TORT TRIAL & INSURANCE PRACTICE

Committee News

Defending Liberty Pursuing Justice

Winter 2009

Property Insurance Law Committee

{Before citing any case or legislative enactment that is mentioned or discussed in this Newsletter, be sure to make certain that the decision has not been overruled or modified, or that the statute has not been amended, subsequent to the time this summary was prepared.}

BI-ECONOMY MARKET AND PANASIA ESTATES: DO THEY REALLY CREATE A NEW CAUSE OF ACTION IN NEW YORK?

By: Jay M. Levin

On February 19, 2008, the New York Court of Appeals issued opinions in *Bi-Economy Market, Inc. v. Harleysville Insurance Co. of New York*, 10 N.Y.3d 187, 886 N.E.2d 127, 856 N.Y.S.2d 505 (2008), and *Panasia Estates, Inc. v. Hudson Insurance Co.*, 10 N.Y.3d 200, 886 N.E.2d 135, 856 N.Y.S.2d 513 (2008). In these two cases, New York's highest court held that where an insurance company fails to timely pay amounts due under a property insurance policy it can be liable for consequential damages that are proximately caused by that failure over and above policy proceeds plus interest.

In *Bi-Economy*, the court specifically held that when an insured suffers foreseeable damages, including collapse of the insured's business, as a result of an insurer's excessive delay or improper denial of coverage, the insurance company is liable for those damages, not as a punishment, but to give the policyholder the benefit of its bargain. *Panasia Estates* relied on *Bi-Economy Market* and held that consequential damages resulting from an insurer's breach of its covenant of good faith and fair dealing may be recovered as long as they were within the contemplation of the parties as the probable result of the breach at the time of or before contracting. Both cases also held that policy exclusions for various types of consequential *loss* did not preclude recovery of consequential

damages resulting from an insurer's breach of contract. Although these cases were decided under New York law, their underlying

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MESSAGE FROM THE CHAIR

Dear Committee Members:

Greetings and welcome to the Property Insurance Law Committee. I am looking forward to an outstanding year for the Committee, which I hope includes a record attendance at our Spring Program in May 2009.

My thanks to Jay Levin and his leadership as Chair over the past year. Jay has done an excellent job and I hope to continue to move the Committee forward during my tenure.

Bill Lewis of Butler Papas in Tampa is Chair-Elect this year. Please feel free to contact Bill (wlewis@butlerpappas.com) or me if you would like to become more involved in the Committee or have any questions or suggestions. Our mission is to serve the members of this Committee and we welcome your input and involvement.

The highlight of the coming year will be our Spring Program to be held May 14-16, 2009, at the Hyatt Regency Lost Pines Resort & Spa, located outside of Austin, Texas. The program, titled "De-Constructing Builder's Risk Coverage," is being chaired by Bill Lewis and Paul Burke. Please plan on attending this program. I encourage you to invite your clients and colleagues to this program. The flyer for the program is included as part of this Newsletter. The final brochure for the program should be available sometime in January 2009.

We are planning at least two teleconferences this year, the first of which will take place in the Spring. Tim Penn is in charge of our teleconferences. Please contact Tim (tpenn@travelers.com) if you are interested in assisting with planning and/or managing teleconferences.

The ABA Annual Meeting will be held in Chicago in August 2009. We have submitted a proposal for a program on "The Changing Climate of Insurance." The program, which will be co-sponsored by other committees, will address the risks, challenges and opportunities that insurers face in the context of global climate change. The program will address the impact on property insurance and claims, excess and reinsurance, and directors and officers and liability insurers. Steve Rogers and Thomas Cook of Zelle, Hofman, Voelbel, Mason & Gette are in charge of the program.

We will have several publications in the coming year. Kellyn Muller is in charge of the Committee Newsletter. If you have any case summaries or articles you would like to submit, please contact Kellyn (kmuller@cozen.com). We will continue to publish "Recent Developments in Property Insurance Law" as part of the *Tort, Trial & Insurance Practice Law Journal*. We are in the process of updating our *Bad Faith Annotations*. Bill Schreiner is our publications chair and is in charge of both of these projects. Also, I am pleased that many of our members have had articles published in *The Brief*. The *TIPS Law Journal* is also interested in law review articles. If you are interested in publishing an article in *The Brief* or the *TIPS Law Journal*, please let me know.

I look forward to working with you in the coming year and encourage your participation.

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http://www.abanet.org/tips/scholarship.html

SAVE THE DATE

May 14-16, 2009
Hyatt Regency Lost Pines Resort & Spa
Lost Pines (Austin area), Texas

Property Insurance Law Committee 2009 Spring Meeting

De-Constructing Builder's Risk Coverage

For information about the Lost Pines Resort & Spa, visit: www.lostpines.hyatt.com

To make room reservations at a rate of $269.00 per night, please call 800/233-1234

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FLORIDA SUPREME COURT'S READING OF LOOSE STATUTORY LANGUAGE LEAVES SURPLUS LINES CARRIERS IN DOUBT

By: Anthony J. Russo

In *Essex Insurance Co. v. Zota*, 985 So. 2d 1036 (Fla. 2008), the Florida Supreme Court recently ruled that dozens of regulatory statutes that apply to Florida's highly-regulated, admitted domestic insurers also apply to out-of-state, surplus lines carriers, leaving those carriers wondering how to conduct business in the state of Florida.

Chapter 627, Florida Statutes, contains the bulk of Florida's statutory regulation of insurers. This Chapter is made up of multiple "parts," where each statutory "part" contains a number of individual statutes. One part deals with rates and contracts, another with life policies, others with property and disability insurance, and so on. Some loose language in a prefatory section of Part 1 of the Chapter, entitled "scope of this part" left open a question concerning whether surplus lines carriers were exempt from Part 1 of Chapter 627, or exempt from Chapter 627, as a whole.

This question came to the fore in the *Zota* case, a dispute between Essex Insurance Company (a surplus lines carrier) and its insured as to whether some regulatory provisions within Chapter 627, regarding the delivery of insurance policies and liability for attorney fees, did or did not apply to surplus lines carriers. The Florida Surplus Lines Services Office ("FSLSO"), a state-sponsored, voluntary organization of surplus lines carriers, appeared as amicus on behalf of Essex. FSLSO argued that no part of the domestic insurer regulations in Chapter 627 should be applied to surplus lines.

The Florida Supreme Court rejected FSLSO's arguments and ruled that the "scope" provision, despite its express language exempting surplus lines carriers from the provisions of "this Chapter," really only exempted surplus lines carriers from the provisions of Part One, thereby concluding that the rest of the Chapter applied to surplus lines carriers. The Court reasoned that the Legislature made a scrivener's error when it used the word "Chapter," and that it really meant to use the word, "Part." This ruling raises far more questions than it answered.

The biggest question raised so far seems to be whether and how section 627.410, a statute found in Chapter 627, applies to surplus lines carriers. Section 627.410 prohibits carriers from using any policy form in a policy issued in Florida "unless the form has been filed with the [O]ffice [of Insurance Regulation] by or in behalf of the insurer which proposes to use such form and has been approved by the office." This issue is pending analysis in *CNL Hotels & Resorts, Inc. v. Twin City Fire Insurance Co.*, etc., 2008 WL 3823898 (11th Cir. Aug. 18, 2008).

In *CNL Hotels*, the insured argued that an exclusion in its surplus lines policy was not enforceable because it had not been filed with and approved by Florida's Office of Insurance Regulation ("OIR"), pursuant to section 627.410. The matter made its way to the Eleventh Circuit Court of Appeals. There, the Florida OIR filed an amicus brief explaining why section 627.410 did not require Twin City, the surplus lines carrier, to first file its forms with the OIR and obtain the OIR's approval before using those forms in policies it sold in Florida. As the OIR explained, Florida's surplus lines law only requires non-admitted or unauthorized carriers selling insurance in the state of Florida to be deemed "eligible" by the OIR, and the insurance they seek to sell deemed "eligible for export."

To qualify as an admitted and authorized insurer, privileged to sell insurance in Florida, an insurer must comply with restrictions on its corporate structure, meet capital and surplus requirements, and guarantee the qualifications of its managers, officers and directors. These highly regulated, domestic carriers must also file specified annual financial reports. A failure to comply with these requirements results in revocation of their certificate to do business in Florida.

Because domestic, admitted carriers do not have the capacity to meet all of Florida's residential and commercial insurance needs, out-of-state carriers, not otherwise authorized to conduct business in Florida, may sell their policies under Florida's surplus lines law. Florida's surplus lines law, found in Chapter 626, was created to provide orderly access to insurance coverage sold by unauthorized carriers – coverage that would otherwise not be available to Florida businesses and residents. The law was also designed to protect authorized, admitted insurers, who

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MIDWEST FLOODS 2008: POTENTIAL ISSUES IF PROPERTY CLAIMS POUR IN

By: James R. Swinehart and Bryan S. Chapman

From June 7 through July 1, 2008, significant flooding occurred across parts of the Midwest, causing damage to homes, businesses, and infrastructure. Heavy rain caused numerous rivers to overflow their banks, along with multiple levee breaches throughout the Midwest. Iowa, Missouri, Indiana, Wisconsin and Illinois were the states most affected by the flooding. Damages have been estimated to exceed $8 billion.[1]

In Iowa, the severe flooding led to evacuations of many homes and businesses. In eastern Iowa, along the Iowa River and Cedar River, flooding exceeded that of the Flood of 1993.[2] Major levees in Des Moines and Cedar Rapids were breached, forcing evacuations and causing extensive damage. In Cedar Rapids, city wells were flooded and water use was restricted, as the Cedar River crested at 31.3 feet.[3] In Iowa City, reports estimated that 16-20 buildings at the University of Iowa were under water.[4]

In Indiana, the Governor projected damages from the flooding to exceed $1 billion.[5] Columbus Regional Hospital closed for an extended period of time due to power outages, generator failures, and extensive flood damage.[6] The hospital is expected to resume operation by December 2008.[7]

In Missouri, flooding caused the Mississippi River to crest 10 feet above flood stage in the city of Hannibal on June 10 and continued to be at or near flood stage for the rest of the month. A levee along the Mississippi River in Lincoln County breached at the end of June, forcing the evacuation of around 100 homes.[8]

The Midwest flood waters could give rise to many insurance coverage claims. Here, some of the potential first-party property coverage issues are identified, as well as holdings from courts on similar issues.

A. DAMAGE TO PROPERTY BY FLOOD WATERS

1. *The Flood And Surface Water Exclusions*

Many property policies contain a "flood" exclusion. Though the language may slightly vary from policy to policy, a "flood" exclusion in a homeowners policy often does not cover "any damage due to flood, surface water, waves, tidal water or overflow of a body of water, whether or not driven by wind."[9] Courts have routinely found these provisions to be enforceable. If the term "flood" is not defined in the policy, courts usually apply a plain meaning to the term.

For example, in an Illinois case, where a man-made watercourse overflowed and inundated the insured's home, the court held that the plain meaning of "flood" was "water that escapes from a watercourse in large volumes and flows over adjoining property in no regular channel, ending up in an area where it would not normally be expected."[10] Another Illinois court has defined "flood" as the "rising and overflowing of a body of water that covers land not usually under water."[11] In defining "flood," Illinois courts have refused to

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1 http://www.ncdc.noaa.gov/oa/climate/research/2008/flood08.html#impacts.

2 Iowa City Press-Citizen. "*Officials: Flood of 2008 To Be Worse Than Flood of '93*." Iowa City Press-Citizen, June 6, 2008.

3 Adam Belz, "*Cedar River Dropping Faster Than Expected*," Cedar Rapids Gazette, June 15, 2008, p.1.

4 Diane Heidt, "*Hancher Joins List of Flooded Buildings at UI*," Cedar Rapids Gazette, June 16, 2008, p.1

5 http://www.insideindianabusiness.com/newsitem.asp?ID=29796.

6 The Republic. "CRH Communications, Saturday Update."

7 *Id*.

8 "Floodwaters breach Mississippi River levee." CNN.com (2008-06-27).

9 ISO Homeowners Policies HO 00 03 10 00.

10 Wallis v. Country Mut. Ins. Co., 723 N.E. 2d 376, 383 (Ill. App. 2000).

11 Industrial Enclosure Corp. v. Northern Ins. Co., 2000 U.S. Dist. LEXIS 11567 at *11 (N.D. Ill. 2000). See also Western Nat'l Mut. Ins. Co. v. Univ. of North Dakota, 643 N.W.2d 4, 9 (N.D. 2002) (finding that the plain meaning of flood as found in Webster's Dictionary and Black's Law Dictionary is "an overflowing of water on an area normally dry").

STEPPING INTO ARBITRATION AGREEMENTS

By: Todd C. Harshman

Although it may claim to be the birthplace of modern arbitration, when someone mentions New York, does arbitration leap to mind? If so, you're probably the odd duck. More likely are thoughts of the Empire State Building, Broadway, Wall Street, Times Square, or Fifth Avenue. Interestingly, even these images (especially Wall Street and Fifth Avenue) are strongly connected to the factors that led to the growth and establishment of modern arbitration in the early 1900s: the vibrant sense of finance and commerce associated with both the City and the State of New York.

As business grew after World War I and more commercial transactions took place, the courts found themselves overwhelmed by commercial disputes, and the business community faced increasingly burdened courts. Because commercial and financial centers like New York felt these pressures acutely, the New York Chamber of Commerce and the New York State Bar Association responded by co-sponsoring legislation designed to bolster the effectiveness of arbitration as an alternative legal remedy. Their efforts were successful, and after enactment in 1920, New York became the first state with a modern arbitration statute. Other states quickly followed suit. Much of the language of these early arbitration acts was even included in the Uniform Arbitration Act (UAA), initially promulgated in 1955, and revised in 2000.

What made the New York statute a "modern" arbitration statute was that it provided not only for the legality of agreements to arbitrate but also for their irrevocability and enforcement. Previously, parties could obtain money damages for breach of an arbitration agreement, but not specific performance. Agreements to arbitrate were considered freely revocable under New York statutory and common law. The modern statutes' enforcement schemas – specifically the threat of court-imposed sanctions – are credited with establishing arbitration as the force it is today.

In insurance litigation, and especially in subrogation actions, arbitration is steadily becoming a more prominent feature. Those inclined to avoid arbitration because of its expense, a perceived lack of accountability or neutrality, the lack of a precedential impact, or any other reason may soon find their hands tied by the increasing procedural and contractual preference for arbitration. Procedurally, litigants in California may well be subject to a state rule, like California's Rules of Court §3.811, that mandates arbitration if the amount in controversy is less than fifty thousand dollars. Contractually, many insurers have prospectively agreed to arbitrate particular types of claims. For example, a subrogation action for property damage where the claim is under a hundred thousand dollars will have to be arbitrated if both the subrogated plaintiff and the defendant's insurer are among the hundreds of signatories to Arbitration Forums, Inc.'s, property program.

This trend towards arbitration is further seen in a recent decision of an Illinois state appellate court. Like New York, Illinois is home to one of this country's commercial and financial centers: Chicago. Earlier this year, an Illinois court was faced with the specific issue of whether an insurer has standing as a subrogee to invoke an agreement to arbitrate between its insured and a third party tortfeasor. *Equistar Chemicals, LP v. Hartford Steam Boiler Inspection & Insurance Co. of Conn. ("Equistar")*, 883 N.E.2d 740 (Ill.App. 4 Dist., 2008).

The dispute arose when a subrogee-insurer (Hartford), pursuant to a contract between its insured and Equistar, sought to arbitrate the question of whether damage to a turbine generator owned by Hartford's insured was caused by the negligence of one of Equistar's employees. *Id.* at 743. Equistar objected to the arbitration and petitioned the courts for a stay of same in order to resolve several issues, including whether a non-signatory such as Hartford had standing to compel arbitration based solely on its subrogee status. *Id.* The trial court declined to address this question, finding instead that the issue of standing was itself an arbitrable issue – one that should be decided by the arbitrators rather than the courts. *Id.*

Because of the UAA's initial grant of jurisdiction to the courts to determine "whether the parties have agreed to arbitrate a dispute" (adopted in Illinois as 710 ILCS 5/2(a), (b)), because the issue before the court was one of subrogation law rather than something requiring the "special skill" of arbitrators, and because of a desire to avoid unnecessary delay, the *Equistar* decision overruled the trial court and unequivocally held that the courts may properly determine a subrogated insurer's standing to invoke an arbitration agreement. *Id.* at 743-46. The court noted initially that this was a matter of first impression for Illinois courts and

stated, "Nationally, no known case has yet held that a subrogee may *invoke* an arbitration agreement signed by others." *Id*. at 748.

In fact, only one case was known to have squarely addressed the question prior to *Equistar*: a California appellate decision, *Valley Casework, Inc. v. Comfort Construction, Inc*., held that absent decisional authority addressing the interplay between equitable subrogation and contractual arbitration, or without an applicable exception to the general rule preventing non-signatories from invoking arbitration clauses, there was no basis for allowing a subrogated insurer to do so. 90 Cal.Rptr.2d 779, 784-87 (Cal.App. 4 Dist., 1999); see *Equistar*, 883 N.E.2d at 748. The *Equistar* court, however, was not swayed by this argument, seeing in it "a simple reluctance to expand the established list of exceptions to the rule…where there was no precedent for doing so." *Equistar*, 886 N.E.2d at 749.

More persuasive, the *Equistar* court opined, was a New York appellate decision addressing the flip side of the *Valley* question: whether an arbitration agreement could be enforced *against* a non-signatory subrogated insurer. See *Solomon v. Consolidated Resistance Co. of America, Inc*., 468 N.Y.S.2d 791 (1983). *Solomon* held that because the insured could be compelled to arbitrate the dispute, "then plaintiffs' insurer will be similarly bound." *Id*. Flowing from the equitable concept that a subrogated insurer is put in the place of its insured (often referred to as "stepping into the shoes" of the insured), the *Equistar* court agreed with the *Solomon* principle: because Hartford's insured would have been required to arbitrate the negligence action, then Hartford should be similarly bound. *Equistar*, 883 N.E.2d at 749.

"In considering the general question of whether a subrogee-insurer may invoke its insured's contractual right to arbitration; the *Equistar* and *Solomon* decisions sit better with the principles behind equitable subrogation. The law indulges the fiction that a subrogated insurer is the insured, thus the insurer's right to recover is defined by its insured's rights."

In considering the general question of whether a subrogee-insurer may invoke its insured's contractual right to arbitration; the *Equistar* and *Solomon* decisions sit better with the principles behind equitable subrogation. The law indulges the fiction that a subrogated insurer *is* the insured, thus the insurer's right to recover is defined by its insured's rights. Further, defenses applicable to the insured's cause of action apply with equal force to the subrogation claim. In this respect, it is unclear why the *Valley* court cites, but does not discuss, the rule allowing a non-signatory to enforce an arbitration agreement when there is a "sufficient identity" between the non-signatory and a signatory, as in the case of agency. *Valley*, 90 Cal.Rptr.2d at 785. A subrogated insurer "stepping into the shoes" of its insured at least arguably meets this standard. This is not to say that *Valley* was wrongly decided. For reasons not discussed in this article, including assertions of claims against multiple non-signatories to the arbitration agreement, an injunction staying arbitration seems appropriate in *Valley*.

However, the holding of *Valley* may not survive outside of the facts of that case. As stated above, the *Valley* decision implied that its result might have been different if the parties had presented "authority for the application of the equitable doctrine of subrogation in the contractual arbitration context." *Id*. at 786. In light of federal and state policies strongly favoring arbitration of claims and disputes, *Equistar* may be exactly the kind of case law that persuades a future California court – and for that matter courts across the country – to rule in favor of a subrogated insurer's right to compel arbitration.

As arbitration organizations, facilities, and officials continue to develop size, expertise, and sophistication, arbitration may become more and more of a "go to" option for resolving disputes, whether commercial, financial, subrogation-based, or otherwise. Also, as more and more construction contracts, leases, indemnification agreements, etc., call for arbitration of disputes, it is in the subrogated insurers' own interests to be able to institute proceedings in the proper forum from the start, rather than spending the money, time, and energy establishing a lawsuit, only to dismiss it when the alleged tortfeasor invokes an arbitration agreement with the insured. Saving your clients' money and your time by going straight to arbitration in the appropriate case may not be as glamorous as a Broadway play or a hard-fought Wall Street deal, but the good news is that you don't have to be in New York, Chicago, or any other commercial or industrial center to think about adding this tool to your subrogation arsenal.

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MIDWEST FLOODS...

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differentiate between a flood caused by the overflow of a man-made watercourse and one caused by the overflow of a natural watercourse.[12]

Another Illinois court further defined "surface water" as "water derived from natural precipitation that flows over or accumulates on the ground without forming a definite body of water or following a defined watercourse."[13] Surface water was not limited to water whose flow had not been altered by paved surfaces, buildings, or other surfaces.[14]

Wisconsin courts have not defined "flood," but in a case where rainwater entered an insured's basement while construction work was taking place, a court found that a provision excluding water damage caused by "flood" or "surface water" was unambiguous.[15] Another Wisconsin court defined "surface water" as "natural water that has not penetrated much below the surface of the ground."[16]

Where excessive rainwater inundated a drug store after a boat crashed through the store's front door, a Missouri court found the exclusions for "flood" and "surface water" to be unambiguous and not inconsistent, resulting in the insurer's dismissal from the case.[17]

2. *Is A Levee Failure A "Flood?"*

Levees broke at various locations along rivers in Iowa, Missouri, and Illinois, resulting in the inundation of water in various areas. A question that may arise is whether water inundation from a levee failure is a "flood," thereby placing any loss from the inundation within a "flood" exclusion. Though not addressed by a court in one of the Midwest states, this issue was addressed by the U.S. Court of Appeals for the Fifth Circuit[18] and by the Louisiana Supreme Court[19] in litigation arising out of Hurricane Katrina. Applying the plain, ordinary and generally prevailing meaning of the word "flood," both Courts held that water inundation due to a levee failure is still a "flood," for purposes of a "flood" exclusion.[20]

B. WHEN FLOODING AFFECTS PROPERTY OTHER THAN THE INSURED'S

1. *Civil Authority Coverage Issues*

Because of the flooding, mandatory evacuations were ordered by various mayors.[21] Given these orders, insureds may claim a loss of business income and seek civil authority coverage, if available. Civil authority coverage may apply when access to an insured's property is prevented or prohibited by an action or order of civil authority, issued as a direct result of damage to premises not the insured's, but in the same proximity.[22] While language may vary, a typical "civil authority" provision may read:

> We will pay for the actual loss of Business Income you sustain and necessary Extra Expense caused by action of civil authority that prohibits access to the described premises due to direct physical loss of or damage to property, other than at the described premises, caused by or resulting from any Covered Cause of Loss.[23]

When presented with a claim for this type of coverage, one inquiry is whether the policy requires an "order" by the civil authority[24] or simply "action" by the civil authority,[25] prohibiting access to the insured property.

Another inquiry is how proximate the damaged property must be to the insured property. Again, policy language may vary. A court has

12 *Wallis,* 723 N.E.2d at 383.

13 Smith v. Union Automobile Indem. Co., 752 N.E. 2d 1261, 1268 (Ill. App. 2001).

14 *Id*. at 1267.

15 Josephson v. Am. Family Ins. Group, 610 N.W. 2d 230 (Wis. App. 2000).

16 Atlantic Mutual Ins. Co. v. Lotz, 384 F. Supp. 2d 1292, 1302 (E.D. Wis. 2005).

17 Madison Block Pharmacy v. USF&G, 620 S.W.2d 343, 346 (Mo. 1981).

18 *In Re Katrina Canal Breaches Consolidated Litigation*, 495 F.3d 191 (5th Cir. 2007).

19 Sher v. Lafayette Ins. Co., 2008 La. LEXIS 796 (La. Apr. 8, 2008).

20 *In Re Katrina,* 495 F.3d at 214; *Sher*, 2008 La. LEXIS 796 at *9-10.

21 City of Waterloo, Iowa, June 11, 2008, Press Release; City of Iowa City, Iowa, June 25, 2008, Mayor's Withdrawal of Proclamation of Civil Emergency, Order for Curfew, and Hour Restrictions for Certain Areas; Ken Fuson, Molly Hottle and Juan Perez Jr., "Cedar River Blasts Records; Residents Flee; Rail Cars Fall," Des Moines Register, June 12, 2008.

22 See Penton Media, Inc., v. Affiliated FM Ins. Co., 2006 WL 2504907 (N.D. Ohio Aug. 29, 2006), aff'd, 2007 WL 2332323 (6th Cir. Aug. 15, 2007).

23 ISO Businessowner's Policy BP 00 03 01 06.

24 Altru Health Sys. v. American Protection Ins. Co., 238 F.3d 961, 962 (8th Cir. N.D. 2001) (civil authority clause provided that access to the described premises be "prohibited by order of civil authority.")

25 Narricot Indus. v. Fireman's Fund Ins. Co., 2002 U.S. Dist. LEXIS 19074 (E.D. Pa. Sept. 30, 2002)(civil authority provision did not mention "order," only "action" on the part of a civil authority.)

held that, when a civil authority clause required the damage to occur "adjacent to" the insured's premises, the term "adjacent" was unambiguous, which, under an ordinary and popular reading denoted a sense of physical proximity.[26] Accordingly, damage occurring in an unspecified area at least two blocks away from the insured's property was not adjacent.[27]

Another question is whether complete access to the insured's property must be prohibited. If a civil authority provision uses the word "prohibits," courts have found that complete denial of access to the property, by the civil order, is required before coverage applies.[28] In one case arising out of the 9/11 attacks, the court held that civil authority coverage was available for the three days after September 11, when access to the insured's property was prohibited, but coverage was not available once pedestrian access was restored, even though vehicular traffic was restricted.[29] Therefore, no coverage was afforded when access to the insured's property was simply impaired.

2. *Ingress/Egress Coverage Issues*

Flood waters could cut off access to the insured property though the water may not have damaged the insured property itself. In such circumstances, consideration must be given to whether a policy provides "ingress/egress" coverage, that is, coverage where access to the insured's premises was prevented, even though the insured property was not physically damaged.[30]

In an Illinois case stemming from 9/11, the City of Chicago sought recovery under the Ingress/Egress provision of its policy for lost revenue at O'Hare Airport.[31] The City of Chicago argued that the damage to the World Trade Center prevented ingress to and egress from O'Hare.[32] The court granted the insurer's motion for summary judgment, finding that the direct cause of business interruption at O'Hare was the FAA orders shutting down air commerce after the attacks, not the physical damage to the World Trade Center.[33]

3. *Contingent Business Interruption Issues*

The flooding could have damaged the property of an insured's supplier or customer, such that the insured might not be able to receive goods or services from a supplier or provide goods or services to a customer.[34] This scenario could give rise to a claim for lost business income under a contingent business interruption provision, if available. Courts have defined contingent business interruption as insurance that "protects against the loss of prospective earnings because of the interruption of the insured's business caused by an insured peril to property that the insured does not own, operate, or control."[35]

There are not many reported cases dealing with contingent business interruption coverage. One case that dealt with contingent business interruption issues is noteworthy because it arose from the flooding of the Mississippi River in 1993.[36] This case held that an indirect supplier to an insured could be a "supplier" for purposes of contingent business interruption coverage.[37]

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[26] Syufy Enters. v. Home Ins. Co., 1995 U.S. Dist. LEXIS 3771 at *5 (N.D. Cal. Mar. 20, 1995)
[27] *Id.*
[28] *Id.;* See also, *730* Bienville Partners, Inc. v. Assurance Co. of Am., 2002 U.S. Dist. LEXIS 18780 at *6 (E.D. La. Sept. 30, 2002).
[29] Royal Indem. Co. v. Retail Brand Alliance, Inc., 33 A.D.3d 392, 394 (N.Y. App. Div. 1st Dep't 2006).
[30] Fountain Powerboat Indus. v. Reliance Ins. Co., 119 F. Supp. 2d 552, 555 (E.D.N.C. 2000).
[31] City of Chicago v. Factory Mut. Ins. Co., 2004 U.S. Dist. LEXIS 4266 (N.D. Ill. Mar. 11, 2004).
[32] *Id.* at *7.
[33] *Id.* at *10.
[34] For an example of contingent business interruption policy language, see Miller's Standard Insurance Policies Annotated, CPBI, vol. I, p. 459.7.
[35] Penton Media, Inc. v. Affiliated FM Ins. Co., 245 Fed. Appx. 495, 499 (6th Cir. 2007) citing CII Carbon, LLC v. Nat'l Union Fire Ins. Co. of La., Inc., 918 So. 2d 1060, 1061 n.1 (La. Ct. App. 2005).
[36] Archer-Daniels-Midland Co. v. Phoenix Assur. Co., 936 F. Supp. 534 (S.D. Ill. 1996).
[37] *Id.* at 543-44 (Midwest Farmers, which provided grain through dealers and not directly to the insured, were suppliers.) But see, Pentair, Inc. v. Am. Guar. & Liab. Ins. Co., 400 F.3d 613, 615 (8th Cir. 2005) (electrical substation supplying power to factories was not a "supplier" to insured because it did not supply a product or service ultimately used by insured.)

FLORIDA...

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had agreed to comply with the State's onerous regulatory scheme, from unwarranted competition by unauthorized insurers who are not subject to similar requirements.

Surplus lines carriers sell their products through managing general agents. A policy from an otherwise unauthorized, surplus lines insurer may be sold only if the agent confirms under oath that it has contacted three admitted insurers who do not, or cannot provide the insurance product needed by the customer. These unauthorized, out-of-state insurers are then permitted to "export" into the state of Florida the insurance products that they sell in their home states. Surplus lines carriers typically insure high-risk, difficult to insure properties, and risks in Florida that are not otherwise insurable by domestic, authorized insurers.

By way of example, surplus lines carriers provide property and builder's risk insurance for waterfront condominiums, government buildings, cell phone towers, new small and medium sized businesses, and coastal construction. They offer several lines of insurance and their business in Florida is substantial. The FSLSO reports that nearly 650,000 commercial and personal policies were issued in 2006. Far and away the greatest amount of coverage, as a function of premiums collected, was for commercial general liability, commercial property, commercial package, commercial inland marine, builder's risk, and excess general liability policies. Most of these policies were written in hard-to-insure coastal counties. Since the admitted market will not insure the operations of social service organizations, cargo transportation, organized public events, or professional services, such activities would be stalled in the absence of surplus lines insurance.

In the *CNL* case, the OIR's amicus brief analyzed the legislation that created the FSLSO. The legislative history plainly states that surplus lines insurance "is not subject to Florida regulation of rates or forms and there is no insurance guarantee fund protection if an insurer becomes insolvent." Based on this analysis, and the legislative history, the OIR argued to the Eleventh Circuit that despite the Florida Supreme Court's statement in the *Zota* case, nothing in the law required surplus lines forms to be filed with and/or approved by the OIR before their forms could be used in policies issued in Florida.

With no mention made of the OIR's analysis, the Eleventh Circuit ruled that the Supreme Court's decision in *Zota* required the case to be remanded to the federal District Court for a determination of whether an exclusion found in Twin City's surplus lines policy, found on a form that was neither filed with nor approved by the OIR was void and, therefore, unenforceable. A decision is pending.

The end result is the arrival of a perfect storm for surplus lines carriers conducting business in Florida. Chapter 627's loose statutory language has been construed by the Florida Supreme Court in a decision containing sweeping language and no safe-harbor period granting the Legislature the time it needs to correct the scrivener's error. Florida insurance regulators now find themselves at odds with their own state's Supreme Court and the federal district courts within the state, and no mechanism exists for surplus lines companies or regulators to comply with the *Zota* ruling. To say that all of this creates an uncertain business environment for surplus lines carriers is a gross understatement.

Ultimately a legislative fix will be required to make clear exactly which regulations found in Chapter 627 apply to surplus lines carriers. Until then, disgruntled surplus lines insureds can be expected to seize on the opening created by the Supreme Court's ruling, and the Legislature's slow action to correct it. All of this has heightened anxiety among surplus lines carriers on how to comply with a law that was never intended to apply to their business, which will ultimately force surplus carriers to decide whether it is worthwhile to conduct business in Florida while the state of the law is in such disarray.

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BI-ECONOMY...

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rationale and the result they reach are powerful and should have influence across the country.

Much has already been written about these two cases, with most commentators focusing on whether they signal that the New York Court of Appeals has now recognized, or may soon recognize, a cause of action for bad faith failure to pay a claim. It is not clear whether *Bi-Economy* created a new tort of "bad faith" in New York. However, it is clear that the Court in *Bi-Economy* applied basic contract law to insurance contracts, in the same way that courts around the country purport to apply basic principles of contract construction to policyholder-insurer disputes. However, when one considers some unnecessary language in the opinion along with what was apparently written as a "follow-along" opinion in *Panasia Estates*, it seems that New York law may now recognize, or at least be closer to recognizing, a separate action for "bad faith."

The *Bi-Economy* opinion is far more detailed and more interesting than the opinion in *Panasia Estates*. The facts are fairly simple. The Bi-Economy Market lost its entire inventory and suffered heavy damage to its building and business personal property in an October 2002 fire. Harleysville provided both property and business interruption coverage. Harleysville disputed the amount of loss and paid only $163,161.92 towards the property loss and only seven months of the business interruption loss, despite the fact that the policy provided for 12 months of BI coverage. Bi-Economy never resumed operations. A year later, after what the court characterized as an "alternative dispute resolution" proceeding (most likely appraisal), Bi-Economy was awarded an additional $244,019.88. Bi-Economy then sued Harleysville claiming, *inter alia*, consequential damages resulting from the loss of its business because Harleysville improperly delayed paying the property claim and failed to timely pay the full amount of the BI claim. Bi-Economy also claimed that liability for these consequential damages was reasonably foreseeable and contemplated by the parties at the time of contracting. Harleysville moved for partial summary judgment on the consequential damages claim and the trial court granted the motion. The Appellate Division affirmed, holding that the policy specifically excluded coverage for consequential losses and, therefore, the claimed consequential damages were not contemplated by the parties when the contract was formed. The Court of Appeals reversed.

New York's high court relied on the general contract law of consequential damages in holding that a breaching party is liable for those risks actually foreseen, or which should have been foreseen, at the time the contract was made. To determine whether consequential damages were reasonably contemplated by the parties, courts look to the nature, purpose and particular circumstances of the contract. Consequential damages, which are designed to compensate the non-breaching party for reasonably foreseeable damages, must be proximately caused by the breach. The Court noted that every insurance contract contains an implicit covenant of good faith and fair dealing, including an understanding that the insurer promises to investigate and pay covered claims in good faith. The court cited various cases for the non-controversial proposition that policyholders buy insurance not only for the money to be paid in case of loss, but for peace of mind and protection against calamity.

The most important part of the *Bi-Economy* holding is that the clear purpose of BI coverage is to ensure that policyholders have the financial support necessary to sustain business operations in the event of a loss. Therefore, according to the Court of Appeals, limiting a policyholder's damages in the event of a breach by the insurer to policy proceeds plus interest does not place the policyholder in the position it would have been in had the insurer properly performed the contract. According to the Court:

> Thus, the very purpose of business interruption coverage would have made Harleysville aware that if it breached its obligations under the contract to investigate in good faith and pay covered claims it would have to respond in damages to Bi-Economy for the loss of its business as a result of the breach. [Citation omitted].

10 N.Y.3d at 195. The purpose of the contract of an insurance policy is not just to receive money, but to receive it promptly to enable a business to get up and running again as quickly as possible. Therefore, according to the Court of Appeals, the policy "included an additional performance-based component: the insurer agreed to evaluate a claim, and to do so honestly, adequately and - most importantly - promptly." *Id*. Finally, the Court held that an insurance company is liable for consequential damages where they are proximately caused by the insurer's "excessive delay or improper denial" of coverage. *Id*.

The Court of Appeals also rejected the carrier's argument that

the policy's exclusions for consequential *loss* show that the parties contemplated and rejected the possibility of consequential *damages* in the event the carrier breached its obligations under the policy. The opinion makes clear that the policy's exclusion for consequential *loss* applies to outside factors which increase the amount of covered loss, not consequential *damages* caused by an insurer's failure to live up to its obligations. This has been almost lost in the shuffle of articles, blogs and commentaries on the case. However, it is a very important holding and one crucial to the result. It is also worth noting that Harleysville's argument is not a new one as it has been raised by insurers for years. However, any court which understands the *Bi-Economy* opinion should be able to draw the same line distinguishing between excluded loss and damages available for breach of contract.

The *Panasia Estates* opinion is far more limited and contains far fewer facts. That case involved Hudson Insurance Company's denial of a claim for rain damage under a builder's risk policy. In the exact reverse of the situation in *Bi-Economy*, both the trial court and the Appellate Division rejected Hudson's attempt to have Panasia Estate's claims for consequential damages dismissed on preliminary motion. Relying on its holding in *Bi-Economy*, the Court of Appeals held that consequential damages may be recovered under the facts as alleged, which included allegations that the insurer breached its duty of good faith and fair dealing by failing to timely investigate and pay a covered claim. The Court remanded for a determination of whether the specific damages sought by Panasia Estates were foreseeable consequential damages.

"While *Bi-Economy* may have opened the door to policyholders bringing "bad faith" claims under New York law, it is more properly read and applied as a straight forward application of traditional contract law to insurance policies."

The *Bi-Economy* opinion has already been cited in several cases and the courts seem to have focused on the Court of Appeals' discussion of an insurer's breach of the duty of good faith and fair dealing. Thus, in *United States Fire Insurance Co. v. Bunge North America*, 2008 WL 3077074 (D.Kan. Aug. 4, 2008), the district court applied New York law and, relying on *Bi-Economy* and *Panasia Estates*, held that the policyholder's claim for consequential damages based on allegations of breach of the duty of good faith and fair dealing under environmental liability policies could proceed. The same result was reached by the New York Supreme Court in *Handy & Harman v. American International Group*, 2008 WL 3999964 (N.Y. Sup. Aug. 25, 2008), where the Court, relying on *Bi-Economy*, and *Panasia Estates*, held that an environmental pollution policy was designed to pay for pollution remediation and to make sure the insured had the financial ability to finish the remediation. Therefore, AIG should have assumed when it entered into the policy that, if it breached its obligations under the contract "to timely investigate in good faith and pay covered claims," it would have to respond for any consequential damages to the policyholder's business. Finally, in *Hoffman v. UnionMutual Stock Life Insurance Co. of New York*, 51 A.D.3d 633, 857 N.Y.S.2d 680 (2008), the Appellate Division went even further, and affirmed the trial court's decision to allow an actual "*bad faith*" claim to proceed.

It is apparent that both lawyers and courts have read *Bi-Economy* and *Panasia Estates* as requiring that policyholders allege that the insurance company breached the duty of good faith and fair dealing in order to recover consequential damages. Many of those same people equate breach of the duty of good faith and fair dealing with "bad faith" conduct. This is an understandable, but incorrect, reading of *Bi-Economy*. While *Bi-Economy* may have opened the door to policyholders bringing "bad faith" claims under New York law, it is more properly read and applied as a straight forward application of traditional contract law to insurance policies.

In *Bi-Economy*, the Court of Appeals based its decision on three basic principles: (1) implicit in every insurance contract is the carrier's duty to timely investigate and pay covered claims; (2) insurers know and understand that policyholders buy property insurance not only to fund the cost to repair or replace damaged property, but to keep their businesses afloat while repairs take place; and (3) damages arising out of an insurance company's failure to timely pay the full amount it owes are foreseeable consequential damages under standard contract law. None of these three principles is controversial. They stand up without reference to either the insurance company's duty of good faith and fair dealing or "bad faith." While the breach of the duty of good faith and fair dealing constitutes a breach of the insurance contract which allows the recovery of consequential damages, under the reasoning of

Bi-Economy it is equally clear that any other breach of the insurance contract by the insurer will also allow the policyholder to recover consequential damages. The Court of Appeals created unnecessary confusion by relying on the concept of the duty of good faith and fair dealing to support the first principle, *i.e.*, that implicit in every insurance policy is the carrier's duty to investigate and pay in a timely fashion. That was an unnecessary step in the analysis. The Court created additional confusion by relying almost entirely on the alleged breach of the duty of good faith and fair dealing in its far less analytical opinion in *Panasia Estates*.

As a result, lawyers and courts have focused on the Court of Appeals' reference to breach of the duty of good faith and fair dealing and given it a life of its own. Courts relying on *Bi-Economy* have viewed the breach of duty as an element of the claim for consequential damages (so far the cases have all addressed the issue only at the preliminary motion or summary judgment stage). Insurance companies will no doubt use the language to argue that, absent a showing of something more than mere failure to pay on time, consequential damages are not allowed. As discussed above, this is not a correct reading of the case.

The Court of Appeals' focus on the timeliness and completeness of the insurance carrier's conduct and its discussion of the duty of good faith and fair dealing to support claims for consequential damages leaves many open questions. While it is clear how to plead a claim for consequential damages under *Bi-Economy* and *Panasia Estates*, some of the questions practitioners will now have to address include: (1) the scope of discovery policyholders will be allowed as they try to prove that the insurer's investigation was incomplete and its payment inadequate and untimely; (2) the standard to which insurance companies will be held, *i.e.*, whether, as *Bi-Economy* implies, they are strictly liable for consequential damages if they breach the contract by failing to pay in full and on time, or are there any special "insurance related" defenses such as advice of counsel or a good faith analysis of coverage or damages; (3) what types of proof must a policyholder present to show that the consequential damages were or should have been reasonably foreseeable at the time of contracting; (4) whether foreseeability is an issue of law to be decided on motion or an issue of fact to be presented to the jury; and (5) when are the claimed consequential damages too speculative to be allowed. These are just some of the issues that will be fleshed out over time as more and more New York state and federal courts are faced with claims for consequential damages.

At all events, it is clear that the remedies available to policyholders when an insurer does not pay have been significantly enhanced, the stakes for all parties have now gone up, and the cost of denying property insurance coverage cases in New York will increase substantially.

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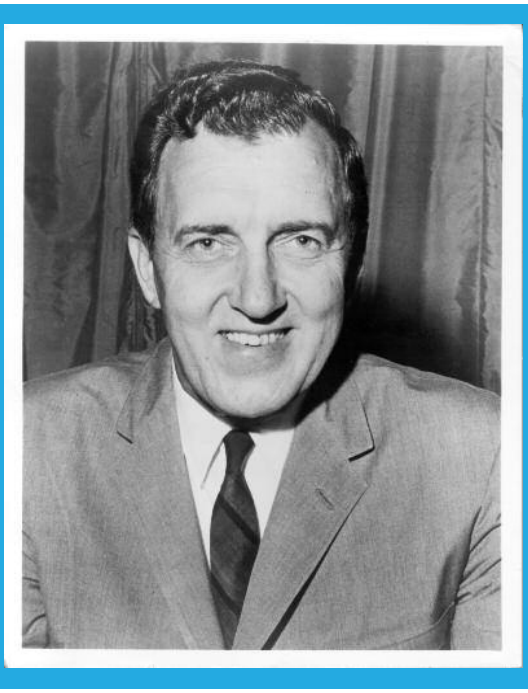

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January

15-18	Annual TIPS Midwinter Symposium on Insurance, Employment and Benefits	Hyatt Regency Coconut Point Resort and Spa Bonita Springs, FL
22-23	FSLC Midwinter Meeting	Waldorf ~Astoria Hotel New York, NY

February

11-17	ABA Midyear Meeting	Marriott Hotel Boston, MA
26-28	Insurance Coverage Litigation Committee Meeting	Millennium Biltmore Hotel Los Angeles, CA

March

5-6	Transportation MegaConference IX	Sheraton New Orleans New Orleans, LA
21-25	TIPS National Trial Academy	Grand Sierra Hotel Reno, NV

April

2-3	Emerging Issues Motor Vehicle Litigation	Arizona Biltmore Resort & Spa Phoenix, AZ
3-4	Toxic Torts Committee Midyear Meeting	Arizona Biltmore Resort & Spa Phoenix, AZ
23-26	TIPS Section Spring Meeting	The Broadmoor Colorado Springs, CO