Becoming a Sommelier of Insurance Claims:
Resolving Complex Cases in Challenging Times

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Introduction

The insurance claim process is a separate, symbiotic relationship between an insured and an insurer that often is the key to successfully resolving complex litigation claims. Like many legal relationships, the insured-insurer relationship has been impacted by outside factors, including plaintiff demands, social inflation and even artificial intelligence, to name a few. This article briefly explores best practices in successfully navigating the claim process in the context of these challenges posed by our ever-changing and more complex world.

Notice

A fundamental component of insurance policies remains the requirement that the insured provide notice to the insurer—within a specified time period, as soon as practicable, or something similar—in the event of a claim or occurrence, or when faced with a lawsuit or even a potential claim.

To be sure, these requirements protect insurer's interests by providing an opportunity to investigate the underlying facts and effectively participate in the defense of a lawsuit as early as possible, which may result in a more favorable resolution. But the notice requirement also benefits the insured by facilitating a smoother claims process and enabling the policyholder to focus on defending the source of the claim itself. The one thing more unnerving than being a party to high-stakes litigation is to find out your insurer is not covering the costs of litigation because it was not timely notified. Take, for example, the recent case of Harvard University, which was stuck with a $15 million legal bill in defending against attacks to its admissions policies because it waited too long to provide formal notice to its excess insurer—despite the highly publicized nature of the underlying lawsuit.[2]

As with other aspects of the law, whether an insurer can properly deny a claim based on late notice depends on the jurisdiction and policy language. In many jurisdictions, courts have concluded that an insured should not be denied coverage solely because notice was untimely, so

[1] We would like to thank Jeremy Krahn, Esq. of Maslon LLP for his substantial contributions to the preparation of this article.

[2] Nate Raymond, *Harvard Cannot Recoup $15 M From Insurer For Race Case Costs, Court Rules*, REUTERS (Aug. 9, 2023), https://www.reuters.com/legal/harvard-cannot-recoup-15-mln-insurer-race-case-costs-court-rules-2023-08-09/; *see also President and Fellows of Harvard Coll. v. Zurich Am. Ins. Co.*, --- F.4th ---, 2023 WL 5089317 (1st Cir. Aug. 9, 2023).

long as the insurer was not prejudiced by the delay.[3] Other states strictly construe notice requirements and, for certain types of policies, permit the denial of coverage regardless of prejudice.[4] One can imagine a situation where untimely notice could prejudice an insurer, such as losing the opportunity to interview witnesses while memories are fresh, raise a viable affirmative defense, or negotiate a less expensive settlement.

But regardless of the jurisdiction, the dangers of untimely notice are a trap for the unwary. As the Harvard example demonstrates, even sophisticated parties can fall into the untimely notice trap; and when they do, costly litigation frequently follows. To avoid these satellite disputes, parties should consider these best practices:

- Review and periodically revisit the policy. Sounds simple, but memories fade. Better to know the terms of the policy before they are needed.
- Draft policy language with solid deadlines. A specific time period to provide notice to the insurer is clearer than "as soon as practicable" and the like and should, therefore, leave less to be disputed should a conflict arise.
- Have an internal system in place to automatically put insurers on notice.
- Communicate in writing and document everything, including an acknowledgement that notice has been received.
- Provide notice as early as possible—perhaps even pre-claim—and err on the side of providing notice for any and all potential claims. Be proactive and over notify insurers to avoid costly litigation over coverage issues. Some policies also provide for coverage for pre-claims in order to mitigate the risk of the pre-claim facts turning into an actual claim.
- When in doubt, call or e-mail your broker and ask about which carriers to give notice to and deadline for notice.

Use of Hammer Clauses

Policyholders and insurers often have different interests in mind when considering whether to settle a claim, and for how much. For example, an insurer's primary concern may be in minimizing costs and liabilities, while the policyholder may be more interested in protecting its reputation and assets or dissuading copycat lawsuits. These differing priorities can cause tension when it comes to settling a claim.

To address these differing interests, insurance policies often include a "hammer clause," which vary depending on the precise language but operate to drive a wedge and force settlement or otherwise limit further exposure to the insurer. In one policy, a hammer clause might require the insurer's consent before settling a claim. In another, the insured who goes against the insurer's

[3] *See, e.g.*, *Gen. Star Indem., Co. v. Guthrie*, No. 19-cv-314-JWB, 2022 WL 4088066 (E.D. Okla. Sept. 2, 2022) (applying Oklahoma law); *PetroSantander (USA), Inc. v. HDI Global Ins. Co.*, 308 F. Supp. 3d 1207 (D. Kan. 2018) (applying Texas law).

[4] *See, e.g.*, *Georgian Am. Alloys, Inc. v. AXIS Ins. Co.*, No. 21-1947, 2022 WL 3971584 (3d Cir. Aug. 31, 2022) (applying Delaware law to claims-made policy); *EurAuPair Int'l, Inc. v. Specialty Ins. Co.*, 787 Fed. App'x 469 (9th Cir. 2019) (applying California law to claims-made-and-reported policy).

settlement recommendation may be on the hook for any damages and costs above what the insurer recommended. Another policy may take a softer approach and allow the insurer and insured to share the costs incurred after the insurer would have settled the claim. The rationale for these types of clauses is that an insurer should not be obligated to defend a claim for an insured that wants to continue litigating when it is unreasonable to do so.

Whether these clauses are drafted on the harder or softer side, there exists a potential for conflict should the insurer decide to "bring down the hammer." If and when this happens, it is vital for the insured and insurer to maintain open and honest communication from the preliminary stages of the claim (or, if possible, before pre-claim) and to share relevant information. If the parties are able to discuss their expectations, concerns, and the claim's strength and weaknesses at the start, it follows that they will be more likely to reach a consensus on an agreeable settlement amount later in the process. If these discussions are left until the eve of mediation, there is bound to be ill-will and the chances of resolution shrink.

Timed Policy-Limit Demands and Bad-Faith Exposure

It is common for plaintiffs to make a settlement demand for the coverage limit set forth in the defendant's insurance policy and to put a time-limit on acceptance. These demands create risk for both insurer and insureds. The demands may also create a duty to settle, under certain circumstances, especially where the demand is "reasonable." This type of offer can be a source of intense tension between the insurer's desire to limit the settlement value and avoid bad faith exposure above the coverage limit and the insured's desire to settle for an amount within its policy limits, be done with the lawsuit and not be exposed to an excess judgment. Where the demand is accompanied by a time limit to accept or reject, plaintiffs are looking to force settlement or expose the carrier above policy limits. Faced with this type of demand, an insurer must walk the tightrope between paying too much and alternatively exposing itself beyond its policy limits. For instance, large damages cases with marginal liability facts can create quite a dilemma with a check-all-the-box policy limits demand with a reasonable, but tight, time horizon. Insurers have to take care to ensure their response does not later expose them to allegations of bad faith and exposure above policy limits.

In general, bad-faith exposure may arise when a plaintiff makes a reasonable demand to settle the claim within policy limits, yet the insurer unreasonably rejects, delays, or fails to investigate the demand. Under those circumstances, if the plaintiff ends up prevailing in an amount exceeding the policy limit, the insured may then either assert, or assign to the plaintiff, a bad-faith claim against the insurer. To avoid this, insurers need lawyers who can evaluate claims timely, give insurers a reasonable basis for responding within the time limits and help maintain lines of communication with insureds and their representatives. Investigations into the claim should be done fairly and documented thoroughly.

The insurer is likely to bring in its lawyers to assist in preparing an early case assessment, particularly where the facts of the case are complex or where there is a potential for a high-damages award. And when there is a time limit associated with the demand, the insured and insurer may often try to seek an extension in order to conduct a fulsome investigation. When does the demand create a duty to act by the insurer? Consider the following:

- Is it a case of liability?
- How clear is liability?
- Can damages exceed the policy limits?
- How much higher than policy limits can damages reasonably go?
- Is a complete release offered in exchange for limits?
- Is a "reasonable amount of time" offered to evaluate?
- What does insured say?

Big damages cases and policy limits demands require careful timely attention and transparent communication between insurer, attorney, insured and the other side.

Preparing for Mediation

It is no secret that alternative dispute resolution has become a ubiquitous component of modern civil litigation. Indeed, the most recent federal court statistics reveal that only 0.8% of civil cases filed in federal court are resolved by trial.[5] The decline of trials corresponds closely with the rise of mediation, with some sources reporting that 85% of commercial matters and 95% of personal injury matters end in settlement after mediating.[6] In other words, mediation is a crucial step in resolving most cases.

Given its significant role in many civil lawsuits, it is imperative that the insured and its counsel be informed and prepared before entering mediation. And when an insurer is covering the claim and being asked to fund the settlement, the insurer must also be informed and prepared well in advance of the mediation date. The latter is often easier said than done, and is a common friction point between insurers and insureds. Among policyholders and even their counsel, it is underappreciated the different layers that are required to obtain settlement authority from an insurer, and the amount time that takes. Even when the insured is dutifully updating the insurer with important case developments, it takes more time than one might think to digest those developments and the evidence, assess the insurer's exposure, and escalate up the chain of command. If these steps are not taken far enough in advance (particularly for more complex cases), the insurer may not be in a position to consider settlement, leaving the mediation itself an exercise in futility. Policyholders and insurers must plan accordingly to avoid this result.

Providing relevant information to the insurer at the front end has the added benefit of ensuring there is an appropriate reserve for the claim. When a new claim comes in, an adjuster will set a "reserve" of funds based on an estimate of the amount of money it will take to resolve the claim. The adjuster's estimate might be informed by looking at the complaint and any information

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[5] *Table C-4—U.S. District Courts—Civil Federal Judicial Caseload Statistics (March 31, 2022)*, ADMIN. OFFICE OF THE U.S. COURTS, https://www.uscourts.gov/statistics/table/c-4/federal-judicial-caseload-statistics/2022/03/31 (select "Download Data Table").

[6] AM. ARBITRATION ASS'N, *A Guide to AAA Disaster Recovery Claims Mediation Procedures* at 1, https://www.adr.org/sites/default/files/document_repository/A-Guide-to-AAA-Disaster-Recovery-Claims-Mediation.pdf.

available at the time the claim is made. For example, in a personal injury case, the reserve amount may depend on the venue, the age of the parties, pre-existing conditions, medical records and expenses, specific diagnoses, future earning potential, and lost earnings, among other things. But the amount of the reserve may change based on current information. New information should, therefore, be shared with the insurer as early as possible so that the reserve remains accurate heading into mediation.

Impact of "Social Inflation"

So-called "social inflation," is the concept that juries are awarding—and insurers are paying—"nuclear verdicts" that are much higher than economic inflation.[7] Legal commentators have generally attributed this phenomenon to three main drivers.

First, the "varying demographic makeup of jury pools, an increasing public distrust of large corporations, and the influences of social media" all have an impact, with corporate parties often playing the role of villain in the eyes of the public.[8] The "greedy corporation" narrative clearly resonates with juries, as evidenced by a recent Pew Research survey where 71% of respondents stated that corporations negatively affect the country's trajectory.[9] Second, third-party litigation funding is now widespread—in cases big and small—and has an outsized effect on social inflation.[10] Because this type of arrangement requires the litigating party to pay the third-party funder a portion of any award, parties are often unwilling to settle for an amount that puts little money in their pocket after repaying the funder.[11] This, in turn, leads to a more difficult settlement process and higher payouts. Third, the plaintiff's bar is increasingly engaging in aggressive psychological tactics that influence juries based on emotions and bias.[12]

Whatever the root cause, this phenomenon is difficult to quantify and results in unpredictable jury awards, which also makes it difficult to evaluate an insurance claim. In the era of social inflation, it may be prudent for insurers to invest in advance analytics platforms that can mine historical data to identify trends and patterns in claims, which can help insurers predict exposure in future claims more accurately. In addition, the value of skilled claims adjusters and

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[7] *Cooling Social Inflation Means Defusing Nuclear Verdicts, Taming Reptilian Tactics*, ZURICH INS. GRP., https://www.zurich.com/en/commercial-insurance/sustainability-and-insights/commercial-insurance-risk-insights/cooling-social-inflation-means-defusing-nuclear-verdicts-taming-reptilian-tactics.

[8] *Social Inflation*, NAT'L ASS'NS OF INS. COMM'RS, https://content.naic.org/cipr-topics/social-inflation.

[9] Joseph P. Moriarty, *Social Inflation: Fighting Back Against the Rise in Nuclear Verdicts*, DRI (Jan. 17, 2023), https://www.dri.org/publications/featured-article/2023/social-inflation#:~:text=Social%20inflation%20is%20typically%20blamed,%3B%20and%20(3)%20plaintiffs'.

[10] *Id.*

[11] *Id.*

[12] *Id.*

legal experts cannot be overstated, as their expertise is necessary to understand the nuances of the modern evaluation process. Finally, insurers should abreast of the latest trends and remain agile in their approach by regularly reviewing and updating their claims handling procedures to reflect the quickly evolving landscape.

The Role of AI in Insurance Claim Handling

A single article or breakout session cannot cover all of the issues facing insurers and policyholders in the modern era. But any discussion would be incomplete without at least briefly touching on the role of artificial intelligence ("AI") in the handling of insurance claims.

In case you have not heard, AI is here, and has been used in the legal industry for some time.[13] The insurance industry, already familiar with the use of data and algorithms, is particularly well suited to adapt to the significant changes brought on by AI.[14] "The insurance business model itself is predicated on the use of mathematical and statistical methods to process personal and non-personal data to underwrite risks and price insurance policies, to quantify losses, to pay customers' claims, and to identify and prevent insurance fraud."[15] Insureds, insurers, and their counsel are positioned to harness the advantages of AI in a variety of ways.

First, AI can expedite the handling of claims and identify relevant facts, which could in turn lead to faster settlements thereby reducing costs and legal fees. For example, certain tools can automatically read, interpret, and process documents and images (e.g., extracting information from medical records and evaluating damage).[16] Second, it can "aid in detecting and preventing fraud by analyzing data patterns and identifying suspicious activity, which can help insurers save money by reducing the number of fraudulent claims they pay out."[17] Third, it "can help insurers evaluate risk more accurately by analyzing large amounts of data such as historical claims data, credit scores and social media activity—thereby enabling insurers to offer personalized coverage to customers and price policies more accurately."[18]

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[13] DELOITTE, *The Legal Department of the Future* at 3 (2017), https://www2.deloitte.com/content/dam/Deloitte/us/Documents/finance/us-advisory-legal-department-of-the-future.pdf; Karen Turner, *Meet 'Ross,' The Newly Hired Legal Robot*, THE WASHINGTON POST (May 16, 2016), https://www.washingtonpost.com/news/innovations/wp/2016/05/16/meet-ross-the-newly-hired-legal-robot/ (reporting on the "hiring" of a robot lawyer to assist with bankruptcy cases).

[14] Winston Yong, *Is Artificial Intelligence Relevant to Insurance*, IBM (May 1, 2023), https://www.ibm.com/blog/is-artificial-intelligence-relevant-to-insurance/.

[15] *Id.*

[16] *Id.*

[17] Manish Gupta, *Harness the Power of AI in the Insurance Sector*, FORBES (Apr. 17, 2023), https://www.forbes.com/sites/forbestechcouncil/2023/04/17/harnessing-the-power-of-ai-in-the-insurance-sector/?sh=3ebf7aeb335d.

[18] *Id.*

AI is already being used in the insurance industry and appears here to stay for the foreseeable future. While the exact role it will ultimately play is still yet to be determined, it should not be ignored, and those involved with insurance claims would be served in embracing its advantages.

Conclusion

This article only briefly explored some of the key issues that are critical to successfully managing the insured-insurer relationship during the claim process. However, there are key takeaways that both insureds and insurers should take note of. From the insured's perspective, it remains critical to provide timely notice of claims, understand how policy terms impact responses to settlement demands, and cooperate with the insurer to evaluate claims and prepare for mediations. From the insurer's perspective, the impact of social inflation has made it even more important to ensure that claims are properly analyzed during the claim process and settlement demands are responded to in a timely manner. Insurers must also harness technological advances, including AI, to make the claim process more efficient and enhance its evaluation of an insured's exposure to the claim.