Artificial Intelligence: A Paradigm Shift for Insurance

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Introduction

Rapid advancements in artificial intelligence (“AI”) are happening in many industries, and the insurance industry is no exception. The new paradigm for AI in the insurance industry is to rely less on human interaction between policyholders and insurers in the placement of insurance policies and in the handling of claims, and to rely more on direct data transfer from a policyholder to the insurer’s AI platform for immediate analysis and decision-making.

Indeed, insurers are now asking their policyholders to provide real-time data from sensors that are measuring the policyholder’s activities, with the data being relayed to insurers for processing by AI with minimal human involvement. For example, with personal lines auto insurance, consider a scenario where the insurer provides a sensor to incorporate into a driver’s automobile. The sensor can relay information to the insurer’s computer to learn how many miles per week the driver is using the vehicle, whether it is mostly highway driving or city driving, what are the speeds at which the vehicle is being driven, whether the driver brakes the car abruptly or gradually, and a whole host of other factors relating to the use of the vehicle. With this information, the AI in the insurer’s computer system determines whether the driver is careful or reckless, and the magnitude of the risk in underwriting insurance for the vehicle – and then the AI calculates a premium for

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coverage and issues a quote. This use of artificial intelligence is not just happening in the personal lines area, but also in commercial lines, where insurers are asking corporate policyholders to provide real-time data about their business operations by use of sensors in their facilities and jobsites.

A host of legal and other issues arise from this new paradigm in the use of AI by insurers. One such issue arises from the accumulation of mountains of personal data by the insurers. Governments in the United States and in Europe have recently enacted laws placing significant responsibility on those entities that collect and process such data to protect its privacy and confidentiality. Moreover, there are constant attacks by hackers and other malicious actors trying to steal, corrupt and misuse such data, and insurers will need to be vigilant against such attacks, and face the consequences if they allow themselves to be victimized.

Another issue that will confront insurers as they rely more and more upon AI to make judgments about underwriting and claims handling is whether the algorithms and formulas governing those judgments incorporate, consciously or unconsciously, inherent bias against subgroups of policyholders. Indeed, the AI relied upon by insurers may not be making mere mathematical calculations, but rather may be reflecting the judgments – and biases – of the programmers writing the code that governs the AI output. So long as there is human involvement in the development of the key formulas that drive that output, then the biases, prejudices and/or predispositions of the programmers can be embedded in those formulas – with the possibility of an unfair result. In such a case, an insurer may be held liable for the unfair result – even if they have little appreciation of what led to the result.

The accelerating use of AI in an insurer’s business operations will also have significant impacts on the application of traditional legal principles that govern the insurer-policyholder relationship. Fundamental issues that have steered the underwriting of insurance policies and the handling of claims for hundreds of years, such as concepts of uncertainty, fortuity, predictability, disclosure and good faith, among others, take on a new dimension when the principal actors to be analyzed are AI machines, rather than human beings. Specifically, if the decisions, judgments and actions that result in the issuance of an insurance policy, or the occurrence of a loss, or the payment of a coverage claim are being made by AI
rather than human actors, how does it affect the application of traditional legal principles governing insurance law?

This Paper considers some of the legal issues that often arise in coverage disputes between policyholders and insurers and reviews those issues in the context of artificially intelligent actors that have a substantial role in the conduct in question. For example, allegations of a policyholder’s alleged misrepresentations and/or material omissions in policy application periodically give rise to coverage disputes. In addition, the concept of “expected or intended” is one that can be the subject of insurer-policyholder disputes when claims arise. Also, the concept of timely notice of claims, and alleged prejudice from late notice, is often debated when claims are presented. Finally, whether an insurer has satisfied its legal duties to a policyholder of good faith and fair dealing can be the point of contention in the handling of an insurance claim.

This Paper can only scratch the surface of the impact of AI on resolution of the coverage issues discussed herein. The authors hope that this Paper will provide food for thought among lawyers practicing insurance law to help shape the law’s development to fit the changing circumstances presented by the rapidly growing role of AI in the business of insurance and in everyday life.²

**Misrepresentation/Material Omission Defense**

Historically, allegations of misrepresentations or material omissions by a policyholder in applying for an insurance policy have been fodder for insurers to deny claims. Yet, the advancement of real time data collection technology may ultimately lead to the extinction of this defense, as risks will be underwritten based on previously-collected (or, in some instances, on-the-spot) data from a policyholder that is directly fed into AI computers, with little or no filtering by the policyholder in the process.

In the past, an insurer seeking to avoid coverage on a theory that it did not fully understand the nature of the risk it was insuring would seek to void the insurance policy based on a policyholder’s alleged failure to disclose, which is

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² As a point of reference, this Paper will discuss legal insurance issues, as they relate to applications of artificial intelligence, principally by reference to New York substantive insurance law.
known as a “misrepresentation” or a “material omission.” See Travelers Indem. Co. of Ill. v. CDL Hotels USA, Inc., 322 F. Supp. 2d 482, 498-99 (S.D.N.Y. 2004). It has been held that a policy procured through material misrepresentation by the insured may be rescinded by a court. See Nat’l Union Fire Ins. Co. of Pittsburgh, PA v. Hicks, Muse, Tate & Furrst, Inc., NO. 02 CIV 1334 (SAS), 2002 WL 1313293, at *5 (S.D.N.Y. June 14, 2002). A misrepresentation is deemed “material” when the insurer “would not have issued the policy had it known the truth.” Id. Specifically, in order for a misrepresentation or omission to be considered “material,” it must be established by the insurer that it would not have issued the same policy if the correct information had been disclosed.” See Parmar v. Hermitage Ins. Co., 21 A.D.3d 538, 540-41 (N.Y. App. Div. 2005) (citing cases).

However, this traditional coverage defense may become obsolete in the new world of AI and the ever-expanding use of real time data collection, transmission and processing. An insurer typically would raise a defense of misrepresentation/material omission if a claim is made and the insurer then determines that there was some fact about the risk that it would have wanted to know at the time of underwriting, but was not informed of it by the policyholder – and further, had the insurer known of it, the insurer would never have issued the policy or would have charged a higher premium.

This coverage defense arose centuries ago when there was unequal information between a policyholder and insurer about the nature of a particular risk to be insured. Indeed, the doctrine of uberrimae fidei (“utmost good faith”) dates back to the 17th Century when marine insurers relied on ship owners to disclose all of the relevant information about the seaworthiness of a vessel before a marine insurance policy was issued. See, e.g., N.Y Marine & Gen. Ins. Co. v. Tradeline (L.L.C.), 266 F.3d 112, 123 (2d Cir. 2001) (describing notion of uberrimae fidei in marine insurance).

Yet, the notion of a policyholder having to disclose all material information about a risk, whether or not the insurer specifically requests that information, should not be viable where an insurer has ready access to all the relevant information through real-time, unfiltered transmission of data from the
policyholder, which is being reviewed and analyzed by the insurer’s AI, along with AI’s review of all publicly available sources of information relevant to the risk.  

Indeed, such transparent, on-the-spot underwriting already is being used for commercial drone insurance, where digital apps allow drone pilots to instantaneously insure drone flights a la carte. See THE ECONOMIST, Huge Volumes of Data Make Real-Time Insurance a Possibility (Sept. 21, 2017), available at https://www.economist.com/finance-and-economics/2017/09/21/huge-volumes-of-data-make-real-time-insurance-a-possibility. These apps collect data from third-party sources to take into account weather, topography, and proximity to airplanes to determine the risk of the drone flight. See id. Further, such insurance apps can monitor the drone itself, “gathering data as it flies to build a risk profile for that machine.” Id. The insurer’s AI can provide an instant premium quote, as well as advise pilots on reducing their risks. Id. Extrapolated to a larger scale, it is not difficult to envision a world in which large, commercial policyholders similarly will be able to quickly insure their risks based on an insurer’s collection of real-time data directly from sensors and cameras at the policyholder’s facilities and operations, and then, with the benefit of AI, quickly analyze the data, quote a premium and execute a sale of the policy.

This type of AI-aided real-time underwriting may become standard operating practice for insurance companies in issuing particular policies. Accordingly, the whole premise for the “misrepresentation/material omission” defense may fade away if an insurance underwriter need not rely on the human element of a policyholder’s employee, with imperfect knowledge, filling out an application to provide relevant underwriting information and submitting it to the insurer. If the insurer is receiving real-time, unfiltered data from the policyholder, then the insurer is in an equal-information position as the policyholder. Hence the insurer cannot complain that there was some misrepresentation or omission by the policyholder that caused it to misjudge the risk.

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3 In addition to making these information-sharing functions more time-efficient, blockchain technology will also achieve these tasks more cost-effectively. See Matthew Lerner, Insurers test out blockchain, BUSINESS INSURANCE, December 2017, at 4.
**Liability for Data Storage & Processing**

Another issue may arise with the new paradigm of insurers receiving direct access to detailed policyholder information, which is being collected, analyzed and processed by the insurer’s AI computer, is the responsibility that comes with possessing massive amounts of such data. Jurisdictions within and outside the United States are enacting legislation intended to hold accountable entities that collect, process, and store personal data. For example, in 2018, California passed the Consumer Privacy Act (the “CCPA”). *See* Senate Bill No. 1121, AB375, Cal. Civ. Code § 1798.100 *et seq.* (2018). The CCPA applies to for-profit entities doing business in California which meet certain criteria. *See id.* The CCPA provides consumers with certain rights with regard to an entity’s storage of their personal information. For example, a consumer may submit a request to the entity in order to ascertain what personal information it has collected regarding the consumer. *See id.* Additionally, a consumer may similarly submit a request for a copy of the personal information that the entity has collected for that consumer. *See id.*

In conjunction with granting additional rights to consumers, the CCPA also places additional responsibilities on the business entities to which it applies. Not only must the entities comply with requests discussed above, but the CCPA also provides for a private right of action for data breaches. *See id.* § 1798.150. Therefore, entities collecting information relating to their consumers face the risk of liability should they inadequately protect personal data. While it is still unclear how such liability will take shape through litigation, it would appear that an insurer’s monitoring of an insured in real time (and therefore collecting substantial amounts of data) could expose the insurer to new risks related to potential breaches.4

Similarly, the European Union’s General Data Protection Regulation (the “GDPR”) took effect in 2018. *See generally* EUROPEAN COMMISSION, 2018 Reform of EU Data Protection Rules,

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The GDPR, much like the CCPA, is intended to protect individuals’ private, personal information during data processing. To this end, again like the CCPA, the GDPR provides for both public enforcement and private rights of action in instances where data processing entities fail to secure consumers’ data and a breach results. See id., Enforcement & Sanctions, https://ec.europa.eu/info/law/law-topic/data-protection/reform/rules-business-and-organisations/enforcement-and-sanctions_en (last visited Jan. 17, 2019). The GDPR applies broadly to companies or entities that “process[] personal data as part of the activities of one of its branches established in the EU, regardless of where the data is processed[].” Id., Who Does the Data Protection Law Apply to?, https://ec.europa.eu/info/law/law-topic/data-protection/reform/rules-business-and-organisations/application-regulation/who-does-data-protection-law-apply_en (last visited Jan. 17, 2019). Thus, any company, including insurers, doing business in the EU likely is affected by this regulation.

A factor that insurers must consider in this new paradigm is whether their AI platform is set up to comply with the data laws being enacted by governments. Specifically, if the law requires a collector of personal data to be able to respond to customer requests to give back data that it has collected, is the platform designed to be able to do that? If not, does the insurer need to modify its platform (or that of its third-party vendor) to be able to comply? One thing is certain, with these new laws permitting private rights of action against collectors and processors of information, lawsuits will ensue when the data is mishandled or misused. Thus, insurers collecting such data may need to buy their own insurance policies to protect them from the consequences of non-compliance and/or private lawsuits.

The “Expected or Intended” Defense

Generally, the expected or intended coverage defense (“Expected/Intended Defense”) is one in which an insurer argues that liability coverage is precluded because the policyholder expected or intended the damage or injury giving rise to the liability. In other words, the insurer argues, when the policyholder engaged in the act or omission giving rise to the injury or damage in question, the policyholder expected or intended that the injury or damage would result. Many policyholders
are now using AI in their business operations to make judgments and decisions that humans made in the past -- and this has significant implications for the continued viability of the Expected/Intended Defense.

The presence of AI in policyholder decision-making may impact the application of the Expected/Intended Defense in a number of ways. For example, courts will be forced to grapple with the question of whose expectation or intention is relevant? Is it the person who allowed AI to make the critical decision that led to the liability – or is that person blameless if the decision was made by an algorithm embedded in the AI function, with no explicit ratification by a human actor? This question implicates a number of commonly debated legal questions relating to the Expected/Intended Defense.

For example, one issue typically debated between policyholders and insurers is the question of whether the “expected or intended” question should be resolved by application of a “subjective” or “objective” standard. Policyholders typically argue that the subjective standard applies – namely, did the policyholder, in his or her mind, actually expect the resulting injury or damage resulting from the activity in question. By contrast, insurers frequently argue that an “objective” standard should apply – arguing that, regardless of whether the policyholder actually did expect or intend damage, a reasonable person in the position of the policyholder should have expected, or should have understood, that the activity in question would lead to injury or damage.

The New York Court of Appeals, in Continental Casualty Co. v. Rapid-American Corp., 609 N.E.2d 506, 510 (N.Y. 1993), adopted a subjective approach to the Expected/Intended Defense. At issue in Rapid-American was a policyholder’s insurance coverage for asbestos-related personal injury actions. Id. at 508-09. The insurance policy at issue in Rapid-American defined the term “occurrence” as a “continued or repeated exposure to conditions which unexpectedly or unintentionally results” in injury/damage. Id. at 509. As the Court of Appeals explained, “[f]or an occurrence to be covered under the [insurer’s] policies, the injury must be unexpected and unintentional. We have read such policy terms narrowly, barring recovery only when the insured intended the damages.” Id. at 510 (emphasis added). Accordingly, in Rapid-American, the Court of Appeals essentially collapsed the meaning of expected or intended into an
inquiry solely limited to the policyholder’s intent. In adopting a subjective standard, the Rapid-American court favorably cited two earlier Court of Appeals decisions, both of which are consistent with the subjective approach that measures expectation or intent based on the policyholder’s actual state of mind. Id. (citing McGroarty v. Great Am. Ins. Co., 329 N.E.2d 172 (N.Y. 1975), and Miller v. Cont’l Ins. Co., 358 N.E.2d 258 (N.Y. 1976)).

In McGroarty, the Court of Appeals of New York held that the policyholder’s excavation and construction on its own property, resulting in continuing property damage to a neighbor’s building, was not expected or intended despite policyholder’s knowledge that its actions “might lead to some eventual damage to the building.” 329 N.E.2d at 173-75. This knowledge of a “calculated risk,” however, did not equate to a finding that the policyholder “intended that plaintiff’s building should, as a result, incur the damage which did eventuate.” Id. at 175. Similarly, a New York Appellate Division court has held that a policyholder who manufactured asbestos-containing products did not expect or intend — for purposes of voiding insurance coverage — the resulting asbestos-related injuries. See Union Carbide Corp. v. Affiliated FM Ins. Co., 955 N.Y.S.2d 572, 575 (App. Div. 2012). Instead, that court found that the policyholder “was merely aware that asbestos could cause injuries and that claims could be filed” and that its “‘calculated risk’ in manufacturing and selling its products despite its awareness of possible injuries and claims does not amount to an expectation of damage.” Id.

By contrast, an insurer typically argues that an “objective standard” should be applied to determine if a policyholder expected or intended injury such that the resulting liability is excluded from coverage. For example, insurers cite County of Broome v. Aetna Casualty & Surety Co., 540 N.Y.S.2d 620, 622 (App. Div. 1989), which involved a coverage dispute concerning environmental liability arising from a landfill that the County had operated for more than a decade before ceasing its operation. A federal complaint against the County alleged that certain wastes dumped in the landfill while it was in operation were contaminating the nearby soils and groundwater and causing personal injuries and property damages. Id. at 621. The insurers contended that there was no occurrence because the injuries and damage caused by the dumping should have been expected by the County, which was “aware” of pollution being caused by its operation of the landfill and yet it
chose to continue its operations unabated. *Id.* at 621-22. The County argued that the “consequences” of the dumping “were neither expected nor intended” and it was “at most only negligent in allowing pollution to development.” *Id.* The Appellate Division sided with the insurer and found that the evidentiary record indicated that the County “was aware of the problems at the landfill” based on previous inspections conducted by various governmental units, and despite this awareness, the County “continued to permit dumping at the landfill.” *Id.* at 622. In reaching this conclusion, the Appellate Division stated: “…personal injuries or property damages are expected if the actor knew or should have known there was a substantial probability that a certain result would take place.” *Id.* (citing *Auto-Owners Ins. Co. v. Jensen*, 667 F.2d 714, 719-20 (8th Cir. 1981)).

Considering these two different approaches for analyzing the Expected/Intended Defense, let’s hypothesize that a pesticide manufacturer engages in robust pre-product-launch testing to determine if a newly developed pesticide product can be used safely and effectively for its intended purpose. In so doing, the manufacturer commissions hundreds of tests to be conducted regarding product efficacy, toxicity, and possible side effects under many different environmental conditions, over a period of many years, in many different countries around the world. Because of the magnitude of the volume of data generated from this multi-year battery of testing, the manufacturer feeds all of the data into an AI computer (think IBM Watson) to review all of the data and determine whether the product, when used, will be safe and effective such that it can be launched into the market for sale. Subsequently, the AI computer analyzes all the data and concludes that the pesticide manufacturer should proceed with launching the product.  

After the product launch, however, there is a significant harm caused by the product – hypothetically, the pesticide kills desirable honey bees in addition to killing undesirable insects. This killing of honey bees leads to liability claims of farmers and others that rely on honeybees to pollinate their crops.

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5 One example of an industry in which AI can assist a policyholder in business decisions is pharmaceuticals. See, e.g., Faggella, Daniel, 7 Applications of Machine Learning in Pharma and Medicine, TECHMERMERGE (Jan. 11, 2018), [https://www.techemergence.com/machine-learning-in-pharma-medicine/](https://www.techemergence.com/machine-learning-in-pharma-medicine/) (“The use of machine learning in preliminary (early-stage) drug discovery has the potential for various uses, from initial screening of drug compounds to predicted success rate based on biological factors.”) (last visited Jan. 25, 2018).
Under the “subjective standard” for the Expected/Intended Defense, the policyholder cannot be said to have “subjectively expected or intended the damage giving rise to liability because the policyholder’s only relevant thought was to rely on AI to make the determination that the product, when launched, would be safe for use. Because there was no subjective judgment by any particular individual at the pesticide manufacturer one way or another, there could not be any subjective expectation (or intention) of harm. The manufacturer is simply relying on the AI computer to make that judgment. Thus, it would seem that a pesticide manufacturer using AI in that scenario would, by definition, be insulated from any argument by the insurer that the Expected/Intended Defense applies.

On the other hand, if the “objective standard” applied under the relevant state law for consideration of the insurer’s Expected/Intended Defense, the analysis would be different in our pesticide product hypothetical. Specifically, the insurer would argue that, based on all available information, the policyholder “should have expected” the damage resulting from the product launch. Nonetheless, the pesticide manufacturer could counter that the judgment to launch the product was made by the AI computer, and therefore, in relying on the “go forward” decision of AI, it cannot be argued that it “should have known” of the adverse consequences of the product launch because a purely objective analysis of the data performed by the AI computer made the determination that harm was not foreseeable. Thus again, the policyholder could insulate itself from an “objective standard” Expected/Intended Defense because the quintessential objective actor – i.e., the AI computer dispassionately analyzing all available data – did not expect the harm that ultimately occurred. See also William Shaw, What Insurers Need to Know as Driverless Cars Hit UK Roads, LAW360 (Jan. 17, 2018, 6:35 PM GMT), https://www.law360.com/insurance/articles/1002678/what-insurers-need-to-know-as-driverless-cars-hit-uk-roads?nl_pk=9d1f10d8-b507-4f78-a964-0f044d49e0dc&utm_source=newsletter&utm_medium=email&utm_campaign=insurance (noting that proposed law for driverless cars would “essentially impose strict liability for insurers” who can then “pursue their own product liability claims against the manufacturers of software, or of the vehicles themselves”).

The analysis may be further complicated by a manufacturer’s retention of a third-party consultant to use its AI computers to analyze data and make product launch decisions. Consider a scenario where a policyholder outsources those
decisions to be made by a consultant that uses AI for such decisions. In this circumstance, an insurer advancing an Expected/Intended Defense can pivot to a new argument that the relevant issue is whether it was reasonable for the policyholder to retain and rely upon a third-party consultant with an AI computer to make the product-launch decision because that reliance was the relevant act, rather than the product launch itself, that led to the harm in question.

In short, the development of AI in business judgment decision-making adds a new dimension to the “Expected/Intended Defense” that policyholders may be able to take advantage of in fending off this particular coverage defense by insurers. If policyholders are no longer making the key subjective business judgments that may give rise to liability, how can they be alleged to have “expected or intended” the injury or damage arising from those judgments? After all, “expected” or “intended” is an analysis of a human state of mind, and not an analysis of a computer calculation.

**Late Notice Defense**

A common disputed issue in insurance coverage claims is that of whether the policyholder provided “timely notice” of a claim or loss to the insurer. If notice is deemed to have been untimely, some jurisdictions require an insurer to prove that it was prejudiced by the late notice in order to avoid coverage for the claim or loss, *see Brakeman v. Potomac Insurance Co.*, 371 A.2d 193, 196 (Pa. 1977), whereas, under other jurisdictions, a showing of prejudice may not be required before an insurer can deny coverage based on late notice grounds. *Am. Home Assurance Co. v. Int’l Ins. Co.*, 684 N.E.2d 14, 18 (N.Y. 1997). *But see N.Y. INSURANCE LAW § 3420 (McKinney 2013) (“No policy or contract insuring against liability . . . shall be issued or delivered in [New York], unless it contains in substance the following provisions . . . (5) A provision that failure to give any notice required to be given by such policy within the time prescribed therein shall not invalidate any claim made by the insured . . . unless the failure to provide timely notice has prejudiced the insurer[.]”). In the case of reinsurers, a showing of prejudice is required before the reinsurer can deny coverage based on late notice. *See Unigard Sec. Ins. Co. v. N. River Ins. Co.*, 594 N.E.2d 571, 583 (N.Y. 1992) (“[F]ailure to give the required prompt notice is of substantially less significance for a reinsurer than for a primary insurer.”).
With the rise of AI in insurers’ claims-handling operations, the importance of a policyholder giving specific notice to an insurer of a loss may diminish in importance. For example, if a hurricane makes landfall in a particular area of the Texas Gulf Coast, it would be relatively easy for an insurer’s artificially intelligent computer to scan all of the underwriting files of its policyholders and to determine, with speed and precision, which of its policyholders’ facilities are located in the landfall area. Indeed, the insurer may also have sensors at the policyholder’s location automatically transmitting data showing that it has been flooded and/or damaged. At that point, the insurer may make the initial contact with the policyholder regarding any potential loss or damage and send out a claims adjuster immediately. In such a scenario, what is the necessity of the policyholder going through the formality of sending an email to the insurer giving notice about the potential for hurricane-related loss at its facility? That fact would already be knowledge that is available to, and known by, the insurer.

It would make no sense to penalize the policyholder for failing to give timely notice to an insurer, when the insurer already knew about the potential loss – or could easily have learned about the potential loss – through its own AI business processes. Indeed, in the context of a marine insurance policy that provides hull and cargo insurance, marine insurers likely have access to worldwide shipping information that rapidly conveys to interested parties notice that a particular ship has gone down in the ocean. Again, with that information, an AI business process could quickly search an insurer’s business files and underwriting records to identify which policyholders either owned or chartered the vessel or had cargo being conveyed on that vessel. Moreover, there may be an existing, commonly accessible blockchain record that contains all transactions for that vessel, such that an insurer’s AI computer can connect to that blockchain record and search for any relevant policyholder property located aboard the vessel.

In these foregoing examples, the requirement of a policyholder giving formal notice of a loss as a prerequisite to coverage should no longer be necessary,

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6 See Vincent Branch, Chief Executive of Accelerate, *Artificial intelligence & insurance: The unexpected love affair?*, XL CATLIN (Nov. 26, 2017), http://xlcatlin.com/fast-fast-forward/articles/the-unexpected-love-affair (“And artificial intelligence will influence all parts of insurance, from how the product is sold, how we price and underwrite and to, most importantly, how we quickly pay claims.”).
given that the insurer can quickly learn of the loss – maybe as early or earlier than
the policyholder learns of the loss. Accordingly, if an insurer is made aware of a
policyholder’s potential loss through some means other than the policyholder’s
own communication of a formal notice of loss, the insurer should not be able to
point to the policyholder’s lack of timely communication about the loss to serve as
a basis for avoiding coverage.

**Bad Faith Claims Handling**

Finally, insurance policies place on insurers an obligation of good faith and
fair dealing in their claims-handling practices. Under New York law, for example,
bad faith claims are a type of punitive measure arising out of breach of contract
insurer acts in bad faith when: (1) its conduct is actionable as an independent tort;
(2) the tortious conduct is egregious; (3) the egregious conduct is directed toward
the plaintiff; and (4) the conduct is part of a pattern directed at the public generally.
*Id.; see also Sichel v. Unum Provident Corp.*, 230 F. Supp. 2d 325, 328 (S.D.N.Y.
2002) (describing N.Y.U. test as claim for “bad faith denial of coverage”). Bad
faith is a tort remedy available as the result of a breach of contract. *See Wiener v.
claim is available to an insured who can demonstrate that the insurer made a bad-
faith refusal to pay out policy benefits. *See Acquista v. N.Y. Life Ins. Co.*, 285

Recent reports suggest that insurance companies may be relying more and
more on AI in the handling of policyholder claims. *See Brenna Hughes Neghaiwi
& John O’Donnell, Zurich Insurance starts using robots to decide personal injury
stating “We recently introduced AI claims handling . . . and saved 40,000 work
hours, while speeding up the claim processing time to five seconds[. . . We
absolutely plan to expand the use of this type of AI[.]]”); *see also Norton Rose
Fulbright, Unlocking the blockchain: A global legal and regulatory guide*, at 10,
15 (noting that insurers are considering use of “smart contracts” to aid in claims
handling); Matthew Lerner, *Blockchain technology breaks through*, BUSINESS INSURANCE, July 2017, at 7 (same).

If an insurer’s decisions on whether to accept and pay a claim – or alternatively to deny a claim – are made by AI, rather than by human judgment, there are significant implications for insurance bad-faith law. For example, in bad-faith cases, key issues that are often litigated include: (i) whether an insurer’s decision to deny a claim is “unreasonable”; and (ii) whether, in denying coverage, the insurer acted with malice – namely, with a reckless disregard for the facts supporting coverage. *See Rancosky v. Wash. Nat’l Ins. Co.*, 170 A.3d 364, 377 (Pa. 2017) (holding that an insurer acts in bad faith when it knowingly or recklessly disregards its “lack of a reasonable basis in denying the claim,” which can be demonstrated by a “motive of self-interest or ill-will,” among other factors).

Thus, a bad-faith claim against an insurer can include inquiries that are objective in nature – *i.e.*, whether a claim denial is unreasonable – as well as inquiries that focus on the state of mind of the insurer – *i.e.*, whether the insurer’s decision to deny coverage was motivated by self-interest or ill-will. In this regard, an insurer may attempt to insulate itself from a bad-faith claim by arguing that a denial of coverage was determined by an AI computer, applying parameters set forth in an algorithm that was designed without any particular desired result. Of course, this argument may be rebutted by showing that an insurer’s reliance on AI to make coverage decisions was unreasonable because of obvious flaws in the relevant algorithms, or because the algorithms were skewed improperly toward denying coverage rather than accepting coverage for a claim. Policyholders may also argue that it is *per se* unreasonable for an insurer to delegate claims-payment decisions to a computer, without human review of those decisions. Such a debate could require new and different kinds of expert testimony on both sides of the bad-faith debate. Indeed, rather than each side proffering a bad-faith expert who typically has had decades of experience handling insurance claims, the parties may need to retain technical experts who understand in detail how the AI computers are programed, and whether the programs have particular biases or leanings. Indeed, the battle of bad-faith experts could be transformed into a battle of AI experts.
Conclusion

As the foregoing discussion illustrates, the growing use of AI by insurance companies and policyholders may provide interesting new twists on traditional legal issues that are commonly disputed in the insurance coverage arena. In addition, entirely new areas of dispute will likely arise in the context of contested coverage claims. Courts will no doubt be forced to grapple with these new areas of dispute, and the insurance lawyers who are best equipped to understand and explain the workings – and limitations – of AI will be ahead of the game when these questions arise.