Claims®

COVERING THE BUSINESS OF LOSS

February 2015

Volume 63 . Number 2

PropertyCasualty360.com

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By Melissa Hillebrand, PropertyCasualty360.com

President Barack Obama signed into law a six-year reauthorization of the Terrorism Risk Insurance Act (TRIA) which had expired on Dec. 31 after the Senate failed to authorize the bill.

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EDITOR'S NOTE

Insurers are encountering more and more environmental issues in the course of their everyday business. In our increasingly global society, threats once thought relegated to the other side of the ocean are making their way to the U.S. in startling numbers. One of the newest threats surrounds the Ebola virus and the healthcare workers who have been exposed to it both in West Africa and in the U.S.

These dangers are driving insurers to create new coverage options for situations such as the loss of income when businesses are ordered to close because of an Ebola outbreak or when the government suspends public transportation in a particular area. There is also coverage for supply chain interruptions since companies collaborate with suppliers around the globe.

The number of healthcare facilities equipped to treat patients with Ebola has expanded to 35 and more are expected to be designated in the coming weeks. And while the care of the patients and the protocols that should be followed have been identified and implemented, there is still a question of how to handle the remediation of the settings impacted by patients or care givers affected by the virus.

Very few products have been specifically approved for use in the remediation of Ebola because testing would require exposure to the virus. This creates a catch-22 for manufacturers who believe their products would be effective for the remediation of environments impacted by the virus. Their efficacy can't be tested ahead of time and when an exposure occurs, the products may not be able to be utilized because they haven't been approved for use in that situation.

Several organizations are creating guidance documents for contractors involved in the remediation of environments impacted by Ebola. The Environmental Contractors Association is working on a comprehensive document for its members and the Restoration Industry Association recently released a guidance document for contractors. At a minimum, workers should be in compliance with OSHA's Bloodborne Pathogen Rules, which address training, proper PPE and other factors to consider when handling a biological incident.

Our cover story this month is a primer of sorts for claims managers and adjusters who are on the front lines of these types of bioremediation claims. The rules for a biological event are different and more stringent for anyone working in a high risk environment. Due to the nature of the work, it takes a higher toll on workers because of the psychological effect it has on individuals, plus it requires special training and the need to comply with a host of regulations. It's definitely not a field for the faint of heart.

A future issue of *Claims* will look at some of the industry guidelines I've mentioned here, but if you haven't encountered a bioremediation claim before, this overview highlights some of the factors you need to be aware of to keep you and your staff safe.

Patricia L. Harman
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Allianz survey identifies 5 business risks for 2015

By Patricia L. Harman, PropertyCasualty360.com

The globalization of today's economy means that businesses are more interconnected than ever, creating a greater risk of business interruption, supply chain disruption, and exposures that can quickly multiply. According to UNCTAD.org, over the last 50 years the number of multinational companies has grown exponentially from 7,000 to almost 104,000, and could reach more than 140,000 by 2020.

The Allianz Risk Barometer 2015 surveyed more than 500 risk managers and corporate insurance experts in 47 countries to identify the primary challenges facing businesses this year. Some risks such as political upheaval, cybercrime and business interruption were viewed as a greater risk, while natural catastrophes, technological innovation and market stagnation were viewed as having less of an impact.

Here are the top five business risks for 2015 as identified by the Allianz Risk Barometer.

1. Business interruption and supply chain risks (46 percent)

Business interruption (BI) and impacts to the supply chain continued to lead the list of major concerns for businesses for the third year in a row. With so many businesses interconnected on a global scale, the impact of an event in one part of the world can have negative repercussions halfway around the globe.

"The growing interdependency of many industries and processes means businesses are now exposed to an increasing number of disruptive scenarios. Negative effects can quickly multiply. One risk can lead to several others. Natural catastrophes or cyber-attacks can cause business interruption not only for one company, but to whole sectors or critical infrastructure," says Chris Fischer Hirs, CEO of Allianz Global Corporate & SpecialtySE (AGCS). "Risk management must reflect this new reality. Identifying the impact of any interconnectivity early can mitigate or help prevent losses from occurring. It is also essential to foster cross-functional collaboration within companies to tackle modern risks."

The top risks leading to supply chain disruptions are: natural catastrophes, the political environment in a country, and globalization, particularly for specialty suppliers. The major causes of business interruption that concern companies the most include: fire/explosion, natural catastrophes, and a service delivery failure by a supplier.

2. Natural catastrophes (30 percent)

Despite a relatively quiet year in terms of catastrophes, companies are still acutely aware of the impact Mother Nature can have on their balance sheets.

"The lessons of the Bangkok floods and Japan tsunami have resulted in growing awareness from businesses of the knock-on effect from BI and supply chain management," explains Mark Mitchell, regional CEO, Asia, AGCS. "Companies now have a greater understanding of the need to monitor risk aggregations, not just geographically, but also in business interruption exposures."

3. Fire/explosion (27 percent)

An analysis by AGCS found that fire is the number two cause of business loss overall, with business interruption causing more damage than the actual fire itself.

In 2013, fire impacted eight of the 20 largest non-natural catastrophes, resulting in almost $4 billion in insured losses.

4. Changes in legislation and regulation (18 percent)

For the financial sector, the number one risk involved changes in legislation and regulations. The risk jumped nine positions from 2013 and has the second largest impact on supply chain disruptions (53 percent) after natural catastrophes. There is also concern that the lower oil prices will impact the budgets of countries deriving most of their income from oil revenues.

5. Cybercrime (17 percent)

Concern about the risks associated with cybercrime rose significantly, jumping 10 positions from 2013, when it ranked number 15. Cybercrime brings with it concerns about economic impacts, loss of reputation, as well as business interruption issues. And while companies are far more aware of the cyber risks, according to 73 percent of the responses, they are still underestimating its impact.

For businesses, the main cost of a cyberattack involves the impact to their reputation and the resulting financial damages, as well as the loss of customer business. The breaches at Sony, Target, Staples and Home Depot demonstrated the damage that can be caused to corporate reputations. Seventy-one percent of customers indicated they would leave an organization following a data breach according to the Edelman Privacy Risk Index.

Allianz also found that companies are still underestimating the risks from a cyberattack and fail to take the necessary precautions due to budget constraints or a failure to analyze their vulnerabilities.

Purchasing better hardware, implementing stronger internal processes, and improving training and awareness among employees were identified as the primary solutions to the problem.

Future risks

The study also identified the primary risks for the next five years. These included:

- Cyber risks (37 percent)
- Political/social upheaval and war (21 percent)
- Natural catastrophes (19 percent)
- Terrorism (15 percent)
- Business interruption and supply chain risks (11 percent)

Long-term risks (5-10 years) were identified as:

- Climate change (19 percent)
- Natural catastrophes (19 percent)
- Political/social upheaval and war (18 percent)
- Technological innovation (17 percent)
- Cyber risks (15 percent)

"Weather is becoming more volatile and less predictable at a time when cities and populations are growing in areas exposed to natural catastrophes," said Michael Bruch, head of emerging trends, AGCS.

Technological innovations such as 3D printing and nanotechnology will bring new risks, which must be managed through a collaborative approach.

New jockey accident program introduced by NTRA, Lockton, and Burns & Wilcox

The National Thoroughbred Racing Association (NTRA), Lockton Insurance Brokers and Burns & Wilcox Brokerage have combined their efforts to launch a new jockey accident program for racetracks.

According to Terry Meyocks, national manager of the Jockeys' Guild, Inc., there are several thousand thoroughbred and quarter horse jockeys in the U.S. He says the new program provides important coverage for injuries and the Guild "is very supportive of it."

"Having worked on racing risks for nearly two decades, I have seen first-hand the volatility surrounding jockey accident insurance coverage due to the risks inherent in the sport," said Jared Mitilier, leader of Lockton's Gaming, Entertainment, and Sports Practice. "We have been able to introduce new insurance capacity, along with creative terms and conditions, and favorable pricing, to a very complex

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Towers Watson report says close supervision drives better claims outcomes

By Patricia L. Harman, PropertyCasualty360.com

Supervisors actively involved in reviewing the files of their direct reports can drive better outcomes and improve claims performance according to a recent report from Towers Watson. While 86 percent of the survey participants said they "empower their supervisors to make decisions and provide direction to their teams because it delivers the most value," the supervisors often fail to capitalize on that authority because they spend too little time reviewing their direct reports' files.

While supervisors said they budgeted two to six hours for supervisors to review the files, in reality the majority (51 percent) were spending only two to four hours on this task, while 26 percent spent four to six hours, and 20 percent only one to two hours. The two key barriers to superior claim performance were identified as ineffective supervision (60 percent) and passive claim handling (77 percent).

The study identified a critical link between effective supervision and vital claim functions such as customer service and cost containment. Supervisors who review cases can provide valuable guidance on which cases will require less time and effort to resolve and which will require more time and attention. According to the study, "proactive supervision facilitates and encourages proactive claim handling (and best practice execution), and the two are inextricably linked."

"Greater focus on reviewing claim-handler files is necessary — three hours a day is insufficient to efficiently manage claims," said Frank Ramsay, Towers Watson's North American Claim Management practice lead. "Competing priorities prevent supervisors from spending enough time reviewing the files of their direct reports. This inhibits the claim operation's ability to deliver optimal claim outcomes and can have an adverse effect on insurers' profitability."

The biggest challenge for supervisors involved the high number of claims they are required to manage and the supervisor-to-handler ratio (49 percent). Using a more hands-on approach and triaging claims files to identify routine claims or others that could be handled more expediently may help improve outcomes. Other factors impacting supervisor effectiveness included a lack of understanding of claim indicators and metrics (37 percent), insufficient supervisor expertise (31 percent), a lack of claim leading indicators/metrics (29 percent) and slow or cumbersome claim systems (29 percent). Greater supervision could help identify some of these issues earlier in the process and provide support to supervisors managing overly heavy caseloads.

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area of insurance. This will make an immediate positive impact on the industry."

Injuries for jockeys can range from bruises and sprains to more serious broken bones, concussions and brain injuries. Since not all states afford workers compensation benefits to jockeys, NTRA Safety and Integrity Alliance standards recommend that racetracks maintain a minimum of $1 million worth of accident medical expense coverage per incident for all jockeys. Hospital costs alone can run into the hundreds of thousands of dollars depending on the severity of the injuries and how long the jockey is hospitalized.

The new program will be open to all brokers so that the tracks can benefit from the program's competitive pricing. The application process has also been streamlined so companies need only provide three items with their applications: a completed Jockey Accident application, a five-year claims listing, and a copy of their current Jockey Accident policy according to Mitilier.

"Adequate coverage for jockeys has been an area of focus for the NTRA as it is one of the requirements of accreditation from the NTRA Safety and Integrity Alliance," said Alex Waldrop, president and CEO of the NTRA. "Our team has worked closely with Lockton to make this obligation more affordable than ever for tracks of any size."

"We have made this program open to all insurance brokers as it is our stated goal to enhance the overall offerings for the horse racing industry," said Evan Bull, National Property Practice Leader for Burns & Wilcox Brokerage.

Report: Half of American adults will not sign up for pay-as-you-drive programs

By Melissa Hillebrand, PropertyCasualty360.com

More than 20 percent of all U.S. auto insurance companies will incorporate some form of pay-as-you-drive insurance within the next five years, but carriers should think twice about which consumers will sign up for that service.

According to an Insurance Quotes.com report, more than half of Americans (51 percent) would not consider enrolling in a PAYD program, an increase from 37 percent last year. The findings are based on a survey conducted by Princeton Survey Research Associates International of 1,000 American adults.

The reason for the pushback? Privacy issues, according to 21 percent of respondents. When broken down by age, 27 percent of those 50-64 years old cited privacy, compared to only 15 percent of millennials, the report says. Perhaps related, the majority of respondents incorrectly think that PAYD programs monitor for drunk driving and driving in high-crime neighborhoods (they do not).

Millennials, however, do not share those concerns, as they are the demographic most likely to enroll in usage-based insurance programs. Of drivers between the ages of 18 and 29, 43 percent would consider participating in a PAYD program, which compares to 36 percent of drivers between the ages of 50-64 and 28 percent of drivers aged 65 and over. Millennials (47 percent) are also most likely to have heard of usage-based insurance, compared to just 27 percent of those 65 and older.

Ford ambulance recall may be expanded to other trucks

By Rosalie L. Donlon, PropertyCasualty360.com

When you call 911 or have an accident and need an ambulance, the last thing on your mind is whether the ambulance is safe to drive. In 2013, the National Highway Traffic Safety Administration (NHTSA) recalled almost 3,000 Ford trucks used as ambulances to fix a problem with the engine shutting down suddenly. On Jan. 13, the NHTSA opened a recall query, investigating whether the recall should also include nearly 197,000 additional pickups that have similar engines but are not used as ambulances, according to a story in *The New York Times* on Jan. 21.

NHTSA's Office of Defects Investigation noted in a report on its website that it has received 30 "non-duplicative" complaints on similarly equipped Ford trucks. The potential recall affects nearly 200,000 2011-2012 Ford F-350, F-450 and F-550 trucks equipped with 6.7 diesel power stroke engines. Although the majority of the trucks are not used as ambulances, they are often used to tow large trailers — an extremely dangerous situation if the engine stalls while the truck in on a highway at 60 miles per hour.

Anyone who owns or drives one of these vehicles, check with their local Ford dealer or NHTSA to see whether their truck is subject to the recall or should be repaired. Owners should also speak with their insurance carrier to confirm that there are no issues with coverage in this situation.

Cyberterrorists are targeting your phone right now

By Patricia L. Harman, PropertyCasualty360.com

Walk into a restaurant, doctor's office, repair shop or any other place where people can sit for a few moments and over 90 percent of them are on their cell phones. They sleep with them by their bedsides, take them when exercising and feel naked if they forget their phones somewhere.

According to Pew Research, 90 percent of American adults now have a cell phone and 58 percent of those are smartphones. Afraid that they might miss an important call or alert, 44 percent of cell owners sleep with their phones next to them in bed and 29 percent describe their phones as something they can't live without. (These last two figures are from a 2012 data report and could be considerably higher in 2015.)

Of the adults who have cell phones, 93 percent are males and 88 percent are females. Almost 90 percent of residents in both cities and suburbs own cell phones, and the numbers are similar regardless of education or economic level. Pew also says the majority of cell phone owners (81 percent) use their phones to send or receive text messages and to access the Internet (60 percent). All of this is good news for cyberterrorists and bad news for cell phone owners.

Mobile security firm Lookout used information from more than 60 million global users to see which threats pose the greatest risk to mobile phone users, and they identified three categories: malware, chargeware and adware. Some of these are greater threats in other countries, but given this highly mobile society, there are chances of exposure for everyone.

Malware can include programs like viruses, worms, Trojan horses, ransomware and spyware. It can come into a phone as active content, code or an executable script and seeks to steal user data, impact device performance and can even commit financial fraud. Chargeware is a form of malware that can corrupt a mobile device and then manipulates the user into purchasing programs or services without clearly notifying the user that this is occurring. Unsubscribing can often be difficult so the user incurs charges for as long as possible. Adware uses advertisements to generate revenue for the creator, interferes with the use of the phone and can sometimes collect excessive personal data.

Many computer users were introduced to ransomware, a type of malware, last year. That threat has grown exponentially (by 75 percent) and is one of the top threats for mobile users in the U.S., U.K. and Germany. The program locks users out of their phones and forces them to pay a "ransom" in order to unlock the device. Some programs slow down the phone and its functions, while others like ScarePackage result in a complete loss of functionality and a financial loss if the victim elects to pay the ransom.

In their recently released 2014 Mobile Threat Report, Lookout identified several malware programs that users in the U.S. should be aware of:

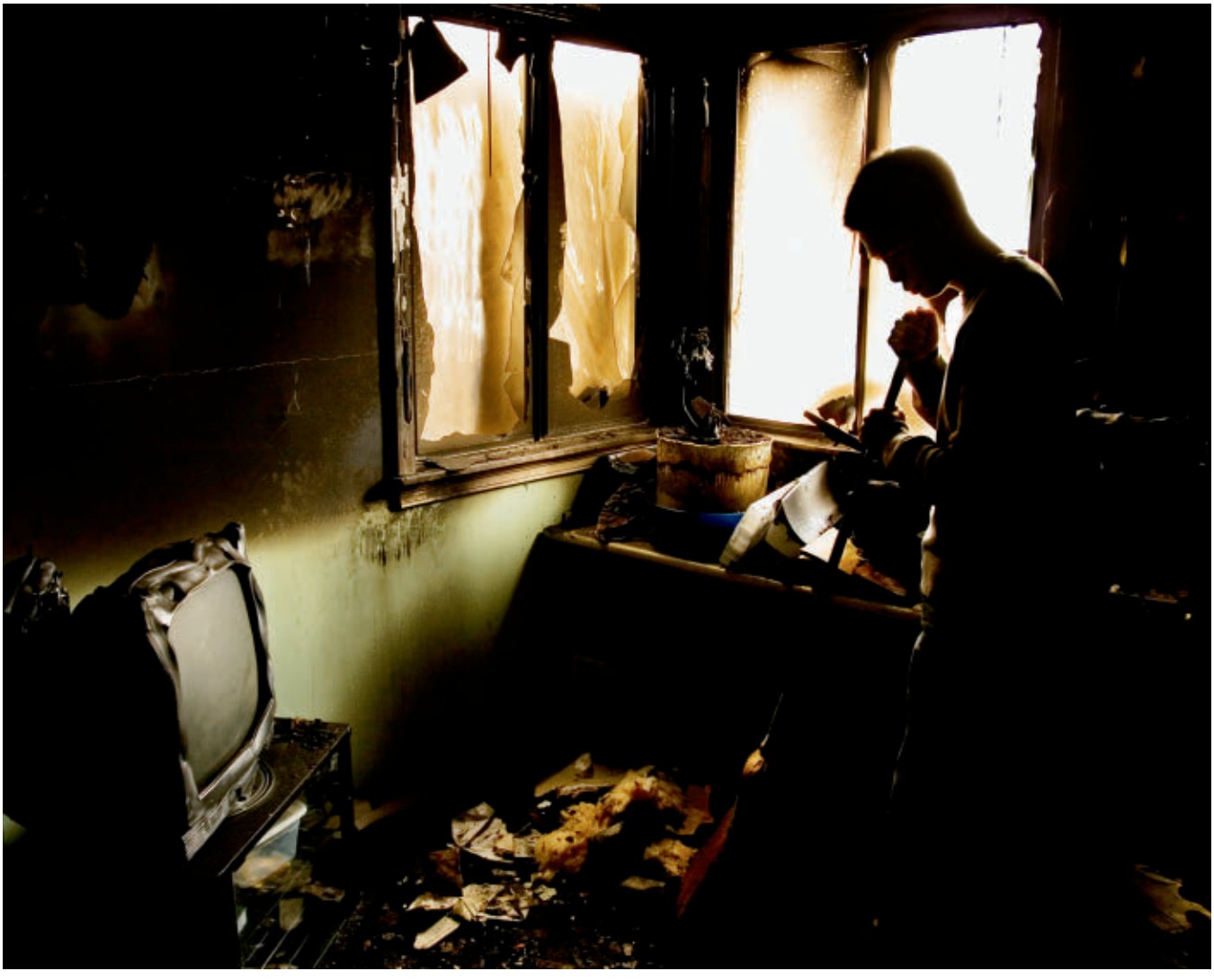
- **NotCompatible** — Lookout identified this Trojan as the number mobile threat in 2014 because it enables the operators "to harness a considerable mobile botnet to do their bid-

ding" and allows hackers to send and receive traffic through the victim's phone. In one instance hackers used infected mobile devices to purchase large blocks of tickets simultaneously to circumvent anti-fraud measures on ticketing websites.

- **ScarePackage** — This program poses as an Adobe flash update. It scans the phone and says that it has found illicit content and then displays a counterfeit message from the FBI to coerce the owner into paying the ransom in order to regain control of the device and avoid criminal prosecution.
- **ScareMeNot** — Like ScarePackage, this Trojan pretends to scan the phone for security issues and reports that it has found illicit content and the victim must pay a ransom to regain control of the device.
- **ColdBrother** — Similar to ScarePackage and ScareMeNot, this program can also take a front-facing photo of the victims and coerces them into paying the ransom.
- **Koler** — Disguised as a media app, Koler operates like the previously mentioned ransomware programs.

The endgame in all of this is what will bring in the most money for hackers. Ransomware programs can charge victims as much as several hundred dollars to unlock their phones. The best defense is to purchase apps from a legitimate app store. If something looks fishy, it probably is says Kevin Mahaffey, Lookout's co-founder and chief technology officer. Apps that ask for a lot of personal data should also be suspect.

While Lookout's report found that more Android devices were impacted than Apple products, the fact that there are more Android devices on the market and apps for them can be downloaded from a variety of sources may be why they experience a higher incidence of attacks. Apps for Apple products can only be downloaded through Apple's App Store, which has a more stringent review process. But as more and more consumers turn to Apple products, cybercriminals will be shifting their efforts there as well.



Duties After a Loss

Every insurance policy has things in common: covered perils, definitions, exclusions, and conditions. While the conditions at first glance are self-explanatory, there is still room for confusion. States have even added statements concerning proof of loss to their fair claim handling procedures in order to help avoid duplicated efforts.

The items that cause the most confusion are the proof of loss and inventory form. The ISO HO 00 03 requires an inventory of damaged personal property showing the quantity, description, actual cash value and amount of loss. Bills, receipts and related documents that justify the figures are required. However, not all insureds keep receipts, so an insured may not have the necessary documentation. While the policy asks for it, there is no statement that the claim will not be paid without the documentation. Many carriers will accept affidavits from others vouching for the insured that they owned something highly valuable or significant; friends and neighbors will likely know about an expensive 50-inch television or a fancy leather sofa, even if it is a few years old.

We recently received a question from a subscriber where the carrier was requiring specific receipts and documentation before providing any coverage. The insurer's statement in part was as follows: "If proof of ownership is not shown for the items, they will not be covered.

We will be having Servpro and CRDN provide us a detailed list of all items they inspect. The items we are able to match exactly to the inventory form, we will not need proof of ownership for. However, if CRDN lists flip flops on their list and we are not able to verify these are the Nike flip flops listed on the personal property inventory, we will still need proof of own-

ership for this item. It is your responsibility to prove the items on your inventory form. As a courtesy, we will be going through trying to match as much as possible on our own.

Proof of ownership will also not be necessary for any items that we clean or restore.

Proof of ownership can be in the form of receipts, invoices, warranties, registrations, shipping receipts or bank statements matching the exact amounts. For example, line 135 lists a pair of flip flops purchased from Nike.com. A bank statement showing a purchase from Nike.com for this amount would be sufficient." The carrier was taking the position that if the insured cannot provide receipts, bills, or invoices for the items claimed, the insurance company does not owe for these items. According to our subscriber, this is happening more frequently.

The policy does not require insureds to keep every receipt for every item ever purchased; the statement requiring the signed, sworn proof of loss clearly states that the statement must be to the best of the insured's knowledge and belief. While with the proof of loss the inventory is required, and the inventory statement states that "all bills, receipts and related documents that justify the figures in the inventory" are to be attached, there is nothing to say that if the insured does not have such documentation that the claim cannot be paid. In most losses there is salvage; most property is damaged, and not totally obliterated.

As far as retaining receipts, it is difficult for the carrier to demand them when individuals are encouraged to shred documents such as bank statements and credit card receipts due to the threat posed by identity theft. Various consumer agencies recommend keeping ATM and credit card receipts for only one month, just long enough to balance the checkbook and pay the bill. Keeping the bill or receipt is only recommended for products with warranties, and not every sweater, dish or towel the insured has ever purchased. These same groups encourage throwing out general receipts immediately. The IRS recommends keeping tax receipts for six years. And what if the receipts burn with the property? Ideally they'd be kept in a fireproof safe, but there is a big difference between the ideal and reality.

It is unfair to deny payment if the insured cannot produce receipts unless there is a question of fraud; while fraud is an issue, many people honestly do not have receipts for every item they own. If the insureds are cooperative with the carrier and try their best, the claim should be paid. Some insureds may have household inventories but no receipts; many carriers provide online inventories that insureds can fill out, and many agents and carriers recommend that their insureds not only make an inventory but also videotape their belongings. However, this is not a reliable source of information since many insureds do not follow through on such recommendations.

At the time of a loss, many insureds are upset and confused. They will cooperate to the best of their ability, but matching a receipt, bill or bank statement to every piece of property damaged is difficult, if not impossible for many insureds. Fraudulent incidents should be investigated, but unless fraud is an issue, working with the insured in reviewing the salvage and the list of items is the best course of action, even if there is not proof for every possession. Without a household inventory it is impossible for most people to list every possession from memory; likewise, with the common recommendations to destroy receipts, using them as proof of loss in a claim may become more and more difficult.

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By Gary Jennings, CPCU, ARM, ALCM, AIC, ARe, SCLA

Workers' Compensation Challenges in the Transportation Industry

It has been said that trucking is the lifeblood of America's economy. Trucks are constantly transporting raw materials and goods for manufacture, assembly, or further distribution. The American Trucking Association states that over-the-road transporters deliver 100 percent of consumer goods in the nation and approximately 70 percent of freight tonnage transported domestically. There are also smaller trucks that travel local routes to deliver the products we have all grown to expect.

The wide geographic dispersion of truck drivers and other professionals who travel extensively for their jobs presents specific challenges that make advance planning essential for employers in the transportation industry. We will identify some of those challenges, as well as steps employers should take to overcome some of them. The recommendations do not include Department of Transportation (DOT) requirements,

which must also be considered. While we will focus on the trucking industry for this article, the same issues and principles apply for fleet operations or for any organization where employees travel extensively.

The challenges of "high mileage" occupations

Transportation companies must consider how they will handle employees who are injured at a site far from the employer's office. This is less of an issue for firms where employees remain primarily in a fixed location. Research, creativity, the advice and assistance of your insurer or third-party administrator (TPA), and the use of key vendors will help employers overcome some of these dilemmas. Here are five challenges and recommendations to help prepare for and manage the claims when they occur:

CHALLENGE 1: In some cases the injured employee may be able to opt for benefits in a state other than the hiring state, including the state in which the incident occurred. This can dramatically change the employer's risk factors, the administrative requirements for managing the claim, and the ultimate cost of the claim.

Recommendation:

- As much as possible, identify the states which the drivers will travel across, as well as the states where the greatest probability of incidents might occur based on weather, terrain, distances, and other factors.
- Identify the states along the route and determine which may allow the employee to select that state's benefits. Build your claims organization or prepare your insurer or TPA to work with you quickly when those circumstances occur, so there will be less likelihood that the employee will choose a jurisdiction other than his/her hire state.

CHALLENGE 2: Employees who are traveling need a way to report the incidents in which they were injured. Mobile phones, tablets, laptops, and other electronic devices now make reporting easier, and some employers utilize tracking devices that show where the vehicles are at all times. However, it is still important for employees to know what to do when an incident occurs.

Recommendation:

- Provide training and documentation for drivers on the steps to take after an on-the-job injury. This should include who to contact in the event of an incident that causes injury or illness. Place written instructions in each truck and provide an electronic copy for mobile phones or tablets.
- Direct drivers to call the designated contact promptly so the claim can be reported in a timely fashion, and he or she can obtain the appropriate treatment if needed.
- Direct the employee to take photographs of the injured body part to send to the contact, and instruct the employee to send additional photographs if the injury site changes. This may not be as helpful with soft tissue injuries, although it may help to clarify the injured body part later if questions arise. It will be particularly helpful if the employee has suffered lacerations, abrasions, burns, or other visible injuries.

CHALLENGE 3: Once the employee has reported the incident, how do we determine the level of care required, since the employee may be far from the employer site and there is no one to assess the employee's injury, illness, or condition?

Recommendation:

- If the employee has not sustained a severe injury requiring emergency room treatment, direct the employee to call either a company representative with some medical training, a company medical provider, or a triage nurse of a medical management company (MMC) to assess the injury. The photograph of the injured body part will also help in this assessment. The company representative, medical provider, or MMC triage nurse may direct self-treatment or refer the employee to a medical provider based on the employer's ability to direct care per jurisdictional rules. If the employer can take no part in the medical direction, at least the company can assist the employee in finding an appropriate medical provider so he or she can receive treatment and begin the recovery process.

CHALLENGE 4: How does an employer direct an employee to medical care in his or her state or where the employee may opt for benefits, and get the employee to an appropriate medical provider?

Recommendation:

- Research the jurisdictional requirements for selecting medical provider(s). The options vary widely, so the employer should understand the differences. Some of the medical direction options include:
  - The employer provides a panel of medical providers from which the employee may select his/her attending physician.
  - The employer directs care to a specific medical provider, which in some states may be only for the initial examination or for limited periods.
  - The employer uses a Preferred Provider Network, which requires the employee to select a medical provider within the network (which may already have a network of providers in the area where the employee was injured).
  - The employee has the ability to select his/her attending physician.
- Using the information obtained in Recommendations 1 and 3, work with your broker, insurers, TPA, and/or MMC to identify medical providers in the states. While medical providers cannot be identified throughout the entire states in which the employees may travel, the selection process can still focus on the primary areas and larger cities where drivers are more likely to travel and medical providers are more plentiful.
- Provide the employee with transportation when possible. This may include using employer representatives if some

are close to the area, or transportation companies that assist injured employees. These companies should be contacted prior to an incident to gather information on the extent, cost, and timeliness of services. A taxi company may also be considered.

CHALLENGE 5: The medical provider authorizes modified duty with restrictions. How can an employer accommodate this if an employee lives far from the office or if the employer has no on-site work?

Recommendation:

- This is perhaps one of the most difficult challenges for some employers. Employees may live far from the employer's office and simply be dispatched from their homes. Even if modified duty can be found that meets the medical provider's restrictions, it may not be feasible for an employee to travel to the employer's office. Nevertheless, employers should work with their insurers/TPAs to provide and offer modified duty when possible and practical. There are also vendors or other service providers who can work with the employer and employees to provide volunteer opportunities or other activities that will help employees remain in working condition, making it easier for them to return to work sooner.

The research, planning, and use of partners (i.e., brokers, insurers, TPAs, and claims vendors) to handle these challenges should create a smooth workflow. This will make it easier for company representatives, employees, and medical providers to offer the appropriate treatment in a timely manner so the employee can recover quickly and return to a productive life.

While these challenges are specific to the transportation industry, they may exist for other employers in varying degrees. It is wise for an employer to consider some of its workers' compensation challenges, including those applying to all employers. It is important for employers to plan so injured employees can obtain prompt and appropriate treatment following an incident, and so the claim can be managed smoothly with fewer surprises. This not only allows the employees to return to work sooner, reducing their pain, disability and financial stress, but will also reduce the overall claims and expense costs to the employer.

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A strategic approach to insurance fraud

The cost of insurance fraud is staggering with estimates ranging from $80 to 120 billion annually. Many insurance companies have started to take anti-fraud efforts more seriously in recent years, but why? Perhaps this is a result of better analysis to justify ROI or insurance executives are simply trying to hedge against what appears to be a growing threat. Whatever their motives, understand there are numerous reasons insurance companies should be taking a closer look at their special investigations unit (SIU), but more specifically, their overall fraud strategy.

But what is strategy in an insurance fraud context? Large-scale anti-fraud efforts are a relatively new frontier in the insurance world. Unlike marketing, underwriting, or customer service, fighting fraud has rarely gotten lots of attention, but the fundamentals of a good strategy are still the same. Collect information, form decisions based on analysis, and be willing to adapt as fraud does.

Unfortunately, some companies are taking a more arbitrary approach to the design of their SIU and overall fraud strategy, but here are some tips to ensure your company is on the right track:

Know your people and their skills

There are a lot of questions to consider in the development and design of your SIU, one of the most important being your personnel. Most often there are two types of people seen in the SIU industry. The first are investigators, routinely from law-enforcement or investigative backgrounds who are great at investigations, but weak on business fundamentals. The second type, insurance/business professionals who understand business, but possess little knowledge on how to obtain confessions or run an effective investigation.

It is very rare that individuals possess both skill sets, so if you see this clear divide in your personnel, ensure you have the business-minded "managers" in supervisory positions, triaging cases and assisting with analytical assessments that shape your fraud strategy. Just the same, make sure you have "investigators" on the front lines who understand fraud dynamics, run efficient investigations, and possess critical interview skills.

Those managers should be forming into fraud strategists; business professionals who understand fraud dynamics and make innovative yet data-driven decisions to combat this growing threat. When you find individuals capable of delivering that approach, here is where you should be headed:

Develop your SIU's strategy

Ask yourself: How many investigators do I need, how many cases do they get, which cases do I assign, what technology should I use, how much should I spend?

The effects of insurance fraud are not universal. Insurance companies are designed differently, both in the products they offer and their application/claim processes. As such, their exposure to fraud is not universal. This means that while industry benchmarks can be a terrific starting point in the design and operation of your SIU, the most important element of your fraud strategy should involve data collection and analysis. Ask yourself, do we have the right measurement systems in place and are we analyzing this data to tweak our fraud strategy and SIU efforts to obtain maximum ROI?

Understand the Power of Deterrence

Deterrence is one of the most power-

ful tools to fight fraud. In 2004, a British insurance company reported to the *New York Times* they had seen a 25 percent decrease in the number of auto-theft claims after customers were notified they had implemented CVSA lie-detection software (computerized voice stress analysis) in their claim process.[1]

In the past few years insurance companies have been very focused on projecting an image of simplicity in the claim process. For example, it's not uncommon to see catch phrases like "easy and hassle-free" or "we will pay you in as quickly as…" These efforts are well intended. However, as a consequence many insureds believe there is no real vetting process going on behind the scenes. Instead, they think insurance companies are simply shuffling paperwork in order to pay them as quickly as possible.

This is evident in a 2010 survey by Accenture, where 68 percent of those surveyed said they believed insurance fraud happens because people believe they can get away with it. That number is up from 49 percent in 2003, hence the "growing threat."

So let's assume we want to change that perception to assist in the deterrence of insurance fraud. How do we tell people there is a vetting process and scammers are getting caught, without simultaneously hurting our image and making our customers believe we are just working to deny claims?

First, ensure your SIU has a dedicated webpage on your company's website. On this page you can display information about your SIU and what they do. Try highlighting successful investigations, perhaps showing when suspects were arrested by police. First impressions are important, you don't say "look at our fraud unit… they are helping put our insureds in jail," instead "another SIU success, collaborating with law-enforcement and working hard to ensure scammers don't take another bite out of your premium discounts!" See the difference?

By projecting the unit's success you are helping convey the fact that there is a vetting process and fraudsters are getting caught. Fraud stories are interesting and no one likes getting scammed, so help customers see how insurance fraud is affecting them.

So if you are ready to move beyond the status quo, remember, know your people, develop your strategy, and understand the power of deterrence!

Footnote:

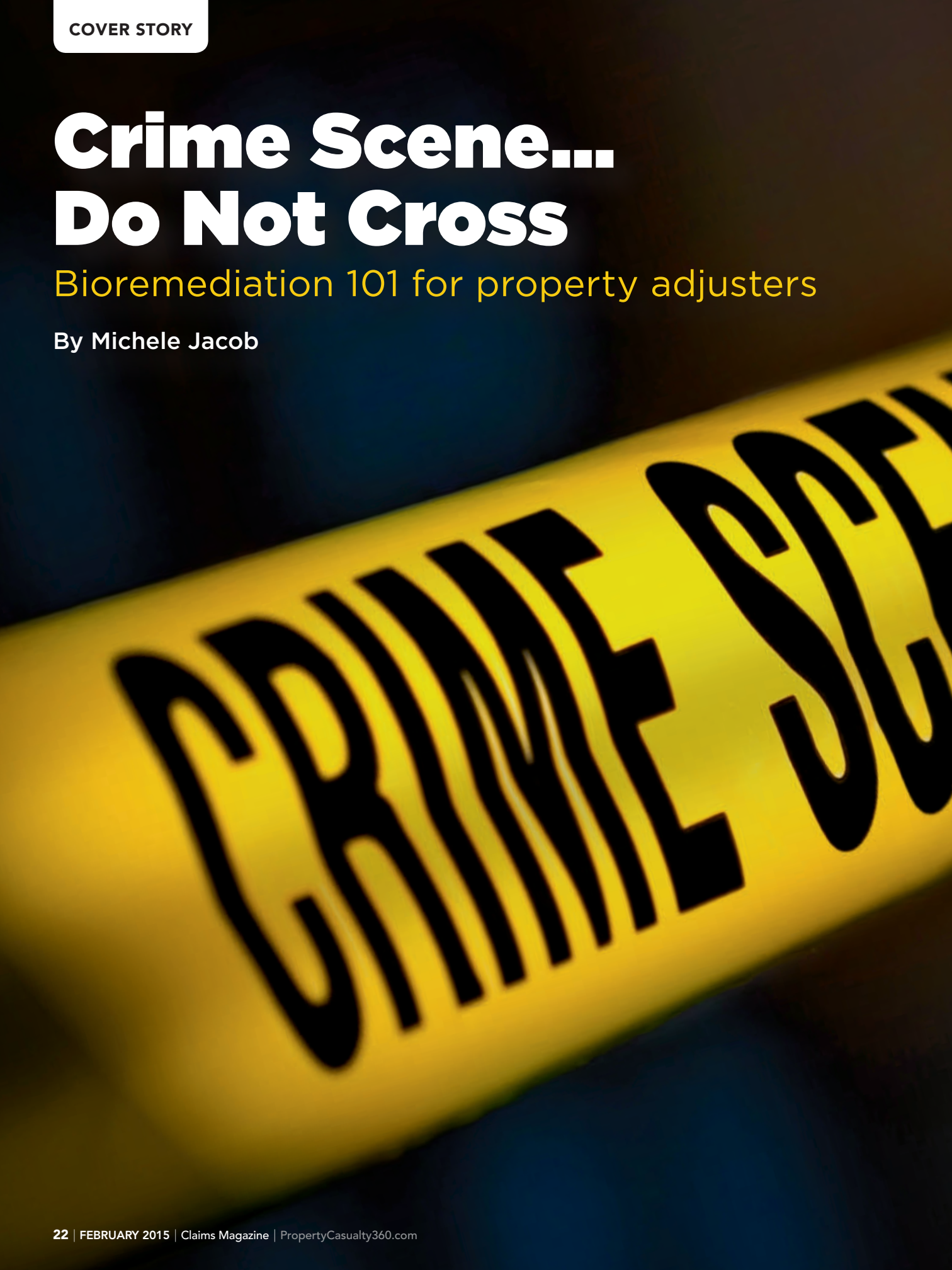
[1] Douglas Heingartner. (2004). NY Times, "It's the Way You Say It, Truth Be Told."

Alex Egan is a consultant with Choice Training Group, a boutique firm focused on helping insurance companies and law-enforcement combat insurance fraud through strategy and training. For more information visit ChoiceTrainingGroup.com.

Crime Scene... Do Not Cross

Bioremediation 101 for property adjusters

By Michele Jacob



Losses involving suicides, severe bodily injuries and decomposition frequently require the services of a restoration or bioremediation firm trained in handling trauma and crime scene cleanup. Bioremediation involves the clean-up of blood and bodily fluids, and infection control resulting from exposure to diseases such Hepatitis, HIV, MRSA and C-diff, Ebola, and bloodborne pathogens.

Bioremediation poses serious risks to those who work in the field and every scene should be treated as though it contains bloodborne pathogens. Other potentially infectious materials (OPIM) and bloodborne pathogens are microorganisms or viruses that can be found in blood and bodily fluids. Extreme caution should be used on these claims since unknown infectious materials may be involved. Even the slightest contact with these materials could result in exposure to a life-threatening disease.

Factors such as insurance, upgraded personal protective equipment (PPE), training, and the licensing required to generate, transport, store and dispose of biological waste impact pricing for these projects.

Bioremediation requires compliance with all applicable laws and regulations including OSHA's Bloodborne Pathogens standard (29 CFR 1910.1030), which covers all employees who come in contact with human blood or other potentially infectious material in the course of their work. Implemented in conjunction with the OSHA standard should be Universal Precautions, an infection control approach that requires that all human blood and certain bodily fluids be treated as if they were infectious.

Other governing bodies such as the National Institute for Occupational Safety and Health (NIOSH), the Environmental Protection Agency (EPA), the Centers for Disease Control and Prevention (CDC), as well as the Department of Transportation (DOT) and individual states have regulations concerning the transport of biological waste.

This type of work can take both a physical and emotional toll on employees. Ongoing and extensive training in crisis management, post-traumatic stress disorder and sensitivity/compassion should be provided to all technicians. Turnover for those employed in this field is extremely high, which can add to the training costs.

Training is not limited to the rules and regulations that govern the industry. A technician is literally a "jack of all trades" who frequently has additional experience in areas such as biology, chemistry, carpentry, HVAC, plumbing, flooring, materials, equipment, evidence preservation, photographic documentation, sketching, estimating, and project management.

Claims handling

When an adjuster encounters a bioremediation claim, a number of coverage questions may arise surrounding the exclusions. The question as to whether or not coverage applies is often the first hurdle an adjuster will encounter. Common coverage issues may include:

- **Intentional act**
- **Innocent spouse**
- **Pollutant**
- **Named peril**

The standrd policy and the Unfair Claims Settlement Practices Act in most states encourage insurers to extend coverage in favor of an insured when policy language is unclear or interpretation is ambiguous.

He who estimates the loss

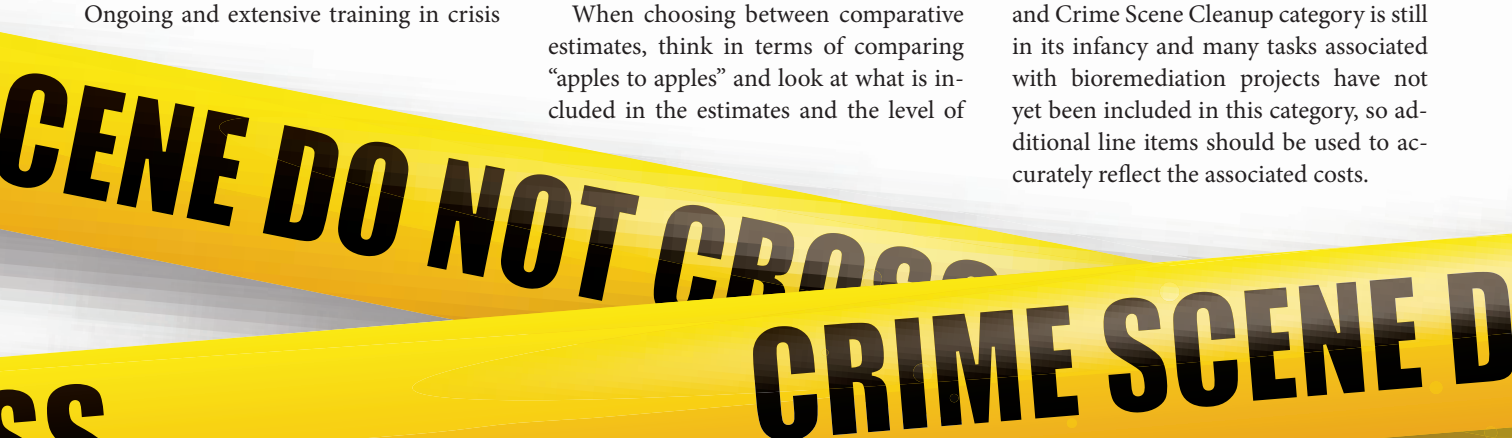
When writing an estimate, an adjuster should be cognizant of the differences between the restoration and bio remediation industries and why the claims associated with a bioremediation project may have a different pricing structure than traditional restoration claims.

When choosing between comparative estimates, think in terms of comparing "apples to apples" and look at what is included in the estimates and the level of expertise provided to ensure the various companies submitting bids are offering the same services.

Building the estimate

Two methods can be used to build an estimate. The first is to allow for a flat hourly rate which includes all tasks performed and utilizes rates consistent with reliable published resources specific to the bioremediation industry, such as The Bluebook Residential & Light Commercial Cost Guide for Cleaning, Reconstruction and Repairs. Another resource for pricing would be the American Bio Recovery Association (ABRA).

The second method involves estimating software, such as Xactimate, which is used by the restoration industry. The Trauma Crime Scene Cleanup category was added almost three years ago and includes approximately 67 different line items. Those figures should be used and not the Hazardous Waste/Mold Cleaning or Biohazard categories. The Trauma and Crime Scene Cleanup category is still in its infancy and many tasks associated with bioremediation projects have not yet been included in this category, so additional line items should be used to accurately reflect the associated costs.



Since cleaning a square foot of flooring on a construction site is not the same as cleaning a square foot of wood flooring that contains human remains, routine tasks such as the removal of flooring, ceilings, walls and cabinetry must frequently be pulled from other categories even though the allowance does not reflect the additional risks of dealing with biological fluids and OPIM.

Estimating software allows for an hourly rate, but then requires one to add in each individual task broken down by square foot to build the estimate in order to arrive at an accurate reflection of the costs associated with the scope of work performed. The estimate must also reflect the total hours required for the various tasks associated with a bioremediation project because many of them are time and labor intensive.

Hazardous waste management

A portion of the estimate that may generate questions involves determining an accurate cost for the disposal of hazardous waste. The amount of contents a biohazard container can hold is based on weight. These containers will be filled with the affected structural surfaces such as flooring, subflooring, drywall, etc., and all non-porous items compromised by biological fluids or OPIM. The containers also hold the used PPE (gloves and suits) and the discarded/contaminated towels.

A qualified company knows there are very specific OSHA requirements concerning how the containers are to be packed. Due to the possible exposure to sharps, waste is not to be "compressed" into the container. Therefore, when an item is placed into a container, one is not allowed to compress the contents to allow for additional room so more items to be placed inside. A container is considered full when it meets the weight restriction or when it cannot hold any additional contents.

There are also very strict regulations regarding the generation, transportation, record keeping and storage of biological material. The cost of the containers will typically include fees relating to the transportation of waste and possibly additional licensing. The cost also includes alterations made to transport vehicles to meet requirements to legally transport the biological waste, temporary storage fees, the pick-up fee per container, and the disposal fee which is determined by weight. The number of bio containers utilized during the course of a job should be clearly documented through a manifest.

This type of work can take both a physical and emotional toll on employees. Ongoing and extensive training in crisis management, post-traumatic stress disorder and sensitivity/compassion should be provided to all technicians.

The "comparative estimate"

A comparative estimate is a tool used to determine if the completed work has been invoiced at reasonable and customary rates. Bioremediation is an emergency service and in most cases the work has already been completed by the time the claim has been filed. Companies offering this service are not bidding on the job when evaluating the invoice, and the question is not necessarily who could have done the work the cheapest, but rather if the price charged was within the reasonable and customary rates for the geographical area and the industry itself.

A company offering a comparative estimate may not be aware of any complications that arose and other factors impacting the project. The review is usually based on photographs without the benefit of being onsite to observe the job being performed in real time.

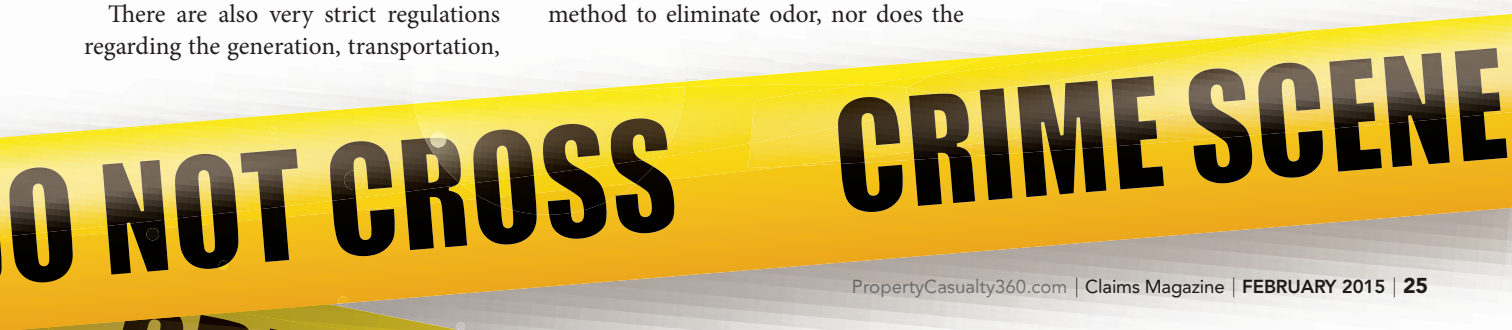
When evaluating the scope of work, there is no specific requirement by OSHA as to what is a preferred/recommended method to eliminate odor, nor does the EPA recognize any one chemical that will sanitize and disinfect on its own. There are various ways to evenly distribute odor neutralization and the use of one method over another is a matter of preference. This does not mean that one method or the other is incorrect, much less unreasonable or unnecessary. The techniques utilized by one company should not dictate the procedures employed by another in its cleaning process.

Resolving the claim

In some cases an adjuster may have very specific questions about the scope of work such as why a specific task was performed or why it took so much time. These are very relevant and legitimate questions to ask when determining if the costs and scope of work to be performed are appropriate. The remediation company should be able to provide the answers the adjuster is seeking.

Understanding what comprises bioremediation projects and how they differ from more traditional restoration claims is an important step to understanding the scope and cost involved. Contractors performing this type of work should have the proper training, expertise and insurance so the employees, insured and the insurer are all protected.

Michele Jacob is the claims manager with Archangels BioRecovery, Inc. and came to the bioremediation industry with 23 years of extensive experience in property and casualty claims. She can be contacted at michele@archangels.pro.



Utility Poles as a Roadside Hazard

The intersection of roadway design and tort liability

By Ned Baldwin and William F. Lyons Jr., PE, J.D.

In the United States, automobile use is extensive and pervasive. Vehicle accidents are such a common occurrence that they are considered an unavoidable part of normal activity. As a result, there is a legal duty to provide safe roadways that are clear of undue hazards.

Transportation policy and design standards reflect this by recommending the provision of a "clear zone" along the edge of the road. According to the Federal Highway Administration, a clear zone is an "unobstructed, traversable roadside area that allows a driver to stop safely, or regain control of a vehicle that has left the roadway."

Nonetheless, along many public roadways in New England and across the United States, above-ground utility infrastructure is located inappropriately close to vehicular traffic, creating a potential hazard. Impact with utility poles is a major category of vehicular accidents, including a large share of fatal crashes. As such, roadway jurisdictions and utility companies should share responsibility for the damages incurred from these collisions.

Legal Framework

Automobile accidents have been recognized by the courts as a "frequent and inevitable contingency of normal automobile use," as in Larsen v. General Motors Corp. (1968). In addition, the courts have recognized the distinction between the reason a vehicle departed from normal traffic movement and the reason damage was suffered in a subsequent collision. "If a governmental body or private party creates a dangerous condition near a highway, the condition may be at least one cause of an injury," says the Insurance Information Institute (I.I.I.) in its publication, *The Law and Roadside Hazards*.

Therefore, a growing body of legal doctrine and policy guidance is aimed at reducing the impact of potential accidents through hazard avoidance and mitigation. "The century-old common-law duty has been construed to require that the areas adjacent to the road…be kept safe and free from hazards." As such, "obstacles or devices capable of causing collisions resulting in injury or death should not be placed so close to a highway that a driver cannot stop before hitting them," states the I.I.I. document.

Within this framework, roadside hazards can be considered public nuisances and indicative of negligence. The government is "liable for public nuisances which endanger travelers," according to the Transportation Research Board book, *Utilities and Roadside Safety*, and has "a duty to maintain the roads in a safe condition, so as not to expose motorists to any undue hazards," as outlined in *The Law and Roadside Hazards*.

Negligence occurs when reasonable care has not been used to avoid an expected hazard. Actions are measured against a standard of care which "may be a written set of instructions, a policy, a guideline, or the accepted normal practice," says *Utilities and Roadside Safety*.

Standard of Care

The American Association of State Highway and Transportation Officials (AASHTO) is the national body that develops the standards for customary and ordinary practice in roadway design. AASHTO standards have been incorporated into the design guidelines of many state departments of transportation, including the Massachusetts Department of Transportation's *Project Development & Design Guide*, and are referenced by the Federal Highway Administration as the guiding principles of roadway design. Therefore, for measuring reasonable care in avoidance of roadway hazards, AASHTO guidelines can be considered the standard of care.

AASHTO guidelines specify the need for a clear zone "beyond the edge of the traveled way, available for safe use by errant vehicles." Vertical obstructions should not be located within the clear

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zone. The width of the clear zone depends on traffic volume, design speed and roadway geometry. The minimum recommended clear zone is seven feet. Roads with higher volumes and faster design speeds should feature wider clear zones. Slopes and curves also influence the size of the clear zone.

However, AASHTO recognizes that in urban environments right-of-ways are often constricted such that providing a full clear zone may not be practical. AASHTO recommends that in these circumstances there should still be an offset of at least four feet, with at least six feet on the outer side of a curve. In addition, since utility poles "can pose a substantial hazard," AASHTO states that "known utility pole hazardous locations should be avoided" and poles should be as far as possible from travel lanes.

Existing Conditions

Throughout Massachusetts, electricity and telecommunication providers utilize roadside poles to support cables and related distribution equipment. These poles are placed with the concurrence of the local jurisdiction with authority over the right of way through a process called a "Grant of Location." Roadside poles are involved in numerous vehicular accidents and "far too many people…are being killed and injured each year in collisions with utility poles," cites *Utilities and Roadside Safety*.

Allowing these roadside hazards to be installed and maintained in close proximity to normal traffic flow contributes to property loss, injury and death. As such, some responsibility should rest upon the locality and the utility. According to *The*

Law and Roadside Hazards, "Where such hazards exist, the duty to maintain the roads in a safe condition means much more than merely an obligation to preserve the roads in their original condition. It includes the duty to make the roads safer."

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In Massachusetts and throughout the United States, unsafe roadway conditions exist due to the placement of utility poles within what should be an unobstructed roadside clear zone. Bodily injury and property damage suffered by people traveling the public roads is in part caused by the presence of the poles, yet under current practices the liability for compensation rests with the driver and his or her insurer. These public nuisances exist due to negligence on the part of the locality and the utility in taking reasonable care, and some liability should be assumed by them for the result.

Legislative and regulatory action is in order to reconcile the current practices of the utility companies and municipalities with the standard of care as articulated by AASHTO and as found by the courts. Until the legal realities of the current landscape catch up with the proper allocation of risk, liability, and cost, drivers and consumers will be saddled with the inappropriate burden of paying higher automobile insurance premiums. These premiums should be reduced to reflect the liability of utilities and municipalities and should not be shouldered by insurance rate payers.

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5 Subrogation Opportunities Insurers Shouldn't Miss

By Kathleen Smith, CSRP, and Donna Geraghty

Experienced subrogation professionals are usually quite adept at pursuing subrogation opportunities. Most property and casualty claims with recovery potential involve mundane automobile accidents with vehicle damage or more challenging homeowner losses involving a faulty product, improper installations or vehicle damage to a structure.

These scenarios are familiar to the seasoned recovery professional; and for cases involving more complicated circumstances, an abundance of reliable information and resources are widely available from peer groups, experts and other sources on the Internet. However, before a subrogation recovery can be successfully pursued, success depends on the last person looking at the claim file before closure. That person must be adept at identifying recovery potential or there is automatic failure.

Failure to Identify + Failure to Pursue = No Recovery.

Just as the loss facts and state negligence rules in every automobile loss vary; there are certainly numerous loss scenarios in property and workers' compensation claims with countless recovery opportunities that are often overlooked to the untrained eye. Here are five loss scenarios frequently missed as a result of a failure to identify a recovery opportunity.

Acts of God and weather-related claims. Everyone is familiar with runaway shopping carts on windy days or leaky roofs during heavy down pours. To rule out recovery potential it is critical to delve deeper into the facts surrounding a claim when conducting an investigation. A properly constructed chimney should not topple over nor have bricks come loose during a normal wind storm unless there is an underlying cause such as poor construction which created the dangerous condition. Insight can be gained by inspecting the weather report to determine if the wind alone was strong enough to cause the damage while simultaneously investigating the age of the failed structure.

This same premise applies to roofing claims where water has penetrated the roof tiles or areas which should have been sealed. Determining the age of the roof can often lead to a recovery for faulty workmanship or defective materials. Not every snowstorm causes structures to collapse, yet many do. The cause of the collapse should be investigated early on when the adjuster is on premises to establish age, wear and tear versus poor construction. Too often, claims like these are written off as weather-related claims with no subrogation when in fact there is recovery, even if it's negotiated and compromised.

Burglaries. In many jurisdictions, crime victims have been defined to include indirect victims such as insurance carriers. If the culprit is apprehended and the courts include court-ordered restitution as part of the sentencing or plea, or in lieu of time served, the insurance carrier may have a right of recovery. Pursuing a subrogation claim against a criminal tortfeasor may have challenges due to the unlikelihood of the financial means to make restitution. However, if restitution is established by the court, it is more likely the tortfeasor will make payments to avoid incarceration. It is certainly wise to contact the local district attorney or law enforcement agency to alert them of the loss paid by the insurance carrier, thereby placing the judicial system on notice for potential recovery.

Statutes and regulations. In state specific statutes and regulations such as the New York Loss Transfer recovery, it is all too common for a claims handler to not realize the subrogation potential if any of the vehicles involved in the loss are over 6,500 pounds or are used for the livery of persons or property. Specifically, the at-fault vehicle need not meet the criteria since the vehicle need only be involved in the loss, even if parked.

Another example is the right of recovery for no fault payments in Florida, where payments made by the injured party's personal automobile carrier (whether the individual was the driver or passenger of a commercial vehicle) are recoverable from the carrier for that vehicle. The recovery is not based on liability since under the Florida state statutory scheme personal injury protection (PIP) is mandatory for all noncommercial vehicles registered and licensed in Florida. While owners of vehicles with PIP coverage are immune from subrogation claims, uninsured owners of vehicles without PIP coverage do not enjoy that immunity. Knowing the state statutes and regulations is crucial in reviewing PIP claims for potential recovery.

Parental lack of or negligent supervision. Depending on the policy language of a homeowners policy, neglectful parents may be responsible for claims arising out of the misdeeds of their children under the age of 21 and residing in their household. The age and intelligence of the child will play an important role in whether or not a child can be held liable for negligent acts. Parents can be held with negligent supervision if it can

be shown the child had dangerous tendencies of which the parents were aware.

Parents have been held responsible for damage to personal property resulting from fires, explosions, water and other perils. A thorough investigation is required to determine the intent of the child at the time of the event and the availability of insurance coverage. Given the potential cost to repair damages resulting from a fire to a home or building, it is certainly worth the time and expense to determine if there is a responsible party to pursue.

Workers' compensation direct action claims. This is definitely an area often missed by over-burdened reps working to make sure the medical bills and indemnity are paid in a timely manner. They get the injured worker back on the job as quickly as possible and close the file. How many times has a representative wondered if there was a "Mr. Somebody" who may have been responsible for those injuries? If the compensation carrier is placed on notice by a third-party attorney, the carrier will be aware that there may be money coming back on their lien.

But what about the claims where the non-litigious employee does not retain representative counsel? How often are these claims closed without pursuing the at-fault party directly? It is crucial for a workers' compensation adjuster to be aware of the recovery rights associated with a specific statute since they do vary widely. Some jurisdictions allow a carrier to pursue a recovery claim directly against a negligent party, while others give the injured worker the first right to pursue a liability claim within a specified timeframe, but afterwards either party can commence an action. Workers' compensation claims managers must make a strong effort to educate their claims teams on the laws governing the states where their policyholders are conducting their business.

Experienced subrogation adjusters and a high-performing subrogation program can contribute significantly to a company's financial health. Companies can facilitate the effectiveness of their program by routinely conducting subrogation awareness discussions with their claims adjusters and subrogation specialists. It's easy for recoveries to slip through the cracks if the potential is not properly identified.

External resources may be utilized to conduct closed file reviews to capture any claims that may not have made it to the subrogation team. It is wise to get the subrogation adjuster involved early in claims with high dollar potential to be certain the investigation is conducted with subrogation recovery in mind. While the recovery potential may be obvious, the paid loss amount may not seem worth the pursuit, but smaller recoveries can add up to a larger amount. And who doesn't want a lot of recoveries?

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GOING MOBILE: 'The tipping point is close'

By Michael Voelker

Four years ago, Apple trademarked the phrase, "There's an app for that." With more than 1.2 million offerings in the iTunes App Store — and about 1.4 million in Google Play — it would seem that the phrase is more true than not. However, only a few general-market agent productivity apps exist, and none have more than a few reviews from users.

"It's a relatively small number of agents who are using insurance-specific apps today," says Chad Hersh, senior vice president at The Nolan Co., an insurance management consulting firm. "Granted, a lot of agents use general apps on their mobile devices to the extent that many people do in their daily lives and jobs, but the penetration just isn't there for insurance apps for agents."

"I have many apps installed on my phone, but most of them are not insurance specific, nor are they specifically used for my business," says George Page, president of Page Insurance in Guilford, Conn. "Bottom line, I use my phone [mainly] for calls, texts and e-mail. After that it's a mixed bag of PayPal, a weather app, Facebook, Feedly, Capital One, Google Maps, Ring Central and Alarm.com."

Mobile Opportunity

Ed Higgins, vice president of Thousand Islands Insurance Agency in Clayton, N.Y., and vice chair at the Applied Client Network, says he believes that independent agents are missing out on the opportunity that mobile apps provide.

"Unfortunately, there is very little mobile app adoption among agents," he says. "However, mobile can be an incredibly useful tool for agents. More importantly, customers' expectations for mobile capabilities — and the ability for agents to provide service when agents are mobile — are increasing. The market paradigm has changed, and that is an alarm agents should be hearing."

Thousand Islands Agency was an early adopter of the MobileProducer, the mobile-app version of Applied System's agency management platform. For Higgins, the key benefit of the app is the ability to deliver what he calls the "Starbucks experience" for customers.

"Starbucks has mastered the process of delivering targeted information at those

tiny little moments at the point of sale that customers need or that cause customers to take action," he says. "What MobileProducer does is deliver a small snippet of information at just the right time for me. Being able to identify, for instance, details of a client's physical damage coverage and servicing that client at 10 p.m. on a weekend as a result, is a great way to build a long-term relationship."

"Agents love to be across from a customer and have the information they need at their fingertips," says Hersh.

Since first introducing the app to agents in 2012, Thousand Islands has enhanced it by adding dictation capabilities via Dragon NaturallySpeaking. "That improved the workflow by replacing the need to use a small virtual keyboard of a mobile device with the ability to simply dictate activity detail into a client file," Higgins says.

Thousand Islands is looking at ways to expand the reach of the app for agency management, including in the prospecting process. "MobileProducer allows you to do a complete new-business risk survey analysis in the field by capturing data, creating a new client record, and collecting information application. We're still evaluating how useful that capability would be for us," Higgins says.

Other agency management vendors, including Vertafore and QQ Solutions, offer mobile-app versions of their platform as well. In addition, agents can choose sales and service apps for agents provided by carriers or MGAs. In August 2014, Burns & Wilcox joined the fray by introducing a sales app, available in both the iTunes App Store and Google Play, for recreational marine insurance.

"We felt it was important to give agents a mobile application that would enable them to actually transact business, rather than just provide them with promotional information. We felt that giving the agents an app they could use while on the docks or at the marina would be convenient and efficient," says Bill Gatewood, corporate vice president and director of personal insurance.

"As we continue to move forward in mobile app development, we will look for applications that help agents and brokers write business in a more efficient manner. We also have the ability to personalize the application so our partners can make it their own and add additional lines of coverage they sell in their office. We can help our agents and brokers create their own mobile app for a fraction of the cost they would normally incur," Gatewood claims.

Through the mobile app, agents and brokers can complete a recreational watercraft application and send it directly to the Burns & Wilcox marine underwriting team. Agents can request an application be emailed directly to them, submit a question regarding a watercraft or coverage, upload photos of a boat, and access marine-related information and FAQs.

With the app new to the market and the boating season in hiatus in many areas of the U.S., usage of the app by retail agents has been slow by design. "We launched the mobile app with little fanfare since the boating season was nearly over and we wanted to be sure it worked as expected. Our plan is to push it hard in February as the season begins," says Gatewood.

Burns & Wilcox is developing a second mobile app that will allow Canadian retail brokers to submit U.S. risks to Burns & Wilcox's cross border team. "We think that also provides some convenience to retail brokers — we will see," Gatewood says.

Dual-Purpose

Also available for agents are dual-purpose apps, designed for agencies to offer to customers as a self-service tool but which can also be used for agency productivity and agent-delivered customer service. One offering on both the Apple and Android marketplaces is the aptly named Insurance Agent from goinsuranceagent.com.

"Insurance Agent is an interesting take on the consumer-facing mobile app," Hersh says. "It's like a carrier app from the customer's point of view, but it's offered by the agency so it allows the agency to both build customer relationships and capture information more easily from clients."

"If the agent is going to stay a critical part of the triangle between carriers, consumers, and the agency, the app [offered to consumers] needs to keep agency in the loop. When you go carrier to customer, as carriers are going, those apps aren't helping the agency because they cut the agency out or fragments the industry," says goinsuranceagent.com's Kiki Johnson.

Paradiso Insurance, headquartered in Stafford Springs, Conn., introduced an agency-branded version of the Insurance Agent app to customers in October 2014. The app allows customers to perform a number of common servicing functions, including paying a bill, calling or e-mailing the agent without having to look up a number or address, storing insurance cards, vehicle registration and other information, and reporting claims.

"We've had a great success rate with reporting claims. People like it," says agency owner Chris Paradiso. The app syncs with the agency's QQ Solutions management system to deliver insurance cards and other documents in near real-time.

"Car-buying is a key touch point with customers," Paradiso says. "If you call me and you want an insurance card because you bought a new car, as soon as we hang up that insurance card is sitting inside your app on your phone. That's a powerful capability."

From an agency management perspective, the app delivers Paradiso Insurance several key benefits. First is communication. "We use the app for sending texting-type messages to individual consumers," Paradiso says. "Texting is more effective than an e-mail because people pay attention to it more — it's immediate."

The agency also provides safety-related information to customers via the app, including videos and vehicle logs. It also uses the app for push notifications; for instance, when a winter storm approaches,

the agency uses the app to advise customers to clear their roof of snow.

By controlling the app, the agency also is able to analyze customer activity and use the results in relationship building. "The downside of carrier apps is that they don't provide any real tracking for agency owners. If you can't see who is downloading the app and what they're using it for, what good is that? It's like having a website without analytics," says Paradiso.

Insurance Agent provides a dashboard that delivers current information and analytics. "Having information stored and synced on the dashboard allows agents to use that information for upselling and cross-selling opportunity, compared to carrier apps," Johnson says.

The Case for Mobile

Other agents, including Page, are still unconvinced that many consumers need or want apps from their agent. "With respect to consumer-facing mobile apps, I've looked at the few offerings and I'm thoroughly unimpressed," he says. "For starters, very few people will want an insurance app. If given the choice to download Candy Crush or a mobile insurance agency app — well, enough said."

However, Johnson believes that offering customers an app is becoming a competitive necessity in particular for independent agents.

"The industry fell behind with creating websites, but could get away with it because the competition wasn't there. Today, the competition is there [for mobile]. The direct writers are there who can build mobile capabilities to do everything that needs to be done, and they've got the money on the mobile side to build apps that are equivalent to what banking or commerce is doing, or anybody else," Johnson says.

"The insurance industry doesn't have the luxury of saying, 'We'll wait on this one and see how it goes, because mobile isn't going away," she adds. "It will be more and more pervasive."

Paradiso Insurance has achieved a 40 percent mobile-app penetration among customers, but has had to work hard to achieve that level.

"We send out cards and mailers, we use LinkedIn, Twitter, Vine, we do e-mails to build awareness. We try to hit them from every direction," Paradiso says.

Higgins believes that agents will increase their use of mobile apps for agency management in the months ahead.

"There is not currently the kind of aggressive, visible pressure for agents to use mobile apps, but that is changing," he says. "Agents need to take a broader view and recognize that the world is going mobile. Our customers have the capacity to have services that serve them at their moment of need, and they expect the same from us."

"It's a bit of a calm before the storm," Hersh says. "There might not be a reason now where you must have an app for your agents, but that will change. The tipping point is close."

Michael Voelker is a contributing editor to National Underwriter Property & Casualty.

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Understanding Litigation and Court Decisions — Part 2

Adjusters as judge, jury and litigation manager

Many decades ago, beginning adjusters often heard the phrase, "it's a jury question," meaning that the facts were not clear enough to decide if the insured was responsible for what happened or the claimant was at fault. What this really meant was that there was not yet enough information to make a correct decision. It meant: "go dig some more," with documentation, photos, diagrams, statements, data and details. Why? Because it is too expensive to litigate every claim.

Only when adjusters dig as deep as possible into the facts and lay them out logically in a report, will the kind of decision a judge and jury make be the result. Judges and juries don't always get it right, and neither will adjusters. But if enough research has occurred, the odds for correct decisions increase. If an allegation of coverage, liability, damage or injury is not valid, a wrong decision to settle will be expensive. But a wrong decision to deny a valid claim will be even more expensive if it results in litigation.

What is Litigation?

While a majority of small claims may simply be processed if the facts are reasonably clear, it is the serious claim that may trigger litigation. It may be a dispute over whether the policy applies to the loss, requiring a court's declaratory relief judgment; a dispute of fault or how much the damage or injury or lost lives are worth. These issues reach courthouses daily, and adjusters are responsible for managing the litigation. There is an eight-corners rule: the four corners of the lawsuit must match the four corners of the insurance policy that applies.

In first-party claims, litigation most often involves whether coverage applies to the loss or how much covered damage resulted. There is enough of this litigation (or "appraisal," a form of arbitration required in some first-party coverages) that insurers want to be sure that the adjuster is absolutely correct before saying "No."

In third-party lawsuits, often both the claims industry and the insureds fail to understand what is called the "tripartite relationship." With very few exceptions (such as indemnification policies or "consent to settle" forms), it is the insurance company that must defend and/or pay on their insured's behalf up to the policy limits. The insurer may elect to settle or defend as it *alone* decides, even if payment is entirely within a commercial insured's deductible.

The adjuster must select the defense counsel best suited for the lawsuit and make the decision whether to continue with the litigation or settle the claim. Timing is crucial; if the insured is liable, but the plaintiff's demand is unreasonable, the adjuster may recommend aggressive discovery (demands for information). This may discourage the plaintiff into making an earlier settlement. If the demand exceeds the insured's policy limits and both damages and the allegations of the suit are true, to defend rather than settle exposes the insurer to bad faith. Every attempt to settle within or at policy limits *must* be made.

Understanding Court Decisions

The losing side in any litigation has a right of appeal, at least if they file their appeal in a timely manner, which differs in various jurisdictions. One key word is "venue." There are hundreds of venues in the United States, and it is part of the adjuster's litigation management role to see that the correct venue is chosen. The plaintiff will sue in the venue where courts may be most receptive to his or her position, but the defendant can oppose that venue if there is a valid reason to do so. The plaintiff may file in state court, but the defendant may argue that there is diversity of citizenship and move to transfer the case to federal court. Occasionally there may be no choice. Claims involving the Employee Retirement Income Security Act (ERISA) or the Federal Employers Liability Act (FELA) must be filed in federal courts. Claims under state workers compensation acts must be filed in the proper state court, usually in the state where the accident occurred, although there are exceptions.

Next month we will look at all the potential venues for litigation and appeals, and explore court reporting of decisions.

Ken Brownlee, CPCU, is a former adjuster and risk manager based in Atlanta, Ga. He now authors and edits claims-adjusting textbooks.

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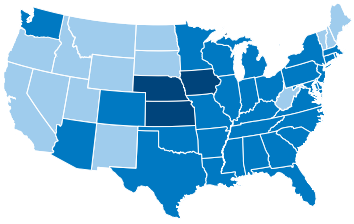

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