COVERAGE OPINIONS
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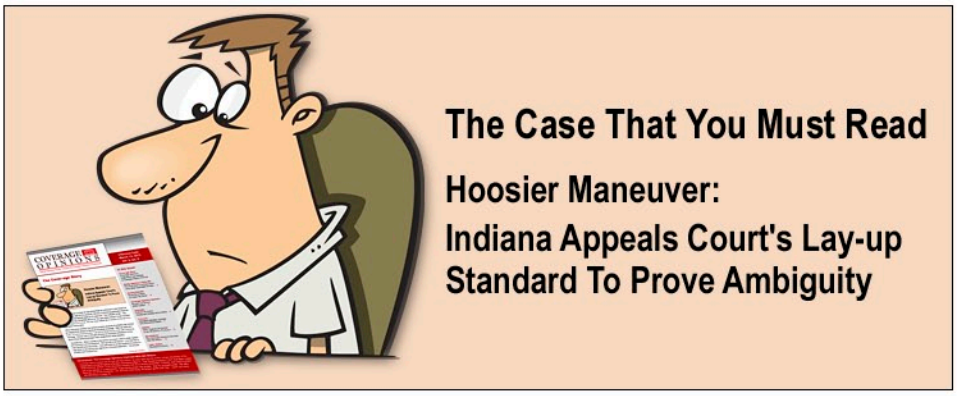
The Cover-age Story



I read a lot of coverage cases. The ones of real significance stay with me for a while. The Indiana Court of Appeals's recent decision in Hammerstone v. Indiana Insurance Company, No. 06A04-1211-PL-595 (Ind. Ct. App. Apr. 8, 2013) is in that category. I haven't been able to shake it since I first read it. The decision is bewildering. It is the Kim Jong Un's haircut of coverage decisions. While insurers and policyholders will disagree wildly whether the decision was correct, there is no denying that it provides valuable lessons

Gary Hammerstone was injured while using a Trac-Vac lawn and leaf vacuum. Specifically, when it was no longer suctioning leaves he attempted to remove a hose in an effort to locate a clog. The vacuum was still running and Mr. Hammerstone severely injured his right hand and arm. He filed suit against certain manufacturer/seller parties and alleged, among other things, that they were negligent when they designed, manufactured, marketed, distributed, supplied, advertised, maintained, serviced, repaired and sold the Trac–Vac and that they failed to properly and adequately warn of the hazards of the Trac–Vac, etc. In other words, a garden variety (pun intended) products liability claim.

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Declarations: The *Coverage Opinions* Interview With Kenneth Kobylowski, Commissioner Of The New Jersey Department Of Banking And Insurance

There is no doubt that Ken Kobylowski knew that claims issues would be on his to-do list when he signed on to be New Jersey's Commissioner of Banking and Insurance. But he certainly could not have imagined that they would play the part that they are following the pounding that his state took from Hurricane (or not) Sandy. The Commissioner has not been lost in the flood when it comes to the Sandy claims process.

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Nobody can dispute that. What was disputed, however, was whether an umbrella policy provided products liability coverage for the manufacturer/seller defendants.

Indiana Insurance Company's umbrella policy stated on the declarations page that it provided an occurrence limit of $2,000,000, a products/completed operations aggregate limit of $2,000,000 and a general aggregate limit of $2,000,000. But that's not all there was. The declarations page also listed the forms and endorsements made a part of the policy, which included one titled "Exclusion – Products–Completed Operations Hazard."

So, to recap, the umbrella policy specified that it was subject to a $2,000,000 limit for products-completed ops. but also contained an endorsement that stated: "This insurance does not apply to bodily injury or property damage included within the products-completed operations hazard." Hmmm.

Indiana Insurance filed a declaratory judgment action against the manufacturer/seller defendants. Following a slew of cross motions for summary judgment the trial court found in favor of Indiana Insurance, holding that no coverage was owed under the umbrella policy.

The manufacturer/seller defendants appealed to the Indiana Court of Appeals. Their argument was simple and predictable: "The Appellants allege [an] ambiguity existed because the declarations page clearly stated that the Umbrella Policy included coverage for products-completed operations hazard, but that later the Umbrella Policy language stated that the insurance did not apply to injuries and damages included within the products-completed operations hazard. Because there is an ambiguity in the Umbrella Policy, the Appellants assert that it should be construed against the insurer, Indiana Insurance, and that coverage should be found to exist."

The Indiana Court of Appeals agreed with the manufacturer/seller defendants. While the court's decision is devoid of detail, the court presumably believed that none was needed based on the simple test being applied: ambiguity. The court held: "Indiana Insurance argues that the declarations page actually clearly and unambiguously states that the products-completed operations hazard is excluded from coverage and that, therefore, the Appellants' argument fails. However, we disagree. We believe that this language stating that there is an exclusion for products-completed operations hazard actually further demonstrates the inherent ambiguity in the Umbrella Policy. When taking this language into consideration, the information found on the declarations page both provides

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About The Editor

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$2,000,000 of coverage for products-completed operations and then states that such coverage is excluded. We find this to make the Umbrella Policy inherently ambiguous."

Insurers will look at Hammerstone and be certain that it was wrongly decided. While the policy's declarations page may have stated that it provided a $2,000,000 limit for products-completed ops., any such coverage was then removed by way of the endorsement titled "Exclusion – Products–Completed Operations Hazard."

It should be likened to this: Consider an accidental release of hazardous substances that causes environmental harm. That probably qualifies as "property damage," caused by an "occurrence," to satisfy a commercial general liability policy's insuring agreement. But any such damages are then excluded by the pollution exclusion. Thus, you could say that, since the policy both provided coverage for the property damage, as well as excluded it, it must be ambiguous. But no court ever does. And that's because a grant of coverage is not automatically absolute. Once coverage is established under the insuring agreement, the analysis turns to the exclusions to determine if any apply. If so, whatever coverage may have been initially established under the insuring agreement is then eliminated by way of the exclusion. By the Hammerstone court's logic, every claim that is excluded by way of an exclusion must fall under an ambiguous policy since, to have reached the exclusion, the excluded claim must have also initially been covered under the insuring agreement.

Policyholders will look at this decision and be certain that it was correctly decided. As they'll see it, the policy said opposite things. That makes it ambiguous. End of story.

You may be wondering about this -- What did the underwriting file say about the availability of coverage for products? There may have been evidence in there that stated very clearly whether products coverage was intended under the umbrella policy. In some states, even if a court concludes that policy language is ambiguous, such finding does not lead to an automatic determination that coverage is owed. Rather, once there is a finding that a policy is ambiguous, consideration then turns to extrinsic evidence to determine the intention of the parties.

I did not examine this issue in depth. Instead I reached out to counsel for Indiana Insurance and asked for an explanation of it. Counsel did not immediately respond.

You may look at Hammerstone and conclude, well, what do you expect, Indiana is a not a friendly state for insurers.

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Randy Spencer's Open Mic

Masters Of Their Own Insurance Domains

I loved this case when it was first decided. So I was thrilled when it recently came back for an appellate encore (its third). Travelers Indemnity Company is, well, Travelers. It is a behemoth of a property-casualty insurance company, one of the largest, been around since the mid-1800s and has an impressively low spot on the Fortune 500. It spends a small fortune on the promotion of its products and services. The company didn't just wiggle its nose and that little red umbrella magically came to be associated with Travelers.

Now enter Deepak Rajani. He registered the domain name Travellers.com. In other words, he added a second l to Travelers and off he went into the insurance business. His website prominently displayed Travellers.com and touted itself as a "gateway to sites on the Internet for insurance." Travellers.com provided insurance-related advertisements and pay-per-click links to third-party websites, including competitors of Travelers Indemnity Company

You don't need to be from MI6 to figure out Mr. Rajani's plan. He registered a domain name for an insurance-related website that is

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I previously addressed this issue in *Coverage Opinions* (January 3, 2013) and concluded that there is no such thing as a "good" or "bad" state for insurers. Such across the board statements are too general, and wide-reaching, to be of any value.

Hammerstone could be an anomaly. Not to mention that it may not mean much in a state that allows extrinsic evidence to clarify any ambiguity in policy language. But the decision should not be ignored. It is not from the Iowa dog catcher. It is a to-be-published opinion from an appellate court in a state that has a very well developed body of insurance coverage case law.

Hammerstone provides three lessons, all of which are simple.

I believe that the inclusion of a products aggregate limit on the Dec Page of the Indiana Insurance umbrella policy had no bearing on the availability of products coverage. But, to be safe, a policy that is not intended to provide coverage for products-completed operations should state "N/A" as the products-completed operations aggregate limit on the declarations page.

Second, care should be taken to ensure that a policy that intends to exclude any type of specific coverage should not contain any provision that could be read as providing such specific coverage.

Lastly, and most importantly, Hammerstone demonstrates a huge risk for insurers that is inherent in their business. An insurer accepts a few thousand dollars from a party in exchange for the possibility of having to turn around and pay that party several million dollars. But the insurer knows this going in. It accepts this seemingly odd arrangement because it has concluded that the event that is required to cause such mismatched exchange of capital has a low probability of taking place. But, as Hammerstone shows, with this arrangement also comes the risk that the insurer will have to write a big check, in exchange for a small one, that was never in the cards. All that was needed for this wildly bad deal to take place for Indiana Insurance were a few key strokes.

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Randy Spencer's Open Mic

one letter off from Travelers -- a word that people could conceivably misspell as having two ls. He could then attempt to profit from the website visitors who must have some sort of insurance issue or purchase on their mind to have ended up where there did. Hopefully, for his advertisers' sake, they are not in the business of writing Spelling E&O coverage.

Needless to say this did not sit well with the folks at Travelers with one l. The company filed suit against Travellers.com alleging cybersquatting, trademark infringement and the like. Long story short, Travelers prevailed and the court ordered that the registrar of Travellers.com be changed to Travelers Indemnity Company. The Fourth Circuit affirmed in early April.

I decided to borrow a page from Mr. Rajani's playbook and register the domains Zurick.com, Eerieinsurance.com and Heartford.com. But I discovered that in each case someone beat me to it. I wasn't surprised by this. But I was surprised that none of the owners of these domain names appeared to be the ones that I expected.

That's my time. I'm Randy Spencer.

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The Boston Bombing: Early Thoughts On Insurance Coverage

In the aftermath of the September 11th attacks, the insurance industry and federal government took a hard look at insurance coverage and put many provisions in place to address any future attacks. Thankfully, all of that work collected dust for over a decade. But the tragic Boston Marathon bombings changed that. While the property damage from the Boston attack was generally not as wide in scope as the insurance industry and federal government had in mind when addressing coverage in the post-9/11 era, questions about the availability of insurance coverage for Boston are being asked. Some initial thoughts follow, based on the information available, and speculated about, one week after.

I examine coverage for two types of affected businesses: those in the close proximity to the bomb blasts and those located nowhere near the blasts but were shut down on Friday April 19th on account of the manhunt for the second suspect. The following discussion is general, based on standard industry forms and not intended to be exhaustive of every policy term and condition and case law and everything else that comes into play when insurance coverage is being considered. This discussion does not look at any considerations that, owing to the unique nature of the claims, could be relevant to how they are adjusted.

Businesses in the close proximity to the Boston Marathon bomb blasts have been shut and of course properties in that area sustained physical damage. The Boston Globe reported on Sunday (6 days after the attack) that the exact timetable for the reopening of the six block crime scene area is unclear.

Businesses in the vicinity of the bomb blasts that sustained physical damage and have been shut because they are within the area cordoned off for the investigation, have an opportunity to make claims under their Commercial Property policies. Specifically, coverage may be available for property that was physically damaged, as well as business income lost and other expenses incurred while the property is being repaired (business interruption).

Businesses in the vicinity of the bomb blasts that did not sustain physical damage (or not enough to have caused them to close) but have been required to be shut because they are within the area cordoned off for the investigation, also have an opportunity to make claims for business interruption. These businesses would be seeking business interruption coverage based on access to them being prohibited by civil authority. The reason why these businesses may be able to make claims for business interruption, based on prohibited access by civil authority, will be clear when you see below why businesses that were shut down on Friday April 19, on account of the manhunt for the second suspect, are not able to make such claims.

For businesses in the vicinity of the bomb blasts that sustained physical damage and/or were shut because they are within the area cordoned off for the investigation, the consideration of any potential coverage (in addition to all other issues) must include an assessment of the Terrorism Exclusion. For businesses that did not purchase terrorism coverage, their commercial property policies likely include a Terrorism Exclusion.

Insurance Services Office's definition of a "certified act of terrorism," as contained in its Commercial Property Terrorism Exclusion, is as follows: "[A]n act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State and the Attorney General of the United States, to be an act of terrorism pursuant to the federal Terrorism Risk Insurance Act. The criteria contained in the Terrorism Risk Insurance Act for a "certified act of terrorism" include the following: 1. The act resulted in aggregate insured losses in excess of $5 million in the aggregate, attributable to all types of insurance subject to the Terrorism Risk Insurance Act; and 2. The act is a violent act or an act that is dangerous to human life, property or infrastructure and is committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion."

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The Boston Bombing:

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While President Obama stated that it is an act of terror whenever bombs are used to target innocent civilians, the definition of terrorism, for purposes of insurance coverage, is more technical than that. It is tied to the motivation of those that committed the act. Who knows why the Tsarnaev brothers allegedly did what they did. It remains to be seen if this motivation test is met. But at least based on the background of the older brother that is being unearthed by the media, it seems like the test may be met. It also seems unlikely that the President would call the act terrorism, but then have his Secretary of the Treasury, Secretary of State and Attorney General say otherwise, especially with the "terrorism" classification being tied to the type of criminal charges that can be brought (even with a caveat that their conclusion, that it is not terrorism, is only for purposes of the Terrorism Risk Insurance Act).

Therein lies a quirk with the definition of "terrorism" for purposes of insurance coverage. The President stated that whenever bombs are used to target innocent civilians it is terrorism. And many people seem to define terrorism as "I know it when I see it." But with the insurance definition of terrorism being more technical, an act that looks and feels like terrorism may not be so, if the actor's motivation was simply criminal, or caused by mental illness, and included no other agenda.

Thus, for businesses in the vicinity of the blasts, if their commercial property policies include a Terrorism Exclusion, coverage is unlikely to be available for physical damage and business interruption.

As for businesses located nowhere near the blasts, but were shut down on Friday April 19, on account of being told by authorities to stay inside because of the manhunt for the second suspect, business interruption coverage is unlikely to be available. But this has nothing to do with Terrorism issues. Because these businesses did not sustain physical damage, any potential coverage would be for business interruption, based on prohibited access by civil authority.

However, for at least two reasons, these businesses are unlikely to obtain coverage for business interruption based on prohibited access by civil authority. First, for these affected businesses, the action of the civil authority was not taken in response to damaged property. Rather, it was taken in response to the manhunt for the second suspect. Second, there is a 72 hour waiting period before business income coverage, based on civil authority, begins.

Thus, business interruption coverage is unlikely to be available for businesses that were shut down on Friday April 19, on account of being told by authorities to stay inside. While this has nothing to do with Terrorism issues, any Terrorism Exclusion would serve as an additional potential impediment to coverage.

Idaho Supreme Court: No Covered Damages – But Coverage Still Owed For Plaintiffs' Attorney Fees

When an issue comes up with some regularity, and there is a dearth of case law nationally addressing it, a decision from a state supreme court that sheds light on it is the ultimate qualifier for it to be labeled significant. Such is Employers Mutual Casualty Co. v. Donnelly, No. 38623 (Idaho April 19, 2013).

The decision is on the lengthy side, and involves several issues, but the one subject of discussion here is this. In almost all litigation here, Alaska aside, the losing party is not obligated to pay the prevailing party's attorney's fees. This is often referred to as the "American Rule." But there are some common exceptions, most notably when a contract or statute allows the prevailing party to recover its attorney's fees. Consider this situation. An insured is found obligated to pay compensatory damages to a plaintiff and it is also determined that the insured violated a consumer protection statute that allows for the prevailing party to recover its costs and attorney's fees. Now assume that the damages awarded are themselves not covered. This is not a far-fetched situation. After all, for there to have been a determination that a consumer protection statute was violated, the insured's actions

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may have been of the nature that are uninsurable.

Query: If the compensatory damages awarded against the insured are not covered, are the corresponding attorney's fees also not covered? This was the question before the Idaho Supreme Court in Employers Mutual Casualty Co. v. Donnelly. The Idaho high court concluded that, even if the damages were not covered, the corresponding prevailing party attorney's fees were.

At issue was coverage for a construction defect suit (what else). A jury concluded that a construction company breached its implied warranty of workmanship to a homeowner and awarded $126,000. The jury also concluded the construction company violated two provisions of the Idaho Consumer Protection Act and awarded $2,000. The homeowners were also entitled to recover their costs and attorney's fees of 297,000.

For various reasons, no coverage was owed for the damages awarded to the homeowners for breach of warranty. Nonetheless, the Idaho Supreme Court held that coverage was owed for the costs and attorney's fees award of nearly $300,000.

The commercial general liability policy at issue contained a "Supplementary Payments" provision that provided, in pertinent part, as follows: "We will pay, with respect to any claim we investigate or settle, or any 'suit' against an insured we defend: a. All expenses we incur. e. All costs taxed against the insured in the 'suit'." The policy defined "suit" as "a civil proceeding in which damages because of 'bodily injury', 'property damage' or 'personal and advertising injury' to which this insurance applies are alleged."

The trial court held that the insurer was obligated to provide coverage for the attorney's fees, despite the absence of coverage for the construction defect damages: "[T]he insurance policy plainly states that with respect to any suit pursued against an insured which it defends, EMC will pay all costs taxed against that insured. The language appears to be unambiguous, and thus, it must be given its plain meaning. EMC has never set forth any specific language in its policy that ties its promise to pay costs on a finding that there is coverage. Because EMC defended its insured, RCI, in the underlying litigation, EMC is responsible to the Donnellys for the $296,933.89 in fees and costs taxed against RCI in that lawsuit, as well as any interest on that judgment which has accrued."

The Idaho Supreme Court affirmed, focusing on the fact that the policy defined "suit" as needing to only allege "property damage." The court stated: "Under the plain language of the contract, RCI's policy states that damages only need to be 'alleged' to trigger coverage, they do not need to be proven. Since the Donnellys clearly alleged damages that implicate the applicable provisions of the policy, EMC is obligated to pay '[a]ll costs taxed against the insured in the 'suit.'" Of note, ISO's CG 00 01 from (including the 2013 version) likewise defines "suit" as a civil proceeding in which damages to which the insurance applies are "alleged."

A dissenting opinion was filed. While more complex than just this, the dissenting justice focused on a different aspect of the definition of "suit." While "suit" is a civil proceeding in which damages are alleged, such damages must also be ones "to which the insurance applies."

The dissenting justice's conclusion was that "[i]t has clearly been determined that Donnellys recovered no damages covered by any provision of the EMC policy. Since it is clear under the policy that there is no 'coverage' for any damages awarded against the insured, there can clearly be no 'supplementary payments' for costs and fees when it is established there is no coverage for damages awarded in the lawsuit."

Seven Year Itch: North Dakota Supreme Court Overrules Its Decision Addressing Construction Defect Coverage

Nodak High Court Pulls A Moradi-Shalal

I know I'm getting old when a decision that I can remember being decided is overruled. This is what just happened in North Dakota in the area of coverage for construction defects. Ordinarily I might not have addressed the Nodak high court's recent decision in K&L Homes, Inc. v. American Family

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Seven Year Itch:

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Mut. Ins. Co., No. 2012 0060 (N.D. Apr. 5, 2013). While it is from a supreme court, it is just one more in a very long list of cases to address the "occurrence" issue in the context of construction defect claims. But it is discussed here because the court took the opportunity to overrule ACUITY v. Burd & Smith Construction, a case that it decided a mere seven years ago.

Of course courts sometimes change their minds. And in some cases that's a good thing. But it is unusual to see a supreme court overrule a decision so soon after it was decided. The best-known insurance coverage overruling, in whiplash fashion, came from the Supreme Court of California. The court held in 1979 in Royal Globe Ins. Co. v. Superior Court that the Unfair Practices Act of the state's Insurance Code afforded a private party, including a third-party claimant, the right to sue an insurer for violation of the Act—addressing various unfair claims settlement practices. However, just nine years later Royal Globe was overruled by Moradi-Shalal v. Fireman's Fund Ins. Companies. The Supreme Court concluded that "developments occurring subsequent to our Royal Globe decision convince us that it was incorrectly decided, and that it has generated and will continue to produce inequitable results, costly multiple litigation, and unnecessary confusion unless we overrule it."

It is no secret that insurers and policyholders have been fiercely battling whether property damage, caused by faulty workmanship, qualifies as an "occurrence" under a commercial general liability policy. The number of cases addressing the issue, and rationales involved, is legion. And within the past few years legislatures in several states have gotten into the mix, passing laws to address court decisions on the "occurrence" issue with which they disagreed. Not that more evidence is needed of the absence of agreement on this issue, but here it is anyway. The North Dakota Supreme Court cannot even agree with itself.

Briefly, as described by K&L Homes, in 2006 the North Dakota Supreme Court held in ACUITY v. Burd & Smith Construction that "under a CGL policy faulty or defective workmanship, standing alone, is not an accidental occurrence but if faulty workmanship causes bodily injury or property damage to something other than the insured's work product, an unintended and unexpected event has occurred and coverage exists."

In K&L Homes, the North Dakota Supreme Court overruled Burd & Smith to this extent and held that "faulty workmanship may constitute an 'occurrence' if the faulty work was 'unexpected' and not intended by the insured, and the property damage was not anticipated or intentional, so that neither the cause nor the harm was anticipated, intended, or expected."

In general, the court's reasons for taking a 180 degree turn on the issue were the history of the CGL form and the manner in which other supreme courts concluded: "There is nothing in the definition of 'occurrence' that supports that faulty workmanship that damages the property of a third party is a covered 'occurrence,' but faulty workmanship that damages the work or property of the insured contractor is not an 'occurrence.'" Not surprisingly, a decision overruling such a recent one included two dissenting opinions.

Declarations:

The *Coverage Opinions* Interview With Kenneth Kobylowski,

Commissioner Of The New Jersey Department Of Banking And Insurance

Kenneth Kobylowski

There is no doubt that Ken Kobylowski knew that clams issues would be on his to-do list when he signed on to be New Jersey's Commissioner of Banking and Insurance. But he certainly could not have imagined that they would play the part that they are following the pounding that his state took from Hurricane (or not) Sandy. And now he probably doesn't think he'll ever get off this tilt-a-whirl.

With Governor Chris Christie being no shrinking violet, it should come as no surprise that his insurance commissioner, Ken Kobylowski, has not been lost in the flood when it comes to the Sandy claims process.

I don't think it had even stopped raining before the Commissioner announced that insurers may not apply hurricane deductibles because the National Weather Service downgraded Sandy to a post-tropical cyclone before it reached land in New Jersey. As a result, policyholders would not have to pay a deductible based on a home's insured value (such as 2% or more), which would likely be (much) higher than a standard homeowner's policy deductible. In my opinion, we have not heard the last of this issue.

I suspect that, going forward, some insurers will seek to apply higher deductibles for named storms, whether they technically be hurricanes or something else, when they make landfall.

In late February the Department of Banking and Insurance announced the creation of a mediation process to give policyholders the option to settle disputed (non-National Flood Insurance Program) claims without resorting to a lawsuit. The mediation program is described as follows in the official announcement: "The new program will allow property owners to submit homeowner's, automobile and commercial property claims to a mediator who will review the case and assist in settlement discussions. Disputed non-flood Sandy-related claims greater than $1,000 that do not include a reasonable suspicion of fraud and are based on policies in force at the time Sandy made landfall will be eligible for mediation. Insurance carriers will pay for the cost of the mediator."

Participation in the program is mandatory for insurers authorized or admitted to transact business in New Jersey. Such insurers are required to notify insureds with open or unresolved homeowner's, auto and commercial claims that they can ask for a mediation conference and detailed instructions for filing that request.

As Chief Operating Officer for the Department of Banking and Insurance, Commissioner Kobylowski has full responsibility for all legislative, regulatory, operational and administrative matters. He was previously in private law practice for 20 years, beginning at Connell, Foley & Geiser in Roseland, New Jersey, and then moving to Herrick, Feinstein LLP, in both its New York City and Newark offices. Before practicing law, Commissioner Koby lowski began his professional career as a bank analyst at the Federal Reserve Bank of New York. He is a magna cum laude graduate of Seton Hall University and a cum laude graduate of New York Law School.

Commissioner Kobylowski, thank you for taking the time to speak with Coverage Opinions. It has been reported that, as of February 15, 87 percent of Sandy claims have been closed. What are some of the common reasons why claims remain open?

As of March 1, 93% of Sandy-related homeowner's cases in New Jersey have been closed. Cases may remain open for many reasons including lenders who are

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co-recipients of insurance claims, and are managing disbursements of funds; other claims remain open because the claimant is not satisfied with the insurer's offer. A top concern of consumers calling the Department is unsatisfactory settlement offers. To address that issue, the Department is starting a mediation program designed to settle open claims. The Department has also seen an influx of calls regarding delays in flood insurance claims handling. That area is administrated and financed by the National Flood Insurance Program. (see below) Business-related claims such as commercial property, commercial auto and business interruption are generally closed at a slower pace than personal claims for a variety of reasons including that the issues tend to be more complex, policy-specific and require a longer investigation.

What are some of the things that your office does to assist consumers when they call for help with their claims?

Staff at the Department's Consumer Inquiry and Response Center (CIRC) assists consumers by answering any banking and insurance related questions regarding their case. Depending on the circumstances, a Department investigator will then contact the policyholder's insurance company or bank to try and resolve any outstanding issues in order to settle the claim. If a consumer files a formal complaint, staff from the Office of Consumer Protection will investigate to determine if any State laws or statutes relating to banking and insurance have been violated. Violations are referred to the Department's Enforcement Unit for possible administrative action. If the case in question involves a company not licensed by the Department or a program not regulated by the state such as the National Flood Insurance Program, the Department will still contact the parties involved and act as advocates for New Jersey consumers.

Can you describe the Department's recently announced program to offer mediation as a way to resolve the outstanding claims?

The Department of Banking and Insurance is finalizing the selection of a vendor to operate a mediation program that would enable business and property owners who have unresolved insurance claims related to Superstorm Sandy to hopefully settle those cases. We expect mediation to begin in April. Mediation will prevent costly and time consuming legislation for thousands of open Sandy cases. Faster case resolution will permit New Jerseyans to rebuild and recover from Sandy in a timelier manner. Here is a link providing more details: http://www.nj.gov/governor/news/news/552013/approved/20130225a.html

What has been the response that you've received from insurers to the program?

The state's insurance companies have been supportive of the new program.

Can you describe the response that you received from insurers after your announcement that hurricane deductibles would not apply to Sandy claims?

State insurance carriers recognized that Superstorm Sandy did not meet the regulatory threshold for applying the deductible. The National Weather Service downgraded Sandy to a tropical cyclone before it reached land in New Jersey.

Governor Christie stated in early February that the National Flood Insurance Program's handling of claims in New Jersey has been "a disgrace," noting that, at that time, only 30% of claims had been resolved, compared to 80% of the more than 430,000 other insurance claims. The Governor called for changes. Has there been any improvement in the NFIP numbers since that time?

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The percentage of Superstorm Sandy-related flood insurance claims settled should be obtained from the National Flood Insurance Program. Over the last month, the NFIP has begun to work more closely with the Department including establishing a call center at 1-800-427-4661 and providing on the ground support. Discussions continue regarding possible NFIP participation in the state's mediation program.

Are you considering any initiatives for claims handling for future storms based on the experience that you've had with Sandy?

As noted before, as of March 1, 93% of homeowners claims; 88% of personal auto and 90% of overall claims, excluding flood have been closed in New Jersey. Overall the state's insurance carriers did a commendable job in responding to the storm. However there is always room for improvement. Two areas that warrant continued analysis are ensuring that insurance carriers have sufficient numbers of adjusters and improving communications between adjusters and policyholders in the aftermath.

Late-r Notice:
A Look At Decisions To Come

9th Circuit To Address Coverage For Ticketmaster For Suit For Fees

My Springsteen Lawsuit Against Ticketmaster

In 1999 I sued Ticketmaster in small claims court in Chester County, Pennsylvania over a purchase of Springsteen tickets that went bad. It's a long story. It was back in the day when internet commerce was just getting started. So a lawsuit over a failed internet purchase, based on a problem with a website (my allegation), was something of a novelty. The story was picked-up by The National Law Journal who titled its mention of it "Born to Litigate." How clever. The case settled, I got my tickets, went riding down the New Jersey Turnpike on a wet night, Bruce rocked the joint and we all lived happily ever after.

One consequence of this experience is that I always take close note of any media stories about Ticketmaster. And if the story also happens to involve coverage – well, you can just imagine. Insurance Law360 reported that the Ninth Circuit recently heard oral argument in Ticketmaster, LLC v. Illinois Union Insurance Co. At issue is coverage for Ticketmaster, under an E&O policy, for an underlying suit that alleges that the company misrepresented UPS delivery fees and other processing fees concerning the sale of tickets on the internet. The trial court found for Illinois Union, concluding that it properly disclaimed coverage based on an exclusion in its policy that precludes coverage for "any dispute involving fees, expenses or costs paid to or charged by the insured."

According to Law360's report, counsel for Ticketmaster argued to the appeals court that coverage was owed because the underlying suit was about misrepresentation. For example, Ticketmaster's coverage complaint cited several allegations from the underlying action that it believed supported this point, such as: "Ticketmaster falsely represented that the fee was a mere pass-through charge imposed by and collected for UPS, and that such charge represented the actual UPS shipping cost."

According to Law360, counsel for Ticketmaster argued that it would be unfair to bar coverage for any claim related to fees, no matter how tangentially related. As counsel put it: "There's not a single aspect of our business that doesn't involve fees." Anyone with experience with Ticketmaster certainly won't dispute that.

Guest Column

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