

#### Reinsurance Administration Professionals Association

#### Data Committee

#### *presents*

Reinsurance Reporting Guidelines and best practices

**DOCUMENT INFORMATION**

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**INTRODUCTION**

Introduction

“**Reinsurance Reporting Guidelines and Best Practices**” is meant to serve as a guide for best practices in reinsurance administration and reporting. It covers topics such as treaty implementation, overall data quality guidelines, and accurate reporting of conversions/continuations among other topics. It also contains usable templates to assist in reporting and a form that can be used to communicate reporting changes to your business partners.

This document was created through a collaborative effort of industry experts from all areas of the industry representing various companies. This group plans on continually updating this document and welcomes any feedback and ideas. Please contact any of the leaders of the Reinsurance Administration Professionals Association (RAPA) listed on the web site, <http://www.reinsadmin.org/> or the contributors below.

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**TREATY**

Treaty Implementation Workflow

## Introduction

This guide provides a best practice workflow process for taking a treaty from paper through to system implementation. It outlines examples of information captured in internal systems upon issuance of a Letter Of Intent (LOI) and lists the data fields that are updated once the actual treaty is executed.

## Purpose

* Provide process guidelines when implementing negotiated terms in to the system (see ***Workflow***)
* Provide a check list of information that a Ceding Company, Reinsurer and Retrocessionaire would capture and validate on internal systems (see ***Appendix 1***)
* Illustrate a workflow chart for treaty implementation (see ***Appendix 2***)

## Workflow

### Initial Assessment

🞎 1. The department that is accountable for setting up a treaty on the system would obtain a copy of signed LOI.

🞎 2a. Review to see if any questions need to be addressed by the appropriate risk management/pricing or other departments accountable for negotiation of the treaties.

🞎 2b. Review and discuss with Operations and IT to determine if there are any system modifications required to administer the terms.

🞎 3. Once all questions are answered, determine the treaty naming convention in the system.

### Treaty Setup in Non-Production

🞎 4. Create the treaty terms in a non-Production environment based upon the information in the LOI and any other information received from the appropriate risk management team.

At time of LOI from a Ceding Company’s perspective, and from a Reinsurer’s/Retrocessionaire’s perspective, please see *Appendix 1* for the required fields to be captured within the system.

🞎 5. Perform an *independent review* to make sure that the treaty setup in the system reflects the LOI. This task should be performed by someone other than the person(s) who set up the treaty in step 4. If the review results in the discovery of differences, step 4 should be repeated until the independent review provides the required sign off.

### Treaty Setup in Production

🞎 6. Create the treaty terms in the production environment.

🞎 7. Perform an *independent review* to make sure that the treaty setup in the system reflects LOI. This task should be performed by someone other than the person(s) who set up the treaty in step 6. If the review results in the discovery of differences, the process should be repeated from step 4 (optional) or from step 6 until the independent review provides the required sign off.

### Documentation & Business Partner Communication

🞎 8. Create procedures manual for administration and other internal parties that require the information.

🞎 9. Create Implementation notice with customized reinsurer information, for the reinsurance partner.

Note: For sharing such information, we recommend use of RAPA’s published document "Communicating System Data or Administrative changes to Business Partners” available within this document and on RAPA’s website.

### Treaty Signoff

🞎 10. A final signed treaty is received.

🞎 11. Compare terms of the signed treaty with the treaty that was previous set up in the system. If there are differences, the process should be repeated from step 4 (optional) or from step 6 until all differences are cleared. This process may require additional discussions with various parties that were involved in the negotiations.

At time of “signed Treaty” from a Ceding Company’s perspective, and from a Reinsurer’s / Retrocessionaire’s perspective, please see ***Appendix 1*** for the required fields to be captured within the system.

### System Changes

🞎 12. If system changes are required, continue to next step, else go to step 19.

🞎 13. Perform system changes in a non-Production environment. Follow IT process specific to your company (It may be optional in some companies to implement and test system changes in a non-Production environment).

🞎 14. Review and sign off system changes made in step 13 in a non-Production environment. If the review results in the discovery of issues, the process should be repeated from step 13 until sign off.

🞎 15. Determine if any historical information (billing or other transactions) is required to be updated or corrected to reflect the changes. If historical information is required to be adjusted continue to next step, else go to step 17.

🞎 16. Provide estimates of any financial adjustments to Reinsurers and others applicable business partners.

Note: For sharing such information, we recommend use of RAPA’s published document "Communicating System Data or Administrative changes to Business Partners” available within this document and on RAPA’s website.

🞎 17. Implement system changes in the Production environment.

🞎 18. Review and sign off system changes made in step 17 in the Production environment. If the review results in the discovery of issues, the process should be repeated from step 13 (optional) or from step 17 until sign off.

### Peer Review & Business Partner Communication

🞎 19. Perform an independent peer review of the treaty. This task should be performed by someone other than the person(s) who performed treaty setup or independent reviews on this treaty. If issues are identified, the process may have to be repeated from one of the prior steps depending on the magnitude of the issue.

🞎 20. Provide actuals of any financial adjustments to Reinsurers and other applicable business partners.

Note: For sharing such information, we recommend use of RAPA’s published document "Communicating System Data or Administrative changes to Business Partners” available within this document and on RAPA’s website.

### Business as usual

* 21. Perform normal administration of treaty.

### Periodic Audit

🞎 22. Every one to two years, perform internal audit of the treaty setup to ensure the business being processed conforms to the treaty terms.

## Appendix 1 – List of Treaty Elements



## Appendix 2 – Treaty Implementation Workflow (Flowchart)



**SYSTEM**

Communicating New System, Data, or Administration

## Introduction

These guides were created as references for initial communication of seriatim data and summary reporting to your business partners. Examples of applicable uses of this form include, but are not limited to, reporting of inforce, transactional, policy exhibit, premium, reserve, and claims data in recommended file layouts. Key elements are fields such as treaty codes, plan codes, residence codes, claims reasons and underwriting preferred classifications.

## Purpose

Data reporting and financial reporting are key to the proper administration of life insurance business being ceded to a business partner. These guidelines will help you get started, help eliminate questions and make the overall process more efficient. Even with an effective administration and reporting process, a review of the reporting examples may help with the understanding of the key elements in monthly and quarterly reporting. The goal for you and your business partners is to be able to manage business quickly, accurately and consistently.

Several relevant areas are addressed as listed below. Please see below attachment for additional details.

* Inforce and Transactional data
* Policy Exhibit and Premium data
* Plan Code Notification template
* Underwriting Preferred Classification
* Residency Code
* Claims Reporting Guidelines
* Reserves
* Processing Information

## Appendix 1 – Communicating New System, Data, or Administration to Business Partners



Communicating Changes to System, Data or Administration

## Introduction

As system changes and modifications are made, it is imperative that communication between a Ceding Company and a Reinsurer, or a Reinsurer to a Retrocessionaire be maintained through the entire process. Lack of communication can cause errors in downstream processing and inefficiencies for all parties involved. It is important to have this open communication with all business partners. These forms provide an efficient means for communicating pertinent information to all involved.

## Purpose

The attached forms identify items to address between the business partners, such as:

* The scope of the change being addressed
* The relevant fields and files being changed
* Specific procedure changes that may result from the changes

## Appendix 1 – Communicating general changes to Systems, Data or Administration



## Appendix 2 – Notifications of Recaptures



## Appendix 3 – E&O and Late Reported Notifications



## Appendix 4 – Data Clean Up Notifications



## Appendix 5 – Changes in Billing Method Notifications



## Appendix 6 – Acquisition Notifications



## Appendix 7 – Name Change Notifications



## Appendix 8 – Disbursement and Payment Information Change Notifications



**DATA**

Data Quality

## Introduction

This guide was created as a best practice for initial review of the quality of the data sent between the business partners. This document steps through specific data quality issues as seen by the various business partners in a reinsurance arrangement (Ceding Company, Reinsurer, Retrocessionaire).

## Purpose

* Explain the definition of data quality from each of the perspectives
* Define specific concerns with the systems being used, and give some best practice ideas for resolution (see ***Appendix 1***)

## Data Quality Definitions

What does Data Quality mean to each player? Each player in the reinsurance stream has different needs for quality data.

1. For the **Ceding Company**, data used by the reinsurance system is only as good as the administration system supplying the data. A “Garbage-in = Garbage-out” philosophy. Unless checks are made back to the administration systems, the data within the reinsurance system can be suspect. Assumptions are made that the source data is coming into the reinsurance system correctly. Constant monitoring of the administration systems is required to ensure all changes are accurately being transferred to the reinsurance system. Internal reporting is also impacted by the quality of the reinsurance data.
2. For the **Reinsurer**, data quality is multi-dimensional. One dimension is accuracy. This is not just limited to formatting accuracy but also field accuracy and is the most difficult to measure. A second dimension is completeness and is defined as having the data meet all the minimum data requirements. A third dimension is consistency with data being consistent from period to period. The fourth dimension is recency and measures the freshness of the data.
3. For the **Retrocessionaire**, high quality data is complete, accurate, available and timely. Complete data means no information is missing from the data file, meaning less time is taken to query for missing information. Accurate data is when all information provided is correct, with less time to review information for errors. Available data means that the information is provided and there is no need for a request. Timely data implies no significant lag between the effective date of the data and when it’s provided. High quality data enables the company to make sound business decisions.

## Conclusions

1. What is the main source of data quality issues? The systems being used to administer the reinsurance data seems to be the driver for the data quality. If manual intervention is required because of system limitations this can compromise the quality of the data.
2. The industry indicates that there are three major types of systems in use today: vendor provided (Ex: TAI, Quasar), home-grown systems and worksheets.
3. Some specific concerns regarding the systems being used are:
4. System upgrades or modifications not adequately being tested
5. Who is performing the system upgrade (internal programmer or external consultant with the industry system)
6. The age of the system
7. System restrictions for hardware and file sizes
8. Limited reinsurance knowledge of the parties giving the system support
9. Inconsistent file formats (period to period)
10. Incomplete files
11. Lack of mutual agreement on data needs
12. Lack of regular audits on the data files

## Appendix 1 – Data Quality



Reporting Issue – Late Reported Transactions

## Introduction

Late reported transactions impact users of the data. These delayed transactions may be due to company mergers or acquisitions, changes in administrative systems, or poor cedent controls that result in errors and omissions reporting. Late reported transactions may have impacts on sales, financials, company credibility, reserves and capacity.

## Purpose

* What to do when you first learn you will have late reported transactions
* How to monitor for late reported transactions
* Impacts created by late reported transactions

## Appendix 1 – Late Reported Transactions



Reporting Issue – Missing Fields

## Introduction

Completeness of data reporting is very important to the submitting company as well as the receiving company. If key fields are missing when the data is reported to the Reinsurer/Retrocessionaire, the data may be misinterpreted. This can lead to more time in answering questions or incorrect assumptions, potentially resulting in financial impacts to the bottom line. Complete data reporting is one method to ensure the business is processed efficiently and correctly.

## Purpose

* Present causes for missing data fields
* Display impacts of missing data fields
* Present some best practices for preventing missing data fields
* Provide example scenarios (see ***Appendix 1***)
* Provide impact grid for missing data fields (see ***Appendix 2***)

## Causes of Missing Key Data Fields

1. Key field not stored in client administration system
2. Conversion of systems and key field not converted properly
3. Data obtained via acquisition and prior company did not provide key data field
4. Client may use Third Party Administrator and not stored on that system
5. Key field not obtained from insured
6. System constraint with not being able to process all given values for key fields
7. Type of reporting system and ability to support system updates

## Impacts of Missing Key Data Fields

1. Insured information such as Name, Policy Number, Date of Birth, State of Residence/Residence Country could cause duplicate policies in databases. Often some of these fields are used as primary keys to identify an insured. If the field is populated and then subsequently not populated a new coverage may be created instead of updating the coverage in the database that already exists. Agreements may be split based on State of Residence or Last Name alphabetical placement so these fields are critical. Complete client data is critical for retention management and timely claims processing. If the policies for an insured are not linked together properly a client may not have proper retention on the life impacting financials.
2. Insured information such as Underwriting Basis, Risk Basis/Ratings, Smoker Code and Smoker Classification are needed to ensure proper rates, proper premium payments and needed for audits and reviews. These values may also be critical to determine if the policy applies to an agreement and are needed for reserves and proper treaty placement.
3. Effective Date of Transaction, Transaction Code and Transaction Sequencing are needed to properly process business in the correct order. If not correctly sequenced, multiple transactions could end up with a policy being in an incorrect status or with an incorrect Ceded Amount.
4. Issue Date and Issue Age are needed for use of proper rates and durations. These fields are also needed for calculation of reserves, mortality studies and determination of coverage. For example, if the upper age on an agreement is 65 but the Issue Age is not populated, the policy may be accepted when it should not have been
5. Treaty Code and/or Plan Code are needed so the policies may be tied to the proper legal agreement. These fields are used in a number of ways:

* determination of rates
* calculation of reserves
* determination of retention and retrocession placement/binding limits

1. Reinsurance Type and Reinsurance Mode are used to validate proper treaty, determine rates and reserves.
2. Paid to Date is needed to ensure premiums are paid to a current date. If the Paid to Date is less than current date the policy may be assumed to be terminated. If a claim occurs when the policy has not been paid to a current date, this may impact timely payment by the Reinsurer.
3. The Net Amount at Risk is used for retention management, validation of binding limits, calculation of premiums and reserves.
4. Conversion and reissue data is needed for proper processing. Transaction Type as well as original and new policy information is important to have a full picture of the policy and the changes that occurred.
5. Second insured information is needed for proper processing for joint life and second to die policies, such as determining joint ratings and ages, premium and other processing, such as retrocession placement.
6. Type of rider, if not provided could assume joint insured but may be child or spouse rider.

## Best Practices

1. A best practice is to validate your data to be reported for any missing values prior to submitting. If fields are missing work to include them. If the data cannot be added, immediately contact the downstream users of the data so they are aware of the issue and can develop a work around for their systems.
2. Queries may be used to find missing file values prior to file submission.
3. File size and record count can be reviewed to see if in line with usual reporting.
4. System controls may be developed to populate missing fields based on derivations. For example if you have Date of Birth and Issue Date of policy but not Issue Age then the two populated values may be used to derive an Issue Age.

## Appendix 1 – Missing Data Fields - Scenarios



## Appendix 2 – Missing Fields Impact Grid



Conversions

## Introduction

This guide has been created as a reference to assist with the handling of conversions. Policy conversions occur within the life insurance industry with regularity and can follow different processes as needed to support various consumer needs. Additionally, each reinsurance agreement typically contains the negotiated terms for covering the converted policies. Therefore it is important that the conversion activity be reported to the Reinsurer(s) and Retrocessionaire(s) in a manner to ensure the contractual terms are honored.

## Purpose

The attached document (see ***Appendix 1***) is a guideline that provides industry standard rules of thumb for

* Determining whether or not the conversion is reinsured, and under which agreement
* Identifying areas where clarity of terms may be lacking within the agreement
* Identifying premium rate and allowance options
* Addressing reporting needs for the Reinsurer(s)/Retrocessionaire(s)

## Appendix 1 – Conversion Guidelines Matrix



Reporting Issue – Partial Reporting

## Introduction

The accuracy of data reporting is very important to the submitting company as well as the receiving company. Some companies have multiple systems that compile reporting or use third party administrators for reporting. It is important the submitting company confirms all reporting is created when expected and sent to other parties. A system error may also occur that would result in partial reporting. It is important the submitting company confirms files are correct or develop a process to confirm this.

## Purpose

* Present causes for Partial Reporting
* Display impacts of Partial Reporting
* Present some Best Practices for preventing Partial Reporting
* Provide example scenarios

## Causes of Partial Reporting

* Reporting created by multiple administration systems and not run at same time interval
* Reporting created by multiple clients or third party administrators and not run at same time interval
* System error and not all records on reporting
* Issue with data file transmittal or storage to site for retrieval
* Client practice of supplying all data for monthly reporting but cash payment based on a different timeframe (Data has all activity from first to thirtieth of month but payment is based on first to twenty-fifth of month, last 5 days paid on next month reporting)
* Field changes on the administration system (physical move of the field, or change in size/content of the field), so that when information is fed to the reinsurance system, the field is either blank or has corrupted information. It is possible that as field sizes are changed in the administration system, the rest of the data in the file gets shifted causing all of the subsequent fields to become corrupted, leading to partial reporting

## Impacts of Partial Reporting

* Additional time spent by data recipient to review and follow up on reporting issues
* The partial file could be considered full reporting and cause downstream impacts to internal systems
* Additional time spent at data recipient company to confirm payment if no match to partial reporting
* Partial reporting may leave some policies showing as not paid and delinquent
* Unreported transactions may lead to incorrect status at data recipient company
* Additional time spent to split policies not paid and to add to next reporting cycle
* Additional time spent locating files needed by data recipient
* Additional time spent validating premium receipt prior to remitting claim benefits

## Best Practices

* Validate all files are created for submission.
* Validate all files are complete- queries or a review of file size and record count. This check should be done by all business partners. If any issue is discovered on the recipient’s end it should be communicated to the provider.
* Communicate with other reporting outlets as needed to confirm files are created as expected.
* Cash payments should tie to reporting files and summaries.
* Communicate with data recipients as to file names and how data is transmitted, keeping up to date on any changes.
* Monitor changes made on the administration system, to confirm relevance to reinsurance data. Test any changes made here to confirm proper handling, proper codes, etc. If necessary, communicate with the data recipient any file changes (field location, or size/content changes) that happen on the administration system, and that subsequently feed to the reinsurance system. Use the “RAPA-Communicating System, Data, or Administration Changes to Business Partners” created by RAPA to detail the extent of the changes.

## Scenarios

1. Partial reporting and cash matches.
   * File is received and cash matches so data recipient proceeds with processing.
   * The data recipient may notice the number of records is lower than normal and raise the question as to if complete.
   * The data recipient may notice an additional payment or additional reporting file received and see data was not complete.
   * The data recipient may complete processing and not notice until a later time.
2. Partial reporting and cash does not match- known file names.
   * File is received and cash does not match. A part of data is not supplied but it does not always have transactions each month so data recipient client proceeds.
   * Cash does not match so data recipient reviews summaries and contacts client in regards to missing part.
   * Client sends missing part and then data recipient can proceed.
3. Partial reporting and cash does not match- new file reported.
   * File is received and cash does not match. All parts of reporting the data recipient expects are received.
   * Data recipient contacts client in regards to excess payment.
   * The client updates the data recipient that they have added a new file that should be picked up for processing.
   * Data recipient updates their records to add new reporting file. Data recipient picks up additional file and can proceed.
4. Partial reporting and cash does not match- reporting does not match summaries.
   * File is received and cash does not match. All parts of reporting the data recipient expects are received.
   * Data recipient reviews summaries and notices summaries have higher totals than data.
   * Data recipient reports to client and they send files again due to earlier system error and not complete.
   * Data recipient proceeds with new reporting files when received.
5. Partial reporting and cash does not match- record count too low.
   * File is received and cash does not match. All parts of reporting the data recipient expects are received.
   * No summaries submitted so data recipient cannot check reporting to summaries.
   * Data recipient notices the number of records is much lower than usual reporting.
   * Data recipient contacts client and client acknowledges file sent was not complete. Client agrees to send new file.
   * Data recipient proceeds with new reporting file when received.
6. Field is moved from one location to another in the administration system file
   * Coordinate programming changes so that the reinsurance system will pick up the new location for this information.
   * Test the change once it is made, to confirm accuracy of the reinsurance file.
7. Field is changed in size or content
   * An example of this might be changing of the sex code on the administration system for a male from M to a 1.
   * Coordinate programming changes so that the reinsurance system will pick up the new information appropriately. In the above example, the programming change would be to have the interface program change the 1 to an M.
   * Test the change once it is made to confirm the accuracy of the reinsurance file.
   * Communicate the change to the data recipients if necessary. In the above example, if it is not possible to have the interface program changed to reflect the M, the communication needs to be that the new field will now be a 1 instead.

Reporting Issue – Policy Number Changes

## Introduction

Because policy number is typically a static data element, it is a key reporting field used to identify and apply policy changes to correctly represent the risk and the treaty terms under which the policy is covered. An unreported change in the policy number potentially leads to overstatement of reserves and assumed NAR as it may appear to be two separate policies in the systems. Conversely, policy number changes which are communicated in advance of the reporting, or reported as a change, provide an opportunity for the business partners to make modifications to accommodate the change and avoid any appeared duplication or financial overstatements.

## Purpose

* Present causes for changes to the Policy Numbers
* Display impacts of Policy Number changes
* Present some Best Practices for managing Policy Number changes
* Provide example scenarios

## Causes of Policy Number Changes

* Administrative system conversion
* Policy conversions or exchanges reported as new business instead of Conversion In or Exchange

## Impacts of Policy Number Changes

* Doubling of risk within retention management processes resulting in overstated NAR amounts reinsured/retroceded and premiums remitted.
* Overstatement of reserves.
* Potential overpayment of benefit amounts if error not detected on a timely basis.
* Business partner could associate the conversion or exchange with an incorrect treaty impacting profitability results, incorrect share percentages, incorrect premium and allowance structures.
* Compromises identification of policies eligible for recapture if the conversion or exchange is not reported as such.

## Best Practices

* Advance communication of the scenario(s) resulting in policy number changes to the business partners.
  + Utilize “RAPA-Communicating System, Data, or Administration Changes to Business Partners” document developed by the RAPA Data Initiative to share advance policy number format changes.
  + Include a description of the change being applied and the reporting period the change will take effect, i.e. ‘Adding ABC prefix to each policy associated with the block of policies acquired from ABC Insurer, adding leading zeros to the policy number, etc. If there is no logic that can be applied to the change, provide a listing of old policy number to new policy number.

## Scenarios

1. Administrative system conversion - Change to new platform as represented in the following examples:
   * New platform may not allow for the policy number to remain the same.
   * Internal Migration/Implementation to new platform decisions may drive formatting of policy numbers.
     1. Previous multiple system solutions into one standard solution – renumber all with consecutive numbers.
     2. Previous multiple system solutions into one standard solution – add leading/ending character(s) to preserve historical system solution.
     3. Improved product functionality in new platform.
     4. Correction of inconsistencies in prior policy number assignment (generally occurs with manual administrative solution -Excel or Access DB).
     5. Larger field size, so zero fill (beginning or end).
2. Policy Conversions or Exchanges – Reported as New Business instead of Conversion In or Exchange:
   * Conversion or exchange of a policy administered on one system solution to a policy administered on a different system solution (e.g original policy on legacy system and new policy on server based system).
   * Term conversions or exchanges staying on the same system can also cause some confusion and inaccuracies for the business partners.

Joint Life Claim Reporting

## Introduction

Since Joint Life policies cover 2 individuals in most cases the date of deaths differ. If the type of joint policy is last survivor, second to die or similar then the policy is still inforce after the first death covering the survivor. It is important to report these policies properly to know they are still inforce and to know which life is inforce and the one that is inactive due to death. This becomes even more important for reinsurance cessions of Joint Last to Die plans where one life is uninsurable as the benefit is paid at the time of the ‘healthy’ insured’s death irrespective of whether it was the first or second death.

## Purpose

* Present causes for incorrect joint life reporting
* Display impacts of incorrect reporting
* Present some Best Practices for reporting joint life policies
* Provide example scenarios (see ***Appendix 1***)

## Causes of Reporting Both Joint Lives as Inactive

1. System constraint- system cannot have 2 different statuses so if one is inactive due to death the second is marked in same manner
2. System logic- if primary insured is first to die and marked as inactive then automatically matches secondary to the same status
3. Historical reporting of both lives as deceased and inactive at first death

## Impacts of Reporting Both Joint Lives as Inactive

1. Potential over-retention by reinsurer / retrocessionaire
2. Potential understatement of reserves
3. Risk may not be active to downstream users since lives are inactive
4. Policy could be marked as not inforce by downstream users

## Best Practices

* Report only the deceased life as inactive- keeping 2nd insured active with all values still populated for volume and premium
* In situations where the ceding company’s administrative system does not provide for storing and/or reporting an insured status or specific policy status to represent which insured is deceased, there is typically a field on both the Inforce and Transaction/Billing data files where notes can be captured and the policy status can remain Active, Premium Pay, etc. Reporting a standardized flag & comment in this field to depict which insured is deceased (Primary or Secondary), the deceased’s name and the Date of Death clearly defines for downstream users the policy activity.

## Appendix 1 – Reporting both lives at time of first death - Scenarios



Flat Extra Reporting

## Introduction

Flat extra reporting fields are key fields to identify an added risk associated to a particular policy. Depending on the client’s reporting system, the flat extra fields are sometimes fully provided and other times only partially provided. The way those fields are reported on the data files are not necessarily consistent or complete. It is important that the submitting company reports the data in those fields properly to ensure the flat extra premium paid is correct and as per the expected premium rate.

## Purpose

* Present overview of flat extra reporting on data files
* Present causes for variations in the reporting of flat extra fields
* Display impact when flat extra fields are not properly reported
* Present some Best Practices for managing incomplete flat extra data
* Provide scenarios

## What is a Flat Extra charge?

Insurance companies handle higher than standard mortality risks by applying what is called a “flat extra” charge. The flat extra charge can be temporary or it can be permanent. A good example of when a permanent flat extra would be required is if someone has what is considered a dangerous occupation or hobby. They are usually assigned to risky activities such as skydiving, scuba diving, or any hazardous occupation. A temporary flat extra example would be where a person is recovering from a serious illness and to qualify for an insurance coverage that person may be required to pay a flat extra premium for a specified period of time let’s say 4 years. After the 4 years the flat extra charge falls off and the insured can keep paying normal premium amount associated with the base policy.

## Overview of Flat Extra reporting on data files

1. The expected flat extra fields consist of Flat Extra Type, Flat Extra Rate, Flat Extra Duration, Flat Extra Premium and Flat Extra Allowance.
2. TAI companies provide separate fields for the temporary and permanent flat extras.
3. Clients with Homegrown files, Excel or Access files may be limited in providing the data in these fields.
   * On some clients’ files flat extra premium and allowance are provided but duration and rate are not.
   * Other times, duration fields have to be used in order to map the flat extra as either temporary or permanent.
   * Some clients are unable to separate temporary from permanent flat extra, and therefore only provide one flat extra field.
   * Even though the client may not provide a flat extra rate or duration, a field with an indicator is sometimes supplied which helps with the mapping of the flat extra premium as either temporary or permanent.
4. There are a variety of acceptable temporary and permanent flat extra durations and this varies by company and treaty.
5. While most treaties clearly specify the applicable flat extra durations for temporary and permanent flat extras, there are some treaties where the flat extra wording is somewhat vague.
6. Even though it is expected for temporary flat extra duration to be 5 years or less and the permanent flat extra durations to range from 6-99, there are instances where the permanent flat extra duration is reported with a duration of less than 5 years.
7. It is expected for the temporary flat extra duration to remain the same until the flat extra drops off.
8. For TAI companies, expired flat extra rate and duration will continue to be reported in the flat extra fields with no premiums paid after the date of expiration.
9. Some clients handle the flat extra premiums on joint policies differently and will include any applicable flat extras for last survivor cases in the frasierized calculations and report as part of the Premium\_1 field.

## Causes for variations in the reporting of Flat Extra fields

* System limitations with not enough fields on the client’s system to report all the flat extra information.
* Due to merger and acquisition, data received from prior company may not contain all the necessary flat extra fields.

1. System defects could cause data to be reflected in the wrong fields such as net flat extra premium showing in the FLX\_AMT fields or recalculation of several years of premium not brought forward correctly.

## Impacts of Flat Extra fields not properly reported

1. More difficult to explain at audit time due to inadequate data provided.
2. Lapse experience studies typically capture several years of data and questions regarding policies with flat extra can be difficult to explain if these policies have lapsed several years ago with incomplete flat extra data provided back then.
3. Causes concern to the Financial Management team and Actuarial team as they are unsure whether the data reported is reliable or not, when only premium amount is present but no flat extra premium rate or duration is reported. This may lead to potential impact on reserves.
4. Harder to test the accuracy of the data if not all fields are provided.
5. Increase the complexity of the premium validation exercises if mapping of these fields are incorrect and/or not all the fields are provided.
6. Incorrect/Incomplete flat extra data can lead to incorrect premium payments and incorrect premium processing.
7. Potential for incorrect mapping of flat extra information since homegrown client’s layout does not always specify whether or not the flat extra is temporary or permanent.
8. It can result in incorrect display of flat extra information in databases if mapping of these fields is incorrect.
9. Potential for reinsurers to pass along incomplete flat extra information to their retro partners, when details are not always provided by the issuing company.

## Best Practices

1. If a policy is submitted on a facultative basis, then always verify the underwriting details to what actually is reported in terms of rate and duration.
2. There will be instances where a specified flat extra rate is agreed upon at underwriting time but not necessarily added to the policy and therefore the policy is sent without the specified flat extra rate or premium.
3. There is another scenario where the rate and duration are different from what was originally agreed. If so, contact the client and ask if they can make corrections or explain the differences.
4. For clients that use Non-TAI system there may be flat extra mapping differences. Review each client individually as the systems and mapping would be unique.
5. Review the mapping of flat extra fields on both transaction and inforce files to ensure accuracy between the two files.
6. Request that your audit team includes sample policies with flat extra rating when conducting an external audit so they can verify all paperwork related to these policies when on-site.
7. Perform reasonability check by taking the Temp Flex rate (Amount) and Perm Flex rate (Amount) fields and compare to the flat extra premium received.
8. Inquire with your client if you are noticing flat extra duration outside of the acceptable range.
9. Conduct regular analysis of the flat extra fields to ensure the client is reporting properly.
10. Refer to the client’s message field in the client’s files as you may be able to retrieve pertinent information provided by the client to support adjustments they may have made to fix their flat extra premiums.
11. When doing a recalculation back to an old period, ensure all the values are brought back correctly and that the rate, duration and flat extra premium are all populated.

## Scenarios

1. Some records have temp flat extra premium but no TEMP\_FLX\_AMT reported
2. It should be that Temp flat extra premium = Temp flat extra premium rate\*Reinsured NAR /1000 (i.e. TEMP FLAT EXTRA PREM = TEMP\_FLX\_AMT\*RV\_REINS\_NAR\_1/1000)
3. Some records have PERM\_FLX\_AMT, but no perm flat extra premium
4. It should be that Perm flat extra premium = Perm flat extra premium rate\*Reinsured NAR/1000 (i.e. PERM FLAT EXTRA PREM = PERM\_FLX\_AMT\*RV\_REINS\_NAR\_1/1000)
5. TEMP\_FLX\_AMT or PERM\_FLX\_AMT can be missing or = 0, but there is still temp/perm flat extra premium associated with the policy.
6. This type of scenario does occur occasionally, and may be due to the client making adjustments. In this case, the permanent flat extra premium and allowance were reported but the flat extra rate (Amount) and duration were zero. The client did provide some explanations in the message field to confirm that the flat extra premiums seen on the file for that period were due to several adjustments made.
7. A facultative policy was underwritten with a flat extra rate of 2.50 and yet the amount of the flat extra on reporting received is 2.40. Some companies use a fixed set of the flat extras that may not correspond to what has been quoted. It is a good practice to check the FAC Underwriting sheet to compare to what is actually received.
8. Inconsistency in the flat extra appearing on the underwriting application compared to what has been received on the client’s file. In this case, the policy is received as FAC and according to the Underwriting worksheet, flat extra appears as permanent for $3.00 for a duration of 99 years and yet on the actual reporting received the flat extra is $3.00 for the first 4 years but then changed to 1.33 for a duration of 68 years. The client has also completed a system conversion in year 4 and since that time the actual flat extra premiums do not match to the expected flat extra premiums as per example below.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Duration** | | **FE Rate** | **NAR** | **Premium** | **Allowance %** | **Allowance**  **Amount** | **Expected FE Net Premiums** | **Actual FE Net  Premiums** | **Difference** |
| 1 | 3.00 | 1,200,000 | 3,600.00 | 75% | 2,700 | 900 | 900 | 0 |
| 2 | 3.00 | 1,196,122 | 3,588.37 | 10% | 359 | 3,229.36 | 3229.37 | -0.01 |
| 3 | 3.00 | 1,193,223 | 3,579.67 | 10% | 358 | 3,221.67 | 3221.67 | 0 |
| 4 | 3.00 | 1,191,299 | 3,573.90 | 10% | 357 | 3,216.89 | 3216.90 | -0.01 |
| 5 | 1.33 | 1,188,281 | 1,580.41 | 10% | 158 | 1,422.41 | 2978.25 | **-1555.84** |
| 6 | 1.33 | 1,191,399 | 1,584.56 | 10% | 158 | 1,426.56 | 2978.25 | **-1551.69** |
| 7 | 1.33 | 1,200,000 | 1,596.00 | 10% | 160 | 1,436.00 | 2978.25 | **1542.25** |
| 8 | 1.33 | 1,200,000 | 1,596.00 | 10% | 160 | 1,436.00 | 2978.25 | **1542.25** |
| 9 | 1.33 | 1,200,000 | 1,596.00 | 10% | 160 | 1,436.00 | 2978.25 | **1542.25** |
| 10 | 1.33 | 1,200,000 | 1,596.00 | 10% | 160 | 1,436.00 | 2978.25 | **1542.25** |

Zero At Risk Amounts Reporting

## Introduction

Because At Risk Amounts are used by ceding companies to determine the total ‘per life’ retained amount, it is a key reporting field used by insurers, reinsurers and retrocessionaires to identify their overall liability should a claim arise. While this sounds straightforward, there are valid situations where a current At Risk Amount may be zero but future At Risk Amounts for the same policy may be a larger value. Additionally there may be situations where, over the course of the policy life, the future At Risk Amounts may increase and then later decrease to zero. Without a good understanding of the reason for a zero At Risk Amount during a policy’s lifetime, there is the potential for the insurer, reinsurer or retrocessionaire to be over retained on a life because they did not secure outside outlets for the over retained amount.

## Purpose

* Present causes for changes At Risk Amounts of zero
* Display impacts of At Risk Amounts of zero
* Present some Best Practices for managing At Risk Amounts of zero
* Provide example scenarios (see ***Appendix 1***)

## Causes of Zero At Risk Amounts

1. Many of the products sold today include in their design cash values which are used to tabulate the Amount at Risk for each policy. Several of these products allow insureds to increase their cash value accounts (a.k.a. cash value pour in), at inception as well as periodically over the life time of the policy. The At Risk Amount is generally tabulated as FACE AMOUNT less ACCOUNT VALUE**1** less AVAILABLE RETENTION. At a point where the Cash Value is equal to the Face Amount, then the At Risk Amount is Zero. ***1Account Value can also be referred to as Cash Value; see treaty for specific language***
2. Products designed to automatically increase in Face Amount at a contractually stipulated point in time following the policy issue. Generally either specified number of years or at an attained age have historically been the most common stipulations. The ceding company may report the At Risk Amount as zero until the increase is applied and the non-zero At Risk Amount is reported to ensure the reinsurer assumes liability when the increase is applied.
3. Products designed with flexible premiums which include corridor factors to maintain a difference between the death benefit and the account values by applying the factor against additional premiums, or pour ins, to effectively increase the death benefits (regulation 7702).
4. System errors associated with system conversions, reporting tool quality, error in source system feed to reinsurance application, etc.

## Impacts of Zero At Risk Amounts

1. Potential over-retention by reinsurer / retrocessionaire.
2. Potential over-retention by ceding company if the zero At Risk Amount occurred due to a system error not detected until claim time and the E&O clause cannot be invoked.
3. Potential understatement of reserves.
4. Potential impacts to Modeling analysis of profitability.
5. Potential compromise of ongoing recapture programs – policies with issue dates later than the policy with a zero At Risk Amount maybe recaptured prematurely.

## Best Practices

1. Develop an automated check of the data files that identifies & reports zero At Risk Amounts so they can be confirmed or flagged as errors for more detailed review PRIOR to distributing the files downstream to the reinsurers / retrocessionaires.
2. Early communication of the scenario(s) resulting in zero At Risk Amounts associated with system errors to the reinsurers/retrocessionaires.
3. Utilize Communicating System, Data, or Administration Changes to Business Partners document developed by the RAPA Data Initiative to provide details around error, estimated number of policies affected, estimated premium/allowance/reserve adjustment.
4. Include a description of approach for correction to be applied and the reporting period the correction will occur (i.e. ‘Reversing all policy transactions for plan IXL179 for 2015 anniversaries and will rebill going forward with new At Risk Amounts, etc).
5. Provide a list of plan/product codes to the reinsurers / retrocessionaires to be used to assist in identifying policies with contractual increases.
6. Include language within the treaty to address At Risk Amount calculations when the corridor factors are invoked.
7. On TAI, there is an Ultimate At Risk Amount field that should be utilized to house the ultimate NAR or Projected At Risk Amount for plans identified as having contractual increases to the Face Amount and for policies having large ‘cash value pour in’s’. Otherwise, use the ultimate amount in tabulating the At Risk Amounts for retention management and reporting to reinsurers / retrocessionaires. Please note, some reinsurers / retrocessionaires may ask that premiums be remitted based on the Ultimate At Risk Amount instead of the actual At Risk Amount.
8. In instances where the ceding company has not advised the Reinsurers/Retrocessionaire of any system errors or supporting information to identify policies with contractual increases, the Reinsurers/Retrocessionaires should confirm with the cedent that the reported zero At Risk Amounts are correct.

## Appendix 1 – Zero At Risk Amounts - Scenarios



Reporting Issue – Inforce & Transaction Files Not Reconciling

## Introduction

The accuracy of data reporting is very important to the submitting company as well as the receiving company. Some of the reports that are typically used to administer the inforce business include the inforce file, transaction file and policy exhibits. The reconciliation of these source data files received each month or quarter is an important step to ensure completeness and accuracy of the block of business being administered. Even with the availability of robust systems to manage policy data, inconsistencies between these various source files continue to be present. Depending on the size of the business administered and time constraints, reconciliation can be performed at either a detailed or less detailed level.

## Purpose

* Present overview of files and the reconciliation methods used
* Present causes for Inforce, Transaction and Policy Exhibit not reconciling
* Display impact of Inforce, Transaction and Policy Exhibit not reconciling
* Present some Best Practices for preventing Inforce, Transaction and Policy Exhibit not reconciling
* Provide example scenarios

## Reconciliation Method Overview

The level of reconciliation performed using the above mentioned files will differ from one company to another. Inforce files and transaction files are received and loaded either monthly or quarterly. Policy exhibits are also received on a monthly basis.

The inforce file, whether produced monthly or quarterly, represents a snapshot of the policies that are in-force at the end of the period, after all of the transaction processing has taken place. Each month or quarter, clients provide inforce data files at a seriatim level for all policies inforce. These inforce files record policy level data and are used to ensure that the Ceding company and Assuming company are keeping accurate parallel records and also for true up purposes.

The transaction file is typically provided on a monthly basis and displays policy by policy level data that records any additions, deletions, changes that have occurred to the policy level data during the month. These transaction files form the basis of the billing statements whose premiums and allowances totals are recorded for premium processing purposes. The transaction data is also used to create termination extracts, to perform audits and to process claims.

The policy exhibit is a document summarizing and reconciling the changes that have occurred on policies reinsured during a reporting period. Such changes may include new business, increases and decreases, conversions, lapses, terminations and reinstatements as well as changes in volumes of NAR. Policy exhibits are summaries showing how an opening balance of policy totals has been added to (e.g. new business, conversions on) and subtracted from (e.g. lapses, deaths) to produce a closing balance of policy totals.

**Different reconciliation methods using these 3 source files can be performed at different levels. Below are a few examples:**

* **Inforce to Policy Exhibit**
* The reconciliation of the inforce file includes a control check that compares inforce policy count and NAR by treaty to the policy count and NAR by treaty found on the client’s policy exhibit for the corresponding quarter-end. The reconciliation confirms that the net change as reported on the policy exhibit reconcile to the changes and total in the inforce data provided by the Ceding company.
* **Transaction to Inforce**
* This reconciliation method involves taking the inforce totals at the end of a quarter e.g. 4Q2014 and then account for all the transactions in 1Q2015 and compare the expected 1Q2015 inforce totals based on the transaction activity to the actual inforce totals for 1Q2015 from the client file and this is done at a treaty/file summary level.
* The client’s inforce file is also used in a process to clean up internal data storage. This reconciliation is performed by referring to the client’s inforce to see if any policies are not inforce with client but a transaction may have been missed or out of order processing and still inforce in internal data storage. Policies may be inforce with client and we do not have them in internal data storage due to out of order processing or missing transactions. Out of order transactions can be a problem. The transaction sequence helps but sometimes clarification is required.
* **Transaction to Policy Exhibit**
* Transaction files are also used to compare to the policy exhibits and associated premium remittances.

## Causes of Transaction and Inforce Files Not Reconciling

* Due to System Conversion and the cleanup stage that follows to better align data discrepancies found.
* Type of reporting system and its limitations.
* Timing issues which can result in transaction not showing up at the end of a reporting period.
* Reconciliation discrepancy can result from billing corrections that are made on the transaction file but are not reflected on the inforce file.
* Client is able to transfer data without transactions (due to special adjustments) and therefore the movement will only be identified by comparing inforce data sets or ending policy exhibit balances from the previous reporting period to the beginning balances for the current period.

## Impacts of Transaction and Inforce Files Not Reconciling

* Reconciliation inconsistencies can lead to incorrect audit assumptions and findings.
* Potential use of incomplete and inaccurate transaction data to generate termination extract to be used in the lapse study which may result in a negative impact on lapse experience.
* Inforce file is used to generate an extract that is used by the Valuation team in the generation of reserves. Out of sync inforce and transaction files can lead to inaccurate modeling of the policies. This may result in a negative impact on mortality and reserves.
* Possible distortion of data needed for statistical reporting, retention management and premium processing.
* Transaction/Inforce data is used by Claims to check the status of the policy and to ensure that premiums have been fully paid up to the claim date; therefore any inconsistency in the inforce and transaction data will impact the Claims area.

## Best Practices

* Validate the data to be reported for any unusual corrections or processing prior to submitting. If you know the correction or change processed made for that period is an unusual one, communicate this to your business partners so they are aware of what is to be expected. This will allow the downstream users of the data to be aware of the situation so they can develop a work around for their systems and make provision to document the inconsistency.
* Communicate changes to your business partners on a timely basis. The sooner the discrepancy is identified and corrected, the better future reporting will be.
* Some cedents generate the inforce file a few days after the generation of the transaction file.
* If there are any terminations or new issues during those few days, the result of that activity is reflected in the inforce file but not in the transaction file. Best practice will be to generate them simultaneously.
* Implement reconciliation as a formal process if not already an established one in your organization.
* Have management review the reconciliation results and provide sign-offs to evidence review and completeness which will facilitate the production of such reports at audit time.
* Inquire on differences with client. Any differences considered to be above your set tolerance level should be brought to the client’s attention as they may or may not be aware of such a difference.
* Put greater emphasis on analyzing and reconciling the data and have a dedicated team member when possible assigned to this task.

## Scenarios

1. **Corrections**

There can be differences due to corrections as in the following examples:

* If a client is making a correction to a terminated policy, the transactions will be sent, but they may not appear on the policy exhibit. This occurs when the client does not change the status from terminated to in-force when they reinstated and then terminated the policy again. Since nothing was added to the in-force, there is nothing to remove; the reinstatement and termination do not appear. This also works in reverse, the client can adjust the policy exhibits without producing transactions, and this usually pertains to offsetting movement.
* Policy #123 was processed as a claim in 2012. Billing corrections were made in January of 2013. The January 2013 Policy Exhibit file has it listed under Death and removed from the Inforce file, but it shows up in the January 2013 transaction file as a Reversal, not a Death since that was the transaction that was processed at that time.

1. **Timing**

There are differences between the transaction, policy exhibit and inforce data files due to timing. One scenario that is encountered during the reconciliation process is where the count matches, but the NAR amount does not. If a policy terminates, the transaction will show the Net Amount at Risk at the termination date, but the policy exhibit shows the Net Amount at Risk at the in-force date as this is the amount being removed when the termination was processed.

1. **System conversion/upgrade**

As a result of the client completing a system conversion, some policies were removed from the inforce file with no corresponding transaction records on a transaction file to terminate these records. Client confirmed that these were UL policies that had multiple coverages in the old system. During the conversion, they were rolled up into the base coverage.

1. **System limitations**:

* Client reports terminations on the transaction file but due to system limitations the policies remain on the inforce until their renewal period. They are dropped from inforce at renewal and until then the inforce picture is not accurate.
* In some instances, a client system removes a policy completely from the inforce file if its NAR is zero but it is still counted in the policy exhibit file. This causes a mismatch between inforce and policy exhibit.

1. **Transfer of business from one entity to another**

Due to internal reorganization, transfer of business from one entity to another is sometimes required. This is done by "shifting" policies from one business entity to another, using a transaction code not captured on either the Transaction file or Policy Exhibits.

1. **Frozen Transactions**

In cases where the policies are frozen, they will not be present in the transaction file and therefore not included in the Policy Exhibit. However, these policies could be in-force and included in the inforce file but missing from the Policy Exhibit.

1. **Lapse grace period**

Policies in the lapse grace period (in arrears but not yet terminated) are not included in the Inforce file but are included in the monthly transaction file until the policy status is terminated.

Reporting Issue – Face Increases and Decreases

## Introduction

Face increases and decreases are an everyday aspect of reinsurance administration. However they are an aspect that has some complexity to it and requires thoughtful consideration as to how they will be administered by the direct writer/ceding company.

## Purpose

* Present definitions of Face Increases and Decreases
* Present Discussion of Administrative Considerations
* Present some Best Practices Administration
* Provide example scenarios

## Definition of a Face Increase or Face Decrease

Face increases can be either contractual or various forms of non-contractual.

1. Contractual face increases are a feature built into a policy that allows the policyholder to increase the face amount of their policy by scheduled amounts at scheduled intervals. Normally there is a cap as to the ultimate face amount the policy can be increased to.
2. Non-contractual face increases fall into three basic categories:
3. Policyholder request: These are not scheduled but are done at the request of the policyholder and often require new underwriting since the policyholder’s circumstances could have changed since the original policy issue date
4. IRS Corridor Regulations: IRS regulations require a policies face amount/death benefit to exceed its cash value by an amount calculated by an IRS formula in order to maintain its status as an insurance product and not an investment product. Since this can be a complex issue we will not address it in this document. See US Code section 7702 for further details.
5. Account Value Increases: On certain products if a policy account value grows to exceed the original face amount then the face amount will automatically increase to equal the account value. Check your company’s products to see if they fall into this category. We will not address this type of increase in this document.

## Best Practices

1. Face increases and decreases are normally manually administered within an admin system such as TAI due to each situation being somewhat unique and potentially complex. As a result diligent peer to peer reviews as well as a manager review of each face increase or decrease transaction is appropriate to prevent future issues, especially at claim time.
2. Communication of face increases or decreases between ceding companies and reinsurers is normally done through the monthly billing record data files sent from ceding company to reinsurer. There are notifications on those files that indicate whether the policy has had a face increase, decrease or some other change.
3. Ceding companies should document what their policies and practices are with respect to face increases and decreases so that they can be shared with reinsurers if or when questions or issues arise. This can help facilitate smoother audits and better overall communication between the parties.

## Face Increase and Decrease Scenarios

* **Contractual Face Increase with Existing Reinsurance on an Excess Basis:** In this scenario the ceding company has a $5M retention limit, the original policy has a $7M face amount, and the face increase is for $2M.



* **Contractual Face Increase without Existing Reinsurance on an Excess Basis:** In this scenario the ceding company has a $5M retention limit, the original policy has a $4M face amount, and the face increase is for $2M. The reinsurance pool is the current pool open for new business.



* **Non-Contractual Underwritten Face Increase with Existing Reinsurance on an Excess Basis:** In this scenario the ceding company has a $5M retention limit, the original policy has a $7M face amount, and the face increase of $2M is newly underwritten. Pool A-D is the original pool and Pool W-Z is the original pool with a separate coverage set up at the current age and duration 1.



* **Contractual Face Increase with Existing Reinsurance on a Quota Share Basis:** In this scenario the ceding company has a 10% Quota Share up to $2M retention limit, the original policy has a $7M face amount, and the face increase is for $2M.



* **Non-Contractual Underwritten Face Increase with Existing Reinsurance on a Quota Share Basis:** In this scenario the ceding company has a 10% Quota Share up to $2M retention limit, the original policy has a $7M face amount, and the face increase of $2M is newly underwritten. Pool A-D is the original pool and Pool W-Z is the original pool with a separate coverage set up at the current age and duration 1.



* **Non-Contractual Face Decrease with Existing Reinsurance on an Excess Basis:** In this scenario the ceding company has a $5M retention limit, the original policy has a $7M face amount, and the face decrease is $1M.



* **Non-Contractual Face Decrease with Existing Reinsurance on an Excess Basis:** In this scenario the ceding company has a $5M retention limit, the original policy has a $7M face amount, and the face decrease is $3M.



* **Non-Contractual Face Decrease with Existing Reinsurance on a Quota Share Basis:** In this scenario the ceding company has a 10% Quota Share up to $2M retention limit, the original policy has a $7M face amount, and there is a face decrease of $2M.



## Conclusion

The discussion and examples above are presented to provide guidance and examples for discussion. They are not designed to cover all possible scenarios. It is always important to review the ceding company’s retention rules as well as the treaties involved in any face increase or decrease scenario if there is any doubt about how it should be administered.

It is also important for ceding companies and reinsurers to communicate when there are unique or special situations which can arise from time to time to help avoid conflicts or uncertainty.

Underwriting Methodologies

## Introduction

There are several underwriting methodologies that are used by direct writing companies. The use of one methodology over another can be determined by a number of factors including product design, policy face amount, applicant health status and age.

## Purpose

* Present definitions of the primary underwriting methodologies
* Present discussion of the primary underwriting methodologies
* Discuss risks that Underwriters must assess
* Present Best Practices on using the underwriting methodologies and assessing risks

## Definition of Underwriting Methodologies

1. Fully Underwritten: The applicant is required to provide information regarding their health status including their current health status, a complete medical history, full documentation of their financial position including financial statements and tax returns for their personal finances as well as any ownership in any businesses.
2. Simplified Issue: The applicant is required to provide a limited amount of health and/or financial information and if none of that information fall outside of set limits then the policy will be approved for issue.
3. Guaranteed Issue: The applicant is only required to provide the normal application and the policy is guaranteed to be issued within the guarantee issue parameters. These parameters can include policy face amount limits as well as health restrictions.

## Discussion of Underwriting Methodologies

The Fully Underwritten (FUW) methodology is most often used for applications for large face amount policies (i.e. greater than the company retention limit) and/or where the applicant has current or a history of significant health issues. This methodology allows the underwriter to get a full picture of the potential risk being taken by the company so that an appropriate risk rating can be assigned and as a result an appropriate amount of premium charged to the policyholder. This process is normally not a quick process because the applicant is required to gather and provide a comprehensive set of health and financial information, potentially including doctor visits, medical test, financial statements and tax returns and other required documents.

The Simplified Issue (SI) methodology has fewer requirements than the FUW methodology but the applicant still may be required to provide some limited additional information including answering some medical questions. However, no blood or urine testing is done. The issuing company normally sets face amount and other policyholder rating limits on products that can be issued via SI. This process is normally quicker than FUW so an applicant can have a policy issued in a shorter time span.

The Guaranteed Issue (GI) methodology is the quickest route to issuing a policy because it has the fewest information requirements from the applicant. Normally this methodology only requires a normal application or in some cases the issuing company may utilize a more streamlined application including few if any medical questions. The industry is also starting to adopt online application processing so for GI products the applicant may only be required to answer a few questions online and if the answers are acceptable a policy may be issued within a few days. Policies issued on a GI basis are typically small face amounts.

## Underwriting Risks

Aviation Risk: Applicants who are pilots or do a significant amount of flying often have the risk amount retained by the issuing company reduced thereby ceding more of that risk to reinsurers. Aviation risk is a very specific risk that the insurance industry pays close attention to especially for pilots or others who fly frequently like professional athletes. Because of the inherent risk in flying many issuing companies limit the amount of risk they will retain on a life that flies a lot. This can result in more risk on a life being ceded to a reinsurer than would have normally been ceded. This can also impact whether a policy can be issued on this life using the SI or GI methodologies. It is interesting to note that statistically flying is safer than driving but the industry does not limit its risk tolerance for that risk. The primary reason for this is that most people drive/ride in cars and so that risk is already built into the rates whereas not everyone flies a lot so that risk is not built into the rates.

Smoking Risk: The distinction between smoking and non-smoking applicants began in the 1980’s. The health risks for smoking are well documented and insurers distinguish all applicants between smokers and non-smokers. Insurers define smoker in different ways with some requiring the applicant to have never smoked whereas other insurers allow some tobacco use like occasional cigars, pipe and chewing tobacco use.

Health Risks: Other than smoking insurers also assess various health risks such as blood pressure, alcohol/drug use, cholesterol, diabetes, weight, family history and others. The applicant’s health history has a significant impact on the underwriters rating of the applicant. Many insurers use a scoring system to determine the impact of each of these health risks on the policyholders class and/or mortality rating.

Financial Risks: When underwriting applicants requesting large face amount policies underwriters review the applicants financial situation to determine whether their net worth and/or current or potential future income are sufficient to require and support the size of policy applied for. Financial information such as tax returns, bank and brokerage statements, company financial statements and other financial data is used to evaluate this risk.

Other Risks: Other Risks such as lifestyle risks may also be considered. These would include things like skydiving, car racing and other higher risk activities.

## Best Practices

1. Reinsurance administration should work closely with Underwriting to learn about and understand the different Underwriting Methodologies and Risks.

2. Reinsurance Administration should pay attention to how these methodologies and risks could be written into the treaties they administer to see if they impact the rates or other reinsurance classifications on policies.

3. Reinsurance administration should provide the Underwriting Methodology used on each policy to the reinsurers in their regular reporting. This allows the reinsurer to know the method used and better understand the risks they are accepting.

## Conclusion

This discussion is meant to give a high level view of the Underwriting Methodologies and Risks most often used by companies issuing life insurance policies. Reinsurance administration teams are encouraged to contact their underwriting departments to learn more about what methodologies and risks their company uses and accepts, how their company defines those methodologies and risks and how they may impact the reinsurance treaties their companies are a party to.

## Sources

Klein, Allen, Life Insurance Underwriting in the United States – Yesterday, Today and Tomorrow. Mr. Klein’s paper can be found at the following source:

<http://www.actuaries.org/CTTEES_TFM/Documents/Underwriting%20in%20the%20US_Yesterday%20Today%20and%20Tomorrow_Paper%20for%20the%20BAJ_2012-Feb-10.pdf>