

Leaving the Fox in Charge of the Chicken Coop¹

How the administration of retrospective insurance premiums can go awry

Insurance is the transfer of the risk of loss for a fee. The greater the risk of loss, the higher the fee. Where there is little or no “risk” involved—such as where the amount of loss has already been determined—the fee charged for the transfer of the “risk” will be lower because the losses are not large.

This basic principle of insurance has led to the creation of retrospective insurance premium (RIP) policies. RIP policies are attractive to policyholders because the up-front premium costs are lower. They also give policyholders the ability to retain control of any additional premium dollars that may be due after claims against them are actually made, and under some types of policies, settled. RIPs are most often found in workers’ compensation policies, but they are sometimes used in other types of policies as well.

Although RIP policies are convenient and can result in lower insurance premium costs in some circumstances, they can easily cause a company to face unexpectedly high costs. The low up-front premiums charged for RIP policies

¹ John N. Ellison and Jeannine W. Chanes, *Leaving the Fox in Charge of the Chicken Coop How the Administration of Retrospective Insurance Premiums Can Go Awry*, N.J.L.J., Apr. 4, 1999, at 33. (156 N.J.L.J. 33)

have undeniable appeal. However, premium “adjustments”— usually demands for more money—are frequently an unpleasant shock to policyholders.

Premium adjustments can also mean return premiums, but return premiums are less common because insurance companies have a disincentive to deny or fight claims. This anomaly is created by the unique nature of RIP policies: the greater the reserves or losses, the greater the premium and the greater the insurance company’s profits.

Moreover, the insurance company can regulate the amount and timing of added premiums because it has exclusive control of loss disbursements and reserves. As a result, RIP policies create a situation analogous to what is sometimes called “leaving the fox in charge of the chicken coop.”

The Mechanics of RIP Policies

- **Basic Premiums.** The typical RIP policy charges a front-end premium based upon estimated losses as projected by the policyholder’s loss “experience rating”. Front-end premiums are generally a percentage of what the policyholder’s premium would be under an insurance policy with a “standard” premium.

At set intervals—usually at the end of the policy period or on a quarterly or annual basis—the policyholder may be required to pay additional premiums if its losses exceed the amount of the estimated premium. Similarly, if the

policyholder's actual losses are below a certain amount, the premium is reduced or returned accordingly.

Whether premium dollars will eventually be returned to the policyholder or not, the insurance company has the use of the basic premium from the inception of the policy.

- **Additional Premiums.** The policyholder may be required to pay further premiums in addition to the basic premium if more claims are made against it during the policy period than were initially anticipated. Depending on the policy language, premiums can be calculated on indemnity costs only, or can include both defense and indemnity costs. These additional premiums, innocuously referred to as "premium adjustments," can be made on a paid-loss or incurred-loss basis.

For RIPs on a paid-loss basis, the insurance company charges the policyholder an additional premium based on the funds it has expended on the policyholder's behalf. Paid-loss RIP policies are attractive because they allow the policyholder to have control of its money until any claims against it are actually paid.

On the other hand, incurred-loss premiums allow the insurance company to collect funds from the policyholder *after* claims have been made against it, but *before* they have actually been paid. Once a claim is made, the insurance

company estimates the settlement value of the claim and sets a reserve based on that amount. The policyholder pays an additional premium based on the reserve. The insurance company, of course, has the use of the policyholder's money during the weeks, months or years the claim is pending.

- **Premium Add-ons.** As with traditional insurance policies, claims-handling duties for RIP policies are controlled by the insurance company. The difference is that all RIP policies—whether premiums are calculated on a paid-loss or incurred-loss basis—tack on further fees to reimburse the insurance company for its administrative expenses in processing and investigating the claim.

These “add-ons” usually include a general handling charge and tax, calculated as a percentage of the claims settled or amounts reserved by the insurance company, and are *in addition to* any amounts paid for the claims themselves. Add-ons can be as much as 66 percent of the insurance company's estimated or actual claims payments. See *Transit Casualty v. Topeka Transportation*, 663 P.2d 308 (Kan. App. 1983) (66 percent add-on in addition to amounts actually paid in settlement of claims against the policyholder).

Adding insult to injury, where a claim against an incurred-loss basis policy is settled for less than the reserve figure, the amount refunded to the

policyholder is only the difference between the reserve amount and the settlement amount.

Besides having had the use of the policyholder's money while the claim was pending, the insurance company gets to keep the handling charge add-on for the *entire amount of the initial reserve* – not just on what was eventually paid on the claim. As one court noted: “It is thus readily apparent that the creation of reserves larger than the final value of claims would be disadvantageous to plaintiff while more profitable to defendants.” *Benton Express v. Royal Insurance*, 457 S.E.2d 566, 569 (Ga. App. 1995) (McMurray, J., concurring in part and dissenting in part).

In addition, because RIPs are unlike traditional insurance policies in which all claims are paid out of the insurance company's own pocket, the insurance company handling a RIP policy claim is negotiating, settling and paying claims with the policyholder's money. Thus, the insurance company has little—if any—incentive to press for the lowest possible settlement, which it would if it were spending its own money. Not surprisingly, RIPs can be as profitable for insurance companies as they can be costly for policyholders.

- **Future Premiums.** The damage to a policyholder's insurance premium payments does not stop with excessive reserves, settlements and

add-ons, however. Under RIP policies, each year's initial policy premium is determined by referring to the policyholder's "experience rating." This experience rating, in turn, is based on the amounts settled or reserved for the policyholder's claims in the previous policy periods.

Therefore, the greater the claims paid or reserved under a RIP policy, the higher the policyholder's basic premiums will be on its future RIP policies. See *Security Officers v. State Compensation Insurance Fund*, 17 Cal. App. 4th 887, 891, 898 (Cal. Ct. App. 2d App. Div. 1993) (discussing the negative ramifications to policyholder when the insurance company over-reserves claims made against a RIP policy).

- **Stop-Loss Provisions.** Some, although not all, RIP policies have a "stop-loss" or "loss limitations" clause, which caps the amount of the policyholder's extra premiums. Loss limitations can be set on a per-occurrence basis or on an aggregate basis, or both. A per-occurrence stop-loss limits a policyholder's loss for each claim or group of claims resulting from a particular occurrence.

An aggregate stop-loss limits a policyholder's total liability under a particular policy. If a RIP policy contains a stop-loss provision, once the stop-loss limit is reached, the policy functions like a standard insurance policy, with all of the policyholder's subsequent liabilities paid by the insurance company.

State of the Law

- **Insurance Company's Duty of Good Faith and Fair Dealing.**

Courts addressing RIP issues consistently recognize that the inherent conflicts of interest in RIP policies create specific obligations on the part of the insurance company to its policyholders.

First and foremost is the duty of good faith and fair dealing. See *Transport Indemnity v. Dahlen Transport*, 161 N.W.2d 546 (Minn. 1968); *Corrado Brothers v. Twin City Fire Ins.*, 562 A.2d 1188 (Del. 1989); *Port East Transfer v. Liberty Mutual Insurance*, 624 A.2d 520 (Md. App. 1993); *Marten Transportation v. Hartford Specialty Co.*, 509 N.W.2d 106 (Wisc. App. 1993); *Benton Express*, 457 S.E.2d 566; *Liberty Mutual Insurance v. Marty's Express*, 910 F. Supp. 221 (E.D. Pa. 1996).

Although not all courts deciding RIP policy disputes have held this duty of good faith and fair dealing rises to a fiduciary level, some courts have been willing to hold insurance companies to a heightened standard because of the inherent conflict of interest in this type of policy. Compare *Topeka Transportation*, 663 P.2d 308 (fiduciary duty) with *Corrado Brothers*, 562 A.2d 1188 (heightened standard).

- **Potential Conflict of Interest.** Courts have identified four sources for conflicts of interest in RIP policies.

The first stems from the fact that the insurance company has no incentive to fight claims because every claim that is settled under the stop-loss limit is paid for by the policyholder. As a result, when a policy has a RIP, the insurance company is actually funding the cost of some or all settlements with the policyholder's money. As the Maryland Court of Appeals observed, an insurance company is faced with a temptation to act somewhat more cavalierly when spending someone else's money than when spending its own. *Port East Transfer*, 624 A.2d at 524. See also *Marty's Express*, 910 F. Supp. 221.

Another conflict of interest is created by the fact that the higher the settlement or loss payment, the greater the insurance company's profits under a RIP policy. Unlike traditional insurance policies where an insurance company risks losing money when it pays claims, the RIP claims-handling add-on guarantees the insurance company a profit. Since the policyholder pays these add-ons *in addition to* the amount of the actual paid losses or reserves, the insurance company profits more if a settlement is high as long as the settlement is less than the stop-loss limitation (if any).

Obviously, the insurance company lacks the incentive to reduce loss payments, a fact that many courts have recognized. *Port East Transfer*, 624 A.2d at 524 ("Moreover, there may have been a temptation toward generosity when the insurer's fee increased with each dollar paid out"); *Dahlen Transport*,

161 N.W.2d at 549 (“[T]he conflict of interest inherent in the arrangement is exacerbated by plaintiff’s claim that the retrospective-premium-payment provisions... entitled the insurer to charge against the insured not only the amount paid by it to the claimant, but an additional amount said to represent the expense incurred in investigating and adjusting the loss but fixed as a percentage of the amount paid by it in settlement”); *Marten Transportation*, 509 N.W.2D at 111 (“Thus, as some courts have noted, there exists an inherent conflict between the interests of the insurance company and the insured because as the insurance company pays out more in claims, the insured must pay more in premiums, and more in commissions to the insurer”)

Besides profiting from the add-ons themselves, the insurance company also stands to make money from increased basic premiums for future policies if the policyholder’s “experience rating” is artificially inflated by excessive settlements or reserve amounts. *Security Officers Service*, 17 Cal. App. 4th 887.

Finally, the insurance company can manipulate settlements to minimize its own potential liability for a claim. By electing to settle a claim rather than fight it, the insurance company is opting to spend the policyholder’s dollars rather than its own. As the Minnesota Supreme Court pointed out, the insurance company that settles within the RIP avoids the risk of litigating and possibly being found liable for an amount in excess of the retro—which it

would have to pay out of its own pocket. *Dahlen Transport*, 161 N.W.2d at 549; *Insurance Co. of North America v. Binnings Construction*, 288 So.2d 359, 361 (La. App. 1974).

Further, while settlements are paid for by the policyholder, the cost of litigation is borne primarily, if not entirely, by the insurance company. *Corrado Brothers*, 562 A.2d at 1193. Thus, the insurance company's interests are best served by settling all claims – even spurious ones – within the RIP rather than incurring defense costs that it would have to pay out of its own pocket.

- **Breaching the Duty of Good Faith and Fair Dealing.** The breach of the insurance company's duty of good faith and fair dealing is the most common issue involved in RIP disputes. Although RIP policies grant the insurance company broad latitude in handling claims, the insurance company's discretion in claims handling is restricted when it may impair the policyholder's interests under the policy. Courts have held that the insurance company's duty of good faith and fair dealing places three affirmative duties on the insurance company in its handling of claims made against RIP policies.

First, the insurance company must investigate claims paid under RIP policies. Courts recognize that policyholders with RIP policies have given the insurance company exclusive control over claims management. As a result, the insurance company must investigate thoroughly and in good faith.

Examples of adequate investigation include accident reports, medical reports, investigators' reports, adjuster's recommendations, lawyer's recommendations, or any combination of those documents. *Topeka Transportation*, 663 P.2d at 311. See also *Dahlen Transport*. 161 N.W.2d 546; *National Surety v. Fast Motor Service*, 572 N.E.2d 1083 (Ill. App. 1991) (improper claim investigation as a basis for bad-faith); *Security Officers Service*, 17 Cal. App. 4th 887 (duty to investigate claims properly part of covenant of good faith and fair dealing).

Second, the insurance company must settle claims reasonably. This means that all settlements must be based on a good faith belief in the policyholder's liability and the amounts paid in settlement must be reasonable in light of all the facts and circumstances surrounding a particular claim. See *Topeka Transportation*, 663 P.2d 308; *Deerfield Plastics v. Hartford Insurance*, 536 N.E.2d 322 (Mass. 1989); *Corrado Brothers*, 562 A.2d 1188; *Fast Motor Service*, 572 N.E.2d 1083.

Finally, the insurance company must settle claims *promptly* when the RIP is on an incurred-loss basis. The covenant of good faith and fair dealing requires the insurance company to conduct its claims resolution and reserve allocation processes with a good faith regard for the policyholder's interests—and to discharge the claims against it without delay. *Security Officers Service*,

17 Cal. App. 4th 896. Artificially prolonging the claims resolution process, whether through neglect, sloth or avarice, is not within the discretion of the insurance company.

- **Insurance Company Defenses.** When faced with policyholder challenges to RIP payments, insurance companies have few defenses. The most powerful defense is the policy language itself, which grants them broad powers to investigate and settle claims without the policyholder's consent.

However, courts tend to reject this defense, noting that regardless of whether the policy gives the insurance company the right to make claims decisions, the insurance company still must exercise that right in good faith and not put its own interests ahead of those of the policyholder. See *Corrado Brothers*, 562 A.2d at 1191 (settlement must be in good faith and reasonable notwithstanding policy provision vesting insurance company with broad discretion to settle claims); *Fast Motor Service*, 572 N.E.2d at 1087 (insurance company's broad discretion in adjusting claims limited by its duty of good faith); *Port East Transfer*, 624 A.2d at 524 (contract does not grant the insurer absolute authority, the law imposes an implied promise of good faith); *Security Officers Service*, 17 Cal. App. 4th at 896 (insurer's discretion in handling claims is restricted when its exercise may impair the insurer's interests under the policy).

- **Burden of Proof.** State law varies regarding whether the insurance company or the policyholder has the burden of proving that claims handling and settlement was reasonable. The earlier trend, adopted by Minnesota, Kansas, Delaware and Georgia, held the insurance company –not the policyholder—responsible for proving that its claims handling and settlement was reasonable. *Dahlen Transport*, 161 N.W.2d 546; *Topeka Transportation*, 663 P.2d 308; *Corrando Brothers*, 562 A.2d 1188; *Benton Express*, 457 S.E.2d 566.

The rationale behind this allocation is that the insurance company has all the relevant information regarding claims handling that could prove reasonableness and good faith.

The second and more widely held view, however, is that once the insurance company proves it has actually *paid* the claims in question, the policyholder must prove the claims handling was not reasonable. This is the law in Louisiana, Massachusetts, Tennessee, Maryland and New Jersey. *Binnings Construction*, 288 So.2d 359; *Deerfield Plastics*, 536 N.E.2d 322; *Port East Transfer*, 624 A.2d 520; *Liberty Mutual Ins. v. President Container*, 687 A.2d 760 (N.J. App. Div. 1997).

At least one federal court has also predicted that Pennsylvania would follow *Port East Transfer* as well. *Marty's Express*, 910 F. Supp. 221. In

some of these jurisdictions, the insurance company is given the presumption that its claims handling was reasonable, which the policyholder must rebut.

However, other courts place the burden of proof of the insurance company's negligence on the policyholder, but are willing to shift the burden of proving reasonableness back to the insurance company once the policyholder produces some evidence of bad faith – even if it is no more than a “hint” of bad faith.

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The rationale behind this allocation of proof is that modern discovery practices make all the information on claims handling and settlement in the insurance company's files available to the policyholder as well. As the Maryland Court of Appeals noted, “It seems unlikely that [a policyholder] will undertake the considerable expense of an extended inquiry into every case file without some reasonable suspicion that the [insurance company] failed in its implied obligation. If the [policyholder] wish such an inspection, however, modern discovery techniques are entirely sufficient to permit it, and the parties may thereby determine the existence of legitimate issues that should properly be brought before the court.” *Port East Transfer*, 624 A.2d at 525. This is the law in Louisiana, Maryland, New Jersey and Pennsylvania. *Binnings Construction*, 288 So.2d 359; *Port East Transfer*, 624 A.2d 520; *Marty's Express*, 910 F. Supp. 221 (predicting Pennsylvania would follow *Port East*

Transfer); and *President Container*, 687 A.2d 760 (predicting New Jersey would adopt *Port East Transfer* and *Binnings Construction*).

But no matter what jurisdiction a policyholder is in, or who has the burden of proof, the insurance company *always* has the duty to act reasonably and in good faith in handling its policyholders' claims. A refusal or inability to satisfy its duty may expose the insurance company to liability for not acting in good faith toward its policyholder, which in some states can result in punitive damages against the insurance company.

Policyholder Red Flags

Whatever the law in its state, the policyholder must watch for inherent traps in RIP policies. There are seven claims-handling practices that should raise red flags for policyholders:

- **Investigation.** Policyholders must be attentive to how the insurance company investigates claims before it settles them. The insurance company has a duty to investigate thoroughly to ensure all claims are valid and worthy of the amount paid in settlement. Policyholders should watch out for high claims settlements paid by the insurance company even though the claims seem to be sketchy or frivolous.

Also, when defense costs are not included in the RIP, policyholders must keep an eye on whether the insurance company ever spends money defending a

claim. Nonexistent or unreasonably low defense costs are sure signs of problems with claims handling. An insurance company that is looking out for its own interests and not the policyholder's will always settle rather than fight a claim, because it is better off settling with the policyholder's money than it is fighting the claim with its own funds.

Inadequate investigation and half-hearted defense of claims are warning signs that an insurance company may be taking a policyholder for a ride.

- **Settlement.** Policyholders must beware of insurance companies that regularly settle claims at or close to the loss limitation or at or close the policy limit. If the policy has no loss limitation. Policyholders should closely track the insurance company's settlement patterns and regularly review loss reports, which the insurance company should furnish on a regular basis.

If an insurance company does not automatically provide loss reports, policyholders should ask for them. Remember—when an insurance company settles a claim within the loss limitation, the insurance company is better off settling at the high end of that limit (to the policyholder's detriment), rather than fighting the claim.

That's because the company avoids paying any defense costs that it would have borne. The insurer also avoids litigating a claim that could result in

an adverse judgement beyond the stop-loss that the insurance company must pay.

- **Claimants.** Policyholders should pay close attention to the claimants and the reserves set under the policy. When an unfamiliar claimant name appears on a loss run, policyholders should check into the claim to ensure its is valid by asking the insurance company for supporting documentation of the claim.

Another red flag regarding improper claims handling is above-average reserves on particular types of claims. If this is the case, the insurance company may be intentionally setting your reserves high so that it can collect additional premiums (and the add-ons on those premiums). The best way to check reasonableness of reserves is to compare them with reserves set for similar claims made against other policyholders in the same industry.

This enables the policyholder to quickly determine whether the reserves set on the policy are acceptable, or whether it should be demanding that lower reserves be established by the insurance company.

- **Timing.** Policyholders should make sure their claims are investigated expeditiously and settled promptly. An inordinate delay in processing claims works for the benefit of the insurance company and to the detriment of the policyholder. If claims are languishing unresolved for years

while the insurance company has control of the reserves for that claim, the policyholder is not receiving the service it contracted for.

- **Allocation.** It is also important for policyholders to keep track of the manner in which claims are allocated. With multiyear losses, the insurance company has considerable discretion as to the policy to which it allocates the loss. Of course, claims *should* be assigned to whatever year would most benefit the policyholder.

Not surprisingly, however, insurance companies are likely to assign multiyear loss claims to a year in which the retrospective premium is still open. That way, the insurance company ensures a profit for itself on those claims, and the policyholder pays greater premium costs. The insurance company should not be left with complete freedom as to allocation—if it is, the policyholder could end up paying a lot more than it should.

- **Number of Occurrences.** Policyholders should monitor the way the insurance company applies the policy limits to the claims. For instance, group claims such as asbestos cases are often viewed by courts as a single occurrence, resulting in a single retrospective charge for the group of claims.

This is beneficial to the policyholder because either the per-occurrence stop-loss or the limit of the RIP policy is exhausted quickly. In either case, the policyholder's costs will be lower because a greater amount of indemnity is

actually paid out of the insurance company's pocket. Conversely, if the insurance classifies asbestos cases or other groups of claims as multiple occurrences, these claims will seldom, if ever, reach the per-occurrence loss limit.

Thus, the policyholder will be required to pay these multiple losses itself, and will be charged premiums and add-ons for these claims until the aggregate loss limit is reached. If the policy has no aggregate loss limit, the policyholder could end up paying *all* the losses, premiums and add-ons, without ever receiving a cent of the insurance coverage it bargained for.

- **Categorization.** Policyholders should scrutinize how claims are categorized. When the insurance company assigns a claim into an inappropriate category (for example, assigning a general liability claim as a workers' compensation claim), the policyholder pays. The policyholder must review the methodology used to categorize claims and should oversee the application of this methodology. Improper assignment of claims can keep the policyholder's losses in its primary coverage (and within the retro loss limit), preventing it from reaching its excess coverage.

RIP policies are complex and capable of being manipulated in many ways to the benefit of the insurance company and to the detriment of the policyholder. Anyone considering a RIP policy should question the insurance

company regarding the reserves set on the policy, the settlement of claims, methodology used for claims allocation, claims handling add-ons and the potential conflicts of interest that are inherent in these types of insurance policies.

When selecting an insurance company for an RIP policy, consider not only the insurance company's technical expertise, but its payment record and integrity as well. If a policyholder elects to purchase an RIP policy, the policyholder must stay on top of the numbers and the claimants, as well as the assignment and settlement of claims, to avoid falling into costly traps.

Remember, most courts hold insurance companies to a high level of good faith and fair dealing, partially because many courts treat the insurance company as acting as the policyholder's fiduciary. As a result, the insurance company owes a higher duty of care to the policyholder, especially where, as with RIP policies, the insurance company is controlling and spending the policyholder's money.

The fact that the insurance company is legally considered the policyholder's fiduciary is a powerful tool that can help the policyholder in any controversy that might arise. Although the right of policyholders to sue for bad faith can be a significant bargaining chip with insurance companies, the

insurance company needs to be reminded of its obligations to the policyholder on a regular basis.

Although the law is on the policyholder's side in many RIP disputes, policyholders must be aware of how their RIP policies are being administered, or they may never know that something is awry. By keeping abreast of the retrospective policy payments and reserves, policyholders will avoid problems later.

When another party is responsible for a policyholder's money, it makes sense to know how it is being spent. Otherwise, you are truly leaving the fox in charge of the chicken coop.