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# SECOND OPINION

INSIGHT ON INSURANCE ISSUES

# Late Notice: Misinformation, Mistake or Missed Opportunity?

## Why it all matters

Insurance carriers understand that reputations are built upon the promise to pay claims. Experience has taught us that working collaboratively with insureds – with proactive and open dialogue during the entire claims-handling process – is the best way for insureds to efficiently and effectively resolve a claim.

Ideally, this collaboration should begin as soon as the claim is made, or at least, as soon as it is identified/discovered. Why the need for prompt reporting? Once a claim is made against an insured, every day that passes without the insurer being placed on notice potentially means more costs to the insurer, and even more likely, increased costs to the insured. These costs can be quite high. Thankfully, they can also be avoided or mitigated.

## A Claims Perspective:

Insurance coverage is purchased because, should a claim arise, policyholders need the security insurance protection provides. However, in addition to damages and possibly defense costs, an insured also benefits from the vast expertise, contacts and insight that a claims team can provide. Although it's impossible to put a value on this expertise, it can be priceless in helping clients navigate through the labyrinth of legal challenges, local jurisdictional laws and stressful situations. This is why a strong partnership – from the very beginning of the process – is so critical.

In a claims-made and reported policy, understanding the definition of "claim" can make the difference between the claim being covered and the claim being denied. A defined claim can often include an administrative charge, a lawsuit, a written demand for monetary or non-monetary relief, a demand for arbitration, and potentially a request for a variety of other documents, depending on the policy and coverage type. Generally, the insured is required to report a claim to its insurer "as soon as practicable" after it is first made.

When a new matter is tendered for coverage, a crucial component is determining the claims-made date. This is likely to be the subject of an insured's first conversation with its insurer, as it dictates the policy period, the terms and conditions contained therein, and may even shift the payment of the claim from one carrier to another. This initial conversation between the insured and its insurer can set the tone for the entire claim. Unfortunately, the tone of this initial conversation can potentially shift from collaborative to adversarial, especially if the insured isn't familiar with the policy's definition of "claim" or the claim reporting conditions. If the insured has held on to, ignored, fully addressed or even resolved the claim prior to reporting such actions to the insurance company, there could be significant consequences.

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**Why Early Reporting Is Crucial:** From the moment a claim is first made and tendered to the insurer, whether it be a demand letter, administrative charge, or a massive class action lawsuit, a strategy must be developed. The insured and insurer must first discuss, regardless of the type of policy, the best law firm to engage to assist them with developing the strongest defense and forging the best path to resolution. This is true whether the insurer has the right to assign counsel, or simply must provide its consent. The insured, insurer and counsel, also known as the tripartite relationship, must then develop a strategy for moving forward. They may decide if the claim should be settled, when it should be settled, and for what amount. They may decide that the only way to effectively and efficiently resolve the claim

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is to ultimately take it to trial, or to immediately attempt a method of alternative dispute resolution. They may decide what experts may be needed and how much to expend on the same. The longer the insured engages in this strategy development phase without the assistance or input from its insurer, a crucial member of the tripartite team, the more costly this can be for both parties involved.

This strategy development phase, and every stage of its execution, is expensive. If an insurer is denied the ability to be involved in the assignment of counsel, even if it does not carry the right to assign counsel exclusively, the right attorney may not be handling the case. Insurance carriers have a deep panel of defense attorneys that are considered experts in their field. This panel can consist of national firms with the capability and size needed to efficiently take on a multi-litigant class action, or a specialized boutique firm with the local connections needed to most effectively resolve the case. If the most competent and efficient attorneys are not handling the matter, the strategy development phase could be completely ineffective. It is possible that the investigation could be faulty, a poor tone set with opposing counsel, and missteps made. All of these factors could significantly increase the costs of the claim, from both a defense and indemnity perspective.

Delayed claim reporting can cost both the carrier, and the insured, hundreds of thousands of dollars in defense costs. When a matter is not reported in a timely manner, the insurer must immediately determine whether or not the resolution strategy, which may well be set into motion, is going to be effective. Adjusting the resolution strategy to be more effective and efficient may involve assigning a new defense firm altogether. In addition to reviewing what has already been done, if the newly appointed counsel disagrees with any action previously taken, or finds it necessary to redo anything, the insurer, and the insured, will have to bear the additional costs. The longer the claim has been in the hands of the insured without input from, or collaboration with the carrier and the appropriate attorney, the more "catch up" costs there are going to be, and the more difficult it is to shift a strategy already in motion.

> No matter how compelling the reason for late notice is, it does not make the real cost to the insurer any less.

Sometimes, a claim is tendered late and the insured has done nothing with regard to strategy development. It is possible that they have ignored the claim, whether purposefully or by accident, and the demand letter, administrative charge or even lawsuit, has gone completely unanswered. The insured therefore has not incurred any defense fees or set any strategy into motion. In these cases, the costs, albeit potentially more difficult to measure, are no less significant than outlined above. The team is often left with default judgments and more often, missed opportunities.

Missed opportunities will undoubtedly mean higher settlements and adverse verdicts. The insurer is most often faced with a missed opportunity to respond to a demand or to seek an immediate and likely more cost-efficient resolution. Additionally, there may be a missed opportunity to interview a witness while his or her memory remains fresh to assist in a liability evaluation, or maybe a missed opportunity to file a strong dispositive motion. It is not possible to outline every opportunity that is potentially missed when a claim is not tendered in a timely fashion, nor is it possible to accurately measure the effect these missed opportunities have on the ultimate loss. If the right team (one that must include the insurance carrier) has not been assembled to outline a resolution strategy from the onset, there will undoubtedly be a missed opportunity and an adverse effect on the claim.

Prompt reporting and collaboration is a counter balance to the insured making decisions on its own, or failing to make any decisions, at great cost to all parties. To be clear, this is not a suggested timeline or a request to report earlier for mere convenience purposes. Nor is this an excuse, or poorly crafted argument, created by an insurer to provide a reason to deny coverage. This is a condition of coverage, a term of the accepted contract, because the cost of reporting late to an insurance carrier is great, and it's real.

With that said, the carrier is aware that there are speedbumps and unexpected obstacles that its insured may encounter in running a business and encountering claims. Therefore, the carrier may specify who within the insured's organization should be in receipt of the claim in order for it to count as the claim "first being made." For instance, the claim may not count as "being first made" until a member of the insured's executive team receives it. Additionally, the "practicability" requirement in reporting is often specifically measured by a deadline to report after policy expiration, so the insured is not left guessing. For instance, a policy might dictate that the claim must be reported to an insurer as soon as practicable after the claim is first made, but in no event later than thirty, sixty, or maybe even ninety days after the expiration of the policy period. Although not ideal for the insurer, this can potentially give an insured over a year to report a claim, depending on the timeline of events and policy language. So, while the carrier places a requirement that it be informed of claims as soon as practicable as a specific condition of coverage, often times the policy language itself provides the insured with more specific guidance and flexibility to account for speed bumps and human error.

It is not possible to predict all the varying reasons why an insured may not report. The most common is that the insured's team responsible for reporting is unclear on the definition of claim. However, sometimes there is a change in management, a document is lost, or most simply put, a mistake is made. Unfortunately, no matter how compelling the reason for late notice is, it does not make the real cost to the insurer any less.

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## An Underwriting Perspective:

Just as a claim is most effectively and efficiently resolved by working with the tripartite team, the relationship starts with the insured, the broker and the carrier's underwriting team. Transparency and education during the underwriting phase can help mitigate any future issues. Every carrier will have their own version of what constitutes materiality when it comes to information, but all can agree that notice and claims are especially crucial during any placement process, especially during a renewal.

For underwriters, information is like fuel needed to run an engine and the only way to assure they are getting the right grade is to properly engage and educate their partners on what information is needed. Missing, incomplete or incompetent information will have a direct impact on the terms and conditions of a policy. While it may not be the intent of any of the parties involved to purposely withhold claim or notice information, the end result is the same: a renewal cycle ending with carrier price, retention and terms that may look different than if a certain claim or notice of potential claim was reported.

Regardless of ultimate terms, receiving a claim or notice after the renewal process has been completed always leaves underwriters feeling like something was withheld during the negotiation. It is best for brokers and insureds to make notice and claim discussions a crucial part of the renewal cycle, thus assuring that all relevant parties are polled and all relevant information is shared. The claims-made and reported commercial insurance market is a sophisticated space and thus should never leave the impression that a fender bender has gone unreported for fear of rising rates or changing terms.

Tendering the matter is always a wise tactic, but just as (or more) important is understanding how the contract works, especially when it comes to claim triggers and reporting requirements. This starts with underwriters making it a focal point of discussion with brokers and brokers then making it the most critical part of renewal discussions and stewardship meetings.

There has been evidence of a changing or firming marketplace and carrier need for rate across the industry. There are many reasons cited for this including years of depressed pricing in the face of increased exposure. One thing that often is not discussed is the rules of the contract and the convenience of those rules that has become standard for brokers when advocating for their clients. Asking a carrier to ignore reporting requirements because a claim would otherwise be covered is like ignoring the requirements of that contract from the start. There are of course exceptions and there is room for human error, but there needs to be more discussion around the mechanics of how the policy works and what the expectations of the insured are.

The brokerage community spends countless hours dissecting and negotiating perceived holes within the contract and there are constant blogs, posts and articles outlining these deemed deficiencies. What underwriters would like to be talking more about is the mechanics of how the policy works. That includes what events are considered Wrongful Acts, at what time do these Wrongful Acts become a claim and how best to get that claim in the hands of the carrier. All of these are defined within the policy and moving toward a model where this becomes the focal point of all carrier, broker and insured discussions, would result in a better understanding of the process, better functioning contracts and partnerships based on trust and mutual respect.

## Conclusion:

It is clear that the timely reporting of claims and notices can help to build collaborative relationships between insureds and their insurers, foster better claim resolution strategies, and keep costs down for all parties involved. Timely reporting can also help to avoid or mitigate many future problems during the claims handling process. Having reasonable reporting requirements within the policy not only can help lead to better outcomes, it gives the underwriters the information they need to make informed decisions about the risk going forward. Reporting these matters need not be about "when" but rather "how" and if there is any doubt, tendering is always the best solution.

Informed decisions and improved claims reporting metrics will lead to responsible deployment of capital, thus creating a more sustainable market for all.

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## QUESTIONS?

Contact your local Allied World Underwriter.

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