

Controlling Workers' Compensation Costs



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Presenter: Richard "Rick" A. Weden, Jr.

Rick Weden began his presently 31 year long career in the insurance industry in 1983. Since that time he has focused his time in the handling and advising on many forms of insurance coverage. For the past twenty years his focus has become paired down to providing insurance products and advice to a select few specialty industries including Healthcare, Manufacturing Operations, Technology, and a primary focus on Contracting Operations. He has also been called upon to provide expert witness testimony in various insurance related litigation matters.

It was through his experience and enjoyment working in the contracting trades that lead him down a path to a highly focused commitment to providing insurance products and risk advice to the tree care industry which has become his primary specialty.

His methods of addressing the insurance needs of the tree care industry involve a radical departure from normally accepted approach of that process. Along with usual expected practice involving the procurement and delivery insurance products, and other related service activities he also spends a significant amount of time researching and learning all facets of the tree care industry with an emphasis on understanding the causes of loss in the industry, the impact, both financial and emotional of such losses, and methods one can use to avoid them.

Rick is an active member of both TCIA and the Mass Arborists Association. His involvement with TCIA has included the contribution of numerous insurance related articles to the Tree Care Industry Magazine, as well as providing educational services to past “Boot Camp” educational programs at past TCIA Expos. He is actively involved with the TCIA sponsored ArborMAX Insurance Program not only as an agent, but also working in partnership with the ArborMAX Team and other ArborMAX agents to insure a continued availability of a quality insurance option to those in the tree care industry.

Rick runs his insurance practice at Corcoran & Havlin Insurance Group located in Wellesley Massachusetts. He can be reached at RWeden@chinsurance.com.

RICK WEDEN



Section I – Worker Classification

There are a number of worker classifications that insurers might use to properly categorize workers as well as charge appropriate premiums for Workers Compensation Coverage for tree care operations. First and foremost is Classification (0106) Tree Pruning, Spraying, Repairing & Drivers. This class is used for all tree workers on tree work job sites.

Many tree care companies offer services other than tree work, such as Landscape Operations, plant health care, mulch production, retail plant sales, consulting, etc. Most all of the classifications for workers in these other categories carry rates far lower than that of tree work. As a result, proper management and accurate inclusion of these lower rated worker classifications may serve to reduce one's workers compensation costs. For example, it may be permissible for a company to use Class Code (0042) Landscape Gardening & Drivers to classify workers on landscape crews. This classification carries a far lower workers compensation rate than that of the tree work class. As a general rule, in order for a tree care company to be able to take advantage of the use the landscape gardening class, and other less costly classifications the tree care company must have true labor divisions for these services inside their company. Insurers can become uncomfortable when a tree care company has an array of services outside of specific tree work due to a potential of possible worker interchange between one class and another, particularly if this is taking place on the same work site. Those tree care companies who offer a number of different services will need to be able to show good documentation to their insurer outlining the detailed separation of the payrolls for the different work crews and also possibly separate work orders for each project so the insurer can clearly see that there were is true separation between the various types of work being performed.

The combined use of tree work (0106) and landscape (0042) classifications on the same policy has been the cause confusion and misunderstanding among tree care companies and their insurers in the past. Many still hold the incorrect opinion that ground crew workers on tree work sites can fall under the (0042) Landscape Gardening Class which is not the case. The ruling is clear that all workers on a tree work site must be classified under the (0106) Tree Pruning Class.

Some of the other classifications that one might encounter in tree work operations are Class Code (2702) Logging Lumbering & Drivers, (8227) Contractors Permanent Yard, (0046) Fertilizer and Pesticide Application, (6217) Excavation, (8742) Sales Persons, and (8810) Clerical. Other classifications not noted may also be used depending on the detailed nature of the company's operations.

The rulings insurers abide by in the use of various classifications can vary from state to state, so classifications that a tree Care Company might use in one state, may not be permissible in another. It is of extreme importance that one always consults carefully with their insurer and agent to be sure they are using the correct classifications.

DO'S and DON'TS CONCERNING WORKER CLASSIFICATION

DO review all worker classifications carefully and compare them in detail with the services that your company offers. Review them in detail with your insurance provider.

DO know at all times what the true work rate is on your Worker's Compensation Policy.

DO keep a complete list of all worker classifications that your company has handy at all times. Use it to assist in pricing work.

DON'T “play games” on worker classifications with your insurer. This can only lead to trouble!



Section II – Policy Audits

All Workers Compensation Policies are subject to Audit Provision which allows the insurer to annually evaluate, and update the payroll levels and classifications that are being used on a given workers compensation policy. Insurers perform audits so that they are always sure they are using the correct classification codes, as well as charging the appropriate premium for a given policy. Insurers can use several different methods to conduct policy audits. Most common is a field, or “physical” audit, where the insurer sends an audit specialist to the insured’s place of business. While on site the auditor gathers payroll data directly from the insured’s payroll records, often using IRS 941 forms as well as other payroll data sources. If it is determined that the payrolls gathered by the auditor are higher than the payrolls on the current policy then the insured may be subject to additional charge on their prior policy. If the payrolls are lower, the insured may receive a premium credit. The insurer may also take the audit results and use them to adjust the payroll amounts on the insured’s current policy as well.

Some insurers may choose not to send a field auditor to gather updated payroll data, but instead may ask the insured to self-report their current payrolls direct to the insurer through the use of an audit report form. This is what is often referred to as a “voluntary” audit. Many insurers deploy this approach on smaller premium workers compensation Policies as it lowers insurer expenses by avoiding the need for an actual field auditor to personally visit the insured and gather payroll data. Voluntary audits may initially appear as a convenient option to many insured’s but one has to be aware that this process also places a conservable amount of burden directly on the insured, as the insured becomes responsible for properly gathering and evaluating payroll data, as well as being responsible for allocating payroll to the various class codes themselves. Common problems encountered under this provision are insured’s failing to comply with their audits on a timely basis, resulting in insurers estimating payroll amounts, or worse, not complying at all, which can result in policy cancellations. If an insured that is under a “voluntary” audit request is not comfortable with handling this themselves, they should contact their insurer and possibly ask for a physical audit which many insurers are willing to do upon request.

It is important for the insured, regardless of the audit process they are working under, be properly prepared for their audits, having all proper payroll data organized and on hand for either the audit meeting, or to report under the voluntary provisions. The insured should also be prepared to discuss the various classifications currently in use with the auditor to be sure the proper class codes are in use. In many cases an insured may find that they may be eligible for less costly classifications, and of course, things can work on the flip-side, where an auditor may want to use higher class codes where applicable.

Some insurers also offer monthly “pay as you go” payroll reporting options. In these instances, the insured reports current payrolls to their insurer on a monthly basis, and the insurer adjusts the payrolls and workers compensation charges (billing) accordingly on a monthly basis. For many, this can be a very attractive option as it can alleviate potentially large audit charges at the end of a given policy year, or for the insured to have to wait for a return premium (credit) in situations where payrolls may have fluctuated downward. Any insured who considers a “pay as you go” arrangement should understand that it is important that they are prepared and capable of making their reports to the insurer on a timely basis as failure to do so can result in accounting and premium calculation problems.



Audit

DO'S and DON'TS FOR POLICY AUDITS

DO keep good legible records of all payrolls that are broken out into the different service groups. Have the records orderly and ready for your audit.

DO be on time for meetings with auditors.

DO have open communication with auditors. Ask them questions and when applicable, politely but professionally challenge them on decisions they might make on your audit that you may not agree with.

DON'T rely on other sources such as your accountant to “help” you with your audits. These professionals may have your correct payroll data, but often they don't know the details of your operations which can impact worker classification, and, as a result, rates!

DON'T procrastinate audits. Respond to all audit requests in a timely manner.

Section III – Experience Rating & Premium Surcharges

Generally, when a Workers Compensation policy reaches a certain premium size it then becomes eligible for what is referred to as “experience rating”. The experience rating process and potential application for policy surcharges can vary from one state to another so it is important for insurance buyers to have a basic understanding of how these are handled in the state(s) for which one carries workers compensation. The vast majority of states for example, require insurers writing workers compensation insurance in that state to subscribe to NCCI (National Council on Compensation Insurers) to obtain their experience rating data for individual workers compensation policies that they write. The NCCI is a service organization that compiles loss data and risk data that all insurers will use in that state to calculate a policy’s individual experience rating.

There remain a handful of states that do not use this system, but rather, subscribe to a Monopolistic State Fund, which all employers in that state are required to access directly to obtain their workers compensation coverage.

Simply put, Experience Rating rewards policy holders who have favorable claims experience, and penalizes those that have less than favorable claims experience. The end result is either a debit (increase) to the policy premium, or a credit.

The formula itself that is used to calculate experience rating factors is complicated, but the general principal of the formula is simple. That being, how much premium is the insured paying vs. how much in losses is the insurer paying on the insured's behalf. For example, if an insured is paying \$50,000 on average for their Worker's Compensation and they are turning in claims in the \$40,000-\$50,000 range annually, then the insured should expect to see an increase in premium due to the claims activity. In the reverse, using the same premium and the insured turned in few or no claims, and then the insured should expect to see some form of credit to their premium. The calculation of the actual formula involves an accumulation of data using a number of variables. Among them primarily is how far back in time will the insurer look to use loss data from past claims (Experience Period). Generally speaking, an insurer could look back anywhere from 1 year, to 45 months (3.75 yrs) depending on which state(s) the policy is written for and use the value of all of the claims during that time period as part of the calculation.



Then the number, nature, and size of the claims, as well as the payroll levels used on the policy. It is important to note that due to the complexity of the formula, there is room for error in the calculations at the insurer level. Obviously, an error in calculation can result in an error in the amount of premium being charged to the insured. As a result, particularly in situations where an insured is impacted by debit modifications due to past claims activity, that they seek assistance to verify the accuracy of the calculation. Many insurance professionals possess specialized software programs, similar to those used by insurers that can calculate experience rating formulas. Agents who possess this technology can work with their clients to verify the accuracy of the experience modification factor, and the subsequent charges that result. If errors are found in the calculation, the agent can bring these to the attention of the insurer, and possibly secure a correction in the rating on the policy.

Section IV - Managing Claims & Monitoring the Experience Rating Process

Before we get into the actual discussion about monitoring and managing a claim, one should have a basic understanding of how experience rating is calculated.

When a sizeable workers compensation claim occurs, the insured policy holder needs to be cognizant of three key variables that have a direct effect on the amount of additional premium the insured might wind up paying as a result of the claim's effect on the experience rating calculation on the policy.

The variables are the "reserve" on the claim, the time period that the claim will be "open" until when it is then "closed", and the length of time "experience period" that the claim will impact the insured's premium on their policy, which can be anywhere from 1 year, to 45 months after the date of injury/claim.

Let's cover each of the variables in some detail.



When a sizeable loss occurs under a worker's compensation policy one of the first things that the insurer will do after the loss has been reported to them is to establish what is called a "reserve". A reserve is the insurer's best guess, or estimate, made shortly after the time of loss, of what the maximum amount of payout the insurer thinks they might have to pay for the entire claim when all is said and done. This means that reserves on larger claims can be sizeable. Reserve amounts, even though they are estimates, will be used in the experience rating calculation formula. Insurers often change reserve amounts over the life of a claim, and those changes can impact the experience rating calculation and thereby impact the policy premium over time as well. Simply put, if a claim reserve is increased, the premium on the policy may increase also. If a reserve is decreased, then the premium on the policy may decrease as well. It usually takes a period of time from when a reserve is set, before it impacts the policy premium. This depends primarily on the date of the loss, and the policy renewal dates.



During the period of time, starting when the claim is first reported to the insurer, lasting until the claim is finalized, the claim is considered "open" by the insurer. It is during this period that the insurer may adjust the claim reserve either up or down, depending on what is going on with the claim. Once the claim is finalized, then insurer "closes" the claim. The final total amount that the insurer paid for the claim then becomes the actual dollar figure that will be used going forward for the experience rating calculation.



The last variable is the Experience Period. This is the length of time after the injury date that the insured's premium will be affected by the claim. As previously mentioned this period can last anywhere from one year to 45 months (3.75 yrs) after the date of the injury. The length of time will depend on what state the workers compensation coverage is written in.

It is of critical importance to also understand that a policy's experience mod can be impacted not only by one or more large (severity) type claims as discussed here, but also through frequency of smaller claims as well.

Now let's get into the actual process of managing the actual claim as well as monitoring the Experience Rating Process as we discussed above.

The claims management process begins on the date of the injury, and lasts until the injured worker is back to work and the claim has been closed by the insurer. Effective claims management involves not only the practical skills involving the gathering and communicating information on the claim, but also the physiological or “human” side of the claim as well. It is important for example that the employer remain in close contact with the injured worker to make sure they are comfortable with the claim process and that they are effectively recovering from their injuries. This process can involve anything from periodic visits to the injured worker to check on their progress, to possibly providing outside assistance if needed. Outside assistance could involve anything from assisting the injured worker with transportation to medical appointments, keeping the worker apprised of current ongoing inside the company, or assistance in other areas where the injured worker may need help such as meals, yard work, errands, etc. These are pure acts of kindness and caring coming from the employer that go a long way as they are reminders to the injured worker of their importance to their employer.



The employer may also have enacted a formal “light or restricted duty program” inside their company. Such a plan might enable the injured worker to return to work earlier in the recuperation process. For example, an injured tree worker may be offered a set number of hours per week to work inside the office assisting with project proposals, answering phones, or perhaps, traveling with one of the sales staff. Such a plan gets the injured worker back into the work environment sooner and can have very positive psychological effects on worker, and can also speed up the recuperation period. A written authorization from their attending physician is required before a light duty option can be offered.



Simultaneously, while the more emotional aspects of the claim are being addressed, the insured employer also needs to remain in contact with the claims adjuster at the insurer level. This is usually done with the involvement of the insurance agent or broker by having periodic contact with the claims adjuster, usually on a monthly basis. Things to be addressed in this process might be periodic updates on the claim reserve. For example, does the employee seem to be recuperating faster than originally anticipated? If so, is it possible that he or she might be able to return to full duty sooner than expected, and as a result, would the claims adjuster be willing to consider reducing the reserve on the claim? In some cases, when an employee returns on a light duty basis, this can give reason for a reserve change. Remember, a change in the claim reserve, may serve to reduce the workers compensation premium down the road. Maybe this will also result in the insurer closing the claim sooner than expected? This might also serve to reduce the premium at a later date as well.

On the flip side of this situation, there are many cases where a claim heads in the wrong direction, or worse, a situation where a worker may choose to take advantage of the workers compensation system. Sadly, situations such as these happen more frequently than we would like. In situations such as these, it is of extreme importance that the employer be made aware of this as soon as possible, as they may be able to take steps to mitigate these situations. For example, in some situations, if an employer offers a light duty option to an injured worker and the worker refuses the option, the insurer, may, in those situations be able to legally suspend the workers lost wage disability benefits. Such as suspension can reduce a claim pay-out and thereby impact future workers compensation costs down the road, but none of this can happen unless one has their hand on the pulse of the claim, and know what is going on both with the injured worker, or at the insurer level.

DO'S and DON'T'S for Effective Claims Management

DO become involved with a claim as soon as it happens.

DO establish a periodic communication system between your company and the injured worker and use it.

DO look into light restricted duty options that may be available to your injured worker. Review these options with the claim adjuster.

DO involve both your insurance provider and the claims adjuster immediately after a claim occurs. Have handy the contact information for both and establish a periodic follow-up schedule with both of them.

DO utilize your insurance provider to assist in forecasting the claim's impact on your workers compensation costs.

DON'T become complacent. Stay on top of the five "do's" noted above!!

Section V - Subcontractors

Like many other contracting trades, subcontracting is common in tree care operations. Crane services, planting, and landscape services are examples of common types of operations that a tree care company might subcontract, depending on the scope of a given tree care company's services capabilities.

When a contractor subcontracts any services they then become categorized as a "General Contractor" and as such, can then assume the exposures and risks to loss (claims) from the activities of the subcontractor. As a result, insurers are always very interested to learn what types of work their insured might be subcontracting, and will want evidence that the subcontractor does in fact have their own insurance coverage in place that will cover their activities.

In cases where a subcontractor does NOT have certain insurance coverage in place, the insurer of the General Contractor reserves the right to charge their insured for the uninsured subcontractor. For example, if a tree care company subcontracts the crane services of another company, and the subcontracted company does not carry Workers Compensation, then the insurer of the general contracting tree company can charge their insured for the uninsured operations of the company they subcontracted.

Additional charges for uninsured subcontractors often come to light when one's insurer is performing policy audits and they learn through the audit process that certain services were subcontracted and the subcontractor did not provide evidence of coverage. In these cases the insurer will develop charges based on the "cost" paid to the subcontractor and charge their insured accordingly based on the proper worker classifications of their subcontractor.

Rick's Crane Service



For example, if ABC Tree Care Company hires (subcontracts) Rick's Crane Service to perform a complex take-down, and for purpose of this example, Rick's Crane Service does not carry Workers Compensation Coverage. The cost of the job that ABC paid to Rick's Crane Service for the take-down was \$2,000.00. In this situation, the insurer for ABC has the right to charge ABC for \$2,000.00 of payroll using the Tree Pruning Class (0106) rate for the uninsured crane service operations that ABC contracted out.

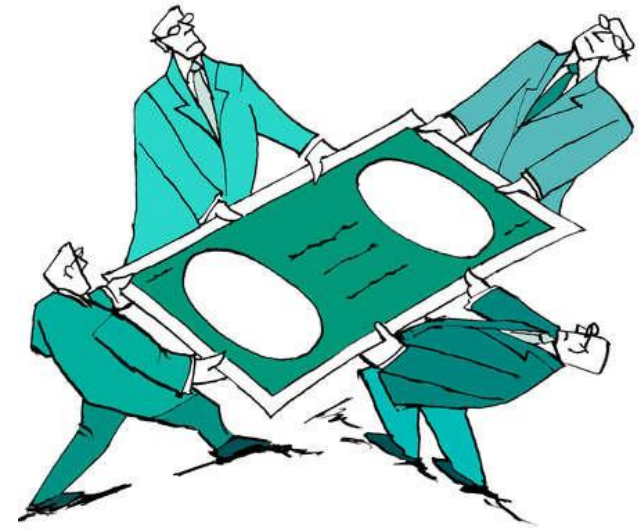
It is therefore of extreme importance that one always obtains verification (Certificates of Insurance) verifying that any and all subcontractors are carrying all necessary and legally required insurance coverage, among them, being of course Workers Compensation. Failure to do this opens one up to increased insurance costs, as well as the potential of claims stemming from subcontractors being paid under General Contractor's insurance. Not far behind would follow additional charges (experience modification/surcharges) to the General Contractor's Workers Compensation from the claims stemming from their subcontractor's operations.

Contractors with Subcontractors

The above mentioned potentially unforeseen additional premium charges, and added costs from claims stemming from uninsured subcontractors are only the tip of the iceberg when one views the exposures one assumes when hiring subcontractors. Even when subcontractors carry all necessary insurance coverage, there still remains the potential for “pass through” of claims from the subcontractor back up to the General Contractor’s insurance.

For example, if the Workers Compensation insurer of a subcontractor, after paying a claim for an accident involving the subcontractor, has reason to believe that the General Contracting company had any culpability in the cause of the accident, they may choose to take action against the General Contractor in an attempt to recover the monies they paid to the subcontractor’s injured worker. This is what insurers refer to as Subrogation and all insurers always look for the potential of Subrogation when they pay claims.

Such situations can be avoided if the General Contracting company enters into a written contract between them and their subcontractors, and the contract contains provisions whereby the subcontractor agrees to defend, indemnify, and hold the general contractor harmless for any claims stemming from the work operations of the subcontractor in what is referred to as an indemnification/Hold Harmless agreement. Along with containing these provisions, general contractor/subcontractor agreements can also include specific insurance requirements spelling out exactly the forms of insurance that the subcontractor is required to carry during the term of the contract. Insurance clauses can further require that the subcontractor add the general contractor as an additional insured to the subcontractor’s policies. Although additional insured status may not be granted under the terms of a Workers Compensation Policy, a condition referred to as Waiver of Subrogation can be included to Workers Compensation policy conditions. The waiver provision would prevent the subcontractor’s Workers Compensation insurer from subrogating back to the general contractor’s insurance for claims as noted above.



Third Party Action Over Claims

Due to the rapid escalation of what are referred to as Third Party Action over Suits, it is important to make special mention of it here as tree care operations clearly have exposure to these kinds of claims.

Third Party Action Over, or TPAO claims happen when an injured worker of a subcontractor files suit against the general contractor on the grounds of work site negligence, or unsafe workplace allegedly created by the general contractor. These suits can happen regardless of the availability of Workers Compensation benefits, and are often filed by a family member of the injured worker after the worker has been granted benefits from a Workers Compensation Policy. Although TPAO claims, when covered, fall under one's General Liability Policy, they stem from a work related injury that was handled under a Workers Compensation Policy.



Do's and Don'ts Regarding Subcontracted Operations

DO use contracts that are drafted by a legal professional that has “contracting” experience and require that contracts be used with ALL subcontractors you hire.

DO require all subcontractors to provide along with signed contracts a complete evidence of existing insurance requirements (Certificates of Insurance). Review these to be sure all subcontractors have all proper coverage in place.

DO maintain complete and accurate records of all insurance and contract information for all subcontractors that you use. Maintain the records and keep them up to date.

DO treat and evaluate all subcontractors as if they are part of your company's direct operations. Because, legally, they are!

DON'T use subcontractors, particularly crane operations who don't have full and complete understanding of tree work, and are not in compliance on Z-133 and any applicable OSHA standards etc.

DON'T use subcontractors who try to “negotiate” out of your insurance and contractual requirements.

Section VI - Shopping Your Workers Compensation Insurance/Choosing an Insurance Provider

Having the right insurance provider for your tree care company is important. The general scopes of insurance coverage sections that a tree care company requires are not all that dissimilar from those of other contracting type businesses. There are however, some nuances that an insurance professional familiar with tree care operations may better understand and be on the watch for when evaluating one's overall insurance program. In all fairness to everyone this is not to say that a given provider who, for example, may only insure one tree care company, compared to another who insures many, is not necessarily a bad fit either. It all boils down to how hard your provider is working for you, and how willing they are to learn about your industry, keep current with it, and understand the risks to loss that it has.

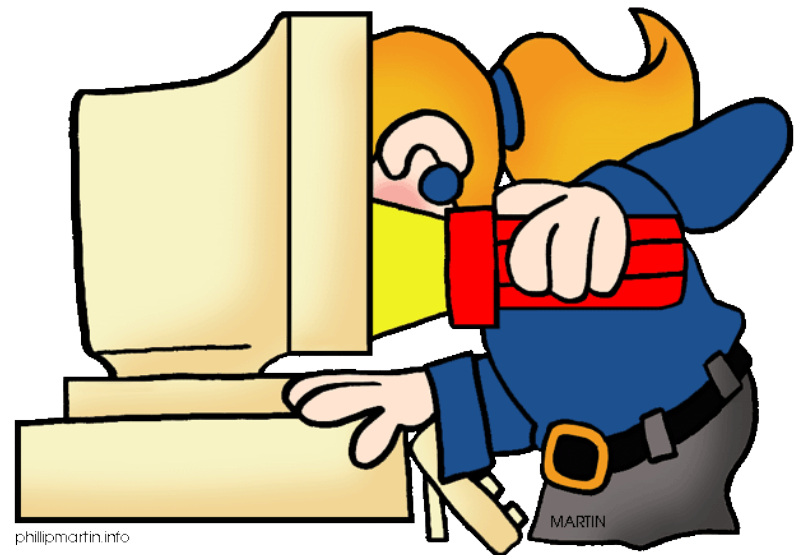
The process of choosing an insurance professional and/or seeking alternative options, if conducted properly, so that one gets the best results, does require some effort and time on the buyer's part so one should have a good up front understanding of what the process entails before one enters into it. On average, a buyer can expect to spend anywhere from six to twelve work hours on the process when all is said and done, and a prospective provider can expect to spend even more time to bring their findings (proposals) to the buyer. It is therefore important that one ask themselves some questions before they begin the "shopping" process.

1. Am I comfortable with my present insurance provider? Do they understand my operations and are they able to answer my questions. Are they responsive to my needs?
2. Does my current provider have my insurance placed with an insurer who has specialty in tree care operations? Have they attempted to show me options in the past with other insurers who also have specialty in tree care?
3. Have there been problems? Perhaps a loss was not properly covered, or not covered at all? Is the current provider not responsive on service issues? Is the provider historically late getting started on the policy renewal process? Is the provider not able to obtain specific coverage that you may need or want?
4. Do I think that I am overpaying for my insurance?
5. Am I truly ready to change providers? Assuming the answers to the former questions lead one to think they should seriously consider alternatives one should then ask themselves if they are prepared to have what could be a difficult conversation with their current provider, basically resulting in the firing of the provider if better alternatives are secured from another. It is very common to see situations where one's provider is making their best effort, and a good relationship exists between the provider and the buyer, but the provider simply does not have the "right stuff" when it comes to insuring a given client. In these situations, the firing process can be difficult for some. Let's face it, no one likes to give someone bad news.

Finding Candidates for a New Provider

The best places to look for finding a new insurance provider are generally obvious, but I mention them here.

Ask other established tree care companies in your area that you respect who they use for their insurance needs. Check with your associations, such as TCIA, or local tree care associations. Search on the web. Many excellent insurance providers can be found through social media such as LinkedIn and Face Book.



How many Providers Should I Bring In To the Process?

This needs to be determined at the very beginning of the process and the answer as to how many different providers one might involve depends greatly on the number, and kinds of options that might be available to you. As a general rule one should work with no more than three, but preferably only one. This is because the workload and time commitment at the buyers end only increases with the number of different providers (agents) they might engage during an RFP (Request for Proposals) process. Understand also that insurance companies will only offer terms to one agent. The agent that they choose is either the agent who approached them first with a complete submission package, or, an agent who presented them with a Broker of Record Letter that was signed by the prospective insured, assigning that specific agent to work with that insurer on the insured buyer's behalf. The Broker of Record Letter can also be used to take access to a given insurer away from one provider, and assign it to another. One should consider options carefully when using multiple providers and assigning various insurers to each provider. The decision of "who gets what" should be made once, communicated to everyone, and not changed later.

For those buyers wanting to use a number of different providers it should be determined up front which ones will have access to which insurers. If this is not done it can cause confusion among the various providers resulting in the buyer finding themselves acting almost as referee in a game between the providers of "who gets what".

Probably the best approach is to try and work with a single prospective provider who, along with having expertise and proven track record, also has access to all, or close to all of the individual insurers who are willing to entertain tree care operations in your region.

There can also be cases where one finds themselves in a situation where they are just simply with the wrong provider, and glaring and obvious things are going on that indicate this. In these situations, many buyers choose not to go through the multi provider process. Instead, they search, qualify and retain the new provider, not altogether different than how one might retain a new accountant, or attorney. Through the use of Broker of Record Letter authorization, they assign their current in force insurance coverage to the new provider, along with directing the new provider to secure for them other insurer options for upcoming renewals. Be aware however that not all insurers are open to Broker of Record situations. Skilled and qualified providers will understand the Broker of Record Process and will guide their clients through this properly and carefully.

How Long Does the Process Take?

As a general rule, one should allow a provider a time period of 30 to 45 days after the provider has all of the required to deliver proposals.



How Long Before The Policy Renewal/Expiration Dates Should the Process Begin?

To allow sufficient time for the process to function correctly one should initiate the process at least 90 days prior to policy renewal/expiration dates. This allows sufficient time to determine which provider(s) one will use, schedule meetings with provider(s), gather and disseminate data, as well as time to review all options prior to the policy renewal dates. It is unwise to let the process run “down to the wire” on policy renewal/expiration time-lines.

How Often Should One Look For Alternatives?

The simple answer is not very often. There are a few buyers for example, who like to “go out” each year, or every two, or three years, to seek out potential alternatives for their insurance coverage. This practice is highly inadvisable. Such buyers quickly develop a reputation in the insurance industry as “price shoppers” who involve a lot of work with no rewards to those in the insurance industry. As a result, insurers begin to refuse to offer terms for them as they know they have a slim chance of ever getting their business. Other providers/agents in their area also begin to catch on to this as well, and as a result, will begin to refrain from agreeing to offer RFP’s as they fear they would be on a “fool’s errand” if they became involved.



Once you find someone you like, stick with them. If you see something you think they should be doing for you, that they are not, ask them about it. There may be a reason.

DO'S and DON'TS When Shopping Insurance Plans

DO evaluate your present situation carefully before you begin the process. Establish the “values” that you want to gain from the process.

DO initiate the process well in advance of your renewal/expiration policy dates so that you have time to undertake the process properly and in a timely manner.

DO take time to evaluate each candidate carefully before you start the process. Ask questions and listen carefully to the answers that you get. Perhaps have a goal in mind to pare it down to one provider.

DO ask provider candidates for references and call the references to get their feedback.

DON'T make a habit of going out for alternative proposals “bids” too often.