

The Art of Adjusting: Best Practices in Handling Claims For Captive Insurance Companies

*“Strong Reasons Make Strong Actions.”
William Shakespeare,
King John Act III,
Scene IV.*

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Generally speaking, claims handling involves investigation, evaluation and resolution of claims. It also necessarily involves interpretation and application of relevant policy provisions. Insurance adjusters are specialized personnel who investigate claims, make determinations as to coverage, verify the value of covered claims, set reserves accordingly, and are fluent in the language of any policy at issue such that they are able to determine an ultimate coverage position on behalf of the insurance company.

Rules of policy interpretation that apply in the commercial policy context also have relevance in the context of adjusting captive claims. Some of those rules are:

- Exclusions are to be interpreted narrowly;
- When a policy provision is ambiguous, the insurance company must strictly construe that provision in favor of the insured;

- Policy language should always be given its plain, ordinary and popular



meaning, and coverage should be construed in accordance with both the mutual intent of the contracting parties and in favor of the reasonable expectations of coverage by the insured.

For more discussion of the rules of policy interpretation and “best practices” in policy drafting, see the companion article to this piece that was published in the April 2015 issue of Captive Visions.

There is most definitely

an “art” to adjusting, where strong policy interpretation skills coupled with strong claims investigation will lead to appropriate claims resolution. This article discusses some of the key components to “best practices” in claims adjusting. There are some moving parts to claims adjusting that are very complicated, such as setting reserves. It is beyond the scope of this article to go into technical detail on

some of the more complicated components to artful adjusting. Instead, what’s here is just a basic primer on certain “best practices” inherent to and part of the claim function generally, with a focus on the need for strong documentation.

What is a Claim?

A claim is a demand for something due or believed to be due, or a right to something. In the context of “claims made” coverage, there is first a demand made against the insured by a

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person or entity (that's the claim made). Then, the insured makes its own demand to its insurance company for coverage of the claim made against it (so the claim made is against the insured but then it is reported in its own right to the carrier).

In the context of a claim under an insurance policy, the word "adjust" generally means to determine the amount to be paid or denied under an insurance policy. In sum, claims are basically demands against an insurance policy by the policyholder/insured and adjusting is the process wherein the claim value is determined and, if covered, paid.

The Life Cycle of a Claim

There are by and large three stages to the life of a claim: (1) the notice stage; (2) the coverage evaluation stage; and (3) closure of the claim.

The notice stage is basically the process through which an insurance company is notified of a claim, an adjuster is assigned, and a claim file is set up so that investigation of the claim can begin. The coverage evaluation stage encompasses investigating the claim and determining whether or not a claim is covered. If a claim has been reported, and if the insurer is evaluating it for coverage or case reserves and it's not yet been fully paid or is in the process of being paid, it's considered an open claim. Claims will close when all liabilities associated

with that claim under the policy or policies cease.

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the claim is closed. A captive can only close a claim when all liabilities associated with the open claim are over, they do not exist any longer, and then and only then should the claim be earmarked for closure.

Documenting the Claim File

Proper claim documentation is at the center of strong and effective adjusting. Ensuring complete and accurate documentation is itself a best practice. The claim file includes all notes, correspondence, investigation and evaluation related documents relevant to the claim.

Many insurance companies, self insurers with claims departments, and/or independent adjusting firms (like TPAs) use electronic reporting systems to assist with the handling and documenting of claims. There are many good reasons to utilize an electronic system for claim adjusting, from ease of reference

to personnel, to ensuring that all relevant documents are conveniently stored in one central location, to ensuring that other departments or functions impacted by claims adjustment get what they need from claims in order to perform their own job functions. Underwriters and actuaries leap to mind in this regard; both have need of claim or loss related information in order to perform their own job functions, such as renewing policies, determining loss triangles, or preparing actuarial reserve studies and/or statements

of actuarial opinion.

Specific documents that become part of a claim file include: notice of claim forms, adjuster reports detailing claim investigation and evaluation, adjuster notes, claim diaries (if they are used, which may be more likely in a commercial than a captive context), claim data, and documents on loss history information (such as loss runs). Let's take a closer look at each of these claim documents:

- **Notice Documentation:**

Every claim begins with a first report which is typically used to document notice. Notice documentation should include information on how the claim/loss was reported, when was it reported and who reported it. This documentation should also include confirmation that the notice under the policy was timely

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made if the policy is claims made, or – in cases when the policy is written on an occurrence form -- what is the proper policy that has been triggered by the claim.

- **Investigation Documentation:**

This part of the adjustment process involves investigating the claim. Whatever is learned during the investigation becomes the factual foundation for the coverage evaluation. As part of the preliminary investigation stage, claim information like the date, time and place of loss are determined. The adjuster will add documentation to the claim file that substantiates the loss, damage, liability or accident, what happened, what is the possible dollar value of the loss, what are the possible liability exposures presented by the claim and so on.

At some point in time, the investigation will lead to the adjuster being able to make an evaluation or render an opinion as to the value of the loss or the scope of liability. The investigation will also touch on claimant-related issues, if any, such as damages or loss to each claimant. In cases where there is a reimbursement policy at issue, then there aren't direct claimants per se, as claim amounts are simply reimbursed to the insured who has already paid claimants.

As part of the claim investigation, an adjuster will also use some form of claim notes to document the current status of a claim, conversations with insureds or witnesses, and/or anything else that is material to the adjustment of a claim that needs to be documented for purposes of the file.

- **Documenting Coverage Evaluation:**

Coverage verification is the process of determining whether a claim is covered under the responsive policy. Early in the coverage evaluation the responsive policy and the applicable limits are determined. This includes discerning whether there a sublimit involved, or just the policy's per claim limits.

During the coverage evaluation stage, the adjuster takes what was learned during the investigation of the claim and decides whether or not the claim is covered, excluded or otherwise precluded from coverage. A claim can be denied for procedural reasons, such as lack of timely notice. If the claim is untimely reported, there most likely does not need to also be an extensive substantive investigation into coverage as the response from the captive can simply be a denial based on lack of timely or proper notice.

In any event, best practices implemented at the coverage evaluation stage of adjusting a loss requires that all coverage issues are identified and documented so that there is a written record in the claim file supporting the claim evaluation and the insurer's coverage position.

- **Documenting Reserves:**

Claims personnel also need to keep accurate records substantiating case reserves. Claims must document the initial setting of case reserves and any change in the reserves over the life of the claim. Case reserve information will also be important to the actuary when he/she is working on estimating ultimate losses.

- **Loss Runs:** Loss runs include claim details such as claimant and insured names, date of loss, report date, loss and expense payments. Loss runs are created by claims personnel but are used by underwriters as discussed below to determine the desirability of renewing policy lines and/or to determine premium. Loss runs are also used by actuaries in estimating ultimate losses.

The Connectivity and Interplay Between Claims and Underwriting

Underwriting involves all the activities necessary to the drafting, review and placement of insurance. In the bigger

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picture, claims and underwriting personnel often work together. It is the underwriter's job to review application materials submitted by an insured to determine whether the risk

Loss runs are generally used to evaluate the frequency and severity of losses over a 3 to 5 year time-frame. So, claims data and loss runs are crucial to the underwriting process.



being submitted for coverage is acceptable to the insurer. If so, what is the appropriate premium for the policy lines being purchased?

Underwriters use underwriting guidelines and methods including underwriting judgment as a basis to accept or decline coverage for a risk. Prior loss history is an important component to evaluating risk as part of those guidelines.

Loss runs are requested by underwriting from claims prior to any policy being renewed. Loss related information also comes from the insured as well, but the claims department plays an important role in renewal of business as claims provides the loss run, which is basically a list of claims that encompass the insurance company's loss history.

claims adjuster who is seeking to interpret it relevant to a claim.

It is not the job of the claims department to decide whether to cancel coverage, but information from claims becomes crucial to any decision to cancel coverage. For example, it is part of the job of claims to bring information to the attention of underwriting that will help underwriting to determine whether to continue to write the policy or to take other action (such as raising premium, changing limits, or writing different terms of the coverage in renewal). Thus, it is important for claims and underwriting to have a strong relationship so strong, connected action can be taken by both departments (using information from the other) as needed.

On the corollary side, adjusters are in the trenches interpreting policies and need to have a clear understanding of underwriting intent in writing any given policy line. Often, the underwriter/s that wrote the policy (or policy language) at issue can be invaluable to the

Having Claim Manuals is a Best Practice for Captives

Captive best practices include the documentation of claims operations to ensure that consistent claims protocols and procedures are put into place and routinely followed by claims personnel. It is important to note that there can be different claims operations for different captives. For example, there might be claims operations performed by the captive insurance company itself versus claims support or services provided by a captive manager. Operations documentation should make it clear who is doing what, and that claims functions can be determined in some instances based on what the manager has been hired to do relative to claims.

Some clients use Third Party Administrators (TPAs) for claims, so there is no internal claims service provided by the manager, other than through the accounting department, which will help facilitate the reporting of reserves or claim payments. Captives that do not use a TPA may rely on their manager to provide claims adjusting services, or they may have internal staff to handle claims. So, the written manuals describing claims operations will be unique to each captive situation based on the nature of their claims handling process.

Claims manuals may include systems information that describes how to use the electronic or other system used by claims personnel to adjust and handle claims. Manuals might also include templates

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for coverage letters or other claim related forms that are used as part of the adjustment process. Form letters include claim acknowledgement correspondence, cover letters requesting completion of some necessary form, letters to the insured/s advising of the coverage position and so forth. Manuals also include claims adjustment guidelines, and the actual protocols and procedures in place for each key component to the claims adjustment process, such as notice, investigation, coverage evaluation, reserving, and claim closure.

Strong Claim Adjusting: The Need for Documentation and Claims Submissions

Artful and strong claims adjusting thus necessarily starts with and has an emphasis on claim documentation, where every aspect of the claim is fully documented, from its intake to its investigation to its evaluation, to the final coverage determination. After all, it could happen that a captive's entire claim history involves only claims submitted for coverage that in the end, for various reasons, wind up as denied claims. This kind of claim scenario would still amount to an active claim history; it's not the payment or the coverage result that defines the history (though these are certainly key components to any claims

history), it's whether or not the insurance is being used. Submitting claims is using insurance.

Moreover, captive insureds

But with captives, when an insured purchases a policy from the captive and there is a loss for which there may be a responsive captive policy, the claim should be submitted so there can be no argument down the line that somehow the insured did not really need that coverage, or had no intention of using the captive program.


are unlike commercial insureds in that if the insurance is purchased from a captive, it should be used if there is a claim or the potential for one. In the commercial context, insureds sometimes decide even though they purchased a commercial policy not to submit a claim for a variety of reasons. Perhaps they don't want to go through an arduous claim process with the carrier, or maybe they don't want the carrier to appoint counsel preferring to use their own lawyer, or they might be concerned that submitting a claim would cause their premiums to go up.

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In conclusion, strong claim adjusting starts with an actual

claim submission. To captive owners and captive insureds, even if you believe the claim might not be covered, submit it and let your insurance company

do its job for you. Let them adjust the loss accordingly. The only reason not to submit a claim is simply because there is no claim. If an insured has loss prevention and safety measures in place

such that it has no underlying claim or loss for which it needs its insurance, then there is no reason to expect either a claim submission or that the captive should have a claim. 



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