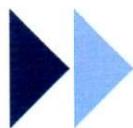


Direct Your Learning



6

Claims

Educational Objectives

After learning the content of this assignment, you should be able to:

- ▶ Explain how an insurer's claim function achieves each of its primary goals:
 - Keeping the insurer's promise
 - Supporting the insurer's profit goal
- ▶ Describe claim departments in terms of the following:
 - How they can be structured
 - The types and functions of claim personnel
 - How their performance can be measured
- ▶ Describe the activities in the claim handling process.
- ▶ Explain how claim representatives handle these aspects of property insurance claims:
 - Verifying coverage
 - Determining the amount of loss
 - Concluding the claim and exercising subrogation and salvage rights
- ▶ Explain how claim representatives handle these aspects of liability insurance claims:
 - Verifying coverage
 - Determining the cause of loss
 - Determining the amount of damages
 - Concluding the claim
- ▶ Identify the special considerations for property catastrophe claims.
- ▶ Describe the elements of good-faith claim handling and the practices prohibited by unfair claim practices laws.

Outline

Goals of the Claim Function

Claim Department Structure, Personnel, and Performance

The Claim Handling Process

Aspects of Property Insurance Claims

Aspects of Liability Insurance Claims

Special Considerations for Property Catastrophe Claims

Good-Faith Claim Handling

Summary



Claims

GOALS OF THE CLAIM FUNCTION

The goals of the claim department include keeping the insurer's promise made in the policy and supporting the insurer's profit goal.

People purchase property-casualty insurance policies to protect against financial losses. When policyholders make claims under their insurance policies, the insurer is called on to honor the promise made in the policy—namely, to indemnify the policyholder for financial losses. This does not imply that the insurer should or will pay every claim that is presented; rather, it implies that the insurer's claim department will conduct a good-faith investigation of a claim and pay only legitimate claims that are covered by the policy.

An insurer's senior management establishes the goals for the claim function. In doing so, managers must equally consider the needs of the insurance customer (the policyholder) and the needs of the insurer. The claim function typically has two primary goals:

- Keeping the insurer's promise
- Supporting the insurer's profit goal

Keeping the Insurer's Promise

The first goal of the claim function is to satisfy the insurer's obligations to the policyholder as set forth in the insurance contract. In a property insurance policy, the insurer's promise is to pay for direct physical loss to covered property by a covered cause of loss. In a liability insurance policy, the insurer's promise is to pay on behalf of the insured any damages for which the insured is legally liable because of bodily injury, property damage, or other specified types of injury caused by an accident, up to the applicable limit of insurance. The insurer also agrees to defend the insured against claims or suits seeking damages covered by the policy.

The insurer fulfills its promise by providing fair, prompt, and equitable service to the policyholder either directly, when the loss involves a **first-party claim** made by the policyholder against the insurer, or indirectly, when the loss involves a **third-party claim** made against the policyholder by someone to whom the policyholder may be liable. See the exhibit "First-Party Insurance and Third-Party Insurance."

First-party claim

A demand by an insured person or organization seeking to recover from its insurer for a loss that its insurance policy may cover.

Third-party claim

A demand against an insured by a person or organization other than the insured or the insurer, seeking to recover damages that may be payable by the insured's liability insurance.

First-Party Insurance and Third-Party Insurance

Insurance coverage is often referred to as either first-party insurance or third-party insurance.

Property insurance is considered first-party insurance because the insurer makes payment for covered losses directly to the insured. Liability insurance is considered third-party insurance because the insurer makes payments on behalf of the insured (first party) to a claimant (third party) who is injured or whose property is damaged by the insured.

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Claimant

A party that makes a claim and that can be either a first-party claimant or a third-party claimant.

Claim representative

A person responsible for investigating, evaluating, and settling claims.

The insurance contract is marketed not only as a financial mechanism to restore policyholders and other claimants to a pre-loss state, but also as a way for policyholders to achieve peace of mind. For a claimant, a loss occurrence and the consequences are not routine and can be overwhelming. A **claim representative** should handle claims in a way that promotes peace of mind for the policyholder who has suffered a loss and that quickly restores a claimant to his or her pre-loss condition.

Supporting the Insurer's Profit Goal

The second goal of the claim function is to support the insurer's profit goal. Achieving this goal is generally the responsibility of the marketing and underwriting departments; however, the claim function serves a role in generating underwriting profit by controlling expenses and paying only legitimate claims.

By managing all claim function expenses, setting appropriate spending policies, and using appropriately priced providers and services, claim managers can help maintain an insurer's underwriting profit. Similarly, claim staff can avoid overspending on costs of handling claims, claim operations, or other expenses. Finally, by ensuring fair claim settlement, claim representatives prevent any unnecessary increase in the cost of insurance and subsequent reduction in the insurer's underwriting profit.

Policyholders and other claimants are likely to accept an insurer's settlement offer if they believe they are receiving fair treatment. Parties who believe they have been treated unfairly may seek to settle their differences with the insurer by filing lawsuits. Litigation erodes goodwill between the parties and generates increased claim expenses, reducing the insurer's profitability. Additionally, dissatisfied policyholders or claimants may complain to their state insurance department, and, if the state regulatory authorities find fault, an insurer may be subjected to regulatory oversight or penalties. Costs associated with regulatory action can further erode an insurer's profits.

An insurer's success in achieving its profit goal is reflected in its reputation for providing the service promised. A reputation for resisting legitimate claims can undermine the effectiveness of an insurer's advertising. Consequently, the



two goals of the claim function work together in support of a profitable insurance operation.

CLAIM DEPARTMENT STRUCTURE, PERSONNEL, AND PERFORMANCE

Because the claim function is crucial to an insurer's promise to pay covered losses, an insurer's claim department must operate efficiently.

The loss payments, expenses, and other information generated by the claim department are essential to marketing, underwriting, and pricing insurance products. Claim personnel are among the most visible of insurer employees to insureds and the public and therefore must be able to interact well with a variety of people. Examining the structure, personnel, and performance of an insurer's claim department helps explain how it operates.

Claim Department Structure

An insurer's claim department can be organized in several different ways. A sample departmental structure can illustrate the various claim positions within the department. See the exhibit "Claim Department Organization Chart."

Usually, a senior claim officer heads the claim department and reports to the chief executive officer, the chief financial officer, or the chief underwriting officer. The senior claim officer may have a staff located in the same office. This staff is often called the home-office claim department. Within the home-office claim department, any number of technical and management specialists can provide advice and assistance to any remote claim offices and claim representatives.

The senior claim officer may have several claim offices or branches country-wide or worldwide. Staff from remote claim offices can all report directly to the home-office claim department, or regional/divisional claim officers may oversee the territory. Regional claim officers may have one or more branch offices reporting to them. Each branch office may have a claim manager, one or more claim supervisors, and a staff of claim representatives. Similar department structures are adopted by **third-party administrators (TPAs)**.

Third-party administrator (TPA)

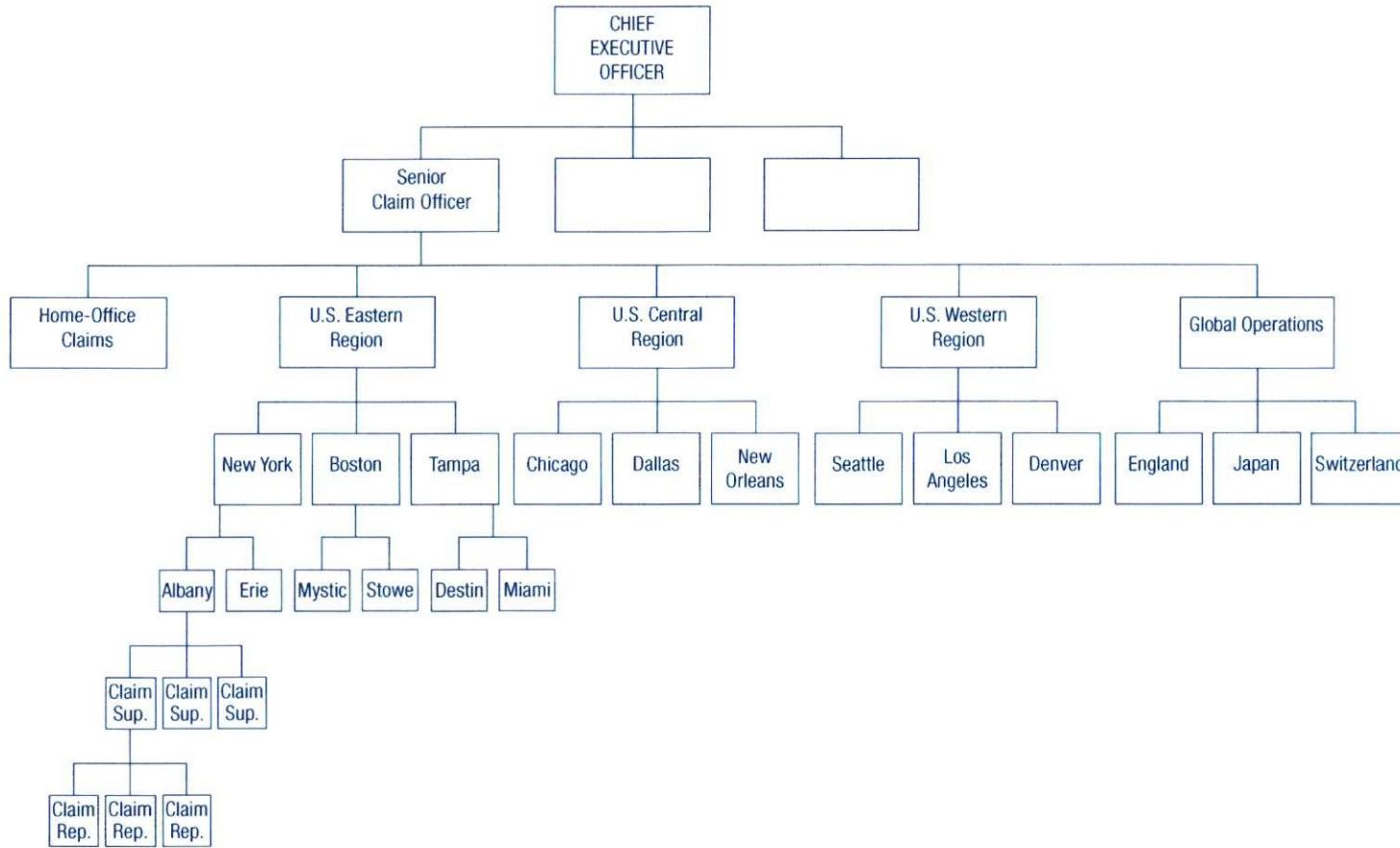
An organization that provides administrative services associated with risk financing and insurance.

Claim Personnel

A claim representative (a generic title that refers to all who adjust claims, except for public adjusters) fulfills the promise to pay the insured or to pay on behalf of the insured by handling a claim when a loss occurs. People who handle claims may be staff claim representatives, independent adjusters, employees of TPAs, or producers who sell policies to insureds. In addition,



Claim Department Organization Chart



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public adjusters also handle claims by representing the interests of insureds to the insurer.

Staff Claim Representatives

Staff claim representatives are employees of an insurer and handle most claims. They may include inside claim representatives, who handle claims exclusively from the insurer's office, and field claim representatives, who handle claims both inside and outside the office. Field claim representatives, also called outside claim representatives, handle claims that require such tasks as investigating the scene of the loss; meeting with insureds, claimants, lawyers, and others involved in the loss; and inspecting damage. Staff claim representatives usually work from branch or regional offices rather than at the insurer's home office. If the branch or region covers a large territory, the insurer may set up claim offices in areas away from the branch office to enable the claim representative to serve insureds efficiently.

Independent Adjusters

Certain insurers may not find it economically feasible to set up claim offices in every state in which insureds are located. Insurers may contract with **independent adjusters** to handle claims in strategic locations.

Some insurers use independent adjusters for all field claim work. These insurers employ claim personnel in their home office or branch offices to monitor claim progress and settle claims but use independent adjusters to handle all the field work.

Some insurers hire independent adjusters when their staff claim representatives are too busy to handle all claims themselves. For example, staff claim representatives may need assistance when a disaster strikes to handle the large number of claims quickly enough to satisfy the insurer and its insureds. Insurers may also use independent adjusters to meet desired service levels or when special skills are needed. For example, some independent adjusters are experts in highly specialized fields, such as investigating aircraft accidents.

Some independent adjusters are self-employed, but many work for adjusting firms that range in size from one small office with a few adjusters to national firms with many offices employing hundreds of adjusters.

Independent adjuster

An independent claim representative who handles claims for insurers for a fee.

Third-Party Administrators

Businesses that choose to self-insure do not use agents, underwriters, or other typical insurer personnel. However, they do need personnel to handle the losses that arise. Self-insured businesses can employ their own claim representatives or contract with TPAs, who handle claims, keep claim records, and perform statistical analyses. TPAs are often associated with large independent adjusting firms or with subsidiaries of insurance companies. Many property-casualty insurers have established subsidiary companies that serve as TPAs.



Producers

The term “producer” is used to describe anyone who sells insurance. This can include agents, brokers, insurer employees, or intermediaries. Insurers may give some producers the authority to pay claims up to a certain amount, such as \$2,500. Those producers can issue claim payments, called drafts, directly to insureds for covered claims, thus reducing the time an insured waits for payment. In this capacity, producers function much like inside claim representatives.

Public Adjusters

Public adjuster

An outside organization or person hired by an insured to represent the insured in a claim in exchange for a fee.

If a claim is complex, or if settlement negotiations are not progressing satisfactorily with the insurer, the insured may hire a **public adjuster** to protect his or her interests. Some states have statutes that govern the services public adjusters can provide. In general, the public adjuster prepares the insured’s claim and negotiates the settlement with the staff claim representative or independent adjuster. The insured, in turn, pays the public adjuster’s fee, which is usually a percentage of the settlement.

Claim Performance Measures

Because a claim department staff can be diverse and may be spread over a wide geographic area, insurers face special issues in evaluating and measuring their performance. Insurers are businesses and, as such, must make a profit to survive. Claim departments play a crucial role in insurer profitability by paying fair amounts for legitimate claims and by providing accurate, reliable, and consistent ratemaking data. Because fair claim payment does not conflict with insurer profit goals, an insurer measures its claim and underwriting departments’ performance using a loss ratio, which is a profitability measure. The quality of a claim department’s performance can be measured using best practices, claim audits, and customer satisfaction.

Profitability Measures

A loss ratio is one of the most commonly used measures for evaluating an insurer’s financial well-being. It measures losses and loss adjustment expenses against earned premiums and reflects the percentage of premiums being consumed by losses. An increasing loss ratio could indicate that the insurer is improperly performing the claim function. Increasing losses could also mean that underwriting failed to select above-average loss exposures or that the actuarial department failed to price the insurer’s products correctly.

When an insurer’s loss ratio increases, the claim department, along with other insurer functions, is pressured to reduce expenses. Claim representatives could quickly reduce loss adjusting expenses in the short term by offering insureds and claimants the settlement demanded rather than the settlement deserved. However, to reduce loss adjusting expenses in the long term, inflated settle-



ment demands should be resisted; researched; negotiated; and, if necessary, litigated. Loss adjustment expenses can also be reduced by following claim procedures. By managing losses and controlling expenses associated with handling losses, the claim department plays an important role in an insurer's profitability.

Apply Your Knowledge

An insurer's chief executive officer is analyzing the organization's profitability. He observes that in 20X0, the insurer's loss ratio was 0.67, while in 20X1 the insurer's loss ratio was 0.70. In 20X2, the loss ratio was 0.75. Further analysis indicates that the actuarial department is pricing the insurer's products correctly and that the underwriting department was selecting above-average loss exposures. This leads the CEO to focus on the claim department as potentially undermining the organization's profitability. Which of the following are measures that the claim department could employ in an attempt to reduce loss adjusting expenses in the long term?

- a. Resisting; researching; negotiating; and, if necessary, litigating inflated settlement demands.
- b. Following claim procedures.
- c. Offering insureds and claimants the settlement demanded rather than the settlement deserved.
- d. None of these measures will reduce loss adjusting expenses.

Feedback: a. and b. Offering insureds and claimants the settlement demanded rather than the settlement deserved reduces loss adjusting expenses in the short term, while the first two choices reduce adjusting expenses in the long term.

Quality Measures

Three of the more frequently used methods of evaluating a claim department's performance are best practices, claim audits, and customer satisfaction.

In the context of a claim department, the term "best practices" usually refers to a system of identified internal practices that produce superior performance. Best practices are usually shared with every claim representative. An insurer can create best practices by studying its own performance or the performance of similar successful insurers.

Claim department best practices are often based on legal requirements specified by regulators, legislators, and courts. For example, a claim department may have a best practice that states "Every claim will be acknowledged within twenty-four hours." This time frame may have been selected because of a



6.10 Property and Liability Insurance Principles

regulation, law, or court decision that requires insurers to acknowledge a claim within twenty-four hours of receipt.

Insurers use claim audits to ensure compliance with best practices and to gather statistical information on claims. A claim audit is performed by evaluating the information in a number of open and closed claim files. Claim audits can be performed by the claim staff who work on the files (called a self-audit), or they can be performed by claim representatives from other offices or by a team from the home office. Claim audits usually evaluate both quantitative and qualitative factors. See the exhibit “Quantitative and Qualitative Audit Factors.”

Quantitative and Qualitative Audit Factors

Quantitative	Qualitative
Timeliness of reports	Realistic reserving
Timeliness of reserving	Accurate evaluation of insured's liability
Timeliness of payments	Follow-up on subrogation opportunity
Number of files opened each month	Litigation cost management
Number of files closed each month	Proper releases taken
Number of files reopened each month	Correct coverage evaluation
Percentage of recovery from subrogation	Good negotiation skills
Average claim settlement value by claim type	Thorough investigations
Percentage of claims entering litigation	
Percentage of cases going to trial	
Accuracy of data entry	

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The quality of a claim department's performance is also measured by customer satisfaction. Claim supervisors and managers monitor correspondence they receive about the performance of individual claim representatives. While compliments are usually acknowledged, supervisors or managers must respond to complaints, and most claim departments have procedures for doing so. Complaints may come directly from the insured, claimant, or vendor, or they can be submitted by a state insurance department on behalf of an insured, a claimant, or a vendor.

However received, the complaint must be investigated by management and responded to in a timely manner. Complaints about issues such as not receiving a return phone call may indicate legitimate service issues. Other complaints can simply indicate dissatisfaction with an otherwise-valid claim



settlement. Review of complaints received in a claim office can show whether problems exist with a particular claim representative, supervisor, or manager.

THE CLAIM HANDLING PROCESS

To ensure that every claim is handled properly, the claim representative must follow a systematic claim handling process.

The claim handling process begins when the insured reports the loss to the producer or directly to the insurer's claim center. Losses can be reported using a loss notice form, which varies by type of loss, through a letter, or as part of a lawsuit. Once a loss notice has been received and the associated information has been entered into the insurer's claim information system, the insurer begins the claim handling process.

The claim handling process consists of a series of standard activities. The activities are not always sequential. Some can be performed concurrently, and others may need to be repeated as new facts are uncovered. Depending on the severity and complexity of the claim, the process may be completed quickly, or may take months or even years. The same basic activities are performed with every claim. These activities provide a framework for handling all types of property, liability, and workers compensation claims:

- Acknowledging and assigning the claim
- Identifying the policy and setting reserves
- Contacting the insured or the insured's representative
- Investigating the claim
- Documenting the claim
- Determining the cause of loss, liability, and the loss amount
- Concluding the claim

Acknowledging and Assigning the Claim

Generally, the first activity of the insurer in the claim handling process involves two functions—acknowledging receipt of the claim and assigning the claim to a claim representative. The purpose of the acknowledgment is to advise the insured that the claim has been received. The acknowledgment also provides the name and contact information of the assigned claim representative and the claim number. Insurers acknowledge claims in a timely manner to comply with insurance regulations.

Insurers use different methods of assigning claims to claim representatives. Some assign claims based on territory, type of claim, extent of damage, workload, or other criteria contained in the insurer's claim information system. The goal is to assign the claim to a claim representative who possesses the appropriate skills to handle it. Some states require claim representatives who handle claims in the state to have an adjuster license. These licens-



6.12 Property and Liability Insurance Principles

ing requirements must also be considered when assigning a claim to a claim representative.

After receiving the claim assignment, the claim representative contacts the insured, and possibly the claimant (if it is a third-party claim), to acknowledge the claim assignment and explain the claim process. For insurers that do not make contact immediately after receiving the loss notice, this contact serves as the claim acknowledgment. For some types of losses, the claim representative may give the insured instructions to prevent further loss, such as to cover roof damage with a tarp. If the claim involves property damage, the claim representative may arrange a time with the insured to inspect the damage or the damage scene. As an alternative, the claim representative may advise the insured or claimant that an appraiser or an independent adjuster will be in contact to inspect the property damage. If the claim involves bodily injury, the claim representative should get information about the nature and extent of the injury.

Identifying the Policy and Setting Reserves

Another early activity in the claim handling process involves two functions—identifying the policy under which the claim has been made and setting reserves. Some insurers do both before they acknowledge the claim. Other insurers identify the policy under which the claim has been made before the claim representative begins the claim investigation.

Identifying the Policy

Usually, the claim representative first identifies the policy under which the claim has been made upon receiving the assignment in order to determine what types of coverage apply to the loss. If it is apparent from the loss notice that coverage may not be available for the loss, the claim representative must notify the insured of this concern through a **nonwaiver agreement** or a **reservation of rights letter**.

Setting Reserves

Claim representatives will establish claim or case (loss) reserves, often in conjunction with identifying the policy. This can occur at almost any point in the claim handling process. While the exact timing may differ among insurers, the setting of an initial reserve(s) usually occurs early in the claim handling process.

The insurer's claim information system often determines the types of reserves that are established. For instance, there may be one reserve for property damage and another for bodily injury. Some systems require separate reserves for each claimant in a claim. Other systems require separate expense reserves for the costs of handling the claim. For example, in a claim for an auto accident, an individual reserve may be set up for damage to the insured's vehicle,

Nonwaiver agreement

A signed agreement indicating that during the course of investigation, neither the insurer nor the insured waives rights under the policy.

Reservation of rights letter

An insurer's letter that specifies coverage issues and informs the insured that the insurer is handling a claim with the understanding that the insurer may later deny coverage should the facts warrant it.



damage to the other party's vehicle, medical expenses for the insured, and bodily injury for the claimant.

Setting accurate reserves is an important part of the claim representative's job. Establishing and maintaining adequate reserves is important for the insurer's financial stability because reserves affect the insurer's ability to maintain and increase business. See the exhibit "Setting Accurate Reserves Can Be Difficult."

Setting Accurate Reserves Can Be Difficult

After the claim representative receives notice of a loss, obtains initial information, and verifies coverage, a loss reserve (or case reserve) for that claim is established. Assume, for example, that an insured had a minor auto accident in which the insured's car hit a guardrail on a foggy night and that no injuries or other cars were involved. After obtaining initial information concerning the accident, verifying coverage, and receiving written estimates of the cost to repair the insured's car, the claim representative establishes a case reserve of \$1,500. This figure is probably a very accurate estimate because a single-car collision loss is relatively easy to evaluate. Two weeks later, the repairs are made to the insured's car, and the insurer issues a check for \$1,500. Once the loss is paid, the reserve is reduced to zero because no future loss payment is expected. Therefore, the \$1,500 claim paid by the insurer equals the initial case reserve.

Conversely, complex claims are often difficult to estimate, especially liability claims. Assume, for example, that an insured was involved in a serious auto accident and that two persons in the other car were hospitalized with severe injuries. The cause of the accident is not immediately clear because of conflicting testimony of witnesses, and it is difficult to determine whether the insured is responsible for the accident. What case reserve should be established? The amount eventually paid because of this accident could range from almost nothing (if the insured is not found to be legally responsible) to hundreds of thousands of dollars (if the insured is responsible and the injured victims die or are permanently disabled). The eventual payment on this particular claim, which may not be made for several years, can vary significantly from the original reserve.

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Contacting the Insured or the Insured's Representative

Another activity in the claim handling process, which occurs soon after the loss is assigned to a claim representative and initial reserves are established, is contacting the insured or the insured's representative. For some insurers (or in certain claims as specified in the insurer's guidelines), this contact occurs at the same time as the claim acknowledgment. Generally, the claim representative reviews the initial loss report and policy and then contacts the insured and schedules a time to speak with the insured or a party representing the insured about the facts of the loss. This can be a face-to-face meeting at the



insured's location or the loss location, or it can be a telephone discussion. If the loss involves a third-party claimant, then the claim representative also contacts the claimant and schedules a meeting with the claimant or a party representing the claimant (such as a public adjuster or an attorney) to discuss the facts of the loss. Once contact is made, the claim representative should take these actions:

- Inform the insured of what is required to protect damaged property and to document the claim.
- Describe the claim inspection, appraisal, and investigation process.
- Tell the insured what additional investigation is needed to resolve potential coverage issues.
- Explain potential coverage questions or policy limitations or exclusions, and obtain a nonwaiver agreement when necessary.
- If medical and wage loss information is part of the claim, obtain the necessary authorizations.
- Explain the amount of time it will take to process and conclude the claim.
- Supply the insured with a blank proof of loss form for property damage and any necessary written instructions so that the insured can document the claim.

Investigating the Claim

Claim representatives begin investigating a claim as soon as it is assigned. They can develop an outline or notes to logically organize the investigation and to ensure that information that may be available only for a short time is investigated first (such as accident scenes or damaged property that may be destroyed or discarded). Claim representatives should contact any third-party claimant early in the investigation. Doing so establishes rapport with claimants, facilitates the investigation, and contributes to a timely settlement.

Claim representatives must also know when they have sufficient information on which to base a decision. Investigations should be geared to obtain information that will help determine the cause of loss, the amount of loss, and liability. The insurer's claim handling guidelines help claim representatives determine the types and extent of investigation needed for a satisfactory claim settlement. Once sufficient information is obtained to make a reasoned determination, the claim representative does not need to continue the investigation, unless the determination is disputed.

Subrogation

The process by which an insurer can, after it has paid a loss under the policy, recover the amount paid from any party (other than the insured) who caused the loss or is otherwise legally liable for the loss.

During the course of an investigation, the claim representative may discover that the insured was not at fault and that a third party caused the accident. When an insurer pays a claim to an insured for a loss caused by a negligent third party, the insurer can recover that payment amount from the negligent third party through the right of **subrogation**. Subrogation rights are established by insurance policies and by law. Claim representatives investigate subrogation possibilities concurrently with other investigations.



Documenting the Claim

Along with the investigation, documentation of the claim must continue throughout the life of the claim. All aspects of a claim must be documented to create a complete claim file. Three crucial parts of the claim documentation are diary systems, file status notes, and file reports.

Because claim representatives simultaneously handle many claims, they must have a system for working on and reviewing each claim. Whether this system is called a diary system, a suspense system, or a pending system, the purpose is the same. The system allows the claim representative to work on a claim one day and then diary it or calendar it for review. For example, the claim representative may ask an insured to provide a repair estimate and then diary that file for review on a date two weeks in the future. During that time, the claim representative would expect to receive the requested estimate. If the estimate has not been received by then, the review would prompt the claim representative to follow up.

File status notes (or an activity log) must accurately reflect and document investigations, evaluations of claims, decisions to decline coverage, or decisions to settle the claims. Because lawyers and state regulators can obtain copies of claim files, the file status notes and other file documentation must reflect these elements:

- Clear, concise, and accurate information
- Timely claim handling
- A fair investigation considering the insured's and the insurer's interests
- Objective comments about the insurer, insured, or other parties associated with the claim
- A thorough good-faith investigation

File reports to various parties are developed by claim representatives to document claim activity. The reports include various types of internal and external reports:

- Internal reports—for parties within the insurance organization who have an interest in large losses or loss of a specific nature, such as death, disfigurement, or dismemberment
- Preliminary reports—acknowledge that the claim representative received the assignment, inform the insurer about initial activity on the claim, suggest reserves, note coverage issues, and request assistance, if needed
- Status reports—periodically report the progress of the claim, recommend reserve changes, and request assistance and settlement authority when necessary



- Summarized reports—detailed narratives that follow an established format with captioned headings that give them structure, usually filed within thirty days of the assignment date
- External reports containing information collected by claim representatives—inform producers, some states' advisory organizations, and others who have an interest in the claim about details of the losses, such as the amount paid and the amount in outstanding reserve

Determining the Cause of Loss, Liability, and the Loss Amount

Claim representatives use the information gained about a claim during their investigation to determine the cause of loss, liability, and the loss amount. The facts of the loss determine the cause of the loss. For example, in a fire loss, the claim representative may find that a toaster caused the fire. The claim representative also determines the liability for the loss based on the facts of the case. For example, in an auto accident, the claim representative applies statutory and case law on negligence to determine liability of the parties involved.

Concurrent to the determination of the cause of the loss and the liability for the loss, the claim representative may determine the amount of the loss. For a property claim, the claim representative investigates the amount of damage to the property and the cost to repair or replace it and may also investigate the amount of business income lost. To determine a loss amount in a bodily injury claim, the claim representative investigates the extent of the injury, the residual and lasting effects of the injury, and the amount of pain and suffering the individual has endured.

Concluding the Claim

When the investigation has been completed and all documentation has been received, the claim representative must decide whether to pay the claim or deny it.

Payments

When a covered claim is concluded through negotiation or other means, the claim representative or claim personnel must issue a claim payment. When issuing claim payments, claim personnel must ensure that the proper parties are paid. Other parties, such as mortgagees on homes and loss payees on autos and personal property, can have a financial interest in the property. Parties named in the policy have rights, described in the policy, to be included as a payee under certain circumstances, such as for property that has been destroyed. For third-party liability claim payments, the claim representative must determine whether an attorney or a lienholder, such as a medical service provider, should be named as an additional payee on the payment. The claim



representative is responsible for including all required payees when issuing a claim payment.

Claim Denial

When claim investigations reveal that a policy does not provide coverage for a loss or when an insured fails to meet a policy condition, the claim representative must make a timely claim denial. Insurers often have strict guidelines that claim representatives must follow when denying claims, and some insurers require a claim manager's approval to issue a claim denial. Before denying a claim, the claim representative must analyze the coverage carefully, investigate the loss thoroughly, and evaluate the claim fairly and objectively. Courts often favor insureds when a claim denial fails to meet these requirements, and the insurer can be assessed penalties in addition to the loss amount.

Once claim management gives authority to deny a claim, the claim representative must prepare a denial letter as soon as possible. Insurers usually send denial letters by certified mail with a return receipt requested to be signed by the addressee. Some insurers also send a copy of the letter by regular mail, marked "personal and confidential," in case the certified mail is not claimed. These procedures help ensure that the denial letter reaches the correct party, and they provide documentation that it was received.

Alternative Dispute Resolution and Litigation

If an insurer and an insured or a claimant cannot agree on the claim value or claim coverage, they may resolve the disagreement in court. However, court costs and delays in the court system have encouraged insurers, insureds, and claimants to seek alternative dispute resolution (ADR) techniques for settling disputes outside the traditional court system, including these:

- **Mediation**
- **Arbitration**
- **Appraisals**
- **Mini-trials**
- **Summary jury trials**

Despite the variety of ADR methods available, many cases are concluded through litigation. Litigation can occur at almost any point during the life of a claim. However, it occurs most often when the parties to the claim are unable to reach an agreement by negotiation or ADR, or when a claim is denied. ADR reduces, but does not eliminate, the possibility that a claimant will sue and take a case to trial. Accordingly, insurers must be prepared to litigate some claims. Many insurance policies require insurers to defend their insureds at trial. The duty to defend usually ends when the amount the insurer has paid in settlements or judgments on the claim reaches the insurer's limit of liability.

Mediation

An alternative dispute resolution (ADR) method by which disputing parties use a neutral outside party to examine the issues and develop a mutually agreeable settlement.

Arbitration

An alternative dispute resolution (ADR) method by which disputing parties use a neutral outside party to examine the issues and develop a settlement, which can be final and binding.

Appraisal

A method of resolving disputes between insurers and insureds over the amount owed on a covered loss.

Mini-trial

An alternative dispute resolution method by which a case undergoes an abbreviated version of a trial before a panel or an adviser who poses questions and offers opinions on the outcome of a trial, based on the evidence presented.

Summary jury trial

An alternative dispute resolution method by which disputing parties participate in an abbreviated trial, presenting the evidence of a few witnesses to a panel of mock jurors who decide the case.



When litigation cannot be avoided, claim representatives participate in developing a litigation strategy for the insured's defense and for litigation expense control. Claim representatives must carefully select and direct defense lawyers. The lawyer's role is to be the insured's advocate. To mitigate the claim against the insured and to encourage the claimant to settle out of court, the lawyer must address every aspect of the claimant's case, from liability to damages.

Closing Reports

When a claim is resolved, the claim representative may complete a closing or final report, which can include the claim representative's recommendations on subrogation, advice to underwriters, and other suggestions. In some instances, subrogation claim representatives use these reports to evaluate the likelihood of a successful subrogation action.

Claim supervisors and managers may use the reports to audit the claim representative's performance. These reports can also be submitted to reinsurers for reimbursement of loss payment. Claim representatives should be aware of claims that should be referred to reinsurers and must complete reports on those claims based on the insurer's internal guidelines and reinsurance agreements.

ASPECTS OF PROPERTY INSURANCE CLAIMS

When an insured files a claim under a property insurance policy, the claim negotiation process ultimately determines how the claim is resolved.

In property insurance claims, two parties are usually involved in the claim negotiation process: the insured and the insurer. Claim representatives usually do not have to determine who was at fault (unless the insured is suspected of an intentional act, such as arson). These are the three crucial components of the claim handling process for property insurance claims:

- Verifying coverage
- Determining the amount of loss
- Concluding the claim and exercising subrogation and salvage rights

Verifying Coverage

One of the claim representative's duties is to verify whether the claim is covered. If a question of coverage exists and the insurer plans to continue its investigation, the insurer might send a reservation of rights letter to the insured. After receiving the initial report of a claim, the claim representative



must gather further information to verify coverage. The initial verification involves three steps:

1. Confirming that a valid policy was in effect
2. Determining that the date of the loss falls within the policy period
3. Establishing whether the damaged property is insured under the policy

The claim representative must determine whether the coverage provided by the policy will pay any or all of the claim submitted. For a property insurance claim, the claim representative must seek the answers to four questions to verify that the claim is covered:

- Does the insured have an insurable interest in the property?
- Is the damaged property covered by the policy?
- Is the cause of loss covered by the policy?
- Do any additional coverages, endorsements, or coverage limitations apply?

The first question determines whether the person or organization making a claim for the damaged property has an insurable interest in the property. In property insurance, an **insurable interest** exists if a person or another entity would suffer a financial loss if the property were damaged. In most property insurance losses, the insured is the property owner, so the question of insurable interest is easily answered. However, others may also have an insurable interest in the property. For example, a mortgagee (such as a bank that has provided a home mortgage loan) has an insurable interest in real property to the extent of the outstanding mortgage. Under certain circumstances, the mortgagee has rights to collect under an insurance policy if the mortgaged property has been damaged or destroyed.

Insurable interest

An interest in the subject of an insurance policy that is not unduly remote and that would cause the interested party to suffer financial loss if an insured event occurred.

The second question that the claim representative must answer is whether the damaged property is covered by the policy. In the case of a damaged home or commercial building, the answer may seem obvious. The answer, however, may not be as simple as it appears. For example, insurance coverage on a building usually includes any item permanently attached to the building and any outdoor equipment used to maintain the building. Although the building may be clearly insured, would a room air conditioner attached to a window frame be considered a part of the building? Would a toolshed connected to a dwelling by a fence be considered a part of the dwelling? These are the types of questions that the claim representative must answer according to the policy provisions.

The question of whether the damaged property is covered by the policy is equally important for personal property. Most property insurance policies exclude losses to certain types of property. For example, a homeowners policy generally does not cover losses to property of tenants or to most motorized vehicles.

The third question the claim representative must answer is whether the cause of loss is covered by the policy. Often, the cause of the loss, such as fire or



lightning, is clearly covered under the policy. In such cases, disputes between the insured and the insurer are unlikely to occur. However, disagreements may arise when the cause of loss is less obvious. Disputes can occur, for example, if there is more than one possible cause of loss, as in a hurricane when damage may have been caused either by wind or by flooding.

The claim representative may also need to interview and take statements from any witnesses to the loss to better understand how and why the loss occurred. When a building is totally destroyed, the best information about how the loss occurred often comes from witnesses. This information can help determine the cause of loss, which could be especially important in situations in which someone other than the insured may be responsible.

The fourth question the claim representative must answer is whether any additional coverages, endorsements, or coverage limitations apply. In many insurance policies, additional coverages and limitations modify the basic coverage provided. The insured might also have purchased an additional coverage, selected one or more optional policy coverages, or modified coverage through an endorsement (policy amendment). Such changes to the basic policy can eliminate or modify exclusions or limitations.

Insurance policies contain important limitations on coverage. For example, although a homeowners policy covers most types of personal property, certain types of property, such as jewelry and furs, are covered for only a specified dollar amount when the loss is because of theft.

The claim representative must also check to see whether a deductible applies to the loss, which would reduce the amount of the loss payment. For an especially large deductible or a small loss, application of the deductible may indicate that no payment can be made. Before determining whether a given loss is covered, the claim representative must confirm that the loss occurred during the time period and within the territory described in the policy.

Determining the Amount of Loss

For personal property, the most important information is what property was damaged or destroyed. Creating an inventory of damaged personal property can be an arduous task for some losses, such as serious fire losses. However, for the claim representative to determine the value of the loss, a detailed inventory is essential and specific information must be gathered. When the loss involves a business, historical valuation information often appears in the company's financial records. In addition, if a business income loss is involved, the financial records are useful in determining the proper valuation of the lost income.



The valuation of loss can be the most difficult aspect of settling property insurance claims. To indemnify the insured according to the policy provisions, the claim representative must be able to answer two questions:

- How does the policy specify that the property be valued?
- Based on that specification, what is the value of the damaged property?

Common Valuation Methods

All property insurance policies include a valuation provision that specifies how to value covered property at the time of the loss. The most common property valuation methods are actual cash value, replacement cost, and agreed value.

Actual cash value (ACV) is the cost to replace the property minus an allowance for the property's depreciation. For example, assume a fire completely destroys a new television and a four-year-old sofa. The television has a replacement cost of \$600 (its cost when it was purchased a week earlier), and the sofa would cost \$800 to replace with a comparable (of like kind and quality) new sofa.

Under these circumstances, an ACV settlement includes \$600 for the television because it has not yet had time to depreciate. For the sofa, however, the claim representative has to place a value on the used property. The claim representative must determine the extent of depreciation that should be considered. This determination is usually made by estimating the property's expected useful life. If, under normal circumstances, a sofa might be used for ten years and it is now four years old, a good estimate of depreciation from normal wear and tear is 40 percent. Therefore, with a replacement cost of \$800 and depreciation estimated at 40 percent, the ACV of the damaged sofa is \$480. A payment of \$480 would indemnify the insured for the loss of the four-year-old sofa.

Actual cash value (ACV)

Cost to replace property with new property of like kind and quality less depreciation.

Depreciation

The reduction in value caused by the physical wear and tear or technological or economic obsolescence of property.

Apply Your Knowledge

A covered cause of loss completely destroys a family's six-year-old pool table. The pool table would cost \$1,100 to replace with a comparable (of like kind and quality) new pool table. A pool table is generally expected to be used for ten years. Explain how, as the claim representative, you would determine the covered pool table's ACV.

Feedback: As the claim representative, you must place a value on the pool table by determining the extent of depreciation that should be considered. Because a pool table might be used for ten years and is now six years old, you estimate the depreciation from normal wear at 60 percent. Therefore, with a replacement cost of \$1,100 and depreciation estimated at 60 percent, the ACV of the destroyed pool table is \$440. A payment of \$440 would indemnify the insured for the loss of the pool table.



6.22 Property and Liability Insurance Principles

Replacement cost

The cost to repair or replace property using new materials of like kind and quality with no deduction for depreciation.

Agreed value method

A method of valuing property in which the insurer and the insured agree, at the time the policy is written, on the maximum amount that will be paid in the event of a total loss.

Another valuation method specified in some property insurance policies allows for valuation on a **replacement cost** basis. In this case, deduction for depreciation is not part of the valuation, and the insured in the previous example would be paid \$800 for the four-year-old sofa. Generally, a loss valued on a replacement cost basis is paid only after the property has been replaced. The insurer may pay the claim first on an ACV basis, and the insured then has 180 days to provide notice of the replacement cost.

Still another method for valuing property losses is **agreed value**, which is used to insure property that is difficult to value, such as fine arts, antiques, and collections. This agreed value is often based on an appraisal, and that amount is stated in the policy declarations. If a total loss to the property occurs, the insurer will pay the agreed value, regardless of the property's exact value at the time of the loss.

Valuation Process

Once the claim representative has verified coverage and identified the valuation method specified in the policy, the valuation process begins. Claim representatives use guidelines to determine both replacement cost and ACV. Personal property and real property present different valuation problems.

If the exact style and brand of the damaged personal property are available for purchase, obtaining the replacement cost is simple. If the particular item is no longer available, the claim representative identifies the closest substitute in style and quality and uses that substitute's value as the replacement cost. For ACV, however, depreciation must be estimated. While claim representatives have attempted to develop straightforward methods, such as the useful-life procedure described in the case of the damaged sofa, these procedures do not fit every circumstance.

For example, if a sofa has an expected life of ten years, the claim representative makes a reasonable estimate in considering the four-year-old sofa to be 40 percent depreciated. But what if the sofa is fifteen years old? Is it considered worthless? The fifteen-year-old sofa has some value as long as it is functional, so the depreciation procedure must allow for that fact. The claim representative may have guidelines stating that property still being used is no more than 75 percent depreciated, no matter how old it is. While such guidelines may be developed to treat most cases, it is impossible to anticipate every situation the claim representative may encounter. Therefore, he or she must use good judgment to determine depreciation.

The replacement cost of real property can usually be determined by using three factors:

- Square footage of the property
- Type and quality of construction
- Construction cost per square foot



The first factor is the square footage of the property. If the building has been badly damaged, its area can be determined from the original blueprints or by measuring the remains.

The second factor is the type and quality of construction. A one-family frame house with standard trim and fixtures costs far less to replace than a house of the same size built of stone with high-quality woodworking, skylights, and other features. The quality of the house or building is more apparent if part of the structure has escaped damage. Pictures of the house or building can be useful, particularly if the structure has been totally destroyed.

The final factor affecting replacement cost is the construction cost per square foot that is currently charged for the style and quality of the destroyed building. Contractors who do business in the general location of the damaged building can quote costs per square foot in various quality-of-construction categories, such as \$65 per square foot for standard quality, \$75 per square foot for medium quality, and \$90 per square foot for superior quality. Multiplying the square footage by the appropriate cost per square foot yields the building's replacement cost.

If the building is only partially damaged, the claim representative usually prepares a repair estimate or obtains repair estimates from one or more contractors. Replacing the property when a partial loss has occurred involves restoring the property to its previous state as closely as possible.

Some policies specify that the ACV method should be used to measure loss to real property. For policies specifying ACV valuation, claim representatives estimate depreciation of real property using methods similar to those used for estimating depreciation of personal property.

Concluding the Claim

After verifying coverage, determining the cause of loss, and determining the amount of damage or extent of loss, the claim representative must conclude the claim. This step usually requires that the claim representative and the insured discuss the details of the loss and the valuation of the damage to agree on an amount for the insurer to pay to settle the loss.

The negotiation phase of claim handling can be relatively simple, as in the example about the fire-damaged television. However, it may be complicated because of a large number of damaged items, property of high value, or disagreement between the insured and the claim representative regarding the value or circumstances of the loss. Whenever possible, questions of coverage, valuation, and other matters should be discussed and resolved as they arise. In addition, investigation and valuation often continue while the negotiation is in progress.

After the claim representative and the insured agree on the amount of the settlement, two other factors can affect the insurer's cost for property claims: subrogation and **salvage rights**.

Salvage rights

The insurer's rights to recover and sell or otherwise dispose of insured property on which the insurer has paid a total loss or a constructive total loss.



Subrogation

When an insurer pays an insured for a loss, the insurer assumes the insured's right to collect damages from a third party responsible for the loss. Subrogation often applies in claims involving auto accidents. Once the insurer pays the insured for the repair or replacement of the damaged auto, the policy provides that any rights to collect from another party responsible for the damage to the auto belong to the insurer (up to the amount the insurer paid the insured for the claim). Subrogation prevents an insured from collecting from both the insurer and the party at fault for the same loss.

The claim representative investigates whether another party involved in the accident is legally responsible for the damage paid by the insurer. If another party is responsible, the insurer can attempt to collect the repair or replacement cost from that person or that person's insurer. Formal legal proceedings may be necessary to determine who is legally responsible for the damage.

Salvage Rights

Salvage rights are the insurer's rights to recover and sell or otherwise dispose of insured property on which the insurer has paid a total loss or a constructive total loss. A **constructive total loss** exists when a vehicle (or other property) cannot be repaired for less than its ACV minus the anticipated salvage value.

For example, if an auto damaged in an accident cannot be repaired for less than its ACV minus the anticipated salvage value, the auto is considered to be a constructive total loss. In this case, the insurer pays the auto's ACV to the insured (or finds an auto similar to the insured's auto before it was damaged). Although the settlement with the insured is paid as a total loss, the insurer might be able to collect some salvage value for the damaged auto. Depending on the condition of the vehicle, an auto salvage dealer may be willing to pay for the auto to obtain scrap metal and undamaged parts that can be resold as used parts. In this way, the salvage value can offset some of the insurer's claim cost.

As an illustration, assume the ACV of the insured's car at the time of an accident is \$10,000, and repairs will cost \$9,000. If the car could be sold for \$1,500 to a salvage dealer, the insurer would consider the car a constructive total loss because it would cost more for the insurer to pay the repair cost than to pay the insured the ACV of \$10,000 and then sell the salvage for \$1,500 ($\$10,000 \text{ ACV} - \$1,500 \text{ salvage value} = \$8,500$, which is less than the \$9,000 cost of repairing the car).

ASPECTS OF LIABILITY INSURANCE CLAIMS

Because liability claims entail elements not present in property claims, claim representatives use different methods to settle them.



In liability claims, the claim representative's investigation focuses on whether the activity leading to liability comes within the scope of the policy and whether the insured could be legally responsible for the loss. If the claim goes to court, the insured could be held liable for compensatory damages (which include special damages and general damages) and, possibly, punitive damages. Often, however, it is in the best interest of all parties to negotiate a settlement out of court rather than to incur the expense and delay of legal proceedings.

These are four key aspects of liability insurance claims:

- Verifying coverage
- Determining the cause of loss
- Determining the amount of damages
- Concluding the claim

How Liability Claims Differ From Property Claims

Liability claim adjusting differs from and may be more difficult than property claim adjusting for three reasons. First, the claimant is a third party who has been injured or whose property has been damaged by the insured. The claimant may perceive the claim representative as an adversary, and this perception could cause the claimant to act in a hostile or unfriendly manner.

Second, a liability claim may involve bodily injury. While it is not always easy to determine the amount of the loss in property damage liability claims, determining the amount of loss is often even more difficult and complex when the claim seeks damages for bodily injury or death.

Liability claim settlement sometimes involves a claim for damage that the insured has allegedly caused to the property of others. The process for handling property damage liability claims resembles the claim handling process for property insurance claims, with the added difficulty of determining whether the insured is legally responsible for the property damage that has occurred.

Verifying Coverage

As in a property claim, the claim representative must gather information to verify coverage. The process includes checking whether a valid policy was in effect and, if so, determining whether the date of the loss falls within the policy period and whether any additional coverages, endorsements, or coverage limitations apply. In handling a liability claim, the key difference from a property claim is that the claim representative must determine whether the insured is legally responsible for the loss; if not, liability coverage does not apply.



Determining the Cause of Loss

After receiving the first report of injury or damage and verifying coverage, the claim representative must gather detailed information relating to the liability claim. Because the amount of the loss is relevant only if the loss is covered under the insured's policy and if the insured is legally responsible for the loss, the question of how much damage occurred may be secondary in importance. Therefore, the claim representative must first determine how and why the loss occurred and whether the insured appears to be responsible.

In investigating a liability claim, the claim representative often inspects the scene of the occurrence or accident. This inspection is particularly useful if a traumatic event has occurred, such as an auto accident, a building collapse, or a fire. By studying the scene and interviewing the insured, the claimant, and any witnesses, the claim representative attempts to reconstruct the events that led to the loss. This reconstruction helps to determine, as closely as possible, how the loss occurred and who is responsible. Additional details are needed to determine the extent of the bodily injury or property damage. At this point, the claim representative collects enough information to help determine whether the liability policy covers the loss and, if so, whether the insured may be legally responsible.

As soon as possible, the claim representative speaks directly with the injured party or the injured party's legal representative to hear that side of the story and to assess what bodily injury or property damage has been sustained. Many times the events surrounding an accident are difficult to reconstruct, and the claim representative may receive different accounts of these events from the injured party and the insured. The claim representative seeks to resolve these discrepancies by taking statements from the claimant, the insured, and any available witnesses.

The injured party has the option of suing the insured, and the ensuing legal process could end in a legal decision determining whether the insured is legally liable and, if so, to what extent. Because of the time, expense, and uncertainty involved in a lawsuit, insurers often prefer to settle claims out of court. If the claim does go to court, the insurer is obligated to provide and pay for the insured's defense for a covered claim (until the insurer has paid the full policy limit for the occurrence involved).

Liability policies usually cover the insured's liability arising from certain specified activities, such as owning or using an automobile or operating a business, subject to certain exclusions. Coverage depends on whether the activity leading to the claim is within the scope of the policy's coverage and whether any exclusions in the policy apply to the specific case. Based on the information gathered, the claim representative must determine whether coverage applies.

If the claim representative's investigation finds that no coverage applies, the insurer will deny the claim. For example, if the policy excludes injury intended by the insured and the insured purposely injures someone with a baseball bat, there would be no coverage unless the insured has evidence that



the injury was careless but not intentional. In that case, the claim representative would need to investigate further to determine whether the injury was indeed intentional on the insured's part. If coverage does exist, the valuation aspect of liability claims settlement then becomes very important.

Determining the Amount of Damages

Damages are money claimed by, or a monetary award to, a party who has suffered bodily injury or property damage for which another party is legally responsible. When bodily injury occurs, determining the amount of damages often depends on medical records and the reports and opinions of physicians. Properly evaluating medical information is important in determining the amount of damages and is a distinguishing factor in the loss settlement process for bodily injury liability claims. This aspect of bodily injury claims requires experience and skill.

Legal liability cases may involve these types of damages:

- Compensatory damages
- Punitive damages

Compensatory Damages

Compensatory damages are intended to compensate a victim for harm actually suffered and include special damages and general damages.

Specific, out-of-pocket expenses are called **special damages**. In bodily injury cases, these damages usually include hospital expenses, doctor and miscellaneous medical expenses, ambulance charges, prescriptions, and lost wages for time spent away from the job during recovery. Because they are specific and identifiable, special damages are easier to calculate than general damages.

General damages are compensatory damages awarded for losses that do not have a specific economic value. Examples of general damages include compensation for pain and suffering; disfigurement; loss of limbs, sight, or hearing; and the loss of the ability to bear children. Because these losses do not involve specific and measurable expenses, estimating their dollar value requires considerable expertise. For the claim representative, the best guide is usually to analyze past cases that are similar to the case currently under investigation. For that purpose, the claim representative may use any of these tools to estimate the bodily injury valuation of specific damages: supervisor's guidance, roundtable discussion with other claim representatives, or computer software.

There is usually no direct relationship between the amount of general damages and the amount of special damages. In some cases, such as when a claimant loses an eye, the amount of special damages may be relatively low, but the general damages may be quite high because of pain and suffering and the change in the claimant's quality of life. In other cases, such as for whiplash injuries, general damages may be minimal, but special damages may be

Damages

Money claimed by, or a monetary award to, a party who has suffered bodily injury or property damage for which another party is legally responsible.

Compensatory damages

A payment awarded by a court to reimburse a victim for actual harm.

Special damages

A form of compensatory damages that awards a sum of money for specific, identifiable expenses associated with the injured person's loss, such as medical expenses or lost wages.

General damages

A monetary award to compensate a victim for losses, such as pain and suffering, that do not involve specific measurable expenses.



considerable because the claimant requires physical therapy or other medical treatment.

In recent years, courts have often made large awards for general damages, particularly for traumatic incidents like automobile accidents. Claim representatives must be aware of the awards for damages made in their jurisdictions, because these awards provide a guideline for negotiating with the injured party.

Punitive Damages

**Punitive damages
(exemplary damages)**

A payment awarded by a court to punish a defendant for a reckless, malicious, or deceitful act to deter similar conduct; the award need not bear any relation to a party's actual damages.

When a court finds the defendant's conduct particularly malicious or outrageous, it might award **punitive damages**. The purpose of punitive damages is to punish the wrongdoer and to deter others from committing similar wrongs. In some states, the insurer's payment of an award for punitive damages is not permitted because such payment by an insurer would not punish the insured. Some policies expressly exclude the payment of punitive damages.

Concluding the Claim

A large percentage of liability cases are settled out of court through negotiations between the claim representative and the claimant or the claimant's attorney. In most instances, neither party wishes to become involved in a formal legal action with the accompanying costs and delays.

When negotiations do not result in a settlement, however, the claimant has the option of suing for the alleged damages. A court then decides who is responsible and determines the value of the bodily injury or property damage.

Even if a claimant initiates a lawsuit, however, the claim negotiation process usually continues. Many out-of-court settlements have resulted after some or all of the courtroom testimony has been given. Negotiating with the claimant while simultaneously preparing for proceedings in court requires a great deal of skill, patience, and understanding on the part of the claim representative.

SPECIAL CONSIDERATIONS FOR PROPERTY CATASTROPHE CLAIMS

Most insurers cover properties that are subject to catastrophic events such as windstorms, floods, and wildfires. Insurers that have these exposures should be prepared to handle the large number of losses associated with a catastrophic event.

After a catastrophe, insureds and regulators expect an insurer to settle losses quickly, regardless of the volume of claims or any disruptions to the insurer's resources. Effective catastrophe response requires careful preparation. Detailed



contingency plans that are communicated to all insurer staff serve several purposes:

- Identifying weaknesses, bottlenecks, and potential difficulties
- Permitting staff to clearly understand their roles and responsibilities during a crisis in advance, so that they can react productively and not emotionally
- Keeping the organization free to focus on handling claims without reallocating essential resources to resolve problems for which it was unprepared

The exhibit presents some of the challenges involved in catastrophe response and illustrates how contingency planning can help an organization prepare to meet them. See the exhibit "Challenges Involved in Catastrophe Response."

Insurers can initiate certain activities to ensure that catastrophe losses are handled promptly, despite the large volume of claims. Changes that insurers make to their work operations to address catastrophes include these:

- Developing and using abbreviated claim handling procedures to speed processing
- Temporarily increasing claim settlement authority to producers for the duration of the catastrophe response
- Temporarily transferring claim settlement authority to preselected independent adjusting firms
- Bringing in catastrophe teams of claim representatives from other regions
- Making advance payments to policyholders for costs such as additional living expenses
- Immediately settling all questions of property valuation in favor of the policyholder
- Suspending all but the most essential recordkeeping
- Reallocating available employees in critical work areas

Claimants are under enormous stress following a catastrophe. After claimants restore their lives to as normal as possible, claim payment from an insurer may be the only step remaining until they can begin repairing their homes and businesses. At this point, claimants may become aggressive in their pursuit of a settlement. Claim staff should be trained in dealing with aggressiveness without resorting to antagonistic responses. Media attention often focuses on the plight of claimants, with insurers portrayed in a negative light. Such media attention can escalate aggressive behavior on the part of claimants, who may perceive a need to assert their rights.

Finally, claim departments should prepare to assist claimants with problems that occur outside normal claim-related issues. For example, some claim settlement checks for property losses are made payable both to the policyholders and their mortgagees. Mortgagees may withhold their signature until they have evidence that repairs to the secured property have been completed. However, in post-catastrophe areas, repairs may require payment in advance.



6.30 Property and Liability Insurance Principles

Challenges Involved in Catastrophe Response		
Area	Potential Problems	Possible Responses
Staffing	Insufficient claim staff to handle volume of incoming claims. Staff unavailable as they deal with their own property damage.	Identify and train staff from other areas to assist. Establish relationships with independent adjusters to help manage overflow. Bring in catastrophe teams of claim representatives from other regions.
Premises	The insurer's premises are damaged or must be evacuated.	Identify and arrange for the use of alternative premises. Secure existing premises.
Systems	Records are destroyed or computer systems are down.	Maintain current backup at a remote location where information can be accessed.
Communication	Communication links are destroyed.	Identify public broadcasting services that may be used. Arrange for wireless communication.
Transportation	Roads and bridges are damaged.	Identify alternative routes and resources to move staff and materials into damaged areas.
Utilities	Utilities are suspended.	Arrange for generator-powered electricity, water tank services, portable toilets, and showers.
Material and labor	Available construction materials and labor are insufficient.	Arrange sources of materials and labor from nearby communities.
Mass evacuation	Policyholders are evacuated from an area.	Identify and secure temporary housing, including motels, mobile homes, and other temporary buildings.
Policyholder needs	Policyholders are confused, stressed, and anxious.	Prepare catastrophe kits, including sources of information and assistance, for distribution to policyholders.
Community needs	Efficient claim settlement depends on restoring resources and community services.	Coordinate with other insurers and community disaster relief agencies.
Employee stress	Employees' stress levels during catastrophes are high.	Train employees in stress management, and have counselors available on site. Provide temporary daycare services and meals as other businesses are closed and employees work longer hours.
Security	Policyholders can become aggressive as they try to recover from their losses and payments are delayed. Insurers may become the target of violence when unfavorable rumors circulate. Criminals are attracted to post-catastrophe locations for temporary employment paid in cash.	Increase security at the insurer's premises and parking lots. Maintain visible security in lobby and public areas. Restrict access to work areas. In the event of a temporary curfew, arrange for travel passes for employees who work before or after curfew hours.

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Elements of Good-Faith Claim Handling

Good-faith claim handling consists of these elements:

- Thorough, timely, and unbiased investigation
- Complete and accurate documentation
- Fair evaluation
- Good-faith negotiation
- Regular and prompt communication
- Competent legal advice
- Effective claim management

Thorough, Timely, and Unbiased Investigation

Investigations that are thorough, timely, and unbiased are the foundation of good-faith claim handling. Claim representatives should collect all relevant and necessary evidence, develop the information and documentation necessary to determine liability and damages, and make decisions when they believe they have sufficient information to do so. In a thorough investigation, the claim representative is alert for new information that may change the course of the claim.

In addition to being thorough, an investigation should be timely. An insured who makes a claim expects prompt contact from the claim representative. Most insurers have guidelines requiring the claim representative to contact the insured and the claimant within a specific period, such as twenty-four hours after the claim has been submitted. Documentation of timely contact in the claim file can help prove an insurer's use of good-faith claim handling procedures.

Finally, investigations should seek to discover the facts and consider all aspects of the claim to reach an impartial decision. Claim representatives should pursue all relevant evidence, especially evidence that establishes the claim's legitimacy, without bias. While striving for impartiality, claim representatives must still be alert to indicators of possible fraud and investigate them thoroughly. Insurers must also make a good-faith effort to find experts who are reputable within their profession and who will provide unbiased evaluations. Insurers may face bad-faith claims for failing to consider an expert's opinion in denying a claim or for failing to ascertain the unreliability of an expert's opinion and acting on it.

Complete and Accurate Documentation

A claim file must provide a complete and accurate account of all the activities of and actions taken by the claim representative. Claim representatives should be aware that many people, each with a different purpose, may read a claim file, including, for example, supervisors, a home-office examiner or an auditor, claim department peers, an underwriter, an agent or a broker, a state insurance



department representative, and so forth. Claim files should provide complete information for all of their purposes.

Fair Evaluation

Fair evaluations are based on facts, not opinions. Claim representatives determine a range of claim amounts based on the facts of the claim, the credibility of the evidence, and applicable laws. Fair evaluations result from thorough, timely, and unbiased investigation and from an understanding of the laws of the jurisdiction in which the claim is brought. For assistance in making evaluations, claim representatives can consult with sources inside and outside the insurance company, including co-workers, supervisors and managers, defense lawyers, people who represent a typical jury, and jury verdict research companies.

File documentation showing that the claim representative used best practices to evaluate a claim is evidence of good-faith claim handling. Fair evaluation is particularly important in liability claims, which may result in damages that exceed policy limits. By evaluating liability claims as if no coverage limit existed, claim representatives can avoid the mistake of unfairly attempting to settle a claim for less than the policy limit when it may be worth more.

A crucial element of fair claim evaluation is promptness. Compliance with statutory time limits for completion of evaluations of coverage and damages can help reduce the insurer's exposure to bad-faith claims. Promptness is also important in responding to the claimant, the insured, or their respective lawyers' demands. Promptness is particularly important when there is a demand for settlement that is at or near the policy limits.

Good-Faith Negotiation

Claim representatives should respond to exaggerated demands from lawyers by offering and documenting a settlement that is consistent with the evidence and documentation in the claim file. An increasing number of bad-faith claims arise from insurers' failure to settle liability claims against the insurer within policy limits. In many such cases, the insured has demanded that the insurer settle the case within policy limits and has made it clear that the insurer is expected to pay the entire amount of the damages if settlement does not occur. If a verdict in excess of policy limits is delivered and the insurer refuses to pay the insured, a bad-faith lawsuit ensues.

To resolve disputes over settlement amounts, claim representatives should use policy provisions, such as arbitration clauses, when applicable. An insurer that adheres to policy provisions and pays the amount determined through arbitration is in a better position to defend a bad-faith lawsuit. Claim representatives should consider all possible forms of voluntary alternative dispute resolution, including mediation or a series of face-to-face negotiations, to resolve claims.



Regular and Prompt Communication

Communicating with all parties to a claim (for example, the insured, the defense attorney, and the excess insurer) is a crucial aspect of good-faith claim handling and resolving claims. Keeping insureds informed is especially important because they expect it, they are most likely to make a bad-faith claim, and they may have the most important information about an accident. The claim representative has a duty to inform the insured of policy provisions that apply to the claim, rights under the policy, and steps to be taken to get maximum benefits. Additional questions from the insured should be answered clearly and promptly. The duty to inform stems from the insurer's duty of utmost good faith under the insurance contract and is also required under many states' unfair claims practices acts.

Competent Legal Advice

Following the advice of competent lawyers can be considered evidence that an insurer acted in good faith. Claim representatives should provide lawyers with all information and documentation necessary to reach a complete and accurate opinion and should avoid any attempts to influence the lawyer's independent judgment.

When resolving a coverage question, insurers should avoid conflicts of interest by using lawyers other than the defense lawyers hired to defend an insured. Asking a lawyer who defends an insured a coverage question creates an ethical dilemma for that lawyer because the answer may not be in the insured's best interest. Insurers that use in-house or staff lawyers to defend insureds should be especially sensitive to the possibility of a conflict of interest and, if any appearance of such a conflict exists, should use outside lawyers.

Effective Claim Management

An insurer's claim management directly affects a claim representative's ability to handle claims in good faith. Claim management in this context refers to how claim departments are managed by claim supervisors and claim managers. Especially crucial to good-faith claim handling are consistent supervision, thorough training, and manageable caseloads.

Unfair Claim Practices Laws

Most claim representatives strive to treat insureds and claimants as fairly as possible while adhering to policy terms and state regulations. It is difficult to gain the expertise to understand complex policy conditions and to determine the value of the loss. Most states have enacted unfair claim practices laws,



which specify claim practices that are illegal. Examples of prohibited claim practices include these:

- Knowingly misrepresenting facts about coverage to insureds or claimants
- Failing to promptly acknowledge communications from insureds and claimants
- Failing to promptly investigate and settle claims
- Failing to settle claims in good faith, promptly, fairly, and equitably when liability is reasonably clear
- Offering insureds or claimants substantially less money than a claim is worth, thereby forcing them to sue to recover the rightful amount
- Failing to affirm or deny coverage of claims within a reasonable time after completing a claim investigation
- Attempting to settle or settling claims based on an application that was materially altered without the insured's notice, knowledge, or consent
- Unreasonably delaying a claim investigation or payment by requiring both a formal proof of loss form and a subsequent verification that duplicates the proof of loss information
- Failing to provide forms necessary to present claims within fifteen calendar days of a request
- When repairs are performed by a repairer that is owned by the insurer or that the insurer requires the claimant to use, failing to adopt and implement reasonable standards to ensure that repairs are performed in a workmanlike manner

Insurance regulators usually learn of unfair claim practices when they receive complaints from insureds and claimants. Claim representatives must be able to justify their actions and provide proper documentation when asked to do so by state insurance regulators. The claim representative or insurer must justify the practices that are under scrutiny or face a reprimand, fine, license suspension, substantial legal judgment, or some other legal penalty.

SUMMARY

The two primary goals of the claim function are keeping the insurer's promise and supporting the insurer's profit goal. Claim personnel help meet these goals by using the claim handling process to promptly, fairly, and equitably pay all legitimate first- and third-party claims and by managing operational and claim handling expenses. Policyholders' satisfaction that the insurer's contractual promises have been upheld promotes goodwill and supports an insurer's profit goals.

Insurers and other insurance organizations have claim departments, which may be structured in various ways. Claim personnel who handle claims may be staff claim representatives, independent adjusters, employees of TPAs, or producers. In addition, public adjusters handle claims by representing the



insured's interests to the insurer. Claim department performance can be measured by mathematical means and also qualitatively through the use of best practices, claim audits, and customer service comments.

Claim representatives must be able to apply the information contained in the policy to the activities in the claim handling process. This process creates consistency in claim handling and helps ensure that claims are handled in a manner that conforms with legal and ethical standards. These activities are performed on every claim, to some degree:

- Acknowledging and assigning the claim
- Identifying the policy and setting reserves
- Contacting the insured or the insured's representative
- Investigating the claim
- Documenting the claim
- Determining the cause of loss, liability, and the loss amount
- Concluding the claim

These are the three crucial components of the claim handling process for property insurance claims:

- Verifying coverage
- Determining the amount of loss
- Concluding the claim and exercising subrogation and salvage rights

Claim representatives must handle liability claims differently than property claims. These are four key aspects of liability insurance claims:

- Verifying coverage
- Determining the cause of loss
- Determining the amount of damages
- Concluding the claim

Most insurers cover properties that are subject to catastrophic events such as windstorms, floods, and wildfires. Insurers that have these exposures should be prepared to handle the large number of losses associated with a catastrophic event. After a catastrophe, insureds and regulators expect an insurer to settle losses quickly, regardless of the volume of claims or any disruptions to the insurer's resources. Effective catastrophe response requires careful preparation.

Good-faith claim handling is essential to an insurer's ability to fulfill its legal duties to insureds. To avoid bad-faith allegations and violations of unfair claim practices laws, claim representatives must understand the law of bad-faith claims. Good-faith claim handling consists of several elements:

- Thorough, timely, and unbiased investigation
- Complete and accurate documentation
- Fair evaluation



- Good-faith negotiation
- Regular and prompt communication
- Competent legal advice
- Effective claim management

ASSIGNMENT NOTES

1. *Slater v. Motorists Mut. Ins. Co.*, 174 Ohio St. 148, 187 N.E.2d 45 (1962).
2. *Commercial Union Ins. Co. v. Liberty Mutual Ins. Co.*, 393 N.W.2d 161, 164 (Mich. 1986).

