**CLAIMS HANDLING**

**For**

**The Modern Adjuster**

**CHAPTER 1:**

**INTRODUCTION TO**

**CLAIMS HANDLING**

 **What is Professional Claims Handling?**

The insurance policy is a promise that the policy holder will be indemnified for losses resulting from an insured peril. The responsibility of the insurance company is to ensure prompt and equitable claims settlements. Doing so establishes a professional claims handling process.

A flexible and creative approach should be adopted to good claims handling in order to solve claims problems and to respect the relationships established among the insurers and the insured’s. The claim services provided by an insurer are invaluable. This is especially true where there is a problem with the construction or meaning of the policy wording, especially in connection with coverage and / or claims provisions. This is also important where a claim is in dispute but the parties concerned prefer a conciliatory resolution, rather than resorting to the more expensive legal proceedings.

An insurance company’s reputation for honesty, integrity, and fairness is the cornerstone of its business. Nowhere is this more evident than in claims handling. The Claims Handling Department must make every effort to review each claim in a timely fashion and to settle the claim cost effectively and promptly, thereby minimizing the overall total expense. A claims staff closely monitors and directs the settlement of all reported occurrences through a nationwide network of independent claims handlers, on staff adjusters, and legal counsel. The maintenance of strict guidelines for attorneys has helped to control loss adjustment expense. Most insurance companies offer a reliable, 24-hour a day, seven days a week claim reporting facility assures customer access to qualified claims handler whenever and wherever the need arises.

The claims handler is often referred to as an adjuster, a claims specialist, a claims examiner, a claims handler, a casualty examiner, or an outside investigator. Generally, within this course, we have tried to be consistent by using the term “claims handler". However, you may find references to other terms as well. When the term “agent” is used, it does not necessarily refer to an insurance agent who sells insurance. Rather, it is used more loosely as the law of agency applies. By means of the law of agency, insurance companies are responsible for their own acts, as well as for the acts of their agents, including claims handlers.

 **A Solid Reputation**

The most prominent feelings of insureds and claimants are anxiety over their loss, doubt and uncertainty about the claim process, and fear and distrust of insurance companies. Professional claims handlers have a great deal of power. Claims handlers have the power of money, the power to wait before paying a claim, the power of wider access to claims handling data, the power of being less personally involved in the process, and they have the litigation power.

An insurance company's claims handling philosophy will largely determine its reputation among insurance consumers. Consumers want to purchase their coverages from an insurance company with a good claims handling history. If the insurance company is marked by a dubious claims handling history, the insurance policy may be of little actual value. Insurance that does not insure is more dangerous than no insurance at all because it lures with false assurances of protection. Over time, policy holders will buy only from those insurance companies that will stay the course and honor their commitments when the coverage is needed.

Law suits brought against insureds tend to seek enormous amounts in damages. Even though actual payments are generally far below the damages sought, the risk presented to consumers without dependable and adequate insurance is considerable. Not only are settlement and judgment costs a concern for the policy holder, but defense costs can pose a huge burden as well. Because defense costs can near the $1 million mark, some insurance companies dispute their coverage obligations almost immediately after the policy holder presents a claim.

Many insurance companies are good at receiving premiums, but they are not as good at paying claims. Insurers spend over $1 billion annually in litigation against their own policy holders. Too frequently, policy holders must sue their insurance companies in order to receive the insurance coverage they paid for. Claims in excess of $10 million rarely get paid without litigation. Indeed, insurance companies spend over $1 billion annually just to fund the insurance coverage litigation battle against their own policy holders. In effect, this forces the policy holder to fight a two front war -- one against the underlying claimant, and another against the insurance company.

Fortunately, sharp claims handling practices are pervasive, and effective claims handling procedures are discussed in detail later in this chapter.

Before purchasing any insurance, it is not uncommon for prospective policy holders to look into the insurance company's claims handling history. Many prospective insureds investigate the claims handling history of potential insurers. As a matter of fact, insurance brokers sometimes recommend first interviewing insurance companies concerning their claims handling background. Many prospective policy holders do not hesitate to ask insurance companies for references. Smart consumers also speak with their colleagues, insurance brokers, and state insurance departments to gain further background on any insurance company under consideration.

Unfortunately, some insurers are notorious for disputing policy holders' claims, while others are more fair. Confidence in an insurance company and its reputation for fair claims handling practices begins with purchasing insurance policies from those insurance companies with good claims handling track records.

However, many people lack a basic understanding of insurance policies and about insurance companies. Policy shopping by price alone is unwise. Policy holders should avoid making premium cost their sole consideration. Shopping for price alone can cost the policy holder a significant amount of money if a claim arises and there is no coverage. Assuming that policies or insurance companies are interchangeable could be a costly mistake for the policy holder also.

Smart consumers shopping for insurance do their home work and investigate the claims handling histories of the insurance companies under consideration. The importance of an insurance company's reputation in the area of claims handling cannot be underestimated. Insurance companies notorious for unnecessarily disputing claims with their policy holders are avoided by insurance consumers.

**The Professional Claims Handler**

The goals of the professional claims handler are to provide efficient claims service to individuals and insured businesses. The claims handler must be ready to meet the insured’s claims needs with professional service and unmatched dedication. He should have an established reputation for handling claims in a professional manner. The insured or claimant must be able to count on the claims handler to handle claims with ease and efficiency. It should be the mission of the professional claims handler to distinguish himself by providing prompt, quality claims service with a focus on the customer. His experience and know how can guide a claim through every step of the claims process.

The professional claims handler should be expected to:

* Provide prompt personal contact
* Provide a full explanation of the claims process
* Provide a full explanation of the benefits and coverages to which the claimant or insured is entitled
* Enter into an agreement to repair an auto or property if it is damaged
* Establish ongoing contact to keep the claimant or insured informed of the status of claim

Naturally, in processing a claim, the claims handler will need the assistance of the claimant or insured. For example, he will require:

* All bills relating to the claim
* Contact by the claimant or insured, should he need additional repairs to his auto or property
* Any additional information as required

**Special Terminology**

When used within the text of this course, the following terms shall have the meanings stated below. These terms are common within the insurance industry, often found in policy language, and are noted here to acquaint the student with them or to refresh the student’s knowledge.

* **CLAIM.** “Claim” shall mean a request for payment of a loss which may come under the terms of an insurance contract.
* **CLAIMANT.** “Claimant” shall mean an insured under a policy of insurance who shall have provided a Notice of Claim to the insurer of the existence of any claim.
* **DAYS.** “Days” shall mean days other than a Saturday, Sunday or a holiday observed.
* **INSURER.** “Insurer shall mean any insurance company authorized and chartered to conduct the business of insurance.
* **NEW INFORMATION**. “New information” shall mean information not furnished to the insurer at the time of the classification of the claim and shall include new or modified allegations, petitions, or complaints.
* **NOTICE OF CLAIM.** “Notice of claim” means any written notification to an insurer by an insured that reasonably apprises the insurer of the facts relating to the claim.

**Other Language Used**

While each state is different in its requirements of claims handling procedures, the following standards are found in the insurance codes of many states, and these terms are often found in this text:

* **PROOF OF LOSS FORM.** If the insurer requires a Proof of Loss Form, the insurer must request the Proof of Loss Form generally within 15 days after being notified of a claim, and the insurer must send the Proof of Loss Form to the insured. A sample Proof of Loss form is included in Chapter 2.
* **CONDITIONAL ACCEPTANCE.** If the insurer is unable to accept or deny a claim in accordance with the terms of the insurance policy or if there is a pending law suit which is the subject of the claim, the insurer must provide a defense to the claimant. The defense may be provided subject to reservations with regard to coverage. The claimant must be notified of the reservation of the insurer's right to contest that a claim is covered under the policy. The notice must be in writing and state the reasons for such reservation. The notice must fully inform the claimant of his or her right to contest the insurer's reservation by stating (1) any time deadlines to contest the reservation under the policy or applicable law, and (2) that the claimant may litigate or arbitrate to the extent provided in the policy the insurer's reservation, if the claimant elects.
* **DENIAL OF CLAIMS**. Any denial of the policy coverage of a claim shall set forth in writing the reasons for such denial. The notice of denial of a claim must fully inform the claimant of his or her right to contest the denial by stating (1) any time deadlines to contest the denial of the claim under the policy or applicable law, and (2) that the claimant may litigate or arbitrate to the extent provided in the policy the insurer's denial, if the claimant elects.
* **LIMITATIONS OR DENIAL OF COVERAGE.** Unless otherwise provided under the policy, an insurer may not deny any claim for the failure of the claimant to cooperate in the investigation of any claim, to file any Proof of Loss Form, or to otherwise cooperate in the handling of the claim, except as such action may prejudice the rights of the insurer. If the claimant has failed to respond within a reasonable time, the insurer must notify the claimant of the failure to provide the information or to cooperate and must notify the claimant of the insurer's intent to take action as permitted by the policy. The notice must specify a date, generally not less than 30 days, after the date of such notice for the claimant to take such action to comply with the insurer's request. If the claimant fails to comply, the insurer may take the actions specified in the notice.
* **REDETERMINATION OF POLICY COVERAGE.** The insurer may redetermine the classification of any claim based on new information.
* **RELEASE.** No insurer may request a claimant to sign a release extending beyond the subject matter giving rise to a settlement, unless the additional subject matter of such release has been fairly and openly negotiated between the insurer and the claimant, including notice to the claimant of any consequences of the settlement to the claimant's rights under the policy.
* **DRAFTS CONTAINING LANGUAGE OF RELEASE.** Insurers may not issue any draft or check to the claimant when endorsement of the draft or check would release the insurer from liability. Any release from liability must be a separate agreement, and the signing of a release cannot be a condition for payment of the amount of loss as finally determined and such expenses as are payable under the policy.
* **RESERVES -- SETTING AND REVIEWING**. Upon acceptance or conditional acceptance of a claim under an insurance policy, the insurer must comply with the provisions of the state’s standards for reserve setting and reviewing.

**Time Schedule for the Handling of a Claim**

The typical time schedule for the handling of an insurance claim is set forth below. Remember, the requirements for each state may vary. However, the guidelines below represent typical time schedules:

* **THE ACKNOWLEDGMENT AND INVESTIGATION OF CLAIM.** The insurer must, typically within 15 days after a notice of claim, do the following:

(1) Acknowledge the claim

(2) Commence investigation of the claim

(3) Request necessary information that is allowed to be requested by the policy. (The insurer may request additional necessary information during the progress of the investigation.)

* **CLASSIFICATION OF CLAIMS (1) ACCEPTANCE; (2) DENIAL; (3) CONDITIONAL ACCEPTANCE.** After the insurer receives all of the requested information, the insurer must notify the claimant of the acceptance, denial, or conditional acceptance of the claim. This notice is sent to the claimant typically within 30 days of receipt of the information. However, should the insurer be unable to determine whether to accept or deny or conditionally accept the claim within the state’s specified time frame, the insurer may notify the claimant of its inability to accept, deny, or conditionally accept the claim. This notice must provide the reason(s) for the inability to accept, deny, or conditionally accept the claim.
* **COMMENCEMENT OF ACTION BY INSURER.** The insurer must begin an action or a combination of actions authorized under the policy of insurance within a specified number of days after notification, typically 15 days after notification to the claimant of the acceptance or conditional acceptance of the claim. The insurer may comply with this section in one of the following ways:

 (1) By employment of appraisers or other persons with knowledge of the value of real property to determine the extent of the loss under the policy

 (2) By written correspondence with third parties to secure a release or satisfaction of the claim

 (3) By employment of counsel to commence or defend on the claim in current or new litigation

 (4) By other written correspondence or evidence of commencement of action by the insurer

* **PAYMENT OF LOSS.** When liability and the extent of loss has been finally fixed in accordance with the provisions of the policy, the loss must be payable within a specified number of days thereafter, generally ten days.
* **LIMITATION OF CLAIM RECLASSIFICATION.** Any reclassification must be made within a certain number of days, typically 30 days, of the insurer's receipt of new information supporting a change. The insurer must provide notice to the claimant generally within 15 days of any reclassification. The notice must state the reasons for the reclassification. The notice must fully inform the claimant of his or her right to contest the reclassification by stating the following:

 (1) Any time deadlines to contest the reclassification of the claim under the policy or applicable law

 (2) That the claimant may litigate or arbitrate to the extent provided in the policy the insurer's reclassification, if the claimant elects

 **Types of Adjusters**

While the discussion of types of adjusters may seem fundamental, it is worthy of a brief study. Generally, there are three types of adjusters who settle claims and who are recognized by most state statutes. These are explained below:

* **The public adjuster**. A public adjuster is any person, except a licensed attorney, who, for money, commission, or any other thing of value, prepares, completes, or files an insurance claim form for an insured or a third-party claimant. A public adjuster is one who, for money, commission, or anything of value, acts or aids in any manner on behalf of an insured or third-party claimant in negotiating for or affecting the settlement of a claim or claims for loss or damage covered by an insured contract. A public adjuster advertises for employment as an adjuster of these claims. The term is also used to describe one who, for money, commission, or any other thing of value, solicits, investigates, or adjusts claims on behalf of any such public adjuster. A public adjuster may not give legal advice. Generally, a public adjuster may not act on behalf of or aid any person in negotiating or settling a claim relating to bodily injury, death, or noneconomic damages.

 Public adjusters may prepare, complete, or file insurance claims or act or aid in any manner in negotiating for or effecting a settlement for a claimant. Once a public adjuster has been retained by the insured or claimant, he must be dealt with, since he is the insured's representative. Ignoring the public adjuster will only complicate the claims handling process and could lead to legal problems for the insurer. Most public adjusters enter into a contingency contract with their clients whereby the amount of their professional fee is directly related to the amount of recovery they obtain. Typically, the public adjuster justifies his fee to the insured or claimant by presenting a claim under all applicable coverages available and / or by inclusion of all property damages potentially recoverable. Sometimes, this contingent fee arrangement between the public adjuster and his client can lead to the potential for fraudulently overvalued insurance claims.

 Since a public adjuster may not give legal advice to his client, attempting to do so would be violating the rule against the unlicensed practice of law. Therefore, the public adjuster may not interpret the contract, advise as to the legal effect of the contract, advise as to the validity of the claim, the possibility of recovery, or the necessity for filing suit.

 Given the nature of the contingent fee agreement between a public adjuster and his client, there is the potential for fraudulently inflated insurance claims. So, the question naturally arises whether the insured may be bound by fraudulent representations made by the public adjuster, his agent. Under the general principles of agency law, the potential exists for denial of an insured's claim based on the misrepresentation clause in the policy, if the public adjuster's fraud were to be proven.

 The public adjuster may not block an independent adjuster or a company employee adjuster from speaking directly with the insured. However, a judgment call must be made before a claims handler circumvents the public adjuster's involvement by attempting direct contact with the public adjuster's client. Here the potential exists for antagonistic relations between the public adjuster and the company adjuster, if the public adjuster's authority should be circumvented. The decision to directly contact the public adjuster's client must be made with caution. A cautious approach would be to correspond with the public adjuster and copy the insured, stating the company adjuster's desire to communicate directly with the insured.

 The public adjuster has no advantages over an insured's attorney or the insured himself in seeking disclosure of claims file materials. The work product privilege that applies to most claims file materials also applies to requests for documents made by the public adjuster. The insured's statement given to the company must be provided to the public adjuster if requested, as must a copy of the actual tape recording of the statement. Any and all records produced to the insurance company by an insured must be made available to the insured if he so requests these records. The insured must be provided with a free copy of his examination under oath when requested. Following these guidelines for production of requested information to the insured, together with an honest and candid disclosure to the insured of the facts of any investigation being conducted, as well as the results of the investigation, will prevent potential bad faith exposure to the insurer.

* **The independent adjuster.** An independent adjuster is any person who is self-employed or is associated with or employed by an independent adjusting firm or other independent adjuster and who undertakes on behalf of an insured to ascertain and determine the amount of any claim, loss, or damage payable under an insurance contract or undertakes to effect settlement of such claim, loss, or damage.
* **The company employee adjuster**. A company employee adjuster is a person employed on an insurer's staff of adjusters and who undertakes on behalf of this insurer, or other insurers under common control or ownership, to ascertain and determine the amount of any claim, loss, or damage payable under a contract of insurance. The company employee adjuster undertakes to effect settlement of such claim, loss, or damage.

**Adjuster Pressure**

Many in the insurance industry today feel that insurers and claims professionals are out of touch with their customers' needs. They are seen has having lost contact with the customer and focusing on satisfying the needs of stock holders and management.

This may be the result of the shift in the philosophy of claims handling. The 1960s were the "handshake era," when insurance claims handlers focused on face to face contact with claimants. During the 1970s, insurers may have lost that focus with customers when many changes in corporate ownership were taking place. There was a lot of noninsurance ownership, and there were naturally expense pressures and an emphasis on savings.

These pressures led to the proliferation of telephone adjusting and a shift in the 1980s from a multi-line concept to a specialist adjusting concept. Now customers are required to deal with several different claims specialists.

The increase in impersonal dealings has probably contributed to the insurance industry's negative image. Every claim should not be handled from the confines of four walls, and containing costs should not be the only focus.

Of course, the pressure to contain costs will continue, in spite of the negative industry image which has developed as a result of cost cutting initiatives. Because cost is a driving factor, the industry has no choice but to get tighter controls over claims. Costs are the driver of the movement to speed up the claims process.

Insurers may soon have no choice but to speed up the claims handling process, as more states pass claims settlement acts that mandate quick resolution. Unfortunately, speeding the claims process is often at odds with the anti-fraud movement. Sometimes claims handlers are under so much pressure to close a file they do not even have time to wait for information from industry data bases to check out a claimant's history.

The insurance industry and the National Insurance Crime Bureau are developing an all claims, all companies data base which will not be limited to searching for names with addresses. This new data base will allow insurers to search for Social Security numbers and other information.

While fighting insurance fraud is critical in containing costs, the industry must make consumers aware of its efforts, or its current negative image may never change. The consciousness of the community must be raised in connection with the benefits of fighting fraud.

**Flexibility in Claims Handling**

It is common for law school professors to state that law is as much, if not more, art as science. This means that the practice of law is interpretative and creative and that cookie cutter applications and rote formulas often do not work. For example, two lawyers might approach the handling of a case in different or inconsistent ways, while both could be doing excellent work.

This applies to the business of insurance claims handling as well. Although the insurance industry has standardized many aspects of insurance policy interpretation by the careful drafting of insurance contracts, a standardized response to a specific situation is not always possible. In many cases, good faith, bona fide disputes regarding whether a certain set of facts when applied to the insurance policy result in insurance recovery. Or, claim denial can arise.

Can reasonable men disagree and both be right? In the adjusting field, there are often problems where coverage questions are routinely fired at overworked members of diminished staffs. Decisions need be made quickly, often by one person working alone.

Often the attitude is simply to adjust this claim and move on. Make a decision to pay or deny the claim and move ahead. Given this approach, it is no wonder that disputes between agents and claims handlers and insureds arise.

For example, consider the argument over the $500 goodwill coverage available under the home owners’ form for "damage to property of others." In this claim, a tree simply fell from an insured's property onto a neighbor's auto. Since this is payment for damage without liability, some claims handlers believed the loss should be covered. However, since the clause requires that the damage be "caused by" the insured, other claims handlers feel that there is no coverage unless other facts supported it (such as the insured allowing the tree to rot to the point that it fell).

These arguments arise in good faith in the field. We see few examples of "bottom line" adjusting where claims are denied for the money involved. Claims adjusting require both art and science. There is often room for interpretation and even creativity.

**A Case for Aggressive Case Management**

The insurance claims handler of the 1990s is confronted with an unprecedented number of complex issues. Some of the most obvious are:

* Runaway legal fees
* Escalating insurance fraud
* Increasingly complex coverage and liability questions
* Cost cutting measures including staff reductions
* Threats of bad faith law suits

All of these require more professionalism and expertise on the part of the professional claims handler. Faced with these pressures, claims handlers are blessed with an array of outside vendors and experts who can lend economic assistance in case management.

Many insurers have responded to prevailing pressures through a bureaucracy that attempts to limit overall corporate risk. This comes at the cost of stifling claims handler initiative and the search for creative solutions to these problems. The claims handler wishing to employ these experts is told by senior management that such vendors are unjustifiable expenses. Managers issue strict guidelines on when these experts can be retained.

In general, part of the insurance bureaucracy is created from an honest attempt to prevent the undertrained or understaffed Claims Handling Department from making mistakes and overpaying claims.

Since the late 1970s, insurers have been focusing on marketing and investment functions to boost profits. At the same time, insurers are thought to be paying up to $2 billion annually in excessive claims pay outs. But while claims pay outs cost between 60 cents and 70 cents on the premium dollar, just $.07 is spent on salaries and benefits for the claims handlers who determine the size of those pay outs!

The industry must make changes. Otherwise we may look back on the 1980s and 1990s as the time the insurance industry lost the war against insurance fraud. Some say the insurance industry has become nearly immobilized with bureaucracy.

Treating claims handlers as professionals and empowering them with sufficient training and trust can be the first step toward a more streamlined claims handling process. Claims handlers should be able manage litigation teams with the authority to make important case management decisions. A corporate culture developed to encourage the claims handler to think for himself, take risks, and be creative may be the solution to the bureaucracy that interferes with customer satisfaction.

The insurance industry is facing increasing competition from self-insured pools and other members of the financial services industry. These competitors will likely recognize the benefits of empowered adjusting and may begin attracting the best and the brightest claims handlers with the promise of more power.

Customer expectations are increasing throughout our society. Insurers that ignore this demand and refuse to sanction more power to their claims handlers may do so at their peril. The single largest cause of runaway legal fees and escalating indemnity payments is the claims handler's inability to devote sufficient time to cases. Their case loads easily range from 150 to 400 files, and most claims handlers spend their time putting out fires instead of engaging in aggressive case management to resolve cases quickly and efficiently.

Reduced case loads and aggressively managing litigation can prove the theory that it is much less expensive to pay a claims handler to work the file than it is to pay an attorney. Aggressive case management by an empowered claims handler who properly employs outside consultants can save millions of dollars and mean fewer bad faith law suits and many more satisfied insured customers.

An empowered and highly trained claims handler who is encouraged to take risks and to be creative will know what tactics or consultants to employ. Instead of the slower, bureaucratic approach to complex, high exposure cases, the claims handler can respond with flexibly to the benefit of both the insured and insurer.

**Efficient Claims Handling Is More Important Than Price**

A relationship is expected to be observed between service quality and price. Claims handling procedures, service time, the distribution system used, and default risk are quality service measures which are observed and analyzed. Property casualty companies with more generous claims handling procedures and fewer complaints are more likely to have the capability of sustaining higher prices. A measure of service time in the insurance industry involves the down time between the initial filing of a claim and the closing of the claim.

Consumers attach a higher relative value to companies with a quicker claims resolution process. Insurance companies using a more costly distribution system are likely to be perceived as providing better quality and service.

A recent study of insurance brokers has found that an insurer's ability to handle claims is more important to brokers than is the price of the product. The study of 450 insurance brokers was commissioned to establish the attitude of brokers toward product suppliers and whether brokers' needs were being met.

The study quoted several survey respondents who said:

"The price has got to be right, but it's not always the price that determines the product. Service, especially in the claims handling area, is more important."

"We are basically looking for insurance carriers who can provide the right knowledge to a particular subject and efficient claims handling when needed."

Of 16 qualities rated by importance in the survey, the brokers said the five most crucial ones were (in order):

* The ability to handle claims quickly and efficiently
* Financial stability
* The ability to solve problems quickly and efficiently
* Claims assessment capabilities
* General professionalism

In insurers' ability to handle claims gained the highest overall average score of brokers rating satisfaction with service factors.

However, the study cited insurers' common area of weakness was in the area involving "the personal touch that is, offering local support, quality of personal relationships, and sympathy to needs." These areas provide the insurance companies with the greatest opportunity for improvement. Naturally, claims handlers are in highly visible positions with insurance consumers and are postured to have a positive effect on these areas needing improvement.

**Industry Shortfalls**

When Hurricane Andrew struck south of Miami recently, shattering dwellings, store fronts, shopping malls, warehouses, vehicles, and offices, it produced more than 700,000 claims for insured losses that reached over $20 billion. In just five hours, decades of property insurance profits in South Florida were blown away, making insurance companies painfully aware of the need to overhaul their catastrophe claims handling operations.

Industry experts claim that the industry's independent claim claims handling system, which has provided nearly infinite flexibility in past disasters is showing signs of age and neglect. Unfortunately, this may leave insurance companies unable to respond in time following the next catastrophe.

The national network of independent claims handlers is simply not as well equipped as it once was. If the hurricane had struck a few miles further north in urban Miami, insurers would have faced a severe shortage of qualified, experienced, commercial property claims handlers.

Today’s system can produce as many as 70,000 claims handlers on short notice. However, when trained, experienced, catastrophe claim claims handlers are needed on the spot, the numbers start to shrink.

Problems facing claim handlers in future catastrophes will be many and varied. Urgent problems are the absence of uniform property claim claims handler licensing among state insurance departments, together with insufficient continuing education requirements in some states where licenses are required.

Another problem is insufficient planning and lack of reciprocal agreements between state insurance departments that would allow insurers to quickly bring in claims handlers from other states in an emergency. Of course, it is difficult and expensive for insurance companies to try to keep a large number of trained, experienced claim handlers on the payroll to meet contingencies.

Insurance carriers must understand that the independents they rely on for support after a disaster have to pay their bills even when catastrophes do not occur. Insurers should help to find work for independent claims handlers in the lean times, or they may not be available for the next emergency.

Possible solutions for immediate greater claims handler capacity include company rotation of staff claims handlers, coordinating catastrophe plans, and having property insurers arrange to assist one another by lending teams of staff claims handlers following a catastrophe.

In dealing with the pandemonium that follows a disaster, success in insurance claim handling comes from staying flexible and being innovative. For example, in order to reach affected policy holders in the first days or weeks after Hurricane Andrew, volunteer customer contact teams were sent out with soft drinks and fruit and hand held FM radios. These people could not write advance checks or handle claims, but they reached many customers quickly, letting the insureds know the insurers cared about them.

Handling a large volume of claims in a short time could become a routine, expensive part of providing claim service to property insureds following a windstorm or other disaster, and claims handlers must be prepared.

**Claims Audits**

The objective of a claims audit is to achieve significant cost savings from current claims handling procedures, whether these are processed in house or outsourced. This is usually achieved by a combination of efficiency savings in process methods and control of the overall claims spend.

Risk managers, third-party administrators, and insureds often have different concerns and priorities. These conflicts cause them to see useful tools, like a claims audit, in different ways. However, a claims audit can benefit all parties involved.

For example, an insurer may need to conduct a claims audit to satisfy company policy or to protect the insured's interest from a marketing or fiduciary basis. The risk manager, however, may want a claims audit conducted for statistical and internal financial reasons. This process can be completed for largely different reasons.

The basic reasons for an independent claims review are obvious. Good claims handling should combine the elements of cost containment and quality of service. When these qualities are diminished, the eventual product loses its value. The claims process for the third-party administrator is simple. The third-party administrator investigates, evaluates, and quantifies and terminates claims liabilities. This periodic evaluation of claims handling by an independent gives all parties a definitive edge in managing costly risks.

When asked to take part in a claims audit, the professional claims handler should not automatically take this is an insult to his performance. As a matter of fact, a successful claims audit can help the claims handler to perform his job more efficiently and to do a better job.

The claims audit should define the good and bad aspects of claims handling and specify the costs associated so management can strengthen the deficiencies and achieve a comfort level associated with handling claims. The frequency of a claim review depends on many factors, but a minimum time between reviews to consider would be every other year, assuming that a comprehensive review is completed and few material exceptions are noted.

Some managers may decide to approve the review over a longer period for specific areas of concern. During any given review period, a claims technical review, claims internal processing and / or financial assessment may be completed. This sectional approach is a useful comprehensive tool.

When should a claims review be conducted if one is not part of a normal insurance management cycle? The obvious signs for a needed claims audit are:

* Poor service
* A high ratio of open claims to closed over a period of time
* Frequent reserve changes
* Constant claims handler turnover
* Documentation differences in the same accounting period
* A constant late reaction to ordinary business

A periodic and systematic review of claims handling procedures can identify problems sooner rather than later, saving money in the long run and allowing for correction of the problems before they become massive.

The human and financial costs required to complete a claims audit are usually significant. Certain parameters are defined, and expectations are outlined so that the success of the program can be quantified. A cost / benefit analysis identifies the specific intent of the audit and the potential for its success in financial terms. The end result should support that effort. If the approach is structured properly, the result can benefit all parties, even though they have differing interests in the overall process.

There are defined standards for conducting a claims audit, and this goes beyond the technical work most commonly defined as a claims audit. A claims audit standard should be defined by distinct tasks categorized in three areas.

The first and most commonly completed area is the claim technical part, is where a team of experienced claims examiners (employees or consultants) go to the third-party administrator to review individual files for overall handling. The file is reviewed for:

* Setup
* Investigation
* Reserving
* Responsiveness
* Identifying recovery possibilities
* Steps taken to close or settle
* Overall adherence to general handling guidelines

The results are captured on a template, and any recommendations are compiled and conveyed to the third-party administrator. The results can be useful for identifying trends -- good or bad -- and for gaining a sense of the abilities of the examiners. With a written plan for the audit and an identified purpose, the reviewing entity can determine if satisfaction has been achieved in the distinct categories reviewed and tested.

The second area to examine is the loss run. Assessing the loss run means following the data path from the files through to the reporting mechanism, which is not often done in a formalized and systematic manner. In theory, the loss run should reflect the same claim detail found in the file. However, many reviews show this is not always true. The degree of accuracy can differ. This area can be critical to both insurers and risk managers because the same inaccurate data is used to report to regulators, promulgate rates, and as a base for the company's business and financial decisions.

The third area to review is the financial part of the claims process. It is binding upon the review team to review, analyze, and test such elements of the process as claim file payment transactions for:

* Adequate support documents
* Approvals
* Timeliness of payments to avoid penalties
* Duplicate and inaccurate payments of expense invoices
* Proper classification of payment type
* Indemnity payments paid as stipulated

This review should include testing for proper coding for recovery of deductibles, subrogation, and second injury funds. In addition, the loss funding and reconciliation process should be reviewed. Standard accepted accounting techniques should be employed on a consistent basis. Mispostings are common, and it makes good business sense to ensure that each activity agrees with statistical postings and that financial controls are working.

When the results of the three areas of review are compiled and analyzed, the interests of all parties are well served. The initial benefit is a higher level of understanding of how the claims process works, which enables better management judgments to be made about the claim handling process.

Once the information has been compiled from a claims audit standpoint, the risk manager, broker, and insurer can write specific account instructions explaining how they expect the account to be handled in order to avoid potential problems. This is of great benefit to the insurer, the third-party administrator, and to the professional claims handler because everyone knows what is expected of them, and a way to measure compliance has been established.

This approach to claims audits provides a comprehensive review of the claims handling organization including claims, finance, law, and systems. Such an extensive audit will provide management with the necessary information to identify areas that need to be addressed. Part of the special relationship between the parties is the knowledge they are working together to provide the best service possible for the lowest cost in an accurate and timely manner.

**Insurance Fraud**

What is insurance fraud? Insurance fraud occurs when someone tries to make money from insurance transactions by deceiving others. Insurance fraud, including selling insurance without a license and filing phony or padded claims, is a criminal offense.

All of us know that insurance fraud is a rampant problem. Whether the claim involves a little padding or outright fraud, there are certain investigative techniques and handling procedures which should be used to combat fraud. We will identify some of the red flags, or suspicions, of fraudulent claim and some of the investigative techniques which can be used to handle them.

The proper handling of the fraudulent or suspicious claims includes rejection of proofs of loss, denial of claims, and compromise settlements.

Thousands of insureds know firsthand the financial harm that insurance fraud can inflict. These victims include people whose car insurance premiums were stolen by outlaw agents, employees stuck with worthless health insurance, businesses that wasted their money on bogus workers' compensation coverage, and doctors whose search for lower medical malpractice insurance rates led them to fictitious offshore companies.

Many more have become victims indirectly when claim fraud drove up their insurance premiums. Dollars paid by insurance companies for fraudulent claims increase the loss statistics used in determining future rates.

Every tax payer is affected when insider fraud results in an insurance company's financial collapse. When licensed companies fail, other insurers contribute to the guaranty associations that pay the failed companies' claims. Insurance companies recover their guaranty association contributions through state tax write offs. This drains away revenue that could have been spent for such purposes as schools, law enforcement, prisons, and mental health.

Fighting insurance fraud should be of great priority of any insurance company. Their job is to detect fraud, to stop it with license revocations and cease and desist orders, and to help law enforcement agencies prosecute those who commit it. Insurance fraud is a confidence game. Those who commit insurance fraud are smooth, but claims handlers and insurers can be protected by learning some common sense defenses. The following information in helpful in studying insurance fraud, especially as it relates to the claims handling process.

What are the most common kinds of insurance fraud? Claim fraud is one of the most common types of insurance fraud, and insurance claims handlers must be aware of claim fraud tactics. Insurance claim fraud drives up everyone’s insurance costs. State Insurance Fraud Units work with insurance company special investigative units (SIUs) and local prosecutors to convict those who commit fraud. Two of the most common types of claim fraud involve auto accidents and health care providers.

**Automobile Accident Fraud**

People commit auto accident fraud to collect from insurance companies for injuries never received or repairs never performed. Sometimes doctors and lawyers collude with "victims" in order to inflate a claim, make it more credible, and pressure insurers to settle.

The four most common types of auto accident fraud are:

1. Staged accidents in which the drivers intentionally collide
2. Caused accidents in which the criminal involves an insured in a wreck that is made to look like it is his fault
3. Auto repair shop fraud by billing for unperformed work or charging to replace parts that were merely repaired
4. Faked accident reports

There are defenses against auto accident fraud. For example, experts recommend:

* NOT putting an insurance company decal or sticker on an insured car. This is only a signal to people planning a caused accident that the car’s owner has liability insurance.
* The driver should not follow too closely, particularly when the vehicle in front of him has three or more passengers. People who cause fraudulent accidents pack their cars to increase the size of the injury claims they will file.
* The driver should watch traffic in other lanes. A common ploy is for a car in an adjoining lane to swerve in front of a car and immediately brake. The driver should watch out for nearby vehicles with three or more occupants. When pulling into traffic, drivers should give themselves plenty of room.
* Insureds can compare the body shop's bill with the insurance claims handler's repair estimate. The amounts -- particularly the parts total -- should be fairly close. Parts should be inspected to see that they were replaced. A repaired part can be distinguished from a new replacement part.

**Health Care Provider Fraud**

Health care provider fraud includes overbilling by providers and duping sick people with useless and often dangerous treatments. The most common type of health care provider fraud is overbilling. Overbilling includes:

* Providing uncovered services while billing the insurance company for covered services that were not performed
* Performing unnecessary tests
* Charging for services not given or supplies not received
* Billing for long-term, repetitive, and costly treatments for unspecified illnesses
* Simplistic cures, a "brilliant" discovery by an unlicensed or non-credentialed person, and cures discovered abroad but supposedly blocked in the United States by red tape or a "conspiracy" are hallmarks of those who con the desperately ill.

There are defenses against health care provider fraud. For example, before agreeing to or paying for treatment:

* The provider of the treatment should be asked what are his or her credentials and background. Was his or her degree from an obscure institution or one unknown? Does the treatment have U.S. Food and Drug Administration approval? How long has the provider been at this location, and where did he or she come from?
* The Better Business Bureau, the state’s Attorney General's Consumer Protection Division, and the state’s Board of Medical Examiners should be queried about whether they have complaints against this provider.
* The insurance company should pays only for approved types of treatment.
* The bill should accurately reflect the services received.

Naturally, these steps will have already been taken by the time the claims handler begins his job. However, he should be familiar with these types of fraud.

**Reporting Claim Fraud**

In some cases, the insured is the first one to suspect claim fraud. For example, if the insured believes he has been in a caused accident, that a health care provider's bill is fraudulent, or that he has been involved in some other type of insurance claim fraud, he should be encouraged to tell his insurance company. The company can conduct its own investigation or furnish evidence for an investigation by the state’s Insurance Fraud Unit.

**Fighting Insurance Fraud**

What carriers can do to fight fraud is the question. Part of the answer is more vigilant claims management. Fraud creates more problems for insurers than does freak accidents or disasters. Insurance fraud is perpetuated through misrepresentations in applications, staged accidents, faked injuries, and other schemes. Many experts estimate that fraud plays a part in ten to fifteen percent all insurance claims. They further estimate that fraudulent claims are costing insurance carriers billions every year.

Naturally, insurance carriers want fraud controlled. Meanwhile, state insurance regulators are growing increasingly concerned about the added costs that fraud creates for honest policy holders, and they want the carriers to do the controlling. Just what can insurers do?

The response to fraud varies and depends on the type of coverage and claim involved in each case. However, there are certain general steps that are widely available.

The first point of fraud control resides with the claims handling process. Although fraud is sometimes detected through law enforcement tips and telephone "hot lines," carriers really have to rely on their claims handlers to spot most fraud. Front line claims handlers do not necessarily need to investigate all claims. However, in order to be effective in this critical area, they must at least be able to identify the claims that are likely to involve fraud.

Professional claims handlers must have profiles to identify claims requiring a specialist's review. Some carriers have already incorporated these kinds of profiles into computer programs that use artificial intelligence to identify files showing signs of possible fraud. Once a claims handler identifies what appears to be potential fraud, prompt investigation is needed.

Many carriers maintain units devoted to fraud investigations. In the era of computer connected databases, much can be done with this technology. Claimants often can be checked for prior claims made and criminal convictions. Sources such as the Washington, D.C. based National Insurance Crime Bureau's database can access comprehensive claims histories.

Further investigation may require traditional field work such as surveillance and videotaping. Insurance investigators have many stories they can tell about individuals who have been seen actively engaged in a very strenuous physical activity, such as heavy lifting, while they had claims pending alleging they are incapacitated by severe injuries.

Fraud also can be investigated and countered through more formalized practices. For example, insurers can require policy holders to submit to examination under oath proceedings, which are essentially depositions. These examinations under oath can be initiated pursuant to the provisions found in most insurance policies that require policy holders to "cooperate" with the insurance carrier's claims investigations. Subpoenas, court orders, or other legal papers generally are not necessary in order to initiate an examination under oath.

Lawyers who specialize in fraud can explore and uncover very revealing bits of information from examination under oath proceedings. In staged accidents, for example, fraud perpetrators invariably have rehearsed their testimony concerning the circumstances of the accident itself. Their testimony on that point will usually be consistent. However, their testimony on the events immediately before and after the claims incident often is unrehearsed and, therefore, inconsistent. Inconsistencies that are stated can be very revealing when looking for signs that fraud is being attempted.

Once a fraudulent claim is determined, carriers have many options. Many law enforcement agencies encourage or require notification of insurance fraud. Most carriers, however, are more concerned with resolving the claim than with resolving criminal issues. Many individuals, who are caught attempting to file a fraudulent claim, simply drop their claims when confronted with the evidence against them.

In other circumstances, carriers have chosen to litigate against policy holders who are caught attempting to perpetrate a fraud. Carriers may seek policy rescission, damages for reverse bad faith, or some other remedy. Some carriers file charges alleging violation of the Racketeer Influenced and Corrupt Organization Act of 1970 (RICO).

Every insurance carrier must now address fraud in its own specific way. The expense of investigating and defending against any one fraudulent claim may outweigh the claim's costs. But, even more importantly, some carriers have concluded that the deterrent value in stopping a fraudulent claim yields greater savings because it prevents other frauds. Some fraud units claim to save several dollars for every dollar they spend.

**Special Investigation Units (SIUs)**

The unfortunately fact is that if the amount of claims fraud in the United States were a corporation, it would rank in the top 25 of the Fortune 500 companies and be considered a growth industry! Insurers today are taking a stand against fraud because it increases policy holder premiums. There are specialized staffs for this unique area who have the education and training required. These are known as special investigation units (SIUs).

Special investigation units are dedicated to the detection, investigation, and deterrence of fraud. They take the proactive position on fighting insurance claims fraud. In order to compete with the dramatic increase in fraud over the past several years, insurers have established these special investigation units located nationwide. Special investigators are actively involved in the deterrence, detection, and investigation of fraudulent claims. The ongoing cooperation of the claims handlers is essential and a major factor in the effective detection and investigation of questionable claims.

In order to ensure that fraud fighting efforts are successful, these investigators have established effective working relationships with federal, state, and local law enforcement authorities and fire personnel. Where available, they report to State Fraud Bureaus and actively participate in professional associations on the federal, state, and local levels.

A unique feature of special investigations units is the Global Information Exchange Network. This worldwide computer network facilitates information sharing among special investigators around the world. Investigative issues are discussed on this network including, training issues and materials, discussion of investigative methods, and emerging trends in the fight against insurance fraud.

An important component of fraud awareness is training. Investigators receive training to combat insurance fraud from organizations such as the National Insurance Crime Bureau (NICB) and the American Educational Institute (AEI). In turn, members of the special investigations units provide fraud awareness training to the claims staff and to agents and brokers.

Expanded strategies in fighting fraud include using fraud awareness posters and a national, toll free fraud hot line. This hot line is a tool for reporting information about fraudulent claims.

**Reducing Litigation Costs**

Recently the insurance industry has targeted litigation as an area primed for cost control. There are many steps that the Claims Handling Department can take to reduce litigation. This is known as litigation management.

There are many ways in which the claims handling function can contribute toward reducing litigation costs. Some areas for consideration are timely and thorough investigation, realistic case evaluation, and the aggressive pursuit of resolution to avoid unnecessary law suits. These can have an impact on individual cases, as well as to improve the management of the claim function, reduce overall cost, and improve service to clients.

Effective management of the litigation process is essential to good claims handling. It begins with recognition of goals and the development of guidelines. Many insurance companies begin with a policy statement which defines the company’s objectives in specific, action oriented terms, relative to avoiding litigation.

The policy statement expresses what the company hopes to achieve in successfully managing its litigation claims. It describes the relationship between the insured, the Claims Handling Department, and defense counsel. It defines the quality results it expects. An effective policy statement also emphasizes teamwork and focuses on managing loss costs and loss adjustment expense.

“Loss cost adjustments" refers to that portion of a rate that includes provisions for expenses, other than loss adjustment expenses, profit, and any modification to the prospective loss costs filed by the rating organization. Loss cost adjustments do not include prospective loss costs.

"Loss adjustment expense" refers to the cost of adjusting losses, excluding the amount of the loss itself.

Essential to a quality result in precluding litigation is a coordinated team including the claim professional, the defense counsel, and the customer. Fortunately, most law suits settle without going to trial, and the first strategy with the objective of settlement is to avoid litigation altogether. This means focusing on aggressive claim handling that strikes the appropriate balance between loss costs and loss adjustment expense.

Once a suit has been filed, use of a suit review committee of experienced claim staff members can assess solution options, match the complexity of the case to the appropriate attorney, and initiate a case specific plan for litigation.

Many Claims Handling Departments pay an hourly rate for outside counsel. However, alternative fee arrangements are becoming more common. Some of these include fixed or flat fees; blended hourly rates; and retainer agreements, which are negotiated dollar amounts paid to a law firm on an annual basis in exchange for its handling a specified number of cases during the year. Other options include fees that fluctuate depending on the law firm's performance in a number of agreed upon areas, including overall results, time to resolution, value added incentives, and actual costs.

Any litigation management program should reflect the overall goals of the Claims Handling Department and the insurance company as a whole. This means making it clear that litigation management is part of the entire claim management process.

Litigation management is part of a complex frame work that includes timeliness of the claim handling, superior customer service, and the effective management of claim activities and loss adjustment expense.

What the insurance company does to manage litigation as part of controlling the loss adjustment expense can affect each of the other parts of the frame work. While the loss adjustment expense must be managed, it must be managed carefully and in connection with the loss costs to ensure the proper balance of the two.

Reliable litigation management, like reliable claims management in general, can do much more than simply save money. It can also empower employees because they understand their roles and responsibilities.

**CHAPTER 2:**

**REQUIREMENTS FOR**

**SUCCESSFUL CLAIMS HANDLING**

**The Claims Handler**

The claims handler may be a staff adjuster, an employee of the insurance company, or he may be a self-employed independent adjuster who represents a number of companies.

The claims handler’s role to bring about a swift and equitable conclusion of valid claims. He must work within the limits of the insurance contract. He must resist improper claims. The claims handler must be willing to settle a proper claim, and at the same time, he must be prepared to decline payment on claims which have no merit or which are not covered under policy provisions.

Some characteristics that a successful claims handler must possess are:

* **Integrity.**  A claims handler must resist the temptations that come not only directly from those with whom the claim is being settled, but also indirectly from those where business associations are formed. These include appraisers, repair shops, replacement outlets, doctors, attorneys, etc. While dauntless bribery is uncommon, sometimes those who are dependent upon claims people for their business offer gifts or services in appreciation, usually without dishonest intent. However, these practices can build obligations. Therefore, a claims handler should refuse all gratuities.
* **Courtesy.**  Courtesy, consideration, patience, and diplomacy, should be shown to everyone.
* **Intelligence.**  The claims handler must be able to quickly grasp many issues and subjects he knows little about. He must be able to investigate claims in fields which are not familiar to him.
* **Tolerance.** Tolerance includes an attempt to understand differences in points of view, politics, and ways of life, as well as race, religion, and foreign background.
* **Common sense, initiative, and persistence.**
* **Training and education.** The claims handler should have a good understanding of language. He will have to read a lot of technical material on such subjects as insurance, law, and medicine, and other subjects involving the investigation and handling of specific products or other claims. He must be able to write and speak clearly.

**Claims Handling Is Regulated by State Statutes**

Government regulation surrounds nearly all consumer product and service, including insurance policies or products and the services that are offered by insurers. All insurance consumers are considered consumers first and insurance consumers second. Insurance consumers are protected by the various laws which protect consumers in general. If a complaint is insurance related, insurance consumers are additionally protected by the insurance codes of the various states.

The objective of consumer statutes is to encourage favorable competition. As this relates to the insurance industry, insurers are required to conform to practices such as certain disclosure practices and claim settlement obligations. In addition, agents and brokers are required to exhibit certain ethical behavior.

Consumer statutes, including those targeted at the insurance industry, are one sided. This means that they have been enacted entirely to protect consumers. For instance, wherever there is ambiguity or confusion over an insurance policy contract, the issue is always decided in favor of the insured. Wherever there are questions in connection with coverage, the issue is decided against the insurance company.

Both the federal and the state governments are given significant powers concerning consumer laws. For example, these levels of government have the power to require and to standardize disclosures. These standardized disclosures allow consumers to compare goods and services, including insurance policies and other insurance products.

All states have legislation that regulates insurers. Most of these state statutes are modeled after federal legislation. There are federal laws of the Consumer Protection Act which regulate consumer practices. Then the states enact legislation which draws from this legislation. While the individual states may call their statutes by varying names, their intent is the same.

The legislation that applies to insurers and their agents, including claims handlers, is discussed below:

* **Unfair Claims Settlement Practices Act.** Under the states’ various Unfair Claims Settlement Practices Acts, insurers or their agents, including claims handlers, may not engage in the following unfair claims settlement practices:
* The failure to acknowledge, with reasonable promptness, appropriate communications concerning claims
* Knowingly misrepresenting to a claimant pertinent facts or policy provisions which relate to his coverage
* The failure to adopt and implement effective and efficient standards for the prompt investigation of claims
* Not attempting, in good faith, to make a prompt, fair, and equitable settlement of a claim submitted in which liability is reasonably clear
* Compelling policy holders to initiate law suits in order to recover amounts due under policy coverage by offering to settle for an amount substantially less than is ultimately recovered by the claimant
* The failure to maintain a complete record of all of the complaints received during recent years or since the date of the last examination by the insurance commissioner, whichever is shorter. This record must indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, their disposition, and the time to process each complaint.
* Committing any other actions which the state defines as an unfair claim settlement practice
* **Unfair Practices Acts.** Most states have some form of unfair practices act. Sometimes these statutes are known as Deceptive Trade Practices Acts, Unfair Trade Practices Acts, or Unlawful Trade Practices Acts. Even if a state does not have specific legislation on its books in connection with certain acts and practices, insurers are still held to the duty of good faith and fair dealing. This regulation is broad in scope, application, and protection. These statutes generally provide for private causes of action for any consumer who is damaged because of another’s misrepresentation, breach of warranty, unconscionable conduct, or unfair practice. This includes insurance consumers.

Violations of Unfair Practices Acts may fall into the following categories:

* **Misrepresentation.** When a seller or service provider, such as an insurance agent or broker, makes a representation, he has the duty to know that the statement is true. The consumer is clearly entitled to rely upon this representation. Misrepresentation provisions of these acts are intended to assure the accuracy of descriptions of goods and services.
* **Failure to disclose.** Allegations of failure to disclose are suitable for many causes of action, including law suits brought against insurance companies. On the one hand, agents and brokers are taught to pronounce the virtues of their products. They are not taught to point out the disadvantages of their products. Most insurance agents are not eager to explain the intricacies of policy exclusions. Any allegation of failure to disclose requires the consumer plaintiff to prove that the defendant intended to induce him into a transaction into which he would not have otherwise entered. Knowledge and intent are the necessary essential elements of the failure to disclose.
* **Breach of warranty.** Breach of express or implied warranty is a clear violation of contract law.
* **Unconscionable conduct.** The act of Unconscionability, or an unconscionable act, takes advantage of the lack of knowledge, ability, experience, or capacity of a person to a grossly unfair degree. An unconscionable act results in a gross disparity between the value received and the consideration paid for any item, including an insurance policy contract.
* **Insurance code violations.** Each state has its own and separate insurance code. Violations of these insurance codes typically fall under some sort of deceptive trade practices legislation.
* **Violations of tie in statutes.** Tie in statutes are also known as linking statutes. An insurance consumer may be granted the right to bring a cause of action under one law by linking it with another.

 There are other practices which are considered to be deceptive acts, and these are subject to appropriate codes of consumer protection as well. These are found below:

* Passing off services as those of another
* Causing a confusion or misunderstanding concerning the source, sponsorship, approval, or certification of services offered
* Causing a confusion or misunderstanding with respect to the affiliation, connection, or association with another
* Using deceptive representations or designations of geographic origin in connection with services
* Representing that services have sponsorship, approval, characteristics, or benefits when, in fact, they do not
* Making false or misleading representation with respect to the services or the business of another
* Advertising services with the intent not to sell them as advertised
* Advertising services with the intent not to supply a reasonable and expectable public demand, unless the advertisement discloses a limitation on quantity
* Representing that an agreement confers or involves rights, remedies, or obligations which it does not have or which are prohibited by law
* Misrepresenting the authority of a sales person or an agent in order to negotiate the final terms or execution of a transaction
* Concerning services, the failure to disclose information in order to induce the consumer into a transaction which he would not have otherwise entered, had the information been disclosed
* Advertising under the cloak of obtaining sales personnel when, in fact, the purpose is to first sell a service to the applicant
* Making false or misleading statements concerning the price or the rate of services
* Employing “bait and switch” advertising in an effort to sell services other than those advertised
* Requiring tie in sales or other undisclosed conditions which must be met prior to selling the advertised services
* Refusing to take orders for the advertised services within a reasonable time
* Showing defective, unusable, or impractical goods for the purposes set forth in an advertisement
* The failure to make delivery of the services advertised within a reasonable time or to make a refund
* Soliciting by telephone or door to door as a seller, unless within thirty seconds after beginning the conversation, identifying oneself and representing the purpose of the call
* Setting up or promoting any pyramid type promotional scheme
* Advertising services which are guaranteed, without clearly disclosing the nature and the limits of the guarantee
* **Unauthorized Insurer False Advertising Acts.** Under Unauthorized Insurer False Advertising Acts, insurers who are not authorized to transact business in a specific state are prohibited from sending advertisements which are designed to induce that state’s residents to purchase insurance. These acts were enacted to protect insurance consumers from insurers not authorized to transact business in the state. Unauthorized insurers are any insurance companies organized under the laws of another state, as well as any territory of the United States or any foreign country.

 Since anyone who is not so authorized cannot conduct the business of insurance within a particular state, this purpose of these acts is to protect insurance consumers concerning misrepresentation. No unauthorized insurer may issue any advertisement, estimate, or illustration, which misrepresents its financial condition, the terms of its policy contracts, benefits, advantages, dividends, etc. This includes newspaper and magazine ads, radio, television, and all circulars, pamphlets, letters, flyers, etc. If the insurance Commissioner of one state has reason to believe that an insurer in another state is engaging in this unlawful advertising, he may take action against the unauthorized insurer. In some states the Commissioner must notify the insurance supervisory official in the state of that insurer.

**Good Faith**

All insurers and their agents, including claims handlers, have the duty of good faith and fair dealing. This comes from the common law of good faith. The Courts have stated that there is a duty of good faith and fair dealing arising from the special relationship which is created by the insurer’s disproportionately strong bargaining position in the claims handing process.

The duty of good faith and fair dealing has been extended, and the Courts have held that the insured must prove two things when bringing a cause of action against an insurer:

1. The absence of a reasonable basis for denying payment of the benefits of the policy

And:

1. That the carrier knew there was no reasonable basis for denying the claim or for delaying the payment of the claim.

The “bona fide dispute” defense should be noted here. Insurance companies may maintain the right to deny invalid or questionable claims and are not subject to bad faith liability for the mistaken denial of a claim. If the insurer denies what is later determined to be a valid claim, he must respond under the terms of the policy. Therefore, as long as there is reasonable basis to deny or delay payment of a claim, and even if this is later determined to be in error, the insurer cannot be held liable for the breach of duty of good faith and fair dealing.

While the duty of good faith and fair dealing requires the parties to “deal fairly” with one another, it does not imply the burden of requiring one party to place the interests of the other party before its own.

**Other Duties of the Insurer**

* **The Duty of Care.** Every insurer has a common law duty of care. The duty of care centers on ones duties with care, skill, reasonable expedience, and faithfulness. In addition, an insurer’s standard of careis measured by requiring a determination of whether a reasonable insurer, under similar circumstances, would have delayed or denied a claim. Insurers are held to “that degree of care and diligence which a man of ordinary care and prudence would exercise in the management of his own business”. Certainly there are limits to the duty of care. For example, the insurer does not have a fiduciary duty or a duty of good faith and fair dealing to a third-party claimant.
* **The Duty to Defend.** Insurers have the duty to defend, and this duty emanates from the liability insurance contract. The insurer has the duty to defend any suit against an insured seeking damages which results from bodily injury or property damage. This duty exists, even if the allegations of the suit are groundless or fraudulent. The duty to defend occurs if the factual allegations against the insured, when they are reasonable construed, state a cause of action which is even potentially covered by the policy. However, the insurer is never obligated to pay any claim or required to defend any suit after the limit of its liability has been exhausted by judgments or settlement.
* **The Duty to Indemnify.** Insurers have the duty to indemnify**.**  As a result of the insurance policy contract, an insurer has the duty to make compensation for the incurred hurt, injury, loss, or damage.
* **The Duty to Settle.** Insurers have the duty to settle**.** The company must settle valid claims within a reasonable period of time. In order to comply with the duty to settle, all reasonable settlement demands, within policy limits, should be accepted by the insurer, unless the company is willing to take the case to trial.

**Bad Faith**

In addition to the obligations described above emanating from the duty of good faith and fair dealing, insurers have the converse obligation to avoid bad faith. Typically, the most prevailing element of bad faith is intent. The most common bad faith assertions are denying a claim or delaying payment of a claim.

When determining bad faith, a two-part analysis is observed:

* The insured must prove that the insurer’s conduct was unreasonable.
* The insured must prove that the insurer intentionally denied his claim or delayed payment of a claim, knowing the claim to be valid. Remember, as long as the insurer has a reasonable basis for denying or delaying a claim, bad faith cannot exist.

In addition to the bad faith assertion of denying a claim or delaying payment of a claim, the other commonly cited bad faith practice is suggesting that a claimant not retain legal counsel. If an insured is forced commence litigation in order to recover benefits, he can probably prove bad faith.

**Defenses to Bad Faith**

Like the defenses to causes of action brought under the terms of the deceptive trade practices acts, defenses to bad faith are also very limited. The defenses permitted to bad faith are:

* **Reasonable basis for conduct.** If an insurer can show a reasonable basis for its denial of a claim or the delayed payment of a claim, there is no breach of good faith and fair dealing and, therefore, no bad faith.
* **Advice of counsel.** An insurer’s good faith reliance on the advice of counsel is a factor in evaluating the reasonableness of the delay or denial of payment of a claim. On the other hand, an insurer’s failure to follow the legal advice of his counsel may be evidence of the violation of good faith and fair dealing.
* **Compromise and settlement.** Presenting a compromise and settlement agreement which declares that the claim dispute is in settlement would halt a bad faith action.
* **Comparative bad faith.** If the insured’s conduct contributes to the insurer’s failure to pursue a claim or to deny or delay a claim, the comparison of the conduct of the insurer and the insured may be a factor in the defense of the insurer.
* **Statute of limitations.** If the statute of limitations on a claim dispute has expired, typically two years, a bad faith action cannot be brought.
* **ERISA preemption.** TheEmployee Retirement Income Security Act of 1974 (ERISA) is a federal act which supersedes any state’s statutory bad faith laws. Group health accident, disability, and death insurance benefits supplied as part of certain benefit programs are subject to ERISA. Therefore, ERISA preempts a state’s remedies for unfair claim settlement practices.

**Bad Faith Damages**

There are four means by which bad faith damages may be awarded:

* **Compensatory damages.** Consumer plaintiffs may recover compensatory damages for all damages which are proximately caused by the defendant’s conduct, as well as mental anguish damages. (Proximate cause is the nearest cause of a loss. It is the first cause in a chain of several events which result in a loss. Proximate cause is an event or thing, without which the loss would not have occurred.)
* **Common law punitive damages.** Punitive damages are recoverable when negligence becomes gross negligence or when the insurer’s conduct is intentional. That is, the insurer must have acted recklessly with a fraudulent attempt or with malice. A punitive damage award requires a preliminary finding of fraud, malice, or gross negligence on the part of the insurer.

* **Preponderance of the evidence.** Punitive damages can be award based on the preponderance of the evidence. Not all states require that punitive damages be based on a preponderance of the evidence. Some states can make these awards simply based on a “clear and convincing standard”.
* **Review of damage awards.** Punitive damage awards for the breach of duty of good faith may be given based on a review of a previous award. In some cases, if an insurer accepts coverage and pays damages, a bad faith action may still be brought. Upon review, further damages may be awarded, such as mental anguish or punitive damages, if reckless disregard of the insured’s right can be proven.

The objective of insurance consumer protection acts is to protect consumers against unfair or deceptive practices or acts. In order to provide consumers with this protection, they must be provided a means of relief. This relief takes the form of grounds for actions to be brought against insurers. In order to secure this relief for the insurance consumer, liability on the part of the insurer must be found. Liability may be based on one or more theories of recovery. If an insurance consumer brings an action against an insurer, the action must be based upon one of the following theories of recovery:

* **Breach of contract.** If an insurance policy contract provides for a specific coverage which is not conferred, a law suit may be initiated under the breach of contract theory.
* **The breach of the duty of good faith and fair dealing.** The duty of good faith and fair dealing is breached if the insurer denies or delays the payment of a claim without a reasonable justification. The duty of good faith and fair dealing is also breached if the insurer fails to determine whether there is a reasonable basis for the claim.
* **Negligence.** Negligence may be established if an insurer fails to perform its duty. For example, the breach of the duty of good faith and fair dealing is often considered negligence.
* **Fraud.** There are several elements of fraud as a theory of recovery. A material representation must be made which is false, and the maker of the representation must know that it is false. Or, the maker must make the representation recklessly. Also, the maker of the representation must make it with the intention that it should be acted upon by the other party, and the other party must rely on it and suffer some resulting injury.
* **Deceptive trade practices.** Deceptive trade practices as described previously are often cited as a theory of recovery.
* **Unfair insurance practices.**  Engaging in unfair insurance practices is often covered by the provisions of unfair competition and unfair practices or under the provisions of unfair claim settlement practices.
* **Claim denial or untimely claim payment.** The denial of a claim or the untimely payment of a claim is grounds for recovery by a claimant. An insurer must comply with certain time limits when paying or denying a claim. Otherwise, the insurer may be held liable.

**The Duties of the Insured**

The insured must follow certain procedures in order to make a claim. First, he must give prompt notice of the claim. If making this notification by phone, it is recommended that the claim also be made in writing.

The insurance company’s obligation to the insured may be reduced or ended if:

* The insured fails to give prompt notice, and
* This failure affects the insurer’s ability to dispose of or to defend the insured against the claim.

The insured must give the insurer a signed Proof of Loss, if requested. This is submitted on a Proof of Loss Form, typically submitted within 91 days of the request. Typically, within 15 days after the insurer receives the notice of the claim, the insurer will request the signed Proof of Loss Form. If the insurance company does not make this request, it’s essentially waives outright to require a proof of loss. However, this waiver will not waive the company’s other rights under the policy.

The Proof of Loss statement must have the following information, to the best of the insured’s knowledge:

* The covered risks which resulted in the loss,
* The dollar amount of the loss
* The method used to compute the amount of the loss

The insured may be required to show records such as checks, letters, contracts, and other papers that relate to the claim of loss, and the insurance company may make copies of these papers.

If the insured states that any of this information is confidential, the insurance company may not disclose it to anyone else unless there is a reasonable belief that the disclosure is necessary to administer the claim.

**Sample Proof of Loss Form**

The following is a sample of a Proof of Loss Form. Students should be familiar with this sample form.

**PROOF OF LOSS FORM**

 Please complete all items to the best of your knowledge and return this form

within 90 days. We will use the form to determine if your loss covered under the policy.

NOTE: DELAY IN RETURN OF THIS FORM MAY AFFECT OUR ABILITY

TO PROMPTLY PROCESS YOUR CLAIM.

FOR INFORMATION OR TO SUBMIT A CLAIM, CALL 1-800- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(1)** Name of Insured(s):

 Address of Insured(s):

 Telephone Number of Insured(s):

**(2)** Your interest in the Property:

\_\_\_OWNER \_\_\_MORTGAGEE \_\_\_OTHER (If other, please explain)

**(3)** Please complete the following to the best of your knowledge or attach a copy of

your policy:

 a) Date the policy was issued, if known:

 b) Policy number, if known:

 c) File or GF number, if known:

 d) Name of issuing agent, if known:

 e) Legal description of the property (see deed or title insurance policy):

 f) Street address of property:

 Failure to provide enough information for us to identify your policy may result

in a delay in processing your claim or denial of your claim.

**(4)** Please describe the problem you believe affects the title to the property:

**(5)** Do you have an opinion about the amount of loss or damage caused by

the title problems described in Item 4? \_\_\_\_\_\_YES \_\_\_\_\_\_NO

 a) If yes, what is that amount? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. (Please contact us if you need to revise this amount after submitting this form.)

 b) How did you determine this amount? (Please attach any documents you have that show how you determined the amount.)

**(6)** Have you been sued or threatened with a law Suit because of the matter described

in Item 4? \_\_\_\_\_\_\_YES \_\_\_\_\_\_\_NO

 a) If yes, how did you learn of the law suit or threatened law suit?

 b) Have you been served with a petition or other legal document in a law suit?

 \_\_\_\_\_\_YES \_\_\_\_\_NO

 If yes, when and how were you served?

 Please attach copies of all documents you have relating to the law suit,

including letters, the citation, the petition, and the complaint. We may need to ask

for additional information about your claim. You are required to provide only

the information the policy allows us to ask for.

 If two or more persons are named in the policy, both may sign the same form:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date

STATE OF\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COUNTY OF\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SWORN AND SUBSCRIBED before me, the undersigned authority, this

\_\_\_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 19\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

The insured may be required to answer questions under oath.

The obligation of the insurer may be effected by the failure of the insured to cooperate. This obligation may be reduced or terminated if the insured fails or refuses to:

* Provide a statement of loss
* Answer questions under oath
* Offer the papers requested

and if this failure or refusal affects the insurer’s ability to dispose of or to defend the insured against the claim.

**Special Provisions**

There are certain provisions found in insurance policy contracts which should be familiar to the professional claims handler. These are discussed in the sections which follow.

**Timeliness Provisions**

There are timeliness provisions of insurance policies which state the actions the insured must take following an insured event and the filing of a claim.

For example, with respect to liability insurance, the settlement and litigation of a liability insurance claim often involve unique problems. This mainly is because liability insurance is a third-party coverage. The insurer’s contractual obligation is to pay all sums which the insured is legally obligated to pay as damages. The liability insurer’s obligation to indemnify the insured is fault based. The insurance benefits are generally paid to a third party, rather than to the insured or to his beneficiary.

The interests of a liability insurer and its insured are not always the same when it comes to tort (a civil action) claims against the insured. The differences in the positions of the insurer and the insured can be in conflict.

Timeliness provisions serve several purposes. Timeliness provisions are essential to permitting the insurer an appropriate opportunity to investigate the claim so that it can assess the coverage issues and the extent of the loss. In addition, timeliness provisions are a matter of public interest because they reduce the opportunities for fraud. Finally, timeliness provisions provide clear, unambiguous, and enforceable contract provisions.

The policy provisions which relate to the timeliness of actions by a claimant after an insured event include:

* Clauses which require that the insured provide the insurer with a prompt notice of a loss
* Terms which require a proof of loss within some specified period of time
* Conditions in liability insurance policies which state that an insurer must immediately forward to the insurer all documents which the insured receives, in the event a suit is filed against the insured
* Provisions which restrict the time within which a suit may be initiated by an insured against an insurer as a consequence of a loss

Some timeliness provisions require that the claimant must perform certain actions within a specified period of time following an insured event. This might be expressed in days, months, or years. These policy provisions are designed for providing certainty. Insurance companies often prefer this specificity in their timeliness contract provisions. For example, when an insured event occurs, many policy provisions state that notice “shall be given as soon as practicable, but in no event to exceed 60 days”.

In some cases, a more generalized time limit may be given. The terms used in generalized time limits are “reasonable” or “adequate”. These policy provisions are designed for flexibility.

Other provisions in insurance policies set forth a time period following the loss within which a law suit may be filed against the insurer.

For example, property insurance policies usually provide that:

“No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law unless commenced within twelve months after the inception of the loss”.

Likewise, some of the policy forms used for uninsured motorist insurance state that:

“No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity unless it is commenced within twelve months from the occurrence on which the claim is based”.

An issue of enforceability arises when a timeliness clause sets forth a time limit for initiating a law suit against the insurer which is less than the statute of limitations period. Naturally, these types of claims generate a great number of disputes.

**Fraud Provisions**

An important aspect of the process of presenting a claim relates to the accuracy of the information that a claimant provides to the insurer. Many insurance policies include provisions which specifically address the issue of fraud in connection with claims. For example, the following is a clause commonly found in fire insurance policies:

**"**This entire policy shall be void if, whether before or after a loss, the insured has willfully concealed or misrepresented any material fact orcircumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto”.

This type of clause is referred to as afraud clause or a false swearing clause**.** Similar or identical language is also used by insurers for other kinds of insurance. In many situations, these types of provision have provided the basis for successful defenses by insurers. For example, when an insured willfully conceals information about an insured loss or if he submits incorrect information in an insurance claim, the claim can be denied. When a claim is deliberately false, a successful defense of the claim can be pursued.

Most of these types of policy provisions employ terms such as “willful concealment” or “misrepresentation of a material fact”.

In many states, there is legislation which regulates defenses based upon a misrepresentation in the proof of a loss. These statutes typically have the following requirements:

* The claimant’s misrepresentation must be fraudulent, that is, not unintentional
* The misinformation must concern a matter which is material to the liability of the insurer.

**Assistance and Cooperation Provisions**

Liability insurance policies generally have provisions which provide that an insured is required to cooperate with the insurer in the investigation, settlement, and defense of tort claims. These provisions are referred to as assistance and cooperation provisions. As a matter of fact, many insurance policies actually require that compliance with the terms are conditions of the liability of the insurer.

Assistance and cooperation provisions usually require the following:

* The claimant’s attendance at hearings and trials
* The claimant’s assistance in effecting settlements and in securing and giving evidence
* The claimant’s cooperation in aiding in the conduct of suits which result from tort claims

In addition, most liability insurance policies have negative assistance and cooperation provisions. For example, negative provisions typically state that, except at the insured’s own cost, the insured will not voluntarily make any payment, assume any obligation, or incur any expense, except when there is an imperative need for medical and surgical relief immediately after an accident. These provisions also address the issue of prohibiting settlements without the consent of the insurer.

Of course, there are limits on what an insurer may request from an insured. For example, an insured may not be required to falsify information or to withhold facts from a claimant. In addition, an insurer cannot require the insured to act entirely without regard to the insured’s interests.

Although the policy provisions above are discussed from the insured’s perspective, these must be familiar to the professional claims handler.

**Tips for Smoother Claims Filing and Handling**

The claims for all perils insured against can be handled more efficiently by simplifying the insurance claim. For example, in connection with storm damage, knowing the basic steps to take and mistakes to avoid can be a big help to insureds in obtaining a prompt and satisfactory insurance settlement after a hurricane.

Insurance companies and the state Departments of Insurance and Claims Handling Departments set up special offices in the disaster areas to help people with their claims. They notify local news media of disaster center locations and phone numbers as soon as they are activated. Policy holders also can usually call their state’s toll free disaster help line to ask questions about the claims process, to get help in locating their insurance companies, or to seek assistance in filing complaints.

If policy holders need help finding their way through the claim process, the state’s staff is usually on hand to help. However, most people can move their claims along just fine if they use common sense and take time to understand what their policies cover.

The following tips are useful for making the claims process run smoothly. An insured must be made aware of the following claim filing tips so that he can be prepared for his meeting with the claims handler:

* The insured should contact his insurance company or agent as soon as possible. In order to speed up the claims handling process, the insured should provide the policy number from the first page of the policy. If the policy has been lost, the agent can look up the necessary information.
* Insureds should make a detailed list and description of damage, including photographs of the affected area, if possible. They should collect canceled checks, receipts, and other documents to help the claims handler set a value on damaged or destroyed property.
* Insured should review their coverage. They might not be aware, for example, that their home owners’ or renters’ policy pays for debris removal and for emergency housing and living expenses if hurricane damage forces them to move temporarily. If he cannot find his policy, the insured can ask his agent or company for a copy.
* Insureds should make temporary repairs and take other steps to protect property from further damage. Receipts should be saved for the materials purchased for repairs. Generally, these can be reimbursed by the insurance company as reasonable emergency repairs.
* Insureds should not make permanent repairs before an insurance claims handler inspects the home. They should make only temporary repairs to protect the property from looting or further damage. The insurance company might deny a claim if the insured makes permanent repairs before the claims handler inspects the damage.
* If damage in the area is extensive, the insured should take extra steps to help the insurance company's claims handler find him. If the damage forces the insured to move, he must be sure to tell the insurer where he is and how he can be reached by phone. A note may be left at the damaged residence telling the insurance claims handler how to find him. Also, the address should be visible from the street. Or, the insured might paint his insurer's name, his policy number, and his temporary address and phone number on a plywood sign.
* If the insured cannot remain in the home because of damage, a home owners’ or renters’ policy will pay for staying in a hotel, motel, or other temporary shelter.
* If possible, the insured should be present during the claims handler's inspection and take notes on the discussion. As a matter of fact, he may even want his own contractor or builder present to represent his interests. However, joint inspections might be difficult or impossible when storm damage is widespread.
* The insured should keep good notes on all contacts with his insurance company and claims handler. The chances of effecting a satisfactory settlement improve when the facts are prepared. For example, names and dates should be written, "who said what," etc. Good records are essential, especially if a claim dispute erupts.
* A final claim settlement should be reached only when both parties are satisfied that it is fair. Insureds may obtain independent estimates if they wish.
* After major storms, public claims handlers offer to help victims pursue their insurance claims -- for a price. If the insured decides to hire a public claims handler, he should be aware of the fee, usually a percentage of the claim payment.
* Insureds should get more than one bid for construction or repair work. A local contractor with a good reputation is the best bet. Storm damaged areas often attract fly by night operators who do shoddy work or who skip town after receiving advance payments.

**When the Insurer is Notified of a Claim**

Insurance policies contain provisions which set forth the procedures which must be followed when reporting a loss and presenting a claim to the insurer. Most policies state that the insurer’s obligation to pay a claim is predicated upon compliance with these procedures.

Claimants can avoid disputes over these policy provisions simply by satisfying the various notice and claim procedures specified. However, in some cases, the necessary actions are not taken by a claimant. This may happen because of a mistake or may occur as a result of confusion or delay. When this happens, the insurer may find itself the target of a law suit.

The types of policy provisions which relate to the claims handling process and which are most frequently involved in litigation include:

* Clauses specifying when notice of a loss must be provided to the insurer
* Terms restricting the period within which a claim must be presented or a law suit must be initiated against an insurer
* Requirements mandating that an insured who seeks coverage under liability insurance must assist and cooperate with the insurer
* Provisions which are used in uninsured motorist insurance restricting an insured’s right to settle tort claims and the arbitration clauses

When a claimant fails to comply with one or more of these requirements and the insurance claim is rejected on that basis, the possible outcome of this may be the elimination of the claimant’s right to bring a suit against the insurer.

After receiving a claim notice, or when the insurer in any other way, learns of a matter for which it is liable, the insurer can elect to do one or more of the following:

* Pay the claim
* Negotiate a settlement
* Prosecute or defend a court case related to the claim

When the insured reports to the insurance company that a covered risk exists, the insurer must promptly investigate to determine if that covered risk is valid and not barred by law or statute. A covered risk is a risk that the policy does not exclude or except.

If the insurer concludes that the claim, or any part of the claim, is covered by the policy, the insurer must take one of the actions listed above, to the extent that it is covered.

If the insurance company denies the claim, or any part of the claim, within not more than a specified number of days, typically 15 days, after denying the claim, the insurer will:

* Notify the insured in writing, and
* Give the reasons for denial of the claim in writing

**Reservation of Rights Letters**

Upon receipt of an insurance claim by the policyholder, many insurance companies routinely respond with "reservation of rights" (ROR) letters. These are often frightening and incomprehensible to the policyholder.

Reservation of rights letters are long, strongly termed statements advancing the insurance company's position as to why insurance coverage may be denied or substantially reduced. They usually recite the very same facts the policy holder presented when the claim was filed. Reservation of rights letters may also list any of the insurance policy exclusions that the insurance company argues are potentially applicable to the claim. These letters also usually inform the policy holder that the insurance company will withdraw from defense of the claim at any time the insurance company believes that no insurance coverage exists under the insurance policy.

Reservation of rights letters frequently prove both awesome and mysterious to the policy holder. They can come as a shock and, if not properly worded, are likely to draw the anger of the policy holder.

Typically, after laying out the grounds for the potential denial of insurance coverage, the reservation of rights letter includes the following clause:

"Unless the insurance company receives written notice to the contrary within ten days of this letter, the insurance company shall assume that the policy holder agrees to its handling of this matter with a full reservation of rights, and the insurance company shall proceed accordingly."

**Handling a Claim or Court Case**

The insured must cooperate with the insurance company in handling any claim or court case and give up all relevant information. The insurer is generally liable for only those settlement costs, attorneys' fees, and expenses which are approved in advance.

If the insurance company elects to defend, the company has the right to choose its attorney. The insured has the right to disapprove the insurer’s choice of attorney for reasonable cause. However, the insurer can appeal any decision to the highest court.

The insurer does not have to pay the claim until the case is finally decided.

**Prompt Payment Laws**

All states have prompt payment laws which require an insurance company to respond within a specified number of days, usually 15 days, after receiving a written notice of claim. At this time, the company may ask for more information to document the loss.

After the company receives all requested information, it has the specified number of business days to accept or reject the claim. If the company is unable to accept or reject the claim within this time, it must notify the insured as to why additional time is required to process the complaint. The insurance company will then have typically up to 45 days to accept or reject the claim. However, in the event of weather related catastrophe or major natural disaster, the claims handling deadlines under the prompt payment law may be extended.

Once the insurance company agrees to pay the claim, it must send the check or draft within a specified number of business days, usually five business days. (Surplus lines carriers get additional business days to pay, usually 20 days.

If the company rejects a claim, it must state why in writing.

The prompt payment laws apply only to claims against the insurance policy. It does not apply to liability insurance claims against another person's insurance company. It also does not apply to claims against HMOs or self-funded plans.

**Paying Insurance Claims**

Insurers do not need to be reminded that the law requires them to pay their customers first-party claims promptly. Otherwise, they are subjected to possible penalties. The failure to pay a first-party claim within the time limits set forth by the state is illegal and may result in disciplinary action, penalties, or both.

A first-party claim is one filed by a policy holder or enrollee against his or her insurance company or HMO. For example, a typical first-party claim by an HMO member would be for emergency care at a hospital outside the HMO's provider network. The state’s Department of Insurance expects compliance with prompt payment laws. Other laws require prompt reimbursement to physicians and other health care providers.

In general terms, the prompt payment laws require licensed insurance companies and HMOs to:

* Acknowledge claims, begin their investigations, and request any needed information from claimants within a specified number of days, typically 15 days, after claims are received.
* Notify claimants in writing of the acceptance or rejection of their claims within a specified number of days, typically 15 days, after receiving all required information
* Give their reasons in writing when they reject claims
* Make payment within a specified number of business days, typically five business days, after notifying claimants that their claim will be paid. If payment is conditioned on some action by the claimant, then payment must be made within a specified number of business days, typically five business days, after that action.

**Often Asked Questions and Answers**

Some of the most commonly asked questions regarding an insurers’ duties to pay claims are shown below with their appropriate answers:

**Q.** How long does an insurance company have to pay a policy holder’s claim?

**A.** After receiving the claim, a company typically has 15 business days to review it and to request additional documents. Whether a company accepts or rejects the claim, it must notify the claimant of its decision, usually within 15 business days after receiving all claim documents. If the company cannot meet that deadline, it must notify the policy holder and give reasons why it needs more time. The company then may typically take an additional 45 business days (from the date notice was given that more time was needed) to reach a decision. If a claim involves an HMO or PPO, other time frames may apply.

**Q.** Why are claims sometimes denied after it being pre-authorized by the insurance company?

**A.** Pre-authorization is not a guarantee of payment. A company decides whether it will pay a claim after receiving all the necessary documents and reviewing its contract with the policy holder.

**Q.** Why do insurance companies sometimes reduce the fee paid?

**A.** Insurers often pay only “reasonable and customary” fees. Insureds may submit these charges to the county medical association for a peer review, requesting that the mediation committee advise if the charges are within the usual and customary range for the services rendered. If the committee agrees that the charges are consistent with those of other physicians, the insured can submit the committees’ statement to the insurance company with a request for additional payment.

**Q**. Who pays claims if a company fails?

**A.** Guaranty associations pay policy holders' claims when licensed insurance companies fail. There are separate guaranty associations for life and health insurance, property and casualty insurance (such as auto, homeowners and workers' compensation), and title insurance. The funds to pay claims on a failed company's policies come from charges, called assessments, paid by all licensed companies writing the same type of coverage. Companies recover some of these charges through tax write offs.

**Q.** What happens to the claim if the insurance company is based in another state?

**A.**  If the insurance company is licensed to sell insurance in a particular state, the insured is covered, subject to the exceptions and limitations of the policy.

**The Insurer’s Limitations of Liability**

Typically, an insurance company’s liability is limited by the following:

* The insurer will pay up to the actual loss or the policy amount in force when the claim is made, whichever is less.
* All payments made under the policy -- except for costs, attorneys' fees, and expenses -- will be subtracted from the policy amount.
* If the insured does anything to affect any right of recovery or defense he may have, the insurer can subtract from its liability the amount by which the insured reduced the value of that right or defense. However, the insured must add back to his liability any amount by which their expenses are reduced as a result of the action.

**Complaints Against Insurers**

Each year the states’ Departments of Insurance consumer protection programs assist insurance consumers with more than 1,000,000 complaints. Because of these efforts, consumers receive millions of dollars in additional claim payments and refunds.

Among the complaints accepted by the state Departments of Insurance are those against insurance companies, HMOs, insurance agents or agencies, and those that involve disputes about claims and benefits, false advertising or misrepresentation of policies, suspected insurance fraud, and other complaints that may fall within the state’s jurisdiction.

The majority of complaints received involve persons unhappy about a claim settlement. The information to follow explains how complaints against insurers can be avoided. Again, although this information with written from the insured’s perspective, the professional claims handler should be aware of this. For example:

* Insureds should read their policies and be familiar with them. The insurance policy is a contract between the insured and the insurance company. Consumers need to understand their policies' coverages in order to settle claim satisfactorily.
* Insured should read their Consumer Bill of Rights, offered in most states. A consumer bill of rights is often included with personal automobile, home owners’ and credit life policies or renewals. The consumer bill of rights explains the insured’s rights and responsibilities under the law.
* Insureds should document all conversations and contacts between themselves and the insurance company involving a claim, as well as time and expenses.
* Insureds should maintain a file of all paper work related to their claims.
* Insureds should ask for a written explanation of what their policy covers. They should find out if any disagreement is a matter of policy interpretation.

With respect to auto and home owners’ insurance, the following can help to assist in settling claims and will help prove that uninsured losses that are tax deductible.

* The insured should find out if he is properly insured. If he is not, he should check on what coverage he needs in order to avoid future problems.
* The insured should make an itemized list of personal property, including furnishings, clothing and valuables.
* The insured should video tape or photograph the inside and outside of his home and / or car.
* An auto or home owners’ policy may require the insured to make temporary repairs to protect the property from further damage. The cost of these repairs is covered by the policy. Insureds should keep all receipts and damaged property for the claims handler to inspect. The insurance company may deny a claim if permanent repairs are made before it inspects the damage.
* If possible, the insured should find out what it will cost to repair the property before meeting with the claims handler.
* Insureds should ask the claims handler for an itemized explanation of the claim settlement offer including depreciation, holdback depreciation, and sales tax. Holdback depreciation is an amount of money withheld from the claim settlement until damage repairs are finished or the items are replaced. Insureds should be aware of which price guide the claims handler uses to base his estimates.
* Insureds should keep records of improvements made to their property.

With respect to accident and health claims, the following can help to assist in settling claims:

* The insured should read his life or annuity annual statements and be aware of economic changes that may affect the value of the policy.
* The insured should review his policy or benefit plan to make sure that it fits his health needs. He should pay attention to restrictions, exclusions, policy limits, lifetime coverage maximums, and policy definitions.
* The insured should determine if his policy or benefit plan covers today's medical needs. For example, does it cover outpatient care or day surgery? Limited benefit policies cost less but probably will not provide the benefits or services needed to meet most health care expenses.
* The insured should obtain required precertification for hospital admissions or provider referrals.
* The insured should understand his responsibility to notify the insurance company or HMO after being admitted to the hospital under emergency conditions.
* If the policy has a provider network, the insured should understand the restrictions or limitations about going to an out of network provider.
* The insured should find out if his policy allows the health care provider to bill him for charges not paid by the health care plan.
* Insureds should ask their physicians to provide the insurance company with additional details about treatment, condition, and prognosis.
* If an insured suspects he is being overcharged by a provider, he may ask the insurance company to audit the bill, asking the company if the proper billing procedure code was used. If there is still a large balance owed, the provider may submit the bill to the local medical society peer review committee to review the charges.

Finally,

* Before contacting the state Department of Insurance, the insured should contact his insurance company or agent first.
* Most companies operating in most states are required to have a toll free telephone line to provide customer assistance. This toll free telephone number should be listed on the policy. Insureds should be prepared and have their questions planned and their policy number available before calling the company.
* If there is a dispute with an agent or with the insurance company, it should be put in writing. This encourages the company or agent to respond in writing. The insured should state his complaint and how he expects the company to handle it. Many property and liability policies, such as auto and home owners’, offer an "appraisal process" to resolve the dispute. This appraisal procedure allows the insured and the insurance company to choose separate damage appraisers. The two appraisers pick an “umpire”. An estimate that any two of these people agree to is binding. However, the insured is required to pay for his appraiser and for half of the negotiator's costs.
* Included with the complaint should be copies (not originals) of letters, notes, invoices, canceled checks, or advertising material that support the complaint.
* Insureds should keep a copy of any correspondence sent or received. A log should be used to document telephone conversations or in person contacts, including the date, the name and title of the person spoken with, and what was said.
* Finally, if the matter is not resolved, the insured can file a written complaint with the state Department of Insurance.
* Insureds should be willing to negotiate.
* Neither party should rush into making a settlement.

**Complaint Notice**

All insurance policies must provide a complaint notice. Should any dispute arise about a premium or about a claim that the insured has filed, the insured should first contact his agent or the insurance company. These names and addresses must be clearly stated on the policy or the declarations, along with a toll free telephone number for contacting either the agent or the company. In addition, it must be stated that if the insurance company does not resolve the problem, the insured may contact his state’s Department of Insurance, giving that address and toll free telephone number.

A notice of complaint procedure is for information only. It does not become a part or condition of this policy.

**How Is a Complaint Against an Insurer Handled?**

Within our study of avoiding consumer complaints, let’s focus on how an official insurance consumer complaint is handled.

When an insured makes a complaint against an insurer, the state’s Department of Insurance assigns a specialist to the case and sends the insured an acknowledgment letter. Next, the state will notify the insurance company of the complaint promptly, usually by fax, asking for a detailed response. The state sends the insured a copy of the response when it is received from the insurance company.

The insured is kept informed by mail of the status of his complaint. He also may write the assigned specialist regarding the status of the complaint. The state will send the complaining insured an explanation of the final outcome. It may take several weeks to complete the complaint process.

Most state laws do not allow the Department of Insurance staff members to give consumers legal advice or opinions.

If the insured is not satisfied with these results, he may consider a law suit against the insurance company. However, there are some alternatives to law suits, and these will be discussed in greater detail later. Briefly, many people are trying Alternative Dispute Resolution (ADR) to settle their insurance complaints. Alternative Dispute Resolution generally refers to the use of a neutral and impartial third party to help settle a dispute outside a formal court of law. Use of alternative dispute resolution to settle an insurance claim can reduce the delays and costs of a trial.

In many states, auto or home owners policies do not provide alternative dispute resolution as a method of claims settlement. The choice to engage in alternative dispute resolution is not that of the insured alone. The insurance company must agree to participate in the alternative dispute resolution process.

Unfortunately, in some cases, a law suit is the only way to resolve a dispute involving fact issues and legal obligations. All states place the burden of proof on the insurance company, not the policy holder. This means the insurance company must prove it was not obligated to pay the claim.

If the insured wins a law suit for the violation of the prompt claim payment laws, the Court can require the insurance company to pay as much as an 18 percent penalty, plus the insured’s attorney fees.

**CHAPTER 3:**

**THE CLAIMS HANDLING PROCESS**

**Aggressive Good Faith and Successful Claims Handling**

What is good faith claims handling? Good faith claims handling involves proper claims handling, reporting, and communication. Good faith claims handling procedures keep insurers out of jeopardy.

Aggressive good faith in successful claims handling is an awareness claims handlers must possess. For example, there are rules and laws formulated to protect the public good in insurance claims relationships. Professional claims handlers must be informed about the various exposures which exist, the reasoning and legal trends which are being applied within the Courts, and the marketplace for insurance buyers.

Experience and good judgment on the part of the claims agent are essential, as are the use of common sense in communication. This behavior results in successful claims handling.

Insurance agents, brokers, and claims agents must be knowledgeable about their responsibilities to the public and the expectations of their insureds.

**Poor Claims Service Can Lead to Litigation**

The case of a Philadelphia janitorial service that is suing its insurance carrier for failing to deliver the professional claims services it had promised is symptomatic of a growing trend in the insurance industry today. The policy holder alleged that the insurer's negligence resulted in additional premiums under a retrospective premium endorsement and an increased experience modification applicable to future policy years. The plaintiff sought unspecified punitive damages in addition to more than $500,000 in compensatory damages.

What sets this law suit apart from others is the plaintiff's reliance on the insurer's representations of the quality of its services made prior to sale of the policy. This case is one more indication that insurance buyers now place greater emphasis on an insurer's quality of service than on its premium or policy terms and conditions alone.

People are suing their insurers for failing to settle cases within policy limits, failing to pursue subrogation recoveries from third parties, and failing to provide the level of services to which the insurance contract entities them. Most cases involve the administration of workers' compensation claims, although some suits have alleged negligent handling of claims under other retrospectively rated policies.

Retrospective rating plans adjust premiums for the policy period based on losses experience incurred during that period. Because that experience cannot be known when the policy is issued, the plans provide for adjusting the premium after expiration. While traditional experience rating -- using past loss experience to modify future premiums-- often is compulsory, retrospective rating plans are always optional.

The special relationship created by retrospective rating plans has led courts to conclude that the insurer is, in effect, playing with the insured's money and, therefore, assumes an independent duty to investigate and settle claims fairly and in good faith. Breach of that duty has led to judgments in tort against insurance carriers in four states. In addition, the Courts have found not only that the provisions of the retrospective rating plan impose an additional duty to settle claims fairly and in good faith but that the burden of proof is on insurers to show that this duty was met.

The prompt and fair handling of claims is a sound measure of an insurance company. After all, with the exception of the initial policy purchase, this is the typically the only area in which consumers interact with an insurance company. The company is judged by the way in which the Claims Handling Department performs its obligations. Proper claims handling is synonymous with fairness and ethics. Proper claims handling requires compassion, diplomacy, and understanding.

**The Beginning of the Claims Handling Process**

After an insured policy holder makes a claim, it is referred to the claims handler. The claims handler’s performance at this point is critical to proper claims handling practices. Proper claims handling procedures are discussed below.

**Reserves**

Reserves are estimated sums of money that are set aside by an insurance company to cover known and unknown claim settlements and verdicts, as well as claim expenses.

There are three principal types of reserves that affect claims and claims handling:

* **Unearned premium reserves.** These represent that part of the premium which has not been earned as of any given time. It is the amount of money that would have to be returned to the policy holders if the company stopped doing business.
* **Incurred but not reported reserves (IBNR).**  IBNR reserves are required by law to take care of accidents which have occurred, but which have not yet been reported to the insurance company. Since all accident reports are delayed to some extent, there is always a delay between the time the accident occurred and the time the company received the report. This may range from an hour to days or weeks or months. At any given time, an insurance company has outstanding claims which have not been reported.
* **Actual claim reserves.** Actual claim reserves represent the best estimate of the amount of money that will be required to pay the outstanding claims at any given time. They are amounts put aside to pay claims that have been reported to the company, but which have not yet been paid in full.

An insurance company must maintain the proper balance between reserves and payments made on claims and suits The solvency of an insurance company depends on its loss ratio, a comparison of premium amounts against claim payments. Reserves are the projection of claim payments plus suit verdicts yet to be experienced.

There are many reasons for making every effort to keep reserves as close to the claim payment as possible. These are:

* Underreserving gives a distorted picture of the profitability of lines of business.
* The financial condition of a company can be affected by unnecessarily higher taxes and less investment profit.
* Retrospectively rated risks can be distorted, which leads to bad customer relations.
* Agency contingent fees become distorted, and this leads to a bad effect on the product.

**Reserve Setting and Reviewing**

Upon acceptance or conditional acceptance of a claim under an insurance policy, the insurer must set an initial reserve, typically within thirty (30) days. This reserve must:

* Set an accurate estimate, in the best judgment of the insurance company's personnel, of the costs expected to be paid to the insured or other parties in the settlement and processing of the claim. A nominal initial reserve is generally used only when opening a file without adequate information to make an appropriate assessment of the risk.
* When a nominal initial reserve has been set in accordance with the above, change the reserve to reflect the risk as soon as sufficient information has been received.
* When a nominal initial reserve has been set in accordance with the above, change the reserve to reflect the risk as soon as sufficient information has been received.
* Review each reserve on a regular basis and adjust the reserves as warranted by new information or changed circumstances. It is equally important that a claim not be over-reserved or under-reserved.
* Maintain written records of the initial reserve and any change to the reserve, including the reasons for any change in the reserve, in the file for review by the state’s commissioner, typically for a period of three to five years.

**Account Servicing Instructions**

Managing claims effectively is nearly impossible without complete and explicit account servicing instructions. Also known as account instructions, claim service instructions, and account handling instructions, account servicing instructions represent the understanding between a large insured client company and the field claims handlers at the insurer's branch offices. This agreement guides the handling of all suits and claims, both litigated and unlitigated. These instructions are disseminated to all branch offices across the country. Given account servicing instructions, the claims handler can proceed with handling claims of this client with minimum interruption.

Account servicing instructions are found in a clear, narrative format. Account servicing instructions include information about how claims are to be handled in every line of insurance. Third-party administrators who provide claims servicing without insurance also have account servicing instructions to guide their claims handlers.

After account servicing instructions are negotiated, the insured client company familiarizes all internal claims handling personnel with the provisions of the instructions and provides them with a written copy to ensure that they understand the responsibilities for key areas of claims handling.

In addition to containing policy holder information and details about coverages and dissemination of data, account servicing instructions can also contain other lesser known guidelines. These might include the referral of medical reports to a physician consultant for preparation of a letter to set up an independent medical examination or a requirement that subrogation can be waived only upon receipt of a written evaluation and agreement by the company.

In implementing an aggressive claims management program by means of account servicing instructions, the insured client company is essentially taking control of its claims, exerting more authority in the handling of claims, and becoming much more involved in their management. When a company has chosen to become more involved in managing, as distinguished from monitoring, the roles and responsibilities of all parties, including the insured client company and the insurance carriers, must be dearly defined.

Account servicing instructions may include instructions about settlement options. For example, there is a world of difference between an insurer having to consult its insured and having to obtain its consent prior to settling a claim. If the insurer agrees to consult its client prior to settlement, the client may not have the power to alter the course of the claim.

From the insured’s perspective, a settlement decision can have an impact well beyond bottom line considerations. Settlements can affect a company's labor policy, its workers' compensation practices, the reputation of its products, and its susceptibility to future claims. For instance, an insurer's denial of a legitimate workers' compensation claim can adversely affect the labor climate.

The insured can negotiate for the right to select legal counsel in any case where the exposure is within its retention level. The right to select counsel is different from the right to suggest or to be consulted on the selection of counsel because it allows the insured to use an attorney of his choice.

The insured may also retain the right to request and select private investigators and may have the right to specify the type of investigation needed. For example, an insured company that aggressively controls its workers' compensation claims may want to have the right to select the investigator of its choice because it has had previous success with a local investigator or a certain firm that it uses nationwide.

An insured company may request that all settlements over, say, $10,000 be considered for structured settlement, and may reserve the right to select a structured settlement company of its choice or to obtain competing bids from financially sound structured settlement companies. Some companies prefer to purchase structured settlements from firms that are affiliated with their company or with their broker, rather than with the insurer.

An additional item often incorporated in the account servicing instructions includes requirements such as "all claims should be evaluated for state second injury fund and subrogation potential." In this case, the insured company would receive a report that identifies recovery potential within 90 days after the claim is received by the carrier. Then carrier should file liens in all actions brought by its employees against third parties, and these liens should not be waived or compromised without the company's prior written consent.

In most cases, the insured client company should be consulted before any claim is denied in order to avoid human resource and morale problems.

Even when account servicing instructions are in place, most client companies want to conduct file audits of all claims every three months or so in local carrier offices. The carrier can provide the entire file for this review that will focus on claim resolution strategies.

As with other claims which are not managed by account servicing instructions, all litigated claims should be considered for alternative dispute resolution.

Typically, insured client companies retain the option to change, revise, or amend the account servicing instructions with a 30 day written notice and to have a reasonable request accommodated.

Unfortunately, many companies change their insurance carriers frequently, a practice known as "carrier hopping," because they are not receiving a high enough level of claims service. Before changing insurance carriers due to this dissatisfaction, the client company should be encouraged to re-read its account servicing instructions to see whether their companies' expectations have been clearly defined. Most insurance carriers are prepared to rise to the level of service that is demanded, but many companies simply do not know what to request or how to use the account servicing instructions document to convey these expectations. It is essential that companies striving to manage claims effectively know that they already have a tool for addressing this critical aspect of business.

**The Evaluation of a Claim**

The evaluation of the cost of a claim or suit is based on information, training, and integrity. A realistic reserve should reflect a sincere appraisal of the settlement value of the claim before it goes to suit. It should reflect a realistic appraisal of the value of the verdict. An insurance company should be willing to pay a fair value to settle a claim or suit.

Some companies review each claim as though it were unreasonable. The claims people look for technicalities that might give them the slightest advantage, and they scramble to save every possible cent. On the other hand, other companies watch every dime spent on investigation. These companies chance winning enough cases to offset the risk of superficial investigations. Unfortunately, this practice can lead to allegations of bad faith. In an effort to efficiently settle a claim, both of these approaches should be avoided.

**Claim Expenses**

Claim expenses fall into two general categories:

1. **Allocated expenses.** Allocated expenses are concerned with the handling of specific and particular claims. Generally, allocated expenses fall into the following categories:
* The cost of physical examinations
* The cost of automobile surveys
* The cost of photographs, plaques, engineering and other special reports
* Police and motor vehicle reports
* Legal fees
* Other similar expenses

 Claim expenses should be maintained numerically and by aggregate amount so that averages can be determined and compared. For example, the number of photographs ordered can show if these items are being ordered casually. The average amounts will suggest whether good judgment is being used.

1. **Unallocated expenses.** Unallocated expenses are generally concerned with the overall handling of the Claims Handling Departments and are not confined to specific or individual claims. Unallocated expense are chiefly such items as salaries, automobile costs and expenses, meals and hotel expenses, telephone, postage, entertainment, building expenses, etc.

**The Preparation of the Claim**

When the claim is referred to the claims handler, he must preparean orderly investigation of the claim. The claims handler must be organized and carefully plan the process ahead of him. He must review the loss report carefully. Notes should be made with respect to any questions or unclear areas. If the loss report is incomplete, a call should be made to the insured to gather additional details.

Proper preparation of the claim saves time and effort for the claims handler and for the Claims Handling Department. For example, thoroughly planned interviews make it more likely that the claims handler will be able to obtain thorough and accurate information in a minimum number of calls. If the claims handler is not prepared and organized, he may have to make additional calls or schedule additional interviews. This is not efficient. When having to make additional or unnecessary calls, the claims handler risks losing control of the claim.

The initial preparation of the claim begins when the claim is referred to the claims handler. At this time, the claims handler must swiftly and completely analyze the information he has been given. This may include:

* Any problems involved based on the available facts
* The coverage information
* Applicable laws

Claims handlers often feel like they are the most overworked people in the Claims Handling Department, and this is probably true. An ideal maximum case load might be 250 to 300 case files. The case load depends on such things as geographic area he covers, the number court dockets ahead, and other circumstances. The reality is that the case loads for most claims handlers vary between 400 and 600 cases. Therefore, it is critical that the claims handler be professional and efficient in his approach to his work load.

There are specific steps for the proper handling of an insurance claim. If followed carefully, the claims handler can be productive and efficient. These steps are described below:

**Review the Claim**

The first step is to review the claim. This includes the Proof of Loss Form, the accident report, and all other documentation relevant to the claim. All of these should be carefully reviewed. Any comments, notes, or questions the claims handler has should be made in the file at this time. Most insurance companies make available preprinted forms for this purpose. We will cover in greater detail how to properly report a claim in the discussion which follows.

If the initial report is incomplete, the claims handler should contact the claimant for further information by telephone. Generally, this call provides the necessary details allowing the claims handler to proceed with processing the claim. Also, if a signed statement is necessary, as in the case of a serious claim, an appointment can be scheduled at this time.

**Examination of the Coverage**

The next step is to examine the coverage**.** The claims handler should study the coverage of the policy. Examining the insurance policy’s coverage is a fundamental, though very important, in the claims handling process. For example, the claims handler should be familiar with the coverage afforded by the policy.

Naturally, it is not possible to memorize or to know all of the particular conditions of all insurance policies, but the claims handler should be familiar with the policy in question. In addition, he should be familiar with the general provisions found in most polices so that he can recognize any coverage problems which may be obvious. When coverage problems are not so obvious, a thorough examination of the coverage will bring these to light.

If is an obvious coverage problem, the claims handler can deny coverage. However, if the issue is less clear, he should consult with his supervisor. All of the facts associated with a problem in coverage must be obtained, and they must be comprehensive. Nothing can be left to chance.

Remember, an insurance policy is a contract, and the terms of the policy are the determining factors which set forth the duties and obligations of both the insured and the insurer.

Fortunately, there has been a recent trend toward simplifying the language found in standard policies. However, these policies are still very complex. Insurance policies are often very obscure and sometimes ambiguous. Naturally, this can create coverage problems in unclear cases. In addition, many insurance policies are multiple line policies or custom policies, and these are even more complex. Finally, the law is constantly changing and evolving, and this can limit or extend the provisions of a policy. Therefore, the claims handler must examine the coverage carefully.

Typical coverage problems include the following:

* **False declarations**, for example, the named insured might not actually the owner of the automobile involved in an accident.
* **The facts do not fall within the scope of the policy**. For example, the date of the accident may not fall within the policy period.
* **The claim is based on an exclusion from the policy**. For example, the claim is brought for flood damage when the policy clearly excludes damage from flood.
* **A breach of conditions**, for example, delayed reporting on the part of the insured.

If coverage problems like the ones described above, or others, are discovered, there are some specific courses of action to be taken. For example, in some cases, there are acts or omissions on the part of an agent. In this case, the insurance company may be prevented from denying coverage.

Whatever the determination after the examination of coverage, the claims handler is required to take some action. In fact, he must take some action even if an immediate decision cannot be made because he does not have sufficient information.

If the determination of coverage cannot be made at this time, the claims handler must pursue one of two directions. The claims handler should:

* Send a letter to the claimant reserving the company’s rights pending an investigation

or:

* Enter into a non-waiver agreement in which both parties agree that no rights will be waived until a final decision is made by the insurer

These two procedures are discussed below.

Prompt action on all coverage questions is necessary for many reasons. First, a delay in asserting the company’s rights could result in the waiver of its rights altogether. Promptness on the part of the claims handler allows the defendant insured to obtain an attorney and to prepare his defense, if necessary. In addition, the insurer will learn quickly whether the defendant insured plans to assume a defense or whether he intends to pursue coverage under the policy.

Promptly responding to a claim also reduces the possibility of collusion on the part of the insured or the claimant. Fraudulent insurance claims are a billion dollar business, and a claims handler’s quick response is a method for its deterrent.

Prompt action on the part of the claims handler avoids uncertainty. It improves the business of the insurer and enhances its public relations.

So, when coverage problems are discovered, there are several courses of action the claims handler may choose. These are discussed below:

* The insurer may accept the coverage fully if a coverage decision has been made in favor of the insured.
* The insurer may disclaim the coverage if the facts are evident against the insured. In this case, the claims handler should refuse to engage in further handling, negotiating, or defending the case.
* The insurer may issue a reservation rights letter or to enter into a nonwaiver agreement if the coverage is unclear (See this discussed in detail below.)
* The insurer may initiate a declaratory judgment action in order to determine the rights of the insured and the insurer. (See this discussed in detail below.)
* The insurer may enter into an agreement to defend the suit without indemnity. This is an exceptional action taken when the defendant agrees that there is no coverage, but defense is offered because of extenuating circumstances.

**Reservation of Rights**

The reservation of rights letter was discussed briefly in Chapter 2. If the claims handler decides to send out a reservation of rights letter, it should be sent at this time. A reservation of rights is a notice to the insured that the insurance company is conducting its investigation. The reservation of rights letter makes clear that the investigation is pending a determination of the right to disclaim or accept the coverage under the policy. The procedure is used when the claims handler requires more time to determine whether or not the claim falls within the policy provisions. The reservation of rights letter serves to prevent the waiver of a breach of policy conditions. It allows the company to delay only to make a thorough investigation before taking a firm stand on the issue of coverage.

The reservation of rights letter must be sent to all parties who are likely to claim coverage under the policy. Since the reservation of rights letter makes the statement that the company’s position is "pending the completion of an investigation", the claims handler must declare the determined position as soon as the investigation is completed.

 The reservation of rights letter should contain the date of the accident and the date the initial loss report was received. It should contain verbiage to convey that as reasons which may become more evident as a result of the investigation, the investigation is being made with the full and complete reservation of all rights afforded by the company. It should further state that every effort will be made to protect the interest of the insured or claimant within the limitations of the conditions and terms of the policy.

**Non-waiver Agreement**

A non-waiver agreement is another tools used by claims handlers. A non-waiver agreement is a written agreement that is entered into by the insurance company and the insured. A non-waiver agreement states that neither party will waive any of its rights under the policy as a result of the investigation or defense of an action brought against the insured.

**Declaratory Judgment Action**

A declaratory judgment action is a procedure initiated by the claims handler when there is a question of indemnification. A declaratory judgment action is a process by which a judicial declaration of the rights of the parties are sought. The declaratory judgment action is useful since it establishes the existence of the duty to indemnify, while determining whether the insurer has a duty to defend a suit against an insured.

**The Investigation of a Claim**

A thorough investigation must be made in order to determine the facts, establish the liability, and preserve the evidence. The extent of the investigation is determined as it develops. If the demands of a claimant are reasonable, efforts should be made toward disposing of the case and avoiding In addition, costly investigation with no purpose.

Once the claims handling process has begun, the ongoing investigation is constantly changing. The investigation phase of the claims handling process must be prompt and orderly. The decision concerning whether a claim will be settled, further investigated, defended, or declined should be made as quickly as possible. If the investigation is complete, and the decision is to decline the claim, informing the claimant should be done quickly, and a proper explanation should be given.

There are three steps to the investigation of a claim:

1. **To determine the facts.** In this step of the investigation, the claims handler meets, questions, and takes statements from insureds, claimants, and witnesses. The insured, claimant, and witnesses may have different interpretations of an accident. The claims handler must assemble the versions of the truth, along with the physical facts, in order to determine how the accident actually occurred.
2. **To establish liability.** As the investigation continues, if the claims handler discovers that the liability rests on the insured, he must begin settlement negotiations for disposition of the case.
3. **To obtain and preserve the evidence.** If the settlement of a claim cannot be promptly achieved, the case may have to be tried. Therefore, the facts of the claim must be converted into a format than can be presented as evidence in a court of law. This might include photographs, diagrams, signed statements, affidavits, etc.

**The Reporting of a Claim**

Reporting the claim includes an introduction to the claim, a suggested reserve, coverage information, the facts of the claim, relevant information on the parties involved, damages, a review of liability, etc. This information must be shown in a file for review. The handling of minor claims, in which the amounts involved are small and routine, is typically accomplished by telephone or on forms. These claims do not require the detail of major claims.

Sometimes a claim can appear to be routine when it is not. It may result in a sizable claim because of suspected fraud or possible new medical developments. Claims that are not obviously small and routine, or those which suggest a more serious character, should contain enough information to make the supervisor aware of potential developments.

As a rule of thumb, the amount of detail necessary can be measured by the size of the claim’s potential liability, the seriousness of the injuries, and other complexities.

After the initial report, subsequent follow up should address new or additional information. If this new information contradicts previously reported details, or if advances the significance of the claim, this new information should be given emphasis.

All claims must be handled in a thorough and accurate manner. Full reporting allows this. These reporting files can be very useful for many reasons. For example, if the claims handler should resign or be transferred, someone else can readily take over the case.

If the investigation is needed at another office, the transfer can be made easily. Or, if the claims handler is away from the office, proper instruction can give to those who are filling in. Also, proper reporting allows the home office to effectively direct any additional investigation, and it permits trial counsel to review the file for trial preparation, if necessary. Finally, it allows for a complete and chronological record of the claim in the event that a defense is required in court.

With respect to the manner and form of reporting, chronological form generally allows for the most efficient and effective reporting and for easy reading. Reports should always be logical. Whenever discrepancies occur, the claims handler should clarify them. Contradictory statements should never be left without explanation. Although the report should be brief, it should also be complete. It should be succinct. When more than one file is involved, the other files should noted for easy reference.

**Interviewing**

Interviewing involves meeting, questioning, and taking statements from insureds, claimants, and witnesses. The interview should always have a positive approach, rather than a negative one. The claims handler should be able to put the claimant or witness at ease. He must convince the claimant or witness of his earnest desire to get the facts. The claims handler must meet, question, and take statements from insureds, claimants, and witnesses. The interview should have a positive, rather than a negative, approach.

* **Interviewing the insured.** Interviewing the insured is usually the smoothest interview. Typically, the insured is looking forward to process so that he can settle his claim. The claims handler should see that the interview is pleasant, taking time to get the information necessary.
* **Interviewing the claimant.** When interviewing a claimant, the claims handler should never misrepresent himself. Any misrepresentation must be avoided. The approach of the claims handler should be one of cooperation. He should pursue the truth and the facts. The claims handler should obtain written permission from the claimant to get doctors’ or hospital records at this time. The initial interview may be a suitable opportunity for discussion of an advance payment. Where appropriate, advance payments are sometimes made to creditable claimants before the settlement is actually achieved. If the claimant informs the claims handler that he is represented by an attorney and gives the attorney’s name and address, the claims handler should immediately bring an end to the interview. Then, he should contact the attorney. Attempts to get further information or a signed statement at this point could be considered an unfair practice.
* **Interviewing the witness.** Although the insured and the insured and the claimant may be witnesses to an accident, they are interested parties. That is, they have something at stake in the outcome of the claim A witness who does not know either party and is who does not have a personal interest in the outcome of a case, is known as a disinterested witness. When interviewing a witness, this must be done earnestly. The claims handler should explain why claims must be paid fairly. He might explain unnecessary investigation and litigation expenses. Naturally, the witness’s cooperation is essential. Generally, it is best to interview the insured and the claimant and to visit the scene of the accident before interviewing the witness. This allows the greatest preparedness on the part of the claims handler. In some cases, it may be necessary to accompany the witness to the scene of the accident. This may help him to remember details. However, the claims handler must be careful not to lead the witness. If a witness refuses to cooperate, a negative signed statement should be obtained.

**The Evaluation of a Claim**

The evaluation of a claim is based on experience, similar claims, and state statutes. The greatest source of evaluation methodology is simply experience. Other sources from which to draw evaluation techniques are studies of awards given by juries in similar cases or the experience of a supervisor or fellow claims handler might be sought when making an evaluation.

The evaluation of a claim depends on:

* The evaluation of liability. A claim without liability has no value. Since liability is based on negligence, in the claims handling process, liability is considered as a question of whether either or both parties play a role in the accident. Liability is defined as whether a rule was violated, regardless of whether or not intention, knowledge, or necessities are involved. Generally, the facts obtained from the steps above are sufficient to answer the question of and to establish liability. This routine method of handling claims allows for handling of large numbers of claims with minimal expense and the least amount of delay. It results in a meaningful consideration of fault and the trade off of presumption for a lengthy and expensive scientific process. However, let’s not underestimate the role that common sense and good judgment play in the claims handling process.
* The evaluation of the damages. The evaluation of the damages depends on the seriousness of the claim. In routine claims, emphasis is placed on the cost of medical services as a basis for estimating the value of the claim, and this is mechanical method of evaluation is known as the “formula method of evaluation”. Simply, medical expenses are given an arbitrary multiplier, typically two to seven. This results in a figure to represent pain and suffering, inconvenience, etc. Routine cases are settled this way because litigation costs effectively occlude lawsuits. However, residual impairment or disfigurement may represent more serious cases. These types of cases must be considered from the perspective of a jury. Naturally, these cases are investigated more thoroughly. In addition, there are other factors that may affect the value of a case. These include out of pocket expenses, pain, suffering, and inconvenience. Grades of seriousness are demonstrated by scars, amputations, prostheses, etc. Serious cases can justify the expense of litigation.

**Methods of Adjusting a Claim**

There are generally four methods available when adjusting a claim. These are described below:

* **Field inspection.** Field inspection typically provides same day contact with the claimant or insured and the inspection of the damaged property within 72 hours.
* **Direct repair.** Direct repair is a voluntary process by which the claimant or insured can select an approved contractor to estimate and perform the repairs immediately. For example, a damaged vehicle can be immediately driven or towed, at the claimant’s or insured’s direction, to an authorized facility for repairs. An estimate is written and repairs can proceed immediately. These contractors are selected by the insurance company for their high quality workmanship and customer convenience. If such a contractor is selected, this usually comes with the guarantee that the work is done to the claimant’s or insured’s satisfaction for 12 months after the repairs are completed.
* **Drive in claims.** Drive in claims service can be used on damaged, drivable vehicles. Drive in locations offer conveniences and immediate payment to complete repairs. This service is not available in all areas.
* **Alternative choice**. Alternative choice is a voluntary service which allows the claimant or insured to choose from a list of repair facilities nearest him. He may take the vehicle to an Alternative Choice repair facility, present the insurer’s estimate, and repairs can proceed immediately. When selecting an alternative choice repair facility, this usually comes with the guarantee that the work is done to the claimant’s or insured’s satisfaction for 12 months after the repairs are completed.

**Negotiating a Claim**

Negotiation is nothing more than a form of persuasion. However, persuasion is not the same as manipulation or coercion. Negotiation is simply a combination of selling, negotiating, and motivating. Through the process of negotiation insurance claims, the claims handler persuades the other side, through motivation, to achieve a common goal. That is, transforming a disputed claim into a settlement agreement which is satisfactory to both sides.

After investigating and evaluating the claim, the claims handler determines the value of the claim. This figure approximates what he believes fair. It is based on sound reasoning.

**The Offer and the Demand**

The first step in the claims handler’s negotiation process is to obtain a demand from the claimant before making an offer. This is the first rule of negotiation, and there is good reason for this. This is because the claimant’s perspective of the claim is probably much different from the perspective of the claims handler. In most cases, the claimant has a higher figure in mind than does the claims handler. A sharp perspective here comes only through experience.

An insurer cannot be held liable to pay a claim unless it would have been able to settle its obligation within the limits of the policy. However, a demand for settlement which is within the policy limits is not required before the insurer has the obligation to respond. An offer to settle must be unconditional before an insurer can be required to accept it.

When no offer to settle is ever made (either within or not within the policy limit), a conflict of interest develops between the insured and the insurer. When the liability is reasonably obvious and the injuries are serious, the insurer cannot be excused from making an offer, even though the claimant fails to make a firm demand.

As the negotiation nears its final stages, the discussion of a settlement amount ensues. The claims handler should obtain a demand from the claimant before making any offer. For example, suppose that the claims handler has thoroughly investigated and evaluated the claim from the information he has. Of course, there are factors of which the claimant alone may be aware. As we said, the claimant’s evaluation of the settlement amount is probably based upon entirely different factors from those of the claims handler. In most cases, the claimant’s figure is more than the claims handler’s settlement amount. However, in some cases, the claims handler may have overvalued the claim, and the claimant’s demand may be lower than the claims handler’s intended offer.

In other cases, the claimant is not at all prepared and has not formed any definite figure in his mind. In the best situations, the claimant has gained the confidence of the claims handler, and the claimant may rely on him to help evaluate his claim and come up with a settlement figure. In this case, the claims handler might set forth the basis for his evaluation and make an offer based on his judgment and sound reasoning before the claimant has made the demand. In any circumstance, the claims handler should allow some room ordinary bargaining.

During the negotiation process, the claims handler can take clues from the claimant. For example, the claimant’s behavior and what he says may give way to indications of his sincerity and character.

However, this is not always true. The claims handler cannot be guileless or be lured into an inappropriate settlement by a claimant who is not what he appears. Again, the claims handler can call upon his experience and judgment. It is said that experience is the best teacher.

Only experience and maturity bring about a keen perspective in these instances. The successful claims handler will have the ability to fairly settle a claim for an equitable amount for both parties.

**Negotiating With an Attorney**

Negotiating with an attorney requires special skills. Once the claimant or insured has retained an attorney, the claims handler must continue any further negotiations directly with the claimant’s attorney. He should not engage in any further discussion with the claimant.

When the claims handler receives a letter of representation from an attorney, this must be acknowledged promptly. This is good business conduct, and it is professional claims handling

In most cases, attorneys that are retained by claimants are cooperative with the claims handler. Of course, this side is just as interested in settling the claim as the insurer is. Probably, the attorney is pressured by his client. Therefore, he is eager to cooperate with the claims handler. Remember, this is a business transaction for him, too.

The professional claims handler should not fear asking an attorney to substantiate his client’s allegations, just as he would if he were negotiating with the claimant directly. In order to justify his client’s demand, the attorney must convince the claims handler that the case is worth reasonably close to their demand. The claims handler should obtain a complete list of all damages, including any special damage allegations. He should ask the attorney for his theory of negligence. His inquiries must include all factual information used to back up the claimant’s allegations.

Of course, the attorney will not give up his complete file on the case. However, will usually offer enough information to justify his claimant’s demand. As in all business transactions, if the attorney is approached in the proper fashion, he will likely give medical information and permit his client to take a physical examination. In many states, however, the claimant is not legally required to submit to a physical exam.

The professional claims handler is never intimidated by having to deal with an attorney, rather than with the claimant personally.

As with any claim, if the claims handler’s investigation and evaluation indicates that the claim should be denied, even if the claimant has engaged an attorney, he must inform the claimant’s counsel as soon as possible after this decision has been made.

If a lawsuit is begun by the attorney, the claims file must reviewed regularly. This will document any changes in circumstances or factors that might affect the claims handler’s previous decision. For instance, a new allegation made by the attorney would be important enough to warrant a review of the claim.

The claims handler must pursue this and all negotiations carefully. He must be select in the wording used in making offers or mentioning figures. For example, even a tentative offer made by the claims handler can be interpreted as a definite offer.

Negotiations with attorneys are good experience. Continued negotiations with attorneys can sharpen the skills of the claims handler.

**Attitude and the Negotiation**

Fortunately, most people are basically honest. However, the professional claims handler cannot assume this about all insured and all claimants. He must maintain an attitude of healthy uncertainty, although be careful not to be inherently distrusting. In connection with negotiating a claims settlement, the proper attitude in approaching is vital.

When approaching the settlement negotiations, some important points to remember are:

* The claims handler should be friendly. He should not approach the negotiation with an angry or hostile manner.
* The claims handler should and direct. He should exhibit a genuine desire to do what is right by the insurer and the insured.
* The claims handler should be courteous and well mannered. His overall behavior plays an important part in the impression he makes on the claimant. Things such as addressing the claimant properly help to begin the negotiations on the right foot.
* The claims handler should be tolerant. He must avoid showing any signs of bigotry or prejudice. For example, he should never make condescending remarks, intended as humor or not. This is thoughtless behavior and can leave a bad impression.
* The claims handler should be sympathetic and understanding. For example, claimants are often visibly angry at his circumstances and at the insured. They often blame the insured for their circumstances. The claims handler should let allow the claimant his anger and try to be a good listener. He should never agitate the claimant or make the situation worse.
* The claims handler should speak at the claimant’s language level. This is an important one. The claims handler should avoid using legal or industry specific terminology which is probably not understood by the claimant or might be over his head. This is not the time to try to impress the claimant with education or language skills.
* The claims handler should be confident. The claimant can very easily detect signs of weakness or indecision on the part of the claims handler.
* The claims handler should be persuasive, calling on the skills discussed previously in this chapter.
* The claims handler should be decisive, avoiding inflexibility. He should be firm, but flexible.
* The claims handler must be well informed. He must be well prepared and have the facts available.
* The claims handler must be honest, keeping his word. He should never promise something that he cannot deliver. The claims handler should never mislead a claimant in any way.
* Finally, the claims handler should always negotiate with the party who in control. This person might be a husband, wife, doctor, or trusted friend, if not the claimant. However, any negotiations of this type should be held in the presence of the claimant. The claims handler should never intimate that the claimant is unimportant. The claimant should never be overlooked.

**The Compromise**

An insurer has the right to offer a compromise or settlement of any claims against the insured. As a matter of fact, liability insurance policies give the insurer absolute authority to settle claims within the policy limits. On the other hand, the insurer does not have the right to act arbitrarily in settling or refusing to settle a claim. The insurer has the duty to properly evaluate a claim and to consider fairly the interests of the insured, as well as its own interests.

If the amount in a claim exceeds the policy limits, the insurer may settle its own liability without the consent of the insured. However, if the proposed settlement exceeds the policy limits and the insured would have to participating in paying the excess of the claim, the consent of the insured is required before the company may act in settling the claim.

The settlement of a claim by an insurance carrier is not necessarily an admission of liability of the part of the insured. In some jurisdictions, however, settlement may be an admission of liability after a claim has gone to suit. Therefore, the claims handler must be familiar with the laws of his jurisdiction. Otherwise he may bias the rights of the insured. An inattentive claims handler may mistakenly eliminate any right of action which the insured may have.

In some cases, a compromise is needed. For example, it may be appropriate for the claims handler to decrease the full value of the claim by a some factor which compensates for any doubt of liability on the insurer’s part. In cases where the liability is questionable, the compromised offer might be one-half or 60 percent the claim. The theory here is that that each party shares some portion of the responsibility. In the formal law, liability either exists or it does not exist. That is, there are no degrees of liability. Therefore, the theory that each party should share some portion of the responsible is incongruous with the formal law. However, for the purpose of settling some claims, this compromise seems to be reasonable.

Another way to justify a compromise is the view that the insurance company might have half or a 60 percent chance of winning the case if it were to go to suit.

In addition, a compromise can take the approach of permitting the claim only for the claimant’s out of pocket expenses. This would include his attorney’s fees, but no consideration for any general damages. In most cases, such a compromise is sufficient to ward off a law suit.

A final approach to a compromise is to settle on an amount which is less than litigation would demand of the insurer.

**Negotiation Skills**

In order to prevent a claimant from becoming a plaintiff in a law suit, claims handlers must sharpen their negotiation skills. The must be great communicators. When meeting with claimants, they should speak slowly and deliberately in precise and clear language.

In addition, claims handlers need to keep in mind that insureds and claimants are not familiar with industry lingo. For example, a claims handler might have to explain that the term “damages” can mean money. Or, the word “liability” means who's at fault. A good rule to follow is, "Educate, do not aggravate."

Education is another issue that claims professionals need to keep in mind when negotiating with insureds or claimants. A good claims handler has to know statistically who he is dealing with. He has to be sensitive to the educational level of the claimant. On the average, there is a seven-year educational difference between a claims handler and a claimant, in favor of the claims handler.

In the United States, it is estimated that four out ten people have not finished high school and eight out of ten people have not attended college. Claims handlers must keep this in mind when trying to communicate effectively with claimants.

Even though a claims handler may not be able to relate directly with these people, he should look for interests in common.

When a claim cannot be settled by means of negotiation, the situation often leads to a law suit. A claims handler can be proactive in heading off a law suit. Before an individual gains the title of plaintiff, he was first a claimant. In many cases, this process is the result of the claimant being ignored by the insurance company.

The key to successful claims negotiation is a combination of many factors. However, they must include:

* **Open mindedness.**  There must always be a certain degree of flexibility and open mindedness in the claims handler’s negotiating position. If he approaches the negotiating process with a resolute attitude of “take it or leave it", the negotiation process may fail.
* **Information.** The claims handler is at an advantage with the most possible information he can get about a loss. Complete and accurate information is necessary in order to negotiate quality settlement that satisfies both sides. Of course, this information must be shared with the other side. Both sides need to share what information they have about the loss so that they can evaluate negotiate the same factors. Holding back information may affect the valuation of the claim for either party. If one party refuses to share information with the other, this may indicate that this party really does not want to negotiate equitably.
* **The ability to bargain.** Insurance claims simply do not come with a price tag. Therefore, the negotiation process begins by either asking for an opening demand or by making an opening offer. Until this first step (of demand or offer) is taken, neither side can know close or how far away it is from a settlement.
* **Fairness.** It is not always possible to negotiate face to face, especially if the claim is a minor one. Minor claims are usually handled by telephone or mail. In this case, the claims handler must impress upon the claimant or insured an attitude of fairness and a genuine desire to resolve the matter equitably.
* **Avoiding danger.** Negotiations are usually not pleasant for one or both sides. For example, a claimant's demand may seem insulting. However, unless there is actual proof that the loss is fraudulent or cushioned, the claims handler must settle. Remember, insurers are required to settle all claims.

**The Settlement of a Claim**

The claims handler must close all claims in a manner that is fair to all parties. There are essentially four ways in which a claim can be closed:

* The claims handler may determine that there is no coverage.
* The insured or claimant may recognize that the insured is not liable for the accident.
* The claim may be settled as a result of negotiations.
* The case may go to court, and it will be disposed of by means of a court decision.

No matter which determination the claims handler makes, the claimant is entitled to know where he stands with his claim. After the completion of the investigation and the evaluation of the claim, if the claims handler determines that the claim is to be denied, this should be reported to the claimant quickly and courteously. If it is determined that the case should be settled, settlement negotiations should begin.

There are few absolute rules which can be offered in connection with settlements and settlement negotiations. This is because of the many different situations involved. However, as we know, making of a fair claim settlements is not only good business practice, it is required by law.

We know that insurers may not engage in any unfair claim settlement practices. The insurer has the right to offer a compromise or settlement of any claims against the insured, and the insurer has the authority to settle claims within policy limits. On the other hand, the insurer does not have the right to act arbitrarily in settling or refusing to settle a claim. The insurer has the duty to properly evaluate a claim and to consider fairly the interests of the insured, as well as its own interests.

If a claim amount exceeds the policy limits, the insurer may settle its own liability without the consent of the insured. However, if the proposed settlement exceeds the policy limits and the insured would have to pay the excess amount, the insurer must first obtain the insured’s consent. The release of all further claims is required in order to complete the claim. A release, as discussed below, is a legal and binding document which relieves the insurer from further responsibility in connection with the claim. At the same time, the claimant gives up all further rights to the claim. With the payment of the claim in full, the release is signed by both the claimant and the insurer.

The insurer has the duty to explore settlement possibilities. In other words, he is not permitted to wait until a settlement offer has been made by the claimant. It is the duty of the insurer to explore settlement possibilities, and this includes the insurer’s total liability in addition to an amount that the insured can contribute.

However, there is no absolute duty on the part of the insurer to attempt a settlement in the following circumstances:

* Where the insurer and its attorneys feel that there is a strong defense against the claim
* Where the insurer has been advised by legal counsel that settlement is impossible because of some extenuating circumstances
* Where the anticipated verdict is well within the policy limits

Essentially, the insurer is the supporter of the insured. The insurer must consider the interests of the insured, rather than the interests of its own, as predominant. The insurer may not speculate with the insured’s funds. If the insurer refuses to settle a claim because it believes the insured is not liable, the insurer is still accountable for taking this position if that determination is arbitrary or negligent.

This obligation is placed upon the insurer because the insurer inherently has the complete control over the negotiations and settlements. In addition, the insurer may not abuse its power in order to determine favorably its own interests in the event of some conflict with the interests of the insured.

The insurer’s obligation to fairly and equitably negotiate a settlement stems out of the contract of the insurance policy. When there is likelihood that there may be a verdict in excess of the policy limits, any unfounded refusal on the insurer’s part to accept an offered settlement which is reasonable and which is within the limits of the policy makes the insurer liable for the entire judgment.

There is no requirement that the conduct of the insurer be egregious in order for liability to be imposed for negligent or wrongful failure to settle. If the claim is not in excess of the limits of the policy, it is not necessary that the interests of the insured be considered. On the other hand, if the recovery sought exceeds policy limits, the insurer has the duty to consider the interests of the insured.

It should be noted here that some insurance policies include a settlement provision which allows the policyholder to prevent a settlement by his refusal to consent to settlement. When this provision is used, it may limit the liability of the insurer in the event of a subsequent judgment in excess of the amount for which the insurer claims the case could have been settled. For example, this typical clause provides that:

 "The insurance company shall not settle any claim without the written consent of the insured. If, however, the insured shall refuse to consent to any settlement recommended by the insurance company and shall elect to contest the claim or continue any legal proceeding in connection with such claim, then the insurance company's liability for the claim shall not exceed the amount for which the claim would have been settled, plus the cost and expenses incurred, with its consent, up to the date of such refusal."

**Transfer of the Insured’s Rights**

When settling a claim, the insurance company has all the rights that the insured had against any person or property related to the claim. The insured must transfer these rights to the insured when asked, and the insured must not do anything to affect these rights. In addition, the insured must permit the insurer to use his name in enforcing these rights.

The insurance company will not be liable to the insured if the insurer does not pursue these rights or if the insurer does not recover any amount that might be recoverable.

With the money recovered from enforcing these rights, the insurer will pay whatever part of the insured’s loss has not been paid. The insurance company has the right to keep what is left.

The policy and any endorsements attached are the entire contract between the insurer and the insured. Any claim made against the insurer must be made under the policy and is subject to its terms.

**First Call Settlements**

Assuming that insurer liability is determined, first call settlements are worthwhile in many instances. First call settlements allow the case to be closed quickly, and they can reduce or eliminate cushioning for additional damages. Even in cases where liability may be questionable, or in cases where the claimant’s demand may be a little on the high side, first call settlements may still have their benefits.

For example, a bothersome or difficult claim usually becomes moreso the longer it remains open. The required continued investigation contributes to the final cost of a claim.

The fact that first call settlements are often useful does not allude to rushing into a settlement, especially if fraud is suspected. Fraudulent claims should always be resisted. However, if fraud is not suspected, and the damages are not extensive, a first call settlement may be in order. Of course, this call is one of judgment and experience for the claims handler.

With a thorough investigation and evaluation of a claim, the claims handler can be sure that he has handled his responsibilities professionally fairly, within the law, and within the standards of ethics of his profession.

**Alternative Dispute Resolution**

Since law suits are so expensive, insurers are increasingly looking for alternative methods to resolve coverage disputes with the insured. They are turning to the options of mediation, arbitration, mini trials, and summary jury trials as alternative resolutions to disputes. Collectively, these procedures are known as alternative dispute resolution. Alternative dispute resolution is also known as ADR.

Alternative dispute resolution an extension of the negotiation approach discussed above. In most cases, the professional claims handler, by means of good faith negotiations, can effectively settle the majority of claims directly. Essentially, the claim is investigated and evaluated, and a settlement is agreed upon. The claims are settled before entering into more lengthy negotiations or a lawsuit.

However, when a settlement cannot be reached, for whatever reason, alternative dispute resolution is a process used to continue the negotiation system. Alternative dispute resolution is set up outside the judicial system. The main difference between alternative dispute resolution and an actual court trial is the resolution is determined by an intermediary, as opposed to being decided by a presiding judge. This intermediary might be a retired judge, an attorney, a professional intermediary, or a combination of these.

Alternative dispute resolution methods are generally less complex and less costly than litigation procedures. In addition, they save time for all parties involved. Each of the alternative dispute resolution methods is used to simplify and facilitate agreements when there is a dispute over a claim. Generally, the parties to these negotiations make a commitment to participate in the process in good faith.

Sometimes alternative dispute resolutions are established by state statutes. For example, in some states, a permanent panel of arbitrators serves under the American Arbitration Association and is monitored by that state’s Department of Insurance Department. All of the methods of alternative dispute resolution are not available in all areas.

The four main approaches to alternative dispute resolution are:

* Mediation
* Arbitration
* Mini trials
* Summary jury trials

and these are discussed below.

Alternative dispute resolution is used to resolve settlement and coverage disputes. As a matter of fact, many insurance policy contracts now contain provisions for binding arbitration or mediation. As a result of insurance policies and the tort laws becoming more complicated, insurance disputes are, unfortunately, on the rise. An effective means is needed to resolve these issues without the added expense and time of litigation. Alternative dispute resolution serves this need.

Alternative dispute resolution is useful because it reduces the settlement time of most cases. In addition, it reduces the cost for the disposition of these cases. Alternative dispute resolution is a set of practices and methods which allows legal disputes to be resolved outside the Courts. It benefits all parties who are involved in the dispute. As a matter of fact, it can actually prevent legal disputes that would otherwise be brought into the court system.

There are many private agencies that offer alternative dispute resolution services to insurers and insureds. Also, the Courts sometimes offer their own alternative dispute resolution procedures. In many states, and in some federal jurisdictions, the parties to participate in these procedures must agree before even earning the right to go to trial.

Some within the insurance industry look at alternative dispute resolution as simply another layer of expense. However, if alternative dispute resolution is used as a tool, bad faith can be extinguished, and the file can be closed.

Some insurance companies are not as willing as others to engage in alternative dispute resolution because they think it adds an unnecessary step to the claims settlement process. Others believe that it allows the claims handlers not to do their jobs. While there may be some truth is this, there are many benefits to alternative dispute resolution. The insurer has some control over the process and some control over the outcome.

In addition, generally the longer a case file stays open, the greater the loss. Open files are costly to administer. It is said that “the only safe file is a closed file."

**The Mediation Process**

Mediation is a nonbinding, confidential meeting among the parties in dispute, and a third, impartial person is the mediator. The goal of mediation is to reach a mutually acceptable agreement. Naturally, insurance claims can involve significant liability and damage issues. Mediation is the alternative dispute resolution process which involves using a mediator to induce both parties to settle their dispute before it advances to the point of litigation and a court room proceeding. Mediation is considered an unstructured method of dispute resolution. It is a practical alternative to letting the Courts determine the outcome of insurance disputes.

The mediation process is an alternative dispute resolution technique that persuades the parties that they will be better off by reaching a settlement than by pursuing the alternative of litigation. As a result of the mediator’s efforts, the parties generally work harder to settle their dispute.

There are many advantages to using mediation to resolve insurance disputes. Some of these are discussed below:

* Mediation permits the parties to negotiate their own settlement.
* The mediator is a neutral third party.
* The mediator as a neutral third party can have an effect of the parties exploring alternatives which they might not have otherwise considered.
* The mediation process often results in the quickest resolution possible for all parties.
* Mediated settlements do not appear as public court records.

In the mediation process, an impartial individual assists all of the parties involved in the dispute. This person is known as the mediator. It is the mediator’s responsibility to help the parties to analyze the relevant issues. He counsels them on the risks of being unable to reach an agreement. Selecting the right mediator is critical. The mediator should be personally interviewed. He should be asked if he carries malpractice insurance. Professional mediators generally have malpractice insurance.

To begin, the mediator generally first meets with a plaintiff and hears his side of the case. The plaintiff is then dismissed from the hearing. Next, the defendant is brought in and presents his case. Then the mediator typically discusses the plaintiff's arguments with the defendants and vice versa.

Usually, the final stage of the mediation process involves the mediator's bringing together the parties to discuss the strong and weak points of each position. The mediator may make recommendations about legal issues, as well as issues of damages.

While mediation can be an effective technique, it should not be used in every single case. When agreeing to mediate, liability is assumed. The mediator may not force the parties to do anything, to render an award, or to pass judgment.

An experienced mediator can help the parties to reach a settlement. In many cases, the mediator uses a formula represented by the settlement amount which a court might award and less the litigation costs. This gives the parties a settlement amount they can work toward achieving.

The four steps involved in the mediation process are:

1. **Initiating the mediation process.** Mediation may be initiated by both parties together. Or, one party may be referred to mediation by a court. Finally, an attorney for one of the parties may initiate the contact with a mediator. In order for the mediation process to begin, all of the parties must consent to participate in the process.
2. **Preparing for the mediated negotiation.** When the parties seek mediation as a means to alternative dispute resolution, they must be well informed on the issues. This includes the parties who are involved in the dispute and the mediator as well.
3. **The mediation session**. The mediation session is known as the caucus. Generally, the parties are represented by their attorneys during this negotiation phase of mediation. The mediator begins by describing his role, the rules of the procedure, the order of the presentation, and the confidentiality of the proceedings. Unlike a judge who is empowered by the state, or an arbitrator who is authorized by the Court to render a decision, the mediator only arranges a communication process. He describes the issues and the positions of all of the parties. He identifies the reasons why the dispute has not been settled up to this point. One of the most important functions of the mediator is to recognize possible approaches to a settlement. The mediator evaluates the merits of each one of these approaches. In order to achieve a settlement, the mediator will often encourage the parities to anticipate possible alternatives to the dispute and settlement options. The mediator’s job is to urge a frank and straight forward discussion of the claim and the dispute. He helps each party to gain an understanding of the other’s issues and demands. With the assistance of the mediator, a compromise can usually be reached.
4. **Preparing the settlement agreement**. After agreement has been reached between the parties, the mediator reviews the details of the agreement and confirms the terms of the agreement to each of the parties. However, the settlement agreement must be drafted by a qualified attorney. It is important to note that the settlement agreement is an agreement between the parties involved in the dispute. The mediator is not a party to the agreement.

**Arbitration**

Arbitration is another option of alternative dispute resolution. Arbitration is a method of alternative dispute resolution which can be either binding or nonbinding. Arbitration is a swift and efficient alternative dispute resolution procedure for obtaining a legally enforceable decision. Like mediation, it provides a speedy, fair, and inexpensive determination of an insurance dispute.

The arbitration hearings are informal. Arbitration usually entails a meeting intended to be used as a forum for the exchange of information or to construct an agenda or a game plan on how the claim dispute might be settled.

The terms mediation and arbitration are sometimes used to mean the same thing. However, these two processes are entirely different processes. Arbitrationis a different alternative dispute resolution technique used to resolve insurance claims disputes. Insurance policies often contain arbitration clauses, and the purpose of such a clause is to direct disputes into private arbitration, as opposed to heading for the court room.

Unlike mediation, arbitration is not voluntary. It is a method of settling differences through the investigation and determination of a disputed matter, for example, a claims dispute or a coverage dispute. The procedure is managed by one or more unofficial individuals who are selected to arbitrate a particular issue. Arbitration is used for settling disputed matters and obtaining a decision and an award, rather than a judicial proceeding.

Arbitration procedures are simple. First, a hearing takes place with the parties and the arbitrator. The parties are usually represented by attorneys, and opening statements are made by the parties’ attorneys. Next, testimony, cross examination, and documentary proof are made part of the proceeding. When all of the evidence has been presented, the hearing is closed. Within 30 days, arbitrator renders an award.

As a matter of fact, many of today’s insurance policies contain mandatory arbitration clauses based on the procedures set forth by the American Arbitration Association. Arbitration clauses are enforced by both federal and state statutes. Therefore, if one of the parties involved in the dispute refuses to arbitrate, a court will order the arbitration. The submission to arbitration is sometimes referred to as an agreement for submission, and this agreement for submission is a contract between the parties. The arbitrator’s decision is usually binding and final, but in some situations, the parties may agree that the award will be only advisory or that it may be subject to review.

Like mediation, arbitration permits the parties to resolve their disputes without lengthy and costly interference from the judicial system. Also like mediation, arbitration proceedings are not a matter of public record. As a result, using arbitration as a method of alternative dispute resolution allows the insurance industry to avoid bad publicity.

Unless compulsory arbitration is provided by state statute, the first step toward arbitration is for the parties to agree to arbitrate. In order to do so, they must enter into an arbitration agreement. If an agreement for arbitration is not prepared, the parties are not bound by the award of the arbitrator.

Of course, the conventional elements of contract law must be present in an arbitration agreement. This includes:

* The agreement to arbitrate
* A description of the particular issue up for arbitration
* An agreement that the parties will abide by the arbitrator’s award

The decision of the arbitrator is called the award. The award is enforced just like any other judgment.

An agreement for arbitration takes into consideration the disposition of the entire dispute between the parties. An agreement for appraisal, however, extends only to the resolution of the particular issues of a claim. For instance, an issue to be resolved by an agreement for appraisal might be a dispute over the amount of a loss. Or, it might be the dispute over the actual cash value in a life insurance policy.

The laws of arbitration require that arbitrators must go to all hearings and hear all material evidence. The arbitrator’s authority is obtained from both parties, and the arbitrator must conform to the standards of arbitration law. As in a court room proceeding, the parties’ attorneys may argue among themselves during the arbitration process. Also, they may make objections to any evidence. However, the arbitrator makes the final decisions concerning the evidence. There is no appeal process from rulings of the arbitrator. His award is final and binding.

When a disputed insurance claim involves the value of the claim, the parties can obtain last offer arbitration. Last offer arbitration restricts the arbitrator to selecting either the last demand from the claimant or the final offer from the insurer. This approach encourages the parties to negotiate toward the real value of the claim. In this way, neither party wants the other side’s last demand or final offer to be selected as final by the arbitrator.

Another arbitration technique is high low arbitration. High low arbitration involves the parties’ agreement to limit the arbitrator to reaching an agreement that falls within some monetary frame work. For instance, the parties might agree that the award should fall somewhere between $50,000 and $75,000. Using this technique, the parties are protected from any award which might fall outside this frame work.

Arbitrators have a very broad authority under the law. An arbitrator may, for example, issue subpoenas, assign hearing dates, and grant postponements. The arbitrator may also enforce ex parte awards (granted on or from one side or party only), as long as there is an agreement to arbitrate.

**The Release**

Generally speaking, with the except of partial settlements or advance payments, once a settlement amount has been agreed upon by all parties, the claim should be closed completely. There should be no unfinished business which might indicate an agreement to pay additionally damages. A release is issued which contains the specific sum for settlement of the claim. There is a proper manner of obtaining a release.

The release should be a “release in full” for all claims past, present, and future which may arise from the particular claim. Naturally, future commitments cannot be made for unknown amounts. However, the only exception to this rule would be when the settlement is only a partial settlement and is not intended as a final settlement.

The release is a method of the disposition of claims where all parties agree that the settlement is the final outcome of a case. When the release is executed, the parties agree that there will be no further action by either party.

Any requests by the claimant to pay additional damages over the amount agreed upon in a settlement, after the case is closed and a release is obtained, should be weighed carefully. Any payment made after the claim is closed could be interpreted as a waiver of the previous settlement. There are, however, rare circumstances where an insurer might want to reconsider a settlement.

**CHAPTER 4:**

**ADVANCING TECHNOLOGY**

**IN CLAIMS HANDLING**

**Increasing Technology in the Claims Handling Area**

Because our society today is technology driven, our discussion on effective claims handling procedures leads us to a short study of advancing technology in the claims handling process. Since professional claims handlers must be up to date on the latest trends and advancements in the industry, we will explore some of the directions that the claims handling process is taking.

More effective claims handling, increased use of technology, and a greater focus on expense management is necessary to enable insurers to sustain growth. The insurance industry is seeing an upward migration toward those insurers who have the most efficient operating structures.

New technologies make this possible. Future growth in the insurance industry will come for the efficient, low cost providers at the expense of the less efficient. Long term, as this market grows, the winners will be those that handle claims in an effective, customer friendly manner. This includes employing on staff claims handlers, as well as investment in automation and technology for adjusting and information management. Insurance companies today spend as much as $.70 of every dollar in the claims handling area.

Insurance companies increasingly turn to technology to strengthen their claims handling operations. Naturally, unprecedented levels of claim services are not easy to achieve. The goal for the industry is to respond to consumers within a short amount of time. Some of the advances in technology below make this more possible than ever.

Over the past ten years, there has been a dramatic change in the way claims are handled. There are still changes ahead, but they will come because of new partnerships in information management, not just improvements in technology.

The changes taking place today with the use of portable and stand alone computers are allowing insurers to automate existing claim processes and to completely rethink their approach, adding real value for the customer and real productivity gains for the company.

There are three reasons an insurer may shift its claims handling process to a more efficient and advanced one. The primary reason is to improve the business process. This focuses on the dramatic gains in productivity and efficiency that come from rethinking how a claim can be handled using current technology. These are not limited to computers, but feature a wide range of technology including everything from fax machines, cellular phones, telecommunications networks, WANS, LANS, etc. All of these tools allow people to communicate more efficiently. Claim settlement is really about communication, which used to be done face to face, claim representative to insured, or appraiser to collision repairer. The telephone, the first phase of automation, probably reduced the amount of communication. Today’s technology can put a human element back into the interaction. This not only makes it more pleasant for the participants, but also makes claims less costly to settle.

Even while companies are changing the way their estimators estimate, others are focusing on the process by changing to a preferred provider methodology where shops, using approved systems, are writing the estimates, transmitting the estimates for approval to companies, and beginning work immediately. This is all done without the involvement or expense of a claims handler. Auto repair shops are pleased with this process because it reduces the time to complete the repair. However, this approach reduces the insured’s personal contact with his insurer even more.

Another reason an insurer might change its claims handling is cost reduction. Intelligent uses of today’s technology and a focus on the claims process have the capability to significantly reduce costs. For example, companies can take advantage of the drop in personal computer costs to equip their people and improve productivity. The expense of personal computers is often less than the fully loaded costs of mainframes used in the past. At the same time, personal computer technology improves communication and increases responsiveness to policyholders.

Finally, there is the issue of improving customer satisfaction. This issue has become a driving force in the industry. Competition has increased dramatically, and new forms of insurance sales (direct mail, phone, affinity groups, etc.) have increased pressure on agency companies. In terms of marketing, the cost of acquiring a customer and making a profit has increased. Therefore, companies must keep a client on the books for at least four years in order to make a profit. Effective claims handling procedures are seen as having the most prominent role in retaining customers.

Today’s technology has a real affect on claims handlers. For example, while many companies have claims handlers who specialize, others want a single work station solution for multi-line claims handlers. Regardless of which approach is used, insurers want their claims handlers out on the front line to be able to receive and send assignments. They want them to be able to run collision estimating and everything else out of a single piece of hardware.

The system must have anti-fraud capabilities, the power to cross check a claim, and show whether the insurer or another has paid the claim previously. Such an interactive claims workstation is on our horizon. Whenever expenses can be reduced, as by our advancing technology, policyholders can be offered a more competitive product.

**Take Advantage of the Computer!**

By taking full advantage of a computer, claims handlers can produce a professional quality file for every property adjustment.  The advantages here are many.  These computer programs help the claims handler and the insurance company to manage files more easily.

Computer programs now give insurance companies the ability to input the database for insureds, distribute this to claims handlers on disk, and have the claims handler return all adjustments to the company on the disk along with the hard copy.  The files are immediately organized when data is entered into the database.  With the availability of multiple databases and full search, sort and group criteria, the power of this program allows further organize and management of claims. This translates into greater office automation, and it streamlines office procedures.  It can eliminate literally hours of time spent on reporting. Some of the features available in these programs include:

* A full featured reporting program
* Complete form generation for any type of loss (i.e., Caption Reports, Statements of Loss, Demonstration of Loss, Proof of loss, Adjuster Assignment List, etc.)
* A calculation of depreciation, distinguishing between recoverable and unrecoverable
* Photo sheets, diagram sheets, letter generators
* Paperless files
* Activity log and notes input
* Full assignment information and all date responses
* Invoice for the claims handler to the client
* Full search

Unhappy insureds because of lost files can be a thing of the past.  Once entered into the database, the files can be logged for timely reporting.

**New Technologies Speed Up the Claims Handling Process**

Insurers move mountains of paperwork, and must do it very efficiently. Blending automation with time tested techniques helps to provide first rate service. Some insurers process millions of medical claims each year, each averaging several pages. This quickly adds up to millions pieces of paper a year just to process claims!

Those insurers with the lowest numbers complaints simply credit their success to speedy claims handling. One health insurer typically mails checks twice as fast as the average health insurer. Each office microfilms and retrieves its own claims. They archive them all and handle the legal requests that come from their headquarters.

Many Claims Handling Departments have installed search systems which operate as computer aided retrieval systems for microfilmed claims, and this has dramatically improved productivity. These search systems interface with microfilm readers / printers. They can automatically identify the roll and frame number where the requested claim and supporting documentation can be found. The images are then retrieved on the microfilm reader / printer, reviewed to ensure that they are in fact the ones needed, and the requested data is immediately printed and passed on to the appropriate approver or customer service representative.

This type of automation has enabled claims support staff to respond to requests for information within 24 hours, even though claims are up 16 percent. A typical day with such a search system averages about 300 requests. Before such systems were installed, the staff was required to manually go through the logs to look up roll and frame numbers, and this was very time consuming, contributing to slowing handling of claims and additional costs attributed to overtime.

These search systems allow customer service associates to get back to customers the next day. Time management skills are improved. Despite increases in volume, offices can now provide nearly immediate service. Previously, customer service associates and approvers often pulled their own files. Today, their efficiency is increased, resulting in improved customer service. Claims handling customer service associates and approvers can now spend their time responding to customers, not retrieving their claims.

File retrieval can be reduced to just a minute. Before the advent of search systems, even if the employee knew the roll number, he would have to roll the film to the right spot. Today the microfilm reader goes right to the data and prints it in seconds.

How do these millions of documents get into the system in the first place? When the office receives customer claims, clerks open and date them, then forward them to the appropriate approvers. The original claim is sent to the Microfilm Department for filming while the explanation of benefits and any reimbursement is mailed to the customer.

The goal is to get the paperwork filmed quickly and accurately, index it, and have it available to claims support so there's documentation once the insured gets the explanation of benefits.

Essentially, we now have a claims handling document management solution that is found somewhere in the middle lanes of the information superhighway. It uses time tested micrographics plus electronic data retrieval. The bottom line is greater efficiency and customer satisfaction.

**CHAPTER 5:**

**CONSUMER PROTECTION AND**

**CLAIMS HANDLING**

**Introduction**

There are certain accepted standards of behavior which are expected from insurers and their licensed insurance adjusters. In addition to this expected behavior, adjusters are governed by both federal and state rules and regulations. Naturally, these regulations can vary between the individual states. However, state laws are typically modeled after federal statutes, and there are certain codes of behavior which are universal. During this chapter, we will be discussing various types of legislation which apply to insurance consumer protection issues. We will also be studying ways to ensure compliance with the consumer protection laws.

**The History of Insurance Consumer Protection**

Although the insurance industry is said to be several hundred years old, insurance as we know it today came about the mid 1700s. The first insurance company in the United States was organized in 1752 by Benjamin Franklin. It was known as the Philadelphia Contributorship for the Insurance of Houses From Loss by Fire. Next, life insurance developed. Later, casualty coverage was expanded.

During the 19th century, many states were affected by unethical practices of some insurance companies and their agents or representatives. Some of the most prevailing of these practices were policies being sold, then the refusal to pay losses and insurers simply refusing to meet their obligations.

Unfortunately, insurers and their representatives continued to engage in disreputable practices until legislation was passed which made insurers and their representatives liable to policyholders for losses. Some of the first legislation aimed at consumer protection was the law of agency.

**The Law of Agency**

The law of agency was created the mid 1800s. The agency system was aimed at those who were involved in soliciting, transmitting, examining, collecting, selling, or in any other way associated with the business of insurance. By means of the law of agency, insurance companies became responsible for their own acts, as well as for the acts of their agents. Agents serve as legal representatives of their companies. Today this concept is known as theagency system.

Please note at this time that the term “agent” will be used throughout this course. This term is not necessarily applied to mean “insurance agent”. It is also used to reference any agent of the insurer created by the law of agency. For example, a claims handler, through the law of agency, is considered an agent of the company.

Soon the states began organizing their own departments of insurance. Typically, these were headed by an appointed commissioner of insurance, and he was empowered to execute the laws of the state relating to insurance. The commissioner was required to certify that the assets of an insurance company were adequate to support the policies in force. He was also required to certify that company reserves were sufficient to meet the legal requirements.

**Early Insurance Legislation**

During the latter part of the century, mutual insurance became widespread. These insurance associations grew rapidly in the late 1800s. Although there was some legislation passed to regulate these and similar associations, many of them operated without the supervision of the legal system. Ultimately, this led to abuses in the industry, and many policyholders were left unprotected. It was not uncommon for unprincipled or corrupt insurers of all types to collect premiums and run off with the funds.

Initial legislation targeted control over insurance activities and practices. These statutes required life insurance companies to register with the state. Registration required certain financial disclosures; specified that marine, fire, and casualty companies could not do business in life insurance; and stated that companies failing to pay covered losses were subject to forfeiting their right to do business within a state.

Subsequent legislation in the late 1800s required the licensing and registration of out of state companies doing business with a state. Procedures were established for the incorporation of life insurance and accident insurance companies.

As regulation of the insurance industry increased, companies were forced to register with the states’ insurance commissioners and to meet specified financial obligations. Fortunately, as a result of tighter regulatory measures, the insurance industry began to improve its image and to gain respectability. The industry was made stronger, and consumers were offered greater protection from unethical insurance companies and their agents.

**The Development of Insurance**

With the increase in population, the expansion of foreign trade, and the growth of manufacturing in this country, the insurance industry saw many changes. People began to recognize the genuine need for insurance as a result of such disasters as the Great Chicago fire, the Galveston hurricane in 1900, and the San Francisco earthquake in 1906. The introduction of the automobile brought about the necessity for auto insurance.

Regulation began to require certain financial disclosures and stated that companies failing to pay covered losses would be subject to, in addition to fines, forfeiting their right to do business. Out of state insurers were required to be registered and licensed within the states where they pursued business. Later, the insurance commissioners were authorized to conduct investigations of insurance companies and their agents, and these companies and their agents were required to assist with investigations and to give full access to their records.

The comprehensive insurance codes, along with extensive reorganization of the state departments of insurance, began in the 1940s. This was made necessary by the swift growth of the insurance industry after World War II. Much of the insurance legislation during this time involved capital and surplus requirements for insurers, and rigid enforcement of this new legislation was seen.

Insurers are subject to the various pieces of legislation enacted within their own states. Typically, these state statues are modeled after federal legislation. For instance, the Consumer Protection Act is a federal law that regulates consumer practices. However, state laws are drawn, or modeled, from this legislation. Although the individual states my call their statutes by different names, their intent is the same.

**Modern Insurance Legislation**

Modern legislation concerning insurance consumer protection brought about the states’ various deceptive trade practices acts. These were the first mechanisms for private causes of action in cases of misrepresentation, breach of warranty, and unconscionable conduct in consumer transactions, including those transactions involving insurance. These laws were enacted to provide consumers with a cause of action without the burden of proof and the many defenses experienced in suits of common law fraud or breach of warranty. It provided for enforcement against fraud and deception by insurance companies. Today, these laws continue to be the most effective weapons for consumer protection.

Until the various deceptive trade practices acts, common law typically recognized the ancient common law of “caveat emptor”, which in Latin means “let the buyer beware”. This law has governed business and consumer transactions in England and the United States for centuries. Under caveat emptor, unethical insurance companies and agents could harbor themselves from the consequences of their actions. Today, all that has changed. Now the term “caveat vendor”, or seller beware, which is more often used and commonly interpreted to mean “let the seller fully and accurately disclose”, commands under the deceptive trade practices legislation. Today, these statutes are the primary grants of consumer rights.

**Why Do We Regulate the Insurance Industry?**

There are many motives for continuing to regulate the insurance industry. These motives include:

* Controlling rates so that they are adequate
* Controlling rates to ensure fairness
* Controlling rates to ensure nondiscriminatory practices
* Preventing unfair insurance practices toward insureds
* Preventing unfair insurance practices toward competitors
* Preventing insolvency of insurers for the protection of insureds

**Consumer Law and Insurance Regulation**

Consumer law is the specialty practice of law which deals with consumer transactions and transactions of business consumers. This includes insurance consumers. Consumer law involves matters relating to deceptive trade practices, unfair claims settlement practices, unfair competition, and other federal and state laws that are designed to protect consumers.

Consumer law includes the prosecution and defense of claims, as well as business compliance. Statutes are often industry specific. That is, they refer to only certain industries, such as the insurance industry.

Government regulation embraces nearly every consumer product and service, including insurance policies or products and the services offered by the insurance companies. Under consumer protection laws, where there is the grant of power to the consumer for a statutory injunction, there is also the power to correct the damage incurred. Therefore, consumer laws protect everyone, not just the consumer plaintiff.

Consumer statutes, including those in the insurance industry, are one sided. They have been enacted to protect consumers. Their objective encourages principled businesses, service providers, and sellers to compete favorably. With respect to the insurance industry, insurance companies and their agents are required to conform to certain disclosure practices, specific claim settlement obligations, and certain ethical behaviors.

**How Are Insurance Consumers Protected?**

The purpose of consumer statutes is to invite service providers, sellers, and others in business to compete favorably. Within the insurance industry, insurance companies are required to conform to certain ethical behavior with respect to disclosure practices, claim settlement obligations, and other trade practices.

All consumer statutes are prejudiced. Their purpose is to protect consumers. This includes insurance consumers. With respect to unclear or ambiguous terms in an insurance policy contract, these issues are always decided against the insurer and in favor of the insured. Whenever there are questions in connection with policy coverage, the question is invariably decided in favor of the policyholder.

Insurance consumers are first considered consumers and then insurance consumers. They are protected by the numerous laws that protect consumers in general. If their complaint is associated with insurance, they are additionally protected by the insurance codes of the various states.

We know that government regulation surrounds nearly every consumer product and service in the market place today. This includes insurance policies or products and the services that are offered by the insurance companies because insurance policies are considered to be “services”.

Both federal and the state governments have significant powers concerning the administration of consumer laws. They have the power to regulate and employ standards with respect to insurance practices. They also regulate disclosure practices. These standardized disclosures permit insurance consumers to compare services, policies, etc.

At the federal level, Congress has maintained that insurance industry and all those who are engaged in it are subject to the laws enacted by the states in which the insurer may solicit business.

**Deceptive Trade Practices**

The states began to enact their various deceptive trade practices acts during the 1960s and 1970s. This was during the height of consumer activism. Naturally, these acts are very broad in their scope and their application. Essentially, they provide for private causes of action for any consumer who is damaged because of another’s misrepresentation, breach of warranty, unconscionable conduct, or unfair practice.

In addition to industry specific codes, insurers must adhere to general consumer protection laws. These consumer protection laws come under legislative acts such as deceptive trade practices or unfair trade practices. While these are not industry specific, they apply to the insurance industry because an insurance policy is considered a service. Therefore, a purchaser of an insurance policy is considered a consumer. All insurance services come under this widely adopted consumer protection legislation.

In general terms, the following practices are considered to be deceptive acts or practices, and these are subject to action by the appropriate codes of consumer protection. The practices described below are not limited to those only within the insurance industry. They are unlawful practices that apply to practices in the conduct of any trade or commerce.

The following are considered to be deceptive acts or practices:

* Passing off services as those of another
* Causing confusion or misunderstanding with respect to the source, sponsorship, approval, or certification of services offered
* Causing confusion or misunderstanding with respect to the affiliation, connection, or association with another
* Using deceptive representations or designations of geographic origin in connection with services
* Representing that services have sponsorship, approval, characteristics, or benefits which they do not have
* Disparaging the services or the business of another by means of a false or misleading representation
* Advertising services with the intent not to sell them as advertised
* Advertising services with the intent not to supply a reasonable and expectable public demand, unless the advertisement discloses a limitation on quantity
* Representing that an agreement confers or involves rights, remedies, or obligations which it does not have or which are prohibited by law
* Misrepresenting the authority of a sales person or an agent in order to negotiate the final terms or the execution of a consumer transaction
* Failure to disclose information with respect to services, which is known at the time of the transaction, if the failure is intended to induce the consumer into a transaction which he would not have otherwise entered, if the information had been disclosed
* Advertising under the appearance of obtaining sales personnel when, in fact, the purpose is to first sell a service to the sales personnel applicant
* Making false or misleading statements concerning the price or the rate of services
* Employing “bait and switch” advertising in an effort to sell services other than those advertised or on different terms or rates
* Requiring tie in sales or other undisclosed conditions which must be met prior to selling the advertised services
* Refusing to take orders for the advertised services within a reasonable time
* Showing defective services which are unusable or impractical for the purposes set forth in an advertisement
* Failure to make delivery of the services advertised within a reasonable time or to make a refund
* Soliciting by telephone or door to door as a seller, unless within thirty seconds after beginning the conversation, identifying oneself and representing the purpose of the call
* Setting up or promoting any pyramid type promotional scheme
* Advertising services which are guaranteed, without clearly and conspicuously disclosing the nature and the extent of the guarantee, without clearly and conspicuously disclosing any material conditions or limitation in the guarantee, without clearly and conspicuously disclosing the manner in which the guarantor will perform, or without clearly and conspicuously disclosing the guarantor.

**Unfair Insurance Practices and Unfair Competition**

In addition to this general consumer protection legislation, the states have enacted their own insurance codes that specifically address the practices of insurers and their agents. For example, insurance consumers are naturally concerned with the issues of unfair insurance practices and unfair competition. Most states have some form of unfair practices act. Sometimes, these statutes are referred to as deceptive trade practices, unfair trade practices, or unlawful trade practices. These statutes provide for private causes of action for consumers who are injured because of an insurer’s misrepresentation, breach of warranty, unconscionable conduct, or unfair practice.

It should be noted at this point that even if a particular state does not have specific legislation on its books with respect to certain deceptive acts or practices, insurers are still held to the duty of good faith and fair dealing.

Violations of deceptive insurance trade practices or acts may fall within these categories:

* **Misrepresentation.** When a seller or service provider, such as an insurer or its agent, makes a representation, he has the duty to know whether that statement is true. In addition, the insurance consumer is entitled to rely on this representation. Misrepresentation provisions of deceptive trade practices acts are designed to ensure the reliability and accuracy of descriptions of goods and services.
* **False Information and Advertising.** States protect insurance consumers by prohibiting false information in advertising. Publishing, disseminating, circulating or placing before the public in any way, directly or indirectly, circulars, pamphlets, newspapers, magazines, or other publications which contain misleading statements is prohibited. This applies to brochures, letters, posters, etc. In addition, untrue, deceptive, or misleading statements may not be made over any radio or television station.
* **Defamation.** Defamation violations take place when false statements, made directly or indirectly, are made which are intended to injure anyone engaged in the business of insurance. The term “directly or indirectly” to statements made as verbal assertions, as well as topamphlets, circulars, articles, literature, etc. No assertions or statements may be made which are false, maliciously critical, or derogatory to the financial condition of the insurer.
* **The Failure to Disclose.** Allegations of failure to disclose are often found in law suits against insurance companies. Insurers and their agents are encouraged to expound upon the merits of their products. They are not taught to demonstrate the drawbacks of their products and services. An allegation of failure to disclose requires that the plaintiff must prove that the defendant intended to induce him into an insurance transaction that would not have otherwise entered. The essential elements under failure to disclose are knowledge and intent.
* **Boycott, Coercion, and Intimidation.**  It is unlawful in most states to enter into any agreement to commit an act of boycott, coercion, or intimidation which would result in a monopoly or in the unreasonable restraint of the insurance business.
* **Breach of Warranty.** Breach of express or implied warranty is a clear violation of contract law, and it is considered a deceptive practice.
* **False Financial Statements.** Restrictions on insurers with respect to false financial statements are very explicit. Insurers are prohibited from misrepresenting the financial condition of any insurer, that is, the insurer itself or any other insurer, with the intent to deceive. Filing with any supervisor or public official or making, publishing, disseminating, or circulating a false statement concerning the financial condition with the intent to deceive is prohibited. These types of misrepresentation include making false entries into any book, report, or statement with the intent to deceive an agent or examiner who has been appointed to examine these affairs. Likewise, purposely omitting such a material fact on any book, report, or statement is also prohibited.
* **Unconscionable Conduct.** Unconscionability, or unconscionable conduct, takes advantage of the lack of knowledge, ability, experience, or capacity of a person to a grossly unfair degree, or it results in a gross disparity between the value received and the consideration paid.
* **Deceptive Name or Symbol.** In most states, insurers are prohibited from the use, display, publication, circulation, or distribution of any name, symbol, slogan, or device which is the same or greatly similar to a name adopted and already in use.
* **Stock Operations and Advisory Board Contract.** In most states, it is a violation of statute to deliver or to permit agents to issue company stock, other capital stock, benefit certificates, shares in a corporation, securities, or other special board contracts and promise returns and profits as an inducement to insurance. No one may issue these instruments and guarantee dividends or proceeds as an incentive. However, participating insurance is excluded from this category.
* **Unfair Discrimination.** Unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract by insurers is prohibited. This applies to life insurance, life annuities, dividends**,** other benefits payable by these contracts and to any terms and conditions of the insurance policy contract. In addition, there may be no unfair discrimination between individuals with respect to the amount of premiums, policy fees, and rates charged for accident and health insurance.
* **Insurance Code Violations.** Violations of any state’s insurance code, Unfair Claims Settlement Practices Act, or Unauthorized Insurers False Advertising Process Act come under the heading of deceptive practices or acts.
* **Violations of Tie In Statutes.** Tie in statutes are also known as linking statutes. Under these types of statues, the claimant is granted the right to bring a cause of action under the by means of another law.
* **Rebates.** In most states, it is prohibited to offer to pay or rebate premiums, to provide bonuses or the abatement of premiums, or to allow special favors or advantages concerning dividends or benefits related to an insurance policy, annuity, or other contract associated with any stock, bond, or security of any insurance company. This applies to all life insurance, life annuities, accident insurance, or health insurance. A rebate is the giving, either directly or indirectly, as an inducement for an advantage for special favors, other than what is specified in the policy contract. Rebates also refer to any giving, selling, or purchasing as an inducement to the insurance. This may include stocks, bonds, securities, or other dividends not specified in the contract. If a rebate were permitted, one policyholder would have a definite and unfair advantage over others in similar situations who do not receive the benefit of the rebate, and this would create an act of unfair discrimination.
* **Other Provisions.** Other provisions might include, for example, bait and switch schemes or pyramid sales strategies.

**Unfair Claims Practices**

States have also adopted legislation concerning unfair claim settlement practices. With respect to claims settlement practices, insurers may not engage in any unfair claims settlement practices.

This legislation provides that insurers may not engage in unfair claim settlement practices. This provisions of these acts apply to proprietorships; partnerships; corporations; unincorporated associations; stock, mutual life, health accident, fire, casualty, hail, storm, title, and mortgage guarantee companies; mutual assessment companies; local mutual aid associations; local mutual burial associations; statewide mutual assessment companies; stipulated premium companies; fraternal benefit societies; group hospital service organizations; county mutual insurance companies; Lloyd’s; reciprocal or inter-insurance exchanges; and farm mutual insurance companies.

Practices that are prohibited by this legislation are:

* The failure to acknowledge, with reasonable promptness, appropriate communications concerning claims
* Knowingly misrepresenting pertinent facts or policy provisions to a claimant which are relative to his coverage
* The failure to adopt and implement effective and efficient measures for the prompt investigation of claims
* Not attempting, in good faith, to make a prompt, fair, and equitable settlement of a claim where liability is reasonably clear
* Compelling policy holders to initiate law suits in order to recover amounts due under policy coverage by offering to settle for an amount substantially less than is ultimately recovered by the claimant
* The failure to maintain a complete record of all complaints received during recent years or since the date of the last examination by the insurance commissioner, whichever is shorter. This history must indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, their disposition, and the time to process each complaint.
* Committing any other actions which a state may define as an unfair claim settlement practice

**Unauthorized Insurers**

Naturally, it is a major concern to regulators that consumers be protected against the inability to bring suit on their policies against out of state insurers. The Uniform Unauthorized Insurers Service of Process Act is a model act which was drafted by the All Industry Committee, and this model has been provided to all states. This Act affords jurisdiction over an out of state insurer by an in state insured.

Unauthorized insurers legislation protects insurance consumers from insurers not authorized to transact business in the state. These unauthorized insurers may be any insurance company organized under the laws of another state, as well as any territory of the United States or any foreign country. Under this type of legislation, insurers are prohibited from sending false advertising to states where they are not authorized to conduct business in order to influence residents into purchasing insurance.

The purpose of this legislation is to protect insurance consumers concerning misrepresentation. No unauthorized insurer may issue any advertisement, estimate, or illustration, misrepresenting its financial condition, the terms of its policy contracts, benefits, advantages, dividends, etc.

**Relief to Consumers**

Consumers are protected from unscrupulous insurance practices under the various deceptive trade practices statues, prohibiting insurers from engaging in these practices. Consumers are further protected by being provided relief through procedures to secure their protection. Since the intent of this legislation is to protect consumers, questionable issues are always decided in favor of the insured consumer and against the insurance company.

In order to secure relief under the various deceptive trade practices statutes, a consumer may maintain an action when any of the following practices produces damages:

* The use of a false, misleading, or deceptive act or practice
* A breach of an express or implied warranty
* An unconscionable act
* The use of an act or practice in violation of any state’s insurance code

Injured consumers may recover damages and penalties. Under the deceptive trade practices acts, a consumer who files a suit maintaining any of the actions described above and who prevails may obtain:

* **The amount of** **his actual damages.** In addition, the Court may award a multiple of the actual damages, for example, three times the first $1,000 of actual damages. Actual damages include the cost of repair, diminished value, mental anguish, out of pocket expense, loss of bargain, interest or finance charges, and consequential economic loss. However, actual damages can be offset as a result of a countersuit by the defendant. Even if there is no net recovery as a result of such an offset, the consumer is entitled to attorneys’ fees.
* **Incentive damages.** If the violation is committed knowingly, the Court may award an amount in addition to actual damages. Typically, this is awarded when the damages exceed $1,000. If personal injury or death is involved, the Court may award incentive damages at high multiples of the damages.
* **Orders necessary to restore real or personal money or property that may have been acquired unlawfully**.
* **Other relief.**  The Court may award any other relief, as it sees proper. For example, this may include the appointment of a receiver or the revocation of a license or certificate authorizing business in the state. In addition, any costs of receivership are assessed against the defendant.
* **Court costs.**
* **Reasonable and necessary attorneys’ fees**. These fees are typically expressed as a percentage of recovery.

**Court Orders**

When it is believed that an insurer has engaged in an act or practice declared to be unlawful by the terms of a deceptive trade practices law, an action may be brought against the insurer by the state. This action may be brought in the form of:

* A temporary restraining order
* A temporary injunction
* A permanent injunction

In addition, civil penalty may be levied. This civil penalty is intended to restore the real or personal money or property of the consumer, which may have been acquired unlawfully by means of a deceptive act or practice. An insurer found to be in violation of the terms of a restraining order or injunction may be required to pay the state a civil penalty, typically between $1,000 and $50,000.

Orders of the Court may include the appointment of a receiver or sequestering of assets.

**Law Suits**

In order to bring action for damages under a deceptive trade practices act, the consumer must give written notice to the insurer, typically 60 days, before filing the suit. This notice must describe the consumer’s particular complaint and the amount of actual damages and expenses. During this 60 day period, a written request may be made by the intended defendant to the consumer to inspect the goods or services which are the subject of the action or claim. This might include requesting a copy of the insured’s policy contract. During this 60 day period, an offer to settle may be tendered by the insurer. If the two parties cannot agree on a settlement during this time, the suit may be brought in court.

**Defenses to Claims of Deceptive Trade Practices**

The defenses to causes of action brought under the terms of the deceptive trade practices acts are very limited. The only defenses permitted are:

* Inadequate notice by the claimant
* Tender of settlement. If the insurer has complied with the claimant’s demand to settle, no suit may be brought.
* The insurer’s reliance upon written materials or advice of counsel
* The payment of damages, fees, and expenses
* Indemnity from the one who has the liability for the damaging event
* Expiration of the statute of limitations
* Any exceptions allowed by law
* Waiver by the consumer

**Assuring Insurer Compliance With Consumer Protection Laws**

Each state has Department of Insurance. This department may be headed by a commissioner, a board, or some other arrangement. For the purposes of this discussion, we will refer to the authority of the state’s Department of Insurance as the “Commissioner”.

The Commissioner of a state’s Department of Insurance may investigate insurers in order to ensure compliance. Generally, the Commissioner must first present a statement of charges against the insurer. Then, he must give notice of a hearing. If, as a result of this hearing, an insurer is found to be in violation of any of the provisions of a deceptive practices act, the insurer will be ordered to cease and desist from further engaging in the practice that brought about the complaint.

In most states, the Commissioner has the authority to order the insurer to make restitution, not only to the victim but to all policyholders affected in the same way. Also in most states, an administrative class action may be filed. In this case, the insurer may be required to refund all premiums, minus policy benefits, to its policyholders.

Generally, the Commissioner has the power to study and investigate the affairs of insurers conducting business in his state. The Commissioner may determine whether any unfair or deceptive act has taken place. The Commissioner also monitors financial practices and ensures compliance with the laws of the state.

The Commissioner has the authority to administer oaths; examine and cross examine witnesses; receive evidence; subpoena witnesses; and require the production of books, papers, records, correspondence, or other documents which it determines to be necessary and relevant.

If any party refuses to comply with a subpoena, refuses to testify, or refuses to cooperate with the Commissioner during an investigation, the Commissioner may appeal to the Courts to have this person comply. Any further failure to comply with Commissioner’s authority can be considered contempt of the Court.

In addition to the powers of enforcement discussed above, the Commissioner also holds other regulatory options for assuring insurer compliance with state laws. While these various methods of assuring compliance may have different names in varying states, all states have some procedures in place for enforcing state regulations. For example:

* **Regular Examinations.** The states’ insurance codes provide for the Commissioner to examine insurance companies on a periodic basis, typically one to five years. This examination applies to the insurance companies, as well as to the books and records of its agents. Negative results of such an examination can lead to revocation or modification of the insurer's certificate of authority to conduct business in the state.
* **Administrative Oversight**. This is an informal procedure that is used for insurers who show troubling financial or policyholder trends.
* **Sanctions.** The Commissioner has the authority to take disciplinary action against companies that violate any provisions of his state’s insurance code. For example, the Commissioner may suspend or revoke the authority to do business in the state. He may order the insurer to cease and desist a specified activity. Or, the Commissioner may order a company to pay restitution to all those harmed by a violation. Finally, the Commissioner may impose monetary penalties on companies found to be in violation of specific provisions of the state’s insurance code.
* **Hazardous Financial Condition.** If the Commissioner finds that the financial condition of an insurer might be hazardous to its policyholders, creditors, or to the general public, he may order, suspend, or cancel the certificate of authority of the insurer.
* **Supervision.** The commissioner has the authority to place a company or its agent in supervision. Supervision typically lasts up to six months. However, either the Commissioner or the insurer may request an expedited hearing to speed up this process. A supervision order usually contains a list of prohibited transactions and corrective actions necessary in order to be released from the supervision. Under a supervision order, the insurance company has the burden of proving that the practices in question have been satisfied, releasing the company from supervision.
* **Conservation.** The Commissioner may place a company into conservation, or conservator ship. Generally, after supervision if the insurance company cannot prove it has satisfied the actions required for release from supervision, the Commissioner orders the company to be placed in conservation. An order of conservation usually requires notice and a hearing. Typically, conservation is used when an insurer is insolvent, its financial condition is hazardous to the public or its policyholders, it has exceeded its powers, or it has failed to comply with the Commissioner’s requirements. During conservation, a conservator can take over the operation of the company.

**The Prompt Payment of Claims**

Most states set strict deadlines for claims handling. However, the Commissioner of Insurance may extend these deadlines, typically by 15 days after a major natural disaster. Under normal circumstances, companies must meet these claims deadlines:

* Fifteen days to acknowledge a claim and start investigating after receiving written notice.
* Fifteen days to accept or reject a claim after the insured has provided all requested documentation -- possibly including a Proof of Loss Form. However, the insurance company can take up to 45 days if it gives written notice that it needs more time. If the company requests a sworn Proof of Loss Form, the insured generally has 91 days to return it. If the insurance company rejects a claim, it must explain why. If a property is covered by a Catastrophe Property Insurance Association, repairs must usually be inspected and certified while they are in progress.
* Five business days to send payment after the company has agreed to pay a claim.