

# **INSTITUTE AND FACULTY OF ACTUARIES**

## **EXAMINERS' REPORT**

September 2017

### **Subject SA3 – General Insurance: Specialist Applications**

#### **Introduction**

The Examiners' Report is written by the Principal Examiner with the aim of helping candidates, both those who are sitting the examination for the first time and using past papers as a revision aid and also those who have previously failed the subject.

The Examiners are charged by Council with examining the published syllabus. The Examiners have access to the Core Reading, which is designed to interpret the syllabus, and will generally base questions around it but are not required to examine the content of Core Reading specifically or exclusively.

For numerical questions the Examiners' preferred approach to the solution is reproduced in this report; other valid approaches are given appropriate credit. For essay-style questions, particularly the open-ended questions in the later subjects, the report may contain more points than the Examiners will expect from a solution that scores full marks.

The report is written based on the legislative and regulatory context pertaining to the date that the examination was set. Candidates should take into account the possibility that circumstances may have changed if using these reports for revision.

Luke Hatter  
Chair of the Board of Examiners  
December 2017



**A. General comments on the aims of this subject and how it is marked**

1. The aim of the General Insurance Specialist Applications subject is to instill in successful candidates the ability to apply knowledge of the United Kingdom general insurance environment and the principles of actuarial practice to providers of general insurance in the United Kingdom.
2. Our expectation of a passing candidate at this stage is that, broadly, they should appear capable of stepping up to a head of function (pricing / reserving / capital) role at a small-mid sized organisation or being a senior member of a function team at a larger organisation. They should demonstrate not only a grasp of the technical aspects of general insurance actuarial work, but also a good sense for products, the competitive marketplace, regulatory environments and the operational aspects of an insurance company. They should be able to pull these areas of understanding together to provide well rounded advice to the users of their services.
3. Consistent with previous examiners' reports, we would offer candidates two key pieces of advice – (i) read the question properly and (ii) take the time to actually think about what is going on. Further to previous reports, we would stress that candidates do not need to get the majority of the points included in this report in order to pass (there are significantly more than 100 marks available for the points in this report). Time spent making sure you are answering the question that is asked is therefore more valuable than a panicked rush to put down as many points as possible, regardless of whether they are relevant.
4. On the first issue, candidates should always work on the assumption that the question wording has been carefully chosen. It is therefore essential to read the question properly.
5. If something is not asked for then candidates will waste valuable time writing answers that will gain no marks. These broader answers may be a logical next step to the question and so may be appropriate for candidates to discuss in a professional context. This is an exam however with a finite number of marks available and so the scope must necessarily be limited and specifically defined.
6. If a question does specifically mention something, candidates should also assume that there are definitely marks available for this aspect of the question. During the exam setting process, any content that is superfluous will have been removed. A clear implication of that is that if there are numbers provided in the question paper then there are marks available for comment and consideration of those numbers.
7. Wording of question sections should also be considered in the context of the position within the overall question. Where new question information is provided between sections, candidates should recognise that this information is specifically relevant to the following section or sections. When answering preceding question sections, candidates should not consider any subsequent information in their answers (although it may cover similar ground).
8. Various examples from this paper of recurrent failure to read the question are noted below. On the second issue, candidates should note that SA3 is the key

paper at which we test candidates' broader thinking. This is generally the final paper before qualifying as a professional, and we consider a capacity for broader thinking to be one of the best indicators of a candidate's suitability to act in a professional capacity once qualified.

9. As such we aim to design exam papers so that it is difficult to pass without displaying some capacity for independent and broad thinking, as well as to heavily reward instances where these skills are displayed. When reviewing past papers, candidates should assume that the marks available for generic points are substantially less than those awarded for the more challenging points that would be the mark of high quality professional insight in a practising actuary. Marks available for list items from bookwork are lower still.
10. We strongly recommend that candidates step back and take the time to thoroughly think about what is actually going on in question situations proposed rather than simply considering numbers to be analysed with standard techniques. For example, candidates might stop to think about what claims actually are for a particular class of business, considering factors such as what actually causes the claim, who brings the claim, how it is dealt with once brought, what makes one claim small while another is substantial etc.
11. This more grounded, real world perspective will help candidates to consider such things as practical issues, stakeholders involved and their potentially diverging objectives, wider impacts, regulatory or ethical issues, inappropriateness of certain actuarial techniques for the specific situation, current economic or cyclical effects etc. This is likely to lead to significantly broader point generation (and indeed reflects the thought processes of the examiners in drafting the questions and solutions) and a more rounded understanding of the underlying risks and dynamics which should also be of value to candidates when dealing with different stakeholders in their professional life.
12. Again, some examples of this failure to think more widely on the current paper are set out below. More generally, we would also advise candidates to employ basic exam techniques such as well structured answers and effective time management.
13. Candidates who give well-reasoned points, not in the marking schedule, are awarded marks for doing so.

**B. General comments on student performance in this diet of the examination**

Performance was relatively in line with expectations overall. Providing examples for candidates to apply knowledge to appeared to be quite effective in differentiating between candidates,

The technical provisions question was relatively badly answered, with a number of candidates having superficially absorbed some of the key words without getting a sufficiently robust understanding to actually apply it to some examples.

Candidates did well on the driverless car question and were able to generate some marks with open ended thinking about a new situation.

Candidates scored averagely on the EL / WC / PL question, with a number not appreciating nuances of EL vs WC and others struggling with focusing their thinking on what experience looks like for individual companies (rather than insurers) or focusing on a single element of a loss exposure. As always it is useful to try and understand at a high level what actual purchasers of insurance do and what real world claims are.

**C. Pass mark**

The Pass Mark for this exam was 57.

**Solutions**

- 1 (i) Under Solvency II, the boundary for existing insurance contracts is set at the point at which the company:
- Can unilaterally terminate the contract / refuse to accept a premium; or [1]
  - Amend the benefits or premiums in such a way that the premiums fully reflect the risks. [1]
- This contract boundary sets the point at which premiums can be recognised on existing contracts. [1]
- These contracts are captured under premium provision within the technical provisions. [1]
- Within the boundary period, both contractual recurring premiums and Premiums arising from policyholder options to renew or extend their policies should be taken into account on a best estimate basis. [1]
- [5, max 4]

*Poorly answered – a number of candidates seemed to have only a cursory sense of what contract boundaries are. Even where candidates seemed to grasp the concept some didn't pick up marks due to only briefly setting out the application in SII TPs.*

- (ii) For example, if a non-life insurance undertaking is one year into a three contract at the balance sheet date, allowance needs to be made for expected premiums and claims, on a best estimate basis, during the remaining two years of the contract. [1]

This could potentially have the effect of increasing or reducing technical provisions, depending on whether or not the contract is expected to be profitable.

*Marks for other appropriate example & impact.*

[2, max 2]

*Again quite poorly answered, many candidates failed to give an example and many that did give examples failed to note the impact and its dependence on the profitability of the relevant contract*

- (iii) The calculation of technical provisions also needs to include allowance for legally-obliged unaccepted contracts. [1]  
 These contracts are also captured under premium provision within the technical provisions. [1]  
 These are contracts which have not yet accepted, but the corresponding liabilities cannot be waived or reduced by the company as of the valuation date. [1]

The crucial consideration is whether or not the contracts are legally enforceable or on what terms a (re)insurer could avoid the liability associated with the exposure. [1]

There is an associated impact on delegated authority or binder business which must be assessed on a look through basis with the boundaries of the actual underlying contract of insurance being tested. [1]

*Credit for other valid answers*

[5, max 3]

*Again candidates often struggled to give clear answers*

- (iv) The legal obligations basis may be material where business is written, for example, by means of:
- Delegated underwriting authorities such as binders [1]
  - Brokers, for example in cases where there are backlogs of aggregated pipeline premiums [1]
  - Year-end renewals, for example reinsurers entering into 1 January renewals prior to a 31 December valuation date [1]
  - Tacit renewal agreements where the business is automatically renewed unless the policyholder decides to move the cover to another provider. [1]

*Marks given for other relevant examples at discretion of marker.*

[4, max 3]

*Most candidates who got the concepts were able to generate three examples*

- (v) Contract 1: Almost certainly should be included... [1]  
 ... as unlikely that a contract incepting the day after the valuation date was not obliged before [½]  
 Contract 2: Not certain to be included, dependent on renewal terms... [1]  
 ... if premium for renewal can be amended or be refused then may not be obliged (alternatively – may depend on whether it has already been agreed in advance) [½]  
 Contract 3: Possible that it should be included as a future management action... [1]  
 ... provided it protects inwards business that has already been written... [½]  
 ...or if it has been legally obliged [½]

Contract 4: Unlikely that the full amount of the binder premium should be included... [1]  
 ... only those underlying policies that have been legally obliged at the valuation date should be included, as the binding arrangement itself is not a contract of insurance [1]  
 [6, max 6]

*This section often highlighted a level of misunderstanding even from candidates who had scored relatively well on earlier sections. Many did not think that 1/1 contracts are generally agreed by 31/12 and many were not aware that binders are addressed on a look through basis*

- (iv) As there are no inwards contracts bound we would expect no recoveries to be assumed (i.e. no cash in-flows) [1]  
 As the reinsurance cover has been purchased we would expect that this is treated as bound [½]  
 It does not matter that no inwards contracts have been bound – the reinsurance contract has been bound at the valuation date and therefore the cost needs to be included as a future cash out-flow [½]  
 The contract specifies a rate of 10% (of written premium) so a total expected cost of \$10m  
 However the full cost has not been bound, only the deposit premium [½]  
 The deposit premium of 80% has been specified so a total cost (future cash out-flow) of \$8m should be accounted for. [½]  
 Using the specified payment schedule, the \$8m cash out-flows should be assumed to occur as follows:  
 • \$0.8m – 10% 31 January 17  
 • \$1.6m – 20% 31 May 17  
 • \$2.4m – 30% 31 October 17  
 • \$3.2m – 40% 4 April 18 [1]  
 These should then be discounted using the prevalent US\$ Discount Rate specified by EIOPA [½]

### Assumptions

Assume rate and deposit premium applies to the estimated written premium as given which is net of any costs... [½]

...for example, commission, brokerage, profit commission, cancellations, return premiums, premium taxes etc.

Assume deposit premium equal to minimum premium [½]

Assume no reinstatements [½]

Assume no reinsurance bad debt offset [½]

[7, max 6]

*Many candidates missed the key point that the inwards contracts to be protected by this had not for the most part been bound as yet, so no recoveries related to those contracts would be in scope. This often led to time wasted on loss calculations. Candidates also missed obvious points like the rate being 10% of written, or did not recognise that the adjustment premium was out of scope as the underlying contracts are not bound.*

[Total 24]

*Overall Q1 was the worst answered question on the paper, highlighting that a number of candidates did not know the bookwork on TPs and that a number that seemed to know the bookwork had somewhat flawed understanding when asked to apply it.*

- 2 (i) Personal injury to third parties [½]  
 Damage to property belonging to third parties [½]  
 Damage to the insured vehicle [½]  
 Likely to include both accidental and malicious damage [½]  
 Including damage arising from fire or theft [½]  
 (Possibly some types of) personal injury to the insured [½]

[3, max 2]

*Almost everyone scored full marks.*

- (ii) Even if government decides the technology is compulsory, it is possible that take-up may not be universal. [1]  
 For example, there may be vehicles where the new technology cannot be installed [1]  
 For example, it may not be possible to install to every vehicle within the time period (roll-out takes longer than expected) [1]  
 For example, motorists may be unable to afford the new technology [1]  
 Even once the technology is fitted motorists may not use it all the time [1]  
 Use of the technology may be optional [1]  
 Motorists may find a way to override the technology [1]  
 The technology may not work in remote areas of the country [1]  
 Or in all weather conditions  
 Something may happen which causes government to change its plans. [1]  
 For example, public concern about the plan, well publicised failings of the technology, etc. [1]  
 May not be possible to broaden to all vehicles e.g. buses [1]  
 Untraceable cars e.g. pool cars [1]



Other valid suggestion [1]  
 Other valid suggestion [1]  
 [12, max 6]

Generally well answered, most candidates were able to generate a reasonable number of points

(iii) **Number of claims**

A high proportion of motor claims are attributable to human error [1]  
 The underlying cause of the human error can include the driver being tired, distracted, making poor decisions, being under the influence of drugs, becoming unwell while driving ( $\frac{1}{2}$  per example) [2]  
 These claims may no longer occur, resulting in a significant reduction in claim frequency. [1]  
 Depending on the quality of the technology [1]  
 Alternatively they may reduce very significantly, as there may still be scope for human error, e.g., in setting the destination. [ $\frac{1}{2}$ ]

New causes of claim may emerge which are related to the FAD technology. [1]

For example Hacking of the FAD causing the vehicle to crash, Poor satellite coverage / mapping of area being driven in, Computer virus, *other valid*  $\frac{1}{2}$  per example [2]

For some claim types, the frequency is likely to reduce but some claims will continue to occur [1]

There may be some types of collision which the system finds difficult to avoid, for example, impact with wild animals [ $\frac{1}{2}$ ]

Fraudulent claims would be expected to reduce, as it would be difficult to stage a crash in a car with FAD technology [1]

Frequencies for some claim types are likely to be relatively unaffected [1]

This includes claims due to natural perils [1]

For example, fire, flood, earthquake, hail etc. (*half per example*) [1]

Although technology may be able to reduce frequency, for example, driving itself away from flooded areas. [ $\frac{1}{2}$ ]

Also includes claims such as theft / windshield etc. [1]

Increasing overall usage [1]

e.g. driving drunk [1]

Decreasing overall usage [1]

e.g. no recreational driving [1]

**Claim cost impacts – average claim size and other points**

Average claim size may decrease as driverless technology prevents reckless driving / driving over speed limit [1]

... reducing likelihood of significant injury claims often the result of this behaviour [1]

Other impacts would depend on quality and nature of technology [1]

... for example average claim size may increase if FAD technology simply fails to trigger at all if there is a failing in the logic [1]  
 ... for example, average claim size may decrease if FAD always applies some level of intervention even if not sufficient [1]  
 Would expect in particular a drop in really large claims [1]

Insurance would also need to cover the cost of damage to / loss of the FAD system [½]

There may also be increased potential for aggregations of claims, for example, if a failure of the FAD system impacts multiple vehicles [1]  
 ... particularly if the technology is reliant on communication between FAD in separate cars [1]

The average distance travelled by each vehicle may increase [1]  
 For example, if vehicles are sent home rather than parked at the passenger's destination [½]  
 Any increase in distance travelled would partially offset the reduction in claim frequency per mile [½]  
 Legal costs may increase particularly with test cases [1]  
 Theft costs may reduce as vehicles become more trackable [1]

*Other valid suggestions* [1]  
*Other valid suggestions* [1]  
*Other valid suggestions* [1]  
*Other valid suggestions* [1]  
*Other valid suggestions* [1]

[30, max 12]

*Mostly well answered, some candidates had some odd expectations for the impacts of driverless cars, even though the governments insistence on them suggests that they would generally be expected to be better (at least expected to be better over time)*

- (iv) Overall claim costs are likely to be lower (various reasons as before) [1]  
 As a result premiums will be lower, at least over time [1]

In addition, some of the remaining claims may fall under product liability insurance, rather than motor insurance, if they arise due to failure of FAD technology [1]  
 The manufacturers of the FAD technology may indemnify motorists in respect of systems failure, in order to encourage the adoption of the system [1]  
 Or the insurers may pursue recoveries from the FED technology manufacturers. [1]

Need to consider how components of premium other than claim costs will change [½]  
 For example, expenses, net cost of RI and profit margins [1]  
 Some expenses may reduce, for example, data collected by the FAD system may allow for automatic reporting and adjudication of claims [1]  
 Overhead costs unlikely to reduce, at least initially [1]

*Other factors which will impact the change in premiums include:*

Speed at which change in average claim costs is identified and reflected in the premium rates [1]

- Some insurers may prefer to wait and see what claim cost reduction arises, before adjusting premium rates [½]
- Competitive factors may determine how quickly each insurer passes on the expected claim cost savings [½]
- Government compensation / incentives to insurers to adapt to technological change (if any) [½]
- Government regulations regarding how premium rates are to be adjusted in response to new technology (if any) [½]

FAD systems is likely to result in better data being available about car use [1]

This will allow premium rates to be better tailored to how the vehicle is used [½]

Higher or lower impacts to particular groups depending on risk characteristics [1]

e.g. young / male / convictions etc [1]

[11, max 6]

*A number of candidates struggled to think more broadly about how a change in underlying risk profile might feed through over time into rate changes depending on the competitive environment*

- (v) Technical actuaries standards (TASs) issued by the Financial Reporting Council (FRC) are limited in scope to the UK operations of entities (or overseas operations which report into the UK within the context of UK legislation or regulation). [1]

The work does not appear to fall within the jurisdiction of the TASs [1]

However some of the principles set out in the TASs might be a relevant point of reference. [1]

The Actuaries Code sets out five core principles which all members are expected to observe in their professional lives, in both the spirit and the letter. [1]

The Actuaries Code would therefore apply to any work undertaken for Company Y. [½]

Actuarial professional standard APS X2 requires the actuary to consider the extent to which review (including independent peer review) may be required for the work. [1]

Non-mandatory resource material may be helpful, for example, regarding conflicts of interest if the actuary is advising multiple insurers on pricing. [1]

Country X's own version of the TASs – and any other professional requirements of Country X, including full knowledge of all relevant legislation [1]

Need to have experience before undertaking this role (part of Actuaries Code) [1]

Having full understanding of scope, payment and timetable before accepting task (part of Actuaries Code) [1]

[9, max 4]

*Generally very poorly answered, a number of candidates had at best a vague sense of the buzzwords (although in this situation the TAS do not apply) or an ability to think more broadly (local regulation etc).*

[Total 30]

- 3 (i) Employers' liability (EL) indemnifies the insured employer [½]  
 against legal liability to compensate an employee or his or her estate [½]  
 for bodily injury, disease, or death [½]  
 suffered in the course of employment [½]  
 owing to negligence of the employer [½]  
 Employee's property may sometimes be covered [½]

Workers' compensation (WC) provides compensation to an employee or his or her estate [½]  
 for bodily injury, disease or death [½]  
 suffered in the course of employment [½]  
 regardless of any fault on the part of the employer [½]  
 Paid directly to employee [½]

Public liability (PL) indemnifies the insured against legal liability to third parties [½]  
 where the insured is at fault [½]  
 for the death of or bodily injury to a third party [½]  
 or for damage to property belonging to a third party [½]  
 other than those liabilities covered by other liability insurance. [½]

[7, max 4]

*Not all candidates managed particularly clear answers picking up the specifics of each policy. In particular many struggled to draw a clear distinction between EL and WC, with a variety of improvisation taking place.*

- (ii) EL and PL policies only respond if the employer is negligent, whereas WC policies respond regardless of fault. [1]

EL and WC cover injuries to employees, PL covers injuries to people who are not employees [1]

PL also covers property damage [1]

EL is compulsory where PL is generally not [½]

Other than horse riding or nuclear power [½]

[4, max 3]

*As in (i) candidates who did not appreciate the differences between EL and WC did not pick up these easy marks*

(iii) **Event 1 – brick hits car**

EL would not respond	[½]
... as property damage	[½]
... not (presumably) employed at building site	[½]
... no likely negligence even if they are	[½]
PL would be likely to respond	[½]
... as third party and property damage is covered	[½]
... potentially might not if overlaps with some other policy	[½]
WC would not respond	[½]
... as property damage	[½]
... although otherwise might as technically working	[½]

**Event 2 – slip in hotel on business trip**

EL would not respond	[½]
... in spite of injury being covered and employee working at time	[½]
... as (assuming not also employed by the hotel) there is unlikely to be any negligence on part of employer	[½]
PL might respond	[½]
... as presumably third party and injury is covered	[½]
... although may overlap with WC if protected as on business trip	[½]
... so may depend on country / existence of WC cover	[½]
WC would respond	[½]
... as sustained in course of employment	[½]
... no need for fault or negligence on part of employer	[½]

**Event 3 – earthquake at office**

EL unlikely to respond	[½]
... in spite of injury being covered and employee working at time	[½]
... as unlikely to be a negligence case against employer	[½]
... unless there is related negligence that caused an injury which might not have otherwise incurred	[½]
... e.g. unsafe environment with precarious shelving that collapsed during the earthquake	[½]
PL would not respond	[½]
... as covers third parties only	[½]
... and no negligence	[½]
WC would respond	[½]
... as at work and no fault required	[½]
... unless policy has natural peril exclusion	[½]

**Event 4 – latent illness**

EL may respond	[½]
... as covered peril for employee	[½]

... provided the link is credible	[½]
... but would require some valid grounds for assuming negligence	[½]
... although in practice policies may pay out as awards tend to favour individuals	[½]
... especially on historical events with poor record keeping	[½]
PL would not respond	[½]
... as would be expected to be covered under EL or WC	[½]
WC would be likely to respond	[½]
... as covered peril for an employee	[½]
... provided link is credible	[½]
... no need to prove negligence	[½]
	[15, max 8]

*Candidates who appreciated the nuances of each type of cover generally answered this well and scored high marks. There were sufficient marks available that candidates who did not get the EL / WC distinction could still make a reasonable score*

(iv)	Simpler to charge everyone a flat rate	[1]
	... e.g. no need to decide the categories by which premium rates will vary, allocate each employer to a category, calculate the rates for each category, update all of the above periodically, or other example (1 per example of simplicity)	[2]
	Expense savings due to simplicity	[½]
	Easier to communicate	[½]
	It may be government intention not to penalise industries which have relatively high claim costs	[1]
	For example, the current system will result in relatively low premiums for primary industries, and high premiums for office work (or other example)	[1]
	Government may be effectively subsidising production costs of certain industries	[1]
	Government intention not to penalise employers with relatively high claim costs	[1]
	This may be because workers comp pays out irrespective of employer negligence	[1]
	May be considered unreasonable to increase an employer's premium if they were not responsible for the claims.	[1]
	Variation may be small enough that this is fair proxy	[1]
	Rate is applied to wages which is a reasonable proxy for claim severity	[1]
	It may be that the total levy rate does not reflect total claim costs (e.g. due to government subsidy of workers comp costs)	[1]
	The premium therefore effectively represents a payroll tax, rather than necessarily covering a particular cost.	[1]
		[11, max 6]

*Reasonably answered, although a number mainly put down generic flat rating points rather than applying to the specifics and thinking about any broader aims that the government might have*

- (v) A must have had a major event in y1, either in absolute terms or relative to size of company (e.g. a single large injury for a small company). [1]  
 Presence of some claims even in more benign years suggests a large event in absolute terms as otherwise would expect clean years for a small company [1]  
 Although may have some residual level of minor loss activity, e.g. slip & trip [1]
- B is showing very stable experience after allowing for rate changes [1]  
 Suggests that may be a large company with no particularly unusual events [1]  
 Overall levels are consistently higher than average suggesting company is higher risk (e.g. heavy industry) [1]  
 C has one clean year and generally volatile experience suggesting it may be a small company [1]  
 Could be new start up [½]  
 Particularly as paid data so might not have paid on any claims incurred in y1 [1]  
 If so trend may not be particularly meaningful [1]  
 [8, max 4]

*Most candidates managed some suitable comments. Many missed that B's experience was very stable after rate changes, or didn't think through implications of paid claims.*

- (vi) Compared to the current arrangements, the new method is likely to result in premiums that better reflect differences in expected claim costs. [1]  
 This is because the current system does not reflect differences in claim cost at all (other than companies with large payrolls paying higher premiums than small businesses) [1]  
 However the calculations have a number of limitations, meaning the premiums will not exactly reflect expected claim costs. [1]
- Premium adjustments reflect employer claim ratio relative to average claim ratio. [1]  
 So it is possible that an employer with a claim ratio above 100% could get a premium reduction, if 100% was below the average (or other example). [½]  
 Premium basis does not reflect systemic drivers of claim costs, for example, an increase in claims inflation impacting all employers' costs. [1]
- Ratio of claims paid to premiums received in a single year may be a poor indicator of expected claim costs. [1]  
 In part this depends on the nature of workers compensation benefits provided in this country. [½]  
 Need to consider the distribution of claim costs, which will depend in part of

the benefits covered [½]

If the benefits are primarily short term in duration, for example, short term medical and loss of wages, paid claims may be a reasonable proxy for benefits incurred. [1]

However it may be that a significant proportion of the premium is required to cover long term compensation for catastrophic injuries, in which case paid claims in a single year is a poor benchmark of expected costs. [1]

For example, an accident may result in limited payments in the year in which the accident occurs, but require significant payments for many future years. [1]

An exceptional event could therefore result in above industry average paid claim ratio for many years. However this exceptional claim may not be indicative of future expected claim costs. [1]

It may be that most employers have below average claim ratios in any given year, and so qualify for premium reductions. [1]

In particular, even employers with high expected claim costs may have claim ratios below the average in most years. The most serious claims will occur infrequently, even at high risk employers. [1]

A small number who have had serious injury claims may have claim ratios significantly above average, and so pay higher premiums. [1]

Payments in a single year will not be a good proxy for latent claim risk, as these are characterised by a long delay between accident date and claim notification / payment. [1]

Injured employees may be able to choose whether to take a lump sum settlement, or ongoing payments over multiple years. [½]

Payment preferences (rather than expected claim costs) could impact premium. [1]

Employers may pressure employees to delay reporting claims under the following year, in order to obtain a premium reduction in the current year, or otherwise impact timing of payments. [1]

If an employer already expects claim ratio to be above average, it may be able to delay paying premiums until the next year. This would increase the likelihood of below average claim ratio the following year. [1]

The nature of an employer's operations may change from year to year. [1]

For example, an employer may increase the number of workers employed in low risk activities, and reduce the number employed in high risk activities, with no change in payroll. [½]

It would take many years for premium rates to adjust to reflect change in expected claim costs. [1]

Need to consider how new employers will be rated. [½]

If they start at the average premium, this is unlikely to reflect expected claim costs. [1]

Premium rates are capped (min 1%, max 3%). Premium will not reflect expected claim costs if they lie outside this range. [1]

[24, max 8]

*Quite poorly answered. Few thought about implications of paid claim basis. A number did not really understand the dynamics for individual companies – generally most will run clean in a lot of years, particularly small companies.*



- (vii) Employers may decide to improve workplace health and safety practices to reduce all claim types, to help ensure premium reduces (or does not increase) the following year. [1]  
This would reduce likelihood of all injury types, including fatalities. [½]

It would be hoped that employers are already doing all they can to avoid fatalities. [1]

The new premium arrangements may not provide a strong incentive to do any more to reduce fatalities. [1]

It may be that employers in high-risk industries always pay premiums of 3% of payroll (the maximum), due to the inherent riskiness of these industries. [1]

The new scheme does not provide an additional financial incentive to employers in such high risk industries. [1]

Even if an employer was reckless, would expect the number of fatalities to be very low, so the premium impact would also be low. [1]

A fatality would only impact premium by 0.2%, which could be reversed the following year [1]

A single fatality may not move premiums at all (if the payroll was very large) – claim ratio could still be lower than average. [1]

*Other valid suggestion* [1]

*Other valid suggestion* [1]

[10, max 5]

*Relatively poorly answered. Many candidates struggled to focus their thinking on fatalities only, and the low frequency of these. Better candidates appreciated that companies generally aim to minimise fatalities in any case.*

- (viii) Employers would have a strong incentive to reduce injuries, as any claim costs would be paid by the employer (and so the employer gets to keep any savings compared to workers comp premium) [1]  
In particular, costs may end up below the 1% minimum premium charged by government insurer. [½]  
Employers should be able to reduce the risk of injury, as they control the operations of their businesses. [1]  
Employers can also reduce claim costs by supporting worker rehabilitation and return to work, for example, by offering an alternative role. [1]  
The alignment of the financial incentive together with the control over workplace health and safety could reduce employee injuries. [1]

Employers with high claim costs may choose to remain with the government insurer if costs are lower, meaning the scheme may not provide additional incentives to reduce injuries for high-risk employers. [1]

Would also need to be rules around joining and leaving the government insurer. [½]

For example, if a large claim occurs which will require payments for many years, the employer would need to cover all payments arising before rejoining government insurer. [1]

Employers may not have access to specialist rehabilitation staff [1]

Especially for the most complex risks and claims [½]

Government insurer may currently provide support to make workplaces safer.  
Self-insurers may not have access to this expertise. [1]  
Employers may not have necessary workers compensation claim management systems [1]  
Loss of capability may impact on employees. [½]

Large employers may be part of multinational groups which manage their own workers comp claims in multiple jurisdictions. [1]  
The new scheme may allow employers to start to use this multinational expertise. [½]

Benefits would need to be at least as generous as those provided by the government insurer [1]  
Some employers may decide to offer more generous benefits, for example, covering a greater proportion of wages following an accident at work [½]

Need to ensure a high degree of confidence that injured employees receive compensation [1]  
Some employers may be unable to pay claims [1]  
Large employers may be better able to afford and budget for this than smaller ones [½]  
However need to ensure claims are paid if employer becomes insolvent [1]  
Employer may not be around many years after the event, e.g., latent claims [½]  
May be difficult to trace employer many years after event [½]  
If a worker has had several employers, may now need to establish which employer is responsible for a claim. [1]  
Could require employer to purchase private insurance. [½]  
Or government could continue to pay in the event of employer insolvency [½]

Some employers may be unwilling to pay claims, or make it difficult to make a claims [1]  
Would need a regulator / appeals body to allow employees to raise grievances. [½]  
[22, max 8]

*In spite of a significant number of points available relative to the marks candidates often struggled to think sufficiently broadly.*

[Total 46]

## END OF EXAMINERS' REPORT