Adjusting COVID-19 claims

Proving the insured sustained a covered loss as a result of the pandemic could be nearly impossible for an adjuster.

By **Chantal Roberts** | June 30, 2020

The prevailing belief in most insurer-oriented circles is that coverage for the COVID-19 claims will be denied. In fact, there are some adjusters who, immediately upon reviewing the policy's virus/contamination/pandemic exclusion, issue declinations of coverage. (Credit: Olivier Le Moal/Shutterstock)

Adjusters are forever between the proverbial rock and a hard place. Gallons of ink have been spilled in articles discussing insurance coverage for claims as a result of COVID-19. The departments of insurance's regulations for good faith claims handling dictate how adjusters must investigate a loss. While courts are months away from interpreting coverage (https://www.propertycasualty360.com/2020/06/25/southern-district-denies-insureds-request-for-preliminary-injunction-seeking-payment-of-covid-19-related-loss-414-181696/), adjusters cannot delay their investigations into COVID-19 losses.

Do

- Inform insureds of available coverages
- Begin reasonable investigation immediately
- Ask insureds if closed due to COVID-19 on staff, or due to civil authority
- Have several managers review claims
- Timely send reservation of rights letters
- Properly document file with coverage determination reasons
- Timely send declination of coverage letters

Don't

- Allow insureds to believe they have coverage for loss (https://www.propertycasualty360.com/2020/06/22/navigating-through-proof-of-loss-requirements-during-the-covid-19-pandemic/)
- Wait for courts to interpret coverage
- Remain silent regarding coverage
- Assume all claims will be denied
- Hide coverage questions from insureds
- Be cryptic about coverage determination in claim notes
- Conceal investigative findings from insured

Adjusting COVID-19 claims appears routine: adjusters review the policy, determine coverage, and resolve the claim. The Model National Association of Insurance Commissioners (NAIC) Unfair Claims Settlement Practices Act has regulations, which most states have adopted, concerning the refusal of paying claims without conducting a reasonable investigation and failing to provide a reasonable and accurate explanation for denying claims.

The definitions of "direct physical damage," "civil authority," or "contamination" will not be rehashed. Definitions are the crux of the issue regarding coverage, yet the departments of insurance do not permit confusion on the definitions to delay good faith claims settlement practices.

Insurers must continue its investigations of insureds' losses. The virus is microscopic and cannot be seen by the adjuster, unlike, for example, windstorm damage to a structure. Photographs of the building are a moot point. While a hygienist could determine if the premises had been affected by the virus, the CDC notes the virus (https://www.propertycasualty360.com/2020/06/22/we-are-open-for-business-now-what/) may not spread easily by touching surfaces and may not live as long on surfaces as once thought. By the time a hygienist arrives to the premises, the virus could either be dead, the site was never infected in the first place, or the hygienist becomes overloaded with assignments and becomes inefficient in promptly investigating the loss. Proving the insured sustained a covered loss could be nearly impossible.

What is a reasonable investigation?

The prevailing belief in most insurer-oriented circles is that coverage for the COVID-19 claims will be denied. In fact, there are some adjusters who, immediately upon reviewing the policy's virus/contamination/pandemic exclusion, issue declinations of coverage. These adjusters are in violation of their states' Unfair Claims Settlement Practices Act, which mandates reasonable investigations.

"Reasonable" is a method to determine if an average person acted with an ordinary degree of thought, practicality, and care. In other words, reasonable is if another adjuster acted or would have acted in a similar fashion. Therefore, the question circles back to what is a reasonable investigation of alleged microscopic

damage and how the insurers can fulfill its obligation to both its insureds and the departments of insurance.

When asked what constitutes a reasonable investigation, coverage/defense attorneys say, "It depends." If the insured has coverage under a Special Cause of Loss form, then an investigation should take place to ensure another cause of loss is not the reason for the claim.

Adjusters should issue a reservation of rights letter informing the policyholder that the insurer has questions regarding the policy covering the loss. This should be issued at the time when coverage and the investigation come into conflict. Unfortunately, many times the reservation of rights letter is deficient in properly informing the insured of the issues negating the letter's efficacy. It is not enough to say that there is a question regarding the claim and coverage. The adjusters must be specific in their letter and tie three parts together in order to properly inform the insured of the coverage issues.

Proper reservation of rights letters includes:

- Why the insurer believes the insurance policy may not cover the claim;
- Detail the facts of the claim; and
- Include relevant policy language.

After the inspection of the premises (https://www.propertycasualty360.com/2020/06/23/verified-inspections-can-help-insurers-with-hurricane-season-in-the-covid-era/), if no other cause of loss is found, which would trip coverage, and the reservation of rights letter has been issued, the adjuster could be in a position to issue a declination of coverage letter. Several managers should review the files so that multiple opinions are obtained regarding coverage. The file must clearly document the insurer's determination of coverage.

Unfair Claims Settlement Practices Act mandates declinations be timely sent after completing the investigation and must provide a reasonable and accurate explanation for the coverage denial.

Adjusters have been between rocks and hard places before. Only 60-90 days have passed since the stay-at-home orders took place. The legal repercussions of the pandemic are in its nascence. It will take time for the courts to rule on coverage. In three to six months, the courts will begin to crystalize how to interpret coverage, but the NAIC will not allow insurers to wait that long for good faith claims handling and investigation.

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