28 What Insurers Should Do

It is a tempting delusion to think of a claim as an ordinary progression.
—C.T. Johns, An Introduction to Liability Claims Adjusting (1986)

§ 28.A OVERVIEW

There are no foolproof methods through which insurers can avoid becoming embroiled in extensive and expensive coverage litigation. As long as lawsuits continue to be filed against policyholders, coverage questions will continue to arise. Moreover, since both insurers and insureds act through individual human beings, mistakes will be made. In a climate where bad faith charges are always a threat, the simplest of errors can be magnified out of proportion and can lead to considerable embarrassment. More serious errors can threaten the solvency of a company.

While there are no tricks, and few shortcuts, there are practices that can reduce risks. Some of these are based on common sense; others are grounded in good conscience. The following sections are offered as suggestions for insurers to reduce risks. However, the best advice for everyone involved when a claim is made—claims personnel, brokers or agents, and insureds—is to begin the process by trying to work together where possible. Addressing the underlying claim promptly and appropriately is the best way for all of them to protect themselves and their respective employers from economic disaster.

§ 28.B SOURCE OF DUTIES

Claims personnel must understand their legal obligations, then act on them. There are at least five sources of their obligations:

(1) the insurance policies under which they review claims;

(2) case law and state statutes governing liability/damage issues particular to the claims reviewed;

(3) internal policies of the insurer for handling claims;

(4) the state statutes governing claims settlement practices; and

(5) case law interpreting "good faith" in the insurance context.

It is not enough to learn the standard policy forms issued by an insurer upon taking a job as claims representative. Responsible employees will stay abreast of new forms and endorsements; they should also develop an understanding of underwriting practices.

Most insurers conduct periodic training seminars for claims personnel. These should include training on substantial legal issues with which claims personnel will have to deal. An often-overlooked method of educating personnel on substantive law is the increasing availability of continuing legal education (CLE) programs. Since most states, including Pennsylvania, now impose mandatory CLE requirements on attorneys, requiring them to complete a set number of educational hours each year, a wide variety of programs are offered in each locality. Claims personnel should not overlook the programs directed to plaintiffs' attorneys and those dealing with bad faith.

It is also important that claims personnel follow any standard procedures adopted by the companies for whom they work. Under Pennsylvania law, insurers must "adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies." 40 P.S. § 1171.5(a)(10)(iii). At a minimum, every claims person must know the company's internal standards and be aware that any unexplained and serious variance from those standards could be used as evidence against the insurer in a bad faith suit.

The Pennsylvania Unfair Insurance Practices Act provides additional guidance, although many internal standards will incorporate portions of this law. The Pennsylvania act is a version of a model act, developed by the National Association of Insurance Commissioners, in an attempt to assure some uniformity across the nation. Pennsylvania's

version contains provisions beyond those in the model act, so it is very important that claims persons working in Pennsylvania be aware of its specifics. See 40 P.S. § 1171.5.

Frequent violations of this act that are committed so often that they constitute "a business practice" may subject an insurer to administrative sanctions in a proceeding before the insurance commissioner. Equally important, however, is the fact that violations may be used as evidence to support claims under Pennsylvania's bad faith statute.

§ 28.C WHAT CLAIMS PERSONNEL SHOULD DO IN RESPONSE TO FIRST-PARTY CLAIMS

Being aware of obligations is not enough; claims personnel must act on them. The conduct disapproved in the Unfair Insurance Practices Act is stated in negative terms, i.e., "misrepresenting facts," "failing to . . . ," and the like. These proscriptions can be converted into positive rules for ease of understanding, and claims personnel should follow these guidelines:[1]

1. Understand coverages and be able to answer questions about them.
2. Promptly acknowledge and act on claims and communications regarding claims.
3. Follow the standards of investigation developed by the insurer.
4. Conduct a reasonable investigation, considering all available information.
5. Accept or deny coverage for claims within a reasonable time after completed proof of loss statements are received.
6. Where liability under the company's policy has become reasonably clear, attempt in good faith to reach a prompt, fair, and equitable settlement.
7. Offer the amounts reasonably due under the policy without forcing unnecessary litigation.

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1. The Motor Vehicle Financial Responsibility Law imposes unique requirements of its own. See 75 Pa.C.S. § 1701 et seq., and particularly sections 1797–1798. See also the regulations at 67 Pa.Code § 221.1 et seq.

8. Avoid reference to advertising materials to undercut reasonable settlements.
9. Never use applications that have been altered in an attempt to settle claims.
10. When making payments or settlements, identify the coverage under which moneys are being paid.
11. Pay arbitration awards without frivolous appeals for the specific purpose of forcing a reduced settlement, and do not threaten such action.
12. Accept reasonably complete proofs of loss, physicians' reports and the like, without requiring duplicate documentation.
13. Settle or pay claims where liability is reasonably clear, even if payment is under one portion of coverage and additional coverage is outstanding; don't delay to influence other settlements.
14. Explain denials of coverage and compromise offers by reference to relevant law or facts.
15. Pay claims that are legitimate, even over the objection of the insured, unless the insured is immune from suit, has the right of consent under the policy, or the insurer has conducted an independent investigation and evaluation.

As can be seen, a claims representative must act promptly, but also must act with an understanding of both the law and the facts. The duties owed under a contract of insurance run to insureds under the policy and not to third-party claimants. Thus, the provisions of the Unfair Insurance Practices Act generally apply to transactions between claims personnel and persons who are insured under the policy. However, a few provisions of the act impose duties that protect the court system from unnecessary litigation. Moreover, the insurer has a duty, *to its insured,* to handle claims in a manner that will not put the insured's personal assets at unreasonable risk. Therefore, a knowledge of the value of claims, especially third-party claims, is extremely important.

In dealing directly with insured claimants who are unrepresented, it is very important to realize that these persons come to rely on "their" agents and adjusters. Accurate information must be given, both to meet their needs and to avoid liability. The Pennsylvania Supreme Court has said that the duty of fair dealing between insurer and insured requires the former to advise the latter of recent case law that

is favorable to the insured's rights, at least in cases where the insured is unrepresented and is justifiably relying on its insurer's employee for advice.[2] In any case, claims personnel should never discourage a claimant from seeking independent legal advice.

Similarly, claims personnel dealing with homeowners and insureds under other personal lines of insurance should realize that there is always the potential for an appearance of overreaching. While it is clearly wrong to take advantage of an unsophisticated first-party claimant, it is also risky to give any appearance of doing so. Correspondence to insureds should be in straightforward language. For an example of a letter used as evidence of bad faith, see *Polselli v. Nationwide Mutual Fire Insurance Co.*, Civil Action No. 91-1365 (E.D. Pa. July 20, 1995), aff'd, No. 95-1715 (3d Cir. May 3, 1996) (requiring release of all claims before issuing check to homeowner who had to move from the home because of fire). It may be difficult not to respond in kind when insureds are represented by counsel who send accusatory or threatening letters, but claims personnel should always be civil and professional.

Finally, records should be documented with the understanding that they are business files, not personal diaries.

§ 28.D WHAT CLAIMS PERSONNEL SHOULD DO IN RESPONSE TO THIRD-PARTY CLAIMS

§ 28.D(1) What to Do When Notified of Suit

When an insurer receives notice of suit against an insured, its employee may turn to a checklist (whether written or mental). Essential components of that list normally will include these items:

1. Confirm that notice has been received by the insurer. If notice came from an agent or broker, make sure the insured gets a confirmation letter.

2. Unless coverage is apparent, carefully review the complaint against the insurance policy issued to the insured. In the case of

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2. *Dercoli v. Pennsylvania Nat'l Mutual Ins. Co.*, 554 A.2d 906 (Pa. 1989) (plurality opinion). In a subsequent case, heard by five justices, the court split 3–2 concerning the extent of the duty in *Dercoli*. The majority held it was limited to cases where the insurer undertook to advise and take advantage of or mislead the insured while two dissenters thought the insurer ought to be viewed as an "advocate" for its insureds. *Miller v. Keystone Ins. Co.*, 636 A.2d 1109 (Pa. 1994). See also cases cited in section 1.B(3), chapter 1, of this book.

occurrence policies, are the injuries alleged within the policy period? Is the named defendant in the complaint insured under the policy? Is there coverage? Is there a self-insured retention?

3. Determine whether there is other insurance available for the same loss.
4. ***Promptly*** communicate any questions or doubts concerning coverage to the insured.
5. If there is coverage—or potential coverage—under a policy and the policy contains a duty to defend, ***promptly*** retain counsel or discuss choice of counsel with the insured. Then transmit information to counsel so that timely pleadings may be filed.
6. Set up a line of communication to the insured or an appropriate representative. Thereafter, be sure the insured is kept informed.
7. If there are sufficient doubts concerning coverage to consider denial, consult with superiors or legal counsel.
8. If a decision is made that the claims brought are ***not*** within coverage, communicate that decision promptly to the insured, giving the reason or reasons.
9. Careful consideration should be given to initiation of a declaratory judgment action, especially when denying a claim. Where the law is not entirely settled, such a move may be necessary to avoid a charge of bad faith. However, where lack of coverage is clear, it may not be necessary—or fair to the insured—to bring an action. It may be a particular burden for some insureds to defend a declaratory judgment action at the same time they are defending an underlying suit; this especially may be true in the case of personal lines.
10. If more than one insured is sued, be careful to avoid conflicts of interest in the assignment of defense counsel and in review and handling of any investigation. Conduct a separate coverage analysis as to each insured who is sued. Where interests of multiple insureds are antagonistic, set up separate files to be handled by separate employees.
11. Evaluate the claim fully and fairly as soon as reasonably possible under the circumstances presented. Identify obstacles to evaluation and how to deal with them.

12. Determine as early as possible whether there is a realistic risk of exposure to the insured beyond the policy limits or outside of the coverage under the policy. Realize that such a risk imposes heightened duties on an insurer who has undertaken to defend.

§ 28.D(2) What to Do in the Course of Litigation

Claims personnel overseeing third-party claims should follow the course of litigation closely. This is always a requirement but it is particularly sensitive (1) when an excess verdict seems possible or (2) when rights to deny coverage have been reserved.[3] If coverage issues that have not been reserved become apparent, claims personnel should communicate them to the insured but should not involve retained defense counsel.

Claims personnel must be alert to settlement opportunities; they must evaluate fully and fairly. When exposure beyond the limits or denial of coverage is realistically possible, they *must* keep the insured informed. They must obtain consent to settle where necessary under a policy and should keep the insured advised, as a courtesy, when settling a claim within limits, even if coverage was never in question.

Finally, claims personnel should keep excess insurers informed whenever there is a realistic possibility that an excess layer of insurance is at risk, and particularly where the excess carrier has requested to be updated by a primary insurer that is defending the suit.

§ 28.D(3) What to Do in Assigning and Directing Counsel

Many insurers, especially in the case of personal lines, retain complete control over selection of counsel and decisions concerning strategy; many auto and homeowner policies reserve that right to the insurer. In some other kinds of coverage, the insured may have more participation. Some insurers provide their policyholders with a list of approved counsel, whose rates have been negotiated, but permit the policyholders to choose among them—a practice that policyholders may appreciate and some ethical authorities endorse.

Whatever the method of selecting counsel, claims personnel must understand some important principles. Once an attorney has entered an appearance for an insured, the attorney represents the insured.

3. Reservation-of-rights practices are discussed in chapter 1 at section 1.C(1).

Courts have been harshly critical of lawyers and insurers who do not recognize and respect the basic duties owed by defense counsel to an insured. Courts have recognized that the duty to defend means the insurer must select competent counsel. (Most insurers maintain objective standards, requiring certain levels of experience for associates and supervisory attorneys.)

Claims personnel must never interfere with counsel's discharge of any ethical duties owed to the client. Nor may they attempt to direct the defense in a manner designed to impair potential coverage.

In the vast majority of cases, the interests of the insurer and its insured will be the same: to defend against and defeat claims without merit, to settle meritorious claims where possible, and to accomplish goals efficiently, with no more inconvenience or expense than is reasonably necessary to either. However, where their interests diverge, claims personnel cannot expect counsel to provide information to the insurer that would disadvantage the insured in its relationship with the insurer. Moreover, whenever defense is undertaken with a reservation of rights to deny coverage for indemnification or an excess verdict is a realistic threat, claims personnel cannot restrict the defense in a manner that puts the insured at personal risk.

§ 28.D(4) What to Do Regarding Settlements

Claims personnel must be aware that courts strongly favor settlements and may enforce them even when settlement offers are mistakenly extended. In *Kramer v. Schaeffer*, 751 A.2d 241, 246–47 (Pa.Super. 2000), an Allstate adjuster offered $3,500 to settle an accident claim after the plaintiffs had been awarded $10,000 in arbitration but an appeal was pending. The plaintiffs rejected the offer; a trial commenced; the jury awarded no damages to the plaintiffs. However, within days after the verdict, the insurer's file was transferred to a second adjuster without the file having been properly updated. The new adjuster, apparently seeing settlement authority documented in the file, contacted plaintiffs' counsel and offered the $3,500. This time it was accepted, plaintiffs' counsel following up with a letter. When the mistake was discovered at Allstate, the second adjuster attempted to withdraw the offer. A panel of the Superior Court stressed public policy in ordering that the settlement go forward. Additionally, two of the three judges on the appellate panel agreed that the plaintiffs should be entitled to sanctions, in the form of interest and attorneys' fees, under a local rule in effect in the Philadelphia Court of Common Pleas.

Claims personnel must also realize that settlement offers will be analyzed by the courts under principles of contract law, separate and apart from the law governing liability claims against the insured. *McDonnell v. Ford Motor Co.*, 643 A.2d 1102, 1105 (Pa.Super. 1994), app. denied, 652 A.2d 1324 (Pa. 1994). Oral agreements may be enforced. *Kramer*, above; *United Coal v. Hawley Fuel Coal, Inc.*, 525 A.2d 741, 742 (Pa.Super. 1987), app. denied, 536 A.2d 1333 (Pa. 1987). And, settlements will not be reopened after a subsequent change in the law.

Settlement based on an exclusion that is enforceable at the time of settlement will not be reopened when the exclusion is subsequently invalidated by a court. *Davis v. Government Employees Ins. Co.*, 775 A.2d 871 (Pa.Super. 2001), app. denied, 812 A.2d 1230 (Pa. 2002). There, children of a decedent settled a claim for the "minimum financial responsibility limit required by Pennsylvania law" pursuant to a policy term applying such limit where a family member was injured. The release was expressly premised on the insurer's representation that the amount paid constituted the legal coverage under the policy. Although the Superior Court held such exclusions invalid as against public policy just four months later, the court nonetheless upheld the settlement. 775 A.2d at 875. The parties who sign a release may not "collaterally [attack] a binding agreement with subsequent case law."

§ 28.E INSURANCE AGAINST BAD FAITH CLAIMS

Courtesy, competence, and care in handling claims—whether first- or third-party claims—should go a long way to avoid future problems. Some more practical suggestions, drawn from case law nationally, also may help.

1. Treat the insured who is making a first-party claim as a customer. Give the insured the benefit of the doubt whenever real doubts exist and cannot be resolved.
2. Do not treat an insured as an opponent unless, and until, it is clear that the insured is an actual adversary. This generally will not be until a first-party claim has been denied or coverage has been declined.
3. Record facts, not feelings, in internal documents. Never employ slang, personal attacks, or sarcasm. The real test of professionalism is how any internal document would appear when shown to a jury.

4. Document decisions; briefly outline the reason for the decisions. In a first-party claim, this can be in the form of correspondence to the insured. In a third-party situation, where litigation is in process, important decisions should be documented in the claims file.
5. Communicate regularly with claimants, counsel, and superiors. Use common courtesy; do not speak or write words that will later be regretted.
6. In all evaluations and decision-making, be firm but fair.
7. Acknowledge mistakes or changing circumstances; act appropriately.
8. Listen to the advice of counsel, but recognize that it may be only one factor for consideration.