Chapter 2 Insurance Company Structure

Types of Insurance Companies
There are two fundamental types of insurance companies – the mutual insurance company and the stock insurance company. A mutual insurance company is owned by its policyholders. Dividends, if any, are paid to the policyholders. The ability to pay dividends is nearly directly proportional to the profitability of a mutual insurance company. Favorable operating results are common in a mutual company. Premiums usually exceed the amount necessary to pay anticipated losses and expenses, resulting in "built-in" premiums to the policyholders.

Policyholders are vested with rights similar to those of shareholders in a for-profit corporation. They can elect directors and vote on extraordinary corporate transactions, such as a change in bylaws or an increase or decrease in the number of directors. Even though mutual insurance companies are designated as not-for-profit corporations, typically they are run efficiently and economically.

Mutual Insurance Companies
Perhaps the most significant type of mutual insurance company is the "advance premium mutual," in which premiums are paid by policyholders upon commencement of insurance coverage, and upon termination, policyholders become eligible for a dividend. Advance premium mutual companies ordinarily do a very high volume of business. In the "assessment mutual," policyholders may or may not pay premiums at the inception of coverage, but they are liable for their pro rata share of expenses and company losses upon termination of their policy. The "factory mutual" is a third type of mutual insurance company which provides significant loss protection such as frequent examination of the insured premises. Factories must satisfy rigid safety requirements, such as including fire alarms and sprinkler systems on the premises, before they can qualify for coverage. A deposit of the entire premium for years in advance may be required.

Stock Insurance Companies
The other type of insurance company is a stock insurance company, which is substantially like any other corporation. It is not a prerequisite that a policyholder must first be a stockholder in the insurance company. Another difference between a mutual insurance company and a stock insurance company is that in the latter, stockholders are not liable for their share of corporate expenses and losses.

The Reciprocal Exchange
A "reciprocal exchange" is similar to a mutual insurance company due to the fact that policyholders provide insurance for each other on a nonprofit basis, although a reciprocal exchange is an unincorporated vehicle. Reciprocal exchanges are popular in the western part of the United States, providing a substantial amount of vehicle insurance. A reciprocal exchange is managed by an attorney-in-fact who is responsible for the performance of all the management functions of the organization.

Divisions
The basic functions of most insurance companies are carried out among four corporate divisions – underwriting, marketing, finance, and claims. The underwriting department is responsible for the evaluation of risks, determining which risks will be underwritten and setting premium rates. Tailoring policies to individual needs, directing sales and advertising are the functions of the marketing department. The finance department is responsible for corporate and financial activities, tax preparation, investments, annual reports and the preparation and filing of necessary reports with state and federal regulatory agencies. The claims department, perhaps the least favored department because of its perception of contributing to the shrinkage of the bottom line, handles the investigation, evaluation and settlement of claims.

Claims Departments
Within the claims division of a sizable insurance carrier, there may be a corporate office claims department which establishes claims procedures and practices for the entire carrier, a regional claims office which supervises branch claims offices within its jurisdiction, and branch claims offices which supervise claims representatives or adjusters as well as the investigation, evaluation and disposition of all but the largest and most troublesome claims presented to a carrier.

The head of a corporate office claims division is responsible for all of the big picture decisions made by the company including the establishment and supervision of common procedures, ensuring conformity and fairness across policies and payouts, and monitoring significant litigation.

The branch claims facility is the office to which most claims are directed. Most branch offices are located in significant population centers. The personnel within a branch claims office handle and supervise claims and issue the settlements. Line supervisors are typically found at branch claims offices and are directly responsible for supervising adjusters. Line supervisors specialize in claims surrounding a line or specific type of insurance. Typically, a line supervisor has the final word on the disposition or settlement of a claim. A line supervisor usually reports directly to a claims manager who is in charge of a branch office and is rarely involved with a claim.

The Adjuster
An insurance adjuster, sometimes referred to by a number of different titles, is a professional, trained in the examination, evaluation, and dispensation of claims as well as the identification of fraudulent or frivolous claims.

Some insurance carriers use both field adjusters, who spend substantial amounts of time at the site of an accident or a loss, and office adjusters, who for the most part remain in their offices handling claims by telephone under the direct supervision of a claims manager. Originally, office adjusters handled only small claims in which there was little or no liability. Presently, most claims are processed by an office adjuster over the telephone. If a claim is within elementary guidelines, many carriers will allow an office adjuster to settle the claim over the telephone without the intervention of an outside adjuster, thus reducing administrative and overhead expenses considerably for an insurer. Quick resolution of small claims also enables a carrier to establish a reputation for the effective handling of claims. Claims of a larger magnitude or that appear to be complex or potentially fraudulent, may be assigned to a field adjuster who makes personal contacts with both the claimant and witnesses and is responsible for the direct investigation of the subject or site of a loss. Turnover rates among field adjusters is understandably high considering that they are usually the target of hate for claimants, are typically underpaid, and are perceived to be low on the corporate ladder.

Adjusters, whether in the office or the field, must keep written progress reports about their investigation and disposition of claim files under their supervision and control. All telephone calls, instructions from supervisors and activities taken on each claim are recorded. Also, both field and office adjusters are, for legal purposes, agents of an insurance carrier. As a result, an insurance company is responsible for the actions of agents that are carried out in the ordinary course of business. Inadvertent or negligent acts or omissions can result in a carrier having to pay a claim it might not otherwise have intended to pay.

The professional loss claims adjuster must possess a substantial degree of expertise and knowledge to avoid imposing a settlement of unwarranted claims on a carrier. To that end, there are two legal principles that an adjuster must be extremely familiar with—”waiver” and “estoppel.” The intentional abandonment of a known right is designated as a “waiver,” and “estoppel” is the result of behavior that is incompatible with asserting a known right. The successful assertion of either one of these legal defenses by a claimant could result in a carrier being saddled with liability it might have otherwise avoided.

Independent Adjusters
A smaller insurance company that does not have branch offices may employ the services of an independent adjuster to provide claims services relative to the investigation, evaluation, and settlement of claims. Independent appraisers are typically hired by carriers for several reasons. During certain times of the year, such as hurricane and tornado season, the needs of many carriers are increased such that a number of extra adjusters are required. In less densely populated areas, the number of claims is not typically large enough to justify staffing a full-time office, so carriers look to independent adjusters to take care of the infrequent number of claims that are filed in such places.

Independent adjusters are typically self-employed but can be associated with a larger group of professional independents. Either way, independent adjusters usually have to pass exhaustive examinations to receive their licenses. The fact that most independent adjusters are paid on a case-by-case or hourly basis, unaffected by any payout or settlement, encourages them investigate quickly and come to a fair decision.

Public Adjusters
Sometimes referred to as a "loss consultant," a public adjuster also works independently of a carrier, but, unlike an independent adjuster, he or she is typically hired by a claimant. Many public adjusters have scanners in the fire and police departments and are labeled ambulance chasers. Unlike an independent adjuster, a public adjuster works on a percentage of the amount recovered. In some states, a public adjuster must be licensed before he or she can offer his or her services to the public, but this is not universal. A competent public adjuster is thoroughly grounded in the subtle provisions of a policy and usually handles all the paperwork and negotiation involved with the claim and settlement on the claimant's behalf. On average, a public adjuster recovers at least 17 percent more than a claimant acting on their own.

Catastrophic Situation Adjusters
One of the most remarkable trends in the development of insurance over the past several decades has been the organization of a team of insurance experts to deal effectively and swiftly with losses in major catastrophes. The result is immediate loss adjustment in an area of a disaster. Insurance professionals, including claims adjusters, sometimes use superhuman efforts investigating, evaluating, and settling claims, and often working long hours under very stressful conditions. The mobile operation may involve the use of sound trucks to advise policyholders of the availability of loss claims adjustment services. Temporary living facilities may be located. Cleanup crews may be made available. Also, the insurance team may assist the victims in securing lumber and other building supplies to begin needed repairs and reconstruction of their homes.

The Claims Department and the Underwriters
One of the responsibilities of the claims department of an insurance company is to advise the underwriters about various obstacles they encounter, such as: unfavorable laws, areas with an excessive incidence of claims, various cost items, and other potentially burdensome items. These claims files assist an underwriter in determining what can go wrong through an evaluation of the costs of different kinds of losses and practices of maintaining reserves. In turn, the underwriters should advise the claims department about stressful situations developing between the company and any policyholders. Expenses involved in the negotiation of claims and the cost of litigation can drive the general and administrative overhead and related expenses of an insurance company through the roof if there is little or no cooperation between the claims department of an insurance carrier and that company's underwriters. Postmortem conferences between the underwriters and the claims departments can help minimize or prevent future problems.

The Marketing and Claims Departments
One commonalty that exists between the marketing and claims departments of an insurance carrier is that both represent the carrier to the public. Nothing tests the performance quality of an insurance product more than a claim. An unsatisfactory resolution of a claim indicates that the

insurance product has failed to perform its intended need and function. The claims department can measure the delivery end of a carrier for the marketing department. Many facts developed from experiences with claims can make for a better insurance product.

The Claims and Loss-Control Departments
A significant amount of information from a claims department can enhance a loss-control specialist's knowledge of what to guard against in an attempt to reduce losses. Safety improvements and other changes may be warranted. Pre-claim activity should have as its goal the mitigation of losses. Necessary evidence should not be lost or misplaced after a loss. Claims and loss control should work together to prepare and maintain records that are invaluable following a loss. Such a system enhances quality control of the insurance product. The combined input of both departments can be provided to an underwriter to help in the decision about whether an insured's potential loss is desirable. Accurate information about losses is important to help emphasize to the carrier the trends in – and resulting costs of – accidents and their effects on premiums and rates and the need for a reliable safety programs.

The Insurance Policy
An insurance policy is a legally-binding contract between an insurance carrier and a policyholder that sets forth certain obligations, such as a requirement on the part of a policyholder to pay premiums in a timely manner, in return for a duty on the part of an insurer to cover losses relating to an insurable event included in the policy upon presentation of a valid claim by an insured.

The property & casualty insurance product differs from other insurance company products, such as an annuity, in that tangible payments or benefits are paid only after the occasion of a loss. A contemporary insurance package may contain a broad range of liability and property insurance at rates considerably less than if each type of insurance was purchased separately.

An insurance policy issued by a property and casualty carrier typically has a number of characteristics in common, including:

The Declaration Page – Sets forth the name and address of the policyholder, the maximum dollar limit of coverage, a description of the property or liaFbility to be insured, the amount of the premiums, the date upon which payment is due, and the types of coverage.

The Insurance Agreement – The relative obligations and responsibilities of both the carrier and the policyholder.

Terms and Conditions – Specifies aspects of the coverage as well as what is required of both parties in the event of an insured loss.

Exclusions – Describes any property and liability that are excluded from the coverage

Fraud and Concealment – Allows a carrier to either deny coverage or declare a policy to be void in the event a policyholder is caught committing fraud or concealing facts.

Exclusions of Peril – Any perilous losses that are excluded from coverage, as well as requirements involving the preservation of property following a loss.

Waivers – Declares that the only modifications to the policy that are acceptable to a carrier are those that are in writing and attached to the policy as an endorsement.

Cancellation – The conditions under which a policy may be canceled are included in this section as well as how premiums would be returned.

Interests of a Mortgagee – The provisions that if property covered by a policy is mortgaged, a

lender has a vested interest in such property that is recognized by the insurer.

Pro Rata Contributions – The provision that each carrier will pay a fair proportion of a loss when there is more than one policy in effect for the same property.

Requirements of a Policyholder in the Event of a Loss – A policyholder's responsibilities to an insurer in the event of a loss and claim requirements.

Appraisal – The procedures to be followed should a carrier and an insured desire to select and pay for independent appraisers to determine the value of a loss.

A Carrier's Obligations – Permits a carrier to take possession of some or all of damaged property at a mutually acceptable value after settlement, to repair, replace or rebuild the property out of materials of a similar quality and type or to settle a claim in cash.

Subrogation – The rights of a carrier to legally recoup the amount of settlement from a third party who is responsible for a loss after payment of a claim.

Standard and Nonstandard Policies
For many substantial types of coverage, a significant number of carriers utilize a standard form of contract containing identical or substantially similar terms which have developed through legislation, rules and regulations, case law or custom within the industry. Associations or organizations that are responsible for developing rates and establishing policy forms prepare, modify, and distribute standard policy forms.

There are a number of advantages to the use of uniform policies of insurance, including conformity of rates and payouts across clients, a reduction in the need for litigation, a lack of overlap between other standard policies, and a general degree of simplicity when it comes to training agents and selling to clients.

Nonstandard forms are those developed by and for a carrier that do not conform in substance to the terms and conditions of a standard insurance policy.

Terms and Conditions of a Policy
An insurance policy is first and foremost a contract, subject to all of the rules involving the interpretation of the meanings of its terms and conditions. An insurance company may establish such terms as it sees fit, so long as there is no illegality involved and the terms are not against public policy. Certain risks may be insured against and others may be excluded, as long as both the coverage and the exclusions are detailed in clear, concise and unambiguous terminology. Because the words in a policy are those of the carrier, they are generally construed by courts in favor of the policyholder and against the insurer.

The reasonable expectations of a policyholder will govern an interpretation of the terms and conditions of an insurance policy. Most insurance policies are what are referred to legally as "adhesion contracts," a type of legally-binding agreement in which there is little or no bargaining among the parties involved. There is very little give and take or negotiating that goes on between a carrier and a prospective insured when an application for insurance is taken.

Legal Interpretations
The ultimate interpreter of an insurance policy is neither a policyholder, an attorney, a carrier, a mediator, an arbitrator nor a state insurance commission. That decision lies with the courts. Questions brought before a court about the meaning of the terminology of an insurance policy result in decisions which ultimately evolve into a body of case law. A carrier is required to act in a manner consistent with such case law when the investigation, evaluation and settlement of claims are involved. To do otherwise can result in actionable "bad faith" or "unfair claims settlement"

practices.

When evaluating the relative interests of a policyholder in light of those of a carrier, courts have consistently decided quite liberally in favor of the insured. The position of a policyholder must be quite clearly erroneous before a court will rule in favor of the insurance company. Because courts have been favorably disposed toward policyholders, carriers have been compelled to adopt exhaustive measures to preserve and protect their rights and privileges under a policy.

Experts believe that the ultimate effect of a body of court decisions has been to broaden coverage and to include unwritten terms and conditions in a policy that might not have been intended by either a policyholder or a carrier. Another result is a growing body of judicially-crafted standard practices that must be followed by the insurance industry in general.

A company’s attitude toward claims and claims administration and adjustment reflects a carrier’s policy involving the resolution of controversial claims and the avoidance of litigation. Carriers may go to great lengths to offer superior service to policyholders by reimbursing claimants for questionable claims or those not under coverage. On the other hand, approaches to claims may reflect a policy that is inconsistent with industry practice or not in keeping with specific terms of a policy.