Claims Process

LEARNING OBJECTIVES	KNOWLEDGE STATEMENTS
A.4. Describe, analyze, or design the information requirements for ratemaking related to loss and loss adjustment expenses and demonstrate the use of loss and loss adjustment expenses in ratemaking. *Range of weight: 8-12 percent*	**a. Organization of the data: calendar year, policy year, accident year, report year** **b. Policy provisions**
B.1. Describe, analyze, and validate the information requirements for estimating unpaid claims. *Range of weight: 2-6 percent*	**a. Types of data and their sources**
B.3. Construct and appraise unpaid claims estimates using each of the following estimation techniques: • Development technique, including case outstanding technique • Expected claim technique • Bornhuetter-Ferguson technique • Cape Cod technique • Frequency-Severity techniques *Range of weight: 12-16 percent*	**c. The claim process**

This section will elaborate on what happens after an event occurs that is potentially covered by an insurance policy. Exam questions generally won't come directly from the material in this section, but the material serves as a foundation for topics that will be tested.

The Claim Occurrence

The claims process all starts with an event that causes some sort of damages that may be covered by the insurance policy. Examples of a potentially covered event for different lines of business include a car accident, theft of property, a severe storm, a customer slipping and falling on an insured's business premises, and an employee hurting their back while lifting something heavy at work. The date that the event occurs can be referred to as the **accident date**, the **occurrence date**, or the **date of loss**.

Note that the accident date isn't always obvious. For example, an insured returning home after a vacation to find property damage or theft may not know on which date the event occurred.

Usually the event is sudden and accidental, but it can also be from prolonged exposure to something harmful over time (e.g., to asbestos). In this case, the accident date is deemed to be the date when the damage first becomes apparent.

After the event occurs, the insurance policy conditions may require the insured to make reasonable efforts to protect the insurer from further damage or from fraud. Examples might include reporting a theft to the police, cleaning up a slippery floor, or using buckets to collect leaking water dripping from the ceiling.

Note that the same occurrence might involve damage to persons, property, or both. Furthermore, the same occurrence can result in damages to multiple people and/or their property.

What is a Claim?

A **claim** is a demand to an insurer for payment under the terms of an insurance policy. The person making the demand is known as a **claimant**. The claimant can either be the insured or a 3rd party.

A single occurrence can result in damages to multiple parties and their property, in which case each party may make a separate claim against the same policy. For example, suppose the insured on a personal auto policy is driving and rear-ends a car that has 2 occupants. This might result in the following combinations of claimant/coverage:

1. The passenger of the struck vehicle makes a BI claim against the insured's policy for his injuries.
2. The driver of the struck vehicle makes a BI claim against the insured's policy for her injuries.
3. The driver of the struck vehicle makes a PD claim against the insured's policy for the damage to her vehicle.
4. The insured makes a Collision claim against his policy for the damage to his vehicle.
5. The insured makes a Medical claim against his policy for his injuries.

In this case, there are clearly 3 claimants. However, different insurers may use different terminology for the word "claim" in terms of how claims are counted. Some possibilities include:

- Counting this as 5 claims, one for each combination of claimant and coverage.
- Counting this as 3 claims, since there are 3 claimants.
- Counting this as 1 claim, since it is a single event for a single policy.

In the latter two cases, insurers may use terms such as "claim units" or "claim features" to count at the claimant/coverage level.

The same event can also result in claims against multiple policies. In the prior example, the driver of the struck vehicle could have also made a Collision claim to her insurance company under her policy. In that case, her insurance company would have had a claim as well.

The same event and multiple policy scenario is more often discussed in the context of **catastrophes**, which are events that result in a substantial amount of damage (usually property damage) to a significant number of policies. Common examples of catastrophes are hurricanes, tornadoes, earthquakes, and large hail storms.

Different insurers may use different definitions of what constitutes a catastrophe in their eyes. A common standard used by many insurers in the U.S. is the definition published by the Property Claim Services branch of the Insurance Services Office (ISO). ISO declares an event a catastrophe when:

1. It results in $25 million or more in direct insured losses to property.
2. It affects a significant number of policyholders and insurers.

While these scenarios result in many claims, insurers and reinsurers may still count them as 1 occurrence. The occurrence definition becomes extremely important in these cases, as policies may provide limits on the amount of coverage provided for each occurrence. For example, there was a substantial amount of litigation after the September 11, 2001 terrorist attacks as to whether the 2 planes striking the World Trade Center constituted 1 or 2 occurrences, and jury decisions varied by insurer.

Reporting a Claim

In order for a claimant to potentially receive some payment from an insurer, the insurer must first be made aware of the claim. A claim is usually reported to an insurer by a claimant, an insured, a claimant's lawyer, or an insurance agent.

How a claim can be reported varies by insurer, and examples include calling an insurer's call center, entering it on an insurer's website or mobile app, going in person to an insurer's local office, a formal letter from a claimant's lawyer, or calling an insurance agent. Some insurers outsource all or part of their claims operation to Third-Party Administrators (TPAs), in which case claims may be reported to the TPAs directly.

Generally, at the first report of the claim, the insurer or TPA will also obtain some basic information about the claim, such as the accident date, which policy the claim is being filed against, who was involved in the claim occurrence, and the circumstances of the claim occurrence.

The date that the claim is reported to the insurer is called the **report date**. The difference between the report date and the accident date is known as **report lag**. Claims that have occurred but have not yet been reported are known as **unreported claims** or **Incurred But Not Reported (IBNR) claims**.

Once a claim has been reported, it will be considered an open claim until it is settled and closed, at which time it will be considered a closed claim.

Claim Handling

The claim handling process from first report of the claim to final resolution includes the following main steps:

1. Assigning the claim to the appropriate claims professionals for further handling
2. Gathering and documenting information about the claim and policy
3. Determining whether the type of claim is covered by the policy
4. Quantifying the damages covered by the policy and possibly maintaining case reserves
5. Settling the claim
6. Collecting any applicable recoveries

Assigning the Claim

Based on the information obtained at the first notice of the claim, the insurer or TPA can assign the claim to 1 or more claims adjusters (also known as claims examiners) that will handle all of or a portion of the claim until it is resolved. If an insurer or TPA is understaffed or lacks expertise on the type of claim, they may hire an Independent Adjuster (IA) to handle the claim.

Claims adjusters can specialize in particular lines of business, claim sizes, perils, coverages, or claim-related tasks. Claims adjusters can also be local to the area where the claim occurred, or they can be in a centralized office location.

Based on the particular claim and the insurer's/TPA's claims handling procedures, the claim can be assigned and later re-assigned to the appropriate claims adjusters.

Gathering Facts and Documentation

Claims adjusters attempt to gather relevant information about the claim and policy for reasons including:

- Understanding whether the claim is likely to be covered by the policy.
- Investigating for possible insurance fraud
- Identifying all possible injured parties and property
- Identifying who is at fault for the accident (if relevant)
- Providing qualitative data for use in actuarial or claims operational analyses
- Providing documentation for the claims adjuster's decisions

Determining Coverage

Based on the information about the claim and policy obtained from the facts gathering step, the claims adjuster can make a determination about whether the policy language provides coverage for the claim. This will be based on things such as:

- Was a policy in-force on the accident date?
- Does the policy have coverage for the type of peril?
- Were multiple perils involved in the claim?
- Is the claim excluded by the policy?
- Who is at fault for the accident (if relevant)?
- Is there evidence of insurance fraud?

Some policies require a policy to be in-force on the report date instead of the accident date for the claim to be covered. These policies are called claims-made policies, and will be discussed in a later section focusing on Claims-Made Ratemaking.

It isn't always obvious as to whether a claim is covered by the policy, especially in cases of claims that weren't intended to be covered by the insurer but weren't specifically excluded. In these cases, the policy language may be open to different interpretations. The claims adjuster may consult with a lawyer for assistance in interpreting the policy in these cases.

A substantial amount of litigation often arises to address these scenarios. For example, after Hurricane Katrina, class-action lawsuits resulted about whether the damages related to the storm surge would be covered by homeowners insurance (which covers wind and rain damage) or flood insurance.

If the claims adjuster determines that the claim is not covered by the policy, then the claim will be denied and closed. The claimant could potentially respond by filing a lawsuit, in which case the insurer or TPA will either work towards a settlement or the lawsuit will go to trial.

Quantifying Damages

Once a claims adjuster has determined that the claim is covered by the policy, the next step is to quantify the amount of damages that the insurer owes under the policy to each claimant for each particular coverage. How damages are quantified varies by insurer/TPA and coverage, and claims adjusters may have software tools at their disposal to make the process easier.

The difficulty of this step varies by type of damage:

- **Damage to property:** Whether related to buildings, contents, automobiles, or other items, this is usually broken down into parts and labor costs. Depending on the policy provisions, the claims adjuster will include or exclude the depreciation on the property.
- **Physical damage to persons:** Some components are easy to quantify such as reimbursement of medical expenses or lost wages, but even for those components the claims adjuster may decide what is reasonable and unreasonable. The component that is more difficult to quantify is the pain & suffering component for liability claims, which may be ultimately negotiated between the claims adjuster and the claimant.
- **Non-physical damage to persons/businesses:** In some cases, this could include very specific financial damages. In other cases, these claims can be very difficult to quantify if they are psychological in nature, such as claims related to mental stress, sexual dysfunction, or slander. Again, this often comes down to a negotiation between the claims adjuster and the claimant.
- **Punitive damages:** These are damages imposed by a court to punish an insurer for misconduct in handling the claim. A claims adjuster usually won't try to quantify these damages.

After quantifying the ground-up damages, the claims adjuster will consider any deductibles, coinsurance, and limits applicable to the claim to quantify the net amount owed by the insurer. If the ground-up damages are below the applicable deductible, the claim may be denied and closed.

Case Reserves

Another important duty often given to claims adjusters is to set and maintain **case reserves**. A case reserve is an estimate at the individual claim level of the total future payments required to settle that claim based on the information available at the time.

Based on the insurer/TPA practices, case reserves for a particular line of business and coverage may be set by individual claims adjusters, by formula (usually automated in a computer system), or using some combination of the two. For other coverages, case reserves may not be set at all.

For most coverages in the U.S., case reserves are not allowed to be discounted to reflect the time value of money. An exception exists for Workers' Compensation indemnity benefits, where the case reserves may include tabular discounts, which are discount factors published in actuarial tables.

Case reserves may be set only for the amounts expected to be paid to claimants, or they may also be separately set for the costs the insurer will incur in investigating and settling the claim. Examples of these types of costs include legal expenses and obtaining police reports.

As new information is obtained about the claim or payments related to the claim are made, the claims adjuster will usually update the case reserves to reflect the latest information.

Settling a Claim

The claims adjuster may make multiple payments for different bills for the claimant's damages depending on when the bills are received. In other instances, the claims adjuster may be able to settle the claim with a single payment. In some cases, the claims adjuster will settle and close the claim, only to need to re-open and re-close it after receiving a new bill from the claimant.

The time between the report date of the claim and the date of ultimate settlement is known as **settlement lag**. Settlement lag can range from anywhere between a single day to multiple decades.

Reasons for a longer settlement lag include:

- Claims where new bills can continue to come for many years (e.g., permanent disability claims in Workers Compensation).
- The claimant may be too injured to communicate with the claims adjuster, and may need time to recover.
- The claimant may be a minor, and the claim will be kept open until they reach the age of majority.
- Litigation over the existence of coverage or amount of damages.

Some lines of business have a long time between the accident date and the settlement date (report lag + settlement lag). These lines of business such as Workers' Compensation and liability coverages are considered long-tailed, and the other lines of business like Homeowners and Auto Physical Damage are considered short-tailed.

Recoveries

After the claim is settled, the insurer may be able to recover some or all of the money spent on paying and handling the claim. There are multiple types of recoveries:

1. **Salvage:** After paying for a total loss to insured property, the insurer acquires the ownership of that damaged property. The insurer can then sell that property, and the proceeds from those sales are known as salvage.
2. **Subrogation:** If the insurer pays for a claim for which a third-party was liable, the insurer has the right to recover that amount from the third-party. For example, if an insured's home burns down because of a fire started by a defective toaster, the insurer can sue the toaster manufacturer for any costs it incurred for paying and handling the claim. A more common example of subrogation is in auto insurance when an insurer pays a collision claim, and then recovers money from the at-fault party's PD insurance coverage.
3. **Deductible Recoveries:** In the case of a claim involving a deductible, the insurer may pay the ground-up damages first, and then recover the deductible from the insured. For example, an insurer might pay an auto repair shop directly for a collision claim, and then recover the deductible amount from the insured.
4. **Reinsurance:** If any reinsurance treaties exist and provide coverage for the claim, then the insurer can collect from the reinsurer(s). Multiple reinsurers may provide coverage for the same claim, either by sharing percentages of the damages, or by covering different layers of damages.

Claims adjusters may set separate case reserves for expected future recovery amounts, they may set their regular case reserves net of expected recoveries, or they may not include case reserve amounts for recoveries at all.

Claim Handling Philosophies

Different insurers may have different approaches about how to handle claims, and these approaches can even vary within the same insurer across lines of business. These approaches may also change over time as the insurer faces different pressures and tries to improve.

Areas in which these differences are the most prominent include:

- **Claims adjuster staffing levels:** Insurers try to be as efficient as possible in handling claims, so the fewer adjusters that are needed, the cheaper from an expense standpoint. However, if the insurer becomes understaffed, the quality of the claims handling may suffer and/or the adjuster may have to spend extra money to hire independent adjusters.
- **Case reserving:** In the case that case reserves are not set by formula, claims departments may take a more conservative or more aggressive approach to case reserving. For example, a lawsuit may exist on a claim in which the insurer will either deny the claim or will pay $100,000 in damages based on the outcome of a court decision. In this scenario, reserves of $0 to $100,000 are all possible depending on the insurer's case reserving philosophy.
- **Customer experience:** Insurers may be more lenient in paying claims in order to improve customer experience or to reduce negative press or potential lawsuits for the insurer.
- **Litigation strategy:** Once a lawsuit has been initiated, insurers may place an emphasis on out-of-court settlements compared to going to trial.
- **Reliance on software:** Claims adjusters may use software tools to assist them in quantifying the damages on a claim. Different software can result in higher or lower estimates based on different underlying data or assumptions, and using software can result in more consistent estimates.

