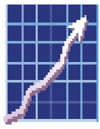

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Audit Report for

REINSURER of

INSURANCE COMPANY

ACCOUNT

DATE thru DATE

Submitted by:

AUDITOR
DATE

I. Introduction

REINSURER provided excess reinsurance for INSURANCE COMPANY on the BUSINESS Program for YEAR and YEAR, and identified a need to conduct on-sight reviews for Workers Compensation, Carve-Out and Occupational Accident.

II. Scope of Assignment

REINSURER's primary audit needs are client premium, underwriting guidelines, premium audit, policy documentation, losses generated from the program and overall claims handling. RMG Consulting, LLC was selected to undertake this assignment, selected policies and claims to be reviewed, and contacted INSURANCE COMPANY to set-up the physical audit.

III. Executive Summary

Noteworthy findings follow:

Premium Audit (pages 6 – 8)

The premium displayed on the INSURANCE COMPANY reports appears to balance with the Final Premium Audits. However, the reasons for the changes in premium were not well documented in the Home Office Underwriting files we reviewed.

Claims (pages 9 – 15)

INSURANCE COMPANY Services, now known as NATIONAL TPA, provides Claims Handling, PPO, Medical Bill Review, and Managed Care services at a fee which was charged to the claim file. The Managed Care portion of these fees is extremely high in comparison to industry standards. The exact amount of profit generated by INSURANCE COMPANY Services, later NATIONAL TPA, and paid to INSURANCE COMPANY Insurance Company as a dividend or rebate is not known. However, we have made a reasonable estimate of the charges which we believe are in excess of industry standards.

As a related issue, we observed gaps in the reporting of updates on many claim files by the various adjusters. We attribute these gaps to the many changes that occurred within the INSURANCE COMPANY organization over the past seven years. Also, we identified significant "stair-stepping" of reserves which concealed the level of losses being incurred by the program for several years.

Underwriting (pages 16 – 31)

Under the INSURANCE COMPANY ACCOUNT, INSURANCE AGENCY sold insurance to the clients of its parent organization NYSE LISTED COMPANY. REINSURER reinsured an excess Workers Compensation layer of this program. Our audit revealed that the Workers Compensation policies were sold with significant price reductions through the use of granting considerable scheduled credits. A review of the INSURANCE COMPANY's policy files and the agent's underwriting files (which INSURANCE COMPANY refers to as marketing files) reveals no Underwriting / Risk Evaluation documentation whatsoever to support the significant scheduled credits.

Other Issues (page 32)

Other key issues include INSURANCE COMPANY's risk retention.

Overall Cooperation

This audit took approximately one year to complete for a variety of reasons which are discussed in this report. During this time, INSURANCE COMPANY personnel were cooperative in attempting to obtain the requested information vital to the completion of our review. As a related issue, we should note that we had to request information to be copied at INSURANCE COMPANY's office, and we were not allowed to make copies at INSURANCE AGENCY's office.

Overall Findings

Based upon our findings and conclusions, the following adjustments should be made in REINSURER's favor:

Premium Audit:		
Job Classifications	$	NUMBER
Total Salary		NUMBER
Sub-Total		NUMBER
Claim Related Issues:		
Medical Bill Review		NUMBER
PPO		NUMBER
Sub-Total		NUMBER
Underwriting		NUMBER
Total	$	NUMBER

IV. Background

Assignment

RMG representatives initially met with CLIENT REPRESENTATIVE 1, CLIENT REPRESENTATIVE 2 and CLIENT REPRESENTATIVE 3 of REINSURANCE COMPANY at the REINSURER'S offices in CITY, STATE. The purpose of the meeting was to review the design of an efficient audit program for the ACCOUNT. Our assignment from CLIENT REPRESENTATIVE 1 was to review the REINSURER's BUSINESS Program at INSURANCE COMPANY Insurance Company. After an initial review of material at REINSURER's CITY, STATE office, we initially selected NUMBER Underwriting Account Files and NUMBER Claim Files for our audit. The Underwriting Files were chosen randomly, and the Claim Files were selected from a listing of losses that had pierced the REINSURER level.

Scheduling

The audit took place over one year, starting in DATE and finishing in DATE. INSURANCE COMPANY provided Claim Files, Claim Abstract Reports, Home Office Underwriting Files, and Underwriting General Correspondence Files. We were not given access to systems, and the reports and files were cumbersome. On the second day of the audit, in DATE INSURANCE COMPANY informed us that we would not be allowed to review the original Underwriting files at their agent, INSURANCE AGENCY, as was arranged prior to our audit. We were eventually allowed to see these files in June, 2005. During our review of INSURANCE AGENCY's files in DATE we were not allowed to make copies of any information. We were informed that this was the result of current litigation, purportedly due to uncollected reinsurance, between INSURANCE COMPANY Insurance Company and NYSE LISTED COMPANY, including INSURANCE AGENCY Insurance Agency and INSURANCE AGENCY's captive insurance company. As was expected, INSURANCE COMPANY would not comment on the pending litigation.

Program

The program incepted with INSURANCE COMPANY effective DATE, and REINSURER supported the program for the YEAR and YEAR underwriting years; DATE – DATE (with one account incepting DATE) and DATE – DATE. The layer of coverage provided was $AMOUNT xs $AMOUNT per occurrence applicable to the following Workers Compensation coverages:

- Accidental Death and Dismemberment
- Accidental Medical Expense
- Permanent Total Disability
- Permanent Partial Disability
- Temporary Total Disability
- Temporary Partial Disability

REINSURER's Life & Health reinsurance agreement with INSURANCE COMPANY Insurance Company excludes Employers Liability, Jones Act, War and Civil Unrest, XPL, Aircraft and Radioactive Contamination.

According to marketing material we have reviewed, INSURANCE COMPANY's BUSINESS Program provides contractors with a full line of specialized insurance coverages and services. This program was written though the INSURANCE AGENCY, which was the leading INDUSTRY contractor insurance agency. INSURANCE AGENCY is a subsidiary of NYSE LISTED COMPANY was America's largest BUSINESS. Insurance coverage is provided for workers compensation, general liability and automobile lines of business.

Persons Contacted at INSURANCE COMPANY included the following:

- CONTACT NAME - Ceded Re Accounting
- CONTACT NAME - Senior Claims Analyst
- CONTACT NAME - Claims Manager Ceded Reinsurance
- CONTACT NAME - Claims Manager
- CONTACT NAME - Underwriter
- CONTACT NAME - Ceded Re Accounting

On DATE, RMG Consulting requested additional information from INSURANCE COMPANY Insurance Company regarding REINSURER's ACCOUNT (Exhibit I). We received a partial response to that request in late DATE (Exhibit II).

IV. Premium Audit

The INDUSTRY consists of many small companies that may have limited bookkeeping resources. As a result, the INSURANCE COMPANY Claims Department often has trouble documentating the average weekly wage of its employees. Occasionally, this is because all or part of an employee's compensation is being paid "off of the books." The Underwriting files we reviewed seldom gave us a good understanding of how the Premium Audit process dealt with "off the books" payrolls. Further, at least two claimants (PERCENTAGE % of the claims reviewed) are illegal aliens:

Claim #	Claimant
CLAIM #	CLAIMANT NAME
CLAIM #	CLAIMANT NAME

While these claimants are entitled to Workers Compensation benefits, we are concerned how Premium Audit and Loss Control dealt with communicating this exposure, which has little or no premium, to INSURANCE COMPANY's Underwriters.

Also, small companies have an incentive to keep employees assigned to low risk occupation classifications, such as sales and clerical. The Workers Compensation expense for an employee coded as a BUSINESS can be PERCENTAGE of payroll. As a result, a company hiring a BUSINESS making NUMBER per year in salary would pay $AMOUNT in Workers Compensation premiums. If this individual was coded as a clerical support person, the Workers Compensation premium would only be $AMOUNT. For example, Policy # NUMBER has $AMOUNT of payroll, split by occupation as follows:

Occupation	Payroll	Dollars	Percentage
Sheet Metal	$ AMOUNT		
Carpentry	AMOUNT		
INDUSTRY	AMOUNT		
Sub-total		$ AMOUNT	PERCENTAGE
Sales	AMOUNT		
Clerical	AMOUNT		
Sub-total		AMOUNT	PERCENTAGE
		$ AMOUNT	PERCENTAGE

Sales and Clerical support for any small INDUSTRY company is seldom PERCENTAGE of the total salaries. In addition, the audit revealed a significant number of examples of sales / clerical being PERCENTAGE or more of the total salaries.

An example is POLICY # for a small INDUSTRY company that has $AMOUNT of salary, but only $AMOUNT for INDUSTRY. An allocation of just PERCENTAGE of the payroll to an INDUSTRY job code for a small INDUSTRY company is not reasonable. Additional examples are documented in the policy audit review sheets. We believe a more aggressive review would have increased overall account premiums by $AMOUNT (Exhibit III), of which $AMOUNT would have been ceded to REINSURER.

In addition, we found NUMBER accounts, PERCENTAGE of the sample, where the number of insured vehicles was not consistent with the overall final payroll reported by Premium Audit. From a practical standpoint, a company can not afford the expense associated with keeping and maintaining vehicles without appropriate revenue. In the BUSINESS Industry, most of the revenue is from services that require workers that have to be paid. As a result, there is direct correlation between the number of vehicles a company has and the number of paid workers used by that company. We believe had there been reasonable coordination between the Underwriting function and the Premium Auditors, INSURANCE COMPANY would have spotted these obvious mismatches. We believe this would have resulted in an additional overall premium of roughly a half a million; of which DOLLAR AMOUNT would have been ceded to REINSURER (Exhibit IV).

The Huffin INDUSTRY account has $AMOUNT of total payroll for thirty-two vehicles. At $7,812.50 per vehicle, we believe this payroll is highly unreasonable as the amount of money being generated by Huffin INDUSTRY is not sufficient to maintain the vehicles.

Another example of a high number of vehicles and a low premium can be found in the Pawcatuck INDUSTRY account. The payroll is listed as $AMOUNT and the number of vehicles is listed as fourteen. Again, there is a question of reasonableness because $AMOUNT payroll per vehicle is not adequate.

The INDUSTRY account has five vehicles with just $AMOUNT of payroll. We do not believe a company can exist with just $AMOUNT of payroll per vehicle.

- **Conclusion – Premium Audit**

  While INSURANCE COMPANY's Premium Audit Department did conduct final payroll reviews, the Underwriting files do not document the findings of the final audit. Further, we saw no coordination between the Claims, Underwriting and Premium Audit functions to identify high risk insureds; including accounts with illegal aliens, insureds with unusually low payroll assigned to high risk job classifications, or accounts with very low reported revenue for the number of vehicles.

  As a result, INSURANCE COMPANY did a less than adequate job of underwriting these accounts. Further, INSURANCE COMPANY insured accounts without knowing the full exposure of the account; thereby not billing or collecting the full premium that should have been charged to the account. Had the Premium Audit Department been more aggressive and had coordination existed between Claims, Underwriting and Premium Audit, INSURANCE COMPANY would have not renewed a significant number of accounts, and would have charged and received additional premium from accounts that were written.

  In total, we believe this would have added approximately $AMOUNT million of account revenue, of which PERCENTAGE or $AMOUNT thousand would have flowed to REINSURER.

<u>Overall Findings</u>

Adjustments in REINSURER's favor:

Premium Audit:

Job Classifications	$	AMOUNT
Total Salary		AMOUNT
Total	$	AMOUNT

VI. Claims

Our review of claims is divided into several sections:

- Claim Billing

On the Claim Billing information, INSURANCE COMPANY did review our concerns and has informed us that they processed AMOUNT of recoveries to REINSURER. At this point we believe this portion of the audit is almost closed. A recap of those items versus our control sheet is as follows:

Claimant	INSURANCE COMPANY	REINSURER
CLAIMANT	AMOUNT Credit	Received
CLAIMANT	AMOUNT Late Penalty Explained	Explanation Accepted
CLAIMANT	AMOUNT Credit	Credit Not Yet Received By REINSURER
CLAIMANT	AMOUNT Credit	Received
CLAIMANT	EL Charges Incorrectly Billed	Received
CLAIMANT	AMOUNT Credit	Received
CLAIMANT	AMOUNT Credit	Credit Not Yet Received By REINSURER
CLAIMANT	COMPANY NAME is a Surveillance Company	Issue Closed

- Vendor Management

Although we felt that for the most part the claim handler was involved in the critical aspects of handling a specific claim, the one area of concern was how they controlled vendors. A review of the claim file reveals that once a vendor such as NATIONAL TPA, which is a Third Party Administrator that handled claims and other services on behalf of INSURANCE COMPANY, became involved, INSURANCE COMPANY abandoned their files to this organization. This occurred even when the vendor was not communicating timely or properly with the claim handler and / or generating bills which may not have been warranted. There was very little communication between the parties in the files reviewed.

Prior to discussing various claim issues involving NATIONAL TPA, we believe it is necessary to specify that there was very little discussion between the INSURANCE COMPANY claim handler and the NATIONAL TPA representative dealing with settlements. When possible, the best way to handle a workers compensation claim is by a settlement which would reduce future indemnity, medical expense exposure, legal fees, and managed care expenses. In the claim files reviewed, we saw very little documentation of resolution plans designed to bring a claim file to closure. Further, if such a plan was not possible due to circumstances surrounding the claim or state law, we did not see any documentation in the claim or the adjuster's notes detailing the line of thinking concerning the handling of the claim files.

In the case of NATIONAL TPA, it appeared that there was more of an interest in generating billings than suggesting a course of solid claim handling which would have closed the file. This type of performance is surprising as it is my belief that the INSURANCE COMPANY claim organization recognizes the benefit of settlement.

On the Cruz claim, INSURANCE COMPANY has no documentation of attempting to determine how to bring the claim to a close, instead focusing on mitigating the claim by introducing realistic medical management. The INSURANCE COMPANY claim representative appears not to be attempting to manage legal expenses on the Caleron claim, while the Steve Smanda claim only closed when the claimant died from unrelated causes.

As a result of not developing a plan to close the files, claim fees related to Managed Care services continue to increase. Most claims organizations document the thought processes reviewed along with the plans to attempt to close a claim file quickly.

- Medical Bill Review

On the Managed Care Medical Bill Review fees, our audit revealed that INSURANCE COMPANY National Services / NATIONAL TPA was charging PERCENTAGE of "savings" versus the more common flat line charge. As this charge based on savings is significantly higher than industry standards, RMG asked INSURANCE COMPANY to research whether or not the method of charging Medical Bill Review Fees was communicated or disclosed to REINSURER. At this time, the only reference to Medical Bill Review billings occurs in INSURANCE COMPANY's Notice of Loss Statements. INSURANCE COMPANY has reviewed these statements and concluded that the misrepresentation that a flat fee arrangement was in place was accidentally inserted into the statements (Exhibit V).

From this information we came to the following conclusions: that INSURANCE COMPANY did not disclose this method of billing of a subsidiary company; INSURANCE COMPANY had available the lower and more commercially reasonable flat rate billing mechanism in place; and INSURANCE COMPANY received dividends from its subsidiary company resulting from profits from this business which were not disclosed, and nothing was communicated to REINSURER about this arrangement.

Out of $195,014.06 of billings reviewed (Exhibit VI) we found $179,990.92 of charges that we believe are in excess of industry standards. Simply put, 92 percent of the charges billed were in excess of industry standards because INSURANCE COMPANY decided to bill clients for PERCENTAGE of claimed Medical Bill Savings versus a standard flat rate line charge for each item of the bill review.

In order to ensure the fairness of our review, we used DOLLAR CHARGE per line for each item reviewed (although some companies charge as little as $ DOLLAR CHARGE per line). We also included an extra header line of $ DOLLAR CHARGE which some companies use, and we set the minimum number of lines at NUMBER per bill. These steps were undertaken to estimate very conservatively the reasonable and customary billing number that would cover INSURANCE COMPANY's cost for undertaking this activity while reducing the overall bill for excessive profit.

Insurance Companies are well aware of the extent of over billing that occurs by medical providers. As a result, no major insurance company pays a provider based upon the billed amount. Further, the industry practice is to purchase this Medical Bill Review services on a flat rate per line basis. With the percentage-of-savings approach, which is less common, the vendor is paid a portion of the total amount the medical bills have been reduced. The flat rate approach is a result of customers discovering that they were often paying very large amounts for relatively standardized services, particularly in states with low fee schedules. INSURANCE COMPANY Insurance Company is a sophisticated, experienced company, and should not be paying above market rates to an affiliated company for a standardized service they fully understand.

For your files, we also have enclosed two binders of claim information supplied by INSURANCE COMPANY Supporting their charges.

In addition to the $179,990.92 of charges that we found to be in excess of industry standards from our limited audit sample, there is almost $400,000 of other Medical Bill Review charges that we did not review. Based upon the way Medical Bill Review charges are currently calculated, we estimate that there will be at least another $AMOUNT of future Medical Bill Review charges on the remaining open claims. As a result, by the time the last claim closes on this account, total Medical Bill Review overcharges might exceed $500,000, and could be as high $700,000.

Again, our audit was confined to looking at the Underwriting and Claim files. For this reason we do not know how much money INSURANCE COMPANY Services rebated or paid as a dividend to INSURANCE COMPANY Insurance Company, which we believe is a sister company under the INSURANCE COMPANY Group, for profit from performing these Medical Bill Review services. At a later date, INSURANCE COMPANY Services was sold to Platinum Equity, and renamed NATIONAL TPA. Again, we do not know how much INSURANCE COMPANY benefited by selling a division with fixed, highly profitable contracts.

- PPO

In addition to the Medical Bill Review charges of PERCENTAGE of the projected savings, INSURANCE COMPANY is charging REINSURER PERCENTAGE of savings related to PPO Network charges. During our audit we reviewed $101,552.63 of PPO charges. Again, we believe that these charges should be a simple flat rate instead of a percentage savings calculated on each claim. These charges seem to be unjustified enrichment for supplying a standard industry service.

Had INSURANCE COMPANY used a more commercially reasonable flat fee approach to charging PPO services, we believe the ultimate charges ceded to REINSURER would have been at least $40,000 less.

- Staffing

  During our meeting with MANAGER'S NAME, who was INSURANCE COMPANY's Workers Compensation Claim Manager in DATE, we learned that there was very little oversight from INSURANCE COMPANY's Home Office after DATE, when INSURANCE COMPANY sold off the service company now known as NATIONAL TPA. Over the last year there have been some staffing changes within INSURANCE COMPANY's Home Office, including the addition of Paul Poppish as the manager. Mr. Poppish appears to be a seasoned claim professional who came to INSURANCE COMPANY from CNA. He has established a reporting structure which mandates that claims reserved at $ 2AMOUNT must be referred to INSURANCE COMPANY's Home Office. We observed recent interaction between INSURANCE COMPANY's Home Office and claim branch offices during our claim file review. As a side note, while we were in CITY, STATE in DATE, we were advised that Paul Poppish had been given new duties, and now is the executive in charge of INSURANCE COMPANY's Home Office. Unfortunately, INSURANCE COMPANY is going through continuous change based on their present financial situation. The staff must be concerned about their individual security. Such uncertainty has the potential to affect overall claim performance.

- Billing Notices

  The billing notices to REINSURER were not part of the claim file. We requested these documents, and they were provided on some files, but could not be located on all the files reviewed. We were unable to verify that the billing notices provided were the last reimbursement request submitted to REINSURER. Since the billings provided on some claims were old, we attempted to compare activity within the claim file as of the date of the billing notice, in an effort to document the validity of the reimbursement request. The amounts requested appeared to be consistent with the documents in the file.

- Reserving

  We identified several claim files which reflect "stair-stepping" of reserves, i.e. CLAIMANT VS. INSURED , CLAIMANT VS. INSURED, CLAIMANT VS. INSURED, CLAIMANT VS. INSURED, CLAIMANT VS. INSURED and CLAIMANT VS. INSURED (34208). Additionally, several files contained reserve changes which coincided with a claim payment, and failed to take into consideration the ultimate exposure of the claim, i.e. CLAIMANT VS. INSURED and CLAIMANT VS. INSURED. The trend of stair stepping reserves occurred across all the claims we reviewed.

  The reserving practices of a ceding company are critical to a reinsurer and we have concerns about INSURANCE COMPANY's overall reserving practices. REINSURER's contract requires claim reporting when the reserve reaches PERCENTAGE of the retention. Therefore, if INSURANCE COMPANY under-reserves its files on a regular basis, REINSURER would not be aware of their potential exposure on a timely basis.

- Special Claim Handling

  We were provided with special claim handling instructions on this program for two time periods: for transactions processed before DATE, and after DATE. The handling instructions for the period DATE - DATE required a formal report (REPORT NUMBER), which INSURANCE COMPANY refers to as a 'Brokers Report.' This report is submitted to the INSURANCE AGENCY every ninety days on controverted claims and/or claims reserved at $ AMOUNT or more. In addition, the INSURANCE COMPANY claim handler must obtain settlement authority from the agency on any settlements above $ AMOUNT.

  The current claim handling instructions for the period DATE, on, still requires a report to the broker every ninety days on controverted claims, but the reserve that now triggers a report is $ AMOUNT. In addition, the claim handler must now obtain settlement authority from the agency on any settlement in excess of $ AMOUNT.

  Although the claim handling instructions make no mention of any requirement for the INSURANCE COMPANY claim handler to request reserve authority in advance of posting a reserve in the system, we believe that the claim handler was requesting the agency's approval in advance. This may have contributed to the "stair stepping" of reserves. This statement is an assumption on our part, but the comments in some of the claim files seem to imply that the claim handlers are waiting for return calls from the broker.

  The DATE claim handling instructions also mandate prior approval from the broker before referring any claim to CLAIM MANAGEMENT TITLE, the INSURANCE COMPANY internal vendor network. It certainly appears that in YEAR the broker took greater control of the claim handling responsibility as their financial responsibility increased.

- Litigation Expenses

  INSURANCE COMPANY maintained an in-house counsel operation throughout the country. We reviewed many payments for litigation expenses, but saw no evidence that the claim department ever asked for litigation budgets, challenged any bills, or practiced any type of litigation management once their in-house legal staff became involved. If a claim department abandons litigation management to defense counsel, be it internal or external, the end result is usually higher litigation expenses. On the files we reviewed, the claim handler simply put the legal bills in line for payment without comment.

- **Conclusion – Claims**

  Our claim review revealed a claim organization which is being affected by the numerous changes going on within INSURANCE COMPANY. The files reflect gaps in reporting caused by staff changes, which in time will have a dramatic impact on the overall claim results.

  The vendor management issues add to REINSURER's exposure and the lack of effective control by the claim department will need to be addressed by you. In our opinion the INSURANCE COMPANY claim department relegates its responsibility whenever an internal vendor becomes involved in the claim file.

  Stair stepping of reserves is of paramount concern, as the adequacy of reserves is essential to any insurance company, and the trend within INSURANCE COMPANY to address reserves only when a particular activity occurs is not effective reserve management. There does not appear to be a specific reserve philosophy being utilized across the board within the claim department. In discussion, the INSURANCE COMPANY representatives told me that it is their reserve philosophy to reserve to the exposure, as soon as practical but we did not see this being done routinely.

  Another concern regarding reserves is an apparent reluctance on the part of the claim handler and claim management to raise reserves without first discussing the reserve with the broker. Although this is not unique within the industry, the INSURANCE COMPANY files reflect delays in establishing a proper reserve until the broker was advised, and agreed with the change. Although there was nothing in writing concerning this practice, the notes within the claim files would lead one to believe that this was an unwritten rule within the department. This delay has an impact on the reinsurer, as the reserve is one of the triggers for a report to you, and if the reserves are understated, you may never recognize your exposure until being asked to pay your portion of a loss.

Overall Findings

Adjustments in REINSURER's favor:

Claim Related Issues:

Medical Bill Review	AMOUNT
PPO	AMOUNT
Total	AMOUNT

VII. Underwriting

- **Assignment**

As stated above, REINSURER contracted RMG Consulting to review Underwriting, Claims, and Accounting documentation relative to the Workers Compensation segment of the INSURANCE COMPANY Insurance Company ACCOUNT. The reinsurance results in the program were not favorable, and REINSURER requested a review of the program to determine the possible reasons for the results experienced.

On DATE RMG representatives met with CLIENT REPRESENTATIVE 2 and CLIENT REPRESENTATIVE 3 of Exit Re at the REINSURER offices in CITY, STATE. The purpose of the meeting was to review available files associated with REINSURER's involvement with the program and to come to an understanding of what transpired from REINSURER's perspective.

The program was written through REINSURER INTERMEDIARY which had an Underwriting Management Agreement with REINSURER to manage Occupational Accident Reinsurance assumptions. The contract provided full power and authority for WRM to select, underwrite, price, negotiate, bind, and execute contracts on REINSURER's behalf. Additionally, it allowed WRM to collect and disburse sums relative to the respective contracts and to adjust and pay claims.

Other files reviewed at Ft Wayne consisted of information from REINSURER's earlier involvement with the BUSINESS program when AIG was the policy issuing carrier. This involvement was for the policy year preceding INSURANCE COMPANY's involvement. Information in this file reflected REINSURER INTERMEDIARY experiencing difficulty in dealing with INSURANCE COMPANY over accounting and reporting issues and resulted in REINSURER INTERMEDIARY terminating the reinsurance through REINSURER.

INSURANCE COMPANY replaced INSURANCE COMPANY as the policy issuing carrier for the program and REINSURER INTERMEDIARY files reviewed generally consisted of information relating to accounting and reconciliation issues for premiums and losses during the YEAR and YEAR policy years. REINSURER INTERMEDIARY underwriting information relative to negotiations for pricing and structure of the reinsurance cover was not included in the material available for review.

The files reviewed contained an underwriting guideline document for the ACCOUNT which was marked with a INSURANCE COMPANY logo. Details of this guideline are elaborated on later in this report.

Based on further discussions with CLIENT REPRESENTATIVE 1, CLIENT REPRESENTATIVE 2 and CLIENT REPRESENTATIVE 3, RMG was directed to concentrate its review activities on the INSURANCE COMPANY involvement time frame and specifically on the YEAR and YEAR treaty underwriting years of the program. RMG submitted a work plan to conduct an audit review of claim files, underwriting files, and accounting records relative to the program at either the offices of INSURANCE COMPANY Insurance or the INSURANCE AGENCY, the producer of the program business.

From a bordereaux of the BUSINESS ACCOUNT POLICIES with inception dates between DATE and DATE a list of NUMBER policies/underwriting files were selected and requested to be reviewed. These NUMBER files represented NUMBER unique accounts. The selected policies were chosen randomly and were not influenced by size or type of claims. The selection reflected both large and small premium accounts as well as a spread of geographic locations and included renewals.

The review was scheduled to be conducted at the INSURANCE COMPANY Insurance offices in CITY, STATE, Illinois during the week of DATE.

- **Initial Meeting at INSURANCE COMPANY**

Persons Contacted:

1. CONTACT NAME - Ceded Re Accounting
2. CONTACT NAME - Senior Claims Analyst
3. CONTACT NAME - Claims Manager Ceded Reinsurance
4. CONTACT NAME - Claims Manager
5. CONTACT NAME - Underwriter
6. CONTACT NAME - Ceded Re Accounting

The INSURANCE COMPANY organization has been in run off since DATE and staff and resources were extremely limited at this time. Staff members are gradually released as their respective areas are either sold, run off is completed, or as business is consolidated. Except for Rita Borcherding the above list of people were relatively new to the INSURANCE COMPANY organization and did not have a specific perspective on INSURANCE COMPANY's involvement in the BUSINESS program. INSURANCE EMPLOYEE NAME was a TIMEFRAME year INSURANCE COMPANY employee and was involved in oversight of the underwriting of the BUSINESS Program.

During the initial meeting the INSURANCE COMPANY staff was cordial toward the RMG representatives. The INSURANCE COMPANY representatives explained their respective roles and set up some general guidelines as to how RMG might request additional information or obtain copies of reviewed information. RMG did not have access to a copier.

RMG had the opportunity to explain respective roles, and a discussion ensued about the program and the issues RMG was interested in pursuing for the audit. RMG was scheduled to have the opportunity to visit the INSURANCE AGENCY offices for two days to review files in that location if deemed necessary.

- **Guidelines for the Program**

The underwriting information received for the ACCOUNT was limited, and the guidelines obtained for review of the program were very general. Targeted business was not well defined. Guidelines were not specific regarding criteria for residential vs. commercial BUSINESS, large premium accounts vs. small, payroll size, or restrictions related to operating above certain number of floors.

Business was to be produced by the INSURANCE AGENCY, a subsidiary of the NYSE LISTED COMPANY. NYSE LISTED COMPANY is a nationwide INDUSTRY supply firm whose customer base was a significant potential source of accounts for the ACCOUNT.

RMG obtained two versions of Guidelines. One copy was obtained from REINSURER files and was viewed as being more restrictive than the second copy obtained through INSURANCE COMPANY from the YEAR Sedgwick Re submission for the program.

The REINSURER file copy contained some specified criteria relating to the use of certain policy issuing carriers due to risk location, loss ratio, accounts with less than three years of experience, premium levels and more specific loss ratios for WC only. This copy was not dated or identified with any specific underwriting year. However, since it came from REINSURER files it was presumed to be applicable for the YEAR and YEAR underwriting years (years REINSURER reinsured the program).

Salient points of the guidelines were as follows:

1. The program is for General Liability, Automobile, and Workers Compensation coverage for contractors in the INDUSTRY and related trades.
2. Pricing on an overall account basis subject to an account minimum premium of $AMOUNT annually. All lines should be attempted to be written and must at least write the Workers Compensation and General liability.
3. Account Loss Ratio must not exceed PERCENTAGE
4. Complete Accord or BUSINESS ACCOUNT NAME Application.
5. Currently valued loss reports for the past three years, not including current policy period.
6. Maximum credits and deviated rates for information purposes as follows:
    - Approved filed rates by state applying no more than PERCENTAGE schedule credit for accounts with a loss ratio under PERCENTAGE.
    - If additional schedule credit or deviated rate is required, then the account is submitted to insurance company underwriting for approval.
    - If located in California, Delaware and Hawaii can only be rated in INSURANCE COMPANY *.
    - If there is less than three years of experience only INSURANCE COMPANY * can be used.
    - If there is over three years experience, a loss ratio below PERCENTAGE and standard premium over $AMOUNT, either INSURANCE COMPANY *, INSURANCE COMPANY * may be used.
    - If over three years of experience, a loss ratio below PERCENTAGE, INSURANCE COMPANY *, INSURANCE COMPANY *, or INSURANCE COMPANY *may be used. Standard premium must be over $AMOUNT to use INSURANCE COMPANY *.
    - For renewals use approved filed rates using the same as expiring schedule credit as long as the loss ratio remains under PERCENTAGE.
    - Also for renewals, if any changes are required to the schedule or need to use deviated rates when previously not used or the loss ratio is over PERCENTAGE then submit to insurance company underwriting.

*

INSURANCE COMPANY	INSURANCE COMPANY
INSURANCE COMPANY	INSURANCE COMPANY
INSURANCE COMPANY	INSURANCE COMPANY
INSURANCE COMPANY	INSURANCE COMPANY

The Guidelines provided by INSURANCE COMPANY for the YEAR program submission through Sedgwick Re referenced guidelines allowing a schedule credit of no more than PERCENTAGE with a loss ratio less than PERCENTAGE without additional approval. Also, the INSURANCE COMPANY provided guidelines did not contain the specific references for using certain INSURANCE COMPANY Group companies depending on location and loss ratio history.

The YEAR Guideline/Renewal binder received from INSURANCE COMPANY contained additional information for Claims and Loss Control Service specifications. Monthly loss reports were to be generated for each account regardless of the activity. Loss control was to be initiated within NUMBER days of binding with the loss control visit completed within NUMBER days of binding, and the report received within NUMBER days from the visit. Quarterly claim and loss control reviews were part of the program for discussion of trends and preventive measures that should be taken.

The differences in guidelines peaked curiosity. During an exchange of questions regarding the underwriting and pricing of the program, we attempted to obtain more information about the guidelines used, and if there were any changes to these guidelines over time. We also questioned whether or not there were any understandings or agreements between WRM, INSURANCE COMPANY and INSURANCE AGENCY over the underwriting management of the program which were not formally documented. INSURANCE COMPANY indicated that the guidelines as presented in the YEAR Sedgwick Re presentation were in place for the entire timeframe of INSURANCE COMPANY's involvement.

Additionally, we were interested in INSURANCE COMPANY's underwriting oversight of INSURANCE AGENCY and the rationale behind the selection of and the differences between carriers used for the WC policies. INSURANCE COMPANY listed four potential carriers whose paper could be used, and all four were utilized for the program.

Following this exchange in DATE, INSURANCE COMPANY staff convened to discuss the information we requested. They subsequently returned to advise that the scope of the RMG audit/review was beyond the scope of their expectations and understanding and that the rules had changed. They specified that RMG was not going to be allowed to visit and review files from the INSURANCE AGENCY and all requested information and questions had to be written and presented to "higher ups" (not identified) for approval and response. The INSURANCE COMPANY staff remained cordial and cooperative. However, the new guidelines made the review more cumbersome. As discussed in detail later in this report, we were eventually allowed to see the INSURANCE COMPANY A Underwriting / Marketing files in DATE.

During our DATE meeting, Rita Borcherding confirmed that INSURANCE COMPANY was using four companies as policy issuing carriers for the program. This was due to different rate filings and deviations and INSURANCE COMPANY's perception of some states being more difficult Workers Compensation environments. She cited California as an example where they would try to use the higher rated filing. The various rate filings provided INSURANCE COMPANY latitude in pricing their business.

Per NAME, the issuing companies had the following rate filings for WC:

INSURANCE COMPANY	Bureau Rate Levels
INSURANCE COMPANY	Bureau Rate Levels
INSURANCE COMPANY	Deviations of PERCENTAGE or PERCENTAGE on Bureau Rates
INSURANCE COMPANY	Deviations of PERCENTAGE to PERCENTAGE on Bureau Rates

- **File Review**

The file review, although not originally planned this way, was conducted in three stages. The additional stages were thought to be appropriate to provide a complete picture of information gathering and underwriting analysis associated with the subject business from both the INSURANCE COMPANY perspective and INSURANCE AGENCY.

Stage 1- DATE at INSURANCE COMPANY – CITY, STATE
Stage 2- DATE at Law Offices and INSURANCE AGENCY
Stage 3- DATE at INSURANCE COMPANY- CITY, STATE

Stage 1

Underwriting files provided by INSURANCE COMPANY consisted of two types: Policy Files and General Correspondence Files. Overall NUMBER files were reviewed.

INSURANCE COMPANY set up separate policy files for each risk and for each policy year for each class of business written in the BUSINESS program. The files selected and reviewed represented only WC policy files. Each policy file contained a copy of the Declaration page and attendant exclusions and endorsements. The Dec page also included a summary of the premium charged by application of the WC rate to the payroll by respective class and demonstrated the application of an experience mod, scheduled credits/debits and other adjustments to correspond to the Declaration page premium.

The General Correspondence (GC) files were described by INSURANCE COMPANY EMPLOYEE NAME as most likely containing sufficient underwriting information to satisfy the curiosity of the RMG review.

The GC files were found to be more voluminous, as they contained information for all lines written for the account, i.e., WC, AL and GL, and the files were cumulative repositories for all years' activity. The GC files were supposed to be arranged in chronological order which was not always the case. The files were not partitioned by the respective line of business nor for the underwriting information contained within and this lengthened the time to review the material. Additionally, policy files and GC files were not always together in boxes and that created a need to conduct searches to locate the companion files.

The GC files typically would contain copies of WC experience mod documentation, pricing worksheets, quoting presentations, binding orders, coding worksheets, applications, occasional loss control reports, some prior carrier loss information, premium audit summaries, general correspondence and loss summary worksheets.

Loss Summary worksheets were forms designed to capture and update prior years' premium and loss information and to calculate loss ratios by line of business and for the total account. These worksheets were considered to be an important document for the risk selection process and for the granting of schedule credits used for pricing determination. The information was to be developed from prior carrier loss reports representing at least three underwriting years of paid and outstanding loss information and not including the most recent year. The most recent year is generally deemed to be too immature for consideration and also is probably not a complete year of activity.

Calculated loss ratios were important and common to both sets of guidelines as they were one of the key determining factors for the accounts' acceptability and for the extent of schedule credits used. One set of guidelines stipulated using loss ratios to determine the selection of the issuing carrier.

The loss summary worksheets were not always in the file, and they were not always complete as either premium or updated loss information was missing. Therefore, it was not always possible to calculate a ratio for determining the accounts' initial and continuing acceptability in addition to providing justification for the extent of schedule credit usage in pricing determination.

In retrospect, the GC files reviewed represented a INSURANCE COMPANY Home office file and served as a repository of information conveyed to INSURANCE COMPANY to set up coding sheets for processing of business. While underwriting information was present, a key missing element was the underwriter's documentation of thought process in the selection, acceptance, and negotiations of risk acceptance. Some correspondence in the claim files hinted of referral to management about key issues. However, the Underwriting files did not appear to reflect a great degree of oversight and control by INSURANCE COMPANY.

Stage 2

After communicating that initial files reviewed at INSURANCE COMPANY - CITY, STATE were essentially Home office files and did not contain all the essential underwriting information, INSURANCE COMPANY arranged an additional review to provide the documentation sought that perhaps was missed in the Stage 1 review. The files were reviewed by INSURANCE COMPANY CONSULTANT and INSURANCE COMPANY EMPLOYEE NAME of INSURANCE COMPANY and they confirmed that the files should contain the information we originally expected to see. The extra review of INSURANCE COMPANY files was conducted at the offices of LAW OFFICE. Files were at that location due to potential arbitration by INSURANCE COMPANY vs. INSURANCE AGENCY. All the files were not available and RMG Consultants scheduled Stage 3 at the INSURANCE COMPANY - CITY, STATE facility.

Additionally we had the opportunity to review the files of the INSURANCE AGENCY at their offices in CITY, STATE. The Agency files consisted of Policy Files and Marketing Files. Similar to INSURANCE COMPANY, the Policy Files contained declaration pages and endorsements. The marketing file contained communications to INSURANCE COMPANY and the insured and essentially served as a transmittal file for the underwriting information compiled.

Stage 3

This review activity was a two day return to CITY, STATE to review the files that were not previously available to review at LAW OFFICE.

Prudent Underwriting Practices

With the limited guidelines in place for this program we decided to review the files based on what the usual and customary prudent underwriting practices should be considered and evaluated for underwriting the WC exposure for this class of business. The following are many that should apply to this line of business, and why they are important for an underwriter to consider.

Receive completed and signed applications annually.

Signed and completed applications are an essential first step in the underwriting process for any class of business. Complete information allows the underwriter to gain an understanding of the risk to be considered as well as data to price for the exposures. Without completed application information underwriters should refer the application back to the agent/insured for completion. Otherwise they are committing to risk assumption without understanding the risk. We did not see any referrals back to the agent for completion issues, clarification, or challenges of information issues in the files. If this data was obtained over the telephone or through other means it was not documented in the file.

Information typically gleaned from the completed application includes the following:

-The number of years in business provides the underwriter with an indication of the experience level of the insured.
-The payroll by job class provides the description of the operations of the insured and serves as the basis for pricing the account. Accurate payroll is important for account experience as well as for eliminating potential collection issues on future premium audits.
-Prior carrier premium and loss information provides data on historical experience and provides the underwriter with an opportunity to question the experience for identifying any large losses or trends. Prior carrier loss data should be updated for the time frames involved in the review process as case values may change over time and alter the risk eligibility.
-The presence of inconsistent markets for an account provides a clue that the risk may shop its coverage or have trouble with renewals because of experience or credit issues.
-Signed applications by the insured and the agent are important as the document provides representation that the information is portrayed accurately. We did not see very many instances where the application was signed by the insured or the agent. On a number of instances the agency's name was typed in the signing location which is not considered a signature.
-The application also provides information regarding coverage for owners/principals. It is important to complete this section as it can eliminate potential issues at audit time regarding accurate payrolls and whether or not losses are to be covered for the principals.
-The questionnaire section should also be completed as it provides additional information about contractors operations and business practices which can have an impact on the exposure being considered.
-Applications should be received annually especially for risks with variable payroll exposures which can change from year to year. It is important for the underwriter to review annual changes and discrepancies and question the data. Information should be reviewed for reasonableness, and underwriters should raise questions wherever appropriate. We did not see evidence of notes or correspondence in files to reflect any questions raised by the underwriting personnel at INSURANCE COMPANY. Payroll information from the application was accepted without challenge and later used for pricing the account.

Loss control should be ordered and reviewed on a consistent basis for this class of business.

The A.M. Best underwriting reference guide classifies the Workers Compensation exposure for INDUSTRY Contractors as very high hazard risk business, and injuries can be frequent and severe. Based on this, loss control should be evaluated timely on each risk and recommendations should be followed up on for compliance.

The underwriting guidelines for the YEAR underwriting year clearly specified a requirement for loss control on each risk and follow up within defined time lines. Based on INSURANCE COMPANY's representation we believe loss control was to be conducted on risks subject to the YEAR and YEAR underwriting year programs as well. However, the file review did not reflect a consistent practice in this area. Few loss control reports were found in file, and this prompted the question as to the possibility of reports being filed in another location or possibly on-line. We were not able to obtain a satisfactory explanation for the lack of loss control reports.

Loss control reports are prepared for the underwriter's review and evaluation and provide for the identification of risks that do not meet satisfactory levels of risk management and safety precautions. Underwriters should be made aware of hazardous conditions in addition to assessing the insured's progress in making corrections to the reported unsatisfactory situations. If progress in compliance is not made, underwriters should make appropriate decisions regarding the continuance of the account or justifying the scheduled mod.

Of the files reviewed there were few instances of loss control conducted, and in those instances we did not see any documentation from the Underwriter regarding the acknowledgement of the report nor of the conditions described.

Supplemental Applications or Supplemental Questionnaires are oftentimes used for hazardous classes to gain a better insight of the risk's operations.

In addition to the standard Accord Application, the ACCOUNT had a supplemental application which provided the opportunity to collect more detail about the description of operations and exposure, i.e. percent of INDUSTRY projects being residential or commercial; height of the projects; materials used, etc.

Diligent use of this form with the information potential it presents would allow the underwriter the opportunity to identify more or less hazardous risks, challenge, where appropriate, the extent of schedule credits requested by the producer, or serve as justification for the use of the credit or debit selected.

The supplemental was not universally located in files, and when used it was not often completed. There didn't seem to be any pattern for using the document in conjunction with the Accord Application and the existence of it, and the additional information provided did not elicit any comments or documentation from underwriters in the course of the risks evaluation.

Experience Mod Documentation

Experience Mod documentation from either the NCCI or the specific state WC rating bureau should be found in files to document prior experience of the account and to substantiate rating factors used in the pricing of each account.

The GC files reviewed typically contained Experience Mod Documentation from either the NCCI or a specific state Workers Compensation rating agency. This document was seen consistently in files and was updated annually to reflect changing trends in experience.

Schedule Credit/Debit documentation

With programs containing a scheduled credit/debit feature in the rating process, underwriters have the ability to effect pricing changes to reflect positive and/or negative risk characteristics. The extent of these modifications is typically expressed as a +/- percentage range subject to a maximum and minimum percentage. Also, the range is usually constructed with increments of PERCENTAGE - PERCENTAGE % for each characteristic.

For example, a positive risk characteristic for a report might be good loss control conditions or responsible and experienced management in dealing with safety issues. Conversely, a negative characteristic might be inexperienced management or a company without a formal safety training program. Underwriters can use this information to credit or debit pricing to reflect exposed characteristics of the risk and price their product to reflect the exposure presented.

When the underwriter utilizes the credit or debit mechanism the practice is to document the rationale behind the pricing movement particularly for credits and especially for substantial credits.

In the GC files reviewed there was little if any documentation of the Underwriters input in using the credits. Most files contained a credit and with the extent of some crediting reaching as much as PERCENTAGE, we believe it to be an essential practice to document the explanation of the justification and magnitude. This program's maximum credit stipulated in the guidelines was PERCENTAGE unless a referral was made to underwriting. Prudent underwriting dictates documentation for allowing any credit or charging for any debit associated with the risk.

Correspondence was found in files from the producer who requested the credit and was typically phrased as "we need this credit to compete for the account". The underwriter should automatically question why the account deserved the credit or what risk characteristics warranted the credit.

The following accounts are examples of high, undocumented schedule credits being applied without rationale in evidence:

ACCOUNT NAME
ACCOUNT NAME
ACCOUNT NAME
ACCOUNT NAME
ACCOUNT NAME

Prior carrier premium and loss information including annual updates

This information is typically a required data element on the Accord Application as well as on Supplemental questionnaires. This information is important because it provides the Underwriter with an indication of the prior experience from the insured's activity. Since the information is requested from the prior carrier, it is theoretically an objective assessment of the loss activity from the prior risk taker and not from the agent or the insured. The information from the carrier is typically presented by underwriting year and provides some detail by claim. This data can be used by the prospective underwriting entity to review the frequency and severity of loss activity of the account and make appropriate underwriting decisions. The prospective underwriter also can question the agent or the insured about certain information to gain an understanding about safety issues and the potential of the prior loss activity being replicated.

Obtaining prior carrier premium and loss information should have been a critical element of this program because of the requirement to determine a three year loss ratio for the account. In our file review we often found that the prior carrier loss information or sufficient information to populate data for the loss summary worksheet was missing. GC files sometimes contained prior carrier loss information from the carrier and sometimes the loss summaries contained loss data from the application without prior carrier verification.

The loss ratio calculations were not always completed due to either not capturing premium from prior years or in some cases capturing premium and no losses. Since the loss ratio calculation is a key to the program it should be present for all new business files and with updated premium and loss data for renewal files.

Additionally, we did not see efforts by underwriters or staff to follow up on the missing data.

The following are examples of accounts where loss ratio calculations were incomplete or not computed:

ACCOUNT NAME
ACCOUNT NAME
ACCOUNT NAME
ACCOUNT NAME
ACCOUNT NAME

Premium Rating Worksheets

Underwriting files should contain worksheets documenting how pricing was determined for the risk. In the Workers Compensation line of business premium rating worksheets typically contain filed rates by classification, payroll by classification, class codes, experience modification factors, schedule credits, debits, and any other premium adjustments including deductible credits, premium volume discounts to the pricing.

INSURANCE COMPANY had a proprietary rating system, referred to as the Compass system, which included the elements described above. The computer printout was a logical document whose information was conveyed to INSURANCE AGENCY for communication of quote proposals to client insureds. INSURANCE AGENCY would typically summarize much of the information and include it within their proposals. We were told that the system's output was controlled by INSURANCE COMPANY underwriters and support staff for the YEAR and YEAR underwriting years of the program. Any revisions to quotes had to be made through INSURANCE COMPANY, and a revised premium rating worksheet was produced with information conveyed.

The process flow between INSURANCE AGENCY and INSURANCE COMPANY as explained to us was that INSURANCE COMPANY provided pricing in response to quote requests from INSURANCE AGENCY. The requests included some basic application information and sometimes with instructions of what Company filing to use and the credit to use that was necessary to write the account. INSURANCE COMPANY complied with requests, and we did not see any requests in YEAR and YEAR Underwriting Years challenged by INSURANCE COMPANY underwriters despite requests for credits significantly greater than PERCENTAGE or accounts with obvious prior loss issues.

Our understanding is that in subsequent years INSURANCE AGENCY Underwriters, Inc. was allowed access to the Compass System and had the ability to quote business for the program.

Underwriting Checklist

Companies often develop a checklist of the items of information required for the underwriting evaluation process as well as the steps to be taken during the process. A check off list would remind the underwriter or assistant that loss runs needed to be obtained or that loss summaries needed completion, etc. INSURANCE COMPANY created a form which appeared to be complete. However, its presence and usage in the files was not consistent. Having this in place and utilized consistently would have provided a reminder to collect all essential data for evaluation and decision making.

Underwriting Thought Process Documentation

Notes in file from the underwriter to document the rationale behind decisions in underwriting and negotiation of binding a risk are important for file completion. On risks such as those presented in the BUSINESS program where premium levels can be large and crediting accounts beyond guideline parameters appears prevalent, it is necessary for the underwriter to provide a trail of what considerations were included within the decision process.

Underwriters should record why decisions were reached particularly if risks were bound without proper documentation of premium and loss data. Also, they should record why risks were written with substantial crediting when supporting data was not present or when the producer requested using a lower rated carrier filing and/or with a substantial premium credit. Documentation should reflect what was questioned and what the underwriter's thoughts were as respects loss control information, either positive or negative.

Notes actually found in files were of the instructional variety. For example, the underwriter instructed the assistant to price the risk using a specific company filing or to re-price the risk with a revised schedule credit. Outside of following directions from INSURANCE AGENCY we did not see notes as to why the instructions were given or the thought process and rationale behind the instructions. It would have been helpful to see comments such as good experience, good loss control, responsible management or some analysis concluding justification of a decision. Documentation or referral to INSURANCE COMPANY underwriting supervisory personnel was not evident in files. Further, we did not see any documentation of INSURANCE COMPANY self audits in the files reviewed.

- **Conclusions - Underwriting**

The conclusions below are based on a review of NUMBER Account files including new and renewal Workers Compensation business of the ACCOUNT produced by INSURANCE AGENCY and underwritten by INSURANCE COMPANY Insurance Group. In an effort to review all possible information, the cumulative subject files of INSURANCE COMPANY and the INSURANCE AGENCY were reviewed and taken into consideration.

Information in files presented a picture of considerable crediting of premium. This served to reduce the premium base to which the reinsurance rates for the program are applied to compute the ceded premium for the reinsurance coverage. The extent of the crediting contributed to a shortfall in reinsurance premium available to cover the reinsurance losses to the program.

This crediting arose from the scheduled credits taken and also in combination with using certain company filings which allowed deviations in pricing from bureau rate filings. The review found examples where specific schedule credits taken amounted to as much as PERCENTAGE. The application of a credit after an experience modification and also after using a deviated rate from one of the INSURANCE COMPANY filings can erode a considerable amount of the premium for the exposure.

The justification of risk selection and the extent of crediting are key issues since both are contingent on loss ratio data, complete information, and confirmation of risk acceptability through loss control inspections. Many of the files reviewed were incomplete with respect to a combination of either the application information or prior carrier premium and loss data which raises the question of why risks were written without full information and why they were granted significant premium credits.

In the absence of seeing any agreements documenting changes regarding guidelines and expectations between INSURANCE COMPANY and INSURANCE AGENCY it appears business was written without full information and this is not considered a prudent practice. Based upon the policies randomly selected for the audit, had INSURANCE COMPANY questioned the significant, undocumented scheduled credits requested by INSURANCE AGENCY, we believe premiums would have been roughly 56 percent higher (Exhibit VII). We arrive at our estimate by backing out all undocumented scheduled premium credits which were revealed by our audit. Our premium estimates did not differ from INSURANCE COMPANY's premiums if we found a documented reason for the premium credit. Also, we did not adjust the premium if an account had no scheduled premium credits. Our calculations are done by account, by year based upon the information we found in the physical policy file.

Simply put, if an account had a AMOUNT premium with an undocumented credit of PERCENTAGE, the account premium would have been $ AMOUNT, of which REINSURER would have received PERCENTAGE, or $ AMOUNT. However, if prudent underwriting practices were used, premium would not have been $ AMOUNT In other words, premium would have been PERCENTAGE higher, or AMOUNT; of which REINSURER would have received $ AMOUNT.

Our understanding is that REINSURER received PERCENTAGE of account premium of AMOUNT (Exhibit VIII), which equates to $ AMOUNT. Had prudent underwriting practices been used, INSURANCE COMPANY would have received additional premium of PERCENTAGE. Of this amount, REINSURER would have received approximately $1.6 million in additional ceded premium. Alternatively, we believe a significant number of accounts would not have been written, and therefore, claims on the ACCOUNT would have been significantly reduced.

Our calculations follow:

Account Premium	AMOUNT
Percentage Ceded to REINSURER	PERCENTAGE
Premium Ceded to REINSURER	AMOUNT
Adjusted Premium Percentage	PERCENTAGE
Additional Premium REINSURER should have Received	$ AMOUNT

Despite INSURANCE COMPANY's role as the underwriting entity controlling risk acceptance and issuance of final pricing, documentation of the rationale and the decision process was not in evidence in the files reviewed. It appears the Agency was driving the decisions and not the underwriting entity.

The possibility exists there are additional guidelines or even letters of understanding that may be more specific as to expected practices for underwriting the program. If any existed, no one we met at INSURANCE COMPANY seemed to be aware of their existence or could explain the exhibited management of the business during the subject underwriting years.

On the question of INSURANCE COMPANY oversight, Rita Borcherding indicated INSURANCE COMPANY did not have a formal periodic process to review and issue a report on underwriting activities at INSURANCE AGENCY. She informed us that INSURANCE COMPANY underwriters visited INSURANCE AGENCY monthly to respond to underwriting issues and would then call in with verbal reports of their activities. She did not recall written reports or documentation being compiled.

<u>Overall Findings</u>

Adjustments in REINSURER's favor:

Underwriting	AMOUNT

- **Other Issues**

INSURANCE COMPANY's risk retention/commitment and program structure.

During conversations with INSURANCE COMPANY staff, information was revealed which indicated INSURANCE COMPANY did not completely retain the full first $AMOUNT per occurrence for either of the YEAR, YEAR or YEAR policy year. Rita Borcherding provided a schedule (Exhibit IX) of the structure and the respective years participations in the program.

For YEAR, INSURANCE COMPANY and a Captive insurer associated with the INSURANCE AGENCY shared on a PERCENTAGE/PERCENTAGE quota share basis the first $AMOUNT per occurrence. In YEAR the percentage changed and INSURANCE COMPANY's share was PERCENTAGE of $AMOUNT. In YEAR the retention of $AMOUNT was shared between the same captive and another carrier who was not identified. INSURANCE COMPANY came back into the program in the YEAR year for statutory amounts above the net and treaty retention of AMOUNT, per occurrence.

Without having the submission for the YEAR or the YEAR underwriting years it is not known if INSURANCE COMPANY's taking less than the full retention was represented to WRM and REINSURER prior to committing support to the program. It is not reflected in either the YEAR Agreement wording or the YEAR and YEAR Placement Slips.