1988 CASUALTY LOSS RESERVE SEMINAR

1B: CLAIMS-MADE RESERVING FOR MEDICAL PROFESSIONAL LIABILITY

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MR. MURPHY: It looks like people have stopped coming in now. We can probably begin. My name is Bill Murphy. Jeffrey Mayer was supposed to be the moderator of this session but an unforeseen event has prevented him from being here this morning and so I'll be wearing two hats, I'll be your moderator and a panelist.

The topic is "Claims-Made Reserving for Medical Professional Liability." As they say on the airlines, "If that is not your destination, please let us know now." We're going to talk something about claims-made reserving, and get some insights on how that's being done currently; talk about some of the topics involved with automatic reporting endorsement coverage, reporting endorsement coverage in general as well; and then we'll get around to some of the accounting aspects of claims-made coverage. We'll talk about both GAAP and statutory accounting.

Before we get on with this, I'd like to take a survey and find out just who our audience is. How many people here are actuaries or actuarial students? Oh, the vast majority. Okay. How about accountants? A few. Okay. And that doesn't leave much else. Is there anyone else here, who's non-aligned?

MR. MURPHY: We've got a few. Okay.

All right, our first speaker is going to talk about claims-made reserving. It's Tim Graham. He's with St. Paul. He's Vice President and Actuary of the Medical Services Division at St. Paul. He's responsible for all pricing of medical malpractice liability products. He's an FCAS member of the American Academy and he's been with St. Paul since 1973, and he graduated from Washington University in St. Louis with a degree in mathematics. Please welcome Tim.

MR. GRAHAM: Questions and answers at the end?

MR. MURPHY: Oh, yes. Excuse me. Please hold your questions until the end.

MR. GRAHAM: Good morning. I've been asked to address you on the subject of reserving for claims-made professional liability coverage. I will be covering pure claims-made coverage and will not be getting into the issues of reporting endorsements that I think Bill will be touching upon later. I'll let Bill get set here because he's going to be doing my slides here in a few seconds.

My discussion this morning will cover some fundamentals on this subject. I will present a main point, discuss date definitions, reserve definitions, raise an issue regarding what defines a claim, and then discuss several particular reserve adequacy issues. I wish to begin with the one concept that I hope all of you will take away from my presentation.

My number one point is that the need for non-case-reserves does not disappear under a claims-made contract. All that the claims-made contract does is eliminate the need for one and only one particular type of non-case reserve. In some of the long-tail liability lines, the IBNR reserve can be significantly reduced but it does not go away. In fact, depending upon how a company processes and handles claims, you may still end up with a very significant non-case or IBNR reserve. I'd like to now go into a number of definitions. Some of these should be familiar to you.

The first definition is the traditional accident or occurrence date definition. This is simply the date that the adverse event occurred. Under most professional liability contracts, there is a so-called retroactive date. This is the date at which the insured purchased their first claims-made contract. Typically, a claim must have occurred subsequent to this retroactive date to have been covered under a claims-made contract. For our purposes in looking at claims-made reserving, the accident or occurrence date is usually not an issue.

The next date that I'd like to refer to is that of notice date. I define notice date as the date at which the company receives notice of the claim. Under a claims-made contract, this is the date at which liability attaches. Later on, we'll get into the subject of what is proper notice, but for now we'll assume the insurer had proper notice; they were aware of an adverse event. Liability attaches that date and that is the date that I will refer to as notice date.

Now I'd like to contrast that with another date that I will refer to as recorded date. Recorded date is the date upon which the company records the claim in its statistical records. Why am I drawing a distinction between notice date and recorded date? Let me point out the problem with a little example. Assume a company receives notice of loss on January 1, 1986, but does not record that loss on its statistical records until January 1, 1988. There is a two-year gap where no liability has been recorded on the company's books for that particular loss. This is a claim that has been incurred but not yet reserved. The claim belongs to the 1986 claims-made contract if proper notice was given, but the company has failed to recognize that particular loss in its reserving. Both the notice date and the recorded date are critical dates when examining claims-made reserves for an insurer.

I'd now like to talk about the different classes of reserves that are a direct byproduct of these date definitions. I'll begin with case reserves. These are simply the reserves established by the company for known adverse events. These case reserves can be established by the claims adjuster or by formula, but they are liabilities established by the claims adjuster or they're liabilities associated with specific adverse occurrences, and each one is individually established.

There is a second class of reserves that I will refer to as supplemental case reserves. We have found that claims adjusters are not perfect when they establish their estimates of liabilities. Consider the claims handling process for a medical liability carrier. The insurer receives notice of an adverse event. If they attempt to process that claim in a timely manner, and record it on the books very quickly, they will usually be dealing with very limited information. We have found that the initial reserve, the reserve that is first established, tends to be on the low side. The claims adjuster established the reserve based upon their best information, but in the initial stages of investigation they simply don't have sufficient information to make a sound estimate. As a result, there is a need for a bulk reserve. This reserve represents the difference between the best estimate of the ultimate value of the portfolio of known losses less the amounts carried for these individual losses.

I wish to stress that supplemental case reserves can be negative as well as positive. An extreme example might be a carrier that establishes policy holder limits as the case reserve when they receive notice of the adverse event. Usually, they will pay less than the limits on those claims and therefore you would expect to show a negative supplemental case reserve.

The third and final category of reserves associated with the pure claims-made contract is the pipeline reserve. Pipeline reserves are simply the reserves established for losses that have been reported to the insurer but that have not yet been recorded on the insurer's books. There should be a pipeline reserve to deal with situations such as my earlier example, the claim that was reported in 1986 that does not get recorded until 1988. Pipeline reserves and supplemental case reserves should tend to balance off against one another. In a company that is very aggressive in recording events, where the claims adjusters are directed to quickly establish a reserve as soon as they are put on notice of the adverse occurrence, the pipeline reserve may be relatively small. There will always be a pipeline reserve but in a fast-recording company it should tend to be small. But in that kind of circumstance, the adjuster is dealing with extremely limited information when they establish that initial reserve, and you would expect to have a significant supplemental case reserve requirement. On the other hand, if the company is less aggressive in recording the reserve and takes the position that they will thoroughly investigate and work up the file on that occurrence before establishing their first reserve, one would expect significantly higher pipeline needs but a significantly less or lower supplemental case need. Case reserves and supplemental case reserves key off of losses that have been recorded as well as reported. Pipeline reserves key off of claims that exist when an insurer is on notice but has not yet had an opportunity to record those events on their books.

Throughout this discussion so far I have referred to a claim. A key question under the claims-made contract, however, is, "What is a claim?" The question becomes one of what is proper notice. Does a call from an insured constitute proper notice to establish a claim? Is notice of claim only established when the insured is served with suit papers or a demand for damages? If the insured has not been served with suit papers but suit papers have been submitted to the courts, does that constitute notice of a claim? I believe this is one of the most ambiguous areas under the claims-made contracts that are currently utilized in the marketplace.

Most health care facilities today have some type of risk management function. The risk management function typically gathers from the staff notices of adverse occurrences. Adverse occurrences include things such as slip and falls, medication errors, adverse patient outcomes. Does submission of such a list to an insurance carrier constitute a list of claim? Would the submission by a physician of his patient list for the last five years constitute proper notice of claims? We believe these do not constitute proper notice. We have had some insureds take the position that they thought they should. We do believe -- or, I do believe, however, that an insured who calls after surgery and states that they had a patient die, become comatose, and that this was not an expected result constitutes proper notice of a claim.

We encourage our insureds to notify us as early as possible of potentially compensable events. I wish to stress here, however, the potentially compensable event element. There must have been some element that could be construed to have resulted in injury to the third party. Ultimately, however, at this point in time, it is still a local claims adjuster call as to whether or not a claim is established. I believe this is a question that will be tested in the courts. We will have situations where the insured will believe that they gave proper notice, the insurance carrier will believe they did not give proper notice. Unless the contract is quite specific, it is a gray area and one that I believe will have to be adjudicated.

To make matters a little more complex, there was a recent decision in California where the plaintiff had filed suit papers with the Court prior to policy expiration. Neither the insured nor the insurer was aware that suit papers were to be served and shortly after

policy expiration the defendant was served with those papers. The insurer took the position that they were not liable in that they had not been given notice during the policy term. The Court, however, decided that even though the insured was not on notice of the suit and had not put their insurer on notice of suit, that the submission of suit papers to the courts without notice to the insured during the insured's policy period established coverage under a claims-made contract. If this decision stands, we will probably be faced with the need for an IBNR for claims that have been incurred but not yet noticed to the insured or to the insurer.

Even with a solid definition of a claim, there are other issues that impact reserve adequacy. The first major issue that must be concerned is the claim processing pattern. Clearly, from my discussion regarding supplemental case reserves and pipeline reserves, how the claims process is handled by each carrier and any changes in that process effect needed reserves. If an insurer in the past was aggressive about establishing initial reserves but begins to slip in its ability to process such reserves in a timely manner, one will see or should see a pipeline reserve inventory grow. Until the actuary determines that there is a slippage in the claim processing pattern, reserves will probably be inadequate. If the claims division establishes a more aggressive posture in recording reserves or in reserving losses, historic reserve patterns will be of significantly less use in estimating future losses.

A second area that will impact the reserving for claims-made contracts is the use of deductibles and changes in the limits profile of the insureds. A simple example will illustrate the deductible problem. Assume an insured carried no deductible. Notice comes in, the company establishes a $10,000 reserve, and two years later they settle the claim with a $50,000 loss payment. Now let's take the same example but assume that the insured had a $20,000 deductible. Notice comes in, the insurer evaluates the loss and assumes it's worth $10,000. The $10,000 falls within the insured's $20,000 deductible. Either no liability shows up on a company's books and maybe not even the claim, or there may be a claim notice but no liability recorded on the carrier's books. Two years later, when the claim settles for $50,000, the $20,000 is paid by the insured, the insurer will pay $30,000. From the actuary or reserve analyst's perspective, they've either seen a new case emerge for $30,000, or they have seen dramatic case reserve development, so any type of introduction of deductibles or growth in the use of deductibles will probably lengthen your loss development patterns under a pure claims-made contract.

A similar situation exists with limits profile. If in the past the insurer had $100,000 per occurrence limits exposed and now has a half million dollar per occurrence limits exposed, the insurer will see a lengthening in its case development pattern.

I've covered a lot of material this morning, covered it fairly rapidly. I want you to come away with one concept, and that is the concept that non case reserves continue to exist and are significant under a claims-made contract. An insurer with a claims-made contract cannot simply look at their carried case reserves and assume that they have an adequate reserve inventory. Case reserves are impacted significantly by the claims function, and it is important that the analyst or the actuary carefully evaluate the forces at work on those reserves.

Thank you.

MR. MURPHY: Putting back on my moderator hat, our next speaker is Bill Murphy, who is an actuary with Milliman and Robertson in New York, works mostly in the medical malpractice area, graduated from the Cooper Union with a degree in physics, worked at the Insurance Services Office for a number of years in both the pricing and government

relations areas.

Well, thank you, Bill, for that introduction.

(Laughter.)

I'm going to be talking about claims-made reporting endorsement coverage and how you go about reserving and to some degree pricing that kind of coverage. I'll use reporting endorsements and tail coverage, use those two terms interchangeably throughout the talk. Let's begin by talking about what the tail coverage is. As I'm sure most of you know, it's the coverage essentially for late reported claims. When an insured has a series of claims-made contracts and then ceases to be insured under a claims-made contract, either because he is retiring or changing to an occurrence policy, which happens infrequently, or perhaps changing to another carrier, he needs to purchase a reporting endorsement in order to cover the late reporting claims, those claims which occur during the course of the original claims-made policies but which are reported to the carrier subsequent to the expiration of the last policy.

In talking about them, I think it would be good to divide them into two types essentially. I'll give you the polar types and the real world generally falls somewhere between the two. The first is the reporting endorsement in which there is no obligation on the part of the insurer to sell the reporting endorsement and the price if any is fixed at the time of sale, so the insurer makes no promises beforehand while he's selling these claims-made policies. That's an extreme example. The other extreme would be where the insurer guarantees that a claims-made reporting endorsement will be available at the expiration of the claims-made policy, perhaps for no additional cost. That would be a guaranteed automatic reporting endorsement. Again, that's a polar example and you don't see that.

What you see more often is that for example in the medical malpractice area, the insurer will guarantee that a claims-made reporting endorsement is available and perhaps give it away for free if you've been in the claims-made program for a certain minimum number of years and you're retiring at or above a threshold age, perhaps 55 or 65 years old. We also see that reporting endorsements are issued without additional cost in the event of the death or disability of a physician. That's fairly common with many of the doctor-owned companies.

These two types of reporting endorsements differ, as you might expect, with respect to reserving and pricing them. The first kind I described, where the insurer basically makes no guarantees, there is no liability until the point of sale. At that point, you need to consider an IBN or a reserve and case reserves and so forth. But until that point, while you're selling the underlying claims-made coverage, the insurer only incurs an obligation with respect to those original contracts and not with respect to the tail coverage.

On the other hand, any time you make a guarantee of any sort, even perhaps a guarantee on a maximum price for the tail coverage, when you sell the underlying policy you're incurring a liability at that time and you need to consider reserving for it, and certainly pricing for it.

In this area, I haven't seen any generally accepted principles emerge on how those reserves are to be set up or in fact how the liability is to be viewed. Depends a great deal on the circumstances and the attitudes of the company. Clearly, mutual and stock companies would differ on their ability to fund a preexisting reserve. They have more access to capital and so forth. The nature of the guarantee certainly enters into it. The more you're guaranteeing, the more carefully you have to look at the liability that you're

incurring at the same time. Certainly the regulators need to be convinced that what you're doing is sound and there are a number of options in doing this. Overall, what you want to do is make sure that you're seeking at least at a minimum a long-term actuarial balance for the program.

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I'll begin by talking about methods of developing reserve estimates for reporting endorsements. The point I want to make with this slide is that if you decide you're going to develop reporting endorsement coverage, you really need to do it according to the number of years that the insured has been in the claims-made program. The development patterns will be different depending on how long he's been insured.

What I've done here is in the first slide, "Number of years in claims-made program," I've assumed a reporting pattern for the losses that would evolve under a contract. If someone had been insured under a claims-made policy for exactly one year and then retired and bought a tail coverage, what you would see would be losses reported under lags 1 through infinity, to ultimate. The term "reporting lag" I guess hasn't been defined to this point so I'll define it. Lag zero we define as losses which are reported in the same year in which they're incurred. I'm talking about report years at this point. It could be done in half-years. Lag one, then, would be losses which are reported in the year subsequent to the year in which the loss occurred, and so forth. So the pattern that I've got here, 20 percent of the ultimate losses are reported as of 15 months, an additional 50 percent would be reported in the next year, and an additional 20 percent in the year after that.

If we take that same pattern now and simply account for the fact that if the insured has been in the claims-made program for two years, what you're going to see in the first reporting year is in essence lag one from his second year of the claims-made policy and lag two from his first year in the claims-made program. So the reports that you get as of 15 months with that sort of tail coverage are going to be relatively more mature than you would see with a fewer number of years in the claims-made program. So that complicates the issue of collecting reserve development data for claims-made reporting endorsements.

I think an appropriate way of doing it would be to collect data according to -- could you cover up the bottom part of that slide from "assume" on up. Let's focus our attention on the top part. We want to collect loss development data according to report lag and maturity. In other words, if we look at our data perhaps even data written under a currents policies, we can segregate that out if we have sufficient information into losses layered according to the report lag. In general, what we would see is different development patterns depending on how long it takes to report the claim. Claims which are reported almost immediately after their occurrence tend to develop somewhat differently than claims which require a large number of years to report. So in general I think it's a good idea to look at the patterns individually according to report lag. But even if it doesn't change, these development patterns will help you a great deal in developing your claims-made losses and particularly for the reporting endorsement. Okay, you can uncover that.

As a simple example, I've assumed that our insured has been in the claims-made program for one year and he decided it was more lucrative to be an attorney so he's dropped out of medical practice and bought his tail coverage. If we look at the losses reported under that tail coverage as of 27 months, to pick an arbitrary date, what we're going to see are the 27 month maturity of report lag one, which is the claims reported in the prior year,

and that is the first year of his reporting endorsement coverage, evaluated now as of 27 months, and then you're going to see additional reports in the second year of his reporting endorsement coverage, which are going to be valued at 15 months. So your reported losses are going to be the sum of .30, the 15-month evaluation of lag two reportings and .18, which is a 27-month evaluation of the lag one reports. Now, these reported amounts will develop to .20 and .40 at ultimate, those are the lags one and two respectively. Which is .60, so if you have data in this kind of triangle, you can take your reported losses and develop them to ultimate.

You also, if you want to use this data for that purpose, can estimate the IBNR, which would be the sum of the ultimate values of the additional report lags. That's one way of doing it. Another way would be to assign a loss ratio to the balance of the premium associated with unreported claims and do a Bornhuetter-Ferguson type method.

These are ways that we can use actual data in developing of reserve estimates, but clearly you can just apply loss ratio to the claims-made tail coverage premium if in fact you're perhaps very new in the business and you don't have that many reporting endorsements issued, the premium volume is very small, then maybe it's not necessary to go through an analysis of this kind.

Turning now to the type of contracts where the insurer has issued some sort of guarantee, I mentioned some of the considerations before that you want long-term actuarial balance, that the circumstances of the company and the nature of the contract have to be considered, and of course the wishes of the regulator need to be taken into account. These are some of the ways in which you can go about reserving for that guarantee. They're listed from the most conservative to the least conservative. The top one that I have shown here is full occurrence reserves.

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In other words, if the insurer is guaranteeing that the reporting endorsement will be available at no additional cost in any event with no restrictions then essentially what the insurer is selling is an occurrence policy, and the reserves need to be set up accordingly.

(Slide)

If we just take a look at the next slide -- we'll come back to this one in a moment -- in essence, if you've got a schedule of claims-made rate factors, which relate the claims-made premium to an occurrence premium, according to the number of years in the claims-made policy, then the accrual for this guaranteed reporting endorsement would just be the balance of the occurrence premium, so in the first year you're charging 10 percent for the underlying claims-made policy but you have to set up an additional 90 percent of occurrence premium for the accrual of your liability on the reporting endorsement. And then each year you would need to set up the incremental difference shown in that third column. This, of course, needs to be properly discounted for investment income and so forth, but this is a simplistic model of what you need to do. You're really selling occurrence policies and you need to be pricing and reserving appropriately.

Another way of doing it, when you begin to offer automatic coverage of some kind, you could amortize the cost over the life of each insured. You're aware that your population of doctors is of various ages and you take that into account in the analysis; you want to be sure that each individual insured or perhaps the insureds as a group, by the time they ultimately retire, die or become disabled or whatever other events incur this automatic

coverage, that you've collected enough premium over the lifetime of that insured to fund the liability.

A slightly less conservative way of going about it is to do your calculations targeting an accrual of the liability over the life of a new insured, so you view a doctor just coming into the system perhaps at 35 years old staying with you for some substantial amount of time and then retiring, you can price your coverage so that that individual will have paid over the course of his lifetime sufficient money to fund the liability. The problem with this is that the companies then have incurred an unfunded liability. We've got people that are being insured that are not 35 years old, they might be 50 or 55. You might be offering them some kind of automatic coverage and you certainly, if you price this way, will not collect sufficient premium for the liability that you're incurring, so you start out with an unfunded liability. You might amortize that over a number of years in some way, or you might just set up the reserve immediately for that.

Continuing down the list, you might set up the reserves as the coverage is invested. As I said, sometimes the insurer will require that the insured has been with the company perhaps 10 years before he's fully vested for this automatic coverage. You could wait until the vesting period until you set up the reserve. Another way of doing it is to view the cost as being incurred when the coverage is issued. That is certainly less conservative, but at least you're still setting aside reserves for the coverage which in fact has been issued. That distinguishes it from the last item on here, pay as you go. In other words, collect enough money and set up reserves to pay for known claims as they come in.

I'm going to go through two examples of these. This is an example of how you might amortize the cost of the life of your insured population. This is a method similar to what is being used in New York. The key to this is some very long-term projections. If we assume that we've got an insured here who's 35 years old, we can do a calculation, we can project out his future stream of claims-made premiums. It requires, as you can see, a very long-term projection, 30 years in this case. Perhaps more; doctors tend to retire later than most people.

Probability of survival, shown in column 3. By "survival" I mean survival under the terms of an insured population, not necessarily death but if the insured has a probability of leaving your program for any reason at all, moving to another state or so forth, that needs to be accounted for in here. You can't, obviously, count on collecting premiums when people can move to a different carrier, for example.

The fourth and fifth column show the projected estimate of reporting endorsement premiums. In other words, this is your estimate of what it will cost you to issue that reporting endorsement when the time comes, and then the fifth column is the probability of issuing that endorsement. That, of course, is a function of the guarantee that's made in the contract if you're simply providing the tail coverage in the event of death or disability, for example, you can use mortality or morbidity tables to get estimates for this, whereas if you're insuring something like retirement, again, you need to come up with some idea of how doctors retire. Our experience is that in all three of these areas: death, disability, and retirement, doctors are a relatively unique population. They're very different from the general population. They have much better experience in death and disability and they do tend to retire significantly later than the general population.

Having done a present-value calculation down on the bottom here, we carry that over to the next slide.

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The calculation was done for a 35-year-old doctor. What you need to do is weight the results over your insured book of business. The indicated loading for this guaranteed coverage is going to differ by age. Clearly, if you've included retirement, or even if you haven't included retirement, death and disability loadings will increase according to the age of the doctor at the time. So in this example we've done it using groups of ages. It could be done in a more refined way if you wished.

We've also assumed two different retirement ages, and we've probably averaged the results here, 65 and 75. That's a relatively critical assumption as you can see by the difference in those two columns. It makes a
substantial difference, especially for the older doctors.

Moving to the next example of a pay as issued kind of accounting, this is being used in Massachusetts currently, where the premium collected in any individual year is sufficient to cover the reporting endorsements that are expected to be issued in that year. And the way the calculation proceeds is, I guess as you might expect, we've got a distribution of doctors, number of doctors according to their age. We've got death and disability decrements. As I mentioned, the experience of doctors is somewhat different from the general population. For mortality, the doctors seem to have about a 30 to 50 percent better experience at any given age than the general population. It really is quite significant. For mortality, it might be a 50 to 60 percent difference. Excuse me, for morbidity -- that's disability.

I've included in column 5 here any other decrement; in this case, what I had in mind was retirement, where perhaps you've got a requirement that the insured be at least 60 years old before he can retire and get his free tail so the probability of retirement before that age is zero and after that age it rises quite sharply with age.

The product of all those columns, then, would get you the estimated number of reporting endorsements to be issued during the coming year, and we can sum them to find that in this example we've got 120 expected reporting endorsements. All of these numbers are just hypothetical. I made them up to illustrate the point. They're generally in the ballpark but I wouldn't take any of them too seriously.

Claims-made premiums. This would be the claims-made premiums that you're writing in a current year, which I've represented as 3500 doctors times an average premium of X. The number of reporting endorsements that you expect to issue is 120. Costs of the reporting endorsement I've assumed is 1.8 times the mature claims-made policy; again, this is just picked out of the air. And your indicated loading then would be on the order of 6.2 percent by following the equation in line 4.

So these are two examples of how you might go about it. They produce quite different answers, and the reason is that in one you're accounting for more of your liabilities more quickly, and in this one you're kind of putting off the day of reckoning until the endorsement is actually issued, to some degree.

Let me talk quickly about some of the sources of information that you might use to do these kind of computations. The best source of information clearly is to gather information about your own book of business: the age distribution of the doctors that you insure, and information about when they might retire, reasons that they leave your company, how often they leave your company, who comes into your company, who are your new insureds, what is their profile and what do they look like? It's a gargantuan

task if you haven't been doing it all along, but at least one company has collected seven to ten years of this kind of historical information and they've found it very useful in pricing that kind of coverage.

Failing that, the American Medical Association does have information on doctors according to their age distributions, which you might find useful. It's not always directly comparable to the kind of insured population that you might see in your own book, so adjustments would need to be made, but that at least gives you a starting point. Standard mortality tables will give you, again, a starting point for the death and disability decrements but you do need to make adjustments to them for the better expected experience of physicians.

A few other issues, again, I'll just touch upon. Some things that will complicate your life, I think, when you get into this business. The idea of adverse selection on reporting endorsements. I'm referring not to the guaranteed part because probably if you offer somebody something for free they'll take it, but in terms of reporting endorsements which are purchased, a doctor may assess his situation, he may have been looking forward to retirement for a number of years, winding down his practice and so forth. He may feel and have some good indication that he's very, very unlikely to be involved in any kind of suit after he retires. He may choose not to buy his reporting endorsement. I've seen doctors with this kind of dilemma, and it's certainly difficult to advise them on what to do, but the choice is being made and people do sometimes go without the tail coverage. On the other hand, a doctor may very well know that there's a real good chance that he's going to be involved in some kind of suit at some point and therefore would be wise to buy the reporting endorsement. So you're subject to some kind of anti-selection there.

For some of the pricing and reserving methods that I indicated for the automatic coverage you've got to be aware that if you see a decline in your book of business, you may run into a lot of trouble. Some of these things assume a steady-state model where you've got a new inflow of doctors coming into your system who will fund to some degree the retirement of the older doctors that could put you in a very serious position if that assumption were not borne out.

And the last thing I'll mention is that doctors may also find that they have a tendency to increase their policy limits as they near retirement age. They have a real good understanding of claims-made and insurance and so forth that it would be to their advantage in the last couple of years of practice perhaps to increase their coverage above the levels they typically carried, knowing that this is going to be reflected in whatever reporting endorsement they buy or are given by the insurer.

That concludes my remarks as Bill Murphy, Actuary. Bill Murphy, Moderator, needs to introduce one more panelist. That is Ed Bader. He will be speaking to us about some of the accounting considerations in claims-made coverage, now that we've talked somewhat theoretically about the coverage itself, he will give us some of the practical implications from a financial point of view.

Ed is a partner with Arthur Andersen. He's in charge of the national industry insurance industry practice there. He's a CPA, and he graduated from Fairfield University and did graduate work at New York University. Ed?

INTRODUCTION

The claims-made commercial general liability contract was developed in an effort to increase the predictability of loss by eliminating the uncertainties associated with determining the reserves for incurred but not reported (IBNR) losses and reducing the risks of having to stack limits on a given occurrence. The attempt to alleviate the problems associated with long-tail exposures has resulted in a new set of problems for the insurance industry to resolve. Among these new issues is the accounting for the claims-made business by the insured as well as the insurer. This discussion will address the current status of these accounting issues.

Accounting for medical malpractice claims-made policies is the same for commercial insurance companies and mono-line medical malpractice carriers that issue policies with a valid transfer of risk. Further, the AICPA Statement of Position No. 87-1 Accounting for Asserted and Unasserted Medical Malpractice Claims of Healthcare Providers and Related Issues clarifies that symetrical accounting is required for purchasers of medical malpractice issues.

It should be noted that since many companies have developed their own claims-made forms in lieu of the standard ISO claims-made CGL policy, a potential for coverage gaps exists. Two main differences between the forms are the trigger points where coverage becomes effective, policy aggregate limits vs. individual occurrence limits, the length of time for a discovery period, specific policy exclusions and retroactive dates. Problems arise when an insured switches carriers or does not fully understand what he is buying. Many critics believe that litigation will increase due to the "enormous potential" for "discrepancies between the actual coverage provided by an insurer and the buyer's expectation of what the policy covers." (Best's Management Report 9/8/86).

Major Accounting Issues

- Accounting for Tail Coverage .
- Recognition of Premium Dollars
- Reporting Disclosure Requirements

Accounting for Tail Coverage

FASB #5 CRITERIA

- It is Probable that a Loss has Occurred
- The Amount of the Loss Can Be Reasonably Estimated

ACCOUNTING FOR CLAIMS-MADE BUSINESS BY THE INSURER

In accounting for claims-made business, the major issues which one must consider are:

Slide No. 1

1. accounting for tail coverage;
2. recognition of premium dollars; and,
3. reporting disclosure requirements

Slide No. 2

Accounting for tail coverage is simply providing a reserve for future losses to be incurred related to the various tail forms which a claims-made policy may include (mini tail, midi tail, automatic tail coverage). According to FASB Statement No. 5, Accounting for Contingencies, an enterprise is required to record a liability if both of the following conditions are met:

1. Information available prior to the issuance of financial statements indicate that it is probable that a liability has been incurred at the date of the financial statements; and,

2. The amount of the loss can be reasonably estimated.

Difficulties arise in trying to estimate what the future losses will be. The claims-made policy is relatively new and the industry does not have a significant amount of historical loss experience data on a claims-made basis.

To effectively reserve for claims-made business, an insurer needs to track losses by report year rather than by accident year basis. Report year data is critical since under claims-made the trigger point for coverage is the date that the accident is reported to the insurer. Schedule P in the Annual Statement required by the NAIC does not provide meaningful loss information for

The Following Characteristics of a Claims Made Policy Must Be Considered in the Pricing and Reserving of the Business

- Mini Tail
- Midi Tail
- Automatic Tail Coverage
- Full Tail Coverage Option
- Retroactive Dates
- Laser Endorsements

The accounting for a claims-made policy is primarily dependent upon the substance of the policy form. One must consider if the policy includes any type of tail coverage provisions, retroactive dates for effective coverage of the policy, specific exclusions or laser endorsements, etc. Many insurers have modified the standard CGL policy to fit their own needs which have accounting implications.

The various tail coverage provisions and characteristics which have been incorporated in various policy forms are:

Slide No. 3

Mini Tail - A provision extending the reporting period 60 days for incidents incurring during the policy period but reported during the 60 day period (unknown to the insured).

Midi Tail - An extended reporting period up to five years after the expiration date of the policy for incidents incurred during the policy period and known by the insured.

Automatic Tail Coverage - This provision is included in Medical Malpractice insurance forms and is effective in the event that a doctor becomes disabled, dies or retires. This provision would cover all run-off business.

Full Tail Coverage Option - An extended reporting period endorsement (ERP) can be offered in the event that an insured converts from a claims-made policy to an occurrence-based policy.

Retroactive Dates - Potential to limit claims that the policy will cover.

Laser Endorsements - Excludes coverage for specific accidents, products, work, etc., and can also limit amounts of losses/claims on a per-risk basis and in the aggregate.

One must evaluate the manner in which the various provisions are priced and the impact they will have on reserving.

ACCOUNTING FOR CLAIMS MADE Slide No. 4

Supplemental Schedule P Required If:

A. Earned Premium on a Claims Made Basis is More than $100,000

B. Claims Made Premium is Equal to or Greater than 15% of Total Earned Premium

ACCOUNTING FOR CLAIMS MADE Slide No. 5

Premium $1,000
Losses 500

	Premium Recognized Over One Year	Year One if Premium Recognized Over Five Years
Earned Premium	1,000	200
Losses	<500>	<500>
U/W Expenses	<100>	<100>
AUI (Loss)	400	<400>
Loss Ratio	50%	250%

Slide No. 4

companies writing significant amounts of claims-made business since all the data is based on accident year information. The NAIC responded to the need for modifications to Schedule P in 1987. An interrogatory has been included for those insurers writing significant amounts of claims-made business. A parallel Schedule P document is required for those carriers who write more than $100,000 in claims-made premiums and the percentage of claims-made premiums to total earned premiums is greater than 15%. The parallel Schedule P is an effort to provide meaningful comparative information for claims-made carriers. However, the loss data may not be as meaningful as intended since insurers account for claims-made policies differently, depending upon the various attributes of the policies (i.e., reserving methodologies of insurers related to tail coverage provisions and premium recognition patterns). I'm sure my fellow speakers will comment on this.

Slide No. 5

Insurers have taken very different approaches to reserving for the tail coverage ranging from not reserving at all under the presumption that the related IBNR is immaterial to reserving for the tail as a percentage of the earned premium. Insurers have also taken various positions regarding the recognition of premium. Questions have been raised over what period the premium should be recognized. Some insurers have held, and AA&Co. concurs, that the premium should be earned over the policy year, usually one year. However, some insurance companies argue that since the various tail coverage endorsements can cover losses reported over a six-year period, the premium should be recognized accordingly. In effect, these companies have chosen to earn the premium based on claim reporting patterns. It should be noted that insurers have the ability to manipulate their underwriting results by changing their premium recognition patterns. In addition, it becomes quite difficult to compare industry results if insurers choose to account for the business differently.

In the initial years of writing claims-made business, the financial position of claims-made insurers will appear to change drastically when compared to the standard occurrence-based companies. The major reason for the changes will be the initial drop in premium rates. For example, in year one, the claims-made policy covers losses incurred and reported in the first year. In year two, covered claims will include incidents incurred in year one or year two and reported in year two. Thus, the loss exposure will be greater in year two than in year one and will be considered in determining the premium for the respective policy year.

As discussed earlier, the insurance industry lacks any claims-made loss experience data. As a result, claims-made premium rates are determined by taking a "multiplier" and applying it to the occurrence rate. The multiplier, in effect, represents the portion of the occurrence rate related to the current year. For a pure claims-made policy, in the first year, premium volume will decrease by more than 50%. Over the years, an increase in premium growth will take place as the exposure increases (and rates increase accordingly). However, the claims-made premium volume in later years is expected to be 5-10% lower than occurrence premiums, due to the expected efficiencies in predicting losses under claims-made.

The premium for tail coverage offered in conjunction with claims-made polices is very difficult to price. As a result, some companies do not provide the insured with the price of the tail at the time that the claims-made policy is first purchased. These insurers are receiving the benefit of one year's loss experience before locking into a tail coverage premium and have the ability to increase the price of the coverage dramatically to compensate for sizable losses during the policy period.

The NAIC has formed a task force to study this pricing issue and determine whether insurers should be required to price the tail coverage at the inception of the claims-made policy or upon renewal (versus at the time of purchase). Some insurance regulators believe that allowing provisions in the claims-made policy to price tail coverage at the time of purchase is an unfair transfer of risk to the insured since the risk of uncertainty to the insured is still great (i.e., their tail coverage may be unaffordable due to unfavorable loss development.)

ACCOUNTING BY INSUREDS FOR CLAIMS-MADE INSURANCE POLICIES

As stated earlier, claims-made insurance policies cover only those asserted claims and incidents that are reported to the insurance carrier while the policy is in effect. Hence, there is no transfer of risk for claims and incidents that have incurred but were not reported to the insurance carrier. The AICPA released a Statement of Position on the Accounting for Asserted and Unasserted Medical Malpractice Claims of Health Care Providers and Related Issues in March 1987 (SOP 87-1) which recommends that a health care provider insured under a claims-made policy account for IBNR claims and incidents when no further coverage is purchased upon expiration of the existing insurance policy.

FASB Statement No. 5 Accounting for Contingencies, which was discussed earlier, is the authoritative pronouncement followed by the AICPA in determining its position that insured's provide an accrual for IBNR claims.

Many insureds had questioned the appropriateness of accruing for the "estimated" cost of tail coverage as IBNR when the probable losses from IBNR cannot be reasonably estimated. The AICPA decided that the estimated cost of purchasing tail coverage is not a relevant factor in determining the IBNR loss to be accrued and FASB No. 5 criteria should be followed in setting the IBNR reserve. Note that an insured should determine if an additional liability is necessary even when tail coverage is purchased. An accrual might be necessary to account for estimated liabilities in excess of the tail coverage policy limit, claims reported after the tail coverage period has expired or specific policy exclusions outlined in the tail coverage policy, or even the claims-made policy.

Interim reporting issues to consider relate to the recognition of IBNR losses and the relationship between the payment of policy premiums and the IBNR liability. A claims-made policy involves two elements:

Potential for Coverage Gaps

- Due to the Hybrid of Forms on the Market
- Discrepancies Between Actual Coverage Purchased and Buyer's Expectations of the Policy Coverage

1. Coverage for claims incurred in previous years and reported during the current policy period, and

2. Coverage for claims that will be both incurred and reported during the policy year.

Since the policy covers those claims incurred in previous years, the purchase of the claims-made policy is a partial settlement of the previous IBNR liability. Thus, the premiums paid for the policy should be offset against the IBNR accrual.

Slide No. 6

An insured also needs to consider the relationship between the policy year and the insured's fiscal year. For example, in the event that a company's fiscal year and policy year do not coincide, two items need to be recognized at yearend:

1. An IBNR liability for the claims incurred prior to yearend but reported subsequent to the expiration of the existing claims-made policy.

2. An asset for prepaid insurance premiums related to the coverage for incidents incurred subsequent to yearend but reported before the expiration of the policy.

If an unusual material event is incurred prior to yearend but will probably not be reported until after the expiration of the current claims-made policy, the insured should recognize the appropriate adjustment to the estimated yearend IBNR liability in the interim period in which it became

known. If the unusual claim incurred prior to yearend, and it is probable that it will be reported prior to the expiration of the policy, there is no affect to net income since the loss will be covered by insurance.

In addition, IBNR reserves need to be established by the insured when a conversion is made from claims-made to an occurrence policy and the insured does not purchase an extended reporting period endorsement. A reserve is required for the IBNR on the years covered under the claims-made policies since the occurrence-based policy only covers those incidents incurred in the current accident year.

The AICPA is in the process of preparing an implementation guide to SOP 87-1 in question and answer format. It is geared to health care providers that purchase claims-made medical malpractice insurance policies. Two actuaries assisted the AICPA Task Force in drafting the implementation guide which should be issued later this fall.

CONCLUSION

In summary, the accounting for the claims-made policy is dependent upon the form itself. An insurer needs to examine the various characteristics included in their form and determine that proper reserves are established for the individual characteristics/exposures. The difficulties arise in estimating an insurer's liability due to the lack of industry data on a claims-made basis. Insurers should strive to be consistent in their accounting and reserving methodologies and keep in mind one of the primary objectives of Generally Accepted Accounting Principles - to properly match revenues with related expenses - when setting accounting and reserving policies.

MR. MURPHY: Okay, we've got time for questions. Yes.

MR. MYERS: Glenn Myers, at ISO. I have what might be a dumb question but I'll ask it anyway, for Bill. If you were to take the claims-made data and arrange it in your loss development triangle by accident year in spite of the fact that it's claims-made, couldn't you go ahead and price the tail coverage and the claims-made -- or the tail reserve and the claims-made reserve using just standard methods?

MR. MURPHY: It seems to me that you could if in fact you're guaranteeing the tail coverage, because then you've incurred the same liability irrespective of what kind of policy form you're selling. The difficulty arises if the tail coverage is not necessarily guaranteed in all instances but only in some so then you're carving out a piece of liability that might not actually exist. For example, somebody goes to another carrier. You no longer have the tail liability necessarily.

MR. MYERS: Does that happen very often?

MR. MURPHY: Yes.

QUESTION: I had one or two questions. I'm not that familiar with claims-made. The first question I had is that Tim talked a lot about the fact that what constitutes proper notice is not clear any more. But one of the things I'm wondering is does the insurance industry at least have something that we say constitutes proper notice? Did we put together some kind of form or something? Or are we leaving ourselves open by not saying what we at least think proper notice ought to be?

MR. GRAHAM: I think it varies from carrier to carrier and contract to contract. We're aware of some carriers that have taken the position that they have to have a demand for damages to establish a claim. We have taken the position that we will accept notice from an insured even though no attorney or demand has been submitted at that point in time.

QUESTION: The other question I had, Bill, you gave a list of possible ways you could reserve for the tail, and it was everything from use the full occurrence method to just pay as you go. What I was thinking was I thought when ISO was going through all the problems trying to get their claims-made policy ironed out, I thought the state insurance departments gradually approved one -- or came to some agreement about how the tail was going to be handled. I remember there was a lot of ongoing discussion that it would or wouldn't be mandatory or what the rules had to be, and I didn't realize it was so open. I was thinking that in many states, whether or not you have to offer tail is fairly clear. And so that one of those methods ought to be better than some of the others.

MR. MURPHY: The ISO contract I'm sure is specific. I'm not sure exactly what the terms are. I kind of lost track there somewhere. But I believe there's a guaranteed maximum price on the reporting endorsement. And it probably is required to be offered -- well, required to be sold if the insured requests it. Those are the terms of the contract and to some extent it will certainly influence your reserving decision, but it seems to me that on an individual company level there still is discretion as to how you're going to account for and establish the reserves for that eventual contingency.

As far as I know, the NEIC did not provide any guidance relative to reserving. And it varies by state as to what the policy language says relative to being offered.

MR. McCLANAHAN: Chuck McClanahan, Coopers and Lybrand. Again for Bill, you listed several different methods for reserving for extended reporting endorsement guarantees. I think probably only the first and second of those would be in conformity with the Casualty Actuarial Society's Statement of Principles or whatever we call it, but my question is, regardless of how you reserve for your extended reporting endorsement guarantee, where do you put it? Is it a loss reserve, a policy reserve, or an unearned premium reserve?

MR. MURPHY: Ed?

MR. BADER: Well, I think that our survey, indicated, as faulty as it was, that at least three of companies had it as an unearned premium reserve, and a few others, I guess about six others, had it as a loss reserve, as an IBNR reserve. But I guess they really didn't get too excited and I think that the more the tax laws change I think everybody was putting it in reserves. But I think they woke up and said, "We don't want it in the unearned premium reserve, we want to put it in the loss reserve," so the tax motivation drove most companies to, I assume, move it to a loss reserve.

MR. MURPHY: Yes?

MR. WELLER: Al Weller, Ernst & Whinney. I'm interested in the relationship between market conditions, policy holder selection, and setting reserves. To the extent a policy holder has options in notifying a company, they can accelerate or decelerate the notification process. And what I'm wondering in Tim's case is if you saw an increase in the number of reported claims prior to the market tightening in 1985 when limits of coverage would have dropped and people could have gotten more coverage sooner, and Bill's case when you go to the extended tail coverage, particularly on retirees and they're raised their limits in the last year, do you find the frequency of claims going up, particularly among the physicians who did not buy the tail endorsement?

MR. GRAHAM: We have seen some situations where health care providers are forming a captive and are leaving our company, going into the captive, and the organizers of the captive have encouraged these individuals or hospitals, whatever, to submit as much as they perceive as potential claims to us before they exit the company. So that has happened. And like I say, given that you've got an unclear notice of claim, that's where we've seen some of these patient lists come in and we've just said, "Forget it." I mean, that's not notice of claim to us. But that's driven more by who they're going to or their concerns about what they're going to have for insurance after they leave our carrier.

MR. MURPHY: I don't really have anything to add to that. I haven't seen any empirical evidence one way or another.

MR. BADER: I think, though, that Tim made the point earlier that it varies by the type of company. Some of these physician-owned mutuals have tended to encourage their policy holders to report almost anything. And they're using that as a basis because they need experience to set up a reserve to get a tax deduction, so whereas in the St. Paul or other cases, and I'm sure obviously what constituted an adequate notice is a much more important issue.

It also depends on how long you expect the policy holder to be around, I guess. In some of these bedpan mutuals I guess they expect them to be there forever, so that has influenced their encouraging, at least from our standpoint, policy holders to report any and all incidences, which probably tends to screw up the reporting patterns and trying to have comparability among companies.

MR. MURPHY: Any other questions? I thank you all. Like to thank our panelists as well.