2020 CLM Focus Conference
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Virtual Conference
Narrative

How Debts and Financial Hardships (Will Continue to) Shape the Claims Process

I. First Party Insurance Challenges of Claimants' Financial Hardships

The current COVID-19 pandemic is affecting almost every area of our lives, and first party claims handling is no exception. In first party cases, the insured's financial distress, in at least some part impacted by COVID at this time, create unique challenges and exacerbates old challenges to claims handlers.

A. Historical Context – 2007-2009 Great Recession

We have a historical context for analyzing the challenges that first party insurers will confront in the event of an economic downturn. Following the 2007-2009 "Great Recession", a number of trends related to insured claims and coverage were noted.

1. Insurance Fraud increased due to economic downturn

During the economic downturn of the Great Recession, several classes of insured fraud claims were noted to have increased due to the downturn in the economy, according to a study from the Florida Department of Financial Services Division of Insurance Fraud (August 7, 2009). According to statistics from the National Insurance Crime Bureau, fiscal year 2008/2009 resulted in a 21% increase in referrals.

The types of fraud in which increases were noted included:

- Marine claims;
- Homeowner claims;
- Mortgage fraud;
- Worker's Compensation;
- Disability claim fraud;
- Auto claims;
    - Vehicle ditching;
    - Arson for profit;
    - PIP fraud via staged accidents;

2. Reductions in coverage limits

Another trend that followed the economic downturn was the reduction in coverage limits, in order to decrease the overall cost of the policy, and the increase in deductibles for the same purpose.

B. Immediate Issues Facing Insurers

Informed by the past, and taking into account the unique challenges due to the COVID-19 pandemic, we have identified a number of areas in which insurers are immediately facing issues.

1. Delays in processing claims

Understandably, there have been delays to the claims investigation process as a result of government mandates ("Stay at Home" orders), as well as social distancing to avoid spreading COVID-19. Specifically, insurers are facing an inability to conduct traditional claims investigations due to being unable or unwilling to engage in face-to-face contact with insureds. In particular, many insureds do not want claims staff coming into their homes or businesses due to fear of disease spread. For the same reason, many claims professionals are not willing to conduct in-person inspections absent Personal Protective Equipment (PPE). Additional delays are presented by a lack of contractors and/or vendors who are willing and able to engage face-to-face contacts with insureds.

Due to COVID-related delays, certain time-sensitive policy provisions are triggered that may not provide coverage for the duration of the loss. For example, homeowner's policies contain dollar and time limits for Additional Living Expenses ("ALE"). Delays in accessing the residence, investigating the loss, and engaging a contractor to perform repairs may lead to insufficient policy coverage and/or limits through no fault of the insured or the insurer.

2. Difficulties with deductibles

Economic challenges may mean that some have a difficult time covering their deductibles. This is aggravated if these same insureds have raised their deductibles in order to control the cost of their insurance coverage. This could lead to difficulty funding immediate repair costs, as well as delays in the repair process.

3. Influx of fraudulent claims, and cases involving aggressive actions by representatives of the insured

In addition to the anticipated increase in fraudulent claims, increased instances of vendors taking advantage of the situation are foreseeable. This could include a vendor allegedly "padding" a claim with the addition of inappropriate line items, inflating estimates, the inclusion of "COVID charges," and PPE charges. At the same time, there may be aggressive courting of the insureds by vendors, public adjusters, and counsel. An influx of cases involving plaintiff counsel's influence is therefore to be expected, with such counsel demonstrating an increased willingness to litigate claims involving denials or limitations in coverage. Increased extra-contractual litigation would be expected to follow.

C. Proactive Insurer Action Is Critical

In the face of any crisis, it is often helpful to return to a core purpose and back to the basics. Empathetic, prompt, and thorough claims handling is the best way to mitigate the challenges posed by COVID 19 and the economic downturn.

1. Focus on Empathetic Customer Service with Consideration of Proactive Business Decisions to Assist Insureds

The focus should be on customer service and showing empathy to the insured. This may require consideration of an expansion of coverage to meet the specific needs of the insured in light of a one-time hardship situation. For example, extensions of ALE or other time-sensitive coverages may be appropriate.

2. Focus on Documentation, Proactive Claims Handling, Claims Guidelines, and Clear Empathetic Communication with Stakeholders

With the expected increase in litigation, including extra-contractual litigation, the focus needs to return to proactive claims handling, and careful consideration of claims handling guidelines in your state. Claims handlers can achieve good results by thoroughly explaining the claims process, all coverages, any limitations or exclusions, and application of any deductibles up front. The policy should be relied upon, but concessions can be considered when appropriate to the circumstances. Pay what you know you owe when you know you owe it, and document all claims communication and handling.

Continue ongoing training, and look for opportunities to creatively engage the insureds. This could include the use of Zoom or Skype to conduct a scene investigation, or the use of video.

3. Early and appropriate involvement of SIU

Finally, in the face of red flags or other indications that insurance fraud may be at issue, engage your SIU departments early and appropriately. Appropriate contact with SIU should include specific facts or examples of conduct that raise the red flags.

II. Liability Insurance Challenges of Insureds and Claimants' Financial Hardships

A. Liability Claims of Increased Prevalence for Insurers and Insureds

1. Cyber Risks

So-called "cyber" policies, although they lack a uniform or prevailing coverage form in the insurance marketplace, often contain both first party components (for losses to the policyholder's own data or other harm to its business), and third-party coverages (for an insured's liability to clients and governmental entities based on a data or privacy breach).

"Work from home" has become crucial to the survival of many office-based businesses. But expanding the number and location of devices doing an insured's work, whether those devices are company-issued or personally-owned, also expands the network's risks. The easy lure of electronic theft and mischief has already threatened many over-extended electronic networks. If

breaches can happen to trusted governmental entities, they can happen to anyone: in Washington state, scammers' May 2020 unemployment-benefits fraud netted hundreds of millions, assisted by delayed mail responses from pandemic-closed offices; and during July 2020, a civil-litigation "Zoom trial" was uncivilly interrupted by "hacktivist" audio and video. Social engineering attacks are also rampant, preying on individual employees' trust and willingness to improve their financial positions by following instructions from familiar-looking links, logos, and names. Predictably, "cyber insurance claims" are following close behind.

Just one uninsured or under-insured "cyber" event or privacy breach could disastrously counteract any financial gains of policyholders that were fortunate enough to continue their business operations during the COVID-19 pandemic.

2. Paycheck Protection Program Recipients and Investigations

Obtaining federal government funds to stay afloat through the pandemic comes with its own novel set of risks, which may implicate both first party and third party insurance concerns. As a component of the federal government's Coronavirus Aid, Relief and Economic Security (CARES) Act relief package adopted in early 2020, the "PPP" (Paycheck Protection Program) provided businesses with 500 employees or less with forgivable loans if certain requirements were met, such as maintaining employees on their payroll and spending portions within a finite period of time.

As a recipient of PPP funds may also have asserted first party business income loss coverage claims, an insurer's analysis of such coverage may require repeated requests for information over a period of time. One matter to ascertain is whether the PPP loan is ultimately repaid or forgiven in whole or in part, to determine if any claw-back of benefits paid may be appropriate. Due care must be taken with particular policy language or the specific agreements entered into with a captive management company. The potential third-party risks include governmental investigations into PPP compliance attestations, which may yet develop to involve greater expenditure of defense costs than the applicant's total exposure to fines and penalties.

3. Consumer Protection Lawsuits / Class Actions

Consumers and their lawyers have used lawsuits as a check on alleged abuses of their financial uncertainties during the pandemic. When fears of price gouging on in-demand goods were relatively short lived, class-action lawsuits moved on to address terms-of-agreement revisions, "no refunds" policies, college tuitions, recurring fees (such as gym fees), and alleged exposure to health risks from continuing to do "business as usual" (e.g., against cruise lines).

Employers have also been subject to broad lawsuits arising out of their employment relationships. Overextended companies deciding on whether to retain or reduce their work force can be faced with a no-win situation. If they decide their employees can all come back to work, even with stringent safety protocols, the companies may be subject to lawsuits contending they subjected their similarly-situated employees and/or their families to unreasonable risks or alleged physical injuries. On the other hand, decisions to fire or release employees may cause them to seek wrongful termination remedies.

4. Professional Liability, including Employment Practices, Errors & Omissions, Directors & Officers coverage claims

The "silver lining" of employers being sued when their finances are likely already shaky is that management professionals are typically subject to well-defined (and broad-based) employment practices liability coverage. Other policy forms available to professional insureds may not be so well-defined, however.

If corporate stock-performance impacts were forestalled by CARES Act funding, allegations of corporate waste, misleading public filings, or failure to exercise strategic oversight could still develop over an extended period of time. Where "financial impairment" may be defined in Directors and Officers (and organization) liability policies as requiring a regulatory body's management or liquidation, the insurer may have a strong basis not to treat corporate interests as subject to hardship that warrants the insurer's proactive assistance during a downturn. But the insurer then needs to continue analyzing available information throughout the life of an underlying claim or lawsuit. This need is also demonstrated by conditions of D & O policies that coverage to directors and officers for their non-indemnifiable loss (known as "Coverage A") has "priority of payment" over the policy's remaining coverages. The insurer will timely pay costs to defend directors and officers on matters that the corporation initially refuses to reimburse, subject to a separate coverage limit and separate retention. If the corporation later relents and pays indemnification, the previously-paid insurance amounts could be subject to reallocation and restoration of the policy's "Coverage A" limit.

By contrast, errors and omissions policies typically fail to define financial impairment and thereby leave it to the insurer's discretion, case by case, regarding how best to address the debts and hardship of an insured that has never before experienced such a profound reduction of its ability to serve its clients, whether they involve construction work, dental, medical, legal or other skilled learning. Professional liability claims can also be driven by hardships such as the professional's alleged inability to perform contracted services, by negligence, or both; or conversely, by an underlying client with unpaid bills that the insured then pursues.

B. How Financial Issues Might Influence Liability Claims and Defenses

1. When it is Permissible to Consider Claimant or Insured's Finances

When evaluating an underlying claim, considering the value of the claim is essential, in addition to considering whether liability is reasonably clear. Such evaluations could come from defense counsel when a matter is in litigation, but during an underlying claim's pre-litigation phase, the exposure the insured faces is usually part of the claim handler's analysis. Who has the financial "upper hand" as between the claimant and the insured is important to determining the underlying exposure of the insured, as distinct from considerations of whether either one has more of an advantage against the insurance company.

When evaluating the existence of coverage under the insurance policy, factual background information about the claimant's and insured's underlying financial leveraging may be relevant. For example, breach of contract is usually non-covered under errors and omissions policies. In the pre-litigation phase of a claim, the insurer is without the benefit of a complaint that says

specifically what the legal theories asserted in a claim and/or counterclaim might be. For example, a "negligent construction" claim (in states that permit them) may potentially be covered, whereas breach of construction and related service contracts would not be covered. The insurer's investigation into the financial health of either contracting entity could be reasonably calculated to address whether the underlying claimant is foreseeably going to make the non-covered failure to perform a contract the gravamen of the complaint.

By contrast, the process of analyzing the insurer's duty to defend is generally subject to more restrictions, as discussed in II.B.2. below.

2. When it is Impermissible to Consider Claimant or Insured's Finances

In states where the "eight-corners rule" requires consideration of only "the claims alleged in the petition and the coverage provided in the policy" to determine if a "duty to defend" exists, there is no impact on the duty to defend so the insured's circumstances should not be considered. *Richards v. State Farm Lloyds*, 597 S.W.3d 492, 494 (2020). As a caveat, in some jurisdictions where the claimants' allegations are inadequate or otherwise unclear, additional information could be considered in favor of the insured, specifically to conclude that the duty to defend does exist. *Truck Ins. Exchange v. VanPort Homes, Inc.*, 147 Wn.2d 751, 761, 58 P.3d 276 (2002).

More importantly, as discussed in II.B.1. above, such extrinsic information is not necessarily irrelevant to whether coverage would be owed for the claim. Therefore, the consideration of an insured's finances could only be "impermissible" when it is entirely unrelated to the resolution of a coverage question under the policy.

Even so, there is a significant difference between considering and affording due care to the vulnerability of an insured and/or underlying claimant, and the untoward purpose of attempting to capitalize on those vulnerabilities to their detriment. The former can properly demonstrate sensitivity to a delicate dynamic in order to reduce mistrust and misunderstandings, and therefore such considerations would not be "impermissible."

C. Pre-Litigation Settlement Opportunities

1. Proactive Management of Limited Insurance Policy Proceeds

In fact situations involving multiple claims and/or profound underlying injuries that are clearly worth more than the insured's applicable policy limits, the insurer's experience can assist used to evaluate the anticipated claims before they are all filed. As part of its evaluation process, the insurer would consider the insured's available and potential resources to make the necessary contributions to resolve and obtain releases from all of the underlying claims. To date, reported case authorities have not held that the insurer's duties of good faith *requires* insurers to engage in early, proactive coordination with their insured to address both the known claimants and all potential future claimants. But in evaluating that an insurer's reasons for considering its insured's debts was to potentially preserve its policy's limits to achieve settlements within the available amounts, or even to preserve its own defense obligations, the insurer's conduct may be favorably characterized as considering the economics for the "right" reasons.

2. Capitalizing on Vulnerability is Neither an Actual or Apparent Goal

When an insurer approaches settlement early enough to discourage the filing of any litigation that involves its insured, its representatives want to avoid any appearance of using their superior financial power to extract concessions and promises that they would not be entitled to receive if the parties had *equal* bargaining power. It is also possible to consider expending the company's financial power for collective benefit. For example, considering the vulnerability of a claimant for the "right" reasons can extend to protecting the insured, and even an underlying claimant, from future related Medicare Secondary Payer (MSP) exposures. If the insurer is aware that a claimant has potential MSP reimbursement obligations, the insurer could provide advance planning assistance or low-cost resources, particularly for claimants that promise to satisfy any Medicare liens but are not wise enough with monetary planning after their receipt of settlement funds to reliably follow through.

III. Litigation Challenges Impacted By Debts and Financial Hardships

A. The First 1000 (or so) Insurance Lawsuits About COVID-19

1. States Where Most Commonly Filed

Before August 2020, almost a thousand cases were filed (973, according to one tracking website) with the subject matter of insurance coverage for COVID-19. The "top 3" states of filings were California, Pennsylvania and Florida with about a hundred each, followed by Illinois and Ohio. At this publication's press time, a motion for federal Multi-District Litigation consolidated proceedings had not yet advanced past a July 2020 hearing to provide for a single venue to address various lawsuits filed in different federal courts with common insurance coverage subject matters (e.g., first-party "direct physical loss or damage" language).

2. Recovery Theories Most Commonly Used

During the first few months of pandemic insurance coverage lawsuits, most involved first-party coverages, for example to cover "business income" losses due to state and local business-closure proclamations and phased reopening protocols. The claimants' theories of recovery included that COVID-19 would satisfy any requirements of direct physical loss of property within the policy form's scope of coverage. When filed as putative class action lawsuits, the recovery theories were designed to address "commonality" requirements by focusing on the common legal issue of a policy provision's legal interpretation. *Wal-Mart Stores v. Dukes*, 131 S.Ct. 2541 (2011). As an obvious benefit to financially-stressed claimants, the costs of proceeding in a class action are not borne by one claimant to obtain only modest (after reduction by amounts of business expenses avoided during the "period of restoration") or moderate first-party recoveries.

Third-party coverage lawsuits have been rarer. Moreover, the universe of underlying civil lawsuits for coronavirus exposure was potentially subject to severe restrictions based on at least one of the mid-2020 U.S. Congressional relief packages being considered. These "business liability" protections, encompassing stringent pleading requirements, "clear and convincing" evidence standards and damages limits, would have predictably reduced the number of controversies over these protected defendants' liability coverage.

B. Navigating Challenges During Litigation

1. Reaching Agreement to What Can Be Agreed Upon

Consistent with the claims philosophy of paying what is owed when it is known to be owed, a beneficial aspect of first-party coverage claims as detailed above, it is often beneficial in litigation to agree or stipulate to what the parties can agree upon. Instead of prosecuting every conceivable coverage defense, which can give the appearance of making litigation prohibitively expensive for the financially vulnerable insured, the litigation can focus on resolving those key coverage defenses that are most likely to be consistent with the contracting parties' intent. As an immediate benefit, the litigation proceeds on a streamlined set of issues that is more consistent with the matter's just, speedy and inexpensive determination. Fed. R. Civ. P. 1. This also demonstrates to the court that the parties are fair-minded enough to identify and focus on their true disagreements, while letting other issues go. One of the collateral or eventual benefits is that in the event of attorney-fee shifting, there will not be an unnecessary increase of costs and relatedly, fee demands, that possibly stand in the way of a beneficial resolution (as referenced in III.B. 4. below).

2. Discovery Is Unavoidably Intrusive, Even With Honest Purposes

The burden on insureds to respond to discovery can be profound. The litigation process is generally supposed to carry its own considerable assurances of procedural fairness to all parties, imposes limits on each type of discovery method such as depositions, interrogatories, requests for admission, etc., and in federal court is subject to considerations of "proportionality". Fed. R. Civ. P. 26(b)(1). One key leverage point, however, could be if attorney-fee shifting is available in the discovery rules; and if available under applicable law, specific statutory and common law prevailing-party attorney fee awards. Otherwise, it is not usually proper for insureds to file suit then assert that their burdens to respond to discovery are part of their damages in that lawsuit.

Insurers are not immune from burden considerations, and they can often calculate the cost projections to respond to burdensome discovery. Rather than engage in mutually broad-range discovery that becomes a battle of burden-creation, the practical approaches include counsel exploring ways to reduce the costs. It often does no harm to the insurer's substantive value obtained from discovery if its counsel reduces the intrusiveness of formal discovery, whether in substance or in method, to a policyholder already reeling from financial losses. Even if the insurer might earn attorney fees for resisting improper discovery from an unfunded party, seeking fee awards that are ultimately uncollectible would not be time well spent.

3. Motions Practice: Insurance that does not "fail of its essential purpose" when an exclusion applies.

Motions to apply exclusions or other defenses to coverage can follow an unpredictable path, and in the absence of clear policy language both the insurer and the policyholder may argue at length and eventually require a trial to determine what coverage the policy premium was paid for. Although insureds may not always agree with the outcome, states that enforce plain exclusionary language provide for a less expensive path to results. Relevant cases in Florida are progeny of *James River Ins. Co. v. Ground Down Eng'g, Inc.*, 540 F.3d 1270 (11th Cir. 2008)

(broad "arising out of" exclusion enforced if other services are still covered). The insured's assertion is often informed by hindsight regarding the known claim, to the effect that it must have paid its premiums for coverage of that claim. To be prepared for an argument that its entire insurance policy was "illusory" if there is no coverage for the known claim, an insurer may wish to consider obtaining and analyzing the relevant underwriting file materials at the earliest juncture when it foresees arguments of ambiguous or unclear policy language. Whether or not the claim matches up to a fact scenario that was discussed in underwriting communications or was intended to be insured, it will at least avoid surprises. Moreover, seeing the insured's application and/or contemplated risks provides currently beneficial information on the relevant issue of whether hypothetical covered claims dispel the argument that an exclusion completely contradicts the coverage and causes the policy to "fail of its essential purpose." *Id.* at 1277.

More predictably, motions to apply sublimits would concede the parties intended to cover the fact scenario presented, yet avoids issues caused by retracing the mutual intent of the parties. The amount of limits demonstrates the parties' mutual understanding that there would be finite, lesser amounts of coverage for this particular claim. These motions can present an inexpensive path to determinations in litigation.

4. Managing Financial Leverage From Attorney Fee and Expert Cost-Shifting Statutes and Rules

The general "American Rule" is that each party bears its own attorney fees in litigation. But as referenced above, one of the key reasons that financially stressed claimants can be emboldened to sue their insurers is because several states have enacted statutes or have common law rules that award attorney fees to only insureds (and not conversely to insurers) that prevail in coverage and "bad faith" litigation. California's attorney-fees rule for economic loss when policy benefits are withheld in bad faith is called *Brandt* fees, based on *Brandt v. Super. Ct.,* 37 Cal. 3d 813 (1985). The threat of fee awards may substantially seize financial leverage back from the insurer. However, it can also have an impractical effect: discouraging settlement opportunities, for example when an insured's lawyers make a required condition of resolution the payment of their attorney fees beyond the value of the claim itself. In today's economy, it may be more reasonable to consider realistic amounts the lawyer would be paid by their client based on the recovery, or alternatively for their opportunity cost of not working on other similar matters.

C. Exploring Settlement Opportunities During The Litigation

1. "Duty to Make Reasonable Settlement Decisions"

As case law develops to provide guidance of duty-to-settle concepts in many jurisdictions that were not specific about how best to address each situation, the 2018 "Restatement of the Law, Liability Insurance" contains additional suggestions from the American Law Institute regarding insurers' "duty to make reasonable settlement decisions" pursuant to their liability policies.

In mediated settlement negotiations it may be reasonable for the insurer to consider the likelihood that its insured would have the financial means to fund an underlying non-covered verdict. Also, an insurer may be reluctant to keep its "head in the sand" as to whether the insured has financial bases for litigation battles against its own insurer, whether independently

or through a "war chest" of funding obtained from other sources (including other insurers). The "consent judgment" scenario that insurers may wish to avoid allows a claimant to take a judgment against the insured, who then assigns that claimant its causes of action against the insurer for alleged breach of its duties. Some influential jurisdictions like California make it more difficult for an insured to assign rights: under *Hamilton v. Maryland Casualty Co.* (2002) 27 Cal.4th 718, 728-29, if an insurer has provided a defense, the parties cannot stipulate that a judgment entered without the insurer's consent is the measure of damages to the insured. Further, in *21st Century Insurance Company v. Superior Court (Tapia)* (2015) 240 Cal.App.4th 322, 331-32, a California appeals court held that an insurance company that is defending its insured could not be bound by a stipulated judgment entered into by its insured without a trial and judgment to which the insured committed after the verdict.

2. Objective Assessments of the Strength of Coverage Defenses

Because insureds are experiencing financial hardships never before seen, insurers have little statistical or anecdotal experience to rely upon at this early phase of litigation arising from the COVID-19 pandemic.

Insurers that maintain objective bases for their responses are in the best position to ascertain what contribution their insureds can make to the efficient resolution of an underlying claim. When there is a likelihood of *no* insurance coverage for the insured's underlying exposure, the insurer is well-advised to deliver that message, and to do so timely. But the financial desperation of insureds faced with unforeseen liabilities could mean those insureds not only use novel bases to lobby for insurer participation, but ultimately could be genuinely unable to commit funds to either an immediate or long-term solution that depends on their business's continued viability. In this way, the financial hardship of its insured can be visited upon the liability insurer. One foreseeable result is that insurers may participate in settlement discussions even when they have strong coverage defenses, based on a good faith interest in exploring the potential rescue of a customer and their customer relationship.

Because there will eventually be enough statistics to ensure objective decision making, insurers should be provided with robust confidentiality assurances when they make special-circumstance funding commitments. Tracking these trends without the downside risk of their being disclosed in future litigation potentially enables insurers' objectively-fair decision making to benefit more insureds in the future.