PROTECTING THE BLOWN-AWAY POLICYHOLDER:

GOOD FAITH CLAIMS HANDLING AFTER HURRICANES AND OTHER WINDSTORMS

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INTRODUCTION

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.

Hurricane, tornado, and other windstorm losses often involve catastrophic damage which is widespread. Management of insurance companies anticipate these catastrophes and are often prepared to send "CAT" teams to areas devastated by these widespread loss occurrences. Claims managers know the importance of fulfilling the claims process. However, without proper training, attitude, authority, and support of adjusters in the field, the adjustment function will never properly, and in good faith, take place.

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 and cultural media have picked up this bad faith conduct during the claims handling process.[1] These reports indicate that insurance companies are notorious for refusing to provide insurance coverage or engaging in sloppy, slow or deliberate bad claims handling.[2] 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 pro-industry press has picked upon this.[3]

Clearly, "the bargaining power of an insurance carrier vis-à-vis the bargaining power of the policyholder is disparate in the extreme.[4] 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:

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

[2] 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.

[3] Leslie Scism, Disputed Claims, Tight-Fisted Insurers Fight Their Customers To Limit Big Awards, Wall Street Journal, Oct. 15, 1996, at A1; Robert H. Gettlin, Fighting The Client, Best's Review P/C, Feb. 1997, at 49, 50 (noting that insurance companies spend over $1 billion a year litigating against their policyholders). See Best's Review P/C, Feb. 1996, at 40 (discussing the industry-wide imperative to stay "sharply focused on the bottom-line results and capital justification").

[4] 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.[5]

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."[6]

The Florida Legislature has attempted to level the playing field by making it less profitable and far riskier for insurance companies to breach their insurance policies by allowing compensation for extra-contractual damages. The prospect of paying damages caused by insurer bad faith conduct adds an element of unpredictability to the insurance company's potential liability. Management must emphasize fair, prompt and honest conduct. Otherwise, it will pay for the damages it causes.

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.

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

[6] 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).

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. 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.[7]

II. STATUTORY AND ADMINISTRATIVE REQUIREMENTS OF GOOD FAITH CLAIMS CONDUCT

The Florida legislature has provided for a cause of action which provides a civil remedy for insurance company claims misconduct under Florida Statute §624.155. It provides policyholders with the availability to sue an insurance company when a policyholder is damaged by any of the following acts:

1. Not attempting in good faith to settle claims when, under all the the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests;

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[7] 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).

2. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made; or

3. Except as to liability coverages, failing to promptly settle claims, when the obligation to settle a claim has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

Additionally, violation of Florida Statute §626.9541(1)(i) is incorporated into the civil remedy so that violation of the following Unfair Claim Settlement Practices is actionable in a "bad faith" lawsuit:

1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured;

2. A material misrepresentation made to an insured or any other person having an interest in the proceeds payable under such contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage under such contract or policy on less favorable terms than those provided in, and contemplated by, such contract or policy; or

3. Committing or performing with such frequency as to indicate a general business practice any of the following:

    a) Failing to adopt and implement standards for the proper investigation of claims;

    b) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

    c) Failing to acknowledge and act promptly upon communications with respect to claims;

    d) Denying claims without conducting reasonable investigations based upon available information;

    e) Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof-of-loss statements have been completed.

f) Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;

g) Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or

h) Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

It is clear from the statutory scheme and the legislative history that a single violation is actionable for compensatory damages, although punitive damages can be obtained by a showing of a general business practice:

> An insured who successfully sues an insurance company under this provision can recover the amount of damages he has suffered, together with his court costs and attorney's fees. So that an insurance company may utilize this provision for his own individual problem, the "business practice" aspect of the unfair claims practices law does not have to be proved by the consumer.[8]

CODE OF ETHICS

Pursuant to Florida Statute §626.878, "an adjuster shall subscribe to the Code of Ethics" specified by the Florida Department of Insurance. Under Florida Adminsitrative Code 4-220.201, those ethical requirements are set forth:

1. Purpose. This rule sets forth the various ethical considerations and constrains for various classes of insurance adjusters.

2. Definitions. The following definitions shall apply for purposes of this rule.

(a) **"Adjuster,"** when used without further specification refers to and includes all types and classes of insurance **adjusters** (company, independent, and public), subject to Chapter 626, Florida Statutes, and regardless whether

[8] Bill Analysis, HB 607, Appendix A, p.15 (Jan. 22,1982).

resident or nonresident, and whether permanent, temporary, or emergency licensees.

(b) **"Client"** refers to and includes both clients and potential clients; and means any person who consults with or hires an **adjuster** to provide adjusting services.

(c) **"Department"** refers to the Florida Department of Insurance.

(d) **"Person"** includes natural persons and legal entities.

3. Violation. Violation of any provision of this rule shall constitute grounds for administrative action against the licensee, upon grounds that include, but are not limited to, that the violation demonstrates a lack of fitness to engage in the business of insurance. Additionally, a breach of any provision of this rule constitutes an unfair claims settlement practice.

4. Code of Ethics. The following code of ethics shall be binding on all adjusters:

    a) The work of adjusting insurance claims engages the public trust. An adjuster must put the duty for fair and honest treatment of the claimant above the adjuster's own interests, in every instance.

    b) An adjuster shall have no undisclosed financial interest in any direct or indirect aspect of an adjusting transaction. This includes the following: An adjuster shall not directly or indirectly refer or steer any claimant needing repairs or other services in connection with a loss to any person with whom the adjuster has an undisclosed financial interest, or which person will or is reasonably anticipated to provide the adjuster any direct or indirect compensation for the referral or for any resulting business.

    c) An adjuster shall treat all claimants equally; an adjuster shall not provide favored treatment to any claimant. An adjuster shall adjust all claims strictly in accordance with the insurance contract.

    d) No adjuster may negotiate or effect settlement directly or indirectly with any third-party claimant represented by an attorney, if said adjuster has knowledge of such representation, except with the consent of the attorney. For purposes of this subsection, the term "third-party claimant" does not include the insured or the insured's resident relatives.

e) An adjuster is permitted to interview any witness, or prospective witness, without the consent of opposing counsel or party. In doing so, however, the adjuster shall scrupulously avoid any suggestion calculated to induce a witness to suppress or deviate from the truth, or in any degree affect their appearance or testimony at the trial or on the witness stand. If any witness making or giving a signed or recorded statement so requests, the witness shall be given a copy thereof.

f) No adjuster may advise a claimant to refrain from seeking legal advice, nor advice against the retention of counsel to protect the claimant's interest.

g) Unless approved in writing in advance by the insurer and such written communication can be demonstrated to the Department, no company or independent adjuster may draft special releases called for by the unusual circumstances of any settlement or otherwise draft any form of release. Except as provided above, a company or independent adjuster is only permitted to fill in the blanks in a release form approved by the insurer they represent.

h) No adjuster may attempt to negotiate with or obtain any statement from a claimant or witness at a time that the claimant or witness is, or may reasonably be expected to be, in shock or serious mental or emotional distress as a result of physical, mental, or emotional trauma associated with a loss. Further, the adjuster may not conclude a settlement when such settlement would be disadvantageous or to the detriment of a claimant who is in the traumatic or distressed state described above.

i) An adjuster shall not knowingly fail to advise a claimant of their claim rights in accordance with the terms and conditions of the contract and of the applicable laws of this state. An adjuster shall exercise care not to engage in the unlicensed practice of law as prescribed by The Florida Bar.

j) An adjuster shall approach investigations, adjustments, and settlements with an unprejudiced and open mind.

k) An adjuster shall make truthful and unbiased reports of the facts after making a complete investigation.

l) An adjuster shall handle each and every adjustment and settlement with honesty and integrity and allow a fair adjustment or settlement to all parties without any remuneration to himself except that to which he is legally entitled.

m) An adjuster, upon undertaking the adjustment of any claim, shall act with dispatch and due diligence in achieving a proper disposition thereof.

n) An adjuster shall not undertake the adjustment of any claim concerning which the adjuster is not currently competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the adjuster's current expertise.

o) No person shall as a public adjuster represent any person or entity whose claim they previously adjusted while acting as an adjuster representing any insurer or independent adjusting firm. No person shall, as a company or independent adjuster, represent themselves or any insurer or independent adjusting firm, against any person or entity which they previously represented as a public adjuster.

p) A public adjuster shall not represent or imply to any client or potential client to the effect that insurance companies, company adjusters, or independent adjusters, routinely attempt to or do in fact deprive claimants of their full rights under an insurance policy. No insurer, independent adjuster, or company adjuster shall represent or imply to any claimant that public adjusters are unscrupulous, or that engaging a public adjuster will delay or have adverse effect upon the settlement of a claim.

q) No public adjuster, while so licensed in the Department's records, may represent or act as an insurance company adjuster, independent adjuster, or general lines agent. No independent adjuster, or company adjuster, while so licensed in the Department's records, may represent or act as a public adjuster.

r) An adjuster shall promptly report to the Department any conduct by any licensed insurance representative of this state, which conduct violates any insurance law or Department rule or order.

s) An adjuster shall exercise extraordinary care when dealing with elderly clients, to assure that they are not disadvantaged in their claims transactions by failing memory or impaired cognitive processes.

5. Public Adjusters, Other Ethical Constraints. The following ethical considerations are specific to public adjusters and shall be binding upon public adjusters, in addition to considerations set out elsewhere in this rule for adjusters.

a) A public adjuster shall not prevent, or attempt to dissuade or prevent, a claimant from speaking privately with the insurer, company, or independent adjuster, attorney or any other person, regarding the settlement of the claim.

b) A public adjuster's contract with a client shall be revocable or cancelable, without penalty or obligation, by the insured or claimant, for at least three business days after the contract is entered into for the insured to elect to settle the claim directly with an adjuster representing the insurer. If the insured elects to cancel the contract, prompt notice must be received by the adjuster. The public adjuster must disclose to the insured that the insured has the right to cancel with prompt notice within the revocation period. Nothing in this provision shall be construed to prevent an insured from pursuing any civil remedy after the three-day cancellation period.

c) The full compensation to the public adjuster shall be stated in the contract with the client. If the compensation is based on a share of the insurance settlement, the exact percentage shall be specified. Any cost to be reimbursed to the public adjuster out of the proceeds, or to be paid by the consumer otherwise, must be specified by type, with dollar estimates set forth in the contract.

d) Choice of counsel to represent the insured or claimant is to be made solely by the insured or claimant.

e) A public adjuster shall not enter into a contract or accept a power of attorney which vests in the public adjuster the effective authority to choose the persons who shall perform repair work.

f) A public adjuster shall assure that all contracts for the public adjuster's services are in writing and set forth all terms and conditions of the engagement.

g) A public adjuster shall not acquire any interest in salvaged property, except with the consent and permission of the insured.

BULLETINS

In addition, the Florida Department of Insurance routinely publishes informational bulletins. Those bulletins are sent to all insurance companies writing property and casualty insurance in the State of Florida. Often, they never communicated to the field adjuster. Some of those past bulletins effecting windstorm claims are set forth herein:

INFORMATIONAL BULLETIN 93-006
ALL INSURERS WRITING PROPERTY AND CASUALTY INSURANCE IN THE STATE OF FLORIDA

APRIL O8, 1993

Several concerns have been brought to our attention as a result of the recent 1993 "storm of the century."

We understand that several agents and adjusters have advised insureds that insurers will not pay losses under the windstorm portion of their policies if the building was damaged by flood waters.

Another position being taken by some adjusters is that insurers are not going to pay for any damages below the high water mark in homes. Consideration must be given to wind damage below the water mark which could have occurred either before or after the water entered the premises.

If a home is totally demolished, the loss should be prorated between wind and flood damage, unless there is sufficient evidence to prove that the entire loss was caused by one peril alone.

Please be advised that each loss must be individually evaluated to determine whether the damages may have been caused by a combination of wind and flood. If an insurer denies coverage under the windstorm peril because of flood, the insurer must be able to document that the portion of the loss denied was actually caused by flood and could not have been caused by wind.

An adjuster must visit the site, assess the damage, and make a determination as to the cause based on documented evidence of the damages at the site or in the surrounding areas.

Any claims denials or offers of compromise settlements must be made in writing to the insured and must include an explanation of the documented evidence which resulted in the denial or offer of compromise settlement.

Non-compliance will be considered a violation of Section 626.9541(1)(i), Florida Statutes, relating to unfair claim settlement practices.

October 7, 1998

BULLETIN 98-006

Florida Windstorm Underwriting Association (FWUA), Florida Residential Property and Casualty Joint Underwriting Association (FRPCJUA) and All Insurers Writing Residential Property Policies

Reporting on Adjusted Claims

Residential insured losses resulting from Hurricane Georges have been estimated to total approximately $200 million in Monroe County and as much as $100 million in the Florida Panhandle.

Insurers are required to adjust all claims in an expeditious manner. As of this date, adjusters should have contacted each insured who has notified the insurer of a claim and the initial assessment of the loss should have been performed.

As to insurers which provide ex-wind coverage, but are responsible for adjusting wind losses in the affected counties pursuant to agreements with the FWUA, if any claim has not yet been adjusted, the FWUA should expeditiously confirm coverage and take such other action as may be necessary to enable the insurer to adjust the claim in a timely manner.

In order to facilitate the Department's review of claims payment practices, each insurer responsible for adjusting Hurricane Georges claims is instructed to report any claims as to which an initial assessment of loss has not been made by an adjuster by 5:00 p.m. on October 9, 1998. Any such report should be filed in electronic format on a 3.5" diskette in either Lotus 1-2-3 or Excel format and contain the following data:

1. Company name.
2. Company FEIN.
3. Company Contact (Name, Phone, Fax).
4. Total # of claims, by county, resulting from Hurricane Georges.
5. Total # of claims, by county, resulting from Hurricane Georges, for which an initial loss assessment has not been made as of 5:00 p.m. on October 9, 1998.
6. For each claim contained in 5 above, prepare a separate spreadsheet, by county, with the dates the insurer was advised of each loss.

INFORMATIONAL BULLETIN 92-036

HOLDBACKS PROHIBITED ON REAL PROPERTY PARTIAL LOSSES

December 08, 1992

The payment of a partial loss on real property must be handled in a manner consistent with existing statuses and case law.

Section 627.702(2) Florida Statutes, while specifying only fire and lightning losses, is instructive in discerning legislative intent in applying the Valued Policy Law to partial losses on real estate resulting from Hurricane Andrew. This statute provides that the insured is entitled to the “actual amount of such loss”, not to exceed the amount of insurance specified in the policy as to such property.

The Florida Supreme Court, in Sperling v. Liberty Mutual, So.2d 297 (Fla.1973) held that the “actual amount of such loss” is the cost of placing the building in as nearly as possible the same condition that it was before the loss, without allowing depreciation for the materials used.

This authority is specifically applicable to the practice by insurers of imposing a “holdback” of insurance proceeds greater than actual cash value until replacement has taken place. While this practice is appropriate for personal property, this bulletin serves to place insurers on notice that for partial losses on real property, “holdback” is inconsistent with established precedent.

The application of a “holdback” to repair of real property can particularly cause hardship to the insured when the actual cash value payment is

insufficient to enter into a contract to make repairs. In such an instance, the insured may be forced to seek other funding sources, at his expense, in order to contract for repairs.

Insurers who have been applying "holdbacks" in claims for partial loss on real property should pay the actual amount of the loss. The best indicator of actual loss is the contract for repair entered into by the insured. Once an actual amount of loss is determined by contract, the full loss payment should be made with no hold back applied. This arrangement satisfies the public policy interests both in timely and sufficient claim payments, and in encouraging rebuilding. In instances where a holdback is currently being applied and a repair contract has been executed, the holdback should be released.

June 3, 1996

All Property and Casualty Insurers Authorized to do Business in Florida Resolution of Claims through Mediation.

During the November, 1993, Special Legislation Session the Legislature passed Florida Statute 627.7015. In accordance with that statute, our Department promulgated Rule 4-166.031. This rule sets forth guidelines for resolution of claims through a mediation process. Under this statute and rule, all property and casualty companies are required to make available the opportunity for mediation on first party property insurance claims, excluding commercial and automobile coverage.

Effective May 1, 1996, there are several changes to Rule 4-166.031. The highlights of these changes are as follows:

1) The rule repeals Rule 4-166.030, Alternative Procedures for Resolution of Disputed Claims Arising from Hurricane Andrew, and merges it into this Rule 4-166-031.

2) Section 2(b)(1) a & b. The definition of claim has been revised to exempt situations where the insurer has a reasonable basis to suspect fraud, or based upon agreed facts as to the cause of the loss, there is clearly no coverage for the claim.

3) Section 6 establishes procedures for the rejection of disputes from property mediation if the dispute does not meet the definition of claim. The insured may appeal their right for mediation to the Department if the company rejects mediation. The appeal must take place within 60 days of the date of the insurer's rejection.

INFORMATIONAL BULLETIN 94-021

May 13, 1994

In preparation for the hurricane season which starts in June, the Department of Insurance is requesting that each insurer writing policies covering Florida residential or commercial property exposures submit a copy of its hurricane disaster plan to the Department by June 1, 1994.

III. EXAMPLES OF UNFAIR CLAIMS PRACTICE CASES

1. **Failure to Thoroughly Investigate -** An insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for a denial of payment in whole or in part.[9]

2. Exploiting the financial vulnerability of the policyholder to obtain a favorable settlement of a coverage dispute.[10]

3. Making unreasonable demands on the policyholder during claims investigation, amounting to harassment.[11]

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[9] McLaughlin v. Connecticut Gen. Life Ins. Co., 565 F.Supp. 434,454 (N.D. Cal.1983); Rawlings v. Apodaca, 151 Ariz. 149, 162, 726 P.2d 565, 578 (1986) ("Indifference to facts or failure to investigate are sufficient to establish the tort of bad faith."); Clayton v. United Servs. Ass'n, 54 Cal. App. 4th 1158, 63 Cal. Rptr. D 419 (1997), (appellate court affirms jury's verdict of bad faith, concluding that the insurance company's failure to investigate constituted "malicious and oppressive conduct"); Miller v. Fluharty, 201 W. Va. 685, 500 S.E. 2d 310 (1997) (insurance company has duty promptly to conduct a reasonable investigation based upon all of available information)

[10] *See, e.g.,* Mohr v. Dix Mut. County Fire Ins. Co., 143 Ill. App. 3d 989, 493 N.E. 2d 639 (1986) (insurance company acted in bad faith in delaying settlement of a claim with the hope that policyholder's financial condition would force him to settle for a lesser amount); Drop Achor Realty Trust v. Hartford Fire Ins. Co., 126 N.H. 674, 496 A.2d 339 (1985) (insurance company may not use knowledge of policyholder's vulnerable financial position to force policyholder to accept less than reasonable amount of settlement).

[11] *See, e.g.*, Filasky v. Preferred Mut. Ins. Co., 152 Ariz. 591, 734 P.2d 76 (1987); McCormick v. Sentinel Life Ins. Co., 153 Cal. App. 3d 1030, 200 Cal. Rptr. 732 (1984).

4. Claims "extortion" – for example, accusing the policyholder, without reasonable basis, of wrongdoing, (for example, arson) or using abusive or coercive practices to compel the compromise of a claim.[12]

5. Spoliation of evidence.[13]

6. Refusal to compromise claims until litigation is threatened or commenced.[14]

7. Repeated low-ball settlement offers, even after a basis for denial is shown to be weak.[15]

8. Unreasonably low counteroffer in negotiating the settlement of an underlying claim.

9. Forcing policyholders to litigate in order to obtain coverage under their insurance policy.[16]

10. Appealing in arbitration award to compel settlement.[17]

11. Failure to pay the full value of a claim.[18]

12. Conditioning payment of the undisputed portion of the claim on the settlement of the disputed portion.[19]

13. Retaliatory rescission or cancellation of the insurance policy after a claim is made.[20]

14. Retaliatory increase in premiums.[21]

15. Failing to inform the policyholder of its rights under the policy.[22]

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[12] Mustachio v. Ohio Farmers Ins. Co., 44 Cal. App. 3d 358, 118 Cal. Rptr. 581 (1975).

[13] Upthegrove Hardware, Inc., v. Pennsylvania Lumberman's Mut. Ins. Co., 146 Wis. 2d 470, 431 N.W. 2d 689 (1988) (reckless or intentional destruction of insurance policies is bad faith).

[14] United Serv. Auto Ass'n v. Werley, 526 P.2d 28 (Alaska 1974); Richardson v. Employers Liab. Assurance Corp., 25 Cal. App. 3d 232, 102 Cal. Rptr. 547 (1972).

[15] Republic Ins. Co. v. Hires, 107 Nev. 317, 810 P.2d 790 (1990) (practice of setting "ceiling" on low and middle-income policyholder claims of 65% of appraised value of property justifies punitive damages).

[16] Richardson v. Employers Liab. Assurance Corp., 25 Cal. App. 3d 232, 102 Cal. Rptr. 547 (1972).

[17] *See, e.g.,* Rios v. Allstate Ins. Co., 68 Cal. App. 3d 811, 137 Cal. Rptr. 441 (1977).

[18] *See, e.g.,* Vernon Fire & Casualty Co. v. Sharp, 264 Ind. 599, 349 N.E. 2d 173 (1976).

[19] *See, e.g.,* Travelers Indem. Co. v. Weatherbee, 368 So.2d 829 (Miss. 1979).

[20] *See, e.g.,* Rawlings v. Apodaca, 151 Ariz. 149, 726, P.2d 565 (1986).

[21] *See, e.g.,* Herbert v. Guastella, 409 So.2d 375 (La. Ct. App. 1982).

16. Failing to advise the policyholder of a right to arbitration.[23]

Insurance companies have an affirmative duty to disclose their policyholders information regarding coverage. This duty is implied in the duty of good faith and fair dealing. Professor Alan I. Widiss, a leading law insurance professor, has argued that this duty to disclose is one of several key elements to the duty of good faith and fair dealing:

> Following notification of an occurrence, I believe an insurer is obligated to disclose all applicable benefits, or to clearly inform insureds about the existence of rights and duties regarding all coverages, or to explain why the insurance benefits will not be paid in order to (a) fulfill the insurer's contractual commitment, (b) comply with the obligation – implied as a matter of law in all contracts – to deal fairly and in good faith, (c) protect the insured's reasonable expectations and (d) avoid omissions that could constitute fraudulent misrepresentation.[24]

IV. PERFORMING THE ADJUSTMENT FUNCTION

An evil myth exists among many claims organizations that the insurance company has no obligation following a loss other than to pay the claim after proofs of loss are submitted. Nothing could be further from the truth and further from a spirit of good faith claims conduct.

Historically, insurance policies were developed to serve commercial interests and were often bargained for at arms length. Insurance and commercial owners negotiated insurance policies on merchant ships which would travel around the world. News of a ship loss might not reach Lloyds for a considerable period of time. Often, the first notice of loss was accompanied

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[22] Weber v. State Farm Mut. Auto. Ins. Co., 873 F.Supp. 209 (S.D. Iowa 1994); Carolina Bank & Trust Co. v. St. Paul Fire & Marine Co., 279 S.C. 576, 310 S.E. 2d 163 (1983).

[23] *See, e.g.,* Sarchett v. Blue Shield, 43 Cal. 3d 1, 729 P.2d 267, 233 Cal. Rptr. 76 (1987).

[24] Alan I. Widiss, *Obligating Insurers to Inform Insureds About the Rights and Duties Regarding Coverage for Losses,* 1 Conn. Ins. L.J. 67, 70 (1995).

by a demand for payment. The only requirement of insurers under then standard insurance policies was to accept or reject the proof of loss and then make, or deny, payment.[25]

Similarly, New York insurance companies wrote commercial insurance on America's great frontier maintaining many of the policy requirements essentially unchanged from the Lloyd's standard forms.[26] The only requirement of the insurer was to make payment within thirty days after receiving a sworn statement in proof of loss. Today, the same language exists in the policies, but the expectations within the insurance industry, the departments of insurance, policyholders and even the insurance companies themselves is far different and demands claims departments devoted to providing customer service.

> The claim department, and specifically the claim representative, is responsible for assisting people in presenting their claims to the insurance company.
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> **It is beyond policy requirements but within the duties of the professional claim representative to provide promptly all benefits due to the policyholder under the terms of the contract, provided there are no indications of fraud.** For example, a claim representative who has walked through a burned home knows the importance of delivering on the promise contained in an insurance policy. Even though a proof of loss is not yet complete, the claim representative should hand to the owners of the house a draft to cover the family's immediate needs of shelter, clothing, and food. Doing so may exceed the explicit policy requirements, but a claims representative who does not advance the money does not really understand the profession or its moral imperatives. This may be one of several fires to which the claim representative has been recently assigned, but it is probably the only fire the insured will have in his or her lifetime.
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> The insured or claimant needs the claims representative's expertise and guidance. Claims representatives see hundreds, if not thousands, of losses in a career without being personally involved in them. Their profession enables claim representatives to gain expertise in the areas insureds or claimants need upon the occurrence of a loss. For a time following a loss, people often experience a period during which rational decision making is impaired. They may forget about policy obligations, such as damage

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[25] **Ethics and Claims Professionalism**, 2(Insurance Institute of America, 1999).
[26] Id.

> reduction or salvage operations. The professional claim representative should be there to help
>
> ….
>
> The insurance industry's reputation and public image are substantially controlled by how well claim representatives perform their responsibilities. From the public's point of view, claim work defines insurance company performance. Yet the claim representative must accomplish his or her work through the cooperation of people who neither understand the claim process nor know what precisely what constitutes a recoverable loss. The client only knows that he or she paid for insurance, that a loss has occurred, and that he or she wants to be paid. Meeting this expectation is at the core of claim work.[27]

In the very basic manual required to obtain an Associate in Claims designation, some of the property insurance adjuster's duties are noted as follows:

> At the initial meeting, the adjuster should explain the adjustment process and do the following:
>
> 1. Explain what inspection, appraisal, and investigation the adjuster will be doing.
>
> 2. Tell the policyholder what is required to protect the property and present the claim.
>
> 3. Supply the policyholder with blank inventory forms, a blank proof of loss, and sometimes written instructions.
>
> 4. Note potential coverage questions or policy limitation or exclusions, and obtain a nonwaiver agreement (when necessary).
>
> 5. Explain the time involved to process and conclude the claim.
>
> 6. Assist the policyholder in protecting the property by arranging for board up, storage, and restoration and cleaning firms (when appropriate).
>
> 7. Make emergency advance payments to the policyholder for clothing, living expenses, food, or other expenses and obtain an appropriate receipt for the payment.

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[27] Id. at 3,4

8. Assist the policyholder by arranging for temporary housing (when necessary).

INVESTIGATION

Following the preliminary interview and discussions, the adjuster should proceed to investigate, inspect and appraise the loss. Good investigation is the basis of every claim settlement. Claim adjusters are responsible for determining what investigation is appropriate in given claims. Small, simple and questionable claims require much less investigation than large, complex, or questionable claims. An adjuster's investigation should determine the facts about what caused the loss, how coverage applies, and the amount of the loss. The policyholder's duties following the loss and statements from the policyholder and witnesses are key tools in the claim adjuster's investigation.[28]

Allstate's slogan "You're In Good Hands", Travelers' motto "Under the Umbrella", Fireman's symbol of protection beneath the "Fireman's Hat", and State Farm's slogan "Like a Good Neighbor, State Farm is there," demonstrate the industry's own efforts to portray themselves as a repository of trust and confidence when people most need their help. Claims adjusters and claims management fulfill the obligation and the trust by promptly investigating coverage, evaluating damages, and paying promptly what is owed.

V. RECOMMENDATIONS FOR CLAIMS MANAGEMENT AND CLAIMS ORGANIZATIONS

1. Train, promote and encourage adjusters to promptly, honestly and thoroughly determine coverage, evaluate damages, pay the insured and help the insured.

2. Abolish claims performance guidelines/bonuses/standards based upon controlling indemnity payments. Claims management goals of claims severity should be avoided because it is establishing unethical, bias claims conduct.

3. Promptly pay what is owed. Do not wait for all the paperwork or other coverages.

4. Promptly evaluate all damages under all coverages with the policyholder. These "joint meetings" prevent disagreements.

5. Explain to the policyholder all coverages and provide practical examples to policyholders so claim recoveries may be maximized rather than minimized.

6. Give the benefit of the doubt to the policyholder when interpreting policy language.

7. Sharp claims practices should be based on obvious policy language and disclosed at the point of sale.

8. Provide enough adjusters, with enough time and enough support to adjust all coverages.

9. Conduct closed claim file reviews – looking not just for over-payment – but especially looking for areas of underpayment and non-disclosure of policy benefits.

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[28] J. Markham, Property Loss Adjusting, Vol. 1, 212, 213 (2nd ed. 1995, Insurance Institute of America)

10. Prevent fraud after the claim by "hands on" claims adjustment. Policyholders who (1) know the adjuster is currently adjusting the loss and (2) that the adjuster appears to be acting in his/her interests will be far less likely to conduct fraudulent activity.
11. Promote Risk Management measures to reduce claim frequency and claim severity.

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, property insurance companies compete against each other in an oligopoly which creates an incentive for some insurers to cheat on their claims handling.

To maintain profit margins and reach acceptable management goals/budgets, claims departments are often under funded and under staffed to properly serve the insureds in the utmost of good faith claims conduct. The emphasis is often placed on controlling claims severities, rather than paying each individual claimant the fully amount deserved without concern for the bottom line. When claims departments are truly free from the unethical budget constraints and monetary incentives placed upon them, policyholders will begin to receive the promise they paid for.

In the interim, it is certain that lawsuits alleging unfair claims practices and insurer bad faith will flourish. The guidelines set forth in this paper provide a minimum of expected standards which courts, juries and the public will hold insurance adjusters responsible if they are not fulfilled.