THEODORA ORINGHER
COUNSELORS AT LAW

# Business Interruption and Insurance Coverage Under COVID-19

## Introduction

The purpose of this Memorandum is to provide guidance for clients who are facing losses resulting from the current Covid 19 environment, from Business Interruption, Lost Inventory, lost lives and employment practices. Additionally, this Memorandum is intended to help clients with ***any*** insurance claim under present circumstances as insurance companies are facing significant losses and will therefore likely scrutinize even the ordinary, garden variety claim for any reason to deny it. In short, while not definitive, the goal of this Memorandum is to provide a brief roadmap to help clients and their businesses navigate the straits and narrows of insurance coverage issues today.

First, though, notice how I do not say, for example, "Business Interruption caused by the Corona Virus." The reason for this is that, after the SARS and MERS epidemics in the early 2000s, insurers began to exclude viral or bacterial outbreaks from standard coverage. Policies may also contain further exclusions for "pandemics" or "pollutants". On the other hand, many losses today result from government orders, rules and regulations such that reasonable arguments can be made that the loss or claim is not caused by the Corona Virus. So remember that word choice matters on coverage issues. Regardless, if a client's business is currently facing a large loss or claim, its insurance policies should be reviewed to make sure potential insurance coverage is not being overlooked. Further, care should be taken on submitting any claim in this environment to avoid giving insurers easy reasons to deny coverage.

## First Steps

Unfortunately, clients often contact us AFTER their coverage claims have already been denied by the insurance company. While we appreciate being contacted, had these clients contacted us first before approaching the insurance company with the claim, their odds of obtaining coverage would have been far greater. Of course, almost every policy contains a provision requiring the insured's cooperation, but this is not triggered until a claim is made. And there is no rule or law that says having counsel is tantamount to refusing to cooperate. Bottom line: if you're thinking of making a claim, contact counsel first.

"Why is that?" you might ask. While an insurance policy is a contract, it is almost always understood best by the insurance company. After all, they wrote it. All policies contain specific provisions and defined terms with which the insurer's personnel are very familiar. You, on the other hand, may have never even looked at your policies. So the insurer's representative may steer the narrative towards language that will bar coverage if you communicate with them on your own. If, on the other hand, you are represented by counsel in the first place the chance of being herded in this fashion are greatly reduced.

## What Next?

Before calling counsel, however, it is important that you gather some important information and documentation starting with your insurance policies. More seasoned companies may have a risk management department, but even these may not have copies of their current policies. So the first place to go is either your insurance **Broker** or **Agent**. You may be asking, what's the difference? Legally, it is as follows:

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Under California Ins. Code §1621, **Agent** is defined as a "person who transacts insurance, other than life, disability, or health insurance, on behalf of an admitted insurance company." Think of your Farmers or State Farm agent.

Under California Ins. Code §1623, an insurance **Broker** is a "person who, for compensation and on behalf of another person, transacts insurance other than life, disability, or health insurance with, but not on behalf of, an admitted insurer."

In short, the **Agent** works for the insurance company and owes his/her allegiance to the company. The **Broker** works for you and owes his/her allegiance to you. Regardless, contact them immediately. Ask them for copies of your current policies. Alternatively, ask them to provide you with a schedule of your current policies.

Do NOT rule out any policy of insurance. Below is a short list of the types of policies/coverages you may and/or should have.

1. **Errors and Omissions** ("E&O"). This is coverage you likely must and should have if you offer professional services to clients or customers. It is intended to cover you in the event of a claim by a client/customer. It essentially covers your mistakes in providing that service. For example, what if your business is facing a claim from a customer claiming it was not provided with adequate warning or advice about the threats it now faces? While this may sound far-fetched, it would be better to let your insurer deal with it than you face it alone.

2. **Commercial General Liability** ("CGL"). Such a policy protects against liability claims unrelated to your professional services. For example, it should cover claims for bodily injury or property damage caused by an accident at or by your business. It may also have various extensions of coverage. What if a customer claims your business exposed them to contagious personnel?

3. **Employment Practices Liability Insurance** ("EPLI"). This covers your employment practices: alleged wrongful termination, possibly discrimination and harassment. If you've had to lay off employees recently, some may claim they were wrongfully terminated, or that you did not follow the law when it comes to laying off groups of employees. So this is certainly something to consider if you have a fairly large group of employees, or recently terminated employees who are naturally upset about what has transpired, given that California is the capital of wrongful termination litigation.

4. **Directors & Officers** ("D&O"). The larger your operation, the more likely you have this coverage. You will certainly have it if you are publicly traded. It almost always has a very broad coverage grant, but one that is reduced by numerous exclusions. In this regard, know that in California exclusions are read narrowly; coverage grants broadly. The insurance company has the burden to prove application of the former; the insured the latter.[1] So what if your company is sued by a shareholder or a member of the public claiming the company should have been more cognizant of the threats faced by Covid 19? Again, it sounds frivolous but stranger things have happened.

5. **Property/Fire.** If your business owns its facilities, you almost certainly have "Fire" or "Property" insurance to cover a loss to the facility, its equipment and its inventory. These policies

[1] *Aydin v. First State Ins. Co.* (1998) 18 Cal.4th 1183.

almost always have a liability part included and possibly other extensions of coverage including Business Interruption.

6. **Business Interruption** ("BI"). As its name implies, this is supposed to provide coverage in case your business is interrupted (e.g., forced to shut down, or reduce hours and/or production). Stand-alone BI policies can be obtained; at least they were available before the onset of the current health situation. Problem is the numerous exclusions they contain, one of which may exclude coverage for "pandemics" and/or "pollutants". As noted at the outset, however, what "caused" your loss or claim may not be so obvious upon closer inspection—the type of inspection that every insurer must perform before denying a claim.

7. **Excess / Umbrella.** These policies literally provide an additional layer of coverage above the primary policy. For example, your CGL policy may provide up to $1 million in coverage. An excess or umbrella policy may add another $5 million on top of that. What is the difference between excess and umbrella? An excess policy usually just "follows" the terms of the primary; an umbrella policy may provide broader grants of coverage than the underlying policy or policies.

8. **Life Insurance.** Many businesses have policies covering the loss of key personnel due to illness and/or death. If the unthinkable happens, the business may not be able to survive without this person's presence and contribution. This insurance is intended to give the business a better chance to survive in the face of such a loss.

After gathering your policy information, you should then gather information and documentation on the loss you've suffered or the claim you are facing. Once armed with this information and documentation, call your attorney. Do not delay as timing is critical.

**What Next?**

You and your counsel have discussed the matter. You have decided to notify your insurer and make a claim. Keep the following in mind when you do.

1. **Notice** to Insurer: should be given as soon as reasonably practical, but be aware of the different requirements depending on the type of coverage involved. Most policies contain instructions on how and to whom to give notice of a loss or claim. Follow it.

2. Occurrence based coverage has a different notice requirement than a claims made coverage. This reflects the type of coverage involved. "Occurrence" based coverage is likely found in your CGL and/or Fire policies: coverage isn't triggered until there is an "occurrence", and once there is, notice to the insurer should be given as soon as reasonably practical. Quite distinctly, "Claims made" coverage, which is found in your "D&O" and "E&O" policies, is not triggered unless and until a "Claim" has been made in the policy period. Moreover, often notice to the insurer must also be given within the policy period. This can be a trap for the unwary.

3. No duty absent notice: insurer cannot help you unless it knows about the claim. Depending on what state laws may apply (each state has different insurance laws and regulations, and just because you may do business in California does not mean its laws will apply to the claim). In many states, late notice is a complete defense to coverage.

4. No obligation for payments made before notice: do NOT spend money dealing with a claim or loss unless you've first given notice to the insurer. Assuming, of course, that you want the insurer to reimburse you for the expenses you have incurred.

5. Duty to cooperate: written into every policy of insurance. In extreme instances, failure to cooperate can be used to deny coverage. On the other hand, be careful what you say while cooperating unless you are conversant with all the policy exclusions. As noted above, having counsel assist and/or represent you does not violate the cooperation clause.

**What Should You Expect After Notice to the Insurer?**

After giving your insurer notice of the loss or claim, keep these concepts in mind. First, whether you gave notice of a liability claim or a fire/property loss, by law in California the insurer is supposed to respond promptly. Moreover, they are not to hide important coverage limitations or time constraints from you when they do respond. As for a liability claim, the insurer has two essential duties: the duty to **defend** and the duty to **indemnify.** In this regard, keep the following in mind.

A. **Duty to Defend**

1. It is broader than the duty to indemnify. You need to know this in assessing the insurer's response and deciding whether to challenge it. As for the duty to defend, the insurer may respond differently depending on the situation.

2. The insurer can agree to defend/cover the Claim without reservation. You should expect this if you've made, for example, a claim on your personal auto coverage because you were in an accident. It becomes more complicated the more complex the insurance and claim.

3. The insurer may write you reserving its rights to deny coverage. This raises the right to Independent Counsel. If you have made a liability claim, and the insurer "reserves" its right to deny coverage and then tells you it will appoint counsel to defend you, by law in California you are almost assuredly entitled to your own choice of counsel. There are, however, down-sides to demanding independent counsel. So again it helps to have legal advice in this situation. See California Civil Code §2860.

4. The Insurer can simply deny the claim. There are consequences for denying a claim, so best to consult with counsel and challenge this denial promptly. If the insurer maintains its denial, consider a suit for breach of contract and "bad faith" denial (see below).

5. Burning Limits-Beware: I thought I had $1 million in coverage? If the insurer agrees to defend, keep in mind that many policies define "loss" to include sums paid to defend the claim. So while the policy on its face may state it provides a $1 million limit of coverage, closer examination reveals that defense costs are included in this limit. So the longer the ensuing litigation lasts, the less money there will be to pay the claim. This can create a conflict for defense counsel, which is another reason why you should have separate counsel if the insurer has hired its appointed counsel.

6. Self-Insured Retention ("SRI") or Large Deductibles. You must spend this first before the insurer starts funding your defense. Depending on the policy, it can be as much as $50,000, so be prepared.

B. **Duty to Indemnify** (i.e., Settle the Claim) and Related Issues.

1. Along with the duty to defend, the breach of the duty to indemnify can lead to a claim for "bad faith". Defense counsel appointed by the insurance company are not likely to concern themselves with pressing the insurer to settle the claim. So you need to be vigilant if you are being defended by the insurance company to make sure opportunities to settle are fully explored.

2. Consent to settle: many policies contain a provision requiring the insurer to obtain your consent to settle. You are more likely to see this, for example, in an E&O policy. You are less likely to see such a provision in an Auto or CGL policy.

3. This raises the related issue of "Hammer" Clauses. If your policy contains a "consent to settle" provision, it will almost certainly have a "hammer" clause. Basically, this says if you do not consent and the case goes to trial and the claimant does better than what the settlement would have attained, you pay the difference. Again, you should consult with counsel.

4. The claimant may make a Policy Limit Demand. If so, you will want to seriously consider having counsel demand that the insurer accept this demand. Failure to accept it will, first and foremost, expose you to the rigors of trial. Equally important, failure to accept it may obligate the insurer to pay for any judgment excess of the demand. Bottom line: you need to be following the litigation. Counsel should be regularly communicating with you about the status of the suit.

**What happens if Insurer Denies Coverage?**

You have made the claim but the Insurer denies it. Consider the following:

1. An Immediate and aggressive push back may be warranted. Report the denial to the California Department of Insurance. Often, if this is done by experienced counsel, the insurer will reconsider its denial.

2. Insured's Options if the push back fails: defend the claim out of pocket; explore settlement options; pursue insurer.

3. If the insurer has denied the claim, your settlement with the claimant might include a stipulated excess judgment in exchange for a covenant not to execute. You should absolutely be represented by counsel in this situation.

**What if Your Policy(ies) Are Coming Up for Renewal?**

This can be another trap particularly if you know about a claim or loss but have not yet notified the insurer. So keep the following points in mind.

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1. If you have a "Claims made" policy, now is absolutely the time to seriously explore whether to make a claim or not. Your renewed policy will not necessarily cover this existing claim. Be careful!

2. Full disclosure is important because a failure to disclose material information may serve as grounds to deny coverage or rescind the policy. Again, it helps to be assisted by your lawyer if in doubt. If you haven't yet involved counsel, at least discuss this with your agent and/or broker.

3. Negligent misrepresentations can occur, so make sure the application is reviewed carefully before submitting it. For example, maybe the number of your employees has increased since the last renewal; or you have acquired additional equipment and/or facilities. Again, if in doubt, ask your broker/agent/lawyer for assistance.

4. It is very important to remember that existing Claims or Losses can be a mine field at renewal, particularly if they haven't already been reported. As for a "Claim", note that it is usually defined in the policy as a written demand by a third party received by the Insured seeking money for or resolution of an alleged loss. Keep this in mind when the renewal application asks about whether you are aware of any facts that could give rise to a "Claim" being asserted against you.

*For more information, contact Anthony Witteman at (714) 549-6200 or awitteman@tocounsel.com.*