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Claims Quarterly

CQ

Volume 22 Number 3 September 2004

The Chairman's Corner

by James D. Klauke, CPCU, AIC, RPA

"We need to learn to set our course by the stars, not by the lights of every passing ship."

—Omar Bradley, General United States Army

The CPCU Society's Annual Meeting and Seminars in Los Angeles October 23–26, 2004, has a theme of "Reach for the Stars!" As Omar Bradley put it many years ago, we need to set our course by the stars. And what is your course? I would hope it is continuing education to help you climb that ladder of success.

Your Claims Section Committee has put together four seminars for the Annual Meeting in order to encourage you to come back to the Annual Meeting. Our seminars on Monday and Tuesday are the following:

- **Auto Technology: What Does the Future Hold?**
  This seminar will explore major improvements in automobile technology and how they impact the insurance industry. The session will discuss the claims handling process, body shop industry, and the policyholder. You will learn what these groups are encountering in terms of complexity and cost as well as how the industry is responding to these changes.
- **New Limitations on the Recovery of Punitive Damages**
  This seminar will discuss the recent United States Supreme Court case and the limitations it put on the recovery of punitive damages. You will learn about the effect of those limitations on the discovery and pre-trial development of your case, tactics used during the trial, and the impact the changes will have on daily claim handling.
- **Structured Settlements—A Relationship-Building Tool**
  This seminar will discuss the use of structured settlements and how it can be an effective tool to get the file closed. Issues to be discussed will be updates on regulatory issues and industry trends. It will also discuss how the use of structured settlements can improve your own productivity and success.
- **Workers Compensation Claims**
  This seminar will appeal to both claims professionals and agency personnel. You will learn strategies for the investigation and management of compensation claims that involve severe injury and extended periods of lost time.

If you're not interested in structured settlements, there is a seminar titled "Implications of Adjusting Homeowners Claims with Inadequate 'Insurance to Value'." If you're not interested in workers compensation, there is a seminar titled "The New World of Claim Handling and Insurance Relations."

In addition to our seminars, you can fill your Sunday at the meeting with any of the following courses:

- Breaking into Senior Management
- Commercial Property Coverage
- Influential Leadership
- Succeeding During Times of Conflict and Change
- Insuring Defective Construction
- Time Element—What Is It and Who Benefits from It

As you can see, the Claims Section and the Society have put together the kind of seminars that will help you in "your career path." The Annual Meeting and Seminars is in Los Angeles, which is one of the best airfare cities in the United States. With a Saturday night stay, you may be looking at "coast to coast" fares under $500 if timely purchased. Your total cost can be well under $2,000. Now is the time to approach your management and obtain approval to attend this dynamic, claim-oriented, 60th CPCU Society Annual Meeting and Seminars.

Finally, we have revamped the web site and added more areas to peak your interest. There is a discussion board where you can place a topic and get feedback from other section members. We are working on getting all the past articles written by section members to a location where you can review them or copy them for reference. We also look for your ideas as to anything you would like to see on the site.

In closing, the Claims Section Committee members look forward to seeing and meeting you at the Los Angeles Annual Meeting and Seminars. Your career will benefit from attendance. ■

"Ideas are like stars; you will not succeed in touching them with your hands. But like the seafaring man on the desert of waters, you choose them as your guides, and following them you will reach your destiny."

—Carl Schurz (1829—1906), Politician

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.

- **James R. Jones, CPCU, AIC, AIS, ARM,** is the executive director of the Katie School of Insurance and Financial Services, Illinois State University. Jones has been a long-time member of the Claims Section and has been involved in insurance claims since 1984.
- **Michael R. Williams, Ph.D.,** is professor of marketing, Illinois State University.

About the Research and Sponsoring Organizations

James R. Jones, CPCU, serves as executive director of the Katie School at Illinois State University. His research partner is Michael R. Williams, Ph.D., who has researched numerous industry performance issues. The Katie School provides top talent to the industry through its leading undergraduate program. It also adds value to the industry by providing top-flight industry-focused research and professional education. A full report is available from the Katie School for a $500 donation to student scholarships. Interested parties should contact Jim at (309) 438-7754. Corporate Systems, the sponsoring organization, is a 36-year-old company that offers P&C risk information management, claims lifecycle management and medical cost management automation. Corporate Systems seeks to add value by providing scalability, reliability, data security, and customer responsiveness. At the time of this writing, the company was involved in a merger agreement with Marsh Risk Technologies.

The Motivation for This Research Project

Our motivation for this project was right in front of us every day. The escalating costs of workers compensation is constantly highlighted in the news. The rate of increase in indemnity (loss time) severity is running at more than three times wage inflation. The rate of increase in workers compensation medical severity has been running as much as 7 percent higher than medical inflation, as overall medical losses now exceed indemnity losses. Industry reserve deficiencies in 2003 totaled more than 18 billion dollars. Before 2003, combined ratios had deteriorated for six consecutive years and 38 percent of the failed insurers in 2002 were active in workers compensation. In that same year, the annual cost of unintentional workplace injuries and deaths exceeded $130 billion including wage and productivity losses, medical costs, and combined investigation and administrative expenses.

Companies are struggling with identifying important cost drivers and examining leverage points where they can apply tools and/or new practices to help improve results. As the challenges pile up, the solutions seem slower to come. Information about how companies can improve effectiveness in managing costs has been limited. Underscoring the need for greater managerial knowledge is the fact that existing methods that do address some of the problems seem underutilized.

Part of the solution is likely to be in the form of better technology and enhanced utilization of existing technology. The need to better understand how technology could be most effectively used to address these issues was the primary motivation behind this research study.

The Katie School research project recognized that claims cost management is a "team sport" and for this reason the study takes a comprehensive approach by combining interviews and surveys from insurers, third-party administrators (TPAs), brokers, and risk managers across the multiple levels in the workers compensation claims process. The goal was to provide an objective and holistic view of the entire claims management process identifying key problems and priorities, and interpreting desired solutions and best practices.

The Research Objectives

The objectives of the study included the following:

1. Determine the overall "points of pain" in workers compensation claims.
2. Determine the extent to which different technologies were employed to address the points of pain and improve outcomes.
3. Determine the kinds of benefits companies attained from the use of these technologies.
4. Determine what obstacles exist in implementing technologies.

These objectives were the main focus of the research as it developed through the various phases.

The Research Phases

This project began in July 2003. Consistent with accepted research practice, the initial phases of the research project involved gathering information from existing literature, brainstorming with industry knowledge experts, and conducting structured interviews across multiple types of organizations at various levels of the organizations. This was followed by a pilot

research survey with a limited number of participants. Finally, a national survey was conducted. This national survey ran from January through June 2004.

The Interviews

Practitioners and executives at insurance carriers, TPAs, brokers, and employer corporations were included in a series of structured interviews conducted by the Katie School in the summer and fall of 2003. Interviewees came from a broad group of presidents, chief information officers, senior vice presidents, claims managers, brokers, and risk managers. All of the interviews involved people who were familiar with the major issues and potential solutions related to workers compensation claims.

The following information captures the findings from these interviews.

Key Concerns and Problems ("Points of Pain")

The first part of each interview detailed the concerns and problems ("points of pain") facing the participants. Nearly all of these fell into the following four broad categories:

1. environmental (and beyond the direct control of the participants)
2. human resources
3. operational/administrative
4. loss costs

Although there were many commonalities especially among carriers and TPAs, several differences existed among the various groups as to the specific concerns and the extent to which the "pain" was felt.

1. Environmental Pain

A number of issues surfaced that were found in the overall claims environment and driven by factors in which neither the participants nor their companies could directly control. The participants were affected by these and developed ways to address them. In many cases, technology was seen as a way to help mitigate the consequences of these factors. The issues mentioned by the participants (in order of frequency in which they came up in the interviews) were:

1. Rising medical costs.
2. The complex and changing legal and regulatory environment (especially new laws such as HIPPA).
3. Lack of data standards and uniformity.
4. Rising severity of claims.

Solutions and Benefits

Barring legislative action, the companies cannot directly impact the benefits levels provided in a given state. It also could not change the overall rate of medical inflation. However, through improved claim processes and information they can deal with these issues better than their competitors. The use of automated medical bill repricing and provider payment, the appropriate use of nurse case managers, application of expert systems and rules-based engines to assist in better claims handling, and providing more information about "at-risk" claims along with increased, detailed reporting of loss information were seen as viable ways to mitigate the costs of rising medical and indemnity payments.

2. Human Resources (HR) Issues

Undoubtedly the single most mentioned issue was adjuster turnover and lack of trained, qualified, personnel to handle workers compensation claims. This "point of pain" was felt by all participants across functions and at every level. Interviewees stated that claims were not handled effectively because of the frequent and untimely change of claim personnel. Concern was expressed because of the inability of the organization to be able to smoothly transition claim files to other adjusters following departures. There is also a general concern relating to the ability to attract qualified people to handle claims.

Trends toward centralization of claims offices and organization of claims teams around customers was seen as beneficial to customers, but had the effect of requiring adjusters to handle more jurisdictions than in the past. This created problems in helping adjusters to learn the various differences among the multiple jurisdictions. Several claim managers expressed concern that the job of adjuster had become too overwhelming.

Solutions and Benefits

The ability of the system to pull routine or non value-added jobs away from adjusters seemed to help address the talent concern to some extent. A few participants see extensive adjuster training as a solution to help adjusters feel more comfortable with their claim decisions. A few companies feel that technology (through flexible, customized exception reports) must be able to step in and help the supervisor "baby-sit" the file because the lack of adjuster talent is too pervasive.

Adjuster scorecards indicating information such as benchmarks on time, lack of activity, reserve adequacy, age of claim, status of investigation, subrogation status, and three-point contact used by supervisors to monitor individual adjuster performance were also indicated as solutions by several participants.

Online portals that help with medical, legal, and regulatory compliance were seen as effective but underutilized technologies for dealing with issues of adjuster turnover, file transition, or the issue of undertrained and inexperienced adjusters. Attracting and retaining top-quality adjusters is obviously a primary concern, but technology is perceived to have a role in addressing the current (and likely future) adjuster deficit.

3. Operational and Administrative Costs

The category with the greatest number of complaints, concerns, problems, and potential solutions were those related to operational and administrative costs. Participants recognized that the system was plagued by unnecessary expenses, often due to inefficient processes. Examples stated included the following:

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1. The lost adjuster time spent responding to claimants, employers, supervisors, auditors, and medical providers calling and asking questions related to the status of the claim.
2. The lost time spent auditing medical bills, sending bills to be audited, and adjudicating differences in fees.
3. The time lost related to paper files such as tracking files, waiting for files, and sending files. (This seemed to be expressed more by carriers than by TPA interviewees.)
4. The inability of the various claims systems to work together and share data.

Solutions and Benefits

Fortunately, this category also seemed to generate the most potential solutions, of which technology plays an important role. Document imaging and "the paperless claim file" were cited as one of the best technology solutions. For those organizations that have electronic claim files, these problems, for the most part, disappeared. The most highly touted benefit of electronic files was the efficiency of file sharing and file reviews. Several interviewees mentioned this as a "best practice" for their company.

The second-most mentioned success story was the use of automation in the medical bill review process. Automation was used frequently in the assignment and turnaround of medical bills that were reviewed manually by a centralized medical bill review unit. A couple of interviewees stated that they had taken the next step and had eliminated manual reviews for bills but instead had the system check the bill and "adjudicate" it. Turnaround time for these completely automated bills could be as little as three days depending on how many bills were in the queue (and how many were hung up because they could not be matched to a file or had coding inconsistencies). The interviewees varied widely in their implementation of this advanced technology (5 percent of bills for one company, up to 70 percent for another).

Providing user-friendly access to claim file information seemed to be the most popular solution for reducing unnecessary adjuster time on calls. Interviewees estimated between 10 and 20 percent savings on adjuster time due to online claim file access.

Overall, the need for some kind of expert system or rules-based engine was seen as a solution to help make the claim process both more efficient and also more effective in controlling loss costs. Exception reports were seen as helpful in identifying which files needed to be reviewed. This kind of report streamlined the claim audit process and reduced the number of files required for audit.

4. Loss Costs

The area in which the interviewees were focusing most of their attention is on loss costs. In addition to the environmental factors previously stated, late reporting was seen as a significant contributor to loss costs. One company said that about 25 percent of claims have late reporting, which increases claim losses. Estimates from participants are that that they could save 10 percent or more on losses with prompt reporting of claims.

Solutions and Benefits

Flexible, user-friendly reporting options, as well as financial rewards and penalties, are viewed as having some potential to improve reporting.

Several claim managers complain that claim files seem to have no strategy ("Hope is not a strategy" as one claims manager put it) and they see the value in having some kind of a decision-facilitating tool to assist adjusters. The areas that they identified as solutions holding the most promise relate to:

- Decisions as to when to bring in a nurse case manager.
- Decisions on which files have subrogation potential.
- Decisions on which files have fraud potential.
- Decisions on how to handle claims in different jurisdictions (even different locations within the same state).

Obstacles and Barriers to Implementing Technology and Process Changes

Interviewees cited a number of obstacles exist in implementing needed solutions. The obstacles were fairly similar among all participants. The most mentioned obstacle and the one considered the most serious is legacy systems. The inability of these systems to work with new technology and the cost to get these systems to integrate seemed to pose the most significant problem. This was followed closely by another obstacle that many interviewees referred to simply as "resistance to change." A number of risk managers did not trust the insurance carriers enough to adopt their systems even if their systems offered them what they needed. They feared getting tied to the carrier and loss of data ownership so they searched for other (oftentimes inferior) solutions to avoid this potential problem.

The Pilot Study

Following the literature review and a number of interviews, a short survey was given in October 2004 to about 100 participants. Participants in the pilot study placed high importance on improving such things as reserve practices, data accuracy, adjuster communications, return-to-work programs, and the ability to analyze and forecast trends in order to better allocate scarce resources to safety and loss control efforts.

The National Survey

Following the pilot study, a national survey instrument was drafted and circulated to industry practitioners to make sure that questions were clear and that the instrument captured useful information that could help companies

better understand the issues and the effect that technology has had on workers compensation claims processes and the future it might hold.

This national survey is divided into the following six parts:

A. key problems and concerns

B. classification of responder (including experience for companies and combined ratio for carriers)

C. perceived usefulness and utilization of 30 different claims technologies

D. outcomes and benefits realized from technology implementation

E. barriers and obstacles to implementing claim technology

F. workers compensation claims management technology decision-making

"Points of Pain": Key Problems and Concerns

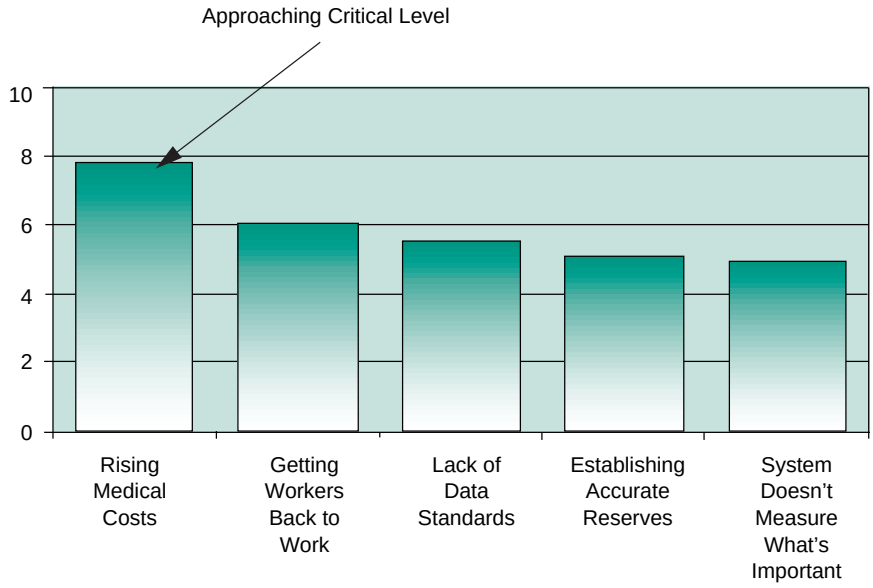
The survey asked respondents to rank 30 different claims issues on a scale of 0 to 10. Ten signified that a problem was critical, five indicated the problem was significant. The findings indicated that risk managers, carriers, and TPAs were most concerned with finding technology solutions to address the following top five problems:

1. rising medical costs
2. getting workers back to work
3. lack of data standards
4. establishing accurate reserves
5. lack of measurement of items that help improve performance

Figure 1 shows the level of concern that respondents had for the various issues.

Organizations rated the importance of ways in which to address the points of pain listed above on a scale of 0 to 10 with 10 being "extremely important" and 5 being "somewhat important." The following indicates rank order and average score of respondents for the various approaches to deal with the key issues:

Figure 1
Top Five Points of Pain



1. Reduce frequency and severity of losses (8.66).
2. Improve reserve accuracy (8.66).
3. Improve customer satisfaction (8.56).
4. Reduce loss costs (8.43).
5. Improve return-to-work results (8.4).
6. Monitor accuracy of medical provider payments (8.24).
7. Improve timeliness of incident reporting (8.19).
8. Improve accuracy of claim information (8.08).
9. Improve reporting of reserve changes (8.04).
10. Monitor timeliness in payments to medical providers (7.65).

Of particular interest was how technology was used to counter these various issues. In the case of rising medical costs, several technology capabilities seemed to be employed. In the case of establishing reserve accuracies, technology seemed to be less employed.

Perceived Usefulness and Level of Utilization of Technologies

The survey also probed the perceived usefulness and utilization of 30 different claim technologies. Figure 2 shows the findings from this set of survey items.

The highest rated technologies, in terms of perceived usefulness, were automated medical bill review and processing; timely, detailed loss analysis; customer loss reporting; data conversion; and integrated incident intake and reporting.

Interestingly, utilization of technology did not necessarily follow perceived usefulness. For example, automated reserve tracking was the eighth highest rated in term of usefulness in dealing with the issue of reserve accuracy and reporting, but was one of the lowest in terms of actual utilization.

Perhaps the most insightful findings are related to the benefits received from the use of technology. Not surprising, technology helped organizations improve work force productivity and expense reduction. The overall average (mean)

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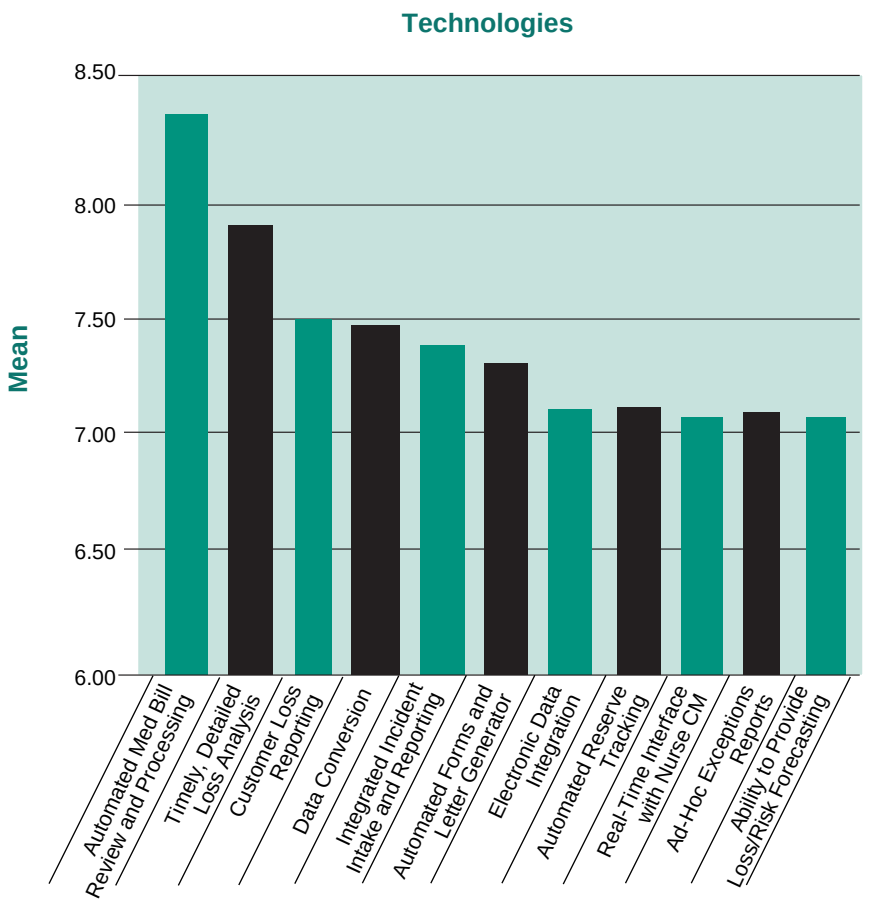
Figure 2
Perceived Usefulness of Technologies



percentage benefits reported by respondents are as follows:

- increase in productivity of claims reviews and audits (21%)
- reduced loss costs (13%)
- improved return-to-work (12%)
- reduced administrative expenses (14%)

More than one-third of organizations reported gains in productivity in claims reviews and audits showing gains ranging from 16 to 30 percent. Another 15 percent reported gains of more than 30 percent. More than one-third of organizations also reported reductions in administrative expenses of greater than 11 percent. These are traditionally expected gains from technology. Figures 3 and 4, shown on the next page, show the distribution of gains in productivity and reduction of administrative costs respectively. The figures show the differences between carriers' gains and overall gains for all respondents.

Study Conclusions

According to what respondents indicated were key issues, and based on how they planned to respond to those issues, it appears that certain technologies are underutilized. This is highlighted even further by the differences between perceived usefulness and actual use of technology capabilities. The most dramatic example seems to be in the underutilization of technology to help address reserving concerns.

Not surprisingly, improvements in results from various practices are not fully measured. This is consistent with several reports in articles related to insurance claims in general. The problem with not measuring improvements is that it becomes difficult to determine what practices are working and what are not. Given the information that is now able to be captured and analyzed, this seems like an area that offers great potential for improvement. One potential obstacle to including more measurements is the perception that claims personnel are already deluged with reports and benchmarks that they can't understand or control. An overall reexamination of what is measured and reported would benefit most organizations and allow the organizations to focus on the measurements that truly count.

Technology provides benefits to most organizations. This does not come as a surprise for most people who have followed the trends. However what is a bit more surprising is that benefits go beyond the "traditional" improvements in productivity and expense management expected in using technologies. This study shows that improvement in these areas are indeed experienced at high levels, but improvements in losses are also significant for many companies. This finding is deserving of greater attention to the role of technology in these areas.

The Katie School and sponsoring organization plan to continue to probe further into these issues to provide managerial knowledge for the industry. ■

Figure 3
Increase in Productivity of Claims Reviews and Audits Due to Technology

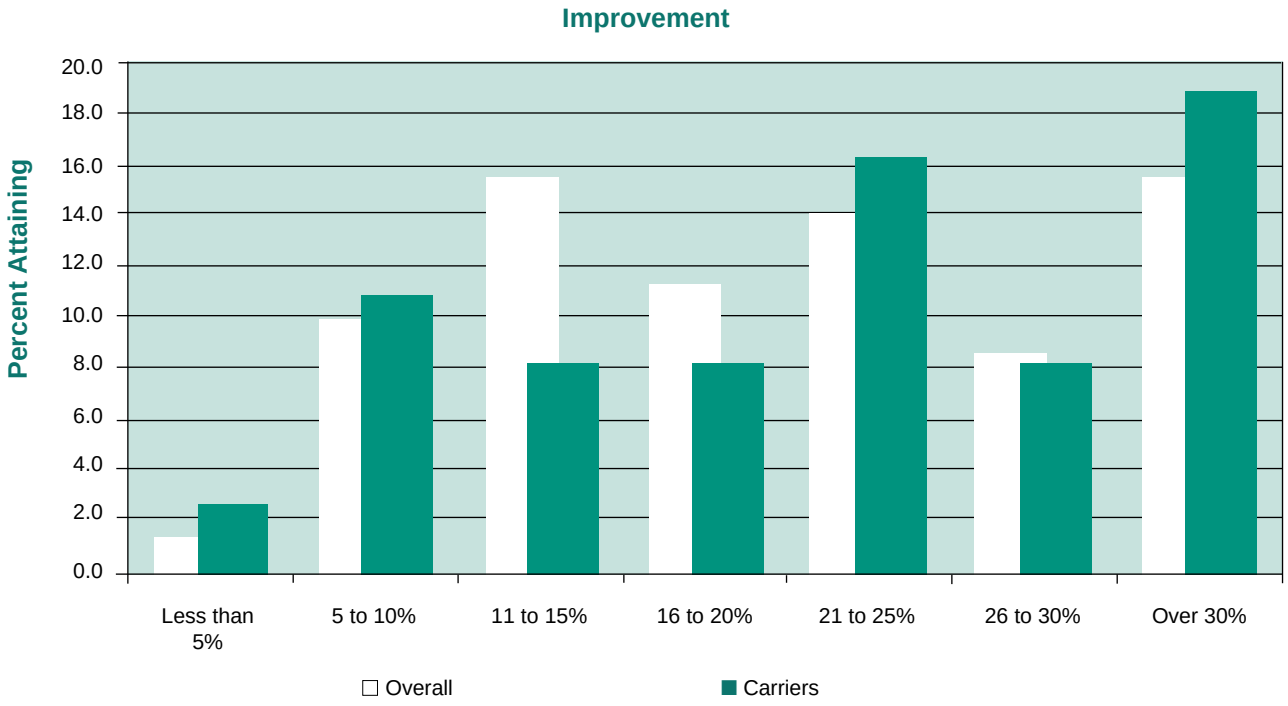
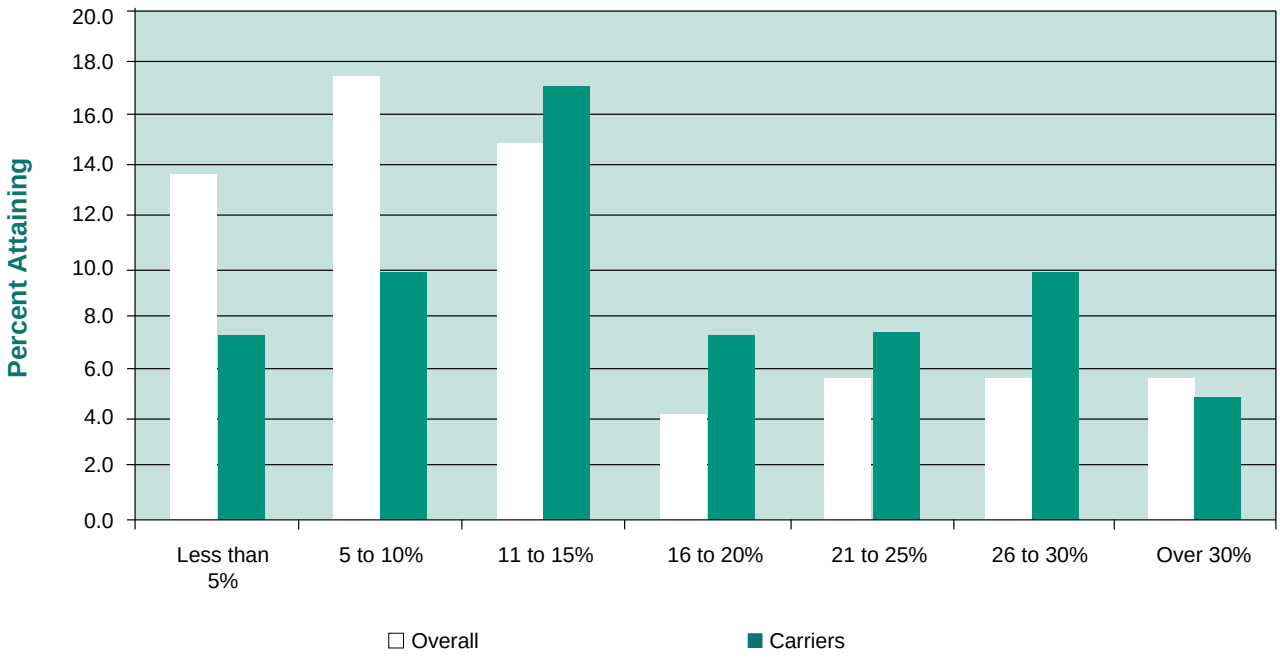


Figure 4
Reduced Administrative Expenses



Guidelines for Handling a Builder's Risk Claim

by The Inland Marine Underwriters Association (IMUA)

Editor's Note: This article is an edited version of one of a six-part series of reports focused on builder's risk loss prevention and claims prepared by the Loss Prevention & Claims Committee of the Inland Marine Underwriters Association. IMUA is a not-for-profit industry trade association representing the interests of commercial inland marine underwriting companies.

This article examines the role of the claims adjuster and follows the logical progression of the investigation of a claim for loss or damage. The steps include:

- coverage review and analysis
- factual analysis of the event
- use of "experts"
- the physical adjustment process
- time element or business interruption loss determination
- settlement
- recovery and subrogation

Assignment to the Claims Adjuster

Once a loss has occurred, an assignment to an adjuster is the first logical step. Depending on individual company practices and procedures, the adjuster will likely make initial contact with the insured in accordance with company policy and within jurisdictional time periods required by individual state fair claim practice laws.

Coverage Verification and Interpretation

One of the first action steps taken by an adjuster handling a builder's loss should be to secure a copy of the policy including all relevant endorsements and correspondence. In addition to a review of the actual insurance policy, and depending upon issues presented in the first report of claim, a review of the underwriting and loss prevention files is also advisable.

This next step is very important because in most states builder's risk is a non-filed line of business. This situation gives the underwriter considerable flexibility when drafting the policy with the following usual approaches:

- some insurance companies may have their own forms; or
- the underwriter chooses to use a standard industry form [e.g. AAIS or ISO]; or
- the underwriter may use a broker/agent drafted form; or
- the policy may actually be a manuscript form containing unique terms and conditions

The declarations page, policy forms, and endorsements will outline the specific parties protected by the policy. The policy generally covers the owner and contractor, and may also cover additional named insureds such as the lender, developer, subcontractors, engineers, and possibly even the architect.

The policy will also likely specify the locations covered. This can be handled in a couple of ways. First, the policy may list the covered locations on the declarations page. If this is the case, the adjuster simply needs to verify that the loss location is the insured location listed on the declarations page. An alternative way of handling insured locations, particularly if the policy is a blanket builder's risk contract, is for the insured to report on a scheduled basis (e.g. monthly or quarterly) the locations and values of projects. In this latter case, it is important that the adjuster verify that the loss location has been reported and that values reported are current. This is particularly important because there can be serious consequences for late or inaccurate reporting of values at risk.

Endorsements Require Special Attention

The adjuster should pay particular attention to and look for any endorsements or changes of limits that may have occurred during the project. Limits can increase or decrease during the course of the project. The limits of coverage are generally outlined on the declarations page and/or within the coverage forms/endorsements. There can be more than one limit represented. For example, the policy may include a location limit, an aggregate limit, and a catastrophe limit. In addition, there may be sub-limits for coverage such as debris removal or pollutant cleanup, or peril-specific limits for loss due to windstorm, flood, or earthquake. In addition, loss of rents, loss of income for delay, and other "soft costs" may also be covered.

The term of the project can also change with policy effective dates becoming shorter or longer. It is not uncommon to see projects fall behind schedule. Generally, underwriters grant policy term extensions. The adjuster should review this documentation because the reasons why the project is off schedule and/or considerations relative to the extension may be relevant to the claim. If the underwriter has requested a site visit by a loss control representative, the report may contain information that would assist in the adjustment of a claim. This information may reveal that part of the loss that is being claimed is not actually physical loss or damage, but is related to the reasons the project was delayed. This is especially important when considering the soft cost portion of the claim.

A Detailed Contract Review Is Required

Turning back to policy review, the contract form normally includes the following sections:

- Property Covered, which can include buildings, structures, installation projects, excavations, underground pipes and flues, temporary structures, scaffolding, office trailers, materials and equipment destined to become a permanent part of the structure.
- Property Not Covered, which can include land, land value, trees, shrubs, contraband, contractor's equipment, aircraft, and motor vehicles licensed

for road use, bridges, tunnels, piers, and buildings or structures that existed prior to alteration or addition.

- Additional Coverages/Extensions, which can include debris removal, pollutant cleanup/removal, materials in temporary storage, property in transit, valuable records research, and outdoor trees and shrubs.
- Exclusions can be varied and complex and can include acts or decisions of people, faulty planning or construction, earthquake, flood, delay/loss of market, wear and tear, dishonesty, disappearance/inventory loss, and mechanical breakdown.
- General Conditions, which can include "when coverage begins and ends," occupancy, mortgage clauses, and preservation of rights.

Builders risk coverage may also include time element coverage including extra expense plus soft costs coverage. These coverages are designed to address losses that may occur should there be a delay in completion of the project as a result of a covered physical loss.

Adjusting the Claim

Having reviewed the terms and conditions of the applicable insurance policy, the adjuster will begin the actual adjustment of the submitted claim. One of the keys to the investigation of a builder's risk claim is the construction contract—often an American Institute of Architects [A.I.A.] based contract. However, the contract may be a boilerplate of the National Builder's Association or a customized contract drafted by lawyers. In addition to identifying the project, parties, and values, this contract will provide information regarding recovery rights against subcontractors, time schedules, financing of the project, and other details needed in the adjustment process. Often, hold harmless agreements are part of this contract, and the adjuster needs to know this because it will determine subrogation or recovery rights.

The first step in adjusting a builder's risk claim usually entails a meeting with the insured and/or his or her representatives at the loss site. Depending on how each individual company operates, the adjuster may not be the actual person visiting the site, and who he or she selects is of critical importance. Choices run from a company-employed field adjuster through an independent adjuster. Irrespective of the employment of the individual, the adjuster should select the appropriate specialist—e.g. a high-rise dwelling versus a petrochemical plant versus a strip mall or mercantile site will likely require a different type of skill set.

During this initial meeting, the adjuster or his or her representative will have an opportunity to perform an initial inspection of the loss, request required documentation, schedule recorded statement appointments from key parties such as the insured's site superintendent or manager as well as employees as needed. The initial meeting also provides a good opportunity to review the overall adjustment process with the insured and address requests for advance payments and authority to secure the property. At the conclusion of the initial meeting, the adjuster or his or her representative should begin to formulate an estimate of the scope of the loss, acknowledge the facts of the loss, and identify relevant parties at the site.

Documentation Required To Support the Claim

Several pieces of documentation are required as part of the adjustment process. Examples of required documents include the following:

- construction contract between the insured and the building owner/developer
- contract between the insured and its subcontractors and material suppliers
- copies of invoices for work already completed—including material receipts, labor records, and records of other expenditures
- plans, permits, and blueprints
- minutes of construction site adjustment process meetings
- Critical Path Charts or PERT Charts and other documentation relative to the planned completion date for the project
- financing documents and other relevant contracts related to the project
- official reports such as fire, police, or OSHA reports relating to the loss

Retaining Experts

An early decision that must be made is the need for experts. It is not uncommon for an adjuster to require the services of one or more of the following experts:

- Construction Consultant: Generally a contractor used to assist with the determination of the scope of the loss as well as the final repair or replacement figures. The consultant can also assist with estimation of the reasonable period or delay or repair time required following a loss.
- Architect/Engineer: May be required to assist with determination of the cause of a loss or the most effective method of repair. The certification of an engineer (licensed professional engineer or P.E.) may be required to obtain permits to undertake repairs.
- Origin and Cause Expert: Used in the event of loss by fire, to determine the point of origin and cause of the loss, this expert can be used to support either a coverage investigation or subrogation efforts.
- Salvor: They can be used for more than just the sale of salvageable items. Their other role, which is often overlooked, is inventory control. This can be useful with such losses as a fire or theft loss where there is a loss of materials, supplies, and fixtures. For example, an experienced salvage company after walking a loss site can map out a blueprint of where and how much of an area would be required to house certain items. This can become very important in the final determination of what was there, what was used in the project prior to the loss, and what is still usable.

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Guidelines for Handling a Builder's Risk Claim

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- Accountants: Required for auditing of records related to the repair costs, soft costs and/or time element claims. Their expertise in this area can minimize the overall loss by eliminating duplicate repair costs, controlling overhead and profit calculations to remove duplication, and providing an accurate analysis of sales and costs involved in the disruption or delay in construction.
- Specialized General Adjuster (sometimes referred to as Clerk of the Works): This independent specialty adjuster hired by the insurer is used to oversee repairs once reconstruction commences. The overseeing of a project can help to minimize the soft costs, extra expenses, and business interruption loss. This is accomplished by separating the repairs due to the loss versus the ongoing construction project costs that are not loss related and by making sure that workers are not being pulled from the overall project to do repairs, thereby causing undo delays in the completion of the project.
- Certified Industrial Hygienist: Water damage may occur in other parts of the building because of plumbing leakage, ingress of rain water, or water used by the fire department to extinguish a fire. Due to the increase of mold-related claims, it is important to make sure the cleanup is done in a timely and correct manner after a loss. This expert can test the damaged area, make recommendations for the protocol of repairs, and then test at completion of the repairs. The adjuster should obtain all copies of testing results for the claims file.
- Restoration Company: A professional "dry out" company should be called immediately to begin to properly dry out the building and materials when water damage occurs. Experts range from very good local companies that can be used for small to mid-sized jobs through national companies that are better equipped for handling large losses.

The Scope of the Loss

The initial and subsequent inspections will provide an opportunity to determine the scope of damage. The next step, often in conjunction with a construction consultant, is to agree with the insured on the most efficient method to repair or replace the damaged portion of the job, including expediting costs, and quantifying the cost to arrive at a physical loss sum.

It's important during this stage to give consideration to the impact on the anticipated completion date of the project. This will have a direct bearing on your insured, and possibly the ultimate amount of the loss, should there be coverage for soft costs. A common pitfall is to pull workers off of another part of the project to repair damage resulting from a covered loss. In some cases, this can result in a delay, which will lead to a much larger soft cost loss. A decision to reallocate labor at a construction site needs to be made carefully, and with consideration of the critical path scheduling impact of the action.

"Soft Costs"—An Overlooked Consideration

Review of the time-element coverage will provide detail on the specific elements of "soft costs" coverage purchased by the insured. One commonly used form includes the following "soft costs" options:

- interest on money borrowed to finance construction
- advertising and promotional expenses
- realty taxes and assessments
- architectural or engineering supervisory fees
- costs resulting from renegotiation of leases
- loss of rental value
- bond interest
- construction loan fees
- expense incurred to reduce loss/delay
- loss of earnings or rental income
- marketing expenses
- real estate and other taxes
- costs of additional permits
- refinancing charges
- insurance premiums
- additional fixed maintenance or operational expenses

The nature of the project will normally dictate the soft costs options elected by the insured.

The first step in successfully handling a soft costs claim is to ensure that the physical repairs are completed as quickly as possible, thereby limiting the period of delay. Care should be taken in expediting the repairs of the physical loss to avoid creating delays in the overall project by inefficiently allocating existing labor and material resources.

An adjuster should consider speeding up the purchase of materials needed to repair damages as a way to mitigate the loss. This can usually be accomplished by dealing directly with the manufacturer, wholesaler, or supplier. It may be necessary to consider express shipping and other measures. While these measures may have the effect of increasing the repair costs, the result on the total loss (including soft costs) must be considered to achieve the best overall claim result.

Often, an insured will decide to make alterations to existing plans following a loss. When this occurs, it is important to involve an architect or construction consultant early to ensure that any delay in the project due to changes is not added onto the overall delay for purposes of computing the soft costs loss. Early communication with the insured on these issues can also prevent serious problems later in the handling of the claim.

The starting point for calculation of the soft costs loss is determination of the date the project would have been completed had no loss occurred and comparison with the actual date of completion. A number of the coverages offered under a soft cost endorsement are driven by the period of delay (e.g. lost rental income or additional interest on a construction loan).

During the factual investigation key documentation needed to adjust the soft costs claim should be obtained. These documents include the construction contract, critical path charts/ documentation, preliminary and interim budgets, meeting notes, financing documents, promotional and other information detailing the specific details of the project and forecasts of occupancy/ revenue for the completed project.

Once all relevant facts have been obtained, and the period of delay established, the adjuster will work with the experts and the insured to establish a fair value for the loss. Adjustment of soft cost claims can be very complex for a large commercial construction project and the settlement ultimately agreed to is often the result of extensive negotiation or appraisal. As with other inland marine coverage, any dispute between the insurance carrier and its insured regarding the quantum of loss can be resolved via the "appraisal provision" in the general conditions portion of the policy.

Subrogation Opportunities

The analysis of recovery in a builder's risk loss includes the same elements as other first-party losses, namely subrogation, salvage, and loss refunds.

Frequently, subrogation potential exists against a subcontractor. In these cases, review of the hold-harmless provisions in the construction contract will be key in determining the viability of a subrogation action.

The contracts frequently used in commercial construction require the owner to insure the project against loss to the full insurable value of the entire work, and also often contains express subrogation waivers whereby the parties waive all rights against each other for perils covered under a policy. Therefore, as a practical matter, subrogation against subcontractors is often difficult.

Recovery potential may be present, however, against product manufacturers or other parties causing or contributing to a loss.

To assist the adjuster in the handling and resolution of builder's risk claims a list of web sites is included.

Web Site Resources

- American Board of Industrial Hygiene (ABIH)
  www.abih.org
- American Institute of Architects (AIA)
  www.aia.org
- American Institute for CPCU (AICPCU)
  www.aicpcu.org
- Associated Builders and Contractors (ABC)
  www.abc.org
- Associated General Contractors of America (AGC)
  www.agc.org
- Institute of Inspection Cleaning and Restoration Certification (IICRC)
  www.iicrc.org
- National Association of Home Builders (NAHB)
  www.nahb.org
- The National Association of Independent Insurance Adjusters (NAIIA)
  www.naiia.com
- National Fire Protection Association (NFPA)
  www.nfpa.org
- Property Loss Research Bureau (PLRB)
  www.plrb.org
- The Infrastructure Security Partnership (TISP)
  www.tisp.org
- Whole Building Design Guide (WBDG)
  www.wbdg.org ■

http://claims.cpcusociety.org

Visit the CPCU Society's Claims Section web site and click on the "Related Links" page for quick access to the web site addresses listed above.

Surfing on the Subject of Experts

by Donald S. Malecki, CPCU

Donald S. Malecki, CPCU, is chairman and CEO of Donald S. Malecki & Associates, Inc., an insurance and risk management firm, and president of Malecki Communications Company, the publisher of a monthly newsletter entitled *Malecki on Insurance.* He has been in the insurance and risk management business for more than 42 years and authored nine books, including three textbooks used in the CPCU curriculum. Malecki is currently serving on the examination committee of the American Institute for CPCU and is an active member of the Society of Risk Management Consultants. He holds a B.S. degree in business administration, with an emphasis on insurance, from Syracuse University.

Generally, an expert on insurance matters can be categorized into two types, assuming he or she is qualified to be labeled an expert. The first is a testifying expert or one who will testify in deposition and/or trial. The second type is a consulting expert. This person is not disclosed to the opposing party and is retained to assist the client attorney on an as-needed basis.

In either case, the expert is someone who is supposed to be well-versed on the subject(s) being litigated, and has the skill, knowledge, education, and experience necessary to consult with legal counsel, or to explain to the trier of fact information that only that knowledgeable person can impart. Examples include the evolution of a litigated coverage provision, or the standard of care exercised by an insurer in handling a claim, or by an insurance agent or broker in his or her role as a salesperson.

One attorney some years ago, in his article entitled "The Direct Examination of the Expert Witness," described his ideal expert witness as:

> [A] gentleman with impeccable credentials, preferably from a prestigious teaching university. He is a full professor in his chosen field, with a curriculum vitae listing education, position, honors, and publications, which, if read to the jury or testified to by the expert, would take over one hour. He should look and act like an elder Hollywood actor, such as Robert Young or Jimmy Stewart. He should have very little courtroom exposure, but at the same time, feel at home in the courtroom, have definite opinions and not be intimidated by the ablest attorney the Bar has to offer as the attorney for the other party. He should know the facts and circumstances of your case thoroughly, and should be up to date on all of the pertinent literature dealing with the subject matter about which he is going testify . . . [1]

So much for wishful thinking.

The fact that someone qualifies as an expert does not necessarily mean that a court will permit that person's testimony. Some courts, based on the facts of a case, will decide that expert testimony is not required. A case in point is *Bergman v United States Automobile Association*, 742 A.2d 1101 (Pa. Super. 1999), which involved a bad-faith action against an insurer. The insured brought this action against its auto insurer of underinsured motorists coverage requesting that the court adopt a "per se" rule regarding expert testimony as bad-faith action by an insured against an insurer. "Per se" is meant that expert testimony be permitted in any bad-faith case against an insurer regardless of the facts.

The court rejected this appeal of the policyholder, stating that whether an expert's testimony in actions on insurance policies for bad faith should be admitted remains up to the discretion of the court. As it turned out, the court had some serious reservations about permitting this expert to testify, based on the expert's curriculum vitae, and decided that the expert's testimony would not contribute anything that was not already said either in his report or by other witnesses in this case.

Equally as important, if not more so, was the decision of this court that if this expert were permitted to testify on bad faith (which is solely a legal conclusion), there would be nothing for the judge to do, since the expert would have already made the decision for the judge.

This decision should not adversely affect that expert in the above matter, since, if this person is specially qualified to render opinions on insurance matters, there are many other subjects on which to do it, other than conduct of an insurer that corresponds or departs from custom and practice.

There is no consensus among the courts whether expert testimony is deemed necessary in cases alleging insurer bad faith. Some courts have concluded that expert testimony is admissible, if the expert can address the standard of care that should have been exercised, paving

the way for the court to make the final decision. While some courts have taken the position that expert testimony should be excluded because insurance is not so technical that the public cannot understand at least the general nature of an insurer's responsibilities, other courts have taken the position that expert testimony should be admitted, if the trier of fact lacks the knowledge and experience on the subject or is incapable of drawing correct conclusions from the facts.

Walking the Straight and Narrow

The testifying expert has to walk on the straight and narrow, and not infringe upon the court's role, which has the burden to decide questions of law on whether coverage applies, or whether the conduct of an insurer or someone else has met or fallen below the standard of care. What the court does not need with use of an expert is another lawyer telling the court the law!

It is, however, easier said than done because testimony about insurance custom and practice over, for example, the purpose of a coverage, can cross over if the expert allows himself or herself to involve testimony on purely legal issues of coverage interpretation. A case where that kind of circumstance arose is *United States Fidelity & Guaranty v Williams*, et al., 676 F. Supp. 123 (E.D. La. 1987). This was a subrogation action where one insurer brought an action against a permissive user of a yacht to recover amounts paid to a yacht owner after the vessel struck a bridge and sunk, also resulting in one death.

The yacht policy contained what one might think as being an oxymoron since it is referred to as a so-called "liability coverage exclusion," found under the "Who Is An Insured" provision that serves the same rationale as a "household" exclusion in a personal auto policy, except that the "liability coverage exclusion" is broader in scope. This type of an exclusion, for example, can preclude a permissive user of a yacht from obtaining defense and coverage under the owner's policy when the yacht owner sustains injuries because of the permissive user's alleged negligence.

Since, in this case, the rationale for this "liability coverage exclusion" was not clear, the court appointed an expert and also permitted experts representing the plaintiffs and defendants. What the court was looking for from the experts was testimony solely to determine what general understanding, if any, the insurance industry had as to the meaning of the provision of this yacht policy.

> ■ *What the court does not need with use of an expert is another lawyer telling the court the law!*

As it turned out, the experts, in explaining the rationale for the "liability coverage exclusion," apparently overstepped the boundary. In doing so, the court stated that the three experts' testimony made useful dialogue on the many legal issues a court must consider to determine the proper interpretation of the policy. Having said that, however, the court went so far as to point out which of the three experts presented the best legal opinions! In stating that these legal opinions were not considered to be legally admissible evidence, the court, interestingly, stated that opinions of the experts nonetheless were forms of legal argument that a court could follow or reject as appropriate.

Some people may wonder why a court would make that kind of a conclusion. The rationale is elusive, but if an expert remains in the insurance and risk management business for any period, he or she will likely see a variety of these decisions by the courts. In fact, in one case involving a question of coverage, the reported opinion of a federal court quoted one expert as saying that the duty to defend is broader than the duty to pay, and the opposing expert as confirming that statement of fact. This also seems somewhat unusual for a court to report, since it does not take an expert to know this.

Some courts are not as kind or as diplomatic to experts who overstep their boundaries, even if done so unknowingly, as the federal court in the preceding yacht coverage case was. Unless it is made clear to the court at the outset that the expert will be testifying on the general understanding in the insurance industry over, for example, the meaning of a given term or provision, the court may coldly and bluntly exclude such testimony.

Sometimes experts have to say "no thank you," following an inquiry for assistance, or if the work is accepted, the expert has to take the "bull by the horns" so to speak, and educate their attorney clients on the extent to which an expert can testify. Some attorneys, unfortunately, are not familiar with the extent to which an expert is permitted to testify and when an expert does not explain his or her limitations, it can be an uncomfortable experience for both.

A case that exemplifies these actions is *Masonic Temple Association of Crawfordsville v Indiana Farmers Mutual Insurance Co.*, 779 N.E.2d 21 (Ind. App. 2002), where the testimony of an expert was rejected, because it dealt solely with two legal issues. The first one was over the meaning of "proximate cause," (a term commonly applied to property losses), and the conclusion that the insurer, in relying on a policy exclusion, committed bad faith. The court here did not feel an expert was necessary to define proximate cause, and the expert's conclusion of bad faith, from the court's perspective, was a matter for the court alone to make.

Also falling into this category of inadmissible testimony are cases where the expert's opinions are purely speculative or founded on assumptions that have an insufficient factual basis. A case in point is *Virginia Financial Associates, Inc. v ITT Hartford Group, Inc.*, et al., 585 S.E.2d 789 (Sup. Ct. Va. 2003).

This was an appeal involving Virginia Financial Associates (VFA), which acted as a "marriage broker" for two insurers Hartford and Medical Protective

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Surfing on the Subject of Experts

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(MedPro). William Montgomery Dise, an insurance agent and part owner of VFA, was instrumental in bringing the two insurers together. The proposal put together by Dise was that Hartford could sell its workers compensation and other coverages to MedPro's approximately 20,000 dentist clients. These two insurers formed a joint venture and created an insurance product known as "The Package," which was sold through a technique called "commercial mass merchandising."

VFA expended significant time and expense to bring the joint venture together. VFA had been assured it would be compensated fairly for its work, but, according to VFA, the compensation it received was inadequate, which led to litigation. VFA presented the testimony of two expert witnesses to establish the value of adequate compensation that the Hartford should have paid to VFA for its services. One of the experts, who qualified on the subject of retail insurance, testified he was knowledgeable on the methods of compensation for commercial mass merchandising programs. During cross-examination, however, this witness admitted that he had "never been paid a commission override for setting up an affinity program, such as this one," and that he was "not aware of anyone else" who had been paid a commission override without providing an ongoing service. The second qualified witness testified on the standard range of compensation in the insurance industry for the services performed by VFA for the Hartford.

Hartford argued that the lower court erred in permitting both of these experts to testify that the customary method of payment for VFA was a commission override, because neither witness could cite an example in the insurance industry of an agent who was compensated on a commission override basis when that agent failed to provide ongoing services in support of an insurance program.

The court disagreed. In doing so, it stated that expert testimony is inadmissible if such testimony is speculative or founded upon assumptions that have no basis in fact. But that was not the case with these two experts.

However, when an actuary, who also qualified as an expert, attempted to opine on the projections that the insurer would have generated more than $250 million in future premiums from its sale of insurance policies to dentists during the next 10 years, his testimony was barred by the court for being speculative. The reason this expert's testimony was inadmissible, the court said, was that the projection was subject to significant unknown variable of whether the insurer's joint venture would enter into a future bargain with another national insurer.

No Hard and Fast Rule

It is the opinion of many that, in light of the *Daubert v Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 case, there are more stringent requirements to qualify as an expert. In the case of *Kumho Tire Co. v Carmichael*, 526 U.S. 137, 119 S. Ct. 1167, 143 L. Ed. 2nd 238 (U.S. 1999), the United States Supreme Court heard arguments as to why the guidelines established by the court in *Daubert* should apply to all expert testimony as opposed to only scientific expert testimony.

The *Daubert* court had established guidelines for federal courts in determining if expert testimony would be beneficial. The Supreme Court held that the standards enunciated in *Daubert* applied to all expert testimony. One purpose for the guidelines established by *Daubert* was a desire by the courts to eliminate what has been referred to as "junk science" or expert testimony that is not demonstrated to have a reliable basis in the knowledge and experience of the profession or industry involved. The courts were said to have a gatekeeper function, in ensuring that expert testimony was reliable, based on a methodology that had been or could be tested and enjoyed general acceptance within a relevant scientific community. The impact of the ruling by the Supreme Court has had far-reaching implications and has cast a shadow over the ruling of many courts regarding expert testimony.

Prior to the *Daubert* case, many courts felt they could hear expert testimony and decide for themselves whether the testimony would be beneficial. Following *Daubert*, however, many courts, particularly at the federal level, are reluctant to allow expert testimony, even from qualified experts for fear of offending the rationale of *Daubert*.

In some instances, under the guidelines established by *Daubert*, experts that were allowed to testify numerous times pre-*Daubert* are still allowed to do so, while experts that have not logged considerable time in court testimony are being precluded from doing so, despite their qualifications. It seems that some courts are comfortable allowing testimony from experts that have testified numerous times, regardless of qualifications, because it can be argued that the mere fact they have testified previously satisfies the *Daubert* guidelines. While this is obviously not the case, it is nonetheless a fact of life in the expert community.

It is up to the lawyer retaining the expert to ensure that the court is properly educated as to the expert's qualifications and to ensure that the testimony will be allowed. Unfortunately, many lawyers have no clue as to this fact or how to

accomplish the goal. When an expert is precluded from testifying, these lawyers run for cover blaming the expert, rather than their presentation of the expert's qualifications and preparation for dealing with the *Daubert* issue.

An Influx of Competition

There has been a great deal of talk in insurance circles, at least, that the *Daubert* case is going to slow down the number of testifying experts on insurance matters. Yet, there seems to be a steady stream of insurance individuals entering the arena of experts who are not even insurance practitioners, and, in fact, have very little knowledge or information to impart to a court, except what they have acquired by trying cases. Within this category are practicing attorneys and retired judges whose only experience (insofar as insurance is concerned) is in practicing law.

How attorneys, who have never worked "in the trenches," can testify on insurance custom and practice is something that is difficult to determine. Perhaps the courts may feel that without an attorney assisting who has had some exposure to insurance, the situation may lend itself to decisions that can be labeled as "bad law." Judging from some of the decisions being made by the courts, one also could easily come to that conclusion.

Some courts, on the other hand, have disallowed the testimony of some attorneys and retired judges based on their lack of experience in the insurance business. Others have been able to put their foot in the door, with more than one appearance as an expert, and have found a niche for themselves to complement their social security payments.

Considering the complexity of the insurance business, there is plenty of work for everyone who wants to do it. Whether, of course, they will be able to qualify as experts will depend on the court in question. If not as a testifying expert, there are still employment opportunities as a consulting expert, a profession that seems to be growing with each passing year. ■

Endnote

1. "For the Defense," September 1981, p. 21, The Defense Research Institute, Inc., Chicago, IL 60601.

Who We Are and What We Do—The 2003-2004 Claims Section Committee

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

This year the CPCU Society is celebrating 60 years of excellence in ethics, education, service, and success. The theme for this year's Annual Meeting and Seminars in Los Angeles is "Reach for the Stars!"

The Claims Section Committee is available to assist you and to provide you with the access to all the technical/functional and leadership opportunities that the Society has to offer for your personal and professional development so that you too can "reach for the stars."

The Claims Section is the largest of the Society's 14 interest sections and has more than 1,400 members. The Claims Section web site, the Claims Section symposia, the *Claims Quarterly* newsletter, and the Claims Section seminars at the Annual Meeting all provide the venues for you to tap into as resources to assist in your career development. CPD points are approved for most activities. The Claims Focus Series Speeches & Seminars, the Claims Chapter Liaison Program, the Society Online Library, the Society's Job Network Center, the National Leadership Institute, and even a CPCU logo credit card are available to you.

Contact any one of us to join in on the networking, leadership development, and technical claim seminars.

While you're at the Annual Meeting and Seminars, stop by to meet and greet the committee and fellow section members at the Sections Booth, the four Claims Section-developed seminars, and don't forget to sign up for the Claims Section Lunch!

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Claims Section Chapter Liaison Report: Connecticut Chapter

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

On April 15, the CPCU Society's Connecticut Chapter Claims Section members co-sponsored the monthly chapter meeting with the chapter program committee. The activities included a claims speaker, claims ID badges, and tables reserved for claims people to meet and network. The Connecticut Chapter Claims Section Liaison is Johanne Upton, CPCU, claims director at Acadia Insurance Co.

Cal Hudson, CPCU, executive vice president of The Hartford Claims Business Group, was the keynote speaker to a sold-out group. Hudson led an interactive presentation to the 100 attendees on the current state of the claims business on the topics of workers compensation, legal reform, fraud and special investigations, the evolving workforce, training issues, and new, emerging claim challenges.

The CPCU Society Claims Section was recognized during the meeting for its support of the monthly program and the claims liaison was introduced and given a round of applause.

We now have quite a few chapter liaisons appointed throughout the country and we would like to hear from you. How are you promoting the Claims Section to your chapter and your community?

Contact James D. Klauke, CPCU, Claims Section chairman, Richard A. Litchford III, CPCU, chapter liaison committee sponsor, or myself. Send in your chapter activity articles and photos and get your story published in the *CQ!* ■

Please Meet the Most Recently Appointed Claims Section Committee Member . . .

Arthur F. Beckman, CPCU, CLU, ChFC, AIM, INS

Arthur Beckman is assistant vice president–general claims at State Farm's corporate headquarters in Bloomington, IL.

Beckman joined State Farm in 1971 as a daily report clerk in the Greeley, CO regional office and became a data processing supervisor there in 1975. Two years later, he moved to the Tempe, AZ regional office as a supervisor and was later named assistant data processing manager at the Wayne, NJ regional office in 1979. Beckman was promoted to data processing manager at the Marshall, MI regional office in 1982 and in 1986 he was moved again and was promoted to assistant division manager at the Concordville, PA regional office, and then claim manager in that office in 1988. Since then he has made one more household move and became director–general claims at corporate headquarters in 1995. He assumed his current position in 1997.

Beckman has a history of continuous education; he graduated from the University of Northern Colorado with a bachelor's degree in business finance. He earned the Chartered Property Casualty Underwriter (CPCU) designation in 1983, the Chartered Life Underwriter (CLU) designation in 1986, and became a Chartered Financial Consultant (ChFC) in 1987.

Working with young people of various ages has been one of his focuses in the past. He has been involved in Big Brother/Big Sisters of Philadelphia, Great Valley Little League board, and assisting at women's golf events sponsored by Illinois Wesleyan University. His wife, Nancy, and an older son are also employed with State Farm Insurance, and his youngest son recently graduated from Bradley University in May 2004.

Beckman is currently a member of the CPCU Society's Central Illinois Chapter. By joining a national committee, he indicates "It offers you a chance to interact with other professionals from across the country and share experiences and ideas. At the national level, you can create programs or activities that can reach out to a broad segment of the insurance industry and help these individuals grow."

We welcome Art to the Claims Section Committee and to national service. ■

What's New on the CPCU Society's Claims Section Web Site

by Eric J. Sieber, CPCU, AIC, RPA
Claims Section Webmaster

Check out the new discussion board called Claims Professionals Discussion Board! This service is designed to keep you updated on group happenings and key issues that are important to you. You can browse the discussion board at your convenience or sign up to have e-mails sent to you whenever new issues are posted.

I hope you enjoy spending time in our online community and I look forward to your participation. Please first subscribe to the discussion board, then post your thoughts on this thread or any other.

Let us know what you want to discuss!

I am sending this invitation to only the Claims Section members to request that you take a moment to go to the web site, log in (your last name and last three digits of your CPCU Society member number are your login name, the year of your designation, forward slash and CPCU Society member number are your password).

Any questions, e-mail me directly at ejsieberco@aol.com.

http://claims.cpcusociety.org

What's in this Issue of *CQ*?

Claims Quarterly
is published four times a year by and for the members of the Claims Section of the CPCU Society.

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Claims Quarterly

Volume 22 **Number 3** **September 2004**

CQ

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720 Providence Road
Malvern, PA 19355-0709
www.cpcusociety.org

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