NEW JERSEY LAWYER

October 2021

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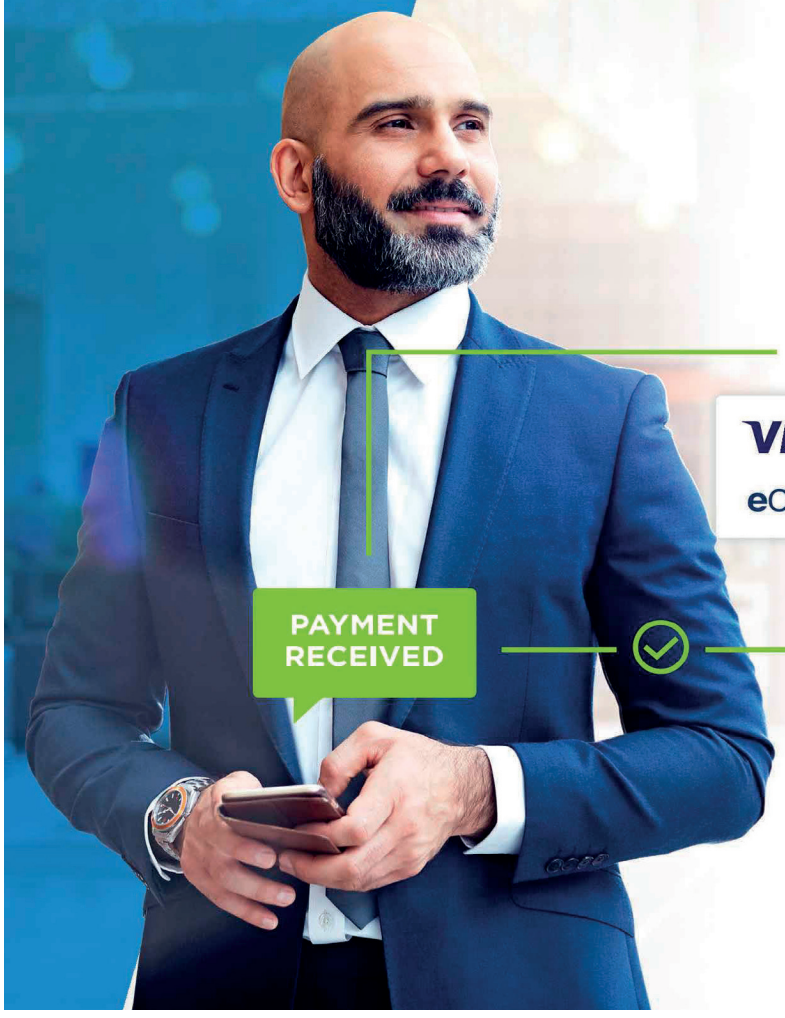

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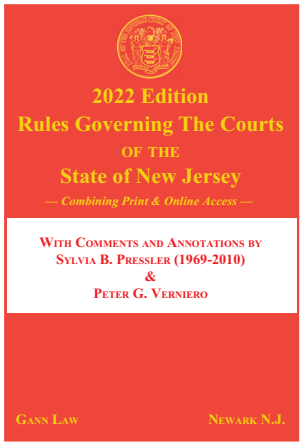

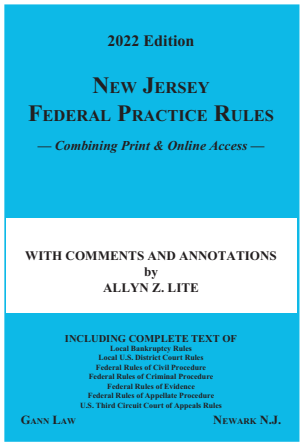

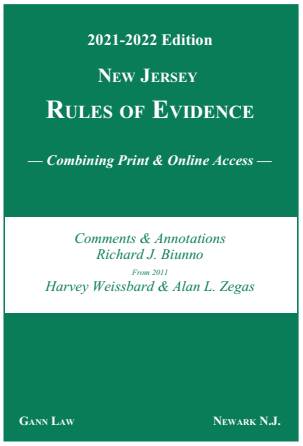

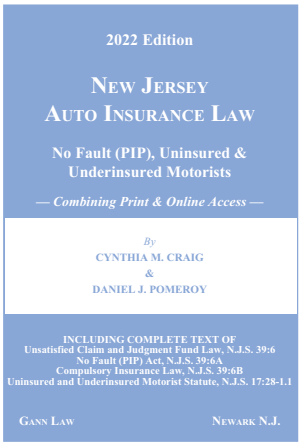

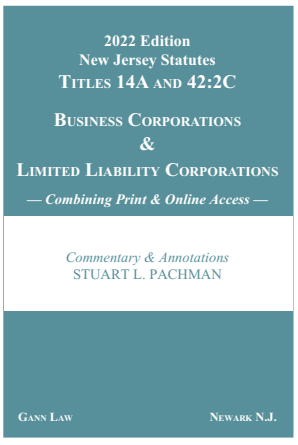

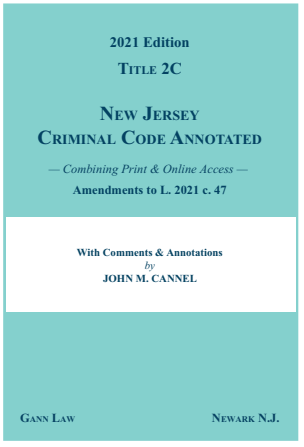

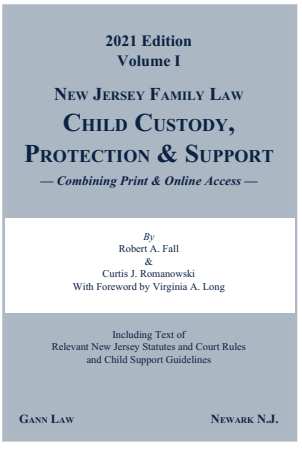

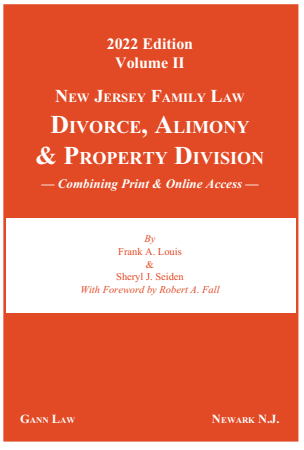

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DOMENICK CARMAGNOLA

Impacting Judicial System and the Way We Practice Through Persevering Advocacy

Advocacy is at the root of what attorneys do every day. We do it with vigor, zeal, professionalism, and integrity on behalf of our clients. It is also a precept that is fundamental to the New Jersey State Bar Association's very foundation. The Association serves as the voice of New Jersey attorneys, advocating on behalf of the profession "to other organizations, governmental entities and the public with regard to the law, legal profession and legal system; to promote access to the justice system, fairness in its administration, and the independence and integrity of the judicial branch," as our mission states.

One of the most powerful tools the Association uses to do this important work is our Amicus Committee. The NJSBA has a proud history of advocacy as a friend to the courts for over a century which has helped to shape case law and improve New Jersey jurisprudence for all those who encounter the legal system.

Our amicus efforts have focused on some of the most critical issues of our time like the constitutional right to a fair and impartial jury. Several of our most recent amicus efforts touch directly on the issues that matter to attorneys and residents in their daily lives, such as what role attorneys should play in real estate transactions, how DWI cases can proceed, what form palimony agreements must take and what kind of information clients should have in arbitration matters.

Recently, the NJSBA filed for leave to appear as amicus curiae in a matter that goes to the heart of the ability of attorneys to practice.

In the matter of *Office of Attorney Ethics v. Wade*, the OAE recommended disbarment of an attorney under Rule of Professional Conduct 1.5 for knowing misappropriation of client and escrow funds from her attorney trust account. In that matter, the NJSBA asked the Court to clarify the *Wilson* Rule and the distinction between knowing misappropriation in circumstances where trust accounting errors or insufficiencies are alleged.

In our brief, the NJSBA agreed that public confidence is maintained with a bright-line rule requiring disbarment where there is clear and convincing evidence of an intent to steal a client's money or to defraud a client. "The NJSBA asserts this is what has historically been understood as 'knowing misappropriation' under *Wilson*. However, the NJSBA believes that absent clear and convincing evidence of theft or fraud, notions of justice and fairness based on the merits of the particular facts presented require consideration of alternative appropriate sanctions, if any, short of disbarment."

Given the severity of the state's disbarment rules, the Association is expected to file a request to be an amicus voice in the coming weeks to join *In re Lucid*, which similarly asks the Court to examine the critical balance of maintaining public trust in the profession and a disciplinary system that is not overly punitive.

In *State v. Dangcil*, the Association's advocacy left an indelible mark on the efforts of the legal system to ensure a fair and impartial jury trial—one that is truly representative of a cross-section of the community—for all future parties. The *Dangcil* case was the first in-person criminal jury trial to be held since the pandemic shut down all in-person trials in March 2020.

The NJSBA participated as amicus curiae out of concern that the selection procedures used raised constitutional concerns and should have been conducted in a more transparent way that preserved the defendant's rights to participate. The New Jersey Supreme Court's opinion reflected the Association's recommendation to collect demographic information about potential jurors to guard against the risk of unconstitutional jury selection and under-representative juries. Especially with the challenges presented by the public health pandemic, the NJSBA's advocacy increased transparency in the selection process which is critical to ensure those rights are fully protected.

Here are some additional examples of the range and impact of the NJSBA's amicus advocacy program.

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FROM THE SPECIAL EDITORS

As Society Evolves, So Do Insurance Provisions Across Industries

In this COVID-19 world, it has become the norm to expect all facets of our lives to be impacted by the pandemic. The insurance industry is no exception, and the pandemic has undoubtedly cast its mark on the way first-party and third-party liability insurance claims are being handled. However, despite the pandemic's inescapable presence, the world continues to advance and grow. Social media has taken on a ubiquitous part of society, changing the way and the speed that people interact with each other. Cyber security programs have become practically a necessity for all types of businesses and commercial entities looking to maintain their footprints in a computer-dependent world. And, new laws have emerged permitting New Jersey businesses to distribute and sell cannabis, which was historically deemed to be an illegal substance until recently.

This issue of the *New Jersey Lawyer* addresses the impact of losses stemming from many of these recent trends, and how these unprecedented losses are affecting insurance coverage and the handling of insurance claims. We learn about recent litigation which could pave the way for more businesses to recoup business interruption losses sustained as a result of the ongoing pandemic. However, insurers are also increasingly relying upon so-called "virus exclusions," which have gained traction years after their promulgation due to the 2006 SARS pandemic. In another article, we delve into cyber liability coverage, which can cover costs associated with cyber losses but could require higher premiums or deductibles for any insured looking to protect against hacking or ransomware attacks.

We also discover the various insurance coverage opportunities—which can include liability, first-party property, workers compensation and commercial auto coverage—available for cannabis businesses following the February 2021 passage of legislation legalizing marijuana. However, even those cannabis businesses are

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subject to various exclusions, such as those targeting the amount of marijuana dispensed or investigating whether the business is manufacturing products in violation of law, that could impede coverage for their losses. Companies are also purchasing insurance coverage to protect against liability from social media usage such as slander, libel, cyberbullying, and even intellectual property rights violations. As a result, media liability coverage has become widespread among commercial entities and is no longer affiliated just with news conglomerates or entertainment companies.

This issue further provides key insight regarding settlement concerns facing both insurers and policyholders, as well as the evolving judicial interpretation of common policy provisions. In one article, we learn of the consequences that occur when a policyholder refuses to consent to an otherwise reasonable settlement demand and how insurers can insulate themselves from excess indemnity exposure in these circumstances. In a similar vein, an article in this issue dives deep into the intricacies of the National Practitioner Data Bank, which provides information regarding settlement decisions involving practitioners and health care providers, and how the dissemination of that information to boards and insurance carriers could impede the ability of procuring professional liability insurance in the future. Finally, we investigate whether bad faith claims should be precluded by the entire controversy doctrine as they pertain to uninsured and underinsured motorist coverage, and the significance of the actual wording used in assault and battery exclusions and how that wording can affect enforceability. ⚖

President's Perspective

Continued from page 5

- The NJSBA is seeking amicus curiae status in a family law matter, *Moynihan v. Lynch*, which is on appeal in the state Supreme Court. The matter focuses on the enforceability of a written palimony agreement where a notarized agreement was unenforceable because the parties had not sought legal advice. The NJSBA argued that the Court has the equitable power to enforce agreements when to do otherwise would be unjust, and that while involvement of legal counsel should always be encouraged, when reviewing the totality of circumstances surrounding an agreement, the lack of such involvement should not render an otherwise valid agreement unenforceable.
- The Association took part in *Delaney v. Dickey*, in which the Court upheld the use or arbitration clauses in retainer agreements but concluded attorneys must provide clients with additional information to ensure clients are fully aware of the differences between arbitration and a judicial trial. Our involvement extended even beyond the legal briefs with the NJSBA also submitting proposed model arbitration disclosure language to the Supreme Court's Advisory Committee on Professional Ethics recommending what those disclosures should be.
- The NJSBA was a friend of the court in *Sullivan v. Max Spann Real Estate & Auction Co.* The case centered on whether the three-day attorney review period and notice regarding the risks of not seeking an attorney should apply to private real estate auction sales. The NJSBA argued they are mandated given the importance of the protection of the public interest. It's a case that stems from the legacy of a lawsuit the NJSBA brought in 1983 to ensure all realtor-prepared real estate contracts contain an attorney review clause cautioning the parties that they had the right to seek advice of counsel within three days of signing the contract.
- Municipal court matters have long been a critical focus of the NJSBA's advocacy, especially those like *State v. Cassidy* that stem from *State v. Chun*, which is regarded as the most important DWI case in the state's history and in which the NJSBA played a pivotal role.
- Our members are volunteering their time on the Association's behalf in ongoing hearings before a special master related to *State v. Olenowski*, in which the NJSBA was an amicus curiae party to advocate for the inadmissibility of drug recognition evaluation evidence unless a proper foundation that meets the Frye requirements is provided. The hearing is expected to last at least six weeks and include testimony from several expert witnesses discussing the validity and reliability of evidence produced as a result of drug recognition evaluations by trained police officers in New Jersey cases.

With such an extensive footprint of advocacy, it should not be overlooked who is responsible for this impressive record of amicus activity. It is with special thanks to our Amicus Committee, Board of Trustees, and volunteer members, who share their outstanding expertise and knowledge in attending hearings, researching issues, and preparing briefs on a completely pro bono basis, that the NJSBA has provided assistance and insights on issues that touch the lives of each of us in the profession and society. Please know that we will continue to advocate for you on all issues of import to the practice, the judicial system and the profession, and feel free to reach out to us if you believe there is a matter the NJSBA should review. ⚖

PRACTICE PERFECT

Reimagining Business Development

By Aparna Tutak
Affinity Consulting

Double-Duty Lawyers

Professional networks have long been a tool used by lawyers seeking employment and law firms for recruiting. The difference now is that the pool of applicants has gotten deeper, making the job-market ultra-competitive. Attorneys with years of experience are suddenly finding themselves vying for jobs with the nation's newest graduates. Maximizing exposure on sites like LinkedIn gives attorneys the opportunity to showcase their expertise and network with their peers. Prospective employers are paying attention to which attorneys, new graduates or their seasoned counterparts, are highlighting their technical expertise as much as their legal accomplishments.

For example, as the pandemic struck, firms were challenged to evaluate their financial status and enact their strategic "in-case-of-emergency" plans. Many firms were left unprepared to do so simply because their professional staff lacked tools to make those decisions. In the foreseeable future, attorneys may be expected not only to understand and interpret law for clients but also to understand legal technology well enough to assist in financial accounting software deployments such as SurePoint Technologies or CosmoLex. An attorney with both legal and technical prowess is an asset to firms focused on maximizing their return in investment on future hires. You may not be expected to handle a complex software migration, but having a solid understanding of the functional requirements of the firm and the ability to cut through technical jargon to acquire necessary tools will be critical.

Bottom line, law firms hiring managers are vetting candidates on more than just their resumé. Lawyers who are going to weather this storm are going to need to stay in front of their peers, self-advocate their unique technological skills on professional sites, and illustrate their expertise and passion for the legal profession and law firm management. Retaining top talent is more cost effective than acquiring new hires. Attorneys who survived the downturn and kept their jobs are now realizing that their employers should be safeguarding their firms from future crises. So, what can law firm employers do to make sure their rainmakers stay and not stray?

The Rise of the "New" Law Firm Marketer

Pre-pandemic, many law firms focused their marketing efforts on billboard advertising, attendance at live conferences and in-person events where those in traditional business development roles were expected to host gatherings to network and solicit new business for their firms. Many firms cut marketing and sales resources from their budgets at the onset of the global health crisis but are realizing that while their skills are still needed, strong aptitude is needed in inbound marketing, data analysis, content marketing, and virtual events. Law firms focused on the future are hiring marketing technologists who help firms develop and execute strategies which drive business remotely. In addition, the importance of nurturing relationships with existing clients has never been as paramount. Maintaining an existing client is typically more profitable than the cost of acquiring a new one, so an employee who can balance both types of relationships consistently for their firm are set to be in high demand.

Fostering Inclusivity

The changing socio-political climate has led firms to focus on Diversity and Inclusion initiatives as they innovate their organizations for increased equity among their ranks. Whether that means developing mentoring programs or networking opportunities

through the ILTA Diversity, Equity and Inclusion Task Force or taking certification courses on building workforces that promote the inclusion of people of differing races, sexual orientation or disabilities, firms are focused on increasing revenue, improving employee performance and overall job satisfaction in an environment where change is already occurring. While many strides have already been made, legal teams "continue to struggle with improving leadership diversity and inclusive cultures," according to the 2020 Inclusion Index Survey Report.

Keeping Your Data Secure

Cybersecurity is central to safely conducting business. According to Law.com, firms with fewer than 20 attorneys accounted for half of all ransomware attacks in the legal industry, with even entire court systems suffering from malicious players. The "work-from-home" movement has led firms to identify gaps in their IT infrastructures which put them at risk for breaches or cyberattacks. Firms wishing to stay ahead of the threat are employing cloud hosting companies like ProCirrus for assistance with data loss prevention and multi-factor authentication. The risk and liability of lost or stolen client information is a threat that firms need help avoiding. A poor security environment even puts attorneys' reputations in jeopardy. Employers wishing to retain their lawyers must heed warnings to protect not only their businesses but safeguard their employees from potential malpractice issues.

One positive side effect of the heightened threat of malicious hackers during the pandemic has been the increased demand for cybersecurity attorneys. Firms are looking to source talent through both internal moves and lateral hires, as many form cybersecurity practices which could lead to increased revenue if included in strategic business development plans.

WORKING WELL

Heeding the Call—
Why Pro Bono Can Make a Difference

By Akil Roper

Legal Services of New Jersey

One afternoon this past summer, a group of *pro bono* attorneys and volunteers gathered for a training run by Legal Services of New Jersey experts to learn how to help people expunge their criminal and juvenile records. Because of a lingering and deadly pandemic—the same pandemic which caused significant disruption in the job market—the training took place over Zoom. But the end goal remained the same—to help create life-changing opportunities for those facing employment discrimination because of a past criminal record.

Expungement is one of many areas in which *pro bono* attorneys can volunteer to provide assistance to those who do not have the means to afford legal representation—and really make a difference.

The need for *pro bono* in New Jersey remains high. Even though legal services staff are working long hours to help clients resolve civil legal issues, a troubling justice gap exists. According to Legal Services of New Jersey published reports, those in poverty may only get legal assistance for one in 10 of their civil

legal problems. Many of those in poverty are people of color, who not only face employment barriers but suffer from disparities in income and wealth, housing, health and education. Simply put, justice remains out of reach—and disproportionately rendered—for far too many.

A key goal of our profession must be to help ensure equal justice for all. And as the struggle for equal justice continues, there is an important role for *pro bono* attorneys and volunteers. In our learned experience, the private bar is filled with people who have a strong passion to give back to their communities and to help people in need. Creating pathways for the unrepresented to access justice is not only personally rewarding but serving the public good upholds the values of justice and equality upon which the profession is built.

Ultimately, providing *pro bono* legal assistance is a fulfilling pathway to help create better outcomes for others. You might even get a call from a former client who you helped, who reports news of a landed job and a brighter future, personally thanking you for it.

WRITER'S CORNER

The Importance of Readability

By Veronica J. Finkelstein and Jack Foley

As Oliver Wendell Holmes famously noted, "Lawyers spend a great deal of their time shoveling smoke." Indeed, legal writing in his day tended to be verbose, philosophical, and dry. Even if contemporary legal writing is more colloquial, there is still room for improvement. In a federal case, U.S. District Court Judge William J. Martini noted that "[m]isused legalese, misplaced Latin terms, unwarranted excerpts from secondary sources and a mishmash of signs and symbols greatly detract from—rather than add to—the value of any legal document." Judge Martini is not alone in his disdain for unnecessarily complex writing.

Judges, like most readers, prefer clear, concise, and engaging writing. As members of the Bar, we should accommodate this preference. Doing so is to our own benefit. Research has discovered that judges not only prefer "readable" writing, but that they may actually deem "readable" briefs and motions to be more credible. Readability is key, yet it is a concept many lawyers know little about. In this first article of a three-part series, we will explain the concept and help you improve the readability of your own writing.

What is "readability?" The term encompasses all of a written text's elements that impact how well a reader will understand it, read it at an optimal speed, and find it interesting. Put another way, readability describes a text's difficulty level. Readability accounts for considerations like word choice, sentence structure, and paragraph length. Using these criteria, you can estimate the education level that would typically be required for a person to read the text without significant difficulty. Readability is not about substance. A complex topic can be addressed in a readable way and in a less readable way—it all depends on the writer's style.

Reading comprehension, in contrast, depends on both a text's substantive complexity and the reader's characteristics (*i.e.*, intelligence, background, and education). Reading comprehension measures whether a reader can understand a text's intended meaning and draw the correct conclusions from it.

The two concepts are intertwined; a variety of readers can comprehend a "readable" text. In the context of a brief, this means both a judge (who may be a subject-matter expert) and a clerk (who may not be) will have an easier time with a more readable brief. You typically cannot change the substantive complexity of your brief. Nor can you change the characteristics of your judge or the judge's clerk. You can change the style of your writing. Of all the factors involved in your brief's success, readability is the one you can control.

How do you measure readability so you can improve it? Researchers have created several tests to assess readability. These tests typically calculate readability based on "the relationship between text features" (*i.e.*, the average number of syllables per word, words per sentence, and sentences per paragraph) and "text difficulty" as measured by reading comprehension and speed. The theory behind readability tests is that shorter words, shorter sentences, words with fewer syllables, and words that are commonly used are easier to read and understand. The less mental work required of the reader, the easier a text is to read.

Microsoft Word contains two built-in readability tests: the Flesch Reading Ease Test; and the Flesch-Kincaid Grade Level Test. Although the two tests use the same core measures (word length and sentence length), the tests weigh various factors differently.

The Flesch Reading Ease scores range from 0 to 100; scores from 0–30 indicate "very difficult" text, scores from 60–70 indicate "standard" text, and scores from 90–100 indicate "very easy" text. The higher the reading ease score, the easier a text is to read and understand. The Flesch-Kincaid Grade Level Test compares a text's readability to a United States grade school level. Flesch Reading Ease scores from 0–30 equate to a college graduate reading level, scores from 60–70 equate to an eighth-grade student reading level, and scores from 90–100 equate to a fifth-grade student reading level.

Translating these metrics into more familiar terms, *Reader's Digest* magazine has a readability index of about 65, *Time* magazine scores about 52, and the *Harvard Law Review* has a general readability score in the low 30s. Legal writing experts recommend a readability score in the 30s for briefs. Next time we will discuss how to score your own writing and improve its readability.

Veronica serves as an Assistant United States Attorney for the Eastern District of Pennsylvania and is an Adjunct Professor at Rutgers Law. Jack is a Legal Intern working for the U.S. Attorney's Office.

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The Clash for COVID Coverage

Business Interruption Insurers May Have Won More Battles, But New Jersey Policyholders Still Can (and Should) Win the War

by Sherilyn Pastor, Anthony Bartell, and Mario S. Russo

Fundamental principles of insurance policy interpretation require courts to construe insurance policy language as would a layperson, and not as would an insurance expert, attorney or legal scholar.[1] New Jersey courts apply this basic tenet of insurance policy interpretation, giving "words in an insurance contract…the meaning of common parlance," and if the language remains susceptible to different meanings, adopting the one most favorable to the policyholder.[2] Insurers litigating cases involving insurance coverage for COVID-19 business interruption losses cannot dispute legitimately these fundamental principles. They, instead, ask and expect courts to ignore the established rules of insurance contract interpretation on the ground that insurers, at least thus far, have "won" the majority of COVID-19-related insurance cases.

Those tracking COVID-19-related coverage litigation have observed the disturbing trend that courts addressing coverage for business interruption losses largely have foregone the required legal analysis, "in favor of treating the issue as determined by what one might term the 'first wave' of trial court decisions." They observe that "a cascade effect appears to have taken hold, with attendant reflexive resistance to COVID coverage rather than the required, closer and more sophisticated analysis the matter deserves."

From top: **SHERILYN PASTOR, ANTHONY BARTELL** *and* **MARIO S. RUSSO** *are insurance recovery attorneys at McCarter & English, LLP, in Newark, New Jersey, where they represent policyholders in complex insurance disputes. The views expressed in this article do not reflect the position of McCarter & English, LLP, or its clients. Issues related to insurance coverage remain fact-specific, and their resolution will depend on the facts at issue, the precise insurance policy terms involved and the governing law, which may vary from state to state. This article is for informational purposes only, and no one should take any action based on it without seeking professional advice.*

Around the country, some courts have obliged, denying policyholders the business interruption coverage for which they paid substantial premiums based not on a rigorous legal analysis, but on the insurers' flawed "headcount" theory. These courts have accepted the proposition that they should follow their fellow jurists' rulings against policyholders even when the previous rulings involve materially different facts and/or governing law. This approach is troubling, particularly in New Jersey where courts must apply carefully established pro-policyholder precedent to the specific facts under consideration. We demonstrate below that at least in New Jersey, the appropriate legal analysis weighs heavily in favor of policyholders, especially where the dispute turns on the policy's "direct physical loss of or damage to property" language.

Insurance companies primarily have asserted two substantive bases for denying coverage for COVID-19-related business interruption insurance claims: (1) COVID-19 does not result in "direct physical loss of or damage to property," as required by most policies; and/or (2) the involved policy purportedly has some version of a "virus exclusion." Thus far, many New Jersey decisions involving coverage for COVID-19-related business interruption losses have involved only the latter issue. Meaning, New Jersey state courts have not yet opined directly on whether COVID-19 satisfies an insurance policy's "direct physical loss of or damage to property" language.

New Jersey, like most other states, abides by certain well-settled principles governing insurance policy interpretation. Courts must construe liberally insurance policies "to the end that coverage is afforded 'to the full extent that any fair interpretation will allow.'"[3] Courts also must construe policy ambiguities "in favor of the insured and against the insurer."[4] "If the controlling language will support two meanings, one favorable to the insurer, and the other favorable to the insured," then a court must apply "the interpretation sustaining coverage."[5] Courts, in fact, must construe policy language against the insurer drafter "even if a 'close reading' might yield a different outcome, or if a 'painstaking' analysis would have alerted the insured that there would be no coverage."[6] Equally importantly, "in the absence of a specific definition in a policy," or "when the meaning of a phrase in a policy is ambiguous," courts must resolve policy language interpretation disputes "in line with the insured's objectively reasonable expectations."[7] Courts accomplish the goal by, among other things, construing insurance policy language in accordance with its ordinary meaning or, stated differently, in conformance with how an ordinary layperson would understand it.[8] New Jersey courts, finally, refuse to construe insurance policies in a way which renders any language thereof meaningless surplusage.[9]

Those tracking COVID-19-related coverage litigation have observed the

Ordinary laypeople…have no idea how courts define specific policy language. Moreover, and perhaps more importantly, to construe insurance policy language as would an ordinary layperson requires courts, by definition, to interpret such language based upon its ordinary meaning, not as courts or the lawyers litigating before them might interpret it or previously have interpreted it.

disturbing trend that courts addressing coverage for business interruption losses largely have foregone the required legal analysis, "in favor of treating the issue as determined by what one might term the 'first wave' of trial court decisions."[10] They observe that "a cascade effect appears to have taken hold, with attendant reflexive resistance to COVID coverage rather than the required, closer and more sophisticated analysis the matter deserves."[11] At least one court has recognized that this inclination constitutes "an abdication of [courts'] judicial role."[12]

Analysis under controlling law and the involved policy language remains critical. It cannot be replaced by reliance on non-binding decisions, especially those rendered out of state and on facts and policy language materially different than those before the court. Building on the momentum generated by these often easily distinguishable and legally flawed cases, insurers have asserted the term "physical," as used in the phrase "direct physical loss of or damage to property," necessarily means "structural." Insurers also argue—contrary to the prohibition against meaningless policy language—that the words "loss" and "damage" mean the same thing, and that both require "alteration" or "destruction." Such positions run afoul of New Jersey's "ordinary person" policy interpretation rule for several reasons. Even if certain other jurisdictions have interpreted "direct physical loss of or damage to property" consistently with the insurance industry's proffered interpretation, ordinary laypeople generally lack knowledge of, and access to, such court opinions. Ordinary laypeople, therefore, have no idea how courts define specific policy language. Moreover, and perhaps more importantly, to construe insurance policy language as would an ordinary layperson requires courts, by definition, to interpret such language based upon its ordinary meaning, not as courts or the lawyers litigating before them might interpret it or previously have interpreted it.

An average layperson most likely would not expect the term "physical" to mean only "structural," or the words "loss" and "damage" to mean the same thing and both to require the "alteration" or "destruction" of property. An ordinary layperson more likely would assign the term "physical" a more general, dictionary definition encompassing anything "of or relating to material things."[13] An ordinary layperson also likely would believe the words "damage" and "loss" mean different things—especially when separated by the disjunctive "or"—and would give the latter word a broad meaning encompassing a myriad of circumstances, including "deprivation." Courts cannot reject these ordinary layperson understandings of policy language without contravening well-settled rules of insurance policy interpretation. To do so also moots one of the judicial system's primary objectives in the insurance context; *i.e.*, to force insurers to draft policies in a way that allows a layperson to ascertain correctly the contours of its purchased coverage.

The insurance industry's proffered policy language interpretation arguments conflict directly with controlling New Jersey law respecting physical damage. As the court recognized in *Optical Services USA/JCI v. Franklin Mutual Insurance Co.*,[14] the Appellate Division held in *Wakefern Food Corp. v. Liberty Mutual Fire Insurance Co.*,[15] that "[s]ince the term 'physical' can mean more than material alteration or damage, it is incumbent on the insurer to clearly and specifically rule out coverage in the circumstances where it was not to be provided."

Wakefern involved a policyholder cooperative, whose members do business under the "ShopRite" banner. The cooperative purchased insurance coverage for damage caused by an interruption of electrical power. The case involved the 2003 Northeast blackout, a cascading power outage that affected major parts of the northeastern United States, and which resulted in food spoilage at the cooperative's stores and warehouses. The involved policy provided coverage for interruption of power resulting from "physical damage to off-site electrical equipment," a phrase significantly narrower than the "loss or damage" language appearing in most property policies. Liberty Mutual there argued the blackout resulted not from "physical damage to" the off-site power grid, but from safety relays that automatically shut-down and de-energized the transmission lines and succeeded in *preventing* physical damage to the equipment.[16] The trial court agreed with Liberty's no physical damage position, but the Appellate Division reversed, finding the trial court's decision "inconsistent with well-settled principles of insurance

law," and entered summary judgment in Wakefern's favor.[17]

The *Wakefern* decision rests largely on the Appellate Division's finding that the phrase "physical damage" is ambiguous:

> We conclude that the undefined term "physical damage" was ambiguous and that the trial court construed the term too narrowly, in a manner favoring the insurer and inconsistent with the reasonable expectations of the insured. In the context of this case, the electrical grid was "physically damaged" because, due to a physical incident or series of incidents, the grid and its component generators and transmission lines were physically incapable of performing their essential function of providing electricity.[18]

The court relied on the "well settled" proposition that "those purchasing insurance 'should not be subjected to technical encumbrances or to hidden pitfalls,' and that insurance policies 'should be construed liberally in their favor to the end that coverage is afforded to the full extent that any fair interpretation will allow.'"[19] The court also noted that prior precedent from both New Jersey and other jurisdictions support its conclusion regarding the ambiguity of the term "physical damage." The Appellate Division cited a New Jersey case involving whether the loss of value of a soft drink product in a warehouse constituted a "physical loss."[20] The Appellate Division there explained: "Since 'physical' can mean more than material alteration or damage, it was incumbent on the insurer to clearly and specifically rule out coverage in the circumstances where it was not to be provided, something that did not occur here."[21]

The *Wakefern* court also cited with approval the Colorado Supreme Court's decision in *Western Fire Insurance Co. v. First Presbyterian Church*.[22] The court there held that a church, required by the local fire department to close its doors due to the accumulation of gasoline vapors under and around the premises, had suffered a "physical loss" within the meaning of its insurance policy because that phrase could encompass a "loss of use."[23]

The *Wakefern* court, moreover, discussed *Southeast Mental Health Center, Inc. v. Pacific Insurance Co.*,[24] which concluded "physical damage" could include loss of "functionality," even if the affected machinery remained intact following a power outage.[25] The Appellate Division also cited with approval *American Guarantee & Liability Insurance Co. v. Ingram Micro, Inc.*,[26] which found "'physical damage' is not restricted to the physical destruction or harm of computer circuitry but includes loss of access, loss of use, and loss of functionality."[27]

Insurers in pandemic-related coverage cases have tried to twist footnote 7 of the *Wakefern* decision, which states:

> We would reach a different result if, for example, a governmental agency had ordered that the power be shut off to conserve electricity. *See Source Food Tech., Inc. v. U.S. Fid. & Guar. Co.,* 465 F.3d 834 (8th Cir.2006) (no coverage for insured's inability to obtain beef product due to government action prohibiting importation of Canadian beef)."[28]

That *dicta*, however, does not support the insurer's position because (among other reasons) the coverage-triggering language in *Wakefern* required "*physical damage to* off-site electrical equipment." This language remains much narrower than that found in most property policies, which provide coverage for "physical *loss of* ***or*** damage to" property. Although a purely unprompted and prophylactic government order to shut down electrical equipment may not constitute "physical ***damage to"*** that equipment, such an order would constitute a "physical ***loss of"*** the equipment. This conclusion flows precisely from footnote 7's citation to *Source Food*.

The Eighth Circuit in *Source Food* noted that a one-word change in policy language would have made all the difference in that case: "Moreover, the policy's use of the word 'to' in the policy language 'direct physical loss to property' is significant. Source Food's argument might be stronger if the policy's language included the word 'of' rather than 'to,' as in 'direct physical loss *of* property' or even 'direct loss *of* property.'"[29] The government-ordered prohibition in *Source Food*, therefore, would have fallen within the policy's coverage had the policy contained the coverage-triggering language contained in most policies, requiring "physical loss of or damage to" covered property.

Notwithstanding the fact that New Jersey substantive insurance law remains strongly on the side of COVID-impacted policyholders, insurers litigating in this state likely will continue asking courts to abdicate their responsibilities to conduct a rigorous legal analysis based upon New Jersey precedent and insurance principles. This is shocking given that insurers, themselves, concede and have represented to courts that loss of use constitutes "physical loss or damage" under New Jersey law and, relatedly, that "physical loss or damage" to property exists when the presence of a physical substance renders property unfit for its intended use, despite causing no structural alteration to property.[30] Despite their prior inconsistent positions, insurers shamelessly will urge the easiest path for courts already burdened by heavy dockets is to follow previous COVID coverage rulings even when inapplicable or simply wrong. New Jersey state courts should reject this approach and, instead, embrace their judicial role. They can and should apply the state's rock-solid precedent, which almost certainly will result in deserved coverage victories for policyholders. ⚖

Endnotes

1. *See, e.g.*, *Hooters of Augusta, Inc. v. Am. Glob. Ins. Co.*, 272 F. Supp. 2d 1365, 1372 (S.D. Ga. 2003) ("The policy should be read as a layman would read it and not as it might be analyzed by an insurance expert or an attorney." (citation omitted)), *aff'd*, 157 F. App'x 201 (11th Cir. 2005); *accord Park Univ. Enterprises, Inc. v. Am. Cas. Co. of Reading, PA.*, 314 F. Supp. 2d 1094, 1107–09 (D. Kan. 2004), *aff'd sub nom. Park Univ. Enterprises, Inc. v. Am. Cas. Co. Of Reading, PA*, 442 F.3d 1239 (10th Cir. 2006).
2. *See Rudolph v. Home Indem. Co.*, 138 N.J. Super. 125, 136 (Law. Div. 1975).
3. *President v. Jenkins*, 180 N.J. 550, 563 (2004) (quoting *Kievit v. Loyal Protective Life Ins. Co.*, 34 N.J. 475, 482 (1961)); *accord Sandler v. N.J. Realty Title Ins. Co.*, 36 N.J. 471, 479 (1962).
4. *Doto v. Russo*, 140 N.J. 544, 556 (1995) (citations omitted).
5. *Mazzilli v. Accident & Cas. Ins. Co. of Winterthur, Switzerland*, 35 N.J. 1, 7 (1961); *accord Voorhees v. Preferred Mut. Ins. Co.*, 128 N.J. 165, 173–74 (1992); *Atl. Emp'rs Ins. Co. v. Chartwell Manor School*, 280 N.J. Super. 457, 465 (App. Div. 1995); *Danek v. Hommer*, 28 N.J. Super. 68, 77 (App. Div. 1953) (citation omitted), *aff'd*, 15 N.J. 573 (1954).
6. *Flomerfelt v. Cardiello*, 202 N.J. 432, 441 (2010) (internal and external citations omitted).
7. *Fairlawn Indus., Ltd. v. Gerling Am. Ins. Co.*, 342 N.J. Super. 113, 118 (App. Div. 2001) (citing *Crest-Foam Corp. v. Aetna Ins. Co.*, 320 N.J. Super. 509, 519 (App. Div. 1999), and *Voorhees*, 128 N.J. at 174); *see also Sparks v. St. Paul Ins. Co.*, 100 N.J. 325, 336 (1985) (noting insurance contracts must be enforced "in accordance with the reasonable expectations of the insured").
8. *See Rudolph*, 138 N.J. Super. at 136.
9. *See Homesite Ins. Co. v. Hindman*, 413 N.J. Super. 41, 47 (App. Div. 2010) (refusing to "read one policy provision in isolation when doing so would render another provision meaningless"); *Zurich Am. Ins. Co. v. Keating Bldg. Corp.*, 513 F. Supp. 2d 55, 64 (D.N.J. 2007) ("[W]hen interpreting an insurance policy, [a] court must endeavor to give effect to all terms in a contract and the construction which gives a reasonable meaning to all its provisions will be preferred to one which leaves a portion of the writing useless or inexplicable.") (internal quotations omitted) (quoting *Linan-Fay Constr. Co. v. Housing Auth.*, 995 F. Supp. 520, 524 (D.N.J. 1998)); *accord J. Josephson, Inc. v. Crum & Forster Ins. Co.*, 293 N.J. Super. 170, 216 (App. Div. 1996).
10. Erik Knutsen & Jeff Stempel, *Knutsen & Stempel on the Federal Court Rush to Judgment,* Univ. Penn. Carey Law School (July 25, 2021), cclt.law.upenn.edu/2021/07/25/knutsen-stempel-on-the-federal-court-rush-to-judgment/.
11. *Id.*
12. *See MacMiles, LLC v. Erie Ins. Exchange*, No. GD-20-7753, 2021 WL 3079941, at *5 n.12 (Pa. Com. Pl. May 25, 2021) (quoting *Fayette Cty. Hous. Auth. v. Hous. & Redevelopment Ins. Exch.*, 771 A.2d 11, 15 (Pa. Super. Ct. 2001), *appeal granted, cause remanded*, 568 Pa. 126 (2002)).
13. *Physical,* Meriam-Webster, merriam-webster.com/dictionary/physical (last visited Aug. 18, 2021).
14. No. BER-L-3681-20, 2020 N.J. Super. Unpub. LEXIS 1782 (N.J. Super. Ct. Law Div. Aug. 13, 2020).
15. 406 N.J. Super. 524 (App. Div.), *certif. denied*, 200 N.J. 209 (2009).
16. *Id.* at 535.
17. *Id.* at 529.
18. *Id.* at 540.
19. *Id.* at 539.
20. *Id.* at 541–42 (citing *Customized Distribution Servs. v. Zurich Ins. Co.*, 373 N.J. Super. 480, 491 (App. Div. 2004), *certif. denied*, 183 N.J. 214 (2005)).
21. *Id.* at 541–42 (citation omitted).
22. 165 Colo. 34, 437 P.2d 52 (1968).
23. *Id.* at 540 (citation omitted).
24. 439 F. Supp. 2d 831 (W.D. Tenn. 2006).
25. *Id.* at 543 (citation omitted).
26. No. CIV. 99-185 TUC ACM, 2000 WL 726789, at *2 (D. Ariz. Apr. 18, 2000).
27. *Id.*
28. *Id.* at 540 n.7.
29. *Source Food Tech., Inc. v. U.S. Fid. & Guar. Co.*, 465 F.3d 834, 838 (8th Cir.2006) (emphasis in original).
30. *See, e.g.*, Plaintiff Factory Mutual Insurance Company's Motion *In Limine* No. 5 Re Physical Loss or Damage at 3, filed Nov. 19, 2019 in *Factory Mut. Ins. Co. v. Fed. Ins. Co.*, No. 1:17-cv-00760-GJF-LF (D.N.M.) (conceding that (1) "case law… broadly interprets the term 'physical loss or damage' in property insurance policies," and (2) "[n]umerous courts," including those applying New Jersey law, "have concluded that loss of functionality or reliability… constitutes physical loss or damage," and citing cases).

A Hack a Day—Can Insurance Keep the Resulting Losses Away?

How Insurance Protects Against Cyber Risks and How Courts Interpret Coverage

by Kimberly Parson and Eugene Killian

The 1996 movie *Independence Day*, like many books and movies that are more than a few years old, now seems hilariously dated with respect to technology. As you probably know, the movie involves the invasion of earth by massive, murderous alien spaceships. At one point, David Levinson (Jeff Goldblum), the movie's computer nerd, is sitting on the floor contemplating the fate of humanity. Julius Levinson (Judd Hirsch), his father, tells him to get up before he catches a cold. That creates the light bulb moment in David's mind. He'll give the alien computers a "cold!" A "virus!" That will save the day!

Difficult as it is to believe 25 years later, a computer virus was a novel and mystifying concept to most moviegoers in 1996.

This past Independence Day weekend, things became more real, with one of the largest criminal ransomware attacks ever. Kaseya, a global IT infrastructure provider, suffered an attack that utilized its Virtual System Administrator (VSA) software to deliver REvil (also known as Sodinokibi) ransomware to customers through an automatic update. Between 800 and 1,500 small businesses and other organizations had their data encrypted, including a grocery store chain and several schools. Eventually and fortunately, Kaseya was able to obtain a decryption key from an unidentified third party. Sadly, these types of attacks are expected to continue indefinitely, in part because the Russian government will do nothing to stop them as long as they do not target Russian interests.

The Kaseya attack, and other recent high-visibility attacks such as the one on Colonial Pipeline, have again made the issue of insurance coverage for cyber-losses a hot topic. To what extent does insurance protect against, among other things, liability for costs incurred by customers and other third parties, the cost of repairing or replacing lost systems and data, losses from business closure or slowdowns, regulatory fines for failure to adhere to state and federal-mandated compliance requirements for protecting cus-

tomers' data, and related lawsuits? The answers remain largely unclear, with Courts continuing to render seemingly contradictory rulings.

Businesses continue to look to various types of insurance policies to protect from losses and liabilities arising from cyber-attacks and IT-related incidents. These include what the insurance industry has labelled "silent cyber" coverage, such as the following:

- **Comprehensive General Liability** (CGL) policies for property damage (to tangible property), as well as personal and advertising injury liability coverage for injuries caused by the publication of material that violates a right to privacy.
- **Crime Insurance** coverage, which protects against loss of property resulting from intrusion into a computer system, and typically insures against the "direct loss of, or direct loss from damage to," money, securities and other property "directly" caused by fraud.

Unfortunately, policyholders seeking to enforce coverage under CGL or crime insurance coverage are often in for a fight. Given the high level of exposure for cyber-liability, insurance companies tend to construe these policies very narrowly, and often argue that coverage for most hacking incidents was never intended.

Stand-alone cyber coverage is also available, although underwriting requirements for such policies are now tightening due to the proliferation of attacks. Broadly speaking, cyber insurance policies specifically cover the costs of cybersecurity failures, including data recovery, system forensics, and the costs of defending lawsuits and making reparations to customers. There is no standard form of cyber policy, and little decisional law interpreting coverage.

Cyber coverage cases under "traditional" business policies generally fall into four categories. First, cases under CGL or property policies finding that coverage exists due to a user's computer hardware being rendered inoperable. In these cases, Courts find that the requirement of tangible "property damage" has been met.[1] Second, and conversely, cases finding no coverage where only data was lost, on the theory that data constitutes uncovered "intangible" property.[2] Third, cases involving the "personal injury" coverage in a CGL policy, sometimes turning on whether there has been a required "publication" of private information.[3] Fourth, cases finding no coverage where the policyholder's system was breached by a third party who accessed customer information, but the alleged "publication" was by the third party and not by the policyholder. The theory of noncoverage for this type of claim is that the policy only provides coverage for the policyholder's acts or omissions, and not those of third parties.[4]

As a recent example of a claim for cyber liability coverage under a CGL policy, *Landry's, Inc. v. The Insurance Co. of the State of Pennsylvania*[5] involved a policyholder (Landry's) that operates retail properties including restaurants, hotels, and casinos. Landry's discovered a data breach that occurred between May 2014 and December 2015, involving the unauthorized installation of a program on its payment processing devices. For over a year, the program retrieved personal information from millions of credit cards, and at least some of that information was used to make unauthorized charges. The losses totaled over $20 million.

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Landry's credit card processing company, Paymentech, faced large claims from Visa and MasterCard as a result of the breach, and sued Landry's, contending that the losses resulted from Landry's not following proper security procedures.

Landry's filed a claim with its insurance company, ICSOP, requesting a defense to the Paymentech lawsuit. The "personal injury" part of the ICSOP policy covered liability for damages "arising out of the oral or written publication of material that violates a person's right of privacy."

The Court first held that the requisite "publication" had been alleged, writing:

> The *Paymentech* complaint plainly alleges that Landry's published its customers' credit-card information-that is, exposed it to view. In fact, the *Paymentech* complaint alleges two different types of "publication." The complaint first alleges that Landry's published customers' credit-card data to hackers. Specifically, as the credit-card "data was being routed through affected systems," Landry's allegedly exposed that data-including each "cardholder name, card number, expiration date and internal verification code." Second, the *Paymentech* complaint alleges that hackers published the credit-card data by using it to make fraudulent purchases. Both disclosures "expos[ed] or present[ed] [the credit-card information] to view."

Next, the Court, using an apt food analogy, found that the requisite invasion of privacy had also been alleged, writing:

> ICSOP urges us not to follow the plain text of the Policy and instead to alter it. In ICSOP's view, the Policy covers only *tort* damages "arising out of...the violation of a person's right of privacy." Thus, ICSOP suggests, it might defend Landry's if it were sued *in tort* by the individual customers who had their credit-card data hacked and fraudulently used. But ICSOP thinks it bears no obligation to defend Landry's in a *breach-of-contract* action brought by Paymentech. Of course, the Policy contains none of these salami-slicing distinctions.

Other policyholders have looked to their crime coverage for computer fraud issues. With respect to crime coverage, several Courts have found that no required "direct loss" has occurred where unwitting personnel transferred funds as the result of fraudulent communications via computer by imposters.[6] Other Courts have disagreed, finding that the policyholder suffered a "direct loss" because the fraudulent communication entered the policyholder's computer system, and computers were involved in the resulting loss.[7]

A recent interesting decision, *G&G Oil Co. of Ind., Inc. v. Cont'l W. Ins. Co.*,[8] involved the question of insurance coverage under a crime policy for a ransomware attack. After having its data locked by criminals. G&G Oil negotiated the decryption of its data in exchange for a ransom payment. G&G Oil then turned to its insurance company, Continental, which had sold a policy including coverage for, among other things, losses "resulting directly from the use of any computer to fraudulently cause a transfer of…property." Continental denied coverage, in part because G&G Oil had voluntarily paid the hacker. According to Continental, its policy only covered losses where the hackers themselves transferred the funds.

The Indiana Supreme Court first held that the term "fraudulently cause a transfer" can be reasonably understood as simply "to obtain by trick." According to the Court, a trial was needed to determine whether the hackers had accessed G&G Oil's systems through trickery, or whether the hackers simply entered the system unhindered.

With respect to whether the ransomware attack "directly" caused G&G Oil's loss, the Court held that this provision meant that G&G was required to show that its loss resulted either "immediately or proximately without significant deviation from the use of a computer." The Court held that this requirement was satisfied, writing:

> Analyzing G&G Oil's actions in this case, its transfer of Bitcoin was nearly the immediate result—without significant deviation—from the use of a computer. Though certainly G&G Oil's transfer was voluntary, it was made only after consulting with the FBI and other computer tech services. The designated evidence indicates G&G Oil's operations were shut down, and without access to its computer files, it is reasonable to assume G&G Oil would have incurred even greater loss to its business and profitability. These payments were "voluntary" only in the sense G&G Oil consciously made the payment. To us, however, the payment more closely resembled one made under duress. Under those circumstances, the "voluntary" payment was not so remote that it broke the causal chain. Therefore, we find that G&G Oil's losses "resulted directly from the use of a computer."

The bottom line is this. Cyber losses are never going away, because, to paraphrase famed bank robber Willie Sutton in another context, "That's where the money is." Enforcing coverage for such losses under general business policies will continue to be difficult, because insurance companies do not want to create precedent by freely paying claims in an area involving such huge exposure. Preventing losses through training and vigilance is the best protection for businesses. If losses happen, stand-alone cyber insurance policies are far more likely to provide necessary coverage for a variety of first-party and third-party losses. Because we face an environment

of exponentially increasing cyber attacks, principally through ransomware, premiums for specific cyber coverage are increasing, and underwriting requirements are more stringent. Policyholders who obtain such coverage can expect to see increased deductibles and more sub-limits, such as for ransomware attacks. ⚖

Endnotes

1. *Eyeblaster, Inc. v. Federal Insurance Co.*, 613 F.3d 797, 800-02 (8th Cir. 2010) (Minnesota law) (claim covered where visit to insured's website caused damage to third-party's computer, i.e., tangible property, rendering it inoperable, due to infection with spyware and other malicious programming from the insured's website); and *Retail Systems, Inc. v. CNA Ins. Companies*, 469 N.W. 2d 735, 738 (Minn. App. 1991) (Third-party liability policy covering "physical injury or destruction of tangible property" was held to cover damages for the loss of computer tape containing results of a voter survey; the computer tape and associated data were tangible property as defined in the policy).
2. *Ward General Ins. Servs., Inc. v. Employers Fire Ins. Co.*, 114 Cal. App. 4th 548, 7 Cal. Rptr. 3d 844 (2003), *as modified on denial of reh'g* (Jan. 7, 2004) (Insured filed action against insurer for declaration that its commercial policy covered losses incurred when data in its computer was inadvertently deleted, but Court held that data alone constitutes intangible property; thus, no coverage); and *Ciber, Inc. v. Federal Insurance Company*, Case No. 16-cv-01957-PAB-MEH, 2018 WL 1203157 (D. Colo. Mar. 3, 2018) (where customer alleged that software designed by insured failed to perform as required; this did not constitute damage to tangible property, as this involved shortcomings in the insured's software product, which is intangible property).
3. *Recall Total Info. Mgmt., Inc. v. Fed. Ins. Co.*, 317 Conn. 46, 50-51, 115 A.3d 458 (2015) (after tapes containing personal information of employees fell off truck and was retrieved by unknown individual, Court ruled this did not constitute a "personal injury" as defined by the policies because there had been no "publication" of information stored on the tapes resulting in a violation of a person's right to privacy, because there was no proof the lost information had been accessed, i.e. published to a third party); but see *Travelers Indem. Co. of Am. v. Portal Healthcare Sols., L.L.C.*, 644 F. App'x 245, 248 (4th Cir. 2016) (Virginia law) (hospital contracted with the insured for electronic storage of confidential medical files, a class action was filed after a patient's Google search for her name resulted in links that allowed direct access to patient's medical records; insurer had duty to defend, because allowing confidential medical records to be publicly accessible via the internet constitutes "publication" of those materials resulting in personal injury; and stated that publication occurs when information is "placed before the public," not when a member of the public reads the information place before them, so the medical records were published the moment they became accessible to the public).
4. *Zurich Am. Ins. v. Sony Corp. of Am.*, No. 651982/2011, 2014 WL 8382554, 2014 N.Y. Misc. LEXIS 5141 (N.Y. Sup. Ct. Feb. 21, 2014) (after confidential information was released following an illegal intrusion into Sony's secured sites, Court ruled, from the bench on motions, that there was no coverage for the hacking and related release of information, because publication by a third-party does not trigger coverage under CGL policy; as the policy provided coverage for "acts or omissions of an insured that causes covered losses to a third-party" not acts and omissions of third-parties that cause damage to the insured or others); *St. Paul Fire & Marine Ins. Co. v. Rosen Millennium, Inc.*, 337 F. Supp. 3d 1176, 1185-86 (M.D. Fla. 2018) (following a credit card breach caused by malware installed in insured's payment network, court denied coverage on the basis that

the injuries at issue resulted from the actions of third parties, and not those of the insured); and *Innovak Int'l, Inc. v. Hanover Ins. Co.*, 280 F. Supp. 3d 1340, 1347-48 (M.D. Fla. 2017) (insured provided software and database for schools and was sued in a class action after its database and software was hacked allowing access to employees personal information, but there was no indication of publication by hackers of the material they accessed; even so, had materials been published there would be no coverage, as the publication would not have been by the insured).

5. Docket No. 19-20430 (5th Cir. July 21, 2021)
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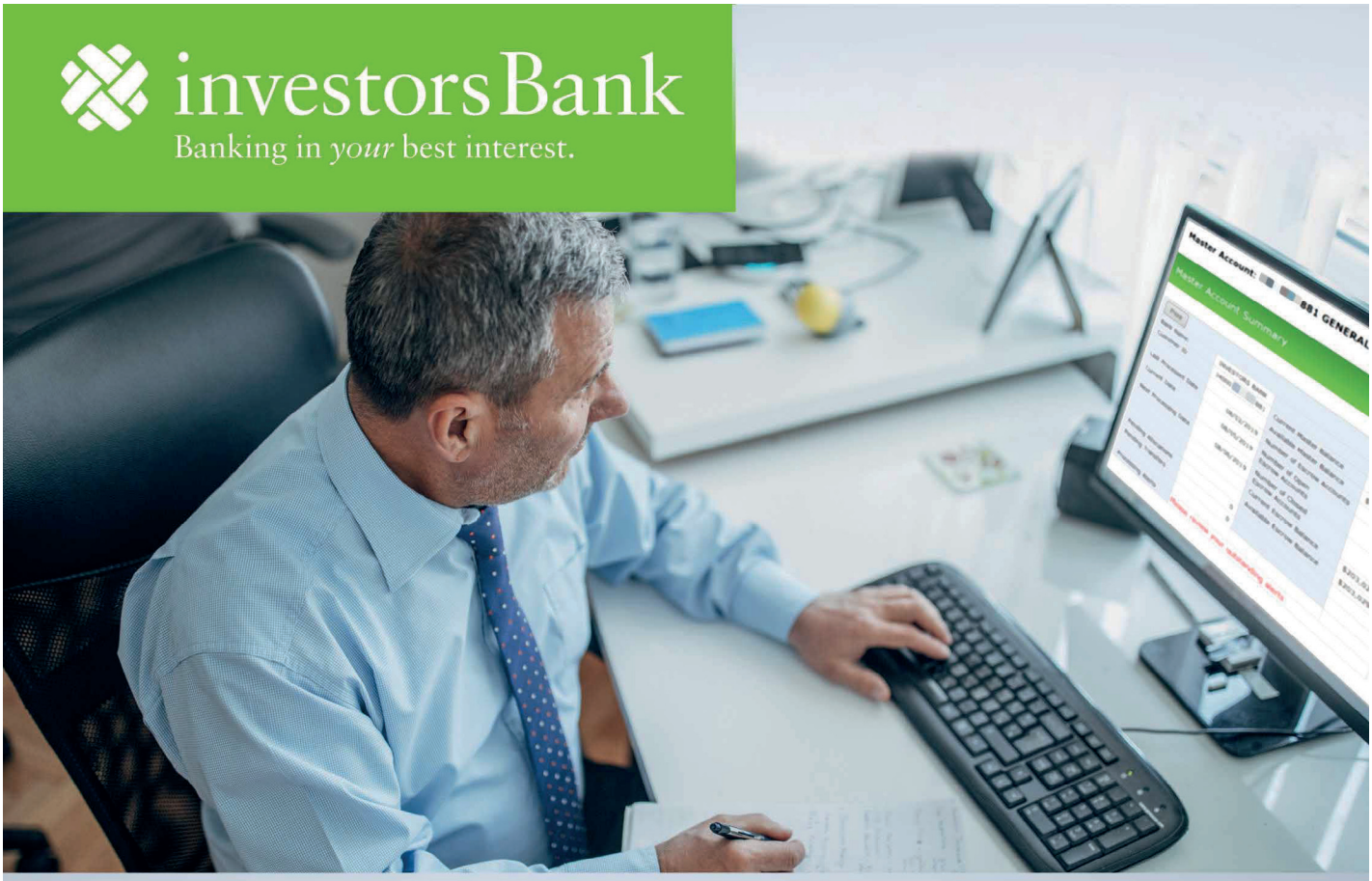

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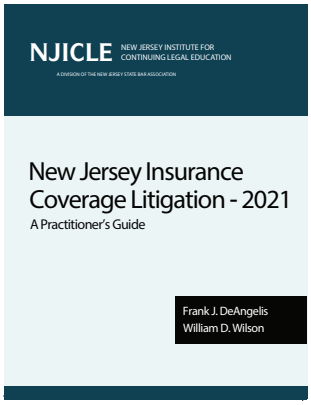

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New Jersey Insurance Coverage Litigation - A Practitioners Guide (2021)

Written by:
Frank J. DeAngelis, Esq.; William D. Wilson, Esq.

It has been almost four years since the second edition of this book was published. In this third edition, the authors have added analysis of every significant insurance case that has been decided by New Jersey state and federal courts since the second edition was published. In addition, this edition contains a new chapter on COVID-19 cases, focusing on first-party property insurance coverage for claims arising out of the coronavirus pandemic. In just the past few months, there have been over 30 decisions issued by both state and federal courts in New Jersey addressing COVID claims.

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High Time to Open a Cannabis Business Legally in New Jersey—and You Can Obtain Insurance

by Joanna L. Crosby

You don't want to be the people in Los Angeles area who were busted in July 2021 in connection with an illegal marijuana business. According to authorities, officials seized more than 370,000 marijuana plants and harvested product that was found by flight reconnaissance. The street value was estimated at $1 billion dollars. This is just one example, however, of how big the cannabis business is and that there is money to be made in this industry. Note that cannabis differs from CBD in that cannabis has a THC level of 0.3% or more. On a federal level, hemp and CBD are permitted under the federal 2018 Farm Bill.[1]

JOANNA CROSBY'S *law practice for over 30 years is primarily devoted to insurance coverage analysis and litigation. An attorney at Powell, Kugelman & Postell, LLC, Crosby is also a New Jersey licensed Property & Casualty insurance producer.*

You and your clients want to do it legally. New Jersey now presents that opportunity. In New Jersey, Governor Phil Murphy signed into law a bill in February 2021 which lays out a path for a legal recreational cannabis market. New Jersey voted to approve legalization of recreational marijuana in late 2020, becoming the 14th state to make cannabis legal. Since New Jersey is not the first, the experiences from other states will not only help regulators but will provide guideposts for potential New Jersey cannabis businesses.

As with any legitimate business, business owners want to protect the business, their interests and the assets from both first-party losses and third-party claims. Protection (via insurance) to cover such losses or claims is also a growing (*pun intended*) business. Despite the recent change to New Jersey law to allow the legitimate sale of recreational marijuana, a number of insurers, along with retail and surplus lines insurance producers, are at the ready to quote and bind first-party and third-party liability coverage for New Jersey businesses.

Insurance Application(s)

The insurance procurement process for a cannabis business, like any other business concern, starts with a policy application. For general liability coverage, typical applications will inquire whether the business is licensed for the marijuana operations in which it is involved. In fact, the insurer will typically require license numbers to be provided along with identification of whether the business is licensed as a:

- Dispensary/Retailer
- Grower/Cultivator
- Manufacturer/ Processor
- Distributor/Wholesaler
- Testing Lab
- Special Event or club
- Home Delivery
- Microbusiness

While many of the above categories are self-explanatory, it is important to examine all definitions in the *New Jersey Cannabis Regulatory, Enforcement Assistance, and Marketplace Modernization Act*[2] (CREAMMA). By way of illustration, CREAMMA defines "cannabis," "Cannabis consumption area," Cannabis cultivator," "Cannabis delivery service" and "microbusiness" etc. For example, the act provides that a "microbusiness" means a:

> Person or entity licensed under P.L. 2021. C. 16 (C24:61-31 et al.) as a cannabis cultivator, cannabis manufacturer, cannabis wholesaler, cannabis distributor, cannabis retailer or cannabis delivery service that may only, with respect to its business operations, and capacity and quantity of product: (1) employ no more than 10 employees; (2) operate a cannabis establishment occupying an area of no more than 2,500 square feet, and in the case of a cannabis cultivator, grow cannabis on an area no more than 2,500 square feet measured on a horizontal plane and grow above that plane not higher than 24 feet; (3) possess no more than 1,000 cannabis plants each month, except that a cannabis distributor's possession of cannabis plants for transportation shall not be subject to this limit; (4) acquire each month, in the case of a cannabis manufacturer, no more than 1,000 pounds of usable cannabis; (5) acquire for resale each month, in the case of a cannabis wholesale, not more than 1,000 pounds of usable cannabis, or the equivalent amount in any form of manufactured cannabis product or cannabis resin [also a defined term], or any combination thereof; and (6) acquire for retail sale each month, in the case of a cannabis retailer, no more than 1,000 pounds of usable cannabis, or the equivalent amount in any form of manufactured cannabis product or cannabis resin, or any combination thereof.

Adding to the requirements to obtain a license for a microbusiness is that 100% of the ownership interest in the microbusiness shall be held by current New Jersey residents who have resided in the state for at least the past two consecutive years. Also, the act requires "at least 51 percent of the owners, directors, officers, or employees of the microbusiness shall be residents of the municipality in which the microbusiness is located, or to be located, or a municipality bordering the municipality in which the microbusiness is located, or to be located." What is obvious from the act is the legislature's intent to help New Jersey residents open businesses and not have this industry in New Jersey completely *smoked out* by large multi-state businesses.

While there will certainly be "T"s to cross and "I"s to dot for the creation of any New Jersey cannabis business as the Cannabis Regulatory Commission (established by the act) develops, *rolls outs* and regulates the industry, it behooves those seeking cannabis licenses or conditional licenses to examine the insurance market and available products.

Available Types of Insurance Coverage and Exposure Considerations

According to Senior Brokerage Specialist Kevin Engelke of licensed New Jersey Surplus Lines Producer JIMCOR Agency, Inc., the evaluation of risk for a cannabis business is essential to obtain insurance. A typical cannabis business will, therefore, likely require first-party property coverage, workers compensation coverage for employees, general liability coverage, products liability coverage and commercial auto coverage. There will be an emphasis on evaluation of the operations exposure. Certainly, security and theft exposures due to the cash nature of the business need to be considered. For example, a grower in New Jersey falls within the definition of CREAMMA as a "cannabis cultivator." That cannabis cultivator will need crop coverage. Crop coverage is not a new type of coverage but here is being

applied to a new crop. Valuation of the crop plants and the number of plants will impact the premium. A cultivator that grows indoors, which provides more security and control, may be more attractive to an insurer than an outdoor crop.

If your new cannabis business is that of an extractor or "cannabis manufacturer" (another defined term in CREAMMA), that uses a high heat process, the cannabis business should expect higher property rates because of the increased fire risk.

A cannabis distributor (defined in part in New Jersey under CREAMMA as "any licensed person or entity that transports cannabis in bulk intrastate from one licensed cannabis cultivator to another licensed cannabis cultivator…or …from one class of licensed cannabis establishment to another class…") may require higher limits because of the value of transport of bulk goods.

On the retail side, there is also professional liability exposure. If your business's dispensary clerks are providing recommendations or advice about the products, budtenders errors and omissions coverage should be considered.

As the market expands, an insurer will identify its company's appetite (more than the munchies) as far as cannabis business size, specifications, and controls.

A typical general liability insurance application will likely inquire about the percentage of gross sales by product type, e.g. an edible infused with recreational marijuana, a concentrate or oil, the more commonly known leaf. Due to the value of the product and risk of theft, an insurance application for a cannabis business will inquire about security protocols and whether a third-party security service is used. No different than other businesses, the insurer will inquire about risk transfer and whether there are written contracts, indemnification provisions and additional insured procurement clauses. Obtaining a quote for liability insurance for a retail cannabis establishment will require providing information about the retail space, whether any drive thru sales occur there and whether there are online sales.

A cannabis business should anticipate that the general liability coverage it obtains may be Claims Made coverage.

Potential Exclusions

As with most general liability policies, the coverage afforded by a standard form is often modified by exclusions. Business and insurance litigators regularly grapple with specific business or product exclusions. That situation will no doubt arise in the cannabis industry as well. By way of illustration, but not limitation, the added exclusions may exclude insurance for bodily injury arising out of the design, manufacture, distribution, sale, serving, furnishing, use or possession of "marijuana" in which "marijuana" is a defined term. The definition may, in turn, exempt "industrial hemp." On at least one policy form used in the industry, the definition of "industrial hemp" would mean having no more than 0.3% THC. Given that CREAMMA uses the term "cannabis" and a procured insurance policy may use the word "marijuana," comparing definitions and what coverage is afforded and excluded is *highly* recommended. Other potential exclusions are Health, Nutrition and Lifestyle Exclusions with a schedule that designates certain products, supplements and additives as excluded such that the policy will not apply to bodily injury, property damage or personal and advertising injury arising out of (or described as "caused by," "connected with," etc.) the listed products. Security for the product and cash at a cannabis business may include utilization of firearms. Any claims involving the use of firearms may be excluded. A general liability policy or products policy may also exclude products manufactured, distributed or sold in violation of any regulation or law. State laws are rapidly changing. Federal law may soon change as well. In July 2021, Majority Leader Senator Chuck Schumer proposed legislation to legalize marijuana at the federal level. The major point is that the Cannabis Administration and Opportunity Act would remove marijuana from the Controlled Substances Act and introduce regulations to tax cannabis products. If an exclusion for "violation of any regulation or law" is in the policy, the cannabis business may obtain modification of that language to limit the exclusion to one for violation of state regulation or law.

In August 2021, the New Jersey regulations implementing CREAMMA were adopted. They can be found at N.J.A.C. 17:30-1.1 et seq. They provide direction and guidance. With regulations now in place, cannabis businesses should carefully evaluate them. The regulations do contain some insurance requirements. For example, pursuant to N.J.A.C. 17:30-12.8 (r) provides "a cannabis retailer and cannabis delivery service shall maintain current hired and non-owned automobile liability insurance sufficient to insure each delivery vehicle in the amount of at least $1,000,000 per occurrence or accident."

Insurance is risk control. Business operates best when risk is controlled. While the above generally describes the types of questions an insurer will ask in an application, underwriting considerations, types of coverage that may be appropriate for a cannabis business and some limitations to that coverage, the take-away is that insurers and producers in New Jersey are positioned to place coverage for New Jersey cannabis business. ⚖

Endnotes

1. Agricultural Improvement Act of 2018, Public Law No. 115-334, 132 Stat 4490.
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Media Liability Coverage Isn't Just for News Conglomerates Anymore

Social Media Use Opens Risk of Slander, Libel, Cyberbullying, and Intellectual Property Rights Violations

by Kathleen J. Devlin and Julia C. Talarick

Social media refers to the means of electronic communication, including websites for social networking and microblogging, through which users may create, share, or exchange information, ideas, personal messages, videos, and other content in virtual communities or networks.[1]

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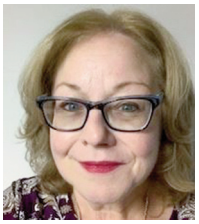

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Popular social media platforms include Facebook, Twitter, YouTube, Instagram, LinkedIn, TikTok, and blogs, to name a few. Facebook is the world's largest social network, with more than 2.8 billion monthly active users.[2] Users create a personal profile and add others as friends, exchange messages, photographs, and status updates.[3] Twitter is another social networking platform that allows groups and individuals to connect through the exchange of short status messages (280 characters or less). YouTube is a video hosting and watching website. Instagram allows free photo and video sharing, as well as digital filters and special effects.[4] LinkedIn is a professional network on the internet where people can find a job and/or build professional relationships.[5] TikTok is an app for making and sharing short videos.[6] "Blog" is an abbreviated version of "weblog," a term used to describe websites that maintain an ongoing chronicle of information, featuring diary-type commentary and links to articles on other websites.[7]

Indeed, social media has changed the way businesses market, disseminate information, and communicate with the public. It has also changed the way individuals communicate. With the advent of social media, we reacquaint with old school friends, join groups with people that have similar interests, look at cute baby pictures of relatives in distant lands, feel connected with family and friends during a pandemic, and learn the latest fashion trends and gossip from Hollywood stars. Comments previously confined to water cooler chatter or private communications are now posted or "tweeted" to thousands of people, friends, and/or "followers."

Potential Liability Arising From Social Media Use

Social media also exposes its users to potential liabilities and implicates various insurance coverage issues. Social media liability may include claims for slander, libel, cyberbullying, harassment, invasion of privacy, or intellectual property rights violations.

A statement is defamatory if it is "false, communicated to a third person, intends to lower the subject's reputation in the estimation of the community or to deter a third person from associating with him."[8] A defamatory statement may consist of libel or slander.[9] Libel is defamation by written or printed words, or by the embodiment of the communication in some tangible or physical form. Slander consists of the communication of a defamatory statement by spoken words or transitory gestures.[10]

Cyberbullying includes repeated harassing, humiliating, and/or threatening of others through electronic devices. Examples include posting embarrassing or inappropriate photos or videos, creating false profiles, sending threatening messages, or spreading rumors.[11]

In the cyber-harassment statute, the Legislature made it a crime when a defendant, through an electronic device or through a social networking site, "threatens to inflict injury or physical harm;" "threatens to commit any crime against [a] person or [a] person's property;" or "knowingly sends, posts, comments, requests, suggests, or proposes any lewd, indecent, or obscene material to or about a person with the intent to emotionally harm a reasonable person or place a reasonable person in fear of physical or emotional harm to his person."[12]

Cyberbullying includes repeated harassing, humiliating, and/or threatening of others through electronic devices. Examples include posting embarrassing or inappropriate photos or videos, creating false profiles, sending threatening messages, or spreading rumors.

Invasion of privacy may include the public disclosure of private facts, such as making public private information about a plaintiff; placing a plaintiff in a false light in the public eye, which does not need to be defamatory but must be something that would be objectionable to the ordinary reasonable person; and appropriation, for the defendant's benefit, the plaintiff's name or likeness.[13]

Further, social media may give rise to claims of infringement of intellectual property rights. Allowing users to share videos, photographs, and other documents, social media is easy for users to improperly use copyrighted materials. Likewise, trademark infringement claims may arise from social media use.

Types of Policies Implicated

As for the mitigation of social media risk, there is no standard approach.[14] Coverage that is available is typically part of a media liability policy or cyber coverage.[15] While the growth of social media has led to policy enhancements and forms that are written to address social media risks,[16] policyholders, faced with a social media liability, may look to different policies for coverage such as media liability, general liability, and directors and officers coverage. However, where policies were once limited to legacy media companies like ABC or CNN, these types of policies are increasing in popularity for commercial entities because of increased risk such as social media. Such media has become a significant tool used by business entities to

disseminate information and promote themselves.[17] In addition, entities also join forces with social media "influencers" to market themselves and their products.[18]

Media liability coverage is typically an Errors and Omissions policy for media-related businesses.[19] It is written on a "named peril" basis, subject to exclusions and conditions, and typically covers defamation, invasion of privacy, and copyright infringement.[20] A typical insuring grant in a media liability policy provides coverage when the insured's performance of media activities during the policy period results in a claim against the insured and arises from covered media or advertising activities, regardless of when a claim is made, including, but not limited to, claims for infliction of emotional distress or outrage, breach of confidentiality, invasion of privacy, a violation of any other legal protections for personal information, and negligent supervision of an employee and any form of negligence but only where the negligence arises from the insured's media content disseminated in covered media or advertising.[21] Terms like media or advertising activities and media content are defined terms.[22] While social media is a specific type of media liability, *e.g.*, Twitter, Facebook or a blog, a policy will need to provide coverage for particular risks associated with social media that include not only typical media risks but employment practices as well.[23]

Alternatively, based on the allegations of the complaint, a policyholder may look to its general liability policy. Such policy can have two separate coverage grants, Coverage A and Coverage B.[24] Coverage A applies to "bodily injury" and "property damage." If the complaint alleges "bodily injury," the insured may seek coverage under Coverage A; however, exclusion o. under Coverage A excludes coverage for "bodily injury" arising out of "personal and advertising injury."[25] In addition, even if a complaint alleged "bodily injury," it may not allege an "occurrence" or an accident.

The insured may fair better under Coverage B, which provides coverage for "personal and advertising injury." "Personal and advertising injury" is typically defined as injury, including consequential "bodily injury," arising out of one or more of the following offenses:

a. False arrest, detention or imprisonment;
b. Malicious prosecution;
c. The wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord or lessor;
d. Oral or written publication, in any manner, of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services;
e. Oral or written publication, in any manner, of material that violates a person's right of privacy;
f. The use of another's advertising idea in your "advertisement"; or
g. Infringing upon another's copyright, trade dress or slogan in your "advertisement."[26]

As discussed *infra,* claims of libel and slander and copyright infringement are not uncommon when an insured is faced with a social media claim. Therefore, Coverage B could, at a minimum, trigger a duty to defend under d., e., f., or g. However, Coverage B has several exclusions. For example, exclusion j. excludes coverage for "personal and advertising injury" committed by an insured whose business is: (1) advertising, broadcasting, publishing or telecasting."[27] Another common exclusion is first or prior publication exclusion that excludes coverage for "[i]njury arising out of oral or written publication of material whose first publication took place prior to the beginning of this policy or such coverage under this policy."[28] Under this exclusion, "it is essential to fix the time vis-a-vis the date of issuance of the policy when the first offending publications took place."[29]

Corporate officers and directors may also look to Directors & Officers (D&O) insurance for coverage. CEOs and other high-level officers may take to Twitter to post something that could be considered potentially false or deceptive as to the company's products or services resulting in shareholders' suit to the extent the company's stock is affected or government action is taken.[30] The act or event that triggers coverage under a D&O policy generally arises from an actual or alleged "Wrongful Act," a defined term under a D&O policy.[31] Typical D&O policy exclusions include the elimination of coverage for claims or activities known prior to purchasing the policy, and losses related to criminal or deliberately fraudulent activities.

Conclusion

The chances of a business or individual being exposed to a social media liability claim has increased significantly with the escalation of various social media platforms and online communications. Businesses can mitigate their social media exposures through risk management practices, such as the preparation and implementation of a social media policy defining acceptable social media usage, controls over messaging, and content. However, it is important that attorneys counsel their clients and increase their awareness of potential social media liability and review their insurance policies. The increased exposure created by social media raises important issues about whether such claims are covered under certain insurance policies. ⚖

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Expediency in Trying Times

Options for a Professional Lines Insurance Carrier Facing the Obdurate Policyholder

by J. Christopher Henschel

What can a professional lines insurance carrier do when a reasonable opportunity to settle presents in an underlying case, but the policyholder refuses under a Consent to Settlement Clause requiring the insurance carrier to obtain the consent of its policyholder before settling? Like almost everything in the world of law, the answer is "it depends." Here, what depends is how the insurance policy may afford consenting rights to the policyholder and settlement rights to the insurance carrier, and the extent to which those competing rights and interests interact with each other. This becomes a case specific, fact intensive inquiry, which turns entirely on the unique circumstances of each implicated matter. Ultimately, though, the insurance company will need to demonstrate that the policyholder's consent to the settlement was unreasonably withheld.

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The duty of good faith and fair dealing remains the paramount concern in any coverage dispute. However, an insurance carrier does not owe infinite deference to its policyholder. Consent to Settlement Clauses are colloquially referred to as "hammer clauses" or the more ominous "blackmail settlement clauses"[1] because they allow the insurance carrier to place a liability ceiling on a claim over the potential objections of the policyholder. Put another way, even if the policyholder refuses to consent to an otherwise reasonable settlement demand, the insurance carrier can limit its own indemnity exposure to the amount of the reasonable settlement demand, while the policyholder faces potential personal liability for any indemnity amounts ultimately in excess of the "refused" demand. Oftentimes, Consent to Settlement Clauses contain a "deems expedient" clause affording the insurance carrier control over settlement decisions. These two seemingly contradictory clauses guide the situation where the policyholder may refuse to settle over the recommendation of the insurance company.

An example Consent to Settlement Clause follows:

> Settlement of Claims. ***The Company shall have the right to make such investigation, negotiation or settlement of a covered Claim that it deems expedient***; provided, however, that the Company shall not settle any Claim ***without the consent of the Insured***, ***which shall not be unreasonably withheld***. If the Company recommends a settlement and the Insured refuses to give written consent to such settlement as recommended by the Company, then the Company's liability shall not exceed the amount which the Company would have paid for Damages and Claim Expenses at the time the Claim could have been settled or compromised. (emphasis added).

New Jersey courts have interpreted "deems expedient" language in a variety of types of insurance policies to afford insurance companies nearly unfettered discretion in managing claims. Absent a policyholder consent provision, this would be the typical end of any analysis addressing whether the insurance carrier has the ability to settle a matter of its own volition.[2] The inclusion of the Consent to Settlement Clause in favor of the policyholder undercuts that power.

However, the additional conditions on the Consent to Settlement Clause allow the "deems expedient" clause to keep its teeth—requiring that the consent shall not be unreasonably withheld, and limiting the damages of the insurance company to the ceiling of the recommended and refused settlement. It is important to recall that most professional lines policies are "defense within limits" policies. This means that both indemnity and defense costs erode the limits of an implicated policy, as opposed to only indemnity payments as seen in other lines of coverage. This makes the potential liability cap even more potent, as continued litigation may result in even greater defense and indemnity erosion than the refused settlement.

Why Would a Policyholder Refuse a Reasonable Settlement?

In addition to professional lines, similar clauses can also be found in Errors & Omissions, Directors & Officers, and other related insurance products. Oftentimes, the cover provided by these products involve claims that implicate, among others, public perception or professional reputation. With specific regard to professional lines, a policyholder's personal interest in defending against, *e.g.*, malpractice claims may, in their mind, outweigh the litigation risk of continuing to defend a claim through verdict. For example, an alleged engineering error on a popular bridge could result in not only litigation, but also media scrutiny for the engineering company. The engineering company's alleged error may become the subject news reports, or the litigation itself may capture the public's attention. Even if the engineering company was ultimately not at fault, a significant amount of professional and reputational damage can occur if the case is settled after these publicizing events. Litigating through a defense verdict might be seen as the only way for the engineering company to recover its reputational damages.

This creates a difficult situation for

New Jersey courts have interpreted "deems expedient" language in a variety of types of insurance policies to afford insurance companies nearly unfettered discretion in managing claims. Absent a policyholder consent provision, this would be the typical end of any analysis addressing whether the insurance carrier has the ability to settle a matter of its own volition. The inclusion of the Consent to Settlement Clause in favor of the policyholder undercuts that power.

To be sure, good faith and fair dealing are at the forefront of any analysis dealing with the objections of the policyholder to a course of action. Ultimately, the risk facing the insurance company is a declaratory judgment action from the policyholder over the reasonableness of the settlement and whether that settlement was in good faith becomes the focal point.

the relationship between the engineering company and the insurance company. The engineering company is concerned not only with the immediate exposure presented by the claim but also, understandably, the effect reputational harm can have future business. This can lead to emotional and biased evaluations of how the claim or litigation should proceed by the engineering company. Conversely, an insurance company will, in theory, evaluate the claim from a dispassionate and analytical approach. Under such circumstances, a settlement offer within or at limits may be tendered by the underlying plaintiff which the insurance company may recommend that the engineering company take, but which the engineering company refuses.

Notably, these Consent to Settlement Clauses are different from their cousins in the commercial general liability (CGL) context. Coverage disputes surrounding the consent to settle provisions in the CGL realm are frequently litigated, and often involve situations where the *policyholder* settles an underlying bodily injury or property damage claim without the prior authority of the insurance carrier. Such disputes revolve around the interpretation of policy terms and conditions involving, *inter alia*, obtaining the prior consent of the insurance carrier to settle, the extent of coverage available for voluntary payments by a policyholder, or even using settlement language that may impair the rights of the insurance carrier. Most of the time, CGL consent to settle issues revolve around the effect the settlement of a claim has on the insurance carrier. This hypothetical raises the opposite end of that question—what happens when the policyholder refuses to settle.

What Happens After the Policyholder Refuses to Consent to a Settlement?

Unlike the CGL consent provisions, the professional lines Consent to Settlement Clause is infrequently litigated. However, the New Jersey Supreme Court has recognized that "there may be situations where it would plainly be unreasonable or in bad faith for the insured to withhold his consent or to attempt to withdraw it."[3] In *Lieberman v. Employers Ins. Co. of Wausau*, the Supreme Court addressed whether the policyholder could revoke its prior consent to a settlement. The insurance company settled the underlying claim despite the subject revocation, and the policyholder sued the insurance company. The Supreme Court explained that in order to recover from the insurance company, the policyholder must be able demonstrate actual damages as a result of the insurance company's settlement over the policyholder's objections including, in particular, that it would have obtained a defense verdict at trial.

To be sure, good faith and fair dealing are at the forefront of any analysis dealing with the objections of the policyholder to a course of action. Ultimately, the risk facing the insurance company is a declaratory judgment action from the policyholder over the reasonableness of the settlement and whether that settlement was in good faith becomes the focal point. However, there is another option for the insurance company. In the event that the insured unreasonably withholds consent to settle, the insurance company can also exercise its further rights to limit liability to the sum total of the offered settlement.

The Deems Expedient and Consent to Settlement Clauses in Action

As a hypothetical, our engineering company was involved on a project for a bridge spanning a major waterway and connecting two states. Very public allegations arise that the engineering company committed significant errors, and a litigation ensues. At the beginning of the litigation, the engineering company receives a $15 million settlement demand. After discovery exchanges, it is revealed that a different company may bear some or all of the responsibility. However, it remains unclear whether the engineering company will be found liable at trial.

The engineering company has a $10 million defense within limits professional lines policy containing the full above referenced Consent to Settlement Clause. Approximately $1 million has been spent on claims expenses already. The underlying plaintiff revises its demand in light of the existence of the potential liability of the second company, seeking $7 million. The insurance company recommends the settlement, but the engineering company believes it has been wrongfully sued and wants to continue the litigation in order to fully

blame the second company for the underlying issues. Therefore, the engineering company refuses to consent to the settlement.

The insurance company now has two choices. It can, pursuant to the "deems expedient" clause, attempt to settle with the underlying plaintiff as demanded. This could result in litigation with the engineering company policyholder, who may seek a declaratory judgment that the $7 million settlement was unreasonable and executed in bad faith. Alternatively, the insurance company can inform the engineering company that it is exercising the ceiling provisions of the clause, and attempt to cap its own exposure at $7 million if the engineering company desires to continue with the litigation. This puts the engineering company in the position of knowing that its total defense and indemnity coverage available under the policy has been limited, and the engineering company will face any additional potential liabilities alone. This can place immense pressure on a policyholder to accept the settlement if it is truly reasonable—recognizing that a reasonable settlement may not provide the desired public perception outcome the engineering company desires.

However, even under the "capped" situation, the policyholder may still choose to engage in a subsequent declaratory judgment action with the insurer. In particular, the policyholder may argue that the settlement demand was unreasonable, and therefore the policyholder should have been entitled to additional limits under the policy. Hypothetically, the engineering company may ultimately spend more money than the demand obtaining a defense verdict and seek to recover that difference from the insurance company. Although the question of whether the consent to settle was unreasonably withheld is not definitively determined by a subsequent defense verdict, the insurance company could still face potential exposure in the way of bad faith and extra-contractual claims in a later declaratory judgment action.

Ultimately, principles of good faith and dispassionate evaluations of whether a settlement demand is reasonable should govern any decisions to execute rights under a Consent to Settlement Clause by an insurance company. Although relatively rare, disputes between insurance companies and policyholders over whether to settle can arise, and present a difficult decision tree of options and outcomes. Insurance companies should evaluate each situation on a case-by-case basis, keeping the principles of good faith and fair dealing at the forefront. ⚖

Endnotes

1. irmi.com/term/insurance-definitions/consent-to-settlement-clause#:~:text=Consent%20to%20Settlement%20Clause%20%E2%80%94%20a,claim%20for%20a%20specific%20amount.
2. *Am. Home Assur. Co. v. Hermann's Warehouse Corp.*, 117 N.J. 1 (1989) (addressing whether an insurance company can settle a claim and demand a deductible under a CGL Policy over the objections of the insured and holding "if, as here, the deductible provision is accompanied by another provision giving the carrier the unfettered right to settle as it 'deems expedient,' the insured has bargained away whatever rights might otherwise be created by what might be perceived as a conflict between insurer and insured."). *See also Travelers Ins. Co. v. Hitchner*, 160 A.2d. 521 (N.J. Super. 1960).
3. *Lieberman v. Employers Ins. Co. of Wausau*, 84 N.J. 325, 337 (1980).

The National Practitioner Data Bank—A Silent Factor at Play

by Nancy Crosta Landale

Of all the factors impacting the decision to settle a medical malpractice case, perhaps the least known or appreciated is the National Practitioner Data Bank (NPDB). This article gives a basic explanation of the NPDB and considers ways in which the NPDB may affect settlement decisions.

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What is the NPDB?

Finding that the "need to improve the quality of medical care" was a "nationwide problem," Congress passed the Health Care Quality Improvement Act of 1986 (HCQIA).[1]

In it, Congress declared a "national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance"[2] with an eye toward making "greater efforts than those that can be undertaken by any individual State."[3]

Regulations[4] promulgated under the HCQIA authorize the Secretary of Health and Human Services (HHS) to establish a NPDB[5] to collect and release certain information relating to the professional competence and conduct of health care practitioners.[6] On the state side, as established by the New Jersey Health Care Consumer Information Act in 2004,[7] New Jersey also has such a database. New Jersey's Division of Consumer Affairs, in consultation with the State Board of Medical Examiners and the New Jersey State Board of Optometrists, is charged with collecting and maintaining information concerning all licensed physicians, podiatrists and optometrists to create a profile of each such practitioner.[8]

What is Reported?

Hospitals, insurance companies, and other entities paying under a policy of insurance, self-insurance, or otherwise in settlement or satisfaction of a judgment in a medical malpractice action or claim must report to the NPDB:

> (1) the name of any physician or licensed health care practitioner for whose benefit the payment is made, (2) the amount of the payment, (3) the name (if known) of any hospital with which the physician or practitioner is affiliated or associated, (4) a description of the acts or omissions and injuries or illnesses upon which the action or claim was based, and (5) such other information as the Secretary determines is required for appropriate interpretation of information reported under this section.[9]

Eligible entities must report medical malpractice payments and other required actions within 30 calendar days of the date the action was taken or payment was made.[10] Each report must include a narrative section limited to statements of fact including "what the subject of the report is alleged to have done and the nature of and reasons for the event upon which the report is based."[11]

NPBD information may be used only by eligible entities, such as a board of medical examiners or other state licensing board or hospital or health plan officials as they assess applications for medical staff appointments, clinical privileges, or other affiliation.

When payments are made on behalf of multiple practitioners, if the amount paid for the benefit of each individual practitioner cannot be determined then the total amount is reported for each practitioner. If an apportionment is possible, then the actual amount paid for the benefit of that practitioner is reported.[12]

In the case of "high-low" agreements,[13] payments are required to be reported unless the fact-finder rules in favor of the defendant and assigns no liability to the practitioner.[14] Individuals are not required to report payments they make from personal funds.[15]

Under New Jersey law, information included in the profile of a health care provider must include:

> All medical malpractice court judgments and all medical malpractice arbitration awards reported to the applicable board, in which a payment has been awarded to the complaining party during the most recent five years, and all settlements of medical malpractice claims reported to the board, in which a payment is made to the complaining party within the most recent five years....[16]

May a Practitioner Dispute a Report?

Federal law provides a procedure for a practitioner to dispute the accuracy of NPDB information.[17] If the NPDB revises its information, entities to whom reports have been sent are alerted that information has been revised.[18] If no revision is made, upon request the HHS Secretary will review the information and include a brief statement by the practitioner describing the disagreement and an explanation for the decision.[19]

New Jersey law provides a limited procedure for practitioners to correct factual errors. Before a profile is made public, it is provided to the practitioner who then has 30 days to correct any factual inaccuracy and advise the Division of Consumer Affairs.[20]

Who May See What is Reported?

NPBD reports are confidential, and limited disclosure is regulated by the Code of Federal Regulations.[21] Unless otherwise provided by state law, all information collected by the NPDB and reported as stated above is released only as specifically mandated by the HCQIA.[22]

NPBD information may be used only by eligible entities, such as a board of medical examiners or other state licensing board or hospital or health plan officials as they assess applications for medical staff appointments, clinical privileges, or other affiliation.[23] Other than to these entities and the practitioners involved, information is not disclosed "except with respect to professional review activity."[24]

Under New Jersey law, provider profiles that include claims and settlements are accessible to the public free of charge.[25] A disclaimer is included, however, explaining that settlement of a claim "and, in particular, the dollar amount of the settlement may occur for a variety of reasons, which do not necessarily reflect negatively on the professional competence or conduct of the physician.... A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred."[26]

The Impact of the NPDB

Practitioners have long been concerned with NPDB reports as well as state reports about claims or suits. Concerns range from how payment is allocated among several practitioners and/or entities against whom allegations have been made; to whether insurance premiums or insurability itself will be impacted; to whether applications to obtain or maintain hospital privileges will be affected; to whether such reports will bode negatively for future applications or promotions.

In addition, as many professional liability insurance policies contain consent provisions allowing the insured to authorize or withhold authority to settle, a practitioner's decision to grant authority to settle often includes deliberation over how the settlement may be reported. Once authority to settle is granted by the insured, however, they may be relinquishing control over the timing of settlement offers and the amounts offered.

A 2005 New Jersey Appellate Division decision provides a vivid example of the interplay of these concerns. In *Webb v. Witt*[27] at issue was whether a practitioner had the right to exercise control over settlement as well as the required reporting to the NPDB and the New Jersey Division of Consumer Affairs where the practitioner had no express right to approve settlement.[28] In ruling the practitioner had no such control, the *Webb* court explored not only insurance contractual considerations but also the potential effects of reporting the settlement on future insurability, insurance premiums, and even the practitioner's employability.

The underlying suit centered on injury to a baby's brachial plexus during delivery, resulting in loss of use of the baby's right arm.[29] Deposition discovery produced divergent testimony as to the delivery events, including the roles and responsibilities of the three providers involved.[30]

The defendant hospital was the sole named insured on a policy that afforded coverage to the defendant physicians as "other insureds."[31] The policy required the insurance company to obtain consent from the hospital before settling, but only to make a "reasonable attempt" to consult with other insureds.[32]

The insurance company decided to settle.[33] Believing she did not deviate from the standard of care, however, one of the providers indicated she did not want a settlement on her behalf.[34] In a series of pleadings and motions, the provider sought to preclude settlement absent her consent; and to bar the hospital and its insurer from apportioning liability to her if there was any settlement.[35] In support of her position, the provider argued that there would be

> adverse consequences to her participation and/or membership in health insurance organizations, HMOs, and/or managed care organizations; adverse consequences to her memberships in the medical staffs of other hospitals at which she maintains privileges, a reduction or elimination of her ability to secure employment as a physician, a reduction or elimination of her ability to provide obstetric and gynecological services and, ultimately, a reduction or elimination of her ability to practice medicine.[36]

The provider's professional liability insurance expert additionally certified that if the insurance company settled and reported to the NPDB that the three physicians involved had "undivided responsibility," it would be extremely difficult or even impossible for the provider to obtain insurance coverage in the future.[37] The expert went as far as to say that even if the provider was able to obtain coverage, the premiums would increase to a point that she would be forced out of the practice of obstetrics.[38] *Amicus curiae* Medical Society of New Jersey added that an insurance carrier

> must not be given unfettered discretion to settle a medical malpractice action without giving due consideration to the impact of such settlement upon the affected physician, and without some mechanism in place, consistent with the requirements of due process, to protect the physician's interests.[39]

The *Webb* court was unpersuaded, finding that the HCQIA "is silent on apportionment among multiple defendants" and is required by federal law to "report all settlements, along with the names of any physicians for whose benefit payments are made, the amount of any payments, the names of the hospitals with which the physicians are affiliated and a description of the acts or omissions and injuries alleged in the claim."[40]

Next, answering the provider's citation of the NPDB Guidebook published by HHS[41] to support an "independent fact-finding process to fix the percentage" of responsibility, the *Webb* court noted that the guidebook "does not have the force of law, nor is it a regulation."[42] More important was the guidebook's silence "as to how a determination of liability apportionment is to be decided and in what forum."[43] The *Webb* court also observed that even where an apportionment can be made, it is the insurer's responsibility to do so and there is no provision for a provider to contest an apportionment.[44] Indeed, the sole statutory remedy for a practitioner dissatisfied with a lack of apportionment or the level of apportionment assigned to them is the opportunity to correct a factual error.[45]

Finally, as to arguments that an absence of a consent to settle clause violates public policy, the *Webb* court observed that an insurance policy is a contract, the terms of which define the parties' rights and obligations.[46] It found the provider defendant failed to show that a consent clause had to be included

as a matter of public policy, especially since such clauses often are the subject of specific negotiation between the parties, and the premiums charged reflect this negotiation and choice.[47] The *Webb* court refused to endorse what amounted to an argument to reform the policy, especially in light of New Jersey's public policy encouraging settlements.[48]

The Silent Factor Revisited

First implemented in the late 1980s, NPDB reporting was designed to prevent "incompetent" physicians from moving around anonymously. The internet age seems to have vaulted the original purpose of the NPDB, however. Modern day underwriting practices and measures such as form interrogatories to be answered by defendant practitioners,[49] combined with the vast amount of information available through public and paid internet searches have dramatically increased the historical data available.

The NPDB now seems to invoke an additional, unintended concern as practitioners consider settlement. Practitioners must face not only that settlements will be reported and may be accessible to state licensing boards, employers, potential employers, and insurance carriers, but also that the decisions made by the reporting entity about how the settlement is apportioned among several practitioners is subjective and out of their control. In some instances, these additional considerations may even cause a practitioner to withhold consent to settle.

Awareness of these considerations may be valuable to parties on both sides during settlement negotiations. This, in turn, may produce more thoughtful and successful negotiations, and prepare practitioners to take a more active role in the reporting process. ⚖

Endnotes

1. 42 *U.S.C.* § 11101
2. *Id.*
3. *Id.*
4. *See* 45 *C.F.R.* § 60.1
5. 42 *U.S.C.* §1320a-7e; s*ee also* https://www.npdb.hrsa.gov/index.jsp (last visited May 1, 2021)
6. 42 *U.S.C.* § 11131
7. *N.J.S.A.* 45:9-22.21 to -22.25
8. *N.J.S.A.* 45:9-22.22; *see also* njdoctorlist.com/ (last visited May 1, 2021)
9. 42 *U.S.C.* § 11131
10. *NPDB Guidebook*, October 2018, p. E-2- *see* npdb.hrsa.gov/resources/aboutGuidebooks.jsp (last visited May 1, 2021)
11. *Id.* at E-11
12. *Id.* at E-21
13. A "high low" agreement is one in which the parties, or some of them, agree that if a verdict is above a specified range of numbers agreed upon by such parties, the defendant's liability for damages shall be the highest number in that range, and that if a verdict is less than the lowest number in that range, including a verdict of no cause for action against such defendant, defendant shall pay the plaintiff the lowest number in the range. If the verdict against the defendant falls within the range, the damages the defendant shall pay is the verdict reached by the jury. *New Jersey Court Rules, 1969*, *R.* 4:24A
14. *NPDB Guidebook*, *supra,* p. E-23
15. *Id.* at E-18, citing *American Dental Association v. Shalala*, 3 *F.3d* 445 (D.C. Cir. 1993)
16. *N.J.S.A.* 45:9-22.23
17. 45 *C.F.R.* §60.21
18. *Id.*
19. *Id.*
20. *N.J.S.A.* 45:9-22.23c
21. 45 *C.F.R.* § 60.20
22. *Medical Soc. Of New Jersey v. Mottola*, 320 *F.Supp.* 254, 259 (D.N.J. 2004)
23. *NPDB Guidebook, supra,* p. A-10, p. B-2
24. 42 *U.S.C.* 11137(b)(1)
25. *N.J.S.A.* 45:9-22.22
26. *N.J.S.A.* 45:9-22.23a(10)(d)
27. 379 *N.J. Super.* 18 (App. Div. 2005)
28. *Id.* at 22
29. *Id.*
30. *Id.* at 24-25
31. *Id.*
32. *Id.* at 23-24
33. *Id.* at 25
34. *Id.*
35. *Id.* at 26
36. *Id.*
37. *Id.* at 27
38. *Id.*
39. *Id.* at 27-28
40. *Id.* at 29-30, citing 42 *U.S.C* 11131(b) and *C.F.R.* §60.5(a)
41. *See* npdb.hrsa.gov/resources/aboutGuidebooks.jsp (last visited May 1, 2021)
42. *Id.* at 30
43. *Id.*
44. *Id.*
45. *Id.* at 32
46. *Id.* at 33, citing, *inter alia, Mancuso v. Rothenberg,* 67 *N.J. Super.* 248, 254 (App. Div. 1961)
47. 379 *N.J. Super.* at 33
48. *Id.* at 33-34, citing, *inter alia, Nolan by Nolan v. Lee Ho*, 120 *N.J.* 465, 472 (1990)
49. Form C(3) interrogatories 5 and 6 require defendant physicians to disclose whether their "full rights or privileges to practice medicine been suspended, revoked or terminated in any state or hospital since [they] started to practice medicine" and, if they have "ever been a defendant in a malpractice suit other than the present one, identify the case by name, court and docket number, and summarize the allegations ... and the outcome of the case, including the terms of any settlement." *New Jersey Court Rules, 1969*, Appendix II

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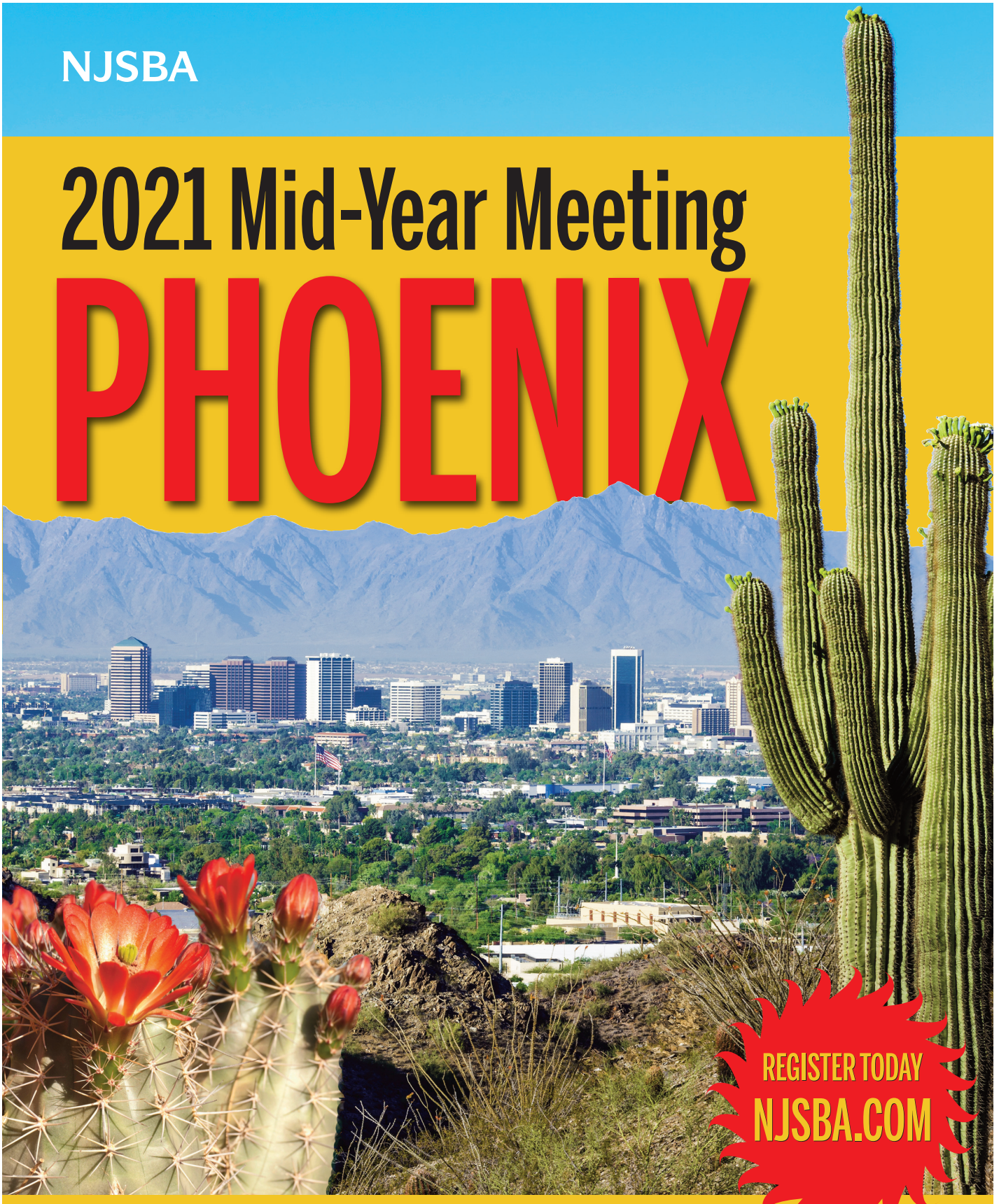

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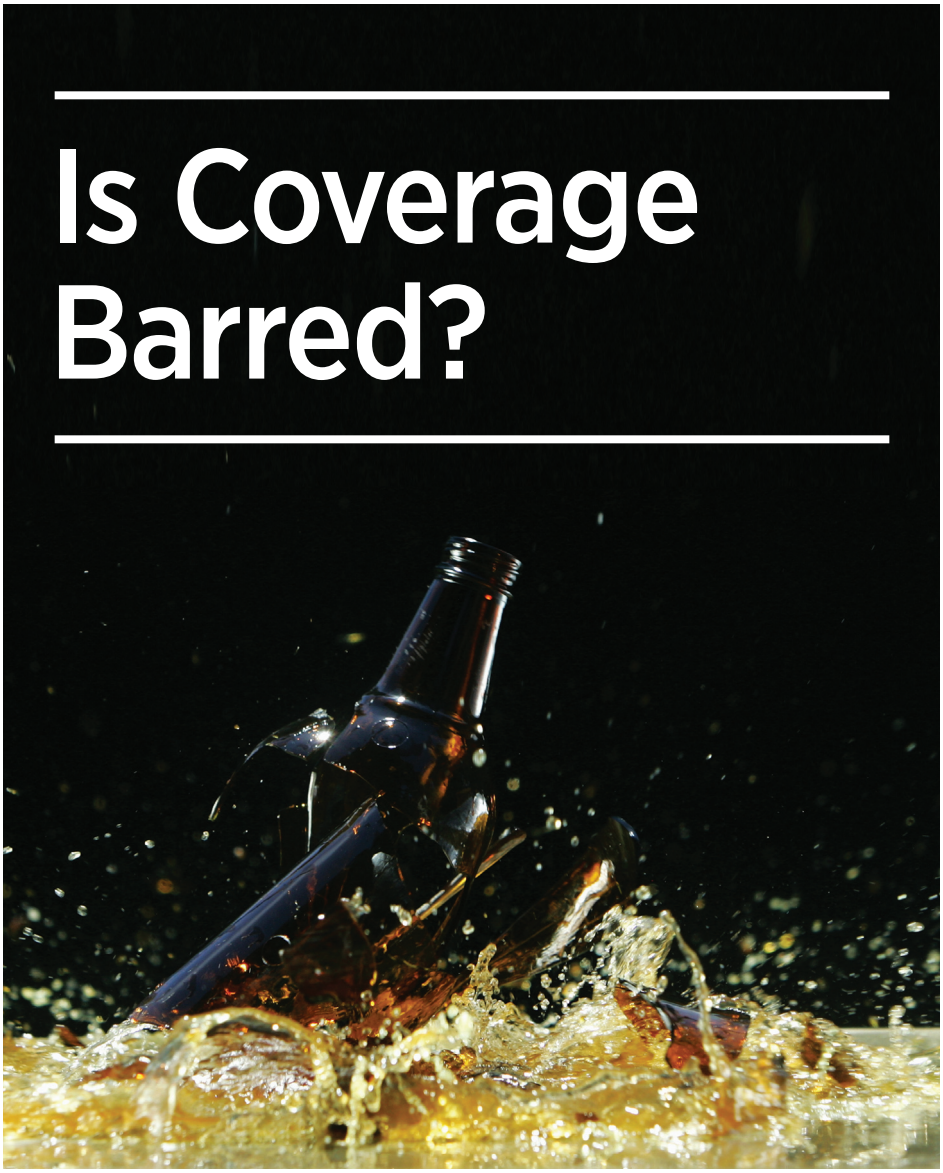

Assault and Battery Exclusions in Commercial General Liability Policies

By Brian R. Lehrer and Thomas N. Gamarello

As the COVID pandemic recedes, life will gradually return to normal. Normal includes the opening of bars and—inevitably—bar fights. This article will examine the assault or battery exclusions in commercial general liability policies.

A number of New Jersey cases have interpreted assault or battery exclusions in a bar's commercial general liability policy. It is important to understand that each exclusion is not worded the same and the issue of coverage may turn on the facts plead in a plaintiff's Complaint.

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The principles governing a Court's interpretation of an insurance policy are longstanding and straightforward. If the plain language of the policy is unambiguous, the Court will not engage in a strained construction to support the imposition of liability or write a better policy for the insured than the one purchased.[1] A provision is ambiguous if it is subject to more than one reasonable interpretation and only where there is a genuine ambiguity, where the phrasing of the policy is so confusing that the average policyholder cannot make out the boundaries of coverage, should a review in Court read a policy in favor of the insured. Consistent with these rules, New Jersey Courts will enforce exclusionary clauses if specific, plain, clear, prominent and not contrary to public policy, notwithstanding that exclusions generally must be narrowly construed and the insurer bears the burden to demonstrate that the exclusion applies.[2]

Guided by these fundamental principles, New Jersey Courts have interpreted assault or battery exclusions on multiple occasions. The earliest case in New Jersey to interpret an assault or battery exclusion found the provision unambiguous and rejected an argument that the exclusion should be limited to bar only claims related to assault or batteries committed by the insured's own employees.[3] In *Stafford*, the underlying suit involved bodily injury claims of three nightclub patrons who were shot by fellow patrons. The plaintiffs asserted, *inter alia*, claims of inadequate security and negligent employee hiring, training and supervision. The insured nightclub, Club Mirage, was insured under a general liability policy issued by T.H.E. Insurance Company. The policy contained an exclusion for injuries resulting from assault and battery which stated as follows:

> "In consideration of the premium charge, it is agreed that NO coverage of any kind (including, but not limited to, cost of defense) is provided by this policy for bodily injury and/or property damage arising out of or caused in whole or in part by an assault and/or battery. Further, NO coverage is provided if the underlying operative facts constitute an assault and/or battery irrespective of whether the claim alleges negligence hiring, supervision and/or retention against the insured or any other negligent action."

The injured patrons filed suit and the carrier disclaimed coverage based upon the exclusion. The trial judge found the exclusion to be ambiguous, but the Appellate Division reversed, determining that the exclusion was unambiguous. The Court observed the language plainly indicates to the average reader that no matter who commits the assault and battery no coverage will be provided. The Court conceded case law provides that if there is a second fair interpretation of an exclusion available to an injured plaintiff, the insurance policy will be construed for coverage against the insurer.[4] The Court cautioned, however, this case law does not stand for the proposition that any far-fetched interpretation of a policy exclusion will be sufficient to create an ambiguity requiring coverage. The Court thus recognized the validity of the exclusion, which barred the patrons' claims under the policy.

Contrary to *Stafford*, a later Appellate Division case found a differently worded policy exclusion did *not* bar coverage where plaintiff's underlying claims included counts for a bar bouncer's negligence.[5] In *L.C.S.*, the policy exclusion stated that the insurance did not apply to bodily injury and certain other claims "arising out of assault and battery or of any act or omission in connection with the prevention or suppression of such acts…whether caused by or at the instigation of or direction of the Insured, his employees, patrons or other persons." The three count complaint filed by the bar patrons claimed: (1) a bar's bouncer intentionally assaulted him by punching him in the face; (2) the bouncer negligently performed his duty; and (3) the bar negligently hired, trained, employed and supervised its bouncers and employees. The bar's alleged negligence in managing its bouncers was both (1) an act or omission in connection with a bouncer's assault; and (2) an act or omission in connection with a bouncer's negligence.

The Appellate Division stated that the relevant inquiry is the "nature of the claim for damages, not the details of the accident or the ultimate outcome, which triggers the obligation to defend…and when multiple alternative causes of action are set forth, the duty to defend will continue until every covered claim is eliminated."[6] The Court pointed out that at the trial of the underlying personal injury action, neither the patron-plaintiff nor his witnesses stated whether he was intentionally assaulted or negligently injured while being escorted from the bar. The plaintiff ultimately settled with the bar based upon his complaint's negligence count. The Appellate Division held that if a negligent act unrelated to the assault and battery caused the patron's injuries (as he alleged in count two), then the carrier's reliance on the exclusion was inapplicable and unavailing.

More recently, the Appellate Division addressed a differently worded exclusion and upheld the denial of coverage to the insured bar.[7] In that case, plaintiff, Pickett, and defendant, Corley, got into an argument in Moore's Lounge in Jersey City. As Pickett turned to walk away, Corley shot him three times killing him. A jury later convicted Corley of aggravated manslaughter, culminating in a term of imprisonment. In the civil action, Pickett's estate alleged the tavern staff subjected Pickett and other customers to a weapon search before they entered, but

Corley, a retired police officer and a regular customer, was allowed to enter with a concealed weapon. The estate also alleged that the staff continued to serve Corley after he had already consumed excessive amounts of alcohol and displayed signs of intoxication.

The estate's complaint against the bar included claims for negligent hiring, negligent management and negligent retention of employees. The bar sought a defense and indemnification from its insurer, Northfield Insurance Co., under its CGL policy. Northfield denied coverage based upon the policy's assault or battery exclusion which barred coverage for:

> "Bodily injury or property damages arising out of any act of assault or battery committed by any person, including any act or omission in connection with the prevent or suppression of such assault or battery."

The trial Court entered summary judgment in favor of Northfield on the coverage claim. The Appellate Division affirmed. The Court noted the policy exclusion barring claims arising out of an assault or battery expressly included any act or omission in connection with the prevention or suppression of the assault or battery. Thus, the exclusion plainly encompassed negligent acts or omissions that failed to prevent or suppress the assault or battery.

> "That embraces the estate's general allegation that [the bar] negligently failed to exercise reasonable care to assure the tavern was a safe place. The exclusion also embraces the estate's allegation that, as a result of [the bar's] negligent personnel management (i.e. hiring, training and retention), [the bar's] staff did not prevent Corley from shooting Pickett. Specifically, staff allowed Corley to enter with a gun, allowed him to retain the gun throughout the evening as he became more intoxicated, and did not intervene when he began arguing with Pickett."[8]

The Court specifically rejected the bar's contention that *L.C.S.* compelled the Court to find the Northfield exclusion did not clearly exclude coverage for the estate's negligent-based claims against the bar. The Appellate Division pointed out the policy exclusion in *L.C.S.* was similar to Northfield's language. The *L.C.S.* Court had recognized that it is the nature of the claim for damages, not the details of the accident or ultimate outcome, which triggers the obligation to defend, and the plaintiff ultimately settled with the bar based on his complaints of the bouncer's alleged negligence. In contrast, the Pickett estate did not alternatively allege that Corley negligently shot Pickett and the bar's alleged negligence was connected only with an assault or battery and thus the Northfield policy's exclusion encompassed the estate's claim against the bar.

If there is a common thread in the case law, it is that the court's interpretation depends both upon the wording of the exclusion and the pleading. Where the language is plain and the average reader could not conclude any other way, courts will not find an ambiguity in a policy exclusion, even where a far-fetched second interpretation is proffered. If the exclusion is broad enough to encompass "any act of assault or battery," courts may also find that negligent acts will also be excluded. Prudent practitioners will want to scrutinize the express language of policy exclusions. ⚖

Endnotes

1. *Templo Fuente De Vida Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 224 N.J. 189 (2016).
2. *Flomerfelt v. Cardiello*, 202 N.J. 432 (2010).
3. *Stafford v. T.H.E. Insurance Co.*, 309 N.J. Super. 97 (App. Div. 1998).
4. *Butler v. Bonner Barnewall, Inc.*, 56 N.J. 567 (1970).
5. *L.C.S. Inc. v. Lexington Insurance Co.*, 371 N.J. Super. 42 (App. Div. 2004).
6. *Id.* at 490.
7. *Pickett v. Moore's Lounge*, 464 N.J. Super. 549 (App. Div. 2020).
8. *Id.* at 556.

When Bad Faith Impacts the Uninsured/Underinsured Motorist

by Lisa A. Lehrer and Sherwin Tsai

Every insurance contract in New Jersey contains an implied covenant of good faith and fair dealing.[1] An insurance company owes a duty of good faith to its insured in processing a first-party claim.[2] This article will examine the application of bad faith to first-party uninsured/underinsured claims.

Uninsured Motorist (UM)/Underinsured Motorist (UIM) insurance is a first-party substitute for a third-party claim. UM coverage provides an insured with a remedy against their own insurance company in the event of an injury caused by a motor vehicle tortfeasor who does not carry liability insurance. UM insurance is required to be provided on all standard motor vehicle policies issued in New Jersey.[3] UIM coverage provides an insured with a first-party claim against their insurance company

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in the event they are injured by a motor vehicle tortfeasor whose liability limits are less than the UIM limits elected by the insured on their own insurance policy. This coverage is required to be offered but is not statutorily required to be included in motor vehicle policies.

In the landmark case of *Pickett v. Lloyd's*, the New Jersey Supreme Court first addressed the issue of a carrier's bad faith failure to pay benefits for a first-party property damage claim. The carrier failed to pay collision damage benefits to the plaintiff arising out of a tractor-trailer accident which resulted in substantial damage to his truck. The carrier agreed to pay $29,000, which represented the full amount of the policy less the $1,000 deductible.

However, due to unjustified delays in the payment of the claim, plaintiff was not able to secure a replacement truck within a six-day grace period allowed by his company, thereby causing him to lose his seniority status and, thus, more lucrative assignments. With the plaintiff's period of unemployment resulting from his inability to secure a substitute tractor, he suffered substantial economic consequences and, as a result, filed a lawsuit against the defendant alleging that failure to settle his property insurance damage claim was bad faith.

The Court in *Pickett v. Lloyd's* set forth the standard in determining whether a carrier may be liable to a policyholder for bad faith in a first-party claim. In order to establish a bad faith claim, the plaintiff "must show the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge of reckless disregard of the lack of a reasonable basis for denying the claim.[4] The Court applied the "fairly debatable standard," which requires a showing that no debatable reasons exist for the denial of benefits to establish a prima facie claim of bad faith against the insurer. In other words, failing to settle a debatable claim in and of itself does not suffice to meet bad faith. In the case of delay of payment, bad faith is established by showing that there was no valid reason to delay processing of the claim and that the carrier "knew or recklessly disregarded the fact that no valid reason supported the delay."[5]

In 2015, the New Jersey Supreme Court addressed the issue of bad faith in the context of UM/UIM claims.[6] In *Wadeer v. N.J. Mfrs. Ins. Co.*, the plaintiff was injured in an automobile accident. He and his wife were insured under a policy issued by defendant, N.J. Manufacturers Insurance Company (NJM). Plaintiff sought coverage under his UM policy because the vehicle which cut him off and caused him to veer off the highway was never identified.

The matter proceeded to a panel arbitration resulting in a net award of $87,500, which was rejected by NJM. An arbitration award in the Court of $162,500 was again rejected by NJM. Ultimately, a trial resulted in a jury award to the plaintiff of $210,000 for pain and suffering which was molded to the $100,000 policy limits. The plaintiff was awarded counsel fees and pre-judgment interest.

On appeal, the Appellate Division agreed with the molding of the jury verdict on pain and suffering but reversed the award of attorney's fees and expenses. The plaintiff then filed a complaint in the law division alleging that NJM breached its duty of good faith and fair dealing. The case ultimately reached the Supreme Court, which ultimately dismissed the plaintiff's claim on the grounds that it was barred from re-litigation in accordance with res judicata. However, the Court then provided guidance concerning bad faith claims in the context of UM/UIM litigation going forward.

The Court held that the nature of first-party bad faith claims warrants exemption from a harsh application of the entire controversy doctrine set forth under Rule 4:30A. The Court further urged the civil practice committee to examine the Offer of Judgment Rule under Rule 4:58 because the construction of the rule provided no incentive for carriers to settle UM/UIM claims where reduction of a verdict was based on the policy limits of a given carrier.

The *Wadeer* case and its companion case *Badiali v. N.J. Mfrs. Ins. Grp.*, decided the same day,[7] reinforced that whether an insurer has acted in bad faith and thereby breached its fiduciary obligation must depend upon the particular circumstances of the case. A finding of bad faith against an insurer in denying an insurance claim cannot be established through simple negligence. Furthermore, a mere failure to settle a debatable claim does not constitute bad faith. The Court made it clear that to establish a first-party bad faith claim for the denial of benefits in New Jersey, a plaintiff must show that no debatable reasons existed for the denial of the benefits. The Court further stated that "under the salutary fairly debatable standard annunciated in *Pickett*, a claimant who could not have established as a matter of law a right to summary judgment on the substantive claim would not be entitled to assert a claim for an insured's bad faith refusal to pay the claim."[8]

Pickett's fairly debatable standard has provided a narrow test for which claimants can establish a prima facie bad faith claim against carriers. Under the fairly debatable standard, a claimant who could not have established as a matter of law a right to summary judgment on the substantive claim would not be entitled to assert a claim for insurer's bad faith refusal to pay the claim. This further presents an obstacle for claims in which the issue is not a carrier's unwillingness to pay, but rather the unexplained delay in payment which results in economic harm to the plaintiff, as seen in *Pickett*.

As a practical matter, bad faith claims

To date, the best avenue for recovering damages for unfair practices from a UM/UIM carrier is through the Offer of Judgment Rule during the course of litigation, rather than a separate bad faith claim.

in the context of UM/UIM litigation present a number of hurdles. First, there is the obvious hurdle of the rather stringent *Pickett* "fairly debatable" standard. Second, there is the common-sense reality that a plaintiff cannot obtain pain and suffering damages over and above the policy limits, regardless of the verdict award. Time and again, New Jersey courts have made it lucid that excess verdicts in UM/UIM cases are to be molded to the policy limits.[9]

However, the news is hardly all bad. Following *Wadeer* and *Badiali*, *R.* 4:30A was amended to indicate that claims of bad faith, which are asserted against an insurer after an underlying uninsured/underinsured motorist claim is resolved in a Superior Court action, are not precluded by the entire controversy doctrine. Second, the Offer of Judgment Rule under *R.* 4:58-2(b) was amended on Aug. 1, 2016, to provide that a verdict in an amount that is 120% of the offer or more, excluding allowable pre-judgment interest and counsel fees, allows the claimant: 1) the costs of suit to all reasonable litigation expenses incurred following the non-acceptance; 2) pre-judgment interest of 8% on the amount of any money recovery from the date of the offer or the date of completion of discovery, whichever is later, only to the extent that such pre-judgment interest exceeds the interest prescribed by *R.* 4:42-11(b) which is also allowable, and 3) a reasonable attorney's fees for subsequent services as are compelled by the non-acceptance.

To date, the best avenue for recovering damages for unfair practices from a UM/UIM carrier is through the Offer of Judgment Rule during the course of litigation, rather than a separate bad faith claim. On June 7, 2018, the New Jersey Senate passed S-2144, otherwise known as the New Jersey Insurance Fair Conduct Act (IFCA), which permits private causes of action for victims of certain "unfair and unreasonable practices by their insurer" in violation of the New Jersey Unfair Claims Settlement Practices Act (UCSPA).[10] The UCSPA prevents carriers from unfair practices including failure to promptly investigate claims, failing to affirm or deny claims within a reasonable timeframe, and failing to promptly settle claims or pay claims without a reasonable investigation. The proposal defined "first-party claimants" to include individuals asserting entitlements to benefits under an insurance policy and allowed for actual damages caused by the violation, pre-judgment interest, reasonable attorney's fees and all reasonable litigation expenses along with treble damages.

After being passed by the Senate, the bill was submitted to the Assembly Financial Institutions and Insurance Committee for review as companion A-4293 for the 2018-2019 session, which ultimately failed to pass. At a hearing on Jan. 9, 2020, the committee provided amendments to the bill, including limiting bad faith claims to UM/UIM claimants and eliminating treble damages as a possible remedy. However, most importantly, the committee amendments provided that a claimant is entitled to "actual damages caused by a violation of this bill, which shall include, but need not be limited to, actual trial verdicts, and prejudgment interest, reasonable attorney's fees, and all reasonable litigation expenses." A-4293 was subsequently carried over into the 2020-2021 session under A-1659. As of this writing no vote has taken place. If passed, this clause would entitle the claimant to the entire verdict amount, notwithstanding the policy limits.

Thus, for now, it appears precedential case law and the Court rules provide the path for any recovery against a UM/UIM carrier who refuses to pay what a claimant believes is a fair value on their claim. In the event the matter proceeds to trial, the claimant is limited by case law in obtaining an excess verdict for pain and suffering, but if they utilize the Offer of Judgment Rule, additional damages are recoverable. *Pickett* and its progeny have provided a stringent standard for claimants asserting bad faith, but it remains seen whether the Legislature can open the gates to valid bad faith claims in the future. ⚖

Endnotes

1. *Wood v. N.J. Mfrs. Ins. Co.*, 206 N.J. 562 (2011).
2. *Pickett v. Lloyd's*, 131 N.J. 457 (1993).
3. *See generally*, *N.J.S.A.* 17:28-1.1.
4. *Bibeault v. Hanover Ins. Co.,* 417 A. 2d 313 (R.I. 1980).
5. *Id.*
6. *Wadeer v. New Jersey Manufacturers Ins. Co.*, 220 N.J. 591 (2015).
7. *Badiali v. N.J. Mfrs. Ins. Grp.,* 220 N.J. 544 (2015).
8. *Id.*
9. *Taddei v. State Farm Indemnity Co.*, 401 N.J. Super. 449 (App. Div. 2008).
10. *N.J.S.A.* 17:B29-4.

Will Insurers Maintain Their Successes in New Jersey COVID-19 Insurance Coverage Litigation?

by Michael F. Aylward and Mariel Mercado-Guevara

It has been nearly a year and a half since the first COVID-19 insurance coverage lawsuit was filed by a New Orleans restaurant on March 16, 2020. In the ensuing 16 months, about 2,000 individual lawsuits have been filed across the country, including hundreds of class actions. Although the number of filings has tapered off in recent months, COVID-19 business interruption coverage litigation remains unparalleled in the number of suits filed in such a brief period and the widespread geographic distribution of the losses and suits.

In New Jersey, the success of insurers in persuading courts to dismiss the COVID-19 business interruption suits is surprising for two reasons. First, New Jersey has a well-deserved reputation of finding creative ways to find insurance coverage for policyholders. Second, there are significant New Jersey precedents that led policyholders at first to bet that they would likely succeed in the Garden State. This article will explore why those precedents have not supported these claims and why New Jersey courts have concluded that businesses are not entitled to coverage for COVID-19 business interruption claims under conventional commercial property and business owner protected (BOP) policies.

Direct Physical Loss

At the outset of this pandemic litigation, policyholders had reason to believe that New Jersey courts might be pre-disposed to rule in their favor on one of the most important issues presented by these cases, namely whether there can be a "direct physical loss" to property without some physical, structural damage.

In *Wakefern Food Corp. v. Liberty Mut. Fire Ins. Co.*,[1] the Appellate Division held that coverage for losses a supermarket chain suffered for spoiled food during a four-day electrical blackout was "physical damage," since the grid and its component generators and transmission lines were physically incapable of performing its essential function of providing electricity. The court ruled that, "The average policyholder in plaintiffs' position would not be expected to understand the arcane functioning of the power grid or the narrowly-parsed definition of 'physical damage' which the insurer urges us to adopt."[2]

In light of *Wakefern,* two federal courts have found that the presence of foreign particles inside a building that rendered it unfit for occupancy constituted "direct physical loss."[3]

New Jersey businesses have asserted that the actual or threatened presence of virus particles renders their properties unfit for their intended use resulting in "direct physical loss." For policies that contain virus exclusions, businesses have asserted that such language is ambiguous, that its losses were due to Gov. Phil Murphy's shut down orders, and that the doctrine of "regulatory estoppel" precludes insurers from asserting such exclusions in the context of these claims. To date, all of these arguments have failed.

In light of expansive interpretations of "direct physical loss" that New Jersey courts have heretofore adopted, "virus exclusions" clauses have rendered those arguments mute. Of the 36 decisions handed down as of July 16, 2021, 30 involved policies that contained virus exclusion clauses. Several of these cases were decided solely on the basis of a virus exclusion and the presence of exclusions in other cases have influenced the court's thinking.[4]

In *Mac Property Group LLC v. Selective Fire & Cas. Ins. Co.*,[5] the Superior Court rejected the insured's argument that its inability to use its property for its intended purpose constituted "direct physical loss or damage to property." The court distinguished *Wakefern Food* as involving entirely different policy language and facts, where the insured's loss was triggered by actual damage to the electrical grid, whereas the stay-at-home orders were due to the virus and not damage to property:

> Ultimately the decision here is specific to the policy language and facts at issue. Plaintiff points to no direct physical loss or damage to covered property. There is no direct physical

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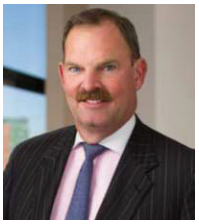

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> loss or damage to property which resulted in the order of civil authority. The direct physical damage to the electrical grid present in *Wakefern Food Corp.* is absent in this case.[6]

In *Jenkinson's South Inc. v. Westchester Surplus Lines Ins. Co.*,[7] the Superior Court was unpersuaded by the insured's contention that there must be virus particles on its premises because an employee had been diagnosed with COVID.[8] Moreover, the court found that the insured had failed to show that any concentration of COVID-19 virus particles on the property had rendered it unsafe or inhospitable and that the case was therefore distinguishable from the federal district court's ruling in *Gregory Packaging*.[9]

On the other hand, it is noteworthy that the insurer prevailed in one reported case even where the policy *lacked* a virus exclusion. In *Arash Emani, M.D. v. CNA and Transportation Insurance Company*,[10] Judge Wigenton declared in an unpublished four-page opinion that "Restrictions on a physician's ability to practice medicine at his office were insufficient to establish what direct physical loss of her damage to property." Citing *Mac Property Group*, the court declared:

> Plaintiff has not alleged any facts that support a showing that its properties were physically damaged. Instead, Plaintiff pleads that the Orders limited access to its facility and restricted Plaintiff's ability to provide medical care which caused Plaintiff to lose income and incur expenses. This is not enough.[11]

It remains to be seen whether New Jersey courts will find "direct physical loss," at least for purposes of surviving a Rule 12(b)(6) motion, if the insured alleges that there are virus particles in the air or interior surfaces inside its business premises. In fact, there are a number of obstacles that lie in the path of policyholder counsel. Unlike *Gregory Packaging* and *Port Authority of New York*, where the presence of ammonia fumes and asbestos inside the insured's buildings was well-documented, it is very rare for a COVID-19 claimant to have documents or admissible evidence of virus particles on its property. As a result, insureds who do go down this path are typically reduced to arguing that there *must* be virus particles on its property because the COVID-19 virus is omnipresent. Whether this is true as a matter of virological science or not, most courts have found such assertions to be conclusory, speculative and insufficient to survive a Rule 12(b)(6) challenge.[12]

Virus Exclusions

Another main argument that policyholders have raised is that their losses were due to governmental shut down orders and not the virus itself. While this argument has rarely met with success, it may be fatally undermined by a claim that virus particles are inside the insured's building causing physical damage.

New Jersey courts have consistently ruled that various virus exclusions are unambiguous and have refused to limit their application to cases in which property has become actually contaminated.[13] These cases have consistently rejected arguments that the exclusion does not apply because the "efficient proximate causes" of its losses were Murphy's executive orders rather than the virus.[14]

For instance, Judge Polansky ruled in *Mack Property Group LLC v. Selective Fire & Cas. Ins. Co.*,[15] that there was no plausible basis for disputing that the virus was a cause of the insured's loss, in light of the fact that the COVID-19 pandemic was specifically referenced in the various executive orders at issue, and that the insured's own complaint:

> [I]dentifies the coronavirus as the cause of the government actions requiring the suspension of business operations … Since the virus is alleged to be the cause of the governmental action, and the governmental action is asserted to be the cause of the loss, plaintiff cannot avoid the clear and unmistakable conclusion that the coronavirus was the cause of the alleged damage or loss.[16]

Courts have also rejected arguments that such exclusions only apply if the insured's property is physically contaminated by a virus.[17] In many cases, these rulings reflect broad anti-concurrent causation language expanding the scope of the exclusion so long as an excluded cause is involved.[18]

However, exclusions lacking anti-concurrent causation language have also been upheld. For instance, in *Causeway Automotive LLC v. Zurich American Ins. Co.*,[19] Judge Wolfson rejected the insured's argument that the exclusion was ambiguous or should or could be interpreted as only applying where the injuries were due to virus particles on the insurance property. Nor did she find that the virus exclusion did not apply because the losses resulted from Murphy's executive orders and not the virus itself.[20]

Regulatory Estoppel

Courts have also declined to extend the "regulatory estoppel" doctrine, that the New Jersey Supreme Court adopted in *Morton International, Inc. v. General Accident Insurance Company of America*,[21] to statements that ISO and AAIS made to state insurance regulators when the most common version of the virus exclusion was promulgated in 2006 following the SARS pandemic. For instance, Judge Hillman declared in *Delaware Valley Plumbing Supply, Inc. v. Merchant's Mutual Ins. Co.*, that plaintiff had failed to demonstrate in any way that the statements that ISO and AAIS made at the time were in any way inconsistent with the positions that the

insurers were now advancing in these cases.[22] Further, courts are ruling that this doctrine does not apply to unambiguous exclusions.[23]

While these early successes have been heartening to insurers and their counsel, the fact remains that what will ultimately decide the fate of this litigation are the views of the federal and appellate courts. In a recent federal case, U.S. District Court Judge Michael A. Shipp added to the growing body of decisions that an insurance policy's virus exclusion bars coverage for losses related to the coronavirus outbreak, holding that such a clause negated a child care center's proposed class action against its insurance company.[24]

In fact, the Third Circuit is already considering New Jersey policyholder appeals in *Eyecare Center of New Jersey, PA v. The Hartford Financial Services Group, Inc*.[25] as well as *Boulevard Carroll Entertainment Group v. Fireman's Fund Insurance Company*.[26] It remains to be seen whether the Third Circuit will consolidate its review of these cases, as was granted on April 6, in connection with requested consolidation by policyholder counsel in fourteen similar appeals from the federal district courts in Pennsylvania. ⚖

Endnotes

1. 406 N.J. Super. 524, 968 A.2d 724 (App. Div. 2009).
2. *Id*. at 541.
3. *See Port Authority of New York and New Jersey v. Affiliated FM Ins. Co.*, 311 F.3d 226, 234 (3d Cir. 2013) (asbestos particles) and *Gregory Packaging, Inc. v. Travelers Property Cas. Co.,* 2014 WL 6675934 (D.N.J. 2014) (release of ammonia fumes "physically transformed the air within the property").
4. *See, e.g. Body Physics v. Nationwide Ins. Co.*, 2021 WL 912815 (D.N.J. Mar. 10, 2021).
5. Camden Docket No. L-2629-20 (N.J. Super. Nov. 5, 2020).
6. *Id*. at 16.
7. 2021 WL 2934875 (N.J. Super. July 2, 2021).
8. *Id*. at *7.
9. *Id*. at *8.
10. 2021 WL 1137997 (D.N.J. Mar. 11, 2021).
11. *Id*. at*2.
12. *See Restaurant Group Management, LLC v. Zurich American Ins. Co.*, 2021 WL 1937314 (N.D. Ga. Mar. 16, 2021).
13. *See Causeway Automotive LLC v. Zurich American Ins. Co.*, 2021 WL 486917 (D.N.J. Feb. 10, 2021).
14. *See Mattdogg Inc. v. Philadelphia Ind. Ins. Co.*, 2020 WL 7702634 (N.J. Super. Ct. Law Div. Nov. 17, 2020); *Causeway*, 2021 WL 486917, at *5-6 ("The Executive Orders were issued for the sole reason of reducing the spread of the virus that causes COVID-19 and would not have been issued but for the presence of the virus in the State of New Jersey. …[T]he 'but for' cause of Plaintiffs' losses was COVID-19—the Executive Orders and the virus are so inextricably connected that it is undeniable that the Orders were issued because [of] the virus"); *7th Inning Stretch LLC v. Arch Ins. Co.*, 2021 U.S. Dist. LEXIS 11326, at *5 (D.N.J. Jan. 19, 2021) ("Because the Stay-at-Home Orders were issued to mitigate the spread of the highly contagious novel coronavirus, Plaintiffs' losses are tied inextricably to that virus and are not covered by the policies.") and *Colby Restaurant Group v. Utica Nat. Ins. Co.*, 2021 WL 1137994 (D.N.J. Mar. 12, 2021).
15. 2020 WL 7422374 at *8 (N.J. Super. Nov. 5, 2020).
16. *Id*. at 16. *See also Mattdogg, Inc.*, 2020 WL 7702634, at *4 ("The Governor issued his executive orders affecting Plaintiff's business as a direct result of COVID-19 . . . and any losses incurred therefrom are squarely within the exclusion.").
17. *See The Restaurant Group, Inc. vs. Utica National Insurance Company*, No. 20-5927 (D.N.J. Mar 12, 2021) ("There is nothing in the Virus Exclusions to suggest that they require actual contamination at the insured properties").
18. *See N&S Restaurant LLC v. Covalent Mutual Fire Ins. Co.*, 2020 WL 6501722 (D.N.J. Nov. 5, 2020) and *Boulevard Carroll Entertainment Group Inc. v. Fireman's Fund Ins. Co.*, 2020 WL 7338081 (D.N.J. Dec. 14, 2020).
19. 2021 WL 486917.
20. *Accord Seventh Inning Stretch LLC*, 2021 U.S. Dist. LEXIS 11326.
21. 134 N.J. 1 (1993).
22. 2021 WL 567994 (D.N.J. Feb. 16, 2021). *Accord Define Six, LLC v. Fitchburg Mutual Ins. Co.*, 2021 WL 1138146 (D.N.J. Mar. 25, 2021).
23. *See, e.g. The Restaurant Group, Inc. vs. Utica National Insurance Company*, No. 20-5927 (D.N.J. Mar 12, 2021) and *Mattdogg, Inc.* 2020 WL 7702634, at *4.
24. *Quakerbridge Early Learning LLC v. Selective Insurance Co. of New England et al*., 2021 WL 1214758 (March 31, 2021).
25. No. 20-5743 (D.N.J. Feb 8, 2021), *appeal filed,* (3d Cir. Mar. 8, 2021).
26. 2020 WL 7338081 (D.N.J. Dec. 14, 2021), *appeal filed*, No. 21-1061 (3d Cir. Jan 12, 2021).

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Publisher *(Name and complete mailing address)*
Angela Scheck
One Constitution Square
New Brunswick, NJ 08901-1520

Editor *(Name and complete mailing address)*
Mindy Drexel
One Constitution Square
New Brunswick, NJ 08901-1520

Managing Editor *(Name and complete mailing address)*

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
New Jersey State Bar Association	One Constitution Square, New Brunswick, NJ 08901-1520

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13. Publication Title New Jersey Lawyer			14. Issue Date for Circulation Data Below 08/01/2021	
15. **Extent and Nature of Circulation** Membership			**Average No. Copies Each Issue During Preceding 12 Months**	**No. Copies of Single Issue Published Nearest to Filing Date**
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