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Introduction

Attorneys at Mound Cotton Wollan & Greengrass LLP are prolific authors. We keep abreast of the legal issues that affect our clients and industries in which they operate. We regularly publish and are often called upon to write for a number of industry-related publications worldwide. This issue includes articles from all of the firm's five offices.

SINCE 1933

Slew of Favorable Rulings Leads to End of Amtrak's Sandy Suit Against Mound Cotton Clients

U.S. District Judge Jed Rakoff of the Southern District of New York signed an order just before the Independence Day holiday dismissing with prejudice all insurers, including Mound Cotton's five clients, from Amtrak's federal lawsuit seeking almost $1.2 billion for alleged damages to its train tunnels beneath the Hudson and East Rivers from Superstorm Sandy.

The dismissals came two weeks before the scheduled trial date and only ten days after Judge Rakoff granted partial summary judgment on several key issues in favor of Mound Cotton's clients and other insurers. In granting insurers' summary judgment motions, the Court rejected each of Amtrak's arguments, thereby limiting the maximum amount Amtrak could recover to $125 million.

Amtrak commenced the lawsuit by filing a complaint for $500 million in alleged damages in September 2014. In December, Amtrak amended its complaint, doubling its claim to almost $1.2 billion. The Court ordered fast-track deposition and document discovery in this complex case, involving more than a dozen locations and 22 defendants, with discovery to be completed less than six months after suit was filed.

Amtrak sought, among other things, a judgment declaring that its Sandy loss constituted multiple occurrences and that the so-called storm surge that inundated Amtrak's property was not flood, or, alternatively, if the "storm surge" was flood as defined in the insurance contracts, the damage was caused by ensuing loss, not subject to the policies' $125 million flood sublimit. The Court denied Amtrak's motions for summary judgment on the flood and occurrence issues in February, and also dismissed the majority of Amtrak's claim for consequential damages.

Costantino Suriano and Bruce Kaliner led Mound Cotton's legal team, which in coordination with the three law firms representing the other insurers, moved for partial summary judgment in March. The insurers argued that all of Amtrak's alleged damages constituted a single occurrence caused solely by flood and thus subject to the $125 million flood sublimit. The insurers also sought dismissal of the portion of Amtrak's claim seeking coverage for the parts of its benchwall and trackbed inside the tunnels that were not damaged by Sandy on the basis that Amtrak could not demonstrate that such costs were covered under the "demolition and increased cost of construction" provision.

Judge Rakoff granted insurers' partial summary judgment motions, agreeing with insurers that all of Amtrak's alleged damages from Sandy constituted flood under the unambiguous definition in the policies and that any damage was not ensuing loss and therefore was subject to the flood sublimit. The Court also agreed that all of Amtrak's claimed Sandy loss constituted a single occurrence. Finally, Judge Rakoff held that, under the policies, Amtrak was not entitled to compensation from its insurers for replacing undamaged portions of the tunnels' benchwall and trackbed, much of which was over a century old.

On July 31, 2015 Judge Rakoff issued a 34-page memorandum explaining his previous "bottom-line" rulings in insurers' favor. Holding that Amtrak's argument that Sandy's storm surge was not a flood "falters at each step," the Court also confirmed that the "chloride attack" on Amtrak's tunnels was neither an ensuing loss nor a separate occurrence from the flood and that there was no coverage for the undamaged portions of the tunnels.

The SEC's Proposed Uniform Fiduciary Standard for Financial Advisers: An Update

By: Barry R. Temkin and Matthew Photis

Introduction

It has been three years since the Securities and Exchange Commission, acting under the authority of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010, released the results of its study recommending a uniform fiduciary standard for the conduct of registered representatives and investment advisers.[1] While SEC Chair Mary Jo White has proclaimed that adoption of a uniform fiduciary standard was a major regulatory priority, the SEC has yet to promulgate final regulations implementing the change.[2] Additionally, the SEC's 2014 regulatory agenda listed "Personalized Investment Advice Standard of Conduct" as a "long term action" and as priority number 40 out of 43, suggesting that other initiatives were higher priorities.[3]

Historically, registered representatives have not been held to a fiduciary standard unless they have written discretion to manage their customers' funds.[4] On the other hand, investment advisers, who typically execute money management agreements with their clients, have been held to a fiduciary standard. Investment advisers have a fiduciary duty to act in their clients' best interests and to place the interests of their clients before their own. As part of this fiduciary responsibility, "an adviser has an affirmative obligation of utmost good faith and full and fair disclosure of all material facts to clients."[5]

The fiduciary standard also requires advisers to extend the duties of care and loyalty to their customers. The duty of loyalty is "to act in the best interests of clients and to avoid or disclose conflicts."[6] In other words, advisers are prohibited from putting their own interests, or those of their firms, ahead of their clients. The duty of care requires an adviser to "make a reasonable investigation to determine that [the adviser] is not basing [his] recommendations on materially inaccurate or incomplete information."[7] Investment advisers, as fiduciaries, must "seek best execution for their clients' securities transactions when they have the responsibility to select broker-dealers to execute client trades."[8]

The Proposed Fiduciary Standard for Registered Representatives

Following passage of the Dodd-Frank Act in 2010, the SEC issued a report concerning: (1) the effectiveness of the existing legal and regulatory standards of care for brokers, investment advisers, and associated persons; (2) whether the existence of different standards of care causes confusion for retail customers; and (3) whether the SEC should develop rules to address existing legal and regulatory standards.[9] The SEC report recommended adoption of a uniform fiduciary standard for both investment advisers (who are currently held to such a standard) and registered representatives (who currently are not). As of this writing, the Commission is considering whether or not to implement the proposed standard.

The SEC report noted that retail customers are confused by the roles of investment advisers and broker-dealers, and do not understand the differences in the standards of care applicable to investment advisers as compared to brokers.[10] This confusion is "compounded by the fact that retail customers may not necessarily have the sophistication, information, or access needed to represent themselves effectively in today's market and to pursue their financial goals."[11] The report notes the importance of uniformly protecting retail investors "when receiving personalized investment advice or recommendations about securities regardless of whether they choose to work with an investment adviser or a broker-dealer." Therefore, the report recommends implementation of "a uniform fiduciary standard of conduct that is no less stringent than currently applied to investment advisers."[12]

The concept of holding retail registered representatives to the same fiduciary standard as advisers has been debated for years. Investor advocates have long lobbied for a fiduciary standard. Seth Lipner, a claimants' lawyer and a founder of the Public Investors Arbitration Bar Association (PIABA), argues that the existing Financial Industry Regulatory Authority (FINRA) suitability rule "doesn't go far enough."[13]

Holding brokers to a fiduciary standard would require them to act in the best interests of their clients, even when doing so would conflict with the brokers' own interests.[14] Other claimants' advocates have argued that the current FINRA suitability rule fails to regulate conflicts in which brokers' financial interests influence their recommendations to clients. As one critic argues, under the current rules, "[t]he broker is free to recommend inferior options that compensate the broker more generously, rather than what's best for the investor."[15] Adoption of a fiduciary standard for registered representatives would "prevent securities firms from selling investment products that a firm created or for which it is receiving extra compensation."[16]

Securities industry professionals have weighed in with concerns about the proposed uniform fiduciary standard. According to *Financial Advisor* magazine, the Securities Industry and Financial Markets Association (SIFMA) does not oppose adoption of a fiduciary standard for brokers, but some broker-dealers urge that a fiduciary standard of care should be carefully crafted to account for the unique role of registered representatives.[17] A SIFMA spokesperson has written "that the federal fiduciary standard of care [should] preserve investor choice and investor access to a broad range of products and services."[18] According to *Investment News*, some brokers worry that "a fiduciary standard would force them to dump less profitable clients or adopt a fee-only business model."[19] A fee-based compensation structure makes wealthy clients more lucrative than middle-class investors. Furthermore, broker-dealers are concerned that a fiduciary standard could diminish the promotion and sale of the firm's own products.

Gary Sanders, vice president of securities and state government relations for the National Association of Insurance and Financial Advisors (NAIFA), suggests that adoption of a uniform standard could lead to increased costs. He warns that "applying the fiduciary standard to broker-dealers as it is now applied to investment advisers would add to brokers' compliance and liability costs, with no certainty of additional protection for investors."[20] Higher costs could incentivize some brokers to cease offering commission-based accounts in favor of more lucrative accounts that compensate brokers based on a percentage of the investor's assets, leaving "many lower- and middle-income investors without anyone to turn to for investment advice."[21] In the words of one financial advisor: "If you impose a fiduciary standard on agents like myself, you'll take us out of the market and make our services unavailable to middle America. . . . I'm sure my E&O coverage would go up substantially, and I can't afford to talk to my clients without them helping to cover that overhead."[22]

The SEC report acknowledges the potential increased costs to broker-dealers in order to comply with a new standard. Costs of compliance would include amending disclosures, training, policies, and monitoring procedures, as well as developing new account documentation.[23]

Some broker-dealers might potentially opt to reregister as registered investment advisers, whereby brokerage accounts could be converted into advisory accounts subject to advisory fees. Alternatively, broker-dealers could unbundle their services and instead offer them through affiliates or third parties, also resulting in increased costs.[24] These increased costs, according to the SEC report, would likely be passed on to the firms' customers.[25]

Implementation of the Fiduciary Standard

Another question is how a fiduciary standard would be implemented, and whether it would impact current FINRA suitability rules. Would imposition of a fiduciary standard upon registered representatives affect suitability analysis? Would a fiduciary standard result in a two-step analysis consisting of, first, an analysis of suitability and, second, a determination of whether the broker breached a fiduciary duty? A fiduciary standard for registered representatives could potentially heighten the scrutiny at an arbitration or disciplinary hearing beyond "Was the recommendation reasonable?" to "Was it the best recommendation for the customer?"

An additional issue is that registered representatives are bound and regulated by FINRA suitability requirements, but investment advisers are not. This raises concerns in light of the SEC's suggestion that a universal standard is necessary to provide clarity to the current confusion as to the difference in standards for brokers and investment advisers.[26] This confusion, in the public's view, may depend on the changing roles of registered representatives and investment advisers — and which investment professionals are actually making recommendations to buy, sell or

hold securities. A uniform standard, however, may not be the solution that the SEC is looking for. To the extent that investment advisers and registered representatives have different roles and serve different functions, it may not alleviate confusion to apply the same legal standard to their conduct, as investment advisors may, in some circumstances, be called upon to answer for FINRA suitability requirements.

One possible solution to investor confusion would be to task FINRA with the responsibility of providing oversight of investment advisers currently regulated by the SEC and the states. This concept, currently under consideration by the SEC, is causing concern among investment advisers, accountants, and state securities regulators, who oppose the move. According to former SEC Commissioner Luis Aguilar, such a move would "amount to outsourcing the SEC's regulatory mission and would be more costly than increasing the SEC's resources to oversee advisers."[27] The American Institute of Certified Public Accountants further warns that FINRA has a "perfunctory approach to enforcement" and that the agency might be biased against investment advisers during compliance exams.[28] FINRA, naturally, is confident that oversight would be improved under its jurisdiction.

Conclusion

It is unclear whether or when a universal fiduciary standard will be adopted. Adoption of a uniform fiduciary standard could lead to the expansion of arguments available to claimants' counsel in FINRA arbitrations. Arbitration hearings could become more complex in order to adjudicate and determine multileveled claims for suitability and breach of fiduciary duty.

As discussed above, the SEC's initial push for a universal fiduciary standard has met some resistance. *Investment News* reported in September 2014 that SEC Commissioner Michael Piwowar was "leaning against a rule that would require all financial advisers to adhere to the 'best interests' fiduciary standard, and instead favors strengthening disclosure."[29] According to Piwowar, "[I]t is not clear that changes in the regulations applicable to broker-dealers and investment advisers are necessary, including the adoption of a uniform fiduciary standard."[30]

Endnotes

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3 Stephanie Quiñones, *Uniform Fiduciary Standard for Broker-Dealers: An Update*, The Securities Edge, Mar. 4, 2014, http://www.thesecuritiesedge.com/2014/03/uniform-fiduciary-standard-for-broker-dealers-an-update/.

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21 Maxey, *supra*.

22 Mark Schoeff Jr., *Fiduciary Duty Rule: No Way Out*, Investment News, Jul. 13, 2014, http://www.investmentnews.com/article/20140713/REG/307139999/fiduciary-duty-rule-no-way-out.

23 SEC Report, *supra* note 1, at 156.

24 SEC Report at 159.

25 SEC Report at 162.

26 Holzer, *supra* note 1.

27 Jessica Holzer, *Adviser Deal Eludes SEC*, Wall St. J., Jan. 11, 2011, at C7.

28 *Id.*

29 Mark Schoeff Jr., *SEC Commissioner Piwowar Leans Against Fiduciary-Duty Rule*, Investment News, Sep. 30, 2014, http://www.investmentnews.com/article/20140930/FREE/140939989/sec-commissioner-piwowar-leans-against-fiduciary-duty-rule.

30 *Id.*

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Finding Coverage in the Absence of Actual Damage: The Continuing Erosion of the Physical Loss or Damage Requirement under First-Party Insurance Policies

By: William D. Wilson

Coverage under a first-party property insurance policy ordinarily is triggered by direct physical loss or damage to covered property. An all-risk policy, one of the most common types of first-party property insurance policies, typically provides coverage for all risks of "direct physical loss or damage," hence the name "all-risk" policy. While some policies specifically define the phrase "physical loss or damage" to include loss of use, most policies do not. In fact, the phrase generally is not defined.

In the absence of an express definition, the threshold requirement that the loss be "physical" has been "widely held to exclude alleged losses that are intangible or incorporeal, and, thereby, to preclude any claim against the property insurer when the insured merely suffers a detrimental economic impact unaccompanied by a distinct, demonstrable, physical alteration of the property." 10A *Couch on Insurance* § 148:46 (West 3d ed. 1998) (footnotes omitted); *see also Ward Gen. Ins. Servs., Inc. v. Employers Fire Ins. Co.*, 114 Cal. App. 4th 548, 556-57, 7 Cal. Rptr. 3d 844, 851 (Ct. App. 2003) (court held that the loss of electronically stored data, without loss or damage to the storage media, does not constitute "'direct physical loss of or damage to' covered property under the terms of the subject insurance policy, and, therefore, the loss is not covered"); *Columbiaknit, Inc. v. Affiliated FM Ins. Co.*, No. Civ. 98–434–HU, 1999 WL 619100, at *7 (D. Or. Aug. 4, 1999) (court held that the insured's "decision not to sell as new [a garment exposed to elevated levels of mold spores], in the absence of distinct and demonstrable physical change to the garment necessitating some remedial action that would preclude honestly marketing [it] as first quality goods, is not a covered loss"); *Harry's Cadillac-Pontiac-GMC Truck Co. v. Motors Ins. Corp.*, 126 N.C. App. 698, 702, 486 S.E.2d 249, 252 (Ct. App. 1997) (concluding that the insured's inability to access its premises during a snowstorm does not equate to direct physical loss or damage for purposes of triggering coverage under a first-party property policy). As observed by the Third Circuit, "[i]n ordinary parlance and widely accepted definition, physical damage to property means a 'distinct, demonstrable, and physical alteration' of its structure." *See Port Auth. of N.Y. and N.J. v. Affiliated FM Ins. Co.*, 311 F.3d 226, 235 (3d Cir. 2002) (citation omitted).

Over time, some courts have taken a more expansive view, however, chipping away at the requirement that an insured prove that it sustained a "distinct, demonstrable, and physical alteration" of its property's structure in order to recover under a property insurance policy. Those courts have found that a mere "loss of use" or a "loss of access," even if only temporary, may satisfy the physical loss or damage requirement. As noted by one court, "[t]he majority of cases appear to support [the] position that physical damage to property is not necessary, at least where the building in question has been rendered unusable by physical forces." *See TRAVCO Ins. Co. v. Ward*, 715 F. Supp. 2d 699 (E.D. Va. 2010).

In one of the earliest cases to address the issue, *Western Fire Ins. Co. v. First Presbyterian Church*, 437 P.2d 52 (Colo. 1968), the Colorado Supreme Court held that the physical loss or damage requirement was satisfied where a church was closed by the local fire department because of the presence of gasoline vapors. The court observed:

> [I]n the instant case, the so-called "loss of use," occasioned by the action of the Littleton Fire Department, cannot be viewed in splendid isolation, but must be viewed in proper context. When thus considered, this particular "loss of use" was simply the consequential result of the fact that because of the accumulation of gasoline around and under the church building the premises became so infiltrated and saturated as to be uninhabitable, making further use of the building highly dangerous.

Id. at 54-55. In that case, the gasoline had actually saturated the insured property and, therefore, the

vapors would not simply dissipate on their own. Thus, while the presence of gasoline vapors triggered the action by the fire department, there was coinciding actual damage to insured property.

In *Sentinel Mgt. Co. v. New Hampshire Ins. Co.*, 563 N.W.2d 296 (Minn. Ct. App. 1997), the court arguably went a step further. There, the insured sought coverage for costs it incurred to remove asbestos contamination in several apartment buildings. The insured claimed that asbestos fibers had been released, thereby contaminating the buildings. Test results showed the presence of asbestos fibers on carpeting and other surfaces inside one of the insured buildings. In finding coverage, the court reasoned:

> Although asbestos contamination does not result in tangible injury to the physical structure of a building, a building's function may be seriously impaired or destroyed and the property rendered useless by the presence of contamination.

Id. at 300. The court noted that the insured was not seeking recovery "for the mere presence of [asbestos containing materials] in the buildings, but for the release of asbestos fibers and resultant contamination." *Id.* Thus, the court concluded that the detection of actual contamination of insured property caused by the release of asbestos fibers triggered coverage, even though the removal of the loose asbestos fibers would not require physically altering the insured property.

Courts in other jurisdictions have reached similar results. In *Farmers Ins. Co. of Oregon v. Truitanich,* 123 Or. App. 6, 858 P.2d 1332 (1993), the court held that the physical loss or damage requirement was satisfied where odors caused by the operation of a methamphetamine lab by a tenant in the insured home rendered the home unusable. Although not specifically relied on by the court, the fact that the odors accompanied actual physical loss or damage to the walls, ceilings, and floors of the home, which had been saturated with the chemicals used to manufacture methamphetamines. The court noted that "the odor produced by the methamphetamine lab had infiltrated the house" and the "odors" could not be removed without decontaminating the home. *Id.* at 1336; *see also Largent v. State Farm Fire and Cas. Co.,* 116 Or. App. 595, 842 P.2d 445, 446 (1992) (insurer acknowledged that "chemicals from the production of methamphetamine permeate porous materials such as drapes, carpets, walls, and woodwork," thereby satisfying the physical loss or damage requirement).

In the cases discussed above, there was at least arguably some actual physical contamination of insured property. In several other cases, however, courts have found that the physical loss or damage requirement was met even in the absence of any evidence of actual damage to covered property. In *Matzner v. Seaco Ins. Co.*, 9 Mass. L. Rptr. 41, 1998 WL 566658 (Super. Ct. 1988), for instance, a Massachusetts trial court held that the presence of carbon monoxide in an apartment building satisfied the physical loss or damage requirement. It ultimately was determined "that the carbon monoxide buildup was due to 'some sections of old round galvanized pipe' that had 'wedged [their] way into the top of' and were blocking the chimney" of the apartment building. *Id.* at *1. The chimney was later cleaned and lined, and an exhaust fan was installed on the top of the chimney. *Id.* Inexplicably finding the phrase "direct physical loss or damage" ambiguous, the court ruled in favor of the insured:

> I find and rule that the phrase "direct physical loss or damage" is ambiguous in that it is susceptible of at least two different interpretations. One includes only tangible damage to the structure of insured property. The second includes a wider array of losses. Following the rule of construction that an ambiguous phrase be accorded the interpretation more favorable to the insured, I adopt the latter interpretation.

Id. at *3. Thus, the court held that the mere presence of carbon monoxide fumes was sufficient to satisfy the physical loss or damage requirement even though its presence did not result from any physical damage to insured property.

A similar result recently was reached by a federal court in New Jersey. In *Gregory Packaging, Inc. v. Travelers Prop. Cas. Co. of Am.*, Civ. No. 2:12-cv-04418 (WHW) (CLW), 2014 WL 6675934 (D.N.J. Nov. 25, 2014), the insured was in the process of building a new juice packaging facility in Georgia when an ammonia gas leak occurred. As a result of the leak, the facility was evacuated and several local governmental agencies were called to the facility. There was some evidence

that an evacuation was ordered within a one-mile radius around the facility, and that the local fire department would not allow anyone to enter the building for some period of time. There did not appear be any physical alteration to the insured's property. Rather, the facility simply could not be used until the ammonia dissipated from the air within the facility.

The court ruled in favor of Gregory Packaging, concluding that the presence of the ammonia rendered the facility unfit for occupancy. The court explained that "[w]hile structural alteration provides the most obvious sign of physical damage, both New Jersey courts and the Third Circuit have also found that property can sustain physical loss or damage without experiencing structural alteration." *Id.* at *5. The court went on to note "that property can be physically damaged, without undergoing structural alteration, when it loses its essential functionality." *Id.* According to the court, "there is no genuine dispute that the ammonia release physically transformed the air within Gregory Packaging's facility so that it contained an unsafe amount of ammonia or that the heightened ammonia levels rendered the facility unfit for occupancy until the ammonia could be dissipated." *Id.* at *6.

Thus, one could read *Gregory Packaging* to mean that any time the air within a facility is "physically transformed," such that the facility is unfit for human occupancy, even on a temporary basis, the physical loss or damage requirement has been satisfied. Such a holding is consistent with the holding in *Matzner.* To be sure, as discussed above, other courts previously have held that the presence of noxious orders rendering a building unfit for occupancy can satisfy the physical loss or damage requirement. In those cases, however, the odors were a manifestation of actual physical damage to insured property. As noted by one court, "the physical damage is demonstrated by the persistent, pervasive odor. In the absence of such odor, no physical damage could be found." *Columbiaknit*, 1999 WL 619100, at *7.

In *Gregory Packaging* and *Matzner*, in contrast, there was no evidence of any physical damage to insured property. The only "damage" consisted of noxious odors temporarily present in the air within the insured locations. Air itself, however, generally is not considered insured property. The structure and the property therein, including the fixtures, fittings, and equipment, are generally covered under an insurance policy. In the *Western Fire* case, gasoline had actually accumulated in the soil around the insured's building, infiltrating and saturating the foundation and making the structure uninhabitable, and in the *Sentinel* case the court based its decision on the actual presence of loose asbestos fibers in the insured property. Therefore, there was arguably physical damage to the insured's property in those cases.

Thus, in an attempt to "find" coverage, both the *Gregory Packaging* and *Matzner* courts reached even further than most courts that have considered the issue, continuing to erode the physical loss or damage requirement. Under the holdings in those cases, the presence of a noxious odor, even if only temporary, constitutes physical damage. While the trend among courts appears to be toward such a conclusion, no court had previously ventured as far as the *Matzner* court until *Gregory Packaging*. It remains to be seen whether other courts will follow in their footsteps. Thus far, while *Matzner* has been cited numerous times, no court has expressly adopted its reasoning and *Gregory Packaging* was decided only recently.

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Corporate Risk Presented by Ever-Evolving and Growing Cyber Crime: Trying Times for Directors & Officers

By: Kenneth M. Labbate and Oliver E. Twaddell

In late 2013, Target was reeling from a massive data breach. And just a few months ago, Sony was dealing with its second significant data breach. Sony's initial breach resulted in the theft of personally identifiable information for more than 80 million of Sony's customers. This time it appears from initial reports that not only was personally identifiable information stolen again, but in addition, certain proprietary information was also stolen from Sony Pictures Entertainment Inc., a subsidiary of Sony Corp., in the form of a film set for release and a screenplay, raising the specter of potential legal exposure for both the company and its directors and officers.[1]

Although there are many areas of exposure for businesses that lose important and classified information, one of the most potentially significant and least developed has been the liability of the directors and officers of these companies. The consensus is, however, that claims in this area will not be the exception for much longer, particularly as the frequency of data breaches grows.[2],[3] What distinguishes the recent breach at Sony Pictures from the earlier breach and most significant breaches which have been reported is the theft of intellectual property from Sony Pictures. How does the theft of essential pieces of business affect not only shareholder equity, but potentially a company's viability? How can companies prevent or mitigate potential exposure, particularly in light of the ever increasing prominence and sophistication of the "hack-tivist"? What is the duty of today's directors and officers to protect against such losses and mitigate exposure if and when data breaches occur? How do today's directors and officers satisfy their fiduciary obligations by keeping up with the ever changing and evolving "cyber-criminal"?

This article will explore what directors and officers should be doing now to protect the interests of corporate shareholders and minimize their own exposure to liability.

According to the Ponemon Institute's 2014 report, the average cost of a data breach in the United States is $5.9 million per incident and $201 per individual record.[4] But these costs make up only a small portion of the pie. Data breaches in which personal data is stolen can cause customer, client, employee and investor dissatisfaction, resulting in a loss of trust and reputational harm. However, the effect of these past breaches does not seem, as of yet, to be negatively affecting a company's stock price. Whether and to what extent the theft of proprietary information alters a company's stock price is yet to be seen.

As these risks are not always preventable, what should directors and officers do to prevent such data breaches, and how should they react to such events? As will be explained, there are numerous safeguards that can be implemented to protect the company and its shareholders from a diminution in value as well as the directors and officers from liability.

As an initial matter, it should be kept in mind that the well-established business judgment rule continues to govern a director's duty of care in making business and managerial decisions. The rule presumes that when a director makes a business decision, it is made "on an informed basis, in good faith and in the honest belief that the action is in the best interests of the company." *Smith v. Van Gorkom*, 488 A.2d 858 (Del. 1985). In evaluating due care, courts will "look for evidence of whether a board has acted in a deliberate and knowledgeable way identifying and exploring alternatives." *Citron v. Fairchild Camera and Instrument Corp.*, 569 A.2d 53 (Del. 1989). Even though directors may rely on reports prepared by others, they may not rely solely on retained experts and management without taking an active and direct role. Thus, the board of directors that neglects to actively monitor and manage its company's cyber-security will undoubtedly face heavy scrutiny.[5]

Data breach cases have not yet provided much insight into the due diligence expected of directors and officers to determine whether they have satisfied their duty of care. Recently, however, an otherwise unremarkable decision provided some guidance on this question. In *Palkon ex rel. Wyndham Worldwide Corp. v. Holmes*, the hospitality company Wyndham

Worldwide Corporation was sued by Dennis Palkon, one of the corporation's shareholders, after it refused Palkon's demand to bring a lawsuit on behalf of the corporation relating to the failure of the directors to familiarize themselves with the data breach. From April 2008 to January 2010, Wyndham had been the victim of three separate data breaches that resulted in the theft of credit card and personal information of over 600,000 customers. Soon after the breaches, the FTC brought an action against Wyndham, challenging its data security practices (the "FTC Action"). In a separate derivative action, plaintiff Palkon alleged that Wyndham and numerous of its corporate officers "failed to implement adequate data-security mechanisms, such as firewalls and elaborate passwords, and that this failure allowed hackers to steal customers' data." Palkon further alleged that the defendants "failed to timely disclose the data breaches after they occurred."[6]

In granting defendants' motion to dismiss, the U.S. District Court in New Jersey found that Wyndham's board of directors had taken various steps to familiarize itself with the data breach. Specifically, the board had undertaken a number of actions to conduct a "reasonable investigation" into the data breach, including:

> (a) the board discussed the cyber-attacks at fourteen meetings from October 2008 to August 2012, and gave a presentation about the breaches and Wyndham's data security and proposed security enhancements;
>
> (b) the board discussed with the audit committee the same data breach and security issues in at least sixteen committee meetings during the same time period;
>
> (c) the board hired technology firms to investigate each breach and to issue recommendations on enhancing the company's security; and
>
> (d) after the initial breaches, the board began to implement the recommendations.[7]

Also important to the court's assessment of the board's activity was that the board had developed information about the breaches through the FTC Action that Wyndham was facing. The court was influenced by the board's time and interest in discussing the data breaches, becoming fully knowledgeable about the issues concerning Palkon's later demand letter, and implementing certain recommendations made by the retained technology firms.

The *Palkon* decision offered some insight into what a board should consider when faced with a data security breach, when responding to and investigating the breach, and in trying to prevent future breaches. As illustrated by the *Palkon* decision, directors and officers must take certain steps in order to prevent or minimize the effect of data breaches, and provide a foundation from which to defend against allegations of breach of fiduciary duty. What remains clear is that when a data breach occurs (and it likely will), plaintiffs' lawyers will look to scrutinize the decisions made by directors and officers in allocating resources to assess and investigate the risk of a breach and to detect and respond to a breach in a timely and effective manner. While achieving this balance is made difficult by the increasing and rapidly evolving risks presented by the cyber-criminal, there are a number of actions that directors and officers can take and questions they can ask[8] to protect themselves and the companies they serve from liability:

- Develop a clear understanding of the company's cyber-security processes and procedures in order to be certain that the company is sufficiently protected in this constantly evolving technology world;
- Hire a reputable security software provider;
- Conduct periodic and frequent tests of the company's cyber-security protocols and safeguards and have consistent and frequent communications regarding the company's cyber-security guidelines for dealing with a data breach;
- Appoint a chief information security officer with expertise on cyber-security and data breaches. Require this officer to regularly update the board on proper protocol and recommend changes when needed. The CISO's premier responsibility should be to vigilantly stay attuned to the company's information security and regularly advise the board regarding the same;
- Form a cyber-security committee

responsible for privacy and security that meets regularly and keeps the board abreast of the company's cyber-security efforts and issues, making timely recommendations for the detection and prevention of data breaches. The cyber-committee should consist of individuals from executive management, information technology, legal, risk management, public relations, and the audit and compliance departments;

- Ensure that the company encrypts data transfers;[9]
- Become knowledgeable on applicable privacy and data breach disclosure laws. Senior management should identify all sensitive data, including personal information, healthcare information, and customer financial and identifying information, and implement safeguards and controls to protect that sensitive information;
- Understand outside vendors' cyber-security protections, and make sure that vendors that have access to company systems and information have sufficient safeguards and recovery plans. As seen in the Target and Home Depot data breaches, the company was infiltrated by the flawed cyber-security protection of outside vendors;[10]
- Make certain cyber-security measures of vendors with which the company does business meet the company's own standards. Utilize indemnification and additional insured provisions to shift risk (and cost) of data breaches to vendors and to minimize the company's exposure to vendor-related breaches.
- Adopt and test a data breach response plan that complies with the laws of the individual states your company is doing business in;
- Ensure that any breach response plan provides for proper notice of a cyber-incident to insurers for all possible insurance lines of coverage. The response plan should also account for how the company will respond to various actors in the aftermath of a data breach, *e.g.*, the media, law enforcement, customers, clients, vendors;
- Periodically use an outside company to audit the company's cyber-security protocol, and compare those findings to the steps and processes recommended by the company's cyber-officers and cyber-committee;
- Ensure that the company has formal written cyber-security practices and procedures with regard to any sensitive data held by the company. The cyber-security officers and committee should periodically review and update these written rules and procedures. The board should be fully knowledgeable about these written procedures, and should oversee any drafting of and revisions to these standard procedures;
- Review the company's cyber-insurance, directors' and officers' commercial general liability, and any other potentially applicable coverages, to be certain the company is adequately protected;[11]
- Identify and quantify any cyber-exposures, and mitigate those exposures, including conducting due diligence, reviewing contractual allocation of liability and implementing information technology best practices in accordance with the National Institute of Standards and Technology Critical Infrastructure framework. This cyber-security guideline is likely to become the security requirement for data breach litigation;[12]
- Mandate periodic training and education sessions for all employees about cyber-risks;
- Comply with the Security and Exchange Commission's disclosure guidance on cyber-security, including potentially disclosing: cyber-security risk factors that arise from the company's business

> or operations, any of the company's outsourced functions that create cyber-liability risks, material cyber-incidents experienced by the company and their costs and consequences, and a description of the company's relevant insurance coverage.[13]

In this relatively new age of data breach liability, individual plaintiffs have had difficulty in proving compensable damages.[14] Without any proof of misuse of their personal information or bank card, establishing a *present*, non-speculative harm is difficult.[15] But as we have seen in the Target litigation, financial institution plaintiffs have alleged a number of damages: the capital and human resources needed to address the breach, including reissuing cards, changing or closing accounts, notifying customers of the breach of their cards, investigating claims of fraudulent activity, refunding customers for fraudulent charges, increasing fraud monitoring on potentially impacted accounts, and lost interest and transaction fees as a result of decreased or ceased card usage.[16]

The damages alleged by financial institution plaintiffs seem rather obvious, but the more problematic question for plaintiffs' lawyers has been: what damages does an individual shareholder or a class of shareholders suffer when their credit card or personal information is stolen? The recent major data breaches, *e.g.*, Target and Home Depot, did not result in more than a nominal change in the company stock prices.[17] It remains unclear what the impact of the theft of proprietary information or intellectual property will be, but the potential effect on a company's stock price is clear. Implementing many of the above recommendations will provide the foundation from which a defense can be built on behalf of a director or officer who is accused of neglect in analyzing the risk of, and in responding to, a data breach.

The novel cyber-risks now faced by companies, both large and small, place businesses in a difficult position to make well-informed monetary decisions about how to most effectively allocate company resources. As data breaches continue to occur, plaintiffs will continue to develop damages theories which will become increasingly easier as the cyber-criminal focus shifts from the theft of personally identifiable information to the theft of proprietary information and intellectual property, as was recently reported at Sony Pictures.

It is up to a company's directors and officers to ensure that resources are properly and timely allocated to assess and respond to the cyber-risks a company faces so as to protect and preserve a corporation's intellectual property and, correspondingly, shareholder equity. The failure of a director or officer to properly discharge his or her duty in this regard will continue to be an ever-increasing focus in the data breach world.

Endnotes

1 Sony Pictures Entertainment Inc. is the subject of a Class Action proceeding in the United States District Court – Central District of California filed by current and former employees of the company.

2 *See* Prepared Remarks of Robert Mueller, Cyber Security Conference (Mar. 1, 2012).

3 Cyber-related directors and officers liability claims expected to increase, Management Liability, Nov. 10, 2014.

4 Ponemon Institute, *2014 Cost of Data Breach Study: United States*, May 2014.

5 D. Barres and D. Picca, Corporate Counsel, "Director Liability for Cybersecurity Risks," Aug. 6, 2014.

6 *Palkon ex rel. Wyndham Worldwide Corp. v. Holmes*, 2014 WL 5341880 (DN.J. Oct. 20, 2014).

7 *Id.*

8 *See* L.J. Trautman and K. Altenbaumer-Price, *The Board's Responsibility for Information Technology Governance*, The John Marshall Journal of Computer & Information Law, Volume XXVIII, 3, 2011.

9 *See* L. Unger, *Breaches to Customer Account Data*, Journal of the Missouri Bar, Sept.-Oct. 2014.

10 *See* K. LaCroix, *Guest Post: The Cloud, Cyber Security and Cloud Cyber Governance: What Every Director Needs to Know*, The D&O Diary, July 29, 2014.

11 A. Radke and J. Cleary, Lessons from Dismissal of Wyndham Shareholder's Derivative Action, Nov. 19, 2014.

12 K. Kalinich and M. Becker, Cyber Risk: Are Boards the New 'Target'?, April 22, 2014.

13 On October 13, 2011, the SEC, Division of Corporation Finance, released cyber-security disclosure guidance entitled "CF Disclosure Guidance: Topic No. 2 – Cybersecurity." As made clear by the guidance, it is not a rule, regulation, or statement of the SEC. However, it may be important to disclose this information, depending on the company's particular facts and circumstances. For example, plaintiffs in shareholder litigation will challenge non-disclosures or inadequate disclosures of important cyber-security risks in order to buttress claims against the company and its directors and/or officers. The SEC's guidance can be found at: http://www.sec.gov/divisions/corpfin/guidance/cfguidance-topic2.htm.

14 D. Meal, *Privacy and Surveillance Legal Issues*, 2014.

15 *See, e.g.*, *Pisciotta v. Old Nat. Bancorp,* 499 F.3d 629 (7th Cir. 2007).

16 Consolidated class action complaint against Target, August 1, 2014, filed in the U.S. District Court for the District Court of Minnesota; MDL No. 14-2522. *See also Lone Star Nat'l Bank, N.A. v. Heartland Payment Sys., Inc.*, 729 F.3d 421 (5th Cir. 2013).

17 Compare *Heartland Payment Systems, Inc. Securities Litigation*, 2009 WL 4798148 (D.N.J. December 7, 2009). Heartland Payment Systems was sued in a securities fraud class action when its system was breached, resulting in the theft of millions of credit and debit card numbers. The breach occurred over the course of 2008, and was not discovered by Heartland until 2009. At that point when Heartland disclosed the breach, its stock price dropped 80 percent. However, the shareholder class action was dismissed because they failed to plead fraud with particularity as required under the Private Securities Litigation Reform Act of 1995. The officers and directors, however, did settle with Visa, MasterCard, and American Express.

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Tanasi v. New Alliance Bank: Second Circuit Clarifies Whether Unaccepted Rule 68 Offers of Judgment Moot a Plaintiff's Claims

By: Sanjit S. Shah

In putative class actions in which the amount of a named plaintiff's potential recovery is relatively low, an offer of judgment pursuant to Rule 68 of the Federal Rules of Civil Procedure has been an attractive device for defendants to end the litigation in its early stages.[1] In the Seventh Circuit, if a named plaintiff rejects a settlement offer in which the defendant agrees to pay him the entire amount to which he would be entitled if he were to prevail on the merits, the plaintiff's claims become moot, and the court loses subject matter jurisdiction over the case.[2] Recently, in *Doyle v. Midland Credit Mgmt., Inc.*, a 2013 decision, a panel of the Second Circuit comprising Judges Leval, Katzmann and Hall appeared to agree with the Seventh Circuit that the rejection by the plaintiff of a settlement offer that would have made him whole mooted his case.[3]

This past May, however, another panel of the Second Circuit comprising Chief Judge Katzmann and Judges Walker and Chin issued its decision in *Tanasi v. New Alliance Bank*, in which it "clarified" and "reiterated" that "it remains the established law of this Circuit that a 'rejected settlement offer [under Rule 68], by itself, [cannot render] moot[] [a] case.'"[4]

Rule 68 Offers of Judgment and the Mootness Doctrine

Rule 68 provides that if, at least 14 days before trial, a defendant offers to allow judgment against it on specified terms, with costs accrued, and the plaintiff rejects the offer but does not obtain a judgment that is more favorable than the unaccepted offer, the plaintiff must pay the costs incurred by the defendant after the offer was made:

> **(a) Making an Offer; Judgment on an Accepted Offer.** At least 14 days before the date set for trial, a party defending against a claim may serve on an opposing party an offer to allow judgment on specified terms, with the costs then accrued. If, within 14 days after being served, the opposing party serves written notice accepting the offer, either party may then file the offer and notice of acceptance, plus proof of service. The clerk must then enter judgment. . . .
>
> **(d) Paying Costs After an Unaccepted Offer.** If the judgment that the offeree finally obtains is not more favorable than the unaccepted offer, the offeree must pay the costs incurred after the offer was made.[5]

The purpose of Rule 68 is to "encourage settlement and avoid litigation."[6] "What Rule 68 does not make clear, however, is the effect, if any, of an unaccepted offer on the justiciability of a plaintiff's claim under the Constitution's Case or Controversy Clause[,]"[7] which

"limits the subject matter jurisdiction of the federal courts such that the parties must continue to have a personal stake in the outcome of the lawsuit."[8] "A case becomes moot [pursuant to Article III's Case or Controversy Clause] . . . when it is impossible for a court to grant any effectual relief whatever to the prevailing party."[9]

Some courts, including the U.S. Courts of Appeals for the Third, Fourth, Fifth, Seventh, Tenth and Federal Circuits, have held that a Rule 68 offer of complete relief, *i.e.*, an offer affording the plaintiff all of the relief to which he would be entitled if he were to prevail on the merits, "renders his case moot for purposes of Article III, regardless of whether judgment is entered against the defendant."[10] In *Damasco v. Clearwire Corp.*, the Seventh Circuit explained that "[o]nce the defendant offers to satisfy the plaintiff's entire demand, there is no dispute over which to litigate, and a plaintiff who refuses to acknowledge this loses outright, under Fed. R. Civ. P. 12(b)(1), because he has no remaining stake."[11] The Ninth and the Eleventh Circuits have reached the opposite conclusion.[12] Although the Supreme Court recognized the existence of a split among the Circuits in 2013 in *Genesis Healthcare Corp. v. Symczyk*, it declined to resolve the split because the issue was not properly before it.[13]

The Interplay Between Rule 68 and the Mootness Doctrine in the Second Circuit

In 2005, the Second Circuit decided *McCauley v. Trans Union, L.L.C.*, a case involving allegations by the *pro se* plaintiff that the defendant consumer reporting agency "had negligently indicated on [his] credit report that he had two outstanding tax liens, thus temporarily preventing [him] from securing a student loan . . . ."[14] The plaintiff demanded damages in the amount of $240, and the defendant, acknowledging that it owed plaintiff that amount, offered that sum plus court costs with the requirement that the settlement be confidential.[15] "Because [the plaintiff] refused to accept the offer, the [district] court dismissed the case . . . holding that the offer constituted everything [the plaintiff] would potentially recover through successful litigation."[16]

The Second Circuit vacated the judgment in favor of the defendant, holding that when the defendant "acknowledged that it owes [the plaintiff] $240, but offered the money with the requirement that the settlement be confidential, [the defendant] made a conditional offer that [the plaintiff] was not obligated to take."[17] Under these circumstances, the court could not "conclude that the rejected settlement offer, by itself, moots the case so as to warrant entry of judgment in favor of [the defendant]."[18] It therefore appeared that in the Second Circuit, an unaccepted offer of complete relief did not moot the plaintiff's case.

Then, in 2013, a panel of the Second Circuit comprising Judges Leval, Katzmann and Hall issued the *per curiam* opinion in *Doyle v. Midland Credit Mgmt., Inc.* In *Doyle*, the plaintiff alleged that the defendant had violated various provisions of the Fair Debt Collection Practices Act ("FDCPA"). At a hearing in the district court, the defendant orally presented the plaintiff with a Rule 68 offer of judgment for the maximum amount to which he would have been entitled under the statute, but the plaintiff rejected the offer.[19] The district court held that the case was moot, and dismissed the case for lack of subject matter jurisdiction.[20]

On appeal, the plaintiff argued, *inter alia*, that the district court erred because a Rule 68 offer could not be made orally.[21] The Second Circuit, however, rejected the plaintiff's argument, holding that "an offer need not comply with Federal Rule of Civil Procedure 68 in order to render a case moot under Article III."[22] The *Doyle* court went on to hold that the plaintiff's refusal to accept an offer that would have made him whole mooted his case:

> Consequently, we agree with the district court that [the plaintiff's] refusal to settle the case in return for [the defendant's] offer of $1,011 (plus costs, disbursements, and attorney's fees), notwithstanding [the plaintiff's] acknowledgment that he could win no more, was sufficient ground to dismiss this case for lack of subject matter jurisdiction.[23]

In its decision, the *Doyle* court did not cite its earlier decision in *McCauley.*

The Second Circuit's Decision in Tanasi

In *Tanasi*, plaintiff Patrick Tanasi filed a putative class action against the defendants arising from the allegedly improper assessment of overdraft fees on his bank account and on the accounts of those similarly situated.[24] Nine days later, the defendants

made a Rule 68 offer of judgment to Tanasi "'on his individual claims' for $10,000 plus interest, reasonable attorneys' fees, costs, and any 'other damages he seeks on his individual claims.'"[25] The $10,000 offered to Tanasi exceeded the individual damages to which he would have been entitled had he prevailed on his individual claims.[26] Tanasi, however, rejected the offer by not responding to it within 14 days, as required by Rule 68 and the terms of the offer.[27] The defendants then moved to dismiss Tanasi's complaint, arguing that the unaccepted Rule 68 offer rendered both his individual and his putative class claims moot.[28]

The district court denied the defendants' motion to dismiss, holding that although Tanasi's individual claims were mooted by the Rule 68 offer, his class claims were not.[29] The court also dismissed one of Tanasi's causes of action on the merits, and allowed the others to proceed.[30]

The defendants moved for a certificate of interlocutory appeal, which the district court granted, holding that "the question of 'whether a pre-certification offer of judgment under Rule 68 moots a putative class action' has divided courts in this Circuit and around the country."[31] The district court stayed the case during the pendency of the defendants' appeal.

On appeal, the Second Circuit (Katzmann, C.J., Walker, Chin, JJ.) held that the unaccepted Rule 68 offer did not moot Tanasi's individual claims and, therefore, it did not have to decide the question of whether the offer mooted his class claims.[32] The *Tanasi* court recognized the split among the circuits on the question before it, and even acknowledged that "our prior case law has not always been entirely clear on this subject."[33] In this regard, it cited a comment from the Harvard Law Review which observed that "the Second Circuit has produced several opinions addressing this question; other courts interpreting these opinions have come to opposite views about the Second Circuit's position without ever acknowledging these divergent opinions."[34]

Quoting its 2005 decision in *McCauley*, the *Tanasi* court held that "it remains the established law of this Circuit that a 'rejected settlement offer [under Rule 68], by itself, [cannot render] moot[] [a] case.'"[35] The court explained that only after a judgment is entered against the defendant can a plaintiff's claims become moot:

> If the parties agree that a judgment should be entered against the defendant, then the district court should enter such a judgment. Then, *after* judgment is entered, the plaintiff's individual claims will become moot for purposes of Article III. Absent such agreement, however, the district court should not enter judgment against the defendant if it does not provide complete relief.[36]

Thus, under *Tanasi*, an unaccepted Rule 68 offer of judgment affording a plaintiff complete relief will not moot a plaintiff's claims, and the district court may not enter judgment against the defendant if the offer does not provide complete relief. It appears, therefore, that the linchpin for determining whether a claim is moot in the Second Circuit is the entry of judgment against the defendant, which cannot happen unless the parties agree to the entry of such judgment, or a default judgment is entered against a defendant that has "thrown in the towel."[37]

What then of the Second Circuit's decision in *Doyle*, decided in 2013? Although the *Tanasi* court did not address *Doyle* in the body of its opinion, it expressed its disagreement in a footnote with those who have claimed that *Doyle* "compels a contradictory result," stating that "*Doyle* never purported to hold that the mere offer of complete relief to an individual moots his claim regardless of whether this offer is accepted."[38] It also noted that "[i]nsofar as it also concluded that 'Doyle's refusal to settle the case in return for Midland's offer . . . notwithstanding Doyle's acknowledgement that he could win no more, was sufficient ground to dismiss this case for lack of subject matter jurisdiction,' it could have done so only as a result of the parties' failure to contest the issue at trial or on appeal."[39]

In addition, the *Tanasi* court noted that *Doyle* did not mention *McCauley*, "much less purport to overrule it[,]" and held that even if the *Doyle* court had wanted to overrule *McCauley*, it could not have done so, because a "subsequent panel is bound by the decisions of a prior panel absent a ruling from the Second Circuit sitting en banc or from the United States Supreme Court."[40] Under these circumstances, the *Tanasi* court held that it had no alternative but to follow *McCauley* over *Doyle*:

> Where a second panel's decision seems to contradict the first, and there is no basis on which to distinguish the two cases, we have no choice but to follow the rule announced by the first panel.[41]

Conclusion

With the Second Circuit's decision in *Tanasi*, no longer will there be any uncertainty among litigants about whether a defendant can "pick off" a plaintiff purporting to represent a putative class representative by mooting his claims through a Rule 68 offer of judgment. A defendant will still be able to moot the plaintiff's claims against the plaintiff's will, but can only do so if he *unconditionally* offers the plaintiff complete relief, and judgment is ordered against the defendant. Without the entry of judgment against the defendant, the plaintiff's claims will remain live, and a district court in the Second Circuit will maintain subject matter jurisdiction over the matter.

Endnotes

1 See, *e.g., Tanasi v. New Alliance Bank*, 786 F.3d 195, 196 (2d Cir. 2015) ("After Tanasi refused to accept the offer, the defendants filed a motion to dismiss arguing, *inter alia*, that the unaccepted Rule 68 offer rendered Tanasi's individual and putative class action claims moot."); *Damasco v. Clearwire Corp.*, 662 F.3d 891, 893 (7th Cir. 2011) ("Clearwire moved to dismiss the case, arguing that its settlement offer stripped Damasco of his personal stake in the case's outcome and rendered his claim moot.").

2 *Damasco*, 662 F.3d at 896 ("To allow a case, not certified as a class action and with no motion for class certification even pending, to continue in federal court when the sole plaintiff no longer maintains a personal stake defies the limits of federal jurisdiction expressed in Article III [of the U.S. Constitution].").

3 *Doyle v. Midland Credit Mgmt., Inc.*, 722 F.3d 78, 81 (2d Cir. 2013).

4 *Tanasi*, 786 F.3d at 200 (quoting *McCauley v. Trans Union, L.L.C.*, 402 F.3d 340, 342 (2d Cir. 2005)) (brackets in original).

5 Fed. R. Civ. P. 68(a), (d).

6 *Tanasi*, 786 F.3d at 198 (quoting *Marek v. Chesny*, 473 U.S. 1, 5 (1985)).

7 *Tanasi*, 786 F.3d at 198-99.

8 *Tanasi*, 786 F.3d at 198 (quoting *U.S. v. Wiltshire*, 772 F.3d 976, 978 (2d Cir. 2014), internal quotation marks omitted).

9 *Tanasi*, 786 F.3d at 199 (quoting *Knox v. Serv. Emps. Int'l Union, Local 1000*, 132 S. Ct. 2277, 2287 (2012), brackets in original, internal quotation marks omitted).

10 *Tanasi*, 786 F.3d at 199 n.4 (collecting cases).

11 *Damasco*, 662 F.3d at 895 (quoting *Rand v. Monsanto Co.*, 926 F.2d 596, 598 (7th Cir. 1991)) (brackets in original).

12 *Tanasi*, 786 F.3d at 199 (citing *Stein v. Buccaneers Ltd. P'ship*, 772 F.3d 698 (11th Cir. 2014), and *Diaz v. First Am. Home Buyers Prot. Corp.*, 732 F.3d 948 (9th Cir. 2013)).

13 *Genesis Healthcare Corp. v. Symczyk*, 133 S. Ct. 1523, 1528-29 (2013).

14 *McCauley v. Trans Union, L.L.C.*, 402 F.3d 340 (2d Cir. 2005).

15 *McCauley*, 402 F.3d at 342.

16 *McCauley*, 402 F.3d at 341.

17 *McCauley*, 402 F.3d at 342.

18 *McCauley*, 402 F.3d at 342.

19 *Doyle*, 722 F.3d at 80.

20 *Doyle*, 722 F.3d at 80.

21 *Doyle*, 722 F.3d at 81.

22 *Doyle*, 722 F.3d at 81.

23 *Doyle*, 722 F.3d at 81.

24 *Tanasi*, 786 F.3d at 197.

25 *Tanasi*, 786 F.3d at 197.

26 *Tanasi*, 786 F.3d at 197.

27 *Tanasi*, 786 F.3d at 197.

28 *Tanasi*, 786 F.3d at 197.

29 *Tanasi*, 786 F.3d at 197.

30 *Tanasi*, 786 F.3d at 198.

31 *Tanasi*, 786 F.3d at 198.

32 *Tanasi*, 786 F.3d at 197.

33 *Tanasi*, 786 F.3d at 199.

34 *Tanasi*, 786 F.3d at 199 n.5 (quoting Comment, *Diaz v. First American Home Buyers Protection Corp.*, 127 Harv. L. Rev. 1260 (2014) (internal quotation marks omitted)).

35 *Tanasi*, 786 F.3d at 200 (quoting *McCauley*, 402 F.3d at 342 (brackets in original)).

36 *Tanasi*, 786 F.3d at 200 (italics in original, citations omitted).

37 *McCauley*, 402 F.3d at 342 (citing *Chathas v. Local 134 IBEW*, 233 F.3d 508, 512 (7th Cir. 2000)).

38 *Tanasi*, 786 F.3d at 200 n.6.

39 *Tanasi*, 786 F.3d at 200 n.6 (quoting *Doyle*, 722 F.3d at 81, citing *Genesis Healthcare Corp. v. Symczyk*, 133 S. Ct. 1523, 1529 (2013) (Kagan J., dissenting).

40 *Tanasi,* 786 F.3d at 200 n.6 (citing *Lotes Co. v. Hon Hai Precision Indus. Co.*, 753 F.3d 395, 405 (2d Cir. 2014)).

41 *Tanasi*, 786 F.3d at 200 n.6.

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Under a Replacement Cost Property Policy, Is an Insured Required to Repair or Replace Property Before Recovering a Judgment Amount for Replacement Cost?

By: Victor J. Jacobellis

Under the typical replacement cost coverage in a property policy, the insured is only entitled to the actual cash value of damaged property unless the property is actually repaired or replaced. If the property is repaired or replaced (usually within a specified time), the replacement cost coverage will pay for the repair or replacement, whichever is less. If the damaged property is timely repaired or replaced, then the amount an insured is owed is easily determined and the process works as intended.

But what is the amount an insured is entitled to recover when a claim is denied, a coverage lawsuit is filed, there is a judgment finding coverage and the damaged property was never repaired or replaced? The insurer may claim that the insured is bound by the terms of the insurance policy and is therefore only entitled to the actual cash value. The insured, on the other hand, may argue that it is entitled to the replacement cost value because the insurer's denial of the claim prevented it from having the funds or obtaining the financing necessary to perform the repairs. The resolution of this issue and the amount of damages recoverable depend on the jurisdiction where the coverage action is pending. Some courts have excused the insured from having to repair or replace the property in order to recover the replacement cost value if an insurer wrongfully denies coverage. However, a trend, exemplified by a recent California decision, has rejected the choice between denying replacement cost coverage to the insured and estopping the insurer from asserting the requirement to repair or replace the property. Instead, these cases have awarded the insured the actual cash value immediately and declared the insured will be paid the replacement cost when the repair or replacement is completed. This approach serves both parties' interests under the policy and administers a judgment closely aligned with the intent of replacement cost coverage. In order to understand the development of this recent approach, this article will first explain why some courts have excused an insured from having to repair or replace property when a claim is erroneously denied.

Nature of Replacement Cost Coverage

When coverage was wrongfully denied, but the insured never repaired or replaced the damaged property, courts have often sought to place the insured in the same position it would have been in if the claim had been paid according to the policy's terms. However, the general nature of replacement cost coverage does not make this a straightforward and easy task. The purpose of replacement cost coverage is to reimburse an insured for the full cost to repair or replace damaged property. *Rockford Mut. Ins. Co. v. Pirtle*, 911 N.E.2d 60, 66-67 (Ind. Ct. App. 2009). In many instances though, the cost to fully repair or replace property will exceed the property's value at the time of a loss because of normal wear and tear and the passage of time. As a result, "there is a moral hazard that the insured will intentionally destroy the insured property in order to gain from the loss. For this reason, most replacement cost policies require actual repair or replacement of the damaged property as a condition precedent to recovery." *Stephens & Stephens XII v. Fireman's Fund Ins. Co.*, 231 Cal. App. 4th 1131 (2014). After a loss, the insured is initially entitled to receive the damaged property's actual cash value. Once repair or replacement is complete, or at least committed to, the insured will receive the difference between the actual cost to repair or replace and the actual cash value. Some policies place a limit on the time to repair or replace, often six months to one year.

If a claim is denied, the property is not repaired or replaced, and a coverage lawsuit ensues, the insurer and the insured have competing expectations as to what the measure of damages should be based upon the policy's terms. An insured has an expectation to receive the full repair or replacement cost. This is the protection the insured believes it has paid for and which is ultimately provided for under the policy. The insurer has an expectation that the insured is only entitled to the actual cash value amount since the property has not been repaired. It rightfully believes that replacement cost is only a conditional benefit that requires damaged property's repair or replacement

and that the insured should not be entitled to a benefit that is not conveyed in the policy. The question for courts then becomes how to fashion an award that fairly addresses these competing interests.

The Doctrine of Prevention Excusing an Insured from Making Repairs

In the past, some courts have typically held that an insured can recover the damaged property's replacement cost value if an insurer is found to have incorrectly denied coverage, regardless of whether the damaged property has been repaired or replaced. This is known as the "Prevention Doctrine" and it excuses an insured's performance of a policy's repair or replacement condition whenever there has been an erroneous denial of coverage. *D & S Realty, Inc. v. Markel Ins. Co.*, 284 Neb. 1, 816 N.W.2d 13 (2012). The excusal under this doctrine is automatic regardless of whether the coverage denial was done in good faith. Courts initially developed this rule of law based on principles of equity. The measure of damages when there has been no repair or replacement was first addressed by a court in *Zaitchick v. American Motorists Ins. Co.*, 554 F. Supp. 209, 217 (S.D.N.Y. 1982). In this case, the court found that equitable considerations required that damaged property's replacement cost was the appropriate method of valuing a insured's damages if there was a finding that coverage was incorrectly denied. The court reasoned that, "a bank would be chary to lend money on the basis of an unlitigated law suit in which the defendant and its vast resources intend to present several defenses to payment." *Id*. The court further reasoned that the insurer was required by the policy's terms to provide the insureds the necessary seed funds to begin the repairs to their home, but the insurer's denial of the claim made it impossible for the insured to fulfill the condition precedent and therefore the insureds were excused from performance of the replacement condition. *Id.*

Following *Zaitchik*, other courts held that an insured was excused from repairing or replacing property if an insurer denied a claim. *See Cornelius v. Badger Mut. Ins. Co.*, 354 N.W.2d 100 (Minn. Ct. App. 1984); *Maine Mut. Fire Ins. Co. v. Watson*, 532 A.2d 686 (Me. 1987); *State Farm Fire & Cas. Ins. Co. v. Miceli*, 164 Ill. App. 3d 874, 518 N.E.2d 357 (1987); *Bailey v. Farmers Union Co-op. Ins. Co.*, 1 Neb. App. 408, 498 N.W.2d 591 (1992); *Pollock v. Fire Ins. Exchange*, 167 Mich. App. 415, 423 N.W.2d 234 (1998); *Ward v. Merrimack Mut. Fire Ins. Co.*, 332 N.J. Super. 515, 753 A.2d 1214 (App. Div. 2000); *Conrad Bros. v. John Deere Ins. Co.*, 640 N.W.2d 231 (Iowa 2001); *Pirtle*, 911 N.E.2d 60 at 66-67. These holdings expanded on the *Zaitchick* court's finding that the denial of a claim prevented the insured from complying with its duty to repair or replace property before receiving the full replacement cost amount. Some courts incorporated further principles in contract law holding that where a party to a contract causes the failure of the performance of the obligation due to him or her, that party cannot take advantage of that failure. 13 Williston on Contracts § 39:3 (4th ed.). Thus, some courts sided with the insured on the basis that the insurer's denial made it impossible for the insured to comply with the repair or replacement condition and that by incorrectly denying coverage, the insurer had also waived its right to rely on the repair or replacement condition to its advantage.

Some courts have held that a wrongful coverage denial automatically excuses an insured from having to repair or replace the property. *See Cornelius*, 354 N.W.2d at 102; *Watson*, 532 A.2d 686 at 690; *Miceli*, 164 Ill. App. 3d at 883; *Pirtle*, 911 N.E.2d 60 at 66-67. However, some courts have held that it is an issue of fact whether an insurer's denial of a claim alone entitles an insured to be awarded damaged property's repair or replacement cost. *Ward*, 753 A.2d at 525; *Conrad Bros.*, 640 N.W.2d at 242. These courts have recognized that the legal principle behind the Prevention Doctrine requires that the insured actually be unable to make repairs and thereby unable to comply with the policy repair or replace condition. But what if the insured already had the funds necessary to make repairs or never intended to the replace the property? The New Jersey Court of Appeals, in *Ward*, 753 A.2d at 525, ruled that it was a question of fact "whether the failure to pay a claim caused the insured to not replace the damaged property." In this case, the insureds were business partners and entrepreneurs and the insured home was investment property situated near the coastline. *Id*. at 526. The property was destroyed by a fire, the claim was denied, and the building had been condemned and torn down by the time there was a judgment in favor of coverage. *Id*. at 519-20. The court found that before the insureds were entitled to recover replacement cost, it must first be determined that the insurer's failure to pay the insureds their damaged property's actual cash value was the cause in fact for

the building's not being repaired. The court surmised that the insureds could have had sufficient funds or could have secured financing to repair the property. *Id*. at 526-27. Similarly, the Iowa Supreme Court, in *Conrad Bros.*, 640 N.W.2d at 242, held that it must be shown that the insurer's denial of the claim caused the insured's failure to repair or replace and that the insured cannot recover the replacement cost if there is evidence that the insureds would have never made the repairs in any event. Generally, the insured has the burden of proving that the insurer's failure to pay actual cash value was the material cause in fact of its failure to repair or replace the damaged property. *D & S Realty, Inc.*, 816 N.W.2d. at 16.

Temporary Suspension of the Insured's Duty to Repair or Replace Supplants the Prevention Doctrine

Courts have recently begun to reject the Prevention Doctrine in favor of a methodology that protects the interests of both the insured and the insurer. Under the new methodology, the insured will receive a judgment in the amount of the damaged property's actual cash value. The insured will then be entitled to receive the full repair or replacement cost when the damaged property is repaired or replaced. *Stephens & Stephens XII*, 231 Cal. App. 4th at 1139-40; *D & S Realty, Inc.*, 816 N.W.2d at 17-18; *Todd v. Wayne Co-op. Ins. Co.,* 31 A.D.3d 1026, 819 N.Y.S.2d 179 (2006); *Miller v. Farm Bureau Town & Country Ins. Co. of Missouri*, 6 S.W.3d 432 (Mo. Ct. App. 1999); *Smith v. Michigan Basic Property Ins. Assn.*, 441 Mich. 181, 490 N.W.2d 864 (1992); *Dickler v. CIGNA Prop. & Cas. Co.*, 957 F.2d 1088 (3d Cir. 1992). Under this theory, the insured's duty to perform the policy condition of repair or replacement is merely suspended while the issue of liability is undetermined. *D & S Realty, Inc.*, 816 N.W.2d at 22. Courts have reasoned that an insured could not be expected to repair or rebuild its property if a claim has been denied and litigation is pending. However, once coverage has been adjudicated in the insured's favor and the carrier pays the actual cash value, the insured will have seed money to undertake the repair or replacement, and should find it easier to obtain financing. *Stephens & Stephens XII*, *231* Cal. App. 4th at 1145; *Smith*, 490 N.W.2d at 868.

Courts that previously excused the insured's duty to repair or replace under the Prevention Doctrine now appear to be adopting the new trend. *See D & S Realty, Inc.*, 816 N.W.2d at 17-18 (Nebraska Supreme Court declining to follow Nebraska Court of Appeals ruling in *Bailey*, 498 N.W.2d at 418-19); *Smith*, 490 N.W.2d 864 at 867-70 (Supreme Court of Michigan declining to follow Michigan Court of Appeals ruling in *Pollock*, 423 N.W.2d at 236-37); *Todd,* 819 N.Y.S.2d at 179 (New York Appellate Division declining to follow the Southern District of New York's application of New York law in *Zaitchick v. American Motorists Ins. Co.*, 554 F. Supp. at 209, 217); *Dickler*, 957 F.2d at 1096 (Third Circuit, applying New York law, declining to follow the Southern District of New York's application of New York law in *Zaitchick*).

The most recent court to visit this issue was the California Court of Appeals in *Stephens & Stephens XII*, 231 Cal. App. 4th at 1143-46, where this issue was a matter of first impression for California. In this case, the insured argued that the Prevention Doctrine should be applied, claiming it was entitled to the full replacement cost because it was excused from complying with the policy's repair or replace requirement as a result of the insurer's, Fireman's Fund, coverage denial. Fireman's Fund claimed the insured was not entitled to replacement cost because the insured had not satisfied the precondition of repair or replacement. The court decided to reject both parties' arguments, instead adopting the middle ground of temporarily suspending the duty to repair. *Stephens & Stephens XII*, 231 Cal. App. 4th at 1144. The court reasoned that under this theory, both the insurer's and insured's interests are adequately protected. The insured is still able to obtain the benefit of receiving the property's full repair or replacement cost. The insurer is also protected because its erroneous good faith denial of a claim does not operate to provide the insured a benefit that was not contracted for – the right to receive repair or replacement cost without actually repairing or replacing the damaged property. *Stephens & Stephens XII*, 231 Cal. App. 4th at 1145-46, citing *D & S Realty, Inc.*, 816 N.W.2d at 16-18. This theory also most closely applies a replacement cost policy's terms and conditions. Once coverage is determined, the insured is entitled to receive damaged property's actual cash value and will then be fully reimbursed once repairs or replacement is made.

Some courts holding that an insured's duty to repair or replace is temporarily suspended have also still held that there are factual situations that will

automatically excuse an insured from having to make repairs or replace. The Nebraska Supreme Court, in *D & S Realty, Inc.*, 816 N.W.2d at 18, stated that if the delay in determining the insurer's coverage materially contributed to a situation so that the insured can no longer perform the repairs or replacement at the time of judgment, then the condition of repair or replacement will be absolutely excused. In this case, the insured, D & S, was the owner of a building insured by Merkel that contained both commercial and residential units. The Merkel policy was a replacement cost policy requiring that the repair or replacement must be on the same property. *D & S Realty, Inc.*, 816 N.W.2d at19. Subsequent to the loss, D & S had sold the damaged building, making the required repair or replacement of the building impossible. The court therefore held that it was an issue of fact whether Merkel's denial of liability and the resulting litigation materially contributed to D & S's selling the building and, thus, making its repair under the policy an impossibility. *D & S Realty, Inc.*, 816 N.W.2d at 19.

Even when the court temporarily suspends the duty to repair or replace, a California court held that there should not be an award of any specific repair or replacement amount. Instead, there should be a judgment conditionally ordering the insurer's payment for the full repair or replacement amount. In *Stephens & Stephens XII*, 231 Cal. App. 4th at 1148-49, the insured had submitted proof at trial of the likely cost for repairs. The court found that there was no basis for awarding a specific repair amount and held that the insured should receive a judgment declaring that the insured is entitled receive reimbursement for the total repair cost once the repairs were timely made.

When the time for the insured to make repairs or replacement is temporarily suspended, the insured is usually still required to make repairs or replacement based on the time limit that is set forth in the insurance policy. Courts have varied, though, on whether the time period commences on the date judgment is entered or on the date the insurer pays the actual cash value judgment amount. In *Miller*, 6 S.W.3d at 441, the Michigan Supreme Court gave the insured 180 days to repair or replace the damaged property from the date of the judgment, which was consistent with the policy's time limit to make repairs or replacement within 180 days of the date of the loss. But in *Dickler*, 957 F.2d at 1096, the Third Circuit instead gave the insured one year from the date he received the actual cash value judgment amount to make the repairs or replace the damaged property. This was, again, consistent with the policy, which required the repairs to be completed one year after the date of the loss.

Although some courts have traditionally excused an insured from having to repair or replace property if a claim is erroneously denied, there is now a trend for courts to instead only temporarily suspend the duty to repair or replace. This type of judgment does not punish an insurer when it has made a good faith denial of claim and it does not unnecessarily award an insured benefits that are not contemplated in the policy. In courts where the measure of damages when property has not been repaired or replaced is a matter of first impression, and even in those courts where the Prevention Doctrine has been applied, temporarily suspending an insured's duty to repair or replace damaged property should be presented as the approach that best serves the contractual interests of both the insurer and the insured.

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The Prize for "Meretricious Performance," and Other Errors

By: Daniel Markewich

Do you remember that the first article in this series concerned dangling "verbals"? Those were primarily participles and gerunds that modified either the wrong noun or else nothing at all. But this problem is by no means confined to verbals, so let's begin this time with **another example of a phrase disconnected from the noun it modifies**:

> From an actual bank presentation: *[1] "**As a valued client** of Citi Private Bank's Law Firm Group *we* invite you to take advantage. . . ." [The bank is not its own client.]
>
> From the same presentation: * "**As a partner** of the law firm, *we* are pleased to offer you. . . ." [The bank is not a partner in the firm.]
>
> From a drug store solicitation: *"**As a valued customer** to CVS, *I* will go ahead. . . ." [CVS is not its own customer.]

I hope you also remember our extensive discussion in the same article about the (usually) improper and (occasionally) proper uses of "based on." This time, we'll deal with "**due to**," another phrase that is used in all the wrong places and all the wrong ways. "Due to" is not a synonym for "because of." All of the following – taken from the same draft memorandum – are incorrect:

> * "**Due to** the company's failure to maintain a system . . ."
>
> * "**Due to** political pressure . . ."
>
> * ". . . **due to** all of the fire code violations."
>
> * ". . . **due to** the defective sprinkler system."

Instead of "due to," use "owing to," "because of," "in consequence of," "as a result of," "through," or even "for" when appropriate.

"Due to" is correctly used when it means "caused by." So "The banquet's cancellation was **due to** the flu epidemic" is correct. But *"The banquet was canceled **due to** the flu epidemic" is incorrect as "due to" is not a synonym for "because of." To determine if you are using "due to" correctly, try replacing the phrase with "caused by" in your sentence and see if it makes sense. If not, rephrase using one of the suggestions above.

Note that the above rule applies when "due" is being used in the sense of "capable of being attributed" to. The word "due" also has other meanings, however, such as "owed or owing a debt" or "required or expected." Accordingly, "due to" is correct when used in the following sentences:

> "There is $25 **due to** me for the survey I completed."
>
> "He is **due to** receive the Pulitzer Prize for his article."

Next principle: **Spellcheck will not correct the wrong word if Spellcheck thinks it IS a word.**[2] In fact, Spellcheck just might substitute the wrong word for the right one!

Be especially careful to double-check e-mails you send from the I-phone, where the keyboard is difficult and the phone makes its own spelling and word "corrections" (including adding apostrophes to what are not contractions[3]). By way of recent example – and, fortunately, these were sent only internally:

> * An e-mail that identified a party police officer as a "**defective**" instead of a "detective."
>
> * An e-mail that stated: "The discovery aids in revealing defendant's intent during the allegedly **tortuous** conduct." Should be "tortious."
>
> * An e-mail that asked: "Anyone brief the issue of the admissibility of **tortuous** or criminal conduct taking place after the tort at issue in the case?" Should be "tortious."

Also beware of "**torturous**."

> * From a brief: "the **cannon** against surplusage." Should be "canon."
>
> * From a draft letter: "The parties' contracting intent would matter here **inasmuch** as this Court were to find an ambiguity in the policies." Should be "insofar."
>
> * "The agent did not know more than that the bag was **laying** on the floor." Should be

"lying."

* "The court denied recovery for parents who saw their son **laying** in a puddle of water after suffering electrocution." Should be "lying."

* "The murder weapon **laid** on the floor." Should be "lay."

(Lie: lay, lain, lying; lay: lay, laid, laying. Thus, "He **lay** down," but "He **laid** the package on the floor, where it was **lying**.")

* "In **regards** to the first element, the code was enacted to prevent discrimination." Should be "regard," but "As regards the first element" is correct.

* From the New York Law Journal: "The judge played the tape of the **conservation** for the jury." Should be "conversation."

* My favorite headline from the New York Law Journal: "Major Copyright Case Poses Distinction Between '**Pubic**' and 'Private' Performance." Should be "public." See also Doris Kearns Goodwin, "The Bully Pulpit": "the sole spur necessary being an insistent **pubic** demand."

* "Respondents continued to harass appellant with complete **immunity** for two more years." Should be "impunity." And watch out for "impurity."

* "This memorandum addresses three **discreet** research questions." Should be "discrete."

* "The legislature has exempted these **polices** from the statute." Should be "policies."

* "We **respectively** disagree with the court's holding." Should be "respectfully."

* "The overriding **principal** is that the First Amendment protects free speech." Should be "principle."

* "The lawyer provided **council** to his clients." Should be "counsel."

* "The officers **apprized** the defendant of his rights." Should be "apprised."

* "The new statute **supercedes** the previous regulation." Spelling error that Spellcheck accepts: should be "supersedes."

* "It is perfectly **alright** to proceed in that fashion." Spelling error that Spellcheck accepts: should be "all right."

* "Plaintiff was **publically** demeaned." Spelling error that Spellcheck accepts: should be "publicly."

From a draft brief: "The District Court **property** concluded: . . ." Should be "properly."

* Notwithstanding the New York Law Journal, not "***de minimus***" but "*de minimis*." (It is the Latin object of a preposition.) Same issue with ***per curium*** (should be "*per curiam*").

"The plaintiff has **now** amended its complaint" or "The plaintiff has **not** amended its complaint.

"The defendant **probably** has not defaulted" or "The defendant **provably** has not defaulted."

"The defendant has now ***perpetrated*** his calumny" or "The defendant has now **perpetuated** his calumny."

He is **disinterested** in the outcome" or He is **uninterested** in the outcome."

"He **lent** me a dollar," but "He made me a **loan** of a dollar."

"I **loathe** him," but "I am **loath** to accept his advice."

The past tense of "plead" is "**pleaded**" or "**pled**," not "plead." The past tense of "lead" is "**led**," not "lead."

And finally, here is the worst one I have ever seen, from an actual community newspaper article: *"The building superintendent's daughter received the Navy Award, presented to the graduating recruit whose **meretricious** performance in recruit training demonstrates exceptional professionalism. . . ." Should, of course, be "meritorious."

Now let's talk about: **Metaphors: misspelled and/or misused, overused, mixed, and** "**literally**":

A. Misspelled and/or misused

"Dire **straits**" and "**strait**jacket," not "straight."

"Free **rein**," not "reign."

"**Champing** at the bit," not "chomping."

"She's a real **trouper**," not "trooper."

"The **die** is cast," not "dye."

"**By** the same token," not "on."

"What's **sauce** for the goose is **sauce** for the gander," not "good."

* Coach Rick Pitino: "He is a vital **clog** in our machine." Should be "cog."

B. Overused

Does anyone know what "beyond **cavil**" means?

How about "not a **scintilla** of proof"?

Or "runs the **gamut**"?

Or "beyond a **peradventure** of a doubt"?

What is a "**gravamen**"?

Is it really true that "Nothing could be further from the truth"?

If it is "Needless to say," then why say it?

And is it correct that "It cannot be disputed"?

C. Mixed[4]

* "We'll burn that bridge when we come to it."

* From a case write-up: "The attorneys had steep legal hurdles to climb."

* Phil Jackson: "I'm shooting from the cuff."

From a speech at a client's meeting: *"You've got our backs on all fronts."

From a lawyer's note: "Something needs to be done about the elephant in the room, and we should be driving the bus."

* "So now what we are dealing with is the rubber meeting the road, and instead of biting the bullet on these issues, we just want to punt."

* "[T]he bill is mostly a stew of spending on existing programs, whatever their warts may be.

* "This is awfully weak tea to have to hang your hat on."

* "All at once he was alone in this noisy hive with no place to roost."

* "Top Bush hands are starting to get sweaty about where they left their fingerprints. Scapegoating the rotten apples at the bottom of the military's barrel may not be a slam-dunk escape route from accountability anymore."

D. "Literally"

A metaphor is by definition figurative. Don't embroider your figure of speech by adding "**literally**" when you really mean "**figuratively**," as in:

* "The cars are **literally** being swallowed by the potholes."

* "This football game is **literally** a slaughter."

* "He **literally** ate them alive."

* "The jurors were **literally** eating out of his hand."

Our fourth topic is: "**Who**," "**whom**":

"Who" is a subject; "whom" is an object. The easiest way to figure out the right word is usually to turn the sentence or clause into a declarative one, as in the bracketed materials below.

A. All of the following lawyers' sentences are incorrect:

* "He is the person **whom** I hope will win the election." ["I hope **he** [subject] will win the election."]

* "**Who** should we invite to dinner?" ["We should invite **her** [object] to dinner."]

* "**Who** did the caller speak to?" ["The caller spoke to **him** [object]."]

* "John is the runner **whom** we hope wins the race." ["We hope **he** [subject] wins the race."]

* "**Whom** do we expect will win the election?" ["We expect **he** [subject] will win the election."]

* "He is the person **whom** was pulled over." ["**He** [subject] was pulled over."]

* "Pick **whoever** you want." ["You want **him** [object]."]

* "She is the person **whom** I hope wins." ["I hope **she** [subject] wins."]

* "**Who** do I give this to?" ["I give this to **her** [object]."]

* "**Who** did you expect?" ["You expected **him** [object]."]

* "**Who** do we ask?" ["We ask **her** [object]."]

* "Was that the person **who** he was talking to?" ["He was to talking to **her** [object]."]

* "**Whom** should I say called?" ["**He** [subject] called."]

This rule is not really very difficult if you take care to follow it.

B. All of the following sentences are correct, because the rule was abided by:

"**Who** is coming?" ["**He** [subject] is coming.]

"Do you know **who** the recipient is?" ["**He** [subject] is the recipient."]

"Give this assignment to **whoever** looks idle." ["**He** [subject] looks idle."] (This one is especially tricky, as at first glance it appears that the object of the preposition is the word following "to," which then should be "whomever"; but actually the object of the **proposition**[5] is the entire clause "whoever looks idle," and "whoever" is correct for the reason already stated.)

"**Who** is the person **who** is speaking?" ["**He** [subject] is the person; **he** [subject] is speaking."]

"**Who** is the person to **whom** I should give the package?" ["**He** [subject] is the person; I should give the package to **him** [object]."]

"John is the candidate **whom** we hope to elect." ["We hope to elect ***John*** [object]."]

"**Whom** do we expect to meet at the party tonight?" ["We expect to meet our **friends** [object]."]

"**Whom** should I ask?" ["I should ask **him** [object]."]

"She is the person **whom** I hope I will marry." ["I hope I will marry **her** [object]."]

"She is the person **who** I hope will marry me." ["I hope **she** [subject] will marry me."]

We close for this issue with: "**As such**" **misused as a muddled connector** "As such" is not a connector, but is often misused as such. (Yes, that was a proper usage.) "As such" is correctly used in the following sentences:

"He is the president of the United States. **As such**, he is entitled to a 21-gun salute."

"The stone was a large yellow diamond and, **as such**, was exceedingly rare."

"The speech was filled with nihilism and, **as such**, provoked a near-riot."

"He is a sergeant. **As such**, he wears three stripes on his sleeve."

NOT:

* "Plaintiff cannot demonstrate that these reasons served as a pretext for discrimination, and **as such d**efendant is entitled to summary judgment."

* "Plaintiff told his manager that he would not be returning to work, and **as such** GMC considered plaintiff resigned."

* "Plaintiff has not alleged any facts to suggest that his voluntary resignation and termination resulted from his disability. **As such**, there is no question that plaintiff has failed to satisfy his prima facie burden."

* "It is settled that a warrant to search for contraband implicitly carries with it the right to detain the occupants of the premises during the search. **As such**, an officer executing a search warrant may use reasonable force to effectuate the detention of the occupants."

* "Plaintiff cannot prove that defendant's conduct was the cause of her injury. **As such**, summary judgment should be granted to defendant."

* "Both amendments, while valid, do not date

back to the dates of original filing. **As such**, the date of filing must be based on the date of the amendments and not of the original filing."

But I cannot resist one more, my favorite malaprop in many a moon – the actual on-the-air statement of an ESPN sportscaster:

*"I drink five bottles of water during every game to **liquidate** my thirst."

See you next issue.

Endnotes

1 Throughout this article, all sentences preceded by an asterisk are incorrect.

2 *See* footnote 5, *infra*. Believe it or not, it may also autocorrect "urination" to "ruination."

3 Such as "its," "ill," "id," "wed," "well," "were," "hell," "shell," "shed," and "cant." And please note the difference between "your" and "you're."

4 The last five in this grouping are examples of mixed metaphors reported and attributed at About.com. Note that some of the same issues can apply to similes, which are figurative comparisons using "like," as in "Heart Like a Wheel" and "He fought like a tiger." Both a metaphor and a simile can be used in the same sentence, as "He fought the other lawyer to the death, like a gladiator in mortal combat."

5 This is a typo, as the word intended was "**preposition**." The error perfectly illustrates the Spellcheck issues discussed *supra*.

Daniel Markewich is a partner in the firm's Long Island office and editor of this Newsletter.

Is Florida Finally "Pulling the Trigger" on Trigger? A Recent Development in the Case Law

By: Lionel F. Rivera

Trigger of coverage is an important issue in the world of insurance litigation. A recent decision by a Florida federal court has addressed this matter, further clarifying that state's law on trigger in the property damage context. Injury-in-fact or manifestation, that is the question. As discussed here, we now may be closer to an answer.

On April 7, 2015, the United States Court of Appeals for the Eleventh Circuit, which encompasses Florida, issued an opinion upholding a Florida federal district court's application of an injury-in-fact trigger in a case involving property damage. In *Carithers v. Mid-Continent Casualty Co.*, 782 F.3d 1240 (11th Cir. 2015), Mid-Continent issued commercial general liability policies to a general contractor, Cronk Duch Miller & Associates, Inc. Cronk Duch built a home for the Caritherses, and after the Caritherses discovered defects in their home, they filed suit against Cronk Duch.

Mid-Continent denied Cronk Duch's request for a defense in the Caritherses' lawsuit. Cronk Duch and the Caritherses then entered into a consent judgment, and Cronk Duch assigned to the Caritherses its rights to recover the amount of the consent judgment from Mid-Continent. The Caritherses' action against Mid-Continent followed.

The policies at issue in *Carithers* applied to "'property damage' only if . . . [t]he . . . 'property damage' occurs during the policy period," and defined "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." Mid-Continent argued that, in Florida, "manifestation" was the appropriate trigger of coverage, and it "present[ed] two versions of the manifestation trigger: (1) that damage occurs when it is discoverable by reasonable inspection; or (2) that damage occurs when it is actually discovered." It was therefore Mid-Continent's contention that it did not owe Cronk Duch a defense (and therefore did not owe it indemnity) since the Caritherses' complaint against Cronk Duch "alleged that the defects [in the home] could not have been discovered until 2010." The last policy issued by Mid-Continent to Cronk Duch lapsed in 2008.

The Caritherses argued instead for an "injury-in-fact trigger," "that property damage occurs when the property is damaged." Accordingly, as the trial court had made a finding of fact that the home was damaged in 2005, the Caritherses contended that coverage was owed under the policy issued by Mid-Continent to Cronk Duch for the March 9, 2005 to March 9, 2006 policy period.

The *Carithers* court ruled that Mid-Continent did owe Cronk Duch indemnity. In doing so, the court stated as follows, "The plain language of the policy does not support Mid-Continent's reading. Property damage occurs when the damage happens, not when the damage is discovered or discoverable." The *Carithers* court's conclusion was driven by its reliance on a previous Eleventh Circuit decision, *Trizec Properties, Inc. v. Biltmore Constr. Co., Inc.*, 767 F.2d 810 (11th Cir. 1985).

In *Trizec*, the court similarly found that injury-in-fact applied in light of the language in the policy at issue in that case. Specifically, the policy in *Trizec* defined "occurrence" as "an accident, including continuous or repeated exposure to conditions, which results in . . . property damage." Against this backdrop, the *Trizec* court held:

The potential for coverage is triggered when an "occurrence" results in "property damage." There is no requirement that the damages "manifest" themselves during the policy period. Rather, it is the damage itself which must occur during the policy period for coverage to be effective.

The *Carithers* decision, and its reliance on *Trizec*, are significant. Certainly, post-*Trizec*, several Florida federal courts cited that case for the proposition that injury-in-fact was the appropriate trigger of coverage in Florida. *See, e.g., CSX Transportation, Inc. v. Admiral Ins. Co.,* No. 93–132–CIV–J–10, 1996 WL 33569825 (M.D. Fla. Nov. 6, 1996); *Boardman Petroleum, Inc. v. Federated Mutual Ins. Co.*, 135 F.3d 750, 754 (11th

Cir. 1998). However, in 2000, two federal district court decisions were issued that began to muddy the waters on the applicable trigger of coverage in Florida.

First, in *American Motorists Ins. Co. v. Southern Sec. Life Ins. Co.*, 80 F. Supp. 2d 1280 (M.D. Ala. 2000), the court (applying Florida law) stated that "Florida courts follow the general rule that the time of occurrence within the meaning of an indemnity policy is the time at which the plaintiff's injury first manifests." Also in 2000, the decision in *Harris Specialty Chemicals, Inc. v. United States Fire Ins. Co.*, No. 3:98–CV–351–J–20B, 2000 WL 34533982, (M.D. Fla. July 7, 2000), further confused the issue. On the one hand, the *Harris* court correctly cited to *Trizec* for the proposition that an event that triggers potential coverage is the sustaining of actual damage to the complaining party. On the other hand, however, the *Harris* court also stated, "[T]he Trizec Court held that potential coverage would be triggered if damage manifested during the policy period."

Thereafter, the law in Florida remained unsettled. A trend did emerge though, away from an injury-in-fact trigger in favor of a manifestation trigger. It appears that the first overt application of the manifestation theory in Florida was in *Auto-Owners Ins. Co. v. Reliance Ins. Co.*, 227 F. Supp. 2d 1248 (M.D. Fla. 2002). In *Auto-Owners,* the court stated that Florida courts follow the general rule that the time of occurrence, within the meaning of an "occurrence" policy, is the time at which the injury first manifests itself. Subsequent decisions addressing the trigger question relied on *Auto-Owners* for this proposition, and the trend towards manifestation began. *See Essex Builders Group, Inc. v. Amerisure Ins. Co.*, 485 F. Supp. 2d 1302 (M.D. Fla. 2006) ("Because Essex's position is that the damage to the apartment buildings was not visible until late 2001, and the PGIC policy expired in November 2000, there was no occurrence within the policy period."). *See also North River Ins. Co. v. Broward County Sheriff's Office,* 428 F. Supp. 2d 1284 (S.D. Fla. 2006); *Assurance Co. of Am. v. Lucas Waterproofing Co., Inc.*, 581 F. Supp. 2d 1201 (S.D. Fla. 2008); *Mid-Continent Cas. Co. v. Frank Casserino Constr., Inc.*, 721 F. Supp. 2d 1209 (M.D. Fla. 2010); *Amerisure Ins. Co. v. Albanese Popkin the Oaks Dev. Group, L.P.*, No. 09-81213-CIV, 2010 WL 4942972 (S.D. Fla. Nov. 30, 2010).

With the *Carithers* decision, Florida trigger law appears to have come full-circle. While, of course, this federal decision is not binding on state courts, unless and until the Florida Supreme Court speaks with regard to the trigger issue, it can be expected that *Carithers* will be cited in support of application of an injury-in-fact trigger in Florida insurance litigation. Interestingly, in *Carithers,* Mid-Continent conceded the fact that a lack of Florida state court jurisprudence exists on this issue, and that Florida federal courts are split on the issue.

In fact, the lack of consensus in the law was the basis for the *Carithers* court's finding that Mid-Continent had a duty to defend Cronk Duch in the action brought against the company by the Caritherses. While the *Carithers* court performed the previously discussed trigger analysis in connection with finding that Mid-Continent had a duty to indemnify, on the duty to defend question the court stated, "Mid-Continent admits that 'no Florida state court appellate decision' has decided which trigger applies to determining when property damage occurs in these circumstances. . . . And, Mid-Continent admits that the issue has split federal district courts in Florida." The *Carithers* court continued that "[g]iven the uncertainty in the law at this time, Mid-Continent did not know whether there would be coverage for the damages sought in the underlying action because Florida courts had not decided which trigger applies." In this event, the *Carithers* court concluded that "Mid-Continent was required to resolve this uncertainty in favor of the insured and offer a defense to Cronk Duch."

While the *Carithers* decision is significant on the issue of trigger, will likely have an impact on insurance litigation in Florida and could be a forecaster of things to come, it is important to not over-read the decision. The *Carithers* court itself cautioned against this mistake. Of procedural significance in *Carithers* was the fact that the trial court had already made a finding of fact that "the property was damaged in 2005." Thus, the *Carithers* court held simply that application of the injury-in-fact trigger was not in error under the circumstances, but acknowledged "the difficulty that may arise in cases . . . where the property damage is latent, and is discovered much later." Therefore, the *Carithers* court limited its "holding to the facts of this case, and express[ed] no opinion on what the trigger should be where it is difficult (or impossible) to determine when the property was damaged."

To be sure, the issue of trigger of coverage is not closed in Florida. Particularly in cases involving latent damage,

the appropriate trigger to apply under Florida law remains an open question. But it can be expected that the *Carithers* decision will be cited in support of the proposition that injury-in-fact is the rule in Florida, therefore leaving for the fact-finder to determine when the property was actually damaged. This is of practical import, as "when the property was actually damaged" is often a harder question to answer than when the damage manifested. Additionally, while the *Carithers* case involves a liability coverage dispute, given the dearth of trigger law in Florida in the first-party insurance context, the *Carithers* decision will likely find its way into first-party insurance litigation as well.

Lionel F. Rivera is the managing partner of the firm's Florida office.

Associated Commercial Property Insurers (General Cover): A Look Back at the Beginning

By: James D. Veach

Associated Commercial Property Insurers, formerly General Cover Underwriters (Association), ceased underwriting in the mid-1980s. The Association operated as a New York-based joint underwriting association. See generally, *Wolcott Dunham, New Appleman New York Insurance Law* § 52.07 (Ch. 52, Specialized Non-Life Entities) (2d ed. 2014).

Mound Cotton began advising the Association decades ago and it continues to represent the Association with respect to its run-off. In conjunction with the run-off, the Association's member companies directed that the Association's claims, underwriting, and other records to be moved to a storage facility in Williamsburg, Brooklyn. Included in these books and records were the Association's minute books dating back to its formation in 1928.

This past January a spectacular fire erupted at the facility. *Massive Seven-Alarm Brooklyn Blaze Could Smolder for Days, FDNY Says*, International Business Times, January 31, 2015; *Williamsburg CitiStorage Fire Under Control After Five Days, FDNY Says*, DNAomfp.com, February 5, 2015; *In Williamsburg Warehouse Fire, Lingering Risks of New York's Analog Age*, NY Times, February 2, 2015. It turned out that about 90% of the Association's records survived the fire, including the minute books, the first volume of which captures how the "business of insurance" was done in the Roaring Twenties.

The "General Cover Form"

According to former Association President James Corbett, the Association began with a new form – the "general cover policy" – that allowed manufacturers or merchants to buy a fire policy on their stock or inventory even if its value constantly fluctuated. At that time, and long before entities could track inventory by computer in almost real time, a standard fire policy wouldn't work unless the insured estimated the highest possible value for the insured property (and thus paid too much premium) or underestimated the property's value (and wound up underinsured).

Even if a manufacturer or merchant could monitor its inventory or goods on a monthly basis and even if an underwriter had the capacity or authority to increase or decrease policy limits immediately, the manufacturer/merchant and the underwriter would be constantly trying to amend or endorse a standard fire policy to match fluctuating values. This process became even more difficult if the insured's goods were stored at multiple locations. These circumstances eventually produced a "general cover policy" that operated with a high limit of liability, but with a fluctuating policy value based on monthly reporting.

When Mr. Corbett was asked for more information on the history of the general cover (or reporting form) policy, he founded a copy of an article – "Metered Fire Insurance: A Survey of the Reporting Form Fire" — written by Bert Cotton, one of Mound Cotton's founding members. Mr. Cotton's article appeared in the April 1958 issue of the Insurance Law Journal and was presented at the Third Annual Insurance Forum of the Brooklyn Law School.

Mr. Cotton not only set out the origin of the general cover policy, his article also described how the policy operated and how courts over the next three decades resolved the new policy's coverage disputes. The Association began as an effort by ten separate insurers to profit from this new type of policy.

Let's Start an Association

On October 23, 1928, representatives from ten insurance companies met at 3:00 p.m. in New York City at the Hotel Roosevelt. The ten company representatives chose a meeting secretary, voted that a "General Cover pool" be formed, discussed how the pooling agreement would operate, considered the type and amount of reinsurance the pool would require, formed an Executive Committee, and adjourned at 5:45 p.m.

By November 22, the member companies had hired a Manager, called for a capital contribution of $2,000 from each member, agreed on the amount and type of reinsurance for the pool, and determined that the pool would be known as the "General Cover Underwriters Association." The Executive Committee directed that the Manager arrange for stationery that would identify him as the head of the General Cover Departments of the ten member companies.

The Association began operation pursuant to two agreements printed on a single piece of paper: an operating agreement appeared on one side and on the other a reinsurance agreement. The operating agreement appointed a Manager and provided that the "direction and control of the affairs of the Association" would be vested in a four-person Executive Committee chosen annually by the ten member companies. The operating agreement also provided that all of the Association's general cover policies would be issued on a member company's paper. The Association's name never appeared on any of the policies issued by the pool members and reinsured by the other pool members.

The Reinsurance Agreement provided that each member would then be liable "for an equal proportion of the loss recommended by the Executive Committee to be paid" (or such loss as was ordered to be paid "by any Court"). Each member company agreed to be "severally liable and bound to the member company that issued the policy" for each member company's proportionate share of the loss. No loss, however, would be paid until the Manager presented the loss to the Association's Executive Committee, whose decision, based on a majority vote, was final.

By June, five additional companies had asked to join the Association. Some of the member company representatives objected to bringing in companies that did not have significant amounts of general cover-type business already on their books to cede to the Association. Other member company representatives hesitated because of their "inability to determine what the future ha[d] in store for" the Association, and the Association stayed with its ten original members.

The Association grew slowly at first. In December, 1928, the newly-hired Manager wrote the President of one of the member companies with respect to the member companies' capital contributions.

> Only one check has come in, and if I pay for the furniture in addition to the rent, and the Remington Vertical Adder bill, to say nothing of the Remington Noiseless previously purchased, the Association will be "broke."
>
> Can you suggest anything to make these Companies 'loosen up" (including [your company])?

The member companies must have "loosened up" because the Association had a good first year of business.

The Association's first annual report shows that the member companies wrote about $600,000 in premium with a 70.4% earned loss ratio and a 22.5% expense ratio. The Association sustained only one major loss and the Association's reinsurers paid no losses.

"Self-Regulation"

Part of the Association's initial success may have been owing to the four-person Executive Committee that scrutinized every policy and every claim. Occasionally, the Committee would find a "Marine Policy" that did not qualify for general cover treatment or an insured that did not fit within underwriting guidelines, but the Committee also determined that certain industries should be avoided. The Committee, for example, noted early on that "exceptional care [should] be exercised in the writing of furniture stocks."

At one point, the Committee asked whether the Association should be "accepting insurance on stock in fertilizer plants under a reporting form as permitted by rules of the Southeastern Underwriters Association." (After polling all ten members, the Association eventually agreed to write the business.)

The Southeastern Underwriters Association (SEAU) referred to in these discussions was the same association whose activities would be described by Justice Black in a 1944 United States Supreme Court decision in these terms:

> The member companies of S.E.A.U. controlled 90 per cent of the fire insurance and 'allied lines' sold by stock fire insurance companies in the six states where the [alleged anti-trust] activities conspiracies were consummated. * * * The conspirators not only fixed premium rates and agents' commissions, but employed boycotts together with other types of coercion and intimidation to force non-member insurance companies into the conspiracies . . . Companies not members of S.E.U.A. were cut off from the opportunity to reinsure their risks, and their services and facilities were disparaged . . . .[these conspiracies] were effectively policed by inspection and rating bureaus in five of the six states, together with local boards of insurance agents in certain cities of all six states.
>
> *U.S. v. South-Eastern Underwriters Association*, 322 U.S. 533, 535-36 (1944) .

The Association never had the SEAU's clout. Nor did the Association use the tactics described above, but the Association certainly did business in a regulatory environment that would be unrecognizable today. For example, the Executive Committee never discussed rates. The Interstate Underwriters Board (IUB) established the appropriate rates to be charged. In fact, the Manager had complained that the IUB provided these rates too slowly, but by the end of the first year's operation assured the member companies that rates were being provided more quickly.

A former New York Superintendent of Insurance described the "business of insurance" during the period in which the Association began underwriting in these terms.

> [The insurance industry] turned again and again to the technique of agreement. * * * Over time, the agreements and the machinery for their enforcement grew into powerful engines of conformity – the bureaus and the boards and fire insurance exchanges, the eastern and western unions, the adherence compacts * * * [functioned as] private law policed by private governments caught up in the romance of self-regulation.

Andrew Tobias, The Invisible Bankers 91 (1982) quoting Richard Stewart, Insurance and Insurance Regulation (Collected Speeches 1968-1980.)

This "self-regulation" eventually led to the *South-Eastern Underwriters* anti-trust decision quoted above and, the following year, the McCarran-Ferguson Act, 15 U.S.C. §§ 1101-1015. (For a look at the legislative history of the Act, see A. Anderson, *Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond*, 25 Wm. & Mary L. Rev. 81 (1983)). Of course, the interplay and tension between federal and state insurance regulation has yet to be resolved. Let's return to the Roaring Twenties.

The Annual Meeting

A year after its formation, the Association held its first annual meeting, in the "Committee Room" of the National Board of Fire Underwriters on John Street. The Association had steadily increased premium collected and policies written. Many of the Association's member companies sent four or five representatives to the meeting.

The attendees considered and debated opening a San Francisco office, which was later done. According to the annual meeting minutes, some of the "men actually selling the policies," *i.e.*, member company agents, attended the annual meeting. The agents proposed several changes to generate more sales, including quicker rating and "changes to the Rules and Regulations of the Interstate Underwriters Board."

The member company representatives and their agents then adjourned for "luncheon at the Drug & Chemical Club." After lunch, the Executive Committee met, apparently in an open session with all the member company representatives present. Before the business of the Committee was taken up, "on motion duly made and seconded," the Committee voted that "bets made during the luncheon be recorded."

A representative from the Automobile Insurance Company (Automobile) bet a representative from the Glen Falls Insurance Company (Glen Falls) "100 Corona Belvederes" (Cuban cigars) that Automobile would in the following year write $200,000 of the Association's projected $1million in premium. Not to be outdone, a representative from Springfield F & M bet the gentlemen from Glen Falls 100 Corona Belvederes that Springfield would write "more premiums in 1930 that any other company."

All of those present at the annual meeting were then invited to join into the Committee's discussions and the meeting adjourned at 3:15. It was October 24, 1929. Five days later, the stock market crashed.

Farewell Roaring Twenties

The tone of the subsequent meetings charged. The Executive Committee focused even more closely on the causes of losses, including a major fire at the "Planters Fertilizer and Phosphate Company." The Committee added credit investigations to their underwriting check list. In 1931, the Committee reported that "production seemed to be falling off, without any appreciable pick-up in activity in sight for the immediate future."

The Association survived the Depression, added members, and continued writing business. The general cover policy evolved into a Manufacturers Output Policy that incorporated an inland marine feature that covered goods and inventory in transit as well as at disclosed locations. According to Mr. Corbett, by the 1970s major brokers had begun drafting manuscript policies that no longer resembled the original general cover forms. The Association wound up participating on contracts insuring Fortune 500 companies and government agencies such as the Port Authority of New York and New Jersey.

By the mid-1970s, the Association employed more than 175 persons, operated U.S. and Canadian pools, and wrote annually between $25-35 million in premium from offices in New York and San Francisco. Nevertheless, the need for the Association waned and the member companies chose to dissolve the Association.

Then and Now

The Association's minute books capture a time when insurers were smaller and neither as price-competitive nor as closely regulated as today. In that environment, insurance executives could set up an association in an afternoon and operate for years with a one-page operating agreement. (At the suggestion of state regulators, the Association subsequently adopted a more detailed Constitution.)

When the Association began operations, insurers were also closely underwriting individual insureds. Here is a recollection of a *reinsurance* broker looking back over the past forty years and describing current reinsurance underwriting techniques:

> The business today is driven by highly sophisticated specialized analysis. Actuaries are fully empowered. In many companies, all business is priced by actuaries using complex ROE and Net Economic Profit models. The focus has shifted from concentration on the exposures and perceived profitability of an individual transaction to a much broader portfolio management perspective examining the dynamics of the entire portfolio in an attempt to maximize overall return on capital

while adhering to formally documented Enterprise Risk Management principles.

P. Feldsher, *Treaty Reinsurance Underwriting Then and Now: a Personal Perspective*, Journal of Reinsurance, Vol. 21, No. 3 at p. 3 (2015). (Full disclosure: I serve on the Journal's Advisory Panel and take every opportunity to promote the Intermediaries & Reinsurance Underwriters Association (IRU) and its Journal.)

It's hard to imagine what the Association's 1928 member company representatives would have made of the preceding paragraph. Before, however, we romanticize the Association's 1920s business model, we should acknowledge the competitive and other downsides described by Superintendent Stewart and Justice Black.

Without taking sides, we will return the Association's minute books to storage, but wonder . . . who *did* win those Corona Belvederes?

Mr. Veach takes full responsibility for any sins of omission or comission in this article, but thanks James Corbett, a former Association President, for sharing his recollection and files. Your author also acknowledges the many attorneys who over the years advised the Association's member companies, including Norman Rein, Bert Cotton, Eugene Wollan, and Leonard Dome. Finally, Mr. Veach thanks the member company representatives for their support during the run-off and for permitting us to share the Association's early history."

James D. Veach is a partner in the New York office of Mound Cotton Wollan & Greengras LLP.

News *of the firm*

Mound Cotton Wollan & Greengrass LLP Recognized in Chambers & Partners Guide for 2015

Chambers and Partners list the top lawyers in 185 jurisdictions throughout the world, ranking individuals in their practice areas on the basis of their legal knowledge and experience, their ability, their effectiveness, and their client service. According to Chambers, commentators — mainly clients — note that Mound Cotton *"have demonstrated vast knowledge of crisis management and are particularly keen on the intricacies involved in handling a crisis management coverage issue."* "*They provide quality service to their clients."*

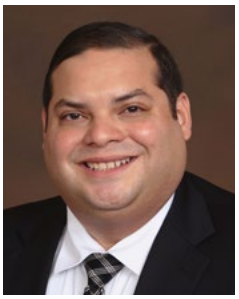

Philip C. Silverberg


Lawrence S. Greengrass

Philip C. Silverberg is admired for his active participation in the first-party property claim arena, where he is frequently brought in by insurers on catastrophe losses. Recently he has been involved in claims arising out of Superstorm Sandy. One commentator noted that he has "*the technical skills and experience to deal with complex matters.*"

Lawrence S. Greengrass is admired for his extensive experience in the arbitration process. One commentator said: "*He is one of the most experienced reinsurance lawyers in the US. He is calm, collected and has a not overly aggressive, professional air that I think serves us well in cases.*"

MCWG Fort Lauderdale office Announces New Partner


Lionel F. Rivera

MCWG is pleased to announce that Lionel F. Rivera has been promoted to Partner.

MCWG Announces New Special Counsel


Gregg P. Hirsch

Gregg P. Hirsch has joined MCWG as special counsel. Mr. Hirsch comes to the firm with 30 years' experience as in-house counsel at the Metropolitan Life Insurance Company, where he served as Senior Associate General Counsel and Senior Vice-President. He is knowledgeable on a wide variety of insurance products and related matters, including retail and group life insurance, annuities, health insurance, affiliated and third-party distribution channels, and self-funded benefits.

Partners Frank J. DeAngelis and William D. Wilson Co-Author a Book


Frank J. DeAngelis


William D. Wilson

Partners **Frank J. DeAngelis** and **William D. Wilson** recently co-authored a book entitled *New Jersey Insurance Coverage Litigation Treatise: A Practitioner's Guide*, which was published by the New Jersey Institute for Continuing Legal Education, a division of the New Jersey State Bar Association.

The book provides a broad overview of New Jersey insurance coverage litigation involving the enforcement and interpretation of insurance policies. Topics covered in the book include everything from a basic overview of general insurance principles to in-depth discussions of complex insurance and reinsurance issues, including coverage for losses resulting from catastrophic events, *Carter-Wallace* allocation issues arising out of environmental and toxic tort claims, and bad-faith and extra contractual damages.

The book is available for purchase from the New Jersey Institute of Continuing Legal Education (http://www.njicle.com).


At microphone, Jeffrey S. Weinstein.

Two MCWG Partners Participate in New York Power Conference

Partners Jeffrey S. Weinstein and Bruce R. Kaliner participated in the New York Power Conference, an annual event held in the financial district of Manhattan that brings together insurance professionals for one day of continuing education in the energy market. NY PowerCon is an energizing educational opportunity for insurance professionals to gain the knowledge necessary to handle dynamic and complex claims.

Calendar of Speaking Engagements

Past Events

The Knowledge Group
Insurance Coverage for Data Breaches: What Every Firm Needs to Know
March 9, 2015
Webinar

Partner Kenneth M. Labbate participated in a webinar presented on the topic "Potential cyber exposure to professionals including directors & officers, attorneys and accountants and insurance agents and brokers."

Claims & Litigation Management Alliance
2015 Annual Conference
March 25 - 27, 2015
JW Marriott Desert Springs Resort and Spa
Palm Desert, CA

Senior counsel Lawrence S. Greengrass presented on the topic: "Reinsurance Fundamentals."

BRMA's Committee Rendezvous
Marriott Princeton Hotel & Conference Center
April 20 - 21, 2015
Princeton, NJ

Senior Counsel Lawrence S. Greengrass presented on the topic, "Marijuana — Insurance, Legal and Risk Management Issues."

American Conference Institute's 10th International Advanced Forum on Run-Off Commutations
April 21 - 22, 2015
The Carlton Hotel
New York, NY

Partner James D. Veach presented on the topic: "Insurance and Reinsurance Pools: Overcoming Run-Off and Commutation Challenges Associated with Pools."

IRU's Reinsurance Contracts Seminar
May 12 - 13, 2015
Crowell & Moring LLP
New York, NY

Partner Lloyd A. Gura presented on the topic, "Dispute Resolution and Service of Suit."

New York City Bar Association
May 14, 2015
42 West 44th Street
New York, NY

Partner Kenneth M. Labbate presented on the topic: "Benefits and Pitfalls of Additional Insured Coverage."

The New York Power Conference 2015
May 14, 2015
New York Academy of Sciences
New York, NY

Partner Jeffrey S. Weinstein presented a Case Study: "The Berkeley Earthquake."

Reinsurance Association of America
Demystifying Reinsurance: A Basics of Reinsurance Course
May 14 - 15, 2015
Westin New York Grand Central
New York, NY

Partner Michael H. Goldstein presented on the topic: "Contract Clauses Required for Reinsurance Credit."

Practising Law Institute - New Jersey Basic CLE Marathon
May 18, 2015
1177 Avenue of the Americas
New York, NY

Partner Frank J. DeAngelis chaired a one-day New Jesrey basic CLE Marathon whose topics included "Basic Estate Planning, Civil Trial Practice, Criminal Trial Practice, Family Law Practice and Law Office Management."

St. John's University School of Risk Management Loss Executive Association
May 22, 2015
London, England

Partner Costantino P. Suriano presented to St. John's University School of Risk Management and the Loss Executive Association on the topic, "Lawyer's View of Claim Handing Process."

American Conference Institute's National Advanced Summit on Swaps & Derivatives Global Markets Regulation
June 29 - 30, 2015
The Carlton Hotel
New York, NY

Partner Barry R. Temkin presented on the topic: "Central Banks: Foreign Exchange, Foreign Currency Trading, and Benchmarking Currency."

Reinsurance Association of America
Re Contracts -The Art of Designing Reinsurance Contracts and Programs
July 21 - 23, 2015
New York, NY

Partner Michael H. Goldstein participated as a facilitator.

AIRROC's Summer Membership Meeting Education and Commutation Day
July 22 - 23, 2015
Chadbourne & Parke
New York, NY

Partner Amy J. Kallal presented an update of recent cases.

Upcoming Events

Reinsurance Roundtable 2015
September 17, 2015
Thomson Hall
New York, NY

Partner Lloyd A. Gura will chair HB Litigation's Reinsurance Roundtable 2015. This conference is designed to educate, inform, and provide networking opportunities for claims professionals who are interested in all facets of the reinsurance market, from collection strategies to disputes, regulatory concerns, and current hot topics.

Product Contamination/Recall Insurance Symposium
October 1, 2015
Andaz Hotel
New York, NY

Partner Jeffrey S. Weinstein will co-chair and present on the topic of claims handling, litigation, and policy drafting involving various "Crisis Management" coverages, including "Accidental Product Contamination," "Malicious Product Tampering," "Contaminated Products Insurance," and "Product Recall."

Reinsurance Association of America
Re Claims
October 15 - 16, 2015
New York, NY

Partner Amy J. Kallal will present on the topic, "Medical Marijuana."

MCWG Published Articles

Corporate Risk Presented by Ever Evolving and Growing Cyber Crime: Trying Times for Directors & Officers, authored by Kenneth M. Labbate and Oliver E. Twaddell (Published in Plus Journal, Vol. XXVIII, Number 3, March, 2015 and Mealey's Litigation Report, Vol. 17, #2 April, 2015).

The SEC's Proposed Uniform Fiduciary Standard for Financial Advisers: An Update, authored by Barry R. Temkin and Matthew Photis (Published in PLUS Journal, Volume XXVIII, Number 3, March, 2015).

Finding Coverage in the Absence of Actual Damage: The Continuing Erosion of the Physical Loss or Damage Requirement under First-Party Insurance Policies, authored by William D. Wilson (Published in DRI, The Voice of the Defense Bar, March, 13, 2015).

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