CLM CLAIMS & LITIGATION MANAGEMENT ALLIANCE™

ADVANCING ETHICS, COOPERATION AND EDUCATION

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GREAT CUSTOMER SERVICE *or* HOW NOT TO CATCH A CASE OF BAD FAITH

A SHORT HISTORY OF EC LIABILITY

The law of extra-contractual (EC) liability developed in response to a debatable yet evolutionary perception that insurers routinely placed their own interests before that of their policyholders, and as a direct consequence, policyholders became personally liable for losses they believed were covered by their insurance.

Hence, they sued their insurers for breach of contract. But, in some cases, the contract remedies were perceived to be inadequate.

In response, courts eventually decided that insurers were subject to the historical **implied duty of good faith and fair dealing** when settling claims made under the terms of an insurance policy. This duty or covenant is formed by the presumption that the parties to a contract should and will deal with each other in honesty, fairness, and good faith so as not to destroy or deny the right of the other to receive the benefits of the contract.

An insurer's failure to comply with this promise can result in an extra-contractual claim; or, as the reverse of good faith, a "bad faith" claim.

Two unique characteristics contributed to the development of extra-contractual liability specifically in respect to insurance policies: first, insurance contracts involve the public interest, and second, they require a higher standard of conduct because of the unequal bargaining power of the parties. Insurance contracts are contracts of adhesion – in other words, the terms of the contract are drafted by one party for a fixed term and price and the other party must accept them as is in order to enter into the same and receive its benefits.

Because insurers ultimately and control how claims made under the terms of the insurance contact are resolved, courts have held them to a higher standard of conduct to discourage and, quite often, punish insurers from abusing their position of power.

GOOD FAITH CLAIM PRACTICES

Good faith behavior is essential in today's insurance claims handling environment. By aggressively practicing good faith – by making a conscious, honest, diligent effort to act in good faith, the claim adjuster and the insurer stand an excellent chance to avoid the consequences of EC litigation actions.

The familiar concepts underpinning not only claims settlement practices statutes but also common law decisions unfailingly emphasize **immediate contact**, **timely and continual communication**, **diligence**, **honesty**, **fairness**, and **reasonableness**. Breaking these concepts down to pertinent component parts, the American Institute for Chartered Property & Casualty Underwriters (AICPCU), for instance, gives the following examples of practices crucial to demonstrating – and exhibiting to the customer – good faith and fair dealing:

- Request and obtain all necessary information or documentation before deciding to accept or deny a claim.
- Include in the claim file detailed analyses of the coverage and liability questions, defenses, and damages issues.
- Support analyses with facts and documents in the file, not rumors or innuendos.
- Do not make derogatory or malicious – even unflattering – comments about the insured, counsel, or witnesses.
- Avoid exploiting or making comments about exploiting the claimant's or the insured's financial hardship.
- Avoid all delays in handling and evaluating a claim.
- Avoid substantial variances between reserves, payments, and offers made.

Beginning to end, it is vital for the claim file to provide a complete and accurate account of all the activities and actions taken by the claim adjuster, because the prevailing assumption is the file is to be read by many different people, each with a different purpose. But regardless of who reads the file, no one should be left wondering or speculating why something did or did not happen or how the conclusion or decision was reached.

CUSTOMER SERVICE & GOOD FAITH

A. The Past:

In his book, *Human Relations in Handling Insurance Claims*, published in 1967, Willis Park Rokes, a professor of law and insurance at the University of Nebraska at Omaha, observed,

> "The keynote to the entire insurance claims handling process, consequently, is the claims man's [let's forgive the usage of the masculine – after all, it was 1967] association with people – all types of people. He deals with all ages and nationalities. Some people can't write their name; others are highly educated. He must use an interpreter to talk to some individuals. He enters the homes of the wealthy and the hovels of slum dwellers.
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> "Most of the people he meets have lost something of value. In these meetings, he sometimes deals with people who are sophisticated in insurance matters, who understand the principle of indemnity. Most of the time, however, he discovers that people are unfamiliar with the legal technicalities involved in insurance claims, and they don't understand much about liability and the law of negligence. Their background and education is foreign to the world of insurance claims. Into this strange world they often bring a complete naiveté, a distrust of unfamiliar things, and an irrationality of approach that is often aggravated by the event that gave rise to their claim. It is within this human environment that the claims man must work.
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> "In handling these claim functions he finds that, more so than in almost any other line of work, conflict and adversary relations with other people can develop. He discovers that in the great variety of claims situations confronting him, one factor is dominant – he is dealing with people during almost every hour of his workday. To be successful, he must understand human relations."

And, in his 1987 book, *Aggressive Good Faith and Successful Claims Handling*, Rokes evolved his argument that a claims adjuster must be educated in and understand human relations to include claims adjusting in the expanding importance of customer service in American business:

> "The insured and the insurance company have operated in a relationship of 'privity of contract.' Insureds are customers. **They are entitled to the same consideration that customers of other businesses are entitled to, no more, no less**.
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> "Thirty years ago, insurance companies were not in the business of giving money away, nor are they now. Good insurance companies paid the insured the amount of money the insured was entitled to, no more and no less.
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> "Conscientious claims people tried to expedite the insured's claim; filled out State accident report forms; and provided whatever other information they could to assist the insured. **They frequently provided services 'above and beyond' the contract responsibilities in order to have satisfied insureds – the customers**.
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> "Top insurance companies sought to provide their insureds with the best possible service, since good service was essential to retain the goodwill and the business of the insured. Occasionally, honest differences of opinion entered into the matter of the determination of liability or the extent of damages, and hard feelings arose in the course of the business. This was regrettable, but unavoidable."

B. The Present:

We examined multiple job postings on a national industry website advertising openings for claim adjusters across multiple lines. As expected, all of the positions had much the same **"primary" accountabilities and responsibilities** outside of educational qualifications:

- "Meet with insured to inspect losses and explain coverage."
- "Collect policy and claim data and information including interviewing persons associated with the case and obtaining recorded statements."
- "Document damage/losses and prepare written cost estimates."

- "Document claim transactions and prepare and forward internal reports as needed."

- "Solid computer, grammar, and multi-tasking skills and mechanical aptitude."
- "Proven ability to work independently with minimal supervision to manage schedules and meet deadlines."

Separate, however, from the primary accountabilities and responsibilities were **"preferred" experience, skills, and knowledge** requirements. Again, taken from a sampling of the postings, all had same or similar characteristics:

- "Strong listening, problem solving, and negotiating skills."

- "Poised and professional demeanor."

- "Making decisions."

- "Customer service."

Take notice of the dichotomy between the terms "preferred" and "primary." The former is regularly defined as "like better," "would rather have," or "be more partial to." The latter is adjectively defined as "principal," "foremost," and "paramount."

And so, based upon a blind sampling of job descriptions ranking qualifications and, conversely, opportunities to be hired, an ordinary **paramount** objective was to hire an individual presenting with strong computer skills, but his or her ability to provide good customer service was relegated to **liked better**.

This is not to suggest that insurers have intentionally back-seated good customer service and moved the ability to manage schedules and deadlines to the front. Yet, when we consider that the foundational covenant on which aggressive good faith is built is the presumption that both insurer and insured will deal with each other honestly, fairly, and in good faith.

And so, it is right to ask of ourselves, "Which is more important?" "Do we emphasize customer service?" "Do we train in customer care?" "Should we prioritize the ability to manage a schedule ahead of strong listening and problem solving skills?"

In an article for *Sloan Management Review* titled "Understanding Customer Service Expectations (the Sloan article)," A. Parasuraman from the University of Miami, Leonard Barry from Texas A&M University, and Valarie Zeithaml from the University of North Carolina Chapel Hill, argued that the key to providing superior service is understanding and responding to customer expectations.

In short, they conclude, customers want service companies – insurers are certainly service companies – to play fair.

> In respect to automobile insurance, the Sloan article stated that customers principally expect five things: (1) **Keep me informed**; (2) **be on my side**, "I don't want them to treat me like I am a criminal just because I have a claim"; (3) **play fair**; (4) **protect me from catastrophe**; and (5) **provide prompt service**.
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> In respect to property and casualty insurance for business customers, the article stated that the same principally expect the insurer to (1) **fulfill its obligations**; (2) **"learn my business and work with me"**; (3) **protect me from catastrophe**; and (4) **provide prompt service**.

The idea that you get what you pay for underlined numerous comments from consumer interviews in respect to the article's findings. The authors said, "Customers are paying good money, and the company should provide good service in exchange. When companies don't play fair, the result is customer **resentment and mistrust** – both of which were very much in evidence in our research."

How are customer service expectations categorized? The Sloan article sets out five overall dimensions: **reliability, tangibles, responsiveness, assurance, and empathy**. In respect to reliability, an auto insurance customer said, "I am annoyed by mistakes not being corrected despite repeated phone calls." Regarding responsiveness, a business insurance customer said, "When I want to put a new policy into effect, I get a quick response. But when I have a problem, forget it." And, with regard to empathy, another auto insurance customer put it plainly, saying,

> "I would like to be able to communicate with the insurance provider who understands that while their [processes] are in black and white, life is played in shades of gray. I don't want to talk to an insurance person who is reading out of a book."

Notwithstanding all of the familiar claims settlement practices set out herein –**immediate contact**; **timely and continual communication**; **diligence**; **honesty**; **fairness**; and **reasonableness** – that insurers have metrically and methodically broken down into repetitive and component parts,

> "Customer relationships are central to exceeding customer expectations. This is because relationship building is process-

> intensive, requiring responsive, assured, empathetic service over time. **Genuine customer relationships are built on the foundation of fairness, sincere efforts to understand and help the customer, and ongoing, personalized communications – attributes of service most demonstrable during delivery**."

In a 2014 article for the Harvard Business Review, *Who Can You Trust?*, David DeSteno from Northeastern University, identified three ways to prompt trustworthiness in others, including customers. First, be generous: feelings of gratitude foster trustworthy behavior; giving new partners a reason to feel grateful to you is a win-win. They benefit in the short term from your generosity and you reap the rewards of their loyalty. Second, emphasize similarity: we instinctively make assessments about which partners are worth the risk of trusting using a very simple shortcut – similarity. Emphasizing common ground increases the likelihood that your counterpart will see you as someone with whom it's possible to build a lasting and beneficial relationship. And, third, don't punish: threats of punishment can prevent untrustworthy behavior in the moment, but such strategies can become counterproductive. Because threats and sanctions reduce the belief that everyone is intrinsically motivated to be honest, they make new partners less likely to take risks to support one another.

CONCLUSION

No matter how many times the claims adjuster requests information, analyzes defenses and damages, sets reserves, takes statements, meets deadlines, complies with a schedule, stays within the metrics, meets expectations, and closes claims, all it takes is one poor customer service experience for the insured – now a motivated insured – to turn to legal counsel will then turn every process on its head because of one thing: the company did not treat its insured fairly.

RECENT AND REAL

Everest Indemnity Insurance Company was hit with a $4.5 million verdict after a Nevada state court jury on **February 11, 2016**, said the insurer acted in bad faith by refusing to cover a construction company's defense costs in a class action stemming from a levee collapse that caused the flooding of hundreds of homes. Courtroom View Network reported that jurors deliberated for only a few hours before deciding that Everest had no basis for refusing to cover defense costs referred to them by Matthews Homes, which held a $2 million commercial general liability policy from the insurer, after Matthews was sued by a class of homeowners claiming poorly designed drains exacerbated the effects of a flood in 2008.

Fidelity National Title Insurance Company must face a real estate broker's claim that it acted in bad faith by delaying payments under a title policy, the Hawaii Supreme Court ruled on **February**

4, 2016, finding that there are still factual questions as to whether the insurer acted reasonably under the policy. The Hawaii high court upheld an intermediate appeals court's ruling that policyholder Lloyd Anastasi can pursue a claim that Fidelity delayed payment under his $2.4 million title policy in bad faith by continuing to fight a lawsuit over the validity of a warranty deed for a property in which Anastasi held a security interest even after learning that the deed had been forged.

Nationwide Mutual Insurance Co. asked the Pennsylvania Superior Court on **February 2, 2016**, to overturn a $21 million award stemming from a bad faith verdict over the insurer's unwillingness to pay $25,000 to settle a collision claim, saying the trial judge willfully disregarded evidence. Meanwhile, the Pennsylvania state judge urged the appellate court to deny Nationwide's appeal of his decision awarding policyholders $18 million over the insurer's "scorched earth" litigation in a collision suit, saying that the company acted in bad faith.

A Federal judge in Washington on **January 29, 2016**, denied an excess insurer's motion for summary judgment on the insured's bad faith claims after determining that the excess insurer had other options, such as issuing a reservation-of-rights letter and seeking a judicial determination on its coverage obligation, prior to denying coverage for underlying environmental contamination proceedings.