Chapter 6

Direct Your Learning

Ethics and Professionalism

After learning the content of this chapter and completing the corresponding course guide assignment, you should be able to:

- Explain why ethics and professionalism are important to a claim representative.
- Describe the ethical and professional dilemmas claim representatives can face.
- Explain how codes of ethics and quality claim practices can promote high ethical and professional standards.
- Given a claim, explain why a situation presents an ethical or a professional dilemma.
- Define or describe each of the Key Words and Phrases for this chapter.

OUTLINE

Develop Your Perspective

What are the main topics covered in the chapter?

Good-faith claim handling depends on the ethics and professionalism of the claim representative. This chapter describes the importance of ethics and professionalism, the ethical dilemmas claim representatives may face, and the standards claim representatives must abide by when addressing ethical dilemmas.

Consider the activities of everyday claim handling.

- Which activities could present a conflict of interest?
- How might competency present an ethical dilemma for claim representatives?

Why is it important to learn about these topics?

Claim representatives can frequently encounter ethical dilemmas. Claim representatives who make professional and ethical decisions better represent the insurer, provide better customer service, abide by consumer protection regulations, and may experience greater personal satisfaction.

Consider an ethical dilemma of claim handling. In resolving that dilemma:

- What stakeholder interests would you consider?
- Who else would you involve in the decision making?
- What activities would you avoid so that there is no appearance of conflict of interest?

How can you use what you will learn?

Evaluate the resolution of an ethical dilemma your employer handled in the past.

- How well did your employer consider the interests of all the stakeholders?
- What might you have done differently in resolving the dilemma?
- Have subsequent ethical dilemmas been handled differently based on lessons learned?

the insured pays a premium for the insurer's promise to handle claims in good faith. The insurance policy states the terms of that promise. In fulfilling the promises insurers make in their policies, claim representatives encounter and attempt to satisfy a variety of parties, including insureds, claimants, producers, service providers, regulators, and the general public. When the needs of these parties conflict, claim representatives may be faced with dilemmas that require their understanding of and ability to apply ethical and professional principles.

In addition to the promises made in the insurance policy, claim representatives make many other promises to insureds, claimants, vendors, and their employers. For example, a claim representative may promise to contact an insured, claimant, or vendor within a specified time. Promises to employers may include a promise to follow an employer's code of business conduct, complete a course of continuing education, maintain appropriate licensing, or conform to dress codes. Claim representatives must keep these promises if they want to behave ethically and professionally.

Another reason ethics and professionalism are important is that claim representatives' behavior can affect public trust in and credibility of insurers. Unethical or unprofessional conduct can affect the insurer adversely. Although claim representatives handle thousands of claims ethically, professionally, and without complaint on a daily basis, one incident that violates the public's expectations of ethical or professional conduct may receive wide publicity and can damage the insurer's credibility and the public's trust. News about collusion between insurers and brokers to fix prices, inappropriate claim denials during catastrophes, and insurance executives' mishandling of corporate funds contributes to a negative public image of the insurance business. Consequently, most insurers recognize that abiding by ethical and professional standards of conduct is essential to improving their public image.

A third reason that ethics and professionalism are important is that consumer regulations create legal duties for insurers. Claim representatives have an ethical and professional responsibility to comply with these regulations to ensure that consumers are treated fairly through prompt, honest, and responsive claim handling. Some consumer regulations may also define the minimum expected ethical and professional standards for insurers and claim representatives. In addition, many insurers have good-faith claim handling guidelines in place that exceed these minimum standards, and such guidelines may also describe the insurer's philosophy regarding ethical and professional conduct. Both regulatory requirements and insurers' guidelines can provide guidance to claim representatives regarding ethical and professional claim handling conduct.

Ethical and professional conduct benefits claim representatives, insurers, consumers, and the general public. For the claim representative, ethical and professional conduct can be the foundation of a successful, satisfying career. For insurers, ethical and professional conduct can help retain customers and attract investors. Consumers who believe they have been treated fairly are more likely to renew their policies with the same insurer, thus reducing

insurers' acquisition costs and improving financial performance. When insurers' financial performance improves, insurers can more easily attract investors.

Ethical and professional conduct can benefit consumers by encouraging fair treatment and prompt payment. Insureds and, by extension, society can reap the benefits of insurance—peace of mind, support for credit, efficient use of resources, and reduction of social burdens—only if the business of insurance is conducted ethically and professionally.

Behaving ethically and professionally is not without challenge; claim representatives often face difficult ethical issues. Recognizing these issues and responding appropriately is a lifelong learning process.

ETHICAL AND PROFESSIONAL DILEMMAS

In addition to the distinction made previously in this chapter between ethical dilemmas and legal dilemmas, a distinction can also be made between ethical dilemmas and moral dilemmas. Generally, moral dilemmas are characterized as right versus wrong and ethical dilemmas are characterized as right versus right. An example of a moral dilemma is keeping the money in a found wallet versus returning it to the owner. An example of an ethical dilemma is answering a question honestly versus keeping a promise to guard confidential information.

Values Conflicts in Ethical Dilemmas

Ethical dilemmas may raise conflicts in values, for example between being honest or keeping a promise, between an individual interest and a community interest, between immediate needs and long-term needs, and between fairness and compassion.

Ethical dilemmas usually provide more decision options than moral dilemmas do. In ethical dilemmas, the choices may be to do Act A, do Act B, do neither, or do both. In moral dilemmas the decision choices usually involve either doing or not doing a particular act. Several frameworks are available for resolving ethical dilemmas. One framework involves answering a series of questions about the ethical dilemma and possible solutions, assuming the options are legal. The questions could include the following:

- Who are the stakeholders, and what are their rights?
- Is the information about the dilemma reliable and accurate?
- Who should be involved in making the decision?
- Who might be harmed by each option and how?
- What are the long-term results of each option?
- What would be the consequences if the decision were made public?

In addition to these general questions, claim representatives can ask themselves personal questions, such as the following:

- How would I feel if my mother (or children) knew of my decision?
- What would a person whom I respect do in this situation?
- Am I using this decision for my own personal gain?
- Does anything about the decision not "feel right"?

Another framework claim representatives can use to help resolve ethical dilemmas is to evaluate three types of effects that decisions can have: maximizing effect, normalizing effect, and empathizing effect. With the maximizing effect, the claim representative focuses on the extent of the decision's effect. A decision that provides the greatest benefit to the greatest number of people would have a maximizing effect. With the normalizing effect, the claim representative focuses on determining the most common, acceptable standard of behavior. A decision to implement a legally acceptable business practice would have a normalizing effect. Finally, with the empathizing effect, the claim representative follows the golden rule: A decision that treats someone the way the claim representative would want to be treated in the same situation would have an empathizing effect. Of course, two different decisions can have more than one effect. For example, implementing a legally acceptable decision could have both a normalizing and a maximizing effect. Therefore, claim representatives can also consider the desirable combination of effects. This framework to evaluate ethical decisions can be an important tool for claim representatives because it allows them to evaluate the effects of different ethical decisions, each effect having merit.

Claim representatives can use these frameworks to resolve specific ethical dilemmas that arise in a variety of situations and those that arise in specific areas of claim handling. These types of dilemmas or situations include conflicts of interest, competency, continuing education, licensing, customer service, *ex parte* contacts, billing practices, privacy, and detecting fraud.

Many of these ethical dilemmas also raise issues of professionalism. For example, the conflict of interest that arises when a claim representative accepts an expensive gift from a service provider (an ethical dilemma) can adversely affect how others perceive the claim representative's level of professionalism. Other service providers may see the behavior as unfair and may conclude that the claim representative is capable of being unduly influenced. Ideally, insurers' claim handling guidelines provide guidance for claim representatives in how to appropriately respond to professional dilemmas. In the conflict of interest example, such guidelines might make it clear to the claim representative that accepting gifts from service providers is not professional behavior. Similarly, a claim representative who does not return phone calls in a timely manner will earn a reputation as someone who avoids work and is therefore not acting professionally.

Conflicts of Interest

Many ethical dilemmas arise from potential conflicts of interest. A conflict of interest is defined as a conflict between a private interest and official responsibilities. A conflict of interest can arise in many ways during claim handling, such as when employees have the opportunity to purchase salvage, when vendors offer claim representatives incentives for referring business to them, or when the insurer provides coverages for one or more insureds involved in the same claim (overlapping coverages or insureds). The conflict may be between the claim representative's personal interest and professional responsibility (in the first two examples) or between the insured's interests and the insurer's interests (in the last example). Generally, conflicts of interest situations involve individual versus community choices or short-term versus long-term choices.

Salvage

A conflict of interest can occur when a stolen item is recovered and is being sold as salvage. For example, a one-carat diamond recovered from a theft claim that sells for $5,000 in a retail store might have a salvage value of $600. A claim representative may be tempted to purchase salvage for a slightly higher amount than the highest bid from an outside salvage buyer. This presents a conflict of interest because the claim representative has an advantage over other potential buyers by virtue of knowing the salvage bids and being able to place a higher bid. Because of the potential conflict of interest in such situations, most insurers have specific guidelines that prohibit claim representatives from purchasing salvage. Violations of these guidelines can be grounds for dismissal.

Vendor Incentives

Claim representatives often refer insureds to vendors that can help them replace or repair lost or damaged property. A conflict of interest can arise when vendors offer gifts (such as vacations or hard-to-get tickets to special events), favors, gratuities, or other incentives in an effort to get more business referrals from claim representatives. Claim representatives should recommend and select vendors based strictly on the vendors' merits. Any other factor, such as friendship or gifts, that influences a claim representative's referral results in a conflict of interest.

Many insurers have guidelines that either prohibit the acceptance of incentives or that set dollar value limits on incentives that can be accepted. Compliance with such procedures helps the claim representative avoid situations in which their claim handling decisions are influenced by vendors' gifts.

Overlapping Coverages or Insureds

Another conflict of interest can arise from overlapping coverages or overlapping insureds. This situation occurs when the insurer provides multiple

coverages for one insured that are triggered by the same occurrence or when the insurer covers several insureds involved in the same claim. A claim representative faced with decisions involving several coverages or claims for several insureds may encounter conflicting responsibilities, such as those related to apportioning liability among parties. To avoid this conflict of interest, insurers may have guidelines that require the claim to be bifurcated, or split into parts, with a different claim representative handling each part independently. Bifurcating the claim handling responsibilities between different claim representatives reduces the potential for a conflict of interest because each claim representative can focus on the assigned coverage or insured, thus protecting the insured's interests.

The following examples illustrate conflicts of interest involving multiple coverages or multiple insureds.

Overlapping Conflicts of Interest Arising From Overlapping Coverages or Insureds

An example of an *overlapping coverages* case involves an insured injured in a vehicle collision with an uninsured motorist who is responsible for the accident. The insured has personal injury protection (PIP) coverage and uninsured motorists coverage on his own policy. The claim representative's responsibilities in handling the PIP claim can conflict with those in handling the uninsured motorists claim because the latter relies on the medical expenses paid as a measure of damages. Some states may have case law that requires insurers to pay PIP benefits based on less stringent criteria than the policy language; for example, a payment for the insured's eyeglasses broken in the accident may be required as a PIP benefit.

For the uninsured motorists claim, the claim representative would evaluate those same medical expenses and determine some of them, such as the glasses, to be an unrelated expense and, therefore, noncompensable. The claim representative's interest in properly paying the PIP claim can conflict with the interest to properly evaluate the uninsured motorists claim. To avoid this ethical dilemma, a different claim representative can be assigned to each part of the claim.

An example of an *overlapping insureds* case involves two insureds, A and B, who have auto liability coverage from the same insurer. A and B are involved in an accident with Claimant C. Claimant C alleges that both A and B are responsible for the accident. The interests of Insured A conflict with those of Insured B. Each wants the other to be found responsible for the accident. The claims against Insured A and Insured B should be handled by different claim representatives, who can make liability determinations independently of one another.

Claim Handling Competency

Claim representatives who lack competency can commit ethical improprieties by paying claims that are not covered; overpaying claims because of poor investigation or negotiation; and denying claims that are covered, leading to increased customer dissatisfaction, turnover, litigation, and bad-faith lawsuits.

Factors That Can Affect Claim Handling Competency

1. Changes in the claim environment
2. Changes in job responsibilities
3. Normal loss of knowledge over time
4. Lack of time or money
5. Inequitable rewards and promotions

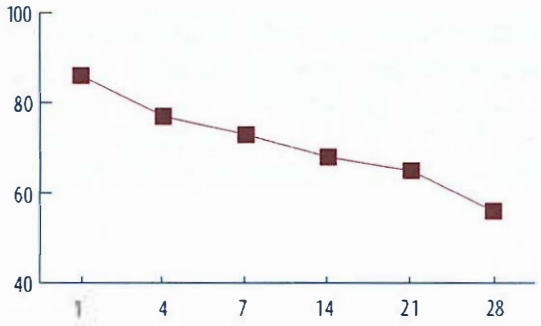
Claim representatives must be aware of the following five factors that can affect their claim handling competency:

1. *Changes in the claim environment.* Consumer, social, and political forces influence insurance coverage, legal liability, damages, and technology. For example, insurers may broaden a coverage provided by a policy. New court interpretations of policy provisions and evolving liability standards can affect claim handling results. Changes in property damage evaluation can result from policy revisions, new laws, and changing technology, and changes in the auto repair field as a result of changes made by auto manufacturers. Relying strictly on one's memory of policy provisions and being unaware of changing liability and valuation approaches can lead to mistakes in evaluating damages and in settling claims. Consequently, claim representatives must continually update their knowledge.
2. *Changes in job responsibilities.* Claim representatives' responsibilities can change when they take a job with a new employer or in their current job through promotion, assignment to a different territory with different laws, or assignment of new types of claims. New duties usually require new knowledge and skills. Training can help claim representatives taking on new duties be more effective and avoid unethical or unprofessional behavior arising from lack of competency. Some employers offer little formal training beyond that given to new employees. Those promoted from within may be expected to rely on on-the-job training from managers or other colleagues who may lack experience or training skills. Outside educational sources, such as workshops and seminars, may also offer training. To ensure competency, claim personnel and their managers should identify the skills and knowledge required in new positions and implement plans for training and education. Human resources personnel can assist in the needs analysis and in suggesting training resources.
3. *Normal loss of knowledge over time.* Imperfections in human memory cause claim representatives to lose knowledge that they once possessed. The rate of knowledge can be graphed based on scientific research. Exhibit 6-1 shows the Dietz and Jones memory curve,[1] which illustrates the rapid loss of knowledge that occurs after original learning. The curve eventually flattens. Several years after learning, individuals retain only a fraction of the original information.

EXHIBIT 6-1

Dietz and Jones Memory Curve

Days from date of learning	Percentage of learning retained
1 day	86%
4 days	77%
7 days	73%
14 days	68%
21 days	65%
28 days	56%



Because of this normal loss of knowledge, even if the claim environment remained static, claim representatives would have to continue learning to maintain the same level of knowledge. Continuing education can reinforce the basics of claim work, refresh knowledge, and enhance skills already mastered.

4. *Lack of time or money.* Line supervisors stretched thin by downsizing have no time to train their staff, and claim representatives with ever-increasing caseloads may think they have no time for training. Such thinking overlooks the fact that training can improve a claim representative's efficiency and save time in the long run. Because investment in training and education is not shown as an asset on the financial statement, insurers may restrict such spending when facing the need to reduce expenses. However, saving money by eliminating or reducing training expenditures is false economy. Finding both the time and money to implement effective training programs can present ethical dilemmas for managers if other expenses must be cut to provide the training. To maintain their own ethical and professional standards, claim representatives may have to be responsible for their own training. Emphasis on reducing expenses may also prevent claim management from hiring before staff shortages occur or from retaining experienced staff. Research by consulting firms and universities indicates that the increased costs incurred for adequate, skilled claim staff are more than offset by the reduction in loss costs and increased customer satisfaction from superior claim service.[2]
5. *Inequitable rewards and promotions.* Claim representatives may be discouraged from improving their competency if they perceive that assignments, promotions, and raises are based on subjective rather than objective criteria. Rewards and promotions that match performance provide incentives for improving competency. Lack of competency and poor performance may become an ethical issue for managers and supervisors if they stem from inequitable rewards, inadequate recognition, or lack of incentives.

As discussed, continuing education is one method to maintain competency. Other ethical dilemmas can also arise from continuing education issues.

Continuing Education

In addition to conflicts of interest and claim handling competency, the need for continuing education can create ethical issues. Claim representatives faced with conflicting demands on their time may be reluctant to pursue continuing education, even where required by law. Continuing education may also be required by codes of professional ethics and insurers' internal codes of ethics. Two examples of codes of ethics relating to claim representatives, found in the appendixes to this chapter, refer to training or education. However, continuing education is valuable to claim representatives not just for complying with such requirements but for maintaining competency, enhancing professionalism and ethical conduct, improving their personal skills, and advancing their careers.

Continuing education can take many forms, including formal classroom education, informal on-the-job coaching from a colleague or manager, and current trade publications. States that require continuing education as a qualification for licensure may specify the form and types of continuing education that fulfill the requirement. Licensing requirements can also raise ethical dilemmas for claim representatives.

Licensing

State licensure laws vary in who is required to be licensed and in the procedures and requirements for licensure. Some states require licensure only for independent adjusters and public adjusters. Other states require staff claim representatives, vehicle damage appraisers, and property appraisers to have licenses. Licensing laws may require claim representatives to pass an examination, pay fees, and provide evidence of continuing education. States often grant temporary licenses to out-of-state claim representatives for catastrophe claim handling.

State laws relating to licensing inside claim representatives can be ambiguous. Some insurers assign groups of inside claim representatives to specific territories that cover more than one state; those claim representatives are licensed in the states in that territory that require licensing. Some insurers encourage or require their claim representatives to hold licenses from states beyond their territories in case their help is needed in a different territory. In the face of varying state licensing laws, such precautions help avoid any legal, ethical, and professional issues that can arise when claim representatives are assigned to new areas either temporarily or permanently.

Licensure-related ethical dilemmas can arise when a manager or supervisor asks a claim representative to assume claim handling responsibilities in a territory in which the claim representative is not licensed. For example, the

claim representative who usually handles those claims is out of the office for an emergency. The supervisor believes that, under the state's somewhat ambiguous licensing law, the claim representative can legally handle the claim; the claim representative's interpretation of the law is that she cannot legally handle the claim. The claim representative faces the ethical dilemma of accepting the supervisor's interpretation of the law or following her own interpretation.

Customer Service

Customer service is another area in which claim representatives can encounter ethical dilemmas. Although thorough in describing insurers' promises about coverage, rights, and duties, insurance policies do not define the level of service that claim representatives should provide. Customer service includes prompt and courteous contact, good communication, and prompt payment. When customers receive a lesser quality of service than they expect, they may complain to their agent, the insurer, or the state insurance department. These complaints may call into question a claim representative's professionalism.

Common State Insurance Department Complaints About Customer Service

1. Claim representatives do not thoroughly explain claim procedures to the public.
2. Claim representatives take too long to settle claims after they have all the necessary information.
3. A lack of communication exists between insureds, producers, and claim representatives.
4. Claim representatives do not return phone calls.
5. Claim representatives do not explain how values are determined for vehicles when settling losses.
6. Claim representatives require insureds to furnish police reports, then later tell them they cannot rely on the police report information.
7. Claim representatives require insureds to obtain service from specific body shops and contractors.
8. Claim representatives refuse to help insureds by referring them to auto body shops or contractors.
9. Claim representatives do not explain how actual cash value is determined on homeowners claims.

As these complaints illustrate, customers have high expectations about the quality and timeliness of claim service. Customers who are accustomed to automated teller machines, online information about their utility bills, and instant access to information on the Internet expect the same level of fast, accurate service in their dealings with insurers. Such expectations can create ethical and professional dilemmas.

Because of caseloads and competing demands, claim representatives may be unable to provide the same level of service to all customers. For example, if asked to make a major insured's claim a priority, the claim representative may have to set aside the claim of a smaller insured. Claim representatives should try to treat all insureds equally, yet achieve a balance between the customer's demands and sound business practices, and to provide the level of service that people expect without compromising good-faith claim handling practices.

Ex Parte Contacts

Another area of ethical dilemmas relates to *ex parte* contacts. ***Ex parte*** contacts are contacts in which only one party is heard. In a claim context, an example of *ex parte* contacts is the claim representative's communication with a claimant without the knowledge of the claimant's attorney. While such contacts are not illegal, they are unethical and unprofessional. However, a claim representative may acquire information from a claimant, unaware that the claimant has retained legal counsel. On learning that legal counsel had been retained, the claim representative faces an ethical dilemma, particularly if the information would benefit the insured or the insurer. To avoid such dilemmas, claim representatives should routinely ask claimants if they have retained legal counsel and should review all claim file correspondence for any notification of legal representation.

Ex parte contacts
Contacts in which only one party is heard.

Another example of an *ex parte* contact is when a claim representative authorizes surveillance to determine the extent or validity of a claimant's injuries or disability. The claimant is unaware of the surveillance; therefore, it is a one-sided activity, but generally it is not unethical. Surveillance is often a legitimate and useful part of a thorough investigation. But surveillance used to harass, intimidate, invade privacy, or discredit someone's reputation may be considered unprofessional or unethical. In addition, if surveillance uncovers information that is unrelated to the merits of the claim, claim representatives must ensure that such information remains confidential.

Recording telephone calls also raises *ex parte* issues, for example, when a claim representative records a phone conversation without the other party's knowledge. Some states prohibit the recording of phone conversations without the knowledge of the parties. If state laws or claim department guidelines do not address such situations, the claim representative may encounter an ethical dilemma. The information gathered in a recorded phone conversation could benefit the insurer or the insured, but the party may not have provided the information with knowledge that the conversation was being recorded.

Billing Practices

Ethical dilemmas can arise from the billing practices of service providers and experts. Ethical dilemmas related to billing can also apply to independent adjustors who bill for their work and to claim representatives who allocate claim costs when more than one policy is involved.

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When necessary, claim representatives hire service providers, such as lawyers, independent adjusters, or experts, to properly handle claims. Generally, service providers bill the insurer for services they provide on a time and expense basis. However, some bills may relate to more than one claim or to more than one insured involved in the same claim. In these cases, the ethical and professional billing practice may be to prorate the bill among all the involved claims or policies. Claim representatives have an ethical duty to make sure that such providers follow insurer billing guidelines and that they understand the scope of their assigned duties so that any unethical billing practices do not interfere with good-faith claim handling practices. Insurers can reduce the potential for service providers' unethical conduct by developing and following guidelines for billing practices that address such issues.

Time and Expense

Ethical dilemmas arise when time is billed in increments that do not reflect actual time spent. When billing is on a time and expense basis, the service provider must maintain accurate, detailed records of time spent and expenses incurred in providing the services. For example, an independent adjuster may bill in tenth-of-an-hour increments. If a phone call to leave a message with the claim representative takes two minutes, the adjuster will bill for six minutes (one-tenth of an hour) because that is the billing increment. The ethical issue arises when the independent adjuster makes a follow-up call that lasts two minutes: whether to bill another tenth of an hour increment for the follow-up call that lasts two minutes, having already billed for six minutes on the first call.

Allocation

Ethical questions related to billing can also arise when one insurer has written policies covering several parties in a claim. The claim representative must decide how to allocate defense costs and other claim costs among the policies. Should a claim representative be influenced by the fact that one policy provides defense cost coverage in addition to policy limits and another policy includes defense costs within the policy limits? If the insurer does not have guidelines in place that address these issues, claim representatives must decide using their own standards of ethics and professionalism.

Privacy

Matters of privacy can raise ethical dilemmas. Claim representatives have access to and acquire personal, medical, and financial information about others in the course of handling claims. Information may come directly from the insured or claimant or from other sources.

Information gathered by claim representatives may be protected by privacy laws or may be of such a sensitive nature that its disclosure would cause harm. In addition, some individuals may be concerned about information that may not seem personal or confidential to others. For example, an insured may not want a relative to know the value of her home, business, or other belongings. Even accidental or unintentional disclosure can be harmful. Claim representatives must therefore acquire only the information needed to investigate and settle a claim and should not misuse the information acquired or make it available to anyone who does not need it.

Ethical dilemmas arise when claim representatives acquire confidential information that, if disclosed, could benefit another. The obligation to protect privacy and an obligation to share information can conflict.

Example of Ethical Dilemma Involving Confidential Information

A claim representative discovers during an investigation that the insured has a serious communicable disease. The disease does not affect the claim's value, so the claim representative does not need the information to handle the claim. However, others in the insured's workplace and home could contract the disease. Should the claim representative tell those people who would obviously benefit if they were able to take precautions to avoid contracting the disease? Should the claim representative respect the insured's privacy and keep the information confidential at the risk that others might contract the disease? Use of one of the two frameworks may help resolve this dilemma.

Balancing the insurer's duty to investigate the claim and the claimant's right to privacy can be difficult in the best of circumstances. However, when fraud may be involved, that balance is even more difficult to maintain. Fraud causes huge losses that harm all policyholders; therefore, privacy rights may be given less weight when claim representatives suspect fraud. Nevertheless, claim representatives cannot ignore information security practices. They must still ensure that information is acquired only when necessary, that the information is accurate, that access to the information is strictly limited, and that the information is not communicated to others unnecessarily. The next section describes additional ethical dilemmas that arise when a claim includes suspected fraud.

Fraud Detection

Fraud is defined as an intentional deception or misrepresentation with the intent to cause another to give up a legal right or part with something of value. Fraud is illegal; therefore, it may seem that no ethical dilemmas are involved. However, the following examples illustrate how detecting fraud may lead to ethical dilemmas.

Examples of Ethical Dilemmas Involving Fraud

Example 1

A claim representative suspects that an insured has committed fraud in submitting a claim for stolen property by including items that were not stolen. The claim representative believes that the insurer can deny the claim because of the fraud but does not have sufficient evidence to meet the legal standards to prove fraud. The claim representative considers offering less than a fair amount to settle the claim in hopes that the insured will accept the settlement. This course of action would reduce the insurer's loss from a fraudulent claim, close the claim, and avoid costs associated with trying to prove fraud. However, despite the claim representative's suspicions, the insured may not be guilty of fraud and may be entitled to the full amount of the claim.

Example 2

A claim representative is handling a claim for XYZ Company, written through a profitable and highly respected insurance agency. The agent, who is the claim representative's brother-in-law and who owns the agency, makes it clear to the claim representative that XYZ Company should be given special treatment because it is an important customer. The claim representative's estimate of damages shows that the policy does not cover about five percent of the damage, or about $2,000. The claim representative gives the agent this information, and the agent indicates that he will take care of it.

Later, the insured submits a damage estimate from another source that is $2,000 higher than the previous claim. If the claim representative accepts the insured's damage estimate, the insured is compensated fully for the loss; the brother-in-law is happy and family harmony is maintained; and the claim representative can close the claim file with adequate documentation to support the payment. However, the ethical dilemma is that the later estimate may be inflated (fraudulent) in order to cover the entire amount of damages. The claim representative must determine the appropriate course of action based on ethical and professional standards.

When a claim representative suspects fraud, the claim may be assigned to a special investigation unit (SIU) for investigation. For some insurers, this means the claim representative no longer works on the claim. For other insurers, the claim representative may continue to investigate the claim to determine the cause of loss and the damage amount while the SIU conducts its investigations. In such instances, the claim representative may be tempted to set the claim aside or conduct a less thorough investigation because the SIU is involved. However, allowing the quality or thoroughness of the investigation to be influenced by unproved suspicions of fraud is unprofessional and may be unethical.

An example of a situation that may predispose a claim representative to suspect fraud is an auto accident in which the vehicle sustains only minor damage but the driver reports serious injuries. While staying alert for the possibility of fraud, the claim representative must investigate the case thoroughly, considering the claim on its own merits. Claim representatives should use good-faith claim handling practices in all instances, treating each insured and claimant fairly and professionally. Preconceptions based on race, gender, or national origin should also be avoided.

Clear guidelines from claim management can help avoid and resolve ethical dilemmas that arise during the claim handling process. Claim representatives also should not hesitate to consult with supervisors or managers about professional and ethical courses of action. Nevertheless, decisions about ethical and professional behavior in claim handling ultimately fall to the individual claim representative. In addition to the two decision-making frameworks previously discussed, ethical standards can serve as useful guidelines for developing appropriate responses to ethical dilemmas.

ETHICAL AND PROFESSIONAL STANDARDS

If everyone agreed on which behaviors were ethical and which were not, always acted in accordance with the values underlying those behaviors, and understood and agreed on how to resolve ethically ambiguous situations, there would be no need for ethical standards or codes of ethics. However, well-intentioned people can disagree about what constitutes ethical behavior in a given situation. One way to seek uniformity in ethical behavior, as well as to promote high ethical and professional standards, is to create codes of ethics. A second way is to define quality claim practices that exemplify professional and ethical behavior.

Codes of Ethics

Insurers can promote high ethical and professional standards in several ways, including the following:

- Define ethical practices in all business areas, communicate them to all employees, and require adherence to them
- Conduct independent reinspections of physical damage claims and perform file reviews of all types of claims at random intervals to detect and address any unethical behavior
- Encourage employees to consult with their supervisors and managers about ethical dilemmas and to report ethical dilemmas involving others, such as service providers
- Dismiss unethical employees
- Enforce a strict written policy or code of ethics, clearly stating the ethical and professional expectations for all personnel, and require every employee to sign it annually

Codes of ethics provide guidelines for addressing ethical dilemmas. They consist of broad principles rather than detailed specifics and set out minimum standards of compliance. Two examples of codes of ethics are the Society of Registered Professional Adjusters Ethics Guidelines, found in Appendix A to this chapter, and the Code of Professional Ethics of the American Institute for CPCU, found in Appendix B of this chapter.

RPA and CPCU Codes of Ethics

The Society of Registered Professional Adjusters (RPA) has developed its Ethics Guidelines to emphasize integrity, competence, sensitivity, and legality. The Code of Professional Ethics of the American Institute for Chartered Property Casualty Underwriters (CPCU) contains canons of ethical performance for all professional activities of all CPCUs and CPCU candidates. Rules in the code set minimum standards of conduct to maintain the integrity of the CPCU designation. CPCUs and CPCU candidates who fail to meet the minimum standards may be subject to disciplinary measures. The Institute's Board of Trustees enforces the canons and rules and can revoke the CPCU designation or otherwise discipline CPCUs who violate the canons or rules.

In addition to ethical standards, professional standards play a major role in promoting ethical and professional behavior. Professional standards for claim representatives are the benchmarks by which they are evaluated, whether the evaluation is performed by a supervisor, manager, auditor, insured claimant, or a department of insurance. Yet no single set of professional standards exists for claim representatives, and unfair claim practices statutes and regulations vary by state. Although claim handling guidelines also vary among insurers, some practices are common to all. The next section examines some of the common practices, which, because of their widespread use, can be considered quality claim practices.

Quality Claim Practices

Insurers identify quality claim practices—those that reflect superiority and professional performance—by identifying customer needs and expectations. Quality-oriented insurers look to their customers, not their competition, to determine what services and products to provide. The following activities provide a foundation on which to build quality claim practices:

- Determining customer expectations
- Improving service based on customer expectations
- Developing claim practices to meet customer expectations

To measure and maintain quality claim practices, insurers use benchmarks—designated standards against which improvements can be measured—and compare practices to the benchmarks to monitor improvement.

Customer Expectations

Insurers begin the process of benchmarking for quality claim practices by reviewing customer expectations and determining how often those expectations are met. Successful insurers and claim representatives view good claim service as one of their best marketing tools. In addition to advertising their quality claim service, insurers hope that satisfied insureds and claimants will

others about their good service. In contrast, dissatisfied customers who to others about their unfavorable experiences discourage people from coming customers. A dissatisfied customer may personally complain to people. However, with access to the Internet, a dissatisfied customer can quickly and easily complain to thousands. A reputation for poor claim service difficult for both an insurer and a claim representative to overcome.

Insurers attempt to measure customer satisfaction in the following ways:

- Analyzing complaints
- Obtaining customer feedback on individual claims through a closed claim follow-up
- Exploring customer attitudes about service through focus groups and surveys

Some complaints are unavoidable; not every insured or claimant will be satisfied with a claim settlement regardless of how well the claim is handled. Nevertheless, measuring customer satisfaction by analyzing complaints is a way both to measure claim department performance and to determine specific problems in individual cases. One measure of claim department performance is the percentage of claim files that produce complaints.

Individual complaints can also be a valuable learning tool for both the insurer and the claim representative because they force reviews of particular files. A supervisor's review may reveal that the claim representative overlooked insurance coverages or laws. Complaints also help the insurer identify training or supervisory needs.

A uniform and consistent complaint review process can optimize the potential benefits of complaints as learning tools and minimize potential damage that complaints can cause. When a complaint is received, it should be recorded and promptly answered. A tracking system helps ensure that complaints are addressed in a timely manner. Claim representatives, supervisors, or managers should respond to complaints based on facts, the insurance policy, and applicable law, not on personalities or emotion. The individual preparing the response should document a timely, well-reasoned, objective response. Such a response can reduce the likelihood that the complainant will file suit alleging bad faith and can also serve as evidence of good faith if such a lawsuit is filed.

Many insurers require an internal audit department to record all complaints and responses and to review and analyze complaints independently for trends and patterns. For example, the audit department may calculate the ratio of complaints to claims handled by claim representative or by type of claim. A chart showing complaints per month by region, division, unit, and claim representative can indicate problems, although managers should consider more than statistics to determine the nature and extent of the problem. For example, a specialized claim unit dealing with suspected arson and fraud may receive more complaints than a claim unit handling automobile windshield losses.

Complaints can also present an opportunity to mend a damaged relationship with a customer. Dissatisfied customers who complain give the insurer an opportunity to address the complaint and reestablish credibility. An insurer's prompt, competent, courteous response that exceeds the customer's expectations can convert dissatisfaction into satisfaction. The financial gain can be substantial if the insurer retains even a small number of such customers.

Another way to measure customer satisfaction is by obtaining customer feedback on individual claims through a closed-claim follow-up. When a claim is closed, the insurer mails a letter or postcard to the insured or claimant asking an open-ended question, such as "How was our service?" Polling both insureds and claimants provides a balanced view of claim performance.

The most valuable responses to a closed-claim follow-up suggest ways to improve service. The problem that prompted the suggestion may affect many insureds or claimants. Respondents may also comment on the performance of service providers (vendors) and others involved in the claim process. Comments about service providers should be evaluated and appropriate action taken. Managers often forward favorable responses to a closed-claim follow-up to the personnel involved with the claim. Good claim handling deserves praise.

An advantage of a closed-claim follow-up is that respondents may be more willing to share their comments after a claim is closed than they are while the claim is open. A disadvantage is that it may not yield adequate information about a claim department's performance. To gain a more complete picture of customer attitudes about service, insurers can use focus groups and surveys.

Focus groups are small groups selected from the broader population of the insurer's policyholders and interviewed through facilitator-led discussions, about their expectations and opinions of insurers and of the claim process, as well as their emotional responses to their experiences. Results are qualitative and are not statistically significant; nevertheless, they can help develop specific solutions. A disadvantage of focus-group feedback is that it represents the opinions of only a small number of customers. Nevertheless, it can reveal attitudes and expectations that were not previously recognized and that may apply to more customers than those involved in the group.

Process Improvement Plan

Using the results of customer satisfaction measurements, insurers develop process improvement plans. Complaint reviews, closed-claim follow-ups, focus groups, and surveys reveal customer expectations that have not been met. After gathering and assessing the information from customer satisfaction measurements, insurers can develop ideas and set professional standards for desired process improvements. A process improvement plan to overcome service deficiencies involves the following five steps:

1. Determining how things work and who makes them work
2. Developing and testing ideas for improvement

3. Implementing improvements (reengineering)
4. Setting and comparing performance standards (benchmarking)
5. Monitoring results

The first step in the process improvement plan is to determine how things work and who makes them work. Flowcharts and process diagrams can document the processes involved in handling claims and can reveal unexpected bottlenecks and redundancies that have evolved over time. The flowcharts and process diagrams are then used for the second step in developing a process improvement plan: developing and testing ideas for improvement.

In addition to ideas developed from the flowcharts and process diagrams, insurers can use investigative questioning and failure analysis to identify areas for improvement in the claim process. The following investigative questions may be useful in this process:

- What is the flow of work from one action to another?
- Are some activities unnecessary or of no value to the customer?
- Are activities duplicated that could be eliminated or combined?
- Can activities be completed more quickly?
- Can documentation be electronic rather than on paper?
- Can fewer people be involved in the claim process?
- Are the right people handling the claim work?

Example of Improvement Plan Developed From Investigative Questioning

Using the preceding questions, an insurer evaluated its claim department and developed ideas for process improvement. Implementation of the following changes could significantly improve the insurer's claim service:

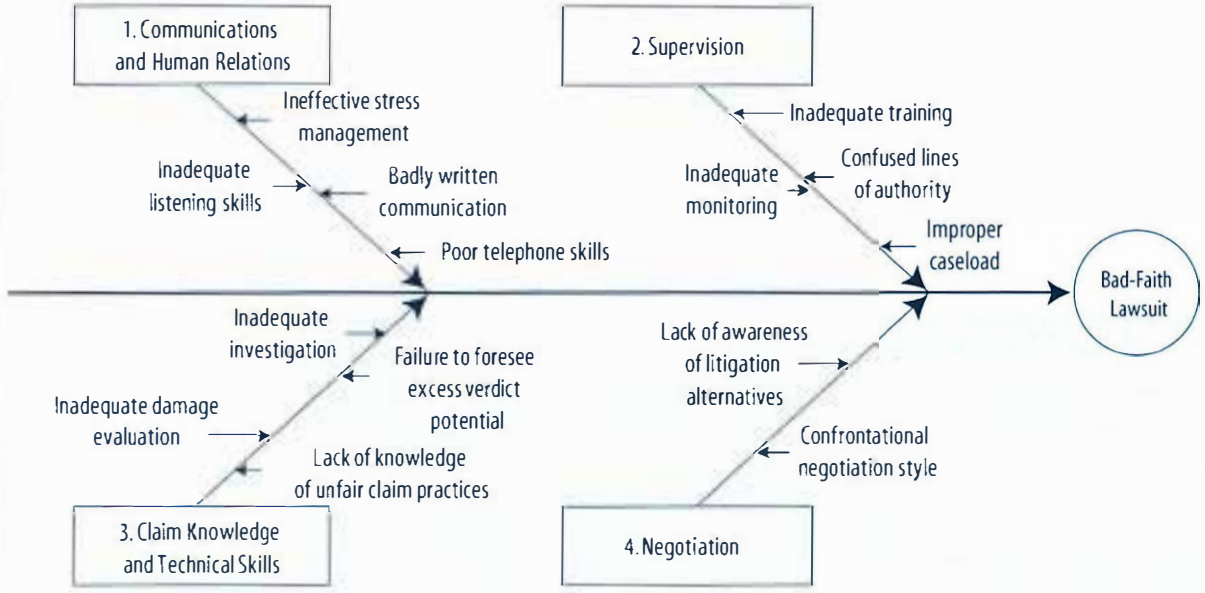
- The department keeps paper copies of salvage logs, large loss information, and other records that are no longer valuable or that are stored in a new computer system. The department should eliminate redundant records.
- Claim representatives and supervisors enter redundant data into their processing system to generate reports. About 35 percent of the information entered by claim representatives was duplicated by supervisors. Clerical support personnel had already entered about 10 percent of the claim data. The department should eliminate duplicate entries.
- It takes four days to send file information to field claim representatives. Imaging technology could be used to send and store file material electronically to reduce the time involved.
- Senior claim representatives spend about 30 percent of their time handling small claims. Managers or supervisors should assign such small claims to claim representatives with less experience.

Failure analysis develops ideas for improvement by tracing the causes of failure. An example of a "failure cost" in the claim environment is an adverse verdict in a bad-faith lawsuit. Exhibit 6-2 shows one process improvement tool used to conduct a failure analysis, the Ishikawa (fishbone) diagram. This exhibit identifies the root causes of a jury award on a hypothetical bad-faith claim. In this case, a failure analysis reveals multiple causes for the adverse award: weak communication and human relations skills, inadequate supervision, lack of technical training, and ineffective negotiation skills.

Such an analysis of one claim may reveal flaws that are symptoms of a larger problem that must be corrected. The fishbone diagram is a good tool for identifying areas that need the most attention.

EXHIBIT 6-2

The Ishikawa (Fishbone) Diagram



Traditionally, insurers have relied on auditing as a failure analysis tool to detect problems. Audits may be conducted by claim staff or by staff from another department, such as a quality control department. If other failure analysis tools have identified a potential problem, files selected for the audit may target claims that are likely to be affected by the same problem. In other cases, a random audit may help identify failures that have not been detected through other tools.

Following the analysis, an insurer moves to the second step in the process improvement plan, developing and testing ideas for improvement. Tests may occur in one unit, branch, or department to ensure that it is feasible to implement an idea in the entire claim department.

The third step in the process improvement plan is implementing improvements. Strong management commitment is the key to successfully implementing improvements. Improvement plans often fail because management fails to devote the resources or encourage the necessary changes to support them. Management must make ethical and professional decisions about how to use resources to best accomplish its quality claim practices goals.

Reengineering, or analyzing and redesigning workflow, is one way to implement claim service improvements. The term "reengineering" is often interpreted to mean downsizing to reduce costs. However, businesses use reengineering to improve efficiency to improve customer service.

Another way to implement claim service improvements is to increase the competency of claim personnel through training. Insurers that make a commitment to high quality claim practices must also commit to ongoing training for their claim professionals.

After improvements are implemented, the next step in the process improvement plan is to establish performance measures, commonly called benchmarks. Effective benchmarks are internal or external performance standards based on specific customer needs and the insurer's philosophy on meeting them. Performance measurements such as closed claims per month and reopened claims per month allow insurers to compare performance from one period to the next and from one insurer to another. The following are other examples of common benchmarks:

- Contact with policyholder within a specified number of hours of receiving loss notice 95 percent of the time
- Response to correspondence within a specified number of days of receipt 100 percent of the time
- Claim expense ratio within a specified range for the calendar year

In setting benchmarks, insurers develop their own best practices or use industry best practices. Best practices define the most appropriate practice based on experience. The keys to identifying a best practice are to know what is most important for the organization and to know how to measure it. Answering the question "Does this practice lead to superior claim performance?" is crucial in identifying a best practice. Superior performance may be based on financial operating results, policyholder approval and loyalty, or employee retention and satisfaction. Managers must distinguish the tasks that really make a difference in the quality or effectiveness of fulfilling the insurance promise. With that information, any insurer can identify a best practice and determine how to implement it.

The final step in the process improvement plan is monitoring results. After establishing benchmarks, insurers must determine whether they meet them and, if not, why not. Insurers can monitor improvement by comparing results over time to the benchmarks and by taking steps to correct deficiencies.

SUMMARY

Ethics and professionalism are key elements in fulfilling in good faith the promises made within an insurance policy. To retain public trust and credibility, claim representatives should do their best to act ethically and professionally.

Ethical dilemmas involve choices between two courses of action, both of which may be right. Although choices between two right courses of action can be difficult, claim representatives can use frameworks for resolving ethical dilemmas. One framework is to answer a series of questions about the dilemma. Another framework is to evaluate the types of effects that decisions can have: maximizing effect, that provides the greatest benefit to the greatest number of people; normalizing effect, to determine the most common, acceptable standard of behavior; and empathizing effect, treating someone with in the same way one wants to be treated in the same situation.

In claim handling, ethical and professional dilemmas can arise in relation to conflicts of interest, competency, continuing education, licensing, customer service, *ex parte* contacts, billing practices, privacy, and fraud detection. How claim representatives respond to ethical dilemmas is a measure of the importance they place on professionalism and ethical behavior. Ethical and professional standards, such as codes of ethics and quality claim practices including customer satisfaction, continuous improvement, benchmarking, and best practices, can help claim representatives conduct themselves professionally and ethically to ensure that consumers receive the benefits of insurance that they expect.

CHAPTER NOTES

1. Sister Columba Mullaly, Ph.D., *The Retention and Recognition of Information* (Washington, D.C., The Catholic University of America Press, 1952), pp. 7–8.
2. Richard Cavalier and G. G. Hedges, "Improving Claims Operations—A Model Based Approach," The Service Productivity and Quality Challenge (The Netherlands, edited by P. T. Harker, 1995), pp. 281–310.

Appendix A

Society of Registered Professional Adjusters Ethics Guidelines

The work of adjusting insurance claims is a profession of public trust. Accordingly, RPAs must maintain a standard of integrity that will promote the goal of building public confidence and trust in the insurance industry.

RPAs will only discharge claims responsibilities for which they possess sufficient technical competence or can acquire adequate training.

RPAs will seek only information they believe to be relevant, timely and accurate, and use only legal and ethical means of obtaining that information. They will handle claims with no intent to mislead or misinform.

RPAs will be sensitive to individuals' rights of privacy, and will take reasonable measures to protect sensitive information from illegal or unauthorized examination.

RPAs will avoid illegal discrimination, and will strive to keep personal feelings and prejudices from influencing their judgment.

RPAs will maintain a courteous and sensitive attitude in their interactions with insureds and claimants, seeking to understand their concerns during times of distress. They will assist insureds in presenting and documenting their losses, and will not place the interests of their employer above those of the insured.

RPAs will maintain their business relationships with others in a manner that will promote the goal of bringing credit and honor to the profession. They will have no undisclosed financial interest in any direct or indirect aspect of an adjusting transaction.

RPAs will obey the laws and regulations related to handling claims.

They will resist fraudulent, unmeritorious or exaggerated claims, and support public and industry organizations involved in the detection and prevention of insurance fraud.

Recognizing that litigation is costly and time-consuming, when appropriate, RPAs will seek out all available alternatives to litigation to resolve issues in an expeditious and conciliatory manner.

Appendix B

The Canons and Rules of the Code of Professional Ethics of the American Institute for CPCU

Canon 1—CPCUs should endeavor at all times to place the public interest above their own.

Rule R1.1—A CPCU has a duty to understand and abide by all Rules of conduct which are prescribed in the Code of Professional Ethics of the American Institute.

Rule R1.2—A CPCU shall not advocate, sanction, participate in, cause to be accomplished, otherwise carry out through another, or condone any act which the CPCU is prohibited from performing by the Rules of this Code.

Canon 2—CPCUs should seek continually to maintain and improve their professional knowledge, skills, and competence.

Rule R2.1—A CPCU shall keep informed on those technical matters that are essential to the maintenance of the CPCU's professional competence in insurance, risk management, or related fields.

Canon 3—CPCUs should obey all laws and regulations, and should avoid any conduct or activity which would cause unjust harm to others.

Rule R3.1—In the conduct of business or professional activities, a CPCU shall not engage in any act or omission of a dishonest, deceitful, or fraudulent nature.

Rule R3.2—A CPCU shall not allow the pursuit of financial gain or other personal benefit to interfere with the exercise of sound professional judgment and skills.

Rule R3.3—A CPCU shall not violate any law or regulation relating to professional activities or commit any felony.

Canon 4—CPCUs should be diligent in the performance of their occupational duties and should continually strive to improve the functioning of the insurance mechanism.

Rule R4.1—A CPCU shall competently and consistently discharge his or her occupational duties.

Rule R4.2—A CPCU shall support efforts to effect such improvements in claims settlement, contract design, investment, marketing, pricing, reinsurance, safety engineering, underwriting, and other insurance operations as will both inure to the benefit of the public and improve the overall efficiency with which the insurance mechanism functions.

Canon 5—CPCUs should assist in maintaining and raising professional standards in the insurance business.

Rule R5.1—A CPCU shall support personnel policies and practices which will attract qualified individuals to the insurance business, provide them with ample and equal opportunities for advancement, and encourage them to aspire to the highest levels of professional competence and achievement.

Rule R5.2—A CPCU shall encourage and assist qualified individuals who wish to pursue CPCU or other studies which will enhance their professional competence.

Rule R5.3—A CPCU shall support the development, improvement, and enforcement of such laws, regulations, and codes as will foster competence and ethical conduct on the part of all insurance practitioners and inure to the benefit of the public.

Rule R5.4—A CPCU shall not withhold information or assistance officially requested by appropriate regulatory authorities who are investigating or prosecuting any alleged violation of the laws or regulations governing the qualifications or conduct of insurance practitioners.

Canon 6—CPCUs should strive to establish and maintain dignified and honorable relationships with those whom they serve, with fellow insurance practitioners, and with members of other professions.

Rule R6.1—A CPCU shall keep informed on the legal limitations imposed upon the scope of his or her professional activities.

Rule R6.2—A CPCU shall not disclose to another person any confidential information entrusted to, or obtained by, the CPCU in the course of the CPCU's business or professional activities, unless a disclosure of such information is required by law or is made to a person who necessarily must have the information in order to discharge legitimate occupational or professional duties.

Rule R6.3—In rendering or proposing to render professional services for others, a CPCU shall not knowingly misrepresent or conceal any limitations on the CPCU's ability to provide the quantity or quality of professional services required by the circumstances.

Canon 7—CPCUs should assist in improving the public understanding of insurance and risk management.

Rule R7.1—A CPCU shall support efforts to provide members of the public with objective information concerning their risk management and insurance needs and the products, services, and techniques which are available to meet their needs.

Rule R7.2—A CPCU shall not misrepresent the benefits, costs, or limitations of any risk management technique or any product or service of an insurer.

Canon 8—CPCUs should honor the integrity of the CPCU designation and respect the limitations placed on its use.

Rule R8.1—A CPCU shall use the CPCU designation and the CPCU key only in accordance with the relevant Guidelines promulgated by the American Institute.

Rule R8.2—A CPCU shall not attribute to the mere possession of the designation depth or scope of knowledge, skills, and professional capabilities greater than those demonstrated by successful completion of the CPCU program.

Rule R8.3—A CPCU shall not make unfair comparisons between a person who holds the CPCU designation and one who does not.

Rule R8.4—A CPCU shall not write, speak, or act in such a way as to lead another to reasonably believe the CPCU is officially representing the American Institute, unless the CPCU has been duly authorized to do so by the American Institute.

Canon 9—CPCUs should assist in maintaining the integrity of the Code of Professional Ethics.

Rule R9.1—A CPCU shall not initiate or support the CPCU candidacy of any individual known by the CPCU to engage in business practices which violate the ethical standards prescribed by this Code.

Rule R9.2—A CPCU possessing unprivileged information concerning an alleged violation of this Code shall, upon request, reveal such information to the tribunal or other authority empowered by the American Institute to investigate or act upon the alleged violation.

Rule R9.3—A CPCU shall report promptly to the American Institute any information concerning the use of the CPCU designation by an unauthorized person.