Best's Insurance Law Podcast

Current Trends in Liability Claims – Episode #204

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Hosted by: John Czuba, Managing Editor
Guest Expert: Fred Fisher, President of Fisher Consulting Group, Inc.
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John Czuba: Welcome to Best's Insurance Law Podcast, the broadcast about timely and important legal issues affecting the insurance industry. I'm John Czuba, managing editor of *Best's Insurance Professional Resources*.

We're very pleased to have with us today expert service provider Fred Fisher of Fisher Consulting Group, Inc.

Fred Fisher has an extensive background in claims with over 48 years.

He's a founding member of the Professional Liability Underwriting Society and also served as President. Mr. Fisher remains a special materials expert for several RPLU courses and as a senior technical advisor for "The Professional Liability Insurance," which is a three-volume manual published by the Insurance Risk Management Institute.

Mr. Fisher has lectured extensively on professional liability issues for over four decades and has authored over 64 articles in trade journals and publications.

Mr. Fisher is also a faculty member of the Claims College and a member of the executive council, School of Professional Lines, sponsored by the Claims and Litigation Management Association, and he is also a course designer and web instructor for the Academy of Insurance. Mr. Fisher has given over 150 CE classes and lectures.

Fred, we're very pleased to have you with us again today.

Fred Fisher: Thank you, John. I always appreciate it when AM Best asks me to participate on a topic that is near and dear to my heart.

John: Today's topic is current trends in liability claims. Fred, for our first question, why don't you tell our audience, how were claims traditionally handled by insurers?

Fred: That's a good question because it certainly has changed over the years. When I first got involved in the claims industry in 1975, it was very common for all types of claims to be investigated by insurers and insurance companies. That was not necessarily as mandated by what later became the Fair Claims Practice Regulations put out by the NAIC.

It was a boots-on-the-ground investigation. That was important so as to be able to quickly develop the facts of any type of claim, even first party claims for that matter, which served two purposes.

Number one, insurance companies are statutorily required to post reserves, although in most states still, they only are required to post liability or ultimate net payout reserves, not necessarily inclusive of any expense.

Obviously, claims expense is an important aspect of any potential claim, so carriers would also look at what they think they might need to set up a reserve for claim expenses such as defense cost and what have you.

By investigating a case aggressively at the outset, it was possible often to have a relatively fairly developed factual matter for analysis within, say, 90 days, maybe as long as six months depending on the cooperation of any third-party claimant.

By having that kind of development, you could set accurate reserves earlier, which served two purposes. Number one, you know where you stand, and number two, actuaries could also have access to that data, and reassess a particular book of business or a particular program to see how profitable it may be over time and make adjustments.

In other words, you could make adjustments to a program as opposed to, after four or five years, realizing, oh, gee, we're losing money, and canceling a program, as opposed to adjusting a program, whether it's increasing premiums or limiting certain types of coverage and claims.

The other thing that claims handlers traditionally did was interface and interact with the underwriting department. The two go hand in hand. Underwriters have a certain view of the world and have certain ways they want to approach coverage, but it's the claims people that have to handle the result of those decisions.

By having interaction between the two, adjustments, again, could be made as to whether or not policy language needs to be changed, or there need to be additional exclusions based on developing appellate decisions and what have you. That level of communication was something that was extremely important, especially to innovative insurance companies.

I don't like mentioning names of any particular carrier in a public event like this, but I know of one company, for instance, that was basically a paper corporation, but they were owned by and managed by a managing general underwriter. They wrote some really scary stuff, and there was no manual for that. There was no information on claims.

How do you set pricing for a company that's going to have a product liability exposure when they're taking pig hearts and turning them into artificial heart valves? There's no background for that. Yet this company was extraordinarily successful because it had good interaction between claims and underwriting.

Over time, that has changed somewhat, but I think that's traditionally been the model. Of course, the NAIC eventually came out with fair practice regulations, mandating that insurance companies investigate their claims. That's the industry that I grew up in starting in 1975 until I opened up a wholesale brokerage 20 years later.

I think that gives you some history on how claims were developed and hopefully be resolved and settled. Yet the Plaintiff Bar would have you universally believe that Companies don't like paying claims. They want to hold onto their reserves as long as possible because they get investment income off of it etc.

On closer review, that argument fails because when you look at the rate of return on reserves, which have to be conservatively invested, like money market funds, you're not going to invest in anything risky with claim reserve cash. It has to be conservative.

Even if you were getting a 10 percent return, you couldn't defend a case at a $100,000 reserve based on investment return. You couldn't defend a case year after year for $10,000 in revenue. It doesn't pencil out. That's number one.

Number two, people forget that every time you put up a reserve on claims, you're also reducing the amount of capital surplus that is available to support underwriting. That's the fallacy.

John: Now, Fred, a short time ago you talked about models that insurers can use. Are there different or several different types of models that insurers can use?

Fred: Oh, yes. Again, this has developed over time, but the basic three models boil down to this. A lot of insurance companies do have internal claim departments where they have their own claim supervisors and examiners and of course, maybe field adjusters.

Depending on the size of the insurance company, they may be able to do this nationally. Because they're writing in all 50 states, and they have physical offices in all 50 states. Or when you have a company that's, say, based in one state but they're still writing nationally or in many states.

That model gets shifted a little bit because now they may have to use independent adjusters and investigators where they can find qualified organizations throughout the country. That's one model. That's been the traditional model.

Another model is to delegate claims for one reason or another, to what's called a third-party claim administrator. There, it gets interesting because what's the fee going to be? How is it going to be negotiated? How much are they going to be paid? Is it a flat rate per claim? Is it going to be by the hour with a cap of some kind?

It can get very interesting, especially with respect to the obligations the third-party claim administrator may have. They can act in a supervisory capacity with claim supervisors and examiners, but they're basically desk jockeys and they may be paid accordingly.

What do you do when you need boots-on-the-ground investigators? Then what do you do? They may or may not have the authority to hire those companies in the locale where the loss occurred, as well as working out an arrangement on what the insurer as to what is acceptable as a method of payment.

They may even be the same boots on the ground adjusting companies that the insurance company itself might have used. That also adds to the equation. The third model, however, is more interesting, and you usually see this in more sophisticated types of claims like professional liability and D&O.

In many respects, it could also backfire cause of the reality of the "what happens." That's where you've got monitoring counsel, where you hire a law firm to act as a claims TPA. That may sound like a great idea, especially on more sophisticated types of claims, but consider this. Number one, who's doing the work?

Is it going to be the relationship partner that you know makes a lot of money and is basically entertaining and promoting the claim department at the insurance company or the underwriting folks, or is it the second, third-, or fourth-year associate that's doing the day-to-day work? Who is he working with?

He's going to appoint defense counsel in a particular state where, again, he's probably going to be working with a second- or third-year associate who's doing the work up for the trial partner. What do they hear? What are they talking about? How to defend the claim.

“We have to file a demurrer. We have to file a motion to strike. We've got to get rid of the punitive damage allegations. Then we've got to do discovery. We need these interrogatories and requests for admissions” and on and on.

How are those people trained to close the file? What is the end result and how long is it going to take? What's the goal? Is it well defined? That's to me, one of the problems I've seen over the years. Not always. I don't want to paint a broad brush but with monitoring counsel. It's also very expensive, much more expensive than the third-party claim administrator.

The other problem, these different models have various variations. Some of them may work, some of them may not. I know in one instance I saw a claims TPA that was hired by a major insurance company. Their contract required, they handle claims consistent with best practices, that was in the contract.

Best practices, which is a higher standard of care. That was number one. On the same token, the amount of money that this firm was being paid was $288 per claim, and that's to handle the claim from cradle to grave. From the time it was first reported to the time the claim was closed.

I don't know how you can take a recorded statement these days at $288 per claim and still handle it from funeral grave at a level consistent with best practices. What ended up happening was the matter would come up on diary every 90 days. The claim person would look at the file and send out an email to the plaintiff attorney or make a phone call or leave a voicemail and diary for another 90 days.

That isn't going to work. It may be cheap, but it is not going to work. It's certainly not going to aid in the development of a claim so adequate reserves can be set because you don't have the information to do it. That's what was happening in that matter.

Bottom line is each model has its pluses, each model has its detriments. The focus, however, is to investigate, develop, adequately reserve, and have a plan to close the file. That's the penultimate goal. Closing the file without doing the obvious, which is throwing money out the window.

Granted, there's always the plaintiff attorney who wants $10 million for a claim that's worth $25,000. That becomes problematic. Those are important. I think technology has aided greatly in trying to reduce that problem somewhat, but you never know.

Number one it's probably a good time to bring it up as any, let's not forget, the profit center of any insurance company is not the marketing department. The profit center of any insurance company is not the underwriting department.

The profit center of the insurance company is the claim department, which is the exact opposite of what a lot of people would expect, but that's how the insurance industry actually functions. It's the opposite of what most other businesses experience.

Unfortunately, over time what has developed is that the claim department is seen as a cost center. As a result, there's not a lot of investment in it. They're always trying to cut costs and they're always trying to cut overhead and trying to cut expenses.

That includes the way attorneys are retained and paid for defense, the defense panel and what have you. Some insurance companies have even significant floats where they've got claims defense reserved, so they've automatically deducted that on an accrual basis from an accounting perspective.

Reserve money is still sitting in their bank account and their attorneys are running up huge bills because a lot of insurance companies are slow pay. They think, "No, that's the way it's always worked. That's the way it's always been. We send you a lot of cases, so you ought to be happy with the fact that eventually you do get paid." kind of thing. That's just wrong.

It's just wrong because ultimately, they end up paying for that cost anyway, so they are being financed for their law firms. You don't think that they're considering that in their rates or how much time they spend? It creates a lot of pressure.

I don't necessarily agree with that philosophy. I do know some insurance companies that promptly pay their lawyers for that very reason. I think those are the different models of some of the upsides to the model and of course some of the downsides.

You can never get away from the fact that the claim department is the profit center. That's where you make or break it. That's where the profit is going to be made or lost. Again, it also goes back to rapid claim development, so that you have accurate reserves earlier, and the actuaries can also assist in determining what adjustments, if any, might need to be made down the road.

John: Fred, what perceptual mistakes are made with respect to claims departments?

Fred: I think I already answered that somewhat, but that perception again is the fact that the claim department is the profit center of the company. Unfortunately, it's not treated this way. I've seen so many examples of it.

I think at one time in another AM Best Webinar, I brought up a particular loss run, and I consider lost runs worthless. They don't tell you very much especially when you're looking from a claim department perspective.

When you're looking at it from either a book of business loss run for a certain line of coverage or overall, or even for a specific policyholder. All the loss runs tell you is what are the open reserves, if any. What are the expenses that have been paid or losses that have been paid on that claim, and what's the total incurred? That's all it tells you.

Of course, you can look at the total incurred and measure that against, say, the premium, to get an idea of whether or not what the loss ratio is between premium and reserves, or total occurred and, whether you're making money or not, but it doesn't tell you why.

It does not tell you it could have been different. I think a good illustration of that is a situation where it's actually bankrupted, I think it was Belfonte Steel Corporation. They set up a captive insurance company to cover their own exposures, and of course, under IRS guidelines, they found they couldn't deduct the premiums paid to their own captive unless the captive started writing business on the open market. Eventually, they ended up reinsuring a fronting company for a brokerage that put together a real estate professional liability program.

I've been involved in real estate professional liability claims my entire career, either as a claim person or as a broker. I can tell you, the real estate agents and brokers, especially residential, have the highest claim frequency of any professional, ever since the 1970s.

Here you have a company that's going to write real estate professional liability, and it was a disaster. The loss runs show tremendous losses. That loss run, unfortunately, was distributed amongst a number of insurance companies and underwriting agencies over some years.

I don't know why or how, but it doesn't matter. All I know is that a lot of these underwriters were using that loss run as a basis to make decisions on whether or not they wanted to write a real estate E&O program for another MGA or MGU, and how to price it.

I even faced that, because I approached a market back in my early days as a wholesale broker to put together a real estate E&O program. The underwriter I was talking to mentioned this particular program and I said, "I know that program very well."

In my claim days, we did a lot of qualitative claim audits. We were actually retained by a court as a neutral auditing firm to look at the claim files as part of a lawsuit that was filed against the MGA by the bankruptcy trustee because it broke the back of Belfonte Steel's captives. Actually, Belfonte Steel went into bankruptcy.

We were hired for that basis. I said to him, "The loss run is accurate." That's exactly what the performance was on this program, but what it doesn't tell you is why, or that it could have been different.

Where in that loss run, for instance, does it show that four different appellate courts in different states ruled that the prior act language was so bad that they basically opened up the policy to cover any wrongful act that took place before the policy accepted?

Where in that loss run does it tell you the appellate courts also talked about the fact that they were still using a language called "claims which may," M A Y, be first made during the policy term...

Which, under a case I think I may be one of three people still alive that knows about it called *Gyler v. Mission Insurance Company* that ruled that language meant, because they used the word "may," that means it could have.

Could a claim have been made, first made, during the policy term? If the answer is yes, you've got coverage even though the claim was first made later after the policy expired. Where in the loss run does it tell you that?

Most importantly, where in the Loss Run does it tell you that there was no claim department as we understand it, even as late as the late 1980s and 1990s when this program was ongoing? Where does it tell you that?

I can tell you, having reviewed the claim files as an auditor, I can tell you as a matter of fact that there was no claim department. It literally was a brokerage firm and the insured, when they would report a claim and, were told go hire your own lawyer, and we'll pay for it, and let us know when you need any money to settle the matter. There was no supervision, not as we understand it since the late 1980's.

Where in the Loss Run did it show you that? The only way you can determine any of that, whether the claims are being handled properly or not, is by having a qualitative claim audit. My claims firm did plenty of those for large, self insured organizations as well as insurance companies. We looked at almost 50 different data points on each claim file.

That was in addition to looking at staffing, and how many claims per person a staff member would be handling, and education levels, and experience levels, and reserve levels, and supervision of counsel, what have you. 50 data points we looked at and grading every file to see whether that is being well handled and effectively handled. That's all very important.

You can't tell anything without doing a qualitative claim audit on a regular basis. These contribute to all the perceptual mistakes but make no mistake about it. The claim department is the profit center, and if run effectively, an insurance company can be very effective.

John: Fred, if there is a qualitative claims audit that's done, what should some of the standards be?

Fred: There's a lot. Number one, you want to be adequately staffed with people that are experienced. Then, of course, for the inexperienced ones, you want them handling the more innocuous and small or what appears to be initially small claims.

You're going to have to set reserve levels or exposure levels. You also have to look at hazards. It's one thing to have a sudden fall where somebody will bang their knee. It's another thing to have a compound fracture. That could be serious.

Easily since the 1980s, there have been claims computer systems set up that tracked all that. I think Corporate Systems was one of the first, and they had a very, very good, powerful system that had a lot of data going into it initially. They used cause of loss codes. They had severity codes; The codes were tied to the type of injury.

Using SQL queries, Structured Query Language queries, you could get all types of claims information like what claims involve compound fractures, what claims involve death, all sorts of things and get reports on this, and then you can look at their reserves.

Or you could actually say, are there any compound fractures where the reserve is under $20,000? That would give you all sorts of information right then and there. It's collecting the data and a good system to track it.

Number two, standards from day one. What's the date of the claim report? First, obviously, the date of loss. Then what was the report date to the claim department? What was the date of the first attempt to contact the insured? When was it finally accomplished?

It's been clear that sometimes, insureds are not as cooperative as one would like. We look at it from the attempt. Did they attempt to contact the insured right away? Did they attempt to contact the claimant or the claimant's representative as soon as possible? At least let them know, we're here and we're looking into it.

Then we look at dates of the nature of investigation. Were all the witnesses contacted? Did they get statements? Were they evaluated? Were the reserves adjusted timely? Were all documents obtained? These are all investigatory issues that also impact reserving.

It's not uncommon to set an initial reserve of a thousand dollars, or a dollar, or whatever, and then you have to adjust it based on developing information. If it's in suit, how fast did we notify or retain defense counsel? Are they panel counsel? Are there coverage issues? If there are coverage issues, is there reservation of rights needed?

Then of course you got to worry about whether or not the insured is going to be allowed to hire their own counsel at the insurance company's expense under what's commonly referred to as the Cumis decision or a Cumis statute. Those are all items to look at.

Then, of course, how's defense counsel handling the matter? Is he being properly supervised? Is there the kind of communication going on between the examiners and the defense counsel with the ultimate goal in mind, closing the file?

Are we going to have to go through trial? One of the things they never tell you...again, a good example of what doesn't show up in a last run is the following: $750,000 in defense cost, closed file, zero indemnity.

Now most people would knee jerk and say, "Who in their right mind would spend that kind of money?" What that doesn't tell you, and unfortunately again loss reserves don't ever tell you is the exposure. I define the exposure in that context as being what is the plaintiff's demand?

In that scenario that I just mentioned with the $750,000 in reserve or in the defense costs, that was a situation where the insured had a $5 million limit on the policy, a no liability case, and the plaintiff attorney never asked for anything less than policy limits and a defense verdict was obtained.

The claims person ended up spending $750,000 to save $4.25 million. I say that's a good result. When you look at that just on a loss run, it's like, "What the heck is that about?" Because one other ratio that we haven't discussed is the ratio between expense and indemnity.

In certain types of claims, for instance, like slip and falls or whatever you would expect for every dollar spent on indemnification or settlement for bodily injury, you're going to spend maybe 25 cents in expenses.

You get into more sophisticated types of claims like attorney malpractice or director of officer liability, it could approach 1:1. When you've got a $750,000 expense, and zero indemnity that blows your expense to loss ratio apart but it's artificial.

Because what never shows up in a loss run is the exposure, the last demand, how much the plaintiff attorney was demanding. That doesn't show up. It's not tracked. For probably good reasons, because, insurance companies are also audited by the state, and they're also audited by reinsurers.

They see something, where they've got a $5 million exposure it's, "Oh my god." That's what happened in that case. It blew the expense to loss ratio out the window. There are ways that actuaries can take a shock loss like that and not even use it as part of the calculation.

Because in my opinion, you spent $750,000 and save $4.25 million. Would the expense to the loss ratio look better if you paid the $5 million on a no liability case? Those are things that don't show up in loss runs. You can always find them on a qualitative law audit.

That's another reason why it's so important to do a qualitative audit regularly. That would identify the fact that that was a well handed claim.

John: Fred, what are some of the trends you're seeing that are taking place that should be a cause of concern by both consumers and regulators?

Fred: One of the things I'm disturbed by is the lack of investigation that's going on. More and more insurance companies are moving towards a trend to evaluate claims, which basically means they're putting the burden on either their policyholder or a third-party claimant to provide the claim department with enough information to justify a payment.

That's not what the Fair Claim Practice Regulations require. Fair claim practice regulations require that you investigate claims. That means you've got to do something affirmative. You're not going to be passive. Evaluating means you're waiting for something to happen, land on your desk, you'll read it and evaluate, and make some decisions.

That's being passive, but the statutes don't require that. I'm seeing this more and more. Granted, in my Expert Witness practice I do a lot of bad faith cases, and so I hate to think that, because I'm seeing so much bad claim handling, does that happen with everybody? I'm starting to think that it might.

A good example was a couple of matters I handled involving total loss fires in Malibu and in Northern California where some of the wildfires that took place. Where that's exactly what happened.

They didn't put any boots on the ground. They didn't send anybody out to take photographs. They didn't send anybody out to talk to the building inspection department with regard to new building codes that were put into place. They kept telling the policyholder, "You tell us that. You go out and do this."

That's ridiculous. That is a trend that I think is not good for anybody because it means also that you're under reserved. The other trend is to use lawyers more and more, and the lawyers more and more are doing that kind of work. They're the ones that are developing the claim, either through legal discovery or otherwise.

In one matter defense counsel was even the one getting information from the claim bureaus as to what comparable claims had been settled for, what amount of money. You're telling me the claim department couldn't do that. You're going to pay a lawyer $300 an hour or more to do that. That's insane. That's nuts.

It's throwing off all the numbers as well. Because the more you delegate to law firms to do things, the higher your claim expense is going to be. That's going to be an actuarial factor to increase pricing unnecessarily. That's one of the real trends that I'm seeing is to me very disturbing.

John: Fred, always very informative. One final question today, are private equity companies good or bad for the industry?

Fred: I don't think you can paint a broad brush on that because there are several different private equity models. The model that I think is bad for the industry is the acquire, grow or grow profitably and flip in less than three years.

That places a lot of pressure to increase profitability, which can be done one of two ways. You can grow organically and be highly profitable as a result, or you can cut internally. Cutting internally can be done in a number of ways with an insurance company in particular because you can cut back on some staff. You can cut back staff and especially expensive staff.

Then more importantly, you can make it more difficult to...and you can do it in a way that doesn't look like this is what you're doing. Basically, you are going to end up being under reserved. That's going to affect profit, that's going to artificially increase profitability.

At some point, whoever buys that insurance company down the road is going to wake up and find out they're grossly under reserved. That has happened many times, especially with smaller insurance companies.

I saw that happen with a company that was an auto insurer in Florida that was acquired. They didn't do a qualitative audit during the escrow phase, which in a way I can understand because qualitative claim audits aren't cheap.

They can cost $30,000, $40,000, $50,000 depending on how many files you're going to look at or how many files you have to review. You have to look at open files and closed files. Closed file audits are very important. More importantly, what they found out was after six months, they were under reserve by over 2 million dollars.

That meant going back to the private equity company and they had to put in more capital. The organization that was running it ended up having to give back some of their ownership. In the long run, it worked out fine.

Once the company became stable from a reserve standpoint and was able to maintain this rating they grew and ultimately it was sold at a significant profit. That's the concern. I know that the NAIC has gotten very concerned about private equity companies coming into the industry for that very reason.

Because again, they're only looking at making profit. They don't care how to get it. Of course, if it means they have to be tied on claim payments and tied on claim reserves, they're going to do it.

Unfortunately, too many departments of insurance are understaffed or underfunded and can't do the kind of departmental audits that they used to make. A lot of companies are getting away with this. Overall, you're seeing that trend not just in the insurance industry, you're seeing it everywhere.

Private equity companies only want a return on investment. They don't care how they get it.

John: Fred, always an engaging and informative session with you. Thanks so much for joining us again today.

Fred: Thank you to AM Best for wanting to put up with me as well. I always look forward to working with you and thank you again.

John: Thank you, Fred. You've just listened to Fred Fisher, President of Qualified Member Expert Service provider, Fisher Consulting Group, Inc. Special thanks to today's producer Frank Vowinkel. Thank you all for joining us for Best's Insurance Law Podcast.

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