This article was originally published in Enforce *(Volume 9, Issue 1)*

Enforce
The Insurance Policy Enforcement Journal

Third Party Administrators
The New Target for Insurer Claims?

By David E. Wood

Rarely are companies under more pressure to be efficient, and to squeeze all available value out of every business transaction, than in a troubled economy. Risk-shifting transactions between an insurance company and a policyholder — i.e., buying insurance — are no exception. Once the scope of coverage is agreed upon and the premiums are paid, many insurance companies look for ways to increase value for their shareholders by reviewing claims with extra scrutiny. Policyholders know to expect this from certain insurers, whose corporate culture is to contest coverage wherever possible.

But even aggressive carriers can't and don't decline every claim. Paying claims is the insurance company's job. It is what the insurance company holds out as its value proposition to its customers. When a policyholder submits a clearly covered claim, the insurer has few legitimate opportunities to garner a discount to reduce the carrier's financial obligation. Yet, as insurance companies work to be more efficient on the pricing side of their business, and must pay obviously covered claims to be competitive, they look for other avenues of generating additional value. Under the press of a down economy, insurers may look outside the insurance policy to enhance their value.

The Great Recession is witnessing an uptick in litigation aimed at shifting otherwise covered losses to third parties who are strangers to the insurance contract. Insurance companies are taking another look at the duties of third-party administrators (TPAs), asking whether breaches of TPAs' professional standards of care may have contributed to a loss otherwise covered by the carrier. The insurer's objective often is to interrupt the investigation and payment of an otherwise covered claim, and to force the TPA (and its professional liability carrier) to the bargaining table as contributors when it comes time to pay the claim.

Corporate policyholders sometimes choose not to purchase first-dollar commercial liability insurance for high-frequency and generally low-severity claims made against them, preferring to hire a TPA to adjust such claims within a high self-insured retention over which they purchase excess coverage. These policyholders, in effect, act as their own

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primary insurers, delegating the actual claim handling to their TPAs.

When a covered claim exceeds the self-insured retention and triggers the insurance policy, the excess carrier may look for a way out of paying the claim by shifting the loss to the insured's TPA. The insurer may contend that the TPA did not give it timely notice of claim, or did not keep it adequately informed of the claim's progress before the self-insured retention was exhausted, or failed to settle the claim within the self-insured retention when it had a chance. These arguments find their genesis in the insured's duties to give notice and to cooperate (found in most policies), or the duty to handle claims in good faith (found in excess workers' compensation policies), which the policyholder has delegated to the TPA. Even though the TPA is an agent for a disclosed principal (the policyholder), the insurance company triangulates the claim administrator and the insured by complaining about handling of a claim, hoping to avoid or reduce its payment obligation.

Common sense, not to mention custom and practice in the insurance industry, suggests that the TPA owes duties of care solely to its client, the policyholder — not to the insurance company with which the TPA is not in privity. In most states, breaches of duty to give notice to and cooperate with the insurance company under occurrence-based policies are valid coverage defenses only when the insurer has been substantially prejudiced. So, if a TPA has been dilatory in giving notice or by failing to cooperate, the policyholder would be the only party with standing to recover the portion of the loss that could have been avoided had notice been timely and cooperation been above reproach.

Traditionally, subrogation was the only route by which the insurance company could gain access to the assets (and professional liability coverage) of the TPA. The insurer would first pay the claim, becoming subrogated to the policyholder's right of action against the TPA, then sue the TPA in the name of the insured. The carrier could not compel the TPA and its malpractice insurer to participate in the process of settling the original insurance claim the carrier received a premium to cover. Reallocation according to relative fault was possible only after this process was concluded by the insurance company's payment of the claim. Nothing stood in the way of the policyholder's recovery of the covered claim from the insurer.

One court has now recognized a direct duty of care running from the TPA to the insurance company, jeopardizing the policyholder's ability to promptly recover a covered claim from its carrier. By asserting a direct malpractice claim against the TPA, the carrier can avoid having to pay the claim (a condition precedent to being subrogated to the insured's rights of action), refusing coverage based on the claim administrator's alleged mistakes. This gives the carrier a new way to avoid or postpone payment of an otherwise covered claim by involving a third party with whom it has no contractual relationship. *See National Union Fire Insurance Company of Pittsburgh, PA v. Cambridge Integrated Services Group, Inc.* (2009) 171 Cal.App.4th 35.

With this case in hand, insurance companies are demanding that TPAs and their carriers attend California mediations and settlement conferences ready to contribute toward payment of covered claims. This disrupts contractual relationships between TPAs and their corporate clients, and allows insurers to avoid covering risks they were paid to assume. The best way to avoid shifting to TPAs the coverage obligations of their clients' carriers is for administrator and client to foster a strong relationship impervious to triangulation by an insurer. This way, if there is ever an issue

about how a claim was handled, it can be resolved privately between client and TPA, without cutting off the client's insurance company's duty to pay the policyholder's loss sooner rather than later.

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