6 – The Claims Function

**1- Overview of the claims Function**

**Objective**: Explain how an insurer’s claim function achieves its primary goals, provides valuable information to other departments, and interacts effectively with its outside contacts

An insurer’s claims function must fulfill its responsibility to the insured and pay covered claims while also supporting an insurer’s financial goals.

An insurer’s success is greatly influenced by the proper and efficient performance of its claims function. The claims function generates a vast amount of information that is essential to an insurer’s marketing, underwriting, and actuarial departments. Because claims personnel are among the most visible of the insurer’s employees, they must be able to effectively interact with individuals inside and outside of the insurance organization.

**Claims Function Goals**

When establishing goals for the claims function, senior management should recognize the effect the claims function has on both the insurance customer and the insurer itself. The claims function has two primary goals:

* Complying with the contractual promise of the insuring agreement to pay, defend, or indemnify in the event of a covered loss is fulfilled; and
* Supporting the insurer’s financial goals

**Complying with the Contractual Promise**

**The first goal of the claims function is to satisfy the insurer’s obligation to the insured as set forth in the insurance policy. Following a loss, the promise of the insuring agreement to pay, defend, or indemnify in the event of a covered loss is fulfilled.**

The insurer fulfills this promise by providing fair, prompt, and equitable service to the insured, either **(1) directly, when the loss involves a first-party claim made by the insured against the insurer, or (2) indirectly, by handling a third-party claim made by someone against the insured to whom the insured might be liable**.

From the insurer’s perspective, claims are expected, and claims representatives must deal with them routinely. For the individuals involved, the loss occurrence and its consequences are not routine and can be overwhelming. Claims representatives, therefore, routinely deal with insureds and claimants in stressful situations. A claims representative should handle a claim in a way that treats all parties involved fairly and equitably, and do so in a timely manner.

**Supporting the Insurer’s Financial Goals**

**The second goal of the claims function is supporting the insurer’s financial goal**. Achieving this goal is generally the responsibility of the marketing and underwriting departments. However, it would be shortsighted not to recognize the role of the claims function in helping insurer achieve an underwriting profit by controlling expenses and paying only legitimate claims.

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

By overcompensating an insured or a claimant, the insurer unnecessarily raises the cost of insurance for all of its insureds. Overpaid claims can lower insurer profits and result in higher policy premiums.

Conversely, underpaid claim can result in dissatisfied insureds, litigation, or regulatory oversight. Insureds and claimants who believe they are being treated fairly are likely to accept a settlement offer, if they feel they are treated unfairly, they might sue the insurer or file a complaint with the state insurance dept.

An insurer’s success in achieving its financial goal is reflected in its reputation for providing the service promised. A reputation for resisting legitimate claims can undermine the effectiveness of insurer advertisements or its goodwill earned over the years. **The two goals of the claims function work together to help bring about a profitable insurance operation**.

**Claims Information Users**

The claims function provides valuable information to other insurer departments. The three primary recipients of claims information are the marketing, underwriting, and actuarial departments.

**Marketing**

**The Marketing Department needs information about customer satisfaction, timeliness of settlements, and other variables that assist in marketing the insurance products.**

Producers must be prepared to explain any premium changes and changes to policy provisions to their insureds. Producers must have insured loss information to prepare renewal policies properly because many commercial policies are subject to rating plans that affect the policy premium, based partly on the insured’s loss experience. In personal insurance, personal auto policies might be surcharged when property damage claims are paid during the policy year. Additionally, claims personnel often inform producers of court rulings that affect the insurer’s loss exposure or pricing, such as interpretations of policy exclusions or application of limits.

**Underwriting**

The insurance business operates effectively if underwriters accept loss exposures that are likely to experience only the types and amounts of losses anticipated in the insurance rates. IF underwriters accept loss exposures that experience more losses than anticipated, the rates charged by the insurer will be inadequate, and the insurer could become financially insolvent. Claims personnel help underwriters in this regard by ensuring that claims are paid fairly and according to the policy. Proper, consistent, and efficient claims handling enables underwriters to evaluate, select, and appropriately price loss exposures based on consistent claims costs.

**When claims representatives inspect accident scenes in homes or at work sites as part of the claims investigation, they sometimes notice loss exposure characteristics, either negative or positive, that were not readily apparent in the insurance application. When claims representatives report such findings to the underwriter, the underwriter may adjust the premium or take other actions to accommodate the difference in the exposure**. For example, they may cancel coverage or renew it only if the insured implements corrective measures. Alternatively, they may grant a premium credit based on an above average loss exposure.

A number of similar claims may also alert underwriting management to a problem of a particular type or class of insured. These might be the result of new processes or technologies being used by the class of insureds as a whole. Example, some roofing contractors might have tried to speed the process of replacing composite roofs my moving the tar smelter to the roof a the structure being repaired. This might have caused a number of fire losses. An adverse court ruling could also cause the loss experience of a class of business to deteriorate or could increase the number of claims presented.

**Actuarial**

*Actuaries need accurate information not only on losses that have been paid but also on losses that have occurred and are reserved for payment, collectively called incurred losses.* Loss reserves can be increased or decreased as the claim develops, and reserve change reports help actuaries more accurately predict loss development*. Incurred loss information helps actuaries establish reserves for incurred by not reported (IBNR) losses an project the development of open claims for which the reserves might change substantially before the claim is finally settled*.

In addition to incurred loss information*, actuaries need accurate information on loss adjusting expenses and recoverable amounts associated with claims, such as salvage and subrogation, any ceded reinsurance recoverable, and deductibles (*when the insurer pays an entire claim and then asks the insured to reimburse the deductible amount).

*All of the claims information that actuaries collect from claims personnel must be accurately represented through appropriate reserving methods in the insurer’s financial statements*. Actuaries must update these statements for reporting at various times during the year. **When claim payments are recorded accurately and realistic reserves are set in the insurer’s claims processing system, then the raw data that actuaries use to develop rates will be accurate and the rates will reflect the insurer’s loss experience**.

**Claims Department Contacts**

Other than the producer, Claims Department personnel are the contacts within the insurer who are most visible to the public. Therefore, the Claims Department must interact effectively with outside contacts, such as the public, lawyers, and state regulators.

**The Public**

Although many insurers have a Public Relations Department that handles advertising, **the insurer’s public image is determined largely by the Claims Department’s behavior.**

**Because the claims representative is an insured’s and a claimant’s primary contact with the insurer, claims service significantly affects an insured’s or a claimant’s satisfaction with an insurer. The claims representative’s skill at communicating directly with claimants influences their satisfaction with the insurer**.

Claims representatives must empathize with claimants to interact effectively with them because most claimants suffer some type of emotional reaction to a loss, which may include anger, depression, frustration, or hopelessness.

Most claimant’s knowledge of insurance is less sophisticated than that of an insurance professional. Claims representatives must be prepared to explain the policy’s claims provisions to the claimant as those provisions apply to the claimant’s property damage or injury. A well-prepared, professional claims representative who empathizes with the claimant will gain the claimant’s confidence and increase the likelihood of reaching a mutually agreeable settlement.

Technological improvements have allowed many insurers to improve the quality and speed of their claims service. From cell phones and the internet growing to wireless technologies, the claims process has been streamlined and improve customer satisfaction. In catastrophe losses, Satellite transmissions and other modern communication devices used in wireless technology may overcome these problems to enable continued electronic communications and ultimately, faster and better customer service for claimants when they need it most.

**Lawyers**

For certain types of claims and in certain areas of the US, claimants are more likely to hire lawyers, often leading to costly litigation. Although legal representation can result in higher payment by the insurer, representation does not necessarily result in higher settlements for claimants, because claimants must pay expenses and legal fees from settlement. Legal representation does not guarantee a faster settlement. **Even if litigation ensues, claim representatives should continue to interact in a cordial, professional manner with claimant’s lawyers.**

**When an insurer needs a lawyer either to defend the insured or to defend itself, it will typically hire a lawyer from the jurisdiction in which the claim is submitted. The lawyer will provide advice regarding specific losses and legal issues. Claims representatives will assist the insurer’s lawyers as needed by sharing claim details and assembling information that supports the insurer’s legal position**.

**State Regulators**

**State insurance regulators monitor insurer’s activities in the claims handling process. Regulators exercise controls by licensing claim representatives, investigating consumer complaints, and preforming market conduct investigations. Enforcement is usually handled through the Unfair Claims settlement Practices Act or similar legislation**.

Not all states currently license claims representatives, and not standard procedure or uniform regulation exists for those that do.

State regulators also handle customer complaints made against an insurer. Most states have specific time limit within which the insurer must answer or act on inquiries from the Insurance Department. Failure to respond can result in expensive fines and even in the loss of the claims representative’s-or his or her employer’s-license.

*Insurance regulators periodically perform market conduct investigations either as part of their normal audit of insurer activities or in response to specific complaints. The typical market conduct audit includes more than just claims practices; it audits all departments that interact directly with insureds and claimants*.

**2 – Claims Department Structure, Personnel, and Performance**

**Objective**: Examine how Claims Department results can be optimized by: Department Structure; The Types and Functions of Claims Personnel; Claims Performance Measurements

Information generated by a Claims Department, including about loss payments and expenses, is essential to marketing, underwriting, and pricing insurance products. In this way, the claims function is crucial to fulfilling an insurer’s promise to pay covered losses, creating an accompanying need for an insurer’s Claims Department to operate efficiently. The claims department can be optimized by its structure, personnel, and performance measures.

**Claims Department Structure**

An insurer’s Claims Department can be organized in several ways. Usually, a senior claims officer heads the Claim Department and reports to the chief executive officer (CEO), the chief financial officer, or the chief underwriting officer. The senior claims officer may have staff located in the same office. This staff often makes up the home office Claims Department. Within this area, any number of technical and management specialists can provide advice and assistance to remote claims offices and claims representatives.

The senior claims officer may have several claims offices or branches countrywide or even worldwide.

Regional claims officers may have one or more branch offices reporting to them. Each branch office could have a claims manager, one or more claims supervisors, and a staff of claims representatives. Similar department structures are adopted by third-party-administrators (TPAs).

**Claims Personnel**

Claims personnel are among the most visible employees of an insurer and must therefore be able to interact will with a variety of people.

A claims representative fulfills the promise to either pay the insured on or behalf of the insured by handling claims when losses occur. People who handle claims may be staff claims representatives, independent adjusters, employees of TPAs, or producers who sell policies to insureds. Public adjusters also handle claims by representing the interests of insureds to the insurer.

**Staff Claims Representatives**

Staff Claims representatives are employees of an insurer and handle most claims. They may include inside claims representatives, who handle claims exclusively from the insurer’s office, and field claim representatives, who handle claims both inside and outside the office.

**Independent Adjusters**

**Independent adjusters are claims representatives with whom insurers contract to handles claims in strategic locations, to meet increased service demand, or when special skills are needed.**

**Third-Party Administrators**

Self-insured businesses may contract with TPAs, who handle claims, keep claims records, and perform statistical analyses. TPAs are often associated with large independent adjusting firms or with subsidiaries of insurers.

**Producers**

Producers can function as claims representatives for certain claims. The term “producer” includes agents, brokers, sales representatives, and intermediaries who place insurance with insurers. Insurers may allow producers the authority to pay claims up to a certain amount. Those producers can issue claim payments, called drafts, directly to insureds for covered claims, thus reducing an insured’s wait time.

**Pubic Adjusters**

**A public adjuster is an organization, or a person hired by an insured to represent the insured in a claim in exchange for a fee. In general, the public adjuster prepares an insured’s claim and negotiates the settlement with the staff claims representative or independent adjuster**.

**Claims Performance Measures**

Because Claims Department members have diverse roles and are spread over a wide geographic area, insurers face special issues when it comes to evaluating and measuring the performance of their Claims Department staff.

Insurers are in business, so they must make a profit to survive. Claims departments play a crucial role in insurer profitability by paying fair amounts for legitimate claims and providing accurate, reliable, and consistent ratemaking data. **Because paying claims fairly does not conflict with insurer profit goals, an insurer measures its claims and underwriting department’s performance using a loss ratio, which is a profitability measure. Loss Ratio is a ratio that measures losses and loss adjustment expenses against earned premiums and that reflects the percentage of premiums being consumed by losses**.

**In addition to reaching profit goals, an insurer strives to ensure that its Claims Department meets quality performance goals by internally identified best practices, claims audits, and customer satisfaction data**.

**Profitability Measures**

**A loss ratio is one of the most commonly used measures for evaluating an insurer’s financial well being. It compares an insurer’s losses and loss adjustment expenses LAE (expenses that the insurer incurs to investigate, defend, and settle claims according to the terms specified in the insurance policy) with its collected premiums and reveals the percentage of premiums being consumed by losses**.

An increasing loss ratio could indicate that the insurer is improperly performing the claims function. Increasing losses could also mean that the Underwriting Department elected to cover loss exposures that were more costly or occurred more frequently than it estimated or that the Actuarial Department failed to price the insurer’s products correctly.

When an insurer’s loss ratio increases, the Claims Department, along with other functions, is pressured to reduce expenses. Claims representatives could quickly reduce LAE in the short term by offering the settlement payments insureds and claimants demand rather than spending resources on investigating and calculating and negotiating fair payments.

**To reduce LAE in the long term, inflated settlement demands should be resisted; researched; negotiated; and if necessary, litigated. LAE can also be reduced by making sure that claims procedures are always property performed by claims representatives**.

Quality Measures

Three frequently used tools provide quality measures for evaluating a Claims Department’s performance: Best practices, claims audits, and customer satisfaction data.

In a claims department, the term “best practices” generally refers to a system of identified internal practices that producer superior performance. Best practices are usually shared with every claims representative. An insurer can identify best practices by studying its own performance or the performance of similar successful insurers. They are often based on legal requirements specified by regulators, legislators, and courts (such as time frame for initial contact 24 hours).

Insurer use claims audit to ensure compliance with best practices and to gather statistical information on claims. A claims audit is performed by evaluating information on a number of open and closed claims files. Claims audits usually have both quantitative and qualitative 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 open/closed each month | Litigation cost management |
| Number of files reopened each month | Proper releases taken |
| Percentage of subro recovery | Correct coverage evaluation |
| Average settlement value by claim types | Good negotiation skills |

The quality of Claims Department performance is also measured by customer satisfaction. Claims supervisors and managers monitor correspondence they receive about the performance of individual claim representatives. While complaints are usually acknowledged, supervisors or managers must respond to complaints. Claims Departments have procedures for responding to complaints, which can come directly from insureds, claimants, or vendors or be submitted by the state insurance department. No matter the source, complaints must be investigated by management and responded to in a timely manner. Complaints may indicate legitimate service issues. They can indicate if there are problems with a particular claims representative, supervisor, or manager.

**3 – Measures Used to Ensure Regulatory Compliance**

**Objective**: Examine how the following measures are used to ensure regulatory compliance: Claims guidelines policies, and procedures; Controls; Supervisor and manager reviews; Claims audits

Insurers institute compliance measures, which are various guidelines that insurers ask personnel to use or other actions that they take to ensure that legal and regulatory requirements are met and to promote good-faith claims handling practices.

A combination of compliance measures helps insurers enforce good-faith claims handling; encourages claims personnel to provide complete and accurate information to management, producers, reinsurers, lawyers, insureds, claimants, and others; and make the insurers operation run efficiently and with sound expense management.

**Claims Guidelines, Policies, and Procedures**

Some insurers have claims guidelines, which are policies and procedures that serve as compliance measure. Claims guidelines specify how certain claims handling tasks should be performed by setting policies and procedures for claims handling. Such as when to assign an IA.

Steps for performing some tasks can be clearly specified in claims guidelines so that claims personnel ensure that information is accurate and that claims are handled properly and in good faith. **Claims departments can use guidelines in training new personnel because they provide instruction for performing tasks properly. They are also useful as a reference for performing infrequent tasks or when one employee must perform another employee’s duties because of vacation, illness, or another absence.**

**Claims guidelines, policies and procedures can also be when an insurer must defend a bad-faith lawsuit**. Evidence that good-faith claims handling procedures were prescribed and followed demonstrates that the insure takes measures to help guarantee good-faith claims handling.

Supervisors and managers often use diaries as reminders to review claim files or perform another activity. A diary, or suspense, is a system to remind claims personnel to perform a particular task on a claim.

**An activity log is a record of all the activities and analyses that occur regarding a particular claim. Claims representative who rely on their memories to recall all the activity on a claim are likely to forget important information. A claim file should speak for itself so that anyone reading the activity log and other documentation knows exactly what has occurred. Claims representatives should carefully document every activity on a claim**.

Activity logs are also useful in claims audits. Producers are sometimes interested in the details of how a claim was handled, and claims personnel can review activity logs to provide those details.

**Controls**

Claim departments can use various electronic controls as compliance measures, such as claims reports, access security, authority levels, and claim information tracking systems.

*Claims information systems can be used to generate periodic claims reports. Claims representatives, supervisors and managers review those reports to ensure that claims have been entered correctly*. Such information on these reports might include:

* Claims with reserves above a specified amount
* Claims assigned to independent adjusters
* Claims in litigation
* Claims closed by agents
* Claims with reserve changes larger than a specified amount
* Claims closed without payment by a claim representative

Reports help insurer personnel monitor claims practices by indicating possible errors. If claims personnel mistakenly entered a $10K reserve as a $100K reserve, the daily report would alert management to the error and it could be corrected before it affected reports produced for parties outside the insurer and agents’ commission calculations.

*Reports of claims assigned to independent adjusters can help an insurer meet corporate goals for expense management. The report may indicate that a staff claims representative should be assigned to a different territory to reduce independent adjusting expenses. Similarly, claims in litigation can be reviewed to ensure that legal expenses are managed prope*rly.

**Access Security refers to an individual’s ability to review, enter, and change information in a claims information system. These limit access to claims information using 3 methods:**

* **The first method of access security requires a person attempting to access claims information to enter a password maintained by the Information Systems Department**
* **The second method of access security restricts access to certain data in the claims information system to managers only**
* **The third method of access security prevents unauthorized individuals from changing crucial information in the claims information system, such as reserve amounts or claims codes**

Authority levels restrict claims personnel from making changes in claims information that exceed their authority and are described next. Authority levels refer to reserve amounts and payments that claims personnel are allowed to set and make. Authority level is a dollar amount assigned to claims personnel to limit the reserves amounts they can set and the payment amounts they can make. *Authority levels help control claims in several ways. First, if a claim requires high reserves or payments, authority levels ensure that experienced, qualified personnel handle those reserves or payments. Second, if inexperienced claims personnel enter a reserve amount or payment inaccurately and the inaccurate amount exceeds their authority level, the claims system prevents the error*.

Claims information tracking systems can be designed to automatically capture information such as the date a reserve was changed, the name of the individual who made the change, the date a payment was requested, and the name of the individual that made the request. Tracking systems discourage fraud and are useful for identifying training needs.

**Supervisor and Manger Reviews**

In addition to the various claims guidelines and controls, supervisor and manger reviews are another type of compliance measure that insurers can use. Supervisors and mangers use diary systems as reminders to review claims. During a review they might check the claims codes, reserves, and payments entered for the claim. They might review the claim representative’s reports to the file, the activity log, and other file documentation. The supervisors and mangers might detect errors that can be corrected.

The review also allows supervisors and managers to coach claims representatives on how to handle claims, on additional investigation that might be needed, and on negotiation or settlement approaches. This review is essential to helping claims personnel learn how to improve job performance.

**Claims Audits**

Most insurers use claims audits as a type of compliance measure. Claims audits are a review of claim files, both paper and electronic to ensure that claims are being handled properly. Claims audits can be conducted by an insurer’s internal personnel or by others.

Internal claims audit is a review of claim files conducted by an insurer’s staff to examine the technical details of claim settlements; ensure that claims procedures are followed; and verify that appropriate, thorough documentation is included. Generally, internal claims audits are conducted by claims personnel, but they might also be conducted by personnel from other departments such as accounting, underwriting, or human resources and training.

*An actuary might review claim files to examine how reserves are set, how frequently they are changed, and how accurate the initial reserves were compared to the final settlement amount*. If reserves were habitually lower than the amount of the final claim settlement, the actuary might increase total reserves beyond the amounts set by the claims department. Such a change would help ensure that total reserves for all claims are adequate to maintain the insurer’s financial condition.

*The underwriting department might audit claim files to see the kinds of claims that are being reported; how much is being paid for those claims; and what, if any, coverage or underwriting standards should be changed to address those claims*.

Human resources and training might audit claim files to identify training needs for the Claims Department.

Internal claims audit might also be conducted to ensure that employee fraud is not occurring. In addition, if employees know that claims will be audited, it might deter them from committing fraud.

**External Claims audits** are claim file review conducted by someone other than an insurer’s own employees. External claims audits are conducted to review overall claims handling practices; to review reserves and other technical details of claims settlement; to investigate consumer complaints; to ensure that claims procedures were followed; and to verify that appropriate, thorough documentation was included.

**State insurance regulators might conduct a claims audit to review and insurer’s claims handling practices. The purpose of the review is to determine whether an insurer is violating any unfair claim settlement practices acts or laws an whether the insurer routinely engages in any illegal claims handling practices.**

Many state regulators are interested in insurers’ reserving practices because adequate reserves are crucial to insurer’s financial condition. This information can be found in the insurer’s annual financial statements however, if regulators need additional information, they may conduct an audit to review the reserving practices.

Insurance advisory organizations such as ISO and AAIS are also interested in insurer’s reserves but rarely conduct a claim audit to study reserves or reserving practices. Instead they rely on information in the insurer’s Annual Statements.

**4 – The Claims Handling process**

**Objective**: Describe the activities in the claims handling process

**To ensure that every claim is handled property, the claims representative must follow a systematic claims handling process:**

The claims handling process begins when the insured reports the loss to the producer or directly to the insurer’s claim center. Once a loss notice has been received and the associated information has been entered into the insurer’s claims information system, the insurer begins the claims handling process. The claims activities are not always sequential. Depending on the severity and complexity of the claim, the process may be completed quickly, or may take months or even years.

**Acknowledging and Assigning the Claim**

Generally, the first activity the insurer in the claims handling process involves two functions – acknowledging receipt of the claim and assigning the claim to a representative. The acknowledgment provides the name and contact information of the assigned claims representative and the claim number. Insurers acknowledge claims in a timely manner to comply with insurance regulations.

Insurer use different methods of assigning claims to claim representatives. Some assign claims based on territory, type of claim, extent of damage, workload, or other criteria contained in the insurer’s claim information system**. The goal is to assign the claim to a claims representative who possess the appropriate skills to handle it**.

**After receiving the claim assignment, the claims representative contacts the insured, and possibly the claimant, to acknowledge the claim assignment and explain the claim process. For some types of losses, the claims representative may give the insured instructions to prevent further loss. If the claim involves property damage, the claim representative may arrange a time to inspect the damage or the damage scene. Or advise the insured or claimant that an appraiser or n independent adjuster will be in contact to inspect the property damage**. If the claim involves bodily injury, the claims representative should get information about the nature and extent of the injury.

Blockchain can assist in processing claims and can make the claims handling process quicker and more cost effective through the use of smart contracts. Sensors or telematics in a car involved in an accident can provide the first report of loss to the insurer while simultaneously notifying recommended repair shops and alerting the insured of next steps.

**Identifying the policy**

**Usually, the claim representative first identifies the policy under which the claim has been made upon receiving the assignment in order to determine what types of coverage apply to the loss and who is an insured and who has an insurable interest? what property is insured, where is it insured, and when is it insured? What are the covered causes of loss?** **If it is apparent from the loss notice that coverage may not be available for the loss, the claims representative must notify the insured of this concern through a non-waiver agreement or a reservation of rights letter**.

**Claims representative may also establish a claim or case (loss reserves), often in conjunction with identifying the policy. Setting an initial reserve(s) usually occurs early in the claim handling process. Setting accurate reserves is an important part of the claims representative’s job. Establishing and maintaining adequate reserves is important for the insurer’s financial stability because reserves affect the insurer’s ability to maintain and increase business.**

**Setting Accurate Reserves can be difficult** – after the claim rep receives notice of a loss, obtains initial information and verifies coverage, a loss reserve is established**. Complex claims are often difficult to estimate, especially liability claims.** Assume for example that an insured was involved in a serious accident that two persons in the other car were hospitalized with sever injuries. The cause of the accident is not immediately clear because of conflicting testimony of witnesses, and it is difficult to determine whether the insured is responsible for the accident. What case reserve should be established?? The amount eventually paid because of this accident could range from nothing (if the insured is not found to be legally responsible) to hundreds of thousands of dollars (if the insured is responsible). The eventual payment on this particular claim, which may not be made for several years, can vary significantly from the original reserve.

**Contacting the Insured or the Insured’s Representative**

*Initial contact occurs soon after the loss is assigned to the claims representative and initial reserves are established, usually established in the insurer’s claims guidelines*. **The adjuster can prepare for it by compiling a list of questions to ask and preparing instructions for explaining how the claim will be handled and what actions the insured should perform.** Once contact is made the claims representative take these actions:

* Inform the insured of what is required to protect damaged property and to document the claim (example, if it is a washing machine that failed causing water damage, has it ever been repaired (or hose replacement), you would request information
* Describe the claims inspection, appraisal, and investigation process (arrange inspection)
* Tell the insured what additional investigation is needed to resolve potential coverage issues
* Explain potential coverage questions or policy limitations or exclusions, and obtain a nonwaiver agreement when necessary
* If medical and wage loss information is part of the claim, obtain the necessary authorizations
* Explain the amount of time it will take to process and conclude the claim
* Supply the insured with a blank proof of loss form for property damage and any necessary written instructions so that the insured can document the claim.

**Investigating the Claim**

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

Determine the dollar amount of the loss, what are the insured’s duties after a loss?

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

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

**Documenting the Claim**

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

Because claims representatives simultaneously handle many claims, they must have a system for working on and reviewing each claim. Whether this system is called a diary system, a suspense system, or a pending system, the purpose is the same. The system allows the claims representative to work on a claim one day and then diary it or calendar it for review.

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

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

File reports to various parties are developed by claim reps to document claim activity.

* Internal reports – for parties within the insurance organization who have an interest in large losses of loss of a specific nature such as death, disfigurement, or dismemberment
* Preliminary reports – acknowledge that the claim rep received the assignment, inform the insurer about initial activity on the claim, suggest reserves, note coverage issues, request assistance if needed
* Status reports – periodically report the progress of the claim, recommend reserve changes, settlement authority, or assistance
* Summarized reports – detailed narratives that follow an established format with captioned headings that give them structure, usually filed within 30 days
* External reports – containing information collective by claim reps to inform producers, some states’ advisory organizations, and other who have an interest in the claim about details of the losses amount paid and amount in outstanding reserve

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

Claim reps use the information gained about a claim during their investigation to determine the cause of loss, and the loss amount. **The facts of the loss determine the cause of loss**. For example, in a fire the claim rep may find that a toaster caused the fire. In a liability claim, the claim rep determines liability on the facts of the case. Statutory and case law on negligence determine liability of the parties involved.

**The adjuster should make diagrams of the damaged areas and take photos of the damage to the structure, furnishing, as well as any other evidence that supports (or negates) the loss description. Follow up for verifying the values of the personal property, for comparison with the damaged inventory, and with the estimates for repair or replacement of any equipment. This may include checking a personal property database for like and kind replacement of the property and printing the documentation for inclusion in the claim file. If the equipment can be repaired, determine if payment will be to repair or replace. Confirm that all the receipts and estimates, and then calculate the loss amounts accordingly.**

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

**Concluding the claim**

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

**Payments**

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

**Claim Denial**

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

Once authority to deny the claim has been given the claim rep must prepare the denial letter as soon as possible. Usually sent by certified mail. Some are sent by regular mail, marked “personal and confidential”. These procedures help ensure that the denial letter reaches the correct party, and they provide documentation the it was received.

**Alternative Dispute Resolution**

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

* **Mediation – neutral 3rd party examines the issues and develop a mutually agreeable settlement**
* **Arbitration – neutral 3rd party to examine issues and develop a settlement – binding**
* **Appraisal – method to resolve an issue over the amount owed on a loss**
* **Mini-trial – abbreviated version of trial and offers opinions based on evidence presented**
* **Summary jury trial – similar to mini trial but panel of mock jurors decide the case**

Despite the variety of ADR methods, many cases are concluded through litigation. Litigation can occur at almost any point during the life of a claim. However, it occurs most often when the parties to the claim are unable to reach and agreement by negotiation or ADR, or when a claim is denied. ADR reduces, but does not eliminate, the possibility that a claimant will sue and take a case to trial.

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

**Closing Reports**

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

*Claims supervisor and managers may use the reports to audit the claim reps performance. These reports can be submitted to reinsurers for reimbursement of loss payment.* Claim reps should be aware of claims that should be referred to reinsurers and must complete reports o those claims based on the insurer’s internal guidelines and reinsurance agreements.

**5 – Framework for Coverage Analysis**

**Objective**: Describe the framework for coverage analysis and the information obtained by following it

Coverage analysis is the process of examining a policy by reviewing all its component parts and applying them to the facts of a claim.

Claim reps begin the process of coverage analysis by carefully reading the policy form and all endorsements. With experience, claims representatives learn to recognize the types of losses covered under the policy forms.

A systematic framework for coverage analysis can guide the claim representative to the parts of the policy that may provide or exclude coverage. It also ensures that all of the component parts are reviewed an reduces the incidence of erroneous coverage determinations. **These questions outlie a systematic framework for coverage analysis and the information it will yield:**

* **Is the person involved covered?**
* **Did the loss occur during the policy period?**
* **Is the cause of loss covered?**
* **Is the damaged property covered?**
* **Is the type of loss covered?**
* **Are the amounts of loss or damages covered?**
* **Is the location of the loss covered?**
* **Do any exclusions apply?**
* **Does other insurance apply?**

**Is the Person Involved Covered?**

**Some policies cover only insureds named or listed in the policy. Most policies define “insured” broadly, so the claim rep must determine whether the persons who suffered the loss are covered**.

For example, the Personal Auto Policy (PAP) part A liability coverage defines insured as you or any “family member, any person using your “covered auto”. According to the PAP definition, a friend who borrows your car and drives it is an insured. A friend who uses your car and pays you for that use is not an insured. In contrast, the HO-3 defines “insured” as you and residents of you household who are Your relatives; or other persons under the age of 21 and in the care of any person named above. In the HO-3, a 16 year old international exchange student who lives in the household is an insured. An independent 24 year old friend who visits over the week end is not.

Most property insurance policies limit recovery to the amount of a person’s insurable interest in the damage or destroyed property. **However, insurable interest alone does not guarantee coverage. An individual may have an insurable interest in a building but not be considered an insured under the policy because the person’s name is not listed in the declarations or on an endorsement.**

Example: Kathy owns a house jointly with her parents, who live in another state. All 3 have an insurable interest in the house, but Kathy is the only named insured on the policy. If a tornado damages the house, Kathy would be paid for the loss because she has an insurable interest in the house and is a named insured. Kathy’s parents are not residents of the house or named insureds, so even though they have an insurable interest, they are not insureds under the policy.

**Claim representatives must determine whether others have an insurable interest in the property on which a claim is based**. In Kathy’s case, the claim representative, on discovering that Kathy’s parents have an insurable interest in the house, should check with a supervisor or manager to determine how to handle the claim payment. Lienholders or mortgagees often have an insurable interest in property, and the claim representative must determine when they should be included as payees on any claim payments.

**Did the Loss Occur During the Policy Period?**

The policy period typically begins and ends one minute after midnight. The Loss of Use section contains an exception to the policy provision. *If a fire leaves a home unfit to live in, the insured can claim expenses for living elsewhere, even if the policy expires the next day. However, the fire must have begun during the policy period.*

Court decisions have offered different interpretations of date of occurrence. For example, a court may determine that the date of occurrence for an occupational disease is the first date of exposure to the harmful condition that caused the disease, the last date of exposure to the harmful condition that caused the disease, or the date the disease was diagnosed.

**Is the Cause of Loss Covered?**

Covered causes of loss, or perils, vary by type of policy and may include fire, theft, hail, windstorm, collision, or a legal obligation to pay damages.

**Specified causes of loss coverage, also called named-perils coverage, covers a loss only if it is a direct result of a specifically listed or named cause of loss in the policy**. Example: fire, lightning, exposition, theft, windstorm, hail, earthquake, flood, mischief, vandalism, or loss resulting from the sinking, burning, collision, or derailment of a conveyance transporting the covered auto.

Causes of loss are not often defined in the policy because the definitions are subject to court interpretation and therefore vary by state. For example, fire may seem easy to define, but does it include smoke or excessive heat with no actual flame? Does it include damage the firefighter cause while extinguishing the fire?

Adjusting Tip: When the policy does not define a cause of loss or another term, claim reps can use other resources to determine the meaning. Statutory provisions and court decisions have defined many terms that are not defined in policies. Standard dictionaries are also resources for defining terms.

*Special Form Coverage, also called all-risks or open-perils, covers every cause of direct physical loss that is not excluded.* The HO-3 provides special form coverage on the dwelling and other structures. Section I – Perils Insured Against in the HO-3 states, in part, “we insure against the risk of direct loss to property described in Coverage A and B (emphasis added). Following that statement is a list of causes o loss that the policy does not cover, such as smog, rust, birds and rodents.

HO-3 Example – An insured accidentally spills a caustic chemical in the kitchen. The chemical splashes on the linoleum floor, table, chars, and are rug. Because spills are not excluded under the special form coverage on the dwelling, the damage to the linoleum floor is covered. Because the spills are not a named peril under the specified perils coverage on the contents, the damage to the table, chairs and rug is not covered.

In answering the question “is the cause of loss covered”? Claim reps should thoroughly investigate all the facts concerning the loss and apply them to the language in all the provisions of the policy.

**Is the Damaged property Covered?**

In following the framework for coverage analysis, the claim rep must determine whether the damaged property is covered. Insurance policies may not cover all of the insured’s property. Certain property must be specified in order for coverage to apply. Such as the PAP policy when a new vehicle not yet added to the policy schedule when an accident occurs. Proof of the new purchase may resolve this.

Is the Type of Loss Covered?

Losses can be classified as direct losses or indirect losses. A crumpled car fender is a direct loss. Indirect losses reduce future income, increase future expenses, or both. Example, a fire destroys an insured’s home, the cost of rebuilding is a direct loss, the rental cost of temporary housing is an indirect loss. Many policies only cover direct losses only. Homeowners policies cover increases in living expenses after a covered loss renders the home untenable.

**Are the Amounts of Loss or Damages Covered?**

Claims representatives should always check the policy to determine whether the amounts of loss are covered. For property damage claims, the amount of loss payable is usually limited to physical damage to, destruction of, or loss of tangible property. The amount is usually based on the cost to repair or replace damaged property with that of like kind and quality. Claim for indirect loss, such as business income, can be payable if indirect loss coverage is included or has been added to the policy.

For liability claims, damages for which the insured may be liable are of two types;

* Compensatory damages which include **Special damages (which pays for specific, out of pocket expenses such as medical expenses, wage loss, funeral expenses, or repair bills**) and **General Damages (which pays for losses, such as pain and suffering)**, and do not involve specific measurable expenses), reimburse, or compensate claimants for their bodily injury or property damages.
* **Punitive damages punish a wrongdoer for a reckless, malicious, or deceitful acts and deter similar conduct**

Some policies do not define or list the types of damages payable under the policy. The PAP liability coverage section begins, “We will pay damages for ‘bodily injury’ or ‘property damage’ for which any ‘insured’ become legally responsible because of an auto accident”. Generally, the term “damages” refers only to compensatory damages.

In a liability insurance policy, the insurer agrees to pay judgements and settlements up to the policy limit. In addition, some liability policies contain deductible. They may also include coverage for certain expenses, such as defense costs and bail bonds, outside the limit of liability. Others may have a self-insured retention (SIR) in which the insured organization adjusts and pays its own losses up to the SIR level. The claim rep must verify all the policy limits applicable to a loss before making a settlement to ensure that any payment made falls within the available limits of coverage.

In addition to ensuring that the type of loss and types of damage are covered, claim reps must verify that the amount of damages is within the policy limits. A first party property policy will have limits of liability and may also have sub-limits for certain types of property or types of losses. Such as the HO-e contains a limit on dwelling and contents and well as special limits for money and theft of jewelry and silverware. First party losses are also subject to deductibles, provisions that specify how the loss is to be valued (either actual cash value or replacement cost), and coinsurance clauses designed to ensure that the appropriate amount of insurance is maintained on the property.

**Is the Location of the Loss Covered?**

The location where the loss occurred must be within the policy’s territorial limits, and for property policies, be shown on the policy as a covered location.

**Do Any Exclusions Apply?**

**Some losses may be excluded in the policy. Exclusions to coverage can involve these elements:**

* **Persons**
* **Causes of loss**
* **Types of property**
* **Types of damage**
* **Other circumstances**

*When claim circumstances fall within a specific exclusion, coverage does not apply. An exclusion applies even if other coverage requirements are met.*

An example: Suppose that an insured uses his car as a taxi and is involved in an accident, severely damaging the driver’s side door. The insured subsequently submits a claim. That claim appears to be covered according to these criteria

* Is the person involved covered? The driver is the named insured
* Did the loss occur during the policy period? In this case, it did
* Is the cause of loss covered? The policy covers physical damage to the insured’s car
* Is the damaged property covered? The vehicle is listed on the policy
* Is the type of loss covered? The policy covers collision
* Are the amounts od loss or damages covered? The loss is within the policy limits and more than the deductible
* Is the location of the loss covered? It is within the policy’s territorial limits

The claim rep would ask another question: Do any exclusions apply? On reviewing the exclusions, the claim rep would find the PAP excludes loss that occurs while the car is used as a public or livery conveyance and deny the claim.

*Sometimes exclusions contain exceptions, meaning they clarify what is excluded.*  For example, the PAP excludes liability for damage to property used by the insured. However, an exception in the exclusions states that the exclusion does not apply to property damage to a residence used by the insured. Claim reps who carefully red the policy can avoid incorrectly denying coverage based on an exclusion when an exception applies.

Adjusting tip: A claim rep must make sure that the exclusion upon which the denial is based has not been declared invalid by a court having jurisdiction over the claim or by a state statute.

**Does Other Insurance Apply?**

Some policies are intended to apply only if not other insurance applies or only above the limits provided by other insurance. The PAP states that coverage provided under that policy is excess over other collectible insurance for vehicles the insured does not own. In other cases, a policy may pay for a portion of the loss based on the limit of insurance available from other policies.

Having answered all the questions in the framework for coverage analysis, the claim rep can apply the policy to the facts of the claim and make a coverage determination.

**6 – Applying the Claims Handling Process and the Framework for Coverage Analysis**

Objective: Given a claims resolution scenario, demonstrate how a claim representative handles the claim and analyzes coverage

To ensure good-faith handling of property and liability claims, insurers’ claims departments adopt specific procedures and guidelines.

**Activities in the Claims Handling Process**

* **Acknowledging and assigning the claim**
* **Identifying the policy and setting reserves**
* **Contacting the insured or the insured’s representative – get description of the accident and details about what happened, confirm ownership and use (if auto)**
* **Investigating the claim – request police report, review the policy for questions regarding coverage Is the person involved covered? Is the type of Loss covered? Do any exclusions apply? Is the location where the loss occurred covered? Does other insurance apply? Do any other policies apply? Are the amounts of loss or damages Covered?**
* **Documenting the claim – Set up claim diary/suspense system**
* **Determining the cause of loss, liability, and the loss amount – did the loss occur during the policy period? is the loss location covered by the policy? Do any other policies apply to this loss? Are the amounts of loss or damages covered? Set Reserves**
* **Concluding the claim – check federal and state databases to ensure that all outstanding legal obligations that would require payment have been met. Obtain all required releases, Apply the proper sub-limits and deductibles, issue payments**