Self-Insurance and Risk Pool Audit Guide

December 28, 2022

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Planning Guide Information

Supercedes previous planning guide dated March 21, 2022. Please direct questions or suggestions to the Self-Insurance / Risk Pool Subject Matter Experts.

Note: This guide is intended for use when auditing stand-alone public entity risk pools as well as other individual self-insurance programs (at a county, city, school district, etc.).

Guidance is based on the extensive research, brainstorming and reviews conducted as part of the planning guide update process. Guidance is intended for internal use only to help auditors gain an understanding of self-insurance. The guide is intended to enhance planning and risk assessment procedures, not replace them. Information in the guide should therefore be considered along with other planning and risk assessment procedures. While guidance is designed to be as comprehensive as feasible, auditors must be alert for audit issues and situations not specifically addressed.

This guide is used by the State Auditor's Office staff as they plan audit engagements. Information presented in this document does not represent policy or legal guidance. State agencies and local governments should contact their legal counsels with specific questions.

WHAT'S NEW

Auditors should be aware of the following significant updates:

- SME Participation – Auditors must invite an SME to the planning conference brainstorm for the financial statement audit of risk pools.
- Unemployment Reimbursable Self-Insurance Programs – The Employment Security Department experienced system problems in 2020 resulting in errors in the billing statements of some entities operating under reimbursable status. Audit procedures should focus on controls over identification and payment of legitimate claims.

REQUIRED RISKS TO ASSESS

The following risks must be documented as red flags and discussed during brainstorming to ensure sufficient consideration. They should be prioritized for audit to the extent they are applicable and significant to the risk pool.

EFT Controls (risk pools only)

Payroll and vendor electronic file transfer (EFT) related cyber frauds continue to occur. Accordingly, controls over EFTs is a required risk to assess for all entities we audit. When assessing this area of risk, auditors should talk with the entity about its controls related to changing existing EFT contact information and associated bank account numbers. The approach perpetrators of these frauds use has evolved to include changing contact information for existing EFT transactions before requesting a change to the associated bank account numbers. Previously, entities were encouraged to follow up with the contact information known at the time of the request for changes to bank account information; however, a stronger control is to independently confirm any change to payroll or vendor profile contact information or banking account information. Individuals with the ability to change or add EFT accounts need to have clear guidance on the process to authorize these changes through a proper validation method. A testing strategy is available in TeamMate at Accountability | Expenses | EFT Disbursements | Controls over EFTs. Contact Team IT Audit at SAOITAudit@sao.wa.gov for additional clarification or guidance.

Financial Condition (risk pools only)

Financial condition risk will be assessed as a baseline test for accountability audits and as part of our going concern analysis for financial audits. However, serious financial condition issues have been rare for risk pools. Governments have experienced a wide range of effects as a result of COVID-19; auditors should be alert for any risks to financial condition and review FYI 2020-01 for expected disclosures.

Review of Medical Claims

Many governments use a third party, such as a plan provider or third party administrator, to review and process medical claims. We often find that government employees are performing little to no review of these medical claims. As a result, we have found that some governments are not complying with RCW 42.24.080 by auditing all claims before payment to verify they are a just, due and unpaid obligation against the government. Governments often state they cannot review all the details of each claim as it would be a HIPPA violation. However, our Office's position is that HIPPA requirements do not absolve governments of complying with state law. We do not expect that the government review every detail of every claim processed as this may not be feasible, but they should have established procedures for providing some level of assurance that the claims are just, due and unpaid obligations of entity's self-insurance program (e.g., eligible claims for program participants). There are different options for governments to gain assurance over these claims. These options include reviewing a list of names of those receiving benefits during the claim period to verify they are covered employees or dependents, statistical sampling and review of claims, and other options. If auditors do not see any procedures, think the procedurs are insufficient or are otherwise unsure, they should contact an SME. See the Third Party Administrator/Insurance Claims Administrator Review and Controls Performed by Third Party Administrator below for more information.

BACKGROUND

Governments can choose to address various risks or obligations (such as property losses, liability claims, workers' compensation, etc.) using different methods. Governments can purchase insurance policies, participate in a joint self-insurance program, or develop formal programs to self-insure against these types of risks (e.g. a government may establish a program in which different departments pay an annual premium to an internal self-insurance fund that pays claims associated with the program).

Governments can also choose to absorb the risk of loss without establishing a self-insurance program. For example, a Sheriff's Office may purchase insurance against medical liability claims for automobile accidents and choose not to insure the replacement costs of its vehicles. In such a situation, no obligation exists that would require the Sheriff's Office to replace its own vehicle at that point – it may simply choose to wait until replacement funds are available in a future budget cycle. Although it involves retaining risk, this type of activity does not constitute self-insurance and does not require an audit every two years (RCW 43.09.260).

JOINT SELF-INSURANCE PROGRAMS ("RISK POOLS")

"Risk Pool" is the generic term used to describe joint arrangements created pursuant to Chapter 48.62 RCW. Chapters 39.34 and 48.62 RCW, allow local governments to jointly self-insure risks, jointly purchase insurance or reinsurance, and/or to jointly manage or contract for claims and administrative services. Joint self-insurance programs are sometimes administered by a participating government, but more often a separate public entity risk pool entity is formed. Membership is limited by the pool's charter, contractual provisions or interlocal agreement (sometimes referred to as membership agreement), which are approved by the State Risk Manager when the program begins and whenever it is significantly changed. Membership is accomplished through interlocal agreement and may include out-of-state governmental members. Board members are elected or appointed by member entities according to governance provisions of the interlocal agreement that established the pool.

Note: For guidance related to risk pools managed by Educational Service Districts, please see the ESD Planning Guide.

Risk Pools collect assessments that it estimates will cover the costs of program administration and all claims for which the pool is obligated. If an individual member's losses are different than its annual assessment, there are typically not additional assessments or refunds made to that member. The insurer (pool) views its activities in the aggregate, rather than on an individual insured member basis. Risk is shared by members, with the pool acting as the insurer. Although risk is transferred by members to the pool, it is not the same as purchasing an insurance policy since the pool is organized as a cooperative - the members as a group remain liable for unpaid claims in excess of pool resources. Most risk pools we audit have a "retroactive assessment" provision in their agreements whereby the risk pool will charge members in the event losses exceed available assets. Alternatively, pools may declare supplemental assessments or refunds depending on the loss experience of members as a whole or may increase or decrease premiums for future coverage.

The risk pool will typically have several layers of coverage. The pool may purchase insurance jointly (joint-purchasing with no risk-sharing) or self-insure (risk-sharing) risks up to a defined limit. The pool may purchase reinsurance, such as stop loss or excess insurance, to reduce potential exposure and liability for significant or larger claims. See Appendix 1 for more details on these items. The cost of insurance purchased is a factor when calculating member assessments. Typically, the pool estimates administrative expenses and claims losses, and then assesses member contributions a proportional share of the estimated costs. Subsequently, member assessments are adjusted based on actual expenses and claims losses.

Pools are also distinguished by the type of risk that they insure. There are two main categories of risks insured by joint self-insurance programs that are separate legal entities:

- Property and liability
- Health and welfare – may include medical, dental vision and prescription

Property and liability programs, and health and welfare programs operate differently, since they insure significantly different risks. Property and liability programs are subject to regulations in Chapter 200-100 WAC, while health and welfare programs are subject to regulations in Chapter 200-110 WAC; however, both program types are subject to Chapter 48.62 RCW.

See additional information below in the "Self-Insurance" section of the planning guide.

Industry, Regulatory and Other External Factors

Risk pool activities are subject to significant regulation and oversight by state agencies:

- Activities for property, liability, health and welfare pools are subject to regulation and oversight by the State Risk Manager (via the State Department of Enterprise Services - Risk Management Division).
- Administration of self-insurance for workers' compensation programs are subject to oversight by the Department of Labor and Industries under Chapter 51.14 RCW.
- Unemployment compensation programs are subject to oversight by the Employment Security Department under Chapter 50.44 RCW; however, the oversight is minimal.

While risk pools are public entities, they compete for membership with each other, private insurance companies and the option to self-insure. Fluctuation in membership is not uncommon, as members frequently shop around for the best price and service.

Key Operational Information

Key information about risk pool operations that the auditor should document in the permanent file includes:

- The types of entities allowed membership and the number and type of participating entities.
- What risks are covered, whether risk is transferred or retained, and the pool's strategy to cover each risk (joint purchase of insurance or self-insured with any reinsurance).
- Governance and management structure required by the interlocal agreement.
- Any other important terms or limitations included in the interlocal agreement (and charter or bylaws, if any). For example, if advance member contributions are required by the contract.

PLANNING & ADMINISTRATION

To comply with the requirements of WAC 200-100-060(3), every joint property and liability self-insurance program authorized to conduct business in the state of Washington must provide audited financial statements to the Department of Enterprise Services (DES) Risk Management Division within eight months of fiscal year end. Audit teams should schedule risk pool audits to allow the audit client adequate time to meet this statutory deadline.

Training and Additional Resources

The following recorded webinar is available in the training system and may be helpful when auditing risk pools or self-insurance programs:

- Know Before You Go: Risk Pools

Additional resources related to risk pools and self-insurance can be found on the SAO intranet site under Auditor Resources | Reference Guide | Self-Insurance Resources.

Required Planning Procedures

These required procedures are included in the risk pool specific planning steps at Planning & Audit Plan | Entity Specific Planning Steps | Risk Pool.

- **SME Participation in Planning Conference Brainstorm and Work Paper Review -** Auditors must invite a Self-Insurance / Risk Pool Subject Matter Expert to the planning conference brainstorm for the financial statement audit of risk pools. Please notify the experts when audit planning has begun and send them draft financial statements and the completed Solvency Test spreadsheet when available, preferably a few days ahead of brainstorm so the expert can review it. Please set aside up to 4 hours for the expert to review these documents, participate in brainstorm, and provide guidance

as needed. Auditors must also invite an expert to the brainstorm meeting for CPA reviews, although no hours are required and the expert will not provide any additional assistance unless requested.

See the steps at Planning & Audit Plan | Entity Specific Planning Steps | Risk Pool | Required Procedures & Modify Rep Letter.

- **Management Representation Letter -** Modifications will need to be made to the management representation letter (see Representation Letter Resource) for both accountability and financial statement audits of risk pools.

- **Review DES Report -** The State Risk Manager has approval, standard-setting and oversight responsibilities for certain local government self-insurance activity (Chapter 48.62 RCW). Joint property and liability programs as well as both individual and joint health and welfare programs are subject to State Risk Manager rules.

  Joint programs are required to submit financial and claims information to the State Risk Manager quarterly and at the end of the year. The Risk Manager monitors programs throughout the year for financial solvency and proper management of the insurance program. Periodically, the Risk Manager also performs a desk or on-site audit of the program. However, for most joint programs, there has not been a recent audit. This audit can consist of a review of the following areas:
  - Program formation and adoption documents
  - Program financing plan
  - Solicitation and disclosure practices
  - Insurance coverage provided
  - Program termination provisions
  - Third Party Administrator contracts and contract procedures
  - Risk management programs, including practices and policies
  - Internal financial reporting practices and procedures
  - Practices in identifying and eliminating conflicts of interest
  - Membership complaint and appeal process
  - Executive Committee meeting minutes
  - Claims administration practices and procedures (*including review of a sample of claims for validity of the claim and proper supporting documentation*)
  - Rate setting, as prescribed in WAC 200-100-033

  Auditors should obtain a copy of the DES State Risk Manager's most recent examination of the risk pool and consider the elements that were reviewed as well as results of the examination. Auditors should consider issues noted for audit consideration and follow-up to see if they have been resolved. See the "Required DES Communications" TM step in the Planning | Entity Specific Planning | Risk Pools folder. You can also access pool reports at DES' website. NOTE: DES may not always have a current audit report; there may be instances in which it has been several years since they audited an entity or they may not have had an audit. We recommend auditors check with the entity to confirm when the last audit occurred.

- **Independent Claims Audit Required -** All joint property & liability programs (WAC 200-100-050) and all individual and joint programs offering medical coverage (WAC 200-110-120) are required to obtain an independent claims audit every three years at a minimum. These audits should be conducted by an independent qualified claims auditor not affiliated with the program. See the "Review Independent Claims Audit" TM step in the Planning | Entity Specific Planning | Risk Pools folder.

  NOTE: The state risk manager may require more frequent claims audits for programs that, in the state risk manager's opinion, are not operationally or financially sound. If an independent claims audit has been performed, obtain a copy and review for any significant findings for audit consideration.

- **Legal Letter from State Risk Manager -** Risk pools are required by state law (RCW 48.62.031(6)) to appoint the State Risk Manager as the attorney to receive legal action against them. This includes only legal action directly against the pool itself, not insurance claims against each member which are paid through the pool. To determine whether a risk pool has any contingent litigation, a template has been created to send to DES. This letter will act as the pool's attorney letter in the event they do not use any additional legal representation. See the "Required DES Communications" TM step in the Planning | Entity Specific Planning | Risk Pools folder for instructions and a template email.

ACCOUNTABILITY

In accordance with RCW 48.62.071, State Risk Manager approval is required for the establishment of the following programs:

- All individual local governments self-insuring for health and welfare benefits (medical, dental, vision and prescription drugs).
- All joint local governments self-insuring for property and liability risks (risk pool).
- All joint local governments self-insuring for health and welfare benefits (risk pool).

NOTE: State Risk Manager approval is NOT required for the establishment of individual local governments self-insuring for property and liability risks.

RCW 48.62.111(3) authorizes risk pools to act as their own treasurer or designate a treasurer by resolution.

Revenues

Risk pools are funded by member assessments or contributions, reassessments (if applicable), insurance/re-insurance reimbursements, and interest. Member assessments, contributions, and re-assessments are usually a result of Board action which should be documented in the minutes, resolutions, and/or ordinances.

Individual health and welfare self-insurance programs can be funded by employee premiums or employer contributions, re-assessments (if any), insurance/re-insurance reimbursements, and interest. Other individual self-insurance programs, such as workers' compensation and unemployment compensation, may be funded through employee premiums, employer contributions or the entity's budget process or cost allocation plan.

We would also expect miscellaneous revenue streams such as refunds of overpayments, rebates, returns on claims, restitution payments for property damage and miscellaneous payments for member or associate member services, administration or commission income.

We would not expect pools or individual programs to receive any state or federal grants, although grants from private foundations are possible. We would also not typically expect bonds or loans, although some pools may issue bonds for construction of administrative facilities. Pools are expected to support activities from operating revenues. WAC 200-100-065 would require that loans be approved by the State Risk Manager as a significant program change.

Expenses

In addition to normal accounts payable and payroll costs, auditors should be aware of the following special systems and types of expenses:

- **Insurance Premiums** - Purchase of insurance/reinsurance policies can be a major expense for risk pools. There may be payments to one or more reinsurers for various policies (property damage, earthquake, flood, marine insurance, liability, medical, vision, etc.).

- **Insurance Broker Costs** - Broker's fees and compensation can be significant and should be supported and accounted for separately.

- **Claims Payable** – Claims payable refers to payment of insurance claims filed against a pool or risk management department. Normally, these claims are paid through the normal accounts payable system, but subject to a different process and controls that includes approving authority for different dollar thresholds for claims. Also, additional information systems (disconnected from the general ledger) may be used to track and estimate claims (such as Origami or RiskMaster). Previous fraud investigations have identified weaknesses in monitoring the validity of claim payments and a lack of segregation of duties when risk management departments are decentralized (such as at a county) and choose to process their own warrants. As a result, there is a risk these payments are processed without adequate review to ensure they are legitimate. It is important within the risk management department to have an independent review process in place for these claims prior to them being sent for processing.

  Note for 2020 audits of reimbursable status unemployment programs: The Employment Security Department (ESD) experienced system problems that led to some entity billing statements not consistently reflecting credits issued in 2020. The ESD is aware of the issue, and has been working to correct statement balances for entities impacted by the system error. This has the potential to lead to significant discrepancies between entity and ESD calculations.

  Audit procedures should focus on internal controls to ensure the entity identifies and pays the appropriate amount for legitimate unemployment claims, including any credits that might be owed to the entity. Because ESD statement balances might be incorrect, entity calculations might not tie to ESD records.

  Unemployment credits, which might not be recorded in ESD statements, include the following:
  - 2020 identified imposter claims
  - Federal relief credits or reductions to amounts due given as part of CARES or other federal programs

  A testing strategy is avalaible in TeamMate at Accountability | Compliance Requirements | Self-Insurance | Individual Self-Insurance of Unemployment Compensation Risks. Contact a subject matter expert if you need assistance evaluating the reasonableness of the audit results in light of the information above.

- **Wellness Grants** – Health and welfare programs are authorized under WAC 200-110-070 to offer wellness programs to their members. The wellness program participants apply for grants to use for reasons relevant to achieving sustainable healthier lifestyles and practices for employees, such as incentive prizes, etc. The risk pool should be able to demonstrate to the auditor how the expenditure of funds served to benefit the risk pool members. This is especially true at a time when the risk pool decides to continue its wellness programs; management should have at least considered evidence that the programs are working before approving their continued funding.

- **Service Contracts / Third Party Administrators (TPA)** – Self-insured risk pools hire and employ an administrator and staff, or they may enter into a professional services contract with a firm to provide claims administration, risk management, accounting and/or other services. This firm would be referred to as a third party administrator (TPA). We have noted weaknesses and even absence of Board or Management monitoring of claims payments and activities performed by third party administrators. See the Third Party Administrator/Insurance Claims Administrator Review and Controls Performed by Third Party Administrator below for more information. See also Required Risks to Assess.

Third Party Administrator/Insurance Claims Administrator Review

Many agencies use a plan provider TPA for claims processing and other duties. In these situations, entity officials may not be reviewing adequate information or performing sufficient procedures to comply with RCW 42.24.080. Most often, officials are not reviewing sufficient detail for medical claims. Many of these

public agencies are claiming it would be a HIPPA violation to review the detail behind these claims, but this does not absolve them of the requirement to comply with state law.

Entity officials may not be able to review the details of all claims processed by the TPA due to volume but they should have established procedures for providing some level of assurance that the claims are just, due and unpaid obligations of entity's self-insurance program (e.g., eligible claims for program participants). If auditors do not see such procedures, they should contact an SME for further discussion. See also Required Risks to Assess for more information.

Controls Performed by Third Party Administrator

Third-party administrators (TPAs) would generally be considered "outside service organizations" meaning that auditors would include any relevant procedures performed by the TPA when gaining an understanding of key controls.

Individual self-insurance programs, as well as risk pools, typically contract with TPAs to manage claims administration, and/or financial management of the self-insurance program. Auditors should consider the following when examining these types of situations:

1. Auditor's should gain an understanding of the activities/services provided by the TPA. Typically, there is a contract between the entity, or pool, and the TPA that describes these services.
2. The entity, or pool, and TPA may have written policies that describe the claims process, including internal controls.
3. The entity should have appropriate controls so that all expenses, including claims payments, are audited, certified, and approved in accordance with RCW 42.24.080.
4. Based on the service(s) provided by the TPA, what type of reports and information does the TPA provide regularly to the entity or pool officials? Is this information adequate? How does the entity know the information is accurate or reasonable?
5. What do entity or pool officials specifically do to monitor TPA activities for compliance with the contract?
6. A best practice is for an entity or pool to obtain a SOC Report (Service Organization Controls) (or SSAE 16) examination of the TPA. Some entities may not be aware of what a SOC Report is and the auditor may need to describe it to them. If an entity relies on its TPA (as a service organization) for key financial statement controls in an opinion unit and the TPA obtains a SOC Report, steps are available to evaluate this in TeamMate at Financial Statements | Rely on Work of Others | Rely on SOC Report. If a SOC report is not available, the auditor may need to understand, confirm and even test the TPA's controls, which may require coordinating access to TPA staff or systems with the Pool.

Compliance Requirements

General compliance requirements apply to risk pools, including Open Public Meetings Act, expenditure audit and certification, conflict of interest laws and authorized investments. Note that pools and any TPAs are also subject to additional conflict of interest provisions described in WAC-200-100-080 and WAC 200-110-150. WAC 200-100-037 and WAC 200-110-090 require pools to establish an investment policy, in addition to general investment requirements.

Since risk pools are formed via interlocal agreement, they are limited by the most restrictive compliance requirements of their members in certain areas. If you have questions about this area, speak with an SME.

- **Rate Setting** – The allocation of pool expenses and losses to members via rates (member assessments - also called contributions or premiums) should be calculated and assessed in a consistent and nondiscriminatory manner (WAC 200-100-033 and RCW 43.09.210). Member assessments should be consistently calculated and billed based on a method approved by the board, which may involve certain members having higher rates or premiums based on factors such as type and frequency of claims and the nature of member operations, among others. Any concessions made to one member have to be made up by increasing the assessments to other members, and would result in one entity benefitting at the expense of another if not applied based on an established rate setting process that is rational

and nondescriminatory. The possibility of unsupported rate concessions may be especially risky for new members as pools may reduce their assessments to entice them to join the pool.

- **Associate Memberships** – Stand-alone risk pools do not possess the authority to include other entities that are not full members of the pool to purchase insurance as associate members (aka affiliate members, interim members, etc.). These associate members would pay for certain services, but cannot participate in insurance coverage, do not own equity in the pool and do not have voting rights in electing governing officers.

- **Actuarially Determined Liabilities** – Joint property and liability programs are ***required*** to obtain an annual actuary review to provide estimates of unpaid claims measured at the expected level as well as at the seventy, eighty, and ninety percent confidence levels as prescribed in WAC 200-100-03001. Joint and individual health and welfare programs are not subject to this requirement but have solvency requirements to meet as prescribed in WAC 200-110-040. If an individual local government self-insures for more than one individual program (such as medical, dental, vision and/or prescription), the entity is required to meet solvency requirements for each program individually. See additional information below at Solvency (regulatory compliance).

- **Membership** – Risk pool membership is limited to those types of entities, which are included in the formation documents approved by the State Risk Manager. When a risk pool adds a new type of member (city pool adds a special district, for example) we should assess whether the pool has the authority to do it. In general, non-public entities (for example, non-profit organizations) cannot join a public entity risk pool. A non-profit risk pool does exist, for non-profit entities.

- **Competitive Solicitation** – WAC 200-100-215 requires pools to use a formal process for the selection of consultants, including actuaries. WAC 200-100-038 requires a competitive solicitation process for third party administrators and the contract term should be no greater than five years and allow for no more than a one-year extension to be exercised at the program's discretion. See WAC 200-100-038 and 200-100-215 for more details. This requirement only applies to joint property and liability self-insurance programs.

- **Solvency –** Solvency continues to represent the most significant potential risk for joint and individual self-insurance programs and auditors should examine solvency during every audit. Even if a program remains a going concern for financial statement purposes, SAO should still report significant financial deterioration or significant solvency risks to users, management, members and the board. Solvency requirements are only applicable to joint and individual health and welfare programs, and joint property and liability programs. Solvency rules described below do not apply to individual property and liability programs, unemployment compensation or workers' compensation programs.

    - Property and liability programs are held to standards of solvency set by WAC 200-100-03001. The standards require a joint property and liability program to maintain enough "primary assets" to pay all unpaid claims estimated at the expected level by an actuary. These pools are also required to maintain "secondary assets" in an amount greater than or equal to unpaid claims estimated at the eighty percent confidence level by an actuary. Definitions of primary assets, secondary assets, and unpaid claims are in WAC 200-100-020.

    - Joint and individual health and welfare programs are held to standards of solvency set by WAC 200-110-040. The standards require programs to set aside program reserves (cash and investments) in an amount equal or greater than 16 weeks for medical programs and eight weeks of vision, dental and prescription program expenses. Program reserves are defined as moneys set aside to pay expenses of an individual or joint self-insurance program, rather than a program's net position or fund balance. In lieu of establishing an eight and/or 16-week program reserve, the entity may obtain an independent actuarial study to determine the total liability of the program under WAC 200-110-040 (3) and can set aside programs to that amount. If the entity obtains an actuary report to determine its program reserves, then the entity should report this liability on its Statement of Net Position or Balance Sheet. In addition, the entity should set aside cash and

investments to fund this liability; however, these cash and investments should not be reported as restricted assets. Cash basis entities should not report the liability on its Schedule of Liabilities (Schedule 09).

Occasionally, we have found governments with individual health and welfare programs are reporting incorrect financial information to the State Risk Manager regarding solvency. Some governments have complex calculations including rolling fund balances (which may or may not agree to their financial statements) and are reporting those figures to the State Risk Manager for determining solvency compliance. In addition to confirming that the government has met its solvency requirement, auditors should also understand the controls and calculations used by entity staff to determine the correct amount to report to the State Risk Manager.

Auditors must use the "Self-Insurance Solvency Test - REQUIRED" step available in Accountability | Compliance Requirements | Self-Insurance folder to assess this risk. The auditor should contact a Self-Insurance Expert with questions or if they note solvency concerns or financial distress.

Note: There are different solvency requirements for medical programs than dental, vision and prescription. It is not uncommon for entities to account for all of these collectively, or in the same account. However, if the programs are funded and structured separately, meaning an employee can choose to participate in the medical program and the dental, vision and/or prescription program individually and separately, and if the premium and funding components of the medical program are separate from the others, then they should not be combined and accounted for collectively. They should also not be combined for purposes of meeting solvency requirements and auditors should refrain from combining these funds when completing the solvency testing spreadsheet. Contact an SME if you have questions about this.

FINANCIAL STATEMENTS

Risk pools are a proprietary-type fund that is required to report using the enterprise fund model. Regular GAAP BARS guidance applies with additional reporting instructions specific to Risk Pools. The BARS Manual requires annual submission of financial statements, Schedule 01, Schedule 19, Claims Development Information (RSI), a List of Participating Members (OI) and a DES Schedule of Expenses (OI).

Joint property and liability programs and joint health and welfare programs are required to submit audited financial statements to DES within 8 months of fiscal year-end. See Agreed Upon Procedures section for more information on joint health and welfare programs that are not operated as a standalone risk pool.

Note: Auditors should consult the self-insurance audit procedures available in the Accountability | Compliance Requirements | Self-Insurance folder in TeamStore for financial statement related considerations.

Reliance on Actuary

As mentioned, joint property & liability programs are required to obtain an annual actuarial study to provide estimates of unpaid claims, under WAC 200-100-03001. The actuarial report will estimate the potential liability for known unpaid claims as well as claims that have been incurred but not yet been reported (IBNR). Actuarial studies can also be used to advise the pool on the rates for member assessments.

Auditors should refer to Audit Policy 3230 and use the "Rely on Specialist" TeamMate step in the Financial Statements | Rely on Work of Others folder when using the work of the actuary as substantive evidence.

There is always a risk that actuary estimates for unpaid claims liabilities are not based on supported, complete and accurate claims information provided by the pool, entity or TPA. As part of procedures necessary to rely on the work of the actuary, auditors should agree certain figures used by the actuary, documented in the actuary report, to source documentation provided by the entity, pool or TPA. There may be small variances between this information occasionally, which should have a satisfactory explanation and

support. Contact an SME if you need assistance in reviewing the actuary report or agreeing it to source documentation.

An additional representation will be needed for reliance on the work of an actuary, as described in the Rely on Specialists step (see Representation Letter Resource). Auditors should also consider further representations related to any significant concerns or uncertainties, if applicable to a particular pool or program. Auditors should also consider contacting the actuary who issued the report – we have found that some actuaries are willing to discuss other concerns that they did not disclose in their report because of the scope of their services. **NOTE: If the auditor considers contact with the actuary necessary, they should work through the audit client to contact them as a professional courtesy and because the client will likely be billed for it.**

Advance Member Receivable

Some risk pools invoice members' their annual premiums before the year of services, sometimes three or four months early. Risk pools may report these amounts as advance member receivables on the Statement of Net Position if their interlocal agreement or other contractual documents require that payment be made before the year of services. If there is no contractual requirement, the risk pool should not report a receivable. In that case, the risk pool has likely invoiced in advance as an administrative convenience, and any payments received before the year of services would be recorded as a liability. Determining if contract terms create a claim to an advance member receivable requires critical evaluation of the multiple factors. If advance member receivables are reported, auditors should contact a subject matter expert.

Reporting and Disclosure of Unemployment Liabilities

GASB 10 par 3 says that self-insurance of unemployment compensation liabilities (whether joint or individual programs) should be reported and disclosed using contingent liability criteria - public entity risk sharing note and RSI requirements of GASBs 10 and 30 would not apply.

Estimated Claims Liability (for risks other than unemployment and workers' compensation)

Estimated claims liability refers to the estimates and line items involved in reporting the pool's liability for all claims incurred, including claims made and claims that have not yet been reported. We would expect to see the following items reported on the balance sheet:

- **Claims Reserve - Current** - This liability is to account for the estimated cost of resolving claims that are expected to be paid within one year after fiscal year-end.
- **Claims Reserve - Noncurrent** - This liability is to account for the estimated cost of resolving claims that are expected to be paid greater than one year after fiscal year-end.
- **IBNR - Current** - This liability ("incurred but not reported") is to account for estimated of claims that have been incurred during the current year, but have not yet been reported (claimed) to the pool, and are expected to be paid within one year after fiscal year-end.
- **IBNR - Noncurrent** - This liability ("incurred but not reported") is to account for estimated of claims that have been incurred during the current year, but have not yet been reported (claimed) to the pool, and are expected to be paid greater than one year after fiscal year-end.
- **Unallocated Loss Adjustment Expense** - This liability is for the estimated costs to administer current claims and estimated unreported claims. If the pool decided to discontinue the program, these costs would still have to be incurred and would represent the cost to contract with another entity to administer the remaining claims until completion.

As described above, joint property and liability programs are required to obtain an annual actuary review that estimates claims liability at what the industry refers to as the expected level as well as several other confidence levels. Such programs normally report their claims liabilities at the expected level. However, some joint property and liability programs may report their claims liabilities at a higher confidence level. We are currently evaluating the appropriateness of this practice and how to respond if joint property and liability programs report in this manner. If you identify that your property and liability joint program is reporting its claims liability at other than the expected level, please contact an SME for further considerations.

Disclosures (for risks other than unemployment)

Risk pool and self-insurance activities require a number of unique and important note disclosures, including:

- Summary of Significant Accounting Policies note disclosure on unique risk pool line items
- Solvency compliance
- Excess insurance contract disclosures
- Members supplemental assessment and credit disclosures

The reporting requirements are for stand-alone pools and for pools included as a fund or component unit of another government. See BARS 3.4.9 (Risk Management Principles) guidance and examples on unique risk pool accounting and disclosures.

Required Supplementary Information (for risks other than unemployment)

Required supplementary information under GASB 10 is as follows:

- 10 Year Claims Development Information
- Reconciliation of Claims Liabilities by Type of Contract

GASB Statement 10 requires that risk pools and individual self-insurance programs (other than unemployment programs) report 10 years of claims information and a reconciliation of claims liabilities by type of contract. See BARS 4.7.420 (Required Supplementary Information) for details. Under GASB 34, this information is considered to be Required Supplementary Information (RSI). A pool with only one type of contract may report the reconciliation of claims liabilities in the notes to the financial statements, for this information to be reported in a separate RSI schedule, in accordance with the reporting package.

A reconciliation of claims liabilities by Type of Contract is only required for pools having more than one type of contract (ex. pools having both property/liability and health/welfare programs). Risk pools with one type of contract can disclose this reconciliation in a note to financial statements. See Appendix 2 for details regarding how to confirm these figures.

For Your Information

SAO encourages risk pools to provide a sample note disclosure to their members for their reporting purposes. This service will help risk pool members have a more accurate and consistent risk management note disclosure. A sample Risk Management note for risk pool members can be found in the GAAP BARS Manual.

Supplemental Information (SI) and Other Information (OI)

The List of Participating Members and DES Schedule of Expenses are required as OI for all governments with joint property/casualty or health/welfare self-insurance programs to meet DES requirements. The auditor will need to make sure these schedules are identified as OI in the audit report and financial statement table of contents and address it in the OI step in TM.

SINGLE AUDIT

We would not expect risk pools to receive any federal funding or require a single audit. If you encounter a risk pool that has received federal grants, please notify an SME.

INDIVIDUAL SELF-INSURANCE PROGRAMS

Public agencies are finding significant cost savings by self-insuring certain risks within their own operations. These individual programs may include many types of insurable risk, such as property, liability, medical, dental, vision, prescription workers' compensation, unemployment and so on. Individual self-insured programs are not as regulated as joint self-insurance programs, increasing the risks associated with these programs. Accountability audits of all local government self-insurance programs must be performed **at least every two years** (RCW 43.09.260 and Audit Policy 1210). ***Self-Insurance will need to be included in every audit for those on a two or three-year cycle - this does not require entities***

to be audited more frequently than the normal audit cycle. Auditors should review the "Accountability" section of this planning guide to help identify potential risks.

Common individual self-insurance programs are described below.

- Workers' compensation and/or unemployment claims for which the government is on 'reimbursable' status.
- Health and welfare benefits (medical, dental, vision and/or prescriptions) that are not purchased from an insurance policy or a risk pool are considered self-insurance.
- Voluntary Plans under the Paid Family & Medical Leave Act.

If the entity being audited is offering life insurance to its employees through a self-insurance program, please consult with an SME for possible testing approaches. This is an emerging practice and we are assessing its prevalence and significance.

Not all governments are aware that they are self-insuring. The "Self-Insurance Assessment" workpaper located in the Accountability Planning folder can assist auditors in better understanding if the entity self-insures and what type of information can be gathered to help better assess risks. Please note: This step and workpaper is a planning procedure to help assess audit risk, and is not intended to be a substantive procedure.

Paid Family & Medical Leave Program (PMFL) Voluntary Plans

Nearly three dozen local governments have obtained approval from WA State Employment Security Department to offer Voluntary Plans under the new Paid Family & Medical Leave law. Voluntary Plans are subject to audit under RCW 43.09.260(1) as a form of self-insurance as they are programs in which assets are set aside in advance in order to pay eligible PFML claims. Employers began withholding employee premiums in 2019 and claims became eligible starting in 2020. As a local government self-insurance program under RCW 43.09.260(1), Voluntary Plans are required to be examined by our Office at least once every two years. FAWF notes were added for the local governments with Voluntary Plans as of October 2020, and a current list of approved Voluntary Plans (including both government and private employers) can be found here. A new testing strategy is available in TeamMate at Accountability | Compliance Requirements | Self-Insurance | PFML Voluntary Plan. Contact a Self-Insurance / Risk Pool SME with any questions.

Solvency

Individual health and welfare self-insurance programs are subject to solvency requirements, see additional information in the Accountability section at Solvency (regulatory compliance). Also, if an individual local government self-insures for more than one individual program (such as medical, dental, vision and/or prescription), the entity is required to meet solvency requirements for each program individually. Auditors must use the "Self-Insurance Solvency Test - REQUIRED" step available in the Accountability | Compliance Requirements | Self-Insurance folder to assess this risk. **Solvency requirements are not applicable to individual programs that self-insure for property and liability, unemployment compensation or workers' compensation. However, we would expect the entity to have a funding plan for these types of expenses. Contact a Self-Insurance Expert if you have questions.**

Schedule 21

All individual local governments that formally or informally self-insure for property and liability risks, health and welfare benefits, unemployment claims or workers' compensation claims are required by BARS to report such activity in their annual report on Schedule 21.

Auditors should determine if the local government has properly prepared the schedule in accordance with BARS requirements.

Financial Statements

Self-insurance activities require a number of unique and important note disclosures. Auditors should review the "Financial Statements" section of the planning guide to help identify potential risks. GASB 10 provides

guidance on accounting and financial reporting for insurance related issues and use of internal service funds.

Required Supplementary Information (for risks other than unemployment) under GASB 10 is as follows:

- 10 Year Claims Development Information
- Reconciliation of Claims Liabilities by Type of Contract

AGREED UPON PROCEDURES

REMINDER: An independent study program is available for Agreed Upon Procedures. Auditors should take this class before performing any AUP engagement. **Auditors should charge their time spent performing these agreed upon procedures to the ATST project code.**

Joint Self-Insurance Programs Providing Medical Benefits

WAC 200-110-090 requires joint self-insurance programs providing medical benefits (as distinguished from vision, dental, prescription, etc.) to submit audited financial statements to the State Risk Manager on an annual basis. For those joint self-insurance programs that are stand-alone entities, this is accomplished as part of the annual audit process. However, we are aware of two approved joint self-insurance programs providing medical benefits which are not stand-alone entities, and we expect there may be more programs of which we are not aware.

We have worked with the State Risk Manager's office to determine the specific financial information they wish to have examined and have developed a targeted Agreed Upon Procedures engagement template should the entity request such an engagement and report. The template, "Engagement Letter – Joint Medical Self Ins AUP", is available in TeamMate in the folder Special Engagements | Agreed Upon Procedures.

Please note, however, that this is not an audit that we initiate; rather, this is an engagement we can perform at the entity's request. If the entity requests we perform this engagement (sometimes referred to as "program audits" by entities), **contact an SME before proceeding**.

Appendix 1: Self-Insurance and Risk Pool Terminology

LAYERS OF INSURANCE COVERAGE

Larger Claim Amounts ↕	**Reinsurance:** When a primary insurer (risk pool or entity that self-insures) purchases additional insurance or coverage from other insurance companies (reinsurers) to reduce the exposure or risk of claims being paid out. The primary insurer is called the ceding insurance company, since they are ceding the risk of claims being filed on the ceded policies. Reinsurance is typically used for larger thresholds of claims. Types of reinsurance include stop loss and excess insurance. Stop loss or excess insurance are sometimes used synonymously and sometimes refer to different types of coverage. **Stop loss or excess insurance:** Insurance purchased from another insurance company (reinsurer), by the primary insurer (risk pool or entity that self-insures), for claims over a certain limit - typically the limit of the or self-insured retention of the primary insurer. The dollar amount at which stop loss or excess insurance policy begins is called the attachment point. Certain policies might include a ceiling, for which the reinsurer will pay all claims above a certain amount (attachment point). Others might cover claims within a certain dollar range, beginning at an attachment point above the risk pool or entity's self-insured retention. There are two main categories of these types of reinsurance, which are mentioned below along with an example*.
	Self-insured retention (SIR): The portion of the exposure or dollar range of claims assumed by the risk pool or entity (if self-insured). This means that claims in the self-insured retention are typically paid out of risk pool or entity funds (i.e. funds generated from premiums for the program).
Smaller Claim Amounts	**Deductible:** Members retain a portion of the risk through this layer by paying deductibles. A deductible is a fixed dollar amount that a member pays towards a covered loss or claim before the Risk Pool or entity (if self-insured) assumes the risk and starts paying for the loss.

*** 1.** One type of reinsurance can provide protection for the primary insurer against a high claim on any one individual or member. This is protection against abnormal severity of a single claim rather than abnormal frequency of claims in total.

2. Another type is an aggregate policy, which provides a ceiling on the dollar amount of eligible expenses that an employer would pay, in total, for a contract period. The reinsurance carrier reimburses the employer for the aggregate claims over the ceiling.

Example: A risk pool has a self-insured retention layer of up to $100,000 per occurrence for auto liability claims. There is a $1,000 member deductible. The risk pool will pay up to $100,000 on each eligible claim from a member for these incidents. The member will pay the first $1,000 back to the risk pool as a deductible (either initially or as a reimbursement to the risk pool). The risk pool also has an excess reinsurance policy for a specific member of an additional $200,000 per occurrence, with an attachment point of $100,000 per occurrence. If a covered claim was received for this member, which was settled at $150,000, the risk pool would pay the total claim, recover $1,000 from the member as a deductible (either after paying the claim or some point into the claim process), and then send the claim to the reinsurer to recover $50,000 from the excess reinsurance policy.

Let's suppose, instead of an excess reinsurance policy, the entity has an aggregate stop loss policy for all members with an attachment point of $1,000,000, which will pay all claims above that amount. If total covered claims for the year were received for $1,400,000, the risk pool would pay the claims and then recover the $400,000 above the stop loss attachment point, from the reinsurer.

Note: In some cases, particularly for very large claims, the reinsurer may arrange to send the funds to the primary insurer for the covered claim before the primary insurer pays the claim.

Self-Insurance: Risk management approach in which an entity sets aside a sum as a protection against a probable loss, instead of transferring the risk by purchasing an insurance coverage or assuming the risk.

Individual Self-Insurance Program: A formal program established and maintained by a local government to provide advance funding to self-insure for risks on its own behalf, as opposed to risk assumption, which means a decision to absorb the entity's financial exposure to a risk of loss without the creation of a formal program of advance funding of anticipated losses.

Joint Self-Insurance Program: Any two or more local government entities which have entered into a cooperative risk sharing agreement subject to regulation under chapter 48.62 RCW.

Public entity risk pool: A cooperative group of governmental entities joining together through a written agreement to finance an exposure, liability or risk. Risk may include property and liability, employee health care, or workers' compensation. A pool may be a stand-alone entity or be included as part of a larger governmental entity that acts as the pool's sponsor. There are two basic types of public entity risk pools:

1. **Risk is *retained* by members** – In this case, members pay a required contribution to a pool based on the individual member's claims/loss experience. Members of this pool are self-insuring for these risks and the pool functions mainly as a claims servicer. We have typically seen two main categories of risk pools where risk is retained by the members:

    a) *Banking:* an arrangement by which monies are made available for pool members in the event of loss on a loan basis.

    b) *Claims-servicing:* an arrangement by which a pool manages separate accounts for each pool member from which the losses of that member are paid.

2. **Risk is *transferred* to the pool** – This is often referred as a risk-sharing pool. In this case, the pool collects assessments that it estimates will cover the costs of all claims for which the pool is obligated. The assessments are based on activities in the aggregate, rather than on an individual insured member basis (as is the case for pools where risk is retained by members). However, the members remain liable for unpaid claims in excess of pool resources.

Cede: When a portion of risk from covered events is transferred from the primary insurer (risk pool) to a reinsurer in exchange for a predefined assessment.

Third party administrator (TPA): An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the coverage recipient or the insurer.

IBNR (Incurred but not reported): Refers to estimated losses during a stated period that have not been reported to the insurer as of the date under consideration.

Claims reserve: An amount of money set aside to meet future payments associated with claims incurred but not yet settled at the time of a given date. This amount can be determined by an actuary based on past claims history.

Claims administrator: A generic term used to refer either to an insurance company claims department or to a third-party claims administrator.

Claims audit: An audit conducted by an independent qualified claims auditor not affiliated with the program, its insurers, its broker of record, or its third-party administrator. The services performed generally include an in-depth, written evaluation of the claims handling activities, identifying strengths, areas of improvement, findings, conclusions and recommendations to improve quality of claims management and processing. These reviews are required to be performed every three years by state law:

- WAC 200-100-050 for joint property and liability programs
- WAC 200-110-120 for individual and joint health and welfare programs

Claims audit requirements are applicable to individual and joint programs providing medical coverage. This same requirement does not exist for programs whose sole coverages are dental, vision or prescription drug benefits.

Subrogation: This is the right for an insurer to pursue a third party that caused an insurance loss to the insured. It is a means of recovering the amount of the claim paid to the insured for the loss.

Healthcare coverage

Group purchasing arrangement: Arrangements in which two or more entities are a member of a cooperative, alliance, association or some other organization to purchase health insurance collectively. These arrangements can function in many ways include: risk pooling, price negotiation, choice of health plans offered to employees, and various administrative tasks.

Fully insured plan: A plan where the employer provides healthcare benefits through insurance coverage purchase through insurance carriers. The insurance carrier collects the assessments and pays the health care claims based on the coverage benefits outlined in the coverage purchased.

IBNP (Incurred but not paid): Refers to estimated losses during a stated period that have not been paid to the insurer as of the date under consideration.

Appendix 2: Tracing Financial Statement Figures

Reconciliation of Claims Liability by Type of Contract

	2019	2018	Financial Statement	Actuary report
Unpaid claims and claim expenses at beginning of year:	6,085,518	5,172,264	Prior year total claim reserves at end of year	
Incurred claims and allocated claim adjustment expenses:				
Provision for insured events of the current year	2,678,334	3,721,282	10-yr claims #3: Estimated net incurred claims and expenses	Ultimate loss for the year
Change in provision for insured events of prior years	(551,510)	(366,139)	See footnote a.	Nothing specifically, but #6 for each year should agree to Ultimate Loss
Total incurred claims and allocated claim adjustment expense	2,126,824	3,355,143	Incurred Loss and Loss Adj Exp sum on Operating Stmt	
Payments:				
Claims and claim adjustment expenses attributable to insured events of the current year	602,729	1,347,196	10-yr claims #4: paid (or net paid)	Paid loss
Claims and claim adjustment expenses attributable to insured events of the prior years	1,345,145	1,094,693	See footnote b.	Nothing specifically, but #6 for each year should agree to paid loss
Total Payments	1,947,874	2,441,889	Operating Stmt - Claims paid	
Total unpaid claims and allocated claim expenses at end of the year	6,264,468	6,085,518		
Unallocated loss adjustment expense at end of year	425,000	-	Operating Stmt - ULAE	
Total claim reserves at end of year	6,689,468	6,085,518		

a. On the 10-year claims development information, calculate the difference between the most recent reestimated net incurred claims and expense (#6) and the next most recent estimate for each of the prior years (2009-2017 in the appendix below). These numbers are highlighted in yellow below. For example, in 2009 take $3,907,491 less $3,907,491, and in 2010, take $3,553,991 less $3,470,529, and so on, adding all these differences together. The total of all of these differences should equal this amount.

b. On the 10-year claims development information, calculate the difference between the most recent net paid amount (#4) and the next most recent amount for each of the prior years, same as above. These numbers are highlighted green.

10-Year Claims Development Information	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Financial Statement	Actuary Report
1. Net earned required contribution and investment revenues												
Earned	19,693,942	20,082,282	21,790,359	24,089,897	26,001,842	28,302,524	28,173,183	30,124,749	31,723,630	32,453,089	Member contributions and investment revenues	
Ceded	11,836,686	13,201,620	13,157,039	13,054,974	14,079,544	17,860,818	18,019,288	19,032,680	19,596,421	19,938,324	Excess/reinsurance premiums (expense)	
Net earned	7,857,256	6,880,662	8,633,320	11,034,923	11,922,298	10,441,706	10,153,895	11,092,069	12,127,209	12,514,765		
2. Unallocated expenses	3,264,075	3,858,520	3,066,948	5,699,351	5,944,718	6,265,615	6,139,349	6,496,631	6,568,425	6,669,452	All expenses but claims paid & excess/reinsurance	
3. Estimated claims and expenses, end of policy year:												
Incurred	16,204,602	31,125,638	6,123,500	6,970,000	23,215,000	6,312,059	6,460,342	6,867,854	6,671,316	15,734,260		
Ceded	11,853,418	27,925,638	831,625	1,825,000	18,240,000	712,059	805,000	2,260,000	1,475,000	10,605,513		
Net incurred	4,351,184	3,200,000	5,291,875	5,145,000	4,975,000	5,600,000	5,655,342	4,607,854	5,196,316	5,128,747	Reconciliation of Claims Liability by Type of Contract - Provisions for Insured events of the current year	Ultimate loss
4. Net paid (cumulative) as of:												
End of Policy Year	879,829	983,077	1,474,811	1,369,518	1,176,957	1,858,128	2,123,940	1,502,422	2,114,765	1,929,768	Reconciliation of Claims Liability by Type of Contract - Claims and claims adjustment expenses attributable to insured events of the current year (only current year)	Paid loss (all years
One year later	1,391,123	1,272,753	2,444,092	2,365,903	2,394,020	3,099,923	3,656,660	2,771,650	4,135,203			
Two years later	2,151,555	2,263,681	3,180,313	3,129,837	2,863,375	3,625,917	4,074,276	3,296,887				
Three years later	2,899,979	2,920,559	3,497,274	3,695,741	3,225,856	4,251,193	4,951,279					
Four years later	3,503,410	3,105,688	4,044,981	4,534,901	3,462,481	4,542,538						
Five years later	3,696,202	3,299,097	4,107,170	4,607,913	3,576,004							
Six years later	3,714,030	3,323,765	4,138,609	4,716,402								
Seven years later	3,790,771	3,419,242	4,216,575									
Eight years later	3,883,962	3,504,198										
Nine years later	3,882,962											

5. Reestimated ceded claims and expenses	23,011,239	43,193,175	11,368,773	7,640,745	20,383,504	2,483,867	4,835,232	18,411,039	2,028,645	10,605,513		
6. Reestimated net incurred claims and expenses:												
End of Policy Year	4,351,184	3,200,000	5,291,875	5,145,000	4,975,000	5,600,000	5,655,342	4,607,854	5,196,316	5,128,747	Reconciliation of Claims Liability by Type of Contract - Provisions for Insured events of the current year	Ultimate loss (all years)
One year later	4,330,000	3,200,000	4,990,000	5,321,875	4,905,000	5,275,000	5,630,342	4,437,854	5,456,316			
Two years later	4,387,500	3,577,000	4,932,971	5,160,000	4,435,000	5,107,000	5,640,342	4,417,854				
Three years later	4,335,000	3,574,316	4,935,000	5,242,500	4,188,000	5,138,460	5,592,575					
Four years later	4,211,290	3,390,401	4,630,000	5,269,647	3,868,571	5,070,460						
Five years later	3,957,391	3,473,526	4,254,860	5,089,647	3,869,182							
Six years later	3,942,491	3,390,529	4,262,798	5,049,647								
Seven years later	3,907,491	3,470,529	4,272,438									
Eight years later	3,907,491	3,553,991										
Nine years later	3,907,491											
7. Increase (decrease) in estimated net incurred claims and expense from end of policy year	(443,693)	353,991	(1,019,437)	(95,353)	(1,105,818)	(529,540)	(62,767)	(190,000)	(5,456,316)	0	Should equal most current reestimate less end of policy year amount	