WHY CAN'T WE JUST GET ALONG? A CRITICAL REVIEW OF PROFESSIONAL CONDUCT OF THOSE ENGAGED IN INSURANCE ADJUSTMENTS AND DISPUTES

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Finally, our many public adjuster friends have provided great detail with their knowledge of insurance policies, claims adjustment methods, and the frequent reminder that proper insurance adjustment is only accomplished by steadfastly ensuring that the policyholder is fully and promptly paid all benefits due under a policy.

I. INTRODUCTION

A typical lawyer's perspective, especially if he or she is a litigator, assumes that adversarial relationships and debate are the norm. Yet, quite often, these highly educated individuals do not appreciate that this is not to be expected in a relationship between adjusters, public adjusters, claimants and lawyers. Indeed, many judges believe that certain decisions and actions by insurance companies are "reasonable," without any notion or study in the field of insurance adjustment. Insurance law is not the same as the field of insurance adjustment, and this is the first hurdle that needs to be overcome if justice is to be served when deciding what behaviors constitute good faith conduct and professional demeanor.

One has to know the duties insurance company adjusters, public adjusters and others must adhere to during a property insurance adjustment. These adjustment "rules" are not typically found in legal cases, but in treatises and other references sources of insurance adjustment. For the same reason a judge would not read medical malpractice cases to determine the proper procedures a surgeon would take, the duties and procedures those involved in adjustment must follow should be learned through authoritative references and in the appropriate context.

II. THE SPECIAL NATURE OF INSURANCE

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 by the policyholder 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 unexpected loss occurs. The entire purpose of insurance is defeated if those involved with insurance adjustment can refuse or delay the prompt and full payment of monies due under the contract.

Automobile crashes, train wrecks, terrorist acts, hurricane, tornado, and other windstorm losses often involve catastrophic damage to people. Management of insurance companies anticipate these events. Often, they 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 does not 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 a party to other types of general commercial contracts, the insurance company promises that it will provide financial security in the event of a catastrophe. The company 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 adjusters delay, refuse or fail to uphold their part of the bargain.

The press and cultural media have picked upon 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 deliberately 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 business media has reported on this.[3]

In 1997 Helen Hunt received an Oscar for her performance in AS GOOD AS IT GETS.[4] In part, she portrayed a waitress whose child was refused treatment for a chronic allergic condition which was ruining her private life and causing the child needless

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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] AS GOOD AS IT GETS (Tristar 1997).

suffering. A doctor obtained outside her HMO network quickly diagnosed the condition, and implied that the treatment should have been approved by her insurance company several years earlier. This scene is significant:

Carol Connelly:	"They said my plan didn't cover it and said it wasn't necessary anyways."
Carol Connelly:	[Pause] "Why, should they have [paid for the treatment]?"
Doctor:	"Well" –
Carol Connelly:	"Fucking HMO bastard, pieces of shit!!"
Carol's mother:	"Carol!"
Carol Connelly:	"I'm sorry."
Doctor:	"That's ok – I think that's their technical name."

Audiences throughout the nation applauded this exchange.

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

> 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 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

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

> money to cover any prejudgment interest, costs, or consequential damages award, or counsel fees collected by the policyholder.[6]

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

The insurance industry recognizes the character of a 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 ("CPCU") discusses the current state of the law of bad-faith insurance company conduct:

1. All insurance contracts contain a covenant of good faith and fair dealing.

2. If bad faith is a tort in a third-party claim, it should be a tort in a first-party claim as well.

3. Insurance is a matter of public interest and deserves special consideration by the courts to protect the public.

4. Insurance contracts are not like other contracts because insurers have an advantage in bargaining power. Insurers should therefore be held to a higher standard of care.

5. Recovery for breach of an insurance contract should not be limited to payment of the original claim.

6. 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.

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[6] Jeffrey W. Stempel, Interpretation of Insurance Contracts: Law and Strategy For Insurers and Policyholders § 19.3, at 466-67 (1994). *The Paper Chase II* (NBC Dateline, July 25, 2000)(exposing industry efforts to deny legitimate claims).

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

7. Policyholders buy peace of mind and are not seeking commercial advantage when they buy a policy. In addition, they are vulnerable at the time of the loss.

8. Policy language is sometimes difficult to understand. The benefit of the interpretation should be given to the policyholder.[8]

III. EXAMPLES OF UNFAIR CLAIMS PRACTICE CASES

The following are some examples of insurers' improper claims practices.

1. Failing 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]

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]

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

[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).

[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).

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

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

8. Making unreasonably low counteroffers in negotiating the settlement of an underlying claim.

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

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

Insurance companies have an affirmative duty to disclose to their policyholders information regarding coverage. This duty is implied in the duty of good faith and fair

[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).
[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).

dealing. Professor Alan I. Widiss, a leading law insurance professor, has argued that this duty to disclose is one of several key elements of 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 unfortunate myth permeates many claims organizations, leading them to believe that the insurance company has no obligation following a loss other than to pay the claim after proofs of loss are submitted. In reality, nothing could be further from the truth, or further from the 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.[25] News of a ship's loss might not reach Lloyd's for a considerable period of time. Often, the first notice of loss was accompanied by a demand for payment. The only requirement of insurers under these standard insurance policies was to accept or reject the proof of loss and then make, or deny, payment.[26]

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[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).
[25] See generally Hugh Cockerell, Lloyd's of London – A Portrait (Woodhead-Faullener Ltd. 1984); D.E.W. Gibbs, Lloyd's of London – A Story of Individualism (McMilland Co., Ltd. 1957).
[26] Ethics and Claims Professionalism, 2 (Insurance Institute of America, 1999).

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.[27] 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, as well as departments of insurance and policyholders, are far different, and these expectations demand 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.
>
> **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.
>
> 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 reduction or salvage operations. The professional claim representative should be there to help
>
> ….

[27] Id.

> 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.[28]

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 non-waiver 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.
>
> 8. Assist the policyholder by arranging for temporary housing (when necessary).

[28] Id. at 3,4

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.[29]

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. These companies recognize that their obligations go far beyond the policy language, which never discusses "trust," "good faith," and/or "confidence" expected following a loss.

Claims adjusters and claims management fulfill the obligation and the trust by promptly investigating coverage, evaluating damages, and paying promptly what is owed. Doing the job right and doing the job quickly is good claims adjustment.

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

V. INSURANCE ADJUSTERS ARE TAUGHT THAT THE TRADE OF CLAIMS HANDLING INVOLVES A SPECIAL RELATIONSHIP OF TRUST WITH THE PUBLIC AND AN OBLIGATION OF GOOD FAITH CLAIMS CONDUCT

Respectfully, for the same reason one would not expect to learn medicine by reading malpractice cases, nobody – especially lawyers and judges - can expect to learn how adjusters are taught to treat policyholders by only reading bad faith case law. Some lawyers and judges are often surprised to learn that claims representatives are taught honest and honorable ways to handle claims. The standard textbook for claims handlers, which leads to an Associate in Claims designation, is James J. Markham, et al., The Claims Environment (1st ed., Insurance Institute of America 1993). There is now a second edition of The Claims Environment.[30]

The Markham textbook for claims handlers and students of insurance sets forth simple, clear claims handling principles. Some of these principles are:

> "Claims representatives….are the people responsible for fulfilling the insurance company's promise."

Markham at vii.

> "When a covered loss occurs, the insurance company's obligation under its promise to pay is triggered. The claim function should ensure the prompt, fair, and efficient delivery of this promise."

Markham at 6.

> "Therefore, the claim representative's chief task is to seek and find coverage, not to seek and find coverage controversies or to deny or dispute claims."

Markham at 13.

[30] Doris Hoopes, The Claims Environment, (2d ed., Insurance Institute of America 2000).

> "…the insurance company should not place its interests above the insured's."

Markham at 13.

> "The claim professional handling claims should honor the company's obligations under the implied covenant of good faith and fair dealings."

Markham at 13.

> "No honest and reputable insurer has either explicit or implicit "standing orders" to its claim department to delay or underpay claims."

Markham at 274.

> "When an insurance company fails to pay claims it owes or engages in other wrongful practices, contractual damages are inadequate. It is hardly a penalty to require an insurer to pay the insured what it owed all along."

Markham at 277.

> "All insurance contracts contain a covenant of good faith and fair dealing."

Markham at 277.

> "If bad faith is a tort in a third-party claim, it should be a tort in a first-party claim as well."

Markham at 277.

> "Insurance is a matter of public interest and deserves special consideration by the courts to protect the public."

Markham at 277.

> "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."

Markham at 277.

> "Recovery for breach of an insurance contract should not be limited to payment of the original claim."

Markham at 277.

> "The public's expectations are elevated by insurers' advertising, slogans, and promises which give policyholders the impressions that they will be taken care of no matter what happens."

Markham at 277.

> "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."

Markham at 277.

> "Policy language is sometimes difficult to understand. The benefit of interpretation should be given to the policyholder."

Markham at 277-278.

> "Upper management also has a responsibility to maintain proper claim-handling standards and practices."

Markham at 300.

The Second Edition of The Claims Environment explains, in part, various aspects of good faith claims handling:

> **Unbiased Investigation**
>
> Claim representatives should investigate in an unbiased way, pursuing all relevant evidence, especially that which establishes the legitimacy of a claim. Claim representatives should avoid using leading questions that might slant the answers. In addition, they should work with service providers that are unbiased. As mentioned previously, courts and juries might not look sympathetically on medical providers or repair facilities that favor insurers. Investigations should seek to discover the facts and consider all sides of the story. Claim representatives should not appear to be looking for a way out of the claim or for evidence to support only one side.
>
> **Evaluation**
>
> Claim representatives can evaluate liability claims in good faith if they evaluate claims as if not limit of liability existed. This approach ensures that claim representatives consider the insured's interests at least equally

> with the insurer's interests. Evaluating liability claims as if there were no policy limit helps claim representatives avoid the mistake of wishful thinking that a claim can be settled for less than the policy limit when it is foreseeably worth more. Prompt, knowledgeable evaluations help insurers to prove their efforts were in good faith.
>
> **Prompt Evaluation**
>
> As described in Chapter 9, unfair claims settlement practices acts often specify time limits within which to complete evaluations of coverage and damages. Claim representatives should be sure to comply with those requirements to reduce their exposure to bad faith claims.[31]

It is important to note that there are professional designations in the insurance trade. One group of insurance professionals is the Society of Chartered Property and Casualty Underwriters (CPCU). An individual becomes a CPCU after a course of professional study, passing an examination, and making a professional commitment. To attain professional status, a CPCU must agree to abide by the CPCU Code of Professional Ethics and take this lofty professional oath:

> I shall strive at all times to live by the highest standards of professional conduct; I shall strive to ascertain and understand the needs of others and place their interests above my own; and shall strive to maintain and uphold a standard of honor and integrity that will reflect credit on my profession and on the CPCU designation.[32]

The CPCU Code of Professional Ethics is generally known, accepted, and followed within the insurance trade. The standards the Code sets forth are established standards. The Canons from the Code of Professional Ethics of the American Institute for the CPCU are:

> CANON 1: CPCUs should endeavor at all times to place the public interest above their own.
>
> CANON 2: CPCUs should seek continually to maintain and improve their professional knowledge, skills and competence.

[31] Doris Hoopes, The Claims Environment 10.7 (2d ed., Insurance Institute of America 2000).
[32] The CPCU Professional Commitment, AICPCU/IIA Catalog, 1999-2000 at 66.

CANON 3: CPCUs should obey all laws and regulations; and should avoid any conduct or activity which would cause unjust harm to others.

CANON 4: CPCUs should be diligent in the performance of their occupational duties and should continually strive to improve the functioning of the insurance mechanism.

CANON 5: CPCUs should assist in maintaining and raising professional standards in the insurance business.

CANON 6: CPCUs should strive to establish and maintain dignified and honorable relationships with those whom they serve, with fellow insurance practitioners, and with members of other professions.

CANON 7: CPCUs should assist in improving the public understanding of insurance and risk management.

CANON 8: CPCUs should honor the integrity of the CPCU designation and respect the limitations placed on its use.

CANON 9: CPCUs should assist in maintaining the integrity of the Code of Professional Ethics.[33]

Insurance companies employ most of the nation's CPCUs. Insurance companies should not be exempt from established trade customs, trade standards, and trade usage, simply because not all of their employees are CPCUs, nor because only individuals and not insurance companies can earn the professional degree. There are more than 30,000 members of the CPCU Society.[34]

Insurance companies themselves recognize that they are obligated to treat policyholders and claimants in good faith. For example, in its standard claims manual, Allstate acknowledges that its relationship to its policyholder is more than that of a

[33] David H. Brownell & Stephen Herald, Ethics in the Insurance Industry: A Case Study Approach 6-7 (American Institute for Chartered Property Casualty Underwriters Institute of America).
[34] See http://www.aicpcu.org/mediacenter/history.html.

"debtor-creditor"; instead, Allstate recognizes its relationship requires good faith and the highest degree of integrity. Allstate's Claims Practices and Procedures Manual provides:

> The conduct of our claim personnel is constantly being scrutinized by all of the people with whom we are in daily contact with – our policyholders, third-party claimants, state insurance departments, and other persons connected with the insurance industry. It is therefore important that we make very clear the basic principles which must be adhered to by Allstate's claim employees at all times.
>
> THE INSURING PUBLIC HAS THE RIGHT TO RELY ON ALLSTATE MEN AND WOMEN TO BE HONEST IN EVERY ACTIVITY OF THE COMPANY. TO FULFILL THAT RESPONSIBILITY, ALLSTATE CLAIM EMPLOYEES ARE EXPECTED TO CONDUCT THEIR DEALINGS WITH THE HIGHEST DEGREE OF INTEGRITY. IF ALL CLAIM EMPLOYEES MAINTAIN HIGH STANDARDS OF INTEGRITY, THE INSURING PUBLIC WILL RESPOND WITH THE CONFIDENCE AND RESPECT THAT ARE ESSENTIAL TO ALLSTATE'S FUTURE GROWTH.
>
> THESE BASIC PRINCIPLES OF INDIVIDUAL CONDUCT ALSO REQUIRE THAT ALLSTATE CLAIM PERSONNEL COMPLY WITH ALL PERTINENT LAWS & REGULATIONS GOVERNING THE STATE OR JURISDICTION INVOLVED.[35]

Allstate recognizes the value of its adjusters receiving the type of training provided by certification, and provides monetary "rewards" to its claims personnel who complete either the Associate in Claims certification or CPCU membership:

> In addition to the Allstate and P-CCSO awards, there are many insurance designations and certification programs that should interest you. A few of them are described in this brochure. Here is a brief summary:
>
> **Chartered Property and Casualty Underwriter (CPCU)**
>
> The CPCU designation is earned by insurance professionals who have passed 10 examinations covering a broad range of risk management and general business topics in the field of Property and Casualty Insurance. The CPCU designation is widely regarded in the insurance industry as signifying a knowledgeable and ethical insurance professional. You may take CPCU examinations in January, June or September. Upon successfully completing the program, you receive a $1,000 cash award

[35] Allstate C-PPP Manual, Vol. 1, Chapter 2 (Rev. Aug 31, 1990).

> and are eligible to attend the national conference with a guest at the company's expense in the year of confirmation.
>
> **Insurance Institute of America (IIA) – Associate in Claims**
>
> The Associate in Claims program is most appropriate for experienced adjusters and claim managers. This program focuses on subjects important to handling all types of claims, including communication, negotiation, workers' compensation issues, laws of contracts, duties under a policy of insurance, and many others. The four course program leads to an Associate in Claims designation. Upon successfully completing the program, you will receive a $200 cash award.[36]

Thus, while insurers may argue in briefs and to judges that the duties and relationships between policyholders and themselves are similar to those of debtor and creditor, the claims management and personnel are at least on notice and agree that the duties and relationships are much more.

A particularly scholarly discussion explaining why insurance is treated differently by courts is found in an article written by Professor Henderson of the University of Arizona College of Law, which includes the following discussion:

> In a free enterprise system, economic development steadily increases the number of situations in which individuals can suffer "loss." At the same time, economic development enhances the ability to avoid the prospect of "loss." In other words, in a relatively affluent society, there is much more to lose in the way of property and other economic interests as the human condition improves. In such a society, however, individuals are more likely to have the requisite discretionary income to transfer and to spread the attendant risks of loss. Disruptive losses to society, as well as to the individual, are obviated or minimized by private agreements among similarly situated people. In this way, the insurance industry plays a very important institutional role by providing the level of predictability requisite for the planning and execution that leads to further development. Without effective planning and execution, a society cannot progress.
>
> ….
>
> This perceived social significance has set apart insurance contracts from most other contracts in the eyes of the law. Insurance is purchased

[36] Allstate P-CCSO Recognition Program, a Guide to Recognition.

routinely and has become pervasive in our society. It protects against losses that otherwise would disrupt our lives, individually and collectively. The public interest, as well as the individual interests of millions of insureds, is at stake. This is the foundation for the general judicial conclusion that the business of insurance is cloaked with a public purpose or interest. This perception also explains the extensive regulation of the insurance industry in the United States, not just through legislative and administrative processes, but also through the judicial process. In fact, as with developments in other areas of tort law, the recognition of the tort of bad faith in insurance cases represents a judicial response to the perceived failure of the other branches of government to regulate adequately the claims processes of the insurance industry. Had the early attempts at regulation been more effective, the tort of bad faith might never have come into existence.

…

The insureds' disadvantage persisted as insurance took on more and more importance in this country. In order to purchase a home or a car, or commercial property, most people had to borrow money, and loans were not obtainable unless the property was insured. In addition, the lender often required that the life of the borrower be insured. On another front, the cost of medical care was rising beyond the reach of many people and insurance programs were developed to spread that risk. The purchase of insurance was no longer a matter of prudence; it was a necessity. Then losses occurred and the inevitable disputes arose. These disputes, however, were not about an even exchange in value. Rather, they were about something quite different.

Insureds bought insurance to avoid the possibility of unaffordable losses, but all too often they found themselves embroiled in an argument over that very possibility. Disputes over the allocation of the underlying loss worsened the insureds' predicament. In most instances, insureds were seriously disadvantaged because of the uncompensated loss; after all, the insured would not have insured against this peril unless it presented a serious risk of disruption in the first place. The prospect of paying attorneys' fees and other litigation expenses, in addition to the burden of collecting from the insurer, with no assurance of recovery, only aggravated the situation.

These additional expenses could prove to be a formidable deterrent to the average insured. For most insureds, unlike insurers, such expenses were not an anticipated cost of doing business. Insureds did not plan for litigation as an institutional litigant would. Insurers, on the other hand, built the anticipated costs of litigation into the premium rate structure. In effect, insureds, by paying premiums, financed the insurers' ability to

> resist claims. Insureds, as a group, were therefore peculiarly vulnerable to insurers who, as a group, were inclined to pay nothing if they could get away with it, and, in any event, to pay as little as possible. Insurance had become big business.[37]

The man on the street knows that it is far more profitable for an insurance company to take a person's money and not pay, rather than to promptly and fully pay what is owed. That this financial incentive conflicts with the extreme public trust placed in the insurance industry is the reason why codes of ethics, good faith duties and common law remedies are imposed upon insurers. Public policy demands recognition of these practical and generally-recognized duties so that citizens are not mistreated at the very time they need the best treatment from their insurers.

VI. WHAT CLAIMS MANAGEMENT SHOULD MAKE SURE THEIR CLAIMS FIELD ORGANIZATIONS DO

The following summarizes the appropriate behavior to expect from an insurance company and its adjusters:

1. Train, promote and encourage adjusters to promptly, honestly and thoroughly determine coverage, evaluate damages, fully 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, biased claims conduct.

[37] Roger C. Henderson, The Tort of Bad Faith in First-Party Insurance Transaction: Refining the Standard of Culpability and Reformulating the Remedies by Statute, 26 U. Mich. J.L. Ref. 1, 10-14 (1992).

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. Explain in person and in writing the coverages, explain the process and provide status up-dates. These "joint meetings" prevent disagreements and distrust.

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.

10. Prevent fraud after the claim by "hands on" claims adjustment. Policyholders who (1) know a "hands on" 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.

4-220.201 Ethical Requirements.

(1) Purpose. This rule sets forth the various ethical considerations and constraints 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 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 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. The following are standards of conduct that define ethical behavior.

(a) An adjuster shall disclose all financial interest in any direct or indirect aspect of an adjusting transaction. For example: 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.

(b) 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.

(c) An adjuster shall never approach investigations, adjustments, and settlements in a manner prejudicial to the insured.

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

(e) An adjuster shall handle 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.

(f) An adjuster, upon undertaking the handling of a claim, shall act with dispatch and due diligence in achieving a proper disposition thereof.

(g) 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.

(h) 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.

(i) An adjuster shall not 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.

(j) 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.

(k) An adjuster shall not advise a claimant to refrain from seeking legal advice, nor advise against the retention of counsel to protect the claimant's interest.

(l) An adjuster shall not attempt to negotiate with or obtain any statement from a claimant or witness at a time that the claimant or witness is, or would 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 shall 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.

(m) 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.

(n) A company or independent adjuster shall not draft, unless approved in writing in advance by the insurer and such written communication can be demonstrated to the Department, 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.

(5) Public Adjusters**,** Other Ethical Constraints. In addition to considerations set out above for adjusters, the following ethical considerations are specific to public adjusters**.**

(a) A public adjuster shall advise the insured and claimant in advance of their right to choice of counsel to represent the insured or claimant, and that such choice is to be made solely by the insured or claimant.

(b) The public adjuster shall notify the insured or claimant in advance of the name and location of any proposed contractor, architect, engineer, or similar professional, before any bid or proposal by any of these persons may be used by the public adjuster in estimating the loss or negotiating settlement, and the insured or claimant may exercise veto power of any of these persons in which case that person shall not be used in estimating costs.

(c) The public adjuster shall ensure that if a contractor, architect, engineer, or other licensed professional is used in formulating estimates or otherwise participates in the adjustment of the claim, the professional must be licensed by the Florida Department of Business and Professional Regulation.

(d) 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.
>
> (e) A public adjuster shall not acquire any interest in salvaged property, except with the written consent and permission of the insured.
>
> (f) A public adjuster shall not accept referrals of business from any person with whom the public adjuster may conduct business where there is any form or manner of agreement to compensate the person, whether directly or indirectly, for referring business to the public adjuster. Except as between licensed public adjusters**,** or licensed public adjusters and members of the Florida Bar, no public adjuster may compensate any person, whether directly or indirectly, for the principal purpose of referring business to the public adjuster**.**

VII. THE RECURRENT PROBLEM OF SEVERITY CONTROL INITIATIVES

The case of Campbell v. State Farm Mutual Auto. Ins. Co., 2001 Utah LEXIS 170 (Ut. 2001), reversed and remanded by, State Farm Mutual Auto. Ins. Co. v. Campbell, 123 S. Ct. 1513 (2003), highlighted a claims management problem involving corporate initiatives to reward adjusters for paying less on claims:

> For over two decades, State Farm set monthly payment caps and individually rewarded those insurance adjusters who paid less than the market value for claims. Agents changed the contents of files, lied to customers, and committed other dishonest and fraudulent acts in order to meet financial goals.[38]

Recently, we took the deposition of Toni Byrd who was in management of Allstate's claim department in charge of its Core Claim Practice Redesign (CCPR) for property claims. She acknowledged the inherent unethical claims behavior driven by this type of performance goal:

BY MR. MERLIN:

[38] Id. at [P29].

Q. It says P-CSSO 1997 target goals. I know it's hard to read, but do you see that?

A. Yes.

Q. As I read down all the way down here it has got CCPR; do you see that?

A. Yes.

Q. And underneath that it has fire paid severity; do you see that?

A. Yes.

Q. And August - - August result, 7.9; do you see that?

A. Yes.

Q. And on the 1997 it says goal; do you see that?

A. Yes, I do.

Q. It has a negative 2.0?

A. Yes.

Q. Who at P-CSSO is responsible for setting the severity goals with respect to items such as fire paid severity?

A. Speculation on my part. It would have been Dan Hebel.

Q. Do you know how they would go about coming up with these goals?

A. No, I don't.

Q. Did you ever participate in any of these goal setting - -

A. No.

Q. Did you ever recall seeing this document before today?

A. It does look familiar.

Q. Were you ever made aware of P-CSSO setting in advance severity goal targets - -

A. In advance?

Q. In advance of the severity actually happening?

A. Gee, it seems like when I first started in the '70's or so, they used to do things like that. But we really got away from that because of the - -

Q. Because of why?

A. Because we didn't want to measure it that way. It drove the wrong behavior.

Q. Do you know why there is a apparent goal in 1997 set by somebody for fire paid severity?

A. No, I don't.

Q. Why would it drive the wrong behavior or have the potential to drive the wrong behavior?

A. Because I think that if it encourages game playing, trying to just reach a goal, versus following the process, because if you follow the process, based on our testing and CCPR methodology, the result will follow.

Q. Have you ever had any discussions about the efficacy of severity goal setting with upper claim management at P-CSSO; has the topic ever come up?

A. No, I have not, no.

Q. When was the last time, to the best of your knowledge, you have ever had a discussion other than here today about what you and I just talked about?

A. Like I say, I remember back in the '70's, years and years ago.

CONCLUSION

In adjusting a property insurance loss, whether as a company adjuster or as a public adjuster acting on behalf of the policyholder, it is crucial to understand, and to keep in perspective, the good faith obligations of the adjusting process. Unfortunately, these lofty goals do not always remain in the forefront of the adjustment of a loss. As a result, the insured may not be treated fairly. It is true that an insurer under certain circumstances may dispute a policyholder's loss without acting in bad faith. However, the more we understand about the relationship, and of the correct methods of property adjustment, the more we can help the insured obtain just compensation for a loss.