

**Subject ST3 — General Insurance
Specialist Technical**

EXAMINERS' REPORT

April 2009

Introduction

The attached subject report has been written by the Principal Examiner with the aim of helping candidates. The questions and comments are based around Core Reading as the interpretation of the syllabus to which the examiners are working. They have however given credit for any alternative approach or interpretation which they consider to be reasonable.

R D Muckart
Chairman of the Board of Examiners

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Comments

Individual comments are shown after the solutions to each part question that follows.

1

- Restrictions on the type/ amount of business a general insurance company can write / classes of business it is authorised to write.
 - Ensures companies have appropriate expertise/ sufficient capital to write the business classes
- Initial authorisation of new insurance companies..
 - Ensures companies have appropriate expertise / sufficient capital to write the business classes
- Limits on premium rates that can be charged.
 - Ensures premium rates are sufficient to meet future claims/ ensure policyholders not overcharged
- Restrictions on information that may be used in underwriting and premium rating.
 - For ethical / anti-discrimination reasons.
- The requirement to deposit assets to back claims reserves.
 - To ensure the company has sufficient funds to pay claims.
- The requirement to maintain a minimum level of solvency.
 - To ensure if claims are significantly worse than expected the company will still remain solvent.
- Restriction on the type or amount of certain assets allowed to demonstrate solvency.
 - To prevent high-risk assets from backing liabilities.
- Restrictions on the currency, domicile and duration of assets allowed to demonstrate solvency (*or mismatching reserves*).
 - To ensure that assets match liabilities by term and currency so that short term changes in exchange rates will not have an impact on solvency margins.
- The use of prescribed bases to calculate premiums, asset values and liabilities to demonstrate solvency.
 - To ensure accurate estimates of liabilities and uncertainty.
- Licensing agents to sell insurance and requirements on the method of sale.
 - To ensure company has necessary expertise and that insured is well informed.
- The requirement for risk-based capital calculations & ICA analyses.
 - To ensure accurate estimates of liabilities and uncertainty.
- Requirement to pay levies to consumer protection bodies.
 - To protect policyholders and maintain faith in insurance market.
- Legislation to protect policyholders should general insurance companies fail, e.g. Financial Services Compensation Scheme.
 - To protect policyholders and maintain faith in insurance market.
- Cooling off period, e.g. fourteen day cancellation rules on policies issued.
 - To protect policyholders and promote confidence in the industry.
- Regulations with respect to treating customers fairly.
 - To protect policyholders and promote confidence in the industry.
- Restriction on countries a general insurance company can write business in.
 - Prevents exposure to volatile risks and unfamiliar legal systems and regulations.
- Restrictions with respect to anti-competitive behaviour
 - Prevents formation of cartels, concentration of risk, and protects policyholders.
- Requirement to file / publish premium rates before they can be used.
 - Prevents anti-competitive practices and therefore protects policyholders.

- Mandatory restrictions on cover e.g. no deductible on EL
 - To protect policyholders and claimants and to ensure consistency of cover.
- Requirements to offer cover e.g. even in high-risk flood areas / motor 3rd party liability.
 - For social responsibility and helps economy as a whole.
- Statutory requirement to offer certain cover e.g. EL & Motor 3rd Party Liability.
 - For social responsibility and helps economy as a whole.
- Disclosure / transparency of reporting requirements
 - To help regulators, investors, capital providers and policyholders assess the soundness of the company.
- Requirement for a Statement of Actuarial Opinion to be produced by an approved actuary.
 - Promotes confidence in the level of reserves and helps to prevent the failure of a general insurance company.
- Requirements for management to be fit and proper.
 - Promotes confidence in the industry and helps prevent fraud.
- Restriction on the type of reinsurance that may be used.
 - To prevent exposure to risky reinsurers or reinsurance products.
- Restriction on discounting of liabilities and discounting rates that can be used
 - To ensure consistency and that reserves are sufficient.
- Prohibiting illegal products from being sold, e.g. kidnap insurance.
 - To discourage illegal practices.
- Requirement for general insurance companies to be audited.
 - To give regulators and investors confidence in the company and to prevent fraud.
-

Comments on Q1: *This question was reasonably well answered by the majority of candidates but some students did not give enough distinct points or specific enough reasons.*

2 (i) *Deductible*

- Amount deductible from claim amount, payable by policyholder.
- Sum insured = S . Deductible = D . Loss = L .
- If $L > S$ insured pays $L - S + D$, insurer pays $S - D$.
- If $L < S$ insured pays D and insurer pays $L - D$.

Excess

- Sum specified by policy which insured must bear before any liability falls on insurer.
- Sum insured = S . Excess = E . Loss = L .
- If $L > S + E$, insured pays $L - S$ and insurer pays S .
- If $L > E$ but $L < S + E$ insured pays E and insurer pays $L - E$.
- Therefore effect differs in the case where $L > S$.
- The primary difference is that the deductible eats into the sum insured whereas the excess sits below the sum insured.
- Hence for a policy with a deductible the maximum the insurer will be liable to pay is the sum insured less the deductible.

Example (this has to be realistic).

- sum insured of £30,000.
- Policy A has an excess of £5,000, policy B has deductible of £5,000
- Each policy experiences loss of £40,000
- Policy A: loss to insurer = sum insured = £30,000, loss to insured = £40,000 – £30,000 = £10,000
- Policy B: loss to insurer = sum insured – deductible = £30,000 – £5,000 = £25,000, loss to insured = £40,000 – £25,000 = £15,000.

An explanation without using L, S, D etc. which is correct is acceptable.

Comments on Q2(i): *This was well answered by the majority of candidates.*

However, some candidates did not understand how a deductible worked with some getting the excess and deductible the wrong way round. Some students did not give an example even though this was specifically requested in the question.

(ii) *Replace excess with deductible*

- Effect of change will be small as this is personal lines business.
- *Any valid reason explaining why change will be small*
- All else being equal insurers profits will increase as claims cost will decrease so profit per policy will increase
- Depends on change in policy volumes
- Option of reducing premium rates to compensate for potential loss of volume.
- Policyholders may not realise that there is a difference
- Although will be obligation to clearly explain policy changes to clients (treating customers fairly)
- Policyholders may realise that there is a difference and demand a reduced premium.
- Possible change in mix of business as a result.
- Effect depends on mix of renewal / new business.
- Also depends on factors such as advertising and distribution channels.
- Significant increase in costs associated with communicating changes to brokers and policyholders, and updating policy documentation.
- Increase in costs associated with system changes & retraining of staff.
- Expenses will most likely increase by more than any benefits gained.

Comments on Q2(ii): *Better candidates picked up on the key points for this part.*

Candidates that did not understand the term deductible failed to answer this part of the question correctly. Also, many students did not comment that the claim cost impact would be small, particularly since it was personal lines business, and some students did not consider the implications for expenses.

(iii) *Model*

- Set up the model to give total profit as an output
- Review company data on past changes in excess and effect on policy volumes and profit
- Review past company data on any deductibles (if available) otherwise review industry data on effects of deductibles on policy volumes and profitability

- Allow for other factors such as distribution channels, advertising
- Allow for any changes to mix of business e.g. age, social economic group
- Allow for level of expenses, both fixed and variable
- Allow for possible changes in premium rates
- Allow for correlations between excess / deductible and other rating factor
- Fit Generalised Linear Model to model outputs.
- Alternatively, fit a stochastic / deterministic model.
- Use results to maximise profits
- Sensitivity test model - test the goodness of fit.
- Set up so that factors can be easily interpreted and monitored

Comments on Q2(iii): *Most candidates struggled to answer this part well with many candidates talking about “choosing a base period and modifying the data”, rather than tailoring the answer to the question and discussing what specific modifications to the data would be needed and what the actual output of the model should be.*

3 (i)

- Check consistent with the data from the previous development period — to check for any errors, e.g. compare diagonals.
- Check any anomalies / large movements in the data. *(If large claims etc. are mentioned it must be because they have seen anomalies in the data)*
- Cumulative paid to incurred ratios — to test for a change in the case reserving strength or claims settlement practise. Look at the ratios by accident and development period.
- IBNR to outstanding ratios — to test for a change in the reporting process. Look at the ratios by accident and development period.
- Average outstanding case estimate — again to test for a change in the strength of case reserves. Look at the ratios by accident and development period.
- Trends in ultimate loss ratios by accident year — for consideration against market benchmarks and knowledge of the underlying market conditions.
- Settlement claims divided by reported claims — to check for changes in the claims handling process.
- Average cost per claim — as a sense check for reasonableness.
- Claim frequency — again for consideration against market benchmarks and knowledge of the underlying market conditions.
- Check development patterns by accident year — to check consistency between accident years and compared to the prior analysis
- Sense checks e.g. the relationship between paid and incurred is as you would expect
- Compare results of different projection methods to see if the results are consistent
- Survival ratios — if class of business includes latent claims.
- Check actual versus expected for the latest development period to identify any large movements / changes in reserving strength
- *any other reasonable diagnostics, based on the available data given, with explanation, are acceptable*

Comments on Q3(i): *This was poorly answered by the majority of candidates. Better candidates mentioned points including: checking for errors and unusual developments but most candidates did not consider any diagnostic checks (looking at specific ratios) or benchmarking results as a sense check. Some candidates gave answers that required additional data although the question specifically stated what data were provided.*

(ii)

- Unusually heavy experience e.g. increase in central bank base rates leading to increase in number of claims
- Random fluctuations / volatility.
- Large or exceptional claims e.g. factory closing down leading to local unemployment with one regional mortgage lender leading to increase in number of claims
- Trends in claims experience numbers due to economic factors e.g. rising unemployment/falling house prices leading to increased number of claims.
- Trends in claims experience amounts due to economic factors e.g. increase in the level of repossessions leading to higher costs for the insurer.
- Changes in risk. e.g. switch to endowment mortgages from repayment mortgages implying higher claim severity.
- Changes in cover e.g. increase in amount by which mortgage exceeds normal advance.
- Unexpected changes in law e.g. introduction of new government legislation stating that insurers must still pay out when the lender has failed to apply any required underwriting.
- Quality and amount of reinsurance cover may have varied e.g. reinsurance review.
- Inadequate claims reserving process e.g. inappropriate assumptions tail selection, future inflation may differ to that assumed
- Change in mix of business e.g. policies sold to people with low job stability
- MIG business has a strange risk profile (uneven with a long tail) that will need to be taken into account. Therefore very difficult to reserve this class.
- Systematic fraud e.g. developers artificially inflating official market prices through the use of incentives, mis-selling through increasing prevalence of self-certification loans.
- Payment patterns may differ e.g. due to system changes
- or settlement patterns may differ e.g. postal strike.

Comments on Q3(ii): *Better candidates understood the impact of the economy on this class of business but could have generated more points. Some candidates did not appear to understand what the question was asking for.*

(iii)

- monitoring the adequacy and use of reinsurance
- comparing the relative profitability of various parts of the account
- reviewing present premium rates
- pricing new or amended products
- determining rating factors

- experience rating
- financial planning and management information
- Assessment and allocation of capital
- monitoring the insurer's asset/liability position
- giving investment advice based on the liability profile
- monitoring actual versus expected for both claims and premiums
- for statutory accounts
- establishing the need for other reserves e.g. URR
- identification of unexpected claims sources to tighten up policy wording / testing efficiency of the claims management teams and loss adjusters
- *plus any other sensible suggestions*

Comments on Q3(iii): *This was bookwork and was well answered by the majority of candidates.*

4

(i)

<i>Claim</i>	<i>Claim size</i>	<i>Claim size in layer</i>	<i>Reinsurer pays</i>	<i>RI Premium</i>
1	£2.5m	£1.5m	£0m	£0
2	£3.5m	£2.5m	£0m	£0
3	£6.0m	£4.0m	£4.0m	£1.2m
4	£4.2m	£3.2m	£3.2m	£1.2m
5	£1.8m	£0.8m	£0.8m	£0.3m
6	£3.0m	£2.0m	£2.0m	£0m
7	£5.0m	£4.0m	£2.0m	£0m
Total	£26m	£18m	£12m	£2.7m

Comments on Q4(i): *Many candidates answered this completely correctly with other candidates making minor mistakes when calculating the reinstatement premiums. Some candidates however misunderstood the impact of the annual aggregate deductible with a few mistakenly assuming this was aggregate excess of loss even though individual claims cover is specified.*

- (ii) A form of excess of loss reinsurance that covers the aggregate of losses, above an excess point and subject to an upper limit,
Sustained from a single event or from a defined peril (or perils) over a defined period.

Comments on Q4(ii): *This is bookwork and was reasonably well answered by the majority of candidates.*

(iii)

- Aggregate XL only provides cover for either one peril over the year or one event. Stop loss extends cover to all claims, arising from all perils or all events, in a class or classes over the defined period
- Stop loss is broader in that it covers not only catastrophe events but also unforeseen accumulations of losses

- Stop Loss reinsurance directly relates to the primary insurer's underwriting results
- In general, Stop Loss reinsurance is difficult to obtain and is usually limited to only a few lines of insurance

Comments on Q4(iii): *This is bookwork and most candidates did understand the difference between the two types of reinsurance although many students did not give enough differences between the two.*

- (iv) By using claims ratios the limits (and premiums charged) rise in proportion to the amount of business written by the direct writer.
If this was not the case then the direct writer could, after taking out cover, write lots more business by cutting premiums and hence trigger the stop loss limits in that way.

Comments on Q4(iv): *Most candidates got this point. However, some candidates did not understand why a reinsurer would not use monetary amounts.*

- (v)
- Direct writer's premium generally under-priced (e.g. a competitive market)
 - Poor underwriting by direct writer
 - Poor premium rating structure leading to adverse selection
 - Unusually heavy claims experience (e.g. catastrophes and/or large claims)
 - Generally adverse claims experience (i.e. random event)
 - Poor claims handling control particularly after deductible reached i.e. moral hazard
 - Risk insurer targets more volatile but profitable business for higher expected returns once downside risk is removed.

Comments on Q4(v): *Most candidates mentioned poor underwriting and claims handling with better candidates generating more points.*

- (vi)
- Only reinsure a proportion of the risk e.g. 90% so that the insured retains an interest in the risk (*can be described as a participation clause / co-insurance / deductible if used in the correct context*)
 - Ensure stop loss cover has an upper limit
 - Maintain some control over underwriting and claims

Comments on Q4(vi): *This was reasonably well answered with most candidates suggesting that the insurer retains some interest in the risk via some sort of participation clause/deductible/co-insurance.*

5

- (i) $g_0 = p_0$
This holds as the minimum claim size is 1

$$\begin{aligned}
 g_r &= \sum_{n=1}^{\infty} p_n f_r^{n*} \\
 &= p_1 f_r + \sum_{n=1}^{\infty} p_{n+1} f_r^{(n+1)*} \\
 &= (a+b)p_0 f_r + \sum_{n=1}^{\infty} \sum_{j=1}^{r-1} (a+bj/r) f_j p_n f_{r-j}^{n*} \\
 &= (a+b)g_0 f_r + \sum_{j=1}^{r-1} (a+bj/r) f_j \sum_{n=1}^{\infty} p_n f_{r-j}^{n*} \\
 &= (a+b)g_0 f_r + \sum_{j=1}^{r-1} (a+bj/r) f_j g_{r-j} \\
 &= \sum_{j=1}^r (a+bj/r) f_j g_{r-j}
 \end{aligned}$$

Above is slightly different from core reading where equations incorrectly contain $(a + bj) / r$ not $(a + bj / r)$

Comments on Q5(i): This is bookwork but was poorly answered by the majority of candidates.

- (ii) $E[S] = E[N] E[X']$ where

$$\begin{aligned}
 X' &= 0 & X &\leq 100 \\
 &= X - 100 & X &> 100
 \end{aligned}$$

$$\begin{aligned}
 E(X) &= \lambda / (\alpha - 1) = 750 \\
 V(X) &= \alpha \lambda^2 / (\alpha - 1)^2 (\alpha - 2) = 1750^2 \\
 \therefore \alpha / (\alpha - 2) &= V(X) / E(X)^2 = 1750^2 / 750^2 = 5.444 \\
 \therefore \alpha &= 5.444 (\alpha - 2) \\
 \therefore \alpha &= 10.889 / 4.444 = 2.45
 \end{aligned}$$

$$\therefore \lambda = 750 \times 1.45 = 1087.5$$

$$\begin{aligned}
 E(X') &= \int_{100}^{\infty} \frac{(x-100)}{(\lambda+x)^{\alpha+1}} \alpha \lambda^{\alpha} dx \\
 &= \alpha \lambda^{\alpha} \int_{100}^{\infty} \left(\frac{1}{(\lambda+x)^{\alpha}} - \frac{100+\lambda}{(\lambda+x)^{\alpha+1}} \right) dx \\
 &= \alpha \lambda^{\alpha} \left[\frac{-1}{(\lambda+x)^{\alpha-1} (\alpha-1)} + \frac{100+\lambda}{(\lambda+x)^{\alpha} \alpha} \right]_{100}^{\infty}
 \end{aligned}$$

$$\begin{aligned}
 &= \alpha \lambda^\alpha \left(\frac{1}{(\lambda+100)^{\alpha-1}(\alpha-1)} - \frac{1}{(\lambda+100)^{\alpha-1}\alpha} \right) \\
 &= \frac{\lambda^\alpha}{(\lambda+100)^{\alpha-1}(\alpha-1)} \\
 &= 660.18
 \end{aligned}$$

Note 2nd line of derivation of $E(X')$ was to simplify integration by splitting numerator in 1st line as $(\lambda+x) - (100+\lambda)$. The alternative is to do integration by parts which is an equally valid approach, as follows:

$$\begin{aligned}
 E(X') &= \int_{100}^{\infty} \frac{(x-100)}{(\lambda+x)^{\alpha+1}} \alpha \lambda^\alpha dx \\
 &= \alpha \lambda^\alpha \left(\left[-\frac{1}{\alpha} \cdot \frac{x}{(\lambda+x)^\alpha} \right]_{100}^{\infty} + \frac{1}{\alpha} \int_{100}^{\infty} \frac{1}{(\lambda+x)^\alpha} dx - 100 \left[-\frac{1}{\alpha} \cdot \frac{1}{(\lambda+x)^\alpha} \right]_{100}^{\infty} \right) \\
 &= \alpha \lambda^\alpha \left(\frac{100}{\alpha(\lambda+100)^\alpha} + \frac{1}{\alpha} \left[-\frac{1}{(\alpha-1)} \cdot \frac{1}{(\lambda+x)^{\alpha-1}} \right]_{100}^{\infty} + \frac{100}{\alpha} \left(-\frac{1}{(\lambda+100)^\alpha} \right) \right) \\
 &= \alpha \lambda^\alpha \left(\frac{1}{\alpha(\alpha-1)} \cdot \frac{1}{(\lambda+100)^{\alpha-1}} \right) = \frac{\lambda^\alpha}{(\lambda+100)^{\alpha-1}(\alpha-1)}
 \end{aligned}$$

$$E[S'] = 125 \times 660.18 = \text{£}82,523$$

Comments on Q5(ii): Most candidates were able to determine the values for α and λ and wrote down the correct integral to be solved but not many were able to solve it.

- (iii) Let $Y + k$ be a gamma random variable with the same first three moments as S . Then equating parameters:

$$\text{Skewness} = 0.6838 = 2 / \sqrt{\alpha}$$

$$\text{Variance} = 23,480^2 = \alpha / \lambda^2$$

$$\text{Mean} = 82,523 = k + \alpha / \lambda$$

$$\text{So } \alpha = 8.555$$

$$\lambda = 0.0001246$$

$$k = 13,848$$

Comments on Q5(iii): This was correctly answered by the majority of candidates who attempted it, although some who did badly on parts (i) and (ii) did not attempt this part.

6

(i) *Advantages*

- Possible reduction in premium rates if the claimant is the policyholder.
- Settlement delays should be significantly less.
- No legal fees (if they are deducted from damages).
- Simpler process.
- More consistent / predictable
- Can still use court system
- If the injury is not severe the overall payout should be higher.
- If no medical expenses or loss of earnings incurred then the overall payout should be higher.
- If claimant has lower than average earnings the payout would probably be higher.
- Awards may be inflated initially to promote confidence in the system.

Disadvantages

- Process will not be specific enough for certain more complicated cases.
- Fee that is non-refundable.
- If the injury is severe the overall payout will be too low.
- If no medical expenses or loss of earnings incurred then the overall payout will be too low.
- No representation.
- Two separate claims will need to be processed if there are property damages as well i.e. 1 through BICA and 1 through insurer.
- May have to go to court anyway so overall costs / delays longer.
- Postal strike will delay the process
- BICA aims to reduce premium rates so may give lower awards
- If the claimant has above average earnings the payout would probably be lower.

Comments on Q6(i): *Most candidates answered this part of the question well although a few candidates incorrectly talked about the advantages and disadvantages from the insurer's perspective.*

(ii) *Adjustments to pricing model*

- Divide injury claims by type of injury
- Base assumptions on claim amounts published and used by BICA rather than on own experience.
- Therefore results have less reliance on rating factors
- However if claims go to court awards will not be based on BICA.
- Therefore need an assumption about the rate of claims to court and the nature of the claims to court.
- Divide claims by severity of injury — need to make an assumption on potential savings or losses as a result of average damages.
- Divide injury claims into general damages and special damages e.g. medical expenses, loss of earnings — need to make an assumption on potential savings or losses as a result of average damages.

Possible changes expected to number of claims:

- Possible increase in number as may be simpler to claim
- Possible decrease as more difficult for solicitors to encourage claims with no win no fee offers
- Possible decrease in fraudulent claims.
- Significant changes in average cost per claim due to standard damages regardless of severity of injury or level of medical expenses etc.
- Possible initial increase in average cost as BICA will want to promote confidence in system.
- In long run possible decrease in average cost as claims inflation decreases.
- Amend assumption about future claims inflation.
- Could be due to rejection of BICA damages.
- or a delay of longer than 2 years before notification.
- Amend expected notification delays.
- Include possibility of longer delays due to claimants waiting 2 years to enter the court system.
- Amend settlement delays.
- e.g. 30 days for small claims — 90 days for larger claims.
- Include longer settlement delays for claims entering court system.
- Refer to industry data from any countries that have a similar system in place to support your calculations.
- Adjust large claim loadings where these are no longer felt to be appropriate due to the change in the data groupings.
- Adjust for any proposed changes in cover following introduction of new system.
- Adjust for any proposed changes in mix of business / target market / distribution channel following introduction of new system.
- Include assumption about the proportion of combined damage and injury claims as this will result in an increase in claims handling expenses as more than one claim will need to be set up.
- Include assumption about the reduction in claims handling expenses as a result of most bodily injury claims being processed by the BICA.
- Include assumption about any longer term reduction in fixed costs that may be possible as a result of this.
- Amend assumption about the level of legal expenses.
- Change reinsurance loadings where appropriate`
- Include assumption about the BICA fees based on forecast market share.
- Amend investment return assumptions to reflect the change in the expected duration of the liabilities.
- Factor in pressure from regulators to reduce premium rates.
- Consider possible changes to competition in the market.
- Amend any profit loadings that may have changed following the introduction of the new system.

Comments on Q6(ii): *Most candidates did not generate anywhere near the number of points on the marking schedule. Better candidates had a more structured answer considering the claims that would be settled by BICA and those that would go to court separately.*

(iii) *Changes to system*

- Add severity of injury as this will result in fairer awards.
 - Severely injured claimants will be less likely to reject the award.
- Employ a group of independent doctors to process the application forms.
 - This will reduce fraudulent claims and ensure consistency of diagnosis.
- Make the fee refundable if the claim is successful and the claimant accepts the award.
 - This is fairer to legitimate claimants and will also discourage fraudulent claims as there are different costs involved depending on the outcome of the claim.
- Include claims older than two years e.g. less than five years old.
 - This could further increase the savings on legal expenses
- Introduce other injury compensation e.g. medical expenses, loss of earnings.
 - This will result in fairer results and claimants who have incurred significant costs will be less likely to reject the award.
- Introduce standard property damage awards calculated by a pricing actuary.
 - This will reduce claims handling expenses for the insurers and make the process simpler.
- Introduce a deterrent for going through the court system e.g. the BICA award is no longer available regardless of the outcome of the court case.
 - This will reduce settlement delays and legal expenses.
- Introduce face-to-face meetings if required. Allow additional documentation if necessary.
 - This will result in fairer diagnosis and ensure claimants are happier with the outcome.
- Introduce an arbitration / appeal process.
 - This will ensure that claimants are happier with the outcome and make it less likely that they will go to court.
- Allow claimants to opt out of BICA.
 - This will save costs relating to those claimants who have no intention of accepting the BICA award.
- Add the option of legal representation if requested but with fees covered by policyholder.
 - This ensures that less educated claimants (or any with other issues) will still be well represented, but still deters the majority of claimants from engaging a solicitor.
- Refer more complicated cases or those expected to settle above a certain threshold to courts.
 - This will result in a more appropriate outcome for complex cases that cannot be properly addressed by the BICA.

- Ban no win no fee practices.
 - This will reduce fraudulent claims and will also reduce the number of claims that are unlikely to be successful.
- Amend the insurer's BICA fee so that it is based on market share by line of business or on a claim-by-claim basis.
 - This will more accurately charge those insurers with a higher proportion of bodily injury claims.
- Process applications by fax / internet / email..
 - This will speed up the process and avoid postal strikes..
- Be more specific with which claims the BICA will apply to i.e. only future notifications or current IBNR claims.
 - This will help pricing actuaries to more accurately calculate their prices and prevent any unnecessary delays in the process.

Comments on Q6(ii): *Most candidates made a reasonable attempt at this question, although some of the reasons given for suggested improvements were questionable e.g. "removing the small fixed fee as some claimants may not be able to afford it" would have the opposite effect on fraudulent claims. Some students did not give specific enough reasons and some tended to focus on the insurance companies' points of view rather than considering the claimants as well.*

END OF EXAMINERS' REPORT