Managing Crisis: The COVID-19 Pandemic and an Insurer's Duty of Good Faith
"Statutory Claims Handling Guidelines Remain in Effect!"
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Background

Numerous state governors have issued "shelter in place" orders that effectively close all "nonessential businesses," i.e., those companies that are not in a critical infrastructure industry as defined by the Department of Homeland Security, such as insurance and pharmaceutical companies, healthcare providers and food suppliers. The White House also issued an updated Coronavirus Guideline to essential businesses that states, "If you work, you have a special responsibility to maintain your normal work schedule." In some cases, essential business are also required to offer separate hours of operation for vulnerable populations.

With respect to the insurance industry, insurers are on the verge of being inundated with claim filings of historic proportions. It is projected that the bulk of these claims will relate to property insurance and the loss of business income associated with the large-scale disruption of global supply chains, interruptions of business operations, major events being cancelled, construction projects halted, and fallout from government-imposed closure orders. In tandem with increased claim volume, insurers have received notifications from a number of state regulatory agencies demanding that they comply with additional and more stringent claims handling requirements, and requiring insurers to submit advisory coverage opinions relating to COVID-19, before a claim is even filed.

Requirement for Advisory Opinions

Preliminary coverage opinions can expose a carrier to a breach of contract or bad faith allegation if their *actual* opinion on a specific claim differs from an earlier advisory opinion. Thus, even most courts will refuse to issue advisory opinions for the same reason, *i.e*., because each case differs! Nonetheless, the New York Department of Financial Services recently issued such a notice to insurers operating in that state:

> Given the potential impact of COVID-19 on business losses, particularly concentrated effects in local communities, DFS considers Insurers' obligations to policyholders a heightened priority. In the interest of the timely and equitable fulfillment of insurance contracts, Insurers must explain to policyholders the benefits under their polices and the protections provided in connection with COVID-19. Any Insurer that writes none of the business described herein should notify DFS in a statement signed by an officer or other authorized representative of the Insurer in lieu of complying with the provisions below.

- First, each Insurer should provide to DFS the volume of business interruption coverage, civil authority coverage, contingent business interruption coverage and supply chain coverage the Insurer wrote that has not lapsed as of the date of this letter, which should be expressed in amounts of direct premium, policy types and numbers of policies written of each type.

- Second, each Insurer should examine the policies it has issued and explain the coverage each policy offers in regard to COVID-19 - both presently and as the situation could develop to change the policyholder's status (i.e., is there any potential for coverage as a result of COVID-19).

- For each policy type, Insurers should prepare such information in a clear and concise explanation of benefits that is suitable for policyholder review. Insurers should then send such explanation to each of their policyholders of the applicable policy types. Insurers should also send copies of all such explanations to DFS, along with a representation that the explanations have been provided to the Insurer's policyholder.

- The explanation to policyholders should include all relevant information, including, without limitation:

    - What type of commercial property insurance or otherwise related insurance policy does the insured hold?

- Does the insured's policy provide "business interruption" coverage? If so, provide the "covered perils" under such policy. Please also indicate whether the policy contains a requirement for "physical damage or loss" and explain whether contamination related to a pandemic may constitute "physical damage or loss." Please describe what type of damage or loss is sufficient for coverage under the policy.

- Does the insured's policy provide "civil authority" coverage? If so, please describe what type of damage or loss is sufficient for coverage under the policy. Please also describe any relevant limitations under the policy. Please explain whether a civil authority prohibiting or impairing the policyholder's access to its covered property in connection with COVID-19 is sufficient for coverage under the policy.

- Does the insured's policy provide "contingent business interruption" coverage? If so, please describe what type of damage or loss is sufficient for coverage under the policy. Please provide the "covered perils" under such policy. Please also indicate whether the policy contains a requirement for "physical damage or loss" and explain whether contamination related to a pandemic may constitute "physical damage or loss."

- Does the insured's policy provide "supply chain" coverage? If so, is such coverage limited to named products or services from a named supplier or company? Please also indicate whether the policy contains a requirement for "physical damage or loss" and explain whether contamination related to a pandemic may constitute "physical damage or loss."

- For each instance of coverage described above, please provide the applicable waiting period under the insured's policy. Please also indicate whether the amount of time coverage remains in effect once becomes active for a given incident.

Demands for Insurers to Waive Policy Exclusions

In addition to the recent spate of regulatory mandates on insurers, there are ongoing legislative efforts seeking to require insurers to waive legitimate policy exclusions, and to cover pandemic-related claims where coverage does not exist. For example, HB 589 (Ohio) states that all existing insurance policies that provide coverage for loss of use and occupancy and business interruption shall be construed to include coverage for business interruption due to global virus transmission or pandemic during Ohio's state of emergency, which was declared on March 9, 2020. If passed, the bill would apply to businesses located in Ohio that employ 100 or fewer full-time employees.

Massachusetts introduced similar legislation in Bill No. SD.2888, which applies to companies that employ 150 or fewer full-time employees. While the Ohio bill does not expressly address the treatment of virus exclusions or the requirement that there be "direct physical loss or damage" to covered property, the Massachusetts bill is very clear on that point: "no insurer in the commonwealth may deny a claim for the loss of use and occupancy and business interruption on account of (i) COVID-19 being a virus (even if the relevant insurance policy excludes losses resulting from viruses); or (ii) there being no physical damage to the property of the insured or to any other relevant property."

The Massachusetts bill also provides that "[f]or the avoidance of doubt, this act is subject to Chapter 176D of the General Laws." Chapter 176D concerns Unfair Methods of Competition, and Unfair and Deceptive Acts and Practices in the Business of Insurance. By including this reference, the Massachusetts legislature is sending a very clear warning to insurers that the bill, if enacted into law, must be complied with fairly and in good faith.

Lastly, the Wisconsin Office of the Commissioner of Insurance recently ordered ("at no extra cost to policyholders") that:

(1) Insurers cannot deny a claim under a personal auto policy solely because the insured was engaged in delivery of food on behalf of a restaurant, until restaurants resume normal operations.

(2) GL Carriers must notify restaurant-insureds that hired and non-owned auto coverage is available and, if requested, must provide this coverage.

Interestingly, there was no mention by the Wisconsin Commissioner about any premiums that the insurance company is out of, i.e., whether the carrier should be entitled to collect back-premiums for being required to provide commercial coverage for future claims under a personal lines policy.

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Under that backdrop, this article will discuss the various minefields that insurers must navigate during the COVID-19 pandemic in order to stay on the right side of good faith claims handling and avoid undue allegations of bad faith.

Reasonable Insurer's Test During a Pandemic

An onslaught of insurance claims of an extraordinary magnitude will likely result from the COVID-19 pandemic, taxing the industry's resources and challenge its efforts to reach timely coverage determinations and adjustments, especially if there is an ongoing need for social distancing. Under normal circumstances, if an insurer takes an unreasonable amount of time to investigate a claim and reach a coverage decision, there will be allegations of bad faith delay made against the carrier. However, the COVID-19 crisis is not a "normal circumstance." Therefore, the question becomes – what is "reasonable conduct" when examining whether an insurer acted in good faith while at the same time being besieged with an inordinate number of claims? Seemingly, the short answer is, "it depends." Most courts have held that whether an insurer's conduct is unreasonable or vexatious is generally a question of fact, not dependent upon any single factor or attitude, length of time, amount of money or situation of the policyholder. Thus, each case must be decided on its own facts.

In addition, it should not be overlooked that there are numerous instances where a good faith claims investigation requires face-to-face contact. Many of these investigatory tasks now must be curtailed, modified or delayed due to "social distancing" recommendations. Does any resultant delay caused by a need for social distancing create an exposure for bad faith? Moreover, lest not forget that policyholders also have obligations that they must fulfill as a precondition to coverage and that might be delayed for similar reasons. For example, most property policies state:

Duties In The Event Of Loss or Damage

a. You must see that the following are done in the event of loss or damage to Covered Property:

(1) Notify the police if a law may have been broken.

(2) Give us prompt notice of the loss or damage. Include a description of the property involved.

(3) As soon as possible, give us a description of how, when and where the loss or damage occurred.

(4) Take all reasonable steps to protect the Covered Property from further damage, and keep a record of your expenses necessary to protect the Covered Property, for consideration in the settlement of the claim. This will not increase the Limit of Insurance. However, we will not pay for any subsequent loss or damage resulting from a cause of loss that is not a Covered Cause of Loss. Also, if feasible, set the damaged property aside and in the best possible order for examination.

(5) At our request, give us complete inventories of the damaged and undamaged property. Include quantities, costs, values and amount of loss claimed.

(6) As often as may be reasonably required, permit us to inspect the property proving the loss or damage and examine your books and records. Also permit us to take samples of damaged and undamaged property for inspection, testing and analysis, and permit us to make copies from your books and records.

(7) Send us a signed, sworn proof of loss containing the information we request to investigate the claim. You must do this within 60 days after our request. We will supply you with the necessary forms.

(8) Cooperate with us in the investigation or settlement of the claim.

b. We may examine any insured under oath, while not in the presence of any other insured and at such times as may be reasonably required, about any matter relating to this insurance or the claim, including an insured's books and records. In the event of an examination, an insured's answers must be signed.

That said, courts rarely punish a policyholder because of an undue delay in complying with these duties and, in fact, many courts give leniency to an insured if it corrects the breach of duty. Conversely, however, as of this writing no legislative bills nor regulatory notices have been issued that seeks to relax an insurer's obligations to conduct a prompt investigation or disposition of claims or to lessen the penalties they suffer for any failure to do so, because of the pandemic.

Is a Hasty Investigation Unreasonable?

If the facts of a policyholder's loss and the law and policy are clear, is it unreasonable or bad faith for an insurer to make a quick decision to deny coverage? What if the denial of coverage was

correctly based on the policy's terms and conditions? A case on point was recently filed in the Northern District of Illinois.

In *Big Onion Tavern Group, LLC, et al. v. Society Insurance, Inc*., No. 1:20-cv-02005 (N.D. Ill. March 27, 2020), the plaintiffs include over a dozen owners and operators of Chicago area restaurants and movie theaters that were allegedly forced, by orders from the State of Illinois, to cease their operations as part of the State's efforts to slow the spread of the COVID-19 virus. The plaintiffs assert that Society Insurance failed to honor its obligations under their commercial businessowners insurance policies that included business interruption coverage for losses caused by a necessary suspension of their operations.

According to Society's denial letter that was attached as an exhibit to the complaint, the insureds' claim was denied because there was no covered cause of loss, i.e., no "Direct Physical Loss" suffered by the plaintiffs that was necessary to trigger coverage, under the terms of the policy. Society's denial letter further contends that a slowdown in business due to the public's fear of the coronavirus, or a suspension of business because a governmental authority (*i.e.*, the governor or the mayor) has ordered or recommended all or certain types of businesses to close is not a direct physical loss.

Society also stated that the policy's Civil Authority provision requires that a Covered Cause of Loss cause damage to property other than the property at the described premises, and that access to the area immediately surrounding the damaged property be prohibited by a civil authority. For those reasons, Society concluded that there is no coverage because:

- The Coronavirus is not a Covered Cause of Loss;
- A civil authority has not prohibited access to the insured's business because of a Covered Cause of Loss that caused damage to a premises other than the described premises; and
- The actual or alleged presence of the coronavirus is not a Covered Cause of Loss.

The plaintiffs contend, however, that Society issued blanket denials of coverage to plaintiffs for any losses related to the closure orders — often within hours of receiving plaintiffs' claims — without first conducting any meaningful investigation. In that regard, Society's denial letter reflects that it was issued three days after the loss was reported. The insureds also allege that, upon receipt of the claims, Society "immediately denied the claims (either verbally or through cursory emails) without conducting any investigation, let alone a 'reasonable investigation based on all available information' as required under Illinois law."

Further, the plaintiffs claim that Society *prospectively* concluded that Society's policies would likely not provide coverage for losses due to a governmental-imposed shutdown due to COVID-19, when the insurer circulated a memorandum to its agency partners, before the plaintiffs even submitted their claims to Society. That memorandum -- "This is how various coverages would likely respond to COVID-19 claims" states:

FIRST-PARTY CLAIMS

Business Income coverage: Whether it be a full shutdown of business, a partial suspension of operations or an alteration in business operations that remain open, Business Income coverage must be due to a suspension caused by *direct physical loss of or damage to covered property at the described premises. The loss or damage must be caused by or result from a Covered Cause of Loss*.

Extra Expense coverage also requires the same coverage triggers. In general, a quarantine of any size, or brought about by a governmental action without a Covered Cause of Loss, would likely not trigger Business Income or Extra Expense coverages under our policies.

Civil Authority coverage: Civil Authority additional coverage pays for actual loss of Business Income and Extra Expense caused by an action of civil authority that prohibits access to the described premises when *a Covered Cause of Loss causes damage to property other than property at the described premises*. A widespread governmental imposed shutdown due to COVID-19 (coronavirus) would likely not trigger the additional coverage of Civil Authority.

The plaintiffs allege that Society's policies did not include an exclusion for loss caused by a virus and that this led the plaintiffs to expect that the insurance included coverage for property damage and business interruption losses caused by viruses like COVID-19. Alleging that Society could have issued policies with a virus exclusion, but chose not to do so, the plaintiffs claim that Society is now "try[ing] to limit its exposure on the back-end through its erroneous assertion that the presence of the coronavirus is not 'physical loss' and therefore is not a covered cause of loss under its policies."

Because of prior pandemic outbreaks, many property policies now contain specific exclusions for damage arising from viral or bacterial related losses. For those carriers that have incorporated the following Insurance Services Office's (ISO) language into their commercial property policies, their exposure to Coronavirus related claims will likely be limited:

EXCLUSION OF LOSS DUE TO VIRUS OR BACTERIA
This endorsement modifies insurance provided under the following:
COMMERCIAL PROPERTY COVERAGE PART

STANDARD PROPERTY POLICY

A. The exclusion set forth in Paragraph B. applies to all coverage under all forms and endorsements that comprise this Coverage Part or Policy, including but not limited to forms or endorsements that cover property damage to buildings or personal property and forms or endorsements that cover business income, extra expense or action of civil authority.

B. We will not pay for loss or damage caused by or resulting from any virus, bacterium or other microorganism that induces or is capable of inducing physical distress, illness or disease. However, this exclusion does not apply to loss or damage caused by or resulting from "fungus", wet rot or dry rot. Such loss or damage is addressed in a separate exclusion in this Coverage Part or Policy.

C. With respect to any loss or damage subject to the exclusion in Paragraph B., such exclusion supersedes any exclusion relating to "pollutants".

D. The following provisions in this Coverage Part or Policy are hereby amended to remove reference to bacteria:

1. Exclusion of "Fungus", Wet Rot, Dry Rot And Bacteria; and

2. Additional Coverage – Limited Coverage for "Fungus", Wet Rot, Dry Rot And Bacteria, including any endorsement increasing the scope or amount of coverage.

E. The terms of the exclusion in Paragraph B., or the inapplicability of this exclusion to a particular loss, do not serve to create coverage for any loss that would otherwise be excluded under this Coverage Part or Policy.

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In addition to allegations for breach of contract, the plaintiffs in *Big Onion Tavern Group, LLC, et al. v. Society Insurance, Inc.* seek statutory penalties under the Illinois Insurance Code, 215 ILCS 5/155 based on among other things, Society's alleged coverage disclaimers issued "without conducting reasonable investigations based on all available information." It is important to note, however, that Illinois courts have stated on numerous occasions that a claim for violation of Section 155 is not available in the absence of coverage under the policy, *i.e.*, "where the policy is not triggered, there can be no finding that the insurer acted vexatious and unreasonably in denying the claim." *Rhone v. First Am. Title Ins. Co.*, 401 Ill. App. 3d 802, 815 (1st Dist. 2010). In other words, a defendant cannot be liable for section 155 relief where no benefits are owed. *Martin v. Illinois Farmers Ins*., 318 Ill. App. 3d 751, 764 (1st Dist. 2000) (internal citations omitted).

Therefore, if Society is successful in proving that coverage was properly denied, the plaintiffs' allegations of vexatious conduct against the insurer should seemingly be dismissed, unless the trial or appellate court elects to use this case as a basis to consider making new law in Illinois, as is the case in a few other states.

For example, in *Coventry Associates v. American States Insurance Co.,* 136 Wash. 2d 269 (1998), the insurer conceded that it conducted a bad faith investigation into a loss. Nonetheless, the trial court granted summary judgment for the insurer on the coverage question and granted its

motion to dismiss the bad faith claim. The court of appeals affirmed, but the Washington Supreme Court reversed.

The court reasoned that under Washington law, insurers have not only a general duty of good faith, but also a specific duty to act with reasonable promptness in investigating and communicating with their insureds following notice of a claim and tender of defense. The court further reasoned that the duty of good faith is broad, all-encompassing and not limited to an insurer's duty to pay, settle or defend.

> The implied covenant of good faith and fair dealing in the policy should necessarily require the insurer to conduct any necessary investigation in a timely fashion and to conduct a reasonable investigation before denying coverage. In the event the insurer fails in either regard, it will have breached the covenant and, therefore, the policy.

Similarly, note the court's holding in *Zilisch v. State Farm Mut. Auto. Ins. Co.*, 196, Ariz. 234 (2000): "if an insurer acts unreasonably in the manner in which it processes a claim, it will be held liable for bad faith without regard to its ultimate merits." *Id* at 236. Also, see *LeRette v. American Medical Security*, Inc., 705 N.W.2d 41, 48-49 (Neb. 2005). The court reasoned that where facts supporting a bad faith claim differ from those supporting a breach of contract claim, an insured need not prevail on the breach of contract claim in order to prevail on the bad faith claim. Nor does ultimate payment of the claim defeat a bad faith claim. Finally, note the court's holding in *Nelson v. Hartford Underwriters Ins. Co.*, 177 N.C. App. 595, 609 (2006):

> [N]othing in the case law… *requires* that the tortious conduct be accompanied by a breach of the contract, even though most, if not all, of the cases have as a factual background the insurance company's refusal to pay. We do not believe an action for punitive damages from tortious conduct is precluded when the company eventually pays, if bad faith delay and aggravating conduct is present." *Robinson v. N. Carolina Farm Bureau Ins. Co.*, 86 N.C. App. 44, 49-50 (1987). Thus, even if an insurance company rightly denies an insured's claim, and therefore does not breach its contract, as here, the insurance company nevertheless must employ good business practices which are neither unfair nor deceptive.

Only a small number of states have established a cause of action for bad faith in the absence of coverage. Therefore, insurers should exercise caution, particularly in those states, before reaching a hasty coverage decision where evidence might suggest a less than thorough claims investigation prior to a rightful denial of a coverage.

Statutory Claims Handling Guidelines are not Relaxed During a National Emergency

Some courts have held that statutory claims handling guidelines, including timeliness requirements, remain in effect during worst-case scenarios. For example, under Louisiana law,

insurers have "an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant." La. R.S. 22:1220. They risk statutory penalties of up to two times the damage incurred if claims are not paid within 60 days of receipt of a valid proof of loss. Notably, these penalties can be imposed even absent a finding of bad faith, and there is no exception in the law if the insurer's resources are taxed.

Notably, in *Maloney Cinque, LLC v. Pacific Ins. Co.*, 89 So.3d 12 (La. App. 4th Cir. 2012), plaintiffs owned several truck stops in the New Orleans area that were damaged as a result of Hurricane Katrina. Settlement of the claim was delayed by Pacific's calculation of a coinsurance penalty as well as scheduling difficulties. Allegedly, Pacific not only failed to timely pay the claim, it failed to timely pay the undisputed damages. The plaintiffs filed suit, arguing that while the claim was ultimately paid, it was not paid timely as required by law.

After trial in May 2010, the district court entered judgement in favor of the plaintiffs (with the exception of attorney fees), ultimately issuing a written opinion awarding $2,386,354.50 in statutory late payment penalties alone. It applied, and later discounted the coinsurance provision. On appeal, and after a rehearing on the coinsurance issue, the court found that the coinsurance provision was inapplicable because the insurer had breached the insurance contract by delaying payment. The appellate court recast the judgement against the insurer as follows: (1) $290,903 for extra expense damages and a penalty of $72,725.75 for late payment of extra expense damages; (2) a penalty of $151,580.50 for late wind-damage payments; (3) $782,241.75 in lost profits and $ $1,173,362.62 in penalties for late payment; (4) a penalty of $50,000 for late payment of claimed business income. Notably, the insurer was not found to have acted in bad faith but it was still punished to the tune of $1,447,668.87 for its delays.

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Insurers operate under a continuing duty of good faith and fair dealing, even during extraordinary circumstances such as disasters and national emergencies. In *Sher v. Lafayette*, 988 So.2d 186 (La. 2008), plaintiff's filed a claim for property damage to his five-unit apartment building after Hurricane Katrina and was only partially paid. Lafayette determined that most of the buildings damage was due to poor maintenance, disrepair, and flooding. They paid the plaintiff a total of $2,755.08 sometime after a November 2005 inspection. Plaintiff sued Lafayette and among the charges in the complaint was a count for bad faith; i.e., Louisiana law requires payment of a claim within 30 days where an insured provides satisfactory proof of loss to the insurer.

The jury returned a verdict against Lafayette and awarded plaintiff $553,615.00, and $184,538.00 of the judgment was for Lafayette's breach of their statutory duty of good faith for failing to pay promptly. The jury found Plaintiff's contention that the loss was reported to Lafayette in the first two weeks of September 2005 more believable than Lafayette's contention that they first received notice of the loss in October of 2005. What is important to note, however, is that the appellate court did not view the insurer's taxed resources as a basis to relax the statutory requirement for the insurer to initiate loss adjustment within the required 30 days.

Conclusion

Bad faith suits against insurers arising out of the COVID-19 pandemic will probably run the gamut, i.e., allegations that the insurance company was too quick to deny coverage, or took too long to investigate a claim and reach a coverage decision. To strengthen its defense in this area, insurers should emphasize to their claims staff the importance of:

– Maintaining a well-documented claims file that outlines the steps of an investigation and which explains the basis for any delays;

– Conducting a reasonable, good faith and prompt investigation;

– Ensuring that "red flags" used to justify a lengthy investigation are material and relevant to the circumstances of the claim;

– Adhering to the contractual and regulatory timelines for reaching a coverage decision on a claim; and

– Ensuring that all coverage rights are properly reserved and that communication with the insured is maintained during the course of an investigation.

About the Author

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