California Insurance Department's Notice Requires Vetting of All COVID-19 Claims

By Robert Tomilson / Apr 15, 2020

On April 14, California Insurance Commissioner, Richard Lara, issued a Notice prohibiting any "insurer, insurance agent, broker or other Department licensee" from dissuading a policyholder from filing a claim under business interruption or event cancellation policy due to COVID-19. Insurers are required to "open and investigate" every such claim noticed under the California Insurance Code ("Code"). While the Notice largely reiterates existing claims handling regulations, it also adds a requirement that every claim is thoroughly investigated and denials documented, even those that the industry has already indicated are per se excluded from coverage. This requirement will undoubtedly place a great burden on the insurance industry, which is already working remotely. The American Property and Casualty Insurance Association estimates that there are nearly 30 million standard commercial property policies currently in force. If even a fraction of those policy-holders present claims, the industries' claim departments will likely be overwhelmed.

Insurers, agents and brokers should all reacquaint themselves with the claims handling regulations highlighted in the Notice:

- Department licensees must accept any communication from a policyholder or its representative indicating that the policyholder desires to make a claim against a policy that reasonably suggests that a response is expected as a notice of claim. (§2695.5(b).)
- Upon receipt of a notice of claim, every Department licensee is required to transmit such notice of claim to the insurer immediately. (§2695.5(d).)
- Upon receipt of a notice of claim, subject to certain exceptions, every insurer is required to acknowledge the notice of claim immediately, but in no event more than 15 calendar days after receipt of the notice of claim. (§2695.5(e).)
- If the acknowledgment of a claim is not in writing, a written acknowledgment of the receipt and date of the notice of claim must be made in the claim file of the insurer. (§2695.5(e)(1).)
- Failure of an insurance agent or claims agent to transmit a notice of claim to the insurer promptly will be imputed to the insurer. (§2695.5(e)(1).)
- Upon receipt of notice, 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. (§2695.5(e)(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. (§2695.7(d).)
- After conducting a thorough, fair, and objective investigation of the claim, the insurer must accept or deny the claim, in whole or in part, immediately, but in no event more than 40 days after receipt of the proof of claim. The amount of the claim accepted or denied by the insurer must be clearly documented in the claim file unless the claim has been denied in its entirety. (§2695.7(b).)
- If the claim is denied in whole or in part, the insurer is required to communicate the denial in writing to the policyholder listing all the legal and factual bases for such denial. (§2695.7(b)(1).)
- Where the denial of a first-party claim is based on a specific statute, applicable law or policy provision, condition, or exclusion, the written denial must include a reference to and explain the application of the statute, applicable law, or policy provision, condition, or exclusion to the claim. (§2695.7(b)(1).)
- Lastly, every insurer that denies or rejects a third party claim, in whole or in part, or disputes liability or damages must do so in writing. (§2695.7(b)(1).)

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