Chapter 1

Direct Your Learning

Risk and Insurance

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

- Explain how hazard risk differs from business risk and what risk management techniques can be used to manage risk.
- Describe the parties to, benefits of, and costs of insurance.
- Describe the claim department structure, types and functions of claim personnel, and claim personnel performance measures.
- Describe each of the different insurance company functions and their purposes.
- Summarize the following aspects of insurance regulation:
  - The three major federal statutes that regulate insurance and their significance
  - The role of the NAIC in insurance regulation
  - The purposes of insurance regulation
  - The activities of insurance regulators
  - The types of insurance regulation
- 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?

Any discussion of claim handling must begin with a discussion of risk. People and organizations face risk every day. They must choose a method of dealing with risk, and insurance is frequently the method of choice. This chapter explains how insurance works; what role the claim department plays in addressing risk; and how insurance regulation serves to protect consumers, maintain insurer solvency, and prevent destructive competition.

Identify different methods of managing risk.

- What informal methods do you use to manage the risks of daily life?
- If you have insurance, what risks does it cover?

Why is it important to learn about these topics?

To properly handle claims, claim representatives should understand what motivates people to purchase insurance and what their expectations are once a loss occurs. Additionally, claim representatives should understand how insurance companies and claim departments are evaluated and regulated, so that claim handling practices conform to company standards and goals and comply with insurance regulations.

Consider how a claim department's performance is measured and regulated.

- How do the activities of the claim department affect the company's loss ratio?
- With what state regulations does your claim department have to comply?

How can you use what you will learn?

Claim representatives must be aware of all the regulations with which the claim department and the insurer must comply.

Analyze your state's insurance regulations.

- How does your company ensure that it complies with regulations concerning unfair trade practices?
- How does your company ensure that it complies with regulations concerning unfair claim practices?

Chapter 1
Risk and Insurance

Few individuals or organizations can afford to bear the potential financial losses associated with their activities and property. For example, homeowners must repair or replace their homes if the homes are damaged or destroyed. Automobile drivers at fault in accidents must pay for injuries to others or for damage to others' property. Organizations can lose income if their property is damaged or destroyed. These losses could range from thousands to millions of dollars a year.

Individuals and organizations can use two methods to manage the risk of potential financial loss. They can control the risk (risk control) by taking steps to avoid loss, prevent loss, or mitigate loss; or they can finance the risk (risk financing) by having funds available to pay for a loss or by transferring the possibility of financial loss to others. Insurance is a risk financing technique. While explaining all of the risk management techniques, this textbook and the entire Associate in Claims curriculum focuses on insurance as a risk management technique.

Insurance, at its most basic level, is a promise; the insurer promises to pay the insured for a covered loss, or to pay a third party on the insured's behalf, when a specific event occurs. The claim representative (a generic title that refers to all who adjust claims, except for public adjusters) fulfills the promise to pay the insured or to pay on behalf of the insured by handling a claim when a loss occurs. The focus of this textbook is on the role of the claim representative, how it fits into the context of the overall insurance function, and the qualities and skills required of claim representatives.

Insurance is only one technique used to manage risk. This chapter begins by examining the concept of risk and risk management techniques to demonstrate how insurance fits into the broader picture of risk management. It describes what insurance is and the insurer's role in managing risk. Focus then narrows to the claim department and how it fits into the broader picture of insurance and into the even broader scope of insurance regulation.

RISK

The term "risk" has different meanings depending on the context. Many in the insurance business use the term to identify the insured or the property being insured. However, for the purpose of this text, **risk** is defined as uncertainty about outcomes, some of which can be either negative or positive. If an outcome is certain, there is no risk.

Risk
The uncertainty about outcomes, some of which can be either negative or positive.

Much of life is uncertain. The degree of uncertainty about something depends on subjective as well as objective information. This combination of perception and fact often determines whether people act on the uncertainty before them. If rain is a possibility, a person may take an umbrella. If an auto accident is probable, a party may buy auto insurance to protect against a possible loss. The terms "possibility" and "probability" are closely associated with the term "uncertainty."

Understanding the distinction between possibility and probability makes it easier to assess risk and determine how to manage it.

Possibility means something could happen. For risk to exist, two or more outcomes must be possible. If only one outcome exists, the result is certain and risk does not exist. The following are some examples of possibilities:

- While walking, a person could be struck by lightning.
- While driving to work, a person could be injured in an auto accident.
- While loading a truck, a person could be injured at work.
- While playing a slot machine, a person could win $1,000.

Each of the examples carries some risk because more than one outcome is possible, and one of the possible outcomes—incurring bodily injury or losing money—is negative.

Possibility does not quantify risk; it only verifies that risk is present. To quantify risk, one needs to know how often the possibilities can occur. Knowing that someone can win the lottery and become an instant millionaire does not provide enough information to quantify the risk. The potential risk-taker needs to know the likelihood of that possibility, that is, the probability of winning.

Possibility and Probability Compared

Probability is the mathematical likelihood that an event will occur in the long run. If something is possible, the likelihood of its occurring can be expressed mathematically as a number between zero and one.

Unlike possibility, probability is measurable. The possibility that a baseball team will win the Super Bowl does not exist. Therefore, the probability that a baseball team will win the Super Bowl is zero. The probability that a particular individual will win the top prize in the Powerball lottery is extremely low (1 in 120,000,000), and the probability of being killed in a fireworks accident is somewhat greater (1 in 620,000). In comparison to the lottery probability, the probability of being dealt a royal flush in a five-card hand of poker is still greater (1 in 40,000), and the probability of spinning a red number in roulette is significantly greater (1 in 2.05) than that of winning the lottery.

Understanding the probability of various outcomes helps focus risk management attention on the risks that can be appropriately managed. Probability is discussed in more detail in later chapters.

Hazard Risk and Business Risk

How someone manages risk is often determined by whether the risk is a hazard risk or a business risk. **Hazard risk** is the risk from accidental loss, including the possibility of loss or no loss. **Business risk** is risk that is inherent in the operation of a particular organization, including the possibility of loss, no loss, or gain. The risk of a fire to a home is a hazard risk. If a house burns, its owner suffers a loss. If no fire occurs, the owner's financial condition remains unchanged. A company that produces a new product is facing a business risk, as that new product may cause the company to lose money, break even, or make a profit. Sometimes owning an asset poses both hazard and business risks. For example, a homeowner may face the risk of a house fire, which is a hazard risk. The homeowner may also face market value risk upon sale of the home, which is a type of business risk. This chapter focuses on techniques for managing hazard risk because insurance is often used by individuals and entities to manage hazard risk.

Hazard risk
Risk from accidental loss, including the possibility of loss or no loss.

Business risk
Risk that is inherent in the operation of a particular organization, including the possibility of loss, no loss, or gain.

Risk Management Techniques

Risk imposes certain costs. It can cause worry and fear in individuals and organizations. It can deprive society of goods and services that are considered too risky to produce. Risk also restricts the use of money by creating the need for an emergency fund to pay for unexpected losses. If individuals and organizations set aside large sums of money for emergency funds, they are unable to use those funds for other purposes. Because of the various costs imposed by risk, individuals and organizations need to manage it. Risk managers do this by implementing a variety of risk management techniques that either control or finance risk.

Risk Management Techniques

Risk Control

- Avoidance
- Loss prevention
- Loss reduction
- Separation
- Duplication
- Diversification

Risk Financing

- Retention
- Noninsurance transfers
- Insurance transfers

Risk Control

Controlling risk is one method of managing risk. Risk control can involve everal techniques.

Avoidance is choosing not to perform actions that would create a risk. Obviously, this technique will not be available for every risk. It is impossible to avoid the risk of death. However, it is possible to avoid the risk of dying in a plane crash by avoiding airline travel. Some businesses successfully use avoidance to manage risk. To avoid a risk that arises out of the manufacture of a hazardous material, a business can choose not to make the product. However, avoidance may not be the most practical means of managing risk. If the business finds that the hazardous material is a commercially viable product, it may be financially irresponsible not to manufacture the product.

Two other techniques of risk control are loss prevention, which is reducing the frequency or chance of loss, and loss reduction, which is minimizing the severity or adverse financial impact of any potential losses. A business can reduce the frequency of auto accidents by having fewer cars on the road. An individual can reduce the frequency of auto accidents by driving less. Despite these efforts, some losses will occur. However, drivers can reduce the severity of an auto accident by wearing their seatbelts at all times. A business or homeowner can also take steps to reduce the severity of potential loss. For example, a business may have a sprinkler system that will be triggered when a fire is detected, thereby minimizing the amount of inventory lost. A homeowner may have a device by the water heater that will sound an alarm should the heater start to leak, thereby minimizing water damage to the surrounding area.

Other techniques for controlling risk are separation, duplication, and diversification. These are more frequently associated with organizations rather than individuals. A manufacturer may store inventory in several locations (separation) rather than in one where it would all be subject to a single loss occurrence. An electric generating plant may have several generators working while maintaining a spare generator off-line (duplication), to be used if another generator fails. Finally, a business can diversify its products and services or geographically diversify its exposures to control risk. For example, an insurer that primarily issues policies for personal autos and homes can diversify by writing commercial business policies, or a large retail chain can diversify location by establishing distribution centers throughout the country rather than having only one location.

Risk Financing

Retention
A risk management technique by which losses are retained by generating funds within the organization to pay for losses.

The second method of managing risk is risk financing. This method ensures that funds are available to pay for or offset losses. One risk financing technique is retention, or the practice of assuming financial responsibility for one's own losses. Retention is a risk management technique by which losses are retained, rather than transferred, by generating funds within the organization to pay for losses. Retention, when used appropriately, can be a practical method of

handling risk. All or part of a risk can be retained. For example, in some states a business can decide to create its own fund to pay for injuries to employees. An individual can choose a large deductible on a home or auto insurance policy, thereby retaining part of the loss. Retention can be a conscious decision or it can occur without any thought, because of ignorance or indifference. For example, homeowners or farmers can retain the risk of polluting the ground water because they are unaware that the pesticide they are using is unsafe.

Noninsurance transfer is a risk financing technique by which the risk of loss is transferred to a person or an organization that is not an insurer. Two possible ways of accomplishing this type of transfer of risk are by the terms of a contract and by incorporation of a business. Risk transfer by the terms of a contract can be found in a variety of contracts. In a contract of sale, a purchaser can transfer the risk of repair or service back to the retailer by purchasing a service agreement. In a lease agreement, the risk of certain types of loss can be transferred from the owner of the building to the renter of the building. Risk transfer by incorporation occurs when a sole proprietor incorporates to protect his or her personal assets from creditors.

Noninsurance transfer
A risk management technique by which the risk of loss is transferred to a person or an organization that is not an insurer.

Finally, insurance is a risk financing technique that involves the transfer of risk.

INSURANCE

Insurance is a system for transferring risk from people and organizations to insurers that reimburse those people and organizations for covered losses. An **insured** is a person or an organization whose property, life, or legal liability is covered by an insurance policy. The insured pays a premium in exchange for the insurer's promise of coverage for specific losses; thus, insureds transfer the potential financial consequences of their loss exposures to insurers. Loss exposures are conditions, situations, or property that present the possibility of loss. A building, for example, is a loss exposure if the possibility exists that it can be damaged by fire.

Insurance
A system for transferring risk from people and organizations to insurers that reimburse those people and organizations for covered losses.

Insured
A person or an organization whose property, life, or legal liability is covered by an insurance policy.

To effectively complete the transfer of the risk, an insurer pools the premiums it receives from all of its insureds and uses that pool of money to indemnify (restore to pre-loss financial condition) the few insureds who sustain covered losses. In any given period, such as a year, a relatively small percentage of insureds suffer covered losses.

The accuracy of their projections is based on the **law of large numbers**. Insurers project the number of losses they will pay in any given period so that they can determine what premium is required to pay for those losses. The law of large numbers is a mathematical principle stating that, as the number of similar but independent exposure units increases, the relative accuracy of predications about future outcomes (losses) based on these exposure units also increases. Insurers underwrite a large number of similar loss exposures and project the dollar amount of all the losses that those insureds are expected to experience. Premiums are based on each insured's share of the projected losses plus the insurer's expenses and an allowance for profit.

Law of large numbers
A mathematical principle stating that, as the number of similar but independent exposure units increases, the relative accuracy of predictions about future outcomes (losses) based on these exposure units also increases.

Principle of indemnity
The principle that insurance policies should provide a benefit no greater than the loss suffered by an insured.

The **principle of indemnity**, a fundamental principle of insurance, holds that insurance policies should provide a benefit no greater than the loss suffered by an insured. For example, if Jill purchases insurance for her five-year-old car and the car is later destroyed in an accident, under the principle of indemnity Jill should be paid (indemnified) for the value of the five-year-old car. Jill is not entitled to the value of a new car because that would put her in a better financial position than she was in before the loss occurred.

Insurable interest
An exposure that a party has to financial loss.

The principle of indemnity is reinforced by the requirement that a party must have an insurable interest to purchase property insurance. An **insurable interest** is a person's or an organization's exposure to financial loss, such as damage to or loss of an insured house. The insurable interest requirement prevents people from profiting from a loss. For example, if Joe purchases insurance for a house that he does not own or rent, he has nothing to lose financially from a loss. If a loss occurs, and if the insurer pays the claim, Joe profits by the amount of the loss payment because he has no incentive to pay to repair or replace the home. Such an arrangement is undesirable because having nothing to lose would encourage insureds to cause losses, which would result in higher premiums for all insureds.

Insurance policies cover los es only to the extent of the insured's insurable interest in the property. Suppose that Jerry owns 30 percent of an office building. The building is destroyed by a tornado. Jerry can collect insurance only on 30 percent of the building's value, even though the entire building was destroyed. This result prevents Jerry from profiting from the loss, supporting the principle of indemnity.

Parties to the Insurance Contract

The insurance contract (policy) involves two parties: the insured and the insurer. The insured is the first party to the insurance contract; the insurer is the second party to the insurance contract. A demand by an insured person or organization seeking to recover for a loss from its insurer is called a **first-party claim**. When an insured injures a third party or damages the property belonging to a third party, the third party's demand against the insurer, called a **third-party claim**, is based on the legal duties the insured owes to the third party.

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

Third-party claim
A demand by a third party against an insured based on the legal duties the insured owes to the third party; it seeks to recover from the insured's insurer for a loss that the issuing policy may cover.

Benefits of Insurance

The business of insurance provides many benefits to individuals, families, businesses, and society as a whole. These benefits include the following:

- *Payment for covered losses.* Payment for losses is the most obvious benefit of in urance. Without insurance, the effects of a loss may be financially devastating for an individual, family, or organization. Insurance enables individuals and families to maintain their homes and standards of living. Insurance enables businesses to continue operating after a loss, allowing employees to keep their jobs, customers to continue receiving goods and services, and suppliers to be paid.

- *Reduction of uncertainty.* The risk of loss produces fear and uncertainty. For example, a restaurant owned by two brothers employs the brothers' wives and their children, who have their own families. If the restaurant is destroyed by fire, many lives will be affected by the loss of income. By purchasing adequate insurance on the restaurant, the owners can eliminate such fear and uncertainty. If the restaurant is destroyed by a covered cause of loss, the insurer would pay to have it rebuilt, preserving the families' source of income. Therefore, insurance reduces anxiety and provides peace of mind.
- *Support for credit.* Before lending money for a large purchase such as a house, financial institutions want assurance that the money will be repaid. If the borrower does not repay the loan, the lender can repossess the house. But if the house is destroyed by fire, the lender cannot repossess it. Insurance would pay for the destroyed home and thus makes loans possible by reducing the lender's uncertainty about whether the borrower would be able to repay the loan.
- *Source of investment funds.* Insurers can use the premiums they receive from their insureds to make loans and investments until they need that money to pay for losses or operating expenses. The interest from those loans and the earnings from those investments help insurers meet operating expenses and reduce premiums. Additionally, loans and investments help generate other business activity, creating new jobs and resulting in new consumer products.
- *Loss reduction and prevention.* Insurers recommend loss reduction and prevention to reduce the severity and frequency of losses. Businesses take loss control measures to promote workplace safety. Individuals and families can benefit from loss control measures such as installing smoke and burglar alarms and deadbolt locks. Such measures save lives and protect property. These and other loss control measures benefit insureds by reducing the amount of money that insurers must pay in claims resulting in lower premiums. Insureds, insurers, and society as a whole are better served when losses are prevented than when losses are covered by insurance.
- *Efficient use of resources.* Without insurance, individuals and organizations would have to set aside contingency funds to pay for property damage, bodily injuries, and lawsuits. Money and other resources that could otherwise be used to produce and deliver goods and services would be tied up. Consumers would be less likely to make major purchases, and businesses would be reluctant to enter new ventures or expand their facilities. Insurance frees those contingency funds for consumer spending and business growth. Insurance premiums are much lower than the costs of contingency funds, so purchasing insurance allows insureds to use the remaining money more productively. Some organizations choose not to purchase insurance, but instead to pay for some or all of their losses with their own funds. That arrangement is called self-insurance, or retention. Self-insurance is actually not insurance because it does not involve risk transfer. Self-insured businesses save some of the administrative costs associated with insurance, but they must maintain sufficient resources to pay for losses that do occur.

- *Reduction of social burdens.* Accident victims who are not compensated for their injuries and individuals who lose all their belongings in a fire can be a serious financial burden to society. The families of these accident victims can become a burden if they depend on that victim for financial support. Insurance helps reduce that burden by compensating injured individuals for lost wages and medical expenses and by paying for damaged or destroyed property.
- *Satisfaction of legal and business requirements.* Some laws require individuals and organizations to purchase insurance. For example, in many states, automobile owners must prove that they have auto liability insurance before they can register their vehicles. State laws require employers to pay for the job-related injuries or illnesses of their employees, and employers typically purchase workers' compensation insurance to meet that financial obligation. Some business relationships require proof of insurance. For example, building contractors are usually required to provide evidence of liability insurance before they are granted a construction contract. In fact, almost anyone who provides a service to the public, such as landscapers, architects, doctors, and lawyers, may need liability insurance to contract for services. In this way, insurance protects both the public and business entities.
- *Source of employment and tax revenue.* The insurance business in the United States employs many people. In addition to the benefits of employment to the individual, governments benefit because those employees pay local, state, and federal income taxes. Insurers pay taxes on their profits and, in most states, on the premiums they collect from insureds. These taxes benefit society by paying for government services.

Costs of Insurance

The direct and indirect costs associated with insurance affect not only the individual or organization that must pay the premium; they also affect society as a whole. Dollars spent on premiums cannot be spent on other things that could be more beneficial to society. Direct and indirect costs of insurance include the following:

- *Premiums.* A direct cost of insurance is the premium . Insurance benefits are not provided free of charge. Insurers charge premiums to have funds to pay claims and to cover their operations. Premiums can be substantial. However, the portion of the premium that is used to pay losses is not an additional cost to society. Most of those losses would have occurred and imposed a cost to society regardless of whether they were insured. The additional cost created by insurance is the portion of premium that is used to pay insurers' operational expenses.
- *Opportunity costs.* Opportunity costs are an indirect cost of insurance. Opportunities are lo t when money is used to pay premiums. Insureds dislike spending money for mandatory insurance because they would rather use the money for some other purpose. Money spent on premiums may be used for other purposes that would be more productive for the

economy, such as investment in a small business or to help finance the down payment on a house. All purchases create opportunity costs for consumers. Because some insurance buyers believe that they do not benefit from insurance unless they suffer losses, they are sensitive to the opportunity costs associated with insurance.

- *Increased litigation.* Another indirect cost of insurance is increased litigation. Liability insurance sometimes pays large sums of money to protect insureds who may be responsible for injury to someone else or for damage to someone else's property. Many people, however, view liability insurance as a pool of money available to pay the claims of anyone who has suffered injury or whose property has been damaged, regardless of fault. The existence of insurance can encourage such persons to sue to recover for their injuries or damages.
- *Moral hazards.* Still another indirect cost of insurance is the economic incentive it provides for insureds to cause losses. **Moral hazards** are conditions that may lead a person to intentionally cause or exaggerate a loss. If moral hazards result in more or larger losses than would have occurred in the absence of insurance, they are an indirect cost of insurance. For example, an insured may intentionally burn an empty warehouse in what has become a dangerous section of a city and use the insurance proceeds to rebuild in a more favorable location. Exaggerated claims are a more common type of moral hazard than intentional losses such as arson or staged auto accidents. For example, an insured may claim that a stolen ten-year-old TV was new in order to obtain a larger claim payment.

Moral hazard
A condition that may lead a person to intentionally cause or exaggerate a loss.

- *Morale (attitudinal) hazards.* **Morale hazards**, also called **attitudinal hazards**, involve carelessness about or indifference to potential loss on the part of an insured. Insurance is available to pay for losses should they occur, so an insured may leave an expensive piece of jewelry or a laptop computer in an unlocked and unattended car, knowing insurance will cover any loss if the item is stolen.

Morale hazard, or attitudinal hazard
A hazard that involves carelessness about or indifference to potential loss on the part of an insured.

Exhibit 1-1 summarizes the benefits and costs of insurance.

EXHIBIT 1-1

Benefits and Costs of Insurance

Benefits	Costs
Payment for losses	Premiums
• Peace of mind	• Opportunity costs
Support for credit	Increased litigation
Funds for loans and investments	Moral hazard
Loss control	• Morale hazard
Efficient use of resources	
Reduction of social burdens	
Satisfaction of legal and business requirements	
Source of employment and tax revenue	

The claim function has a significant role in helping policyholders achieve their risk management goals. It is responsible for keeping the insurer's promise to the policyholder to pay covered losses by providing prompt and professional claim adjusting services. How the claim function fulfills the insurer's promise to pay is discussed next.

CLAIM FUNCTION

Insurers have claim departments; however, claim departments can also be found in large business entities that self-insure, in companies called third-party administrators (TPAs) that handle the claims of others, and in agents' or brokers' offices. The claim representatives in a large business or at an agent's or a broker's office may or may not investigate and pay claims, just as a claim representative working at an insurer would. If they do not investigate and pay claims directly, their role is often that of an examiner, monitoring the actions of the insurer or third-party administrator. A **third party administrator** contracts to provide administrative services to other businesses and is often hired to handle claims by organizations that have self-insurance plans. Claim representatives at a third-party administrator perform many, if not all, of the same claim-related activities as the claim representatives of insurers.

Third-party administrator
A firm that contracts to provide administrative services to other businesses and that is often hired to handle claims by organizations that have self-insurance plans.

This section focuses on the structure of an insurer's claim department and the various parties, policies, and performance measures that help the insurer fulfill its promise to pay covered lo ses.

Claim Department Structure

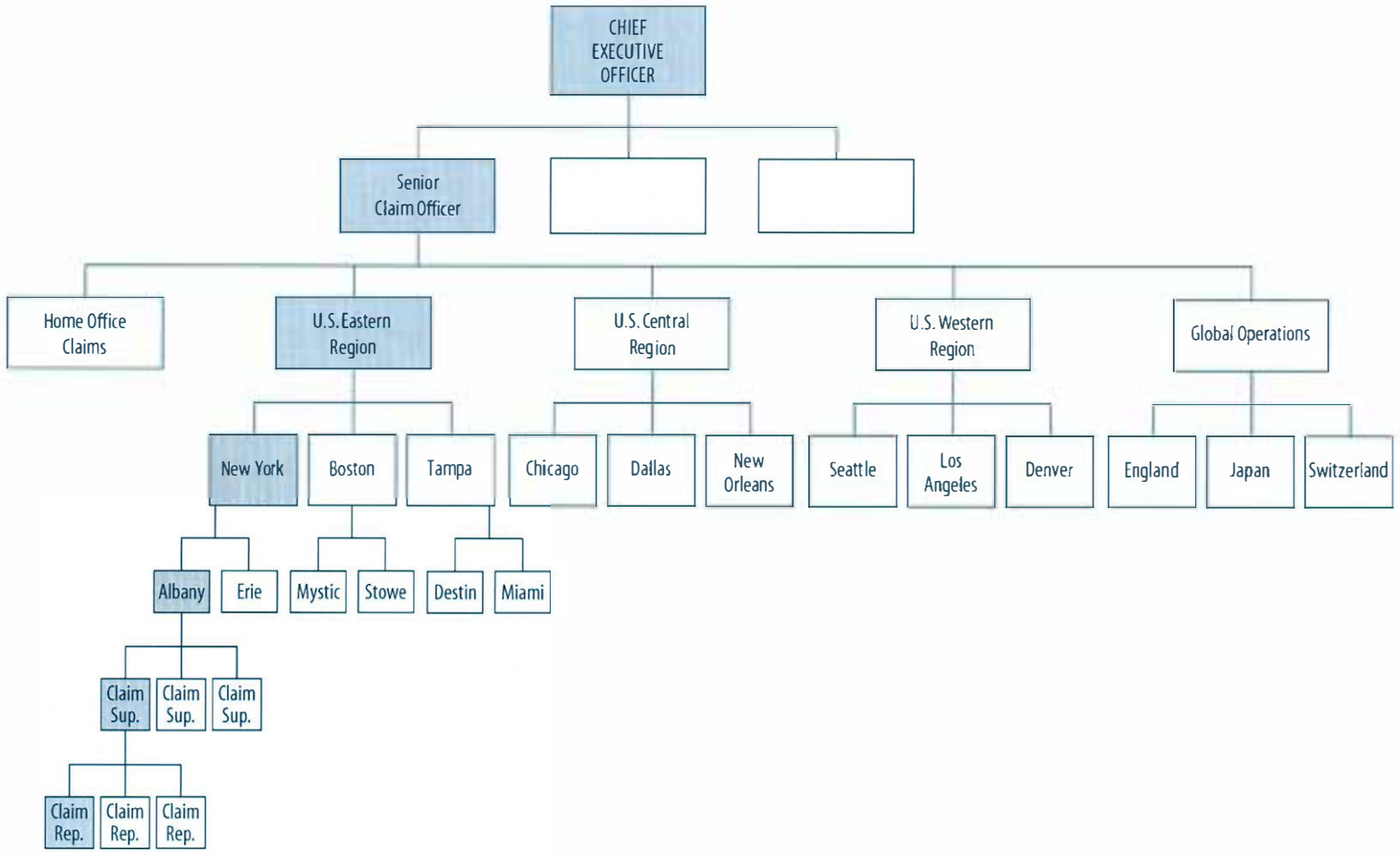
An insurer' claim department can be organized in several different ways. However, only one structure is used here to illustrate the various claim positions within the department. Usually a senior claim officer heads the claim organization and reports to the chief executive officer, the chief financial officer, or the chief underwriting officer. Exhibit 1-2 shows a typical organizational chart for a claim department.

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

The senior claim officer may have several claim offices or branches countrywide or worldwide. Staff from remote claim offices can all report directly into the home-office claim department, or regional/divisional claim officers may oversee the territory. Regional claim officers may have one or more branch offices reporting to them. Each branch office may have a claim manager. Each branch office that reports to the claim manager may have one or more claim supervisors and a staff of claim representatives. Similar department structures are adopted by TPAs, large organizations that self-insure, and large agents and brokers.

EXHIBIT 1-2

Claim Department Organizational Chart



Claim Personnel

People who handle claims may be staff claim representatives, independent adjusters, employees of third-party administrators, or producers who sell policies to insureds. In addition, public adjusters also handle claims by representing the interests of the insureds to the insurer. This section discusses the different personnel who handle claims.

Staff Claim Representatives

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

Independent Adjusters

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

A particular insurer may not find it economically feasible to set up claim offices. In this case, insurers may use **independent adjusters**, who handle claims for insurers in exchange for a fee.

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

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

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

Third-Party Administrators

Businesses that choose not to purchase insurance but to self-insure do not use agents, underwriters, or other typical insurer personnel. However, they do need personnel to handle the losses that arise. Self-insured businesses can employ their own claim representatives or contract with third-party

administrators (TPAs) who handle claims, keep claim records, and perform statistical analyses. TPAs are often associated with large independent adjusting firms or with subsidiaries of insurance companies. Many property-casualty insurers have established subsidiary companies that serve as TPAs.

Producers

The term "producer" is used to describe anyone who sells insurance. This can include agents, brokers, employees of insurers, or intermediaries. **Insurance agents** are legal representatives of insurers for which they have contractual agreements to sell insurance. An **insurance broker** is an independent business owner or firm that sells insurance by representing customers rather than insurers. An insured who purchases insurance through a producer is likely to call the producer first when a loss occurs. Most insurers give some producers the authority to pay claims up to a certain amount, such as $2,500. Those producers can issue claim payments, called drafts, directly to insureds for covered claims, thus reducing the time necessary to pay insured . In this capacity, producers function much like inside claim representatives.

Insurance agent
A legal representative of one or more insurers for which the representative has a contractual agreement to sell insurance.

Insurance broker
An independent business owner or firm that sells insurance by representing customers rather than insurers.

If the producer does not have draft authority, he or she can report the loss to the insurer immediately, give the insured the telephone number of the insurer's claim office, and explain how the insured can expect the claim to be handled.

Public Adjusters

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

Public adjuster
An organization or person hired by an insured to represent the insured in a claim.

Because a claim department staff can be diverse and may be spread over a wide geographic area, insurers face special issues in evaluating and measuring their performance.

Performance Measures

Insurers are businesses, and, as such, they must make a profit in order to survive. Claim departments pay claims, which may be considered to reduce an insurer's profit. But claim departments play a crucial role in insurer profitability by paying fair amounts for legitimate claims and by providing accurate, reliable, and consistent ratemaking data. Fair claim payment does not conflict with insurer profit goals. Consequently, an insurer measures its underwriting and claim department's performance using a loss ratio, which is a profitability measure. A claim department's performance can also be measured by quality, using best practices, claim audits, and customer satisfaction.

Profitability Measures

Incurred losses
The amount equal to paid losses and losses for which the insurer is liable but has not yet paid.

To calculate the loss ratio to measure profitability, insurers must ascertain their incurred losses. **Incurred losses** are paid losses plus losses for which the insurer is liable but which the insurer has not yet paid. Earned premium is the proportion of written premium (total policy premium) that applies to the part of the policy period that has already occurred. For example, if the written premium is $120 for a twelve-month policy, then the earned premium for each month is $10 ($120 divided by 12). Assuming that the policy is written on a calendar year basis, the earned premium at the end of March would be $30, that is, $10 each for January, February, and March.

Loss ratio
An insurer's incurred losses (including loss adjustment expenses) for a given period divided by its earned premiums for the same period.

The **loss ratio** is an insurer's incurred losses (including loss adjustment expenses) for a given period divided by its earned premiums for the same period, as shown in the following calculation:

$$\text{Loss ratio} = \frac{\text{Incurred losses} + \text{Loss adjustment expenses}}{\text{Earned premium}} \times 100\%.$$

Loss adjustment expenses include the following:

- Salaries and expenses for an insurer's claim staff
- Costs of hiring lawyers to defend insureds in lawsuits
- Fees charged by service providers (for example, doctors' fees for independent medical examinations or engineers' fees to inspect damaged property)
- Costs of obtaining medical, police, and other types of reports

Loss reserves
Estimates of the amount of money the insurer expects to pay in the future for losses that have already occurred and been reported.

The amount of loss for which the insurer is liable but has not yet paid is the amount of loss reserve on a claim. **Loss reserves** are estimates of the amount of money the insurer expects to pay in the future for losses that have already occurred and that have been reported to the insurer. They are usually set on a per claim basis by the claim representative. When all the loss reserves are aggregated, they represent the insurer's liabilities. If the reserves are higher than necessary, the loss ratio appears higher (worse) than it actually is. When the loss ratio is high, underwriters tend to decline new risks or to increase premiums for new and existing risks. This practice can cause the insurer to become less competitive in its pricing.

Conversely, if the reserves are lower than necessary, the loss ratio may suggest that the profitability being measured is higher than it actually is. The insurer might aggressively pursue a line of business that is really unprofitable. For insurers to accurately assess their underwriting, claim representatives must consistently set accurate reserves and adjust them as appropriate.

Combined ratio
A profitability measurement calculated by adding loss ratio and expense ratio.

The loss ratio is one component of the **combined ratio**, which represents an insurer's underwriting profitability. The combined ratio is calculated as follows:

$$\text{Combined ratio} = \text{Loss ratio} + \text{Expense ratio}.$$

The expense ratio in this formula uses underwriting expenses and expenses other than claim-related expenses and is calculated as follows:

$$\text{Expense ratio} = \frac{\text{Expenses}}{\text{Written premium}} \times 100.$$

Because claims usually do not occur immediately after a policy is issued and because they take some time to be paid, insurers can invest premiums to generate additional income until the premiums are needed to pay claims. Insurers select stocks, bonds, Treasury bills, and other securities to buy and sell. They seek to earn the highest possible return from investments while making sure that funds are available to meet their financial obligations. Insurers typically spend slightly more on operations (claims and other expenses) than they collect in premiums. Managing investments wisely enables insurers to earn a profit despite a loss on operations.

The following example illustrates the performance ratios and their implications. In fiscal 2005, the Atwell Insurance Company earned $25 million in premiums, incurred $16 million in losses and loss adjustment expenses, and incurred underwriting expenses of $7.5 million. Its combined ratio is calculated as follows:

$$\text{Loss ratio} = \frac{\$16 \text{ million}}{\$25 \text{ million}} = 0.64 \times 100\% = 64\%.$$

$$\text{Expense ratio} = \frac{\$7.5 \text{ million}}{\$25 \text{ million}} = 0.30 \times 100\% = 30\%.$$

$$\text{Combined ratio} = 64\% + 30\% = 94\%.$$

If the combined ratio is less than 100 percent, as for Atwell Insurance Company, the insurer has made an underwriting profit. For every $1.00 in premium, Atwell pays $0.94 in losses and operating expenses, leaving $0.06 for profit. If the combined ratio is 100 percent, every dollar that the insurer earned in premiums was used to pay losses and operating expenses. A combined ratio of greater than 100 percent means that the insurer has incurred an underwriting loss because it paid out more money in losses and operating expenses than it received in premiums. An insurer can have an underwriting loss and still be profitable if its investment income is sufficient to offset the losses. Therefore, by managing losses and controlling expenses associated with handling losses, the claim department plays an important role in an insurer's profitability.[1]

Quality Measures

Even though claim handling is more art than science, there are measures that can be used to evaluate the performance of a claim department. Three of the more frequently used quality measures are best practices, claim audits, and customer satisfaction.

Best practices can mean different things to different people. In the context of a claim department, best practices usually refers to a system of identified

internal practices that produce superior performance. Best practices are usually maintained electronically or in written form and shared with every claim representative. An insurer can create best practices by studying its own performance or by studying the performance of similar successful insurers.

Claim department best practices are often based on legal requirements specified by regulators, legislators, and the courts. For example, a claim department may have a best practice that states "every claim will be acknowledged within twenty-four hours." This time frame may have been selected because of a regulation, law, or court decision that requires insurers to acknowledge a claim within twenty-four hours of receipt. Other best practices may relate to the following:

- Time allowed to make initial contact with the insured and claimant
- Timely responses to outside communications
- Timely and accurate loss reserving
- File documentation
- Timely payment of claim or timely denial of claims
- Complete explanation of payment or denial

Insurers use claim audits to ensure compliance with best practices, in addition to gathering statistical information on claims. A claim audit is performed by reviewing a number of open and closed claim files and evaluating the information contained in the files. Claim audits can be performed by the claim staff that works on the files (called a self-audit), or they can be performed by claim representatives from other offices or by a team from the home office.

Claim audits usually evaluate both quantitative and qualitative factors, examples of which are shown in the box.

Quantitative and Qualitative Audit Factors

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

The quantitative and qualitative factors can be rated or graded individually as can the overall file. The quantitative information gathered can help identify trends that require corrective action. For example, information showing that a claim representative has a high number of files closed each month and has the highest number of files reopened each month may suggest that this claim representative is closing files prematurely. A claim manager would want to review these files to see if this is the case or if there is a legitimate reason for the reopenings.

The qualitative factors are used to determine if claim representatives are following the guidelines and best practices set by the insurer. They must be evaluated in the context of the overall claim file. The type of the claim will dictate how it should best be handled. Consistently poor results in a given area can indicate a need for training and supervision. For example, a consistent failure to correctly evaluate coverage indicates a need for training in coverage analysis.

The quality of a claim department's performance is also measured by its customer satisfaction. Claim supervisors and managers will usually keep track of any correspondence they receive about the performance of individual claim representatives. While compliments are usually acknowledged, supervisors or managers must respond to complaints, and most claim departments have procedures for doing so. Complaints may come directly from the insured, claimant, or vendor; or they can be submitted by a State Insurance Department on behalf of an insured, claimant, or vendor. However received, the complaint must be investigated by management and responded to in a timely manner. Complaints such as "I called a claim representative on January 24 and February 3 and never received a return phone call" may indicate legitimate service issues. Other complaints can simply indicate dissatisfaction with an otherwise valid claim settlement. Review of complaints received in a claim office can show whether problems exist with a particular claim representative, supervisor, or manager.

The claim function is only one part of a larger organization that provides insurance. An insurance company has parties who market and sell the insurance contract, underwrite the insurance contract, price the insurance contract, manage and gather data about a large number of insurance contracts, and ultimately pay the claims made against these contracts. These parties perform the major functions of the insurance company.

OTHER INSURANCE COMPANY FUNCTIONS

This section provides an overview of the principal functions of a typical insurance company, which allow the insurer to fulfill its promises to the insured. Some insurers may not have all of these functions; they may be combined, or they may be called something else. While each of these functions operates individually, each contributes to the insurer's overall effectiveness. The effective interaction of these functions is vital to the insurer's survival and continued

success. Because the purpose of this text is to describe the claim function, it is discussed in more detail than the other functions.

Marketing and Sales

Marketing and sales are the functions that bring business in to the insurer. The terms "marketing" and "sales" are sometimes used interchangeably. However, marketing may encompass the broader perspective of actually delivering products or services to the customer, while the sales function is usually to contact the customer and bring the insurance application to the insurer. This distinction may vary depending on many factors, including the insurer's size and available financial resources, the lines of business written, and the marketing system used.

Many insurers market through producers who are independent agents and brokers and who represent several otherwise unrelated insurers. Some insurers market through exclusive agents, who represent only one insurer or group of insurers under common ownership and management. Others rely on the efforts of their own employees.

Insurers must develop marketing programs. Successful marketing programs are likely to include the following features:

- Market research to determine the needs of potential buyers and markets
- Advertising and public relations programs to inform customers about the insurer's products
- Training programs to prepare the sales force (either employees or independent or exclusive agents) to meet the customers' needs
- Production goals and strategies to achieve them
- Effective motivation and management of the producer network

Underwriting

Once an insurance application is received, the underwriting department determines if the application meets insurer guidelines. The goal of underwriting is to write a profitable book of business for the insurer, that is, to accept those applications (also called submissions) most likely to produce a profit for the insurer. Underwriters are involved in risk selection, pricing, and determination of coverage terms and conditions. Underwriters work with the marketing department. They can also work with the sales department to modify policy conditions or pricing to make an otherwise unacceptable application acceptable for coverage.

Applications from most mid-sized and large commercial organizations are handled by an underwriter. Applications from small commercial organizations and for personal in urance are often handled by computerized expert systems. Such systems are designed to replicate the thought process used by underwriters for risk election, pricing, and determination of coverage terms

and conditions. These systems are used to accept those accounts that clearly fall within the insurer's eligibility guidelines. Any applications that are not clearly within eligibility guidelines are referred to an underwriter for evaluation. This underwriter then reviews the application to determine if pricing or coverage modifications are needed. The underwriter may also consult with the sales department before rejecting the application because the rejection may adversely affect a business relationship.

Loss Control

The loss control function works closely with the underwriting function. Loss control specialists inspect businesses that apply for insurance and suggest ways to prevent losses and reduce the severity of those losses that cannot be prevented. Loss control is an important insurer function that continues to grow in importance as policyholder loss exposures become more complex.

Reinsurance

To underwrite policies, in urers must be financially able to pay claims. One way insurers can ensure that they have sufficient funds to pay claims is by sharing the premiums and potential losses with a reinsurer. A **reinsurer** is an insurer that assumes all or part of the insurance risk from the primary insurer. The reinsurance function within most insurer operations is responsible for establishing reinsurance programs and negotiating those programs with reinsurers or reinsurance brokers. The reinsurance department also establishes guidelines for reinsurance procedures, usually in conjunction with staff underwriters. Reinsurance also protects the financial solvency of primary insurers by enabling them to meet their obligations to policyholders and claimants.

Reinsurer
The insurer that assumes all or part of the insured risk exposures of the primary insurer in a contractual agreement.

Another reason reinsurance is important is that it permits the primary insurer to provide high limits of insurance. For example, a primary insurer that provides insurance for a multimillion dollar high-rise office complex can transfer all or part of that risk to other insurers around the world through reinsurance transactions. Reinsurance also helps cushion the effects of natural disasters on individual insurers and the insurance industries of individual countries. For example, in 1992, Hurricane Andrew caused more than $15 billion of losses in the United States. The insured losses from the 1994 Northridge earthquake totaled almost $13 billion. Without reinsurance, this level of losses would have had a significant effect on the U.S. insurance industry. The reinsurance process spreads the cost of the catastrophes throughout the worldwide insurance industry and therefore substantially softens their overall effects.

Actuarial

Actuaries are highly trained specialists who perform all the mathematical functions underlying insurance operations. Underwriters rely on the actuarial

function to supply the information required to calculate insurance rates (the price of insurance for each unit of exposure that, when multiplied by the number of exposure units, determines a premium amount), to develop rating plans, and to estimate loss reserve . Actuaries may assist in corporate planning and in establishing corporate goals by compiling and analyzing statistical reports. They may also be involved in assessing the insurer's success in meeting these goals.

The actuarial function is also responsible for providing information for regulators and for the ratemaking process. At one time, final rates were developed by rating bureaus that are now called advisory organizations. Organizations such as Insurance Services Office (ISO) now provide loss costs rather than final rates to insurers. Loss costs are the actual or expected costs of claims. Insurance company actuaries are responsible for developing factors to reflect individual insurer expenses and anticipated profits. These factors are applied to lo s costs to convert them to final rates.

Finance and Accounting

The finance and accounting function is important in any insurance operation. Policyholders pay premiums at policy inception and receive benefits later if a loss occurs. The insurer's finance and accounting function invests the premium received until they are needed to pay for losses. Any fund not used to pay for losses or expenses of selling policies and running the company are considered profit. Many insurers lose money on their operation because losses and expenses exceed the premiums collected.

The finance and accounting function may al o prepare the financial statements that in urance regulators use to evaluate the insurer's profitability and solvency. This function can also be responsible for the insurer's day-to-day cash operations.

Information Technology (IT)

The information technology function is responsible for providing the technological infrastructure that supports all the insurer's internal and external communications and provides for many rating, statistical, claim payment, and other processes. The IT function collects and stores data that are used by employees, customers, and regulators. To provide efficient and optimal claim services, insurers depend on IT to improve interactions between office and field staff as well as with customers and claimants.

Miscellaneous Functions

Insurance also involves a number of other equally important functions that are not discussed in detail here, including premium audit, human resources, training and development, and legal services. Each of these functions contributes to the overall effective operation of an in urer.

Though insurers serve society in many ways, their primary purpose is to facilitate the transfer of risk. Their other contributions to the economy, such as the preservation of human and material assets and the accumulation of investment capital, are incidental to that primary purpose. All of the foregoing functions must work together to fulfill the insurer's primary purpose and to achieve insurer goals, and they must do so within the framework of insurance regulation.

INSURANCE REGULATION

Insurance operations are closely regulated. Insurance regulators monitor the solvency of insurers to protect policyholders and members of the public who benefit from the existence of insurance. Regulation also extends to the rates and forms used by insurers. If filed rate increases are not approved by the applicable regulator, an insurer may not meet its profit goal. Also, policy form approval and the time constraints relating to the filing process may keep an insurer from fully meeting a customer's needs. Insurance regulation is complicated by the variance of requirements from state to state and by the added burden of meeting certain federal regulatory requirements. For example, each state may have its own set of unfair claim handling practices. To enhance understanding of the regulatory environment within which the claim representative must operate, a brief discussion of the evolution of insurance regulation is included.

Evolution of Insurance Regulation

The ratification of the U.S. Constitution, which gives Congress the right to regulate commerce among the states, marks the beginning of the history of insurance regulation in the U.S. The Constitution's Commerce Clause in Section 8 provides that "The Congress shall have power to…regulate commerce with foreign nations, and among the several states, and with the Indian tribes." The Constitution also provides that the powers it does not delegate to the federal government belong to the states. Consequently, by the mid-1800s, state insurance departments began forming and states began collecting financial information from insurers operating within their boundaries to collect taxes and fees. In 1869 the U.S. Supreme Court decision in *Paul v. Virginia* effectively ratified the power of the states, rather than the federal government, to regulate insurance.[2] Despite the Supreme Court's decision in the *Paul* case, the debate continued: Who should have the power to regulate insurance—Congress or the states?

In 1944 the Supreme Court reversed the decision of *Paul v. Virginia*. In *United States v. South-Eastern Underwriters Association* (*SEUA*),[3] the Court ruled that insurance was interstate commerce subject to federal antitrust laws. The Supreme Court answered the question of who had the power to regulate insurance by effectively saying "both Congress and the states." This

ruling surprised those in the insurance industry because the states had been regulating insurance for decades.

McCarran-Ferguson Act

In re ponse to the *SEUA* case, Congress passed the McCarran-Ferguson Act in 1945. The act stated the following:

- State regulation of insurance "is in the public interest."
- Insurers are exempt from federal antitrust laws if the states maintain their own comprehensive regulatory systems.
- Federal antitrust law will apply if the business of insurance is not regulated by state law or in cases involving boycott, coercion, or intimidation.

The McCarran-Ferguson Act preserved the structure of existing state insurance regulation. At the same time, it clarified the federal government's power to step in and assume regulatory functions in the absence of state regulation. Today, insurance regulation remains primarily with the states, but the debate continues. In addition, some federal laws that have application beyond insurance can affect insurers in specific ways.

Insurance Fraud Protection Act

The Insurance Fraud Protection Act is part of a federal anti-crime bill titled "Violent Crime Control and Law Enforcement Act of 1994."[4] This broad legislation protects consumers and insureds against insurer insolvencies resulting from fraud.

The act identifies the following crimes as fraud involving the busines of insurance:[5]

- Making false statements or reports to insurance regulators—including overvaluing assets—to influence regulatory decisions
- Making false entries in books, reports, or statements to deceive anyone about an insurer's financial condition or solvency
- Embezzling from anyone who is engaged in the business of insurance
- Using threats of force or "any threatening letter or communication to corruptly influence, obstruct, or impede" insurance regulatory proceedings

The act prohibits insurers, reinsurers, producers, and others from employing a person who has been convicted of a felony involving breach of trust or dishonesty.

Gramm-Leach-Bliley Act of 1999

The issue of state versu federal insurance regulation has never been completely resolved. Many times during the last fifty years, it seemed likely to resurface as a major legislative concern. The issue came to the forefront during the 1990s, when affiliations between banks and insurers began to

form and questions arose about who would regulate these "bankassurance" organizations. Banking activities were traditionally regulated by the federal government and, in some cases, by the states, while insurance was regulated only by the states.

The Gramm-Leach-Bliley (GLB) Act of 1999, also called the Financial Services Modernization Act, addressed this issue. However, although the GLB Act answered some questions, it raised many others that have not been answered, at least as of the writing of this text.

Under the GLB Act, each segment of the financial services business is regulated separately. The act makes it clear that states continue to have primary regulatory authority for all insurance activities. However, the act prohibits state actions that would prevent bank-related firms from selling insurance on the same basis as insurance producers. Meanwhile, securities activities are regulated by securities regulators, and banking activities are regulated by banking regulators.

Information sharing among banks and insurance affiliates raises privacy concerns. The GLB Act addresses these concerns through a provision requiring banks to disclose to customers their information-sharing policies and practices. Because state laws can be more restrictive than federal laws, this provision could lead to some inconsistency in practice.

Role of the National Association of Insurance Commissioners (NAIC)

One disadvantage of state regulation of insurance is the inefficiency that can result when more than fifty different insurance departments perform similar tasks and address the same issues and problems, each in its own way. The National Association of Insurance Commissioners (NAIC) was established to encourage coordination and cooperation among state insurance departments.

Regulators from the fifty state insurance departments and those of the District of Columbia, Puerto Rico, and Guam belong to the NAIC. Members meet periodically to discuss insurance industry problems and issues in insurance regulation. The NAIC itself has no direct regulatory authority, but it has a profound influence on the content and uniformity of state regulation. For example, the NAIC drafts model laws and regulations that state legislatures may adopt as written or modify as they see fit. Consequently, the states that have adopted the model laws and regulations share some degree of uniformity in their practices. In 1990, for example, the NAIC drafted the Unfair Claims Settlement Practices Act, which specifies wrongful claim settlement practices. Many states have either adopted this act or have used it as the basis for writing their own.

The NAIC model act lists fourteen actions that it defines as unfair claim practices. Some state laws list more than twenty unfair or illegal claim practices.

Purposes of Insurance Regulation

Insurance regulation serves the following three purposes:

1. To protect consumers
2. To maintain insurer solvency
3. To prevent destructive competition

Although these purposes clearly overlap, each is examined separately.

Protect Consumers

The primary purpose of insurance regulation is to protect consumers. When consumers buy food, clothing, or furniture, they can usually inspect the products before purchasing them to ensure that the products meet their needs. Even if consumers inspect the insurance policies they purchase, they may not be able to analyze and understand the insurance policy, a complex legal document. Regulators help protect consumers by reviewing insurance policy forms to determine whether they are fair contracts. Regulators can set coverage standards, specify policy language for certain insurance coverages, and disapprove unacceptable policies.

Insurance regulators also protect consumers against fraud and unethical behavior by re ponding to complaints about such alleged behavior. Departments of insurance receive complaints about behaviors, including the following:

- Producers have intentionally sold unnecessary insurance.
- Producers have misrepresented the nature of coverage to make a sale.
- Claim representatives have engaged in unfair claim practices, refusing to pay legitimate claims or unfairly reducing claim payments.
- Insurance managers have contributed to the insolvency of insurers through their dishonesty.

In addition to protecting consumers against such abuses, regulators also try to ensure that insurance is readily available, especially insurance that is viewed as a necessity. For example, all states now try to make continuous personal auto insurance coverage available by restricting the rights of insurers to cancel or nonrenew personal auto insurance policies. At the same time, regulators recognize that insurers sometimes must break long-term relationships with policyholders whose loss exposures no longer match those the insurer wants to cover. Cancellation restrictions aimed at promoting availability can therefore lead insurers to reject more new-business applications, which reduces insurance availability.

Insurance regulators also provide information about insurance matters so that consumers can make more-informed decisions.

Maintain Insurer Solvency

Another purpose of insurance regulation is to maintain insurer solvency. Solvency regulation protects policyholders against the risk that insurers will be unable to meet their financial obligations. Consumers and even some sophisticated businesspeople may find it difficult to evaluate insurers' financial ability to keep their promises. Insurance regulators try to maintain and enhance the financial condition of private insurers for several reasons, including the following:

- *Insurance provides future protection.* Premiums are paid in advance, but the period of protection extends into the future. If insurers become insolvent, future claims may not be paid, and the insurance protection already paid for may become worthless.
- *Insurer solvency is in the public interest.* Large numbers of individuals and the community at large are adversely affected when insurers become insolvent.
- *Insurers have a responsibility to policyholders.* Insurers hold substantial funds for the ultimate benefit of policyholders. Government regulation is necessary to safeguard such funds.

Insurers can become insolvent despite regulatory oversight. However, sound regulation can minimize the number of insolvencies.

Prevent Destructive Competition

Insurance regulation also seeks to prevent destructive competition. Regulators are responsible for determining whether insurance rates are high enough to prevent destructive competition. At times, some insurers underprice their products to increase market share by attracting customers away from higher-priced competitors. This practice drives down price levels in the whole market. When insurance rate levels are inadequate, some insurers can become insolvent, and others might withdraw from the market or stop writing new business. An insurance shortage can then develop, and some individuals and organizations may be unable to obtain the coverage they need. Certain types of insurance, such as products liability or directors and officers insurance, can become unavailable at any price.

Activities of Insurance Regulators

Day-to-day regulation of the insurance business is conducted by state insurance departments, which fall within the executive branch of each state government. State insurance departments enforce insurance laws enacted by the legislature. These laws regulate the formation of insurers, capital and surplus requirements, licensing of producers, investment of funds, financial requirements for maintaining solvency, insurance rates, marketing and claim practices, taxation of insurers, and the rehabilitation of financially impaired insurers or the liquidation of insolvent ones.

Every state insurance department is headed by an insurance commissioner, superintendent, or director appointed by the governor or elected by the voting public. Under the insurance commissioner's direction, a state insurance department engages in a wide variety of regulatory activities that typically include the following:

- Approving policy forms
- Holding rate hearings and reviewing rate filings
- Licensing new insurers
- Licensing producers, adjusters, and claim representatives
- Investigating policyholder complaints
- Rehabilitating or liquidating in olvent insurers
- Issuing cease-and-desist orders
- Conducting periodic audits of insurers, including claim and underwriting audits
- Evaluating solvency information
- Performing market conduct examinations
- Publishing shoppers' guides and other consumer information (in some states)

Many commissioners were employed in the insurance business before they entered public office, and many gain employment with insurers or insurance-related organizations after leaving office. The expertise in and understanding of insurance operations necessary to regulate effectively are most likely found in a person who has worked in the insurance business. I lowever, those connections between in urance commissioners and insurers raise questions about whether some commissioners can act objectively when regulating insurers. In response to such questions, state insurance commissioners may point out that they frequently issue cease-and-desist orders, fine or penalize insurers for infractions of the law, forbid insurers to engage in mass cancellations, limit insurance rate increases, and take numerous other actions that benefit policyholders at the insurers' expense.

State insurance departments are partly funded by state premium taxes, audit fees, filing fees, and licensing fees; premium taxes are the major source of funding. Although state premium taxes are substantial, only a relatively small proportion is spent on insurance regulation. Premium taxes are designed primarily to raise revenues for the state as a whole.

Types of Insurance Regulation

State insurance departments regulate insurance through rate regulation, solvency surveillance, policy form regulation, and consumer protection.

Rate Regulation

Insurance rates are regulated to ensure that they are adequate to pay losses but are not excessive or unfairly discriminatory. Establishing appropriate rates can be difficult even with actuarial analysis. In an open, competitive market, inefficient insurers are allowed to fail. However, the failure of insurers is not in the public's interest. Insurers must be financially sound so that they can compensate insureds for losses for which premiums have been paid. Therefore, one role of regulators is to ensure that rates are sufficient for insurers to collect enough premiums to pay for losses and other expenses and to generate a reasonable profit. Even so, no method of rate regulation can guarantee that rates will be adequate.

Regulation also seeks to protect consumers from excessively high rates, which generate excessive profits for insurers. Regulators have considerable discretion in determining whether rates are adequate or excessive for a given type of insurance, and they use several approaches for doing so.

One such approach is to consider the fair rate of return. An insurer should expect at least some minimum rate of return on the equity invested in its insurance operations. An insurer's fair rate of return presumably should resemble the rate of return applicable to other types of businesses, especially if insurers are to attract investment capital. Another view is that the insurance business, by its nature, involves a higher degree of risk than many other businesses and that higher risks should generally be accompanied by higher returns. Given such varying viewpoints, the question about what constitutes a fair rate of return for insurers is far from settled.

Another goal of insurance rate regulation is to ensure that rates are not unfairly discriminatory. The word "discrimination," as commonly used, carries negative connotations, but the word itself is neutral, meaning only the ability to differentiate among things. Discrimination, in the neutral sense, is essential to insurance rating. However, insurers' discrimination must be fair and consistent; that is, loss exposures that are roughly similar regarding expected losses and expenses should be charged substantially similar rates. For example, two drivers age twenty-five operating similar vehicles in the same rating territory and buying the same type and amount of auto insurance from the same insurer should be charged similar rates.

Regulation prohibits only discrimination that is unfair. If loss exposures are substantially different in terms of expected losses and expenses, then different rates can be charged. For example, if a car is kept in an area that has a high incidence of car theft, the rate will be higher than if the car is kept in an area that has a much lower rate of car theft.

The trend, especially with respect to commercial insurance, is to deregulate rates, that is, to allow rates to be determined by competitive market forces. However, even in states in which rates are being deregulated, regulators continue to monitor insurer solvency.

Solvency Regulation

To monitor insurer solvency, state insurance regulators examine the insurer's financial condition and operations. The financial information collected is evaluated using Insurance Regulatory Information System (IRIS) ratios, designed by the NAIC to help regulators identify insurers in financial trouble. Such insurers are placed on a watch list and receive close scrutiny from regulators.

Why do insurers fail? Some insolvencies occur when an insurer is overexposed to losses resulting from a major insured catastrophe. However, usually no single event or mistake causes an insurer to become insolvent. Rather, poor management and adverse events combine to cause insolvencies. The following factors may contribute to insolvencies:

- Rapid premium growth
- Inadequate insurance rates and reserves
- Excessive expenses
- Lax controls over managing general agents
- Uncollectible reinsurance
- Fraud

Poor management is at the root of most of these factors. A combination of inadequate insurance rates and lax underwriting starts a deterioration in a book of business. If these problems are not detected and corrected promptly, the decline in the quality of the business accelerates.

Rapid premium growth precedes nearly all major insolvencies. Rapid growth by itself is not harmful, but it usually indicates bargain-basement insurance rates and lax underwriting standards. If insurance rates are inadequate and losses understated, net losses and capital deterioration rise faster than management can handle.

The rules governing an insolvent insurer's claim payments vary by state, but the following provides a general overview. An insurer that declares insolvency may be placed in liquidation and its assets and liabilities taken over by the state insurance commissioner. The insurance commissioner appoints a deputy receiver to gather the insolvent insurer's remaining assets. All funds payable to the insurer must be collected, including reinsurance and other debts and recoverables, agents' premium balances, and retrospective premium adjustments. The receiver notifies insureds, claimants, and other creditors of the liquidation order and provides proof of claim forms that must be returned by a specified date. The receiver determines whether to allow or disallow each claim and notifies the claimant. All debts and claims against the insurer (including claims for employee wages and administrative costs) are prioritized into classes. All claims for one class must be paid before payment of another class is allowed. Five to ten years can pass before losses are paid in insolvency. In most cases, those with claims are not paid the full amount of the loss. For example, the liquidator might offer forty-two cents on the dollar for property-casualty claims.

State **insurance guaranty funds** are another source for paying insolvent insurers' claims. The funds cover the unpaid claims of certain types of insolvent insurers licensed in the state. Insurers doing business in the state pay assessments to the fund. Insurance guaranty funds contract with claim representatives, such as independent adjusters, to handle the claims. The claim representative determines coverage, investigates the loss, and negotiates settlement as with any other claim.

Insurance guaranty funds
State funds that pay the claims of insolvent licensed insurers in the particular state.

Insurance Policy Regulation

Many states require that insurers file their policy forms with regulators for approval of policy language. Regulators scrutinize policy language with the goal of making insurance policies fair, clear, and readable so that consumers receive the coverage they expect from the policy. Some states require that insurers use prescribed policy language. Insurance policy regulation is considered necessary for the following reasons:

- *Insurance policies are complex documents.* Because most insurance policies are difficult to interpret and understand, regulating their structure and content is necessary.
- *Insurance policies are almost always drafted by insurers who sell them to the public on a take-it-or-leave-it basis.* Regulation can protect policyholders from policies that are narrow, restrictive, or deceptive.

Insurance policies are regulated through legislation and insurance departments' regulations, rules, and guidelines. Court decisions can also cause changes in policy language and forms. State insurance departments implement specific directives from the legislature or exercise the general authority they have to regulate insurance policies. Administrative rules and guidelines can be stated in (1) regulations communicated by the state insurance department to insurers, (2) informal circulars or bulletins from the same source, and (3) precedents set during the approval process. For example, the state insurance department might require specific wording in certain policy provisions or might notify insurers that certain types of policy provisions will be disapproved.

Although the courts do not directly regulate insurers, they clearly influence them by determining whether insurance laws are constitutional and whether administrative rulings and guidelines are consistent with state law. The courts also interpret ambiguous and confusing policy provisions, determine whether certain losses are covered by a policy, and resolve other disputes between insurers and policyholders over policy coverages and provisions.

Court decisions often lead insurers to redraft their policy language and to modify provisions. For example, based on the legal doctrine of concurrent causation, certain courts ruled that if a loss under a risk of direct physical loss (formerly "all-risks") policy results from two causes of loss, one of which is excluded, the entire loss is covered. As a result of this doctrine, insurers were required to pay certain flood and earthquake claims they had believed were excluded by their property insurance policies. Subsequent revision of the language in many such

property policies explicitly excluded coverage for flood and earthquake losses in cases in which an unexcluded cause of loss contributed to the loss.

Consumer Protection

Generally, all insurance regulatory activities seek to protect insurance consumers. But some activities are designed to *directly* protect consumers. For example, state insurance departments respond to consumer complaints, and they also provide information to consumers in publications, such as insurance buying guides, and information about claim handling practices.

In most cases, state insurance departments lack direct authority to order insurers to pay claims when facts are disputed. Such disputes are best resolved through the courts. However, most state insurance departments investigate and follow up on every consumer complaint, at least to the extent of getting a response from the insurer involved.

Through consumer complaint bureaus, regulators monitor the conduct of insurer employees and representatives who interact with customers. If necessary, these bureaus hear formal complaints. Most states have laws addressing unfair trade and claim practices, which are usually modeled after the NAIC's Unfair Claims Settlement Practices Act.

Many states calculate complaint ratios, and some make them readily available to consumers through the Internet. To help make consumers understand the cost of insurance, some states publish shoppers' guides and other forms of consumer information and may also post such information on the Internet. Consumers can obtain information provided by state insurance departments by linking to each state insurance department's Web site from the NAIC Web site.

Each state has licensing requirements for insurers domiciled (legally headquartered) in the state and for other insurers conducting business in the state. These requirements concern the insurer's financial strength, including whether the insurer has sufficient surplus to meet its obligation to pay losses.

Some states also require licensing for many of the people who sell insurance, give insurance advice, or represent insurers, including producers, insurance consultants, and claim representatives. Such licensing requires passing an examination on insurance law and procedures. Renewing a license often involves completing a specific number of continuing education hour in insurance or related subjects.

Insurance producers must be licensed in each state in which they do business. Insurance producers operating without a license are subject to civil, and sometimes criminal, penalties.

Traditionally, lack of uniformity among the states' licensing requirements has been a source of frustration and expense for producers licensed in more than one state. Provisions in the GLB Act have led to greater licensing reciprocity among states. Regulators' ultimate goal is to move beyond reciprocity and to resolve issues related to uniformity in producer licensing. Meeting this goal

will streamline the licensing process while retaining state regulatory authority over it.

States that issue a separate broker's license may use a different set of examinations than the ones used for other producers to test candidates' competence, or they may establish higher standards for the broker's license than for the agent's license. Some states require anyone taking the broker's examination to have been licensed agents for a specified period, such as two years.

Insurance consultants give advice and opinions about insurance policies sold in the state. Some states require insurance consultants to be licensed, and licensing requirements vary by state. Separate examinations are usually required for one to become an insurance consultant in both life-health insurance and property-casualty insurance.

Some states license claim representatives and adjusters because of the complex and technical nature of insurance policies and to protect claimants from unfair, unethical, and dishonest claim practices. Licensing also provides some assurance that claim representatives and adjusters are aware of prohibited claim practices and have minimum technical skills. Public adjusters, who represent insureds for a fee, are generally required to be licensed to ensure technical competence and to protect the public.

Another regulatory activity that protects consumers is monitoring market conduct. Sales practices, underwriting practices, claim practices, and bad-faith actions are market conduct areas that states regulate.

States have **unfair trade practices acts**, which specify certain prohibited business practices, to regulate the trade practices of the business of insurance as required under the McCarran Act. Unfair trade practices acts prohibit an insurer from using unfair methods of competition and engaging in unfair practices as defined in the acts. Most acts also authorize the insurance commissioner to decide whether activities not specifically defined in the law might result in unfair competition or might qualify as unfair trade practices. Currently, all U.S. jurisdictions and the District of Columbia and Guam have unfair trade practices acts.

Unfair trade practices acts
State laws that specify certain prohibited business practices.

Unfair trade practices cases can be decided by the commissioner of the state in which the activity occurred. An insurer that violates the unfair trade practices act is subject to one or both of the following penalties:

1. *Fine per violation.* The fine is often increased significantly if the activity is considered to be flagrant, with conscious disregard for the law.
2. *Suspension or revocation of license.* This usually occurs if the insurer's management knew or should have known that the activity was an unfair trade practice.

If an insurer disagrees with the commissioner's findings, it can generally file for judicial review. If the court agrees with the commissioner, the insurer must obey the commissioner's orders.

Producers are subject to fines, penalties, or license revocation if they engage in certain illegal and unethical activities. A producer may be penalized for engaging in practices, such as the following, that violate the state's unfair trade practices act:

- *Dishonesty or fraud.* A producer may embezzle premiums paid by policyholders or may misappropriate claim funds.
- *Misrepresentation.* A producer may misrepresent the losses that are covered by an insurance policy, which may induce a client to purchase that policy under false pretenses.
- *Twisting.* A producer may induce a policyholder to replace one policy (usually life insurance) with another, to the insured's detriment. This is a special form of misrepresentation.
- *Unfair discrimination.* A producer may engage in any number of acts that favor one insured unfairly over another.
- *Rebating.* A producer may engage in rebating, which is the practice of giving a portion of the producer's commission or some other financial advantage to an individual as an inducement to purchase a policy. Rebating is currently illegal in all but two states. The practice is especially problematic with life insurance policies for which the producer's first year's commission is sizable. If a producer rebates part of the commission to one policyholder but not to another, that act is considered unfair discrimination. If the producer rebates the same percentage of the commission to all policyholders, the act is not unfairly discriminatory, but it is still illegal.

Insurance regulators are concerned that improper underwriting could result in insurer insolvency or unfair discrimination against an insurance consumer. To protect consumers, insurance regulators do the following:

- *Constrain insurers' ability to accept, modify, or decline applications for insurance.* To increase insurance availability, states often require insurers to provide coverage for some loss exposures they might prefer not to cover.
- *Establish allowable classifications.* Regulators limit the ways in which insurers can divide consumers into rating classifications. For example, unisex rating is required in some states for personal auto insurance. This promotes social equity rather than actuarial equity.
- *Restrict the timing of cancellations and nonrenewals.* All states require insurers to provide insureds with adequate advance notice of policy cancellation or nonrenewal so that insureds can obtain replacement coverage. Insurers are typically allowed to cancel or nonrenew only for specific reasons.

Typical violations that are discovered during market conduct examinations of an insurer's underwriting function include the following:

- Discriminating unfairly when selecting loss exposures
- Misclassifying loss exposures
- Canceling or nonrenewing policies contrary to statutes, rules, and policy provisions

- Using underwriting rules or rates that are not on file with or approved by the insurance departments in the states in which the insurer does business
- Failing to apply newly implemented underwriting and rating factors to renewals
- Failing to use correct policy forms and insurance rates
- Failing to use rules that are state specific

All states prohibit certain claim practices by law. Apart from regulatory penalties, failure to handle claims in good faith can lead to claims for damages, alleging bad faith on the insurer's part.

Unfair claim practices acts prohibit unethical and illegal claim practices. The acts generally are patterned after the NAIC Model Unfair Claims Settlement Practices Act. Prohibited insurer claim practices typically include the following:

Unfair claim practices acts
State laws that prohibit unethical and illegal claim practices.

- Knowingly misrepresenting important facts or policy provisions
- Failing to properly investigate and settle claims
- Failing to make a good-faith effort to pay claims when liability is reasonably clear
- Attempting to settle a claim for less than the amount that a reasonable person believes he or she is entitled to receive based on advertising material that accompanies or is made part of the application
- Failing to approve or deny coverage of a claim within a reasonable period after a proof-of-loss statement has been completed

The NAIC Model Act and state unfair claim practices laws are more fully discussed in a later chapter. Strict regulatory controls on claim practices protect policyholders. Unfair claim practices tarnish the offending insurer's image and reputation, erode public confidence in the insurance industry, and deny claims to policyholders' detriment.

Valid and legitimate claims should be paid promptly and fairly with a minimum of legal formality. Conversely, paying fraudulent claims submitted by dishonest insureds should be vigorously resisted, and paying excessive claim settlements should be avoided.

In some cases, courts have ruled that an insurer's improper claim handling constitutes not only a breach of contract but also an independent tort (civil wrong), the tort of bad faith. **Bad faith** is a breach of the duty of good faith and fair dealing. An insurer that violates good-faith standards can be required to honor the policy's intent (by paying the claim) and pay extracontractual damages for emotional distress and attorney fees. These extracontractual damages—damages above the amount payable under the terms of the insurance policy—are payable by the insurer. Legal remedies for bad-faith actions can lead to both first-party actions (involving the insured) and third-party actions (involving the claimant).

Bad faith
A breach of the duty of good faith and fair dealing.

SUMMARY

Individuals and organizations can use several techniques to manage the risk of potential financial loss. How someone manages risk is often determined by whether the risk is a hazard ri k or a bu iness risk. Hazard risk is the risk from accidental loss, including the possibility of loss or no loss. Business risk is inherent in the operation of a particular organization, including the possibility of loss, no lo s, or gain.

Risk can be controlled or financed. Insurance is a risk-financing technique; it transfers risk from people and organization to insurers. This transfer is feasible because a large group of individual risks are pooled, and individual premiums contribute to a pool of money that is used to pay losses for the few who actually uffer them. The many other contributors who do not suffer a loss benefit from peace of mind, knowing that they are protected from potentially devastating financial loss.

In addition to payment for losses and peace of mind, insurance provides the benefits of support for loans, fund for loans and investments, loss control, efficient use of resources, reduction of social burdens, atisfaction of legal and bu·iness requirements, employment, and tax revenue. Insurance has costs, as reflected in premium payments. Indirect costs of insurance include opportu- nity co ts, increa ed litigation, and the moral and morale hazards associated with losses.

In addition to claim departments, insurer have other functional areas, such as marketing and sales, underwriting, loss control, reinsurance, actuarial, finance and accounting, and information technology, which enable the insurer to obtain business and fulfill its policy obligations.

Claim departments can be found in insurance companies, in large businesses, in third-party admini trator (TPAs), and in the offices of large agents and brokers. A senior claim executive is usually in charge of a claim department, which may also have several mid-level executives and several office locations staffed with claim representatives who directly handle claims.

Claims are handled by insurance company claim representatives, independent adjusters, TPAs, producers with claim settlement authority, and public adjusters, who act on behalf of the insured.

Claim department performance can be measured by mathematical means such as lo s ratio. It can also be measured qualitatively through the use of best prac- tices, claim audits, and customer service compliments and complaints. These performance measures are often tied to insurance regulations.

Insurance operations are closely regulated by states. Only a few federal laws and federal court cases regulate insurance operations. The McCarran-Ferguson Act preserved the structure of existing state insurance regulation but al o clarified the federal government's power to assume regulatory duties in the absence of state regulation. The Insurance Fraud Protection Act protects

consumers and insurers against insurer insolvencies resulting from fraud. The Gramm-Leach-Bliley Act preserves the states' primary regulatory authority for all insurance activities but prohibits state actions that would prevent bank-related firms from selling insurance on the same basis as insurance producers.

The National Association of Insurance Commissioners (NAIC) was established to encourage coordination and cooperation among state insurance departments. The NAIC drafts model laws and regulations that state legislatures may adopt as written or modify as they see fit. The organization has no direct regulatory authority in any of the states or countries it serves.

State insurance departments regulate insurance through rate regulation, solvency surveillance, and consumer protection. Rates must be adequate, not excessive, and not unfairly discriminatory. Most states have laws addressing unfair claim practices that are modeled after the NAIC's Unfair Claims Settlement Practices Act.

Understanding why people and businesses buy insurance and how insurance companies are structured and regulated provides the context for the next chapter's discussion of the claim handling process.

CHAPTER NOTES

1. The combined ratio discussed here is called the *statutory basis combined ratio*. Another version of the combined ratio, called the *trade basis combined ratio*, uses written premium rather than earned premium as the denominator for the expense ratio. The trade basis combined ratio is used more for underwriting purposes than for claim purposes.
2. *Paul v. Virginia*, 8 Wall. 68, 438 U.S. 531 (1869). A Virginia law required licenses for out-of-state insurance companies, and another required licenses for anyone acting as an agent for an out-of-state insurance company. Samuel D. Paul, a Virginia attorney, wanted to test the constitutionality of the laws. Several New York companies appointed Paul as their agent in Virginia. Paul's application for a license in Virginia was rejected because the insurers he represented had not deposited the bonds required by the law. Paul continued to write business, and he was indicted, convicted, and fined. He appealed on the basis that the U.S. Constitution forbids state governments from obstructing interstate commerce, and he argued that insurance is interstate commerce. The Supreme Court disagreed, holding that because an insurance policy is not an article of interstate commerce, the business of insurance is not interstate commerce, and, therefore, the states had the authority to regulate insurance.
3. *U.S. v. SEUA*, 322 U.S. 533 (1944). The SEUA was a rating bureau in Atlanta owned by 200 private fire stock insurance companies. In 1942, the Justice Department charged the SEUA and nine of its member insurance companies with restraint of trade in violation of the Sherman Antitrust Act. According to the Justice Department indictment, the companies that made up the SEUA controlled over 90 percent of the fire insurance business in six southern states. The case was dismissed at the federal district court level. On appeal, the U.S. Supreme Court ruled that insurance is commerce and is subject to federal antitrust laws.

4. 18 U.S.C. §1033 (1994).
5. Ann Monaco Warren and John William Simon, "Dishonesty or Breach of Trust in 18 U.S.C. §1033: Are *You* Criminally Liable on the Basis of an Associate's Record?" *FORC Quarterly Journal of Insurance Law and Regulation*, vol. 10, ed. III, September 12, 1998.