BDA
British Dental Association

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By email to Paul.Lewis@hsf.com

12 June 2020

Dear Sirs

**COVID-19: BUSINESS INTERRUPTION INSURANCE –
BRITISH DENTAL ASSOCIATION MEMBERS' INSURANCE ISSUES AND POLICYHOLDER ARGUMENTS**

Introduction

1. The British Dental Association ("**BDA**") is the trade union and professional body that represents dentists across all fields of dentistry including general practice, community dental services, the armed forces, hospitals, academia, public health and research. There are approximately 42,000 registered dentists in the UK, with the BDA representing 18,000 members. The BDA is owned and run by its members and operates for the benefit of the profession. Our members are at the forefront of public health in local communities all over the UK.

2. As with many UK businesses, COVID-19 has forced the closure of our members' dental practices and places of work. However, due to the physical proximity required for dentists to diagnose and treat their patients and the environment in which they must operate, dentists have been disproportionately affected by the COVID-19 pandemic. Dentists will continue to suffer disproportionately following their reopening on 8 June 2020 due to the strict safety measures they must have in place. Consequently, the BDA's members are a uniquely affected group operating within the private sector who will continue to feel the economic impact in addition to the health and safety impact of COVID-19 for a significant period of time. At a time of crisis, dentists looked to their business interruption policies, held with multiple insurers, for coverage in these unfortunate circumstances and have been unfairly let down for the reasons we outline in this letter.

BDA action and policy review

3. Our members have reported instances of (i) insurers rejecting business interruption claims which, on the wording of the policies, are clearly valid; (ii) different insurers treating the same policy wordings inconsistently; and (iii) ambiguity in wordings being resolved against our members rather than against insurers.

4. Prior to the Financial Conduct Authority's ("**FCA**") announcement on 15 May 2020 inviting policyholders to submit materials and arguments, the BDA instructed Brown Rudnick LLP to lead a review of policy wording for the benefit of our members and to enable us to engage with relevant insurers ("**Review**") in a co-operative and co-ordinated way. We understand that Brown Rudnick LLP spoke with you on 20 May 2020 to raise our initial concerns and agree the format for our submissions to you. The FCA's late intervention and the short time period in which the FCA gave policyholders to contribute any relevant material meant that we were unable to communicate all of the issues our members face by the 20 May 2020 deadline.[1] We are therefore grateful for the agreed extension so that our Review and the associated analysis could be completed. Nothing in this letter is intended to waive any privilege in the advice the BDA has obtained from Brown Rudnick LLP or specialist insurance counsel.

5. The basis for these submissions is that our members are facing very specific challenges that have not been adequately reflected by the FCA, including in the Particulars of Claim published this week. We believe these issues should be considered during the FCA's court hearing in July 2020 with insurers ("**Test Case**") and we are cognisant of our responsibility to bring these issues to your attention in lieu of our members not being represented in the Test Case.

6. We have now completed our Review of more than two dozen policies affecting the profession (and other healthcare providers) and set out our submissions and suggested next steps. The content of this letter is intended to provide further arguments to assist the FCA in its Test Case. We welcome the opportunity to discuss that with the FCA in light of the published Framework Agreement and Particulars of Claim.[2]

The Test Case

7. We note that the FCA published an initial list of 17 policies for the Test Case on 1 June 2020 that are expressed to represent the "key arguable issues."[3] We have compared those policies with our members' policies and note that very few of our members' policies are to be considered in the Test Case and that some of our members' insurers will not be bound by the court's declaration.[4] The FCA has stated:

> *The result of the test case will be legally binding on the insurers that are parties to the test case in respect of the interpretation of the representative sample of policy wordings considered by the court. It will also provide persuasive guidance for the interpretation of similar policy wordings and claims…*[5]

[1] We consider the matters in this letter to be independent of the FCA's documents published on 1 June 2020, though the FCA may wish to factor in the points raised in this letter in the List of Issues and Proposed Questions.
[2] See https://www.fca.org.uk/publication/corporate/bi-interruption-test-case-framework-agreement.pdf.
[3] Update on FCA test case of the validity of business interruption claims: https://www.fca.org.uk/news/press-releases/update-fca-test-case-validity-business-interruption-claims.
[4] We understand that our members submitted policy wordings to you by the 20 May 2020 deadline.
[5] 15 May 2020 announcement: https://www.fca.org.uk/firms/business-interruption-insurance.

8. We understand that not every policy can be reviewed by the court in the time available with a view to a binding declaration, but it is clearly important that our members' cases are considered in this instance given the unique context in which they operate and the unique circumstances affecting the profession. We welcome further engagement with the FCA as to what approach insurers whose policies are not in the scope of the Test Case will be entitled to take following the court's declaration and if and how those insurers will be held accountable by the FCA where they unreasonably deny claims. In short, the reliance on persuasive guidance for related but different policy wordings continues to present a material risk to our members and does not resolve the risk of future coverage disputes.

The overriding issue

9. The BDA believes insurers should not be permitted to argue that business interruption policies were never intended or designed to cover a pandemic in the absence of an express exclusion. Our members have received responses from insurers who rely on that generic response but who do not have appropriately worded exclusions.

10. Firstly, it is obvious that many policy wordings are wide enough to expressly cover infectious disease incidence without any material limitation. Secondly, it is illogical and unfair that insurers, having covered many professions for infectious disease outbreaks and occurrences, could not have foreseen the disproportionate impact of an infectious disease on those professions who do not have the ability to discharge their responsibilities remotely. Indeed, it is clearly relevant that some insurers will have budgeted for this risk in their own reinsurance arrangements or elsewhere and it is important the Test Case explores this.

11. We consider that our members have three arguments against insurers' narrow interpretation and the incorrect conclusion that policies do not provide cover:

    a. In the event COVID-19 did not occur within such a large cover radius, demand for services would have remained largely unaffected. Demand has however been materially affected and implies COVID-19 is present within the radius (see also Issue 4 below);

    b. The absence of any explicit exclusion of pandemics suggests pandemics are covered and an exclusion to that effect cannot be implied. Any implied exclusion of pandemic must be evidenced by the context and circumstances known to the parties at the outset of the policy. When considered objectively it is entirely unreasonable to suggest that policyholders purchasing the policies held by our members would have expected or assumed that a pandemic would be excluded where the policy contained a sufficiently wide clause for disease cover; and

    c. The inclusion of radiuses and "at the premises" requirements as a means of distributing the risk of wide-spread disease instead suggests insurers did not intend to exclude pandemics.

12. The practice of dentistry—both in medical and business terms—is uniquely vulnerable to COVID-19. It requires close proximity between the dental care professional and patient and it involves the routine use of aerosol-generating procedures which may spread the virus (a known vector for the spread of existing airborne infectious diseases). Any intention by insurers to exclude pandemic would, from a dental practice perspective, be uncommercial given such a pandemic caused by an airborne virus would naturally affect the ability of dentists to run a sustainable business.

13. It seems appropriate, given the scale of COVID-19 business interruption insurance coverage, that this issue be expressly addressed for the benefit of our members and the healthcare profession at large. We understand from our engagement with other representative bodies, including the Institute of Osteopathy and the Association of Optometrists, that this issue has also affected their members.

BDA members' specific issues of relevance to the Test Case

14. We consider the following issues must be brought to the court's attention in the Test Case to avoid our members suffering further detriment by wrongful declinatures and elongated claims processes.

Issue 1 – Public authority clauses and the classification of the CDO and CQC

15. Some insurers have disagreed with our members about the application of public authority clauses. Our Review has uncovered a significant issue that is unique to the dental industry in relation to clauses that refer to action taken by a public authority.[6] The following context should be placed before the court to assist it with its interpretation of these clauses:

    a. Sara Hurley, Chief Dental Officer of England, has sent several "preparedness letters" to general dental practices and community dental services regarding the COVID-19 situation. This included letters dated 9 March, 20 March, 25 March and most recently on 28 May 2020. Similar communications have been made by the relevant authorities in the devolved nations.

    b. The 25 March 2020 letter stated that in light of the Prime Minister's recent announcement*: "The emphasis has now shifted away from the delivery of routine care while minimising infection risk to a requirement to stop all non-urgent activity in line with the changes to people's everyday lives that the Prime Minister has signalled". Under Heading A: Changes to Primary Dental Care services the letter stated: "All routine, non-urgent dental care including orthodontics should be stopped and deferred until advised otherwise"* ("**CDO Letter**").

[6] Our Review has found that policies are worded differently and that public authority may also be referred to as "government," "local authority" or "competent authority." The reference to public authority also varies between clauses. Some of these clauses require a prevention and/or hindrance to access. Others are based on a closure of the business.

c. On 25 March 2020, the Care Quality Commission ("**CQC**") also issued a COVID-19 update which stated in reference to the CDO Letter: *"This advice makes it clear that routine dentistry and orthodontic treatment should no longer be provided. Urgent and emergency care will be based on telephone advice and prescription of analgesics or antibiotics as necessary… We are sure dental providers will make these changes and work to reduce the risks of Covid-19 infection across the population."*[7] On 3 April 2020, the CQC issued guidance *that "all routine dental care should have stopped"* ("**CQC Guidance**").

d. The CQC advice was updated on 19 May 2020 to state *"the decision to offer dental care services is one for the provider to take"*.[8]

e. By a letter dated 28 May 2020, the CDO stated *"we are asking that all dental practices commence opening from Monday 8 June for all face to face care so long as they assess they have the necessary PPE requirements in place."* For private practices the letter states: *"A number of dentists have been asking if the advice to NHS dental providers also applies to the private dental sector. We recommend a single approach to the safe and effective resumption of dental care"*.[9]

16. The Test Case in its current form will fail to determine whether the CQC and/or CDO constitute a relevant authority. Similarly, the Test Case will not clarify how communications from the devolved administrations are to be regarded. Dental practices across the country have understandably responded to instructions from authorities by ceasing to provide routine care. These are fundamental issues that affect coverage decisions and, if left unresolved, could lead to significant litigation. Further, the lack of homogeneity of public authority clause wording between policies[10] means insurers may take inconsistent positions with our members, which should be unacceptable.

Issue 2 – Whether closure amounts to a restriction or prevention of access under policies

17. It is important for the Test Case to clarify the uncertainty on the existence of a restriction of access to insured premises, as required by public authority clause wording. Given dentists were not required to close their businesses or restrict their activities under the COVID-19 Regulations but did so in response to the prevailing circumstances, the potential risks to patients, the CDO Letter and the CQC Guidance (and equivalent guidance in the devolved nations), we believe that:

a. There is an unacceptable risk to our members that insurers will rely on the COVID-19 Regulations, CDO Letter and CQC Guidance as a basis to deny claims by arguing the obligations were not mandatory;

[7] https://content.govdelivery.com/accounts/UKCQC/bulletins/2831d1a
[8] https://www.cqc.org.uk/guidance-providers/dentists/current-position-dental-care-services-regarding-covid-19-updates
[9] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/Urgent-dental-care-letter-28-May.pdf
[10] See footnote 6.

b. The Test Case will not address whether the COVID-19 emergency measures are a response to a local outbreak within a geographic area, as many of the public authority clauses require; and

c. Where the insuring clause covers loss for prevention of access, the Test Case will not address whether the COVID-19 Regulations, CDO Letter and CQC Guidance constitute prevention of access. Some policies are worded as requiring prevention rather than hindrance to access or refer to "use," "access," "advice," "order," or action" which may give rise to different literal interpretations.

18. These are questions of interpretation that the court must consider in the Test Case. We invite a declaration to the effect that insurers must pay claims where there is a public authority clause and where dental practices were unable to operate normally notwithstanding the fact that those practices were not required to close (in whole or in part) under the COVID-19 Regulations. Left unaddressed, we consider that a court declaration failing to account for these issues will be directly responsible for:

a. The increased burden dentists will face in distinguishing the legal application of the Test Case decision; and

b. Further delay in pay-outs for legitimate claims and prolonged economic hardship.

19. Whilst we note the same wording is being considered in the Test Case11 it is unlikely the FCA will ask whether a closure constitutes restriction on use or access in this specific clinical context and whether any closure was voluntary or mandatory.[12]

20. We recognise the helpful reference to this issue in the FCA's Assumed Facts document:

5. Opening/closure/impact permutations:

…

b) It closed prior to 26 March 2020 and it is asserted that this was because of COVID-19 in the locality and/or governmental or other advice.

…

d) It stayed open but suffered a downturn in business due to a more limited operation (e.g. emergency appointments only, needing to follow social distancing requirements) or cancellations or incurred additional costs of operating.

6. Where relevant, local authority or police did/did not issue guidance and/or take relevant action and this was causative as required under the policy.

[11] Ecclesiastical 1 of 1.
[12] There are also differences between the devolved nations. In England and Scotland, practices were asked to cease face-to-face care. In Wales and Northern Ireland, administrations said dental practices can continue some limited treatment (non-aerosol generating) before referring to urgent care centres. In essence, the instruction from these authorities severely restricted and interrupted care provision.

21. We hope that by this letter, the FCA is assisted with additional context given that some insurers might take the point that the CDO Letter and CQC Guidance (and guidance in other parts of the UK) amount to non-mandatory advice. Pre-emptively and ahead of insurers' defences, due to be published on 23 June 2020, the BDA wishes to avoid a scenario where there is a general finding in the Test Case that public authority advice needs to be sufficiently mandatory such that our members must then argue about whether that applies to the CDO Letter or CQC Guidance and equivalents.

Issue 3 – Whether a voluntary closure interrupts the chain of causation

22. Some insurers have argued that a member's decision to close their practice or limit care to the provision of remote advice only went beyond what was necessary and raises causation issues and possibly mitigation issues.[13] This issue is sufficiently central to all those policies that otherwise have good prospects of cover.

23. In our view, whether an uninsured or excluded peril breaks the chain of causation between the insured peril and the loss is a question of common sense.[14] To that extent, our members will have three core arguments:

    a. The action of closing practices was not truly voluntary given that lockdown resulted in a drop in income consistent with a closure.[15] It is relevant to the decisions taken by dentists to close their practices for routine patient care that (i) there could have been adverse consequences in disobeying the CQC Guidance; (ii) the CQC amended its guidance to indicate that it was a decision for individual dentists on 19 May 2020, by which time many of our members had closed; and (iii) the CDO published reopening guidance for 8 June 2020, which plainly assumed that practices had been closed up to that point. Importantly, most private practices were required to comply with the same rules applicable to NHS practices.[16] This is an important example where the context of dental practice is relevant to the interpretation of our members' policies;

    b. Causation is highly fact-sensitive. Insurers may provide a number of causation and counterfactual arguments as to why policies are incapable of providing cover or that policyholders failed to mitigate loss by closing early. However the simple point is that practice closures were an appropriate course of action for our members to take when faced with an imminent insured peril and an unacceptable risk to life; and

    c. The correct counterfactual situation is one where no losses would have arisen in the absence of restrictions imposed on dental practices by the government, CDO and CQC resulting from the occurrence of COVID-19.

[13] Whilst such issues are rarely expressed as a failure to mitigate in the insurance context, the BDA fear that it may be raised here given the wording of specific clauses .
[14] Venetico Marine SA v International General Insurance Co Ltd [2013] EWHC 3644 (Comm) at [279].
[15] The CQC Guidance and CDO Letter are based on the necessity for proximate working practices and the use of aerosol-generating procedures.
[16] It is important to recognise the overlap that exists between private practices and NHS practices. In many cases, UK dental practices provide both to varying degrees and hence the announcements apply equally whether a practice's NHS proportion of total care is 5% or 95%.

24. On causation more generally, we consider that where there is more than one concurrent cause of our members' losses (and where those causes are interdependent or independent), policies should provide cover where one cause is insured and other causes are not excluded and/or the policy is silent. We note the FCA's position that the court must, in relation to causation, consider a world where neither COVID-19 nor the subsequent government and public authority restrictions existed.[17] The BDA supports and is encouraged by this argument rather than the position insurers have taken to date.

25. While the Test Case seeks to bring certainty in interpretation, it is clear there is a material role for context when assessing causation. A purely literal interpretation of policies without the benefit of the clinical context may result in an ineffective court declaration for our members. We understand other healthcare professionals, such as optometrists and osteopaths, also face the voluntary closure hurdle having acted consistently with dentists given the nature of the care they provide (and the physical proximity that is required).[18]

Issue 4 – Evidential issue for clauses with a geographic area limitation

26. A significant minority of our members' policies state "a "25-mile radius" requirement in which a disease must occur. Some insurers may seek to deny claims on the basis that members cannot demonstrate that the disease occurred or manifested within the insured area. We consider that our members should not be prevented from cover as a result of this evidential issue given:

    a. Local media reports on COVID-19;

    b. Applications on news organisation websites which provide information on infections in a given area;[19] and

    c. Records at local authorities or hospitals, which if not publicly available could be obtained on an anonymised basis via a Freedom of Information request.

27. Furthermore, a 25-mile radius covers an area of almost 2,000 square miles. As an example, if measured from the centre of London, a 25-mile radius encompasses an area larger than Greater London running from Luton in the North to Crawley in the South, and Basildon to Slough, East to West. We note the FCA has also raised related arguments which we are encouraged by.[20]

28. We therefore invite the FCA to seek a further declaration (in addition to those sought at Declaration (7)) that COVID-19 occurred within any given 25-mile radius on the balance of probabilities. We believe this would be a reasonable finding by the court and would prevent any evidential disputes arising between our members and insurers where a policy contains a 25-mile geographical limitation.

[17] See paragraph 56.8 of the FCA's Particulars of Claim.
[18] In preparing these submissions, we have engaged with the Institute of Osteopathy and the Association of Optometrists to understand the breadth of coverage issues affecting the healthcare industry generally.
[19] e.g. https://www.bbc.co.uk/news/uk-51768274
[20] FCA Particulars of Claim, paragraphs 41 to 43.

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Issue 5 – Quantification of claims

29. One of the primary on-going concerns of our members is how they will return to full-time practice and achieve pre-COVID-19 levels of business activity. The requirement for physical proximity to patients together with the infection profile of COVID-19 continues to present an issue for our members and the costs involved continue to evolve, with research continuing in this area.[21] We feel it necessary to shed light on the fact that some of our members have settled with their insurers for large discounts to their original claim.[22] Where policies have sufficiently wide wording to cover losses suffered and assisted by the relevant context, we are troubled that members are accepting amounts lower than they may be entitled to, where some insurers will take advantage of the cash crisis affecting them.

30. To that extent, it remains difficult for our members to quantify increased or additional costs of working, which are likely to be substantial. The BDA notes that this issue of claim quantification is not intended to be considered in the Test Case given the fact-specific context required for each insured/profession. However, we consider that the court should be asked to provide a declaration and/or guidance as to how increased or additional costs of working should be calculated by insurers, including additional pressure placed upon insurers to resolve legitimate claims with speed. The Government's employee furlough scheme and its impact on the quantification of losses should also be addressed in the Test Case, given the universal application and usage of the scheme. We consider the scheme raises important loss mitigation issues, which insurers may leverage to place unacceptable downward pressure on sums paid under policies that the court decides provide cover for losses in principle.

31. We have also noted that the FCA is considering trends clauses in policies, which we consider play a limited role. The application and relevance of any trends clause must be limited to the effects that would have been observable in the absence of both COVID-19 and the various public authority measures that are interlinked with COVID-19. To that end, there is little evidence to suggest the presence of any underlying trend (independent of COVID-19 or public authority measures) that would have otherwise placed downward pressure on dentists' revenues. To that end, insurers should not be able to rely on trends clauses to reduce any sums payable if a policy covers losses to a dental practice.

32. Whilst the FCA has noted the importance of high-level principles, this case presents an opportunity for the court to offer guidance on reasonable conduct for the settlement of claims, which is a point not yet taken by the FCA.[23] Additionally, and allied to this point, is the question of how the Financial Ombudsman Service should apply the court's decision and how that will impact on the nature and extent of the court's declaration. The BDA also notes that relevant insurers should consider the standardisation of the assessment process between insurers and policyholders in the quantification

[21] The price and availability of personal protection equipment has been well documented for a range of industries and will directly affect the dental profession.
[22] We understand the policyholder's claim was sufficient in size to exceed the sub-limit.
[23] See Insurance Act 2015, section 13A.

of valid claims. An agreed claims handling procedure for those affected by healthcare insurance wordings generally will result in two important outcomes:

a. That no policyholder suffers detrimental treatment in individual discussions with insurers; and

b. That the cash crisis is not indirectly used as leverage to settle claims at a lower level.

Issue 6 – Ambiguity in policy wording

33. In circumstances where Issues 1 to 5 are material to our members' claims against insurers, it is our view that the FCA must pursue a further argument that ambiguity in policy wording must be read in favour of policyholders.

34. We consider that amended wording for new business interruption policies by some of the insurers in the Test Case (that now seeks to reduce ambiguity and explicitly exclude liability for COVID-19 and pandemics) suggests an implied acceptance of ambiguous wording within existing policies. Some insurers have adopted this approach, which both the FCA and the court will wish to consider as relevant context, in particular that contracts of insurance might be properly read on the basis of the mistaken understanding of many dentists that they were covered.

Publication of this letter

35. This letter will be published on the BDA's website for the benefit of our members and will be done so without waiver of privilege consistent with the approach to privilege mentioned in the Framework Agreement.

36. We reserve our right to supplement this letter with any further matters which we believe are relevant to the Test Case and that arise from further engagement with our members following publication of this letter. In particular, we are able to supply relevant advice and directions for all UK nations. We have partnered with Brown Rudnick LLP to set up a direct line of communication with our members for any points or matters arising out of this letter or their claims more generally: dentists@brownrudnick.com.

37. For completeness, this letter is copied to our peer healthcare professionals' representative bodies that we have discussed these submissions with and, where helpful, for the benefit of their members. We understand their members are also facing similar issues and so the FCA may wish to engage with us on a collective basis.

38. We would be grateful for an immediate acknowledgement of this letter by you or the FCA. We are also available to meet, albeit remotely, to discuss the most suitable way to proceed.

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39. Please contact Martin Woodrow (Chief Executive, BDA) and Ravi Nayer (Partner, Brown Rudnick LLP) for any matters arising out of this letter.

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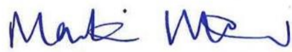
Yours sincerely



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