INSIGHTS

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Battling the Bad-Faith COVID-19 BOOGEYMAN Known as "Deficient-Investigation" Claims

By Kevin Quinley

A core tenet of claims handling is that insurers must conduct a reasonable investigation. Emerging coverage litigation against insurers by policyholders seeking protection against damages related to COVID-19 often includes bad-faith counts alleging "failure to investigate" and deficient fact finding. Although adjusters are urged to conduct good-faith investigations, few authorities cite specific steps that claims professionals should take in investigating COVID-19 claims. This article aims to fill that void by offering nine practical strategies for sound fact-finding processes. It also discusses related perils of hair-trigger coverage denials, challenges pertaining to understaffing, and the implications of remote work on investigative quality.

Author's Note

This article does not address coverage issues related to applying virus exclusions, civil authority actions, and so on. Instead, it focuses on bad-faith claims grounded in allegations of deficient investigation. I am not a lawyer, and what follows is not legal advice. I offer my perspectives as a claims specialist who often serves as an expert witness on bad-faith cases nationwide. The best practices discussed in this article do not necessarily represent claims industry standards of care.

Civet and pangolin are not meat options available at the nearest Whole Foods deli counter.

Nevertheless, these animals—living or not—abound in so-called wet markets in Wuhan, China, and other parts of East Asia. And although the origin of the coronavirus pandemic remains murky, many scientists trace the zoonotic infection to Wuhan's open-air markets, which often sell live animals to people accustomed to eating exotic species.

The resulting COVID-19 virus has triggered an epidemiological crisis and an insurance firestorm, generating an epidemic of lawsuits from breach of contract and bad-faith claims against insurers.

Already, policyholders have launched initial waves of litigation against insurers, with most lawsuits seeking coverage for business interruption losses. The restaurant and hospitality industries have been particularly devastated by business shutdowns.

The race is on to find deep pockets to offset the financial havoc wreaked by the coronavirus. One such attractive deep pocket is the insurance industry, which many consumers view as a repository of riches, swift when billing and collecting premiums, but slow to pay claims.

These consumers contrast warm and friendly TV ads with the treatment some policyholders feel they receive after filing claims. To counter this perceived phenomenon, one restaurant-industry group has formed a Business Interruption Group, beseeching legislators to make insurers cover business interruption claims from coronavirus-driven shutdowns.

Many bad-faith claims resulting from COVID-19 will include allegations of wrongful coverage denial. One battleground will be whether the presence of a virus contaminating—or threatening to contaminate—property constitutes property damage or direct physical loss to property. A related battleground will involve policies with virus exclusions. Yet another attempted coverage pathway may be shutdowns stemming from government edict.

As an expert witness on litigated cases around the country, I see plaintiffs' attorneys routinely allege deficient investigation or failure to investigate, or assert that insurers deny claims without a reasonable investigation. Plaintiffs' counsel usually have no idea, when filing suit, what investigation the insurer did or did not conduct, but deficient investigation is a routine bad-faith allegation.[1] Failure to conduct a reasonable investigation will figure prominently in the forthcoming wave of lawsuits involving coverage for COVID-19.

Good-Faith Guidelines

Emerging lawsuits against insurers include allegations of bad faith based on insurers' failure to conduct reasonable investigations before denying coverage. Axiomatic in claims handling is the principle that an insurer receiving a claim should conduct a reasonable investigation. Section 4 of the NAIC Model Act—Unfair Claims Practices Defined includes as one unfair claims practice, "refusing to pay claims without conducting a reasonable investigation."[2]

Even groundless claims create risks in the form of necessary legal defense fees.

Some insurers have issued what customers view as warp-speed denials—decisions so fast that, plaintiffs reason, there is no way insurers could have done a reasonable investigation. Concerns arise that adjusters simply read "virus" in claims reports, spot "virus" in policy exclusions, and issue hasty coverage denials, slamming claim files shut.

The risk of bad-faith claims from deficient investigations is not purely theoretical. For example, multiple Chicago restaurants sued Society Insurance Company in United States District Court, Northern District of Illinois, alleging, among other things, that 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.'"[3]

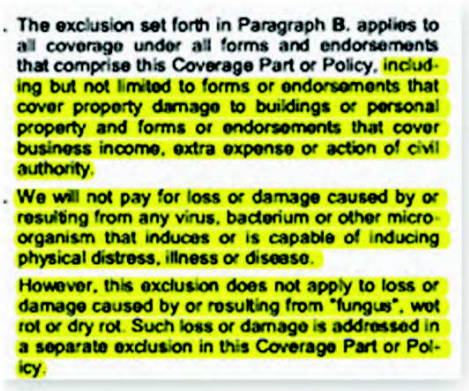
Claims managers or defense attorneys exhort adjusters to conduct reasonable, good-faith, prompt investigations. However, the operational challenge for front line adjusters is translating platitudes into practical, actionable steps.

What is a reasonable investigation for COVID-19 claims? Few templates exist to guide adjusters in such an endeavor. That said, here's an attempt to substitute a list of nine action steps for platitudes through the contours of such an investigation:

1. **Read the entire policy!** Not a sample, not just the Declarations page, and not just the body of the document without any endorsements.

   The claims adjuster should review the whole policy and reference that in the claim file notes. If the form is a post-2006 policy, check to see whether a virus and bacteria exclusion appears.

The following Insurance Services Office, Inc., form will be among those whose language insurers and policyholder lawyers will deconstruct in detail to contest insurance coverage for COVID-19 claims:[4]



. 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.

. 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.

Look closely at how the policy defines key terms such as "property damage."

For third-party liability claims, check how the policy defines "occurrence." Expected or intended exclusions may also influence COVID-19 claims investigations, along with pollution or communicable disease exclusions.

2. **Contact the insured.** An interview with or statement from the insured is warranted. Insurers who deny coverage without ever having spoken with the policyholder are vulnerable to bad-faith claims based on deficient investigation. (Whether such claims succeed is another question.)

3. **Review the relevant state's unfair claim settlement practices act and regulations.** Although many states have common features, certain jurisdictions have detailed requirements for time limits for acknowledging claims, time limits within which insurers must accept or deny, time limits for periodic policyholder updates if insurers lack sufficient information to accept or deny, and so forth.

   Now is not the time to run afoul of state unfair claims practices regulations, so continuing education refreshers for claims staffs are essential.

4. **Involve the agent or broker.** Discuss the file with the insurance agent or broker. If the adjuster is leaning toward a no-coverage stance, discuss your reasoning with the insurance intermediary and determine whether they have a different perspective. The adjuster is not seeking approval from the agent or broker, but the agent or broker might raise an issue or mention a fact that the adjuster should weigh before reaching a final decision. The agent or broker may also concede that the adjuster's coverage analysis jibes with the policy. Or he or she may be agnostic and defer coverage decisions to the adjuster.

   This consultative step also includes the insurance agent or broker in the process, giving the courtesy of advance notice if an irate call comes from a policyholder saying, "I thought you sold me full coverage!"[5] In fact, the adjuster and insurance intermediaries may agree that the latter will provide advance notice to insureds regarding developing (non)coverage notices.

5. **Engage an environmental engineer** to conduct an assessment of contamination or lack thereof.

   If policyholders seek coverage on the grounds that the presence of the COVID-19 virus on their property constitutes damage to property, insurers contemplating denial may include in the investigation testing to see whether an insured property has trace elements of the virus. Test and sample findings may inform coverage decisions.

6. **Contact the underwriter** who wrote the policy, to see whether a blind spot may have afflicted adjusters in analyzing coverage. If an underwriter disagrees with the adjuster's rationale, that's a red flag the adjuster should weigh. If the underwriter concurs with the adjuster's rationale for denial, record that due diligence step in a claim file note, showing that the adjuster was deliberate in investigating coverage and did not rush to judgment.

THE RACE IS ON TO FIND DEEP POCKETS TO OFFSET THE FINANCIAL HAVOC WREAKED BY THE CORONAVIRUS

7. **Seek input from outside coverage counsel.** This will incur expense, but not doing so may incur more expense in the long run by inviting bad-faith claims that no legal opinion vetted the adjuster's coverage analysis. This is not to say that seeking coverage opinions from outside counsel is required, necessary, or standard practice. However, given the contentiousness of COVID-19 claims and the propensity for litigation, adjusters may opt to obtain the advice and counsel of a coverage attorney before making final decisions. This can be an investment in due diligence and money well spent.

8. **Roundtable the coverage issue** within the Claims Department. Include a claims supervisor, perhaps a claims manager, and peer-level adjusters.

The old saying that "Two heads are better than one" applies. This extra step stress tests the adjuster's coverage analysis and minimizes the odds of analytical blind spots that could lead adjusters to shaky denials. Again, this does not imply that every coverage issue warrants a roundtable or that failure to convene one equals bad faith. What insurers seek is a protocol to inoculate themselves from bad-faith claims.

9. **Consider retaining a forensic accountant.** One investigative challenge with business interruption claims is that such losses often need forensic accountants to compare pre-loss to projected post-loss extra expenses and profits. Few claims professionals have this expertise. These calculations take time and are complex.

   Where insurers accept coverage or handle it under a reservation of rights, adjusters should consider retaining a forensic accountant early to avoid delays related to assessing damages and scope of loss. This is part of a reasonable investigation of damages.

   The perils of bad-faith claims investigations are not confined to first-party property claims, however. Other landmines loom.

Bad-Faith Setups and Time-Limit Demands

Although most headlines regarding insurance coverage tussles have focused on business interruption first-party cases, a separate wave of liability lawsuits will crash against corporations and—later, by extension—their insurers. Target defendants include but are not limited to hospitals, senior living facilities, cruise lines, gyms, airlines, and the entertainment industry.

One database developed by an international law firm estimated that as of May 1, 2020, 771 liability claims had been filed.[6] Capturing the number of third-party liability cases arising from COVID-19 is challenging, as that number is dynamic and can change daily. Tabulating this subset of COVID-19 cases is an exercise in trying to hit a moving target.[7]

Insurers should expect attempted bad-faith setups and time-limit demands on third-party claims. Adjusters who fail to promptly respond to or accept a settlement demand within policy limits can find their employer (an insurer or third-party administrator) becoming a defendant in a bad-faith claim. If the claim goes to trial and produces a jury award above the policy limit, the insurer faces a lawsuit from an insured, third party, or excess insurer as a plaintiff alleging bad-faith failure to protect the policyholder (or excess insurer) when the primary insurer could and should have done so.

Clever plaintiffs' attorneys may try to derail insurers, issuing tight time limits for responses (such as 10 days) and sending time-limit demands to insurers' mail processing centers, betting it will take extra time for mail to find its way to the handling adjuster. They may time receipt of demands to fall on weekends or holidays, when adjusters are likely to be out of the office or on vacation.

This is a peril in any claims office's daily operations. But given the tidal wave of claims expected from COVID-19 litigation, savvy plaintiffs' attorneys may exploit the environment and issue more time-limit demands, banking on the likelihood that demands may slip through the cracks in overwhelmed, overworked claims departments and create opportunities to allege that the insurer squandered the chance to defuse a dangerous claim.

Thus, expect and be vigilant for increased time-limit demands. Establish escalation procedures to triage incoming mail for time sensitivity, ensuring that the mail center spots and expedites letters with time limits and matches them to the handling adjuster ASAP. In this way, the mailroom can be an indispensable linchpin in helping prevent large-dollar bad-faith claims.

New Developments in Concurrent Investigation

Adjusters often simultaneously investigate coverage, liability, and damages. However, in some states, this practice can pose claims handling risks.

The California Department of Insurance has suggested that insurers asking policyholders for damages documentation while simultaneously pondering coverage declinations may face allegations of unfair claims practices. The flip side: If an insurer accepts coverage or handles the claim while reserving rights, the damages phase of investigation will be farther along.

In April 2020, California's insurance commissioner, Ricardo Lara, notified all admitted and nonadmitted insurers and licensed insurance adjusters and producers that they must, among other things, "fairly investigate all business interruption insurance claims caused by the COVID-19 pandemic." One aspect of the notice focused on claims investigation:

> Upon receipt of a notice of claim, the insurer is required to provide the policyholder with the necessary forms, instructions and reasonable assistance, including but not limited to, specifying the information the policyholder must provide in connection with the proof of claim and begin any necessary investigation of the claim. [(Regulations, section 2695.5 (2.)] *Thereafter, every insurer is required to conduct and diligently pursue a thorough, fair and objective investigation of the reported claim, and is prohibited from seeking information not reasonably required for or material to the resolution of a claim dispute before determining whether the claim will be accepted or denied, in whole or in part.*[8] [Regulations, section 2695.7(d); emphasis added.]

The notion that insurers must pursue a "thorough, fair and objective investigation" is not new. However, for adjusters who concurrently investigate coverage and damages, the language of this notice may be disturbing. It mandates that adjusters sequence investigations and defer seeking damages information until the insurer accepts coverage.

In practice, adjusters often hedge. At the start of a claim, they don't know whether they will accept or decline coverage.

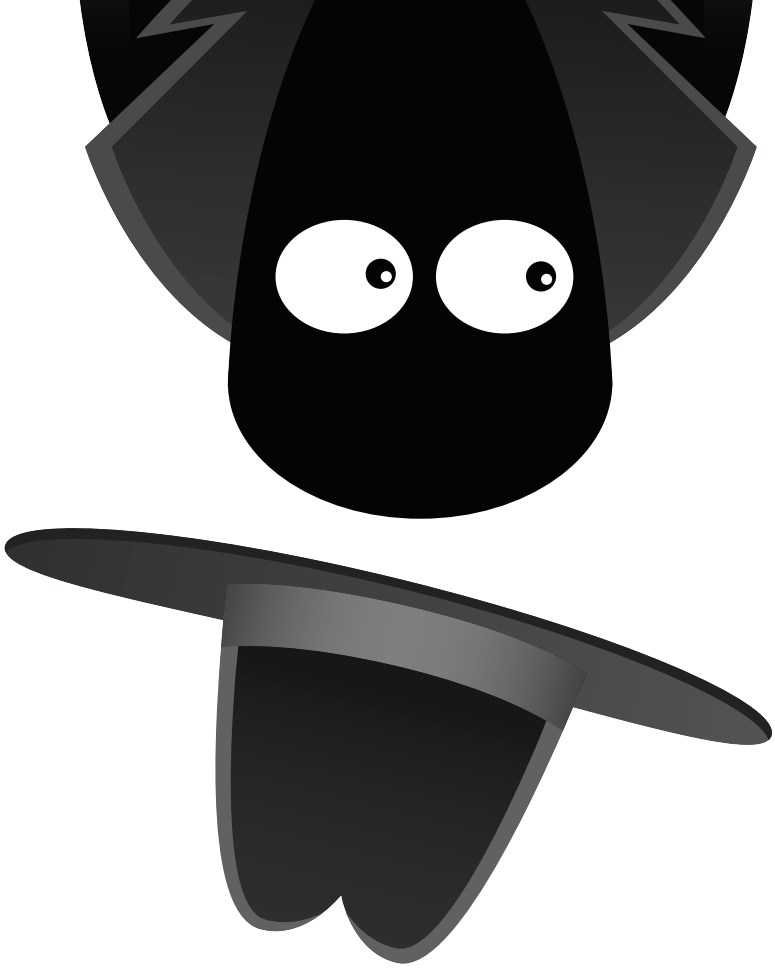
If they accept coverage or handle it under a reservation of rights, they investigate and seek information on damages in tandem with information germane to coverage. If they accept coverage, the claims process is farther along than if they had waited. Here, California's guidance implies that seeking damages documentation while coverage is still in question is verboten and could spawn bad-faith claims.

How Long Is Too Long?

A typical knock on insurers is that they delay and that such delays benefit them financially.[9] Now plaintiffs can criticize them for denying claims too soon.

Policyholders argue that there's no way an insurer could conduct a sound investigation if it denies coverage on the same date as or the day after the first notice of loss. What's a reasonable amount of time after which an insurer can deny coverage without opening itself to such criticism?

When it comes to reaching a coverage decision, no one knows how soon is too soon or how long is unreasonable. Juries may render judgment on the issue years after harried adjusters make coverage decisions based on the facts and circumstances before them.



Adjusters tread a tightrope. Take too long to make coverage decisions, and the insurer may face bad-faith claims arising from the delay. Speedily deny coverage after seeing "virus" in the claim and face accusations of bad-faith failure to investigate.

Insurers seek a happy medium. Overinvestigating can squander corporate resources, and some may view excessive investigation as an unfair claims practice or evidence of bad faith.

Volume Versus Resources

Claims departments may be insufficiently staffed to address the coming tsunami of COVID-19 claims. (And, in fairness, they could not have foreseen the coronavirus pandemic.) Insurers often keep claims departments lean, viewing them as cost centers, and the inclination exists to maximize caseloads per adjuster.

For example, an insurance colleague confided in me that her husband, a claims adjuster, received more than 200 claims in three weeks, 90 percent of which were COVID-19 business interruption losses. A co-worker of his who had 150 claims quit, and he and another adjuster were assigned those 150 between them. My colleague's husband now has 377 claims to handle! The departing adjuster gave two weeks' notice, but management didn't tell the remaining adjusters, nor did they hire a replacement.

Scenarios such as this likely occur throughout claims departments struggling to handle the volume of coronavirus claims. Conducting proper and reasonable investigations takes time, which remains the adjuster's scarcest resource.

MANY BAD-FAITH CLAIMS RESULTING FROM COVID-19 WILL INCLUDE ALLEGATIONS OF WRONGFUL COVERAGE DENIAL

High caseloads tempt adjusters to cut corners. And one of the first corners cut is often investigative thoroughness—leading to superficial or once-over fact-finding processes. Meanwhile, run-of-the-mill claims continue to demand attention.

Adjusters must not only grapple with a rising tide of coronavirus claims, but also face upcoming seasons rife with claims from floods, tornadoes, and hurricanes. This may create a perfect storm for claims departments, heightening the odds of bad-faith claims from COVID-19 and noncoronavirus losses alike, because of the personnel bandwidth devoted to contagion-related business interruption and liability claims.

Remote Adjusters and Investigative Quality

The contagion has accelerated a trend toward claims employees working remotely. Insurers can trim leasehold costs and capture other efficiencies by having claims staff telework.

Although many adjusters enjoy remote work, the arrangement imposes constraints. The pandemic may make it less likely that adjusters will perform in-person site inspections, scope of loss assessments, and hands-on fact finding that are features of many auto, homeowners, and property damage investigations. Limited administrative staff and IT support that normally help claims handlers optimize productivity is another constraint.

Although technology enables collaboration among claims peers and management, the inability of remote adjusters to walk down an office hallway and bounce ideas off co-workers or bosses may degrade the quality of claims handling. In fact, the trend toward decentralized, remote adjusters may have ominous implications for investigative quality with a variety of claims . The challenge for insurers and third-party administrators, then, is to maintain consistent management disciplines that ensure high-quality investigations harmonious with remote work.

As of winter 2020, pharmaceutical companies race to release coronavirus vaccines. Hopes are high for the speedy regulatory approval of the submitted antidotes to date, but even if they are approved and effectively distributed, the related health concerns may persist, as the current offerings have not been 100 percent effective in trials.

Likewise, claims professionals have no foolproof vaccine for inoculating themselves or their companies from bad-faith claims. In the arena of bad-faith risk prevention, no 100 percent guarantees exist. Embracing strategies outlined in this article, however, will help claims professionals mitigate risks of bad-faith claims based on allegations of deficient investigation. ■

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1. In lawsuit complaints, plaintiff attorneys advance opinions and allegations first and seek evidence to support them later through the discovery process. They reach conclusions first and fact-find later. In terms of upholding principles of "reasonable investigation," the methodology of plaintiff attorneys clashes with the standard they apply to insurers.

2. National Association of Insurance Commissioners, "NAIC Model Laws, Regulations, Guidelines and Other Resources," Unfair Claims Settlement Practices Act, January 1997.

3. *Big Onion Tavern Group LLC et al. v. Society Insurance Company*, United States District Court for the Northern District of Illinois, Eastern Division (No. 1:20-cv-02005).

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5. Like it or not, many observers predict a wave of lawsuits targeting insurance agents and brokers for failing to procure appropriate coverage for policyholders and/or misrepresenting the nature of the coverage that the intermediary placed for the policyholder/client.

6. "Businesses Hit by Wave of Litigation," *The Washington Post*, May 2, 2020, p. A20.

7. These resources may assist in tracking the current number of liability cases: COVID-19 Coverage Litigation Tracker and Hunton Andrews Kurth COVID-19 Complaint Tracker.

8. California Department of Insurance, "Commissioner Lara requires insurance companies to fairly investigate all business interruption claims caused by COVID-19," April 14, 2020, press release.

9. In this genre, see, for example, Jay Feinman, *Delay, Deny and Defend: Why Insurance Companies Don't Pay Claims and What You Can Do About It* (New York: Portfolio Books, 2010).