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Chairman's Corner

by James D. Klauke, CPCU, AIC, RPA

For the first CQ of 2005, I would like to talk about volunteer service for the CPCU Society. Some people who attain the designation feel content to place the four prestigious letters on their business card and move on. They seem content that the education received was worth the effort, and further service to the Society will not further improve their business career or personal development.

I challenge those who believe that activity in the CPCU Society will not help in their career path goals to reconsider. I have written many times in the CQ about the ways one can get involved in the Society and the Claims Section, where you are a member. You can get involved in the Society by merely attending chapter meetings regularly and on occasion, raising your hand to help in some chapter activity. There is also an application for national service included in this CQ should you prefer a national committee such as the Claims Section or any of the 13 other interest sections.

Getting involved with the Claims Section can be in the form of the Claims Section liaison with your chapter, participate in a claims program for your chapter I-Day, participate in a Claims Section seminar locally or at the Annual Meeting and Seminars. I am writing today about another way to get involved that does not require any expense or travel that can be a rewarding activity in an area of claims that may be of most interest you.

Today, I would like you to consider creating a seminar/symposium/workshop. To clarify, a **"seminar"** is a program where the speaker lectures for a period of time and then answers questions. A **"symposium"** is a program that involves more than one lecturer and some prepared questions that may be worked out by the audience. A **"workshop"** is a program that involves some lecture followed by a problem-solving period by the audience that is separated into groups that work together on a given problem. After the problems are solved, there is general discussion by the groups as to how they solved the problems.

The Claims Section currently has three such programs titled "Appraisal"; "Depositions for the Insurance Professional"; and "Mediation versus Arbitration." We as a section make these programs available to section members for use in various educational venues. It can be a chapter I-Day, a local seminar/workshop in your area for education credits, or your own company education or training programs. We would like to develop more programs in subjects that are of interest to you, the Claims Section member.

Once the program is prepared, the main function of the workshop/symposium/seminar can be worked on. There are questions designed to bring out the information contained in the program. They should be prepared in such a way to invoke discussion and questions by the group. A key element in the program is not to just lecture the audience but to get the audience as active participants.

All of these activities would help the Claims Section's submission in the Circle of Excellence Recognition Program. The section has won the Gold Level Award every year the program has existed. We win this award because of people like you who choose not to just put four letters on your business card.

If you would like to consider volunteering in this area, it does not require as much effort as you may think. I will help get you started and have posted guidelines on the web site. There is no time limit to preparing one of these programs. I know that if you start, you will finish. We would like to hear from you! ■

"A goal properly set is halfway reached."

—Abraham Lincoln

What's In This Issue

2004: The Year's 10 Most Significant Insurance Coverage Decisions

Fourth Annual Insurance Coverage Hit Parade

by Randy J. Maniloff

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Maniloff expresses his gratitude to firm partner Gale White for her invaluable assistance with the preparation of this article. The author also expresses his gratitude to John Cadarette, a director at LECG, for suggesting the clever phrase "Insurance Coverage Hit Parade." The views expressed herein are solely those of the author and are not necessarily those of his firm or its clients.

Editor's note: This article is an excerpt from an 18-page article written by Randy J. Maniloff and published in the January 4, 2005, *Mealey's Litigation Report*. Feel free to contact the author at maniloffr@whiteandwilliams.com for a full copy of this most interesting and informative article on insurance coverages.

For the insurance industry, 2004 was the year of the hurricane—four in Florida: Charley, Frances, Ivan, and Jeanne, and one in New York: Eliot. The past year was certainly one in which more of the industry's news than usual received ink from publications that do not have the word insurance in their title. Thankfully, the industry responded quickly to get houses in the sunshine state, as well as its own, back in order.

Even the insurance coverage corner of the industry, normally ignored by the mainstream press for being inside baseball, enjoyed a rare moment in the national spotlight in 2004 when New York juries were tasked with deciding the amount of coverage owed for the destruction of the World Trade Center. Many of the year's insurance coverage cases that didn't have $3.5 billion and the future map of lower Manhattan riding on their outcome were also worth taking note. Even if fewer did.

I am once again grateful to *Mealey's Litigation Report: Insurance* for the opportunity to make the case for 10 decisions from the year gone by that are likely to play a part in shaping the insurance coverage landscape in the years ahead. As stressed in prior editions of this commentary, there is nothing scientific or democratic about the method used to select these cases. It is an entirely subjective process, based generally on the following criteria. Each decision (1) is (for the most part) from a state supreme court or circuit court of appeal; (2) addresses a coverage issue that has the potential to affect a large number of future claims; and (3) either alters a previously held position or sheds light on a burgeoning issue.

The following were the 10 most significant insurance coverage decisions in 2004 (listed in the order that they were decided):

- *Benjamin Moore & Co. v Aetna Casualty & Surety Company*—Supreme Court of New Jersey applies another coat to Owens-Illinois. At issue—treatment of deductibles in the context of a continuous trigger and pro-rata allocation. Insurer wins. And even the dissent provides a primer that insurers can applaud.
- *RJC Realty Holding Corp. v Republic Franklin Insurance Company*—New York Court of Appeals issues a head-scratcher concerning the all-important insurance policy phrase "arising out of."
- *Haynes v Farmers Insurance Exchange*—California Supreme Court addresses its principle that ***any provision that takes away or limits coverage reasonably expected by an insured must be conspicuous, plain and clear.***
- *Aetna Health, Inc. v Davila and CIGNA Healthcare of Texas, Inc. v Calad*—In consolidated cases, the Supreme Court of the United States issues a unanimous and sweeping decision concerning the scope of ERISA pre-emption. The result: many state claims arising out of ERISA-regulated employee benefit plans, including for bad faith and malpractice, will remain precluded.
- *L-J, Inc. v Bituminous Fire and Marine Insurance Company*—South Carolina Supreme Court eliminates a large hammer for policyholders in construction defect coverage disputes.
- *Minnesota Fire and Casualty Company v Greenfield*—One justice of the Supreme Court of Pennsylvania provides a useful reminder to insurers

on the importance of the "occurrence" requirement.

- *In re: The Wallace & Gale Company*—Good news for insurers —Fourth Circuit affirms that "once an operations claim, not always an operations claim." Bad news for insurers—get ready for the "abandoned or unused materials" exception to the completed operations hazard.
- *Simonetti v Selective Insurance Company*—New Jersey Appellate Division splits spores and continues a trend that mold can be both a "loss" and a "cause of loss."
- *Royal Insurance Company v Hartford*—Fifth Circuit addresses the "other insurance" clause. As is often the case with this policy provision, what you see is not what you get.
- *Travelers Indemnity Company v PCR Incorporated*—Supreme Court of Florida finds employer's liability coverage for tort claims that satisfy—on an objective basis—the substantially certain prong of the intentional tort exception to the exclusive remedy of workers compensation.

The 10 Most Significant Insurance Coverage Decisions of 2004

Editor's note: As editor, I have chosen one of the 10 case summaries for review in this *CQ*. The *Minnesota Fire and Casualty Co.* case was chosen because the definitions of "occurrence" and "expected and intended" cross multiple lines of coverage, and I felt the case would appeal to a large portion of the Claims Section membership.

Minnesota Fire and Casualty Company v Greenfield, et al., 855 A.2d 854, 2004 Pa. LEXIS 1926.

An "expected or intended" exclusion typically appears in both homeowners and commercial general liability policies. There are also virtually unlimited factual scenarios in which its potential applicability can arise. The "expected or intended" exclusion is therefore at issue in a significant number of claims and, consequently, judicial opinions. For various reasons, when it comes to the "expected or intended" exclusion, insurers do not win as frequently as they believe they should. In *Greenfield*, one justice of the Supreme Court of Pennsylvania provided some useful, yet sometimes overlooked, advice on the issue.

Greenfield involved coverage under a homeowners policy for an insured that provided heroin to a houseguest. The guest voluntarily injected herself with heroin and died of an overdose. The decedent's parents filed a wrongful death and survival action against the insured. The insurer filed an action seeking a declaratory judgment that it did not owe a defense or indemnity for the underlying complaint.

The Pennsylvania Superior Court concluded that, for two reasons, coverage was not owed. First, even though the insured may not have intended to cause the death, the known risks of heroin use make an adverse reaction an "expected occurrence." In other words, the court applied the doctrine of "inferred intent," "presumably for the reason that it was unable to establish ***actual*** intent, given the absence of allegations that Greenfield (the insured) expected or intended Smith (the decedent) to lose consciousness or die." *Greenfield* at 863 (emphasis in original). Second, the public policy of the Commonwealth of Pennsylvania should preclude insurance for the sale of such a notoriously dangerous and illegal narcotic.

The Pennsylvania Supreme Court affirmed, but only for the reason that Pennsylvania public policy precludes insurance coverage for damages—even those unexpected or unintended—that arise out of an insured's criminal acts with respect to a Schedule I controlled substance. The Supreme Court rejected the Pennsylvania Superior Court's reliance on "inferred intent" as an additional basis to disclaim coverage, concluding that Pennsylvania's jurisprudence does not support the extension of "inferred intent" to cases other than ones involving child sexual abuse. While the policyholder in *Greenfield* lost, Pennsylvania policyholders in general secured a significant victory when the Supreme Court refused to extend the doctrine of "inferred intent" beyond its current application.

A concurring opinion by Justice Castille noted that there were narrower grounds than public policy for resolving the dispute, namely, "no 'occurrence.'" Indeed, the majority also made the observation that "no 'occurrence'" may have been an easier road for the insurer to take than "expected or intended," but concluded that the insurer failed to brief the position, instead choosing to rely on the "expected or intended" exclusion. *Greenfield* at 861, n.6. On this point, Justice Castille's concurring opinion stated as follows (as well as came to the insurer's counsel's rescue by pointing out that the insurer did adequately present the "no 'occurrence'" issue to the court):

> [T]he homeowners' policy at issue here promises personal liability coverage for, *inter alia,* bodily injuries which are caused by a covered "occurrence." The policy then unambiguously defines an occurrence as "an accident" which results in bodily injury or property damage. The unfortunate teenage victim in this case, Angela Smith, did not trip down the stairs in Michael Greenfield's home, or fall upon a knife, or die in a fire. Rather, Smith and Greenfield engaged in a common, commercial transaction of a criminal nature, which just happened to occur in the home: Greenfield delivered heroin to Smith in exchange for a quantity of marijuana and, possibly, a small amount of cash. Smith then voluntarily injected herself with the heroin, thereby causing her own death from heroin intoxication. Greenfield did not inject Smith with the drug;

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> instead, the basis for his liability was premised upon the simple fact of his delivering the narcotic to Smith, and her later dying from it while still in Greenfield's home. Whatever else Greenfield's delivery to Smith may have been, it was not an accident.

Greenfield at 870. "Following upon the heels of the intentional and illegal activities of both Greenfield and Smith, the fortuity of the fatal overdose, while tragic, can hardly fall into the category of a covered 'accident.'" *Id.*

In *Greenfield*, the insurer's decision (at least as the majority saw it) to pursue an "expected or intended" defense, instead of arguing "no 'occurrence,'" was no harm-no foul, given the public policy rationale ultimately adopted by the court. However, another Pennsylvania decision from 2004 demonstrates that sometimes a court's failure to adequately consider "no 'occurrence'" as a defense to coverage can be consequential. In *Erie Insurance Exchange v Muff*, et al., 851 A.2d 919 (Pa. Super. 2004), the Pennsylvania Superior Court held that a babysitter's conviction for first-degree murder of a one-year-old girl in her care did not preclude coverage because the conviction did not conclusively establish her intent regarding certain negligent acts alleged in the complaint. You read that right—first-degree murder conviction and coverage was not precluded.

In *Muff*, the argument was made that the babysitter was negligent, careless, or reckless before and after she intentionally caused the death of the infant. Specifically, the babysitter allegedly dropped the infant twice and then failed to provide care to or summon assistance for the injured child. The Superior Court stated, in matter of fact fashion, that such allegations were sufficient to support a negligence action against the babysitter, and, thus, qualified as an "occurrence" or "accident" under the policy.

But were such allegations really an accident or occurrence? Justice Castille, based on his concurring opinion in *Greenfield*, may not have seen it that way. He noted that it was alleged that the insured was negligent for not caring for the overdose victim, presumably when there were signs of trouble caused by the heroin. While this was not pursued as a separate ground for limited relief, Justice Castille made clear that, even if it were, it wouldn't have affected the coverage outcome: "Greenfield's failure to inquire after Smith's condition or to seek assistance for her may have been indifferent, or even callous, but it was hardly 'accidental.'" *Greenfield* at 870, n.3. Thus, at least to the extent that *Muff* involved separate allegations of negligence on account of the babysitter's failure to summon assistance for the injured infant, the Superior Court may have erred by summarily concluding that such allegations qualified as an accident or occurrence.

The South Carolina Supreme Court's decision in *L-J* demonstrates that, in the construction defect context, policyholders sometimes overlook the critical requirement of a CGL policy that bodily injury or property damage must be caused by an "occurrence." The Supreme Court of Pennsylvania's decision in *Greenfield* reveals that the "occurrence" requirement is sometimes overlooked in the "expected or intended" context as well. ■

Emerging Issues: Unsolicited Communications and Silica

by Domenick J. Yezzi Jr., CPCU

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A CPCU since 1979, Yezzi has more than 30 years' experience in the insurance industry, 25 of them with ISO. Before joining ISO, he was an assistant director of research with the Independent Insurance Agents of America and a property and casualty insurance agent. Yezzi originally began his career as a life insurance agent.

Yezzi holds an M.S. degree from Long Island University and an undergraduate degree from Siena College.

Changes in technology and in societal attitudes have been testing the skills—and the patience—of many insurers. Some of these changes follow the same theme, thereby allowing them to be categorized as trends that might affect many policies. Within insurance entities, the job responsibilities of key managers have been expanded to include identifying and tracking these emerging trends. But just because an item is placed on an emerging issues list, it doesn't necessarily follow that a major impact on insurance coverage will result, or that the issue will have a negative effect on insurance rates. Sometimes just heightened awareness within the underwriting or claims-settling ranks are sufficient to handle an issue, while at other times a resolution may not be achieved until the other end of the spectrum—legislative or regulatory action—has been taken.

Here are a few examples of the current issues that analysts are following:

- **Genetically Modified Organisms**—Genetic modification of crops and animals for greater yield, better taste, or medicinal purposes may have as yet unknown and unintended consequences.
- **Identity Theft**—Much has been written about identity theft, and more work needs to be done to implement more stringent safeguards.
- **Nanotechnology**—Questions have arisen over the breakdown of materials or machines built through this process, which involves manufacturing at the molecular level.
- **Pressure-Treated Wood**—The current chromate copper arsenate mixture (which has been found to leach arsenic, with possible attendant health consequences) is being replaced with an alkaline copper quaternary mixture, which requires a specific type of fastener for long-term structural integrity.
- **Spyware**—Software that monitors Internet usage or records keystrokes and can be used for more nefarious purposes.

Two emerging issues—violations of statutes in connection with e-mail, facsimile transmissions, or phone calls, and silicon and mixed dust—are worth exploring in more detail, since they have raised such a level of concern as to cause some insurers to adjust the wording of some insurance contracts.

Violations of Statutes in Connection with E-mail, Fax, or Phone Calls

In 1991, the Telephone Consumer Protection Act (TCPA) became law. It addressed concerns about certain telephone marketing practices. This law permits the Federal Communication Commission to establish a national do-not-call registry for consumers who wish to avoid telemarketing calls. The TCPA also prohibits the use of any device to send an "unsolicited advertisement" to a telephone facsimile machine. An unsolicited advertisement is defined as "any material advertising the commercial availability or quality of any property, goods, or services which is transmitted to any person without that person's prior express invitation or permission." A company placing any such telemarketing calls is subject to fines as much as $500 per junk fax. Willful or knowing violations can be punished by tripled fines.

Several attempts to gain coverage for the liability attached to such violations under the personal and advertising injury liability coverage of the commercial general liability (CGL) policy have been successful, in some cases treating the "junk fax" as an invasion of privacy. There have also been successful attempts to gain coverage for such acts under "property damage" coverage for the lost ink, facsimile sheets, and loss of use of the recipient's facsimile machine. In *Prime TV, LLC v Travelers Insurance Co.*, the court explained that, although the marketing company intentionally sent faxes to recipients who had no desire to receive them, the marketing company believed that the recipients wanted the information concerning their satellite television services.

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There are currently many do-not-call registries operated by individual states, and the possibility exists that attempts at coverage, similar to the claims described above for faxes, will be made with regard to the federal and state registries.

A similar area that causes liability insurers concern is e-mail spam. Congress passed the Controlling the Assault of Non-Solicited Pornography and Marketing Act of 2003 (CAN-SPAM), which imposes limitations and penalties on the transmission of unsolicited e-mail messages. Many states have passed legislation that imposes legal restrictions on the sending of unsolicited commercial e-mail. Some state laws require that commercial e-mail include a label in the e-mail subject line or header showing it is an advertisement. Other states require that unsolicited bulk commercial e-mail messages must include opt-out instructions and contact information.

Although insurers have not yet seen similar cases relating to spam e-mail, the insurance allegations are potentially similar to those involving mass facsimile transmissions; that is, attempts may try to gain coverage as property damage by alleging that the volume of e-mails caused the loss of use of a computer system, and as personal and advertising injury due to the e-mails being considered an invasion of privacy.

The intentional nature of these acts, and the general awareness of the negative reaction of many to such unsolicited contacts, provide support for the conclusion that insurance for such acts is not appropriate. These are also key reasons for the laws being passed to prevent and punish such acts.

It is not likely that insurers intend to provide coverage for property damage or personal and advertising injury claims that arise out of these intentional acts in which the kind of alleged damage is generally known in advance, given such provisions as the Intentional Acts exclusion under Coverage A and the Knowing Violation of Rights of Another exclusion under Coverage B. However, the apparently widespread violations of the TCPA, spam e-mail, or do-not-call lists seem to invite a specific reaction to eliminate any issue on that score. Even if such an exclusion did not apply in a given case, coverage is inappropriate given the intentionally intrusive nature of such acts and the statutory efforts to prohibit them.

The intentional nature of these acts, and the general awareness of the negative reaction of many to such unsolicited contacts, provide support for the conclusion that insurance for such acts is not appropriate.

An additional exclusion under Coverage A and Coverage B would support the preclusion of coverage for liability arising out of unsolicited faxes, phone calls, and e-mails. ISO has developed a general liability endorsement that will be triggered by a violation of the federal statutes, which prohibit the sending of certain unsolicited material. The exclusion will apply to "bodily injury," "property damage," or "personal and advertising injury" arising directly or indirectly out of a violation of the TCPA, the CAN-SPAM Act of 2003, or any other similar laws or regulations prohibiting the sending, transmitting, or communicating of certain material or information.

This exclusionary endorsement, and a similar exclusionary endorsement for commercial liability umbrella, have been filed as mandatory endorsements for a March 2005 effective date.

Silica and Mixed Dust

The past year has seen an increase in silica-related claims and lawsuits. While patterned on asbestos, these suits will probably never reach the level of the immense asbestos litigation in its impact on business and insurers. This new wave of lawsuits is on behalf of thousands of workers who have silicosis, the oldest known occupational disease. It is a respiratory disorder caused by inhaling silica particles from quartz found in rocks and sand. Defendants include companies involved in stone and quartz mining, industrial sand processors, construction, refinery operators, and safety-equipment manufacturers. Mixed dust or pneumoconiosis claims are also on the rise, and may be used in attempts to get around labeling the claim as either asbestosis or silicosis.

Beyond the plaintiffs who have actually developed symptoms of disease, there is a whole body of claims being made out of fear of a disease. Claims could be submitted when traces of silica or mixed dust have been found in a person's house or lungs, although no symptoms have resulted from the contact. These "fear claims" need not be limited to diseases, but include medical devices as well, such as breast implants and heart valves.

Although the full impact of these various cases on general liability insurance is not yet clear, the frequency of these claims and the apparent similarity of these claims to asbestos claims have made silica an area of concern for many insurers. Currently, the majority of the silica claims seem to arise out of workplace exposures and, as such, would appear to be subject to the workers compensation exclusion in the General Liability form. However, as we've seen with asbestos, there also may be attempts to submit claims under different areas of insurance coverage or policies, for example, products liability or premises/operations under general liability insurance.

The National Institute for Occupations Safety and Health (NIOSH) and the Department of Labor (DOL) have indicated that the following industries have the greatest potential exposure of silica dust:

- construction (sandblasting, rock drilling, masonry work, jack hammering, tunneling)
- mining
- foundry work
- stone cutting
- glass manufacturing
- agriculture
- shipbuilding
- ceramics
- railroad
- manufacturing of soaps and detergents
- manufacturing and use of abrasives

Ohio has passed laws that specify the medical criteria for filing asbestos and silica lawsuits. The statutory asbestos and silica medical criteria place limits on lawsuits, requiring a plaintiff to provide medical evidence to prove that exposure to asbestos or silica was a substantial factor in causing his or her illness. The laws were passed amid allegations that unimpaired claimants were clogging the justice system and, in some cases, potentially prohibiting the truly sick claimant with a severe asbestos-related illness from receiving equitable legal and financial remedies. The laws also provide that no damages shall be awarded for fear or risk of cancer in any tort action asserting only a silica claim or a mixed-dust disease claim for a nonmalignant condition.

Although the full impact of these various cases on general liability insurance is not yet clear, the frequency of these claims and the apparent similarity of these claims to asbestos claims have made silica an area of concern for many insurers.

While it has long been ISO's practice not to single out specific types of products or materials for exclusion, concern about these materials has led insurers to file with state insurance departments exclusions for silica and mixed dust. Given this concern, ISO filed an optional silica and mixed-dust endorsement for a March 2005 effective date. ■

Choosing a Claims Consultant

by Donald M. Huffer, CPCU, AIC, AIM

Donald M. Huffer, CPCU, AIC, AIM, is a casualty claims consultant with Liability Management Systems, LLC, a subsidiary of the FSC Group. He is a specialist in asbestos, mass tort, and environmental insurance claims and coverage. His extensive experience in the analysis, management, and defense of such claims, as well as the projection and control of claim losses and expenses has established his authority as an advisor and an expert witness. Huffer has directed the defense and negotiated the settlement of thousands of suits and effected the resolution of numerous coverage-in-place, cost sharing, policy buy-back and cost guarantee issues. He also has led the development of claims management and claims processing systems for large insurers and for Fortune 500 companies.

Huffer, formerly the environmental claim officer for The Kemper Insurance Companies, is a member of the Environmental Claim Manager Association, the Justice in Asbestos Committee, and the former president of the Lead Litigation Association.

Over the last 50 years, claims handling has changed dramatically. In the 1950s and most of the 1960s, the person assigned to handle a claim was known as a field adjuster. This person—equipped with a company car, a statement pad, and a set of field drafts—met in person with the insured claimant and the witnesses.

It was then determined that a greater volume of claims could be more efficiently adjusted from a desk in the claim office. The new claims handler was equipped with an electronic recording device to capture the insured, claimant, and witness statements. No longer did the adjuster go to the accident scene to look for physical evidence. No longer did the adjuster meet in person with the claimant to assess whether his or her version of the accident was credible. The objective became to obtain the maximum number of claims that could be reasonably handled in a single day.

The move to handle claims from inside the claims office continued and soon only large exposure cases warranted actual field investigation. Carriers even changed the traditional adjuster title whose job it was to adjust claims (everyone knew it was not an upward adjustment of the claim value being pursued!) to the more customer-friendly claims representative or claims examiner.

Claims handling was further changed in the 1970s with the introduction of the computerized claim systems. No longer did clerks need to type out multi-part drafts. No longer did it take weeks to get a check out the door; checks were now issued in a matter of days. The increased efficiency of the claims-handling process resulted in fewer people handling more claims. The new century brought with it many changes: the "unbundled" policy underwriting concept, the development of third-party administrators (TPA) to handle claims, policies with higher policy limits, larger self-insured retentions, and the need to outsource some claim-handling functions to achieve an acceptable expense ratio. The changes were designed to make the insurance companies more competitive and profitable. While they achieve new efficiencies, these changes bring about new challenges and the need for another set of specialists (the claims consultants) to streamline the claims-handling process. Carrier claim staff, TPAs, and independent adjusters are trained and equipped to handle routine claims but do not process the expertise nor experience to handle the mass tort mega claim. The claims consultant can bring to the claims process the expertise and experience in handling the large exposure claims not found on staff or at a TPA or independent adjusting firm.

The claims consultant is a relatively new concept and needs to be defined so it is not confused with the traditional concept of the independent adjuster or third-party administrator. Claims today generate far larger financial exposures than in the past. For example, look at the potential financial exposure to a car manufacturer and its carriers if defective tires have been determined to be the cause of multiple accidents with severe personal injuries, or the financial exposure to a drug manufacturer of a diet drug found to cause heart problems. Loss potential in these cases frequently exceed the $25 million to $50 million policy limits of a carrier's excess policies. While a third-party administrator or independent adjuster handles routine claims, a claims consultant works on more complex claims where the context of the claim is more unusual, such as product recall claims, environmental claims, or other mass tort type claims such as asbestos or construction defect claims. The claims consultant should be considered a resource, a source of knowledge and experience for an insured faced with the potential of a major loss.

When Do You Need to Hire a Claims Consultant?

A three-step test can be used to determine if the employment of a claims consultant is necessary in a specific claim scenario:

1. **Do existing staff members have the expertise and experience necessary to properly develop and conclude the claim(s)?** Complex claims require special skills in claim management, analysis of coverage, defense strategies, negotiating techniques, and

experience in handling class-action litigation. Existing internal staff probably does not have the expertise and experience necessary to properly develop and conclude the claim, and, even if they do, their internal work may be substantially impacted.

2. **Is there a senior-level staff person available to handle the claim?** If senior-level staff members are occupied with their daily workload, a claims consultant can be brought in to manage an unusually large and time-consuming complex claim, freeing senior staff to devote their time to routine business.
3. **Does the claim generate a potential financial exposure sufficiently large enough to warrant the employment of an experienced and knowledgeable claim consultant?** When the claim is unusually large and the exposure reaches into the millions of dollars, a qualified claims consultant can use his or her quantitative skills to estimate the size of a firm's exposure as well as use his or her claim experience to manage the claim.

The test is simple and it does not require extensive work to reach a logical and supported conclusion. If staff does not possess the expertise or experience, the claim(s) will never be properly evaluated nor will the defense and/or settlement negotiations strategy options be thoroughly explored to assure the best possible result.

The following example illustrates how a claims consultant can benefit an insurance carrier or a company facing a claim.

The insured is a processor of a prepackaged food product. Numerous cases of illness from eating its product have been reported. Listeria has been identified as the cause, and a major recall campaign has been initiated by the insured. The insured's customer service center is receiving hundreds of calls per day: some related to returning the product, some requesting information about listeria, and some calls by persons reporting claims. The claim reports are sent to the product liability insurance carrier and the product recall carrier, and now questions about how the claim will be managed are being raised.

The company and its insurance company, using the test above, determined it would employ the services of a claims consultant. In this case, a large number or claims were reported, the company's senior-level staff were overwhelmed by the number of calls, and the parties involved wanted insight into how to deal with listeria. Hence, a claims consultant was engaged.

The employment of the claims consultant can bring coordination between the efforts of the insured, insurers, and their counsel. The consultant can arrange meetings of various parties to ensure all assigned tasks were underway and that no duplication of efforts exist. A consultant who has experience in these types of claims will know the claim issues that need to be addressed and how to most efficiently and effectively bring closure.

The claims consultant, however, can also add value before a loss has occurred. He or she can be engaged to prepare a pre-loss plan that takes into account various identified risks. For instance, if a pre-loss product recall plan had been developed before the listeria problem in our example arose, the insured would have known how to deal with the media, the product recall notifications, the hundreds of calls jamming its consumer phone center, and, most importantly, how to deal effectively and fairly with its customers.

Choosing a Claims Consultant

Once a party has determined it needs a claims consultant, the qualifications of the claims consultant need to be carefully reviewed to assure the consultant possesses the resources, knowledge, and experience necessary to deliver a quality product that will generate overall cost savings at the end of the day.

A claims consultant should posses the following qualifications and characteristics:

- claims management experience and skills
- effectively led others through difficult claims
- an outgoing personality who can objectively evaluate the work that needs to be done
- a good analytical mind for complex claim scenarios
- extensive experience in the area of need
- substantial knowledge of insurance coverage and experience in handling complex coverage issues
- substantial experience in handling complex liability situations including class-action litigation
- extensive experience in evaluating bodily injury and property damage liability insurance claims
- extensive negotiating experience including negotiation of buy-back agreements, coverage-in-place agreements, cost-sharing agreements, class-action settlements, and claims administration agreements
- information, systems, and staff available that permit development of state-of-the-art recommendations

Not every claim requires the experience and expertise of a claim consultant and in fact the vast majority of claims do not demand that level of expertise. However, there are those situations where the required claim expertise needed in a complex mass tort case is not on staff or available in the routine handling resource. Those situations need to be acknowledged. There is no greater advertisement or compliment an insurance company can earn than an insured who said, "My insurance company stepped up and took charge of a major claim we faced and brought comfort and peace of mind to our management and our injured customers quickly and professionally." ■

California Workers Compensation Permanency Reform: Providing the Tools for Cost Containment

by Mark J. Nevils, J.D.

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Nevils is a member of the law firm Insurance Recovery Legal Associates and is a frequent speaker on second-injury fund issues and best practices. He previously wrote an article for the CPCU Society's March 2004 *CQ* regarding second-injury funds.

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

The 2004 amendment to the California Workers Compensation Law (SB 899) has several ambiguous substantive and procedural changes, some of which are already under judicial review, with more to come. Even with these outstanding questions, the new law contains statutes with clear and valuable cost-containment tools that became effective on April 19, 2004, the date of enactment.

Carriers and employers must learn how to use these new cost-containment tools as soon as possible to create the savings that the law intended. They should not simply rely on the new law to reduce costs without re-evaluating how information is obtained and used during the claims process.

Apportionment of Permanent Disabilities

One of the major cost-containment tools afforded by the law is the new legal standard for potential entitlement to permanent disability benefits once a claimant's condition becomes permanent and stationary.[1] For claims where there was no existing order for permanent disability benefits before April 19, 2004, new Section 4663(a) applies, stating, "Apportionment of permanent disability shall be based on causation."

More specifically, Section 4663(c) states in part:

> A physician shall make an *apportionment determination* by finding what approximate percentage of the permanent disability was caused by the *direct result* of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries (emphasis added).

Previously, apportionment was based more on disability than impairment. Therefore, a carrier would be fully liable for the permanent disability of an employee who had a previous permanent disability rating (e.g., 50 percent) if that employee was "medically rehabilitated" and was working in his usual and customary job at the time of the most recent injury.

The new law is meant to relieve the carrier and employer of any permanent disability not directly caused by the new work injury. Obvious cases are those when a claimant had a prior permanent impairment to a specific body part (e.g. knee) and now receives a new injury to the same knee. There will also be many less obvious cases needing an expert eye to identify and prove apportionment.

AMA Guidelines

To achieve a more uniform system, the new law also requires physicians to use the fifth edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairments* on a prospective basis when determining permanent impairment and apportionment.[2] Claims personnel should not underestimate the importance of a physician's understanding and proper use of the AMA guides when evaluating permanent impairment and apportionment. Even on those claims where the AMA guides may not be required, a physician that understands the AMA guides will not be tied to a claimant's subjective complaints when determining permanency and making apportionment determinations in the absence of objective findings.

It is noteworthy that physicians are not making the final determination of a claimant's permanent disability or "diminished future earning capacity"[3] but simply triggering the process to make that determination. As the AMA guides state, impairment ratings are "not intended to be used for direct estimates of work disability," AMA *Guides*, at 9.

How to Use the Cost-Containment Tools

To make the most accurate impairment determination (with or without the AMA guides), a physician should be provided with as much information as possible, including, but not limited to, the claimant's pre-injury medical information (work- and non-work-related). A physician should use this information to fully evaluate the proper time for a permanent and stationary determination and the direct cause of any permanent impairment as a result of the work injury. An accurate determination of when a claimant is permanent and stationary and to what degree the permanent impairment rating is related to the work injury is crucial because it is the first step of a calculation used to determine the claimant's permanent disability rating.

To maximize the new law's benefits, an integrated system is required to analyze and effectively use the expertise of claims professionals, medical professionals, and attorneys. Proper documentation must be obtained in a timely manner, and the physician responsible for ultimately writing the final permanent impairment opinion must have this documentation plus a solid understanding of apportionment and the AMA guidelines. Only then will a claims staff be able to secure a proper permanent impairment and apportionment opinion that will expedite the resolution process. At the very least, an expert opinion based upon solid objective evidence will leave little room for subjectivity if the case needs to be litigated.

Conclusion

Workers compensation carriers, self-insureds, and TPAs must understand that maximizing the tools provided in the new California statute requires new systems to recognize a "total cost" savings. Simply sitting back and relying on the same process and personnel will not achieve the cost-saving measures that the law intended. ■

Endnotes

1. "Permanent and stationary status" is the point when the employee has reached maximal medical improvement meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment.
   8 CCR 9785(a)(8)
2. "In determining the percentages of permanent disability, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee and his or her age at the time of the injury…" Sec. 4660 (a)

   "For purposes of this section, the 'nature of the physical injury of disfigurement' shall incorporate the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the American Medical Association (AMA) *Guides to the Evaluation of Permanent Impairment* (5th Edition)" Sec. 4660(b)(1).
3. Sec. 4660(a)

Claims Quarterly Newsletter Article Index—2004

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

If you missed any of the following CQ articles this past year, you can find them on the CQ tab, on the Claims Section web page, http://claims.cpcusociety.org.They also can be found on the Society's online library. If you would like a hard copy of any article please contact me directly, at marcia.sweeney@thehartford.com.

Volume 22, Number 1 March 2004

The Ohio Scott-Pontzer Case Is Reversed—How Did It Happen in the First Place?
by Robert McHenry, CPCU, AIC, AIS

When Property and Casualty Insurers May Share Claim Information
by John Halvorsen

Second-Injury Funds—Still a Valuable Cost-Containment Tool
by Mark J. Nevils, J.D.

Claims Section "Pioneers"—A Short History of the Claims Section
by Marcia Sweeney, CPCU, AIC, ARe, ARM, AIS

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Is Big Brother Watching You? An Update on the Vehicle "Black Box"
by Richard Stevens

The Invisible Pocketbook
by Tony D. Nix, CPCU, CIFI

Leadership: The Dynamics, Challenges, and Transformation in a Changing Corporate Environment
by Brian N. Marx, CPCU

Volume 22, Number 3 September 2004

The Effect of Technology and Automation on Workers Compensation Claims Practices
by James R. Jones, CPCU, AIC, AIS, ARM, and Michael R. Williams, Ph.D.

Guidelines for Handling a Builder's Risk Claim
by the Inland Marine Underwriters Association (IMUA)

Surfing on the Subject of Experts
by Donald S. Malecki, CPCU

Volume 22, Number 4 December 2004

Structured Settlements—2004 and Beyond: A Guide for the Claims Professional
by Thomas R. Woodrow, Esq.

Where Has All the Professional Adjuster Training Gone
by Jonathan Stein, J.D., CPCU

CPCU Society National Service:

Is It Time for You to Volunteer?

There are 14 interest sections, four standing committees, ad-hoc task forces, national governors, section governors, and officer positions that compose the CPCU Society's family of volunteers. The success of the CPCU Society lies in the effectiveness of these volunteer leaders.

There are many ways you can apply your talents and skills at the national level, and now is the time to consider applying for a position for the upcoming year.

We are enclosing the "Application for CPCU Society National Service" in this CQ. The application provides a brief description of the positions and the qualifications. For more detailed information, please visit the Society's web site at www.cpcusociety.org, click on "Membership," then click on "Volunteer for Society Service." ■

Application for National Service

Background Information

Our mission statement defines the future of the CPCU Society. Our success in carrying out that mission is dependent on the quality and effectiveness of our volunteer leaders. Your willingness, as a volunteer, to offer your time and talents is vital to our continued success.

There are many ways to apply your skills at the national level. For each national position we have included a brief description of duties, time requirements, "competencies," and experience desired. For a complete description of each position, the anticipated time and financial commitments required, and "competency" definitions, visit the CPCU Society web site at **www.cpcusociety.org**.

Name

Company Title

Preferred Mailing Address

City, State, Zip

Phone Fax E-Mail

CPCU Society Member Number Designation Year

Current Chapter/Section Region

Personal Data (Complete or Attach Résumé or Curriculum Vitae)

Insurance-Related Studies:

Other Professional Designations:

Highest CPCU Chapter Office Held: Year(s)

Chapter Committee Work:

Highest National Society Position Held: Year(s)

National Committee Service:

National Task Force Service:

National Section Service:

Other Insurance Activities (list organization(s) and highest office(s) held):

Other Volunteer Activities (list organization(s) and highest office(s) held):

Special Awards:

Publications:

Other Noteworthy Achievements:

Complete reverse side also.

Personal Summary

Please summarize your professional competencies and how you would use them to further the Society's mission.

Elected Offices—Check Applicable Box(es)

The applicant who receives a nomination for these positions will have his or her name submitted to the membership for election.

■ **National Officer:**

☐ ***Vice President (four-year commitment)***
Desired experience for this position includes leadership roles in local chapters and/or sections, and national committee or task force work. Demonstrated leadership experience in business, professional, or nonprofit organizations is also required. If nominated, the applicant is expected to be highly visible, represent the Society at various public functions, attend all required meetings, and automatically move into the president-elect, president, and immediate past president offices. Desired competencies include high energy, vision, organizational and interpersonal skills, and the ability to command, communicate, and motivate.

☐ ***Secretary-Treasurer (three-year commitment)***
This position requires attendance at all national meetings and an understanding of accounting and finance issues. Related business, professional, nonprofit, or chapter experience is desirable. Desired competencies include business acumen, process management, strategic agility, and functional skills.

■ **National Governor:**

☐ ***Regional Governor (three-year term)***
This position addresses both local chapter and national concerns. Attendance at all national Board meetings is required. Demonstrated leadership experience in business, professional, or nonprofit organizations, and local chapter or national committee/task force is suggested. It also requires the financial and time commitment to visit and assist local assigned chapters. Desired competencies include managerial courage, vision, organizational and interpersonal skills, intellect, and proven decision quality.

☐ ***Section Governor (three-year term)***
This position addresses the needs of the Society sections and their members. Attendance at all national Board meetings is required. Demonstrated leadership experience in business, professional, or nonprofit organizations, or national section committee is suggested. Desired competencies include managerial courage, vision, organizational and interpersonal skills, intellect, and proven decision quality.

Appointed Positions—Check Applicable Box(es)

National Standing Committee and Section Committee Service

■ **Standing Committees:**

☐ Budget & Finance ☐ Ethics ☐ Nominating
Three "standing committees" are focused on the ongoing needs of the Society. National committees do not change from year to year. A commitment to promote the best interests of the CPCU Society is required. For Budget & Finance, applicants should have appropriate functional skills.

☐ Executive Committee
Eligibility for the Executive Committee is limited to governors serving the last year of their term of office. Desired competencies for the Executive Committee are similar to those for governor.

■ **Section Committees:**
Sections operate within the organizational framework of the CPCU Society and support the overall Society mission. Their specific focus and perspective are centered on common issues affecting their special interest groups. Many of their activities relate to the educational needs of their section members. The position requires attendance at all national meetings. Typical projects include seminars, symposia, publications, newsletters, and research. Desired competencies include functional/technical skills, business acumen, planning, and organizing.

☐ Agent & Broker Section
☐ Claims Section
☐ Consulting, Litigation, & Expert Witness Section
☐ Excess/Surplus/Specialty Lines Section
☐ Information Technology Section
☐ International Insurance Section
☐ Loss Control Section
☐ Personal Lines Section
☐ Regulatory & Legislative Section
☐ Reinsurance Section
☐ Risk Management Section
☐ Senior Resource Section
☐ Total Quality Section
☐ Underwriting Section

Please complete this application and return to: Executive Vice President, CPCU Society, 720 Providence Road, Malvern, PA 19355 or fax to (610) 251-2761

Claims Section Wins the Gold—Three Years Straight!

by Richard A. Litchford III, CPCU, AIC

Richard A. Litchford III, CPCU, AIC, is director of claims for Sequoia Insurance Company. With 31 years of management experience in the insurance and financial services industry, he specializes in process analysis, organizational analysis, design and implementation of regional and national claim management programs, dispute resolution, legal, underwriting, reinsurance, contract negotiation, and catastrophe loss management. Litchford is a member of the CPCU Society's Claims Section Committee and has served as the Brandywine Valley, Del/PA Chapter's research activity chairman. In addition to his CPCU, Litchford holds the AIC designation and graduated with a B.A. degree in political science and history from High Point University.

Congratulations are again in order as the Claims Section was awarded the Circle of Excellence Gold Award for the third year running.

The Circle of Excellence Recognition Program was developed to recognize CPCU Society interest sections that achieve a high level of visibility through participation in various goal-oriented activities.

The mission statement for this program is as follows:

> Awards are a tool for section leaders to utilize for encouraging innovation in adding value to section membership and recognizing contribution.

Interest sections submit their yearly activities each June. A special task force reviews the list of activities in light of how well they facilitate the annual strategic goals of the Society. Each activity is evaluated based upon quantitative or qualitative work, or a combination of both.

Goal #1—Make CPCU the most widely recognized, valued, and highly respected professional designation/brand in the property and casualty insurance industry by CPCU employers, key segments of the financial services industry, and other important audiences.

In this area, the Claims Section performed the following activities:

- We conducted workshops and presentations at the National Association of Subrogation Professionals.
- **Brian N. Marx, CPCU,** authored a chapter of Text for the AIC 34 Workers Compensation Program; and presented "Lien Negotiation Theory" to the National Association of Subrogation Professionals.
- **Eric J. Sieber, CPCU,** offered a presentation on excess verdicts to the California El Camino Chapter, and was a course leader for CPCU and INS 22.
- Many of our section leaders are active in the AIC Segmentation Program managed by **Donna J. Popow, J.D., CPCU,** who is also one of our section leaders.
- **James A. Franz, CPCU,** participated in a well-known public radio program, Bill Bailey's *It's Your Money*.
- Section leaders offered instruction to the NIBC Academy.

CIRCLE OF EXCELLENCE RECOGNITION PROGRAM

- **Tom Cetkosky, CPCU,** made a presentation for a local chapter's I-Day.
- **Christian J. LaChance, CPCU, CLU,** participated in an educational symposium for financial service professionals.
- The Claims Section produced a standing-room-only presentation at the Annual Meeting and Seminars on catastrophe response.

Goal #2—All Society members have access to a continually increasing number of programs and services that position them for success.

This goal involves corresponding activities, including the publication of our highly regarded Claims Section newsletter, and the establishment of a Claims Section web site with a message board and much more.

Here are the activities that were submitted for consideration:

- **Marcia A. Sweeney, CPCU, AIC, ARe, ARM, AIS,** editor of the quarterly CQ newsletter. Going the "extra mile," Marcia produced five newsletters and a total of 96 pages. Topical areas included property, workers compensation, fraud, law, liability, and auto. Feature articles were presented on claims technology, claims training, claims customer service, career development, and leadership. Other articles supported Society initiatives on web site development, "Spread the Word!," and national service. We profiled Claims Section Committee members

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Claims Section Wins the Gold—Three Years Straight!

Continued from page 15

and had several articles on our claims liaison program, a program designed to reach out to the local chapters. One feature article outlined the history of the Claims Section, and another the history of fire marks. We are pleased to report that 19 articles were written by CPCUs.

- **Eric J. Sieber, CPCU,** not to be outdone, has assumed primary responsibility for bringing the Claims Section into the 21st century with our very own web site. We offer surveys, have an electronic copy of current and past Claims Section CQs, and we answer questions submitted by section members in a message board format. We even offer comments and discussion on coverage issues. Check it out!
- In the area of publications, I co-authored a paper entitled "Effective Communication," which was subsequently used to create a PowerPoint presentation. Claims Section members are permitted to use the material as in-house or chapter meeting presentation.

Goal #3—Stewardship

- Various committee members staffed the Sections Booth and the New Designee Open House at the Annual Meeting and Seminars.
- **Marcia A. Sweeney, CPCU, AIC, ARe, ARM, AIS,** initiated an idea we call the Chapter Liaison Program, which is currently managed by **Tony D. Nix, CPCU.** If you want to get involved in the Claims Section and enhance your local chapter at the same time, contact us as we are looking for liaisons. Please contact Tony Nix and become the communications link between the Claims Section and your chapter. We will work with you to help you to offer speakers and programs (such as our Communication Program). You can run your own "outreach program" where you can offer programs and speakers to other non-insurance organizations in your area that might have an interest in the insurance industry.
- One of our most popular programs is the Claims Section Lunch offered each year at the Annual Meeting and Seminars. Come join us for lunch, fellowship, and a great speaker.

Now we are asking for your help. If you are a Claims Section member and want to see your name in print (or just want to make a quiet contribution), please contact **Richard A. Litchford III, CPCU, AIC,** at Rickl@Sequoiains.com or by phone (831) 657-4592.

Let us know what you are up to, as we would like to include your activities in our 2004–2005 ***run for the gold!*** ■

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