



Workers Compensation Loss Projections

By Maureen Gallagher

January, 2016

"It is Difficult to Make Predictions; Especially About the Future!"

Niels Bohr, Nobel laureate in Physics

What is the Definition of Loss Projection?

The total sum the insured, its insurer(s), and/or reinsurer(s) pay for a fully developed loss (i.e. paid losses plus outstanding reported losses and incurred but not reported (IBNR) losses). It may not be possible to know the exact value of ultimate losses for a long time after the end of a policy period. Actuaries are employed to assist with these projections for purposes of financial modeling and/or reserve determination.

Insurance Risk Management Institute (IRMI)

Overview of Loss Projections and Insurance Pricing

It is important to understand the components of workers compensation costs as all workers compensation premiums are based on the same components. The actual losses always represent the greatest cost component. For this reason, understanding the ultimate loss picture is important to underwriters and insureds. Underwriters need to understand the loss picture to price an account. An insured must understand the "full" loss picture (not raw and undeveloped losses off the loss run) in order to better negotiate pricing and collateral. In addition, when an employer is insured under a loss sensitive program (e.g., large deductible, self-insurance) the employer needs to capture the full extent of liabilities under the "cap/retention/deductible" in order to more accurately account for workers compensation liabilities on their books (i.e., profit and loss statement). While the below summary will vary considerably from insurance carrier to insurance carrier, the fact that losses always make up the majority of the overall pricing is consistent.

What goes into insurance pricing/premium determination?

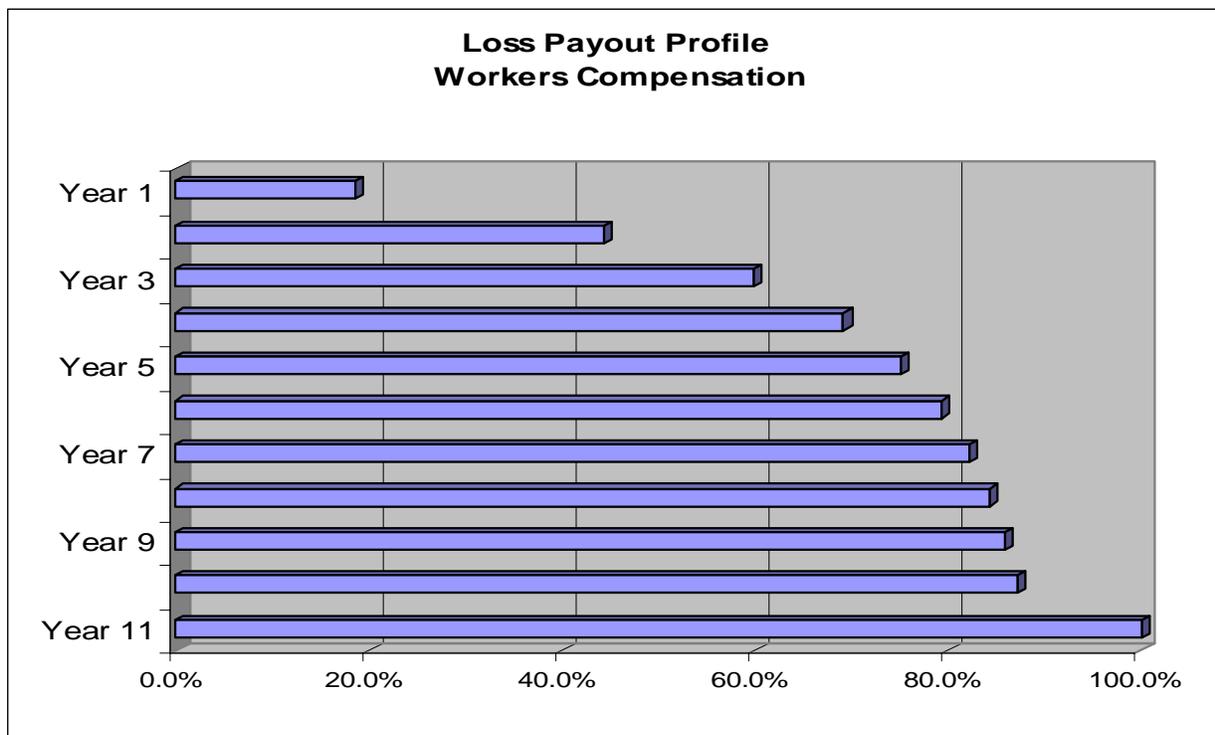
Agent Commission (The amount paid to the insurance agent)	4-12%
Taxes, Fees & Surcharges (Uncle Sam's Take)	4-8%
Loss Control (Safety & Training)	2%
Benefit Delivery Expenses (Cost to Pay Claims)	10%
Reinsurance (Stop Loss for Large Claims & Aggregate Stop Loss for All Claims)	2%
Administration Costs	4%
Subtotal	30%
Actual Claims	70%
Total	100%



Why is a loss forecast/projection needed?

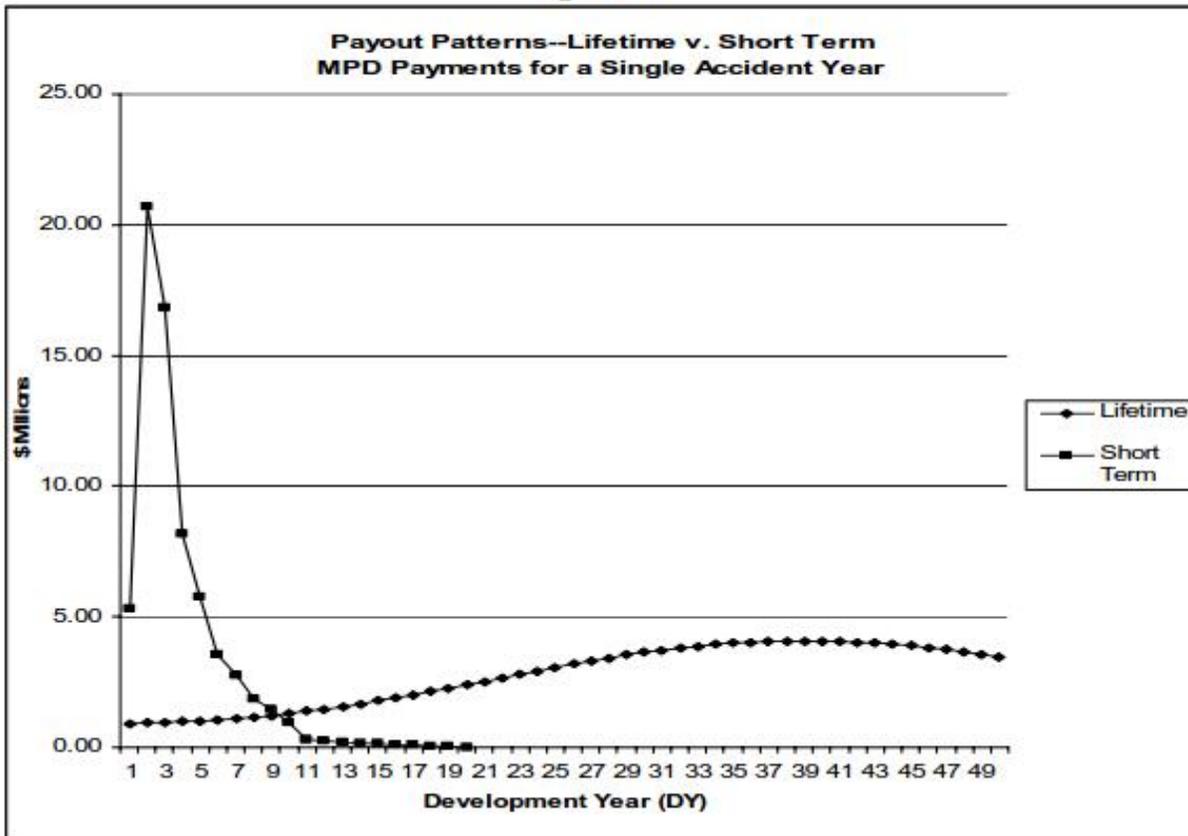
Workers compensations claims are not like wine; they do not improve with age. In general, claim costs will increase over time as more information is learned about the claim. For example, a claim may start out as a back strain which is treated with a few chiropractic visits and painkillers. The initial claim reserve may have been \$3,500. The reserve is a “cash reserve” which represents what the carrier believes the total ultimate cost of the claim will be. Assume the employee does not improve and continues to suffer back pain. In an attempt to discover the source of pain, the treating doctor orders X-rays or an MRI as a next step. The insurance carrier claims adjuster increases the reserve to \$15,000 in addition to the \$2,500 already paid for treatment for a total incurred (paid and reserved) cost of \$17,500 to reflect the anticipated higher claims costs. Finally, let’s assume the MRI reveals that back surgery will be needed. As soon as the adjuster receives this updated information, the reserve is increased again — to \$75,000 for the additional anticipated costs. The progression of the treatment spans a 19-month period. The reserve increases usually lag behind treatment.

In addition, it is not uncommon for workers compensation claims to manifest at a later date. The loss projection will account for these claims under “incurred by not reported” (IBNR). The actuaries’ joke about IBNR goes like this: “In there, but not really”. It is really an accurate description of IBNR. Below is a loss payout profile.



A loss payout profile is a representation of the delay between the time a loss is incurred and the date of the actual loss payments. This is also referred to as a loss payout profile. A payout profile and LDF’s typically have a time horizon of 11 years. The loss payable profile is also referred to as the workers compensation “tail”. Below is another chart from an abstract Richard E. Sherman and Gordon F. Diss wrote called “Estimating the Workers Compensation Tail”. As you can see, 11 years is about where claims are fully paid and accounted for.

Figure 1.1



Link below for full abstract on estimating the workers compensation "tail":

<http://docplayer.net/4188595-Estimating-the-workers-compensation-tail-richard-e-sherman-and-gordon-f-diss.html>

How is Ultimate Claims' Cost Determined? Simply put, by using actuarially-determined loss development factors.

Loss Development Factors Frequently Asked Questions

What are loss development factors (LDFs)? As indicated previously, losses tend to grow over time. This phenomenon is not necessarily due to any shortcomings of claims reserving specialists. It is simply due to the nature of "long tail" exposures of workers compensation risks. "Loss development" refers to the pattern by which the reported losses for a particular year change over time. Loss development factors relate reported losses (either paid or incurred) as of a given date to the ultimate value of those losses when the total for all claims is known. Loss development factors include provisions for the following:



- Upward development on reported (existing) claims; and
- Potential re-opening of closed claims.
- In addition to existing claims, there is another aspect to claims trending and developing called "incurred but not reported" or IBNR. These are claims that are incurred after the statement date but have not been reported (true IBNR claims). Carriers include an IBNR factor in loss trending and development based on generally accepted actuarial reserving techniques. These are estimates for losses and loss expenses incurred but not yet reported.

How are LDFs used? Paid (or incurred) losses as of a given report date multiplied by the appropriate paid (or incurred) loss development factor produces an estimate of developed paid (or incurred) losses. Developed losses reflect an approximation of the ultimate value of losses when all claims and claim amounts are known.

What is the difference between "paid loss" LDFs and "incurred loss" LDFs? Paid loss development factors are calculated using paid loss data, and are to be applied to paid losses. Incurred loss development factors are calculated using reported incurred loss data, and are to be applied to case incurred losses (paid losses plus case reserves on reported losses). Both developed paid and developed incurred losses provide estimates of ultimate losses.

Explain why a "negative" loss development factor can exist. While the value of reported losses tends to rise over time to its ultimate level, it is possible for this quantity to be reduced. Claims can settle for less than the value of the case reserve, or it may be possible to recover some part of a loss through salvage or subrogation. If reported paid (or incurred) losses are greater than the ultimate value of those losses, the appropriate loss development factor will be less than one, and is sometimes referred to as "negative." This can also happen when there is a change in the work comp laws of a state. Over the years the trend has been to limit eligibility and reduce benefits to workers. If the "future" of claims will be less due to the statutory changes, then the LDFs will also be less. This happened several years ago when CA changed their laws limiting benefits to two years like many other states had already done. In many cases the new law applied retroactively. The development factors were below 1.00 when this happened as many of the claims were over-reserved based on the new law.

Do LDFs vary depending on who calculates them (i.e., insurers, rating bureaus, large insureds, consultants)? The short answer is, yes. The selected LDFs are based on the data available and the judgment of the selector. In addition, an inherent assumption is being made that losses will develop in the same way in the future as they did in the past or in a way that can be accounted for with an adjustment of past experience. Insurers' LDFs would, therefore, reflect the past experience of their particular book of business and would reflect, at least to some degree, their claim reserving and payment philosophies. Rating bureaus' data would have greater statistical significance because of their larger database, but in the past it may have been difficult to factor out the influence IBNRs played in their data. Large insureds' IBNRs would be limited to their own particular businesses. Individual consultants' LDFs may vary considerably depending on their database, reserve philosophy, personal judgment, and client base. In my experience insurance carriers' reserves are typically higher than NCCI.

Reference for FAQs – IRMI



How an underwriter views pricing versus what is provided to the insured.

Below is how an insured is presented its pricing for workers compensation premium. However, carriers use "models".

Sample Company - Guaranteed Cost				
Code	Classification	Payroll	Rate	Premium
3081	Foundry & Ferrous	6,333,100	11.73	742,873
8810	Clerical	494,104	.35	1,729
7380	Drivers	450,568	8.47	38,163
Manual (Standard) Premium				782,765
Experience Modification - 1.24				970,629
Premium Discount (9.9%)				(94,050)
Expense Constant				120
Premium (Inception Cost)				876,699

What are Models? When underwriters evaluate an account, they are usually running models. When credits and debits are available to the underwriter they will use them to "back into" pricing where they know they can make a profit. For instance, assume Sample Company has total losses of \$296,000 and after applying development factors to determine ultimate payout of all claims a loss pick of \$415,000 is determined. Once the underwriter has the total trended and developed claims they will run the following formula to determine the break-even cost:

Claims	X	LCF	X	Taxes	+	Loss Control	+	REIN	+	Admin	X	Agents \$\$	=	Premium
415,000		1.10		1.04		8,020		8,050		16,099		1.08		\$538,789

If the underwriter was writing a guaranteed cost program, they most likely would apply scheduled credit to the \$896,699 premium as their model shows the carrier is at "break-even" at \$538,789. This is assuming the state the employer is located in allows scheduled credits.



Insured's Perspective of Work Comp Losses

The average insured — that is, those that do not have experienced risk managers or knowledgeable insurance professionals managing their insurances — typically do not have an understanding of workers compensation loss trending and developing. It is not uncommon for a buyer to comment on (raw and undeveloped) loss runs, that the reserves are too high and the carrier will never pay that much out. Or the insured dismisses the reserves entirely and focuses only on what the carrier has paid. They do not understand why; say for instance, that the annual guaranteed cost premiums being quoted are \$80,000 when they have only had an average of \$25,000 in paid losses and \$10,000 in reserves. Workers compensation stakeholders know that not only will the reserves be paid out but most likely even more than that.

Workers compensation is the most predictable line of coverage. This is because of the amount of groups that collude to share private company information on losses for rate making and determination of loss development factors. We share everything in workers compensation. Employers are required to record all losses on OSHA log sheets and complete an annual report. The volume of information available by industry, type of claim etc. on is staggering. <https://www.osha.gov/> Just peruse Data and Statistics on the OSHA website. In addition, all companies paying over a certain amount of premium (approximately \$8,000) are subject to the Experience Rating Modification calculation. This is not an option for employers; it is mandatory.

What is the Experience Modification?

It's an actuarial formula. It is designed to reward employers with better than average loss experience and penalize employers with worse than average loss experience. The experience modification is designed to adjust the premium to reflect the loss experience of a company.

Purpose of Experience Modification

The experience modification adjusts the premium to more equitably reflect the individual characteristics of the employer. A factor greater than 1.00 means the employer experienced worse than expected losses. A factor less than 1.00 indicates the employer's losses were better than expected. An average experience modification is 1.00 – meaning the frequency and severity of actual losses equal the expected losses.

Who calculates experience modifications?

Experience modifications are calculated by Advisory Organizations. Most states use National Council on Compensation Insurance (NCCI) but some states have their own rating bureaus. NCCI is a private corporation, created and funded by member insurance companies. It is approved by the states, but it is not connected with government in any way. It also calculates mods for some of the states below. While the below states have their own Advisory Rating Organizations that are separate from NCCI, several use NCCI and are combinable with other states. Separate mods will be calculated for MI, PA, DE and CA.

California	Delaware	Hawaii
Indiana	Massachusetts	Michigan
Minnesota	New Jersey	New York
Pennsylvania	North Carolina	Texas
Wisconsin		



In addition, most monopolistic states (e.g., Wyoming, Washington and North Dakota) use their own Advisory Organizations to calculate their modifications. Ohio, also a monopolistic state, uses NCCI to calculate modifications.

In order to calculate the experience modification prior losses and payrolls are needed. Carriers report this information to the Advisory Organizations. The massive amount of payroll and loss (claims) data shared — through OSHA and the Experience Modification system — allows workers compensation stakeholders access to significant data to accurately project/predict ultimate workers compensation losses.

What is the most effective means to demonstrate the concept of the true claims picture?

Many larger companies certainly understand loss development and how the underwriter is viewing losses — the underwriter is not looking at the loss runs but rather their “model” which develops losses then adds all the expenses to determine the “break-even” cost of writing any particular account. However, many smaller to medium sized companies (and agents) focus on the loss runs and do not understand how the underwriter is viewing. This lack of understanding hinders their negotiating abilities as they are making an argument for pricing with only half the picture.

Track Loss/Claims Development

One effective approach to demonstrate the development of claims to an employer is to track the losses of the company. “Freeze/Save” the loss runs at the end of each year and save them in a file. The most logical time to save the loss runs is at the expiration date. Do the same thing for each of the following years. Agents are typically focused on securing recently valued loss runs as that is what underwriters require to underwrite an account. However, for loss development and demonstrating growth of claims, the losses needed are what they looked like at certain intervals. In other words, what were the total losses at the end of the policy year in 2012? Next, what did the same body of claims looked like at the end of 2013 and in following years? In some instances — especially with the national carriers — loss runs can be pulled at varying intervals so there is no need to save them. However, many regional or state-specific carriers do not have these capabilities; therefore, it is recommended the loss runs be saved. Record the information on an Excel spreadsheet. The spreadsheet might look like something below.

CA Employer's Loss Experience This is <u>ONE YEAR</u> – <i>The Same Year</i> – Shown Developing Out Over Six Years			
Year	Paid	Reserved	Ultimate Total Claims
2017	\$125,000	\$95,000	\$220,000
2018	\$140,000	\$105,000	\$245,000
2019	\$165,000	\$120,000	\$285,000
2020	\$180,000	\$115,000	\$295,000
2021	\$195,000	\$115,000	\$310,000
2022	\$265,000	\$65,500	\$330,500



When an employer “sees” its experience laid out this way, there is a much better understanding of how losses develop and the pricing of its workers compensation. The insured may focus on the fact the carrier only “paid” \$125,000 in losses and the “reserves” are too high (the carrier will never pay that out) while the carrier is focused on its “model” which indicates the losses will ultimately be \$330,500 and the break-even premium it needs is \$417,754. . The carrier’s model will look something like below:

Claims	X	LCF	X	Taxes	+	Loss Control	+	REIN	+	Admin	X	Agents \$\$	=	Premium
310,000		1.10		1.04		8,020		8,050		16,099		1.08		\$417,754

An employer focused only on the paid claims of \$125,000 certainly will not understand how pricing of \$417,754 was developed. Explaining the realities of the claims development will assist an agent in managing expectations of the insured. An agent calculating its loss projection for its insureds will be able to have a more intelligent and realistic conversation with underwriters on account pricing. After multiple years, a pattern will start to develop. See Triangle report below, where the *client’s* losses are developed based on their own history.



Assured
NEACE LUKENS

ABC Companies
Incurred Loss Triangle Claim Development
as of May, 2015

Policy Year	18 months	30 months	% Change	42 months	% Change	54 months	% Change	% change from 1st to last	Payroll	# of Employ.
1/1/09-10	\$263,062	\$256,648	-2%	\$242,057	-6%	\$242,057	0%	-8%	\$22,707,610	560
1/1/10-11	\$350,761	\$335,700	-4%	\$367,749	11%	\$336,217	-9%	-4%	\$27,036,092	643
1/1/11-12	\$330,335	\$299,853	-9%	\$342,089	37%	\$408,586	19%	24%	\$28,275,708	676
1/1/12-13	\$98,547	\$114,304	16%	\$156,811	37%			59%	\$30,229,049	704
1/1/13-14	\$412,679	\$631,877	53%					53%	\$34,279,877	897
1/1/14-15	\$652,355								\$45,433,450	1113
Totals	\$2,107,739	\$1,638,382		\$1,108,706		\$986,860				
Average at each Interval	\$351,290	\$327,676	-7%	\$277,177	-15%	\$328,953	19%			



Who publishes development factors and where do I find them?

The National Council on Compensation Insurance (NCCI) maintains workers compensation statistical data submitted by workers compensation insurers. *Statistical data* is submitted to NCCI by way of unit reports, or unit statistical cards, that detail information on each individual workers compensation policy written in a state. The reports include payroll exposure and premium for each classification. In addition, claim counts and incurred benefit costs are reported identifying type of injury, classification code, and separate indemnity and medical costs. Claims are tracked over a period of 5 years or until they are closed (if they are closed before 5 years). NCCI and actuaries don't develop claims beyond 10 years.

Aggregate losses and their development are tracked over time until all claims are eventually closed. Insurance companies are also required to file annual financial data to NCCI. NCCI then calculates loss development factors on an industrywide basis from one period to the next and also on a cumulative basis, e.g., from the first reporting period to ultimate development. Source: IRMI

The development factors are published and readily available from NCCI or IRMI website. An agent or insured can manually develop losses by using the factors provided. Below are current for some states.

Claims Aged in Months

State	12	18	24	30	36	42	48	54
AL	2.001	1.765	1.529	1.459	1.389	1.343	1.297	1.266
AZ	1.654	1.503	1.351	1.309	1.267	1.247	1.227	1.214
CA	3.497	2.759	2.020	1.819	1.617	1.526	1.435	1.383
FL	1.660	1.483	1.306	1.250	1.194	1.169	1.144	1.131
IL	1.823	1.540	1.257	1.186	1.115	1.084	1.052	1.041
IN	1.238	1.141	1.044	1.026	1.008	1.006	1.004	1.005
KY	1.691	1.527	1.363	1.301	1.238	1.207	1.176	1.161
MA	1.948	1.628	1.308	1.238	1.167	1.137	1.106	1.901
MI	1.590	1.401	1.211	1.161	1.111	1.097	1.082	1.073
NY	3.609	2.876	2.142	1.909	1.676	1.571	1.465	1.412
OK	2.206	1.834	1.461	1.362	1.263	1.218	1.173	1.147
OR	1.811	1.544	1.276	1.233	1.190	1.173	1.155	1.149
SD	1.253	1.199	1.144	1.136	1.128	1.116	1.104	1.099
TN	1.677	1.492	1.307	1.273	1.213	1.188	1.166	1.143
TX	1.327	1.225	1.101	1.080	1.073	1.066	1.063	1.060
WI	1.632	1.453	1.274	1.234	1.193	1.171	1.148	1.139



CA Employer's Loss Experience This is <u>ONE YEAR</u> – The Same Year – Shown Developing Out Over Six Years						
Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
Year	# of Months after Expiration	Paid	Reserved	Total	Loss Development Factor	Ultimate Total Claims
2017	12	\$25,000	\$95,000	\$120,000	3.497	\$419,640
2018	24	\$140,000	\$105,000	\$245,000	2.020	\$494,900
2019	36	\$165,000	\$120,000	\$285,000	1.617	\$460,845
2020	48	\$180,000	\$115,000	\$295,000	1.435	\$423,325
2021	60	\$195,000	\$115,000	\$310,000	1.330	\$412,300
2022	72	\$265,000	\$65,500	\$330,500	1.256	\$415,108

Loss Forecaster

Loss Forecaster was developed by Sigma Actuarial Consulting Group, Inc., the same company that developed Mod Master. Both programs were sold to [Zywave](#) but recently Sigma Actuarial bought back Loss Forecaster (Zywave still owns Mod Master). You can find additional information regarding Loss Forecaster here: <http://www.specificsoftware.com/lf/lfproduct.htm> . This is a wonderful tool to assist in forecasting losses, providing credible trends, benchmarking and comparative analysis. There is technical support and Sigma is also developing educational videos to assist users in the input of data and judgement factors that come into play when inputting data. A single user would cost about \$1,500 a year. There are corporate rates for multiple users as well. Contact Tim Coomer, CEO, [Sigma](#) Actuarial, for further pricing information.

How is Collateral Determined?

Losses are developed using an actuarial formula to determine a "Loss Pick". The collateral covers the employer's "obligation" which is the difference between the ultimate incurred claims and paid claim payments subject to loss limitations on individual claims and/or retrospective rating maximum. Carriers review the following factors to determine collateral:

- § The claims history developed by their actuaries to predict future losses. The carrier actuaries will provide its LDFs but may also review other components such as substantial increase or decrease in claims payment/reserves.
- § The financial position of the employer - especially any down-turn.
- § Acquisitions/expansion or shrinking of the estimated exposure (payroll) base.
- § Changes in insurance regulatory requirements or case law. For instance, many states now pay for weight loss surgery to get to the underlying injury. This increases the claim costs by \$100,000 per claim in instances where states' case law has now allowed this. This would adversely affect development factors in those states.
- § Anticipated costs or expenses incurred by carriers to enforce the obligations of the agreement should there be a dispute in the future.



Collateral Illustration:

Collateral Illustration					
Policy Year	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
Loss Projection	\$350,000	\$350,000	\$350,000	\$350,000	\$350,000
Policy Year	Total Policy Year Collateral				
2012-2013	280,000	280,000	150,000	100,000	30,000
2013-2014		280,000	270,000	120,000	90,000
2014-2015			280,000	200,000	130,000
2015-2016				280,000	170,000
2016-2017					280,000
Total Collateral All Policy Years	280,000	560,000	700,000	700,000	700,000

The illustration above assumes fairly steady payroll and loss projection. Typically a carrier will want 80% of the loss projection in collateral. If any of the above factors – especially claims – are favorable, the collateral requirement may not increase at all or to a lesser extent going into the third year. As the program enters its third year, the *prior* years' collateral is reduced as claims are being paid and closed and more is known about how the year is going to play out. Workers compensation has a very long tail so no carrier is going to return collateral when the program ends after the first year. It will take several years — as claims are paid and closed — for all collateral to be returned. In some cases the carrier will want to keep collateral even after all claims are paid to account for potential re-opens, this is especially true in states with life-time medical.

Carriers typically do not have several ILOCs or cash collateral accounts for an insured. The collateral for all years is adjusted up or down as needed. New policy terms are added but the prior years' claims are being paid and closed. There is new collateral needed for upcoming years but less collateral needed for prior years. Assuming the financials and exposures are steady, the fourth year of the program is when the collateral *levels off and stays at a certain amount*. Additional collateral is generally not requested from year to year – again unless collateral determining factors change substantially. If and when the program is canceled, the collateral would be adjusted annually and returned as the claims are paid and closed. Without upfront negotiations for LDF factors and closure when the plan is written, an employer is at the insurance carrier's mercy for how much and when collateral will be returned.

NCCI and most actuaries do not develop claims past 10 years. They use 1.00 LDF. This is because 10 years into a claim, all factors and cost are going to be known and reserving, if any, is most likely quite accurate.



What agreements with the carrier do insured(s) need up front when the program is written?

Pre-determined development factors - Rather than the carrier determining development factors at the annual adjustment, the carrier agrees to development factors at the inception of the program that will be used at the time of annual adjustments. These are typical adjustment factors:

Adjustment Interval – From Policy Inception.	Development Factor – Applied to Paid and Reserved Claims.
18 Months	1.353
30 Months	1.150
42 Months	1.084
54 Months	1.059
66 Months	1.033
72 Months	1.024

How and when the collateral is returned? Many carriers today will agree to a five year closure. They will provide an agreed upon factor (1.044 for example) and close out the program after 66 months. In other words, paid and closed claims (also referred to as *incurred*) are adjusted by 1.044. Paid claims are subtracted to determine the total estimated liabilities. The carrier would then keep the amount of collateral equal to the developed outstanding liabilities less the paid claims amount, close the program and return any remaining collateral excess of the outstanding liabilities to the insured. Without a pre-determined formula, the collateral is reviewed by the carrier and adjusted annually. Without an agreement, it is the insurance carrier's sole discretion how much collateral should be returned. Without a pre-determined closure, the plan stays open until all claims are settled. The carrier determines when the remaining collateral should be returned.

Having a pre-determined closure allows companies to clean up their balance sheets and have only 5 years of workers compensation plans open at any given time.

What type of collateral is acceptable? Traditionally, carriers would only accept Irrevocable Letters of Credit (ILOC). However, in recent years, carriers have become more flexible and will accept cash, surety bonds, trusts or pledge of security or credit buy-down. The most common two forms of collateral remain cash and ILOC.

Irrevocable Letter of Credit - A letter of credit is a bank's promise to advance up to a certain amount of money to the insurance carrier if the insured defaults. An ILOC cannot be canceled or modified in any way without explicit consent by the insurance company. Typically, it erodes an insured's line of credit with its bank.

A trust or pledge of security –Insured assigns, grants and pledges to the insurance company rated securities interest in personal property for collateral. Many carriers will not accept this form of collateral.



Cash – Insurance carriers would prefer an ILOC over cash collateral. In the event of bankruptcy, the cash collateral becomes part of the bankruptcy and may be lost to other creditors if there are liens against the cash. Despite this issue, more and more carriers are accepting cash as depleting or working cash, (in other words, claims are paid out of the collateral) or as collateral held (and not used to pay claims) to secure the program.

Surety – A surety demand instrument (rather than bond) can be used to as collateral. Only a few carriers accept this form of collateral. The carrier will want to approve the surety carrier issuing the bond and may limit how much of the liabilities can be secured by a demand instrument. The surety company may also require collateral to secure the demand instrument as well.

Credit buy-down - Some carriers will allow a credit buy-down for a portion of the collateral. Often used when an insured has issues/restrictions on its credit with its lenders. The insured buys-down or pays the insurance carrier for a reduction in required collateral.

Monitoring Collateral

Collateral is typically calculated before the inception of the policy. The insured will post the collateral based on the amount and type of collateral agreed upon. However, as the policy term develops, losses should be re-forecast (starting six months into the policy term) to compare estimated losses at inception versus losses contemplating real-time data. Monitoring collateral has many benefits including:

- Determines how losses are tracking against the initial projection – more or less favorably.
- Prepares the client for upcoming adjustments. The insured is getting monthly updates on the collateral status.
- Helps understanding trends.
- Prepares the agent for the collateral discussion most likely to take place with the carrier for the renewal.

Monitoring collateral can be done simply on an Excel spreadsheet for each year until the program is closed out. The below exhibit is two policy terms comparative analysis same client.



Sample Company Loss Projections Monthly Tracking Report – Up-to-date Projection compared to Projection at Inception Report Date: December, 2015				
End of Month	Total Incurred losses (uncapped)	Projected Losses as of 12-31-15 per Loss Forecaster (capped)	Projected Losses at policy inception	Difference Between Projection at Inception and Current Projection
Sample Company Policy #12346567 - \$100,000 Deductible Policy Term 3-17-14 to 3-17-15				
1/31/2015	\$130,747	\$291,836	\$357,580	(\$65,744)
2/28/2015	\$228,811	\$356,368	\$357,580	(\$1,212)
3/31/2015	\$224,380	\$345,752	\$357,580	(\$11,828)
4/30/2015	\$226,669	\$323,529	\$357,580	(\$34,051)
5/30/2015	\$253,669	\$327,511	\$357,580	(\$30,069)
6/30/2015	\$267,024	\$328,837	\$357,580	(\$28,743)
7/31/2015	\$272,207	\$327,298	\$357,580	(\$30,282)
8/31/2015	\$277,237	\$317,646	\$357,580	(\$39,934)
9/30/2015	\$277,077	\$332,496	\$357,580	(\$25,084)
10/31/2015	\$277,077	\$332,496	\$357,580	(\$25,084)
11/30/2015	\$277,077	\$332,496	\$357,580	(\$25,084)
12/31/2015	\$277,077	\$332,496	\$357,580	(\$25,084)
Sample Company Policy #1243456 - \$100,000 Deductible Policy Term 3-17-15 to 3-17-16				
3/31/2015	\$9,000	Cannot calculate until after the six month of coverage. Losses are too "green" and no development factors exist until the six month of a policy term.	\$615,471	Cannot calculate until after the six month of coverage. Losses are too "green" and no development factors exist until the six month of a policy term.
4/30/2015	\$33,651		\$615,471	
5/30/2015	\$57,668		\$615,471	
6/30/2015	\$51,701		\$615,471	
7/31/2015	\$71,472		\$615,471	
8/31/2015	\$74,792		\$615,471	
9/30/2015	\$84,863	\$336,050	\$615,471	(\$279,421)
10/31/2015	\$157,090	\$395,080	\$615,471	(\$220,391)
11/30/2015	\$289,000	\$424,090	\$615,471	(\$256,391)
12/31/2015	\$168,000	\$368,550	\$615,471	(\$246,921)

As you can see from the above tracking, this insured is performing well below the projected losses at inception for both years. The renewal collateral requirement will most likely be less than the current term. .



Collateral Return Issues

A significant issue for many employers is how to secure the return of collateral for previous policy terms when insured under a loss sensitive plan. This is especially problematic when no LDF factors or a closure was negotiated up-front. The insured is frustrated that the carrier is holding onto collateral – often times in significant amounts over the calculated outstanding liabilities.

A successful approach in working with carriers includes the following steps:

1. Complete a Loss Forecast report to determine how it compares to the carrier's loss projection.
2. Engage a senior claims consultant to provide a claim-by-claim analysis for trending and development rather than developing the entire body of claims. The claim-by-claim detail can exclude claims from development that cannot re-open due to several reasons:
 - Ø Statutory restrictions – claims that are prohibited from reopening.
 - Ø Full and final settlements on claims that cannot reopen.
 - Ø Short-term wage loss (TTD) or medical-only claims where the adjuster experience tells him or her that these claims have a remote chance of additional activity.

Although this approach is not traditionally embraced by actuaries — actuaries develop the entire body of claims — the information provides a solid basis for discussion in lowering outstanding liabilities and influencing the actuarial report for further discussion with the carrier.

3. Spend some time understanding the insured's story, how they run their business, the claims handling and overall culture. Insurance carriers are positively influenced by a winning company story. Have they recently instituted a return-to-work program? Have they recently hired a safety coordinator?
4. Provide updated financials. Review before sending the financials to the carrier. Arrange a phone call with the carrier's financial representatives and the insured's CFO or CPA to provide any additional information that may be needed. It is critical that the insured's financial status is solid. The carrier needs to be comfortable that the insured has the ability to pay any claims under the deductible/retention it is liable for according to the contract.

Summary

Every agent and employer can benefit from understanding loss projections, LDFs and how collateral is determined. The alternative is having the carrier dictate terms and pricing due to an inability to have an informed conversation and advocate a more reasonable and equitable position for both parties. In addition, paying attention to losses, trends and benchmarking with real-time data will eliminate surprises and allow an employer to make adjustments quickly. Finally, understanding what carriers are willing to do will result in a better program with agreements in writing ultimately, eliminating frustrations and disputes on collateral as the program matures.