Ethics for Insurance Adjusters: Standing at the Intersection of *Malum in se* and *Malum Prohibitum*

I. Nature or Nurture?

A. The nature vs. nurture debate within the science of psychology is concerned with the extent to which certain aspects of behavior are a product of either inherited (i.e. genetic) or acquired (i.e. learned) characteristics.

B. "Am I ethical because I was born that way, because I was raised that way, or because I learned it at a seminar?"

C. I'm not a scientist. I don't know if anyone is born ethical or unethical.

D. So, the fair answer is that ethics for adjusters is a combination of the way you were raised and what you learn in classes, seminars, and work experience.

Thus, the offensive requirement that you be "trained" to be ethical every two years is not so offensive after all; it is just the requirement that you receive a fair dose of updated nurture on a regular basis.

II. Your job as an insurance adjuster involves a complicated mix of knowledge of the rules, compliance with the rules, and juggling conflicts of interests. In our minds, this is the essence of "ethics" in your profession so before we talk about the rules themselves we will look at the framework for ethical adjustment practices.

III. "Ethics" for insurance adjusters is the product of both *malum in se* and *malum prohibitum*.

A. "*Malum in se*" is a Latin phrase meaning "wrong or evil in itself." It refers to conduct which is offensive or inherently wrong by nature without regard to any rule, regulation or statute.

1. For example, we can all agree that murder and theft are wrong regardless of whether they are prohibited by law.

2. More specifically, we can all agree that lying to a claimant about the existence of an insurance policy is wrong – *malum in se* – even in the absence of a statute saying that it is "bad faith" to misrepresent "pertinent facts or insurance policy provisions relating to any coverages at issue..." LSA-R.S. 22:1973(B)(1).

B. "*Malum prohibitum*" is conduct that is not inherently wrong in a moral sense but is "wrong" because it is prohibited by rule, regulation or statute.

1. For example, we can agree that there is nothing inherently wrong with going 100 mph on an interstate highway but it is "wrong" in a legal sense because the speed limit is fixed by statute.

2. More specifically, we can all agree that there is nothing inherently wrong with not paying a settlement within thirty days after the agreement is reduced to writing but it is "wrong" in a legal sense because the legislature has declared by statute – *malum prohibitum* – that such conduct is "bad faith." LSA-R.S. 22:1973(B)(2).

C. Your parents taught you about *malum in se*. You learn about *malum prohibitum* in classes and seminars and through work experience.

D. The State of Louisiana and the Department of Insurance expect you to be proficient in both.

IV. Even you can be better trained than a Harvard lawyer.

A. A good example of the intersection of *malum in se* and *malum prohibitum* is expressed in Louisiana State Bar Association v. Thalheim, 504 So. 2d 822, (La. 1987)

B. In a nutshell, an attorney collected for a client a large sum of money on a worker's compensation claim. Rather than depositing the money into a separate trust account, he dropped it into his general operating account and used part of it to fund the ongoing construction of his office building.

C. When the Bar Association called upon him to explain his misconduct in comingling funds, he offered an interesting defense: "At the time respondent attended Harvard Law School, he claims to not have taken an ethics course as it was not a requirement for graduation from the law school."

D. The Supreme Court was unimpressed. "The fact that respondent did not take an ethics course in law school and was ignorant of the Disciplinary Rules does little to mitigate his conduct. Ignorance of the Disciplinary Rules which set forth the minimum level of conduct below which no lawyer may fall ... is no excuse."

E. So, aside from the fact that it is fun to talk about Harvard lawyers using a lack of ethics education as an excuse for being unethical, what does this case have to do with ethics for insurance adjusters? I think the point of the case is simple... there are some things

that are just plain wrong and the court will punish you (or your employer) whether you know the rules or not. As a licensed adjuster, you are expected to know what is *malum prohibitum* for your profession, particularly when that which is *malum prohibitum* is also *malum in se*.

F. And, although the legislature has tempered imposition of bad faith penalties with a requirement that the violation be "arbitrary, capricious, or without probable cause" ignorance of the rules will never be a valid defense and will always be arbitrary and capricious.

V. Managing the inherent conflict of interest of your job as an insurance adjuster

A. Knowing and following the rules is not all that is expected of you. You are also expected to maintain a delicate balance between your duties and responsibilities to your employer and your contractual, statutory and ethical duties to your insureds.

B. Everyone who draws a paycheck from your employer works for the company, right? Generally speaking, this includes general management people, sales and marketing people, underwriters, and claims people.

C. Aside from the obvious distinction in duties, what is the difference between the employment responsibilities of the people who work in claims and those who work in all other aspects of the business? What distinguishes you from everybody else in the company?

D. Simply stated, everybody else in the company owes undivided loyalty to the company.

E. Not so with claims – by law and by contract, claims people have divided loyalties. You have responsibilities of loyalty to your employer and to its shareholders but you also have duties and responsibilities to your insureds.

F. Sometimes your duties of loyalty to your employer come into conflict with your responsibilities to your insured. Sometimes the decisions that are best for your employer – things that will make your employer more profitable – are not the decisions that are best for your insured.

G. In those circumstances where the profitability of your employer conflicts with the best interest of the insured then, by law and by contract, you must act for the benefit of the insured and to the detriment of your employer.

H. What we have learned is that, in reality, acting in your insured's best interest is, in broad terms, an act of loyalty to your employer. That is, things that you do in the micro-

context of each claim actually serve the best interest of your employer when viewed in the macro-context. So, things that may seem adverse to your employer's interest are actually protective of that interest because those individual decisions, when correctly made, protect the company from catastrophic exposure and its shareholders from catastrophic loss.

I. Which leads me to our **Golden Rule of Insurance Defense**: When faced with choices you must always ask "but how does this help or hurt my insured?" If the action hurts your insured, then you must never do it even though failing to do it may hurt your employer. In other words, when given the choice you must always come down on the side of the insured even though it might benefit your employer to go a different direction.

J. Of course, these types of decisions are all tempered by the limitations on coverage so certainly you are not required to take actions that expand the coverage under the contract, but within the limitations of coverage, always favor the insured's best interest. At the end of the day, this will benefit not just the insured, but the company as well.

VI. So, where does this leave us?

A. You must not do those things that are inherently wrong or *malum in se*.

B. You must know what is required by (or prohibited by) rule, regulation or statute and is thus *malum prohibitum.*

C. You must comply with those rules, regulations, and statutes.

D. You must do all the above while juggling the divided and conflicting loyalties between your employer and your insured.

Statutory rules that govern the conduct of a licensed adjuster

I. Why are "bad faith" statutes relevant to the ethical execution of your duties as an insurance adjuster? Do statutory prohibitions related to the business of insurance create ethical obligations on the part of individual adjusters even when the statutes themselves are targeted at insurers rather than their individual employees?

A. As adjusters, you are in the business of insurance thus these rules apply to you personally, as well as to your employer. Rules of behavior, conduct and practice create ethical obligations on the part of the adjusters. But doesn't this create a potential for conflict between you and your employer? Your employer writes the checks. Your employer makes the final decisions. Your employer creates the guidelines under which claims are handled. How then, can you comply?

B. I would suggest that complying with the reasonable guidelines created by your employer satisfies your ethical obligation as a licensed adjuster when such guidelines deal with overall policy and procedure. For example, if you employer requires that all phone calls be returned within three business days then compliance with that requirement satisfies the obligation to "*acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies,*" even though you might personally believe that calls should be returned by the next business day. In other words, your employer's reasonable guidelines and policies and procedures on how claims are processed, managed and paid would, in my opinion, satisfy your ethical obligations for such ministerial functions even though you personally might hold a different opinion on compliance.

C. However, on matters of personal integrity and issues of practices directly prohibited by law, compliance with employer rules will never be sufficient to satisfy your ethical obligations as a licensed adjuster. For example, suppose your employer offers an incentive plan that will pay you personally one percent of every dollar you save off the policy limit in resolving claims. That employer policy or procedure does not exempt you from the statutory prohibition that "*No insurer shall ... contract to pay to any insurance adjuster or any person engaged in the business of adjusting losses, any portion of the amount saved to said insurer through the efforts of said adjuster or person engaged in adjusting losses...*"

II. **LSA-R.S. 22:1674 provides as follows**:

Standards of conduct

A. An adjuster shall not permit an unlicensed employee or representative of the adjuster to conduct business for which a license is required under this Part.

B. An adjuster shall not have a direct or indirect financial interest in any aspect of the claim, other than the salary, fee, or other consideration established with the insurer.

C. An adjuster shall not acquire any interest in salvage of property subject to the contract with the insurer.

D. An adjuster shall not solicit employment for, recommend or otherwise solicit engagement, directly or indirectly, for or on behalf of any attorney at law, contractor or subcontractor, in connection with any loss or damage with respect to which such adjuster is concerned or employed.

E. An adjuster shall not solicit or accept any compensation, direct or indirect, from, by, or on behalf of any contractor or subcontractor engaged by or on behalf of any insured by which such adjuster has been, is, or will be employed or compensated, directly or indirectly.

F. Adjusters shall also adhere to the following general requirements:

(1) An adjuster shall not undertake the adjustment of any claim if the adjuster is not competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the adjuster's current expertise;

(2) An adjuster shall not knowingly make any oral or written material misrepresentations or statements which are false or maliciously critical and intended to injure any person engaged in the business of insurance;

(3) No adjuster, while so licensed by the department, may represent or act as a public adjuster; and

(4) No adjuster shall materially misrepresent to an insured or other interested party the terms and coverage of an insurance contract with intent and for the purpose of effecting settlement of a claim for loss or damage or benefit under such contract on less favorable terms than those provided in and contemplated by the insurance contract.

III. **LSA-R.S. 22:1926 provides in part:**

Duties of companies and others

A. ***Any person, company, or other legal entity including but not limited to those engaged in the business of insurance, including producers and adjusters, that suspects that a fraudulent insurance act will be, is being, or has been committed shall, within sixty days of the receipt of such notice, send to the division of insurance fraud, on a form prescribed by the commissioner, the information requested and such additional information relative to the insurance act and the parties claiming loss or damages because of an occurrence or accident as the commissioner may require.*** *The division of insurance fraud shall review such reports and select such insurance acts as, in its judgment, may require further investigation. It shall then cause an independent examination of the facts surrounding such insurance act to be made to determine the extent, if any, to which fraud, deceit, or intentional misrepresentation of any kind exists in the submission of the insurance act.*

This statute is interesting because the duty to report is imposed not just on companies but upon licensed adjusters. It also suggests that direct reporting is expected although, in my experience, insurer's normally have a conduit by which the matter is sent up the chain by SIU or some other designated employee.

IV. **LSA – R.S. 22:1675 provides in part:**

Payments to adjusters limited; reciprocal fee; disposition of funds

A. No insurer shall pay to any insurance adjuster or adjusters or to any person engaged in the adjustment of losses any fee or compensation in excess of a regular fixed salary or stipend, nor shall such insurer contract to pay to any insurance adjuster or any person engaged in the business of adjusting losses, any portion of the amount saved to said insurer through the efforts of said adjuster or person engaged in adjusting losses, in addition to or in lieu of any such salary or stipend.

V. **LSA – R.S. 22:1928 provides in part:**

Civil immunity

A. *No insurer, employees, or agents of any insurer, or any other person* ***acting without malice, fraudulent intent, or bad faith,*** *shall be subject to civil liability for libel, slander, or any other relevant tort, and no civil cause of action of any nature shall exist against such person or entity by virtue of the filing of reports or furnishing other information, either orally or in writing, concerning suspected, anticipated, or completed fraudulent insurance acts when such reports or information are required by this Part or required by the division of insurance fraud as a result of the authority herein granted or when such reports or information are provided to or received from:*

(1) Law enforcement officials, their agents, and employees.

(2) The National Association of Insurance Commissioners, the state Department of Insurance, a federal or state agency or bureau established to detect and prevent fraudulent insurance acts, as well as any other organization established for the same purpose, their agents, employees, or designees.

(3) A person involved in the prevention and detection of fraudulent insurance acts or that person's employees, agents, or representatives.

This statute is the protection for those reporting suspicion of fraud under R.S. 22:1926. The key requirements are two-fold: 1) good faith or absence of malice, and 2) proper reporting procedure. We were involved in litigation where one of the major factors that protected the company from exposure was that they followed to the letter the reporting procedure required by the DOI. That is, the claims material was passed through proper channels from the company's designated contact to NICB and then from NICB to the State Police. Those procedures may have now changed and are beyond the scope of this presentation but the important thing to remember is strict adherence to reporting procedures.

VI. **LSA – R.S. 22:1964 provides in part:**

Methods, acts, and practices which are defined as unfair or deceptive

The following are declared to be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(5) False financial statements and false entries.

(b) Knowingly making any false entry of a material fact in any book, report, or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer, or

knowingly making any false material statement to any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to which such insurer is required by law to report, or which has authority by law to examine into its condition or into any of its affairs.

(13) Fraudulent insurance act. *A fraudulent insurance act is one committed by a person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, producer, or any agent thereof, any written statement as part of, or in support of, or in opposition to an application for the issuance of, or the rating of an insurance policy for commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which he knows to contain materially false information concerning any fact material thereto; or conceal for the purpose of misleading information concerning any fact material thereto.*

(14) Unfair claims settlement practices. *Committing or performing with such frequency as to indicate a general business practice any of the following:*

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.

(b) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(d) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

(e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

(f) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(g) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds.

(h) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(i) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured.

(j) Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made.

(k) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(l) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(m) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(n) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.
(o) Failing to provide forms necessary to present claims within fifteen calendar days of a request with reasonable explanations regarding their use, if the insurer maintains the forms for that purpose.

VII. **LSA – R.S. 22:1896 provides in part:**

Right to transparency and integrity in adjustment of property claims

A. An insurer of a residential or commercial property shall respond to all inquiries or requests from the insured within fourteen days of the inquiry or request, unless such time period to respond has been extended by the commissioner of insurance because of a disaster or emergency declared in accordance with R.S. 29:721 et seq.

B. An insurer of a residential or commercial property shall provide prompt adjustment by a qualified adjuster pursuant to the provisions of R.S. 22:1661 et seq., the Louisiana Claims Adjuster Act.

VIII. **LSA – R.S. 22:1895 provides:**

No payment of a claim on a homeowner's insurance policy shall be considered a final settlement if the insurer fails to provide the insured with a statement that accurately reflects the amount paid under each category of coverage under the policy. The statement shall list each provision of coverage in the policy under which the insured may be entitled to payment, the maximum amount that may be paid under each category of coverage, and the amount actually included for payment under each category of coverage. The statement shall be given to the insured prior to the execution of a release by the insured.

IX. **Ethical Considerations in maintaining claim notes, records or files:**

When you are adjusting a claim, you are balancing competing interests. In a first-party claim you are obligated to treat your insured fairly within the coverage limitations of the policy. In a third-party claim you are obligated to protect the insured against any personal liability that might result from the claim. In both circumstances, you are working outside of the insured's presence, gathering documents, evidence and information that is important to managing the insured's affairs. It is suggested that the insured's interest in the investigation creates an ethical obligation for the adjuster to maintain complete, professional records of the investigation and adjustment.

A. A deliberate failure to document information is certainly problematic. When you screen the record of what you learn from the investigation it presents a false picture and that is not compliant with your obligation to adjust the claim in good faith.

B. You owe a duty to your insured to keep them informed of the status of the claim. Always keep your insured advised of settlement offers. Your claim notes should document the steps taken to inform the insured of the ongoing status of the claim. If you have not advised

the insured of settlement offers, and the insured gets an excess judgment, the insurer will most likely owe it.

C. Claim notes are not your personal diary. Do not put snide comments or personal criticism of the attorney, your insured, the plaintiff, or anybody else in these notes.

D. Claim notes should reflect objectivity and freedom from personal bias. There should be no negative reference to race, religion, national origin, sexual orientation or any other non-relevant characteristic of any person.

E. In a Bad Faith case your claim notes are your best defense. They prove what you did. They show all the steps you took to initiate loss adjustment and all that you did to protect your insured. They document the things you did not have to satisfy the proof of loss. They are your record of compliance with the ethical obligations of your profession.

X. **Your ethical obligation to make an "informed decision":**

We all know that you have an obligation to the insurer and the insured to adjust claims competently. A competent adjustment means a complete investigation.

A. Don't judge too quickly as a premature denial may be bad faith. Moreover, your ethical obligation to your insured must include a duty to make a complete investigation before making a decision.

B. Each liability issue and each damage/causation issue stands on its own merit and you must keep an open mind until all facts are gathered. For example, you might see a claim where there is little or no property damage and you suspect, as we all naturally would, that there was not a sufficient transfer of force to the vehicle occupants to cause injury. But the inquiry does not end there. You need to know the details of this specific claim and this specific claimant. Suppose this specific claimant had back surgery a week before the accident. If you have denied the claim with no medical records and no reasonable inquiry into the facts then you might expose your insured to an excess judgment which in turn exposes the company to a bad faith claim. Moreover, that premature denial doesn't satisfy your responsibility to make a competent adjustment of the loss.

C. The duty to investigate and make an informed decision is even greater in First Party claims so, once again, maintain an open mind and don't take hard positions, particularly one of denial, until you have made a thorough inquiry.

D. Initiation of Loss Adjustment and the premature denial: Remember, La. R.S. 22:1892 (A)(3) requires that you initiate loss adjustment within 14 days of receiving notice of loss. The courts will generally require that this be a legitimate and meaningful loss adjustment. If

you start the process with a premature denial then the court may conclude that there was no actual loss adjustment.

E. Company policies and "arbitrary and capricious" decisions: As a matter of practice we discourage the use of arbitrary rules that regulate the payment of claims, and I certainly discourage the reference to broad company policies in the denial of a claim. In other words, when a claim is denied based upon a uniform company policy or procedure then it is, by definition, arbitrary. But when a claim is denied based upon the facts of the individual claim, then it is not arbitrary, even though that denial ultimately comports with general company policies and procedures.

XI. **Thoughts borrowed from the National Association of Independent Insurance Adjusters:**

NATIONAL ASSOCIATION OF INDEPENDENT INSURANCE ADJUSTERS

CODE OF ETHICS

1. To serve the business of insurance with loyalty and cooperate with insurers and their loss and claim executives and representatives in the proper handling of claims and losses.

2. To conduct ourselves so as to command respect and confidence.

3. To promote, by an unvarying attitude of fairness, by competence, by integrity, and by a proper respect for the persons with whom we have dealings, good will toward the business of insurance.

4. To approach investigations and adjustments with an unprejudiced and open mind.

5. To make truthful and unbiased reports of facts as we find them.

6. To resist influences tending to produce improper and extravagant settlements and serve our clients fearlessly.

7. To avoid improper alliances.

8. To work for economy in expense and render equitable bills.

9. To refrain from improper solicitation.

10. To render the highest quality of service.

11. To work in harmony with one another and with our clients so as to foster cordial relationships among ourselves and with the insurance fraternity.

12. To refrain from dealing directly with any claimant known to be represented by an attorney without the attorney's knowledge and in all ways abide by the principles as stated in the Conference Report on Fair Insurance Claims Adjustment as adopted by the National Conference of Lawyers, Insurance Companies and Adjusters.