Insurance Meets Automation

How Carriers Implement Fair Claims Practices in a Hands-Off World

By Kathleen J. Maus and Julius F. Parker III

The increased efficiency and decreased processing time resulting from claims automation increases customer satisfaction and reduces litigation, but this automation will raise many questions in the bad faith arena.

Insurance bad faith claims are among the most contentious and heavily defended lawsuits in civil litigation. This article will explore the growing use of automation and predictive analytics in the insurance industry, and how courts may evaluate bad faith liability in an increasingly hands-off world.

While the digital value proposition in claims handling is enticing, carriers must continue to align their practices with fair claims handling. As any insurer knows, handling insurance claims can be fraught with danger. The ever-present, looming danger of a bad faith claim hangs like the sword of Damocles over every claim professional who is merely seeking to adjust claims fairly and competently. Make one arguable misstep and the potential exposure to the insurer can go from minimum policy limits (even as low as $10,000) to several hundred times that amount.

One approach to minimizing bad faith exposure is automation of the claims process. Figure 1 favors an automated approach, following extensive study that introduced the concept of touchless claims handling.

Automation can have the added benefit of reducing loss adjustment expense and reducing the time from first notice of loss to claim closure. This is beneficial to the insured both in terms of claim satisfaction and reduced premiums. But is this workable for all claims? Are the claims that create the greatest possibility for extracontractual exposure the ones that can and should be automated? Are the claims that are going to reach your courtroom affected by these approaches? Time will soon tell. This article discusses various aspects of bad faith allegations and the effect of various claims automation practices on possible bad faith exposure, claim duration, and claims expenses.

Before we can consider claims automation and its effect on claims handling, it is important to understand the history and significance of what is means to an insurer

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to be allegedly liable for "bad faith." One or more of these claims likely has or will make its way to your docket.

Third-Party Bad Faith

Almost uniformly, third-party bad faith allegations arose and developed over many years from each state's common law. *See* V. Schwartz, *Common-Sense Construction of Unfair Claims Settlement* Statutes, 58 Am. Univ. L. Rev. 1477 (Aug., 2009) (compiling cases). As insurance policies changed from "indemnity-only" policies to "defense-and-indemnity" coverage, an insurer was noted to have complete power to control the defense of its insured, including deciding whether to settle a case as the insurer "deems expedient." At times, insurers rejected settlement opportunities and required the plaintiff to take the case to trial with a possibility of entry of a judgment against its insured far in excess of the policy limits. Therefore, the insurer literally had the power to bankrupt its insured in the event of an adverse verdict. Accordingly, the concept of bad faith law developed in order to ensure that insurers acted in the best interests of their insureds, at least as often as it acted in its own best interests.

The Supreme Court of Florida articulated one standard for bad faith in *Boston Old Colony Ins. Co. v. Gutierrez*, 386 So. 2d 783 (Fla. 1980):

> An insurer, in handling the defense of claims against its insured, has a duty to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business.… For when the insured has surrendered to the insurer all control over the handling of the claim, including all decisions with regard to litigation and settlement, then the insurer must assume a duty to exercise such control and make such decisions in good faith and with due regard for the interests of the insured.

The duty of good faith requires that the insurer advise the insured of settlement opportunities; advise as to the probable outcome of the litigation; warn of the possibility of an excess judgment; advise the insured of any steps he or she might take to avoid an excess judgment; investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts; and, settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so. *Id*. These factors are considered under a "totality of the circumstances" standard, taking into account all factors related to the presentation of the claim, evidence in support of the claim, the timing of such, and whether any opportunities to settle existed. Although negligence is related to the analysis, negligence alone is often insufficient to support a bad faith finding in Florida.

Other states require different levels of care. For example, in order to subject an insurer to extracontractual damages in Arkansas, the insurer must have acted in a "dishonest, malicious, or oppressive" manner. *See Aetna Cas. & Sur. Co. v. Broadway Arms. Corp.*, 664 S.W.2d 463, 465 (Ark. 1984). Conversely, California merely applies a negligence standard. *See Crisci v. Sec. Ins. Co. of New Haven, Conn.*, 426 P.2d 173 (Cal. 1967). In Mississippi and New Mexico, the standard is gross negligence. *See Aetna Cas. & Sur. Co. v. Day*, 487 So. 2d 830, 832 (Miss. 1986); *Jessen v. Nat'l Excess Ins. Co.*, 776 P.2d 1244, 1247 (N.M. 1989). However, most courts align with the approach taken by the Wisconsin Supreme Court's decision in *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368 (Wis. 1978), which stated:

> To show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim.

Id. at 376. When the bad faith allegations are permissibly asserted (i.e., in the initial complaint or after the conclusion of all issues of coverage, liability, and damages) varies state by state.

Depending on the jurisdiction, bad faith actions in the third-party setting can be initiated by the injured third party and/or the insured directly against an insurer under a number of circumstances, such as: where the third party obtains an excess judgment against the insured; where the third party enters into a consent judgment and the insured's assignment of the insured's rights against the insurer after coverage was wrongfully denied, *see, e.g., Bird v. Best Plbg. Group, LLC*, 287 P.3d 551 (Wash. 2012) (*en banc*); *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982); where the third party enters into a "*Cunningham*" agreement with the insured, *Cunningham v. Standard Guar. Ins. Co.*, 630 So. 2d 179 (Fla. 1994.) Where coverage is not at issue, a *Cunningham* agreement allows the plaintiff, defendant, and insurer to stipulate to trying the bad faith action in advance of a trial of the underlying issues of negligence, causation, and damages. If the terms if such an agreement can be reached (which is difficult), this can save substantial time, expense, and court resources if 1) no bad faith is found to exist, or 2) where or where an excess carrier is subrogated to the rights of its insured against a primary insurance carrier by virtue of having to pay an excess judgment.

Duty to Settle

In some states, if the insured's liability is clear and injuries are so serious that judgment in excess of policy limits is likely, the law recognizes an affirmative duty on the part of the insurer to initiate settlement negotiations with the third-party claimant, even in the absence of the presentation of a formal notice of claim or demand to settle. *Powell v. Prudential Prop. & Cas. Ins. Co.*, 584 So. 2d 12 (Fla. 3d DCA 1991), *rev. den.*, 598 So. 2d 77 (Fla. 1992). Other states reject the duty to initiate settlement negotiations. *See Hana v. Illinois State Medical Inter-Insurance Exch. Mut. Ins. Co.*, 105 N.E.2d 35 (Ill. Ct. App. 2018); *Reid v. Mercury Ins. Co.*, 162 Cal. Rptr. 3d 894 (Cal. Ct. App. 2013). Even where a personal representative for a decedent's estate was not yet established or a guardian of a minor is not yet appointed, some states recognize the need for an insurer to attempt to settle the claim, and tender its policy limits, even prior to receiving the protections of statutorily required court approval. *See Berges v. Infinity Ins. Co.*, 896 So. 2d 655 (Fla. 2004).

Bad faith allegations can also arise out of numerous other pitfall situations. For example, in a multiple claimant situation, if the insurer attempts, but is unable, to settle within its limits with all claimants, the insurer must attempt to settle and extinguish the claims with the largest exposure. *Farinas v. Fla. Farm Bureau Gen. Ins. Co.*, 850 So. 2d 555 (Fla. 4th DCA 2003); *DeMarco v. Travelers Ins. Co.*, 26 A.3d 585 (R.I. 2011); *Mesa v. Clarenden Nat'l Ins.*

Co., 799 F.3d 1353 (11th Cir. 2015). Did it pick the right one(s) to settle? Similarly, if the insurer attempts but cannot obtain a release of all parties qualifying as insureds under its policy, the insurer can and should protect the insureds it can, even where that leaves other insureds exposed. *See, e.g., Contreras v. U.S. Security Ins. Co.*, 927 So. 2d 16 (Fla. 4th DCA 2006); *Kemp v. Hudgins*, 133 F. Supp. 3d 1271 (D. Kan. 2015) (finding the insurer acted in good faith by rejecting a settlement demand that only included release of one insured); *Pride Transp. v. Continental Cas. Co.*, 511 Fed. Appx. 347 (5th Cir. 2013) (same); *Williams v. GEICO Cas. Co.*, 301 P.3d 1220 (Alaska 2013) (same); *Kauffman v. Cal. State Auto. Ass'n Interinsurance Bureau*, 2009 WL 4049153 (Cal. Ct. App. Nov. 24, 2009) (unpublished) (same).

First-Party Bad Faith

First-party claims are claims where policy benefits are payable directly to the insured, such as under homeowners or commercial property, uninsured/underinsured motorist, personal injury protection (No-Fault/PIP), or medical payments coverages. When and how an insured can assert a bad faith claim against its own carrier for claim denial, delay, or insufficiency of payment varies by state. In all fifty states, first-party bad faith is a purely statutory creation. *See* V. Schwartz, *Common-Sense Construction of Unfair Settlement Statutes*, 58 Am. Univ. L. Rev. 1477, 1487, n. 47 (Am. Univ. L. Rev. 2009). Florida provides a cause of action against the insurer only after the insured serves a statutory notice on the insurer and the insurer then has a period of sixty days in which to "cure" the violation by payment of benefits allegedly due, or deny the violation. If denied, and after coverage and liability on the policy is judicially determined favorably to the insured, the insured may bring a first-party bad faith lawsuit. *See* Fla. Stat. §624.155.

In many other states, an insured may bring a bad faith action against an insurer for violating consumer protection statutes or for statutorily enumerated bad faith conduct. Although variable, awardable damages include those that are "a reasonably foreseeable result of the bad faith conduct" and may include an award or judgment in an amount that exceeds the policy limits, plus attorneys' fees, costs, interest since the date of the demand or proof of loss, interest, and possibly punitive damages. Fla. Stat. §624.155(8).

How and Why Insurance Claims Are Becoming Automated

Adjusting insurance claims has traditionally been a hands-on process with substantial documentation of numerous communications. The first major improvement to claims handling came with the transition to a paperless environment. Most insurers accomplished that task decades ago. Since then, software and adjusting systems have steadily improved. But even with the improvements made by the transition to computer-based adjusting, the possibility of human error, as with any process or procedure, remains.

Although they involve many "moving parts," most insurance claims in a given line (e.g., third-party auto liability, uninsured/underinsured motorist, commercial liability) can be grouped into various types, based on the type and severity of the claim. For example, auto liability claims could be grouped into the following categories: 1) minor claims that do not present liability near the policy limits; 2) severe claims where liability is clearly in excess of policy limits; 3) property damage-only claims; and 4) high exposure and high limits claims. These categories are meant to be illustrative and not exhaustive.

Automation provides the possibility of quicker claims payments and reduced loss adjustment expense (LAE). The quicker claims payments lead to greater customer and claimant satisfaction, and the reduced expenses lead to lower premiums that benefit all insureds. Further, given the various ways of categorizing claims, automation makes a great deal of sense. Artificial intelligence can work seamlessly through online interfaces with insureds and claimants, thereby speeding up the adjustment process and taking some of the possibility for human error out of the equation. Through direct access communication portals, insureds and claimants can upload first reports, including photographs, estimates, medical bills, and records, and ask questions with timely response. They can also directly view the status of the claim that increases customer/claimant knowledge and satisfaction.

Services Offered and Vendor Claims

There are a number of vendors currently marketing claims automation suites, including Ushur, Genpact, Aberdeen, Waterstreet, and Swiss Post Solutions, to name just a few. A recent survey found that by automating the claim intake process at the first notice of loss (FNOL), insurers reduced the time from FNOL to payment on bodily injury claims by 14 percent, and reduced claim severity by 10 percent. *See* **https://www.insurancethoughtleadership.com/future-of-claims-automation-and-empathy/.**

Aberdeen offers claim automation, also using artificial intelligence for property and casualty claims. It boasts an average reduction in LAE of 40 percent, as well as cutting the average time from FNOL to claim resolution by 70 percent. Aberdeen boasts:

> The utility of an automated claims solution can be significantly enhanced with the implementation of an electronic claims archive. Once the necessary claims documents have been uploaded and converted to the preferred format, they can immediately go into the electronic claims archive.
>
> Of respondents who have adopted automated claims solutions, 63 percent have a centralized digital claims archive. Doing so provides real-time visibility into that data, therefore cutting out the time wasted sharing that information with individuals across the organization. Plus, the repository enables a self-generated audit trail for each claim, which reduces errors and the chance for fraud.

https://www.aberdeen.com/cfo-essentials/future-insurance-claims-automation/.

Similarly, Ushur uses artificial intelligence to automate the claim intake process. According to its marketing material:

> Powered by AI, email classification and routing eliminates the countless hours your team is wasting triaging emails that could be classified and routed in seconds.

Artificial intelligence allows insurers to classify communications based on criteria specified by the insurer. Examples include the use of keywords or certain statistically significant aspects of a claim to flag claims that pose a greater risk of bad faith. Those claims may then be routed to experienced claims professionals, thereby reducing potential bad faith exposure. That signifi-

cantly reduces the conundrum of bad faith claims arising in low-limit claims.

"Intelligent Process Automation" is a similar approach to automating the claims process. As one author notes:

> Intelligent Process Automation (IPA) is a new approach that is particularly well-suited to the challenges of claims processing. For one, it is specifically designed for all the unstructured content and document-based workflows that are so important to accurate claims processing. Unlike other automation technologies, IPA has the ability to understand text, images, documents and other unstructured data. It can "learn" a set of tasks related to a business process and gives claims processing personnel the ability to dramatically improve their throughput and efficiency.

T. Wilde, *Viewpoint: Streamlining Claims Processing with Intelligent Process Automation*, **https://www.claimsjournal.com/news/national/2019/10/10/293523.htm**.

Is a Human Element Still Required?

Similar to *Flippy*, the burger flipping robot, some people fear automation will eliminate the human element. However, in our opinion, the human element is still essential, especially for the more complex claims. If a windshield shatters, a fixed cost and loss adjustment can be easily reached in an automated format. A similar process can be used for home or car parts, labor, and repair. By using predictive analytics, the insurer can quickly value a claim by comparison to a database of historical claims falling into the same category. This makes the claim valuation process fairer. However, the more complicated the claim, the more individualized adjustment the claim requires. But even for complex claims, automation will help to identify those that are straightforward or simple versus those that require more analysis and care.

Although it could be argued that claims automation is nothing more than an attempt by insurers to keep more money and increase the bottom line, nothing could be further from the truth. Using automation and predictive analytics allows insurers to identify claims with unique facts and circumstances. Once identified, they can be routed to seasoned claim professionals who are well-versed in the nature of the particular claim at issue and provide it the attention it necessarily deserves, which directly benefits the insured. By doing this, the insurer can efficiently and effectively evaluate those claims in order to reach a prompt, efficient, and fair resolution.

Creating Settlement Values from Historical "Paid" Data

Less a question of automation and more a function of claim analytics, determining settlement values based on historical "paid" data is becoming more and more common. By categorizing injury claims according to type of injury, age of the claimant, type of accident, type of property at issue, venue, etc., insurers are able to use historical "paid" data from prior similar settlements and verdicts/judgments to estimate a reasonable value range for any particular claim. For example, if all cases involving forty- to fifty-year-old females involved in a rear-end automobile accident with claimed soft-tissue injury to the cervical spine settled between $8,000.00 and $12,000.00 along a typical bell-shaped distribution, an insurer can reasonably rely on this information when setting its reserves and attempting to settle the claim within this range. This benefits the insurer by putting hard information behind the proposed settlement offer within that range. The insurer can use the hard data to show that it offered an entirely reasonable amount.

Nevertheless, in a third-party liability claim, as opposed to a first-party property claim, more factors are at play than simple mathematics and analytics. Individualized factors in the claimant's life, the medical history of the claimant, the ego of the attorney representing the claimant who believes that he or she can obtain a better-than-average result, and other factors can move the claim value based on predictive analytics up or down. Expected arguments will also surround the sample size used, the reliability of the coding, and allegations of data "manipulation." To overcome such arguments, insurers will need to vet the vendors properly, and require testimonial support from the vendors offering these programs to answer these challenges. This will likely create a new source for expert testimony, and judges will be called upon to evaluate this expert testimony under *Daubert* or other applicable "gate-keeping" reliability standards.

Defending Policy Limit Demand Rejections Based on the Use of the Above

A frequent occurrence in third-party claims is the policy limit time demand. The claimant's attorney sends a letter outlining the claimant's injuries and demands that the insurer tender the policy limits within a certain time. This may be the only opportunity the insurer has to settle the claim within the policy limits. Given the relatively short time period usually allowed to respond to the demand, the use of claim valuation through past data and predictive analytics offers a great deal of support and protection to the insurer where the claim valuation is less than the policy limits. Nevertheless, as noted above, complex cases still require the individualized attention and analysis we see today from the insurance industry.

Conclusion

Insurers are automating their claims processing systems for many reasons. Automation reduces errors and leads to faster processing times. Automation cuts loss adjustment expense significantly, while also getting claims resolved to the benefit of the insureds and claimants alike. Claim automation allows fine-tuning the claim adjustment process using artificial intelligence to spot fact patterns reflecting greater complexity, in both first- and third-party claims, which further allows the insurer to get those claims into the hands of experienced claims professionals for individualized analysis. Finally, increased efficiency and decreased processing time based on reliable settlement data increases customer satisfaction and reduces litigation.

As with any new innovation, claim automation will raise many questions in the bad faith arena. Therefore, attorneys and judges should be prepared to tackle the questions arising from claim automation in the near future. But will these processes lead to fewer overall bad faith claims? The answer appears to be "yes." While bad faith claims cannot be eliminated altogether, a reduction of the number of such claims, and a resultant decrease in insurance premiums, is a clear win for both insurers, policyholders, claimants, and our courts' clogged dockets. FD