2014 WL 12278735 (D.S.D.) (Expert Report and Affidavit)
United States District Court, D. South Dakota,
Southern Division.

DZIADEK,
v.
THE CHARTER OAK FIRE INSURANCE COMPANY.

No. 411CV04134.
November 14, 2014.

**(Report or Affidavit of Rob Dietz)**

**Case Type:** Insurance >> Automobile Policy
**Case Type:** Insurance >> Bad Faith & Coverage
**Case Type:** Insurance >> Unfair Claims Practice
**Case Type:** Insurance >> Uninsured/Underinsured Motorist
**Jurisdiction:** D.S.D.
**Name of Expert:** Robert B. Dietz
**Area of Expertise:** Insurance >> Claims

**Representing:** Plaintiff

*Disclosure of Plaintiffs Claim Practices Expert: Supplemental Opinions and Conclusions.*

Throughout this report, and my initial report, I refer to Travelers and Charter Oak as one, as it is not even known if Charter Oak has any employees. This supplemental report incorporates the report and my opinions from my May 12, 2012 report.

Information/File material sent for review

Since the date of my May 12, 2012 initial disclosure report, Plaintiff counsel has provided me with binders of materials that consist of the following Bates stamped documents labeled:

Charter Oakes:

1000-1124

2000-2575

3000-3220

4000-4186

5000-5016

6000-6301

  

7000-7042

7043-22702

22812-24308

PLRB 1-69 ,and 148-643

Since my initial report, I have also received the depositions of the following:

Faith Styles

Tim Westbrook

Laura Dziadek

Steve Barnes

Dan Brendtro

Jeff Cole

Pat Palaniuk

Brian Koerner

Amy Hennessy

Philip Castagnet

Dawn Midkiff

Wendy Skiervan

I have recently reviewed:

Charter Oak Insurance Company's Memorandum In Opposition To Plaintiffs Third Motion To Compel Discovery; Affidavit of Michael Cashman and its exhibits; Affidavit of Faith Styles and its exhibits; Affidavit of Brian Koerner and its exhibits; Affidavit of Richard Ives and its exhibits; and Affidavit of Daniel Kulakofsky.

I have reviewed J. D. Power Reports on Customer Satisfaction for the years 2009, 2010, 2011, and 2013.

**Opinions and Conclusions**

A claim is filed when a notice of loss is made. In this matter, notice of loss was 1/30/2009. Once a claim is filed, verification of coverage is the first step of the claims process. [1] The duty to investigate coverage includes investigating and knowing the law of the state as it applies to coverage. While adjusters are not lawyers, the reasonable industry custom is that the claims professional has a working understanding of the laws that affect claims handling. The reasonable industry custom

  

or standard is to review all forms and endorsements that may potentially provide coverage to an insured in relation to the facts of the loss and the law, and to communicate the results of the coverage investigation.[2] Travelers failed to do so here.

Legitimate and honest insurers do disclose potential coverage. The standard or custom is to advise its insured-even where the insured may not recognize that coverage is available, regardless if an insured is represented by an attorney or not.[3] The reasonable industry standard is to not discriminate in claims matters. Travelers' employees have testified that they do not communicate and disclose these coverage matters if an insured is represented.

It is the claims professionals who undertake training and course work in policy forms and endorsements, and in coverage investigations. It is their job and responsibility to determine whether coverage applies, and how much.[4] The reasonable industry standard is that claims professionals are expected to have expertise in coverage evaluation. Reviewing the policy forms and endorsements is part of a coverage investigation. To blame Dziadek's counsel for not knowing about available UIM and Med Pay is unreasonable. Travelers conducted a 'round table' review in part to determine coverage-and they had the policy forms and endorsements on hand to review. Dziadek's counsel asked for these, they were not timely provided, and Travelers sent them by the correspondence that highlighted the definition of "insured', and stated there was no coverage for Dziadek under the policy.[5] Moreover, Travelers even sought a coverage opinion from its in-house counsel.[6] The affirmative duty to determine and disclose coverage is the reasonable industry standard or custom.[7] Travelers knows this as evidenced by its Knowledge Guides and Good Faith training documents, among other evidence. The claims professional is charged with having a working understanding of controlling law as it affects the insurance matters in the given jurisdiction.[8] Travelers failure to disclose coverage to Dziadek's counsel violated industry standards.

Travelers informed Dziadek's counsel in February 2009 that it had reviewed the facts of the loss in conjunction with the policy, and determined (1) "that no coverage for your client exists under this policy." And (2) "Lori Peterson's liability coverage would be primary.

When Travelers finally issued the UIM benefits in February 2012, it stated in its February 16, 2012 fax/letter to Jeff Cole that it now recognized Ms. Dziadek as an underinsured motorist since her counsel dismissed claims against Knife River Midwest and Dakota Traffic Services. The actual policy language does not require the insured to litigate or pursue anyone other than the uninsured/underinsured motorist in order to be eligible for the Travelers UIM benefits. This February 16, 2012 communication misrepresents pertinent policy provisions, which is a departure from reasonable industry standards. It is contrary to reasonable industry standards to impose conditions that are not part of the policy. Indeed, if Dziadek had been told the truth about UIM coverage back in February 2009, she could have accepted the tender of Progressive's $100K liability and thus triggered UIM coverage under the Travelers policy. Travelers knew at that time the loss far surpassed the Progressive liability limits. The facts indicate that Travelers failed to disclose UIM and Med Pay coverage, and worked to conceal such coverage by (1) not affirmatively disclosing it as an ethical insurer would, (2) leading Dziadek's lawyers to believe there was no coverage available to Laura Dziadek under the policy, both in those words as well as the highlighted definition of "insured", and (3) by not providing the UIM and Med Pay endorsements when the policy was requested. This violated industry standards.

Travelers' claims practices change or are predicated on whether an insured is attorney represented or not. This is contrary to the industry custom that all insureds/claimants are treated fairly, honestly, and in a similar manner regarding claims for similar benefits.[9] It is discriminatory, which is below the reasonable industry standard. The documents I reviewed leave no doubt that Travelers does not want attorneys involved in the claims process. Also evidenced is the fact Travelers recognizes, measures and rewards employees who contribute to bottom line results, including low ball settlements consistently below its low range value, and settlements for specials only.

  

I am otherwise familiar with the case known as *Alice Torres vs. Travelers. United States District Court, District of South Dakota, Western Division.* CIV. 01-5056-KES, from my work and study of claims practices. I subscribed to Claims Magazine, and have a copy of its October 2004 issue, wherein there is an article discussing this case, focusing on incentive based pay schemes and the likely consequences of performance based pay schemes that incentivize, reward or punish the claims staff for reaching loss reduction and other conflict of interest goals. I have documents from that case, including the Court's Order of September 30, 2004.

The documents show that Travelers has since at least 1999 used compensation programs that track, measure and provide financial incentive and reward for lowering claims payments. This includes goals for lowering average paid claims. These programs are created at the top of the organization and cascade down to the claims adjuster level, who are far removed from actuarial and underwriting departments which are legitimately concerned with the study of claims payments and losses as far as in the law of large numbers analysis. Industry training teaches us that at the claims handling level such goals are considered perverse and actionable, as it is not possible to know how many, what type, or how severe of claims an adjuster, or even a claims office will handle. Profit is correctly accounted for at the time of sale. Goals to arbitrarily lower claims payments through questionable initiatives and performance measures have no place in an ethical insurance company, as they are contrary to reasonable industry standards of paying what is fairly owed on claims. [10]

Based on my review of the documents, after the verdict in Torres and the Court's Order of September 2004, Travelers was not so obvious about its goals for measuring and rewarding lowering average paid claims as it was before. However based on my review of this case, it still goes on. It is less evident in the performance reviews, but management still tracks these numbers and drills them down to the individual level, in a face to face manner. This is what the discovery documents state.

Average paid was a metric or indicator on adjuster Faith Styles' monthly scorecard up through 2008, the year of the Dziadek loss, and immediately before Travelers closed the file as a CWP (Closed without payment), another metric constantly measured. Now under the compensation plan, it is recommended that goals and performance coaching be done orally-face to face, versus a paper record.

Severity or average paid remains a key performance indicator that is measured and tracked in great detail, and available to claims unit managers (and others). They are instructed to drill down expected behavior and performance expectations to the individual level, the desk level. Management is expected to communicate expectations to the team on an ongoing basis, and with a sense of urgency to achieve goals. Management is expected to consistently demonstrate how claims can influence company profitability and management of severity, while leveraging data (OMPI and Dashboard as some of the sources of data) to make the most of opportunities, support strategic initiatives, and improve results.

In 2010, for example, there was a goal of reducing loss costs-claims payments, by $100 million. Based on the documents I reviewed, Travelers was for years, significantly outperforming the industry in loss ratio, combined ratio, and severity. I could not identify legitimate causes or concerns of overpayments, or to justify a goal of loss cost reduction of $100 million. These sorts of goals and schemes to arbitrarily reduce claims payouts create a conflict of interest for claims professionals, whose task is to fairly and promptly pay what is owed on a claim. The Travelers compensation system states it is a direct link to compensation for individual results that link to bottom line results. Further, Unit managers and adjusters were aggressively managed out of their jobs in cases where the expected results were not consistent and on goal, or happening with a sense of urgency. It is contrary to reasonable industry standards for claims professionals to have a financial stake in making claims decisions. [11]

Between employees Koerner, Westbrook (who were promoted into management in part for lowering average paid claims and making low ball settlements), and Styles, Travelers measured and compensated performance that included such things as: denying claims (CWP); settling claims consistently below the low range of value; and settling claims for only specials. Many of these were first contact settlements. One example was a settlement that was below the evaluation, the reserve, and only 16% of the value of the claim. Travelers called these success stories. These are examples of how mischief

  

can creep in when claims employees are measured and rewarded on lowering claims payments, and focusing on profit and bottom line results. [12]

Based on the documents I reviewed, loss costs and average paid claims remains a goal of Travelers' performance pay scheme. While less blatant than ten years ago, these measures and initiatives continue to be focus. Management measures these metrics and drills down the message of expected performance and behavior to the claims staff, and is urged to do so face to face-verbally. The evidence I have seen shows that Travelers measures, demands, and rewards or punishes results relative to initiatives designed to lower loss payments. The customer service results (claims satisfaction) I have seen indicate that Travelers actually has poor customer service results (once being higher that the industry average since J.D. Powers began reporting on this).

Travelers measures immediate and face to face contact. The goal is measured not just in days but by 2, 4 .. hours to contact. Typically injured people are vulnerable financially, emotionally, and physically after a loss: they are not at their best. This leads to early contact settlements before (1) an injured party may know the seriousness of an injury, and (2) before an injured person retains an attorney to assist them, and perhaps level the playing field. These are the metrics being measured and tracked to gauge performance, that directly effect average paid claim severity. It violates industry standards to use metrics in a way that predictably leads to the underpayment of claims.

The Knowledge Guides are available to provide direction for proper claims handling. For the most part, these guides have set forth industry standards. Travelers employees have testified they are just guides and they are not required to abide by them. It violates industry standards to allow claims representatives to depart from industry standards.

Travelers handled this claim in a manner which will repeat itself, as the testimony is it was handled as Travelers expected, and it would handle the claim the same way again.

The wrongdoing I have discussed is the expected outcome of an incentive based pay scheme-a pay for performance system where Travelers management condones, encourages, and indeed demands behavior by its claims staff to continuously reduce its claims payouts, arbitrarily, and which is contrary to reasonable industry standards. These pay systems create pressure on claims staff to focus narrowly on profit and bottom line results, and detract from those tasks of what claims employees should focus on, and creates and maintains a conflict of interest by giving claims employees a financial stake in the outcome of claims, which is contrary to reasonable industry standards.

Travelers acted in a way that showed greater concern to its financial interests over the financial harm to both Ms. Dziadek and Ms. Peterson. That violates industry standards, which requires equal consideration of the insured's interests.

Footnotes

1 “Coverage is the first issue that must be investigated”. The Claims Environment, First Edition 1993. Insurance Institute of America. James Markham, Kevin Quinley, Layne Thompson. Page 45,

2 “Determining coverage may be very simple or extremely complicated depending on the specific facts of the case. An investigation must often be undertaken to fully develop the facts needed to determine coverage.” *Id.* at 29.

3 “The primary duty of the claims representative is to deliver on the promise to pay. Therefore, the claims representative's chief task is to seek and find coverage, not to seek and find coverage controversies or to deny or dispute claims.” *Id.* at 13.

4 “... claim representatives must have thorough and precise knowledge or coverges.” *Id.* at 59.

5 It appears Dziadek's lawyers did not understand or realize that the definition of “insured” changed within the UIM and Med pay endorsements, affording coverage, and reasonably relied on Travelers that there was no coverage for Dziadek under the policy.

6 Dawn Midkiff was the in-house lawyer sought out for a coverage opinion. She remembered looking at the policy, declarations, and forms. She testified she did not remember a discussion about there being a passenger in the subject accident. It is

  

unreasonable to expect a reliable coverage opinion if such basic facts such us there being a passenger in the vehicle are withheld. For that matter, there would not even seem to be a need for a coverage opinion (even if just for liability) unless there was liability-and if so to whom? If such an important fact is indeed disclosed as part of seeking a coverage opinion, I would expect a competent coverage expert to recognize potential coverage issues such as UIM and Med Pay in a loss like this.

7 "Coverage Question. When the claim representative has a question about whether the loss is covered by the policy, he or she should do the following: Recognize the question. Tell the insured. Resolve the question. Involve appropriate decision makers. Be correct. Be consistent...It should also be a decision dial is consistent with similar claims. Be honest and open," *Id.* at 305-306, 308.

8 "Claims professionals should have expert knowledge of insurance policy coverages. the law, and determination of damages." *Id.* at 12. "Allowing oneself to handle a matter without the required competency is a fundamental breach of duty to the customer. Claim representatives likewise have an ethical obligation to police their own incompetency." *Id.* at 397

9 "The insured or claimant needs the claim representative's expertise and guidance.: *Id.* at 375.

10 For example. see Zilisch vs. State Farm, Arizona Supreme Court, No. CV-98-0535-PR, May 2000.

11 "However, all honest and reputable insurers recognize that claims are an expected part of business and are to be paid fully and fairly. No honest and reputable insurer has either explicit or implicit 'standing orders' to its claims department to delay or underpay claims." The Claims Environment at 17.

12 Part of the bonus payment is in the form of stock options. This makes the employees investors who have an ongoing stake in the bottom line results, where loss payment reduction means financial gain.

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