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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.

SINCE 1933

Percentage-Based Deductibles, Logically Applied

By: Jeffrey S. Weinstein and Andrew H. Rice

Some first-party property insurance policies commonly utilize what is known as a percentage-based deductible, or, a deductible that is calculated as a percentage of the total value of property or properties insured. These deductibles generally look to the "total insurable values" at risk by location, and rely on values submitted by the insured or its broker during underwriting, or shortly after policy inception. Thus, in the event of a covered loss or occurrence, the applicable deductible is a fixed percentage of the previously reported "total insurable values" involved in or affected by that loss or occurrence.

While this straightforward calculation method is often used to determine deductibles without issue, some insureds have attempted to circumvent its application – almost always in the aftermath of a large loss requiring a substantial deductible. Such arguments can range from claims of ambiguity to illusory coverage, with all forms of creative pleading in between. Most insureds making these arguments, however, fail to highlight the significant premium savings and risk management that percentage-based deductibles can afford policyholders.

To the benefit of the industry as a whole, a number of courts have rejected these *ex post facto* interpretations and upheld the use of percentage-based deductibles. Two recent decisions in particular – from federal and state courts applying New York law – offer guidance on the logical application of these deductibles.

***Aspen Specialty Ins. Co. v. 4 NYP Ventures LLC*, Case No. 1:13-cv-03367 (PAC) (S.D.N.Y. Feb. 25, 2016)**

In *Aspen Specialty*, Judge Paul Crotty of the Southern District of New York granted summary judgment to plaintiffs Aspen Specialty Insurance Company ("Aspen") and Landmark American Insurance Company ("Landmark") (collectively, the "Insurers"), holding that five percent of the insured property's value – or, $19.2 million – was the proper deductible, rather than the $100,000 that the insured, 4 NYP Ventures LLC ("4 NYP"), argued should apply.

The Insurers were part of a secondary excess layer, providing insurance to 4 NYP's office building located in lower Manhattan. 4 NYP had a $100 million multi-layered insurance program including flood coverage when the building was heavily damaged by Superstorm Sandy. Under the program, Factory Mutual Insurance Company ("FM") provided $20 million in primary coverage, while the next $30 million in coverage was provided by the first excess layer of non-party insurers. Thereafter, Aspen, Landmark, and non-party Lloyds covered the remaining $50 million in varying shares.

The FM master policy contained certain exceptions to the policy deductibles. For Flood, the policy provided "USD100,000 for Property Damage and Time Element combined, per Occurrence except as respects Locations as described in Appendix F, the following will apply…." Appendix F of the FM policy identified "High Hazard Flood Locations," and 4 NYP's office building was added to Appendix F shortly after the FM policy was bound, with concurrent notice to the insured's broker. For locations listed on Appendix F, the FM policy identified the deductible, in relevant part, as "Property Damage – 5% of the value, per the VALUATION clause of the LOSS ADJUSTMENT AND SETTLEMENT section, of the property insured at the Location where the physical damage occurred, per Location." This same provision stated that the "above Flood deductibles are subject to a minimum deductible of USD100,000 for Property Damage and Time Element combined, per Location."

In providing second layer excess coverage, the Landmark and Lloyds authorizations specifically referred back to this 5% primary deductible. Landmark's authorization stated that "[t]his excess policy will require the primary to have at a minimum the following: 5.00% Per Occurrence (Property Damage & Time Element)," while the Lloyds authorization noted that the FM deductible was "5% or $19,200,000." Separately, a first layer excess insurer also referenced "primary deductibles of 5%."

Though the Insurers made partial payment on their second excess layer coverage, 4 NYP sought the full

limits, contending that the FM policy provided only for the $100,000 deductible referenced in the first line of the Flood deductible provision. The parties cross-moved for summary judgment on the issue and oral argument was held before Judge Crotty on January 14, 2016. 4 NYP argued, inter alia, that the deductible provision was ambiguous and counseled in favor of a $100,000 deductible. It further argued "that interpreting the FM Master Policy to impose a $19.2 million deductible results in illusory coverage," in light of FM's $20 million limit. The Insurers disagreed, pointing to the plain language of the provision as requiring a deductible of "5% of the value ... of the property insured at the Location where the physical damage occurred…."

In its February 25, 2016 Order and Decision, the court rejected 4 NYP's various contentions, noting that "none of the arguments hold water." In the court's opinion, the deductible clause was "unambiguous" and the Insurers' interpretation was "clearly correct." Essentially, because "the property was added to Appendix F, the five percent flood deductible applie[d]. And since the quote that Defendant agreed to provide[d] for a combined property value plus time element of $384.2 million, the deductible [was] $19.2 million." Furthermore, "[s]ince the FM Master Policy afford[ed] Defendant $20 million in flood loss coverage on top of the $19.2 million deductible (which FM has in fact paid to Defendant), the coverage [wa]s not illusory."

(Note: Mound Cotton represents the Insurers in this matter.)

***Castle Oil Corp. v. ACE American Ins. Co.,* 137 A.D.3d 833 (2d Dep't 2016)**

Less than two weeks after *Aspen Specialty* was decided in a New York federal court, New York's Appellate Division, Second Department also ruled on the application of a percentage-based deductible in *Castle Oil*, holding that the only "reasonable interpretation" of the policy's deductible provision was the insurer's, which required a deductible of "2% of the total insurable values at risk per location…."

There, ACE American Insurance Company ("ACE") appealed a trial court's grant of summary judgment in favor of Castle Oil Corporation ("Castle"), denying ACE's motion to dismiss the complaint against it and essentially adopting Castle's contention that the applicable flood deductible was $250,000.

Castle had obtained a commercial property insurance policy from ACE that included flood coverage for three locations, including Castle's Port Morris Terminal (the "Terminal") adjacent to the East River in the Bronx. The Terminal was subject to a $2,500,000 sublimit of liability because it was located in a FEMA Special Flood Hazard Area. Castle had reported values of $124,701,000 for the Terminal ($66,850,000 in real and personal property, $49,451,000 in average inventory, $7,000,000 in business interruption, and $1,400,000 in rents). ACE's deductible provision stated that a flood occurrence deductible would be calculated as "2% of the total insurable values at risk per location subject to a minimum of $250,000."

Thereafter, the Terminal suffered flooding damage from Superstorm Sandy and Castle "timely submitted a claim to ACE in the amount of $2,284,239.95." ACE responded by notifying Castle that the claimed loss was less than the deductible applicable to the Terminal. Relying on the express deductible language in the policy, ACE pointed out that the applicable deductible was $2,494,020, or, "2% of the $124,701,000 valuation for the [Terminal] that [Castle] had provided." Castle disagreed, contending that the deductible was $250,000, "which it arrived at by applying the 2% provision to the flood sublimit of $2,500,000 applicable to the [Terminal] and then applying the $250,000 minimum deductible override."

In granting Castle's motion and denying ACE's cross-motion, the Supreme Court looked to the reasonable expectations of an insured in connection with the undefined phrase "total insurable values at risk per location." The Supreme Court concluded that the "values at risk" referred to the $2,500,000 sublimit, rather than the "total value of the property insured under the Policy," because the most ACE was ever "at risk" of paying out was the flood sublimit. The Supreme Court also ruled that ACE's interpretation would render the $2,500,000 flood sublimit meaningless and the coverage Castle obtained "illusory." On ACE's motion for leave to reargue, the Supreme Court effectively "granted reargument and adhered to its original determination."

On appeal, a unanimous panel of the Second Department dismissed the Supreme Court's order and reversed the decision on the law, thereby granting ACE's cross-motion for summary judgment. While agreeing with the parties and the court below that the

deductible provision was not ambiguous, the panel disagreed with the lower court's interpretation of the provision.

The panel concluded instead "that the average insured could have only one reasonable expectation as to the meaning of the phrase 'total insurable values at risk,' namely, its own risk of loss and damage." Moreover, the panel ruled that the "policy's coverage is not rendered 'illusory' simply by the fact that [the] claim [fell] entirely within the deductible." Indeed, "[i]f Superstorm Sandy had instead caused $5,000,000 of damage and loss at the [Terminal], Castle Oil would have been out-of-pocket for the $2,494,020 deductible, but also would have been paid the entire $2,500,000 coverage sublimit."

The panel further noted that Castle's interpretation was "unreasonable" in that "it would render much of the deductible provision … entirely superfluous." Lastly, the panel ruled that the "premium purposes only" language of the Locations Endorsement did not "preclude the use of [those] values in the calculation of the applicable flood deductible, which, in any event, is relevant in determining the amount of the premium."

Accordingly, the Appellate Division found that Castle's claim did not meet the deductible and that ACE's cross-motion should have been granted in the first instance.

THE KEY TAKEAWAY

Policyholders and insurers alike benefit from the straightforward application of a percentage-based deductible, which provides all parties with a knowable, fixed deductible amount based on the type of covered loss and location(s) involved. As these recent decisions prove, however, insureds must appreciate the operation of these deductibles and plan accordingly, because courts have repeatedly shown that they will not rewrite a contract of insurance to void a percentage-based deductible provision that a policyholder agreed to but subsequently finds inconvenient.

Mr. Weinstein is a partner and **Mr. Rice** is an associate in the New York City office of the firm.

Endnotes

1. 4 NYP's broker quoted the property's value at $384.2 million ($355.2 million replacement value and $29 million time element from rental income).

2. 4 NYP alternatively argued that it wasn't notified of the building's addition to Appendix F (though its broker was); that the Landmark policy did not specifically reference the underlying primary deductible (though the Landmark authorization did); that its rights were determined by a certificate of insurance (which explicitly stated it conferred no rights). The court likewise found these arguments to be without merit.

3. These values appeared on a Locations Endorsement, which stated that "[v]alues shown above are for premium purposes only."

4. The Supreme Court also took issue with the Locations Endorsement's language of "for premium purposes only," interpreting this to mean that the values Castle provided could not be used in the deductible calculation.

5. A recent New Jersey decision similarly rejected the premise that a deductible would be based on a sublimit of liability rather than a percentage of the "Total Insurable Values" provided by the insured. See *Wakefern Food Corp. v. Lexington Ins. Co.,* No. L-6483-13 (TLF) (N.J. Super. Jan. 23, 2015) (finding no basis for reconsideration of its original grant of summary judgment to defendant insurer on deductible issue) ("Plaintiff's view that the deductible was based on a sublimit of liability was not convincing.") (Note: Mound Cotton represents Lexington in this matter); see also *Saratoga Res., Inc. v. Lexington Ins. Co.,* No. 15-20343, 2016 WL 1127399, at *2 (5th Cir. Mar. 22, 2016) (affirming district court's grant of summary judgment in favor of defendant insurer) ("The 'ordinary meaning' of '5% of Total Insurable Values' is 5% of the 'Total' of the 'Insurable Values' of the damaged properties — that is, 5% of the aggregate sum of the insured value of each damaged property.").

6. The panel noted that Castle's interpretation meant the 2% provision would always be overridden by the $250,000 minimum, rendering the 2% provision "completely unnecessary." If that were the intention of the parties, they would have simply used a flat $250,000 deductible.

New Jersey Supreme Court Clarifies the Mode-of-Operation Rule

By: William D. Wilson and Frank J. DeAngelis

In order to succeed in a premises liability action, a person who slips and falls in a retail establishment generally must establish that the business owner knew or should have known of the unsafe condition that led to the patron's fall and failed to correct it. In other words, the injured patron must show that the business owner was somehow at fault (*i.e.,* negligent). In the first instance, that "fault" consists of actual or constructive notice of a hazardous condition. Once notice is established, the injured patron must then demonstrate that the business owner failed to address the hazardous condition in a timely manner. It is not enough for the injured patron to simply show that she fell or even that she fell because of the existence of a dangerous condition; the business owner must have notice of the hazardous condition.

There are, however, exceptions to the notice requirement. One such exception is the mode-of-operation rule. That rule permits the trier of fact to draw an inference that a business owner had constructive notice of a hazardous condition if it can be shown that there was a substantial risk of injury inherent in the business owner's method of doing business. While the injured party must still show that a hazardous condition existed, he or she is not required to prove that the business owner had notice of that condition. When the rule is invoked, the burden shifts to the business owner to show that it was not at fault. To do that, the business owner must show that it exercised due care. What constitutes due care depends on the nature of the risk posed by the particular business method or practice at issue. Thus, the mode-of-operation rule substantially alters the ordinary burden of proof.

The mode-of-operation rule applies to retail establishments whose operations involve a self-service component. Under the rule, there is a presumption that customers will act carelessly in situations where the business's mode-of-operation is designed to allow patrons to directly handle products or merchandise. Thus, if, for example, a grocery store allows customers to select produce from bins or displays, a patron who slips and falls on produce that has fallen to the floor can benefit from the mode-of-operation rule. Similarly, if a restaurant has a self-service salad bar the mode-of-operation rule may be triggered. The rule applies regardless of whether the customer slipped on something he or she dropped on the ground or whether it was dropped by the business owner's employee or another customer.

The mode-of-operation rule was first adopted by the New Jersey Supreme Court in 1964 in *Bozza v. Vornado*, Inc., 42 N.J. 355 (1964). In that case, the plaintiff claimed she slipped on "a sticky substance which was very slimy" in the cafeteria of the defendant's store, which was self-service. *Id.* at 358. The plaintiff claimed that patrons carried their food with or without trays and that there were "drippings, paper straw holders, napkins and dirt on the floor." *Id.*

Two years later, the court revisited the rule in *Wollerman v. Grand Union Stores,* Inc., 47 N.J. 426 (1966). In that case, a woman claimed she slipped and fell on a string bean in the produce aisle of the defendant's supermarket. In explaining why the mode-of-operation rule applied in that case, the court noted:

> When greens are sold from open bins on a self-service basis, there is the likelihood that some will fall or be dropped to the floor. If the operator chooses to sell in this way, he must do what is reasonably necessary to protect the customer from the risk of injury that mode-of-operation is likely to generate; and this whether the risk arises from the act of his employee or of someone else he invites to the premises. The operator's vigilance must be commensurate with that risk.

Id. at 429.

Over thirty-five years later, the New Jersey Supreme Court expanded application of the rule in *Nisivoccia v. Glass Gardens, Inc.,* 175 N.J. 559 (2003). In that case, the plaintiff slipped on a grape in the defendant's supermarket. The "grapes were displayed in open-top, vented plastic bags that permitted spillage." *Id.*

at 561. The grapes, which were located in the produce aisle, were pre-packaged; the customers did not have to place the grapes in the bags. The grape that caused the plaintiff to slip, however, was not located in the produce aisle. Rather, the grape was located on the floor near one of the cash registers. On those facts, both the trial court and the Appellate Division concluded that the mode-of-operation rule did not apply. The New Jersey Supreme Court reversed, reasoning as follows:

> Customers typically unload their carts onto the checkout counter. Droppage and spillage during that process are foreseeable. Indeed, because of the way the grapes were packaged, they could easily have fallen out when accidentally tipped or upended in a shopping cart anywhere in the store. The open and air-vented bags invited spillage. It was foreseeable then that loose grapes would fall to the ground near the checkout area, creating a dangerous condition for an unsuspecting customer walking in that area.

Id. at 565.

The only "self-service" aspect in that case, however, involved a customer's picking up a pre-packaged bag of grapes and placing it in his or her cart and then removing the bag from his or her shopping cart and placing it on the checkout counter. This was not a situation where the customer actually selected the grapes and placed them in the plastic bag. Thus, the court's holding went beyond the traditional application of the mode-of-operation rule. Indeed, the court suggested that the mode-of-operation rule would apply any time "a dangerous condition is likely to occur as the result of the nature of the business, the property's condition, or a demonstrable pattern of conduct or incidents," not just when the injury has a nexus to a self-service operation. *Id.* at 563.

The New Jersey Supreme Court recently clarified the scope of the mode-of-operation rule in *Prioleau v. Kentucky Fried Chicken, Inc.,* 223 N.J. 245 (2015). There, a patron of a Kentucky Fried Chicken restaurant slipped and fell while walking to the restroom. "She alleged that she fell either because defendants failed to exercise reasonable care to keep the restaurant floor dry on a rainy evening or because defendants' employees tracked oil and grease from the restaurant's kitchen to the area near the restroom." *Id.* at 248. The plaintiff claimed that the floor "felt greasy and wet" and was as slippery as ice. *Id.* at 251. Significantly, the plaintiff did not allege that her injuries were related to any self-service aspect of the defendants' operations. Nonetheless, the trial judge instructed the jury on application of the mode-of-operation rule.

The jury rendered a verdict in the plaintiff's favor and the defendants appealed. The Appellate Division reversed, finding that the mode-of-operation charge was improper. However, one judge dissented, in part, finding no error with that charge. Because one judge dissented, the plaintiff was able to further appeal to the New Jersey Supreme Court.

The New Jersey Supreme Court affirmed, as modified, the majority opinion of the Appellate Division, disagreeing with the dissenting judge. According to the court:

> The trial record establishes that plaintiff's injuries were unrelated to any aspect of defendants' business in which the customer foreseeably serves himself or herself, or otherwise directly engages with products or services, unsupervised by an employee. Neither theory of liability advanced by plaintiff involved the limited circumstances in which the mode-of-operation rule has been held to apply.

Id. at 249. As further observed by the court:

> Significantly, for purposes of this appeal, nothing in the record suggests that when she fell, plaintiff was engaged in, or in contact with, any self-service activity, such as filling a beverage cup at a restaurant soda machine, selecting items from a condiment tray, or that patrons were carrying their drinks or food to the restroom area. Indeed, plaintiff's testimony established that she had not yet ordered or purchased her dinner when her accident occurred. Instead, by her own account, plaintiff fell immediately after entering the restaurant.

Id. at 251-52. The court concluded that "[b]ecause the mode-of-operation rule significantly reduced plaintiff's burden of proof, and may have determined the outcome, the trial court's charge on the rule constituted reversible error." *Id.* at 249-50. The court then remanded the matter to the trial court for a new trial.

Thus, the mode-of-operation rule does not automatically apply every time the defendant's method of operation gives rise to an arguably hazardous condition, even if the defendant's business involves a self-service aspect. Rather, there must be some "nexus between the self-service aspect of defendant's business and the plaintiff's injury." *Id.* at 261.

The mode-of-operation rule gives rise to a rebuttable "inference of negligence, shifting the burden of production to the defendant, who may avoid liability if it shows that it did 'all that a reasonably prudent man would do in the light of the risk of injury [the] operation entailed.'" *Id.* at 338. Because the mode-of-operation rule "substantially alters the ordinary allocation of the burdens between the parties," it should be used only when certain prerequisites are met. The court's decision in *Prioleau* clarifies exactly what those prerequisites are. One of the most important prerequisites identified by the court, which was missing in *Prioleau,* is that there must be a nexus between a self-service aspect of the defendant's business and the plaintiff's injury.

The *Prioleau* trial court's decision to use a mode-of-operation jury charge demonstrated how far courts had strayed from the limited use of the mode-of-operation rule. It is a credit to the plaintiffs' bar that courts extended the mode-of-operation rule in certain circumstances to apply to a business's "mode-of-operations" or method of operations as opposed to the limited self-service situations in which the Supreme Court intended the rule to apply. Nonetheless, the New Jersey Supreme Court's decision in *Prioleau*, and subsequent case law, clearly set forth the limited applicability of the mode-of-operation rule to those situations where a plaintiff is injured in the narrow circumstance of a self-service situation.

Mr. Wilson and **Mr. DeAngelis** are partners in the New Jersey office of the firm, and are also co-authors of the *New Jersey Insurance Coverage Litigation: A Practitioner's Guide (2015).*

Court Upholds Flood Sublimit, Dismisses Case Against Mound Cotton Client

By: Daniel Markewich

On June 27, 2016, Justice Manuel J. Mendez of New York County Supreme Court issued a decision in the case of *XL Insurance America, Inc, v. The Howard Hughes Corporation* ("HHC") granting summary judgment dismissing HHC's claim against XL for alleged losses from Superstorm Sandy to HHC's properties at the South Street Seaport. Mound Cotton partners Costantino P. Suriano, John Mezzacappa, and Jeffrey C. Crawford represented XL in this proceeding.

XL was one of a number of insurers that, by separate policies all of which conformed for the most part to a Willis manuscript, provided two-tiered property, business interruption, time element, and extra expense coverage to HHC for, among other properties, those South Street Seaport properties of which HHC was the ground lessor. By Endorsement 2 to its policy, XL agreed to provide 50 percent of $150 million, or $75 million, in excess of $50 million and also 100 percent of $50 million in excess of $200 million. HHC's coverage with other carriers provided the first $50 million for a loss in excess of the deductibles and also covered the $75 million above $50 million but below $200 million that XL did not insure.

Endorsement 2 also clearly stated that XL "does severally, but not jointly, agree to indemnify the Insured for the amount recoverable in accordance with the terms and conditions of this Policy and any Endorsements hereto, provided that ... [XL's collective liability does not] exceed its percentage of the Limit of Liability or any appropriate Sub-limit of Liability or any aggregate Limit of Liability in any annual Policy Year."

The Willis manuscript also contained a $50 million limit of liability for loss caused by flood with respect to locations set forth in an appendix, and provided at clause 13, titled Earthquake and Flood, that "Flood does not mean Flood and Storm Surge as a result of Named Storm."

The XL policy was revised by the addition of Endorsement 3. That endorsement defined "flood" — "[n]otwithstanding any provisions to the contrary" in the policy or endorsements — as including the inundation of normally dry land from "storm surge" and "Named Storm." Endorsement 3 also defined "High Hazard Flood Zones" so as to encompass the Seaport properties and provided that for floods in High Hazard Flood Zones XL would "not be liable, per occurrence and in any one policy year, for more than its proportion of $50,000,000 which shall apply separately to each peril."

Endorsement 3 to the policy capped XL's liability for a flood in a High Hazard Flood Zone at "its proportion of $50,000,000," but under Endorsement 2 to the policy XL was liable for *no* portion of the first $50 million of any loss. Accordingly, XL sued HHC for a declaratory judgment that HHC's loss was caused by storm surge and was subject to the $50 million limit of liability for flood and that the claim was not covered under XL's policy because it provided coverage only for loss in excess of $50 million. After joinder of issue and document discovery, XL moved for summary judgment declaring that there is no coverage under XL's Policy for HHC's claim.

Alleging some $86 million in damages from Superstorm Sandy at the South Street Seaport, HHC made two main arguments in opposition to summary judgment. First, HHC maintained that clause 13 of the Willis manuscript trumped Endorsement 3 to XL's policy so that the damage to the Seaport properties from the storm surge of Superstorm Sandy was not a "flood" in a High Hazard Flood Zone and XL's coverage was not limited by Endorsement 3 but fell under Endorsement 2. Second, HHC maintained that even if the $50 million limitation of Endorsement 3 was applicable, it incepted not ground up but, by its terms, only above the first $50 million for which XL had no liability under Endorsement 2. In either event, according to HHC, XL should be held liable for 50 percent of HHC's damages between $50 million and $86 million or whatever higher amount eventuated up to $100 million.

As Justice Mendez wrote in his decision, XL's contention was "that there were multiple insurers providing coverage to HHC, with each participating for a stated percentage, at varying levels of coverage, and that under the policy Endorsement 2, plaintiff [XL] had no participation and no liability for loss."

Justice Mendez held that the definition of flood in clause 13 of the policy was self-contained and intended to apply only to that paragraph. To the contrary, Endorsement 3 was "not ambiguous or self-contained," but clarified the definition of flood for High Hazard Flood Zones and referred to both storm surge and Named Storm.

Justice Mendez also found no ambiguity in the policy's limitations of coverage, which specifically identified HHC's Seaport properties as within the High Hazard Flood Zone. According to the court, "There never was flood coverage for 'High Hazard Flood Zone' properties, including the Seaport Properties, because the initial attachment point is at, or above, an amount equal to the imposed sublimit. In other words, ... 'High Hazard Flood Zone' properties are covered by other insurers and not part of plaintiff's [XL's] layer of coverage."

Finally, Justice Mendez held in declaring that XL is not liable for HHC's claim that "[d]efendant has not stated a basis to avoid summary judgment for outstanding discovery. The discovery sought would not avoid the plain meaning of the policy." XL's motion for summary judgment was therefore granted in all respects.

Mr. Markewich is a partner in the Long Island office of the firm, and is editor of the Newsletter.

Failure to Provide Timely Notice under Claims-Made Policy Results in Forfeiture of Coverage

By: William D. Wilson

Most third-party liability policies are occurrence based. In order for a loss to be covered under such a policy, the damage at issue must "occur" during the policy period. In most instances, it does not matter when a claim is actually asserted as long as the damage took place during the policy period. A claims-made policy, on the other hand, provides coverage only for claims first made against the insured and reported to the insurance company during the policy period or shortly after expiration thereof. A key feature of a claims-made policy is that it provides coverage for acts or omissions that took place prior to the effective date of the policy as long as any claims arising therefrom are first asserted against the insured and reported to the insurance company during the policy period.

Under a claims-made policy, it is not necessary to determine when the particular event that gave rise to the claim occurred because it is *the making of the claim* that triggers coverage and not *the occurrence of the damage* that gave rise to the claim. Thus, insurers can limit the time during which they will be subject to claims being made under a particular policy to a certain finite period. Under an "occurrence" based policy, in contrast, insurers can be subject to claims many years — and even decades — after a policy has expired.

As noted above, claims-made policies typically require that in order for coverage to exist, a claim must be first asserted against the insured and reported to the insurance company during the policy period, or within a specified "discovery" period following expiration of the policy. Moreover, most policies provide that notice of a claim be provided to the insurer "as soon as practicable." Thus, an insured actually has two notice requirements under a claims-made policy: (1) the claim must be reported within the policy period; and (2) the claim must be reported "as soon as practicable." Unless an insured meets both of the notice requirements, there will be no coverage under the policy.

The first notice requirement was addressed by the New Jersey Supreme Court in *Zuckerman v. National Union Fire Ins. Co.,* 495 A.2d 395, 100 N.J. 304 (1985). There, the insured failed to provide notice of a claim to its insurer prior to expiration of the policy. The court held that coverage was barred as a result of the late notice. The court ruled that, unlike an occurrence policy, it is not necessary for an insurance company to establish that it was prejudiced as a result of the late notice to avoid coverage. *Id.*, 100 N.J. at 323. The reason for this, as explained by the court, is:

> In exchange for limiting coverage only to claims made during the policy period, the carrier provides the insured with retroactive coverage for errors and omissions that took place prior to the policy period. Thus, an extension of the notice period in a "claims made" policy constitutes an unbargained-for expansion of coverage, gratis, resulting in the insurance company's exposure to a risk substantially broader than that expressly insured against in the policy.

Id., 100 N.J. at 324.

The second notice requirement recently was addressed by the New Jersey Supreme Court in *Templo Fuente De Vida Corp. v. National Union Fire Ins. Co.,* 129 A.3d 1059, 224 N.J. 189 (2016). There, the court dealt with the issue of whether an insurer was required to show prejudice when notice of a claim was received during the policy period, but the insured failed to provide the notice "as soon as practicable." That case involved a claim under a directors and officers liability policy, which is a common type of a claims-made policy. Although the claim at issue was reported to the insurer within the policy period, the insured waited until six months after it had been sued to provide notice to its insurer. The policy specifically required the insured to provide notice of a claim "as soon as practicable."

Whether an insured has provided notice of a claim "as soon as practicable" generally presents a question of fact. However, the court held, based on the facts before it, that the insured failed to provide notice of a claim "as soon as practicable" as a matter of law.

According to the court:

> Because plaintiffs fail to assert why the delay occurred, let alone why we should consider [the insured's] reporting of the claims to be "as soon as practicable" under the "circumstances," there is no factual dispute that the notice given was not timely. Thus, we hold only that on this record the unexplained six-month delay did not satisfy the policy's notice requirement.

Id., 224 N.J. at 207. The court was unwilling, however, to adopt a "bright line" test for determining "timely compliance with an 'as soon as practicable' notice provision." *Id.* Thus, whether notice was timely will have to be decided on a case-by-case basis.

Significantly, the court further held that an insurer is not required to show that it was prejudiced as a result of the untimely notice in order to avoid coverage, finding that the notice provision was a condition precedent to obtaining coverage. *Id.*, 223 N.J. at 204. Once again, however, the court was unwilling to adopt a bright-line rule applicable to all claims-made policies. Rather, the court simply observed:

> In this instance we need not make a sweeping statement about the strictness of enforcing the "as soon as practicable" notice requirement in "claims made" policies generally. We need only enforce the plain and unambiguous terms of a negotiated Directors and Officers insurance contract entered into between sophisticated business entities. Its notice conditions contain mutual rights and obligations and a clear and unambiguous requirement that the insured report a claim to the insurer "as soon as practicable," ... thereby preserving the insurer's rights ... to associate and influence how the litigation proceeds from its inception.

Id., 224 N.J. at 209.

The court's decision was based, in part, on "the conceptual differences between 'claims made' and 'occurrence' policies." *Id.*, 224 N.J. at 200. As noted by the court:

> The prompt notice requirement and the requirement that the claim be made within the policy period in "claims made" policies "maximiz[e] the insurer's opportunity to investigate, set reserves, and control or participate in negotiations with the third party asserting the claim against the insured" and "mark the point at which liability for the claim passes to an ensuing policy, frequently issued by a different insurer, which may have very different limits and terms of coverage."

Id., 224 N.J. at 203 (quoting 13 *Couch on Insurance* 3d §186:13 (2009)). As discussed above, coverage under an "occurrence" policy is triggered based on the happening of an event during the policy period that gives rise to a claim. Consequently, it can be very difficult for an insurer to predict its future liability because claims may be made decades after a policy has expired. Under a "claims made" policy, on the other hand, it does not matter when the particular event that gave rise to the claim occurred. Rather, what matters is when a claim is first asserted against the insured. Thus, there is a finite period of time during which the insurer may be held liable.

In ruling in favor of the insurer, the court placed great weight on the fact that the insured was a "sophisticated" insured represented by an insurance broker in connection with the procurement of the policy. Many of the special rules governing the interpretation of insurance policies are based on the premise that insurance policies are contracts of adhesion. Most non-commercial insurance policies are based on standard forms used by insurers, and insureds have little or no bargaining power to negotiate the terms of the policies. In other words, policies are presented on a take-it-or-leave-it basis. That often is not the case, however, with sophisticated commercial insureds. Such insureds generally are represented by insurance brokers that have the ability to negotiate the terms of the insurance policies. Indeed, brokers often draft insurance policies that are presented to insurers for review and acceptance. Those policies are referred to as broker-drafted manuscript forms.

There is no question that the insured in *Templo* was a sophisticated commercial insured, and it was represented by an insurance broker in connection

with the procurement of the insurance policy at issue. Specifically, the court observed:

> [W]e note first the importance of the characteristics of [the insured. The insured] is not an individual and this policy is not a simple personal liability insurance policy. To the contrary, the insured was an incorporated business entity that engaged in complex financial transactions. During the initial application process for the Directors and Officers policy, [the insured] listed itself as having at least fourteen full-time employees, two part-time employees, and a human resources department. The policy covered a broad variety of complex civil and criminal matters, including employment practices claims and security claims. In the procurement of a complex policy like this one, [the insured] did not simply obtain a professional liability policy on its own; it sought out a broker, who procured the policy on First Independent's behalf.

Id., 224 N.J. at 208. Consequently, the court refused to treat the insurance policy at issue as a contract of adhesion and strictly enforced the notice requirement.

As argued by the plaintiff in *Templo*, some courts in other jurisdictions have treated the two notice requirements under a claims-made policy differently. Specifically, a no-prejudice standard has been applied to the requirement that notice be provided within the policy period, whereas a prejudice standard has been applied to the requirement that notice be provided "as soon as practicable." In *Templo*, the New Jersey Supreme Court essentially rejected any distinction between the two notice requirements and held that a no-prejudice standard applies to both.

Mr. Wilson is a partner in the New Jersey office of the firm.

The Foster Poultry Farms Decision: Update

By: Jeffrey S. Weinstein and Sara N. Lewis

Introduction

As a follow-up to the article published in MCWG's Winter 2015 newsletter, this article will discuss the final decision issued in the *Foster Farms* case, and the revisions to the court's original summary judgment decision. Even before this final decision, the impact of the summary judgment decision had already begun having wide-reaching effects for insurers issuing policies that cover "Accidental Product Contamination" and "Product Recall." Policyholders' attorneys quickly latched onto the *Foster Farms* opinion as justification for coverage in situations not contemplated by the policies, such as where no harm actually occurred, or where there was minimal government intervention. Already, insureds seem to be using this case for the proposition that insurers must find coverage where there is even an indicium of a covered event. In the wake of this decision, insurers will need to be extra-careful in examining coverage wording and supporting any decisions to decline coverage.

While the summary judgment decision finding coverage will have far-reaching effects on the issue of coverage, the court was careful to judiciously review each of the insured's claimed damages. After conducting a bench trial on the damages issue, the court awarded $2,706,398, representing Foster's covered loss. This figure was conservative given Foster's claim for over $12 million in damages. Although the court did grant

coverage in a close situation, it did not allow the insured to run wild with its claimed damages, and stuck closely to the letter of the policy in order to evaluate what portion of the claimed loss was covered.

Here is a brief recounting of the case facts, the revised summary judgment decision, and the court's findings after its bench trial:

Facts

Foster Poultry Farms is a poultry plant with a large processing facility in California. On October 7, 2013, the United States Department of Agriculture Food Safety and Inspection Service ("FSIS") issued a Notice of Intended Enforcement to the facility based on the high prevalence of salmonella at the facility, its implication in a recent outbreak of salmonella, its noncompliance with federal regulations, and the fact that live cockroaches had been spotted at the facility. On the basis of these findings, on January 8, 2014 FSIS issued a Notice of Suspension ("NOS") for Foster's continued noncompliance and the cockroach infestation. This NOS caused a shutdown of the facility for several days. This notice "stressed that Foster was unable to ensure that its chicken product was not adulterated or injurious to health and noted Foster's overall failure 'to abide by the rules and regulations promulgated under the Poultry Products Inspection Act.'"

Foster's processing facility was insured under a products contamination policy issued by a number of London carriers (the "Policy"), which provided coverage for "all 'Loss' arising out of 'Insured Events' during the policy period." Two such "Insured Events" listed in the Policy were "Accidental Contamination" and "Government Recall."

Foster submitted a claim under the Policy's Accidental Contamination and Government Recall provisions for over $12 million in expenses that it allegedly incurred as a result of the NOS. The Insurers denied coverage under both provisions, and Foster brought an action for declaratory relief and breach of the insurance contract. Foster moved for partial summary judgment on the declaratory relief claim, and the Insurers moved for summary judgment on both of Foster's claims. The United States District Court for the Eastern District of California, applying New York law, addressed two significant issues in the field of Contaminated Products Insurance, *viz.*, accidental product contamination and government recall, in granting summary judgment in favor of the insured. *Foster Poultry Farms, Inc. v. Certain Underwriters at Lloyd's, London,* No. 1:14-953 WBS SAB, 2015 WL 5920289 (E.D. Cal. Oct. 9, 2015).

The court conducted a four-day bench trial on January 12-15, after both parties waived their rights to a jury trial. On January 20, 2016, the court issued an Amended Memorandum and Order addressing the prior summary judgment decision, which is discussed in more detail below. *Foster Poultry Farms, Inc. v. Certain Underwriters at Lloyd's,* No. 1:14-953, 2016 WL 235211 (E.D. Cal. Jan. 20, 2016). On February 11, the court issued an award to Foster in the amount of $2,706,398.00. *Foster Poultry Farms, Inc. v. Certain Underwriters at Lloyd's,* No. 1:14-953, 2016 WL 541441 (E.D. Cal. Feb. 11, 2016).

The Revised Summary Judgment Decision

On October 9, 2015, the court issued its original summary judgment decision, finding that there was coverage for Foster's claim under the Policy under both the Accidental Product Contamination and the Government Recall provisions. In its January 20 Amended Memorandum and Order, the court did not alter its ultimate findings concerning summary judgment, but it did slightly alter the wording of the opinion with regard to its findings concerning the Accidental Product Contamination. *Foster Poultry Farms.,* 2016 WL 235211. Most significantly, rather than explaining what "error" and "bodily harm" potentially encompass, the court shortened the opinion to reflect that there was no dispute that Foster's failure to comply with federally mandated sanitation standards was an "error" under the Policy, and amended the standards by which it evaluated bodily injury.

The court went further in addressing the Insurers' argument that one could not know with certainty whether the product would lead to bodily injury or sickness unless the product had been consumed. In particular, the court stressed that it would not be a reasonable interpretation of the Policy to require that a contaminated product be put into commerce to prove that it is harmful before coverage is triggered. Accordingly, the court found that "the Policy must be interpreted to require a showing of something less than an absolute certainty of bodily injury or sickness." *Id.* at *5. The court then found that a reasonable standard

to rely on would be that used by the government when deciding if a risk of contamination is significant enough to preclude public consumption of the product, such as in this case where it issued a suspension of all production. *Id.*

Ultimately, the court found that the "would lead to" language indicated something less than "absolute certainty" that bodily injury would result, but rather the standard was much more akin to there being a "reasonable probability" that harm would occur. Further, even if the Insurers' argument concerning certainty were to be considered as a possible interpretation, this would indicate an ambiguity in the Policy wording that would necessarily be interpreted against the Insurers. The court also found that in this case, as contrasted with the cases cited by Insurers, the court was dealing with a different definition of contamination, and that the product here was in fact contaminated within the meaning of the Policy's definition.

These alterations seemed to have been made in advance of the court's verdict in order to allow it to more seamlessly reach its verdict and explain the various loss amounts that would be covered, as its new standards concerning bodily harm are mentioned in the verdict. While these modifications did not drastically change the court's opinion, the more expansive discussion concerning "bodily injury" and "error" could have implications for future cases.

The Court's Award

The verdict itself was rendered after a four-day bench trial. *Foster Poultry Farms.,* 2016 WL 541441. The court awarded Foster $2,706,398 on its breach of contract claim, as contrasted with the claimed amount of over $12 million in losses. The court reiterated its summary judgment finding that Foster was entitled to coverage as a matter of law, as the contamination and shutdown would be considered an "Insured Event" under the Policy's Accidental Contamination provision or under the Government Recall provision.

In order to address the covered amount of loss, the court first considered the covered shutdown period and whether it extended from January 8 to 22, as argued by Foster, or the second shutdown instituted by Foster was voluntary and should not be considered part of the Insured Event, as explained by the Insurers. The court found that Foster had resumed some operations on January 11 and the remainder on January 12, and that the second shutdown that took place on January 12 was a voluntary business decision undertaken by Foster. The court concluded that the Insured Event did not include this second voluntary shutdown. The court also found that Foster had not provided any evidence that the chicken produced after the notice of suspension was placed in abeyance "would lead to" bodily injury or sickness, in accordance with the standard cited in the court's amended summary judgment opinion. Importantly, this finding ensures that extraordinary precautions taken by an insured are not covered losses under a policy. The court clearly states that "Foster has not and cannot argue that preventative measures taken to avoid the risk of an Insured Event are covered under the Policy." *Id.* at *8.

The court then went on to consider the loss calculations presented by each side. The court stated that, in general, it considered the Insurers' expert to have provided more credible and reliable calculations and analyses of the claimed losses in this case. This finding was based primarily on three facts: (1) defendants' expert's use of GAAP versus Foster's expert's failure to do so, (2) Foster's expert's failure to rely on her own calculations rather than simply accepting those done internally by Foster; and (3) Foster's expert's failure to address the contested loss period. The court found that the second, voluntary shutdown "did not arise solely and directly out of the Insured Event." Rather, the court believed it was a "deliberate and calculated business decision."

First, the court examined Foster's claimed Recall Expenses. The court accepted Foster's claimed disposal fees in the amounts of $11,733 and $7,500, respectively, which were not contested by the defendants. The court, however, rejected Foster's calculation of Public Relations, and accepted defendants' calculations. It only accepted the PR expenses arising solely and directly out of the Insured Event, $14,958, and as Foster did not attempt to allocate these costs between the two shutdown periods, it accepted the defendants' calculation of this figure.

Second, the court reviewed Foster's loss of gross profit. Here, the court awarded damages as follows: (a) $1,047,700 in lost gross profit for the chicken that did not receive the USDA's marks of inspection

and could not be sold; (b) $3,726 for organic chicken that was downgraded to be sold as regular chicken in order to fill its sale orders; (c) $346,164 in loss of gross profit from unfilled orders; and (d) $54,241 for customer claims and credits. The court did not award lost gross profits for Foster's claimed incremental sales that it would have received had it not canceled several promotional ads as a result of the shutdown, as the court found that Foster had not carried its burden to show that these ads were canceled as a result of the shutdown. The court also refused to award damages related to the resale of the damaged chicken on the commodity market, as Foster did not provide adequate records to support this deficiency and it was at odds with Foster's claim that it did not have enough product to fill sales orders.

The court did award $1,107,550 based on Foster's expert's calculation for the early exit of its customer, which covered Foster's lost sales and canceled order to this customer. The court refused, however, to award damages for Foster's alleged lost business to Kroger, as the evidence provided by Foster of this claim was "far too speculative." The court also refused to award any lost gross profits based on a loss of sales from Albertsons, because Foster failed to demonstrate that this loss was not related to the second, voluntary shutdown rather than the Insured Event. Finally, while the court agreed that incremental labor costs can constitute an element of loss of gross profit under the Policy, the court accepted defendants' expert's calculations and awarded only $11,457 of Foster's claimed $3 million because, again, Foster failed to separate out those incremental costs attributable to the Insured Event as opposed to the second, voluntary shutdown.

Third, the court considered Foster's claimed increased cost of working. The court awarded $101,369, based on the calculations of the defendants' expert, because Foster failed to adequately relate its claimed losses solely to the Insured Event. The court did, however, accept claimed costs of invoices from "Buzz Off," exterminators, concerning the remediation costs accepted in the Verification Plan approved by the USDA, as these costs would have been incurred regardless of the second shutdown.

The award is fairly instructive in pointing out the various elements of loss that are covered and the evidentiary requirements for meeting the threshold to prove such elements. While the court granted summary judgment in favor of Foster, it did temper the verdict by mostly accepting the Insurers' view of the damages.

Conclusion

Because there is not much judicial precedent in the crisis management arena, the series of decisions and rulings in the *Foster Farms* case has been the subject of considerable analysis and commentary. While the court's interpretation of the applicable Policy terms has somewhat limited application to the unique wordings of the Policy at issue, there has been no shortage of enthusiastic debate over these rulings. The effects of these rulings will continue to create ripple effects in crisis management circles as the scope of coverage of these policies is constantly being challenged.

Mr. Weinstein is a partner and **Ms. Lewis** is an associate in the New York City office of the firm.

My Computer Won't Work: First-Party Insurance Coverage for Cyber Losses

By: Jonathan R. Gross and Victor J. Jacobellis

Introduction

We live in a world where businesses are computer dependent — employees require a computer to perform their jobs; business transactions are conducted via computer systems; and company records, customer information and company work-product are now electronically stored across computer networks instead of in file cabinets. There is no doubt computer technology has improved the way we do business, both internally and with customers. Computer dependency, however, has created a new realm of cyber risks, many of which traditional property insurance, even with a computer coverage endorsement, is not crafted to cover. This article focuses on how courts have applied the coverage afforded under traditional property policies to cyber losses and, to a limited extent, new first-party cyber insurance coverages.

Just What Is a Cyber Loss Anyway?

There is no specific definition of what a "cyber risk" is or what type of loss constitutes a "cyber loss." Generally speaking, a cyber loss can refer to any loss associated with the use of electronic equipment, computers, information technology, or virtual reality. Gregory D. Podolak, *Insurance for Cyber Risks: A Comprehensive Analysis of the Evolving Exposure, Today's Litigation, and Tomorrow's Challenges*, 33 Quinnipiac L. Rev. 369, 371 (2015). The event that often comes to mind when thinking of a cyber loss is a data breach resulting in the theft of company and customer information. An example of a data breach is the 2013 Target data breach that compromised credit card and banking card information for 40 million shoppers and cost Target almost $150 million. Dan Kedmey, *Target Expects $148 Million Loss from Data Breach*, Time, August 6, 2014. These losses are becoming more and more common. As FBI Director Robert Mueller aptly stated, "there are only two types of companies, those that have been hacked and those that will be. And even they are converging into one category: companies that have been hacked and will be hacked again." Roberta D. Anderson, *Viruses, Trojans, and Spyware, Oh My! The Yellowbrick Road to Coverage in the Land of Internet Oz*, Tort and Trial Practice Law Journal (49:2), Winter 2014, p. 535.

A data breach is not the only cyber event a company is at risk of suffering. Other events that can cause a cyber loss include the injection of a virus into a computer network, loss of electronic data or disruption in the operation of computer systems. Often times the occurrence of one cyber event can lead to another cyber event. For example, the injection of a virus into a computer can trigger the loss of data or disrupt an entire network's operation. The losses and expenses associated with such events can include the cost to replace hardware, the cost to replace software and data, the loss of business income that occurs while a computer network is not operating, and extra expenses incurred to return the business to normal operation as quickly as possible.

When a cyber loss occurs, business income losses and extra expenses incurred can far outweigh the cost to repair or replace physically damaged property. An example of this is a law firm that experiences the failure of a hard drive server resulting in the loss of access to the computer network for a few days. The cost to replace the damaged hard drive may only be $1,500; this is a minor expense in comparison to the loss of billable hours.

Cyber Losses Under a Traditional Property Policy: Fitting the Square Peg into a Round Hole

The risks related to a modern day cyber loss did not exist when property insurance was first being developed. In late seventeenth century London, merchants, bankers, and ship owners gathered in a coffee house owned by Mr. Edward Lloyd where they agreed to share the risks of marine ventures among themselves. 2 Admiralty & Mar. Law § 19-1 (5th ed.). It was from the risks of the sea and the need for protection to owners of ships and cargoes that marine, and eventually property, insurance was born. *Unkelsbee v. Homestead Fire Ins. Co. of Baltimore,* 41

A.2d 168, 170-71 (D.C. 1945). Early marine policies insured against extraordinary and unusual perils that vessels did not reasonably expect to encounter such as shipwreck, foundering, stranding, collision, and damage resulting from violent wind and waves or damage from heavy weather. Am. Jur. 2d, Insurance § 641. Accordingly, in order to recover under insurance, actual tangible property was required to have been damaged or lost. Marine insurance policies did not contemplate insuring against the loss of information.

These types of marine losses became the basis for how coverage is provided in a typical modern day property insurance policy. A typical first-party property policy states an insurer "will pay for direct physical loss of or damage to Covered Property at the premises described in the Declarations caused by or resulting from any Covered Cause of Loss." Businessowners Coverage Form, Miller's Standard Insurance Policies Annotated, ¶ 1-1A1 (7 Ed. 2013). In order to recover for a business income loss, "the suspension [of business operations] must be caused by direct physical loss of or damage to property." Businessowners Coverage Form, Miller's Standard Insurance Policies Annotated, ¶ 1A5f1b (7 Ed. 2013). Under extra expense coverage, the extra expense "must be caused by or result from a Covered Cause of Loss." Businessowners Coverage Form, Miller's Standard Insurance Policies Annotated, ¶ 1A5g1a (7 Ed. 2013).

When it comes to cyber losses under a traditional property policy, the threshold question is whether physical loss or damage has occurred. For example, is electronically stored data property that can be physically lost or damaged? Is there direct physical loss or damage when a computer virus causes electronic data to be lost, but there is no actual physical damage to any computer, server or equipment, *i.e.*, is lost data alone a physical loss? Or, what if there is a power surge that causes an online retailer's computer network to turn off for three hours resulting in millions of dollars in lost sales, even though there is no actual physical damage to a computer system and its components? Different courts have answered these questions in different ways. The majority of courts have required that there be damage to a tangible component of a computer or network in order for there to be coverage. Other courts have broadly construed the term "physical loss and damage" to encompass the loss of use of a computer or data.

Cases Narrowly Construing "Physical Loss and Damage" to Apply Only to Tangible Property

Some courts, when analyzing coverage for "physical loss or damages," have required that there be physical damage to a tangible item. One of the first cases to analyze this issue was *America Online, Inc. v. St. Paul Mercury Ins. Co.*, 347 F.3d 89 (4th Cir. 2003). Although this case involved a general liability policy, the court analyzed whether electronic data was tangible property and whether the loss of use of a computer, in and of itself, constituted damage to tangible property. This matter was a class action lawsuit against America Online ("AOL") where the plaintiffs claimed the installation of AOL software altered existing software on plaintiffs' computers, disrupted the plaintiffs' computer network connections, caused the loss of stored data on the plaintiffs' computers and caused plaintiffs' computer operating systems to crash. *Id.* at 91-92.

AOL argued there was physical damage to tangible property because computer software involves the arrangement of atoms on computer drives and, therefore, software has a physical property. *Id.* at 92. St. Paul, on the other hand, asserted computer software and data are not tangible property because software and data are nothing more than ideas that happen to be stored in electronic form. *Id.* The court sided with St. Paul. In doing so, it first noted that a computer drive, which is a physical magnetic medium to store information, is separate from the data, software, programming information and instructions stored on the computer drive. The court, taking a technical approach, found that "data, information and instructions used in a computer are codified into a binary language and the binary language is processed by the computer." "Thus, if a hard drive were physically scarred or scratched so that it could no longer properly record data, information or instructions, then the damage would be physical, affecting the medium for storage of the data. But if the arrangement of the data or information stored on the hard drive were to become disordered or the instructions were to come into conflict with each other, the physical capabilities and properties of the hard drive would not be affected. Such disordering or conflicting instructions would amount to damage to the data and information and to the instructions (*i.e.*, the software) but not to the hard drive." *Id.* at 95.

By analogy, the court reasoned, "when the combination to a combination lock is forgotten or changed, the lock becomes useless, but the lock is not physically damaged. With the retrieval of or resetting the combination—the idea—the lock can be used again…. With damage to software, whether it be by reconfiguration or loss of instructions, the computer may become inoperable. But the hardware is not damaged. The switches continue to function to receive instructions and the data and information developed on the computer can still be preserved on the hard drive. While the loss of the idea represented by the *configuration* of the computer switches or the *combination* for the lock might amount to damage, such damage is intangible property. It is not the damage to the physical components of the computer or lock, *i.e.*, to those components that have 'physical substance apparent to the senses.'" *Id.* at 96.

In *Eyeblaster, Inc. v. Federal Ins. Co.*, 613 F.3d 797 (8th Cir. 2009), the court took a similar approach in narrowly construing what constituted physical loss and damage. Like *AOL*, this case also involved a liability policy, but the focus was the insurance policy's coverage for "physical injury to tangible property." Eyeblaster provided online advertising services. The plaintiff filed suit against Eyeblaster alleging an Eyeblaster spyware program caused his computer to freeze up, caused data pertaining to his unfinished tax returns to disappear, caused pop-up ads to appear, hijacked his web browser's communication with web sites, slowed his computer's performance and caused his computer to crash. *Id.* at 799-800. One of the issues before the court was whether the plaintiff's complaint contained any allegations for damage to tangible property. The court, relying on *AOL*, held the claimed damage, *i.e.*, the operation of plaintiff's computer, did not constitute "physical damage to tangible property" and damage to the computer's hardware was required to trigger coverage.

The leading first-party property case is *Ward General Ins. Servs., Inc. v. Employers Fire Ins. Co.*, 114 Cal. App. 4th 548 (2003), involving a claim for data loss under a traditional property policy. The *Ward* court also took a narrow approach in determining if electronic data constitutes tangible property. In this case, human error caused the insured's computer database to crash, resulting in the loss of data necessary for business operations. The crash did not cause any damage to the hardware on which lost data was stored. The insured spent over $50,000 to restore the lost information, suffered a business income loss of over $200,000, and submitted a claim under its businessowners policy for these costs. *Id.* at 550-51.

The *Ward* court considered whether electronic data was tangible property, and the sole issue before the court was whether the loss of electronically stored data, when there is no accompanying damage to any tangible parts of the computer system, constituted direct physical loss or damage. In order to answer this question, the court examined the plain and ordinary meaning of the word "physical," defined as "having material existence" and "perceptible especially through the senses and subject to the law of nature." The court then looked to the definition of material, defined as "capable of being perceived especially by the sense of touch." On the basis of these definitions, the court said "with confidence that the loss of the [insured's] database does not qualify as 'direct physical loss,' *unless* the database has material existence, formed out of tangible matter, and is perceptible to the sense of touch."

The court then examined the nature of a database. It defined "data" as "factual or numerical 'information'" and "database" as a large collection of organized data and concluded the "loss of a database is the loss of organized information." *Id.* at 556.

The court's conclusion, based on this analysis, was that there was no loss of or damage to physical property and, therefore, no "direct physical loss of or damage to" covered property. In coming to its decision, the court reasoned that it failed to see how "data" or "information" can have a material existence, be formed out of tangible matter, or be perceptible to the sense of touch. And although data is stored on a physical medium, *e.g.*, a magnetic disc or tape, the information itself is intangible. Even though the insured lost stored information, it did not lose the tangible material of the storage medium, which was still capable of storing information. *Id.*

Metro Brokers, Inc. v. Transportation Ins. Co. (No. 1:12-CV-3010-0DE) 2013 WL 7117840 (N.D. Ga. Nov. 21, 2013), demonstrates a creative, yet unsuccessful, argument through which an insured sought coverage for a cyber loss involving a fraudulent electronic transfer of money. In this case, Metro Brokers had money stolen when thieves logged onto its bank account and used the bank's Automated Clearing House System ("ACH") to make payments from Metro's bank account. Metro submitted a claim for the money stolen through ACH payments under its business property policy's "Forgery and Alteration" coverage. Under this coverage, the insurer agreed to pay for any loss resulting from forgery in any check, draft, promissory note, bill of exchange, or similar written promise to pay money by anyone acting as you or your agent. The coverage included the forgery of an electronic signature. *Id.* at *2. Metro claimed there was coverage because its electronic signature was forged to make the ACH payment. *Id.* at *3. Although Metro's claim was inventive, the court nonetheless found there was no coverage because the forgery and alteration coverage clearly applied only to losses pertaining to promises to pay contained on written instruments, making the ACH payment outside the scope of coverage. *Id.* at *5.

Cases Broadly Construing Data Loss and the Loss of Computer Use as "Physical Loss and Damage"

Some courts have broadly construed what constitutes physical loss and damage when a cyber loss occurs to find coverage under a traditional property insurance policy. One of the first cases finding coverage for a cyber loss under a traditional property policy is the unpublished, but often cited, case, *American Guarantee & Liability Ins. Co. v Ingram Micro, Inc.* (No. 99-185 TUC ACM) 2000 WL 726789 (D. Ariz. April 18, 2000). In this case, the court did not focus on whether or not information stored on a computer was tangible property. Instead, this court found "physical loss and damage" was not restricted to the physical destruction or harm to computer circuitry. The court chose to broadly define "physical loss and damage" to include loss of access, loss of use and loss of functionality to computer systems when stored information on a computer was lost. In this case, the insured, Ingram Micro, was a wholesale distributor of microcomputer products. All of Ingram Micro's sales were processed through a computer network known as Impulse. *Id* at *1. A power outage caused all of Impulse's programming information to be erased, causing Impulse to became inoperable and all of Ingram Micro's computers to not function for eight hours. *Id.* at *1-2.

Ingram Micro made a claim for business income losses caused by the power outage under an American Guarantee business property policy. The only issue before the court was whether the power outage caused direct physical loss or damage to Ingram Micro's computer system. *Id.* at *1. American Guarantee admitted the power outage affected Impulse's ability to function. American Guarantee argued, however, Ingram Micro's computer system was not "physically damaged" because the system's ability to function remained intact and was still able to receive the input of programming information that had been erased, which allowed the system to operate properly again. Ingram Micro, on the other hand, argued "physical damage" includes loss of use and functionality and, therefore, the fact the computer system could accept information and eventually operated as the system did before the loss did not mean the computer system had not been "physically damaged."

The court sided with Ingram Micro's broader definition of "physical damage." *Id.* at *2. The court concluded the loss of use and functionality of the computer system in and of itself constituted "physical damage." It based this conclusion upon an examination of the U.S. and several states' penal codes addressing cybercrimes. The court held that penal codes'

relevance was significant because law makers around the country have determined that when a computer's data is unavailable, there is damage; and when a computer's software or network is altered, there is damage. The court found that restricting coverage to actual "physical damage" to the computer system components, as American Guarantee suggested, would be archaic. *Id.* at *3.

In *Southeast Mental Health Center, Inc. v. Pacific Ins. Co., Ltd.*, 439 F. Supp. 2d 831 (W.D. Tenn. 2006), it was found, under the principles of *Ingram Micro*, that the loss of computer data constituted physical damage under a business property policy. In this case, a storm caused Southeast Mental Health Center, the insured, to lose power causing a data loss. *Southeast Mental Health Center*, 439 F. Supp. 2d at 834-35. The insured subsequently submitted a claim for the recovery of the lost data, which was denied on the basis that the data loss did not constitute "physical loss and damage" because the actual computer on which the data loss occurred was not damaged. The court, citing *Ingram Micro*, found the data loss was "physical loss and damage" because the lost data affected the computer system's ability to operate. *Id.* at 837-38.

Coverage for a cyber loss was more recently considered in another unpublished case, *Landmark American Inc. Co. v. Gulf Coast Analytical Labs., Inc.* (No. 10-809) 2012 WL 1094761 (M.D. La. March 30, 2012). This case specifically addressed whether electronic data is physical, *i.e.,* tangible property, or nonphysical in nature, *i.e.*, not tangible property, and, therefore, whether the loss of electronic data constituted "physical loss and damage." *Id.* at *3. The insured, Gulf Coast, suffered a computer server failure that caused its electronic data to be corrupted and permanently unusable. The data loss caused Gulf Coast to lose over $1 million in business income and it expended over $100,000 to recover the data. Gulf Coast submitted a claim to Landmark for the losses and Landmark claimed electronic data is not tangible property and, hence, not susceptible to physical loss and damage. Landmark further argued that electronic data can be subject to coverage only if the associated hardware is damaged and causes a loss of electronic data. Gulf Coast, on the other hand, argued electronic data was physical in nature because data was physically disrupted when the computer server failed. *Id.* at *1.

The court sided with Gulf Coast and held electronic data was physical in nature and the loss of electronic data constituted physical loss and damage under the insurance policy. Applying Louisiana law, the court noted tangibility is not a defining feature of physicality. The court reasoned that although electronic data is not tangible, it is still physical because it can be observed and altered through human action. It further found Gulf Coast's electronic data "has physical existence, takes up space on the tape, disc or hard drive, makes physical things happen, and can be perceived by the senses." *Id.* at *4.

Coverage Under a Cyber Policy

In order to meet the demand for protection from a cyber loss, insurance companies have added a variety of coverage extensions for cyber risks to their existing business property policies and have begun to create new specialty cyber insurance policies designed to address these risks. This is still a new and developing area of coverage and there is no typical cyber risk policy. Some policies extend coverage to the loss of data or software from different specified causes of loss. Such policies often also offer coverage for the loss of business income from a cyber loss and the expenses incurred to restore lost data. 2 Computer Software § 9:49 (West 2015). Policies may also provide coverage for losses associated with a data breach, including: (1) the cost to investigate forensically a data privacy or cybersecurity incident; (2) attorney costs for the review and determination of whether data privacy laws were violated; (3) the cost to send letters notifying customers or at risk individuals about a data breach, incident in accordance with statutes and regulations; (4) the cost of credit or fraud monitoring for affected individuals; and (5) the cost of complying with a regulatory investigation in connection with a data privacy incident. Scott Godes, *Managing Cybersecurity Risks in the Ever-Changing Cyber Insurance Law Environment*, Understanding Developments in Cyberspace Law, 2015 Edition, Leading Lawyers on Analyzing Recent Trends, Case Laws, and Legal Strategies Affecting the Internet Landscape, August 2015, at 1. There is also a wide range of coverage that may be provided under a cyber loss policy and the terms and conditions in such a policy may often vary from insurer to insurer and may even vary in different policies issued by the same insurer.

Since cyber coverages are relatively new, there are only a limited number of cases addressing them. The case law concerning cyber policies and the courts' opinions, consequently, are reflective of the specific policy language concerning coverage and the application of the policy to the facts. This is a good reminder that most evaluations of coverage under a cyber policy should focus on the policy at issue and the facts of the loss.

Retail Ventures, Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa., 691 F.3d 821 (6th Cir. 2012), involved a claim made under a special coverage entitled "Computer & Funds Transfer Coverage." This coverage protected against any loss resulting from the theft of any insured property by computer fraud. Computer fraud included the act of wrongfully converting assets through a computer system and insured property included the theft of property held by the insured in any capacity. *Id.* at 827. This coverage contained an exclusion for any loss of proprietary information, trade secrets, confidential processing methods, or other confidential information of any kind. *Id.* at 832. The insured, which operated retail shoe stores, DSW, had a data breach by hackers who accessed DSW's computers and downloaded credit card and checking account information of more than 1.4 million DSW customers. DSW made a claim under its "Computer & Funds Transfer Coverage" for investigative costs it incurred in connection with the data breach and amounts it reimbursed customers for fraudulent transfers made with their financial information. *Id*.

The parties agreed the data breach was theft of insured property under the "Computer & Funds Transfer Coverage." The insurer, however, claimed there was no coverage for the loss under the policy's exclusion for loss of proprietary information, trade secrets, confidential processing methods, or other confidential information of any kind. *Id.* at 832. The court disagreed and found the exclusion did not apply and there was coverage. The court first found customer information was not proprietary since the information was held by the customers' financial institutions and because the customers provided their financial information to merchants. It further held the customers' financial information was neither a "trade secret," found to mean information used in the insured's business, nor a "confidential processing method," found to mean a secret process or technique used in the insured's business. Finally, the court held the catchall phrase "other confidential information of any kind" could only refer to the insured's own confidential information because it was part of a sequence pertaining to the insured's secret information and not the secret information of the insured's customers. *Id.* at 833-34.

In *Lambrecht & Assoc., Inc. v. State Farm Lloyds*, 119 S.W.3d 16 (Tex. App. 2003), the insured was found to have coverage under its policy for its business income loss and extra expense the insured incurred after a virus shut its computer systems down and damaged its software and data. The policy specifically stated it would pay for accidental direct physical loss to electronic media and records, defined to include storage media, electronic data, storage media and the data stored on such media. *Id.* at 25. State Farm Lloyds argued the injection of the virus was not accidental and there was no coverage for the damages that resulted from the virus. The court disagreed and held the injection of the virus and the resulting damage was an unexpected and unusual occurrence and was, from the insured's view, unexpected. *Id.* at 21. State Farm also contended that an exclusion pertaining to electronic data losses caused by an error in programming applied to losses caused by the virus, but the court held the injection of a virus was not an error in programming. *Id.* at 25.

Conclusion

The advancement of cyber risks and policy forms to address those risks are still in the early stages of development. How the courts will address cyber loss coverage disputes will likely be on a case by case basis according to the specific facts of the loss and the particular language of the applicable insurance policy.

Mr. Gross is the managing partner of, and **Mr. Jacobellis** special counsel in, the California office of the firm.

This article accompanied a presentation Mr. Gross gave at the Defense Research Institute's "Insurance Coverage and Claims Institute Seminar" on April 7, 2016 in Chicago.

Health Republic's Curious Liquidation: Committees Would Help

By: James Veach

Health Republic Insurance of New York, New York's only Affordable Care Act non-profit health insurer, has finally been placed in liquidation. Health Republic's liquidation definitely could use a Policyholders' Committee and a Health Providers' Committee to sort out how this failed insurer will be wound up, particularly given the liquidation's chaotic and belated commencement.

Health Republic's failure took up a substantial part of the New York Senate Insurance Committee's June 8th confirmation hearing for then-Acting Department of Financial Services (DFS) Superintendent of Insurance Maria T. Vullo[1] and certainly got a lot of attention when it failed. For those familiar with Health Republic's demise, skip to: "Liquidating Health Republic." For those who are not familiar with the Health Republic story, a little background is in order.

Non-Profit Obamacare CO-OPs

The 2010 Affordable Care Act (ACA) included a Consumer Operated and Oriented Plan Program to create nonprofit insurance companies or CO-OPs. Congress intended for these CO-OPs to compete against larger (and increasingly fewer) for-profit health insurers like Anthem, UnitedHealthcare, and Aetna.

Under the ACA, the federal government's Department of Health and Human Services (HSS) and its Centers for Medicare & Medicaid Services (CMS) were to provide capital for the CO-OP program.[2] Congress, however, did not pre-empt state regulatory oversight over the CO-OPs themselves[3]. As a result, even though federal tax dollars funded the CO-OPs, state insurance regulators remained responsible for CO-OPs operating in their states. In New York's case, that meant that NY's DFS had to approve Health Republic's rates and policy forms and assure that Health Republic stayed solvent.[4]

Twenty-three Affordable Care Act CO-OPs were ultimately established in twenty-six states. For a comprehensive, albeit arguably partisan, review of the CO-OP program and the poor job done by the federal government overseeing the CO-OP program, see *Failure of the Affordable Care Act Health Insurance CO-OPs*, Majority Staff Report of the Permanent Subcommittee on Investigations for the Committee on Homeland Security and Governmental Affairs (March 10, 2016) (Portman Report).[5]

Freelancers' Union Applies to the CO-OP Program

In February 2012, the CMS approved the Freelancers Union's application to participate in the CO-OP Program. The Freelancers Union is a non-profit, New York-based organization that advocates for and makes health insurance available to its more than 300,000 members, most of whom work as consultants, independent contractors, temps and part-timers and more than half of whom live in New York State.

When CMS approved Freelancers' application to participate in the CO-OP program, CMS also approved two loans: (1) a $23.7 million start-up loan and (2) a $151 million solvency loan. The solvency loan covered capital reserves and other solvency requirements imposed by the DFS.

In July 2013, the DFS licensed Freelancers to write health service indemnity coverage. In October 2014, Freelancers had changed the name of its CO-OP to Health Republic of New York. The DFS approved Health Republic's proposed rates, rates that were far lower than any of its competitors'.

In September 2014, the CMS approved an additional $90 million loan to Health Republic in order to satisfy reserve requirements set by the DFS. This brought the total solvency funding to about $241 million. (Health Republic later sought an *additional* $70 million loan, but by then HHS had exhausted its CO-OP loan authority and Congress had refused to provide further funding.)[6]

The DFS required that Health Republic, now a licensed NY health insurer, submit annual and quarterly financial statements to the Superintendent. Health Republic was also subject to examination by the DFS at any time. Health Republic opened offices located at 30 Broad Street in Manhattan, literally around the corner from DFS's offices.

Health Republic's Short, Unhappy Life

Health Republic began writing on January 1, 2014. Within hours, 30,000 people signed up, including five new enrollees who were admitted to Memorial Sloan Kettering Cancer Center for expensive treatment. For a comprehensive take on how and why Health Republic failed, *see* M. Waldholz, *The short and chaotic life of an Obamacare darling*, Crain's New York Business; http://www.crainsnewyork.com/article/20160417/HEALTH_CARE/16041989 (Crain's Article).[7]

The Crain's Article describes many mis-steps, including management's decision to set rates below those recommended by its actuaries at Milliman, Inc. and the Superintendent's approving those too-low rates and then the Superintendent's refusing to allow a new Health Republic CEO to increase Health Republic's rates.

The Crain's Article also addresses what Mr. Waldholz characterizes as the DFS's failure to monitor Health Republic. Although Health Republic lost more than $77 million in its first year of operation, the DFS waited until early 2015 to demand monthly, as opposed to quarterly or annual, financial statements and allowed Health Republic to continue to issue policies until October 31, 2015. By that time, Health Republic had lost $544 million in 2015 alone.

In January, joint New York State Senate Committees on Health and Insurance conducted a hearing in Albany concerning Health Republic's collapse.[8] During the hearing, Insurance Committee Chairman James L. Seward asked, but was not answered, why the Acting Superintendent of Insurance had not already petitioned to place Health Republic in receivership.

Liquidating a Failed NY Insurer

New York-domiciled insurers that fail are placed in liquidation under New York Insurance Law Article 74.[9] Since 1909, the New York Liquidation Bureau (NYLB), a non-New York-State agency that operates outside the DFS (and its Division of Insurance), has overseen the rehabilitation or liquidation of troubled/failed New York insurers.[10] Under Article 74, New York insurance company liquidation proceedings are subject to the exclusive jurisdiction of a New York Supreme Court Justice.

Article 74 calls for the Superintendent, in her/his role as liquidator to prepare a plan to liquidate the insurer.[12] Within 180 days after the order of liquidation has been entered, the Superintendent should apply to the court with a proposal to disburse the failed insurer's assets.[13]

Claimants, be they policyholders, general creditors, or others, are to submit their claims against the estate within four months of the entry of the liquidation order pursuant to a claims procedure devised by the Superintendent, although this four-month claim submission deadline is often extended.[14] Claims are then divided into nine classes and, under the court's supervision, every claim in each class is paid in full before the members of the next class receive any payment.[15]

Health Republic's Liquidation

The receivership process for Health Republic is off to a slow start.

About half of the original twenty-three ACA CO-OPs had failed by early 2016.[16] Nevertheless, New York was one of the last states with a troubled CO-OP to place its CO-OP under supervision or in rehabilitation or liquidation.

State insurance regulators in Iowa, Nebraska, Louisiana, Nevada, Kentucky, West Virginia, Tennessee, Colorado, and Oregon obtained orders of supervision, rehabilitation, or liquidation for failed CO-OPs in late 2014, throughout 2015, or by the latest January 2016.[17]

The DFS directed that Health Republic cease writing new policies on September 25, 2015 but did not cancel Health Republic's existing policies. Nevertheless, acting on a subsequent DFS and CMS review of the company's finances, the DFS and CMS announced on October 30, 2015 that it would be "in the best interest of consumers to end all Health Republic policies ... on November 30, 2015."[18]

Even though Health Republic had at that point lost more than half a billion dollars and would receive no additional HHS funding and even though Health Republic's board had consented in October 2015 to have the company placed in liquidation, the DFS waited until April 22, 2016 to petition for an order liquidating Health Republic and placing it under court supervision.

In almost all instances, the NYLB works in conjunction with state guaranty insurance funds that pay, up to a statutory limit, approved policyholder claims. Although New York has several different guaranty funds for policies written by insolvent insurers writing property-casualty, life, workers' compensation, and automobile insurance, New York does not have a guaranty fund for a failed health insurer, including an ACA CO-OP. While policyholders in CO-OPs in Colorado, South Carolina, and Iowa have access to guaranty funds, Health Republic's policyholders have no guaranty fund capable of paying some or all of their allowed unpaid medical claims.

The Liquidation Begins

In New York, the liquidation process usually begins with an application from the New York Attorney General for an order to show cause (OTSC) why the insurer should not be placed in liquidation. In the case of a domestic insurer, notice of the OTSC must be given to the insurer's president with constructive notice usually provided to its policyholders through publication in newspapers or by other means as required by the court issuing the OTSC.[19]

The Health Republic OTSC required service on only one person: Ronald J. Vance, Jr. Mr. Vance, however, is not Health Republic's president. Mr. Vance is the Chief Restructuring Officer of Health Republic and an employee of Alvarez & Marsal, a financial advisory firm that is assisting with Health Republic's run-off.[20]

Although the OTSC did not direct that notice be mailed to Health Republic's policyholders and health providers, on May 10th about five dozen Health Care members/policyholders, as well as a few health providers represented by counsel, crowded into Justice Carol Edmead's courtroom on the fourth floor of 60 Centre Street.

The court quickly discovered that many Health Republic policyholders attending the hearing spoke only Spanish. The court directed that a Spanish interpreter translate the proceedings. After an Assistant Attorney General completed his presentation urging that a liquidation order be entered, the court determined that no objections to the liquidation itself had been filed and granted that part of the application.[21]

Interestingly, counsel who had been representing Health Republic after the DFS directed that Health Republic cease writing business or paying claims, but *before* the Liquidation, Weil, Gotshal & Manges, then addressed the court as counsel for Acting Superintendent Vullo.

Although no party opposed the liquidation itself, an objection had been filed concerning the scope of an injunction within the proposed liquidation order. This provision would enjoin not only the commencement or prosecution of any action against Health Republic, the NYLB, or the Acting Superintendent in her role as Liquidator, but would also bar any action on her claim against the DFS and would thus enjoin the pro-se objector's previously commenced suit against the DFS.

The court denied the motion to modify the injunction, but you can find on another website — www.HealthRepublic.org — a copy of the papers objecting to the scope of the injunction. This website is maintained by the Garden City Group, which describes itself on its website as an organization that handles "complex class action settlements, bankruptcy reorganizations, mass tort administrations and legal notice programs like no one else."

No NYLB Involvement

Ordinarily, the NYLB marshals a failed insurer's assets, collects all records, establishes a claims procedure, processes policyholder claims, collects reinsurance, and otherwise winds up the company. Although Acting Superintendent Vullo has designated two persons at the NYLB and one former NYLB employee who now works at the DFS, as her agents with respect to Health Republic, at this point it appears that the NYLB's role with respect to NY's failed CO-OP is confined to posting court orders on its website.

With respect to their claims, Health Republic's policyholders are, at this point, being directed to the website maintained by the Garden City Group. This website advises that Health Republic's policyholders should "submit their claims for out-of-network services by March 31, 2016 in accordance with the procedures and deadlines set forth in their insurance policies" and that they will receive an "Explanation of Benefits statement[] ... as soon as available."

Brokers and vendors, however, are told not to bother filing claims in that "it is highly unlikely that Health Republic will have sufficient funds to pay any claims," other than administrative expenses, *i.e.*, the expenses

presumably already incurred and being incurred by vendors such as Alvarez & Marsal, the Garden City Group, and Weil, Gotshal.

Health Republic's last quarterly financial statement covered the period ending on June 30, 2015. At this point, it remains unclear how much of Health Republic assets remains or when the Liquidator will establish an Article 74 claims procedure.

Nothing has been posted on the NYLB or the Garden City websites with respect to Health Republic's assets and liabilities. Under these circumstances, committees of policyholders and health providers would assist greatly in opening up and expediting Health Republic's liquidation.

Committees in Bankruptcy and Insurance Receiverships

The U.S. Bankruptcy Code provides for committees in both liquidation (Chapter 7) and reorganization (Chapter 11) proceedings.[22] In a Chapter 7 Liquidation proceeding, the court *may* appoint a creditors' committee consisting of not more than eleven or fewer than three creditors, but the committee's members are usually not reimbursed for their time or expenses.[23]

In a Chapter 11 Reorganization, the Trustee *must* appoint a committee of unsecured creditors.[24] A Chapter 11 creditors' committee may consist of representatives from entities that hold the seven largest claims against the debtor. Creditors' committees are usually formed within a few weeks of the commencement of the case.

The Bankruptcy Court may also appoint other committees, including multiple creditors' committees or committees consisting of equity security holders. These committees may retain attorneys, accountants or other professionals to advise the committees, and the court may reimburse members of the committees subject to limitations in the Code.[25]

Under the McCarran-Ferguson Act, 15 U.S.C.A. § 1012(b), state insurance company insolvencies are conducted under the law of the state in which the insurance company is domiciled. These state laws are derived from model laws drafted by the National Association of Insurance Commissioners (NAIC). These model laws and state statutes do not specifically address the use of committees in insurance company insolvencies.[26] Nevertheless, committees have been effectively used in insurer receiverships in New York.

In the liquidation of Midland Insurance Company, which began in 1986 and continues today, Justice Michael Stallman, at the urging of the then-Liquidator's outside counsel, brought together Midland's major policyholders and Midland's larger reinsurers to explore how to resolve asbestos-related claims and to structure a framework in which the Liquidator could collect reinsurance for those claims.

In June 2006, four of Midland's major reinsurers and twelve of its Fortune 500 policyholders crafted a Case Management Order (CMO) that allowed Justice Stallman to address issues that stood in the way of collecting Midland's reinsurance, including what law should be applied to determine coverage questions and how reinsurers might participate in the Liquidator's claims determinations.

The CMOs produced by these committees and so-ordered by Justice Stallman allowed the policyholders to move to resolve a choice of law dispute that eventually resulted in a Court of Appeals determination upholding Justice Stallman's ruling.[27]

Years before Midland, Supreme Court Justice Walter Schackman concluded that a cedants'/creditors' committee would help the Liquidator of Constellation Reinsurance Company evaluate proposals to bring Constellation, a failed professional reinsurance company, out of liquidation. Pursuant to that order, the creditors' (actually cedants') committee passed information back and forth between Constellation's cedants and the Liquidator.[29]

The committee's membership fluctuated and at various times included representatives from reinsurance intermediaries, attorneys for cedant companies, and non-lawyers from the cedants themselves. Neither the committee members nor the committee's co-counsel were paid from Constellation's assets and the committee also paid for the cost of copies, postage, and Federal Express.

In 1991, Zurich Reinsurance Company of New York offered to buy Constellation pursuant to a 100% quota share contract. The committee gathered comments and obtained several changes to the proposal. At a hearing that approved the Zurich proposal and took Constellation out of liquidation, Justice Schackman noted that the committee's counsel and the committee itself had been "very helpful."

Policyholders' and creditors' committees have also played useful roles in insolvency proceedings in Pennsylvania (Mutual Fire)[30] and Missouri[31] (Transit Casualty). Although receivers in some jurisdictions have successfully prevented the formation of creditors' or policyholders' committees, or at least the formation of formally recognized committees whose members would be reimbursed by the estate for professional fees or other expenses, even those courts have left the door open to "unofficial or informal" committees of policyholders.[32]

Health Republic is not a typical insurance company receivership and cries out for committees of policyholders and medical providers to promote the transparency needed to understand how New York intends to step up and address the loss of taxpayer monies and the unpaid or unreimbursed losses sustained by more than 200,000 Health Republic policyholders and health providers.

The Need for Transparency and Committee Involvement

Health Republic policyholders include many energetic and alert writers, assistants, and part-time employees who can add value and shine light on the liquidation. Health Republic health providers are, in many cases, represented by in-house or outside counsel, as well as trade associations, but thus far have been only observers in the Health Republic liquidation. The health providers (and their counsel) should bring their resources and considerable talents to the Health Republic liquidation.

Here are a few of the areas that the committees could explore:

1. Timeline. The New York Senate Insurance Committee and others have asked about the delay in liquidating Health Republic, but regardless of the explanation, how long will the Health Republic liquidation take? Committees are needed to press for a timetable and an end-game for the liquidation.

2. Proofs of Claim. Policyholders have been promised an "explanation of benefits" with respect to their unreimbursed claims, but nothing has been announced with respect to filing proofs of claim. "Deadlines are set for filing proofs of claim in order to encourage all claimants to file promptly, making possible an early partial distribution of the insurer's assets."[33]

Committees should have input with respect to the filing of proofs of claim. Committees should also participate in the drafting of any case management orders.

3. Assets and Liabilities. Nothing has been posted on the NYLB or Health Republic websites with respect to Health Republic's assets and liabilities. The New York State Senate has passed a measure that would create a special "Health republic insurance of New York fund" that would collect monies from certain fines, tobacco settlements, lotteries, and other fees and authorize the Superintendent of the DFS to distribute that money pursuant to "terms to be set forth in a future chapter of the law," but the bill provides that these monies may only be distributed after distribution of all assets in connection with a [Health Republic] liquidation proceeding.[34] This measure passed in the Senate, but no similar action has been taken in the Assembly.

Committees could ask about measures like these and give both health providers and policyholders a voice with respect to how the lack of a guaranty fund for Health Republic will be addressed, both in the Liquidation Court and in the New York Legislature. And committees certainly should be heard with respect to the posting of reports on Health Republic's remaining assets.

4. Administrative Expenses. At this point, it is unknown how much in Health Republic assets has been spent from October 2015 to date on outside vendors and counsel working, presumably, at the direction of the DFS.

At the May 10th liquidation hearing, counsel for the then-Acting Superintendent stated that there exists a reinsurance arrangement, pharmacy rebates, and "certain amounts that Health Republic is entitled to receive from federal programs" that may be collected.[35] Counsel also promised that "financial statements" would be prepared "during the liquidation" to "apprise the Court of the liquidator's progress," but no dates were offered as to when these reports will be made available. Committees could monitor and comment on these reports.

5. Recoupment. Actions have been commenced in other states to recover monies from the federal government on behalf of failed CO-OPs. Complaint, *Health Republic Insurance Company [of Oregon] v. United States of America*, No. 16-259 C (Ct. Fed. Cl. February 24, 2016). This action seeks to recover monies allegedly promised by the federal government under the reinsurance and risk-sharing provisions of the Affordable Care Act. Health Republic (Oregon) shut down in October 2015, but continued paying claims and has not yet been liquidated. Another Oregon CO-OP, Oregon's Health CO-OP, survived the reduced amount of federal risk-sharing monies and continues in operation.[36]

In Iowa, Commissioner Nick Gerhart took over CoOpportunity Health, Inc., an Iowa CO-OP, in December 2014 and placed the company in liquidation in February 2015. Unlike New York, the Iowa liquidation order provided a claims procedure and the federal government has already filed a proof of claim against the CoOportunity estate. Commissioner Gerhart seeks a declaration that the federal government is not entitled to priority claim status in the government's efforts to recoup solvency loans that Gerhart claims are subordinated to policyholder claims. *Gerhart v. U.S. Department of Health and Human Services*, No. 16-cv-00151 (S. D. Iowa May 3, 2016).

Committees of Health Republic policyholders and health providers

should be given standing to address how claims on behalf of and against the Health Republic estate will be handled and to explore whether New York's Acting Superintendent will commence similar actions.

As one attorney with experience working for and with the liquidators of insolvent insurers put it while advocating for policyholder committees: "The desirability of creditors' committees is manifest. After all, it is the creditors who paid good money for bad insurance. They are the only ones who are hurt by the insolvency."[37] In Health Republic's case, the need is even more manifest.

Health Republic has no guaranty funds to pay policyholders or providers. Nor are there any private investors; all of Health Republic's capital came from federal taxpayers. And most of Health Republic's policyholders and health providers are New York residents. For that reason, the Health Republic liquidation poses a fraction of the difficulties posed by the failures of large 50-state multi-line insurers like Midland or Union Indemnity.

Policyholders shouldn't be shunted to a third-party website and provided almost no information on their claims other than being told that an explanation of benefits may be headed their way one of these days. The Health Republic liquidation should be conducted in the open so that additional monies will not be wasted by outside vendors whose work remains unevaluated and largely unknown.

While advocates for committees in U.S. insurer liquidations have argued that only creditors can push for such committees, in this case Superintendent Vullo should take the lead. Health Republic's policyholders and health providers should not be kept in the dark with only a website and a few FAQs to guide them. Health Republic should be wound up quickly and with as much policyholder and health provider participation as possible.

And if the federal government intends to seek a priority claim status in the Health Republic liquidation, let's find that out sooner rather than later. Committees would bring light and energy into the Health Republic liquidation, which was adjourned on May 10th without date, and help avoid having New Yorkers suffer a second Health Republic debacle, this one during its liquidation.[38]

Mr. Veach is of counsel in the New York City office of the firm.

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Endnotes

1. Acting Superintendent Maria T. Vullo's testimony during her June 8, 2016 confirmation hearing may be viewed at https://www.nysenate.gov/calendar/meetings/insurance/june-08-2016/insurance-meeting. The NY State Senate confirmed Governor Andrew Cuomo's appointment of Ms. Vullo on June 15, 2016.
2. The Affordable Care Act also provided certain "risk sharing" mechanisms to shift funding among the CO-OPs and provide certain excess reinsurance in order to help these new insurers deal with policyholders, many of whom were previously uninsured. *See generally*, Durkin & Taylor, Emerging Disputes Over Risk Sharing Under The ACA, www.law360.com/articles.785120/emerging-disputes-over-.
3. Under the McCarran-Ferguson Act, 15 U.S.C.A. §§ 1011 et seq. (2016), Congress left the business and regulation of insurance to the states unless a Federal statute "specifically relates to the business of insurance." *See United States v. Fabe*, 508 U.S. 491, 493, 498 (1993).
4. *See generally, Obamacare's CO-OPs: The "Charter Schools" of Health Care*, 17 Quinnipiac Health Law Journal 105 (2013-2014).
5. Senator Portman left Congress in 2005 to serve as the United States Trade Representative and then served as the Director of the Office of Management and Budget under President George W. Bush.
6. Portman Report, p. 43, n. 257.
7. Crain's commissioned this article, supported in part by a CUNY Journalism School Grant. Mr. Waldholz is a Pulitzer-winning former editor and journalist at the Wall Street Journal and Bloomberg News.
8. You can view a video of the hearing at: https://www.nysenate.gov/calendar/events/insurance/james-l-seward/january-06-2016/demise-health-republic-and-preparing-future.
9. *See generally*, NEW APPLEMAN NEW YORK INSURANCE LAW (2d. Ed.) Vol. 3, Ch. 45 (2015) (APPLEMAN).
10. *Dinallo v. DiNapoli*, 9 N.Y.3d 94, 103 (2007) ("The Bureau is not part of the Insurance Department's budget, operates without the benefit of state funds, maintains its own errors and omissions coverage, and is represented by its own private counsel, not the Attorney General, as is normally the case when a state agency is sued.") For a comprehensive critique of the Bureau and how it might be improved and restructured, see P. Bickford, *New York's Liquidation Bureau: a Critical Analysis*, Parts I and II, Insurance Advocate, No. 10 (May 18, 2009) at 18 and No 11 (June 1, 2009 at 24.
11. *Knickerbocker Agency, Inc. v. Holz*, 4 N.Y.2d 245, 252 (1958 quoting *Motlow v. Southern Holding & Securities Corp.*, 95 F.2d 721, 725-26 (8th Cir. 1938) ("[I]t is essential that the title, custody, and control of the [insolvent insurer's] assets be entrusted to a single management under the supervision of one court.")

12. In re *Lawyers Title & Guar. Co.*, 254 App. Div. 491, 495, 5 N.Y.S.2d 484, 487 (lst Dept. 1938), reh'g denied, 255 A.D. 1032, 9. N.Y.S. 2d 126 (lst Dept. 1938) ("The Superintendent may not be compelled to surrender his trust created by statute. * * * He may ask the help of the Court in solving the problems which arise from time to time but all propositions for the liquidation of the corporation must be approved by him." * * * There is nothing to prevent the Superintendent himself from negotiating with parties interested for the formulation of an appropriate plan of liquidation, and, when he has decided upon such plan, it may be submitted for the approval or disapproval of the court.")
13. NYIL § 7405 (f)(1).
14. NYIL § 7432(b).
15. NYIL § 7434.
16. C. Borrelli, *What The Demise of Insurance Co-Ops Says About the ACA*, www.law360.com/articles.748140.What-the-demise. (January 22, 2016).
17. Portman Report, pp. 10-15.
18. NYDFS, NYSOH, CMS Announce Additional Actions Regarding Health Republic Insurance of New York: http://www.dfs.ny.gov/about/press/pr1510301.htm. The New York Department of Health then oversaw an emergency effort to enroll Health Republic policyholders with fifteen other NY health insurers.
19. NYIL §7418 (a)(1).
20. Crain's Article at 11/19 ("The insurer's office in downtown Manhattan shut down in November and its assets, if any, are being managed by the restructuring firm Alvarez & Marsal, which didn't return calls for comment.").
21. The court also directed that a copy of a transcript of the May 10th proceeding, including a Spanish translation, be posted on the NYLB: www.NYLB.org.
22. 11 U.S.C.A. § §705, 1102.
23. 11 U.S.C.A Section 705.03[3].
24. 11 U.S.C.A. § 1102.
25. See *generally* COLLIER BANKRUPTCY MANUAL (co-chief editors Alan N. Resnick and Henry J. Sommer), chs. 705, 1102, 1103 (2008).
26. See D. Hartz, *Creditor Committees, Constituencies, and Constitutions*, The Insurance Receiver, Vol. 9, No. 4 (Winter 2000).
27. *In re Liquidation of Midland Insurance Company*, 16 N.Y. 3d 536, 542 (2011) ("Consequently, during the spring of 2006, the parties negotiated and agreed upon a proposed case management order * * * The CMO set forth a procedure to resolve the legal disputes between the parties . . . ."); see also, *Veach and Milrad, Threshold Choice-of-Law Analysis Required for Each Midland Policy*, Mound, Cotton, Wollan & Greengrass Newsletter, Vol. 18, Issue # 3 (2011); see also, *T. McCarthy, Creditors' Committees in U.S. Insolvencies – the Wave of the Future (Only if Creditors Demand it!)* at 18, Insurance Receiver, Vol. 9, No. 3 (2000) (McCarthy, Creditors' Committees).
28. *In re Liquidation of Constellation*, Index No. 43178/1986 at 7 (1990).
29. J. Veach, *Creditors' Committees: The Constellation Story*, Insurance Receiver, Vol. 10, No. 1 (Spring 2001) at 18-21.
30. *Foster v. The Mutual Fire, Marine and Inland Insurance Company (appeal of the cedent's committee)*, 544 PA 387, 404 (1996) (Supreme Court agreed with committee's argument that fee petitions should not be filed under seal).
31. McCarthy, Creditors' Committee at 18 discussing ad hoc committee of guaranty associations established during the Transit Casualty Insurance Company liquidation, as well as a proposed creditors' committee.
32. *In Re Liquidation of Integrity Ins. Co*, 231 N.J. Super 152, 161, 555 A.2d 50 (Ch. Div. 1988).
33. APPLEMAN § 45.09[4] at 45-52.
34. NY LEGIS 54 (2016) Sess. Law News of N.Y. Ch. 54 (S. 6406-C, Part LL amending NY State Finance Law § 99 (McKinney's).
35. May 10th Liquidation Hearing Trans. at 18.
36. N. Budnick, *Health insurer beats odds with luck*, caution: http://portlandtribune.com/pt/9-news/294025-169504-health-insurer-beats-odds-with-luck-.
37. McCarthy, Creditors' Committees at 18.
38. For an outrageous example of all that can go wrong in an insolvency proceeding in which outside vendors played a huge role, but no policyholders' or creditors' committees participated, see B. Coffin and others, *The Complete ELNY Saga: 21 Years of Mismanagement, Corruption, Broken Promises, and Shattered Lives*, HealthPro: http://www.lifehealthpro.com/pages/the-complete-elny-saga.php?slreturn=1466011347; P. Bickford, *The Elephant in the Courtroom*, AIRROC MATTERS, Summer 2012 at 6.

When Property Insurance Policies are Enforced as Written: Lessons from *HP Hood*

By: Jeffrey S. Weinstein and Jared K. Markowitz

Manufacturers of goods face the constant risk of loss caused by hidden defects and production errors. Left undiscovered, such issues can lead to batch-wide product contamination, recalls, and even reputational costs. Many manufacturers are opting to protect themselves by purchasing specialized insurance against the risk of such recall-related or food-contamination costs. But when policyholders in the manufacturing industry elect instead to purchase no more than a general "all risks" property insurance policy – which will almost always exclude faulty workmanship/design – they are often left without coverage, and rightly so.

One policyholder, H.P. Hood LLC, learned this the hard way when the Massachusetts Court of Appeals recently upheld a denial of coverage pursuant to a faulty workmanship/design exclusion for nearly two million faulty beverage products that H.P. Hood had destroyed. *See H.P. Hood LLC v. Allianz Global Risks U.S. Ins. Co.,* 39 N.E.3d 769 (Mass. Ct. App. 2015). Following a recent Law360 article [link to: http://www.law360.com/articles/732774/when-all-risks-insurance-policies-fall-short] arguing that the case was decided incorrectly, this article takes the opposite view and explains why the court got it right.

The Facts

The insured is H.P. Hood, a company that manufactured certain bottled beverage products for a third-party customer. The finished beverage products are supposed to be "shelf stable," such that the unrefrigerated products do not go bad over time so long as the products remain securely sealed. To ensure that the products are securely sealed, H.P. Hood must screw the caps onto each bottle using a certain amount of circular force (or "torque").

Following a 2009 production run of nearly two million products, H.P. Hood discovered that a significant number of bottles were not sealed securely. Subsequent testing revealed that the problem had to do with the bottle caps in that their liners became more slippery over time. This affected the amount of torque that H.P. Hood needed to use to seal the bottles properly. Since the production process H.P. Hood used for the run at issue did not take into account the particular age of the bottle caps, some caps did not receive optimal torque when the bottles were capped.

H.P. Hood's customer refused to accept any finished products from the production run at issue, because the products were no longer marketable, even though not all of the nearly two million products had spoiled. H.P. Hood therefore made the business decision to destroy all of them.

H.P. Hood then sought coverage for the nearly two million destroyed products under H.P. Hood's general "all risks" property policy issued by Allianz Global Risks U.S. Insurance Company. Allianz denied coverage in part on the basis of an exclusion for "faulty workmanship, material, construction or design, from any cause." The trial court upheld Allianz's denial of coverage on this, among other, grounds, and H.P. Hood appealed.[1]

The Court of Appeals Decision

On appeal, H.P. Hood argued that the faulty workmanship/design exclusion at most precludes coverage only for the bottle caps themselves, and that the loss of the product inside the bottles is covered. H.P. Hood asserted this argument on the basis of the following exception to the exclusion, commonly referred to as an "ensuing loss" or "resulting loss" provision: "This 'policy' does not cover [faulty workmanship, material, construction or design, from any cause], but if physical loss or damage not otherwise excluded by this 'policy' to Insured Property at Insured Location(s) results, then only such resulting physical loss or damage is covered by this 'policy.'"

The Court of Appeals rejected H.P. Hood's argument, siding instead with Allianz. The court first explained that the exclusion's plain language applied here: "[T]he plain language of this exclusion applies to the bottle cap liner issue, whether that problem be viewed as one of faulty 'material' (the fact that the characteristics

of the bottle cap liners changed as they aged), faulty 'workmanship' (the failure by [H.P.] Hood to apply the correct torque), or faulty 'design' (the fact that the bottling process did not take into account the changes to the liners as they aged)."[2]

The court then explained that the exclusion's exception for "resulting loss" does not "sweep[] back into coverage all losses caused by faulty workmanship and, in any event, such a reading would render the exclusion of no effect (something the parties are presumed not to have intended)."[3] The court observed that other courts, facing similar exclusions with exceptions, have advised that, at the very least, there must be two "'separable events'": one that led to the excluded damage and one that led to "resulting losses" that thereby would fall within the exception thereto; moreover, the "'ensuing loss must be different in kind, not just degree.'"[4]

H.P. Hood Was Decided Correctly

The *H.P. Hood* court interpreted the "resulting loss" exception to require that some separate, covered event take place that leads to property damage separate from the excluded, faulty workmanship/design damage. Here, the court correctly held that the problem with the bottle cap liners "directly rendered the entire product unsaleable," and the "loss of that product falls squarely within the exclusion language."

The main criticism of the case [link to: http://www.law360.com/articles/732774/when-all-risks-insurance-policies-fall-short] is that the court's interpretation of the "resulting loss" exception to the exclusion supposedly rendered the exception "illusory." That critique is clearly unfounded.

A policy coverage provision would be rendered "illusory" where, unlike here, the provision is interpreted such that it becomes practically impossible for an insured to obtain coverage under any set of facts. The court's interpretation of the "resulting loss" exception here does not render it illusory; under the present facts, for example, if the bottle-cap issue had caused liquid inside the bottles to leak out, leading to the growth of mold on the shelves and floors of the facility that housed them, such losses would most likely have been considered to constitute "resulting losses." The court here correctly construed the "resulting loss" provision to be no more than an exception to the general exclusion, thereby allowing the court to enforce the exclusion as written.

Lessons From *H.P. Hood*

Manufacturers of products, particularly food products, that elect not to purchase specialized insurance that specifically covers losses arising out of product defects, contamination, and/or recalls, do so at their own peril. As the *H.P. Hood* decision shows, courts will enforce exclusions in general property insurance policies exactly as written, including exclusions for faulty workmanship/design. Policyholders are well advised to read their policies and to know exactly what is covered and what is excluded, and to ensure that they have purchased additional coverage to fill in any gaps as desired.

Mr. Weinstein is a partner and **Mr. Markowitz** is an associate in the New York City office of the firm.

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Endnotes

1. *Id.* at 770.

2. *Id.* at 772-73.

3. *Id.* at 774.

4. *Id.* at 774 (quoting *Holden v. Connex-Metalna*, No. 98-3326, slip op. at 21, 2000 WL 1876338 (E.D. La. Dec. 22, 2000)).

5. *Id.* at 774-75.

News *of the firm*

Mound Cotton Wollan & Greengrass LLP Recognized in Chambers 2016

Chambers and Partners extensively researches law firms and lawyers in the United States. Its objective is to identify and subsequently recognize top firms and individuals in the legal community.

Mound Cotton Wollan & Greengrass was recognized in the category Insurance: Dispute Resolution. In addition to the firm's being acknowledged, senior counsel Lawrence Greengrass and partner Philip Silverberg were recognized as Leading Individuals.

Chambers had the following to say about the firm and the highlighted attorneys:

The team is notable for its work on direct insurance and reinsurance matters. Displays a range of coverage experience relating to catastrophic loss including first party property, business interruption and product contamination. Handles litigation as well as arbitrations with strong capabilities in handling mass and toxic tort claims.

Strengths (Quotes mainly from clients)

"They're absolutely terrific: they really have a broad range of capability which you don't often find. They're very well rounded and, from the perspective of experience, they have it all, it's one-stop shopping for us."

"The team there is good at untying fairly complex fact patterns and drilling down to the real issues."

Notable practitioners:

Lawrence Greengrass is highly respected as a reinsurance-focused attorney who has experience in the life and health and property and casualty spheres in particular. *"It's like hiring two attorneys in one!" quips one impressed client, elaborating that "his advice is quick and efficient, really spot on. He offers a combination of good customer service and deep knowledge of the subject."*

Philip Silverberg has a strong practice in the first-party property and business interruption space, often working with clients during the aftermath of catastrophic events such as earthquakes and hurricanes. Clients are highly impressed with his excellent service, saying: *"He's a great lawyer: very attentive, very responsive, very hard-working. Any need we have, he's immediately there to help us."*

The Chambers list is issued by Chambers and Partners researchers. A description of the selection methodology can be found at http://www.chambersandpartners.com/about-chambers. No aspect of this advertisement has been approved by the New Jersey Supreme Court.

Jill Levy Joins Firm

MCWG is pleased to announce that Jill Levy has joined the firm as a partner. Ms. Levy is a skilled litigation and trial attorney with over 20 years of experience representing domestic and international clients in complex professional liability matters. She is a member of the New York State and American Bar Associations and the Chairperson of the Subcommittee on Directors & Officers Professional Liability and the New York City Bar Insurance Law Committee.

MCWG Partner and Senior Counsel Named Among Best Lawyers in America for 2017

MCWG is pleased to announce that Stuart Cotton, Lawrence S. Greengrass, and Michael H. Goldstein were named Best Lawyers by Best Lawyers in America for 2017 as among the best lawyers in the field of insurance.

Congratulations to MCWG partner Bruce Kaliner, who finished in fifth place in the age 55-59 category in the 2016 New York City Triathlon.

MCWG Partner Costantino P. Suriano Named to Advisory Board of the St. John's University Center for the Study of Insurance

Costantino P. Suriano

Costantino P. Suriano continues his role for the St. John's University Center for the Study of Insurance Regulation as a member of its Advisory Board. The Center for the Study of Insurance Regulation enhances awareness of St. John's School of Risk Management as a center for thought leadership in the field of insurance and reinsurance by creating a forum for candid discourse on the subject of insurance regulation among business leaders, lawmakers and other government officials, educators and others involved in developing and implementing public policy affecting the business of insurance in the U.S. and globally.

MCWG Co-chairs 2016 New York Power Conference

MCWG co-chaired the New York Powercon conference on May 5 at World Trade Center 1. New York Powercon was conceived to fulfill the need for a forum in which the insurance industry could come together to discuss, debate, and learn about the issues relevant to the power generation sector. The 2016 Powercon attracted the largest number of attendees to date. The value of Powercon is in the dialogue among the underwriters, claims professionals, loss adjusters, consultants, and outside counsel that are active in the community of insurance professionals in the power generation sector. The attendees make it possible for Powercon to facilitate a high level of discourse and debate regarding issues of concern and note to the community.

Jeffery S. Weinstein of MCWG

MCWG Co-chairs London Product Recall & Contamination Insurance Symposium

Jeffery S. Weinstein

This symposium was held in London on Thursday, April 28, 2016. MCWG partner Jeffrey S. Weinstein co-chaired and discussed the history, current wording, trends and litigated issues involving crisis management products, including accidental product contamination, malicious product tampering and contaminated products product recall.

MCWG Hosts IRUA Claims and Underwriting Emerging Risks Educational Seminar

Lloyd A. Gura

MCWG hosted IRUA's "Life Cycle of Emerging Risks" program on March 9, 2016. Partner Lloyd A. Gura presented on the topic: "Medical/ Legalized Marijuana" – Discussion of liability aspects and claims arising from the manufacture, sale, and distribution of marijuana for medical use as well as in those states that have agreed to legalize marijuana.

From left to right: Jonathan Gross, MCWG; Philip C. Silverberg, MCWG; Dave DiCenso, Swiss Re; Jonathan Held, J.S. Held LLC; Tom Casson, AIG; John Roberts, AIG

Calendar of Speaking Engagements

Past Events

IRUA Claims and Underwriting Emerging Risks Educational Seminar
March 9, 2016
Mound Cotton Wollan & Greengrass LLP
New York, NY

Partner Lloyd A. Gura presented on the topic: "Medical/ Legalized Marijuana" – Discussion of liability aspects and claims arising from the manufacture, sale, and distribution of marijuana for medical use as well as in those states that have agreed to legalize marijuana.

Re Claims Bermuda 2016
Navigating the World of Reinsurance Protection When Loss Strikes
March 16-17, 2016
Hamilton, Bermuda

Partner Lloyd A. Gura spoke on the topic: "Unique Issues Affecting the Reinsurance Industry Arising out of 2015 Winter Storms."

Enforcement & Interpretation of First-Party Insurance Policies
New Jersey Institute for Continuing Legal Education
NJICLE, a Division of the NJSBA
March 31, 2016
New Brunswick, New Jersey

Partners William D. Wilson and Frank J. DeAngelis presented on the topics: Causation, Anti-Concurrent/ Anti-Sequential Causation Clauses, Damage Coverage issues — *viz.*, property damage, business interruption, Valuation of loss Coverage Defenses — *viz.*, increase of hazard, wear and tear exclusion and ensuing loss exception.

BRMA's Annual Committee Rendezvous
April 20-21, 2016
Princeton, NJ 08540

Senior Counsel Lawrence S. Greengrass spoke on the topic: "Marijuana – Insurance, Legal And Risk Management Issues."

ARIAS·U.S.
Webinar - Sureties & Financial Guarantees - An Overview
April 19, 2016

Partner Amy J. Kallal served as moderator for the webinar, which included a review of the basics of suretyship in general and some key differences from traditional insurance. The panelists also discussed in more detail contract surety bonds and financial guarantee insurance and their related underwriting and claim-handling considerations, as well as applicable regulations and current market issues.

London Product Recall and Contamination Symposium
April 28, 2016
London, England

Partner Jeffery S. Weinstein discussed the history, current wording, trends and litigated issues involving Crisis Management Products, including accidental product contamination, malicious product tampering, contaminated products, product recall.

American Conference Institute's 4th Annual Advanced Forum on Captive Insurance
May 2-3, 2016
The Carlton Hotel
New York, NY

Of counsel James Veach discussed the topic "Captives in Run-Off or Insolvency."

June 23-24, 2016
The Carlton Hotel
New York, NY
Senior Counsel Lawrence S. Greengrass spoke on the topic "The Reinsurer's View of Allocation."

Upcoming Event

Mound Cotton Wollan & Greengrass LLP 3rd Annual New York City Reinsurance Conference in Collaboration with St. John's University School of Risk Management, Insurance & Actuarial Science and Reactions Magazine
September 29, 2016
New York, NY

MCWG partner Lloyd A. Gura will again chair this one-day educational and networking conference for experienced industry professionals. This highly-regarded event is a forum designed for learning from first rate speakers on important and wide-ranging topics impacting all facets of the reinsurance market. The goal is also to provide high-level networking opportunities for individuals responsible for claims adjusting and collections, in-house and outside counsel, brokers and intermediaries, underwriters, actuaries, arbitrators, and experts.

Offices:

New York City Office

One New York Plaza
New York, NY 10004
P: (212) 804-4200
F: (212) 344-8066

Long Island, New York Office

855 Franklin Ave
Garden City, NY 11530
P: (516) 417-5700
F: (516) 741-6831

New Jersey Office

30A Vreeland Road
Florham Park, NJ 07932
P: (973) 494-0600
F: (973) 242-4244

Florida Office

101 NE Third Avenue
Fort Lauderdale, FL 33301
P: (954) 467-5800
F: (954) 467-5880

California Office

1900 Powell Street, 6th Floor
Emeryville, CA 94608
P: (510) 900-9371
F: (510) 900-9381