Case Study #1—[*draft work in progress. Copyright Earl H. Nemser @ 6/1/20]* The Insurance Industry and COVID-19 Claims--*How a Disintermediated Solution Can Sustain a Socially Essential Industry and Adequately Compensate Policyholders By Eliminating Unnecessary Middlemen (This Case Study Is Not Funded.)*

Syllabus: *This Case Study examines the development of the global controversy over whether Business Interruption Insurance Policies cover the tragic losses suffered by thousands of businesses around the world as a result of the COVID-19 Pandemic. The study approaches the issues in the COVID-19 Insurance Litigation without any bias other than in favor of a Disintermediated Solution that would lead to a favorable conclusion for the real parties in interest—a conclusion financed by the savings realized by eliminating the Middlemen. It will discuss the three competing factions that are aligned in some respects, but with somewhat different financial interests.*

Policyholders: *This faction includes the businesses that paid insurance premiums for years and may now find that the language of their Business Interruption Insurance Policies, which they comfortably put away and "relied" on, but likely never read or understood, may not cover their COVID-19 losses. The Policyholders are the most important parties, but they do not always have independent champions to educate them and to protect their interests. They are ordinarily not professionally equipped to navigate the complex legal process and as currently structured, it may likely fail many of them and leave bankruptcy as their most reasonable option.*

Middlemen: *This faction includes a small, but vocal breed of lawyers and the Litigation Finance Industry regularly engaged in the business of Big Ticket Litigation. This faction can be important to help Policyholders understand their rights, and to level the playing field when they are in disputes with dominant business interests. However, a stated mission of some in this faction is to "exploit the opportunities generated by crisis." As such, it can agitate matters, create tensions, escalate disputes and make them more expensive than necessary. Some lawyers (who are not representative of the legal profession generally) thrive in this environment. This faction is not a real party in interest. It is burdened with conflicts of interest that may compromise judgment and disadvantage Policyholders instead of providing them with practical outcomes consistent with their best interests.*

Insurance Industry: *This is the other important faction. It sold insurance policies with the good intention of removing uncertainty and protecting their Policyholders from calamities by spreading risk across society so none must suffer inordinately. The industry must deal with the unprecedented COVID-19 losses that were unanticipated, and not accounted for in the premiums it charged, while retaining adequate reserves for*

unrelated perils. It must grapple with the problems created by insurance policy language written by underwriters, some of whom, it has been argued, lacked foresight and linguistic skills.

The real parties in interest, the Insurance Industry and the Policyholders, in many respects are ordinarily "partners" of sorts. Their shared interests include minimizing losses and spreading them through broad elements of society, so none suffer inordinately. Their financial fortunes are in many respects aligned. Policyholders want financially healthy insurers as their safety nets and the Insurance Industry wants stable Policyholders to pay premiums to be used to compensate those who suffer losses. In all circumstances, it is optimal for the real parties in interest to work in harmony and solve claim disputes among themselves. Perhaps that is why Chubb, an industry leader, embraces this motto: "If a solution is possible, we'll find a way to make it happen."

Against the backdrop of the COVID-19 Pandemic, this study will demonstrate how the Middlemen faction can be gently set aside to permit the real parties in interest to use simple tools to create a Disintermediated Solution so that they can realize an optimal financial outcome. ***Disintermediation*** *means removal of intermediaries from the supply chain—in plain words: "eliminate the middlemen." It is successfully implemented in most areas of our everyday life, as Amazon disintermediated the retail industry by eliminating the stores. Disintermediation can be deployed in the COVID-19 Insurance Litigation to resolve it on a timely and efficient basis allowing the Policyholders to get on with their business, and the Insurance Industry to focus on its socially desirable mission: protecting their Policyholders by spreading the risk of catastrophic events.*

In the course of developing a Disintermediated Solution, this study will review the Insurance Industry's initial, very proper and sympathetic response to the "coverage crisis," and then explore how the industry "took the bait" cast widely by the lawyers and other Middlemen, who tended to agitate. The Insurance Industry permitted the controversy to escalate as it banded together on a course committed to fight back "tooth and nail." The discussion addresses how this unnecessary litigation brawl can continue to unravel and take unanticipated turns; and whether this could ultimately present a serious threat to the Insurance Industry's performance of its essential role that protects Policyholders and is intimately tied to the public interest.

*The study will review details of the current COVID-19 Insurance Litigation in plain language, including the major elements of the dispute, the law as it relates to the actual insurance policy language. At the outset the language seemed to clearly favor the Insurance Industry, backed by a long history of case law, but later it became open to question. It will examine the four important words common in Business Interruption Insurance Policies: "****Physical Loss or Damage****" which is required to trigger coverage. It will then discuss how the dispute might play out in the traditional legal process, and why this theatre should be avoided.*

While doing so, this study observes that the Middlemen appear to entice Policyholders into suing the Insurance Industry in Aggregated Cases, like class actions, that combine groups of claims, to increase the Middlemen's "take", without corresponding incremental effort or expense. Some of these Middlemen appear to operate inconsistently with the interests of the Policyholders who would be significantly better off rejecting the opportunity to be part of an Aggregated Case, and instead, just sitting tight, protected by what are called "Tolling Agreements", observing test cases from the sidelines and avoiding legal costs entirely.

This study will conclude by offering a practical blueprint for a Disintermediated Solution to the COVID-19 Litigation Crisis based on a hypothetical $90,000 case in which the parties realize 75% of their best case scenario simply by eliminating the Middlemen. It will demonstrate how a simple solution can be implemented world-wide to more quickly end the burdensome COVID-19 Insurance Litigation that has turned into its own massive economic plague. Instead of wasting time navigating the painful legal process, and the prospect of courtrooms filled with angry people, the Insurance Industry and the Policyholders can shatter the faded mold and resume their "partnership", end the Litigation Crisis and realize a better financial result, allowing the Policyholders to spend their time re-building their businesses and exploring a better life, and the Insurance Industry to serve its social purpose without distractions.

Disintermediation — Avoid Courtrooms With Angry People

A Disintermediated Solution would be implemented by a Summit attended by Insurance Industry leaders and leaders from major trade groups that represent Policyholders from important business segments with COVID-19 related claims. It would be led by an Administrator who is assisted by econometricians who will model various scenarios as well as other professionals.

Part One: The Disputes About Insurance Payments For COVID-19 Losses Began Quietly And Could Have Been Controlled.

Soon after the COVID-19 Pandemic "lock-downs" began in California on March 19, 2020, business owners began making light inquiries about whether their common All-Risks Business Interruption Insurance Policies might cover their anticipated losses. Policyholders were facing tragedies of all sorts. The Insurance Industry's position, while sympathetic towards the Policyholders, understandably discouraged them from making claims based on the then prevailing view of standard policy language and the coverage it afforded.

The general understanding had been that the common policies simply did not cover business losses or damage unless:

(a) the actual business facilities, for example, the restaurants, the casinos, the hotels, etc., suffered what was commonly thought to be "**Physical Loss or Damage**", as one would observe if a fire damages a kitchen; or

(b) the policies contained an uncommon, specific and very expensive Pandemic Coverage—most policies did not.

Since the lock-downs that followed the spread of the COVID-19 Virus was the reason that businesses suffered losses, and since the lock-downs did not cause this kind of "Physical Loss or Damage" (as the phrase was then generally understood), the Insurance Industry's position, sympathetic declinations, seemed to be legally correct and the right way to treat Policyholders.

Initially, this was explained to Policyholders, and they understood their predicament. It was simple enough to understand the difference between the kind of "Physical Loss or Damage" caused by fire, and what Policyholders experienced by lock-downs. The lock-downs did not cause any structural damage to their facilities that could be discerned by the five human senses. The resigned Policyholders realized that they could have purchased specific Pandemic Coverage, that did not require this kind discernable damage, but that it would have been very expensive.

On the other hand, businesses like The All England Lawn Tennis & Croquet Club Limited, which conducts The Championships, Wimbledon, were among those who were then thought to be fortunate because they actually purchased Pandemic Coverage for the 2020 tennis tournament. It had paid $2 Million a year for this insurance which enabled it to realize a policy payout of almost $150 Million. But very few businesses had the foresight, the financial resources or the risk appetite to purchase Pandemic Coverage, and without it, there appeared to be little hope that most businesses would receive any insurance payments to cover their losses.

These quiet early days were the perfect time and presented a unique window of opportunity for the Insurance Industry to develop a global template to provide settlement payments to most of the Policyholders, perhaps a private Global Disaster Settlement

Fund, notwithstanding that the plain language of the insurance policies, as it was then understood, strongly favored the Insurance Industry's position—sympathetic declinations.

Why would the industry offer any settlement payments if the policy language was well understood as not covering COVID-19 losses? Because, as the industry experienced in the past, policy language can be made to appear "slippery" or malleable, and it is not difficult for lawyers to then adapt them to unusual circumstances (like a pandemic) particularly when the words are contained in an "All-Risks" insurance policy. Slippery words are common in everyday life and there are common ways to avoid them. Saeed, *Semantics pp. 56 et seq. (*Wiley Blackwell 4th ed. *2016).* But since meaning can be a circular concept, underwriters must tolerate some language difficulties understanding that they are unavoidable. Kroeger, *Analyzing Meaning pp. 3* et seq. *(Language Science Press 2nd ed. 2019).*

Events progressed rapidly, and the window of opportunity for a global settlement began to close. Lawyers developed interpretations of the words "**Physical Loss or Damage**" and began to advise Policyholders that specific Pandemic Coverage was not necessary for them to recover losses under their common Business Interruption Insurance Policies. These lawyers encouraged suffering locked-down businesses, desperate for relief, to make claims based on newly made policy interpretations adapted for these unanticipated events, and soon the Insurance Industry was inundated. Nobody can reasonably fault the advice of these lawyers because that is their job. But the force of this advice was not anticipated by the Insurance Industry. Indeed, losses caused by a pandemic as forceful as COVID-19 was not at all priced into the premiums for the common policies.

The Insurance Industry continued to sympathetically reject claims. But Policyholders started to ban together in protest encouraged by the growing optimism and popularity of the lawyers' advice. Regulators became involved. Legislatures started looking into the issues, and the press was all over it. As the lawyers continued to micro analyzed the policy language—they concentrated on four simple words in particular: "**Physical Loss or Damage**." They developed theories (but not particularly novel theories) about these four words (to address the novel circumstances of a pandemic), and they were encouraged by Middlemen, the moneyed Litigation Finance Industry, naturally chasing the profit potential that could be exploited if it could identify a credible way to bring the Insurance Industry into court.

The Litigation Finance Industry facilitates litigation by providing capital to a party that needs to commence a lawsuit. At first glance, it sounds bad because it suggests that this industry is in the business of "fueling the flames." For example, in the COVID-19 Crisis, these "Funders" offer "loss leaders" to Policyholders by offering to review their insurance policies and potential claims--"for free" and they work with lawyers who recommend litigation. Some believe these kinds of activities result in frivolous cases that burden the legal system.

But the Funders are only thought to be bad if they conduct themselves improperly. The financing can be helpful by advancing funds for a plaintiff's legal fees and other costs such as the expenses of experts, investigators and discovery vendors. It can also provide interim working capital for businesses or even pay for personal expenses of business owners. In return, the Funders get a percentage of the plaintiff's recovery. It is contingent or non-recourse funding so if the plaintiff loses, he does not have to pay back the Funders. If he wins, the Funders get their agreed cut and they get paid back for the expenses they advanced, with interest out of the first dollars of a Policyholder's recovery.

These Funders are Middlemen. They are companies with vast financial resources (some are public companies like Burford Capital), and they are basically in the business of handicapping litigation. They are praised by some who think that they pursue noble goals by "level the playing field" for the average person who has a claim against big corporate interests. Without the Funders, some people simply would not otherwise have access to the court system because they do not have the financial resources necessary to fund expensive litigation.

They are criticized by others who claim that their cut takes too much of a plaintiff's recovery, that they discourage settlements and that they stimulate unnecessary litigation, perhaps evidenced by statistics that suggest they are linked to 75% of all class actions and provide more than $7 billion in funding. The critics point to statements by Funders that suggest that their interests are not aligned with those of their clients. For example, one large Funder has said quite directly that its financial strength places it in a "good position to exploit the opportunities generated by crisis." It added: "We also generate significantly higher profits when matters do not settle and proceed to adjudication."

The merits of this debate are not relevant to this study. What is relevant is that the Funders are Middlemen who by definition make the legal process less efficient. They make it more expensive to operate; and they take a significant part of a plaintiff's recovery. Like any Middlemen, in the right circumstances they can advantageously be eliminated by a Disintermediated Solution. In the COVID-19 Litigation, they should gently be cast aside.

As claims were facilitated by lawyers and the Funders, the early quiet days ended, and it became too late for the Insurance Industry to avoid a litigation crisis that looks like it will become the largest in history. The insurers began acting together, closing ranks and assuming a very hard line approach which, according to some Policyholders (or the Middlemen), involved wrongfully delaying consideration of claims, flip flopping, and rejecting claims without reasoned explanations. The industry's sympathy for the Policyholders at times seemed to disappear, suggesting that there was no containment or crisis control strategy at all. The industry could have learned important lessons from institutions that used Disintermediated Solutions to navigate their own crises so well. Examples of this success present useful studies.

In the beginning, a few lawsuits were filed by Policyholders, notably one against The Hartford brought by Thomas Keller, the famed chef behind The French Laundry

Restaurant in California's Wine Country and Per Se in New York City. Soon thereafter, Travelers turned the tables and jumped in with a pre-emptive strike bringing its own lawsuit against the high profile Geragos law firm in Los Angeles. The suit sought a declaratory judgment; that is a ruling that there was no coverage for the income the Geragos firm lost when it suspended its operations in the lock-down. Now that both sides initiated court proceedings, the battle lines formed on a global scale and the publicity started to run out of control. Naturally, the publicity caused more and more Policyholders to visit with their lawyers and the Funders.

Part Two: <u>The Insurance Fight Quickly Escalated into a Feeding Frenzy.</u>

As time progressed further, and publicity of the lawsuits increased, with the help of massive PR, more and more insured business owners, big and small, lined up to have their litigation options assessed--from hotels, casinos, restaurants, entertainment venues, cruise lines, to doctors, dentists, beauty parlors, health spas, and gyms. They were encouraged by Middlemen like the class action lawyers, who raced in to be first, so they could earn big fees by becoming "Lead Counsel to the Class", and the Litigation Finance Industry. As business owners started to "lawyer up", the Insurance Industry pushed back with equal force.

The legislatures entered the scene and considered passing laws to force the Insurance Industry to pay COVID-19 pandemic losses even though it was still commonly believed that the language of the standard policies did not provide coverage because there they did not involve "Physical Loss or Damage" to business facilities. Sophisticated industry lobbyists, more Middlemen, made an all-out effort against these proposed laws—and they earned big fees doing so. The U.S Treasury Department weighed in, opposing any laws that would retroactively force insurance companies to pay on the grounds that they would fundamentally conflict with the contractual nature of insurance obligations, implicating the Contract Clause of the U.S. Constitution, and introduce stability risks to the industry.

Some industry regulators weighed in and curiously seemed to take sides in favor the Insurance Industry—at least in the beginning. For example, in April 2020, the UK Financial Conduct Authority, the FCA, sent an open letter to the Insurance Industry and said: "our estimate is that most policies have basic cover, **do not cover pandemics** and therefore would have no obligation to pay out in relation to the Covid-19 pandemic." A couple of weeks later, as the Policyholders became more vocal, the FCA announced that it would organize an effort to bring a series of cases before the UK courts to clarify the uncertainty over whether the Insurance Industry must pay for business losses caused by the pandemic. Then, on May 15, 2020, the FCA appeared more even-handed: it said that it would invite the Policyholders, and later it said it would invite the insurance brokers, to express their positions on the coverage issues.

It may well be, as it appears, that the FCA is engaged in a sophisticated, even-handed attempt to disintermediate the process and bring it to a very quick conclusion through a few test cases. This may not be in the financial interests of the lawyers, and the other Middlemen who appear, without any subtlety, to inflate the dispute. If this kind of Disintermediated Solution does lead to a rapid conclusion, one wonders if the Middlemen will reduce their fees since little work would have been done, or if they do not, whether the Policyholders will seek to rescind the agreements that have with them on the grounds that they were fraudulently induced because the Middlemen, who owed significant duties to them, never advised that they could avoid entering retainer agreements that require large contingent fees by merely observing the outcome of test cases.

All of these developments predictably caused Policyholders, who are unsophisticated in the legal process, to further ban together in collective pressure groups, some aimed at particular insurers, like the Hiscox Action Group (which is still growing with more than 500 angry members pitted against the Hiscox Insurance Companies.) The Action Groups, in turn, engaged law firms that advised of a "good chance of success", in spite of the plain language "**Physical Loss or Damage**" that the Insurance Industry believed to be an insurmountable obstacle to coverage. But, as the Policyholders were encouraged, they continued to line up financing from the Funders—that use teasers (like free policy reviews) to grow the ranks.

The attacks continually broadened out. Lawyers also worked to craft lawsuits against the Insurance Brokerage Industry claiming that brokers negligently selected coverage that did not cover the circumstances of a pandemic—as if the brokers should have been more prescient than the rest of mankind and anticipated COVID-19. Recently, the UK independent insurance consulting firm Mactavish issued a report entitled "Broker Conflict" which criticized brokers who are paid commissions by both the Insurance Industry and the Policyholders, suggesting that this creates conflicts of interests and might slant their judgment. The brokers will not come out of this without a messy time ahead.

The Middlemen that encouraged the Policyholders ramped up the PR campaigns—one coined a new phrase to describe a company that dishonors claims: "Doing a Hiscox." This Action Group uses Twitter extensively, including to make threats like: "Start praying [Hiscox]. Your time is limited. You will be found out and your customers will leave in droves…." Before this fight began, Hiscox had propagated positive mottos like: "We Encourage Courage" and "Team Happiness Delivered." Now, in addition to fighting the lawsuits, it will need to devise a crisis strategy to avoid a damaging boycott. As the fight escalates, PR firms, crisis control consultants and more and more Middlemen jump in to wrestle away their own piece of the limited pie—all unnecessary and ultimately to be paid for by the Insurance Industry and the Policyholders.

Companies like Hiscox appear concerned, but they seem to take it all in stride. The Hiscox Group has been in business for 100 years and has more than 3,000 employees in 14 countries serving 300,000 Policyholders in just its small business segment alone. It does not seem likely that an attempted boycott would seriously set it back. Consistent

with this, a Hiscox spokesperson just ignored the threats and commented: "As we have said previously, we welcome all steps to expedite resolution of any disputes and we will work with the industry, its regulators and our customers to achieve this through the range of independent mechanisms available."

A feeding frenzy occurs when predators are overwhelmed by the amount of prey available. This is where it stands right now, and the backlogged courts are soon to be overwhelmed with fresh lawsuits. Obviously, the Policyholders are trying to speed up the cases so they can get paid, and the Insurance Industry is trying to delay any ultimate determination so it can hold on to its cash and earn money investing it.

For example, Policyholders in Pennsylvania tried to persuade the court to expedite consideration of their claims on a consolidated basis, but this attempt failed. On May 14, 2020, the Pennsylvania Supreme Court declined to exercise what are called its "King's Bench Powers" and assume what is called "plenary jurisdiction" over a suffering restaurant's business interruption case against the Erie Insurance Exchange, and to consolidate it will all other similar cases, to develop an expedited vehicle for resolving them. Several members of the Insurance Industry, including AIG, had filed *amicus curie* briefs opposing an aggregated, expedited solution.

Similarly, that same day, in a case against the Sentinel Insurance Company, a federal court in New York denied emergency relief to require the insurance company to pay a Policyholder up-front for damages suffered because of its COVID-19 lockdown. Reports say that the court relied on the common understanding and past case law determinations of what the four simple words: "Direct Physical Loss or Damage" require. But this understanding may indeed be superseded by the results of the micro analysis still being conducted by those taking the side of the Policyholders.

The French courts' first dealings with the issues have gone the other way with amazing speed. On March 22, 2020, a Paris court ruled that Axa is liable to a restaurant chain for COVID-19 related revenue losses. This was considered an important precedent that, in the words of the restaurants' owner might have "global resonance." Almost immediately, Axa's CEO Thomas Buberi said that it would quickly pay a "substantial part" of the claims as the specific kind of policy in question was ambiguous and represented less than 10% of its book.

We will soon see other court decisions trickle in from around the world.

Part Three: The COVID-19 Insurance Litigation Involves Simple Legal Issues and Essentially Four Words: "Physical Loss or Damage."

As discussed, in order to collect under the typical "All Risks" Business Interruption Insurance Policy, the Policyholder must show that a covered peril caused "**Direct Physical Loss or Damage**" to property insured by the policy. (Note that the operative language in such policy tracks the same language in the common Property and Casualty

Policies such that a loss thereunder would trigger business interruption coverage. An interesting question arises as to whether both policies are implicated by a lockdown.) The Industry has so far denied the typical claims on these grounds that are somewhat well established in past case law; that is, because the pandemic did not cause any "**Physical Loss or Damage**" to the Policyholders' business facilities. While these grounds are well established in the apparent weight of authority, there are some cases that have departed from this view.

For example, in a Michigan case, *Universal Image Productions.,* v. *Chubb Corp.,* 703 F. Supp. 2d 705 (E.D. Mich. 2010), the court considered a case involving water seepage into a building that resulted in damage in the form of pervasive odor, mold, and bacterial contamination. In an interesting opinion, the court canvassed decisions of other courts, and concluded that this damage did not trigger the requirement of "Direct Physical Loss or Damage" because it was not what it called "structural" or "tangible" damage. See also 10 *Couch On Insurance* § 148:46 (3d ed. 1999) (stating that the "requirement that the loss be 'physical' precludes any claim against the property insurer" when the loss is "unaccompanied by a distinct, demonstrable, physical alteration of the property.")

However, in *Gregory Packaging, Inc.,* v. *Travelers Prop. Cas. Co. of Am.,* No. 2:12-cv-04418, 2014 U.S. Dist. LEXIS 165232 *(D.N.J. June 11, 2014),* a court in New Jersey, canvassed a different line of cases that engaged in a "Functional Analysis", and concluded that ammonia released inside an insured facility caused "Direct Physical Loss or Damage" because, although there was no structural damage, it was rendered unfit for occupancy. Most of the cases are easily identified and often collected in well-considered articles such as Johnson, *What Constitutes Physical Loss Or Damage In A Property Insurance Policy*, 54 Tort Trial & Ins. Pract. L. J. 95 (2019).

Courts that follow the reasoning of the Michigan case will favor the position of the Insurance Industry. But even if some courts follow the precedent of the New Jersey case, and are willing to engage in a Functional Analysis, the Policyholders will have to convince the courts to take that analysis one step beyond where most courts have gone thus far. The Policyholders will have to convince the courts that a Functional Analysis should be used to establish "Physical Loss or Damage" even when nothing at all, not water, not ammonia, nothing physically entered, or even touched the insured facility that could be detected by the senses—nothing that could be seen, touched or smelled. These are simple arguments to make but they are not easy to sell. We will see how the courts wrestle with them, and whether the prevailing emotional sympathies will have an influence on the outcome.

Under the prevailing cases, as they have developed the law until now, it seems pretty clear that "Physical Loss or Damage" did not occur, for example, in a restaurant facility when it locked-down following a Government Directive. This is because there was no change in the restaurant's physical appearance as would be seen in a clear cut case, for example, when a fire destroys a kitchen. It also seems pretty clear that before the COVID-19 pandemic, this is what most people, including Policyholders and those employed in the Insurance Industry's Underwriting Departments (charged with drafting

"clear and precise" policy language), would have reasonably thought is required by the words "Physical Loss or Damage."

Accordingly, the Insurance Industry seemed perfectly correct in denying the typical claim, relying on legal prevailing precedent that favored its position. But then the Plaintiff's Bar and their Litigation Finance partners advanced a few ways to analyze the four words "**Physical Loss or Damage**" and to work around past precedent. This did not require heavy lifting. Instead, by using simple tools, like the dictionary, some plausible positions have been suggested. These positions do somewhat diminish the strength of the Insurance Industry's very basic notion of "Physical Loss or Damage." These workarounds introduce an element of uncertainty, and because of the size of the potential claims world-wide, they pose a threat.

Here are some of the most common positions put forward by the current thinking on behalf of the Policyholders, and how the Insurance Industry might respond:

1. The common policies require "**Direct Physical Loss or Damage**" to trigger coverage. It will be argued that the words "Physical Damage" should be determined by courts to be "ambiguous." That is, that they are subject to two reasonable interpretations, one of which favors the Policyholder. The common "All Risk" policies do not define the word "**physical**" in the phrase "Physical Loss or Damage," so it is appropriate to consult the dictionary. The dictionary defines the word "physical" as merely: "**relating to an object.**" Accepting this definition, the policy language "Physical Loss or Damage" is said to beg the question: What kind of damage **relating to an object**? Under what is called the "Functional Approach", if a restaurant's facility can no longer **physically** function consistent with its intended purpose, the facility might be considered **physically** damaged or impaired. This very simple theory has not been tested in court. And the Insurance Industry has yet to identify its best counter-argument, but it will likely analyze the meaning based on developed theories of semantics and pragmatics, and it will differentiate between the characteristics of "performance of functions" and "attributes." It will provide every day, simple to understand examples to convey meaning. For example, if a restaurant owner loses the key to the front door or stays home because he is ill, the restaurant will not, but still can function as intended. Similarly, a restaurant can, but will not function as intended if a Government Directive imposes a lockdown. Accordingly, it will argue that a Functional Analysis is not helpful ("sufficient" in the study of semantics) to understanding the scope of insurance coverage; and one must look to the attributes of the facility to determine if a change caused damage which is not the case with respect to a lockdown. Then a debate about "functional attributes" will ensue as meaning is determined.

2. It is also argued on behalf of Policyholders, with some authority, that in the typical policy, the first two words of the pivotal phrase, "**direct physical**", modify only the word "**loss**", as in "losing an object", and perhaps "**direct**

physical damage" is not even required for policy coverage under an All-Risks Policy if the lock-down "damaged" a restaurant's operations in any way at all. Here the Insurance Industry will rely on simple grammar books and point to preferred usage namely that when an adjective is paired with multiple nouns, it modifies both of them.

3. The Insurance Industry has been denying some claims based on what is called the "Virus Exclusion", which ordinarily provides that the insurance will "not pay for loss or damage caused by or resulting from any virus…." But this position has been questioned by Policyholders who argue that the damage from the lock-down was not caused by any identifiable virus particles found in any restaurant, so the Virus Exclusion does not apply at all. Rather, Policyholders argue that the damage was caused by a the "circumstances surrounding the pandemic" triggered by Governmental Directives that mandated lock-downs. Those who make this argument note that although many policies have the Virus Exclusion, they do not contain any generalized "Pandemic Exclusion." The Insurance Industry will simply take the position that it does not rely on the Virus Exclusion.

4. Pointing to Government lock-down Directives, the Insurance Industry seems to take the position that it will not pay because the policies ordinarily deny coverage if the loss is caused by the "enforcement of any ordinance or law." But the Policyholders argue that no law was "enforced" because the police did not charge in to "enforce" the lock-down directives; rather there was voluntary compliance. The Insurance Industry will likely retreat from this position.

5. Pointing to what is called "denial of access" or "ingress, egress" coverage, the Insurance Industry seems to take the position that there is no coverage because access was really not denied. The industry argues that notwithstanding the lock-downs, one could still enter and exit the facilities. But the Policyholders in turn argue the "Functional Approach" and contend that access is denied to the extent that the Government Directives (not ordinances or laws that were "enforced") prevent access to the facilities to the extent necessary for them to function consistently with their intended purpose. Here the parties will spar back and forth and ultimately find themselves engaged in the same exercise set out in paragraph 1 above.

There are many other positions being examined by lawyers for both sides. But these are the most relevant positions, and the ones that utilize the "Functional Approach" are perhaps the biggest threat to the Insurance Industry. They are the positions that the industry can to defuse—with an answer that is just as simple and attractive as the propositions themselves. But we do not know what the courts will do in these sympathetic times.

Aside from the four pivotal words, "Physical Loss or Damage", the lawyers for the Policyholders support their arguments by advancing some well-established legal principles. These include:

1. The principle of *contra preferentem* that requires that insurance policies be interpreted against the interests of the draftsmen, here the Insurance Industry, when two reasonable interpretations are presented by ambiguous language. The argument goes like this: without a definition, the four words are ambiguous, particularly in an All-Risks Policy, and if the industry meant to define "Physical Damage" in a way that **excludes** the kind of damage caused by the mere "loss of functionality", as it does notably with respect to some insurance coverages, it could have easily done so, and this failure will be interpreted in favor of the Policyholder. But the Insurance Industry would respond by arguing that the principle is not applicable because there is no real ambiguity; that is, the lawyers are just torturing the language to create an ambiguity where none really exists.

2. The principle of *expression unius exclusion alterus* which teaches that the express mention of one thing, in any contract, but particularly in an insurance contract, like a Virus Exclusion, means the parties meant to reject similar things, like a Pandemic Exclusion, an exclusion that does not appear to expressly exist in most of the standard policies. In other words, the argument goes: if the Insurance Industry intended to exclude pandemic losses, it could easily have written that into the policy as it did with the common Virus Exclusion. This legal principle is closely read along with another principle of contract interpretation teaching that contracts should be interpreted narrowly to avoid a forfeiture, when the words reasonably allow. And, the Insurance Industry would in turn respond by saying that it is not about expressing one thing and excluding another—they are two different things. That is, "virus" is a word that describes a "particle" and "pandemic" is a word that describes an "outbreak", so lawyers are simply mixing apples and oranges.

For now, the Insurance Industry remains somewhat advantaged by the clear ring of the simple words: "Physical Loss or Damage." This advantage is fading as the suffering Policyholders are favored by the sympathies (which can play out nicely before understanding judges and juries in their neighborhood courtrooms.) It is impossible to predict how this will ultimately resolve, and there will likely be some conflicting court decisions.

Nevertheless, the Insurance Industry soldiers on. It will naturally do what it can to keep the cases away from the juries—which would be a very dangerous place to wind up. How will it seek to accomplish that? The most common way of proceeding is to engage in what is called "dispositive motion practice." Dispositive motions are maneuvers that a litigant can engage in to put an end to a case (dispose of it) before it goes to an actual full-blown trial. If successful, this kind of dispositive motion can save the expenses of trial and also pre-trial discovery that could be damaging if there are dangerous witnesses

or documents that may be "smoking guns." A successful dispositive motion will deny any relief to the Policyholder and the insurance company will emerge as the winner.

Most jurisdictions allow for some kind of Motion for Summary Judgment, which is a dispositive motion that involves a presentation to the court in the form of a written argument--a "Brief" that that sets out the reasons why a case does not involve any disputed material facts to be decided by the court or jury. If the court rules that the material facts are not reasonably contested, there is no reason for a jury which sits to resolve contested issues of fact. And, for this reason, the court can apply the law to the uncontested facts and make a decision without a trial at all.

In the COVID-19 Insurance Litigation, the Insurance Industry will argue that words such as "Physical Loss or Damage" are clear and unambiguous and can reasonably have only one meaning. That is, damage that alters the appearance of an insured facility like what a restaurant would experience in a fire. It would concede all of the facts about the COVID-19 pandemic and the loss of income the restaurant experienced by reason of the lock-down so that there is no need for a jury trial. In the first instance, the judge will determine "as a matter of law", without a jury, whether the words can reasonably mean only one thing. If the court determines, that they mean only damage that alters appearance or can be detected by the senses, there would be no trial. The Policyholder would lose, and the insurance company keeps its money and avoids dangerous pretrial discovery. For the industry, it would be problem solved!

On the other hand, if the court finds the words to be ambiguous, that is, subject to more than one reasonable meaning, Summary Judgment is not available. The parties will argue about what is "reasonable", but if a court finds that the words "Physical Loss or Damage" can reasonably be understood by a Policyholder to include damage that cannot be observed by the senses, but that merely impairs the way a restaurant "physically functions", then the dispositive motion will be denied and the parties must proceed to dangerous pretrial discovery and then a full-blown trial with evidence in the form of witnesses and documents, and likely a jury.

Whether words are ambiguous is ordinarily a question of law for a judge to decide in the first instance. There is a large body of law that addresses how this is determined. The Insurance Industry will argue that the lawyers for the Policyholders are simply trying to manipulate the four words in different ways and to split hairs in order to "create an ambiguity where none really exists" a phrase commonly used. There is a large body of law collected in many places that discusses how this argument is treated by the courts. E.g., Ostrager & Newman, 1 *Handbook on Insurance Coverage Disputes 1.02 (19th ed. 2018).* And there are various nuances that can bear on the consequences of this inquiry such as whether a possible ambiguity is "latent" or "patent", whether an ambiguity was consciously created to be a "slipper" (as in "slippery language"), and the consequences of undefined terms. There are several interesting discussions of this topic, e.g., Duhl, *Conscious Ambiguity: Slaying Cerberus In The Interpretation Of Contractual Inconsistencies*, 71 U. Pitt. L. Rev. 71 (2009).

Because of the importance of the COVID-19 cases, the parties will enlist experts in Semantics, the study of meaning, and they will provide guidance, supported by textbooks, on foundational concepts such as "meaning" and "ambiguity." See Kroeger, *Analyzing Meaning* (Language Science Press 2019); see generally, Cruse, *Meaning in Language, An Introduction To Semantics and Pragmatics* (Oxford University Press 2018). Some, but not all judges will entertain the views of experts to assist in their analysis.

The cases will move on to trial only if the four words are found to be ambiguous. At the trial, the jury will have to determine what the policy means for the purpose of adjudicating the case. That is, it will have to determine what the intent of the parties was when they entered the policy of insurance. At that stage, some matters will be clear.

--The insurance company and the Policyholder never discussed whether the policy would cover losses caused by a Government Directive to lock-down because of a pandemic.

--The insurance company did not intend to sell pandemic insurance. Otherwise, it would have collected a much bigger premium in order to reasonably spread the risk among all policyholders, which is what insurance is all about.

--The Policyholder did not believe he was buying pandemic insurance in the sense that he never thought about it.

--The Policyholder intended to purchase "All Risks" insurance; that is insurance to cover every peril except for perils specifically excluded by the policy.

--The insurance company did not specifically write the policy to exclude coverage for a pandemic.

--The insurance company could have but did not define the phrase "Physical Loss or Damage" in its policy language.

--The insurance company knew there were conflicting court decisions on the issue of whether policy coverage requires "Physical Loss or Damage" that is structural and can be detected by the senses.

--There were no past precedents that considered whether there is insurance coverage for losses caused by Government Directive to lock-down because of a pandemic

The parties will try to address each of these clear points to their advantage. For example, the Insurance Industry will address its failure to provide a definition of the phrase "Physical Loss or Damage." It will explain that Semantics teaches that definitions often introduce the "danger of circularity: a definition can only be successful if the words used in the definition are themselves are well-defined." Kroeger supra at 7. It will argue that no words selected for such a definition could adequately anticipate all events, and that in the best interests of Policyholders generally, if meaning is developed by case law that examines new and different situations as they arise based on broad principles that are developed. It will also explain that it is appropriate for meaning to develop differently in different jurisdictions from time to time, and in the fullness of time, in the hope that the differences will ultimately merge to identify optimal meaning and outcomes.

The Insurance Industry will explain that the time-tested theory of the insurance regime is not about any one decision in any one case. Rather, it is a collective effort of

Policyholders generally and the Insurance Industry to determine how they want cases to resolve, and then how they want the risks of catastrophe to be shared. It is a journey of sorts to determine the right formula for sharing risk. But it was not anticipated that this journey would "fast forward" with thousands of cases at one time in hundreds of jurisdictions. This kind of event does not allow for the fullness of time to determine the optimal sharing arrangement. It is simply too expensive for the Insurance Industry and the Policyholders to try to solve it as a matter of "red or black on the roulette wheel."

As an aside, at this point, it should be noted that the Middlemen do not see it that way. This is because they are not "partners" with the Insurance Industry and the Policyholders. Rather they are seeking to realize maximum short term profit in order to "exploit the opportunities generated by crisis [and to] generate significantly higher profits when matters do not settle and proceed to adjudication." (The source of this quotation is available on request.)

If the case progresses and summary judgment is denied, lawyers will try to maneuver the witnesses into admissions about the policy wording that may provide them with some superficial advantage. Below is an example of the kind of examination that can be expected from a Policyholder's lawyer questioning an insurance company witness from the Underwriting Department, about the words "Physical Loss or Damage":

Q. How could you make the words "Physical Loss or Damage" clearer so a Policyholder who operates a restaurant would know that when he buys business interruption insurance, the coverage excludes losses caused by a pandemic lock-down?
A. You cannot make the words any clearer. The words are perfectly clear. A lock-down alone does not cause "Physical Loss or Damage."
Q. Why do you say that?
A. Because a lock-down does not result in any identifiable changes in the structural elements of the facility that would interfere with its functioning as a restaurant. I mean changes that you can detect with the senses; that you can see, feel, touch, taste, or smell.
Q. But a pandemic lock-down does prevent the restaurant facility from physically functioning consistently with its intended purpose as a restaurant, right?
A. I guess that is right.
Q. Would you consider that to be damage?
A. Hmm, I guess that I would consider it to be some kind of damage.
Q. Would you consider damage to the way a facility physically functions to be damage relating to a physical facility?
A. Would the damage relate to a physical facility? Yes, I guess that it would relate to the facility.
Q. Are you saying the damage would relate to the facility even though there are no structural changes to the facility?
A. Yes, I think that I am saying that.
Q. Are you saying that would be damage even if you cannot detect the damage by using your senses?
A. Yes, it would be damage, but it would not Physical Loss or Damage if you cannot detect it.

Q. So you admit that the damage relates to the facility; do you admit that it would be covered by the policy?
A. No, I do not.
Q. Would the policy be clearer if it said that "Physical Loss or Damage only includes, as you put it: "damage that results in identifiable changes in the structural elements of the facility that would interfere with its functioning as a restaurant"?
A. I do not think so.

How a judge or jury will react to this kind of examination will depend on whether they are sophisticated enough to identify the subtle fallacies in the questions and the problems with the answers. Will they be equipped to perform a semantic analysis? None of this is complicated and courts are accustomed to sorting out these kinds of problems and coming to a reasoned view about the "intent of the parties". But it is a long, expensive process and it is dangerous.

The most important point for the purposes of this study, is that all of the issues are known, and when all is said and done, they are simple. There is no extensive legal research to perform. There is no need for the same documents to be prepared and the same Q&A to be played out in the courtroom more than once; certainly not hundreds of times in courtrooms all around the world. There is no reason (aside from the presence of the Middlemen) why a Disintermediated Solution cannot be crafted based on everything that is already known.

Part Four: The COVID-19 Dispute Can Unravel With Consequences?

What started as a pretty safe situation for the Insurance Industry now seems to have a degree of uncertainty, but its extent is hard to measure. There is some risk that the words of the insurance policies will be held to be ambiguous, in which case the litigations will move forward in the courts with the emotional sympathies likely to favor the Policyholders; although it will be diminished if the foundations of the Insurance Industry (risk sharing) are adequately conveyed. That risk could be eliminated with a Disintermediated Solution that would work well for all of the important parties, but not so for the lawyers and the other Middlemen.

How serious is the problem, and does it pose an existential threat to the Insurance Industry that would require it to consider any sort of supervised reorganizations or bailout? That does not appear very likely right now. We start with the proposition that the COVID-19 problem is very big, and the Insurance Industry can also be hurt by bad a season for wildfires, hurricanes, rioting etc. In fact, the U.S. National Oceanic and Atmospheric Administration forecasts a 60% likelihood of an above-average season with a 70% chance of three to six hurricanes of Category 3 or higher. And we all expect riot damage to be significant. But aside from its enormous capacity, the industry is dynamic enough to adjust its financial structure as needed. Among other things, it can raise capital, borrow, and raise premiums (as it is currently doing in anticipation of the COVID-19

expenses). It is certain to continue to be an integral part of almost everyone's lives because it must do so.

Some industry leaders see dark prospects if the COVID-19 Insurance Litigation trends if favor of Policyholders. Chubb CEO Evan Greenberg is reported to have said that the industry cannot take on all the business interruption claims that would flow to it, should legal efforts to force the majority of claims through, emphasizing that this risks "bankrupting the industry." Oliver Bate, CEO of Allianz is reported to have expressed similar sentiments saying that the losses can be "massive [and have] a meteorite impact." AIG's CEO Brian Dupeneault said: "We believe COVID-19 will be the single largest CAT loss the industry has ever seen." Although it is denied, these remarks make one wonder whether the industry has a "playbook" for the worst case scenario, and what that book is all about.

In this vein, some commentators make suggestions of solvency concerns and break it down this way. The total surplus **and** reserves for the Insurance Industry is said to be about $1.5 Trillion. This number is a large, but the charges against it could be serious: (a) if the high estimated business loss numbers are correct and continue to grow—US alone of almost $400 Billion per month (only some of which is covered by insurance); and (b) if the four important words in the policies, "Physical Loss or Damage", are interpreted by the courts in favor of the Policyholders. The numbers are clearly astonishing, when compared to catastrophes of the past. Before COVID-19, the largest catastrophes on record were Hurricane Katrina with $65 billion losses, then the Tohoku earthquake with $35 billion in losses, Hurricane Irma with $30 billion in losses, and Superstorm Sandy with $30 billion in losses. But the pandemic is subsiding around the world, so worst case scenarios are unlikely.

On the other hand, those who study the financial condition of the Insurance Industry do not seem overly concerned with any sort of industry-wide solvency risk. On May 18, 2020, AM Best, the Insurance Industry Rating Agency, issued a detailed Special Report entitled "Stress Testing Rated Companies for COVID-19." It concluded that "Global insurers are well capitalized to absorb the hit from rising claims and costs related to the COVID-19 pandemic." The results of its stress test confirmed that a majority of rated insurers and reinsurers performed well. KPMG, which also issued a report on May 18, generally shared a guarded positive view of the industry generally. It seemed to express some isolated concern saying that while it does "not expect mass insolvencies, the risk of insolvencies in the industry is certainly not zero and this situation has started to bring some challenges to the forefront." Consistent with this general tone, the stock reaction to the Insurance Industry has stabilized, so indicators suggest that matters will be under control.

The views of KPMG and AM Best are extremely important, but they are only as good as the assumptions they make; and they are subject to change. It is not known if the assumptions adequately consider the position of the lawyers who represent the Policyholders, or simply reflect the industry's characterization of the litigation threat. For the time being, they seem to be following industry guidance, but, as AM Best explains,

"it will continue to monitor developments and adjust its analysis according to the changing landscape [based on key considerations, including] rulings on contract clauses, litigation, and government decisions."

The Insurance Industry's characterization of the litigation threat is clear and to the point. For example, Peter Zaffino, President of AIG, explained it this way at AIG's May 5, 2020, earnings conference: "the overwhelming majority of the standard commercial property policies do contain clear exclusions for viruses, and it's fairly standard in the industry. These policies also require that there's direct physical loss or damage that impact the insurance business operations. As to these policies, COVID is not covered." If Mr. Zaffino is right, then the KPMG and AM Best observations will turn out to have been prescient.

Unfortunately, the struggle between the Insurance Industry, the Policyholders, and the Middlemen, some of whom may be fueling the fire, appears to be escalating even further. The Insurance Industry recently took an unusually public and tough stance on the COVID-19 lawsuits and the arguments put forward by the lawyers for the Policyholders. Chubb CEO Evan Greenberg said: "Lawyers and the trial bar would come to torture the language on our standard industry forms and try to prove something exists that actually doesn't exist and try to twist the intent when the intent is very clear…. The industry will fight this tooth and nail."

The problem with the tough approach is that the allure of big legal fees attracts some very talented members of the Plaintiffs' Bar who too will fight back hard and will comb what they find in pre-trial discovery for any trace of weakness. Chubb's Mr. Greenberg has said: "that the profound impact and global nature of COVID-19 is something we have never encountered. There's no playbook…." But the Plaintiffs' Bar must believe that the Insurance Industry has great "what if" analysts, and it will likely seek discovery of documents that might indeed model the industry's worst-case scenarios and contain compromising statements.

It is hard to quantify the risk that courts and juries will disagree with Mr. Greenberg when he says that the Plaintiffs' Bar is "torturing" the language, and that they might welcome the opportunity to embrace a simple "Functional Analysis" that would compensate local business owners who have paid large insurance premiums over the years. The Insurance Industry still seems to have a somewhat better side of the argument, based on past precedent, and it is likely that the industry will identify the flaws in the "Functional Analysis." But the question remains whether it should assume the associated risks, which changes, and whether there is enough to gain by doing so?

There is nobody better suited to evaluate that risk than Mr. Greenberg, a straight shooter who knows the math. He has said that Chubb is dealing with tens of thousands of claims in 55 countries. Chubb recently hiked its quarterly dividend and announced that it will continue its stock buy-back program. This evidences confidence. Chubb has a motto on its website that says: "If a solution is possible, we'll find a way to make it happen." It is likely that Mr. Greenberg is several steps ahead, and that he knows exactly where this is

heading. He appears to be passionate about litigation reform. One focused way to achieve litigation reform on a grand scale, is to disintermediate the COVID-19 Insurance Litigation and find a better way to dispose of claims.

But, since the course is not determined, the question remains: can this mess further unravel and spin out of control? Press reports in the U.S. suggest that the Plaintiffs' Bar may decide to put a spot light on the idea of including Punitive Damage claims by positing some kind of concerted action taken by the Insurance Industry in bad faith to delay payment of claims and cause damage to the public generally, i.e., not just the suffering restaurants, casinos and hotels, but also their employees, vendors, and all of the others who rely on them. In the UK, the Hiscox Action Group has already threatened to invoke what is called The Enterprise Act that provides Policyholders with the ability to claim excess damages if insurers have failed promptly pay valid claims. Developments like this would raise the stakes. And matters can still get worse.

It is not difficult to imagine that the Plaintiffs' Bar, assisted by their Litigation Finance partners, will try to show that the Insurance Industry's loss reserves are not sufficient to cover the realistic chance of a bad outcome, perhaps pointing to some "playbook" that might turn up in discovery--if one exists. If this turns out to be true, Insurance Industry shareholders might consult with their own Class Action Lawyers. Then the industry directors may check their D&O insurance policies. And, the Insurance Regulators, prompted by the Plaintiffs' Bar, may begin to take a deep dive into the reserve calculations. Even the analysts and the rating agencies may get concerned. If developments like this occur, it can all unravel rapidly. But, it can all just as easily be prevented, and the parties can proceed in a productive direction if they devote resources to achieving a global Disintermediated Solution. This would seem to be so easy and so much more sensible.

For a Disintermediated Solution to work, the industry would have to acknowledge the magnitude of the litigation risk and the attending complications. With a kinder approach, perhaps it can engender sufficient good will to emerge stronger than it would by following the current path that could unravel in several different directions. The Policyholders would have to realize that their battle is not easy and the lawyers and the other Middlemen that encourage them might be wrong about their chances of success. There could be a "Disintermediated Solution" and the lawsuits can end quickly. The savings can partially fund the Policyholders, and likely leave a lot for the insurance companies to continue to thrive.

Part Five: The Problems Presented For The Policyholders, The Middlemen and The Insurance Industry.

This is a terrible situation for two of the three competing factions.

The Policyholders, the suffering businesses face massive, immediate problems and will be frequent visitors to the bankruptcy courts no matter how the insurance issues develop. That is where the emotional sympathies should and do lie.

The Insurance Industry is really a wonderful mechanism for society to spread and absorb the economic impact of catastrophic events. It cannot fail and any threats have to be carefully considered and resolved. This industry needs to thrive so it can continue to perform it function and spread the risk of catastrophic events.

The Middlemen, including the lawyers and the Funders, face problems that do not appeal to our sympathies--they can gain or lose a lot depending on whether the situation spins out of control or is contained and resolved. Resolution is best for the Policyholders and the Insurance Industry, but not for the Middlemen. A Disintermediated Solution will not only deprive them of big opportunities, in the COVID-19 Insurance Litigation, but it may be a blueprint for future cases and threaten their business model going forward.

First, let's look at the Policyholders: After all, the Policyholders are the most important players. They are the ones who suffered tragic losses and they are paying half the freight for this unnecessary mess. They are the unsophisticated strangers to the process and the most vulnerable who were lured into the system, pitted against their insurers in an unnecessary vitriolic war, by advertisements and hype. They are just a small part of an Aggregation Business; and they do not know that they have a much better, much less expensive way to proceed because they do not have an independent champion to guide them.

A First-Year Law Student would not advise them to be part of an Aggregation Business. There is absolutely no need for the Policyholders to aggregate their claims with hundreds, or in some cases thousands of others, in a Class Action or other big group, and sign away a percentage of their recovery to lawyers, the Litigation Finance Industry and the other Middlemen. Of course, it is great for the lawyers and Funders—they get paid on thousands of cases when the work is essentially the same as it would be if they were doing it for one case. What alternative course would a First-Year Law Student advise? Every student with passing grades knows what a "Tolling Agreement" is, but few Policyholders know, and their lawyers and Funders likely never told them. What is a Tolling Agreement?

***"Tolling Agreement:** A tolling agreement is an agreement to waive a right to claim that litigation should be dismissed due to the expiration of a statute of limitations. Its purpose is typically to allow a party additional time to assess and determine the legitimacy and viability of their claims and/or the amount of their damages without the necessity of filing an action. During this period, the parties waive any defense by way of any statute of limitations which would otherwise arise during such period."*

There are many reasons to enter a Tolling Agreement, but they usually all come down to saving money—avoiding litigation costs. These agreements are simple and cost basically nothing to prepare—forms are all over the internet. A Policyholder does not have to be

part of an Aggregated Case or a Class Action and sign up to pay, 33%, or in some cases up to 45%, of what he would ultimately recover in the case, to a lawyer and a Funder. Rather he can sit on the sidelines and watch the "test cases" and then "coattail" the result by settling with his insurer based on the outcome of the test case—and keep 100% of his winnings for himself. That is precisely what a First-Year Law Student would recommend.

With respect to Tolling Agreements, we can only engage in guesswork. Most lawyers representing Policyholders probably never mentioned a Tolling Agreement and the option of just coat tailing the test cases, without paying lawyers a dime. If the lawyers did not so advise the Policyholders, should they have at least disclosed the option to the them so they could make an informed decision on their own? If this option was not disclosed, will these client Policyholders one day realize what they signed up for and how they could have avoided an obligation to pay anything to lawyers and Funders? Will they then sue their lawyers and Funders, in a class action, to rescind their retainer or funding agreements or for return of the fees on the grounds of fraudulent inducement by reason of non-disclosure—or perhaps enter a Tolling Agreement with them and coattail a Test Case? And, will those lawyers then look to (or even sue) the Insurance Industry to get it to pay their defense costs or any adverse judgment under their malpractice insurance policies? This can all become another big mess, but it can easily be avoided.

The Policyholders would be best served by staying on the sidelines; filing short Notices of Claim; entering into Tolling Agreements to make sure they do not miss the statutes of limitations. They will enjoy a Disintermediated Solution without paying lawyers a dime. To achieve this result, the Policyholders need an independent champion who will protect their interests and guide them along the way—a champion without a conflict of interest. The Insurance Industry should welcome this and even provide some assistance because it has absolutely nothing to lose; rather it will drastically reduce its own costs.

Second, the lawyers, and the other Middlemen--the real entrepreneurs: The battalions of lawyers and other Middlemen, are the least important players. Certainly, thousands of lawyers all around the world are not required to resolve the meaning of four little words: "**Physical Loss or Damage**." They, and the other Middlemen like the Funders, have some interests that are identical to those of the Policyholders; but they also have some inconsistent interests to the extent that the Middlemen are driven by their own financial self-interest, which is enhanced as the controversy continues to unravel and more cases are aggregated. Could the Funders directly or indirectly use their financial strength to finance PR campaigns hoping to have business owners boycott companies like Hiscox to weaken it and try to force big settlements? Could they be hiring detectives to discover unrelated "information" that will advance this cause? Would this be considered ethical? These questions will be considered, as matters move on. But one thing is for sure, Policyholders do not need the Middlemen at all, and they are better off on the sidelines. Disintermediated Solutions that work in favor of the Policyholder and the Insurance Industry would be the natural enemy of the Middlemen.

The lawyers and the Funders are not the only Middlemen. The legal process is burdened by the costs of all sorts of vendors like experts, printers, jury consultants, mock trial

consultants, graphic consultants, PR companies and E-Discovery firms (which alone earn many billions a year.) The expense is enormous--the cost of civil torts alone in the U.S. is estimated to be over $500 billion a year with approximately 35% attributed to legal expenses.

The lawyers and Funders work together to pile on more and more clients to aggregate, requiring insignificant incremental work or cost. They keep their financial arrangement secret, so we do not know the extent to which their contingent fees are reduced as they aggregate more cases; or whether they simply enjoy the Multiplier Effect so the ultimate prize (for them) just gets bigger and bigger. (Remember the days when lawyers were not permitted to advertise, and do you recall why this ban was in place for so long?) But it is clear that aggregation of claims diminishes what the Policyholders ultimately receive and increases what the Insurance Industry will ultimately have to pay.

The lawyers say they are doing good work for the Policyholders. They say that they came up with "novel theories" of policy interpretations, like those outlined in Part Three of this Case Study, and that they should be compensated well for this work. These so-called "novel theories" may have some appeal, but they are not novel at all. Rather, they are as ordinary as one would expect from First Year Law Students applying simple contract principles in a two hour examination.

As an important aside, it should go without saying that not all lawyers are this way. Of course, the vast majority of lawyers are not motivated by fortune and entered the practice to enjoy the satisfaction of doing a job well and helping their clients. They would be "shaking their heads" in confusion about how these disputes can become such run-away trains; hurt so many innocent people and perhaps threaten an industry that plays such an important societal role.

Third, the Insurance Industry: The function of insurance is to safeguard Policyholders from financial loss by having the "losses of the few" paid by the "contributions of many" that are exposed to the same risk. This is called "pooling of risk" and can be viewed as a kind of "mutual aid" administered by the Insurance Industry. The Industry maintains of portion of the premium dollars it receives in "reserves" to pay policy claims, and it invests the premium dollars which stimulates the economy. The premiums are calculated to cover expenses and the cost of projected losses.

Insurance is a risky business. It is a great business and in good times it makes lots of money. Ordinarily it pays about 80-85 cents of every premium dollar it receives to Policyholders and for administrative expenses which it tries to minimize, and the rest is profit. The problem with the COVID-19 Crisis is that the damage happened all at once to so many who contributed to the pool that there isn't enough to pay everyone if coverage is triggered by losses caused by the circumstances of the pandemic. This is solvable over time as premiums rise, particularly if the expenses of the Middlemen are avoided so the problem is not compounded.

Everyone likes insurance and it helps keep the economy strong. It spreads the risk so none of us have to suffer inordinately. It removes uncertainty and provides a safety net for our everyday life. It is a wonderful stabilizing force. Why does it have all this trouble, and what can be done?

One problem is that it allows the Middlemen to disrupt the partnership it has with its Policyholders. The Insurance industry does not ordinarily "pay" for its Policyholders' losses in the sense that a business pays for a new piece of computer hardware. What it does is it allocates risk, so all Policyholders share the cost in a pooled mutual effort that spreads the risk. As certain Policyholders present an inordinate amount of risk to the pool, their premiums rise. The Insurance Industry partners with its Policyholders to decrease risk and this decreases premiums. When the expense of the legal process rises, it damages this partnership. The Industry needs to solve this problem and eliminate the Middlemen to the extent possible.

Another problem is that those who write the policies are perhaps not the best writers and might need practical linguistic and semantics training. They create language in a patchwork fashion borrowing from different places and creating disorder. Policies contain too many endorsements, modified endorsements, riders and supplements of all sorts—some of which make sense and some of which seem perfectly arbitrary and inconsistent with what one would expect policies to provide. Sir Harold Evans, the famous British American journalist and writer, wrote a book entitled "*Do I Make Myself Clear*?" He said: "Writing is like thinking, it is hard." More effort needs to be devoted to the underwriting function and educating Policyholders, who do not read the fine print in policies, about what they buy. There are many ways that this can be done. Those who write the policies also appear to lack foresight. They simple do not appear to stress-test policy language to anticipate how lawyers might use techniques to identify real ambiguities, or create false ones, where the draftsmen think none may exist.

The best road ahead for the Insurance Industry is to embrace Disintermediated Solutions that will end the COVID-19 Litigation so Policyholders can receive some payment and it can save money and earn good will. It should very publicly practice the worthy goals that it broadcasts in the mottos it features in its advertising campaigns and try hard not to create any false hopes. Chubb has an expression on its website that is apropos: "Welcome to Chubb Claims. Life is about to get easier." There are ways to make this happen, and they should be embraced right away.

The Insurance Industry and the Policyholders would be advantaged by resuming their "partnership" to resolve the problem without the Middlemen. The problem can be resolved and if compensation is involved, it will be funded by the partnership over the years in the fullness of time with increased premiums and various forms of financing. Since this is inevitable, there is no reason to increase the cost by paying Middlemen who are not parties in interest.

Part Six: A Disintermediated Solution:

Disintermediation is about removal of intermediaries from the supply chain and "eliminating the middleman." It's modern form was prompted by early technology like the fax machine that essentially eliminated reliance on the world's massive postal systems. When the world migrated to the web, disintermediation quickly improved almost every aspect of daily life, positively disrupting most forms of commercial activity by facilitation of concepts like peer to peer, buy direct, telemedicine, crowdsourcing, open innovation, etc. Companies like Amazon, eBay, Dell, Apple, Expedia, StubHub, Airbnb, Zillow, Craig's List, Interactive Brokers, and Betterment continuously try to earn more with increased disintermediation realizing financial rewards that they share with their clients. They speed up life's journey; and eliminate unwanted tasks.

Disintermediation has worked so well in so many industries, and it has worked well with respect to some very simple legal matters. Simple legal forms are freely available on the internet and "do-it-yourself" divorces are easy to find. Arbitration and mediation, the traditional alternate dispute resolution techniques, are progressive and often offer friendlier, less expensive ways to resolve disputes. But they too are burdened with unnecessary elements of legal costs that can be eliminated.

The core of the contentious legal process has not been disintermediated and the reasons for this are unclear. But one thing is clear: the lawyers and the Middlemen are not likely to facilitate disintermediation. The COVID-19 Litigation Crisis provides the Insurance Industry and the Policyholders with the opportunity to make this happen. It is not a difficult task, and the efficiencies and financial rewards that can be realized and shared are vast.

Here is an example of how the efficiencies can be harnessed to produce financial rewards in a simple case involving an insurance company and a Policyholder whose $90,000 claim was rejected.

The example assumes that, after careful evaluation, it is determined that the hypothetical case is a toss-up, i.e., each side has a 50% chance of winning or losing. This percent is only for ease of analysis and is not meant to suggest the odds in the COVID-19 Litigation, so it should not discourage use of the example for purposes of analysis only. By disintermediating the hypothetical dispute, both parties can realize 75% of what would otherwise be their Best Case Scenarios.

Loss Suffered=90,000
Insurance Policy=90,000
Lawyers' Fees 33.3% (1/3) each side (total of 60,000 fees can be eliminated):

Best Case in Success Scenario for each side—if case goes to Court:
--For Policy Holder: Net Recovery **60,000** (Policy Payment of 90,000 less legal fees of 30,000)
--For Insurance Co: Net Saving **60,000** (Avoids Policy Payout of 90,000 but incurs legal fees of 30,000)

Worst Case in Loss Scenario for each side—if case goes to Court:
--For Policy Holder: Loss **120,000** (90,000 Loss Suffered plus legal fees of 30,000)
--For Insurance Co: Loss **120,000** (90,000 Policy Payout plus legal fees of 30,000)

Disintermediation creates a "Notional Settlement Fund" of **60,000**, adding together legal fees savings of 30,000 for each side, which transforms a 50/50 compromise into only a 25% discount from each side's Best Case Scenario.

The Disintermediated Solution:

--Policy Holder: Net Recovery of **45,000** (25% less than Ultimate Success of 60,000 Payment)
--Insurance Co: Net Savings of **45,000** (25% less than Ultimate Success of 60,000 Savings)

A Disintermediated Solution will provide each side with more than half a loaf while the risk of loss is much greater—the difference is notionally financed by the legal community, and all of the Middlemen, based on the value of savings realized by eliminating the legal process. And, there is more—there is a "**Disintermediated Solution Dividend**" (that sets-off a big part of the 25% discount) in the form of savings realized by eliminating litigation burdens and delay, e.g., executive time and the reputational toll (good will) for the Insurance Industry, and the time element and emotional toll for the Policyholder.

What steps would need to be taken to disintermediate the massive COVID-19 Litigation Crisis and implement a prompt solution? It would be relatively easy. A Summit (virtual or live) would be hosted by an appropriate law school with leaders from the major participants in the Insurance Industry and leaders from the major trade groups that represent important business segments with COVID-19 claims and an Administrator.

The Administrator would lead the Summit in discussions about the merits of the claims based on existing law and new theories being advanced. Most of this is known so the discussion will not be lengthy. With the assistance of econometricians, the Summit would discuss the appropriate elements that could be used to model a Disintermediated Solution. For example, it would make a realistic assessment of the magnitude of the insured losses, assuming coverage, discounted by a time element based on the value of early payment; and the value of certain benefits available for Policyholders, such as various degrees of reduced future premiums. With respect to the Insurance Industry, it would consider the current value of a portion of the participating companies' capital, including reserves; and since they are essential businesses that cannot fail, their future discounted cash flow, adjusted by future premiums that might be reduced for Policyholders as an element to fund a solution. These elements would be adjusted by the impact of various settlement methods, such as lump sum vs. periodic payments and loans vs. outright payments. Administration of claims and documentation would be made simple based on experience elsewhere.

Policyholders will discover that they cannot reasonably turn down palatable numbers because any possibility of an incremental benefit of non-acceptance is uncertain, hard to quantify and likely to be eroded by the legal costs. Policyholders would extricate themselves from any contingency arrangements they may have made with their lawyers and other Middlemen because they were likely not properly advised to avoid aggregation of cases in order to sit on the sidelines protected by Tolling Agreements.

Insurers similarly are unlikely to be able to identify a better way of proceeding when the alternatives are reasonably assessed along with the value of the good will otherwise at risk. Accepting the numbers will avoid the kind of boycotts being threatened and substitute them with a happy, "sticky" customer base that will be loyal for a long time into the future. The Insurance Industry will consider how this crisis can further unravel quickly if it is not resolved; and how the Middlemen will continue to harass them. Finally, the Insurance Industry will understand that a Disintermediated Solution in the COIVD-19 Litigation will become a blueprint for the future and pave the way for real litigation reform—this element will benefit it for many years to come. The choice will be compelling.

The mechanics of how the solution is determined will vary depending on the jurisdiction and the willingness of the participants. The Administrator may split the summit into jurisdictions, for example one for jurisdictions with cases that require structural damage that can be perceived by the senses, another for jurisdictions that have adopted a functional analysis, and another for jurisdictions that have not determined this issue. There are several more mechanics, but they are not difficult to implement.

Once a Disintermediated Solution is secured for some test cases, others will see the benefits and be compelled to follow suit.

Part Seven: <u>To Be Continued:</u>

This case study will continue, and we will see whether the Policyholders and the Insurance Industry would have been better served starting out with a different approach by trying to solve this massive, complex problem with some simple tools and a Disintermediated Solution. Could something like the simple $90,000 analysis of a hypothetical case actually work on a massive scale?

The study may also explore whether the animus that is so prevalent in this controversy is emblematic of a deeper combative, destructive spirit—another novel plague of sorts—a spirit engendered by the performance of our journalists and political leaders who could do better by using simple tools to find Disintermediated Solutions to reduce political differences.

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