

Message from the Chairman: Passing the Baton

by David S. Medvidofsky, CPCU, CIC, AAI



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Medvidofsky is a summa cum laude graduate of Franklin Pierce College (B.S. degree in business management), where he was selected to the Alpha Lambda Sigma National Honor Society, and was the top graduate within his major. He also holds a master's degree in leadership from Franklin Pierce. He is active in educational pursuits, including CPCU instruction, and has been published in *The National Underwriter*, the *CPCU Journal*, *Underwriting Trends*, *Best's Review*, and *Technology Decisions*. He currently serves as chairman of the CPCU Society's Underwriting Section Committee, and has served on many Automobile Insurance Plan committees.

"Every day you may make progress. Every step may be fruitful. Yet there will stretch out before you an ever-lengthening, ever-ascending, ever-improving path. You know you will never get to the end of the journey. But this, so far from discouraging, only adds to the joy and glory of the climb."

—Sir Winston Churchill
British politician (1874–1965)

With the pace of daily life we tend to measure our progress by milestones. January 1 is just another day on the calendar; however, we use it as a time to reflect on the past year and make resolutions for the coming year. Birthdays provide opportunities for reflection on where our lives are in relation to where we thought we might be. With that in mind, I end my term as chairman of the Underwriting Section, and reflect on the wonderful opportunity I have had the past three years. I pass the baton to the

talented **J. Brian Murphy, CPCU**, to lead your excellent section committee.

I thoroughly enjoyed my time in this role and will hold this experience as one of the highlights of my career. Our committee was focused on our strategic goals of providing our membership:

- timely information
- educational materials

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- career development tools
- networking opportunities

Indications are that we consistently delivered quality content. We conducted six Annual Meeting seminars, produced 12 high-quality newsletters, and established our web presence (<http://underwriting.cpcusociety.org>). We also wrote several articles for industry trade magazines, guest lectured at universities, hosted three Annual Meeting luncheons, networked with new designees, and served as an industry resource for people interested in changing careers or in learning more about underwriting.

As a committee, we consistently kept the needs of our section members at the forefront, always asking: "what more can we do?" We challenged ourselves to look at what we had done that worked well. We were not afraid to examine what we might improve upon—this enabled continuous progress as individuals and as a committee.

On several occasions I have had the good fortune to speak to professionals that have completed a course or a designation program. I always acknowledge that completing a course is a unique accomplishment requiring hard work and sacrifice. There are family demands, pressures on leisure time, increased workloads, etc., etc., etc. There are probably hundreds of reasons not to pick up an insurance book and study—these are not excuses; they are all good and valid reasons. Still, the select few pick up that book anyways. They take personal risk by exposing themselves to an examination. But, in doing so, they become difference makers for themselves, for their families, for their employers, and for the industry. Despite obstacles, they take the fruitful steps and follow the ever-improving path that "adds to the joy and glory of the climb." As you know, committing to section or chapter membership provides similar rewards. I have experienced this same reward in my role as chairman of the Underwriting Section Committee.

Great things are ahead for both the CPCU Society and sections. Under Murphy's leadership, the Underwriting Section will continue to provide high-quality technical content. They will remain open to your ideas and suggestions for meeting your needs and will, no doubt, follow the "ever-improving path."

I sincerely thank the section members for the opportunity to serve. I thank the Society staff for their wonderful support. I also thank the members of the Underwriting Section Committee for making my term so easy and for providing me the opportunity to experience "the joy and glory of the climb." ■



The Underwriting Section Committee

We put the YOU in underwriting. The importance of this slogan is that insurance is still a people and relationship business. People make the difference.

Make sure to put the YOU in the underwriting process.

Join the Underwriting Section Committee at the CPCU Society's 62nd Annual Meeting and Seminars

September 9–12, 2006 • Nashville, TN



Your Underwriting Section Committee will again develop two educational seminars and a presentation luncheon. Plan on attending these great events.

Underwriting Section Luncheon

**Sunday, September 10, 2006
11:30 a.m.–1 p.m.**

This is a great opportunity to network and learn more about the Underwriting Section Committee. As an added bonus, we offer an opportunity to walk away with a special gift. This year's luncheon will include a discussion on emerging exposure issues in insurance, such as nanotechnology, avian flu, contamination, and climate changes. Our speaker will be **Domenick J. Yezzi Jr., CPCU**, a senior vice president with ISO.

"High-Tech Tools: How's the ROI?"

**Tuesday, September 12, 2006
8–10 a.m.**

Presented in partnership with Accenture and developed with the IT Section, this seminar will use a recent Accenture survey conducted with input from more than 800 Underwriting Section members. You will hear about how some industry leaders are using technology to change the underwriter's role and maximize underwriting profitability. Key industry executives will also assess the survey findings such as:

- The participant's belief that technology has actually increased the underwriter's workload. Could this really be true? If so, what can be done to reverse this trend while improving the quality of underwriting decisions?
- How technological changes are, in many cases, supporting outmoded underwriting practices.
- The role of technology in attracting tomorrow's leaders as seasoned underwriters.
- Ways companies are reducing premium leakage, lowering expenses, and improving profitability.
- How technology may be used to attain a competitive advantage.

"Society's Addictions and Their Impact on Insurance"

**Tuesday, September 12, 2006
1:30–3:30 p.m.**

This session will examine how the rise in activities such as drug use and nonrecreational gaming are increasing loss exposures.

- Learn how societal trends, particularly addictions, impact workers compensation, property, crime, and inland marine underwriting, pricing, and claims.
- Hear the magnitude of addiction on today's society.
- Identify clues to addictions that agents, underwriters, and loss control can utilize.
- Assess trends, and risk management techniques, such as drug testing.

Register today for the CPCU Society's Annual Meeting and Seminars at www.cpcusociety.org. For more information, contact the Society at (800) 932-2728, option 5. ■



Photo courtesy of Nashville CVB and Barry M. Winiker.

Underwriting Processes and Compliance Issues

by Michael Cronin, CPCU



Michael Cronin, CPCU, president of Cronin Consulting Services, Inc., is a consultant in the field of insurance pricing and product management. As a consultant and a line manager responsible for profit and loss, he has worked both on national initiatives and on state-specific issues in more than a dozen states. Cronin also works with both insurance companies and investors in the area of competitive intelligence, and conducts seminars on product management methodologies. Cronin began his insurance career in 1986 with Progressive Corp. and gained further experience with GMAC Insurance Holdings. He began consulting in 1999. He is a graduate of the University of South Florida and earned the CPCU designation in 1996.

Editor's note: On June 16, 2006, after this article was completed, AM Best upgraded American Physicians Assurance Corp. to B++, citing much improved underwriting results, improved financial flexibility, reduced leverage, and the group's recently restored underwriting focus.

Somebody's head must have rolled. American Physicians Capital, Inc., a medical malpractice insurer, reported in its March 2005 10K report to investors that, in addition to improving loss ratios and favorable reserve development, one of its offices failed to maintain adequate controls over underwriting and claims operations. The report went on to cite several material weaknesses, including insufficient monitoring and oversight,

inadequate documentation, and a lack of system controls.

Ouch! What underwriting manager hasn't been there? Inexperienced staff, supervisor vacancies, departments not communicating with each other, backlogs, unsupported legacy systems, reports that don't reconcile. . . . These aren't corporate scandals; they're just part of the job, right?

Most of the time, yes. But American Physicians (or perhaps its auditors) felt that its particular set of process problems, even though it had no impact on 2004 financial statements, rose to the level of a material weakness it was required to disclose to its shareholders. Not a scandal, but embarrassing nonetheless. Today's hair-trigger compliance environment forces companies to evaluate controls in far more places in the organization. To its credit, American Physicians recognized the problem, disclosed it, and identified the changes necessary to correct it.

So what can an underwriter do to keep these problems out of the disclosure pages? First of all, don't leave compliance to the lawyers. Ensuring that each functional area is operating optimally—balancing growth, profitability, customer satisfaction, and compliance with the law—is first and foremost the responsibility of the people charged with running the business. Attorneys and compliance experts are excellent resources to identify specific requirements and prohibitions, but it's up to the business side to design and operate a successful process.

Secondly, remember that processes cannot be in control unless they are defined. Automation has forced insurers to establish well-defined and well-documented procedures for many transactions, but there are still many processes that require a person to make a decision and take an action. If those decisions and actions are not based on established criteria and defined standards, there is no way that they can be executed consistently day after day. Processes that are solely dependent on the expertise of a few key people are not replicable and

cannot be scaled-up for growth. Now this does not mean that a checklist can replace an experienced underwriter, but even a team of experienced underwriters can improve consistency and controls by carefully defining the standards by which they evaluate the business.

Only processes that are well-defined can be measured. And measurement is the best way to demonstrate controls. Productivity, inventory, and timeliness metrics are all ways to describe how much work is being done. Accuracy and quality measures ensure that the work is being done consistently according to the established standards. Measurements are most useful when they can be compared to a goal or standard, and when they are compared over time to detect trends. An underwriting department with a good quantitative understanding of its performance will stay in control even as business conditions ebb and flow.

Finally, an audit process is essential to ensure that the procedures and standards are practical, achievable, and consistently applied. Internal audits often have a bad reputation as punitive, but an audit itself is simply a tool. The way the audit is used can make it punitive or productive. Audit programs that emphasize evaluating the work product and the process for improvement opportunities and training needs can be a tremendous force for continuous improvement in addition to an assurance of control and consistency.

Underwriters have long understood their role in improving a company's profitability. Today's business climate demands not only profitability, but also transparency, consistency, and integrity in all parts of an organization. It's not just a job to leave to the lawyers, accountants, and auditors. Line business managers have a role to play in meeting all of these demands. And, while no underwriter wants to be featured in a "material weakness" press release, it's not just a compliance problem. Well-designed, consistent, measurable processes and standards are good business, too. ■

It Could Happen to You—Or to Your Customers (and They Might Not Like It)

by Donald S. Malecki, CPCU



Donald S. Malecki, CPCU, is a principal at Malecki Deimling Nielander & Associates L.L.C., based in Erlanger, KY. During his 45-year career, he has worked as a broker, consultant, archivist-historian, teacher, underwriter, and insurance company claims consultant; and as publisher of *Malecki on Insurance*, a highly regarded monthly newsletter. Malecki is the author of 10 books, including three textbooks used in the CPCU curriculum. He is past president of the CPCU Society's Cincinnati Chapter; a member of the American Institute for CPCU examination committee; an active member of the Society of Risk Management Consultants; on the Consulting, Litigation, & Expert Witness Section Committee of the CPCU Society; and a past member of the Commercial Lines Industry Liaison Panel of the Insurance Services Office, Inc.

Editor's note: Donald S. Malecki, CPCU, brings a wealth of knowledge and experience to any insurance forum. If you see his publication *Malecki on Insurance*, you know that he consistently provides guidance concerning issues that may just be rising above the insurance horizon for most of us. His treatment of subjects is not just in the abstract, as he often summarizes cases relevant to his subject matter or answers questions sent to him by readers. Please read on for two descriptions of real-life situations, followed by Malecki's commentary.

We have heard of situations where a high judgment of liability damages was awarded against a commercial entity. While this entity was covered by an umbrella liability policy for limits sufficient to pay those damages in excess of the primary liability limits, the umbrella liability insurer has refused to pay those damages because, unlike the primary policy, the umbrella policy is on an indemnification basis and the entity in this case has been declared bankrupt. The umbrella liability insurer, therefore, has maintained that until the bankrupt entity pays those damages, the umbrella insurer has no obligation to indemnify its insured.

Is the insurer of the umbrella liability policy on firm ground here? Are you aware of any cases on this subject?

Whether the insurer is on firm ground here really depends on the circumstances. Generally speaking, and in a literal sense, there is a distinct difference between "indemnify" and "pay on behalf" contracts.

Under an excess indemnity policy, the insurer arguably may not be required to pay damages on behalf of the insured. Rather, the excess of loss above the primary or SIR is reimbursed after the insured pays. Some of these policies have a wording that allows payment by the insurer when the insured is obligated to pay, as opposed to actually paying the damages and other applicable costs, although this is the exception. Many insurers, however, disregard the formality of requiring the insureds to pay first, and instead pay damages on behalf of the insured as soon as a court renders a judgment making damages payable.

Whether an insurer of an umbrella or excess liability policy will elect to disregard the word "indemnify" in actual practice may hinge on the size of the action. Thus, the greater the amount of the damages payable, the more likely the insurer is to enforce its policy language of requiring the insured to incur the payment of damages first before the insurer honors its promise to indemnify the insured.

The propriety of this approach is questionable, particularly since, with excess coverage, the insured may easily be bankrupted by paying an award before triggering excess coverage, especially since the insurer's duty is to the insured and this approach taken by the insurer could actually be injurious to the insured. This approach seems inconsistent and is difficult to justify, given the industry precedent of disregarding the indemnify/pay on behalf of distinction in many instances.

But it should be pointed out that when it comes to insolvency of the insured, certain provisions of the umbrella liability policy may preclude the insurer's requiring the insured to pay the damages first, before the insurer is obligated to indemnify the insured. In this regard, all provisions of the umbrella liability policy should be reviewed carefully.

If the umbrella policy, for example, contains a provision that in effect states that bankruptcy or insolvency of the insured will not relieve the insurer of its obligation under the policy, a strong argument can be made that the insurer should "pay on behalf of" such insured, because when the bankrupt insured cannot pay the judgment, there is nothing to "indemnify." This is one situation, however, where it is not the interests of the insured that are being protected but rather those of the injured claimant and the creditors. While this argument

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It Could Happen to You—Or to Your Customers (and They Might Not Like It)

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has merit, it lacks the persuasiveness it would have if the insured's interests were involved.

A review of the loss payable provision of the umbrella policy also is important. If this kind of a provision states that the insurer's obligation attaches when the ultimate net loss is finally determined by final judgment, it likewise might be difficult for the insurer to enforce its agreement to "indemnify."

The indemnity language has been upheld at least twice in cases involving insolvent insureds. These cases, however, involved the protection and indemnity (P&I) coverage of a marine policy and are: *Ahmed v American Steamship Mutual Protection & Indemnity Assn.*, 640 F.2d 993 (9th Cir. 1981) and *Miller v American Steamship Owners Mutual Protection and Indemnity Company*, 509 F.Supp. 1047 (U.S.D.C., N.Y. 1981), as cited in Arthur L. Flitner and Arthur E. Brunck, *Ocean Marine Insurance*, Vol. II, 2d ed., Malvern, PA: The Insurance Institute of America, 1992.

As a matter of interest, one of the significant differences between a P&I policy and a commercial general liability

policy is that the P&I policy is always on an "indemnify" basis, whereas the CGL policy is on a "pay on behalf of" basis.

Suppose a parent company (A) has three subsidiary companies: (B), (C), and (D). Neither (B) nor (C) has any employees. The treasurer of the parent company, who also is a director of all subsidiaries, charges the subsidiaries a fee for handling the financial affairs. The fee is paid to the parent company. The treasurer is compensated for his services by the parent company.

Unfortunately, the treasurer embezzled a considerable amount of money from subsidiaries (B) and (C) and fled to Mexico. We are wondering whether the loss sustained by the two subsidiaries is covered under the parent company's employee dishonesty coverage. If not, would it be possible to maintain that the loss is therefore covered under the theft, disappearance, and destruction coverage as it applies to the subsidiary companies?

Assume, for purposes of this question, that these subsidiaries otherwise meet the eligibility rules for coverage and are, in fact, listed as named insureds along with the parent company (first named insured).

Part of the question has been answered by stating that neither subsidiary company (B) nor (C) has any employees. That being the case, it can hardly be argued that any employee dishonesty coverage, as may be applicable to the subsidiaries, would apply, since this coverage is contingent on "employee dishonesty."

This opinion, however, is subject to the caveat that inherent in this fact pattern are a number of complex legal issues. For example, consider the potential for the parent company's direct liability, thus allowing coverage to apply to the treasurer as an employee of the parent. Since there were no employees in the subsidiaries, it may be argued, for example, that there was no independent function performed by the subsidiaries and that they were mere instrumentalities of the parent.

It also could be argued that the lack of separate employees made the conduct of the subsidiaries a joint venture with the parent, thus exposing the parent to direct liability on that basis. These and other legal precedents might be used to obtain coverage in your situation by arguing that it applies to the treasurer as an employee of the parent.

Furthermore, it is doubtful that the treasurer, who performed work for the subsidiaries, could be considered to have been an "employee," as that term is defined in the policy, insofar as subsidiary companies (B) and (C) are concerned. The term "employee" is defined in General Crime Provisions, CR 10 00 as follows:¹

1. "Employee" means
 - a. Any natural person:
 - (1) While in your service and for 30 days after termination of service; and
 - (2) Whom you compensate directly by salary, wages, or commissions; and
 - (3) Whom you have the right to direct and control while performing services for you; or

b. Any natural person employed by an employment contractor while that person is subject to your direction and control and performing services for you excluding, however, any such person while having care and custody of property outside the "premises."

But "employee" does not mean any:

- (1) Agent, broker, factor, commission merchant, consignee, independent contractor, or representative of the same general character; or
- (2) Director or trustee except while performing acts coming with the scope of the usual duties of an employee.

While the subsidiaries paid the parent company for the services of the treasurer, the treasurer was an employee of the parent and compensated by it for all services rendered. Thus, definition a.(2) above makes clear that the treasurer was an employee of the parent and not an employee of the subsidiaries who sustained the loss, because neither such subsidiary compensated the treasurer directly by salary, wages, or commissions.

Another issue to be considered here is whether the treasurer/director was performing acts as a director that would normally be done by an employee. If not, the treasurer/director would not qualify as an employee based on the above definition of employee, part 1.b.(2).

One might argue that since the treasurer is not an employee of the subsidiaries, coverage therefore should apply under the Theft, Disappearance and Destruction Coverage Form CR 00 04, since the embezzlement was clearly a theft of money. The problem with this reasoning, insofar as this question is concerned, is that this coverage form not only excludes dishonest or criminal acts committed by the named insured's employees, but also by its directors, trustees, or authorized representatives.

Since the treasurer was a director of the subsidiaries and the subsidiaries were named insureds on the policy issued to the parent company, as the first named insured, the theft loss would not be covered under this form either. However, here, too, legal precedent may allow for coverage to apply to the parent company, assuming the insured is successful in its efforts to show that the subsidiaries were the "alter ego" of the parent.

While this approach might succeed in getting coverage for the loss at hand, it might also be used to defeat coverage for other types of losses and even lead to fines and penalties against the entities involved. A number of complex legal issues must be taken into consideration before allowing the parent company to argue that its subsidiaries are its instrumentally as opposed to separate and distinct entities. ■

Endnote

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Identifying Drivers Who May Be “At Risk” of Becoming Involved in a Collision: MVR Analysis

by Paul Farrell

Paul Farrell is the CEO of SafetyFirst, a team of experts from the transportation, insurance, and software industries that specialize in reducing commercial auto collisions through management information systems and programs, such as 24/7 call center and “Safety Is My Goal” decals for vehicles. The decals feature a phone number to a call center encouraging motorists to report risk-taking behaviors by drivers. The company provides solutions in partnership with insurance carriers and transportation firms. More information can be found at www.safetyfirst.com.

Who drives your company vehicles? How are they qualified? Are you certain that their license is valid and not suspended? Many states do not physically “take back” the license—seeing it doesn’t mean it is valid!

To protect your interests and help ensure a crash-free workplace, you must take steps to keep “at-risk” drivers from getting behind the wheel. Most firms (and their insurance carriers) have adopted a process of reviewing the Motor Vehicle Reports (MVR) (aka “Driving Abstracts”) of their drivers.

According to current National Safety Council data, during 2003, motor vehicle collisions resulted in:

- 44,800 deaths and
- 2.4 million nonfatal injuries

In fact, the most costly lost-time workers compensation claims by cause of injury, according to NCCI data, continue to be those resulting from motor vehicle crashes. These injuries averaged more than \$27,500 per workers compensation claim filed in 2001 and 2002. Your investment in screening is vital to safety results!

MVR Analysis Overview

Along with licensing drivers, each state has a mechanism to enable employers and insurance carriers to obtain the history of that driver’s tickets, violations, suspensions, and collisions (that have been reported by the police).

A great way to verify the validity of an employee’s license, and to identify “at-risk” drivers is to look at their MVR. The MVR will let you know if the license is valid or under suspension, and the history of tickets and police-reported collisions.

- There are firms that enable you to order these reports centrally, instead of dealing with each state’s own department of motor vehicles. The cost per MVR report ranges from \$3 to \$20 depending on various factors.
- Most companies that conduct MVR reviews do so at the time of hire for all new employees, and again, annually to see if there have been any changes to the records.
- Most companies use a “point system” to rate each driver’s MVR—good, average, clean, and beyond reason (ie. “terrible” or “unacceptable”). If a driver accrues too many crashes or tickets, they are removed from driving duties, and in many cases this equates to dismissal if no other position is available.
- MVRs are widely regarded as accurate, despite studies that challenge their completeness, and the ability of drivers to mask, hide, remove, or challenge items on these reports.

Benefits and Challenges of MVR Analysis

MVR analysis is a vital tool for fleet managers and insurance carriers. We advocate this type of process and its value, as one element of a screening program is not in question. However, we do want to point out some of the possible “gaps” in MVR review programs so that you might consider additional mechanisms to help spot “at-risk” drivers.

Benefit: This screening mechanism helps spot “at-risk” drivers who have a history of tickets and violations—hopefully before they have been offered a job.

Challenge: It makes sense that a “bad driver” usually continues to be a “bad driver;” however, a clear MVR (no historical data on crashes or tickets) does not necessarily equate to a “safe driver.” Each year, drivers with “clean” MVRs are, tragically, killed or injured in collisions.

Is there a way to spot improper behavior of drivers without tickets or police-reported crash records? Safety hotlines provide this input.

Benefit: States encourage drivers to get education on how to drive safely. As an incentive to commit their time and money (often to contracted vendors who are not affiliated with the state), guarantees of “point removal” are made. In simple terms, take the class and get your MVR “sanitized” for better insurance rates.

Challenge: The practice of ticket/point removal for attending traffic school is that many “false negatives” are created—drivers who routinely get points removed, but continue to drive aggressively and continue to be “at-risk” drivers.

Companies that routinely use “defensive driving” programs to reduce points on their driver’s MVRs may be masking an underlying program with dispatch, pressure to speed, or other concerns that



could lead to an increased incidence of collisions despite a good MVR review.

“Real-time” reporting of actual behaviors witnessed on the road may provide a clearer picture of day-to-day activity that is dangerous, but does not result in a collision or a police-issued citation. Safety hotlines provide this input.

Benefit: The program has a predictable cost based on your employee turnover rate and the average number of prospects who are discarded prior to selecting the final candidate. The benefits include spotting “troubled” drivers who need help from management.

Challenge: The program provides this benefit at a high cost to both your company and to your employees. The cost of a ticket, paid for by the employee, has additional costs in increased insurance rates for your employee’s family and often your own company, too. The cost of collisions similarly affects the employee in a highly personal way when there are injuries or fatalities.

Wouldn’t it be great if you could get this type of “indicator of behavior” information without incurring crashes or points on licenses?

Benefit: By updating existing drivers’ MVRs annually (or more frequently), management can notice changes in behavior as time progresses.

Challenge: The program only provides a snapshot in time—it is not dynamically updated (except in certain states such as California). In other words, the day after you order the MVR, the affected driver may get a ticket and you may not know about it until you update his or her MVR a year later.

Wouldn’t it be great if you could get this information delivered by e-mail, direct to your desk as it happens throughout the year, regardless of what state is involved (and without the paperwork and fees of “pull programs”)?

“False Negative” Issues In Depth

A “false negative” is a driver who may be “at risk,” but has a clear or mostly clear MVR. These drivers may have had tickets or may drive unprofessionally, but their MVR doesn’t indicate their relative risk factor. How does this occur?

1. Purging—According to a report issued by the National Conference of State Legislatures, “States also purge records to clear files and create additional storage space. When a state deletes prior serious violations

from the record, however, the state risks losing valuable information about a driver. Moreover, if a driver transfers to a different licensing state, the new state may not be aware of the driver’s previous record even if the new state is required to keep records about serious violations over a longer period of time. Ultimately, inconsistent purging practices could affect driver record accuracy, although no study substantiates this concern.”¹

2. Diversion, Deferral, and

Plea Bargains—According to the same report mentioned above, “Statutes in 33 states specifically authorize diversion, deferral, masking, probation, or point or conviction removal for traffic offenders. These programs allow drivers to postpone prosecution or sentencing for traffic offenses, hide convictions posted to their records, or remove points or convictions from their records. According to the NCSL survey, 22 states use point removal, six states mask convictions, 20 states use traffic schools, 14 states use diversion, seven states defer sentences, and four states remove convictions. Additionally, diversion programs in at least seven states allow eligibility only for drug and alcohol cases.”²

3. Driving School Participation

Other research, published by the Insurance Research Council (IRC) examined “. . . more than 50,000 traffic convictions in four states to determine the accuracy of MVRs.”³ Additionally, the report notes “. . . traffic schools and other conviction avoidance methods across the United States . . . further reduce the appearance of traffic violations on MVRs.”⁴

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4. “Out of State Drivers”—The IRC report also details a situation where drivers who receive tickets outside of their “home jurisdiction” may never see the conviction appear on their MVR: “. . . convictions for traffic violations issued to out-of-state drivers appeared even less frequently on motorists’ driving histories. Nearly half (47 percent) of a sample of convictions were missing from MVRs in a separate analysis of Florida drivers who were convicted of traffic violations while in Connecticut.”⁵

5. Common Mistakes—The IRC report also detailed that there are many instances where convictions simply do not make it onto MVRs for no apparent reason. “Twenty-two percent of convictions sampled in Connecticut and 21 percent of convictions sampled in Florida were not found on the respective drivers’ MVRs. Also, 14 percent of traffic convictions from a sample in Ohio and 10 percent of sampled convictions from the state of Washington were missing from MVRs. The analysis was limited to those traffic citations that resulted in convictions, either from fines paid without contesting the charges or from guilty findings in court. It did not include any tickets dismissed through traffic school, court supervision, or any other legal methods that prevent traffic violations from appearing on MVRs.”⁶

6. Legal Tactics—Although there have always been attorneys who will represent motorists in court to get tickets dismissed (DUI/DWI and excessive speed being common violations of concern), there has been an explosion of “self-help” strategies published freely across the Internet, which pledge to “prevent points on your driving record” (ie www.beatmytrafficticket.com, www.paynoticket.com).



Safety Hotlines as an Enhancement to MVR Analysis

Many companies use “safety hotline” (aka “How’s My Driving?”) data to uncover:

- behaviors that may lead to tickets and crashes, delivered “live” (as it happens) so that coaching may be offered in a timely fashion (to help improve behavior)
- issues with both newly hired drivers **and** existing drivers whose habits may be changing over time
- behaviors of drivers, hopefully before tickets and accidents occur, which have a high personal cost (family insurance rates, injuries, etc.) to the affected drivers
- “false negatives”—drivers who had prior tickets removed by participating in a traffic school, but still drive poorly/aggressively
- unreported drivers who only “occasionally” drive company vehicles

- drivers who were intentionally left off of the drivers’ list by a location that knew about adverse history, but wanted to keep it from the corporate management team

Summary

MVR analysis **is** very helpful and necessary; however, to ignore the potential shortcomings may leave a gap in your risk management efforts.

- “False negative” reports represent drivers who may be “at risk,” but may not be recognized as needing help.
- Safety hotline programs provide additional, timely insights into driver behaviors.
- Safety hotline programs do not replace MVR review, but enhance its results by dealing with some of the timeliness of reporting and “false negative” issues. ■

Endnotes

1. “Driver History Records for Commercial Drivers,” December 2001—National Conference of State Legislatures.

2. Ibid.

3. Accuracy of Motor Vehicle Records: An Analysis of Traffic Convictions, Summer 2002—Insurance Research Council.

4. Ibid.

5. Ibid.

6. Ibid.

Maximizing Value from Data Warehouse and Drill-Down Tools

by Erik Taylor and David Feldman

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Information is powerful. In the health care arena, the payoffs of harnessing information can be big—better evaluation of medical care, better tracking of services, better setting of rates and prices, better patient care, and better education of consumers. In order to realize these gains, many organizations have invested substantial sums in building data warehouses and drill-down reporting systems to extract the informational power of their internal and external data. Unfortunately, warehouse construction is only a first step to generating useful, insightful, actionable answers. Many organizations fail to take the necessary next steps, and as a result do not realize the big payoff of their warehousing.

Typically, an organization's information technology (IT) department leads a warehousing project. The IT team determines business requirements, develops specifications, designs the database and update process, and finally creates the warehouse and deploys the reporting tools. An icon appears on the user's computer screen, training occurs on the mechanics of using the reporting tools, and then, after many months of effort, the project is declared a success.

But wait! Where's the payback? At this point, there hasn't been any! How can the organization realize a significant return on investment for the warehousing and reporting tools project?

Payback Comes from Use

A primary payback of warehousing is a more efficient process for Information Systems to produce and deliver standard reports. Better yet, it should be much easier to develop new reports, and having the data centralized will increase the probability of reports footing to each other since they come from a common data source. These efficiency gains are real and substantial, and may in themselves justify the warehousing and reporting effort.

However, there is much more value to be had in the warehouse than this streamlining of standard reports; after all, there were standard reports produced before the data warehousing project. The bigger payoff comes from using data in an ad-hoc fashion to support decisions and allowing the organization to identify and exploit market opportunities and competitive advantages. For example, an ad-hoc analysis of member characteristics identified a subgroup of members who were more likely to stay with a plan during open enrollment. This allowed the plan to make more effective use of its marketing dollars by fine-tuning outreach efforts.

Many organizations are not able to make this leap from the passive use of the system via standard reports to the active ad-hoc use that can truly unlock the potential of data warehousing and drill-down reporting. But there are three steps that any organization can take to move itself toward realizing more value from its warehouse. These steps are:

1. Develop an analytic team.
2. Get to know the data.
3. Ask the hard questions of the results.

Develop an Analytic Team

There will be a core group of individuals who will be the primary users of the tools. These analysts, executives, programmers, operations managers, marketing specialists, etc. hold the key to unlocking the value of the data. To help maximize their contributions, consider:

1. **Forming a User Group**—Analysts benefit from working with other analysts. A user group fosters this collaboration, even if the individuals involved are from different departments. Another possibility is to create a staff dedicated to providing analysis and decision support, but

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that level of integration is not necessary to realize the benefits of analysts' collaboration.

2. Analyzing Data Before a Decision Is Imminent—Using data to support decisions should not slow up the decision-making process, yet understanding the subtleties and interactions among data takes time and resources. The only way around this conundrum is to have analysts and decision makers working and understanding the data on an ongoing basis. One easy way to get this activity going is to customize the standard reports; after all, manipulating the data into the best format is why the reporting tools were purchased in the first place.

3. Working Hard on Framing Analytic Questions—It is easy to get the right result to the wrong query, and this often confuses the decision making even more. An example is deciding which date field to use in an analysis of claims data. A question regarding processing efficiency most often needs to be based on the processed date of the claim, not when the health care service was incurred.

A question based on the effect of a given benefit plan typically needs to be based on the incurred date of the claim, because benefit plans are usually framed around the dates services are performed. The wrong choice of date fields would provide confusing results.

Get to Know the Data

Assembling the analytic team, aligning them with the business, and getting to work with the data is a good beginning, but is not enough to generate the big returns that come from fully using the data. It is also necessary to thoroughly understand the data. Three important steps are:

- 1. Understand How the Data Is Aggregated and Categorized**—Standard aggregations can be misleading if their specifications are not understood. For example, looking at a categorization of inpatient care, it is important to understand what types of facilities, bed types, and services are included. If nursing homes or rehab beds are included, average length of stay will be longer and cost per day will be lower than if they are not included. This could be critical in interpreting the results for decision-making.
- 2. Compare Definitions**—Each business has a unique lexicon. Company colleagues know what a given term, e.g., allowed charges, means to the business. However, these terms are not necessarily the same across an industry, and these differences in definitions can cause erroneous conclusions. The example above about defining the inpatient care aggregation is a case in point.
- 3. Look at More than Averages and Totals**—Most cubes and reports present either a total or average for any given continuous variable. Although it is often convenient to have a one-number answer, in our experience using one number generally obscures what is really going on with the data and the

business. For example, the average health cost for an individual may be \$2,500 per year. While correct, using this statistic exclusively misses the point that 40 percent of individuals have no health cost in any given year, and 5 percent of individuals account for 50 percent of the cost. Benefit planning and design decisions will want to consider this spread.

Ask the Hard Questions of the Results

The analytic team is formed, is on its way to understanding the data (note that it never will be completely understood!), and presents results. Now is the time for the hard work, the type that separates the pros from the amateurs: detecting and correcting errors in both the findings and conclusions of the analyses. The following questions, and a critical eye, will go a long way toward discovering mistakes, and thereby avoiding making decisions based on incorrect analyses.

1. “How Do I Know this Is Right?”

Studies have found that 80 percent of spreadsheets have errors in them that affect the bottom line. The staff completing these spreadsheets consistently reported that they were confident or very confident that the spreadsheets were accurate. Reviewing and questioning results is the chief problem for the consumer of information. One method to tackle this question is to find comparative data. Possibilities include other production reports, last year's results, and external data.

2. “Is the Difference Meaningful?”

If numbers change from measurement to measurement, a bit of statistics elegantly applied with business sense will ground subsequent decision making. For example, if this year's result is 42.00, and last year's result was 41.69, it would be good to know if this is a real difference or within the bounds of chance. Moreover, do the differences, if real, have any real business significance?

3. “Do these Results Apply to the Future?”

A common error is to assume the future will be like the past. Just because last period’s average was 36 does not mean this year’s average should be 36. Similarly, just because the last year-over-year trend was 11 percent does not mean that next year’s trend will be 11 percent. Simple assumptions of future performance are almost always used in pro-forma reports, and they are almost always wrong—the key is to understand the source of uncertainty and to discount the conclusions appropriately.

4. “Is the Relationship Causal?”

Data cubes make it easy to drill down and discover that different groups have different outcomes on a given variable. A common mistake is to assume that the different outcomes are caused by the different groupings. For example, a warehouse and associated cube may show that the Sacramento office processes claims faster (as measured by turnaround time) than the Houston office. A naïve manager might conclude that shifting claims from Houston to Sacramento would improve overall turnaround time, i.e., that the office



is somehow causing the turnaround statistic. In this case, further analysis might reveal that the Sacramento office has a much larger proportion of electronic claims that are processed much faster. Shifting claims to Sacramento will not change the proportion that is electronic, so turnaround time does not improve overall.

Are We There Yet?

Information is valuable. Developing a data warehouse and deploying reporting tools are good steps on the path to unlocking the value stored in the data. But these are only the initial steps. By following the outline above, organizations can move further along the path to fully realizing the potential of the data.

An organization has become data-actualized when data is brought into most decisions, and bringing it into the decision is not the result of a Herculean effort. By developing an analytic team, knowing the data, and asking the hard questions about the results, the company will begin to have a deep understanding of the quantitative areas of the business. This deep understanding will enable even instant, “gut-level” decisions to be based on data and analyses that have already been assimilated into organizational wisdom. ■

Thought to Ponder

... and speaking of ethical behavior ...

“Good people do not need laws to tell them to act responsibly, while bad people will find a way around the law.”

—Plato

Construction Defect Coverage Analysis— Easy as 1, 2, 3?

by Ginny L. Peterson, J.D., CPCU, and Marie L. VanDam, J.D.



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It is Monday morning. Bleary-eyed from watching the late-night basketball game (why are there so many NBA games anyway?) and from the late-night request of his daughter for one last drink of water, the busy claims professional staggers to his desk to begin his day. Upon opening his e-mail, he sees an urgent message: "Call me immediately about the latest construction defect claim. I am not sure where to begin; it is different than all of the other ones. Please read the 20-page complaint and call me."

How often has this scenario happened to you? How many different types of construction defect claims can there be . . . and how does one begin to determine whether an insurance company has the duty to defend or indemnify for such a claim?

The coverage analysis for construction defect claims, while perhaps not easy, should be completed sequentially. The facts of a given case, tied with the policy language and a court's past interpretation, are critical for any coverage analysis. Forgetting an important step can lead to unexpected and unfortunate results. If any of the potential determinations are overlooked, an incorrect acceptance or denial of coverage can result.

Step One: Determine if the Individual or Entity Is an Insured Under the Policy

If the insurer is notified of a construction claim, it should first determine if the individual or entity requesting coverage is an insured under the policy. While in most cases the individual or entity requesting coverage is listed in the declarations, sometimes it is not. The insurer then must check the section entitled "Who is an insured?" The policy explains who an insured is, depending on the type of business entity, individual partnership, limited liability company, or other. Be sure to consult the Definitions

section carefully—if the entity is not named, there may be no coverage.

Conversely, even if the entity is not named, coverage may exist for newly acquired or formed entities (usually for a period of time). There may be coverage for predecessor or successor liability, a topic hotly debated in courts. *Henkel Corp. v Hartford Accident & Indemnity*, 62 P.3d 69 (Ca. 2003); *P.R. Mallory, Inc. v American States Ins. Co.*, 2004 WL 1737489 (Ind.Cir. 2004); *Northern Ins. Co. of New York v Allied Mut.*, 955 F.2d 1353 (9th Cir. 1992).

Lastly, check the endorsements for additional insureds, which are common in construction insurance. Often, the general contractor will be listed on a subcontractor's policy, or the project owner or developer will be listed on the general contractor's policy. The scope of the insurance coverage is usually limited to the liability of the additional insured arising out of the operations of the named insured.

Step Two: Analyze the Insuring Agreement

The next step is to analyze the insuring agreement. The insuring agreement of a commercial general liability (CGL) policy, the most common policy under which a construction professional's liability will be insured, states what insurance is actually being purchased and the details of the applicable coverage. While many insurance companies adopt the specific language contained in standardized Insurance Services Office (ISO) policies, some insurance companies may modify the standardized language or provide additional endorsements to the insured, thereby potentially broadening or limiting the coverage available under the policy. It is also necessary to consult the Definitions section of the policy for further clarification of certain terms used in defining the coverage.



For construction defect claims, the applicable coverage will generally be outlined in the "Bodily Injury and Property Damage Coverage" section of the CGL, the first section of the policy to be examined when determining coverage. The standard coverage language typically found in most policies states:

SECTION I—COVERAGES

COVERAGE A. BODILY INJURY AND PROPERTY DAMAGE LIABILITY

Insuring Agreement

We will pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies. We will have the right and duty to defend any "suit" seeking those damages. We may at our discretion investigate any "occurrence" and settle any claim or "suit" that may result.

This insurance applies to "bodily injury" and "property damage" only if:

The "bodily injury" or "property damage" is caused by an "occurrence" that takes place in the "coverage territory;" and

The "bodily injury" or "property damage" occurs during the policy period.¹

Under this standard insuring agreement language, three key terms may be in dispute for coverage for construction defects: "occurrence," "property damage," and "during the policy period."

What Is an Occurrence?

According to the standard Definitions section of a typical CGL policy, an "occurrence" is defined:

SECTION V—DEFINITIONS

12. "Occurrence" means an accident, including continuous or repeated exposure to substantially the same general harmful conditions.

Most CGL policies do not go the one step further to define "accident," therefore, whether an act constitutes an "occurrence" is often determined by the courts. The majority of courts have determined that an "accident" consists of an unexpected happening without intention or design; however, the natural and ordinary consequences of an act are *not* an "accident." See *R.N. Thompson & Assoc. v Monroe Guaranty Ins. Co.*, 686 N.E.2d 160 (Ind.Ct.App. 1997); *Hawkeye-Security Ins. Co. v Vector Const. Co.*, 460 N.W.2d 329 (Mich.Ct.App. 1990); *Indiana Ins. Co. v Hydra Corp.*, 615 N.E.2d 70 (Ill.App. 1993); *Mid-Century Ins. Co. v Lindsey*, 997 S.W.2d 153 (Tex. 1999).

When a claim involves faulty workmanship, several courts have determined that poor workmanship alone does not constitute an "occurrence" under standard CGL policies. See *Corder v Smith Excavating Co.*, 556 S.E.2d 77 (W.Va. 2001); *USF&G Co. v Advance Roofing and Supply Co.*, 788 P.2d 1227 (Ariz.Ct.App. 1989); *Reliance Ins. Co. v Mogavero*, 640 F.Supp 84 (D. Md. 1986). Damages resulting from the normal, expected consequences of faulty workmanship are not considered "occurrences" under the standard policy language because CGL policies were not designed to act as a performance bond. Likewise, poor business decisions are not considered "occurrences" under standard

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policy terms since they are intentional acts, even if the results of those acts are unexpected or unintended. CGL policies were not designed to provide insurance coverage for an intentional, albeit poor choice in the management or operations of a business.

On the other hand, some courts have held that defective workmanship does constitute an “occurrence” as long as the resulting damage was not intended or expected by the insured. See *Fidelity & Deposit Co. v Hartford Casualty Ins. Co.*, 189 F.Supp 1212 (D. Kan. 2002); *Federated Mutual Ins. Co. v Grapevine Excavation, Inc.*, 197 F.3d 720 (5th Cir. 1999) (applying Texas law); *High Country v New Hampshire Ins. Co.*, 648 A.2d 474 (N.H. 1994). In other words, faulty workmanship is not an accident but faulty workmanship that causes an accident is covered under a CGL policy. *R.N. Thompson v Monroe Guaranty*, 686 N.E.2d 160 (Ind.Ct.App. 1997).

The following are examples of “occurrences” as determined by the courts:

- Property damage due to moisture seeping into the walls as a result of negligent construction methods constituted an “occurrence” under the applicable policy language, *High Country v New Hampshire Ins. Co.*, 648 A.2d 474 (N.H. 1994).
- Possibility that collapse of building during construction was caused by an Act of God, for example high winds, could be an “occurrence” such that coverage may exist under the CGL policy. *Shelby Ins. Co. v Northeast Structures, Inc.* 767 A.2d 75 (R.I. 2001).
- Cracked walls and structural damage to building project was an “occurrence” because the defects were not intended by the insured, *Fidelity & Deposit Co. v Hartford Casualty Ins. Co.*, 189 F.Supp 1212 (D. Kan. 2002).

Conversely, the following are examples of what are not “occurrences” according to the courts:

- The uneven settling of a new home addition is the natural and ordinary consequence of contractor’s faulty workmanship in failing to properly compact the soil prior to building the addition and is not an “occurrence.” *State Farm v Tillerson*, 777 N.E.2d 986 (Ill.App. 2002).
- Cracks in concrete floor and loose paint were natural and ordinary consequences of installing defective concrete flooring and applying incorrect type of paint and therefore did not constitute an “occurrence” under the CGL policy. *R.N. Thompson v Monroe Guaranty*, 686 N.E.2d 160 (Ind.Ct.App. 1997).
- Faulty repair work on roofs did not constitute an “occurrence” because defective work, standing alone, is not an occurrence as provided in standard CGL policy language. *USF&G Co. v Advance Roofing and Supply Co.*, 788 P.2d 1227 (Ariz.Ct.App. 1989).
- Premature deterioration of roads resulting from contractor’s faulty workmanship was not caused by an “occurrence” within the meaning of the contractor’s CGL policy. *L-J, Inc. v Bituminous Fire and Marine Ins. Co.*, 621 S.E.2d 33 (S.C. 2005).
- Failure of insulation systems on construction project did not constitute an “occurrence” under CGL policy since systems failed due to defective workmanship. *Amerisure, Inc. v Wurster Const. Co.*, 818 N.E.2d 998 (Ind.Ct.App. 2004).

As you can see, the threshold issue of whether an occurrence exists is not always clear-cut. While it appears that most courts rely on the general definition of “accident”—an unexpected happening without intention or design—they differ when it comes to whether faulty workmanship alone constitutes an “occurrence.” Some courts rely on the “natural and ordinary consequence”

rationale to exclude coverage under a standard CGL policy, while other courts examine whether the insured intended to cause the damage resulting from the defective workmanship.

What Is Considered “Property Damage”?

The next issue to determine when analyzing a claim for construction defects is whether the occurrence caused “property damage” as defined in the insuring agreement. It is important to keep in mind that commercial liability insurance coverage applies to the insured’s tort-based obligations. These policies are generally not intended to pay costs associated with repairing or replacing the insured’s defective work and products. See *Ohio Casualty Ins. Co. v Bazzi Const. Co.*, 815 F.2d 1146 (7th Cir. 1987). A claim of breach of contract, for instance, is not a tort-based obligation of the insured.

A CGL policy may define property damage as follows:

SECTION V—DEFINITIONS

17. “Property damage” means:

- a. Physical injury to tangible property, including all resulting loss of use of that property. All such loss of use shall be deemed to occur at a time of the physical injury that caused it; or
- b. Loss of use of tangible property that is not physically injured. All such loss of use shall be deemed to occur at the time of the “occurrence” that caused it.

Another definition found in many CGL policies reads:

SECTION V—DEFINITIONS

17. “Property damage” means physical damage to or destruction of tangible property, including loss of use of this property.

In general, CGL policies cover property damage to property **other than** the product or the completed work itself.

In other words, the coverage is not for contractual liability of the insured for economic loss suffered because the completed work is not what the damaged person bargained for. See *R.N. Thompson v Monroe Guaranty Ins. Co.*, 686 N.E.2d 160 (Ind.Ct.App. 1997); *St. Paul Surplus Lines Ins. Co. v Diversified Athletic Services*, 707 F.Supp. 1506 (N.D. Ill. 1989); *Lamar Homes, Inc. v Mid-Continent Gas Co.*, 335 F.Supp.2d 754 (W.D. Tex. 2004). However, at least one court has allowed coverage for claims partially based on a breach of contract/breach of warranty theory on the grounds that physical damage actually occurred to the work performed by the insured. See *American Family Mut. Ins. Co. v American Girl, Inc.*, 673 N.W.2d 65 (Wis. 2004).

When a diminution in value of property is claimed as damages, some courts have held that coverage does not exist for diminution in value when no physical property damage actually occurs. See *Hartford Acc. & Indemnity Co. v Pacific Mut. Life*, 861 F.2d 250 (Okl. 1988). Along the same lines, diminution in value does constitute “property damage” when the property itself sustained physical damage. See *Missouri Terrazzo Co. v Iowa Nat. Mut. Co.*, 740 F.2d 647 (8th Cir. 1984).

While most courts appear to adhere to the rationale that “property damage” under a CGL policy must result in physical damage to property other than the product or work itself, this issue is not clearly defined across the nation. For this reason, it is important to consult the language of the insuring agreement and case law applicable in each state.

What Is Considered “During the Policy Period”?

The next issue to consider when analyzing a construction defect claim is whether the property damage occurred during the policy period. This is an important consideration because if the property damage did not occur within the applicable policy period, there may not be coverage available depending on the jurisdiction.

The test for determining when an occurrence happens for purposes of coverage varies by jurisdiction. The following “triggers” are used:

1. Exposure (first exposure of injury to the claimant).
2. Manifestation (injury manifests itself during the policy period).
3. Continuous exposure or multiple triggers (either by exposure or when injury is manifested).
4. Injury in fact (the cause of the occurrence and the resulting damage happened during the policy period).

Most jurisdictions conclude that property damage occurs when the damage occurs or manifests itself. See *Wrecking Corp. of America v Ins. Co. of North America*, 574 A.2d 1348 (D.C. 1990); *Aetna Casualty & Surety Co. v PPG Industries, Inc.*, 554 F.Supp. 290 (D.Ariz. 1983). Consequently, the policy in effect at the time the damage occurred or manifests itself is applicable, not the policy in effect when the work was performed. See *U.S. Fidelity & Guar. Co. v Warwick Development*, 446 So.2d 1021 (Ala. 1984).

The following cases illustrate how the timing of the property damage is significant for coverage purposes:

- No coverage under policy for fire occurring after the policy period expired even though contractor installed insulation during policy period that caused the fire. *Millers Mut. Fire Ins. Co. of Texas v Ed Bailey, Inc.*, 647 P.2d 1249 (Id. 1982).
- Damage must occur during the policy for coverage to be effective but in the case of continuous damage, the

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damage must manifest itself during the policy period. *Auto Owners Ins. Co. v Travelers Cas. & Surety Co.*, 227 F.Supp.2d 1248 (M.D. Fla. 2002).

- Fire that occurred after the policy period ended was not covered under the policy even though the faulty wiring of the building that caused the fire occurred during the policy period. *St. Paul Fire & Marine Ins. Co. v Valentine*, 665 So.2d 43 (La. 1995).

Clearly, when analyzing a construction defect claim, the timing of the resulting property damage can affect whether the CGL policy provides coverage. Examining the specific language in the applicable policy as well as the law in the applicable jurisdiction is of the utmost importance.

Step Three: Analyze the Exclusions

Once the insuring agreement has been reviewed, the next step is to examine the Exclusions or Limitations section of the policy. This section generally limits coverage previously given in the insuring agreement and, therefore, it must be consulted after reviewing the insuring agreement itself.

While many exclusions may apply to a construction defects claim, the following are the most prevalent:

- “Your Work” exclusion: A contractor is not covered for the repair or replacement of defective workmanship on its own work; it is only covered for damage that its work causes to other property or persons. Often this exclusion states that work completed by the subcontractor on the insured’s behalf is covered. The trick is that the insuring agreement requirement of “property damage” caused by an “occurrence” must still be met. If the general contractor is sued for the subcontractor’s work that does not damage other property, there is still generally no coverage for the general contractor.

- “Your Product” exclusion: Any damage to the named insured’s product is likewise not covered, but if the product defect leads to damage to other property, coverage may exist.
- “Expected or Intended” damage: Most jurisdictions define “expected” and “intended” but vary on whether the standard is objective or subjective.

The list of exclusions should serve as a checklist to verify coverage. Each one should be thoroughly analyzed and compared to the facts of the case at hand.

Step Four: Analyze the Conditions

The Conditions section of the insurance policy is often overlooked in construction defects coverage analysis. It contains numerous areas for exploration including the following:

- Promptness of notice of a claim: Late notice may bar coverage in some jurisdictions while others require late notice and prejudice to the insurance carrier.
- Known loss: If the insured knew of the property damage before the effective date of the policy and the insurer did not, coverage for the property damage in that policy period may be barred. Sometimes this language is express in the insuring agreement while in other cases it is implied.
- Other insurance: Under certain situations, the CGL coverage may be primary while in others it is excess.
- Pollution exclusion: Some jurisdictions recognize that construction defects that arise from dispersal of pollutants are barred from coverage.

Conclusion

The analysis of insurance coverage for construction defect claims is like walking—you must take one step at a time in order to reach your destination. While the answers that each jurisdiction gives can certainly be different and the policy language varied, the essential steps of analysis remain the same. ■

Endnote

1. All references to policy language are taken from court pleadings and do not pertain to any one particular standardized form or any particular insurance carrier’s independently developed policy language.

When the Next Storm Strikes

by Edmund F. Kelly

Editor's note: As seen in the May 31, 2006, *Wall Street Journal* Commentary. This article has been reprinted with the permission of the author.

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We have been hearing calls for the federal government to expand its role in providing insurance for those who build or live in catastrophe-prone areas. With the hurricane season starting, these calls are likely to grow louder—especially when the first major storm hits. The reasons this is a bad idea should be obvious.

People who willingly and knowingly live in catastrophe-prone areas should assume the risk, and pay the cost, of doing so; government-subsidized insurance just loads this risk, and cost, on average taxpayers. And what proponents of a greater role for the government don't like to discuss is that the Federal Flood Program has a \$20 billion deficit—and has notably failed to meet its original purpose of encouraging people to rebuild away from areas vulnerable to devastating coastal storms.

Nevertheless, groups such as ProtectingAmerica.org (a coalition of insurance and business organizations) persist in advocating, among other things, the creation of so-called catastrophe funds. Recent storm history helps explain why. Two highly destructive hurricane seasons in 2004 and 2005 underscored dramatically the danger of living in coastal areas.

While the ferocity of the storms was notable, the stories about them followed a predictable cycle. A hurricane strikes with high winds, driving rains and storm surge; the media coverage documents the human drama—the tales of those who escaped serious injury and those who were not so lucky. In the aftermath, awe over the destruction wrought by the storm is countered by vows to rebuild.

This cycle will be repeated as two trends clash. The first is the desire of people to live on or near the coast. Despite the cost, the demand for primary and secondary homes in coastal areas is unabated. The ensuing building boom has produced tens of thousands of new residences—and billions of dollars of new property to protect in Florida and other catastrophe-prone states. The second trend is storm frequency. While the causes may be debated, there is agreement that we are entering a protracted period of increased and more intense hurricane activity. Thus, we should view the last two hurricane seasons as the norm, not aberrations.

These trends, taken together, raise two questions: What can we do to reduce human injury and the financial cost of natural catastrophes; and who should pay for the damages?

■ **With the major and glaring exception of Katrina, state and federal efforts to deal with storms are now better coordinated.**

The answer to the first question can be found in part in stronger building codes to make homes and other structures less susceptible to severe storms. Wilma, the last major storm of a 2005 hurricane season that spawned four Category 5 storms, roared across the Florida coast in late October, causing severe damage in several cities, including Palm Beach, Fort Lauderdale and Miami. But the property toll wasn't nearly as bad as it might have been, for the simple reason that Florida has been enforcing stricter regulations that require better building materials and construction practices. An inexpensive metal band now used to secure joists, for example, helps prevent roofs from being blown away, as was tragically common in past storms, most memorably Hurricane Andrew in 1992. And impact-resistant

windows have significantly reduced damage from flying debris, wind, and rain.

With the major and glaring exception of Katrina, state and federal efforts to deal with storms are now better coordinated. Florida has faced seven hurricanes in the last two years and, in the process, shown the nation how to respond before and after major storms to avoid loss of life, limit property damage, and help affected areas return to normal as soon as possible. More states need to follow Florida's lead in assuring that homes are better able to withstand hurricanes and that response capabilities are in place to handle dislocation.

At first glance, the second question—who should pay for damage—also seems straightforward: the private insurance market. This market has proven the best mechanism to compensate individuals and businesses for property damage caused by hurricanes, tornadoes, wildfires, and other natural disasters. (Floods present a unique set of problems and are covered under the Federal Flood Program.)

In the 10-year period from 1995 to 2004, insurance companies paid out \$124 billion to cover losses from natural catastrophes. Katrina, the worst natural disaster in U.S. history, will result in losses of up to \$60 billion. Yet, as demonstrated by recent news of positive earnings in 2005, the insurance industry was able to handle this enormous burden because substantial historical data on natural disasters has enabled companies to understand and manage their exposure to such large losses. A government insurance plan, on the other hand, is almost certain to be underfunded—as political pressure would keep rates below their true cost. The difference would be subsidized by taxpayers, the vast majority of them inland residents who would receive no benefit.

Continued on page 20

When the Next Storm Strikes

Continued from page 19

Instead of looking to government to create special funds, private insurers and public partners should press to reduce the costs of natural disasters before they occur. They could explore incentives for homeowners and businesses to make their properties more storm-proof; find better ways to protect infrastructure; encourage building-code improvements; and develop sensible land-use planning to control construction in the most vulnerable areas. Further, regulatory processes need to allow insurance pricing to better reflect risks. Those who choose to live in catastrophe-prone areas should not be shielded from the consequences of their decisions by raising prices for people who opt for less-risky locations.

Katrina, the worst natural disaster in U.S. history, will result in losses of up to \$60 billion.

Thanks to Katrina, the sentiment for government financial support is understandable. But expanding the federal role in insurance will do nothing to spur preventive measures or policies. Devoting resources to reduce the human and economic toll from storms, on the other hand, is a long-term investment—one that will help assure that high-risk areas can cope when the next storm strikes and that the private insurance market can continue to fulfill its historic role in paying for damage to homes and property following a disaster. ■

2006 Annual Meeting Seminars Developed by the Underwriting Section

High-Tech Tools: How's the ROI?

Tuesday, September 12 • 8 – 10 a.m.

When it comes to the use of technology in the underwriting profession, stakeholders have a right to ask, "Are we maximizing the return on investment?" This seminar will examine how industry leaders are using technology to change the underwriter's role and thereby maximize underwriting profitability. Much of the information presented in this seminar is based on a survey of 800 CPCUs conducted by Accenture.

Developed by the Information Technology and Underwriting Sections, and Accenture.

Moderator:

J. Brian Murphy, CPCU

Brokers' Risk Placement Service

Presenters:

John B. Hennessy

CNA

Richard Shellito, CPCU, CLU

State Farm Insurance Companies

Gail E. McGiffin

Accenture

Society's Addictions and Their Impact on Insurance

Tuesday, September 12 • 1:30 – 3:30 p.m.

Every underwriter, risk manager, agent, loss control professional, and claims professional must understand the impact of social trends, particularly addictions, on underwriting, pricing, and claims. A diverse panel of speakers will discuss hazards created by addictions in workers compensation, property, crime, and inland marine lines of coverage. They will discuss the roles of the insurer's Special Investigation Unit, local and federal law enforcement, and social workers.

Developed by the Underwriting Section.

Moderator:

Gregory J. Massey, CPCU, CIC, CRM, ARM, PMP

Selective Insurance Company

Presenters:

Ellery P. Ferrara, LPSC

Indiana Insurance Company

Wayne Suss

Liberty Mutual Group

Larry R. McCart, CIFI, FCLS

Liberty Mutual Agency Markets

Register today for the 2006 Annual Meeting and Seminars at www.cpcusociety.org!

Register for the CPCU Society's 62nd Annual Meeting and Seminars

September 9-12, 2006 • Nashville, TN



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- Celebrate with your colleagues and new designees at the Opening Session and national Conferment Ceremony on Saturday afternoon, followed by the Congratulatory Reception.
- Enjoy a memorable evening at the Grand Ole Opry.
- Be inspired at Sunday's Keynote Address by retired New York City Fire Department Battalion Commander Richard Picciotto, the highest-ranking firefighter to survive the World Trade Center collapse and author of *Last Man Down*.
- Attend two new exciting panel discussions conducted by industry leaders, focusing on critical industry issues and environmental catastrophes.
- Choose from 35-plus technical education and professional career development seminars.

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at www.cpcusociety.org.*



Retired FDNY Battalion Commander Richard Picciotto will speak at the CPCU Society's Annual Meeting on September 10, one day before the fifth anniversary of 9/11.



Photo courtesy of Nashville CVB and Heavenly Perspectives.

The Daenzer Story: A Book Review

by Andrew J. Barile, CPCU

■ **Andrew J. Barile, CPCU**, is president and CEO of Andrew Barile Consulting Corporation, Inc. (www.abarileconsult.com). He first met Daenzer at the 1970 CPCU Society Annual Meeting and Seminars in Los Angeles, and later joined the Alexander Howden Group to start the Howden Reinsurance Corporation, in New York City.

The biography of **Bernard John Daenzer, CPCU**, written by Carolyn I. Furlong, CPCU, CLU, CEBS, CPIW, is a must-read for all insurance professionals, as this dedicated insurance industry personality over his long lifetime “would paint the insurance industry not as it was, but as it ought to be.”

As Furlong makes clear in *The Daenzer Story*, the book is written to cover the 100-year period from 1900 through December 31, 1999. Although Furlong is quick to point out “in early 2005, having just turned 89 years old, Daenzer was instrumental in founding an insurance agency, Angelfish Risk Management, owned and operated by several businessmen in Ocean Reef Club, Key Largo, Florida.

The Daenzer Story is a detailed account of Daenzer’s insurance industry exploits, and all of the insurance executives he influenced along the way, and there were many. In 1947, Daenzer was the 88th person in the country to get a Chartered Property Casualty Underwriter designation. Daenzer was rightly considered a pioneer in the field of personal packages. *Rough Notes* magazine made Daenzer the authority for homeowners insurance.

Many of us referred to Daenzer as the “Father of the Surplus Lines Insurance Industry.” Furlong writes, by 1957, Daenzer found that there was no body of literature in the United States or England on the broad field of excess and surplus lines or Lloyd’s-type coverages. This led to his writing a series of articles for the *Weekly Underwriter*, about 400 over the years, in a bi-weekly column called Cover



■ *Bernard J. Daenzer, CPCU, was recognized for attending 58 out of 61 CPCU Society Annual Meeting and Seminars during the 2005 Annual Meeting in Atlanta.*

Notes. Booklets were made from the articles that later became the *Excess and Surplus Lines Manual* published by The Merritt Company. These publications included thousands of pages on several hundreds of topics peculiar to the business. “I made them required reading by all of us at Howden Reinsurance Corporation.”

In the field of risk management, Daenzer was also instrumental in “leading the way.” Daenzer and several other CPCUs were working on a professional designation for risk managers and came up with Associate in Risk Management. He wrote one of the textbooks for the ARM course, and a later one for RIMS on risk analysis of company locations.

On November 27, 1968, Daenzer was the first non-Briton to go through ROTA and to be elected a name at Lloyd’s. “This broadened membership base is good for both Lloyd’s and the insurance-buying public in general,” Daenzer noted, “because it helps to fill the need for a greater capacity in the world-wide insurance market.”

Daenzer, in 1978, was elected chairman of the Board of Trustees of The College of Insurance, the only fully accredited college and graduate school under the support of one industry.

Furlong does a great job in documenting the institutions that had touched

Daenzer’s life and have undergone changes, such as:

- The College of Insurance that Daenzer worked to support and promote over the years remains the prominent source of higher insurance education. It merged with St. John’s University and is now known as the School of Risk Management and Actuarial Service, a part of the Tobin College of Business, the New York City branch of St. John’s University.
- RLI Corporation of Peoria, Illinois continues to flourish.

Daenzer had an almost encyclopedic knowledge of how the insurance industry worked, but he did not stop there. As related in this story of his life, Daenzer responded to new types of risks by creating new coverages to protect policyholders and by carving out niche products to respond to the needs of industry.

This book should be read by all in the insurance industry, and set the example for the actions of future insurance leaders. ■

You can order *The Daenzer Story* at Amazon.com. Royalties from the sale of this book will be shared by the CPCU-Loman Education Foundation and the Insurance Scholarship Foundation of America—NAIW Education Foundation.

Being CPD Qualified Just Got Easier!

Being a Continuing Professional Development (CPD) qualifier is important to a CPCU. It shows that you have maintained the continuing education commitment as an insurance professional.

CPCUs are committed to professional development; however, up until recently the CPD program was a manual process. Today, getting CPD qualified is a 10-minute process and can be done online. Here's what you need to do:

1. Go to www.cpcusociety.org.
2. Log in.
3. Click on "Professional Development."
4. Then click on "Continuing Professional Development" and "CPD Online Application."
5. Fill out the application and click on the "Submit Application" button.
6. You're now CPD qualified (upon approval).



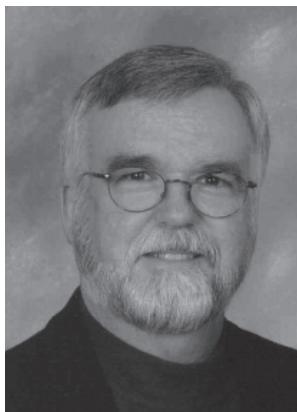
Here are the highlights of the program:

- You need 60 points every two years. Attending insurance meetings with a speaker, educational meetings, state CE courses, industry I-Days, and taking a course are just some of the ways one can accumulate points.
- No need to submit documentation; however, 5 percent of the CPD qualifiers are audited each year, so you should save records relating to your CPD activities.
- Apply for CPD qualification no more than 30 days prior to your CPD expiration. If you are not CPD qualified, you can go through the above process at any time.

Why Be CPD Qualified?

- Shows you've made the commitment to professional development, as you committed to when you first earned your CPCU designation.
- Supports your chapter, as chapters can earn national recognition by increasing the number of CPD qualifiers within their chapter.
- It's free.
- If you choose, a certificate suitable for framing recognizing this accomplishment can be requested for a \$25 fee.
- Apply the CPD activities to other CE requirements.
- Join the ranks of thousands of CPCUs that have already made the CPD commitment. ■

Section Committee Member Spotlight



Stephen W. White, CPCU

State Farm Group
Bakersfield, CA

Chapter: California Golden Empire

Stephen W. White, CPCU, is now a co-editor of the Underwriting Section newsletter, working closely with Gregory J. Massey, CPCU, CIC. White, a member of the Underwriting Section Committee for three years, earned his CPCU designation in 1996. He is currently a commercial fire insurance underwriting section manager with State Farm in Bakersfield, CA. White has been with State Farm for 29 years and is a graduate of the University of Alabama. ■

Attend the Underwriting Section Luncheon in Nashville

Sunday, September 10, 2006
11:30 a.m. – 1 p.m.



Photo courtesy of Nashville CVB and Barry M. Winiker.

The CPCU Society's 2006 Annual Meeting and Seminars will be held at The Gaylord Opryland Resort & Convention Center, known for its indoor gardens, world-class spa, and first-class entertainment.

When registering for the CPCU Society's 2006 Annual Meeting and Seminars in Nashville, don't forget to sign up for the Underwriting Section Luncheon.

Network with fellow CPCUs who share your career interests, and hear specialized presentations at the Underwriting Section Luncheon. **Dom Yezzi, CPCU**, vice president of specialty commercial lines, ISO, will discuss new and changing exposures, and the potential impact on the industry.

Luncheon tickets are required. Tickets are \$33 each. (To register, select this option under Section 4 of the Annual Meeting registration form.)

Register today for the 2006 Annual Meeting and Seminars, and Underwriting Section Luncheon at www.cpcusociety.org.

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<http://underwriting.cpcusociety.org>

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