

COLLISION COURSE WITH THE
COLOSSUS PROGRAM:

HOW TO DEAL WITH IT

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I. THE ALLSTATE CLAIMS PROBLEM

From 1994 through 1997, Allstate Insurance Company underwent a significant change in the way it adjusted claims. Allstate conducted a thorough review and analysis of its claims practice procedures. As a result, in 1995 the Core Claim Practice Redesign (CCPR) program was established as an agenda for Allstate to change its claims focus.

Traditionally, insurance companies accepted the premise that the average amount paid in indemnity dollars (actual dollars paid to the claimant on average) could not be ethically changed. Allstate challenged this notion and accepted a new premise. It decided that severities could be managed and devised a claims practice to do so. Thus, CCPR and CCPR II were developed by Allstate to control claims severity and focus on small to mid-size claims which Allstate believed provided the greatest opportunity to save money.

As part of this claims focus shift, Allstate Insurance Company developed several programs. It attempted to influence claimants to remain unrepresented by attorneys because Allstate's own studies revealed that it was cheaper for the company to negotiate directly with the claimant than when an attorney became involved. It developed a specialized handling of relatively minor impact claims involving soft-tissue injuries.

Further, Allstate attempted to improve the objectivity and consistency in its evaluation process. The central theme of the change was that adjusters could begin to rely upon a software program known as "Colossus" which provided adjusters with a tool indicating what a particular case *should* be worth. Colossus, along with its historical settlement information, and a second

review by an “Evaluation Consultant”, was a primary evaluation change made at Allstate in its claims process.

Eventually, the changes were first tested in various “Focus” areas throughout the United States. The bottom line result was that the new evaluation process saved the company money, albeit at the cost of greater litigation and trials – especially of those cases involving relatively minor amounts in controversy. From the perspective of the consumer, Allstate would not pay fully for the value of a case and challenged the consumer to spend a significant percentage of any eventual recovery in litigation costs and otherwise unnecessary attorney’s fees. Attorneys representing policyholders and claimants of Allstate have widely criticized Allstate for this tough negotiation position rather than simply paying the full amount owed, quickly and without the need for litigation.

II. AN OVERVIEW OF COLOSSUS

Colossus is the trade name for a software program which is licensed for use by The Continuum Company, Inc. The principal place of business for The Continuum Company is in Austin, Texas. Continuum is now a subsidiary of Computer Sciences Corporation.

Continuum is marketed as a software program which provides insurance companies help in assessing damages for bodily injury claims. It is essentially a relational data base where adjusters in-put information regarding a bodily injury claim. The program then provides information regarding the evaluation of damages. Adjusters take information regarding a claim, including liability, medical information and other general damage information and in-put the same within parameters set by Colossus. The information is processed and a valuation range for the value of the case is returned to the adjuster.

The software requires the adjuster to enter general information regarding the adjuster's name, date of loss, regional/branch office, claimant's name, date of birth, gender, etc. It can provide responses based upon various economic regions to account for changes which are purely the result of geographical differences. Next, the adjuster must enter injury codes appropriate for the type of injuries sustained. Information regarding the length of treatment and resolution of each injury, including the type of treatment received, the medical provider providing the treatment and the dollar amount of the treatments are all recorded.

It is important to note that actual medical records and medical evidence, such as a doctor's report, is utilized to determine the information fed to Colossus. The claimant's attorney's allegations are not sufficient as evidence. Accordingly, permanent impairment and work/household duty impairment must be supported by medical evidence.

Other information may also be calculated. Whether or not an attorney is involved, medical liens, aggravating circumstances contributing to the accident, and whether the claimant used available safety equipment may all be considered by the Colossus program. Obviously, wage and medical specials are considered in detail.

As a result, the Colossus makes recommendations regarding general damages, gross settlement ranges and final settlement ranges. *While most insurance companies use Colossus as a tool, Allstate uses it as a rule to determine settlement value.*

III. WHAT IT MEANS TO THE CLAIMANT WHEN THE ADJUSTER IS USING COLOSSUS

Interestingly, discovery in bad faith Allstate files has shown that Allstate has tracked the performance of adjusters with respect to their ability to negotiate settlements under the Colossus reports. For example, in the Seattle claims service area an evaluation was made in October, 1996 regarding the percentage of amounts paid in relation to Colossus activity. Since the Colossus evaluation can be reviewed by claims management and field adjusters know their managers can easily determine whether they are adjusting within the Colossus recommendations for settlement, there is a great deal of pressure placed upon the adjusters if they deviate from the recommendations made by the computer regarding the value of another human's claim.

As a result, many attorneys representing claimants complain that human adjusters would otherwise settle claims and blame the Colossus analysis as an excuse for not doing so. Thus, the Colossus analysis and recommendation becomes paramount if a claimant is to receive fair treatment from Allstate.

Unfortunately, an old adage becomes very important – **“garbage in results in garbage out.”** The adjuster conveniently blames the computer software program as an alleged reason for not settling the case. The adjuster will not share the results of the information despite the fact a written report is generated, nor will the Allstate adjuster explain how the computer software program arrived at its conclusion(s). While many would certainly claim that Allstate should openly share the information with its own policyholders – and third-party claimants if one really believed it treated third-party claimants the same as policyholders - it is really looking out for the policyholder's interests, Allstate simply refuses to share how the information is manipulated by the computer program to provide the result it renders.

Nevertheless, some very important lessons can be gleaned from the aforementioned and from the relatively few materials available regarding Colossus. First, the adjuster putting the information into the Colossus program may not be adequately or properly trained which leads to misinformation fed into the program which, in turn, places a lower value on the claim than what the software program would otherwise make. While very few adjusters will ever share how they in-put this information, it is strongly suggested that the attorney go over in detail each fact regarding each injury, the initial treatment, the subsequent treatment, the future treatment, each prognosis with respect to each part of the body injured and the duration of injury and/or impairment for each part of the body injured. The Colossus program breaks down these injuries in a very detailed fashion and requires the adjuster to make numerous entries which the adjuster may have improperly fed into Colossus by not correctly reading the information about the case. It does little good to argue in generalities regarding the injury and settlement value if the adjuster is prevented from offering a higher amount because of “garbage in” information.

Further, ask the adjuster what the settlement ranges and evaluation ranges are regarding the Colossus report. From the best information available, Colossus will provide the adjuster a “recommendation” regarding settlement. Detailed notes regarding these conversations should be kept by the claims attorney if it later turns out that the Allstate adjuster deceptively offered an amount less than these ranges.

A perfectly acceptable method to settle these cases would seem to have Allstate simply offer the amount it determines to be within the fair settlement range generated by Colossus. Instead of claimant’s attorneys being accused of asking for “too much” for a particular injury, a number of claimant’s attorneys have simply asked the insurance company to make the first offer which they believe is fair based upon the computerized opinion from Colossus. Sine Allstate has

invested so much money to license this equipment and make “fair” evaluations, it would seem Allstate should be willing to offer and share the results of evaluations with its shareholders. After all, it was the shareholders whose premiums paid for this software to begin with.

Finally, many catastrophic injuries and significant subjective scarring cases have not been traditionally within the use of Colossus. Certainly, the software program will have a greater difficulty providing an accurate range in the major catastrophic case than in cases where there is a greater historical data base upon which it can rely. Attorneys representing catastrophically injured claimants should not expect any Colossus type of adjustment from Allstate which is accurate.

IV. A COLOSSUS CHECK-LIST

My general suggestion to Plaintiff’s counsel would be to ask for the following information during the negotiation process and prior to litigation:

1. The specific injuries used to determine the Colossus claim value.
2. The specific complaints which the claim representative used to evaluate the claim and in which medical report they were found. Remember, **each complaint must be documented in a medical report if it is to be considered by Colossus.** If counsel submits a demand letter and states that the client has headaches arising from the injury, Colossus will give no value for the headaches unless it is documented in a medical report. Typically, such documentation is worth more if made by a medical doctor rather than a chiropractic physician.

3. If appropriate to the particular claim, make sure that duties under duress, permanency, excess medicals, and lost wages were considered. Documentation as to how the figures were arrived at must be provided and discussed during negotiations. If these factors are not considered, ask the claim representative why they were not and make sure they provide you a definitive answer on these questions regarding these factors which have a significant value in the Colossus evaluation.

SPECIFIC FACTORS TO BE CONSIDERED

1. **Nature of pre-existing injury** – Aggravation of a pre-existing injury significantly increases the value of a Colossus evaluation. Accordingly, a medical document indicating that such pre-existing conditions, such as arthritis, disc bulges, etc., should be noted along with the degree of aggravation and permanency of the aggravation.
2. **General Practitioner and out-patient visits** - If a claimant is going to physical therapy after the last date of treatment by a physician, the last date of physical therapy is used in Colossus as the last date of treatment.
3. **Chiropractic Visits** – Colossus does not place a great deal of value on chiropractic visits. If chiropractic treatment is indicated, the Colossus system will inquire if the injured person was referred to the chiropractor by a general practitioner or other medical specialties if there is medically documented referral to the chiropractor, this fact would increase the value of the claim.

4. **Spinal Treatments** – Any treatment of the spine must be documented specifically as to the treatment, the injury and why the treatment is related to the injury. For more severe cases, the exact amount of days for hospitalization and bed rest are counted. Medically documented needs for aids, such as walkers, crutches, canes and the time required for the use of each are all considered. Plaintiff’s counsel should be prepared to document in the medical literature the need for each treatment, length of treatment and aid since each of these factors are considered. With regard to immobilization in a spinal injury, cervical strain choices considered by Colossus for cervical strain aids, such as a soft collar, polyurethane collar, neck brace or stiff neck brace are all segregated. Accordingly, Colossus is sophisticated enough to make a distinction between the types of collars being prescribed by the doctors and the Plaintiff’s attorney must ensure that the claim representative is in-putting the proper information.
5. **Length of treatment** – The system asks how long a specific treatment occurs. For example, the system will ask how many weeks of home traction or use of a TENS unit is physician prescribed. If it is prescribed on a permanent basis, that must be documented in the medical literature.
6. **Injections and medications** – Colossus has the ability to in-put significant information regarding injections and medications for treatment and/or relief of pain. For example, it distinguishes between cortisone steroid injections, epidurals or nerve blocks. It is important for Plaintiff’s counsel to provide the proper substances and procedures used for each of the same. Epidurals and nerve blocks greatly increase claim value.

7. **Soft-tissue complaints** – Anxiety, pain and/or depression complaints must be noted in medical reports and medications must be prescribed solely for the treatment of those claims before they will be considered in the claim evaluation.
8. **Delay in treatment** – Delays and gaps in treatment decrease the value of the claim under a Colossus evaluation. The longer the lapse of treatment, the more the value will be decreased. If there is an explanation for the gaps, the attorney should include this at length in any demand letters and, preferably, it should be documented in the medical records of the claimant.
9. **Impairment** – Colossus only recognizes the 4th Edition of the American Medical Association Guidelines to Permanency (which is reproduced in its entirety in the Colossus system) and uses only ratings to the person as a whole. There are certain injuries which in and of themselves carry a permanency rating. Your client's doctor may not mention this in any report, but you should be aware of the same since a Colossus evaluation will indicate to the claims examiner if an injury has an automatic permanency rating. For example, a compression fracture of the cervical spine under some circumstances may not require aggressive or long-term treatment. However, this injury automatically carries a permanency rating under the AMA guidelines. Under a Colossus evaluation, the permanency rating greatly increases the value of the claim. Typically, if the doctor will merely perform the angulation test under the AMA guidelines, Colossus will fully recognize the value of the permanent injury.
10. **Independent Medical Examinations** – Colossus recognizes information in independent medical examinations. Unfortunately, Allstate Insurance Company

does not use independent medical examination reports and the information contained therein as in-put data for some unknown reason. It has been suggested that for carriers other than Allstate, Plaintiff's counsel may wish to have a client examined by a medical doctor who will perform an in-depth medical examination of the client so that the detailed areas often overlooked by the busy treating practitioners is documented. With the documentation, the information can be considered for a full Colossus evaluation and will drive the value higher and prevent the claimant from receiving an otherwise improper analysis.

11. **Loss of Enjoyment of Life** - Colossus will consider this area only if there is a permanency rating. A loss of enjoyment of life claim must be supported and documented in a physicians report or notes and a specific claim must be made by the plaintiff's counsel or it will not be considered by Allstate. Accordingly, it is imperative that the treating physician interview the client and document in the medical records the expected areas of impact which the claimant will have to deal with as a result of the permanent injury.
12. **Special Damages** – Colossus considers all medicals and wage losses incurred to date. It also asks for projected medicals and/or wage loss. However, documentation from the treating physician regarding his opinion as to future treatment and medicals and of his opinion on the future duration of wage loss is required.
13. **Aggravating Factors** – The two most aggravating factors which affect claims evaluation under Colossus are (1) whether the injured client was wearing a

seatbelt and (2) whether the factors of aggravated liability, such as intoxication, exist.

V. OTHER FACTORS WHICH MAY AFFECT COLOSSUS CLAIM EVALUATION

1. **Non-demonstrable injuries** have a very low Colossus value. Accordingly, any injury which cannot be verified by a diagnostic test such as an x-ray, MRI, bone scan, etc., do not receive high financial evaluation by Colossus. Typically, cervical and thoracolumbar injuries, sprained ankles, contusions, abrasions, and shoulder strains never seem to have significant evaluations placed upon them under the Colossus evaluation.
2. **Allstate is the only insurance company which we are currently aware of that negatively evaluates adjusters who settle claims for an amount higher than the highest Colossus value.** Accordingly, if it appears that the claims adjuster is not willing to negotiate, it is because the claims adjuster is stuck with the dollar amount a computer has assigned as the top dollar to be paid on the claim. Essentially, Allstate has taken the role of the adjusting from a licensed adjuster and given it to a computer. The computer software inherently cannot take into consideration all factors involved in a claim.
3. **Pick-list, injury questionnaires, dissection sheets, are often used by various offices to more easily in-put information into the Colossus evaluation.** Sometimes, although not very often, the adjuster will share the questionnaire with

the claimant's counsel so that claimant's counsel can help ensure that areas are not missed and are correctly in-putted. One would think that the adjuster would voluntarily provide this information if the adjuster was acting in good faith and wanted to ensure that the claimant was being paid fairly for the value of the injuries and circumstances.

4. **Orthopedists and any other medical specialist drive values upward.** General practitioners, emergency room doctors, and chiropractors are not assigned as a high a value for their treatment and opinions for some unexplained reason. Accordingly, if one wants to receive full value under a Colossus evaluation, obviously, treatment and opinions from a medical specialist are paramount.

VI. COLOSSUS AND THE INSURANCE INDUSTRY CLAIM PROBLEM

The special nature of insurance and the role it has played in society has been recognized by courts and legislatures for many years. An insurance policy is not obtained for commercial advantage. Instead, it is obtained by people and entities protecting against unknown calamities which may, or may not, ever occur. Often, the policyholder, after paying the premium and expecting protection against calamity, is in an especially vulnerable economic and personal position when the calamity loss occurs. The entire purpose of insurance is defeated if insurance companies and adjusters can refuse or delay the prompt and full payment of monies due under the contract.

Today, the insurance industry is in a much more favorable legal and financial position than the purchasers of their products. An insurance policy contains mutual obligations. Unlike

other general commercial contracts, the insurance company promises that it will provide financial security in the event of a catastrophe. It further promises and warrants that the policyholder has “peace of mind” that in the event of a catastrophe, such as a hurricane, the policyholder will be fully and promptly indemnified. Unlike a typical commercial contract, a non-breaching party (the policyholder) cannot replace the performance of the breaching party (the insurance company) by paying the then prevailing market price for counter-performance. Instead, the policyholder is completely dependent on performance by the insurance company when the insured is at its most vulnerable position. If the insurance company fails to fulfill its obligations completely, the policyholder will likely suffer contractual and extra-contractual damages. Unfortunately, many insurance companies and adjusters delay, refuse or fail to uphold their part of the bargain.

Lately, the press, television and cultural media have picked up this bad faith conduct during the claims handling process.¹ Helen Hunt received an Oscar for her performance in *AS GOOD AS IT GETS*.² In part, she portrayed a waitress whose child was refused treatment for a chronic allergic condition which was ruining her private life and causing the child needless suffering. A doctor finally obtained outside her HMO network quickly diagnosed the condition and implied that the treatment should have been approved by her insurance company several years earlier.

¹ See generally, Lisa B. Royle, Insuring Good Faith, ABA Journal, Oct. 1995, at 86. J. Grisham, The Rainmaker (Doubleday 1995).

This scene is significant:

Carol Connelly: “They said my plan didn’t cover it and said it wasn’t necessary anyways.”

Carol Connelly: [Pause] “Why should they have [paid for the treatment]?”

Doctor : “Well” –

Carol Connelly: “Fucking HMO bastard, pieces of shit!”

Carol’s Mother: “Carol!”

Carol Connelly: “I’m sorry.”

Doctor: “That’s ok – I think that’s their technical name.”

Audiences throughout the nation applauded this exchange.

These reports indicate that insurance companies are notorious for refusing to provide insurance coverage or engaging in sloppy, slow or deliberate bad claims handling.³ It does not take a financial genius to figure out than an insurance company can make more money by collecting premiums and not paying claims, than the insurance company can make by collecting premiums and paying claims. Even the business media have noted this trend⁴

Clearly, “the bargaining power of an insurance carrier vis-à-vis the bargaining power of the policyholder is disparate in the extreme.⁵ Moreover, unless an insurance company is confronted with the prospect of paying all damages caused by its wrongful conduct, it will have no incentive to honor its obligations under its existing insurance policies:

² AS GOOD AS IT GETS (Tristar 1997).

³ See Joseph Segal, Sluggish Claim Process Can Cause Insured Business’ Demise, Claims, Feb. 1995, at 86; Jim Urban, Take It Or Leave It, EXEC. REP., Aug. 1996, at 18; Leslie Scism, Disputed Claims, Tight-Fisted Insurers Fight Their Customers To Limit Big Awards, Wall Street Journal, Oct. 15, 1996, at A1.

⁴ Quote attributed to Noted Consumer Advocate, Eugene R. Anderson.

⁵ Hayseeds, Inc., v. State Farm Fire and Cas., 352 S.E. 2d 73, 77 (W. Va. 1986).

Unlike most other commercial actors fighting for supremacy in a world where possession is nine-tenths of the law, insurers always have the nine-tenths advantage: They hold the money. Consequently, insurers always get to play “play the float” in any dispute. Even where the judicial system acts rapidly and efficiently to provide compensation to wronged policyholders, the carrier may find that it made money by delaying payment of the claim. If its investments have been good, it may even have made money to cover any prejudgment interest, costs, or consequential damages award, or counsel fees collected by the policyholder.⁶

Yet while greater risk may deter some insurance companies, the *status quo* is still clear from the viewpoint of the policyholder: “The insurance company is in no hurry. It has the money. It has your premium. It has an army of lawyers.”⁷

The insurance industry recognizes the breach of its duty of good faith and the scope of the remedies available for breach of that duty. For example, a mandatory text studied by prospective Chartered Property and Casualty Underwriters (CPCUs) discusses the current state of the law of bad-faith insurance company conduct:

1. All insurance contracts contain a covenant of good faith and fair dealing.
2. If bad faith is a tort in a third-party claim, it should be a tort in a first-party claim as well.
3. Insurance is a matter of public interest and deserves special consideration by the courts to protect the public.
4. Insurance contracts are not like other contracts because insurers have an advantage in bargaining power. Insurers should therefore be held to a higher standard of care.
5. Recovery for breach of an insurance contract should not be limited to payment of the original claim.

⁶ Jeffrey W. Stempel, Interpretation of Insurance Contracts: Law and Strategy For Insurers and Policyholders § 19.3, at 466-67 (1994).

⁷ Herb Denenberg, “How Insurance Companies Avoid Payment of Claims”, Reading Eagle, May 26, 1995, at A12 (Mr. Denenberg is a former Commissioner of Insurance for Pennsylvania and Professor of Insurance at the Wharton School of the University of Pennsylvania).

6. The public's expectations are elevated by the insurer's advertising, slogans, and promises, which give policyholders the impression that they will be taken care of no matter what happens.
7. Policyholders buy peace of mind and are not seeking commercial advantage when they buy a policy. In addition, they are vulnerable at the time of the loss.
8. Policy language is sometimes difficult to understand. The benefit of the interpretation should be given to the policyholder.⁸

CONCLUSION

Good faith claims handling and outstanding customer service are pledges often heard by the insurance company management. Unfortunately, the reality of the product provided in relation to the aforementioned goal is often sadly lacking. Today, Allstate competes against others in an oligopoly which creates an incentive for Allstate and other insurers to cheat on their claims handling.

To maintain profit margins and reach acceptable management goals/budgets, Allstate claims departments are under funded or under staffed to properly serve their insureds. The emphasis is often placed on controlling claims severities, rather than paying each individual claimant the full amount deserved, without concern for the bottom line. When Allstate adjusters are truly free from the unethical budget constraints, the culture to "keep the claim down," and monetary incentives placed upon them, policyholders and victims will begin to receive the promise they paid for.

⁸ A.E. Anderson, et al., Insurance Coverage Litigation, 11-7 (2nd ed. 1999), citing James J. Markham, et al., The Claims Environment 277-78 (1st ed. 1993).

