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A PUBLIC POLICY PRACTICE NOTE

Retained Property Casualty Insurance- Related Risk: Interaction of Actuarial Analysis and Accounting

April 2018

Developed by
The Casualty Practice Council's Committee
On Property and Liability Financial Reporting



AMERICAN ACADEMY *of* ACTUARIES

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Corporate entities are exposed to many types of risks that vary by types of operations. Typically corporations will go through a decision-making process on how to manage those risks. Options for financing the costs associated with these risks often include commercial insurance or some form of retaining the risk.

Many corporate entities that retain significant amounts of risk often engage actuaries directly or indirectly through consulting firms, insurance brokers, or insurance companies to assist the entity in valuing the unpaid claim estimates associated with these exposures. This actuarial estimate is in turn referenced by the management of the entity when selecting a value for the liability on its balance sheet for the unpaid claim liability for the entity's obligations. The way in which these liabilities become part of an entity's financial statements is governed by the applicable accounting standards for the type of entity, the type of exposure to loss, and the domiciliary jurisdiction of the entity and its parent. This practice note is intended to provide information to property/casualty actuaries providing assistance to these companies related to the financial reporting of the unpaid claim estimates and associated accruals for U.S.-based risks. This information is being provided in order to give the actuary context relative to the accounting standards but is not intended to provide accounting guidance. The actuary is expected to work with its principal and the principal's accounting advisors in preparing the actual estimates.

The focus of this practice note is the types of retained risk that could be written by a property/casualty insurer where an actuary may be involved. Later in this practice note, there is a description of the various ways in which an entity can retain this risk, often using a combination of traditional insurance products that may touch the retained amount. In other words, the entity may insure part of the exposure to loss through a more traditional insurance product but also retain a portion through a deductible, self-insured retention, or other means.

The actuary's role relative to the financial reporting of the retained risk is primarily a valuation exercise with implications for the costs associated with retaining these risks. While this note will focus on the balance sheet effect of the valuation, any changes in these valuations will affect the income statement of the entity as far as taking additional charges or profits when estimates turn out differently than the prior expectation.

We welcome comments and questions. Please send comments to casualty@actuary.org.

Retained Property Casualty Insurance-Related Risk: Interaction of Actuarial Analysis and Accounting

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Overview of the Practice Note

In this practice note we define various ways that entities use to retain risk—often described in other literature as methods of financing the entity’s exposure to risk. Because the type of entity often determines the particular approach or applicable accounting treatment, we have described the various types of entities and the associated variation in the retained risk characteristics. A description of the common exposures that these various entities may retain also is described.

This practice note describes the relevant accounting guidance that will apply to the various entities and exposures, the interaction of the accounting guidance with the relevant actuarial concepts and the variation by type of entity. Several specific situations are described that have particular applicable definitions and considerations.

As an entity determines its type of risk financing and then in turn quantifies and prepares its financial reporting, there are separate roles requiring communication and interaction between the actuary, accountants, third party administrators and risk managers/internal attorneys. The external auditor and its actuary also work with all of these same parties to complete the cycle from retention of risk, valuation of potential liabilities, and financial reporting of those liabilities. The practice note defines these roles and the series of interactions that occur.

After adding some additional considerations, the practice note summarizes the actuarial standards of practice (ASOPs) that are most applicable to the work described in the practice note.

Chapter 1

Method of Retaining Risk and Associated Treatments

INTRODUCTION

This chapter addresses types of risk retention and risk transfer from the point of view of the entity that initially bears the risk. We then illustrate what has been transferred by discussing the effect of a bankruptcy on each entity’s financial responsibility.

When an event occurs, there is one or more responsible party who immediately assumes the entire loss. Liability always attaches on an unlimited basis. That is, unless and until that entity transfers some of the risk or the loss is limited by statute, there is no limit on the size of a potential loss.

Types of Risk Transfer

There are various ways for an entity to transfer some or all of its risk via insurance. The term “self-insurance” is often used colloquially to refer to many different types of risk retention. In this practice note, we use the term “retained risk” generally and “self-insurance” as discussed below.

Guaranteed Cost Policies

In the simplest case, the entity can transfer all of the liability, subject to any limit specified in an insurance contract, to an insurer for a fixed premium. This type of risk transfer often is referred to as a “guaranteed cost” policy, because the entity’s costs are not influenced by the actual loss experience. It is, however, typical for the final premium to depend on a retrospective audit of the exposures base (e.g., payroll or sales). The entity may take back a small per claim deductible (for example, up to as much as \$10,000) so that the entity’s final cost is the audited premium plus the deductibles on actual losses. Such policies generally are not cost effective for large entities when a substantial portion of the loss experience is predictable.

Retrospectively Rated Policies

Alternatively, the entity can transfer all of the liability, subject to any limit specified in an insurance contract, to the insurer for a premium that is a function of the actual loss experience. This type of policy typically is referred to as “retrospectively rated,” and the final premium will depend on both the audited exposure base and the loss experience, possibly subject to a minimum and maximum. In recent years, this type of policy is most common in workers’ compensation. The entity’s final cost is the final premium, which may not be determined for several years after the policy’s expiration date. Until the final premium is determined, the entity has a potential liability to (or potential asset from) the insurer for the difference between the final premium and premiums paid to date.

Large Deductible Policies

In a third scenario, known as a “large deductible” policy, the entity can transfer all of the liability, subject to any limit specified in an insurance contract, to the insurer, then take back a substantial deductible via an endorsement to the policy. In this case, the final premium for the policy depends on the audited exposure base, but the entity’s final cost is the sum of the final premium, the losses within the deductible, and possibly claims handling costs. Until all of the claims within the deductible are paid, the entity has a liability to the insurer for the unpaid deductible claims.

Self-Insurance

In an arrangement known as “self-insurance,” the entity can purchase no coverage (and thus retain all of the risk) or purchase coverage that only applies to large claims, typically called “excess insurance.” The final premium for the excess coverage may depend on a retrospective audit of the exposure base. Self-insurance is very common for exposures where insurance coverage is not required by regulation, such as auto physical damage and other first-party exposures, general and products liability, warranty coverages, medical professional and general liability coverages, and many management type risks. Entities also continue to bear risk for costs not covered by their commercial policies. Self-insurance also is common for workers’ compensation, but has become increasingly less common for commercial entities with the growth of large deductible policies. Workers’ compensation self-insurance is regulated by states, usually by a division that is separate from the insurance regulator, which is charged with approving entities to become self-insured and holding any required collateral. Self-insurance is uncommon for other exposures where insurance is required by statute, such as automobile liability for regulated vehicles, because it can be interpreted to violate state or federal financial responsibility requirements, but it is permitted and regulated in some states.

Claims Made Coverage

In all cases, if the entity purchases coverage on a claims made basis, liability for claims that will be reported after the expiration of the policy remains with the entity. For some lines of business with substantial reporting lags, such as professional or products liability, this means that even entities that purchase guaranteed cost insurance can accumulate substantial unreported claim liability that is uninsured as of a given accounting date. As an example, consider a hospital that purchases annual guaranteed cost claims-made medical professional and general liability insurance policies effective January 1, 2018. For the hospital's financial statement as of June 30, 2018, liability for all claims reported through December 31, 2018, has been transferred to the insurer, but claims with occurrence dates prior to June 30, 2018, that will be reported in 2019 or later are *not* insured and thus must be accounted for as an unreported claim accrual of the hospital. So long as the hospital continues to purchase coverage, it will not actually pay any claims. Instead, its unreported claim accruals will be converted to purchase future insurance policies while simultaneously adding newly incurred but unreported claims to the accrual.

Some claims-made policies include an extended reporting period, covering claims reported after the end of the policy, usually for a limited period of time. In such cases, claims that will be reported during the extended reporting period are covered by insurance and thus may be treated as insured by the entity. Typically, such reporting periods extend for 30 to 90 days following the end of the policy period. Claims that will be reported during the extended reporting period are covered by the expiring policy until the inception of the renewal policy, at which time they transfer to the renewal policy. Note, however, that unless the extended reporting period is unlimited, there well may be unreported claims that are expected to be reported after the end of the extended reporting period and thus remain uninsured. Also, an insured may purchase a separate policy that provides limited or unlimited extended reporting (tail) coverage.

Captives

An entity can transfer some or all of its liability to an affiliated insurance company known as a "captive." Captive insurers typically are regulated by a special division within a state's insurance department and are subject to somewhat less stringent regulation than an admitted carrier. Captives also may be in non-U.S. domiciles subject to the local regulations. Captive regulations typically limit the coverages that a captive can write. A captive can either insure its affiliated entity directly or reinsure the entity's insurer. Captives may limit their overall exposure by purchasing reinsurance.

Direct Policies

An entity can purchase insurance directly from its affiliated captive insurer. This is typical for coverages that would be otherwise self-insured, although self-insurers usually are not permitted to purchase workers' compensation insurance from a captive. Often, a captive writing direct coverage will not fulfill financial responsibility requirements for personal or commercial automobile liability. Captive coverage also may be viewed as unacceptable in contracting situations where proof of insurance is required. Entities with captives often enter into arrangements that share risk between the captive and the commercial market.

Fronting Arrangements

When the entity has purchased a guaranteed cost policy, it can take back some (or all) of the risk it has transferred by having its captive reinsure some of the risk. In this case, the captive typically will reinsure losses on a ground-up basis, leaving losses excess of its limits with the commercial insurer. In this type of arrangement, the commercial carrier is known as a “fronting” company.

Deductible Reimbursement

In the case where the entity has purchased a large deductible policy, the captive can write a policy directly reimbursing the entity for its deductible obligations. In this case, the captive covers its affiliated entity for the entity’s obligations to the insurer *not* for its obligations to claimants. A deductible reimbursement policy, then, can be used to transfer the entity’s retained cost for workers’ compensation or automobile liability losses to a captive without running afoul of regulations limiting the direct writing of such coverages in captives.

Trusts

Trusts most often are used to finance professional liability exposures and may be treated as separate entities with their own audited financial statements. Coverage typically is provided to an affiliated entity on a direct basis, often when risk management and documentation of costs is required. Trusts often provide coverage to their affiliated entities on a claims-made basis, leaving the unreported claims with the original entity. Excess insurance may be purchased by the original entity or by the trust.

Risk Transfer Illustrated by What Happens in Bankruptcy

Although fronted captives, retrospectively rated policies, large deductible policies, and self-insurance with excess coverage all may be used to share risk between the original entity and a commercial insurer, in the case of third-party claimants the legal obligation to the claimant may or may not be transferred.

The following sections describe the implications of credit risk to the original entity and the insurer for various risk retention financing arrangements. The chart summarizes by arrangement the effect when either goes into bankruptcy.

When the Insured Entity Goes Bankrupt

Guaranteed cost, retrospectively rated, and large deductible policies obligate the insurer to pay the entire cost of a claim, subject to any limit specified in an insurance contract, regardless of the solvency of the insured. Premium audit, retrospective premium adjustments, and large deductible provisions are all agreements between the insured entity and the insurer that affect how the entity will pay for its coverage but do not affect the coverage provided by the insurer. Thus, if the insured entity cannot fulfill its obligations, the insurer will continue to pay claims and third-party claimants will not be affected. The insurer will have a claim against the bankrupt entity’s estate for premium audit adjustments, retrospective premium adjustments, and the deductible portion of losses but, like any creditor, may not recover all of its claim. Insurers have various ways of mitigating this credit risk, such as requiring collateral or pre-paid loss funds for large deductible policies.

In the case of self-insurance, however, the excess insurer has assumed risk for losses only in excess of the self-insured retention. This means that a third-party claimant will have a claim against the bankrupt entity's estate, not against the insurer, for claims below the excess insurance. In the case of workers' compensation claims, there may be a state self-insured fund that will take over payment of claims within the self-insured retention.

Captive insurers are legal entities. It is, therefore, legally possible for a captive to go bankrupt, although there would be significant pressure on a bankrupt captive's solvent owner to recapitalize. In the event of a bankrupt captive where the captive has reinsured a fronting carrier, the carrier has a claim against the captive and not against the original entity; however, where the captive has written a deductible reimbursement policy, the large deductible carrier continues to collect from the original entity.

When the Insurer Goes Bankrupt

When an insurer becomes insolvent, state guaranty funds generally take over the insurer's responsibility to pay claims, although the limit paid by the guaranty fund may be lower than the limit of coverage purchased by the insured entity, leaving the entity exposed for losses in excess of the guaranty fund maximum. The liquidator for the insurance company will recover audit and retrospective premium adjustments and deductibles from the insured entity. In the event that the limit on the guaranty fund's claim payment is less than the entity's deductible, the guaranty fund may nevertheless recover the full loss (up to the deductible) from the entity. This can result in the entity paying both the guaranty fund and the claimant for the portion of the loss between the guaranty fund maximum and its deductible.

In the case of a self-insured entity whose excess carrier is liquidated, the entity will continue to pay claims within its retention. The state guaranty fund will pay claims in excess of the retention up to its maximum obligation, which may leave the self-insured entity with liability for claims in excess of the guaranty fund's maximum.

Much like the case with a large deductible policy, the liquidator will collect the full value of the reinsurance from a fronted captive reinsurer, but the guaranty fund may only pay a portion of the claim, again leaving the insured entity with liability for claims in excess of the guaranty fund limit.

Bankruptcy of Insured vs. Insurer – Impact by Type of Insurance

Type of Risk Transfer or Type of Entity	Insured Entity Goes Bankrupt	Insurer Goes Bankrupt
Guaranteed Cost	Commercial carrier still retains risk and pays claims.	Transferred to guaranty funds; possible cap on payments.
Retrospectively Rated	Commercial carrier still retains risk and pays claims; commercial carrier has a creditor's claim for unpaid retro premiums.	Transferred to guaranty funds; possible cap on payments; liquidator may recover premium adjustments from insured.
Large Deductibles	Commercial carrier still retains risk and pays claims; commercial carrier has a creditor's claim for unpaid deductibles.	Transferred to guaranty funds; possible cap on payments; liquidator may recover deductible payments from insured.
Self-Insurers	Workers' compensation claims are transferred to a self-insurance guaranty fund if the state has one; other claimants become creditors.	
Captives	Captive insurer is usually an asset of the bankrupt entity; regulators will require that claims be paid before releasing any remaining funds.	If the captive covers the insured directly (e.g., a deductible reimbursement policy), it will be unaffected. If the captive reinsures the commercial insurer, it will be treated like any other insurer by the liquidator and may have to pay the full amount of reinsured claims even if the guaranty fund caps its claim payments.
Excess Insurer	Excess carrier still retains risk and pays claims.	Excess losses transferred to guaranty funds; possible cap on payments; liquidator may recover premium balances from insured.

Chapter 2

Types of Entities that Retain Risk

INTRODUCTION

In order to retain risk that would otherwise be insured, an entity must be large enough to have significant losses in at least one commonly insured exposure. Larger privately held, publicly traded, and governmental entities all may retain risk.

Smaller entities, however, can sometimes combine with their peers to share risk through mechanisms other than traditional insurance. The accounting treatment for such risk-sharing mechanisms is sometimes more similar to individual risk retention than to insurance. We also will touch on some of these arrangements.

Private Sector Entities (Privately Held or Publicly Traded)

If the entity's corporate structure is entirely within the United States, its accounting will be governed by United States Generally Accepted Accounting Principles (US GAAP), and the U.S. ASOPs will apply to actuarial services provided by actuaries who are members of the five U.S. actuarial organizations and subject to the Code of Professional Conduct (Code of Conduct). In the case of an entity with a parent domiciled outside the United States, however, additional accounting and actuarial standards may apply. The U.S.-based entity may consolidate its U.S. financial statements into corporate financial statements that are governed by International Financial Reporting Standards (IFRS) or by another country's GAAP. The actuary may be asked to provide additional information to allow for the use of the work product to comply with different financial reporting requirements and may be obligated to observe applicable standards of qualification and practice for the jurisdiction in which the actuary renders actuarial services, according to Precepts 2 and 3, respectively, of the Code of Conduct.¹

An example of such a situation is that of a Barbados captive writing deductible reimbursement coverage on the U.S. exposures of its Canadian-based parent. The accounting requirements and actuarial standards of all three jurisdictions may apply, and in some cases they may conflict.²

Group Programs

Smaller entities (usually with some type of affiliation) may combine to share risk in an entity that may be termed a pool, a group, a fund, or a trust. Conceptually such arrangements function much like mutual insurance companies but with the exception of Risk Retention Groups (RRGs), the accounting for the group program is usually on a US GAAP basis not a statutory accounting basis. RRGs file National

¹ Unless there is an agreement in place between the actuary's home organization and the actuarial organization in the host country to the contrary, actuarial services are deemed to be "rendered in the jurisdictions in which the Actuary intends them to be used," according to the introduction of the Code of Conduct.

² See the Academy's Council on Professionalism discussion paper "Considerations of Professional Standards in International Practice" (2016), which describes how the Code of Conduct applies to international practice. <https://www.actuary.org/files/publications/InternationalPractice.pdf>.

Association of Insurance Commissioners (NAIC) statutory financial statements, but for many RRGs the values within the filing are on a US GAAP basis with a reconciliation to statutory accounting. Regulation of such entities may be by the insurance department and/or a separate government entity.

Governmental Entities

Individual governmental entities at all levels can retain risk, from the federal government and states through counties, municipalities, school districts, and special purpose entities (e.g., water and sewer authorities). Accounting for governmental entities within the United States is governed by the Governmental Accounting Standards Board (GASB) rather than US GAAP and is discussed further in Chapter 6.

Governmental Groups and Pools

It is very common for collections of similar public entities within a state to share risk (e.g., a school district liability pool, a workers' compensation fund covering counties). GASB accounting has explicit provisions for pools as opposed to individual entities.

Government Quasi-Insurance Programs

There is a wide range of governmental entities at both the federal and state level that function much like insurance programs. These entities may be created by a specific federal or state law, usually to address a particular issue that is not considered commercially insurable or that is not sufficiently covered by available insurance, such as underground storage tank mitigation, workers' compensation second injuries, or specific types of medical professional and general liability claims. These quasi-insurance programs provide coverage rather than retaining risk, but they may be subject to GASB accounting rather than statutory insurance accounting. Some of these entities may fund only on a pay-as-you-go basis, and for state-level entities, their liabilities may or may not roll up into the state's balance sheet.

Health Care Entities

Health care entities may be governmental or non-governmental (in this practice note referred to as public or private). Health care entities that are public entities are subject to GASB accounting, like other governmental entities. US GAAP has a number of special provisions regarding accounting for the liabilities of non-governmental health care entities. It is important to note that health care entities include hospitals, nursing homes, and physician group practices but also less obvious classes with health care exposure such as large employers with onsite clinics or correctional facilities. These entities have exposure to professional liability as well as to traditional risk management exposures.

Large health care entities of all types are likely to retain risk. Because professional liability insurance for health care entities most often is written on a claims-made basis, they may have retained risk for unreported claims even if they have purchased guaranteed cost claims-made insurance.

State laws regarding professional liability may place special limitations on a physician's liability, and some states have created patient compensation funds (governmental quasi-insurance funds) that limit a

physician's exposure. The presence or absence of such tort limitations or compensation funds can have a significant effect on the development of professional liability claims.

Chapter 3

Exposures and Coverages

INTRODUCTION

All entities face a variety of retained property/casualty insurance risk. These risks can be first party or third party in nature. Workers' compensation and other work-related injury coverages are a significant type of third-party retained risk for many entities. There are also a wide variety of other enterprise risks that often are uninsured or underinsured and, therefore, retained.

First-Party Risks

First-party risks are those that apply to an entity's own property. One common first-party coverage is related to property losses. The retained risk can be related to traditional property losses, such as those due to fire, wind, and theft, often within a retained deductible. In areas exposed to significant risk of hurricanes or tornadic activity, these deductibles often can be quite large dollar amounts or percentages of insured values.

Additional forms of property and first-party retained risk are difference in conditions (DIC) coverage, business interruption, and auto physical damage. Most commercial auto policies insuring physical damage include fixed dollar deductibles. In addition, many entities make the risk management decision to forego comprehensive coverage or all physical damage coverage on some or all of their commercial autos. For trucking companies and public livery (e.g., bus and taxi companies), these retained risks can be quite significant. Auto dealers and service and repair shops also have specialized first-party risks related to auto physical damage.

Third-Party Risk

Third-party risks include bodily injury and/or property damage caused to a third party by the entity (including the entity's employees and agents). There are many third-party retained risks to which an entity may be exposed.

Similar to commercial auto physical damage, many entities have retained risk related to commercial auto liability. Often the retained risk is that portion of insurable losses within a specified deductible or self-insured retention. Auto dealers and repair shops have additional potential retained risks related to garage liability and garagekeepers liability.

Many entities have retained risk exposures that fit within the broad category of general liability and products liability risk. The most basic form of retained risk in this group of coverages is the use of deductibles or retentions within commercial coverages. There is also potential for retained risk as part of commercial umbrella and excess policies. Retained risk in excess of all commercial coverage also may be a material risk due to limitations in available commercial coverage limits. In fact, manufacturers in

some industries, like chemical companies, may not be able to find commercial coverage available at any cost and are forced to retain the entire risk.

Similarly, there are a wide variety of general liability standard policy exclusions that give rise to retained risk related to DIC. Common examples include personal and advertising injury, contractual liability, and intellectual property risk exposures. Products liability DIC risk exposures include product recall and pollution coverages that frequently are excluded due to their significant severity potential, particularly with certain industries (e.g., petrochemical) or products (e.g., paints and solvents).

A third-party risk akin to products liability and product recall is manufacturers' warranty exposure and related extended service contracts. There are several unique characteristics and accounting issues related to warranty exposures. Non-manufacturers such as health care providers and contractors also have similar risks related to product rework (e.g., dentists) and construction defects (e.g., contractors).

A common general liability retained risk is the default of subcontractors and other unrelated businesses with interrelated business interests. General contractors often face significant risk from subcontractors who go bankrupt and leave third-party liabilities, such as construction defect claims, that often transfer to the general contractor. Commercial coverage only recently has become available for this type of subcontractor default liability exposure. Landlords and real estate investment trusts face a similar exposure when tenants declare bankruptcy and have outstanding liabilities (e.g., slip and fall claims) that often transfer to the property owner.

Public entities also face the potential for numerous retained general liability risks. Examples include public officials' liability and law enforcement liability. Many public entities find retaining some portion of this risk to be a prudent risk management approach.

Another large area of retained third-party risk is professional liability risk. This includes medical professional liability, non-medical professional liability (e.g., lawyers, architects, engineers, accountants, actuaries), and other forms of errors and omissions coverage. Often these types of coverage are provided on a claims-made coverage form, which creates unique accounting and actuarial challenges that will be addressed in other chapters.

Another similar group of coverages that often are insured on claims-made coverage forms are broadly known as executive risks. These include directors and officers liability, employment practices liability, and similar risks.

A quickly evolving and expanding area of risk relates to cyber liability and related coverages. Some industries such as technology, health care, and retailers view cyber liability as a nearly mandatory insurance coverage; however, significant amounts of retained risk remain. Cyber risks include both first- and third-party exposures, including related risks such as data breach, cyber extortion, regulatory fines, loss of reputation, and first- and third-party electronic data loss.

Workers' Compensation

Almost all private and public entities have some exposure to work-related injury risks; the financing of these exposures is regulated. For most entities, this risk is financed through workers' compensation insurance. However, retained risk situations remain. Some entities choose to use insurance contracts

with deductibles, retentions below excess insurance, assessable premium features, or retrospective rating. All of these financing approaches result in retained risk.

There also are several insurance programs that are quite similar to workers' compensation in that they insure specific types of industries or work-related injuries (e.g., the United States Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, other federal programs).

Another approach to work-related injuries is the "opt out" or "non-subscriber" program that exists in Texas.

Other Property/Casualty Risks

Large- and medium-sized businesses are exposed to a wide array of property/casualty risks beyond the traditional insurance coverages. Examples include reputational risk, brand rehabilitation, loss of key customer, supply chain risk, kidnap and ransom, and crisis management.

A number of financial risks also present the potential for significant property/casualty retained risks. Credit risk and default on customer receivables both are common financial risks. Similarly, loyalty programs, gift cards, service contracts, and similar business incentives can all present material risks to an entity. So can weather-related insurance, event cancellation, and other unique risks.

Chapter 4

Relevant Actuarial Concepts and Considerations

INTRODUCTION

This chapter categorizes and discusses the various key concepts and considerations that could be evaluated when performing an analysis related to retained insurance risk. Many of these items are discussed to provide a framework for key considerations to review prior to performing an actuarial analysis. The actuarial practitioner will benefit from understanding the context, purpose, and appropriate structure prior to performing the actuarial analysis. Many other types of actuarial communications or reports may have different audiences and uses. The same is true with the analysis of retained insurance exposures. The purpose of the analysis may drive the way the analysis and communication is structured. The actuary also may consider the appropriate structure for the analysis by understanding other key items such as a company's insurance program, timing of financial reporting periods, data availability, and the applicable accounting standards.

Considerations for unpaid claim estimates are covered in detail in ASOP No. 43. This section addresses some unusual considerations that may be encountered by the actuary in the context of retained risk.

Intended Purpose of the Actuarial Analysis

Typically a retained risk actuarial analysis will be used in one of three contexts, with the potential that analysis components could be used in some combination of the three:

1. Adequacy of Accruals for Financial Reporting

2. Internal Financial Reporting and Cost Allocation
3. Regulatory Filing for a Qualified Self-Insurance Designation³

Adequacy of Accruals for Financial Reporting

Frequently actuaries are asked to estimate the indicated financial accrual for self-insured or retained liabilities. Company management may utilize the actuarial indications to directly record the accrual or as a control to confirm the reasonableness of the management estimates. The accruals can include provisions for deductibles, self-insured exposure, or potential retrospective premium amounts. Many key issues arise when values will be used for financial reporting since the actuarial estimates as presented in an actuarial work product may be compared to amounts recorded in a company's general ledger. Some key considerations are:

Net or Gross of Insurance Recoverables

Based on the accounting framework under which a company is required to report financial results, the accrual values may be presented on a basis either gross or net of insurance or excess insurance recoveries. For example, US GAAP accounting requires the separate presentation of a gross liability accrual for expected future loss payments and an asset related for the related expected insurance recoveries, which may partially offset the gross liability for economic purposes. This type of presentation will require a more complex analysis than for a simpler presentation on a net basis.

Discounting for the Time Value of Money

Companies may elect or be required under different accounting frameworks to reduce their accrual estimates for the time value of money. The inputs to a discounting calculation include the cash flow assumptions and the discount rate assumption. In order to provide an estimate on a discounted basis, analysis of the pattern of relevant cash flows will allow the determination of present value estimates. The pattern of cash flows for discounting purposes match the cash flow pattern for the entity, which may not match the cash flows to claimants. The accounting basis may provide considerations in selecting a rate for discounting as described in a later section on relevant accounting guidance.

Combined Accruals that Include Other Insurance-Related Balances

Many times the actuary will encounter a financial entry that may be a combination of related accruals where only a portion is encompassed within the actuarial analysis. For example, the financial statement accrual may contain lines of business or insurance-related items such as third-party administrator (TPA) fees that may not be contemplated in the actuarial calculation. Such a situation may make it difficult to produce a direct comparison of the results of the actuarial analysis with the financial statement entry.

³ Additional regulatory filings related to captives in the form of feasibility studies and statements of actuarial opinion. This practice note will not describe the details of either.

Prepaid Balances or Amounts Due From or To TPAs and/or Excess Insurers

A third-party claims administrator may be involved with a retained risk arrangement. In order to efficiently manage claims, a TPA typically will pay losses on a company's behalf. This creates two potential issues that are both timing related when performing an actuarial analysis. The data supplied to the actuary may be derived from a TPA's systems, which will indicate that a payment has been made and typically would be treated as such by the actuary. The second issue relates to the treatment of upfront funds in the form of a loss fund when provided to the TPA for the payment of claims on a company's behalf.

To the extent that payments have been made by the TPA but not yet reimbursed to the TPA, the entity's accrual will be greater than the actuarial estimate. To the extent that the entity has paid the TPA in advance, the accrual will be less than the actuarial estimate.

Some companies adjust their accruals to account for these types of timing differences, while others carry a separate timing accrual. Other companies treat the timing difference as immaterial and make no adjustment unless an unusual payment is made. Actuaries may or may not assist the company in calculating such adjustments. The need for such adjustments highlights the need to document the basis for the actuarial analysis.

A similar timing issue can arise when a claim has been paid by the entity but not yet reimbursed by an excess insurance carrier.

Retrospectively rated policies are frequently billed on an annual basis. This can result in a significant timing lag between claim payment and premium payment to the insurer. Some large deductible policies convert from a paid to an incurred claim basis after several years, usually with less frequent billing (quarterly or annually), resulting in similar timing gaps. For example, large deductible workers' compensation policy materials covering the 2012 accident year include a provision outside of the consideration of ultimate loss, as follows:

"deductible payments will be paid from insured to carrier on a monthly basis, within 5 days of each month end, through June 30, 2017 (66 months). At that time, carrier will bill insured for all case reserves on open claims within the deductible, and will bill insured on an annual basis for any change in incurred losses (paid losses plus case reserves) thereafter."

Through June 30, 2017, the timing of payments from the insured to the carrier is closely aligned with the evaluation date of the losses, and it is likely that no adjustment is needed. After the conversion to annual billing, however, two elements of timing difference are introduced:

1. The insured is now paying the carrier for losses including case reserves and payments, rather than as they are paid. This results in an asset for the insured equal to the difference between the case incurred losses and the losses paid to date (often referred to as credit for pre-paid case reserves). Note this asset is in addition to insurance recoverable assets.
2. The insured now pays the carrier only once a year, rather than monthly. Note, however, that the asset from #1 should be based on the incurred losses *as of the most recent billing date* rather than as of the accounting date, while the payments are based on the accounting date. It is not

uncommon for paid losses to develop between billings to such an extent that current paid losses exceed the incurred losses as of the billing date, resulting in an additional liability rather than a credit.

Internal Financial Reporting and Cost Allocation

Another frequent use for the evaluation of a company's financial exposure for retained liabilities involves internal management financial reporting. Tracking financial performance and the achievement of financial goals is a key function of company management. Actuarial indications, either in aggregate or split into subcomponents such as operating divisions, product type, or production facility, may be used by company management to monitor financial results at a detailed level. The availability and credibility of claim and exposure data at the level of detail necessary for allocation of reserves to subcomponents may be limited resulting in additional considerations for the actuary performing these calculations.

Regulatory Filing for a Qualified Self-Insurance Designation

A company that is either applying or renewing its application for permission to self-insure in a specific state may be required to file an actuarial report and certification along with its application package. To the extent that an actuary is requested to contribute to the application process, the requirements on report content will differ from state to state. The following excerpt from the Iowa Insurance Division's renewal application for self-insured workers' compensation employers is an example (different provisions may exist in other states):

Actuarial opinions must be submitted with renewal applications by June 1 of each year. To the extent that the actuarial opinions provide usable company specific information in a uniform manner, these opinions facilitate prompt issuance of license renewals and in some instances help in limiting the size of the required bond. In an effort to ensure more companies obtain all possible benefits of their actuarial opinions, we provide the following list of standard requirements for the opinions.

- 1) The actuarial opinion should be given by a member in good standing of the Casualty Actuarial Society;
- 2) The opinion shall provide actuarially appropriate reserves for Iowa claims only and include provisions for known claims and associated expenses, claims incurred but not reported and associated expenses, and previously closed claims;
- 3) The opinion shall be based on reserves estimated from the inception date of the company's self-insurance program to the valuation date of the opinion;
- 4) The opinion shall state the amount of appropriate reserves, before discounting and gross as to subrogation, by accident year on all Iowa claims, both reported and not yet reported, since the inception date;
- 5) The valuation and accounting dates of the opinion should be the last day of the preceding calendar year.

The opinion shall also include: a paragraph identifying the actuary, the actuary's employer and credentials; a second paragraph identifying the scope of the subjects on which the opinion is being rendered; a third paragraph expressing the actuary's opinion on the subjects of the second paragraph.

The opinion should include a brief description of the method(s) used to estimate the reserve level; at least one exhibit showing the methodology; the name and affiliation of the person(s) responsible for the data used by the actuary in his or her analysis; a reconciliation of the data used to the data submitted on pages 6 and 7 of the application; and an explanation of any checking, verification, or auditing the actuary performed on the data.⁴

Coverage or Policy Period

Any actuarial valuation model is constructed in conjunction with an understanding of the structure of any existing insurance or excess insurance coverage. Two basic elements of coverage are the inception and the end dates of the applicable policies. The interaction between the organization of the actuarial development data by a selected exposure year and the related policy periods generally are considered. The limits and coverage period of applicable self-insured retentions or excess coverage and the alignment with the exposure/accident year could simplify or complicate the actuarial model. For example, if the company in question is self-insured but has excess coverage from 7/1 to 6/30 attaching at \$500,000 per claim, organizing the loss data by an exposure period also from 7/1 to 6/30 will simplify the calculation of the liability net of excess insurance. If the exposure period was in the traditional calendar year (1/1–12/31) the allocation of insurance recoverable would be over two exposure periods. The situation would be further complicated if the excess insurance attachment point had changed over time.

The timing of a company's fiscal year is also a consideration. Many times corporations will not have fiscal years that align exactly with calendar years. For example a retailer typically has a fiscal year that ends on 1/31 given the effect of holiday sales on annual financial results.

If the actuarial accrual calculation will be utilized in financial reporting at fiscal quarter ends, the organization of the data may need to allow for the calculation of an accrual at a fiscal quarter end.

Key Dates and Interactions

ASOP No. 43 defines three key dates: the accounting date, the valuation date, and the review date. In practice, due to the required timing of the indications as input to the financial decision-making process and other issues such as data availability, the actuarial valuation date may precede the accounting date. If this is the case, either the actuary or the company must develop a roll forward procedure to allow for direct comparison of the actuarial indications and the accounting balances. A practical example of how these dates may interact is illustrated in the following:

In order for a manufacturing company to appropriately record its workers' compensation 12/31/17 self-insurance accruals and support the values in the financial statements, it engages a consulting actuary to produce a supporting analysis. The company also requires indicated accruals within several days of year end due to time constraints set to meet its year-end financial close.

⁴ <https://iid.iowa.gov/documents/workers-compensation-renewal-packet>.

In order for the actuary's projections to be available in time for the company's year-end close, the actuary selects a valuation date for the data of 9/30/17. Using data extracted as of historic third quarter cut-offs, the actuarial data is compiled and an analysis is performed. Since initial results will produce indications as of the 9/30/17 valuation date, the actuary creates a roll forward process to adjust the indications to the desired accounting date of 12/31/17. In this case the actuary projects the paid and case incurred loss activity from 9/30/17 to 12/31/17, adds a provision for fourth quarter exposure, and subtracts the projected fourth quarter payment activity. Often the actual activity between 9/30/17 and 12/31/17 is compared with the projection to confirm the continued reasonability of the overall results and a discussion related to the activity. After a discussion on January 2, 2018, with the company related to fourth quarter large loss activity, the actuary finalizes the report with a January 2, 2018, review date without additional adjustment considering the aggregate payment activity in comparison with the actuary's expected payment calculation.

In this example, the accounting date is 12/31/17, the valuation date is 9/30/17, and the review date is 1/2/18.

Loss Adjustment or Claim Adjustment Expenses

In addition to loss-related amounts, other expenses incurred by the entity relating to the retained risk may be accrued. These expenses generally fall in two categories: costs that are related to the disposition of claims and other expenses or assessments associated with retained risks that may be a percentage of losses.

The costs related to claim disposition generally fall into two categories: those related to expenses directly allocable to a loss and other claim settlement expenses. The direct costs, typically known as allocated loss adjustment expense (ALAE) costs, are composed of items such as legal fees or expert witness costs that can be associated with a single claim. Indirect claim settlement cost, which are known as unallocated loss adjustment expense (ULAE) costs, could be items such as TPA fees, costs of internal claims staff of the entity that retained the risk, etc. that are associated with multiple claims. Note that most entities that retain risk and most insurance policies continue to use the traditional categories of ALAE and ULAE rather than the statutory accounting categories of defense and cost containment and adjusting and other expenses.

Some entities do not accrue for ALAE costs at all. As discussed in Chapter 6, US GAAP accounting allows for an election either to accrue or not to accrue for claim expenses.

ULAEs typically are treated as period expenses under US GAAP accounting standards and are not accrued for non-insurance entities. Period expenses mean that in a given period, such as a quarter or a year, the amount that is paid for the expense is recognized. This is different than the typical treatment under insurance accounting standards in which these costs are accrued as ULAE and there is an unpaid accrual amount recognized.

Insurance policies cover ALAE in several different ways, and the accrual reflects the policy terms. Coverage of ALAE may not be included in the policy terms, in which case the entity retains all ALAE costs. If coverage is included in the policy terms for excess or large deductible policies, common

treatments include combining the loss and ALAE prior to applying the retention or deductible; applying the retention or deductible to the loss alone and then sharing the ALAE in proportion to the loss (pro-rata); or applying the retention or deductible to the loss alone with 100% coverage of ALAE by the insurer.

At times disputes may arise between a policyholder and insurer regarding applicability of coverage under insurance policies. These disputes typically can arise in two main areas: coverage limits and exclusions or the insurer's duty to defend claims. Conflicts on coverage limits and exclusions often revolve around conflicting interpretations of contract wording, including scope of insured perils, entities or individuals, per-occurrence and aggregate limits, and other terms and conditions. Duty to defend disputes are disagreements over the insurer's duty to provide legal defense for a policyholder in a lawsuit. While these disputes may involve litigation and legal expenses related to retained claims, the amounts expended are not treated as ALAE and typically are not accrued as part of the retained risk accruals.

The other category of expenses that are included in accruals is expenses or assessments that are charged to self-insurers by government entities or excess insurers. Examples of this include second injury fund assessments, self-insurance guaranty fund assessments, and loss conversion charges under retrospective rating plans. Since these items typically are charged as a percentage of indemnity costs they can be calculated as a percentage of the loss accruals.

Chapter 5

Applicable Standards of Practice

INTRODUCTION

The Code of Conduct⁵ and the ASOPs⁶ from the Actuarial Standards Board provide guidance to property-casualty actuaries in many areas of their professional work. This chapter is a summary of applicable standards and focuses on some elements of these professional standards that are particularly important in the area of retained risk. Actuaries are encouraged to read the Code of Conduct and the ASOPs for further clarification. The intent is not to describe the applicability of the Code and the various ASOPs in detail, but rather to provide particularly noteworthy elements of the standards for the actuary's consideration.

⁵ The revised [Code of Professional Conduct](#) took effect Jan. 1, 2001. The code identifies the professional and ethical standards required of actuaries who belong to the actuarial organizations that have adopted the code. The Code sets forth what it means for an actuary to act as a professional. It identifies the responsibilities that actuaries have to the public, to their clients and employers, and to the actuarial profession. Identical codes have been adopted by the American Academy of Actuaries, Society of Actuaries, the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, and the Conference of Consulting Actuaries.

⁶ <http://www.actuarialstandardsboard.org/standards-of-practice/>.

Code of Professional Conduct

Precept 3 requires the actuary to ensure that actuarial services performed by or under the direction of the actuary satisfy applicable standards of practice. It also states that an actuary must be prepared to justify the use of procedures that depart materially from those set forth in an applicable standard. Multiple standards of practice apply to the types of projects addressed by this practice note as further described later in this chapter. But because the principals often are less knowledgeable about the work and results, they may not understand that the actuary is following a code of conduct and standards of practice; thus, they may request that shortcuts be taken, both in the actual work and in the documentation of the work. The actuary may develop effective communication explaining why certain practices are important.

Precept 4 deals with communications and disclosures and specifically states that the actuary “shall take appropriate steps to ensure that the Actuarial Communication is clear and appropriate to the circumstances and its intended audience, and satisfies applicable standards of practice.” Oftentimes, entities dealing with retained risks have less experience with insurance than many principals with which actuaries commonly work. Actuaries in these circumstances need to take this lack of experience into consideration. Similarly, some of the unique coverages and accounting requirements need to be clearly and appropriately communicated to these non-technical intended audiences.

Precept 8 states that an actuary “take reasonable steps to ensure that such services are not used to mislead other parties.” It further explains in Annotation 8-1 that “[t]he Actuary should recognize the risks of misquotation, misinterpretation, or other misuse of the Actuarial Communication and should therefore take reasonable steps to present the Actuarial Communication clearly and fairly and to include, as appropriate, limitations on the distribution and utilization of the Actuarial Communication.” Principals with little or no insurance experience often can unintentionally misuse or mislead others. The actuary needs to be proactive to avoid these situations in written and verbal communications. This applies to both formal and informal communications.

Precept 10 addresses the need for the actuary to perform services with “courtesy and professional respect” and obligates the actuary to “cooperate with others in the Principal's interest.” This is noteworthy in the retained risk arena because of the number of other service providers involved, many of whom have little or no insurance-related training. In addition, when the entity changes actuaries, sometimes as a result of changes in ownership through mergers and acquisitions or for other reasons, Precept 10 spells out detailed rules of engagement between the prior and successor actuaries to ensure a smooth transition.⁷

ASOP No. 7 – Analysis of Life, Health, or Property/Casualty Insurer Cash Flows

ASOP No. 7 is particularly valuable in the retained risk arena as there are several different cash flow methods and assumptions that are commonly part of a retained risk evaluation. Specifically, cash flow testing is an important part of discounting (also addressed in ASOP No. 20) and also in the allocation of

⁷ For more information on this topic, see Beuerlein, “[Talking the Talk: Professionalism and Actuary-to-Actuary Communications](#)” in the May/June 2017 issue of *Contingencies* (p .24).

liabilities into short- and long-term categories. ASOP No. 7 also discusses asset risks. This often is an important consideration in retained risk actuarial services as many entities do not necessarily have invested assets supporting their retained risks and often are relying on their operating income to provide the return on assets supporting the discount rate assumptions. This standard also makes it clear that other cash flows, such as reinsurance recoveries, dividends, and other cash flows may need to be considered. Many of these issues are more fully addressed in ASOP No. 20.

ASOP No. 13 – Trending Procedures in Property/Casualty Insurance

ASOP No. 13 addresses the many aspects of trend. In retained risk, many aspects of trend may be materially different for an entity with retained risk than is seen in industry benchmarks. A company may be implementing proactive safety, loss control, and loss prevention programs with an effect on the frequency and severity trends. These assumptions can affect any reserving method that relies, either wholly or in part, on *a priori* expected loss indications as well as prospective funding calculations. The actuary also needs to be careful in identifying appropriate sources of trend data for entities with retained risk.

ASOP No. 20 – Discounting of Property/Casualty Unpaid Claims Estimates

As discussed in the section on ASOP No. 7, discounting for the time value of money is frequently a significant consideration for entities with retained risk. There is extensive guidance on payment timing and specific guidance is provided related to the timing of recoverables (3.3.6) and other unpaid claim components (3.3.7). Differences between the timing of payment of losses to claimants as compared to the timing of the actual entity cash flows suggest a heightened level of attention by the actuary.

The other important aspect of ASOP No. 20 for actuaries working on retained risk relates to the actuary's assumption(s) regarding discount rates. The standard offers three alternative approaches: 1) a risk free rate; 2) a portfolio approach (that can be complicated by the lack of directly corresponding invested assets); and 3) "discount rates requested by another party." This last option requires additional documentation in the actuarial report (4.1.i) but is often a viable alternative.

ASOP No. 21 – Responding to or Assisting Auditors or Examiners in Connection with Financial Audits, Financial Reviews, and Financial Examinations

As mentioned in the Code of Conduct Precept 10 discussion, many actuaries practicing in the retained risk area may face some different challenges when dealing with other service providers and regulators overseeing retained risk. The importance of communicating the actuary's data, methods, and assumptions to these other parties is the focus of section 3.5.4. Environmental considerations and operational changes (3.5.5) also can have a material effect on retained risk and are important items for auditors and regulators to better understand the actuary's methods and assumptions supporting their findings. Responsibilities of the reviewing actuary also are highlighted in this standard and can be important when two actuaries are involved in retained risk assignments. Finally, many retained risk assignments may use highly sensitive and confidential information. Section 3.5.6 provides both the retained risk actuary and the reviewing actuary guidance on this issue.

ASOP No. 23 - Data Quality

Many retained risk actuarial analyses have limited data available for the actuary's use. This could be due to the nature of the entity with the retained risk and/or the low frequency and high severity nature of numerous retained risk exposures. Therefore, ASOP No. 23 on data quality has great importance to the actuary practicing in the area of retained risk.⁸

Many retained risk actuarial analyses rely on limited data. Similarly, the data often is provided by the entity with the retained risk exposure or by another third party source. One particular type of information commonly used is industry benchmarks. This could include loss costs, publicly available rates, increased limits and deductible factors, loss development factors, frequency and severity benchmarks, and a myriad of other benchmark elements. These sources need to be adequately disclosed and documented. Section 3.7 is particularly instructive on these matters.

ASOP No. 36 – Statements of Actuarial Opinion Regarding Property/Casualty Loss and Loss Adjustment Expense Reserves

ASOP No. 36 may have limited applicability when considering retained risk. To the extent that retained risk is then financed in a captive insurance company, risk retention group, or other insurance vehicle within the scope of the standard, ASOP No. 36 may be applicable dependent upon the jurisdiction and type of insurance vehicle. In addition, some forms of retained risk require formal statements of actuarial opinion. These include some qualified self-insured workers' compensation programs and government insurance programs.

ASOP No. 38 – Models Outside the Actuary's Area of Expertise (Property and Casualty)

This standard has at least two areas of applicability with regard to retained risk. First, specialized coverages (e.g., black lung, product liability, asbestos and environmental, occupational disease) can have specialized non-actuarial models used for both expected loss estimation (i.e., funding) and also for unpaid claims liability estimates. In addition, the methods and assumptions used to develop the frequency, severity and/or expected loss estimates for enterprise risks that may not be traditionally insured in the admitted market often are based on non-traditional actuarial techniques. In both situations, ASOP No. 38 may come into play.

Important sections of the standard for the actuary:

- a. Appropriate reliance on experts; and
- b. Understanding of the model.

⁸ According to the Applicability Guidelines for Actuarial Standards of Practice (AGs), ASOP 23 applies to every assignment in every practice area (as do ASOP No. 1 [Introductory ASOP] and ASOP No. 41 [Actuarial Communications]). AGs are a tool that suggests to actuaries which ASOPs might provide guidance to them on more common assignments. AGs are updated by the Academy's practice councils and are not themselves guidance and are not published by the Actuarial Standards Board. <https://www.actuary.org/content/applicability-guidelines-actuarial-standards-practice-0>.

ASOP No. 41 - Actuarial Communications

One of the most important standards in general, and in particular with regard to retained risk, is ASOP No. 41. Actuarial techniques often are not well understood by the principal that may be less experienced in working with actuaries and the actuarial work product. ASOP No. 41 provides guidance to the actuary on how to structure clear communication.

ASOP No. 43 – Property/Casualty Unpaid Claim Estimates

Any estimate of unpaid claims liabilities for retained risk would be subject to ASOP No. 43. Sections of particular importance include guidance on dealing with:

- the use of the unpaid claims estimate;
- material constraints that exist in performing the analysis;
- the scope of the analysis: particularly loss adjustment expenses, reinsurance, other assessments, etc.; and
- the data, methods, models and assumptions, and the nature of the losses under consideration.

Chapter 6

Relevant Accounting Standards

INTRODUCTION

By retaining risk an entity has created a potential future payment based on activities undertaken in the past. At each financial reporting date, the entity has an obligation to fairly state its financial position by recording accruals for these future costs to the extent that these future payments are estimable for financial reporting purposes and have occurred as of the financial statement date.

Some items for which an actuary may have provided an estimate or range of estimates may not reach the accounting definition of estimable, but the estimates still may provide value to the management of the entity. Such retained risks may be disclosed in financial statements, but a specific accrual for the items may not be recognized in the financial statements.⁹

Retained risk items generally are reflected in one of two ways depending upon the accounting standard: 1) as a combination of a gross liability for future payments and an offsetting asset for any expected future insurance recoverable; or 2) as a liability net of recoveries. The treatment depends both upon the accounting standard and upon the estimability of the future insurance recoverable amount (i.e. amounts above the retention of the entity).

⁹ Recognition refers to recording of an asset or liability within a financial statement. Disclosure is distinct from recognition.

Note: The descriptions in this chapter are meant to be a summary only, and actuaries are encouraged to read the relevant standards themselves for further clarification. In the case of an inadvertent variation between the description provided here and the standards themselves, the standards take precedence.

U.S Generally Accepted Accounting Principles¹⁰

The Financial Accounting Standards Board (FASB) produces financial accounting standards codification (ASC) for the United States, which codify US GAAP. In 2009, the U.S. accounting guidance underwent codification resulting in a reordering and renumbering of the guidance. For example, major components of the old FAS 5 became ASC 450. The primary standards applicable to property-casualty retained risks are:

- ASC 450 – Contingencies, Subtopic 20 – Loss Contingencies
- ASC 405-30 – Insurance-Related Assessments
- ASC 805 – Business Combinations, due to special accounting considerations of the fair value of acquired entities

A contingency is “an existing condition, situation, or set of circumstances involving uncertainty as to possible gain (gain contingency) or loss (loss contingency) to an entity that will ultimately be resolved when one or more future events occur or fail to occur.”¹¹ The scope of ASC 450-20 specifically excludes the insurance-related transactions of insurance entities, which are covered by other accounting standards, but it is relevant to all entities that retain risk. Many employment-related costs (e.g., pension obligations) also are excluded from FAS 450-20 but retained Workers’ Compensation accruals fall within the scope.

A loss contingency is recognized when:

“a. Information available before the financial statements are issued or are available to be issued indicates that it is probable that an asset has been impaired or a liability has been incurred at the date of the financial statements. Date of the financial statements means the end of the most recent accounting period for which financial statements are being presented. It is implicit in this condition that it must be probable that one or more future events will occur confirming the fact of the loss.

b. The amount of loss can be reasonably estimated.”¹²

Only accruals for past events are included in financial statements. For retained first-party property damages, any significant loss events are likely to be known when the financial statements are published, and loss estimates may be based on actual damages. But for other retained risk coverages, particularly liability or workers’ compensation coverage, events are likely to have occurred but are not yet known to the entity or the total cost of known occurrences may still need to be estimated using actuarial techniques.

¹⁰ Cited documentation as of publication date, accounting standards may be subject to change in the future.

¹¹ FASB ASC 450 Glossary.

¹² FASB ASC 450-20-25.

The requirement that an amount for a loss contingency cannot be reasonably estimated does not delay the recognition of an accrual if a range of amounts can be reasonably estimated.

The measurement criteria note that:

“If some amount within a range of loss appears at the time to be a better estimate than any other amount within the range, that amount shall be accrued. When no amount within the range is a better estimate than any other amount, however, the minimum amount in the range shall be accrued. Even though the minimum amount in the range is not necessarily the amount of loss that will be ultimately determined, it is not likely that the ultimate loss will be less than the minimum amount.”¹³

The phrase “not likely” to be less than the minimum amount of the range is not defined in the accounting literature. It generally would not be appropriate for an entity to accrue the minimum of the range without first considering whether a better estimate exists. Indeed, the entity will consider whether a more likely estimate exists before considering only a range of outcomes.

If a liability is not recognized for a probable loss because a reasonable estimate or range of estimates cannot be made, the entity is required to disclose the loss contingency and that the loss contingency has not been accrued because a reasonable estimate cannot be made.

Whether a loss contingency is estimable may depend on the entity’s experience with similar uncertainties or similar entities’ experiences. The entity will evaluate the particular risk or exposure to loss in relation to the current environment, including the entity’s industry and geography that are relevant to the specific uncertainty. If a reasonable estimate cannot be determined, then disclosure of the loss contingency is required. However, we expect it to be rare for an entity to be unable to identify a reasonable estimate related to retained risk. As noted earlier, the measurement of a loss contingency often is determined through an actuarial analysis.

Accounting guidance for non-insurance companies does not require an accrual for the loss adjustment expense, with the exception of health care entities. As a result, some entities treat the loss expense as a period cost. The ULAE and ALAE on occasion may not have the same treatment at a particular entity. For example, the defense costs may be accrued for liability claims but not workers’ compensation claims. Entities may use either method as an accounting policy decision, but the accounting policy generally is expected to be applied consistently from period to period and disclosed if material.

Discounting is permitted under US GAAP when the liability and cash flows are reasonably determinable. US GAAP literature contains little guidance on the discount rate to use.

FASB ASC 720-20 – Insurance Costs

An entity often enters into insurance arrangements to mitigate its exposures to various loss contingencies. These arrangements may be structured to transfer risk to the insurer and others may simply limit risk so that the arrangement is more similar to a financing. The existence of an insurance arrangement to cover losses typically does not result in the creditor or plaintiff legally releasing the

¹³ FASB ASC 450-20-30.

insured from being the primary obligor. Accordingly, a liability is recognized if the criteria to record a loss contingency are met, regardless of whether an entity is insured for such losses.

The decision process in accounting for an insurance contract may be complex. The entity must determine whether the insurance contract adequately transfers the insurance risk (i.e., provides indemnification against loss or liability) in order for the contract to be accounted for as insurance. If the insurance risk is not adequately transferred, the contract is accounted for as a deposit.

Separate accounting codification applies to insurance expenses for insured entities with specific types of contracts: a) retroactive contracts; b) claims-made contracts and c) multiple-year retrospectively rated contracts.

ASC 720 includes guidance on deposit accounting used for contracts that do not transfer insurance risk. Such contracts are unusual, but the standard does provide a typical example. Actuaries may be involved in determining whether a contract does include transfer of insurance risk in order to determine whether the premium paid is treated as a deposit or expense in the financial statements.

Generally, insurance premiums paid are treated as deposits rather than expenses if:

- insurance risk is not adequately transferred;
- the contract is retroactive (covering past rather than future events); or
- the contract is a multiyear retrospectively rated contract.

Further discussion of risk transfer testing can be found in Reinsurance Attestation Supplement 20-1: Risk Transfer Practice Note.¹⁴

Claims-Made Contracts

ASC 720 also notes that for entities with claims-made contracts, recognizing the liability from incurred but not reported claims should use the guidance of ASC 450-20-25 if the loss is probable and estimable. Therefore, most entities with claims-made insurance contracts (e.g., professional liability, product liability) will need to recognize a liability for the unreported “tail” claims or disclose the contingency if an amount cannot be estimated. In addition, section 720-20-30-2 includes:

“30-2 The estimated cost of purchasing tail coverage is not relevant in determining the loss to be accrued because paragraph 210-20-45-1 prohibits netting the insurance receivable against the claim liability. However, if the insured entity had the unilateral option to purchase tail coverage at a premium not to exceed a specified fixed maximum, then the insured entity could record a receivable for expected insurance recoveries (after considering deductibles and policy limits) for the portion of the incurred but not reported liability that is insurable under the tail coverage. In that case, the entity would need to record as a cost the expected premium for the tail coverage. The purchase of tail coverage does not eliminate the need to determine if an additional liability should be accrued because of policy limits or other factors.”¹⁵

¹⁴ http://www.actuary.org/files/publications/pc_risk_jan2007.pdf.

¹⁵ FASB ASC 720-20-30-2.

Specific accounting codification applies to health care entities accounted for under ASC 954, which includes guidance on medical professional and general liability claims (note that the accounting guidance refers to this exposure as medical malpractice). ASC 954-450-25-2 notes that medical professional liability is required to be recorded *gross* of insurance recoveries but entities will recognize an insurance receivable at the same time that it recognizes the liability. The insurance receivable is required to be measured on the same basis as the liability, subject to the need for an allowance for uncollectible amounts. The ASC specifically notes that accruals will not be based on a funding amount “which in addition to the determined liability also includes a provision for both of the following: (a) Credit for investment income and (b) a margin for risk of adverse deviation.”¹⁶ That is, the accounting guidance calls for accruals to be set at management’s best estimate separately from the funding assumptions that included discount and risk margin.

The ASC also includes “factors to consider and adjustments that may be required to convert actuarially determined malpractice funding amounts to an appropriate loss accrual to be reported in the financial statements:

- a. The risk of adverse deviation is an additional cost factor applied to bring a funding requirement to a selected confidence level. This factor does not meet the criteria for recognition as a liability in accordance with Topic 450.
- b. An evaluation shall be made of the extent and validity of industry data when the credibility factor actuarial technique is used. The lower the credibility factor, the greater the blending of industry data. This may create an unacceptable level of industry data at lower confidence levels. Further, a low credibility factor may indicate that provider-specific data is not sufficient to support the claims liability estimation process.
- c. A review of the discounting approach used is necessary to develop the required disclosure. The impact on the discounting calculation of any other adjustment made to the actuarially determined amounts (such as risk of adverse deviation or the credibility of the risk management system) has to be evaluated.
- d. A review of the expenses included in the loss estimation process shall be made. Such expenses include the expense of settlement and litigation (that is, allocated loss adjustment expenses).¹⁷

In practice, however, the inclusion of a risk margin and/or use of discounting may become part of management’s best estimate and may be discussed separately in relation to other components of how the reserves are determined.

This language describes the uses of risk provision in determining the funding but states that that the risk provision does not meet the criteria for being a liability. Discounting requires further disclosure and evaluation. Specifically for health care entities, it does require accruals of unpaid claim estimates on a gross basis and an offsetting asset of expected insurance recoverable. This is common when an entity

¹⁶ FASB ASC 954-450-25.

¹⁷ ASC 954-250-25-2B.

may retain losses up to a given per claim retention but has insurance in place for losses above the retention. For health care entities, insurance coverage often is on a claims-made basis; therefore, no recoverable amount generally is recorded on “tail” occurrences that are uninsured as of the accounting date.

In the measurement of the contingency for medical professional liability claims, the ASC includes specifics of what the estimated losses are required to include:

“30-1 Estimated losses from asserted and unasserted medical malpractice claims shall be accrued either individually or on a group basis, based on the best estimates of the ultimate costs of the claims and the relationship of past reported incidents to eventual claims payments. All relevant information, including industry experience, the entity's own historical experience, the entity's existing asserted claims, and reported incidents, shall be used in estimating the expected amount of claims. The accrual includes an estimate of the losses that will result from unreported incidents, which are probable of having occurred before the end of the reporting period.

30-2 In estimating the probability that unreported incidents have occurred, some health care entities may develop a range of possible estimates of the number of unreported incidents, including zero. However, the greater the volume of a health care entity's operations, the greater the likelihood that the entity's minimum estimate of the number of probable unreported incidents will be greater than zero. In estimating losses from malpractice claims, a health care entity may need to modify data drawn from industry experience so it is relevant to developing an estimate that is specific to the entity. Various factors (such as the nature of operations, size, and the provider's past experience) shall be considered in assessing comparability. Further, industry data that are not current may not be relevant.”¹⁸

In addition:

“50-1 Health care entities shall disclose their program of medical malpractice insurance coverages.

50-2 Health care entities that discount accrued malpractice claims shall disclose in the notes to the financial statements the carrying amount of accrued malpractice claims that are discounted in the financial statements and the interest rate or rates used to discount those claims.”¹⁹

Medical Malpractice Trust Funds

Medical malpractice trust funds as described in Chapter 1 have specific accounting requirements: “The entity’s estimated losses in the Trust from asserted and unasserted claims shall be accrued and reported, as indicated in paragraphs 954-450-30-1 through 30-2.”²⁰ These trusts assume the liabilities

¹⁸ FASB ASC 954-450-30.

¹⁹ FASB ASC 954-450-50.

²⁰ FASB ASC 954-450-25-3.

generally on a claims-made basis with the tail component remaining with the originating healthcare entities.

Environmental Obligations

An entity's environmental obligations relate both to current operations and prior operations. Current operations may involve accidental releases or retirement of the current operations that will require clean up at some time in the future.

FASB ASC 410 addresses retirement of assets and legally required environmental obligations associated with such retirements, with Section 30 specifically addressing environmental obligations. Often with a tangible long-lived asset, such as chemical plant or mining operation, there are legal obligations associated with retirement of the asset and potential environmental obligations after the retirement. Obligations to remove asbestos from normal operations of such an asset can fall within the scope of this accounting standard, as well as other environmental obligations.

The liability associated with asset retirement is often an estimate based on the expected settlement date or range of dates, the method of settlement, and probabilities associated with either, resulting in a fair value estimate. Typical items needed are "information that is derived from the entity's past practice, industry practice, management's intent, or the asset's estimated economic life."²¹

The measurement basis for asset retirement is an expected present value, using expected cash flows and a credit-adjusted risk-free rate, so that the entity's credit standing is reflected in the discount rate rather than in the expected cash flows.²² The discount rate used under this accounting standard may differ from other retained risks.

The disclosures required for these obligations include the following, many of which can be provided through actuarial estimates:

"An entity shall disclose all of the following information about its asset retirement obligations:

- a) A general description of the asset retirement obligations and the associated long-lived assets
- b) The fair value of assets that are legally restricted for purposes of settling asset retirement obligations
- c) A reconciliation of the beginning and ending aggregate carrying amount of asset retirement obligations showing separately the changes attributable to the following components, whenever there is a significant change in any of these components during the reporting period:
 - i) Liabilities incurred in the current period
 - ii) Liabilities settled in the current period
 - iii) Accretion expense
 - iv) Revisions in estimated cash flows.

²¹ FASB ASC 410-20-25-11.

²² FASB ASC-410-20-30.

If the fair value of an asset retirement obligation cannot be reasonably estimated, that fact and the reasons therefor shall be disclosed.²³

Tax Accounting

Retained risk losses often are not tax deductible until they are paid. Accruals for retained losses often represent a temporary difference that must be accounted for in accordance with ASC 740, Income Taxes. This ASC is beyond the scope of this practice note.

GASB 10 Requirements

Some governmental entities, such as publicly owned hospitals, may use GAAP accounting. Accounting for U.S. governmental entities and governmental entity pools is determined by the GASB rather than by the FASB. The requirements of Statement No. 10 of the GASB (GASB 10), "Accounting and Financial Reporting for Risk Financing and Related Insurance Issues,"²⁴ are discussed in the following paragraphs.

The requirement to report an estimated loss is based on the same criteria as for private entities under US GAAP. How the estimated loss is accounted for, however, is somewhat different and depends on whether an individual governmental entity or a pool is involved.

Entities Other than Risk Pools

If the GASB 10 requirements are met to report an estimated loss and the risk of loss has not been transferred to a third party, the entity accrues for the loss. GASB 10 specifies that if there is a range of estimates, if some amount "appears at the time to be a better estimate than any other amount within the range,"²⁵ that amount is accrued. The bottom of the range only is accrued if no value within the range is a better estimate than any other.

The accrual should include incurred but not reported (IBNR) claims. In addition, "Claim liabilities should be reduced by amounts expected to be recovered through excess insurance."²⁶ Thus, the liability for a government entity is reported net of excess insurance, in contrast with the gross reporting in accordance with US GAAP guidance. Discounting is neither mandated nor prohibited, with the exception of structured settlements that specifically are required to be discounted if the payment stream is determinable. The selected discount rate, if any, considers the entity's settlement rate for the liabilities and its investment yield rate. GASB 10 notes that the liability is based on the "estimated ultimate cost of settling the claims (including the effects of inflation and other societal and economic factors), using past experience adjusted for current trends, and any other factors that would modify past experience."²⁷

²³ FASB ASC 410-20-50.

²⁴ <http://www.gasb.org/st/summary/gstsm10.html>.

²⁵ GASB 10-54.

²⁶ GASB 10-64.

²⁷ GASB 10 57.

GASB 10 also addresses premium and assessment liabilities. The entity accrues for its ultimate premium liability under a retrospectively rated policy. Similarly, if the entity participates in a pool and an assessment is probable and reasonably estimable, then the entity accrues a liability for the assessment. As with other types of gain contingencies, anticipated policyholder or pool dividends, however, are not accrued until the dividend is declared.

As with GAAP accounting, entities that purchase claims-made insurance accrue liability for their unreported claims that are uninsured as of the accounting date or disclose if the amount is not estimable.

Public Entity Risk Pools

Risk pools account for their activities separately in an enterprise fund regardless of whether there is a transfer or pooling of risk. Premiums, often known as contributions, are earned as an insurer would earn them. For premiums that can be adjusted, i.e., retrospectively rated, the ultimate premium is recognized, if it is reasonably estimable, and revised to reflect current experience. If the ultimate premium cannot be estimated, then a “cost recovery method” or “deposit method” is used until it becomes estimable.

Liabilities are to include estimated unreported amounts and are net of anticipated salvage and subrogation on both settled and unsettled claims. Liability is accrued for both allocated and unallocated expenses. Note that GASB 10 continues to use the terms allocated and unallocated, with the traditional definitions of those terms.

Discounting is neither mandated nor prohibited, with the exception of structured settlements (e.g., annuity contracts). The selected discount rate, if any, is supposed to consider the entity’s settlement rate for the liabilities and its investment yield rate. Annuity contracts that have been purchased to cover a structured settlement are omitted from the balance sheet (but disclosed) if the probability of the liability reverting back to the pool is remote.

Experience-based refunds are accrued in a separate liability from the loss reserves.

GASB 10 also calls for the accrual of a premium deficiency reserve, if appropriate. In the event that a premium deficiency reserve is needed, deferred acquisition costs are reduced or eliminated within the calculation of the remaining premium deficiency. The pool posts deficiencies from risk-sharing pool participation as (an offsetting) expected revenue receivable if it has a legally enforceable claim to the amounts and their collection is probable and reasonably estimable.

Unlike individual governmental entities, for risk pools reinsurance premiums paid and reinsurance recoveries on claims may be netted against related earned premiums and incurred claims costs. In practice, however, most public entity pools post loss reserves net of reinsurance.

GASB 10 includes a fairly extensive list of required disclosures (see GASB 10 paragraph 49). The disclosures include:

“f. The nature and significance of excess insurance or reinsurance transactions to the pool’s operations, including reinsurance premiums ceded, and estimated amounts that are recoverable

from reinsurers and that reduce the liabilities as of the balance sheet date for unpaid claims and claim adjustment expenses.”²⁸

There also is required supplementary information in GASB 10 paragraph 50. Actuarial assistance may be called upon for some of these, particularly disclosure of 10 years of paid and incurred (ultimate) losses by policy year, including calculation of one-year development statistics.

GASB 10 includes significant guidance for pools on cost accruals, recognition of income, and other balance sheet items outside the scope of this note.

International Accounting Requirements

International accounting is governed by International Financial Reporting Standards (IFRS). This summary will examine international accounting treatment of U.S. exposures; that is, what happens when U.S. liabilities roll up into financial statements governed by IFRS. For liabilities that roll up into statements governed by other national standards (e.g., Canadian accounts), those national standards may require different treatment than is discussed in this practice note.

Unlike accounting in accordance with U.S. GAAP, more than one standard applies to the various types of retained risk typically evaluated by U.S. property/casualty actuaries. An important distinction for international accounting is whether the liability is associated with employee benefits or not.

IAS 19 – Employee Benefits

IAS 19 prescribes the accounting and disclosure by employers for employee benefits. Most auditors have interpreted the definition of employee benefits to include U.S. workers’ compensation. Some workers’ compensation benefits would fall into the short-term category described as follows, while the rest would meet the definition of other long-term employee benefits.

“The Standard identifies four categories of employee benefits:

- (a) short-term employee benefits, such as the following (if expected to be settled wholly before twelve months after the end of the annual reporting period in which the employees render the related services): wages, salaries and social security contributions, paid annual leave and paid sick leave, profit-sharing and bonuses and non-monetary benefits (such as medical care, housing, cars and free or subsidised goods or services) for current employees;
- (b) post-employment benefits such as retirement benefits (e.g. pensions and lump sum payments on retirement), post-employment life insurance and post-employment medical care;
- (c) other long-term employee benefits, such as long-service leave or sabbatical leave, jubilee or other long-service benefits, long-term disability benefits; and
- (d) termination benefits.”²⁹

In addition:

“Employee benefits other than short-term employee benefits, post-employment benefits and termination benefits are other long-term employee benefits. For other long-term employee

²⁸ GASB 10 49- f.

²⁹ IAS 19 IN2.

benefits, the Standard requires the same recognition and measurement as for post-employment benefits but all changes in the carrying amount of liabilities for other long-term employment benefits are recognised in profit or loss. The Standard does not require specific disclosures about other long-term employee benefits.”³⁰

Liability for short-term benefits is recognized on an undiscounted basis, presumably less any expected recoveries from qualifying insurance, although IAS 19 is silent on insurance for short-term benefits (IAS 19 paragraph 11).

Liability for long-term benefits (more than 12 months) is recognized as a long-term defined benefit liability. The long-term defined benefit liability is determined as the discounted liability less the discounted value of any expected recoveries from qualifying insurance (IAS 19 paragraphs 57 and 115). Actuarial assumptions are to be unbiased and mutually compatible (paragraph 75). The rate used to discount is determined by reference to market yields on high-quality corporate bonds (paragraph 83). There is no provision for a risk margin (paragraph 84).

In some cases, estimates, averages, and computational shortcuts may provide a reliable approximation of the detailed computations illustrated in the standard (paragraph 60), and in practice many employers record all of their workers' compensation liability under the requirements for accounting for long-term defined benefits.

IAS 19 includes extensive guidance on actuarial assumptions, compatible with the US ASOPs, in particular ASOP No. 43.

IAS 37 – Provisions, Contingent Liability and Contingent Assets

IAS 37 applies to contingent liability unless covered by another standard (e.g., IAS 19 for employee benefits or IAS 4 for insurers).

IAS 37 makes a distinction between a “provision” and a “contingent liability.” Entities recognize a liability for a “provision” but not for a “contingent liability.” The determination of when to recognize the liability is very similar to the U.S. determination:

“A contingent liability is:

- (a) a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the entity; or
- (b) a present obligation that arises from past events but is not recognised because:
 - (i) it is not probable that an outflow of resources embodying economic benefits will be required to settle the obligation; or
 - (ii) the amount of the obligation cannot be measured with sufficient reliability.”³¹

“A provision shall be recognised when:

- (a) an entity has a present obligation (legal or constructive) as a result of a past event;

³⁰ IAS 19 IN7.

³¹ IAS 37-10.

- (b) it is probable that an outflow of resources embodying economic benefits will be required to settle the obligation; and
 - (c) a reliable estimate can be made of the amount of the obligation.
- If these conditions are not met, no provision shall be recognised.”³²

The amount recognized as a provision is the best estimate of the expenditure required to settle the present obligation at the end of the reporting period (paragraph 36). This is the amount that an entity would rationally pay to settle or transfer the obligation (paragraph 37). In the case of a large population of items, it is supposed to be the expected value, or the mid-point of an equally likely range of estimates of the expected value (paragraph 39). In practical terms, the expected value is adjusted for time value of money and potentially a risk margin in order to achieve these values equivalent to settlements.

IAS 37 allows for a risk margin but cautions against one that is overly prudent, giving as an example not double counting by including a prudent estimate of a particularly adverse outcome that is also given more than a realistically probable weight (paragraphs 42–44).

Provisions are present-valued (where the discount is material) using a pre-tax rate that reflects current market assessments of the time value of money and the risks specific to the liability, again not reflecting risks for which future cash flow estimates have been adjusted (paragraphs 45–47). The risk adjustment can either be embedded within the cash flows or within the selection of the discount rate. In practice, many entities post a risk adjusted discounted liability using a risk-free rate. Note that there is no provision for offsetting, so as with GAAP the most typical treatment under IAS 37 would be a gross liability with an offsetting asset for expected insurance recoveries.

The following chart compares the different bases of accounting related to several specific areas.

Summary of Accounting Standards

Accounting Basis	Type of Risk Transfer	Balance Sheet Liability Accrual	Balance Sheet Offsetting Asset	Net Result (Liabilities Minus Assets)	Discounting /Risk Margin
US GAAP Non-Insurer	Guaranteed cost	Usually none	Usually none	Nil	N/A
	Self-Insurance (SI)	Unlimited unpaid losses & ALAE	Expected excess recoveries	Unpaid losses & ALAE limited to SI retention	Optional/No
	Large Deductible	Unlimited unpaid losses & ALAE	Expected excess recoveries	Unpaid losses & ALAE limited to deductible	Optional/No

³² IAS 37-14.

Accounting Basis	Type of Risk Transfer	Balance Sheet Liability Accrual	Balance Sheet Offsetting Asset	Net Result (Liabilities Minus Assets)	Discounting /Risk Margin
	Retro-Rated	Unlimited unpaid losses & ALAE	Expected excess recoveries	Difference between ultimate retro premium and premiums paid to date	Optional/No
		+ expected loss sensitive premium adjustments other than losses (generally associated with unpaid limited loss)	+ Difference between premiums paid to date and limited unpaid losses & ALAE		
	Claims-made SI & Large Deductible	Unlimited unpaid losses & ALAE on an occurrence basis = report year plus tail	Expected excess recoveries on reported claims	Limited unpaid losses & ALAE on reported claims + unlimited IBNR	Optional/No
US-domiciled captive	Generally use US GAAP for insurance companies. Most captive domiciles have abbreviated statutory forms based on US GAAP for regulatory filings; exception: Risk retention groups file a standard statutory annual statement				Sometimes permitted by domicile
Governmental Entity (GASB)	Self-Insurance	Unpaid losses & ALAE limited to SI retention	None	Unpaid losses & ALAE limited to SI retention	Optional/no
	Large Deductible	Unpaid losses & ALAE limited to deductible	None	Unpaid losses & ALAE limited to deductible	Optional/no
	Retro-Rated	Difference between ultimate retro premium and premiums paid to date	None	Difference between ultimate retro premium and premiums paid to date	Optional/no
	Claims-made SI & Large Deductible	Limited unpaid losses & ALAE on reported claims + unlimited on un-asserted claims	None	Limited unpaid losses & ALAE on reported claims + unlimited on un-asserted claims	Optional/no

Accounting Basis	Type of Risk Transfer	Balance Sheet Liability Accrual	Balance Sheet Offsetting Asset	Net Result (Liabilities Minus Assets)	Discounting /Risk Margin
International Accounting: Non-Insurer	Employee Benefits (including WC): short term	Net of expected insurance recoveries	None	Net of expected insurance recoveries	No/No
	Employee Benefits (including WC): long term	Net of expected insurance recoveries	None	Net of expected insurance recoveries	Required/No
	Other than Employee Benefits	Unlimited loss and ALAE	Same as GAAP	Same as GAAP	Required/permitted
Footnote: Per accounting standards accruing for expenses is optional; however, accruing for ALAE is usual practice.					

Chapter 7

Roles and interactions of Actuary, Accountants, and Risk Managers/Internal attorneys

INTRODUCTION

Various professionals with differing roles are involved in preparing, understanding, and using an actuarial report prepared for a non-insurance entity. These individuals, internal and external to a company, approach the project with considerations surrounding the particular results each needs from an actuarial report. Additional considerations include the controls around the process for collecting the data for the report and around its ultimate use for financial reporting.

Definitions of Roles and Responsibilities

A non-insurance entity that retains the types of risks discussed in this practice note has several internal and external participants that have hands-on responsibilities related to defining, valuing, monitoring, and accounting for the retained risk.

The entity internally often has a risk manager or has assigned the risk management responsibilities to a particular individual. The risk management responsibilities include identifying the risks of the entity, deciding which risks to retain or transfer, dealing with insurers, and administering the program around the retained risk.

When losses occur, the claims may be handled by a combination of the insurer, a third-party administrator and attorneys both internal and external. For some larger entities, internal legal counsel will have oversight of certain aspects of the claims handling. The risk manager may have responsibility for the claims processing or this may be separate.

The loss reserve and associated liabilities for the balance sheet as well as accounting for payments are controlled by and are the responsibility of accounting/finance professionals.

The actuary that the entity uses to provide actuarial valuations is generally a consulting actuary. This actuary is external to the entity but works closely with both the entity's risk manager and finance professionals. In some situations, the actuary will work more closely with one rather than the other of these parties.

Most of the entities that have a balance sheet effect from the retained exposures described in this document will engage outside audit firms to perform financial statement audits and provide an associated audit opinion.

The core audit team is composed of accounting professionals whose goal is to determine if the financial statements of the entity are fairly stated and may include an opinion on the design and operating effectiveness of the entity's controls over financial reporting. Through a risk assessment process, the core audit team will determine the scope of the audit and within this scoping process will determine if the liabilities associated with the retained risk are within scope for testing during the audit.

Some audit firms have actuaries as employees and some engage outside actuaries to become part of the audit team and assist in the testing of the associated actuarially determined liabilities.

Actuarial Report and Presentation

Consulting actuaries are engaged by risk retaining entities because of their actuarial expertise. The particular specialty of the individual in the entity's management that engages the actuary may determine the format of the requested deliverable. A risk manager may be looking for different information in an actuary's report than the finance/accounting professional. But in the end, the actuary's report may end up serving a dual purpose to meet the needs of both parties. The actuary is required by Code of Conduct and ASOPs³³ (in particular ASOP No. 41 Section 3.1) to understand the uses for the report at the outset of the project in order to serve all the needs of the client and to prevent misinterpretation of the actuary's work.

The risk manager's focus is often on the future in terms of the costs for the program in the prospective year as well as backward looking to assist in collateral negotiations with its insurers. The risk manager in concert with the entity's safety and claims professionals often also is looking for validation of the effect in changes to claim prevention efforts or post-claim loss mitigation protocols. The risk manager also may be administering an approach to allocating costs of the retained risk funding among various business units in the entity to encourage the loss control agenda of the entity. When the risk manager requests a

³³ http://actuary.org/files/code_of_conduct.8_1.pdf, <http://www.actuarialstandardsboard.org/asops/actuarial-communications/>.

valuation, the instructions and listing of desired deliverables may lead to a forward-looking study that includes prospective funding with allocation to business units as well as claims diagnostics. Enough information may be included to support the financial reporting of the entity but may be on a basis different than that directly used for financial reporting. Differences between the cost of the retained losses within the programs and financial statement accruals may cause confusion in the focus of the report for the particular user. These differences include the accounting date of the results, the valuation date of the underlying claims data, the loss limits of the analysis, or the inclusion of only amounts within a self-insured retention or deductible.

The finance/accounting focus of an actuarial report is on supporting the liability accrual at a particular balance sheet date as well as supporting the incremental amount to expense for new occurrences and exposures. The more sophisticated accountants will request a split of the liabilities into short and long term (short term is liabilities expected to be paid within twelve months of the accounting date; long term is the rest). Others will prepare that split themselves. The finance teams often will do analysis on the results presented in an actuarial report and look to understand the change in the reserves from one evaluation to the next. They also may request additional analytics that will assist them as non-actuaries in understanding the reasonability of the results of the actuarial report and allow them to describe changes in results to management and the board/audit committee of the entity.

Financial Controls

The entity generally establishes financial controls over various parts of the actuarial process that feed financial reporting. The formality of these controls may vary with the size of the entity, the size of the retained balances, and the length of time that the particular entity has been in a significant retained risk program. The points within the actuarial process where controls are typically found are related to the data, the core analysis, and the booking process.

The data used in the actuarial analysis may be maintained by an insurer or third-party administrator rather than by the entity. The third party administrator may have had its processes and its controls tested and reported in a Service Organization Control report (sometimes referred to as a SOC 1 report), also referred to as a SSAE 16³⁴ report. In addition, the entity may perform reconciliations of the claim data to payments to the claims administrator or to the information provided to the actuary or received from the actuary. The goals of these reconciliations and reports are to provide assurance that the process yields complete and accurate data.

The entity will rely upon the expertise of the outside specialist, the actuary, to provide input into the entity's liability for its accruals associated with retained risk. The entity's management will make the final determination on what the accrual will be. Generally either the risk manager or the finance staff becomes the owner of the results of the actuarial work product. This owner will take responsibility for understanding the specialist's work product in order to be able to use the results of the report appropriately. The actuary has responsibility to work with this individual to help ensure that the report is understood and will be used in the appropriate context.

³⁴ Consulting actuaries do not have these types of reports prepared related to the actuarial work product.

The entity's governance over the booking of the actuarial indication may be described as a control with component parts around the documentation of whether or not the actuarial indication is booked with or without a difference. There also may be additional controls around reconciling the carried reserve with the actuarial report. Alternatively, the entity may have its own process for deriving the carried reserves, and the actuarial report may be used as a control over the results of the internal process, becoming part of the control structure. The actuary may only implicitly be aware of the role of the actuary's work in the control structure of the company.

Interaction with the Internal Accountants

The outside actuary preparing a valuation on behalf of the entity may work closely with the internal accountants to ensure that the actuarial report is used appropriately in the financial reporting process. In some instances, the risk manager may serve as an intermediary between the external actuary and the internal accountants. Lack of direct communication between the actuary and the internal accountants may lead to confusion and misinterpretation. The actuary can mitigate this risk by having direct lines of communication with the accounting professionals at the entity in addition to the risk manager.

Interaction with the External Auditor

When the external auditor plans the audit, the auditor defines materiality using generally accepted auditing standards. The auditor's definition of materiality³⁵ will be defined in numerical terms. If certain account balances are below the numerical materiality levels and the level of risk associated with those accounts are not at a high level, detailed review of the actuarially determined accrual may not be within the scope of the audit. If the actuarially determined accruals are within the scope of the audit, the auditor will consider testing the completeness and accuracy of the data used by the entity's actuary and review the reasonability of the detailed actuarial report.

Testing the data likely will include inquiries of both the entity and the actuary related to the sources of the data and reconciliations to the source data, as well as other testing approaches designed by the auditor. The auditor will review the actuarial analysis and report and will develop an assessment of its reasonability either through understanding the methods and assumptions employed by the actuary or independent testing. The auditor may make this assessment of the reasonability through the use of actuarial resources, either employed or engaged or on the auditor's own.

The actuary who prepared the analysis that the entity used in establishing its financial statement accrual has the role of the responding actuary as defined in ASOP No. 21 (2.10). In this role, there may be some level of interactions with the auditor depending upon the auditor's scope.

³⁵ http://www.actuary.org/files/materiality_06.8.pdf/materiality_06.8.pdf.

Chapter 8

Special Situations and Special Treatments

INTRODUCTION

For the purposes of this practice note, certain retained risks are classified as special situations due to the nature of the specific exposure, the credibility of the entity's experience for the exposure, the specificity of the exposure to the entity, the specialized accounting treatments for the specific exposure, or some other consideration. This is not an exhaustive listing of situations with specialized treatments, but describes some overall approaches to consider and lists several specific commonly encountered situations.

When confronted with a situation that may be difficult to estimate or that is new to the actuary and the result of the valuation is intended to support financial reporting, consider both the principles related to what has occurred as of the financial statement date, as described in the chapter on accounting, combined with the actuarial literature on how to develop an estimate for the particular exposure. Using this approach of starting from the basics will help the actuary enter into a discussion with the actuary's principal and potentially the principal's auditor of an appropriate approach to prepare the requested valuation. Management of the entity, often in concert with the actuary, may develop a view on the estimability, as defined in ASC 450-20,³⁶ of the unpaid claims estimate of the gross loss reserve for both known claims and claims that may be reported in the future.

Several special situations commonly encountered are listed here and described in more detail as follows:

- Asbestos-related exposures
- Black lung
- Environmental
- Group Health
- Other chemical-related exposures, such as diacetyl, talc, lead paint, benzene
- Product recall
- Silicosis-related exposures
- Warranty

Asbestos-Related Exposures

Asbestos exposures of non-insurance corporate entities are based upon historical operations of the entity or its predecessor entities in the mining, manufacture, installation, or use of asbestos-related

³⁶ See Chapter 6.

products or presence in the vicinity of asbestos. Many of the allegations related to new asbestos third-party or employee-related claims are based upon exposures in the past but newly manifested in a recent diagnosis of asbestos-related diseases. Actuaries have developed models to estimate the value of currently known claims, the future reporting of claims, and the associated severity of these claims on both a gross and net basis. Management often will work with the actuary to develop its accounting policy for recognizing the unpaid claims estimates for financial reporting purposes and document the approach in an internal memo.

Under US GAAP for non-insurers there is no requirement to estimate and in turn to accrue a liability for defense costs. As a result, while defense costs are significant related to asbestos liabilities, some companies have developed an internal accounting policy that does not include establishing an accrual for the defense costs. For these entities, a description of this policy is often documented in an internal accounting policy.

Black Lung

Coal mines generate significant amounts of black coal dust that historically has been inhaled by coal miners before and even after the development of personal devices that filter the air breathed by a worker. The lung disease associated with this exposure, pneumoconiosis, or black lung, generally is considered an occupational disease under workers' compensation. Compensation for the effect of this exposure is defined in both state and federal statutes (Black Lung Benefits Act, see Glossary) and often changes on both a prospective and retrospective basis. Because of the entitlement nature of the regulations that affect the compensability of black lung claims, the valuation of the associated liabilities considers not only the valuation of case development on known claims and incurred but not reported estimates but also an active lives component of the liability that considers currently employed miners who may file in the future for current exposure to coal dust. The individual mine and its auditors may make a choice on the selected accounting treatment that may further define specific outputs of the valuation approach taken.

Environmental

Environmental liabilities associated with the investigation, remediation, and ongoing maintenance of a remediated site are a component of the obligations of many industrial entities. The types of sites (owned by the entity, or rivers and streams in the watershed of the entity's property) as well as the impetus for the remediation (a particular regulator or other party) will vary by situation. The starting basis for valuing the unpaid estimate is often based upon engineering studies. Actuaries may be involved in understanding the ramifications of the engineering studies as well as converting the engineering study into an unpaid claim estimate.

Group Health

Many entities retain a significant component of the group health coverage that they provide to their employees. The retained exposure is part of the liabilities of the entity and the accounting is consistent with other exposures described in this practice note.

Other Chemical-Related Exposures

From time to time new liabilities emerge related to allegations of injury and an associated liability for the manufacturer, distributor, or industrial user of a particular chemical or substance. The principles described previously related to determining the estimability of retained risk in a particular situation apply. The associated liabilities will develop and change as the litigation related to these specific situations matures. The actuary may develop an approach to value the associated liabilities in concert with the principal's claim experts and legal advisors.

Product Recall

A product manufacturer may recall a particular product. The resulting costs to the manufacturer include the administrative costs of the recall, the costs of compensation through a replacement product or cash settlement to the consumer, and associated legal fees. Sometimes an actuary may assist a principal in developing the value of the associated costs. Many product recall events are valued by the particular entity in a budgetary approach.

Silicosis-Related Exposures

Silicosis-related exposures and the manifestation of associated claims follow a similar latency as asbestos-related claims. The modelling approaches are similar to those for asbestos as well as the approach for recognition in financial reporting.

Warranty

Many products are covered by warranties that are purchased by the customer or included in the cost of the product. The components of warranty and extended service contract reserving go beyond just the loss reserves and encompass deferring the revenue associated with the fees obtained by establishing a deferral of the revenue that acts like an unearned premium reserve. Discussions with the accounting professionals to keep current with revenue recognition accounting guidance will help the actuary develop the appropriate actuarially determined earnings pattern for the revenue.

Appendix: Glossary

Accretion Expense – This is the periodic expense recognized when updating the present value of a balance sheet liability that has arisen from a company's obligation to perform a duty in the future and is being measured by using a discounted cash flows approach. This kind of liability typically has a long and predetermined life on a company's balance sheet, and so it is valued using a discounted cash flow measurement. The accretion expense amounts to a change in the liability due to time and the discount rate applied.

Automobile Physical Damage Insurance – A type of first-party insurance that provides protection for property damage to an owned vehicle. This general term includes collision coverage (damage resulting from collision with another object or vehicle), as well as comprehensive coverage (damage resulting from risks other than collision, including fire and theft). If the vehicle is owned by an individual, the coverage is classified as personal or private passenger auto physical damage. Vehicles or equipment owned by commercial entities are covered by commercial auto physical damage.

Black Lung Benefits Act³⁷ – A United States federal law that provides monthly payments and medical benefits to coal miners totally disabled from pneumoconiosis (black lung disease) arising from employment in or around the nation's coal mines. The law also provides monthly benefits to a miner's dependent survivors if pneumoconiosis caused or hastened the miner's death.

Business Interruption Insurance – A type of first-party insurance that covers the loss of income that a business suffers after a disaster. The income loss covered may be due to disaster-related closing of the business facility or due to the rebuilding process after a disaster. Business interruption coverage is typically limited to events that affect the entity's premises. Other risks that may be covered under a business interruption policy (usually by special endorsement) include disruption of the entity's supply chain, the untimely and unexpected loss of a key employee, the loss of a franchise (e.g., restaurant or auto brand), an event that results in damage to an entity's reputation or negative publicity, or the loss of a key customer due to events outside of the entity's control.

Completed Operations Liability Insurance – See Product Liability Insurance.

Construction defect – A deficiency in the design or construction of a building or structure resulting from a failure to design or construct in a reasonably workmanlike manner and/or in accordance with a buyer's reasonable expectation. The most dangerous defects have the capacity to fail, resulting in physical injury or damage to people or property. However, many defects present no increased risk of injury or damage to other property but nevertheless cause harm to the property owner in the form of loss of use, diminution in value, and extra expenses incurred while defects are corrected. This latter type of defect is often referred to as a passive defect.

Contractual Liability Insurance – A type of third-party insurance that provides coverage for the named insured's liability that is created when it assumes, in an oral or written contract, the financial consequences of another's negligent acts or omissions that results in bodily injury or property damage to a third party.

³⁷ <http://uscode.house.gov/view.xhtml?path=/prelim@title30/chapter22/subchapter4&edition=prelim>.

Coverage-in-place Agreements – Agreements that are used to resolve claim disputes and avoid costly litigation when future liability is difficult to quantify.

Cyber Liability Insurance – A type of third-party insurance that provides coverage for business' liability for a data breach involving sensitive customer information, such as Social Security numbers, credit card numbers, account numbers, driver's license numbers, and health records.

Difference in Conditions Insurance – A type of first- or third-party insurance that provides expanded coverage for some perils that are not covered by standard insurance policies. Difference in conditions (DIC) insurance is designed to fill in gaps in insurance coverage and is most frequently used by larger organizations looking for protection from catastrophic perils. Common forms of property DIC that often result in retained risk include flood coverage, earthquake and earth movement, and mold coverage. A liability DIC policy, for example, might fill the gaps between the coverage provided by a multinational organization's master insurance policy and coverage provided by policies purchased locally.

Directors and Officers (D&O) Liability Insurance – A type of third-party insurance covering directors and officers for claims made against them while serving on a board of directors and/or as an officer. D&O liability insurance can be written to cover the directors and officers of for-profit businesses, privately held firms, not-for-profit organizations, and educational institutions. In effect, the policies function as "management errors and omissions liability insurance," covering claims resulting from managerial decisions that have adverse financial consequences.

Employment Practices Liability Insurance – A type of third-party insurance that provides coverage to employers against claims made by employees alleging discrimination (based on sex, race, age or disability, for example), wrongful termination, harassment, and other employment-related issues, such as failure to promote.

Errors and Omissions Liability Insurance – See Professional Liability Insurance.

Federal Employees Compensation Act – A United States federal law,³⁸ enacted on September 7, 1916. It establishes compensation to federal civil service employees for medical costs and wages lost due to job-related injuries and occupational disease.

Federal Employers Liability Act – A United States federal law³⁹ that protects and compensates railroaders injured on the job.

Financial Accounting Standards Board (FASB) – An independent, private-sector, not-for-profit organization that establishes financial accounting and reporting standards for public and private companies and not-for-profit organizations that follow GAAP accounting. FASB is recognized as the designated accounting standard setter for public companies. See also GAAP, GASB, SAP.

First-Party Insurance – A type of insurance policy under which an insured (the first party) is paid by his or her insurer (the second party) in the event of an accident, injury, or loss whether caused by the insured, natural causes, or someone else (the third party). See also third-party insurance. Examples of

³⁸ <https://www.dol.gov/owcp/dfec/regs/statutes/feca.htm>.

³⁹ The Federal Employers Liability Act (FELA), 45 U.S.C. § 51 et seq. (1908) is a United States federal law that protects and compensates railroaders injured on the job.

first-party risks include property (fire, wind, hail), automobile physical damage, difference in conditions coverage, and business interruption coverage.

Garage Liability Insurance – A type of third-party insurance purchased by automobile dealerships and repair shops that covers property damage and bodily injury resulting from vehicles owned or held for sale by the dealership (garage dealers insurance). Garage dealers insurance also covers liability for claims that would typically be covered by automobile liability insurance. Garagekeepers' liability insurance covers accidents and damage to cars that are brought into the shop or dealership for repair or maintenance.

General Liability Insurance – A type of third-party insurance issued to business organizations to protect them against liability claims for bodily injury and property damage arising out of premises, operations, products, and completed operations; and advertising and personal injury liability. See also products liability, personal and advertising liability, product recall, and contractual liability.

Generally Accepted Accounting Principles (GAAP) – This is the standard framework of guidelines for financial accounting in the United States. GAAP accounting is based on four core principles: historical cost principle, revenue recognition principle, matching principle, and the full disclosure principle. GAAP accounting may differ from other accounting principles in the way that certain items are recognized and valued within the accounting framework. See also FASB, GASB, SAP.

Governmental Accounting Standards Board (GASB) – The independent, private-sector organization that establishes accounting and financial reporting standards for U.S. state and local governments that follow GAAP accounting. The GASB standards are recognized as authoritative by state and local governments, state Boards of Accountancy, and the American Institute of CPAs. See also GAAP, FASB, SAP.

Incurred But Not Reported (IBNR) – An estimate of the liability for claim-generating events that have taken place but have not yet been reported to the insurer or self-insurer. The sum of IBNR losses plus paid loss and case reserves provides an estimate of the total ultimate cost for losses during a given period. IBNR is sometimes further broken down between true, or pure, IBNR (i.e., a provision for claims not yet reported) and Incurred But Not Enough Reported (IBNER), which is a provision for future case reserve development on reported claims. Often these terms are used interchangeably and is important to clarify exactly which component of IBNR is being referred to in a specific instance.

Intellectual property — A work or invention that is the result of creativity, such as a manuscript or a design, to which one has rights and for which one may apply for a patent, copyright, trademark, etc.

Law Enforcement Liability Insurance – A type of third-party insurance that provides coverage for bodily injury, personal injury, or property damage caused by a wrongful act committed by or on behalf of a public entity while conducting law enforcement activities or operations.

Medical Professional Liability Insurance – See Professional Liability Insurance.

Medical Malpractice – Accounting guidance generally refers to medical professional liability as medical malpractice; either terminology refers to the same risks.

Non-subscriber (Opt-Out) Workers' Compensation Programs – The term “non-subscriber” is commonly used to identify businesses that do not subscribe to the traditional workers' compensation system.

Currently, only Texas allows employers to opt-out of the otherwise applicable workers' compensation laws. Employers who are nonsubscribers are not protected by the exclusive remedy protection of statutory workers' compensation laws. To mitigate the risk of being sued, companies typically structure an employee benefit plan that provides coverage for medical expenses and wage loss due to on-the-job injuries. Employers who are nonsubscribers also may have an additional general liability exposure for workplace injuries. See also workers' compensation insurance.

Personal and Advertising Liability Insurance – A type of third-party insurance that provides protection from injuries resulting from one or more of the following: false arrest, detention or imprisonment, malicious prosecution, wrongful eviction, wrongful entry, or invasion of private occupancy of a room, dwelling or premises, libel, slander or disparagement of goods, products or services, oral or written publication of material that violates a person's right of privacy, use of another's advertising idea, or infringing upon another's copyright.

Product Recall – A request to return a product after the discovery of safety issues or product defects that might endanger the consumer or put the maker/seller at risk of legal action.

Products Liability (Including Completed Operations) Insurance – A type of third-party insurance providing protection against financial loss arising out of the legal liability incurred by an insured because of injury or damage resulting from the use of a covered product or out of the liability incurred by a contractor after a job is completed (completed operations cover).

Professional Liability (Errors and Omissions Liability, Medical Professional Liability) Insurance – A type of third-party insurance that provides coverage for liability faced by someone acting in a professional capacity from negligence that may result from failure to perform on the part of, financial loss caused by, and errors or omissions in the rendering of professional services or advice. For medical professionals, this type of insurance is referred to as Medical Malpractice or Medical Professional Liability. For other types of professionals, this type of insurance is referred to either as professional liability or errors and omissions liability.

Public Entity – Any state or local government or any department, agency, special purpose district, or other instrumentality of a state or states or local government (including counties, towns, cities, parishes, and other municipal subdivisions).

Public Officials Liability Insurance – A type of third-party insurance that provides coverage for liability exposure faced by a public official from wrongful acts, defined as actual or alleged errors, omissions, misstatements, negligence, or breach of duty in his or her capacity as a public official or employee of the public entity. See also professional liability, D&Os liability, law enforcement liability.

Recognition – In accounting terms, recognition is the recording of the monetary effects or a transaction or estimated contingency into the books of account or financial statements. If an estimate for a significant contingency cannot be made, it is disclosed in the financial statements, but the monetary effects are not included in the books of account.

Statutory Accounting Principles (SAP) – Rules for insurance accounting codified by the National Association of Insurance Commissioners or as promulgated by a domicile as rules to be used in reporting an insurer's results to regulators. These rules focus on the insurance company balance sheet and

solvency analysis and differ from the GAAP. For example, statutory accounting rules do not allow the inclusion of certain nonadmitted assets on the balance sheet; require that certain loss reserves be set by conservative formulas instead of the insurer's estimates; require the insurer to immediately recognize the expenses associated with writing new business instead of amortizing them over the policy period; and do not allow premiums for reinsurance placed with unauthorized reinsurers to be recognized as an asset. See also GAAP, GASB, FASB.

Third Party Administrators (TPA) – An organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity. This can be viewed as outsourcing the administration of the claims processing, since the TPA is performing a task traditionally handled by the company providing the insurance or the company itself. Often, in the case of insurance claims, a TPA handles the claims processing for an entity that retains risk. The risk of loss remains with the entity and not with the TPA. An insurance company may also use a TPA to manage its claims processing, provider networks, utilization review, or membership functions. While some third-party administrators may operate as units of insurance companies, they often are independent.

Third-Party Insurance – Liability insurance purchased by an insured (the first party) from an insurer (the second party) for protection against the claims of another (the third) party. See also first-party insurance. Examples of third-party risks include general liability, products liability, workers' compensation, medical professional liability, warranty coverage, and construction defect.

United States Longshore and Harbor Workers' Compensation Act (USL&H) – A statutory workers' compensation system enacted in 1927. Initially, it provided coverage to employees injured only on navigable waters of the United States.⁴⁰ Today, it provides coverages to certain maritime workers, including most dock workers and maritime workers not otherwise covered by the Jones Act. In addition, Congress has extended the LHWCA to cover non-appropriated fund employees (i.e., certain Morale, Welfare and recreation (MWR) and Army and Airforce Exchange Services (AAFES) employees), Outer Continental Shelf workers, and U.S. government contractors working in foreign countries under the Defense Base Act. The Act is administered by the Division of Longshore and Harbor Workers' Compensation, a division of the Office of Workers' Compensation Programs of the United States Department of Labor.

(Manufacturer's) Warranty and Extended Service Contracts – Coverage for electrical or mechanical breakdown that may or may not cover peripheral items, wear and tear, damage by computer viruses, normal maintenance, accidental damage, or any consequential loss. Most state insurance regulators have approved the inclusion of normal wear and tear, accidental damage from handling, rental car and towing, power surge and other coverages in addition to the standard coverage for defects in materials and workmanship. The indemnity is to cover the cost of repair and may include replacement if deemed uneconomic to repair.

Workers' Compensation Insurance – A type of third-party insurance established under law to provide income, medical care, and rehabilitation to employees for illness, injury, or death arising out of, and in the course of, their employment whether or not the employee was at fault. These benefits are claimed by the employees (or their dependents) as a matter of right and the employer cannot resort to any legal defense. The amount paid as compensation is based on the salary of the employee (also on the number

⁴⁰ <https://www.dol.gov/owcp/dlhwc/lhwca.htm>.

of his or her dependents in some jurisdictions) and is usually subject to a specified maximum. In the United States, workers' compensation coverage is compulsory, although agricultural and domestic workers may be excluded under certain circumstances. See also Non-Subscriber Workers' Compensation programs.