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Effective Claims Management Involving Multiple Decision-Makers

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INTRODUCTION

Most catastrophic claims have multiple levels of management in addition to traditional claims management internal to the carrier. An example would be a large manufacturer, which may have an in-house general counsel, a Third Party Administrator and/or a risk manager all charged with evaluating and protecting the company from liability to third parties. And each member of the team approaches the task with certain goals beyond simply getting the claim or case settled. Ramifications from the terms and timing of a settlement involve the GC and/or RM's concerns about protecting the company's reputation within its industry and certainly with its customers. Companies with a large SIR or a captive carrier, have even more control over the claims, at least until it involves the primary and/or independent carrier's money. There have even been cases where the "primary" carrier claims that it is effectively a second level due to the size and control of the company's SIR. The Third Party Administrators (TPAs) may have split ethical duties as between the carrier and the claimant and though bound to their duties by contract to a carrier, may have similar duties to the insured. The number of parties with some responsibility is a mine field, ready to go off as the claimant's counsel works the system. The left hand not knowing what the right is doing; the inevitable duplication of work or worse, tasks being left undone because one part of the team assumes someone else has done it; and finally, conflicts arising out of a lack of consensus as to settlement amounts and tactics are all recurring problems.

Each party to the defense side of the claims process has a role in assessing the claim, recommending and setting reserves and arriving at a value. But as the old saying goes, "too many cooks spoil the broth" and there has to be a hierarchy and predetermined responsibilities. Each involved party should be keenly aware of their role, and those roles need to be determined before the claims arrive.

I. SIX KEY AREAS OF POTENTIAL CONFLICT:

There are innumerable areas where the competing, ethical, business or other duties arise as between the insured's GC and/or risk manager; outside TPAs and "in-house" claims people. By

their very nature, catastrophic claims are complex, with many moving parts. But there are certain areas of the claims process that bring about conflict more than others:

A. What's the Plan?

Sometimes, the claim or even the case comes in and right from the start, there are issues over who is managing it. And what does that management entail? Who has primary responsibility of the overall strategy? Who will manage the investigations? Who will choose and manage outside counsel?

All of these issues should be decided well in advance of the specific issue arising. Is there a Relationship Manual that defines the responsibilities? Or is it defined solely by interpretation of the policy and any contractual arrangements? Defining who does what and when before the claim hits, is at the heart of avoiding conflicts

B. Who Sets Reserves?

While the carriers ultimately control the purse strings, that purse may also contain a considerable amount of money from the insured through the SIR or captive program. And, carriers can't be expected to set reserves in a vacuum. That vacuum can be filled by the TPA and/or the outside counsel and risk manager, in addition to the carrier's claims department. The fact investigation, legal precedents and analysis of the potential settlement range can come from multiple sources. But in the event the data presented is in conflict, what controls to effect a decision?

C. Working with the company General Counsel.

Regardless of being in or outside the corporate walls, counsel has ethical duties and responsibilities to maintain the confidences of his or her client and to put the client's interests first. For instance, if there was evidence of pre-existing conditions on property the company owns that could affect an ambiguity under the policy, in-house counsel may be bound by the attorney-client privilege from disclosing such facts, even where it could significantly affect the exposure to the carrier in subsequent litigation. Outside counsel may have the same fiduciary duty to the insured as to the true client but inside counsel has no such accepted conflicts. Moreover, there are Bar Association ethical rules that specifically define the relationship between outside counsel, the insured, and insurer. But, a TPA, not being an attorney, may be able to disclose some of those facts gathered during the normal course of its work that an in-house counsel may make a general counsel feel uncomfortable. This is especially true when an insured company has received a reservation of rights.

D. The Claims Manual.

In an ideal world, companies would provide their claims manual to the TPA, in- house counsel for the insured and any internal risk managers so that everyone involved could understand the procedures the insurer expects to be followed in handling a claim. But disclosing the claims manual or even parts of it is impractical in many instances, mainly due to the threat of a waiver of confidentiality in litigation or possibly inadvertent disclosure. Another concern is where the insured company could be at odds with the carrier over coverage. While disclosure within the "defense sphere of influence" including TPAs are supposed to carry with them the attorney-client and/or claims privilege, in the real world there are myriad ways the company's "bible" can get to the wrong people. So how to the people involved in claims know one another's expectations?

E. Who Controls the Settlement?

The big issue in any claim is usually who will pay and how much? It is disconcerting to have someone else spend your money even with your permission and this is at the heart of many of the disputes between insurers and among TPAs, Risk Managers, and corporate counsel. An effective claim settlement process should be designed that provides both the who and the when at the outset. Having a defined claim settlement process allows a policyholder to accept the settlement of a case that might not be resolved due to factors other than monetary value. Similarly, while the insurer cannot arbitrarily withhold its consent to a settlement of a claim within the insured's SIR or captive policy limits, it may have concerns over factors such as the timing and structure of the settlement.

F. Legal Standards of Good Faith required of All Participants

The insurer owes its policyholder a duty to act in good faith, which requires the insurer to agree to a settlement where (i) the policyholder receives a reasonable settlement demand or is able to negotiate a reasonable settlement subject to its insurer's approval; and (ii) the settlement amount is within the limits of the insurer's policy. The insurer's duty to settle arises out of the covenant of good faith and fair dealing that exists in all contracts. *See, e.g., Communale v. Traders & General Ins. Co.,* 328 P.2d 198, 201 (Cal. 1958) ("[T]he implied obligation of good faith and fair dealing requires the insurer to settle in an appropriate case although the express terms of the policy do not impose such a duty."); *Harris v. Standard Acci. & Ins. Co*., 191 F. Supp. 538, 540 (S.D.N.Y. 1961) ("[T]he law imposes upon the insurer the obligation of good faith—basically, the duty to consider, in good faith, the insured's interests as well as its own when making decisions as to settlement.")

This requirement runs to the TPA and outside adjusters. But what happens if the actions of the insured affect the ability of the insurer to act in a manner consistent with the above duty. How about where the insured refuses to turn over material it considers confidential, but the insurer does not share that view and believe it is obligated by the prevailing insurance code to disclose it. Who decides before letters denying coverage are issued or motions for sanctions are filed?

II. LIMITATIONS AND EXTENT OF DUTIES OF THE TPA

Third party claims administrators, are increasingly handling claims for both the external insurance company and the corporate insured. Generally the extent and duty of a TPA is determined by contract with one or the other. The primary duty of the TPA is one of Fiduciary Responsibility. But to whom? The answer is much easier where the TPA has no contractual or other relationship with the insured. But in more and more cases the insured selects the TPA due to management issues with its SIR or captive. Who then does the TPA answers to where there is a conflict? The insurer wants the TPA to get the claim settled within the SIR. The insured does not believe the claim is valid and/or believes it will set off a torrent of litigation against the company. Who makes the decision? Essentially, a Standard Insured Retainage policy is "excess" of coverage, but not in the traditional sense. In *Vulcan Corp. v. Superior Court*, 185 Cal.App.4th 677 (2010), the California Court of Appeals held that primary insurers on policies with a SIR must still provide an "immediate, 'first dollar' defense" (subject, of course, to their right to later recover the SIR amount from the insured) unless the policy expressly imposes exhaustion of the SIR as a precondition to the duty to defend. Does the TPA know this? The GC might and the resulting conflict of "no you pay it" avoided if who pays who first is established at the outset.

There are certain rules that help define the relationships:

A. An Insured cannot completely transfer the duty of good faith to a TPA.

The duty to act in good faith is non-delegable and an insurer or self-insured cannot escape liability for bad faith by delegating its responsibility to attorneys, third-party administrators, or other agents. *Scott Wetzel Servs., Inc. v. Johnson*, 821 P.2d 804, 813 (Colo. 1991) (en banc); *Majorowicz v. Allied Mutual Ins. Co.,* 569 N.W.2d 472 (Wis. Ct. App. 1977). Under some state law, the carrier is on the hook for most everyone down the chain. Certain jurisdictions hold adjusters and TPAs independently accountable for wrongful conduct without reference to the carrier's actions and certain states do not. The relationship between adjuster and insured is sufficiently attenuated by the insurer's control over the adjuster to be an important factor that militates against imposing a further duty on the adjuster to the insured. *Meineke Bus. Servs., Inc., v. GAB Business Services, Inc.*, 195 Ariz. 564, 567 (Ariz. Ct. App. 1999). It is the general rule that an insured may bring claims for breach of contract and bad

faith against the insurer who issued the policy but not against related parties, such as reinsurers and third-party administrators, who are not in privity with the insured. *TPA. Brand v. AXA Equitable Life Ins. Co* 2008 U.S. Dist. LEXIS 69661 (E.D. Penn. 2008). The duty to act fairly and to reasonably investigate a claim can override a lack of contractual privity. *Brand v. AXA Equitable Life Ins. Co.*, 2008 WL 4279863, at *2 (E.D. Pa. Sept. 16, 2008) (citing *Reid v. Ruffin,* 503 Pa. 458, 469 (Pa.1983))

1. For example, in *Morvay v. Hanover Insurance Companies,* the insureds owned property that was damaged by fire, for which they were insured. Hanover, the insurer, hired Verity Research Limited to investigate the fire. Verity concluded that the fire was of an incendiary nature. On that basis, Hanover denied the claim. The insureds sued Hanover and Verity and its investigator under the policy. The insured alleged that Verity negligently conducted the investigation. The trial court dismissed the claim against Verity. The Supreme Court of New Hampshire reversed, finding that while Verity and the investigator were not in privity with the insureds, they owed the insureds a duty to conduct a fair and reasonable investigation of the claim. 127 N.H. 723 (N.H. 1986).

2. In contrast in *Continental Ins. Co. v. Bayless and Roberts, Inc.*, Continental refused a settlement demand recommended by independent counsel defending the insured. Continental and Stanford, the branch manager of Underwriters Adjusting Company, an outside adjuster functioning as Continental's claims department, were sued for breach of fiduciary duty. Stanford allegedly failed to adequately investigate the claim and to inform previous panel counsel when the insured's principal testified differently at deposition than in a prior affidavit. The court held Stanford could not be held liable for breach of fiduciary duty arising out of the insurance contract, but could be held liable for negligence arising out of a breach of the general tort duty of ordinary care. 608 P.2d 281 (Alaska 1980).

3. In *Nat'l Plan Adm'rs, Inc. v. Nat'l Health Ins. Co*, a TPA revealed the underwriter's confidential policy information to another carrier and then moved the underwriter's active-at-work book of business to that carrier. While the lower court determined that a presumption of unfairness applied and that the alleged breaches arose from the administrator's duties of loyalty, fidelity, and honesty, the Supreme Court did not agree and instead determined that the Insurance Code did not create a general fiduciary duty applicable to third-party administrators. 235 S.W.3d 718, 724 (Tex. App. Austin 2004).

B. Issues of confidentiality under the attorney-client privilege

Generally the insured has the right to rely that Attorney-Client Privilege protects all communications between the insured and their attorney. An example of state law in this regard is Fla. Stat. § 90.502(4)(e) where the privilege is waived when "a communication is relevant to a matter of common interest between two or more clients". In other words, when the insurer and the insured are co-clients of the same defense counsel, shared information may be permitted. The attorney must protect the confidential interests of the insured when a conflict between the insured and the insurer arises. *In re* Rules Governing the Conduct of Att'ys in Fla., 220 So. 2d 6 (Fla. 1969). This seminar is not designed to cover all claims of privilege or the ways the privileges can get waived. However, it can be said that while the claims and attorney-client privileges are broad enough to include just about anyone on the insurance/defense side of the claim, the opportunities for waiver of the privileges are equally broad. Defining who everyone on this side considers part of the privilege and setting forth in advance all communications considered confidential is key to avoiding waiver.

C. The chartered property casualty underwriters

Many if not most insurance professionals are members of the Chartered Property Casualty Underwriters ("CPCU") Society. The CPCU is an organization that, according to its mission statement, is "dedicated to meeting the career development needs of a diverse membership of professionals who have earned the CPCU designation, so that they may serve others in a competent and ethical manner." As a condition for membership, the CPCU Society requires all members to abide by the CPCU Society's Code of Ethics. All CPCU Society members also agree to abide by the American Institute for CPCU Code of Professional Ethics.

D. The Society and the American Institute for CPCU Code of Professional Ethics share several canons.

i. Canon 1 states *"CPCUs should endeavor at all times to place the public interest above their own."* What does this mean? According to many insureds and certainly the plaintiff's Bar this means that an adjuster, and thus its principal, the insurer, owe a fiduciary duty toward its insured. That is, the adjuster must place the insured's interest above the interest of the adjuster, or, presumably, the insurance company. Since a fiduciary relationship is the highest duty imposed by the law, one can see where an insured and its representatives would want the insurer to owe such a duty to them.

ii. *Powers v. USAA,* 962 P.2d 596 (Nev. 1998), *aff'd on rehearing,* 979 P.2d 1286 (Nev. 1999) (the relationship is akin to a fiduciary duty). But issues arise as to who is the insured and who is a claimant and where they are close to being one in the same, a situation that often arises in worker's compensation claims. The employee is part of the "insured" but is also a claimant of "comp" benefits. In addition, the employee may or may not be at odds with the employer, though still employed. Does a fiduciary relationship exist? And if not, is there still the duty of good faith inherent in every contract? And what's the contract?

iii. Canon 3 states *"CPCUs should obey all laws and regulations, and should avoid any conduct or activity which would cause unjust harm to others."* This simply means be "lawful" and be "fair." These are concepts that would be difficult to dispute in any context, let alone in the context of adjusting an insurance property damage claim resulting from a fire, windstorm, or other calamity. But what is "fair" is subjective in the extreme as anyone paying income tax can agree. Moreover, what is fair to one party may be correspondingly unfair to the other.

iv. Canon 4 states *"CPCUs should be diligent in the performance of their occupational duties and should continually strive to improve the functioning of the insurance mechanism."* Since lack of diligence or "delay" is the cornerstone to almost all bad-faith claims, this Canon is of particular importance. Of course, what is "diligent" can only be defined in the context of the particular circumstances. Almost every state has statutes or regulations and almost every carrier has promulgated its own best practices or standards defining its expectation of diligence. Unfortunately few Code of Ethics specifically define expectations where multiple players on the claims side are involved, other than saying "everyone". But in many cases performance of duties requires diligent performance of precursor duties by someone else in the chain.

E. State requirements of conduct: adjuster code of ethics

i. Florida

1. As an example, the State of Florida provides that an adjuster's license can be suspended or revoked if an adjuster violates the Unfair Claims Practices Act. Florida Statute § 626.621 expressly states that there are compulsory grounds for suspending, revoking or refusing to renew an adjuster's license based, upon among other things, *"willful misrepresentation of any insurance policy or annuity contract or willful deception with regard to any such policy or contract, either in person or by any form or*

dissemination of information or advertising . . . [or] [i]f, as an adjuster, or agent licensed and appointed to adjust claims under this code, he or she has materially misrepresented 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 claim for loss or damage or benefit under such contract on less favorable terms than those provided in and contemplated by the contract. . . [or] [Engages in] [f] fraudulent or dishonest practices in the conduct of business under the license or appointment . . .

2. Additionally, Florida Statute § 626.878 states in pertinent part:

   "An adjuster shall subscribe to the code of ethics specified in the rules of the department."

   The "Code of Ethics" referenced in this statute is found in Rule 690-220.201 of the Florida Administrative Code, which provides a set of standards for adjusters generally, and an additional set of standards for public adjusters specifically. Among another things, the Code states that *"[t]he work of adjusting insurance claims engages the public trust. An adjuster must put the duty for fair and honest treatment of the claimant above the adjuster's own interests, in every instance."* Again, there are those who self-servingly twist this language into an attempt to create a fiduciary relationship between the adjuster and the insured. This is not the intent of such language. It is certainly not the intent of any code of ethics to circumvent the otherwise valid language of the insurance contract that is enforceable under the laws of contract.

3. The Florida Code of Adjuster Ethics also states: *"[a]n adjuster shall not knowingly fail to advise a claimant of their claim rights in accordance with the terms and conditions of the contract and the applicable laws of this state."* Again, there is apparently a difference, and often a tension, between an insurance company's contractual obligations and its adjuster's "ethical" obligations to the insured. It is exacerbated where there are competing duties undertaken by the carrier, the TPA and the internal risk managers at the insured company. This "ethical" provision would seem to indicate that an adjuster must advise the insured of the insured's claim rights in accordance with the terms and conditions of the insurance contract and of the applicable laws of the State. However, there are no such contractual obligations under the terms of the subject insurance contract. The question becomes whether an adjuster is acting on behalf of a first-party insurer, obligated to

advise the insured about all the insured's rights under the terms and conditions of the insurance contract and all applicable laws of the state? Although it may be wise to do so, it is difficult to find such an obligation within the terms and conditions of most insurance contracts, yet some States' Code of Adjuster Ethics can be argued to envision something otherwise.

So in the situation of the TPA having been instructed by the carrier that coverage is not available under Endorsement Z of the policy, and the TPA believing otherwise, what can the TPA do when the insured asks it to take steps to establish coverage? Should the TPA even be put in this position? Hopefully not, because the corporate insured, the TPA and the insurer have agreed in advance that it cannot take any position on coverage issues other than to recommend an outside opinion by agreed-upon counsel.

This is only one suggestion, but by establishing a mechanism at the outset, everyone involved can keep "pulling on the same oar."

III. FIDUCIARY RELATIONSHIPS

Who owes what duty probably affects the interplay of claims relationships most. Knowing the basis for those relationships is essential. A few examples of State law is useful.

A. Texas

i. In Texas, an agent or an attorney relationship can rise to become fiduciary in nature. An agent's authority to act on behalf of a principal depends on some communication by the principal either to the agent (actual or express authority) or to the third party (apparent or implied authority). *Protocol Techs., Inc. v. J.B. Grand Canyon Dairy, L.P.,* 406 S.W.3d 609, 616 (Tex. App.-Eastland 2013, no pet.) (citing *Gaines v. Kelly,* 235 S.W.3d 179, 183 (Tex. 2007)). There is no presumption of an agency relationship; rather, the party asserting agency has the burden of proving the relationship. *IRA Res., Inc. v. Griego,* 221 S.W.3d 592, 597 (Tex. 2007).

ii. Despite the broadness of agency in Texas, its Insurance Code does not create a general fiduciary duty applicable to third-party administrators. *Nat'l Plan Adm'rs, Inc. v. Nat'l Health Ins. Co.*, 235 S.W.3d 695, 701 (Tex. 2007).

iii. The required fiduciary duty for attorneys is *uberrima fides*, which means "most abundant good faith," requiring absolute and perfect candor, openness and honesty, and the absence of any concealment or deception." To determine the breach of fiduciary duty a trial court must determine from the parties whether factual disputes exist that must be decided by a jury. The court considers the following factors: the gravity and timing of the violation; its willfulness; its effect on the value of the lawyer's work for the client; any other threatened or

actual harm to the client; the adequacy of other remedies; and the public interest in maintaining the integrity of attorney-client relationships. The court must determine, based on the factors, whether the attorney's conduct was a clear and serious breach of duty to his client and whether any of the attorney's compensation should be forfeited, and if so, what amount. *Burrow v. Arce*, 997 S.W.2d 229, 246 (Tex. 1999).

iv. There is a presumption of unfairness in Texas. The burden is on the fiduciary to show the complete fairness of the transaction to the beneficiary. *See Bank & Trust Co. v. Moore*, 595 S.W.2d 502, 509 (Tex. 1980); *Archer v. Griffith* 390 S.W.2d 735 739 (Tex. 1964); *Cooper v. Lee*, 12 S.W. 482, 485 (Tex. 1889).

B. California

i. Under California law, there is no insurer/insured fiduciary relationship as a matter of law. *See Gen. Am. Life Ins. Co. v. Rana*, 769 F. Supp. 1121, 1126 (N.D. Cal. 1991); *Hassard, Bonnington, Roger & Huber v. Home Ins. Co.,* 740 F.Supp. 789, 792 (S.D.Cal.1990). *See also, Love v. Fire Ins. Exchange,* 221 Cal.App.3d 1136, 1149 (1990); *Henry v. Assoc Indem Corp.,* 217 Cal. App. 3d 1405, 1418,, 586 (1990).

ii. California provides that the scope of an attorney's fiduciary duty is to be determined as matter of law, based on Rules of

iii. Professional Conduct, which, together with statutes and general principles relating to other fiduciary relationships, define the duty component which an attorney owes to his or her client. CA ST RPC Rule 4-100 quoting *Stanley v. Richmond*, 41 Cal. Rptr. 2d 768 (App. 1 Dist. 1995). Violations of the duty are presumptively fraudulent and cast a burden on the party gaining the advantage to show fairness and good faith in all respects. *Boyd v. Bevilacqua*, 247 Cal. App. 2d 272, 288-89 (Ct. App. 1966).

C. Florida

i. In Florida, an insurer and an insured have a fiduciary relationship "much akin to that of attorney and client," and the insurer has a duty to not pursue its own interests in the settlement of claims. *Baxter v. Royal Indem. Co.*, 285 So. 2d 652, 655 (Fla. 1st DCA 1973), *cert. discharged*, 317 So. 2d 725 (Fla. 1975).

ii. An insurer must "exercise the utmost good faith and reasonable discretion" when negotiating for a settlement. *Id*. For example, failure of the insurer to disclose settlement, could constitute a breach of the fiduciary relationship, when the insured relies upon the insurer to conduct those settlement negotiations. *Powell v. Prudential Property & Casualty Ins. Co*., 584 So. 2d 12, 14-15 (Fla. 3d DCA 1991)

iii. Florida also construes a second layer of fiduciary responsibilities that apply to adjusters and third parties. While the duties of the adjuster may vary according to the terms of the contract, a fiduciary duty exists and the "breach of this duty subjects the adjuster to liability for the insurer's resulting loss and the insurer can seek indemnity for liability accruing from the adjuster's negligence." *King v. Nat'l Sec. Fire & Cas. Co.,* 656 So. 2d 1338, 1339 (Fla. 4TH DCA 1995) Additionally, if the principle is held liable due to the negligent acts of the adjuster, the principal may bring an action against the adjuster in tort for breach of the fiduciary duty. *Id.*

D. New York

i. A key case in New York for the fiduciary obligations of insurance companies is *Hartford Accident & Indemnity Co. v. Michigan Mutual Insurance Co.* 61 N.Y.2d 569 (1984). In *Michigan Mutual,* the court held: It is well established that, as between an insurer and its assured, a fiduciary relationship does exist, requiring utmost good faith by the carrier in its dealings with its insured. Further, in defending a claim, an insurer is obligated to act with undivided loyalty; it may not place its own interests above those of its assured. Moreover, the primary carrier owes to the excess insurer the same fiduciary obligation which the primary insurer owes to its insured, namely, a duty to proceed in good faith and in the exercise of honest discretion, the violation of which exposes the primary carrier to liability beyond its policy limits.

ii. In addition, the Court of Appeals of New York held “Michigan Mutual as the primary liability insurer owed to Hartford as the excess carrier the same duty to act in good faith which Michigan owed to its own insureds. *Id.* at 574.

iii. Nevertheless, courts in New York have routinely dismissed complaints against insurance adjusters and insurance adjusting companies due to the lack of privity between the adjusters and the claimants. *See, e.g., Bardi v. Farmers Fire Ins. Co*. 260 A.D.2d 783 (3d Dep't 1999*); Schunk v. New York Cen. Mut. Fire Ins. Co.,* 237 A.D.2d 913 (4th Dep't 1997*); Page One Auto Sales v. Commercial Union Ins. Cos*., 176 Misc. 2d 820 (Sup. Ct. New York County 1998).

iv. For instance, in *Page One Auto Sales v. Commercial Union Ins. Co.,* the insured plaintiff sued its insurer and its claims adjuster, alleging among other claims, a claim for breach of contract, estoppel, and bad faith. The *Page One* court held that because the insurer performed the actions of the adjuster within the scope of his employment, and because there were no allegations of separate tortuous conduct by the adjuster, no basis existed to impose personal liability upon him.

IV. SUCCESSFULLY AVOIDING THE ISSUES WITH MULTIPLE ENTITIES INVOLVED

The insurer, the TPA and the claims people in-house at the insured have many different roles taking into consideration coverage, liability, limits, reporting, etc. Separating and defining those roles to avoid overlap and important tasks being left undone is essential. As with virtually all difficulties of this nature, communication, and especially advanced communication is the key. "When we *assume*, we…"

After coverage is determined, if there is a coverage issue, two separate adjusters will need to be assigned to the investigation of the claim. One to resolve any coverage issues and a completely separate adjuster to investigate the liability and injuries of the claim. The coverage adjuster should only discuss the results of the coverage investigation with the liability adjuster.

When the same risk is covered by two or more policies, each of which was sold to provide the same level of coverage, priority of coverage among the policies is determined by comparison of their respective other insurance clauses.

In compliance with the applicable policy, the TPA will need to inform the insured of the coverage issue, both verbally and in writing. In person, if needed. The broker will be involved in this conversation also. Reports to the liability and umbrella carriers and to all levels of reinsurance will also need to be completed to advise them of the coverage issue.

The broker involved with the claim is going to have the insured's best interest to take care of. They will be pushing for coverage to be afforded and the claim to just be settled so their insured does not have to go through the stress of a trial, especially where there is even a hint of an excess verdict.

Some insurers would rather go through a trial as they feel the allegations and/or injuries are just ludicrous. Others will want whatever amount it is going to take to make the claim go away.

When the time comes that coverage is going to be afforded, and settlement is going to be achieved, the TPA has to coordinate with the carriers, both the General Liability & the excess layers, and also with all levels of the reinsurer that is involved in the claim. Coordinating with the defense counsel and coverage counsel will need to be done also. Some claims will have a coverage counsel as well. Some claims will have multiple defense Attorneys for the multiple co-defendants. All will have their own client's interest in hand when attempting settlement. Along with all of the players, any experts will also need to be brought into the discussion to express to the insured, broker, carriers and reinsurers the results of the expert's own investigation.

A. Notice to the Insured

i. Virtually every state has statutory requirements for notice in the insurance realm. There are requirements for notice to the insured of a denial of coverage. Notice of a reservation of rights is required when coverage is in dispute. There are requirements of notice to assert rights 0of indemnity and subrogation. Notice of a trial or other action involving the insured's rights is necessary. And all of the notices must be timely or at least within statutory limits.

ii. There are exceptions. "An insurer's delay in notifying the insured of a disclaimer may be excused when the insurer conducts an "investigation into issues affecting [its] decision whether to disclaim coverage" *Brother Jimmy's BBQ, Inc. v American Intl. Group, Inc*., 2011 N.Y. Misc. LEXIS 2335, 13 (N.Y. Sup. Ct. May 10, 2011).

iii. But the overwhelming question is who sends the notice? A corollary is whether the notice is in a form that the law requires. Finally, does everyone having a say agree with the form and content of the notice.

iv. Too often the carrier believes the serving of a statutory or other notice is the responsibility of the TPA, whether by custom or specific agreement. The insured is looking to both to see if coverage is available and if there is a question, was the notice perfected in time?

v. A simple observation is that better there was "too much" notice than too little. The requirement of notice is due to the law's favoring an opportunity to assert one's rights rather than have them pass by without a chance to assert them.

vi. At the outset of a relationship, the TPA, the insurer and as to many tasks the insured should all agree to who is doing what. In these matters due to the potential loss of untimely-asserted defenses, any delegation of responsibilities must be in writing, and acknowledge the statutory obligations. Typically, where a TPA is involved, its closer proximity to the insured lends itself to providing the required notices. On the other hand, that same close proximity may present the TPA with uncomfortable circumstances like putting its continued relationship with the insured at risk because it gives and takes the blowback of bad news.

vii. The important point is that the duty of providing timely notice should be clearly defined, in writing and as to what notice at the outset of the relationship. If at all possible, the insured should be requested (required) to sign on to who will be providing the notice to eliminate any confusion. Finally, when in doubt about whether a particular state will or will not allow the delegation of forwarding notice to a TPA or contract adjuster, a brief opinion from sophisticated defense counsel is always preferable.

B. Communicating Settlement

i. Communicating both the demand and the settlement authority requested to everyone in the chain is essential. Just as careful defense counsel do everything possible to establish and confirm their authority before making any offers to the other side, so should the TPA and the insured's representatives be notified, and if possible given a say in if not the amount then the timing of the offers. While

the insurance contract vests the carrier with ultimate authority, in many cases an insurer will delegate the authority to settle a claim/case to the TPA so long as it does not exceed a specified sum. This is perfectly acceptable and a standard procedure. The problem arises when circumstances change that may cause a knowledgeable claims person to believe the value has significantly increased or fallen. Then the prearranged authority may now appear to be over or underpaying the claim.

ii. If the value is above the underlying primary policy limit, the excess carrier will be the ultimate decision maker, once tender is made. Now, when and whether tender has been formally made is another area fraught with potential confusion. Who is making the tender? Absent extraordinary circumstances the primary carrier does. But what happens in the instance of a captive carrier or an SIR? Those decisions usually come from the internal risk manager or more commonly the general counsel of the insured. The TPA often finds itself in the middle of it. The "you said it was going to exceed…" accusation is one that most TPAs and GCs do not like to hear, at least where the excess carrier is now settling the claim with a belief it has the full use of the primary/SIR/Captive's money.

iii. Most excess and/or umbrella policies are follow-form, so the coverage conflict aspect of miscommunication is minimized. In any close situation, the excess or umbrella carriers will want their own representative at mediations and settlement conferences and involved in the discussions whether they have been tendered or not. Who provides the notice of the mediation, settlement conference, etc. usually begins with the primary defense counsel. However establishing procedures such that if one gets notice, all get notice, whether they say they want it or not avoids strained relationships and even bad faith cases down the road. Accordingly, continuous communication throughout the life of the claims investigation is required so everyone with an opinion can make an accurate assessment of the exposure, liability, settlement process and verdict range. Especially if there are co-defendants, the apportionment of liability will need to be spelled out to these carriers and reinsurers.

V. ENSURING GOOD RELATIONSHIPS

Understanding each party's individual objective is key to maintaining a good, and conflict free relationship. In the age of emails and communicating at the speed of light, it is important to know when to slow down and just pick up the phone.

Continuous communication throughout the life of the claim will reduce some of the push back you may get during the conversations about both strategy and value. This way the insured and insurer are not surprised by any information that they may receive late in the claim and will be more receptive to any settlement suggestions from the TPA and/or insured.

Coordinating with the expert (if one is hired) and attorneys in these conversations is also helpful. Using separate, independent counsel as an "ombudsman" to render opinions early in possible disputes avoid expensive litigation down the road. Making sure the insured knows what to expect and that he or she are being kept in the loop by the TPA, the carrier and the attorney is essential to stopping coverage and bad faith litigation before it starts.

Whether to make consensus decisions on utilizing legal team and expert resources will also need to be taken into consideration. Whether you facilitate these resources or decide to act unilaterally to coordinate these resources will need to be decided. If an insurer is the only one footing the bill, then there is an understandable temptation to make the decision without worrying excessively about how others involved in the process feel about the choices. But there are long term consequences potentially involved, particularly in the highly competitive field of insurance underwriting and claims. Keeping a good insured happy has value.

VI. REPORTING AND ETHICAL REQUIREMENTS

As the liability and damages investigation proceeds, the same entities will need to remain involved in the results of claim investigation and later, discovery. Every carrier has specific guidelines and time frames as to reserves and injuries that require specific reporting. A higher level of reserves will go to higher levels of authority within the carriers and reinsurers. Still, all the while, the insured and the TPA will be involved in the results of the analysis, and any reserve increases or decreases and the reasoning behind both. This is not to say that the insured, or for that matter the TPA has a right to be involved in setting reserves, but to avoid problems down the road they should be provided essentially the same factual information upon which the carrier is basing its decision.

Finally, never assume that anyone on the claims/defense side has all the information you do. Realizing that it sounds like a broken record but the effective transfer of information and confirmation that everyone has received it is the key.

VII. WHAT WORKS

The introduction of litigation management guidelines and outside counsel guidelines is a primary means of avoiding conflicts. Early and precise establishment of procedures for receipt, review, approval and payment of legal and expert bills is essential. Confidential posting systems such as Serengeti are often useful in making sure everyone "got the memo" but something as simple as making sure defense counsel knows who to copy on case synopsis and updates, and requesting confirmation back in some cases, goes a long way in avoiding problems.

Coverage issues must be decided or "Agreements to Disagree" and other reservations of rights should be hammered out at the start and everyone updated on the limitations on the exchange of certain information established early. The difference between defense counsel and coverage counsel is an example.

The TPA contract should be precise and detailed, and where possible, the insured should have input such that it understands what the TPA can and cannot do for it.

Not to be too extreme on the point but in setting settlement authority and offers, that same "confirm back to me you've received it" strategy has considerable benefit.

And, a much of an inconvenience as it can become, regular conferences with defense counsel, TPA representatives, the insured and the in-house claims people involved avoids a lot of miscommunication.

VIII. END RESULT DESIRED

When there are multiple positions and opinions at stake, continuous and detailed communication coordinated with all the resources involved in the matter is key to a successful resolution. Getting all parties on the same page will help resolve conflicts and greatly reduce possible allegations of breach and even bad faith in the end. All of this leads to a less stressful and costly claims resolution and more contented insureds. And that should be the goal.