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The Chairman's Corner

by James D. Klauke, CPCU, AIC, RPA

"Nothing is impossible; there are ways that lead to everything, and if we have sufficient will we should always have sufficient means."

—Francois De La Rochefoucauld (1613–1680)

I have exciting news for the section members. We have been given permission by the Society to put on four seminars at the Annual Meeting and Seminars this October in Los Angeles, CA. We sought this permission in an effort to encourage all CPCU Society Claims members to come back to the Annual Meeting.

Our past surveys indicate that the main reason people do not attend the Annual Meeting is because their employers do not pay the cost. We hope to give the employers a reason to pay the cost to send their claim people to Los Angeles. In the past, we were only able to provide one claim session. We have been given four slots for Los Angeles for the sole purpose of attracting claims people to this Annual Meeting.

The four slots will be back-to-back sessions on Monday, October 25, and Tuesday, October 26. Each session will be filed for continuing education credits from most states and from the RPA. Currently the sessions are the following:

Good Faith Adjusting

This seminar will discuss the recent State Farm case that went to the United States Supreme Court that defined punitive damages and bad faith for the entire country. The speakers are some of the attorneys who were involved in the case.

Workers Compensation and "Continuing Trauma" Cases

This seminar will explore the "continuing trauma" cases when employees change companies and the latest issues in workers compensation claims.

Auto Seminar

This seminar will explore the latest in auto claim issues including information on air bags and OnStar. Many new issues have come up following these innovations.

Structured Settlements

This seminar will discuss the new issues and benefits of structured settlements for the more severe cases and how they can be useful in smaller cases.

We are also looking into the possibility of being a co-sponsor with the Personal Lines Section to possibly do a fifth seminar that is claims related. We will know more about the possibility of the fifth seminar by the next issue of CQ. At that time we will provide more detail on each session to help you sell this dynamic educational program to your manager.

In addition to the education programs, we will also have our networking lunch of just Claims Section and other claim members of the Society. All members of the Claims Section Committee will attend as well. It is one of the best networking events of the Annual Meeting. You will have a chance to meet other claims professionals and learn how you can get involved in the CPCU Society and section activities without being a financial burden on your employer. We have many local programs at the chapter level where you can get involved.

One chapter program is our Chapter Section Liaison Program where one member of each chapter represents the Claims Section Committee at the chapter level. We encourage the chapter members in the Claims Section to work together to put on one monthly chapter program per year. We also encourage members to participate in Chapter I-Day programs. Finally, we are always looking for articles for the CQ and material for your Claims Section web site.

One thing I always say to new designees and recent CPCUs is to go to the chapter meeting and volunteer to get involved. All you have to do is attend a meeting and raise your hand. Tell the chapter officers you want to get involved, and they will find you something of interest for you. It is a professional way to give something back to the Society.

In closing, we encourage you to make an effort to get your management to support your attendance at the next Annual Meeting and Seminars for the best educational event of the year. You will not regret this effort and the educational benefits will help your career. I look forward to meeting each of you at the Annual Meeting in Los Angeles, October 23-26, 2004. ■

"There are no secrets to success; don't waste time looking for them. Success is the result of education, hard work, learning from failure, loyalty to those for whom you work, and persistence."

—General Colin Powell
Secretary of State

The Ohio *Scott-Pontzer* UM Case Is Reversed, How Did It Happen in the First Place?

by Robert McHenry, CPCU, AIC, AIS

■ **Robert McHenry, CPCU, AIC, AIS,** is a member of the CPCU Society's Akron-Canton Chapter and the Claims Section Committee. He is a claims specialist at Westfield Group in Independence, OH, and has 29 years of claims experience in the state of Ohio.

Ohio passed the original version of 3937.18, Uninsured Motorists Law, in 1965. Its purpose was to provide low-cost protection for the public from injuries caused by an uninsured driver. All carriers selling automobile liability coverage were required by law to offer Uninsured Motorists Coverage. Ohio's Uninsured Motorists Law is now said to be the most litigated law in the United States.

On June 23, 1999, the Ohio Supreme Court ruled in *Scott-Pontzer v Liberty Mutual* (1999), 85 Ohio St.3d 660, that the term "you" in an ISO Commercial Auto Policy's Uninsured Motorists Coverage Form CA2133 was ambiguous. Further, that since a corporation could not suffer a bodily injury, the coverage was illusory. Since corporations act through employees, the coverage extended to them even when not in the course and scope of their employment. This ruling applied to the Commercial Auto and Umbrella policies. Note that the decedent was in his wife's vehicle and not in the course and scope of his employment when this accident happened.

A few months later the *Ezawa v Yasuda Fire & Marine* (1999), 86 Ohio St.3d 557 case further expanded the ruling of *Scott-Pontzer*. Using the same coverage form, the definition of a Named Insured included . . ."If you are an individual, any 'family member.' . . ." This allowed spouses, children, grandparents, etc. to access the Commercial Auto Policy's Uninsured, Underinsured and, in some cases, the Automobile Medical Payments Coverage.

Imagine your household situation. If you, your spouse, and three children were all injured, there would be one *Scott-Pontzer* and four *Ezawa* claims. That calculation applies if each person only had one employer. I handled one *Scott-Pontzer* claim that involved 17 different carriers.

The resulting cost to Ohio's insurers is estimated between $1.5 and $3 billion dollars. Literally thousands of cases were filed. Carriers and law firms hired and trained existing staff in this complex arena. Premiums drastically increased, and two major carriers stopped writing Commercial Auto Coverage. The Common Pleas and Courts of Appeals issued conflicting rulings making adjusting difficult to nearly impossible.

The real question is how did Ohio law, claimants, and insurers get to *Scott-Pontzer* in the first place? It is important to look at a brief history of the cases that led to this disastrous decision. Then we can look at the attempted legislative fixes and how the Ohio Supreme Court got around some of these bills.

Sexton v State Farm Mutual (1982), 69 Ohio.2d 431 held that non-resident family members had uninsured or underinsured motorist claims under their own automobile policies, and that a provision requiring a "family member" to suffer a personal injury is unenforceable. A "family member" is defined as person related to you by blood, marriage, or adoption who is a resident of your household.

Senate Bill SB20 was passed October 20, 1994, to counteract the *Sexton* decision. The Ohio Supreme Court held in *Moore v State Automobile Mutual* (2000), 88 Ohio St.3d 27 that the General Assembly's intent was not to supersede the Ohio Supreme Court's ruling in *Sexton* limiting recovery in such a way that an insured must suffer bodily injury, sickness, or disease in order to receive damages from the insurer.

Gyori was injured in the course and scope of his employment. He sought uninsured motorists coverage under Coca Cola's Commercial Automobile Policy. *Gyori v Johnston Coca Cola* (1996), 76 Ohio St. 3d 565 was decided in 1996. Coca Cola had negotiated a manuscript policy with National Union of Pittsburgh. It chose not to purchase Uninsured Motorists Coverage. The Ohio Supreme Court ruled that there could be no rejection without a written offer of this protection, and any rejection must be knowingly made in writing and received prior to the policy period. Despite being a sophisticated commercial buyer, since there was no written offer, the coverage existed by "operation of law."

In response to *Gyori*, carriers designed forms including the insured name, policy number, signature, and date. The Supremes then decided in *Linko v Indemnity Insurance Company of North America* (2000), 90 Ohio St.3d 445. *Linko* held that it was not enough to have just a signature and date on a rejection form. Since this was a contract, the form must have an explanation of the coverage, the estimated premium, a selection area, and signature plus date. This ruling negated nearly all current rejection forms forcing carriers to extend even more coverage without premium. *Linko* was decided on a pre-HB261 policy.

Selander v Erie Insurance Group (1999) 85 Ohio St.3d. 541 was decided in 1999. Erie's Commercial General Liability policy contained a Hired and Non-owned Auto Liability endorsement. The purpose of this form was to provide automobile liability coverage to the commercial insured that occasionally rented a vehicle. The endorsement is frequently attached to a Commercial General Liability or Business Owners Policy. The Ohio Supreme Court ruled that since a company offering liability coverage must also offer Uninsured Motorists Coverage the UM applies by operation of law. The *Selander* decision was also based on a pre-HB261 policy.

HB261 became effective September 3, 1997, responding partially to *Linko* and *Selander* and amending 3937.18. HB261 defined an Automobile Liability Policy as

one that serves as proof of financial responsibility under 4511.09 of the O.R.C. for motor vehicles specifically identified in the policy. It also allowed certain exclusions within the policy including deleting an owned vehicle in the definition of an uninsured auto. This seemingly eliminated *Selander*-type claims.

Did HB261 eliminate *Selander* claims? The Ohio Supreme Court decided *Ross v Farmers* (1998), 82 Ohio St.3d 281. *Ross* ruled the law in effect at the time of inception governed which version of 3937.18 applied. So, a claim adjuster had to go back to the original inception date of the policy. The next curve was *Wolfe v Wolfe* (March 29, 2000), 88 Ohio st.3d 246. It amended the *Ross* decision by ruling that an automobile liability policy was issued for a minimum of a two-year guarantee period. Now an adjuster had to go back to the original inception date and count every two-year period. Then you would see where the date of loss fell, and apply the version of 3937.18 in effect at that that time. The effect was to keep *Selander* around longer despite the legislative fixes.

The legislature then passed SB267 September 21, 2000. It specifically eliminated *Moore* and *Sexton* claims, eliminated the *Wolfe v Wolfe* decision, and eliminated the owned vehicle exclusion of the definition of an uninsured motor vehicle. Let's emphasize that Ohio contract law has a 15-year statute of limitations. So, a 1986 accident was still viable post-SB267.

The next legislative fix was SB97, effective October 31, 2001. It eliminated the mandatory offering of Uninsured Motorists Coverage. Its purpose was to help eliminate Uninsured Motorists Coverage by "operation of law" under any policy type or form. Part of its reading is that a carrier may, but is not required, to offer Uninsured Motorists Coverage. This bill effectively eliminated *Linko, Gyori, Moore, Sexton, Scott-Pontzer*, and *Ezawa* claims but only for policies effective after October 31, 2001.

Scott-Pontzer was decided on the employer's policy. It did not decide how the involvement of personal Uninsured Motorists Coverage interacted. Each personal and commercial auto policy had to be reviewed to determine if primary, excess, or pro-rata sharing applied. Personal line carriers delayed settlement holding for *Scott-Pontzer* carriers to be identified and brought into the litigation. *Scott-Pontzer* carriers did likewise. Some personal lines insurers sued commercial carriers seeking pro-rata sharing. While seeming to make sense on the surface, this course of action backfired by clogging the courts even further and making bad case law affecting all Ohio insurers.

Ohio has a Common Pleas Court in each of its 88 counties. There are 12 Courts of Appeals. Numerous conflicting decisions were issued between these courts. Ohio Uninsured Motorists law was in chaos. Adjusting and litigating claims was nearly impossible because of the unsettled legal situation. This went on for more than four years.

Westfield Insurance Co. v Galatis 100 Ohio St.3d, 2003-Ohio-5849 was certified to the Ohio Supreme Court because of a conflict between Courts of Appeals. Oral arguments were heard on March 26, 1993. Attorneys for Travelers argued that the *Scott-Pontzer* decision should be overturned. In a 4-3 decision issued November 5, 1993, the *Scott-Pontzer* case was confined to employees in the course and scope of their employment. "*Ezawa*" claims were barred unless the "family member" was a named insured.

What were the results of *Galatis*? Combined with this decision, the Ohio Supreme Court also ruled on more than 90 cases in a joint decision called *"In re: Uninsured Underinsured Motorists Cases."* Any case that was pro-*Scott-Pontzer* was overturned and vice versa. The plaintiff firm prosecuting *Galatis* filed a motion for reconsideration on a case-by-case basis. Several additional firms also filed amicus briefs. Numerous opposition briefs were filed. The Supreme Court issued five decisions citing *Galatis* and perhaps sending a message about its reconsideration decision. Finally, on December 24, 2003, the Ohio Supreme Court issued a 5-2 decision and denied the motion to reconsider *Westfield v Galatis*.

This is a brief history of the *Scott-Pontzer* decision and its impact on Ohio insurers and insureds. Several other states including California, Kentucky, and Massachusetts have rejected the "you" ambiguity theory in favor of intent of the parties.

The real issue is how to help prevent this decision in your state. ISO form CA2133 11-01 eliminated the word "you." It also includes "anyone else occupying a covered auto" removing the appearance of being an illusory coverage. Carriers designed Uninsured Underinsured Motorists Supplemental Applications that met the four corners of the *Linko* decision. The form now should have an explanation of the coverage, the approximate premium, an offer of the coverage, and a signature line. Most importantly, we should learn to pay attention to the case law trends in our own and surrounding jurisdictions.

On a lighter note, the Ohio Supreme Court did decide that a helicopter was not a motor vehicle for purposes of Uninsured Motorists Coverage. It also decided that a homeowners policy was not an automobile liability policy as defined by the Ohio Revised Code, and Uninsured Motorists Coverage was not required by "operation of law." ■

When Property and Casualty Insurers May Share Claim Information

by John Halvorsen

ISO ClaimSearch® is the property and casualty insurance industry's first and most comprehensive system for improving claims adjustments and fighting fraud. Each year, participating insurers and other organizations submit tens of millions of reports on individual insurance claims. ISO maintains those reports in a single database that helps insurers, self-insurers, third-party administrators, law enforcement agencies, and state fraud bureaus detect and prevent fraud, evaluate risk, and adjust meritorious claims.

Insurers and other ISO ClaimSearch participants frequently request additional information on claimants identified in an ISO ClaimSearch report from other participating companies. Participants may need this additional information to conduct a complete investigation on a specific claim. Insurers often use a written form to request the additional information that is not contained in ClaimSearch reports.

ISO has no rules of participation that require insurers to share information beyond what is distributed in their claim data as reported to ISO ClaimSearch. However, it is important to note that intra-industry sharing of nonpublic personal financial and health information without claimant authorization is permitted under current privacy regulations for a variety of purposes, including claims administration and fraud fighting. A summary of the applicable requirements follows.

Insurance Information and Privacy Protection Model Act

The NAIC's 1982 Insurance Information and Privacy Model Act establishes standards for the collection, use, and disclosure of information that insurance institutions, agents, and support organizations collect in connection with insurance transactions. The act specifically permits insurers to disclose personal information to other insurers and insurance support organizations for claims investigation purposes without an individual's authorization:

Section 13 provides:

> **Disclosure Limitation and Conditions**
>
> An insurance institution, agent, or support organization shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is:
>
> C. To an insurance institution, agent, insurance support organization, or self insurer, provided the information disclosed is limited to that which is reasonably necessary:
>
> (1) To detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with insurance transactions; or
>
> (2) For either the disclosing or receiving institution, agent or insurance support organization to perform its function in connection with an insurance transaction involving the individual.

The Gramm-Leach Bliley Act and the 2000 NAIC Model Regulation

Title V of the Gramm-Leach-Bliley Act (GLB), 15 U.S.C. 6801 et. seq. requires insurers to protect nonpublic personal information. The National Association of Insurance Commissioners' (NAIC) Privacy of Consumer Financial and Health Information Model Regulation protect both nonpublic personal financial and health information. Both the G-L-B Act and the NAIC Model Regulation contain exceptions to the general privacy rules. These exceptions permit insurers to share information for essential business functions such as claims administration and fraud detection without the consent of the individual to which the information relates.

> ***Each year, participating insurers and other organizations submit tens of millions of reports on individual insurance claims.***

ISO ClaimSearch and insurers operate within several overlapping, multiple, and redundant provisions of GLB and the NAIC Model Regulation. The following are of interest:

- **Section 502(e)(1)** permits insurers to share information "as necessary to effect, administer or enforce a transaction requested or authorized by the consumer." Section 509(7)(c) defines this phrase to mean that "the disclosure is required, or is a usual, appropriate, or acceptable method . . . for any of the following purposes as they relate to a consumer's insurance . . . reporting, investigation or preventing fraud or material misrepresentation . . . [and] processing insurance claims." The NAIC Model Regulation Sections 15B(2)(b) and (e) contain similar language.

- **Section 502(e)(3)(B)** permits insurers to share information to protect against or prevent actual or potential fraud, unauthorized transactions, claims, or other liability. Similar language appears in the NAIC Model Regulation Section 16A(2)(b).
- **Section 502(e)(4)** permits insurers to provide information to insurance rate advisory organizations. The NAIC Model Regulation Section 16A(3) has similar language.

Nonpublic Personal Health Information

The NAIC Model Regulation Section 17 establishes disclosure requirements for nonpublic personal health information. However, Section 17B expressly permits insurers to disclose nonpublic personal health information for several essential insurance functions, including claims administration and fraud fighting.

Section 17 provides:

> Nothing in this section shall prohibit, restrict or require an authorization for the disclosure of personal health information by a licensee for the performance of the following insurance functions by or on behalf of the licensee: claims administration, claims adjustment and management, fraud investigation. . . .

HIPAA Standards for Privacy of Individually Identifiable Health Information

ISO has reviewed the United States Department of Health and Human Services (HHS) medical privacy rule ("Rule") implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Rule took effect April 13, 2003.

The Rule restricts the use and disclosure of "protected health information" (PHI). For the most part, P&C insurers won't be affected. However, information that originates in a report prepared by a health care provider, health insurer, pharmacy, or other type of health-related entity (i.e., a "covered entity") might include PHI.

ISO has modified its operations to ensure that PHI reported to ISO ClaimSearch is disclosed only in accordance with the Rule. P&C insurers should also implement procedures to ensure that they do not share PHI (i.e., information that originates in a health-care provider's report) with other insurers without authorization.

ISO has modified its operations to ensure that PHI reported to ISO ClaimSearch is disclosed only in accordance with the Rule.

Protecting Insurer Claim Information

Insurers receiving claims information directly from other insurers should observe the same disclosure and use policies that govern the operation of the ISO ClaimSearch database. The ISO ClaimSearch database is operated in accordance with policies that ensure all information is: (1) accessed by appropriate entities and limited to appropriate individuals, (2) used according to law, (3) protected from damage and destruction, and (4) used for authorized purposes only. For example, ISO ClaimSearch users may not access the database for underwriting, policy cancellation and renewal, establishing or stabilizing claims payment levels, granting of credit, or other similar purposes. Employees of participating companies accessing the system must be involved in the investigation or payment of claims. All customers must observe the access, use, and disclosure restrictions that are outlined in the ISO license agreements and comply in all respects with the ISO ClaimSearch Privacy and Security Policy and all updates.

Further Information

For operational information, please contact John Giknis, assistant vice president-ISO ClaimSearch, at (201) 469-3103, or jgiknis@ISO.com. For legal advice, consult your legal counsel. Your lawyers are welcome to contact John Halvorsen, senior counsel, ISO Legal Department, at (201) 469-2980, or jhalvorsen@ISO.com. ■

Second-Injury Funds: Still a Valuable Cost-Containment Tool

by Mark J. Nevils, J.D.

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Nevils is a member of the law firm Uehlein and Associates, and he is a frequent speaker on second-injury fund issues and best practices. He gave a presentation to the CPCU Society's Westchester Chapter in May 2003.

Nevils has litigated and managed the litigation of numerous second-injury fund claims and was the lead counsel in several ground-breaking decisions against the Massachusetts Second-Injury Fund.

Background to Second-Injury Funds

The debate continues on whether workers compensation second-injury funds (SIF) fulfill their intended purposes. The fact remains, however, that these funds still exist in many jurisdictions, and provide employer/carriers with a very valuable cost-containment tool when properly handled.

As the workers compensation claims process becomes increasing segmented, more companies are dedicating personnel to in-house programs or outsourced vendors to achieve maximum cost containment. An estimated $800 million is paid out annually from these funds across the country, primarily by either reimbursement to the carrier or directly to the claimant.

The first second-injury fund was created in New York in 1916. Such statutes, however, gained more popularity across the country in the 1940s when a National Model Code was promulgated in large part to help combat employment discrimination against disabled WWII veterans. Many jurisdictions adopted a variation of the model code to fit within their own workers compensation scheme. As these statutes found their way into each jurisdiction's workers compensation system, they developed various other names, e.g., special disability funds, subsequent injury trust funds, apportionment funds, workers compensation trust funds, handicap reimbursement funds, etc.

As the workers compensation claims process becomes increasing segmented, more companies are dedicating personnel to in-house programs or outsourced vendors to achieve maximum cost containment.

These funds were created to relieve a portion of the employer's/insurer's claims costs when the employer hired a claimant with a pre-existing disability and that claimant then suffered a "second" injury, creating a greater disability because of the combined effects of the prior and subsequent disabilities. Prior to second-injury fund statutes, such a situation could create a disproportionate claim cost as it related to the industrial injury; therefore, reluctance existed on the part of employers to hire anyone with a pre-existing medical condition.

Initial funding mechanisms for these funds were essentially inadequate since they had little relationship to the actual exposure of the second-injury fund. Today, in most jurisdictions, employers/insurers are required to pay a yearly assessment based on a percentage of premiums written or losses paid the previous year. In turn, the funds pay, directly to the claimant or reimbursement to the carrier, for a portion of the claims costs when a prior impairment combines with the industrial injury to create a greater disability and claims exposure.

For various reasons some of these funds have had a volatile life within their jurisdictions' workers compensation systems and several such statutes have been repealed. Surviving funds, however, are quite active and share many of the same characteristics while remaining consistent with their own jurisdiction's workers compensation statutes.

Common Second-Injury Fund Elements and Issues

The following are some common elements and issues found in today's more active second-injury funds:

Pre-existing Medical Condition

Most second-injury fund statutes state that in order prove a claim, there must be evidence that the claimant suffered from a known pre-existing impairment arising from a prior accident, disease, or congenital condition and that this impairment was diagnosed before the date of the second injury.

The prior impairment is generally required to have been permanent and some statutes, such as Arizona and Nevada, actually require the prior permanent impairment to qualify as a specified percentage under the AMA guidelines (10 percent and 6 percent, respectively).

Unfortunately, many qualified claims do not get filed because there is no existing documentation of a previous rating for the prior permanent impairment. However, if a statute allows prior impairments to be from any cause, then many of these conditions will not have prior ratings and, therefore, such evidence needs to be obtained from medical experts, as opposed to being found in the files or prior medical records.

To further qualify claims under this element, many statutes will list a number of exclusive or presumptive prior impairments. It is important to note the difference between an exclusive list and a

presumptive list because when a list of prior impairments is merely presumptive, a claim may still be filed with the fund if the prior impairment qualifies outside of the list.

Another qualifier commonly found with the prior impairment is that the impairment be a hindrance or obstacle to employment. This definition is usually inserted by stating that prior impairment "is or is likely to be" a hindrance or obstacle to employment **or** "an obstacle or hindrance to employment should the employee become unemployed." As a somewhat subjective qualifier, "hindrance" can be satisfied numerous ways, including evidence of the claimant's vocational background, medical expert records and opinions, employer statements, or a combination thereof.

Notice to Fund

Almost all active second-injury fund statutes have a notice provision that require the employer/insurer to put the fund on notice of a potential claim within a specified time, e.g., within 100 weeks from the employer's first report of injury. Failure to notify the fund within the statutory time limit is generally a complete bar to fund liability.

Notice can be as simple as filing a letter. Some jurisdictions, however, require the notice to include more specifics about the potential claim, and failure to include required information can bar a claim at a later date. For example, New York's fund requires notice within 104 weeks of the claimant's disability, and the form must specify the prior impairment upon which the employer/insurer will rely when it files the claim with the fund at a later date. Failure to list the proper prior impairment on the notice form can be corrected within a certain amount of time. If it is not corrected, then the employer/insurer will not be able to use that prior impairment later on to prove its claim.

Employer's Knowledge of the Pre-Existing Medical Condition

Most, but not all, second-injury fund statutes contain language stating that the employer must have knowledge of the prior impairment before the date of the second injury. Alaska, Arizona, Georgia, Louisiana, New Hampshire, Nevada, South Carolina, and Massachusetts are examples of active SIF statutes with a strong employer knowledge element, although Massachusetts did not require employer knowledge until it changed its workers compensation statute in December 1991. Conversely, New York did have an employer knowledge element in its statute until 1987 when that requirement was eliminated.

Notice can be as simple as filing a letter. Some jurisdictions, however, require the notice to include more specifics about the potential claim, and failure to include required information can bar a claim at a later date.

A common misconception about the employer knowledge element is that the employer's knowledge of the prior impairment must be ascertained at the time of hire. Most statutes actually allow employer knowledge to take place at any point before the time of the second injury. Massachusetts is one of the only "knowledge" jurisdictions that provides a time limit for employer knowledge from the date of hire or retention in employment (30 days). Allowing knowledge to be ascertained after the date of hire is one of the ways that the second-injury fund statutes try to dovetail with disability discrimination laws.

Jurisdictions, such as New Hampshire, Alaska, and Nevada, also require the employer's knowledge to be corroborated with some documentation from the employer. The purpose of written documentation is to verify the employer's statement that it knew of the prior medical condition before the second injury. Unfortunately, such a strict requirement disqualifies many deserving claims in these jurisdictions. Many employers do not document their employees' prior medical conditions although they are well aware of a prior disability.

Combination of Disabilities

Most funds require medical evidence to prove that the claimant's disability after the second injury is substantially greater because of the combined effects of the prior and second injury than it would have been had the second injury happened alone. A common misconception of this element is that the prior disability must be to the same body part as the second injury, and that the second injury must somehow directly aggravate the prior disability. Direct aggravation is not always required, and many different combinations of disabilities can give rise to a fund claim.

Certain funds will even promulgate a form containing questions to be answered, preferably by the treating physician, before they will approve a claim. Careful review should be taken of these forms, as they do not always conform to the requirements under the statute. Most claims can be perfected by an expert report whose opinion mirrors the statutory language, whether or not it is the treating physician.

Point of Fund Liability

The point at which the fund has potential liability varies from state to state. Georgia, Louisiana, and South Carolina's second-injury funds allow reimbursement for medical benefits after a certain monetary threshold ($5,000, $5,000, and $3,000 respectively) and indemnity after a certain amount of weeks of indemnity has been paid on the claim. For example, in Georgia, if all the statutory requirements are met, then the Subsequent Injury Trust Fund will reimburse the employer 50 percent of all medical bills paid between $5,000 and $10,000, and then 100 percent of those bills thereafter in addition to 100 percent reimbursement for all indemnity benefits paid after 104 weeks of disability.

New Hampshire's statute allows for reimbursement of almost all medical and indemnity benefits after the first $10,000 of those benefits combined. Fifty percent

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of payments are reimbursed within the 104 weeks of disability, and 100 percent thereafter.

Some statutes will only allow second-injury fund liability if the claimant receives permanent benefits as in New York, New Jersey, Massachusetts (after December 1991), District of Columbia, Arizona, and longshore claims.

Some funds are liable for indemnity and medical benefits and some for indemnity only. A few funds limit indemnity liability to disability claims and exclude dependency benefits on death cases, such as New Jersey.

Types of Funds

The two major types of second-injury funds are reimbursement funds and take-over funds. In both of these situations, the employer/insurer is able to significantly write down any future reserves on a claim when the fund becomes liable. In certain jurisdictions, such as Georgia, South Carolina, and Louisiana, the fund requires the employer/insurer to sign an affidavit that it is writing down its reserves on the claim before a reimbursement check will even be issued.

Reimbursement Funds

Most of the funds noted above reimburse the carrier for indemnity and medical benefits made to or on behalf of the claimant. In those funds, once fund liability has been established, the employer/insurer remains the primary claims handler and must request periodic reimbursements from the fund (e.g., quarterly) for certain payments made on the claim.

More proactive reimbursement funds will want to be involved in any workers compensation settlement discussions between the claimant and the employer/insurer. Some jurisdictions, such as New Hampshire and New York, require the fund to be involved before the settlement between the claimant and the employer/insurer. In these jurisdictions, if the fund is not involved, then any reimbursable amount within the settlement cannot be recovered.

Also in New York, if the fund's liability has been established, it must be involved with any third-party settlement. Not all funds want to be involved at this level, but most funds will review any third-party settlements and take appropriate credits so as not to reimburse an employer/insurer for monies on which it has already received recovery.

Take-Over Funds

Certain second-injury funds will pay the claimant directly once its liability has been determined. These funds can be referred to as "take-over" funds because the fund literally takes over the compensation payments from the employer/insurer. In New Jersey, for example, once the fund's liability has been established, it can pay the claimant's permanent and total benefits for the life of the claim. Although, the employer/insurer remains liable for the medical aspect of the claim, it can write down the indemnity reserves, which is usually a significant amount.

A charge to funds exists when a non-self-insured employer in a monopolistic jurisdiction is allowed to "charge" that portion of the claim cost caused by a combination of a prior and second disability, to a fund in that state so that the cost for that claim will not be calculated into the employer's experience modification rate. In Ohio, for example, that portion of the claim that otherwise would have been charged to the employer's experience is deducted from that claim and charged to the Statutory Surplus Fund.

Conclusion

There are many active second-injury funds in existence today, and perfecting all claims takes focused time and effort. Strict attention should be paid to the statutory requirements along with any corresponding regulations. Although no one fund is exactly the same, they were all born from the same intent. Therefore, a sound knowledge of several different funds will go a long way in handling any one jurisdiction's claims. ■

AICPCU Activity Report

by Donna J. Popow, J.D., CPCU, AIC

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Each year, the American Institute for CPCU and the Insurance Institute of America prepare a report to the CPCU Society that outlines the Institutes' activities for the prior year. The following is a summary of that report:

The October 2003 report to the CPCU Society highlighted the major changes in the CPCU program and reported statistics on examinations. The major changes are:

- requiring students to concentrate in either commercial or personal insurance
- having an enhanced financial services focus with the introduction of a new Financial Services Institutions course and a new Personal Financial Planning course
- consisting of eight rather than ten courses and examinations
- allowing waivers for J.D. and M.B.A. degrees

The Institutes administered 73,551 exams in 2002. Of these exams, 19,235 were CPCU exams, and 54,316 were IIA exams. The projection for 2003 was to administer 74,900 exams, a 1.8 percent overall increase over 2002. It was anticipated that 55,500 of these exams would be IIA exams, which amounts to a 2.2 percent increase over 2002, and that 19,400 would be CPCU exams, for an increase of slightly less than 1 percent over 2002. The CPCU class of 2003 consisted of 2,269 designees.

Exams were to be administered during four, month-long test windows:

- February 15 to March 15
- May 15 to June 15
- August 15 to September 15
- November 15 to December 15

Candidates take their exam at a Prometric Testing Center or at an employer-sponsored on-site testing center. One important note is that the November 15 to December 15, 2003, test window was the last time a hand-written exam option would be available. Keyboarded answers have allowed the Institutes to significantly reduce the time required to grade the exams and provide students with their grade.

The number of exams delivered at employer locations has grown significantly. In 2003, there were 340 employer testing sites.

The Institutes offer segment exams for the Accredited Adviser in Insurance (AAI®) program through four state agents' associations: Florida, Georgia, North Carolina, and Virginia. Three other state associations will become part of this program. This approach allows agents to earn the AAI designation by attending three seminars for each of the three AAI courses.

In 2003, the Institutes released 16 new and revised textbooks, 29 course guides, and three new CPCU study aids. Practice exam CD-ROMs were included in the course guides for INS, CPCU, AIC, and AIS. Institutes texts have been translated into Chinese, Japanese, French, Portuguese, and several other languages. The Center for Educational Innovations (CEI) is responsible for producing Focus Series® courses, SMART study aids, and customized texts and courses for cooperative ventures and partnerships.

AICPCU IIA *Succeeding together.*

EDUCATION • RESEARCH • ETHICS

Focus Series courses are individual segments of the Institutes' curriculum, one to three chapters in length. They can be used for CE credits in many states. Combinations of the Focus Series courses have been awarded college-level credit by the American Council on Education (ACE), so students can gain credit toward college degrees.

The Institutes have agreements with several colleges and universities that allow CPCU and IIA students to gain undergraduate and graduate credit for the programs shown in Tables 1 and 2 on pages 10-11.

The Institutes' most recent cooperative venture is with the New England College of Finance (NECF) and LOMA. Together, these organizations have formed the Insurance Industry Educational Consortium. Consortium members include Drexel University; the continuing and professional education divisions of New York University (NYU); University of Maryland, University College (UMUC); and University of California, Berkeley.

The Institutes continue to support their students by offering the three INS courses, the four AIC courses, and 11 CPCU courses as instructor-led classes over the Internet. Students can also

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Table 1
Undergraduate Programs

Institution	Degree Incorporating Institutes' Courses	Credits for Institutes' Courses	Special Notes	Contact
Drexel University (undergraduate) Accredited by Commission on Higher Education of the Middle States Association of Colleges and Schools	• B.S. Degree in Communications and Applied Technology • B.S. in General Studies (Concentration in General Management)	• Up to 135 quarter credits of the required 180 quarter credits	• All Drexel courses offered online • 10 percent discount off Drexel's tuition for the Institutes' students • No application fee • No transfer credit fee • No residency requirement	www.drexel.com/aicpcu
Excelsior College formerly Regents College (undergraduate) Accredited by Commission on Higher Education of the Middle States Association of Colleges and Schools	• B.S. Degree in Risk Management and Insurance (RMI) • B.S. Degree in General Business • AICPCU credits can be applied to B.S. and A.S. degrees in a wide variety of additional degrees.	• Up to 63 credits hours of the required 120 credit hours • Up to 55 credit hours of the required 120 credit hours	• Founded more than 30 years ago • Provides many avenues to degree completion, at a distance, for busy working adults (college-level proficiency exams; college credit transfer; distance courses or campus-based courses, designation programs, and more) • Affordable, flexible, self-paced programs • No transfer credit fee • No residency requirement	• www.excelsior.edu (home page) • www.excelsior.edu/bri.htm (for specific information about RMI degree)

Table 2
Graduate Programs

Institution	Degree Incorporating Institutes' Courses	Credits for Institutes' Courses	Special Notes	Contact
Boston University (graduate) Accredited by New England Association of Schools and Colleges	Master of Science in Insurance Management (beginning in Fall 2003)	CPCUs obtain 16 credit hours out of the required 48 credit hours.	• All BU courses offered online	www.bu.edu
Drexel University LeBow College of Business (graduate) Accredited by Accredited by the American Assembly of Collegiate Schools of Business (AACSB)	• M.B.A. (Concentration in General Management) (beginning in Fall 2003) • M.B.A. (Concentration in Technology Management)	• CPCUs obtain 6 credit hours out of the required 60 credit hours for CPCU 8 and CPCU 9. • An additional 6 credit hours can be earned based on previous academic background and other CPCU courses taken.	• No residency requirement • All Drexel courses offered online • Discount off Drexel's tuition for the Institutes' students • No application fee • No transfer credit fee • No residency requirement	www.drexel.com/aicpcu
Walden University (graduate) Accredited by Commission on Higher Education of the North Central Association of Colleges and Schools	• M.B.A. (Concentration in Finance, Risk Management, and Insurance)	CPCUs obtain credit for up to 7 of the 17 required courses (based on the student's undergraduate work)	• All Walden courses offered online • Accelerated program allows completion in 15 to 18 months • Corporate group rate for 5 or more students • No transfer credit fee • No residency requirement	www.waldenu.edu

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search an online public class list to find convenient class locations, and use the Web Student Advisor to determine what courses they need to complete a program.

The Insurance Research Council (IRC), a division of the Institutes, released the following research reports:

- *Insurance Fraud: A Public View*, June 2003
- *Public Attitude Monitor Series, PAM 2003, Issue 1: Protecting Homes from Natural Disasters and Household Perils, Homeowners Insurance Discounts and Claims*
- *Trends in Auto Injury Claims*, 2002 Edition, October 2002
- *Accuracy of Motor Vehicle Records: An Analysis of Traffic Convictions*, June 2002

Research projects underway include a closed claim study of auto injury claims paid by major auto insurers countrywide; a topical analysis of 3,400 auto accident victims injured between 1999 and 2001; PAM 2003, Issue 2: Tort Reform, Personal Injury Lawsuits, Class-Action Lawsuits.

The Institutes continue to broaden the educational experience of their students by hosting two executive education programs. The Advanced Executive Education Program is a three-week residency program for senior executives in financial service organizations. The Insurance Executive Development Program is a two-week residency program for experienced managers who have the potential to become senior executives.

The Institutes accomplish all of this with a staff of approximately 130 employees and the assistance of many designees who act as reviewers, authors, graders, and content advisors. ■

Reminder . . .

Claims Section Online Survey

In the December CQ we had an article that provided you with the background for this new Claims Section Survey. It is a very important survey to us, and I would like to remind you that the survey is online for your convenience. It can be found on the first page of the Claims Section web site, and will only take three minutes of your time to complete.

Visit www.cpcusociety.org, click on "Sections," then click on "Claims."

We would truly appreciate your feedback and comments.

This is your opportunity to comment on the issue of what the Claims Section can do for you as a member.

Thank you,
James D. Klauke, CPCU, AIC, RPA
Claims Section Chairman

Claims Section "Pioneers"

A Short History of the Claims Section

by Marcia Sweeney, CPCU, AIC, ARM, ARe, AIS

Marcia Sweeney, CPCU, AIC, ARM, ARe, AIS, is claim manager for HartRe, a Hartford Financial Services Group Company. Sweeney is also editor of Claims Section Quarterly newsletter *CQ*.

The year 1982 sounds like yesterday to many of us, but it was 22 years ago that the CPCU Society's Claims Section was formed. I have completed some archive research and have interviewed several people with the goal of pulling together a document to preserve some of the history of the Claims Section. This article shares my findings.

I would like to thank **Pat Coleman, CPCU** (Univ. of CT), **Larry Klein, CPCU** (Zurich NA), **John Kelly, CPCU** (CPCU Society) and **Ray Stoll, CPCU** (Structured Financial Assoc.) for sharing their memories and archived files.

The Claims Section was formed in October 1982. The first Claims Section Committee was the entire section!

The original committee members were: **J. Robert Batterson, CPCU** (Employers Reinsurance Co.), **Robert Bender, CPCU** (State Farm), **Kenneth Brownlee, CPCU** (Crawford & Co.), **Frank Comella Jr., CPCU** (State Farm), **Robert Prahl, CPCU** (State Auto Insurance Co.), **Ray U. Stoll, CPCU** (Structured Financial Assoc.), **Stephen M. Utrata, CPCU** (State Auto Insurance Co.), **Wilkerson Wright, CPCU** (Defense Attorney, Miami), and **Walt Zimmer, CPCU** (Fireman's Fund).

On the Claims Section's tenth anniversary (1992) Ken Brownlee shared some memories with the CQ. These quotes are taken from that CQ article.

"Back in the early 1980s, few of us had any notion of what the Claims Section would become. We had only a common concern. It seemed to many of us in the claims field that the Society was not really offering us anything that was uniquely for us. If we wanted to move the claims field into a more professional status, we'd have to do it ourselves—so we did!

"We decided we needed a means of communication, on at least a quarterly basis. This idea became the *Claims Quarterly*. We agreed to submit at least one article annually for the *CPCU Journal*. We decided to sponsor a major seminar—the first of which was held in Miami, and which produced ideas I am still using today. We also decided we needed a presence at the Annual Meetings and Seminars. All that came to be the heart of the Claims Section, as well as the model for all of the other sections to come. In addition, the Claims Section became a professional resource for the Institutes. Bob Prahl and Steve Utrata became active in the IIA's Associate in Claims program, authoring a text. Other members also participated in Institute activities, creating a professional liaison that fulfilled the original desire of the founding members to create a truly national, professional claims organization—not just a business organization or social club, but one dedicated to the profession of claims adjusting."

Since October 1982, the Claims Section has come a long way and has grown from nine members to more than 1,540, with 19 people now on the Claims Section Committee.

Larry Klein, CPCU, was working in Malvern at the CPCU Society in the early 1980s and shared with me some of his recollections of how the Claims Section came to be:

Members Call for Specialized Segments

Klein recalled that in October 1980, the CPCU Society welcomed the largest class of new designees in its more than 35 years of existence. Approximately 1,700 new CPCUs joined slightly more than 10,000 members in the CPCU Society. Nearly every one of these new members also joined one of the Society's approximately 115 chapters that existed at that time. As with most classes of new designees, approximately 90 percent chose to continue their membership and those who did not often made that decision for a variety of reasons. The various reasons back then were about the same of those today—the CPCUs employer did not reimburse the cost of dues; the chapter meetings were inaccessible or held at inconvenient times; or that the membership benefits did not sufficiently respond to the CPCUs particular professional interest. Over the next two years the Society's leadership observed and heard an increasing call for the Society to be more attentive and responsive to members engaged in specialized segments of the property and liability insurance community. The general cry was the existing chapter structure was too generalized or often focused exclusively on the interests and needs of agents and underwriters.

Pilot Programs Rolled Out in 1982

Throughout 1981 and into early 1982, the calls for the Society to do something to retain the interest of its members interested in claims, reinsurance, and risk management grew. Klein recalls that the structural changes to the membership were led in large part through the experience of **Joe Decaminada, J.D., CPCU,** and the leadership of **Frans Eliason, CPCU,** who identified that these three interest segments were to be "pilot" sections commencing at the 1982 Annual Meeting and Seminars in Miami Beach, Florida.

Naming These New Specialized Segments

Klein recalls that there were lengthy discussions regarding the appropriate terminology for sections. He recalled that it initially was agreed to ***not*** use the word "special" since it could be interpreted as

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Claims Section "Pioneers"

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though it conveyed a higher or superior classification of CPCU. Additionally, it was decided to ***not*** use the word "interest" because such a term might be perceived as limiting. The implication could be that the section members were only interested in matters of the particular section and had no interest in other aspects of the insurance community. Alternatively, it could be concluded that members who did not join a particular "interest" section had no interest in the discipline. The consensus conclusion was the word "section" was sufficiently descriptive. Over the next few years the term "interest section" emerged into the Society's vocabulary and did not present the issues that were initially anticipated.

Determining Section Membership Criteria and Eligibility

The next issue that the Society grappled with was the issue of membership eligibility. A recommendation was made to open section membership to non-CPCUs, especially to individuals who held corresponding associate designations from the Insurance Institute of America. Others with opinions felt that if sections could potentially grow in size and strength, that it might erode the Society's chapter structure. After sometimes heated debate, it was concluded that section membership would be restricted to holders of the CPCU designation who also were dues-paying members of a chapter.

Control of the Sections

Governance and leadership of the newly formed sections posed a particularly troubling issue. Some of the most outspoken proponents for creating sections also strongly advocated a high degree of self-governance. However, the Society's leadership feared a renegade section leadership could cause irreparable harm, especially since some of the more vocal section proponents had little or no experience elsewhere in CPCU Society leadership ranks. A compromise was reached whereby the individual section membership would elect its own *governing* committee. Governing being italicized. The term was later abandoned as it conveyed more authority than the Society's leadership wished to delegate. The section's leadership would then select from within their segment ranks the nominees for committee positions and submit those names to the Society's president. The Society's president reserved the right to accept and appoint the nominee; or, alternatively, to appoint any other CPCU to section leadership positions.

Dues for the Sections

Section membership dues apparently had little debate. Dues fees were discussed and raised little or no disagreement. At the time, the national Society dues were $125 per year, and most chapters' dues were between $20 and $25 per year. Since section membership would include newsletters, require some staff support, and committee support at the Annual and Mid-Year Meetings, $25 per year was deemed reasonable. Some minority but vocal individuals felt that section membership should be free or nominal since one of the primary reasons sections were needed was the feeling that the Society was not responsive, and payment of national and chapter dues should be sufficient. Annual section dues were set at $25 and remained at that level except for a brief test period, which Klein thought might have been in the late 1980s when they were reduced to $5 for a short period of time.

Malvern Staff Support of the New Sections

All of the issues above were accomplished in the first few months of 1982. At the Mid-Year Meeting of the CPCU Society's Board of Directors, the Board approved the formation of pilot sections for Claims, Reinsurance, and Risk Management. In the ensuing months, Society leadership discussed including pilot sections for Agents and Brokers, Underwriters, and other segments. At that, it was thought that the participation in an Agent and Broker or Underwriting Section would be so large that it would be difficult to manage its orderly creation.

Over the last few months in 1982, **Frans Eliason, CPCU,** appointed individuals to serve on the pilot section committees. Each section was assigned to a member of the Society's staff for logistical support. **Michael Cabot, CPCU,** was designated to support the Reinsurance Section, **Jack McCafferty, CPCU,** was designated to support the Claims Section, and **Larry Klein, CPCU,** supported the Risk Management Section.

Klein added that although not on the section committee, but rather on the Society's Board of Directors, the late **Wally Clapp** lent tremendous support to the Claims Section from his position with the *Rough Notes* Company.

The First Three Sections Were Up and Running by the Fall 1982

The Claims and Risk Management Section then started to hold organizational meetings beginning with the Society's 1982 Annual Meeting and Seminars. The Reinsurance Section had its inaugural organizational meeting in Philadelphia shortly thereafter.

Fall 1982— The Claims Section Moves Into Action . . .

Within the first year of formation, the Claims Section was off to a running start, the *Claims Quarterly newsletter* had its inaugural issue of Volume 1, Number 1 in September 1982, and the section members were putting on symposia and seminars around the country and at the Annual Meeting and Seminars in Miami. The first CQ editor was **Ken Brownlee, CPCU,** who held the position of editor from 1982 to the end of 1990.

In April 1984, the Claims Section chairman was interviewed by the *CPCU News* to determine how the section had furthered the objectives of the Society

and benefited the Society members. The following excerpts are from that article in which Claims Section Chairman **J. Robert Batterson, CPCU, CLU,** was interviewed:

(Q) What contributions has your section made to add to the body of insurance knowledge?

(R) Batterson: Among our many activities in the Claims Section, one project that directly answers your question is a cooperative research project the section is producing with the National Underwriter Company. We will produce a series of articles to appear in the *FC&S Bulletins* focusing on significant claims issues affecting particular lines of coverage. The first series will deal with commercial auto insurance. Once each series is complete, the collection will be published in monograph form.

(Q) What do you offer your members in the way of educational programs?

(R) Batterson: Our 1984 symposium, "The Litigation Jungle" brought 17 experts and over 100 claims professionals together for a two-day program. The series of individual presentations covered a variety of topics that claims professionals need to be concerned with as they analyze insurance claims. In 1985, we will focus on specific claims issues in a "workshop" approach where small groups will meet in concurrent sessions. Of course, last year and again this year, the section produced one of the seminars during the Society's Annual Meeting and Seminars. The 1984 seminar will address the topic, "Alternatives to Litigation."

(Q) How does your section support chapter activities?

(R) Batterson: Over the past several years, Claims Section members have held leadership positions in many of our chapters. They also have frequently been called upon to present programs at chapter meetings. During the coming years, our section expects to formalize and publicize ourselves as a resource for use by chapters.

(Q) How can new designees benefit from section membership?

(R) Batterson: New designees are suddenly exposed to the world of the Society of CPCU and our chapters. Chapter activities respond to new members 'needs in their local insurance community, and they appear to do a very good job of it. Membership in the Claims Section will expose claims-oriented new designees to their counterparts across the country, even the world. Nearly every chapter in the Society has a member in the Claims Section, and through the Claims Section, members can learn from and share with their peers in other chapters.

Fall 1985—The Claims Section committee is chaired by **Wallace R. Hanson, CPCU,** vice chairman is **Francis X. Comella Jr., CPCU,** and the recording secretary is **Robert A. Bender, CPCU**. There are seven other committee members.

Fall 1986—The Claims Section Committee is chaired by **Wallace R. Hanson, CPCU,** with vice chairman **Richard J. Watson, CPCU,** and recording secretary **Ray U. Stoll, CPCU.** There are eight other committee members.

The Claims Section is five years old in 1987; the Claims Section Committee members were: **Richard J. Watson, CPCU,** chairman, **John F. Carlson, CPCU,** vice chairman, **Willard T. Fones, CPCU,** recording secretary.

Members:

Wallace R. Hanson, CPCU, Gary L.Willoughby, CPCU, John G. DiLiberto, CPCU, Alexander Bojak, CPCU, Ray U. Stoll, CPCU, Harold A. Stone, CPCU, James I. Sullivan, CPCU, Ken Brownlee, CPCU, is the CQ editor.

By July 1987, there were now six interest sections in the Society, with the Claims Section the largest.

In the Fall 1988, the Claims Section announced the new committee officers: chairman **Richard J. Watson, CPCU,** vice chairman **Williard T. Fones, CPCU,** and recording secretary **John G. DiLiberto, CPCU.** There were seven others on the committee for a total of 10 members.

Fall 1989—John G. DiLiberto, CPCU, is the chairman of the Claims Section and has a section committee of 11.

Fall 1990—John G. DiLiberto, CPCU, is chairman of the Claims Section and the membership of the committee grew to 16. There are now 14 sections and Claims is the largest section.

The Claims Section is 10 years old in 1992 and has a committee of 14; chairman is **Harold A. Stone, CPCU.**

Members are: **Wayne T. Browne, CPCU, Timothy J. Gephart, CPCU, James D. Klauke, CPCU, J. Patrick Gates, CPCU, June C. Glenn, CPCU, Ralph K. Riemensperger, CPCU, John J. Sauro, CPCU, Rudolph F. Trosin, CPCU, James A. Franz, CPCU, George N. Gould Jr., CPCU, Christian J. LaChance, CPCU, Gary L. Willoughby, CPCU,** and **Kathleen J. Robison, CPCU,** who served as the CQ editor.

The Claims Section is 15 years old in 1997 and has a committee of 17! The chairman, **Kathleen J. Robison, CPCU.**

Ken Brownlee, CPCU, returns as CQ editor. Members: **Scott D. Brown, CPCU, James A. Franz, CPCU, J. Patrick Gates, CPCU, Donald R. Gerten, CPCU, June C. Glenn, CPCU, Patrick H. Jeremy, CPCU, James D. Klauke, CPCU, Marcia Kulak, CPCU, Christain J. LaChance, CPCU, Jill A. Murphy, CPCU, Darnell W. Pettengill, CPCU, Ralph K. Riemensperger, CPCU, James A. Trent, CPCU, Gary L. Willoughby, CPCU,** and **Richard G. Witkowski, CPCU.**

By the Claims Section's 20th anniversary in 2002, the section had grown to more than 1,500 members, had a committee of 19, and won the Circle of Excellence Gold Award for Sections. Chairman is **James A. Franz, CPCU;** CQ editor is **Marcia Sweeney, CPCU.**

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Claims Section "Pioneers"

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The technical knowledge, the industry experience, and the organizational and administrative skills of these many people have led the Claims Section to become and remain the largest of the interest sections, and a consistent winner of the Society's Circle of Excellence Gold Award for Sections. ■

Updates and/or corrections are most welcome. As additional information is gathered that pertains to the history of the Claims Section and its past members and activities, I will continue to update the document and keep it on file at the CPCU Society's offices in Malvern, PA. If you have any Claims Section information or stories to share please contact me, Marcia Sweeney, at (860) 520-2761 or marcia.sweeney@thehartford.com.

Meet Claims Section Committee Member—Donna J. Popow, J.D., CPCU, AIC

Donna J. Popow, J.D., CPCU, AIC, joined the Institutes in 2002. As director of curriculum, she maintains the textbooks, course guides, and examinations for the Introduction to Claims course and the Associate in Claims (AIC) designation program.

Before joining the Institutes, Donna was vice president and litigation manager, home office claims, for the Marine Office of America Corporation/CNA in Monmouth Junction, NJ. Her previous positions include serving as a claims consultant for The Graham Company in Philadelphia, PA; as managing attorney for the law firm of Lewis and Wood, also in Philadelphia; and as deputy executive director of the Unsatisfied Claim and Judgment Fund, New Jersey Department of Insurance in Trenton, NJ. She also held claims-related positions with Hanover Insurance Company in Piscataway, NJ; Accredited Movers, a franchise of North American Van Lines in Parsippany, NJ; and Liberty Mutual Insurance Company in South Plainfield, NJ. She is also a former Fire and Allied Lines Arbitrator.

Donna earned an A.B. degree from Franklin and Marshall College in 1977. She received the Insurance Institute of America's Certificate in General Insurance in 1983 and became a Property Claims Law Associate in 1985. She was awarded a J.D. degree by Seton Hall Law School in 1988, and was admitted to the Bar in New Jersey and Pennsylvania the same year. She earned IIA's AIC designation in 2002 and received her CPCU designation in 2003.

Donna and her husband, John A. Chionchio, Esq., live in Hatboro, PA, with their West Highland Terrier, Duchess. ■

Claims Section Chapter Liaisons—Openings Throughout the Country

The Claims Section Chapter Liaison program has expanded into a few more chapters in a few more states. This past quarter we appointed claims CPCUs in Arizona, Massachusetts, and Tennessee.

We are still looking for many more of the Claims Section members to step forward and get involved in the local chapters. Help us "Spread the Word!" about the claims profession in your area.

The purpose of an individual Claims Liaison at the local chapter level is to promote high visibility of the CPCU Society's Claims Section by encouraging the involvement of all local CPCU claims people.

Through the Chapter Claims Liaison position, the Claims Section Committee plans to be able to:

- Achieve ongoing, expanded visibility of the Claims Section at the local chapter.
- Encourage CPCU claims professionals to take a more active role in the activities of the chapter and Society.
- Develop future Claims Section and Society leaders.

Role of the Claims Liaison:

- Work with Chapter Program Committee to present one claims speaker for a chapter meeting, or help sponsor one claims symposium in the area.
- Obtain the list of Claims Section members in your chapter and invite them to a meeting.
- Coordinate a Claims Section table at the chapter meetings; create claims badges.
- Provide Claims Section materials to the chapter via the chapter web site, handouts at monthly meetings, the chapter newsletter, etc.

The national Claims Section committee has a subcommittee ready and able to assist you with the support you need to achieve these objectives.

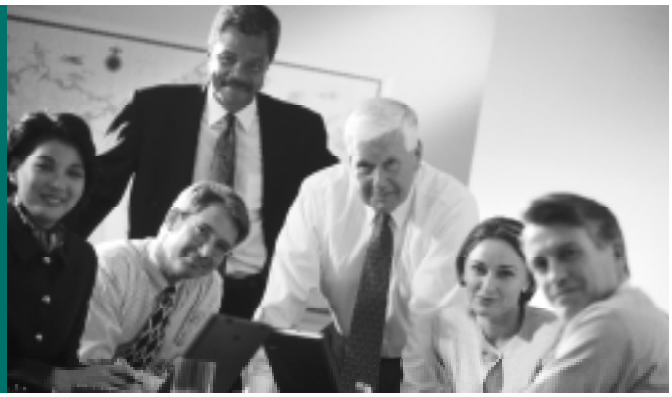
Contact Chairman **James Klauke, CPCU, AIC, RPA,** or committee members **Lola Hogan, CPCU,** or **Tony Nix, CPCU,** to learn more about how you could participate. Their contact information is also on the Claims Section web site at **http://claims.cpcusociety.org**.

James D. Klauke, CPCU, AIC, RPA
Claims Section Chairman
james_klauke@us.crawco.com

Lola Hogan, CPCU, Claims Section Chapter Liaison Committee
lolah@sequoiains.com

Tony Nix, CPCU, Claims Section Chapter Liaison Committee
tony.d.nix.aqf9@statefarm.com

Hope you will join us! ■



JIRC Study Finds Skyrocketing Auto Injury Losses Despite Declines in Serious Injuries

A new study by the Insurance Research Council (IRC) finds that reported losses in auto injury claims are escalating in spite of the fact that the rate of serious auto injuries has decreased. In the past five years, increases in the average amounts that auto injury claimants report for expenses stemming from their injuries, particularly among personal injury protection and medical payments first-party claimants, are nearly double the annualized growth in medical inflation. Additionally, they are three times higher than increases in general inflation.

The IRC study, which is based on more than 70,000 auto injury claims collected from insurers countrywide, reveals that escalating medical costs are the key factor behind this growth in losses. Only modest increases have occurred in lost wages and other out-of-pocket expenses associated with injuries. The study points to sharp increases in charges for the treatment of auto injuries and increased use of certain medical professionals and diagnostic procedures as the basis for the rising medical costs.

The IRC report reflects 25 years of gathering information on auto injury claiming behavior. It explores countrywide auto injury claim patterns under each of the five principal private passenger auto insurance coverages: (1) bodily injury liability (BI), which pays for an insured driver's legal liability for injury caused to someone else; (2) medical payments (MP), which pays the medical and funeral expenses of insured drivers and their passengers; (3) personal injury protection (PIP), which pays benefits to persons injured in auto accidents without regard to fault; (4) uninsured motorist (UM), which pays when an insured driver is injured by an uninsured motorist; and (5) underinsured motorist (UIM), which pays when an insured driver is injured by an underinsured motorist.

The IRC study identifies emerging claim patterns associated with medical treatment. In the five-year period from 1997 to 2002:

- Injury patterns remained consistent, but the seriousness of auto injuries actually declined.
- Sprains and strains continued to be the most common type of injury reported by at least eight out of ten auto injury claimants.
- A smaller percentage of claimants in the 2002 study experienced any disability or fatality as a result of auto injuries. In addition, fewer claimants experienced days of restricted activity or missed time from work.
- Despite declines in the overall seriousness of injuries, the study found increases in the use of some medical professionals—and the costs associated with their use.
- Increases occurred in the number of different medical professionals visited and in the use of chiropractors, physical therapists, and alternative treatment professionals such as massage therapists. The number of times claimants received treatment from these professionals also increased.
- The average charges for treatment by these same medical professionals increased considerably.
- Claimants were more likely to receive more expensive diagnostic procedures using magnetic resonance imaging (MRI) while, concurrently, the proportion receiving X-rays decreased. In addition, the average per-procedure charge for most diagnostics increased.

In stark contrast to trends noted from 1992 to 1997, reported losses for BI, PIP, and MP claimants grew significantly between 1997 and 2002. These increases were particularly significant among PIP and MP claimants, who had experienced declines in reported losses in the previous decade. Average PIP losses increased from $4,804 in 1997 to $6,711 in 2002. MP losses rose from $3,348 to $4,621. Both increased 7 percent on an annualized basis since 1997. In contrast, medical care inflation rose just 4 percent on an annualized basis during the same period.

"Given the development of numerous automotive safety innovations and increased emphasis on improved highway safety legislation, it is not surprising that we would see evidence of a decline in the seriousness of injuries related to auto accidents," said Elizabeth A. Sprinkel, senior vice president of the IRC. "However, the paradox of increases in auto injury costs associated with higher use of medical resources and escalating medical expenses, despite declines in injuries, suggests that the auto insurance system may be vulnerable to overuse. This is a concern for the public because rising auto injury losses ultimately translate into rising auto insurance premiums."

Claim payments have not risen as substantially as losses, yet the study found that on average, BI payments continue to exceed losses. Growth in claim payments was strongest among the most seriously injured claimants.

"The encouraging payment trends noted in this study suggest that the auto insurance system is becoming more efficient in compensating claimants with respect to the seriousness of their injuries," Sprinkel said. "It is the role of insurance to indemnify injured persons for their losses, and the study suggests that insurers are doing a better job of putting payments in the hands of those who need them the most."

The recently released IRC study, "Auto Injury Insurance Claims: Countrywide Patterns in Treatment, Cost, and Compensation," examines detailed claim information from 72,354 claims that closed with payment in 2002. Thirty-two insurers, representing 59 percent of the 2002 private passenger auto insurance market in the United States, participated in the study. The report also contains information on the claim settlement process and the level of attorney involvement and its impact on auto injury claims. ■

For more detailed information on the study's methodology and findings, contact Elizabeth Sprinkel by phone at (610) 644-2212, ext. 7568; by fax at (610) 640-5388; or by e-mail at **irc@cpcuiia.org**. Or visit IRC's web site at **www.ircweb.org**. Copies of the study are available at $250 each in the U.S. ($265 elsewhere) postpaid from:

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Source: Insurance Research Council

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