketing team identifies who the customer is: Is it the agent? Or is the agent a business partner and the insured is the mutual customer of the agent and the company?

Marketing: Corporate marketing considers every possible touch-point with a consumer. These can be overt or even subliminal. External communication can be with customers, agencies, regulators, and others and is critical to consumers' positive perceptions of the company. These communications include ads, customer response, annual reports, media, brochures, and in-person meetings. Marketing creatives come up with a brand identity that includes internal and external communications. These creatives must believe in the brand, and agencies and consumers must also be able to buy-in to the brand and its message. Differentiation, recollection, scalability, complementary touch-points, and applicability are factors in building a successful and effective brand. Advertising then "spreads the brand." These are the formats considered for this task: fliers and brochures; billboards; television and radio; internet and intranet marketing and messaging; social media, blogs, etc.; search engine optimization (SEO), and cooperative marketing.

Distribution: Concurrent with marketing activity, sales management must begin to create the distribution network needed to impact the success of the EMT's strategic plan and the company's growth. Factors to be considered when choosing distribution methods are: expense, control, desired market penetration, and scalability. The main methods of distribution are: the independent agency system and their clients and outreach; and exclusive agents who represent only one company or group, eliminating competition but limiting broad product lines and the use of high rates. Direct marketing is another method of reaching consumers; preselecting and targeting customers and using in-house personnel makes this a useful tool. Online distribution is another method and must have a strong quoting tool and requires online chat and follow-up with telephone or other means. Some consumers find this method suspect when making a final choice, but this works well for them when they research options and pricing.

Relationship Management: If the insurance company selects the independent agency system as its primary distribution method, the sales management team must find, appoint, and develop the relationships necessary for the company to implement its strategic plan and meet its goals. Consequently, the company must take a serious approach in its selection of agencies to partner with them. Criteria for selection include: competent leadership and management, is well run, efficient and effective, good communication and a positive healthy culture, advanced automation, track record of success, and profitable growth and client retention. Additional criteria include a strong sales culture and a consistent marketing plan, personnel who are knowledgeable and committed, timely and strong accounting practices, has a perpetuation plan. The company will have field reps—sales or marketing reps that meet with agencies during the appointment process. These reps evaluate appointed agencies and ensure they meet production and financial objectives, establish territory responsibilities, and gather information on competition within the territories. Each agency must be evaluated using written premium, actual sales to goals, loss ratios, and other metrics set by the company. Rehabilitation or termination of an agency may be recommended. Other agency services offered to the insurance company's agency partners are: marketing assistance, account management access, mentoring, education, licensing assistance, and financial support.

Policyholder Services/Client Access: Twenty-four-hour access by policyholders for help and information is more important than ever. This can include mobile apps, interactive websites, and interactive phone systems.

Service Centers: Insurance companies offer service centers as an option to their agency partners, lifting the burden from the agency by handling the small administrative issues. Characteristics of a service center agreement include centralized services, metrics, lower expenses, improve customer satisfaction, and provides other options like cross-sell and up-sell functions.

Value-added Services: The company may offer value-added services like disaster preparedness, safety tips, and other expanded resources like videos, articles, and blogs.

Sales and Marketing Technology: The technology used in sales and marketing is primarily for enabling interactions between the insurance company and the external world, such as evaluating external markets, conveying public-facing communications, managing distributors, attracting new customers, and retaining and servicing existing customers. This technology must connect with internal functions like underwriting and finances. Data is used to evaluate the best opportunities for growth. External data can be bought and

compared to internal data and can be used to identify potential customers. The company website is perhaps the most important access technology and sometimes as the first point of contact with customers. The brand should be highlighted on this most important entry point. Security technologies are very important for the protection of clients' private information.

Agency Management Technology: A producer management system is used to evaluate the performance of each producer by line of business, submission activity, quoting success, new premium, and retention. Key contacts in the agency, company services used, incentives used, and the status of the agency are also tracked. A customer relationship management (CRM) system provides tracking means for outreach to agents and customers. With it, the company and producers can capture notes, attach emails, and understand the external customer relationship efforts of each producer. Producer self-service technology gives producers access to direct transactions with customers like policy printing, certificates, and simple actions like address changes.

Additional technology features like customer portals, agency portals, upload/download capability, and electronic mailboxes are provided to agencies to streamline services and improve customer relations and retention.

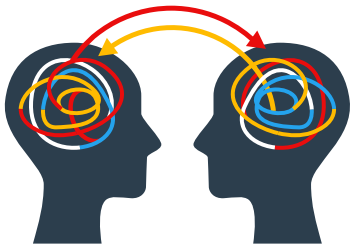
Retention and Policyholder Services Technology: Other technologies are used to receive and process changes that current customers want to make quickly and easily. Other services for these customers are answering questions about coverage and requests to add or delete coverage, exposure questions rerouted to underwriters, simple changes that can be switched to admin staff at a low cost, and billing requests.

The product distribution, sales, and marketing departments and their tactical plans require ongoing and complex evaluation. These teams have access to sophisticated tracking and data programs that can interface and provide rich feedback on how the strategic plan is working in its full public-facing roll-out, and by continuous monitoring. Not only is technology critical here, but the field reps for both sales and marketing are incredibly important as well for a company to receive good, immediate information on public perception, agency practice, growth, and retention.

Speaking From Experience

For valuable reinforcement, some important concepts related to the learning objectives in this section, use the following link to access video clips from insurance company professionals actively engaged in these departmental strategies.

scic.com/ICOresources



Section 5: Self-Quiz

Corporate Marketing and Sales Management

Directions: Name one of the first questions to be answered for sales management?

1. _____

Corporate Marketing

Directions: Circle True or False related to the following statement.

2. Brand identity is the collection of the elements that make the company the same in the marketplace.

True **False**

Directions: What is the term used to describe the sharing of advertising Cody's with its agency distribution network?

3. _____

Distribution

1. Select the factors considered when deciding the methods or methods of distribution. Select all that apply.
   - ☐ Control
   - ☐ Loss ratio
   - ☐ Timely accounting practices
   - ☐ Competent management
   - ☐ Desired market penetration

2. Some companies may use multiple distribution methods including independent agents, exclusive agents, and online sales.

True **False**

Relationship Management

1. An insurance company's expectation of an agency is for the agency's track record to indicate:
   - ☐ profitable growth, high retention rates, and low loss ratios
   - ☐ slow growth, low retention rates, and low loss ratios
   - ☐ fast growth, low retention rates, and low loss ratios
   - ☐ profitable growth, low hit ratio, and low retention

2. Select the most accurate statement that includes some of an insurance company's expectations of an agency.
   - ☐ Assertive producers who are more focused on sales than retention
   - ☐ Producers and staff that effectively use automation even though they have a low close ratio
   - ☐ Assertive and productive producers and a professional staff who have knowledge of the insurance company's appetite and who effectively use automation
   - ☐ Professional staff more focused on sales than on front-line underwriting and retention

3. Select the statement that most accurately describes the agency appointment process.
   - ☐ In order to meet production goals, appoint as many agents as possible to saturate the territory, and if asked, provide assistance.
   - ☐ In order to meet production goals, appoint only those agents that are willing to do book rollovers and contact the assigned underwriters to provide assistance to that agency.
   - ☐ After conducting a territory analysis, identify and contact the appropriate number of qualified agents and assist with the appointment process.
   - ☐ Identify the number of agents needed to achieve territory saturation and appoint an agency that has the number of needed producers to achieve that goal.

4. Which of the following is true regarding maintaining an agency's relationship?
   - ☐ If an appointed agency has problems/issues with the insurance company, always side with the agency principals in order to maintain the relationship.
   - ☐ If an underwriter brings up an issue about an agent, don't get involved so as not to jeopardize the marketing rep's relationship with the agency.
   - ☐ After the appointment process, don't bring up sales goals to the agency principals so as not to offend them.
   - ☐ After the appointment process, meet with the agency principals and staff to discuss quoting, issuance, and product challenges.

Directions: Circle True or False related to the following statements in regard to an evaluation of an agency.

5. If an agency does not meet production goals, identify the cause of the issue, help agents identify new sources of business, and offer sales and marketing assistance.

True **False**

6. If an agency has a poor loss ratio, rehabilitation may include re-underwriting all or a portion of the agent's book of business.

True **False**

7. If an agency has a low loss ratio, identify factors that may have contributed and offer risk management techniques.

True **False**

8. If a review indicates an agency has low retention, recommend termination.

True **False**

9. Termination of an agency is recommended only when an agency fails to meet production goals.

True **False**

Policyholder Services

Directions: Indicate which of the following are typically included as services provided to agents and brokers of an insurance company.

1. Access to insurance company manuals, quick reference guides, appetite guides, insurance company specific marketing and sales materials

Included **Not Included**

2. Access to the agency's book of business and production reports; access to the agent's policyholder accounts, such as policies, billing, certain types of claim information, etc.

Included **Not Included**

3. Access to other agencies' books of business, policyholder information, etc.

Included **Not Included**

4. Access to mobile apps

Included **Not Included**

5. Certain types of education and training

Included **Not Included**

Directions: Check which of the following is an accurate statement in regard to electronic interfaces?

- ☐ Electronic billing and electronic fund transfers for premium payment are a mandatory policyholder requirement.
- ☐ Many insurance companies offer client interface to allow policyholders to access their account information and complete certain transactions.
- ☐ Electronic fund transfers for payment of claims is a mandatory policyholder requirement.
- ☐ All policies and insurance cards are electronically distributed by all insurance. Paper copies are distributed at an additional cost.

Directions: Indicate which of the following is true in regard to Service Centers.

6. An advantage is that service centers are not centralized.

True **False**

7. A benefit is that the use of a service center allows an agency to redirect resources to production and also to focus on larger clients.

True **False**

8. A benefit is that service centers are typically accessible to clients 24/7.

True **False**

9. There is no fee/cost/expense to the agency for the use of a service center.

True **False**

10. There are no licensing requirements involved for up-selling or cross-selling.

True **False**

Directions: Select the statement that most accurately describes services provided by most insurance companies to their policyholders.

- ☐ Most insurance companies will provide post-event disaster services to a policyholder for a fee, but only for certain types of covered disasters.
- ☐ Many insurance companies will offer privacy and security tips for free to a commercial lines policyholder who has purchased a cyber policy, but none to a homeowner.
- ☐ Many insurance companies will offer, at no charge, safety tips, and also provide severe weather alerts via email, text, or other electronic communication.
- ☐ Many insurance companies will offer and provide auto and driver safety tips and discounts, but only to those who are using telematics.

Technology

1. CRM system evaluates the performance of each producer.

True **False**

2. Electronic mailbox uploads application data from the agency's system directly to the carrier's system.

True **False**

Appendix

Exam Preparation

For many learners, exam preparation is stressful. Please keep in mind that the most important measure of your knowledge will be witnessed in your service to your organization. Think of the exam as a tool. Use it to come to an understanding of what you know, how it affects your work, and what more you would like to know to have even greater success in the workplace.

The exam period is two hours long. You are required to earn a minimum of 140 outof 200 possible points. Questions appear in the same order as the presentation of the topics.

Remain aware of the time as you take the exam. Pace yourself and be aware that unanswered questions are considered incorrect.

Study Guide

Use your browser to access a downloadable Study Guide at **scic.com/ICOresources.**

The Self-Quizzes offer a variety of brief activities to help you become more familiar with the content in this Insurance Company Operations learning guide. Check your answers to gain confidence in your understanding of the concepts and details presented in this course.

Study Techniques

Here are some techniques you can use to help you prepare for the end-of-course exam. Apply the same techniques to each section in your learning resource guide.

1. Re-read the Introduction.

2. Review each Learning Objective.

3. Try changing each heading and subheading into a question, and then answer the question. For example:

   Heading: Risk Tolerance and Risk Appetite

   Question: What is Risk Tolerance and Risk Appetite?

4. Review each diagram, graph, and table. Interpret what you see. Ask yourself how it relates to a specific learning objective.

5. Check your answers you gave for each Knowledge Check. Consider ways to improve your original answers.

6. Re-read the summary at the end of each section.

7. Review any comments, highlights, or notes you made in each section.

8. Build mind maps to find the connections among the concepts presented in the learning guide.

9. Rewrite important ideas in your own words. Find ways to relate those ideas to your own work experiences.

10. Make flash-cards to help you review important vocabulary.

Sample Exam Items

The end-of-course exam consists of short-response questions.

Sample 1

There are various types of uses of reinsurance. Describe excess of loss reinsurance and identify two ways it applies. (5 points)

Acceptable answers:

(non-proportional) - an agreement to share specified losses.

And

The reinsurer indemnifies the ceding company (primary insurance company) for the amount of loss in excess of a specified retention.

Or

The retention amount can be stated as either a dollar amount or a percentage amount.

Or

The reinsurer does not participate in losses until a loss exceeds the amount retained by the primary insurance company.

Sample 2

Claims reporting is the first step in the claims process. There are various goals and significance related to proper reporting. Prompt reporting is essential. What are two goals for timeliness and accuracy of reporting? (6 points)

Acceptable answers:

Ability to stabilize and mitigate quickly

And

Preserve the details for accuracy and completeness

Glossary of Terms

Active Approach to Culture Development – Executive Management Team is deliberate with creating the culture

Adverse Development – upward adjustments that must be made to loss expenses when claims are higher than reserves

Agile Approach – replaces the large upfront investment and the long delivery timelines with a more iterative approach

Allocated Loss Adjustment Expenses (ALAE) – expenses that are directly assigned to or arise from a particular claim

Bad Faith – an insurance company's unreasonable and unfounded refusal to provide coverage in violation of the duties of good faith and fair dealing owed to the insured

Base Technology – refers to technology that is necessary as a requirement of conducting business

Bulk Reserve – the gross IBNR that actuaries are responsible for determining; comprised of adverse development, reopened claims reserve, IBNR, and RBNR

Capital – a large sum of money used to start a business, or which is invested to make more money

Case Reserve – the best estimate of what the claim will ultimately cost when the claim is initially filed

Catastrophe (CAT) Management – the use of CAT models for pricing and underwriting, as well as solvency and capital management

Ceding Company – the primary insurance company that is transferring part of its liability to another insurance company

Combined Ratio – the primary measure of the profitability of a book of business

Comparative Negligence – states that when an accident occurs, the fault and/or negligence of each party involved is based on their respective contributions to the accident

Contractual Liability – arises out of the assumption of liability by the parties to the contract

Cooperative Advertising – when a company shares advertising costs with its agency distribution network

Correlation of Risk – the likelihood that a given catastrophe or different catastrophes will affect more than one territory or state

Detrimental Reliance – occurs when one party is reasonably induced to rely on a promise made by another party

Direct Marketing – uses insurance company employees to sell its products to consumers

Discretionary Pricing – refers to the ability of an individual underwriter to credit or debit an account or a portion of an account based on the merits of the risk, program or agency segmentation

Enterprise Risk Management (ERM) – is used as part of the review of external threats. ERM focuses not only on external issues that can impact a company from a competitor standpoint, but also the likelihood of other occurrences that may have serious impact on its ability to meet strategic goals

Estoppel – a legal principle that prevents someone from arguing something or asserting a right that contradicts what they previously said or agreed to by law

Exclusive Agents – agents that represent only one company or company group

Executive Management Team (EMT) – performs critical functions within leadership framework; responsible for managing the company's core business operations as a whole

Exposure Management – process that the company may use to reduce exposure by nonrenewing policies in areas where the company may have too many policies

Extrinsic Evidence Rule – outside evidence and information not contained in the policy or lawsuit that may be considered in determining whether coverage will apply

First-party Claims – losses suffered by the insured

Frequency – large numbers of losses

General Damages – damages that are not easily quantifiable, such as pain and suffering, which are typically assigned a dollar amount by a jury

General Ledger – part of accounting structure that includes lines for every transaction that takes place as a company begins to do business

Incurred But Not Reported (IBNR) – claims that have occurred but have not been reported to the carrier

Independent Agency System – made up of individual insurance agencies that are independently owned

Insured – consumer of the insurance product

Joint and Several Liability – when responsibility is shared by two or more parties to a lawsuit and the wronged party has the ability to collect damages from any or all parties involved

Loss Cost Multiplier (LCM) – contemplates underwriting expenses and desired profit

Loss Ratio – measures the portion of each premium dollar that is used to pay losses

Market Conduct – the behavioral characteristics of a company operating in a certain market or industry; governed by guidelines and parameters set by regulators

MIHCs – Mutual Insurance Holding Companies

Multivariate Rating – rating based on the relationship between multiple variables at the same time

Mutual Holding Company – non-stock corporation, which is the holding company parent

Mutual Insurance Company – an incorporated insurance company owned by policyholders

Negligence – liability based on the failure to exercise the appropriate amount of care given certain circumstances

Non-Waiver Agreement – a bilateral document, in the form of a contract or agreement, acknowledging that there is potentially an issue with coverage, but that the investigation of the claim will proceed while the issue is being resolved

Online Distribution – a form of direct marketing that takes place via the internet

Passive Approach to Culture Development – allows a culture to be created over time

Policyholder Surplus – essentially the amount of money remaining after an insurer's liabilities are subtracted from its assets

Pooling – simply aggregating all of the premiums for a specific line of business

Predictive Modeling – modeling and data analysis techniques used to discover predictive patterns and relationships

Production Underwriters – underwriters that travel to different insurance agencies to develop agent relationships and promote the company's products and services

Pro-Forma – a forward-looking document that forecasts anticipated results from objectives and priorities of the financial projections

Proof of Loss – a sworn statement by the claimant that is signed an notarized which includes an inventory of the lost or damaged property and its value

Rating Agencies – assist regulators, agents and consumers by setting financial standards and assigning alpha numerical ratings related to those standards

Ratemaking – calculating premiums that policyholders should pay for their insurance

Reciprocal Insurance Company – group of individuals or organizations who join together into an unincorporated association

Reinsurance – a contractual arrangement in which one insurance company agrees to insure the assumed liabilities of another insurance company

Reinsurer – an insurance company that accepts the liabilities from a ceding company for a stated premium

Reopened Claim Reserve – the provision for future adjustments of case reserves

Reported But Not Recorded (RBNR) – claims that have been reported to the insurer but have not yet been recorded on the insurer's books

Reservation of Rights (ROR) Letter – a unilateral document sent by the insurance company to the policyholder advising them that although there is a question about whether or not a loss is covered, the insurance company will proceed with the investigation of the claim, but reserves the right to deny the claim at a later date

Reserves – the amount a company must set aside to pay all future benefits for obligations that already exist; considered liabilities on a company's financial statements

Risk Appetite – the maximum amount of risk the organization is willing to accept while striving to meet its strategic and tactical plans

Risk Tolerance – the maximum amount of risk a person or organization is willing to assume

Salvage – the sale of an insured's damaged goods by an insurance company after the insured has been indemnified for the value of the loss

Severity – large dollar losses

Special Damages – damages which compensate a party for those losses that are quantifiable, such as medical bills or property damage

Spread of Risk – created when a company writes in all areas of a single state or in multiple states

Statutory Accounting Principles (STAT) – set of accounting regulations prescribed by the NAIC for the preparation of the insurance company's financial statements with the primary goal of assisting regulators in monitoring an insurance company's solvency

Statutory Liability – liability created by law which may establish a standard of care

Strategic Business Plan – the formulated roadmap that describes how the company executes its chosen strategy

Strategic Planning – the process used to create the strategic plan; may include an Enterprise Risk Analysis and/or SWOT analysis

Strategic Technology – refers to technology that is unique, dependent upon, and intended to enable an insurance carrier's chosen operating model

Strategy – a thoughtful, deliberate plan of action

Strategy Formulation – the first step in the process where the EMT decides what it wishes to build and asks: where are we now, where are we going, and how will we get there?

Strategy Implementation – strategy that is put into action to implement a company's objectives and goals

Stock Holding Company – subsidiary of the mutual holding company

Stock Insurance Company – an incorporated insurance company owned by stockholders

Stockholders – investors in the organization

Sustainable Competitive Advantage – all things that will distinguish the company from other companies In the eyes of its target customers

SWOT Analysis – focuses on identifying strengths, weaknesses, opportunities, and strengths

Third-party Claims – involve claimants who are not insureds but have been injured or had property damaged by an insured

Topline Growth – increase in written premium month over month

Tort – a civil wrong other than breach of contract

Treaty Reinsurance – occurs whenever the ceding company agrees to cede all risks within a specific class of insurance policies to the reinsurance company

Unallocated Loss Adjustment Expenses (ULAE) – expenses not specifically allocated or charged to a particular claim

Underwriting Expense Ratio – measures the portion of each premium dollar used to pay for a company's operating expenses

Waterfall Approach – characterized by a large upfront investment, a period of building systems, and eventually — sometimes years later — a large technology release that unveils the finished product

Yellow Books – detailed financial statements provided by insurers to rating agencies that has a required yellow cover