COURT OF APPEALS

Year in Review: Insurance Law

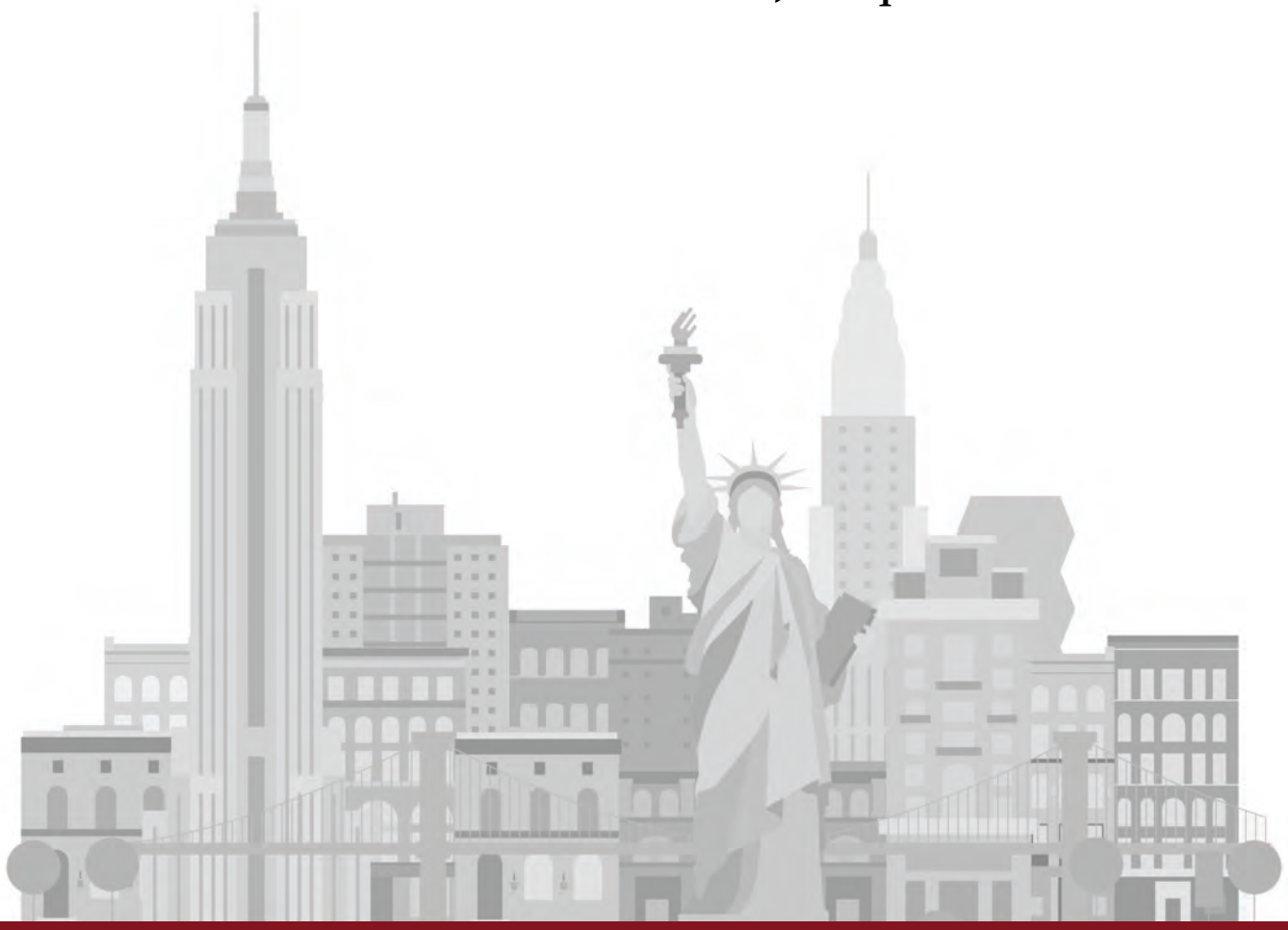
as seen in

New York Law Journal

1995-2020

Columns by

Evan H. Krinick, Esq.



RIVKIN RADLER LLP
ATTORNEYS AT LAW

List of Indices

Navigation Tips

Each item in the above List of Indices is hyperlinked and clickable to the respective index.

At the bottom of every page is a hyperlink that reads "**Click here to return to the List of Indices.**" That button will return you to this page.

All of the case names on pages 3-20 are hyperlinked and clickable to the *New York Law Journal* article discussing that case.

To search the entire document for a specific term, press Control (CTRL) + F, which will open a search bar. Type in the term and press Return to find all of the instances of that term in the document.

Table of Contents

Case Name Alphabetical with Case Citation

ABN AMRO Bank, N.V. v. MBIA Inc.
17 N.Y.3d 208, 952 N.E.2d 463, 928 N.Y.S.2d 647

Admiral Ins. Co. v. Joy Contractors, Inc.
19 N.Y.3d 448, 972 N.E.2d 103, 948 N.Y.S.2d 862

Aetna Health Plans v Hanover Ins. Co.
27 N.Y.3d 577, 56 N.E.3d 213, 36 N.Y.S.3d 431

Agoado Realty Corp. v. United International Ins. Co.
95 N.Y.2d 141, 733 N.E.2d 213, 711 N.Y.S.2d 141.

American Building Supply Corp. v. Petrocelli Group, Inc.
19 N.Y.3d 730, 979 N.E.2d 1181, 955 N.Y.S.2d 854

American Economy Ins. Co. v. State of New York
30 N.Y.3d 136, 87 N.E.3d 126, 65 N.Y.S.3d 94

American Home Assurance Co. v. International Ins. Co.
90 N.Y.2d 433, 684 N.E.2d 14, 661 N.Y.S.2d 584.

American International Specialty Lines Ins. Co. v. Allied Capital Corp.
35 N.Y.3d 64, 149 N.E.3d 33

American Transit Ins. Co. v. Sartor
3 N.Y.3d 71, 814 N.E.2d 1189, 781.Y.S.2d 630

Andrew Carothers, M.D., P.C. v. Progressive Ins. Co.
33 N.Y.3d 389, 128 N.E.3d 153, 104 N.Y.S.3d 26

Appalachian Ins. Co. v. General Electric Co.
8 N.Y.3d 162, 863 N.E.2d 994, 831 N.Y.S.2d 742

Argentina v. Emery World Wide Delivery Corp.
93 N.Y.2d 554, 715 N.E.2d 495, 693 N.Y.S.2d 493.

Automobile Ins. Co. of Hartford v. Cook
7 N.Y.3d 131, 850 N.E.2d 1152, 818 N.Y.S.2d 176

Badillo v. Tower Ins. Co.
92 N.Y.2d 790, 709 N.E.2d 104, 686 N.Y.S.2d 363.

Basil Development Corp. v. Generall Accident Ins. Co.
89 N.Y.2d 1057, 681 N.E.2d 1274, 659 N.Y.S.2d 828

Belt Painting Corp. v. TIG Ins. Co.
100 N.Y.2d 377, 795 N.E.2d 15, 763 N.Y.S.2d 790

Benesowitz v. Metropolitan Life Ins. Co.
8 N.Y.3d 661, 870 N.E.2d 1136, 839 N.Y.S.2d 706

Bentoria Holdings, Inc. v. Travelers Indemnity Co.
20 N.Y.3d 65, 980 N.E.2d 504, 956 N.Y.S.2d 456

Bi-Economy Market Inc. v. Harleysville Ins. Co. of New York
10 N.Y.3d 187, 886 N.E.2d 127, 856 N.Y.S.2d 505

BP Air Conditioning Corp. v. One Beacon Insurance Group
8 N.Y.3d 708, 871 N.E.2d 1128, 840 N.Y.S.2d 302

Briggs Avenue LLC v. Ins. Corp. of Hannover
11 N.Y.3d 377, 899 N.E.2d 947, 870 N.Y.S.2d 841

Burlington Ins. Co. v. New York City Transit Authority
29 N.Y.3d 313, 79 N.E.3d 477, 57 N.Y.S.3d 85

Carlson v. American International Group, Inc.
30 N.Y.3d 288, 89 N.E.3d 490, 67 N.Y.S.3d 100

Catholic Charities of the Diocese of Albany v. Serio
7 N.Y.3d 510, 859 N.E.2d 459, 825 N.Y.S.2d 653

Central General Hospital v. Chubb Group of Ins. Co.
90 N.Y.2d 195, 681 N.E.2d 413, 659 N.Y.S.2d 246.

Certain Underwriters at Lloyd's, London v. Foster Wheeler Corp.
9 N.Y.3d 928, 876 N.E.2d 500, 844 N.Y.S.2d 773

Charles F. Evans Co., Inc. v. Zurich Ins. Co.
95 N.Y.2d 779, 731 N.E.2d 1109, 710 N.Y.S.2d 301.

Chase Scientific Research, Inc. v. NIA Group, Inc.
96 N.Y.2d 20, 749 N.E.2d 161, 725 N.Y.S.2d 592

Consolidated Edison Co. of New York, Inc. v. Allstate Ins. Co
98 N.Y.2d 208, 774 N.E.2d 687, 746 N.Y.S.2d 622..

Contact Chiropractic v. New York City Transit Authority
31 N.Y.3d 187, 99 N.E.3d 867, 75 N.Y.S.3d 474

Continental Cas. Co. v. Stradford
11 N.Y.3d 443, 900 N.E.2d 144, 871 N.Y.S.2d 607

Continental Ins. Co. v. State of New York
99 N.Y.2d 196, 782 N.E.2d 1145, 753 N.Y.S.2d 9

Country-Wide Ins. v. Preferred Trucking Services
22 N.Y.3d 571, 6 N.E.3d 578, 983 N.Y.S.2d, 460

Cragg v. Allstate Indem. Corp.
17 N.Y.3d 118, 950 N.E.2d 500, 926 N.Y.S.2d 867

Crouse West Holding Corp. v Sphere Drake Ins. Co. PLC
92 N.Y.2d 1017, 707 N.E.2d 435, 684 N.Y.S.2d 480.

Case Name Alphabetical with Case Citation

Crump v. Unigard Ins. Co.
100 N.Y.2d 12, 790 N.E.2d 244, 760 N.Y.S.2d 71

Curiale v. Ardra Ins. Co., Ltd.
88 N.Y.2d 268, 667 N.E.2d 313, 644 N.Y.S.2d 663

Darby & Darby, P.C., v. VSI Int'l, Inc.
95 N.Y.2d 308, 739 N.E.2d 744, 716 N.Y.S.2d 378

Dean v. Tower Ins. Co. of New York
19 N.Y.3d 704, 979 N.E.2d 1143, 955 N.Y.S.2d 817

Dingle v. Prudential Casualty Co.
85 N.Y.2d 657, 651 N.E.2d 883, 628 N.Y.S.2d 15

Dzielski v. Essex Ins. Co.
19 N.Y.3d 871, 969 N.E.2d 1162, 947 N.Y.S.2d 47

ELRAC, Inc. v. Masara
96 N.Y.2d 847, 753 N.E.2d 855, 729 N.Y.S.2d 60

ELRAC, Inc. v. Ward
96 N.Y.2d 58, 748 N.E.2d 1, 724 N.Y.S.2d 692

Estee Lauder v. OneBeacon Ins. Group
28 N.Y.3d 960, 63 N.E.3d 66, 40 N.Y.S.3d 346

Excess Line Association of N.Y. v. Waldorf & Associates
30 N.Y.3d 119, 87 N.E.3d 117, 65 N.Y.S.3d 85

Executive Plaza v. Peerless Ins.
22 N.Y.3d 511, 5 N.E.3d 989, 982 N.Y.S.2d 826

Executive Risk Indem v Pepper Hamilton
13 N.Y.3d 313, 919 N.E.2d 172, 891 N.Y.S.2d 1

Fair Price Medical Supply Corp. v. Travelers Indemnity Co.
10 N.Y.3d 556, 890 N.E.2d 233, 860 N.Y.S.2d 471

Fasso v. Doerr
12 N.Y.3d 80, 903 N.E.2d 1167, 875 N.Y.S.2d 846

Federal Ins. Co. v. International Business Machines Corp.
18 N.Y.3d 642, 965 N.E.2d 934, 942 N.Y.S.2d 432

Fieldston Property Owners Assoc. Inc. v. Hermitage Ins. Co. Inc.
16 N.Y.3d 257, 945 N.E.2d 1013, 920 N.Y.S.2d 763

First Financial Ins. Co. v. Jetco Contracting Corp.
1 N.Y.3d 64, 801 N.E.2d 835, 769 N.Y.S.2d 459

Friedman v. Connecticut General Life Ins. Co.
9 N.Y.3d 105, 877 N.E.2d 281, 846 N.Y.S.2d 64

Frontier Insulation Contractors, Inc.. V. Merchants Mutual Ins. Co.
91 N.Y.2d 169, 690 N.E.2d 866, 667 N.Y.S.2d 982.

Gaidon v. The Guardian Life Ins. Co. of America
94 N.Y.2d 330, 725 N.E.2d 598, 704 N.Y.S.2d 177.

Gaidon v. The Guardian Life Ins. Co. of America (Gaidon II)
96 N.Y.2d 201, 750 N.E.2d 1078, 727 N.Y.S.2d 30

Georgitsi Realty v. Penn-Star Ins.
21 N.Y.3d 606, 999 N.E.2d 520, 977 N.Y.S.2d 157

Gilbane Building Co./TDX Construction v. St. Paul Fire and Marine Ins.
31 N.Y.3d 131, 97 N.E.3d 711, 74 N.Y.S.3d 162

Global Reinsurance Corp. of America v. Century Indemnity Co.
30 N.Y.3d 508, 91 N.E.3d 1186, 69 N.Y.S.3d 207

Goldman v. Metropolitan Life Ins. Co.
5 N.Y.3d 561, 841 N.E.2d 742, 807 N.Y.S.2d 583

Goshen v. The Mutual Life Ins. Co. of New York
98 N.Y.2d 314, 774 N.E.2d 1190, 746 N.Y.S.2d 858

Government Employees Ins. Co. (GEICO) v. Avanguard Medical Group
27 N.Y.3d 22, 49 N.E.3d 711, 29 N.Y.S.3d 242

Great Canal Realty Corp. v. Seneca Ins. Co., Inc.
5 N.Y.3d 742, 833 N.E.2d 1196, 800 N.Y.S.2d 521

Great Northern Ins. Co. v. Mount Vernon Fire Ins. Co.
92 N.Y.2d 682, 708 N.E.2d 167, 685 N.Y.S.2d 411.

Green v. William Penn Life Ins. Co. of New York
12 N.Y.3d 342, 907 N.E.2d 700, 879 N.Y.S.2d 822

Haar v. Nationwide Mutual Fire Ins. Co.
34 N.Y.3d 224, 138 N.E.3d 1080, 115 N.Y.S.3d 197

Hahn Automotive Warehouse, Inc. v. American Zurich Ins. Co.
18 N.Y.3d 765, 967 N.E.2d 1187, 944 N.Y.S.2d 742

Harvey v. Members Employees Trust for Retail Outlets
96 N.Y.2d 99, 748 N.E.2d 1061, 725 N.Y.S.2d 265

Hiraldo v. Allstate Ins. Co.
5 N.Y.3d 508, 840 N.E.2d 563, 806 N.Y.S.2d 451

Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co.
9 N.Y.3d 312, 879 N.E.2d 1291, 849 N.Y.S.2d 473

In the Matter of Worcester Ins. Co. v. Bettenhauser
95 N.Y.2d 185, 734 N.E.2d 745, 712 N.Y.S.2d 433.

Case Name Alphabetical with Case Citation

Inchaustegui v. 666 5th Avenue Limited Partnership
96 N.Y.2d 111, 749 N.E.2d 196, 725 N.Y.S.2d 627

Incorporated Village of Cedarhurst v. Hanover Ins. Co.
89 N.Y.2d 293, 675 N.E.2d 822, 653 N.Y.S.2d 68

Insurance Premium Finance Ass'n of New York v. New York State Dep't of Ins.
88 N.Y.2d 337, 668 N.E.2d 399, 645 N.Y.S.2d 428

J.P. Morgan Securities Inc. v. Vigilant Ins. Co.
21 N.Y.3d 324, 992 N.E.2d 1076, 970 N.Y.S.2d 733

K2 Investment Group v. American Guarantee & Liability Ins
22 N.Y.3d 578, 6 N.E.3d 1117, 983 N.Y.S.2d 761

K2 Investment Group, LLC v. American Guarantee & Liability Ins. Co.
21 N.Y.3d 384, 993 N.E.2d 1249, 971 N.Y.S.2d 229

KeySpan Gas East Corp. v. Munich Reinsurance America, Inc.
31 N.Y.3d 51, 96 N.E.3d 209, 73 N.Y.S.3d 113

KeySpan Gas East v. Munich Reinsurance America
23 N.Y.3d 583, 15 N.E.3d 1194, 992 N.Y.S.2d 185

Kramer v. Phoenix Life Ins. Co
15 N.Y.3d 539, 940 N.E.2d 535, 914 N.Y.S.2d 709

Lane v. Security Mutual Ins. Co.
96 N.Y.2d 1, 747 N.E.2d 1270, 724 N.Y.S.2d 670.

Lang v. Hanover Insurance Co.
3 N.Y.3d 350, 820 N.E.2d 855, 787 N.Y.S.2d 211

Lend Lease (US) Constr. LMB v. Zurich Am. Ins. Co.
28 N.Y.3d 675, 71 N.E.3d 556, 49 N.Y.S.3d 65

LMK Psychological Services, P.C. v. State Farm Mutual Automobile Ins. Co.
12 N.Y.3d 217, 906 N.E.2d 1046, 879 N.Y.S.2d 14

Maroney v. New York Central Mutual Fire Ins. Co.
5 N.Y.3d 467, 839 N.E.2d 886, 805 N.Y.S.2d 533

Matter of Allstate Ins. Co. v. Rivera
12 N.Y.3d 602, 911 N.E.2d 817, 883 N.Y.S.2d 755

Matter of Arbitration Between Falzone and New York Central Mut. Fire Ins. Co.
15 N.Y.3d 530, 939 N.E.2d 1197, 914 N.Y.S.2d 67

Matter of Beth V. v. New York State Office of Children & Family Services
22 N.Y.3d 80, 3 N.E.3d 113, 980 N.Y.S.2d 47

Matter of Brandon v. Nationwide Mutual Ins. Co.
97 N.Y.2d 491, 769 N.E.2d 810, 743 N.Y.S.2d 53

Matter of Elrac, Inc. v. Exum
18 N.Y.3d 325, 961 N.E.2d 643, 938 N.Y.S.2d 252

Matter of Excellus Health Plan, Inc. v. Serio
2 N.Y.3d 166, 809 N.E.2d 651, 777 N.Y.S.2d 422

Matter of Mancini v. Office of Children and Family Services
32 N.Y.3d 521, 118 N.E.3d 191, 93 N.Y.S.3d 652

Matter of Medical Society of the State of New York v. Serio
100 N.Y.2d 854, 800 N.E.2d 728, 768 N.Y.S.2d 423

Matter of Metropolitan Property and Casualty Ins. Co. v. Manusco
93 N.Y.2d 487, 715 N.E.2d 107, 693 N.Y.S.2d 81.

Matter of Monarch Consulting v. National Union Fire Ins. Co. of Pittsburgh, PA
26 N.Y.3d 659, 47 N.E.3d 463, 27 N.Y.S.3d 97

Matter of New York Central Mutual Fire Ins. Co. v. Aguirre
7 N.Y.3d 772, 854 N.E.2d 146, 820 N.Y.S.2d 848

Matter of the Liquidation of Midland Ins. Co.
16 N.Y.3d 536, 947 N.E.2d 1174, 923 N.Y.S.2d 396

Matter of Vega
35 N.Y.3d 131

Matter of Viking Pump
27 N.Y.3d 244, 52 N.E.3d 1144, 33 N.Y.S.3d 118

McCarthy v. Aetna Life Ins. Co.
92 N.Y.2d 436, 704 N.E.2d 557, 681 N.Y.S.2d 790.

Michaels v. City of Buffalo, et al.
85 N.Y.2d 754, 651 N.E.2d 1272, 628 N.Y.S.2d 253

Mostow v. State Farm Ins. Co.
88 N.Y.2d 321, 668 N.E.2d 392, 645 N.Y.S.2d 421.

Mount Vernon Fire Ins. Co. v. Creative Housing Ltd.
88 N.Y.2d 347, 668 N.E.2d 404, 645 N.Y.S.2d 433

Murphy v. Kuhn
90 N.Y.2d 266, 682 N.E.2d 972, 660 N.Y.S.2d 371.

Myers , Smith & Granady Inc. v. New York Property Ins. Underwriting Ass'n
85 N.Y.S.2d 832, 647 N.E.2d 1348, 623 N.Y.S.2d 840.

Nadkos, Inc. v. Preferred Contractors. Ins. Co. Risk Retention Group LLC, No. 37
34 N.Y.3d 1, 132 N.E.3d 568, 108 N.Y.S.3d 375

Nesmith v. Allstate Ins.
24 N.Y.3d 520, 25 N.E.3d 924, 2 N.Y.S.3d 11

Case Name Alphabetical with Case Citation

New England Mutual Life Ins. Co. v. Doe
93 N.Y.2d 122, 710 N.E.2d 1060, 688 N.Y.S.2d 459

New York and Presbyterian Hospital v. Country Wide Ins. Co.
17 N.Y.3d 586, 958 N.E.2d 88, 934 N.Y.S.2d 54

New York University v. Continental Ins. Co.
87 N.Y.2d 308, 662 N.E.2d 763, 639 N.Y.S.2d 283.

Northville Industries Corp. v. Nat'l Union Fire Ins. Co.
89 N.Y.2d 621,679 N.E.2d 1044, 657 N.Y.S.2d 564

Nyack Hospital v. General Motors Acceptance Corp.
8 N.Y.3d 294, 864 N.E.2d 1279, 832 N.Y.S.2d 880

Oberly v. Bangs Ambulance Inc.
96 N.Y.2d 295, 751 N.E.2d 457, 727 N.Y.S.2d 378

Panasia Estates Inc. v. Hudson Ins. Co.
10 N.Y.3d 200, 886 N.E.2d 135, 856 N.Y.S.2d 513

Panepinto v. New York Life Ins. Co.
90 N.Y.2d 717, 688 N.E.2d 241, 665 N.Y.S.2d 385.

Perl v. Meher
18 N.Y.3d 208, 960 N.E.2d 424, 936 N.Y.S.2d 655

Peters v. State Farm Fire and Casualty Co.
100 N.Y.2d 634, 801 N.E.2d 416, 769 N.Y.S.2d 195

Pierre v. Providence Washington Ins. Co.
99 N.Y.2d 222, 784 N.E.2d 52, 754 N.Y.S.2d 179

Pioneer Tower Owners Ass'n v. State Farm Fire & Casualty Co.
12 N.Y.3d 302, 908 N.E.2d 875, 880 N.Y.S.2d 885

Platek v Town of Hamburg
24 N.Y.3d 688, 26 N.E.3d 1167, 3 N.Y.S.3d 312

Plavin v. Group Health Inc.
35 N.Y.3d 1, 146 N.E.3d 1164, 124 N.Y.S.3d 5

Polan v. State of New York Insurance Department
3 N.Y.3d 54, 814 N.E.2d 789, 781 N.Y.S.2d 482

Pommells v. Perez
4 N.Y.3d 566, 830 N.E.2d 278, 797 N.Y.S.2d 380

Presbyterian Hospital in the City of New York v. Maryland Casualty Co.
90 N.Y.2d 274, 683 N.E.2d 1, 660 N.Y.S.2d 536.

Preserver Ins.Co. v. Ryba
10 N.Y.3d 635, 893 N.E.2d 97, 862 N.Y.S.2d 820

QBE Ins. v. Jinx-Proof
22 N.Y.3d 1105, 6 N.E.3d 583, 983 N.Y.S.2d 465

Raffellini v. State Farm Mutual Automobile Ins. Co.
9 N.Y.3d 196, 878 N.E.2d 583, 848 N.Y.S.2d 1

Ragins v. Hospitals Ins.
22 N.Y.3d 1019, 4 N.E.3d 941, 981 N.Y.S.2d 640

Raymond Corp. v. National Union Fire Ins. Co.
5 N.Y.3d 157, 833 N.E.2d 232, 800 N.Y.S.2d 89

Regal Construction v National Union
15 N.Y.3d 34, 930 N.E.2d 259, 904 N.Y.S.2d 338

Rekemeyer v. State Farm Mutual Automobile Ins. Co.
4 N.Y.3d 468, 828 N.E.2d 970, 796 N.Y.S.2d 13

RJC Realty Holding Corp. v. Republic Franklin Ins. Co.
2 N.Y.3d 158, 808 N.E.2d 1263, 777 N.Y.S.2d 4

Roman Catholic Diocese of Brooklyn v. National Union Fire Ins. Co. of Pittsburgh, PA
21 N.Y.3d 139, 991 N.E.2d 666, 969 N.Y.S.2d 808

Rosner v. Metropolitan Property and Liability Ins. Co.
96 N.Y.2d 475, 754 N.E.2d 760, 729 N.Y.S.2d 658

Royal Bank & Trust Co. v. Superintendent of Ins.
92 N.Y.2d 107, 699 N.E.2d 852, 677 N.Y.S.2d 228

Royal Indemnity Co. v. Providence Washington Ins. Co.
92 N.Y.2d 653, 707 N.E.2d 425, 684 N.Y.S.2d 470.

Selective Ins. Co. of America v. County of Rensselaer
26 N.Y.3d 649, 47 N.E.3d 458, 27 N.Y.S.3d 92

Sierra v 4401 Sunset Park LLC
24 N.Y.3d 514, 25 N.E.3d 921, 2 N.Y.S.3d 8

Slayko v. Security Mutual Ins. Co.
98 N.Y.2d 289, 774 N.E.2d 208, 746 N.Y.S.2d 444

Smith v. General Accident Ins. Co.
91 N.Y.2d 648, 697 N.E.2d 168, 674 N.Y.S.2d 267.

Sorbara Constr. Corp. v. AIU Ins. Co.
11 N.Y.3d 805, 897 N.E.2d 1054, 868 N.Y.S.2d 573

Spoleta Construction v. Aspen Ins. UK Limited
27 N.Y.3d 933, 50 N.E.3d 222, 30 N.Y.S.3d 598

Springer v. Allstate Life Ins. Co. of New York
94 N.Y.2d 645, 731 N.E.2d 1106, 710 N.Y.S.2d 298.

Case Name Alphabetical with Case Citation

State Farm Mut. Auto. Ins. Co. v. Langan
16 N.Y.3d 349, 947 N.E.2d 124, 922 N.Y.S.2d 233

State Farm Mutual Automobile Ins. v. Fitzgerald
25 N.Y.3d 799, 38 N.E.3d 325, 16 N.Y.S.3d 796

State Farm Mutual Automobile Insurance Co. v. Mallela
4 N.Y.3d 313, 827 N.E.2d 758, 794 N.Y.S.2d 700

State v. Wells Fargo Ins. Services Inc.
16 N.Y.3d 166, 944 N.E.2d 1120, 919 N.Y.S.2d 481

Strauss Painting v. Mt. Hawley Ins.
24 N.Y.3d 578, 26 N.E.3d 218, 2 N.Y.S.3d 390

Tanzer v. Health Ins. Plan of Greater New York
91 N.Y.2d 850, 690 N.E.2d 1257, 668 N.Y.S.2d 151.

The Argo Corp. v. Greater New York Mutual Insurance Co.
4 N.Y.3d 332, 827 N.E.2d 762, 794 N.Y.S.2d 704

The Guardian Life Ins. Co. v. Chemical Bank
94 N.Y.2d 418, 727 N.E.2d 111, 705 N.Y.S.2d 553.

Toure v. Avis Rent A Car Systems
98 N.Y.2d 345, 774 N.E.2d 1197, 746 N.Y.S.2d 865

Town of Amherst v. Granite State Ins. Co.
29 N.Y.3d 1016, 77 N.E.3d 357, 54 N.Y.S.3d 639

Town of Harrison v. Nat'l Union Fire Ins. Co. of Pittsburgh
89 N.Y.2d 308, 675 N.E.2d 829, 653 N.Y.S.2d 75

Town of Massena v. Healthcare Underwriters Mutual Ins. Co.
98 N.Y.2d 435, 779 N.E.2d 167, 749 N.Y.S.2d 456

Travelers Casualty and Surety Co. v. Certain Underwriters at Lloyd's of London
96 N.Y.2d 583, 760 N.E.2d 319, 734 N.Y.S.2d 531

U.S. Fidelity & Guaranty Co. v. American Re-Ins. Co.
20 N.Y.3d 407, 985 N.E.2d 876, 962 N.Y.S.2d 566

U.S. Underwriters Ins. Co. v. Val-Blue Corp.
85 N.Y.2d 821, 647 N.E.2d 1342, 623 N.Y.S.2d 834

U.S. Underwriters Insurance Co. v. City Club Hotel, LLC
3 N.Y.3d 592, 822 N.E.2d 777, 789 N.Y.S.2d 470

Union Carbide Corp. v. Affiliated FM Ins. Co.
16 N.Y.3d 419, 947 N.E.2d 111, 922 N.Y.S.2d 220

United Services Automobile Ass'n v. Curiale
88 N.Y.2d 306, 668 N.E.2d 384, 645 N.Y.S.2d 413

Universal Am. Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.
25 N.Y.3d 675, 37 N.E.3d 78, 16 N.Y.S.3d 21

Vigilant Ins. Co. v. The Bear Stearns Companies Inc
10 N.Y.3d 170, 884 N.E.2d 1044, 855 N.Y.S.2d 45

Viviane Etienne Medical Care v. Country-Wide Ins.
25 N.Y.3d 498, 35 N.E.3d 451, 14 N.Y.S.3d 283

Voss v. Netherlands Ins
22 N.Y.3d 728, 8 N.E.3d 823, 985 N.Y.S.2d 448

Westview Associates v. Guaranty National Ins. Co.
95 N.Y.2d 334, 740 N.E.2d 220, 717 N.Y.S.2d 75

White v. Continental Casualty Co.
9 N.Y.3d 264, 878 N.E.2d 1019, 848 N.Y.S.2d 603

Worth Construction Co. Inc. v. Admiral Ins. Co
10 N.Y.3d 411, 888 N.E.2d 1043, 859 N.Y.S.2d 101

Zurich Ins. Co. v. Shearson Lehman Hutton Inc.
84 N.Y.2d 309, 642 N.E.2d 1065, 618 N.Y.S.2d 609

Case Name by Term

1994-1995

Dingle v. Prudential Casualty Co.

Michaels v. City of Buffalo, et al.

Myers , Smith & Granady Inc. v. New York Property Ins. Underwriting Ass'n

U.S. Underwriters Ins. Co. v. Val-Blue Corp.

Zurich Ins. Co. v. Shearson Lehman Hutton Inc.

1995-1996

Curiale v. Ardra Ins. Co., Ltd.

Insurance Premium Finance Ass'n of New York v. New York State Dep't of Ins.

Mostow v. State Farm Ins. Co.

Mount Vernon Fire Ins. Co. v. Creative Housing Ltd.

New York University v. Continental Ins. Co.

United Services Automobile Ass'n v. Curiale

1996-1997

American Home Assurance Co. v. International Ins. Co.

Basil Development Corp. v. Generall Accident Ins. Co.

Central General Hospital v. Chubb Group of Ins. Co.

Incorporated Village of Cedarhurst v. Hanover Ins. Co.

Murphy v. Kuhn

Northville Industries Corp. v. Nat'l Union Fire Ins. Co.

Presbyterian Hospital in the City of New York v. Maryland Casualty Co.

Town of Harrison v. Nat'l Union Fire Ins. Co. of Pittsburgh

1997-1998

Frontier Insulation Contractors, Inc.. V. Merchants Mutual Ins. Co.

Panepinto v. New York Life Ins. Co.

Royal Bank & Trust Co. v. Superintendent of Ins.

Smith v. General Accident Ins. Co.

Tanzer v. Health Ins. Plan of Greater New York

1998-1999

Argentina v. Emery World Wide Delivery Corp.

Badillo v. Tower Ins. Co.

Crouse West Holding Corp. v Sphere Drake Ins. Co. PLC

Great Northern Ins. Co. v. Mount Vernon Fire Ins. Co.

Matter of Metropolitan Property and Casualty Ins. Co. v. Manusco

McCarthy v. Aetna Life Ins. Co.

New England Mutual Life Ins. Co. v. Doe

Royal Indemnity Co. v. Providence Washington Ins. Co.

1999-2000

Agoado Realty Corp. v. United International Ins. Co.

Charles F. Evans Co., Inc. v. Zurich Ins. Co.

Gaidon v. The Guardian Life Ins. Co. of America

In the Matter of Worcester Ins. Co. v. Bettenhauser

Springer v. Allstate Life Ins. Co. of New York

The Guardian Life Ins. Co. v. Chemical Bank

2000-2001

Chase Scientific Research, Inc. v. NIA Group, Inc.

Darby & Darby, P.C., v. VSI Int'l, Inc.

ELRAC, Inc. v. Masara

ELRAC, Inc. v. Ward

Gaidon v. The Guardian Life Ins. Co. of America (Gaidon II)

Harvey v. Members Employees Trust for Retail Outlets

Inchaustegui v. 666 5th Avenue Limited Partnership

Lane v. Security Mutual Ins. Co.

Oberly v. Bangs Ambulance Inc.

Rosner v. Metropolitan Property and Liability Ins. Co.

Westview Associates v. Guaranty National Ins. Co.

Case Name by Term

2001-2002

Consolidated Edison Co. of New York, Inc. v. Allstate Ins. Co

Goshen v. The Mutual Life Ins. Co. of New York

Matter of Brandon v. Nationwide Mutual Ins. Co.

Slayko v. Security Mutual Ins. Co.

Toure v. Avis Rent A Car Systems

Travelers Casualty and Surety Co. v. Certain Underwriters at Lloyd's of London

2002-2003

Belt Painting Corp. v. TIG Ins. Co.

Continental Ins. Co. v. State of New York

Crump v. Unigard Ins. Co.

Pierre v. Providence Washington Ins. Co.

Town of Massena v. Healthcare Underwriters Mutual Ins. Co.

2003-2004

American Transit Ins. Co. v. Sartor

First Financial Ins. Co. v. Jetco Contracting Corp.

Matter of Excellus Health Plan, Inc. v. Serio

Matter of Medical Society of the State of New York v. Serio

Peters v. State Farm Fire and Casualty Co.

Polan v. State of New York Insurance Department

RJC Realty Holding Corp. v. Republic Franklin Ins. Co.

2004-2005

Great Canal Realty Corp. v. Seneca Ins. Co., Inc.

Lang v. Hanover Insurance Co.

Pommells v. Perez

Raymond Corp. v. National Union Fire Ins. Co.

Rekemeyer v. State Farm Mutual Automobile Ins. Co.

State Farm Mutual Automobile Insurance Co. v. Mallela

The Argo Corp. v. Greater New York Mutual Insurance Co.

U.S. Underwriters Insurance Co. v. City Club Hotel, LLC

2005-2006

Automobile Ins. Co. of Hartford v. Cook

Goldman v. Metropolitan Life Ins. Co.

Hiraldo v. Allstate Ins. Co.

Maroney v. New York Central Mutual Fire Ins. Co.

Matter of New York Central Mutual Fire Ins. Co. v. Aguirre

2006-2007

Appalachian Ins. Co. v. General Electric Co.

Benesowitz v. Metropolitan Life Ins. Co.

BP Air Conditioning Corp. v. One Beacon Insurance Group

Catholic Charities of the Diocese of Albany v. Serio

Nyack Hospital v. General Motors Acceptance Corp.

2007-2008

Bi-Economy Market Inc. v. Harleysville Ins. Co. of New York

Certain Underwriters at Lloyd's, London v. Foster Wheeler Corp.

Fair Price Medical Supply Corp. v. Travelers Indemnity Co.

Friedman v. Connecticut General Life Ins. Co.

Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co.

Panasia Estates Inc. v. Hudson Ins. Co.

Preserver Ins. Co. v. Ryba

Raffellini v. State Farm Mutual Automobile Ins. Co.

Vigilant Ins. Co. v. The Bear Stearns Companies Inc

White v. Continental Casualty Co.

Worth Construction Co. Inc. v. Admiral Ins. Co

Case Name by Term

2008-2009

Briggs Avenue LLC v. Ins. Corp. of Hannover

Continental Cas. Co. v. Stradford

Fasso v. Doerr

Green v. William Penn Life Ins. Co. of New York

LMK Psychological Services, P.C. v. State Farm Mutual Automobile Ins. Co.

Matter of Allstate Ins. Co. v. Rivera

Pioneer Tower Owners Ass'n v. State Farm Fire & Casualty Co.

Sorbara Constr. Corp. v. AIU Ins. Co.

2009-2010

Executive Risk Indem v Pepper Hamilton (Decision)

Regal Construction v National Union (Decision)

2010-2011

ABN AMRO Bank, N.V. v. MBIA Inc.

Cragg v. Allstate Indem. Corp.

Fieldston Property Owners Assoc. Inc. v. Hermitage Ins. Co. Inc.

Kramer v. Phoenix Life Ins. Co

Matter of Arbitration Between Falzone and New York Central Mut. Fire Ins. Co.

Matter of the Liquidation of Midland Ins. Co.

State Farm Mut. Auto. Ins. Co. v. Langan

State v. Wells Fargo Ins. Services Inc.

Union Carbide Corp. v. Affiliated FM Ins. Co.

2011-2012

Admiral Ins. Co. v. Joy Contractors, Inc.

Dzielski v. Essex Ins. Co.

Federal Ins. Co. v. International Business Machines Corp.

Hahn Automotive Warehouse, Inc. v. American Zurich Ins. Co.

Perl v. Meher

New York and Presbyterian Hospital v. Country Wide Ins. Co.

Matter of Elrac, Inc. v. Exum

2012-2013

American Building Supply Corp. v. Petrocelli Group, Inc.

Bentoria Holdings, Inc. v. Travelers Indemnity Co.

Dean v. Tower Ins. Co. of New York

J.P. Morgan Securities Inc. v. Vigilant Ins. Co.

K2 Investment Group, LLC v. American Guarantee & Liability Ins. Co.

Roman Catholic Diocese of Brooklyn v. National Union Fire Ins. Co. of Pittsburgh, PA

U.S. Fidelity & Guaranty Co. v. American Re-Ins. Co.

2013-2014

Country-Wide Ins. v. Preferred Trucking Services

Executive Plaza v. Peerless Ins.

Georgitsi Realty v. Penn-Star Ins.

KeySpan Gas East v. Munich Reinsurance America

K2 Investment Group v. American Guarantee & Liability Ins

Matter of Beth V. v. New York State Office of Children & Family Services

QBE Ins. v. Jinx-Proof

Ragins v. Hospitals Ins.

Voss v. Netherlands Ins

2014-2015

Nesmith v. Allstate Ins.

Platek v Town of Hamburg

Sierra v 4401 Sunset Park LLC

State Farm Mutual Automobile Ins. v. Fitzgerald

Strauss Painting v. Mt. Hawley Ins.

Case Name by Term

Universal Am. Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.

Viviane Etienne Medical Care v. Country-Wide Ins.

2015-2016

Aetna Health Plans v Hanover Ins. Co.

Government Employees Ins. Co. (GEICO) v. Avanguard Medical Group

Matter of Monarch Consulting v. National Union Fire Ins. Co. of Pittsburgh, PA

Matter of Viking Pump

Selective Ins. Co. of America v. County of Rensselaer

Spoleta Construction v. Aspen Ins. UK Limited

2016-2017

Burlington Ins. Co. v. New York City Transit Authority

Estee Lauder v. OneBeacon Ins. Group

Lend Lease (US) Constr. LMB v. Zurich Am. Ins. Co.

Town of Amherst v. Granite State Ins. Co.

2017-2018

American Economy Ins. Co. v. State of New York

Carlson v. American International Group, Inc.

Contact Chiropractic v. New York City Transit Authority

Excess Line Association of N.Y. v. Waldorf & Associates

Gilbane Building Co./TDX Construction v. St. Paul Fire and Marine Ins.

Global Reinsurance Corp. of America v. Century Indemnity Co.

KeySpan Gas East Corp. v. Munich Reinsurance America, Inc.

2018-2019

Andrew Carothers, M.D., P.C. v. Progressive Ins. Co. b

Matter of Mancini v. Office of Children and Family Services

Nadkos, Inc. v. Preferred Contractors. Ins. Co. Risk Retention Group LLC, No. 37

2019-2020

American International Specialty Lines Ins. Co. v. Allied Capital Corp.

Haar v. Nationwide Mutual Fire Ins. Co.

Matter of Vega

Plavin v. Group Health Inc.

Case Name by Insurance Policy

Auto

Carlson v. American International Group, Inc.

Country-Wide Ins. v. Preferred Trucking Services

Crump v. Unigard Ins. Co.

Dingle v. Prudential Casualty Co.

ELRAC, Inc. v. Masara

ELRAC, Inc. v. Ward

Haar v. Nationwide Mutual Fire Ins. Co.

In the Matter of Worcester Ins. Co. v. Bettenhauser

Insurance Premium Finance Ass'n of New York v. New York State Dep't of Ins.

Matter of Allstate Ins. Co. v. Rivera

Matter of Arbitration Between Falzone and New York Central Mut. Fire Ins. Co.

Matter of Brandon v. Nationwide Mutual Ins. Co.

Matter of Medical Society of the State of New York v. Serio

Matter of Metropolitan Property and Casualty Ins. Co. v. Manusco

Matter of New York Central Mutual Fire Ins. Co. v. Aguirre

Michaels v. City of Buffalo, et al.

Mostow v. State Farm Ins. Co.

Murphy v. Kuhn

Nyack Hospital v. General Motors Acceptance Corp.

Oberly v. Bangs Ambulance Inc.

Pierre v. Providence Washington Ins. Co.

Pommells v. Perez

Presbyterian Hospital in the City of New York v. Maryland Casualty Co.

Raffellini v. State Farm Mutual Automobile Ins. Co.

Rekemeyer v. State Farm Mutual Automobile Ins. Co.

Smith v. General Accident Ins. Co.

State Farm Mut. Auto. Ins. Co. v. Langan

State Farm Mutual Automobile Ins. v. Fitzgerald

State Farm Mutual Automobile Insurance Co. v. Mallela

Toure v. Avis Rent A Car Systems

Business

Badillo v. Tower Ins. Co.

Estee Lauder v. OneBeacon Ins. Group

Executive Plaza v. Peerless Ins.

Selective Ins. Co. of America v. County of Rensselaer

Universal Am. Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.

Voss v. Netherlands Ins

CGL

Admiral Ins. Co. v. Joy Contractors, Inc.

Agoado Realty Corp. v. United International Ins. Co.

American Building Supply Corp. v. Petrocelli Group, Inc.

American Transit Ins. Co. v. Sartor

Basil Development Corp. v. Generall Accident Ins. Co.

Belt Painting Corp. v. TIG Ins. Co.

BP Air Conditioning Corp. v. One Beacon Insurance Group

Briggs Avenue LLC v. Ins. Corp. of Hannover

Burlington Ins. Co. v. New York City Transit Authority

Charles F. Evans Co., Inc. v. Zurich Ins. Co.

Consolidated Edison Co. of New York, Inc. v. Allstate Ins. Co

Crouse West Holding Corp. v Sphere Drake Ins. Co. PLC

Dzielski v. Essex Ins. Co.

Fieldston Property Owners Assoc. Inc. v. Hermitage Ins. Co. Inc.

Case Name by Insurance Policy

First Financial Ins. Co. v. Jetco Contracting Corp.

Frontier Insulation Contractors, Inc.. V. Merchants Mutual Ins. Co.

Gilbane Building Co./TDX Construction v. St. Paul Fire and Marine Ins.

Great Canal Realty Corp. v. Seneca Ins. Co., Inc.

Hahn Automotive Warehouse, Inc. v. American Zurich Ins. Co.

Hiraldo v. Allstate Ins. Co.

Inchaustegui v. 666 5th Avenue Limited Partnership

Incorporated Village of Cedarhurst v. Hanover Ins. Co.

KeySpan Gas East Corp. v. Munich Reinsurance America, Inc.

KeySpan Gas East v. Munich Reinsurance America

Lend Lease (US) Constr. LMB v. Zurich Am. Ins. Co.

Mount Vernon Fire Ins. Co. v. Creative Housing Ltd.

Nadkos, Inc. v. Preferred Contractors. Ins. Co. Risk Retention Group LLC, No. 37

Nesmith v. Allstate Ins.

Northville Industries Corp. v. Nat'l Union Fire Ins. Co.

QBE Ins. v. Jinx-Proof

Raymond Corp. v. National Union Fire Ins. Co.

Regal Construction v National Union

RJC Realty Holding Corp. v. Republic Franklin Ins. Co.

Roman Catholic Diocese of Brooklyn v. National Union Fire Ins. Co. of Pittsburgh, PA

Royal Indemnity Co. v. Providence Washington Ins. Co.

Sierra v 4401 Sunset Park LLC

Spoleta Construction v. Aspen Ins. UK Limited

Strauss Painting v. Mt. Hawley Ins.

The Argo Corp. v. Greater New York Mutual Insurance Co.

Town of Amherst v. Granite State Ins. Co.

Town of Harrison v. Nat'l Union Fire Ins. Co. of Pittsburgh

U.S. Underwriters Ins. Co. v. Val-Blue Corp.

U.S. Underwriters Insurance Co. v. City Club Hotel, LLC

Worth Construction Co. Inc. v. Admiral Ins. Co

Zurich Ins. Co. v. Shearson Lehman Hutton Inc.

Disability

American Economy Ins. Co. v. State of New York

Benesowitz v. Metropolitan Life Ins. Co.

Friedman v. Connecticut General Life Ins. Co.

Matter of Beth V. v. New York State Office of Children & Family Services

Matter of Elrac, Inc. v. Exum

Matter of Mancini v. Office of Children and Family Services

Matter of Monarch Consulting v. National Union Fire Ins. Co. of Pittsburgh, PA

New England Mutual Life Ins. Co. v. Doe

Panepinto v. New York Life Ins. Co.

Preserver Ins. Co. v. Ryba

Polan v. State of New York Insurance Department

White v. Continental Casualty Co.

Excess

American Home Assurance Co. v. International Ins. Co.

Appalachian Ins. Co. v. General Electric Co.

Certain Underwriters at Lloyd's, London v. Foster Wheeler Corp.

Excess Line Association of N.Y. v. Waldorf & Associates

Executive Risk Indem v Pepper Hamilton

Federal Ins. Co. v. International Business Machines Corp.

Matter of Viking Pump

Case Name by Insurance Policy

Ragins v. Hospitals Ins.

Rosner v. Metropolitan Property and Liability Ins. Co.

Sorbara Constr. Corp. v. AIU Ins. Co.

Union Carbide Corp. v. Affiliated FM Ins. Co.

Financial Guarantee Insurance

ABN AMRO Bank, N.V. v. MBIA Inc.

Health

Harvey v. Members Employees Trust for Retail Outlets

Matter of Excellus Health Plan, Inc. v. Serio

Homeowners

Automobile Ins. Co. of Hartford v. Cook

Cragg v. Allstate Indem. Corp.

Dean v. Tower Ins. Co. of New York

Great Northern Ins. Co. v. Mount Vernon Fire Ins. Co.

Lane v. Security Mutual Ins. Co.

Lang v. Hanover Insurance Co.

Maroney v. New York Central Mutual Fire Ins. Co.

Peters v. State Farm Fire and Casualty Co.

Platek v Town of Hamburg

Slayko v. Security Mutual Ins. Co.

Life

Gaidon v. The Guardian Life Ins. Co. of America

Gaidon v. The Guardian Life Ins. Co. of America (Gaidon II)

Goldman v. Metropolitan Life Ins. Co.

Goshen v. The Mutual Life Ins. Co. of New York

McCarthy v. Aetna Life Ins. Co.

Springer v. Allstate Life Ins. Co. of New York

Life Insurance

Green v. William Penn Life Ins. Co. of New York

Kramer v. Phoenix Life Ins. Co

Malpractice Insurance

Continental Cas. Co. v. Stradford

Malpractice/Professional Liability

American International Specialty Lines Ins. Co. v. Allied Capital Corp.

Chase Scientific Research, Inc. v. NIA Group, Inc.

Darby & Darby, P.C., v. VSI Int'l, Inc.

Fasso v. Doerr

J.P. Morgan Securities Inc. v. Vigilant Ins. Co.

K2 Investment Group v. American Guarantee & Liability Ins

K2 Investment Group, LLC v. American Guarantee & Liability Ins. Co.

Vigilant Ins. Co. v. The Bear Stearns Companies Inc

No Fault

Aetna Health Plans v Hanover Ins. Co.

Andrew Carothers, M.D., P.C. v. Progressive Ins. Co.

Central General Hospital v. Chubb Group of Ins. Co.

Contact Chiropractic v. New York City Transit Authority

Fair Price Medical Supply Corp. v. Travelers Indemnity Co.

Government Employees Ins. Co. (GEICO) v. Avanguard Medical Group

Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co.

LMK Psychological Services, P.C. v. State Farm Mutual Automobile Ins. Co.

New York and Presbyterian Hospital v. Country Wide Ins. Co.

Perl v. Meher

Viviane Etienne Medical Care v. Country-Wide Ins.

Case Name by Insurance Policy

Other

Argentina v. Emery World Wide Delivery Corp.

Other (Agent Liability)

The Guardian Life Ins. Co. v. Chemical Bank

Other (Commercial Crime Liability)

New York University v. Continental Ins. Co.

Other (Employers' Liability/Workers' Compensation Policy)

Continental Ins. Co. v. State of New York

Other (Foreign Insurer)

Curiale v. Ardra Ins. Co., Ltd.

United Services Automobile Ass'n v. Curiale

Other (Health)

Plavin v. Group Health Inc.

Other (Insurance Security Fund)

Royal Bank & Trust Co. v. Superintendent of Ins.

Other (Medical)

Tanzer v. Health Ins. Plan of Greater New York

Other (Personal Injury Liability)

Town of Massena v. Healthcare Underwriters Mutual Ins. Co.

Other (Prescription)

Catholic Charities of the Diocese of Albany v. Serio

Other (Unemployment)

Matter of Vega

Property

Bentoria Holdings, Inc. v. Travelers Indemnity Co.

Bi-Economy Market Inc. v. Harleysville Ins. Co. of New York

Georgitsi Realty v. Penn-Star Ins.

Myers , Smith & Granady Inc. v. New York Property Ins. Underwriting Ass'n

Panasia Estates Inc. v. Hudson Ins. Co.

Pioneer Tower Owners Ass'n v. State Farm Fire & Casualty Co.

Reinsurance

Global Reinsurance Corp. of America v. Century Indemnity Co.

Matter of the Liquidation of Midland Ins. Co.

Travelers Casualty and Surety Co. v. Certain Underwriters at Lloyd's of London

U.S. Fidelity & Guaranty Co. v. American Re-Ins. Co.

Umbrella

Westview Associates v. Guaranty National Ins. Co.

Various

State v. Wells Fargo Ins. Services Inc.

Case Name by Legal Issue

Arbitrability (choice of forum)

Matter of Monarch Consulting v. National Union Fire Ins. Co. of Pittsburgh, PA

Town of Amherst v. Granite State Ins. Co.

Bad Faith

Smith v. General Accident Ins. Co.

Capacity to sue

Excess Line Association of N.Y. v. Waldorf & Associates

Choice of Law

Certain Underwriters at Lloyd's, London v. Foster Wheeler Corp.

Zurich Ins. Co. v. Shearson Lehman Hutton Inc.

Constitutionality of Statute (statutory)

American Economy Ins. Co. v. State of New York

Coverage

Admiral Ins. Co. v. Joy Contractors, Inc.

Agoado Realty Corp. v. United International Ins. Co.

Andrew Carothers, M.D., P.C. v. Progressive Ins. Co.,

Appalachian Ins. Co. v. General Electric Co.

Automobile Ins. Co. of Hartford v. Cook

Basil Development Corp. v. Generall Accident Ins. Co.

Belt Painting Corp. v. TIG Ins. Co.,

Bentoria Holdings, Inc. v. Travelers Indemnity Co.

BP Air Conditioning Corp. v. One Beacon Insurance Group

Burlington Ins. Co. v. New York City Transit Authority

Carlson v. American International Group, Inc.

Charles F. Evans Co., Inc. v. Zurich Ins. Co.

Continental Cas. Co. v. Stradford

Consolidated Edison Co. of New York, Inc. v. Allstate Ins. Co.

Continental Ins. Co. v. State of New York

Cragg v. Allstate Indem. Corp.

Crouse West Holding Corp. v Sphere Drake Ins. Co. PLC

Dean v. Tower Ins. Co. of New York

Dingle v. Prudential Casualty Co.

Dzielski v. Essex Ins. Co.

Executive Risk Indem v Pepper Hamilton

Fair Price Medical Supply Corp. v. Travelers Indemnity Co.

Federal Ins. Co. v. International Business Machines Corp.

Fieldston Property Owners Assoc. Inc. v. Hermitage Ins. Co. Inc.

Friedman v. Connecticut General Life Ins. Co.

Frontier Insulation Contractors, Inc.. V. Merchants Mutual Ins. Co

Georgitsi Realty v. Penn-Star Ins.

Gilbane Building Co./TDX Construction v. St. Paul Fire and Marine Ins.

Goldman v. Metropolitan Life Ins. Co.

Great Northern Ins. Co. v. Mount Vernon Fire Ins. Co.

Green v. William Penn Life Ins. Co. of New York

Harvey v. Members Employees Trust for Retail Outlets

Hiraldo v. Allstate Ins. Co.

Hospital for Joint Diseases v.Travelers Prop. Cas. Ins. Co.

Incorporated Village of Cedarhurst v. Hanover Ins. Co.

J.P. Morgan Securities Inc. v. Vigilant Ins. Co.

KeySpan Gas East Corp. v. Munich Reinsurance America, Inc.

Lane v. Security Mutual Ins. Co.

Lend Lease (US) Constr. LMB v. Zurich Am. Ins. Co.

Case Name by Legal Issue

Maroney v. New York Central Mutual Fire Ins. Co.

Matter of Allstate Ins. Co. v. Rivera

Matter of Arbitration Between Falzone and New York Central Mut. Fire Ins. Co.

Matter of Brandon v. Nationwide Mutual Ins. Co.

Matter of Metropolitan Property and Casualty Ins. Co. v. Manusco

Matter of Viking Pump

Michaels v. City of Buffalo, et al.

Mount Vernon Fire Ins. Co. v. Creative Housing Ltd.

Nesmith v. Allstate Ins.

New England Mutual Life Ins. Co. v. Doe

Nyack Hospital v. General Motors Acceptance Corp.

Panepinto v. New York Life Ins. Co.

Northville Industries Corp. v. Nat'l Union Fire Ins. Co.

Perl v. Meher

Peters v. State Farm Fire and Casualty Co.

Pierre v. Providence Washington Ins. Co.

Pioneer Tower Owners Ass'n v. State Farm Fire & Casualty Co.

Platek v Town of Hamburg

Preserver Ins.Co. v. Ryba

QBE Ins. v. Jinx-Proof

Raffellini v. State Farm Mutual Automobile Ins. Co.

Raymond Corp. v. National Union Fire Ins. Co.

Regal Construction v National Union

RJC Realty Holding Corp. v. Republic Franklin Ins. Co.

Royal Indemnity Co. v. Providence Washington Ins. Co.

Roman Catholic Diocese of Brooklyn v. National Union Fire Ins. Co. of Pittsburgh, PA

Selective Ins. Co. of America v. County of Rensselaer

Sierra v 4401 Sunset Park LLC

Slayko v. Security Mutual Ins. Co.

Springer v. Allstate Life Ins. Co. of New York

State Farm Mutual Automobile Ins. v. Fitzgerald

State Farm Mut. Auto. Ins. Co. v. Langan

State Farm Mutual Automobile Insurance Co. v. Mallela

Strauss Painting v. Mt. Hawley Ins.

Tanzer v. Health Ins. Plan of Greater New York

Travelers Casualty and Surety Co. v. Certain Underwriters at Lloyd's of London

Toure v. Avis Rent A Car Systems

Town of Harrison v. Nat'l Union Fire Ins. Co. of Pittsburgh

Town of Massena v. Healthcare Underwriters Mutual Ins. Co.

Union Carbide Corp. v. Affiliated FM Ins. Co.

Universal Am. Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.

U.S. Underwriters Insurance Co. v. City Club Hotel, LLC

U.S. Underwriters Ins. Co. v. Val-Blue Corp.

Vigilant Ins. Co. v. The Bear Stearns Companies Inc

Westview Associates v. Guaranty National Ins. Co.

White v. Continental Casualty Co.

Worth Construction Co. Inc. v. Admiral Ins. Co

Insurance Business

ABN AMRO Bank, N.V. v. MBIA Inc.

American Building Supply Corp. v. Petrocelli Group, Inc.

American International Specialty Lines Ins. Co. v. Allied Capital Corp.

Fasso v. Doerr

Haar v. Nationwide Mutual Fire Ins. Co.

Case Name by Legal Issue

Hahn Automotive Warehouse, Inc. v. American Zurich Ins. Co.

K2 Investment Group v. American Guarantee & Liability Ins

K2 Investment Group, LLC v. American Guarantee & Liability Ins. Co.

Matter of Elrac, Inc. v. Exum

Matter of the Liquidation of Midland Ins. Co.

Murphy v. Kuhn

Panasia Estates Inc. v. Hudson Ins. Co.

Ragins v. Hospitals Ins.

State v. Wells Fargo Ins. Services Inc.

U.S. Fidelity & Guaranty Co. v. American Re-Ins. Co.

Voss v. Netherlands Ins

Other (Beneficiary Designation)

McCarthy v. Aetna Life Ins. Co.

Other (Breach of Fiduciary Duty)

Darby & Darby, P.C., v. VSI Int'l, Inc.

Other (Payments)

Badillo v. Tower Ins. Co.

Other (Recovery)

Inchaustegui v. 666 5th Avenue Limited Partnership

Policy Notice Requirement

American Home Assurance Co. v. International Ins. Co.

American Transit Ins. Co. v. Sartor

Briggs Avenue LLC v. Ins. Corp. of Hannover

Central General Hospital v. Chubb Group of Ins. Co.

Country-Wide Ins. v. Preferred Trucking Services

Estee Lauder v. OneBeacon Ins. Group

First Financial Ins. Co. v. Jetco Contracting Corp.

Great Canal Realty Corp. v. Seneca Ins. Co., Inc.

KeySpan Gas East v. Munich Reinsurance America

New York and Presbyterian Hospital v. Country Wide Ins. Co.

Presbyterian Hospital in the City of New York v. Maryland Casualty Co.

Rekemeyer v. State Farm Mutual Automobile Ins. Co.

Sorbara Constr. Corp. v. AIU Ins. Co.

Spoleta Construction v. Aspen Ins. UK Limited

The Argo Corp. v. Greater New York Mutual Insurance Co.

Reinsurance Coverage

Global Reinsurance Corp. of America v. Century Indemnity Co.

Statutory

Aetna Health Plans v Hanover Ins. Co.

Argentina v. Emery World Wide Delivery Corp.

Benesowitz v. Metropolitan Life Ins. Co.

Catholic Charities of the Diocese of Albany v. Serio

Chase Scientific Research, Inc. v. NIA Group, Inc.

Crump v. Unigard Ins. Co.

Curiale v. Ardra Ins. Co., Ltd.

ELRAC, Inc. v. Masara

ELRAC, Inc. v. Ward

Gaidon v. The Guardian Life Ins. Co. of America

Gaidon v. The Guardian Life Ins. Co. of America (Gaidon II)

Case Name by Legal Issue

Goshen v. The Mutual Life Ins. Co. of New York

Government Employees Ins. Co. (GEICO) v. Avanguard Medical Group

In the Matter of Worcester Ins. Co. v. Bettenhauser

Insurance Premium Finance Ass'n of New York v. New York State Dep't of Ins.

Kramer v. Phoenix Life Ins. Co

Lang v. Hanover Insurance Co.

LMK Psychological Services, P.C. v. State Farm Mutual Automobile Ins. Co.

Matter of Beth V. v. New York State Office of Children & Family Services

Matter of Excellus Health Plan, Inc. v. Serio

Matter of Mancini v. Office of Children and Family Services

Matter of Medical Society of the State of New York v. Serio

Matter of New York Central Mutual Fire Ins. Co. v. Aguirre

Matter of Vega

Mostow v. State Farm Ins. Co.

Myers , Smith & Granady Inc. v. New York Property Ins. Underwriting Ass'n

Nadkos, Inc. v. Preferred Contractors. Ins. Co. Risk Retention Group LLC, No. 37

New York University v. Continental Ins. Co.

Oberly v. Bangs Ambulance Inc.

Plavin v. Group Health Inc.

Polan v. State of New York Insurance Department

Pommells v. Perez

Rosner v. Metropolitan Property and Liability Ins. Co.

Royal Bank & Trust Co. v. Superintendent of Ins.

The Guardian Life Ins. Co. v. Chemical Bank

United Services Automobile Ass'n v. Curiale

Statutory/Burden of Proof

Viviane Etienne Medical Care v. Country-Wide Ins.

Statutory/Coverage

Contact Chiropractic v. New York City Transit Authority

COVERAGE ISSUES DOMINATED AGENDA; ASSAULT AND BATTERY EXCLUSION CONSTRUED BROADLY; Court of Appeals Special Report: A Change in the Wind?; Special Pullout Section; Insurance Law

New York Law Journal

October 10, 1995 Tuesday

New York Law Journal

Section: Pg. 9, (col. 4); Vol. 214

Length: 2778 words

Byline: Evan H. **Krinick**

Body

Court of Appeals Special Report: A Change in the Wind?

Special Pullout Section

Insurance Law

ASSAULT AND BATTERY EXCLUSION CONSTRUED BROADLY

D URING THE PAST YEAR, the insurance law cases considered by the Court of Appeals ranged from coverage issues in various contexts to public policy concerns regarding the insurability of punitive damages and the purpose of interest accruing on judgments against policyholders. With a brief memorandum decision in a lawsuit involving 349 of the General Business Law, the Court also set the stage for argument this fall in a case that may determine the applicability of that section to an insurance carrier's claims settlement practices.

Coverage Claims

In **U.S. Underwriters Ins. Co. v. Val-Blue Corp.,**[1] the Court gave a broad reading to an insurance contract's exclusion for any claim based on assault and battery.

The complaint against the Val-Blue Corporation asserted that Val-Blue employed Eugene DiSilvo, a retired New York City police officer, as a security guard in its nightclub. In the early morning hours of Feb. 3, 1990, John Hanley, an off-duty police officer, apprehended a suspect outside the nightclub and, with gun drawn, brought the suspect into the club to use the telephone. DiSilvo told Hanley to drop the gun and, when Hanley did not do so, shot him twice. In his suit for damages against Val-Blue, Hanley alleged that the guard negligently, carelessly and recklessly shot him. Hanley's complaint further charged respondeat superior and negligence in the hiring, supervision and training of DiSilvo.

Click here to return to the List of Indices

Val-Blue forwarded the complaint to its liability insurance carrier, seeking defense and indemnification. The carrier sought a declaratory judgment that it was not obligated to defend or indemnify Val-Blue because of an exclusion in the policy for any claim, demand or suit based on Assault and Battery and Assault and Battery shall not be deemed an accident, whether or not committed by or at the direction of the insured.

A unanimous Court first found the language of the exclusion to be unambiguous. The Court then determined that the plethora of claims surrounding Hanley's injury, including those for negligent shooting and negligent hiring and supervision were all based on the assault and battery without which Hanley would have no cause of action. Rejecting the argument that the mere pleading of a negligence cause of action was sufficient to take it out of the exclusion, the Court held that the exclusion precluded coverage for all the pleaded claims. Accordingly, it directed that judgment be entered declaring that the carrier was not obligated to defend or indemnify Val-Blue.

There can be little doubt that the Court's decision will have the effect of limiting the coverage available under insurance contracts that contain an assault and battery exclusion. The **Val-Blue** decision should also limit coverage for assault cases with negligence-related claims even if the applicable insurance contracts do not contain an assault and battery exclusion.

A recent Appellate Division decision relied on **Val-Blue** to find no coverage for a negligence claim arising out of an excluded event.[2] In that case, the Appellate Division, First Department, ruled that an insurance carrier that had issued to a camp a general liability policy with an automobile exclusion was not obligated to defend the camp against a lawsuit brought by a person injured by a motor vehicle owned by the camp.

The injured plaintiff alleged negligence in the operation of an automobile and negligent supervision of campers. Finding that the case was indistinguishable from **Val-Blue,** the First Department determined that absent the injury resulting from the operation of the camp's automobile by its employee, the injured plaintiff would have had no claim against the camp for negligent supervision. The court concluded, therefore, that the automobile exclusion in the general liability policy operated to exclude coverage for the camp for liability arising from the accident. There is no doubt that the First Department's decision is but the first of many court decisions that will consider the breadth of **Val-Blue.**

Accident Defined

On June 8, the Court issued its opinion in **Michaels v. City of Buffalo,**[3] another insurance coverage case. In **Michaels,** a decedent's estate alleged that the failure of an ambulance to start was due to the negligent maintenance of the vehicle and that the delay caused or contributed to the decedent's death. The ambulance company was insured under a business automobile policy that provided that the insurer would pay all sums the insured legally must pay as damages because of bodily injury or property damage to which this insurance applies, caused by an accident and resulting from the ownership, maintenance or use of a covered auto.

The carrier disclaimed coverage on the ground, among others, that the loss was not caused by an accident. The Court agreed, again unanimously, stating that mechanical failure and consequent delay was not an accident within the meaning of the term as used in the policy.[4]

In the Court's view, the average person purchasing automobile insurance for a business vehicle for injuries or property damage caused by an accident would not presume that damages arising from mechanical failure and delay would be insured. The Court ruled that the term accident as used in automobile insurance policies refers to an event involving some trauma, violence, or casualty, or application of external force in which the auto is involved.

The Court then applied its definition of accident to conclude that the mechanical failure and resulting delay of the ambulance in this case was not an accident but was, instead, merely a series of routine and foreseeable, albeit unfortunate, events. The Court implicitly rejected the analysis of the trial court and two justices of the Appellate Division, which relied on familiar canons of insurance contract interpretation that require liberal construction in favor of policyholders and strict construction against carriers. The Court, instead, relied on equally familiar insurance contract principles that look to the reasonable expectations of the insurance-buying consumer and the carrier. In so doing, the Court found that there was no coverage provided by the policy and no duty to defend.[5]

Punitive Damages

In 1990, the Court ruled that a New York insurance carrier was not obligated to indemnify a New York policyholder for punitive damages awarded against the policyholder in an action in Illinois when the public policy of both states precluded indemnification for punitive damages.[6]

In **Zurich Ins. Co. v. Shearson Lehman Hutton Inc.,**[7] the Court was faced with a choice-of-law issue that was not presented to it and that it did not decide in 1990: whether New York's public policy precluding insurance indemnification for punitive damages[8] should prevail over the public policy of a judgment state that allows such indemnification.

The issue arose after a former broker successfully sued Shearson Lehman Hutton Inc. for slander in a Texas state court and was awarded both compensatory and punitive damages.

Shearson sought indemnification from the Zurich Insurance Company under a general comprehensive liability policy that Zurich had issued to Shearson. The policy provided coverage for slander actions but contained no choice-of-law provision. In turn, Zurich brought a declaratory judgment action in a New York State court for a determination that it had no duty to provide coverage for the punitive damages award because New York public policy precluded indemnification for punitive damages.[9]

The Court stated that the appropriate analytical approach to choice-of-law questions in contract cases was the center of gravity or grouping of contacts approach, the purpose of which is to determine which state has the most significant relationship to the transaction and the parties. In addition to what the Court referred to as the traditionally determinative factor of the place of contracting, the Court noted that the Restatement (Second) of Conflict of Laws indicates that four other factors should be considered to establish which state has the most significant relationship: the place of negotiation; the place of performance; the location of the subject matter; and the domicile or place of business of the contracting parties.

As the Court pointed out, Shearson has its principal place of business in New York, where the insurance contract was negotiated and issued and where claims under the policy were handled. The Court also accepted the Appellate Division's conclusion that Zurich, which has maintained a selling office in New

York to act as the main supervisor of Zurich's U.S. branch, qualified as a New York insurer. Thus, the Court concluded, the grouping of contacts factors pointed to the application of New York law.

The Court also noted that the Second Restatement separately addresses insurance contracts and takes the position that where liability insurance contracts are concerned, the applicable law is the local law of the state which the parties understood was to be the principal location of the insured risk unless with respect to the particular issue, some other state has a more significant relationship. Shearson and Zurich took opposing views on the question of what the parties understood to be the location of the risk.

The Court did not resolve the conflict or even try to shape an abstract rule of general applicability concerning the location of the risk in general liability contracts where the insured party conducts business in many States. Rather, it held that even if the risks insured against were located in Texas, New York public policy still would apply because it was so clear and unambiguous against insurance coverage for punitive damages.

Significantly, the Court emphasized that its consideration of New York's governmental interests did not transform its choice-of-law analysis into the interest analysis applied in tort cases. Indeed, it specifically rejected Shearson's attempt to apply a tort analysis to a situation involving what the Court emphasized was an insurance policy - a contract. Moreover, the Court added, it was unwilling to deviate from the state's strong policy choice even though the case involved vicarious liability for punitive damages, where the policy question [a]dmittedly is more problematic.

The Court's decision is important in a number of respects. First, of course, it reinforces what the Court referred to as New York's unswerving policy against permitting insurance indemnification for punitive damage awards, even for vicarious liability. Beyond that, however, it provides both insurance carriers and policyholders with a guidepost for determining choice-of-law issues when laws or public policies of different jurisdictions conflict.

In a decision with important practical ramifications, the Court in **Dingle v. Prudential Property and Casualty Co.**[10] severely limited an insurance carrier's obligation to pay interest, holding that, unless an insurance contract otherwise states, a carrier may only be held liable for interest on that portion of a judgment against its policyholder up to the policy limits. The Court's decision resolved a dispute between the First and Third Departments about the extent of an insurance carrier's liability for interest on an excess judgment.[11]

The decision arose from a lawsuit brought by Joyce Dingle against Patricia Virga after Dingle was injured in a car accident. Dingle obtained a judgment against Virga, who was insured by the Prudential Property and Casualty Company, in excess of her policy limits. Dingle then filed suit against Prudential, seeking to be paid interest on the amount of the entire judgment from the date Virga was determined to be liable to Dingle until the date Prudential tendered payment to Dingle.

In its decision, the Court noted that interest is intended to indemnify successful plaintiffs for the nonpayment of what is due to them and is not meant to punish defendants for delaying the final resolution of a lawsuit. Therefore, the Court stated, in light of the nature of interest as a component of a plaintiff's recovery, the controlling inquiry should be who has retained or benefited from the money belonging to the plaintiff during that period.

The Court concluded that the only fair conclusion in the **Dingle** case was to require the carrier to pay Dingle for use of the portion of the judgment it was responsible for under the policy and to require Virga to pay Dingle for use of the money in excess of the policy limits. Thus, as a result of the Court's decision, a carrier may be held liable for interest on its policy limits, but not on the full extent of an excess judgment against its policyholder.[12]

Section 349

In February, the Court issued a brief memorandum decision in **Myers, Smith & Granady Inc. v. New York Property Ins. Underwriting Association.**[13]**Myers** involved 349 of the General Business Law, a consumer protection statute modeled after the Federal Trade Commission Act that provides private parties with a cause of action for injuries resulting from deceptive acts or practices.

As the Court indicated in a non-insurance-related decision it issued the same day as **Myers,** a prima facie case under 349 requires a showing that: (i) the defendant's conduct had an impact on consumers at large; (ii) the defendant was engaging in an act or practice that, to a reasonable consumer acting reasonably under the circumstances, was deceptive or misleading in a material way; and (iii) the plaintiff was injured as a result.[14]

In **Myers,** a policyholder asserted two 349 claims against an insurance carrier. First, the policyholder contended that the carrier internally rejected a claim that the policyholder had filed but withheld the decision from the policyholder to avoid triggering its obligation to notify the policyholder of the time within which to file a lawsuit against the carrier. Second, the policyholder argued that the carrier acted deceptively in its method of processing the claim so as to avoid triggering the notification requirements.

The Court ruled that even if the carrier's acts qualified as consumer-oriented under 349 and met one of the requirements of a prima facie case under that law, the policyholder's claims had to fail because it offered no evidence to support its principal contentions.

Significantly, the Court did not specifically decide in **Myers** whether a policyholder may rely on 349 - rather than the more traditional breach of contract and bad faith causes of action - to complain about a carrier's allegedly unfair claim settlement practices; it may so decide, however, this fall.[15]

1. 85 NY2d 821 (1995).

2. See **New Hampshire Ins. Co. v. Jefferson Ins. Co. of New York,** 624 NYS 2d 392 (1st Dept. 1995).

3. 85 NY2d 754 (1995).

4. Courts have developed a three-part test to determine whether an accident arises from the ownership, maintenance or use of a covered auto. See, e.g., **United States Oil Ref. and Mktg. Corp. v. Aetna Casualty & Sur. Co.,** 581 NYS2d 822 (2d Dept. 1992).

5. Cf. **Handelsman v. Sea Ins. Co.,** 85 NY2d 96 (1994) (Court finds definition of insured ambiguous).

6. **Home Ins. Co. v. American Home Prods. Corp.,** 75 NY2d 196 (1990).

7. 84 NY2d 309 (1994).

8. See, e.g., **Soto v. State Farm Ins. Co.,** 83 NY2d 718 (1994).

9. A second action against Shearson, brought in Georgia, also resulted in a judgment for punitive damages against Shearson for which Shearson sought indemnification from Zurich. With respect to the Georgia judgment, the Court found that there was evidence to support an award of both punitive and compensatory damages against Shearson under Georgia law. Relying on **Home Ins. Co. v. American Home Prods. Corp.,** n.7 supra, which established that indemnification is precluded by New York public policy only when a damages award is of a punitive nature, the Court concluded that Zurich was required to indemnify Shearson.

10. 85 NY2d 657 (1995).

11. See **Shnarch v. Empire Mut. Ins. Co.,** 535 NYS2d 180 (3d Dept. 1988); **Rodriguez v. Rodriguez,** 462 NYS2d 1 (1st Dept. 1983).

12. It should be noted that, subject to policy terms, a carrier's interest clock begins to run after entry of judgment against a policyholder. See 11 NYCRR 60.1(b) (a carrier, subject to policy terms, shall pay interest accruing after entry of judgment against a policyholder).

13. 85 NY2d 832 (1995).

14. See **Oswego Laborers' Local 214 Pension Fund v. Marine Midland Bank, N.A.,** 85 NY2d 20 (1995).

15. See **New York University v. Continental Ins. Co.,** 618 NYS2d 634 (1st Dept. 1994), leave to appeal granted, 623 NYS2d 100 (1st Dept. 1995).

Load-Date: August 4, 2011

End of Document

RULINGS RESOLVE COVERAGE ISSUES AND BUSINESS DISPUTES; Court of Appeals: Targeting the Judiciary; Special Pullout Section; Insurance Law

New York Law Journal

October 7, 1996 Monday

New York Law Journal

Section: Pg. 2, (col. 1); Vol. 216

Length: 2779 words

Byline: Evan H. **Krinick**

Body

Court of Appeals: Targeting the Judiciary

Special Pullout Section

Insurance Law

T HE SIGNIFICANT insurance-related decisions rendered by the Court of Appeals during the past term can be divided into two broad categories: those that resolved insurance coverage disputes between policyholders and carriers, and those that resolved disputes between carriers and the state government arising out of the insurance business.

Both kinds of decisions obviously will affect carriers and policyholders alike in a wide variety of ways. The business of insurance decisions, moreover, illustrate the multi-faceted presence of the insurance industry in the state and its increasing importance to the state's economy.

The decisions of the Court that are discussed in detail in this article are notable for at least one other reason: Each was rendered unanimously.

Section 349

Late in December, the Court issued a decision in **New York University v. Continental Ins. Co.**[1] that severely limits the ability of a policyholder to rely on General Business Law 349 to complain about a carrier's allegedly unfair claim settlement practices.

The case arose in April 1990 after New York University determined that one of its employees had defrauded it of more than $1.6 million. The university then submitted a claim to its carrier, Continental Insurance Co., under the commercial crime liability insurance policy that Continental had issued.

Continental and its claims servicing agent conducted an investigation and denied the claim. Continental thereafter informed NYU that its open-ended policy would expire on its anniversary date and would not be renewed for underwriting reasons.

NYU filed suit against Continental and alleged, among other things, deceptive business practices in violation of 349. The complaint also included claims for breach of contract and punitive damages. The trial court dismissed all but the breach of contract claim; the Appellate Division affirmed and granted leave to appeal to the Court of Appeals.

The Court first found that NYU was not entitled to punitive damages from Continental because NYU had alleged no tort independent of the contract.[2] This aspect of the ruling is the second consecutive recent decision by the Court rejecting claims for punitive damages against insurance carriers.[3]

The Court then turned to NYU's 349 claim. It applied its recently articulated 349 standard to the facts in the complaint and concluded that NYU had not met a threshold requirement that Continental's acts in selling the insurance policy and handling NYU's claim were consumer-oriented conduct.[4]

The Court emphasized that the parties were a major university acting through its director of insurance and a large national insurance company; the policy was not a standard policy, although it contained standard provisions, but was tailored to meet NYU's wishes and requirements; the premiums were in excess of $55,000; the policy provided coverage for losses up to $10 million; and the sale was handled by one of the largest insurance brokers in the nation, which managed through negotiations to obtain several enhancements to the policy for NYU's benefit and assisted it in presenting its claim to Continental.

Although the Court indicated that relief under 349 is not necessarily foreclosed by the fact that a transaction involves an insurance policy, its decision in this case suggests as a practical matter that policyholders will not be able to rely on 349 very often in the future in suits against their carriers.

SUM Limits

On June 5, the Court issued a decision in the underinsurance area that may have ramifications for all types of liability insurance policies.

In **Mostow v. State Farm Insurance Co.,**[5] the dispute was over the meaning of a standard declarations page of an automobile insurance policy that expressed the policy limits as $100,000 each person, $300,000 each accident and a supplementary uninsured motorist (SUM) endorsement to the same policy that stated that the $100,000 per person policy limit is the amount of coverage for all damages due to bodily injury to one person and that the $300,000 limit for each accident is the total amount of coverage for all damages due to bodily injury to two or more persons in the same accident.

The carrier, which was represented by the author of this article, argued that the provisions have long been understood to mean that a person injured in an accident may not recover more than $100,000 and that if two or more people were injured in an accident, each could recover up to $100,000 subject to a maximum payment by the carrier of $300,000. The endorsement was identical to the required endorsement promulgated by the Superintendent of Insurance for all automobile policies in the state.

The policyholder, who had been injured in an accident and awarded $190,000 in an arbitration, asserted that the provisions were ambiguous and that his arbitration award was proper.

The Court noted that Insurance Law 3420 states that policies that provide for SUM coverage must at least provide up to a maximum of $100,000 because of bodily injury to or death of one person in any one accident, and, subject to such limit for one person, up to $300,000 because of bodily injury to or death of two or more persons in any one accident. In the Court's view, 3420, by rendering the $300,000 per accident maximum subject to the per person limit of $100,000, makes clear that no injured person may recover greater than $100,000 under the provision.

The Court stated, though, that the insurance policy at issue in **Mostow** did not contain any language deeming the $300,000 per accident limit subject to the per person limit and concluded that it was ambiguous. Accordingly, it ruled that the arbitration award should not be reduced to $100,000.[6]

Assault and Battery

The week after **Mostow,** the Court decided **Mount Vernon Fire Ins. Co. v. Creative Housing Ltd.**[7] The case arose after a woman was assaulted in an apartment building owned and managed by Creative Housing Ltd. The woman sued Creative, alleging negligent supervision, management and control of the property. Creative sought a defense and indemnification from its insurance carrier, the Mount Vernon Fire Insurance Co. But Mount Vernon filed an action in federal court seeking a declaratory judgment that it had no duty to defend or indemnify Creative in the underlying lawsuit because the policy excluded coverage for claims based on assault and battery.

The district court ruled against Mount Vernon, holding that the exclusion was ambiguous because reasonable minds could differ on whether the language based on assault excluded coverage for negligence claims arising from assaults. The district court also found the exclusion ambiguous when, as happened here, it was applied to an intentional tort committed by a third party unrelated to the policyholder.

The carrier appealed to the U.S. Court of Appeals for the Second Circuit, which then certified the case pursuant to 22 NYCRR 500.17 to the New York Court of Appeals to determine the breadth of the insurance policy exclusion for claims based on or arising out of assault and battery.

The Court of Appeals accepted the certification and noted that in **U.S. Underwriters Ins. Co. v. Val-Blue Corp.,**[8] it had decided that an exclusion containing language identical to the language found in the Mount Vernon policy was unambiguous and precluded coverage for negligence claims. In that case, the Court applied a but-for test to determine coverage in such cases: If no cause of action would exist but for the assault, the claim is based on assault and the exclusion applies.

In **Mount Vernon,** the Court responded to the Second Circuit by reaffirming its **Val-Blue** decision and concluding that the phrases based on and arising out of, when used in insurance policy exclusion clauses, are unambiguous and legally indistinguishable. It also decided that coverage is excluded even when a third party perpetrates an assault, because the basis of the victim's claim for negligent failure to maintain safe premises against the policyholder is still assault.

The clarity of the Court's decision in **Mount Vernon** is likely to further limit the potential coverage for intentional torts, such as an assault, especially under insurance contracts that contain an assault and battery exclusion.

MCTD Tax Surcharge

The Court's April 30 decision in **United Services Automobile Ass'n v. Curiale**[9] involved the business of insurance, specifically, a challenge to one component of New York's system of retaliatory taxation against foreign insurance companies.

Foreign insurance carriers doing business in New York are potentially subject to four franchise taxes under Article 33 of the New York Tax Law as well as a retaliatory tax that is designed to retaliate, albeit indirectly, against states with more onerous tax laws than New York.

To determine whether a retaliatory tax is owed by a foreign insurer, the New York Superintendent of Insurance calculates the total amount of taxes, aside from any potential retaliatory tax, that New York imposes on the foreign insurer for the privilege of conducting an insurance business in New York. Then, the Superintendent calculates the total amount of taxes that the foreign insurer's state of domicile would impose on a comparable New York insurer for the privilege of doing business in that state. If the foreign state's hypothetical tax bill is higher than New York's actual tax bill, New York adopts the foreign state's greater tax burden as its own and imposes it on the foreign insurer.

In assessing the amount of retaliatory tax owed, a foreign insurer is generally entitled to a credit for the amount of Article 33 franchise taxes it pays to New York. However, the law does not permit a credit for what is known as the MCTD Tax Surcharge.[10] The United Services Automobile Association brought a declaratory judgment action against the Superintendent in which it argued that the disallowance of this credit violated its constitutional right to equal protection.

Retaliatory tax schemes are not necessarily unconstitutional.[11] However, the Court said, absent a legitimate purpose apart from simple revenue creation, a state only may retaliate to the extent of the difference between its actual and the foreign state's hypothetical tax bill. Determining that the Superintendent had cited no legitimate purpose other than revenue enhancement in support of this portion of New York's retaliatory tax law, the Court found a violation of the Equal Protection Clause.[12]

Alien Insurer

The Court issued another insurance decision on the same day that it decided **United Services.** In **Curiale v. Ardra Ins. Co., Ltd.,**[13] the Court considered a due process attack against Insurance Law 1213(c) that was brought by the Ardra Insurance Co., Ltd., a Bermuda reinsurance company that was being sued by the Superintendent of Insurance as liquidator for a failed insurance carrier. Section 1213(c) provides that before filing an answer to a complaint, an unlicensed alien insurance carrier (such as Ardra) must post security in an amount sufficient to cover any final judgment that may be rendered.

The trial court ordered Ardra either to post security in the amount of $10,351,877.38 before filing its answer or to seek a license to do the business of insurance in New York. Ardra informed the court that it would not seek a license and could post only $1 million security. The court found that inadequate and ultimately entered a default judgment against Ardra.

Ardra argued to the Court of Appeals that it was financially unable to post the pre-answer security in the amount set by the trial court and that the default judgment unconstitutionally deprived it of due process of law.

The Court of Appeals disagreed. It noted that the Insurance Law clearly provides notice that pre-answer security will be required if an alien insurer chooses to conduct business in New York State without a

license. It also pointed out that because Ardra had received premiums from a New York insurer in exchange for providing coverage under various reinsurance treaties, it could not repudiate its obligation to post security for the risks that it had been paid to underwrite. Under these circumstances, the Court found Ardra's claim of poverty to be disingenuous.

In addition, the Court concluded that the state's interest in ensuring the availability of funds from which a judgment against an alien unlicensed insurer may be promptly paid, instead of requiring claimants to resort to far-flung forums for satisfaction of their judgments, justified striking the answer of an alien insurer if that insurer failed to provide adequate pre-answer security. Concluding that Ardra had received all of the due process protections required by the circumstances, it affirmed the entry of judgment against Ardra.

A final insurance decision dealing with the business of insurance, **Insurance Premium Finance Ass'n of New York v. New York State Dep't of Ins.,**[14] is also significant.

This case involved an Article 78 proceeding challenging a decision by the Superintendent of Insurance that approved a plan proposed by the New York Automobile Insurance Plan (AIP) to change the method for financing assigned risk insurance policies.

The petitioners pointed out that the Superintendent had approved the plan without publishing any notice of proposed rule, affording any opportunity for public comment, issuing either a regulatory impact statement or regulatory flexibility analysis, or filing the proposed plan with the Secretary of State. Because of these omissions, the petitioners contended that the Superintendent had failed, among other things, to satisfy the requirements of the State Administrative Procedure Act (SAPA).

Noting that SAPA applies only to the rule-making activities of state agencies, the Court analyzed whether AIP should be deemed a state agency.

The Court noted that AIP was created by private insurers to provide liability insurance for drivers unable to otherwise obtain it and is administered by a 15-member governing committee, all of whom, except two appointed by the Superintendent to represent the public interest, are elected by the member insurance companies. The Court added that AIP is funded entirely by private assessments against members and staffed by private employees paid from the funds so collected. Accordingly, the Court held that AIP is not a state agency within the definition of the SAPA.

Moreover, it held that the Insurance Department's status as an agency may not be imputed to AIP merely because the Superintendent had approved the plan. In the Court's view, the Superintendent's actions did not constitute agency rule-making because the plan related to the operations of a private entity rather than the Insurance Department, and the Superintendent did not exercise extensive supervision and control over AIP. Thus, SAPA's requirements did not apply.

It should be noted that the Court indicated that other insurance industry entities might similarly not be subject to SAPA, including the Motor Vehicle Accident Indemnification Corporation, the New York Property Insurance Underwriting Association and the Medical Malpractice Insurance Association.

1. 87 NY2d 308 (1995).

2. See **Rocanova v. Equitable Life Assurance Soc'y,** 83 NY2d 603 (1994).

3. See, e.g., id.

4. See **Myers, Smith & Granady, Inc. v. New York Property Ins. Underwriting Ass'n,** 85 NY2d 832 (1995); **Oswego Laborers' Local 214 Pension Fund v. Marine Midland Bank, N.A.,** 85 NY2d 20 (1995).

5. 1996 WL 296220 (June 5, 1996).

6. For further discussion of the ramifications of this decision, see Nancy L. Isserlis, Ruling on SUM Limits Is Ripe for Review,**NYLJ,** Sept. 7, 1995, at 1, and Norman H. and Jonathan A. Dachs, Policy Limits: Taking Nothing for Granted,**NYLJ,** July 29, 1996, at 3.

7. 1996 N.Y. LEXIS 1182 (June 11, 1996).

8. 85 NY2d 821 (1995).

9. 1996 WL 248685 (Apr. 30, 1996).

10. The Metropolitan Commuter Transportation District, or MCTD, is the region encompassing the counties of New York, Bronx, Kings, Queens, Richmond, Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk and Westchester. The purpose of the MCTD Tax Surcharge is to provide additional funds for the support of mass transportation in the MCTD.

11. See, e.g., **Western & Southern Life Ins. Co. v. State Board of Equalization,** 451 U.S. 648 (1981).

12. Cf. **Industrial Indemnity Co. v. Cooper,** 81 NY2d 50 (1993) (no credit need be given under the retaliatory tax statute for a commercial rent tax assessed under the New York City Administrative Code, which the Court characterized as a quasi-property tax).

13. 1996 WL 248743 (April 30, 1996).

14. 1996 WL 303059 (June 6, 1996).

Load-Date: August 5, 2011

End of Document

NUMEROUS RULINGS ON WIDELY DIVERSE ISSUES; Court of Appeals; Special Pullout Section; Insurance Law

New York Law Journal

October 20, 1997 Monday

New York Law Journal

Section: Pg. 1, (col. 1); Vol. 218

Length: 2630 words

Byline: Evan H. **Krinick**

Body

Court of Appeals

Special Pullout Section

Insurance Law

T HE COURT of Appeals' past term was one of its most active in recent memory. The Court resolved many significant insurance law issues, ranging from decisions on environmental coverage, construction coverage and no-fault insurance to the applicability of the no prejudice rule for untimely notice to excess insurance carriers and an agent's duty to recommend coverage to a policyholder.

Environmental Coverage

The Court issued a triumvirate of decisions on the pollution exclusion clause, including two on Dec. 18.

Incorporated Village of Cedarhurst v. Hanover Ins. Co.[1] arose after the Village of Cedarhurst was sued by three of its residents for personal injuries and property damage allegedly caused by a rush of water and sewage from the municipal sewage system that caused massive flooding of their basement. In a separate action, the village was also sued for damages allegedly caused by an overflow of sewage onto the plaintiff's property. Plaintiffs in both actions alleged that the flooding and overflow had occurred because the village had negligently failed to maintain the municipal sewage system.

The village sought defense and indemnification for these actions under two insurance contracts issued by the Hanover Insurance Company. Hanover disclaimed coverage on the ground that the policies' absolute pollution exclusion clauses excused its duty to defend and indemnify the village; it relied in part on the fact that the policies included waste in the definition of pollutant. The village filed suit against Hanover, seeking a declaration of coverage.

A divided Court of Appeals ruled, 4-3, that Hanover was obligated to defend the village. Judge Smith's majority opinion did not consider the conclusion reached by the Appellate Division that the pollution exclusion clauses were ambiguous with respect to whether raw sewage is a pollutant. Instead, Judge Smith based his analysis on the fact that the complaints in the underlying actions alleged injury from a flood-like event and that neither complaint alleged an injury from the polluting, irritating or contaminating nature of the sewage. Therefore, in the majority's view, the pleaded complaint placed any risk of liability faced by the village on the flood-like nature of the discharge rather than its polluting character, which made the pollution exclusion clauses inapplicable on the issue of a defense obligation.

Judge Smith conceded that Hanover may not be required to actually indemnify the village if a trial ultimately shows that the plaintiffs' damages were caused by pollution as contemplated by the pollution exclusion clauses.

The dissenting opinion by Judge Levine, in which Chief Judge Kaye and Judge Titone joined, emphasized that the underlying complaints would not support a cause of action but for the intrusion of sewage into the plaintiffs' buildings. Accordingly, in Judge Levine's view, the pollution exclusion clauses controlled. The three dissenting judges also specifically disagreed with the Appellate Division's interpretation of the pollution exclusion clauses and stated that these clauses unambiguously include raw sewage as a pollutant.

Unlike the split in the Court engendered by the **Village of Cedarhurst** case, the Court's other Dec. 18 decision on the pollution exclusion clause was unanimous. In **Town of Harrison v. National Union Fire Ins. Co. of Pittsburgh,**[2] the Court, in an opinion by Judge Ciparick, settled an important issue that previously had been unresolved in this state.

The Court held that the language of the pollution exclusion clause does not require that the policyholder be the actual polluter for the exclusion to apply. The Court found no ambiguity regarding the scope of the pollution exclusion clause and ruled that by giving the words their plain meaning, it is evident that coverage is unavailable for any claim involving the discharge or dispersal of any waste, pollutant, contaminant or irritant regardless of the cause or source of the claim.

The Court was just as clear in **Northville Industries Corp. v. National Union Fire Ins. Co.,**[3] its third pollution exclusion decision of the term. The focus in this case was somewhat different from the focus in the other two cases because this case did not involve the absolute pollution exclusion clause but a clause that included an exception that stated that the pollution exclusion did not apply for any discharge, dispersal, release or escape of pollutants that is sudden or accidental.

The Court's ruling moved beyond its decision in **Technicon Elecs. Corp. v. American Home Assurance Co.,**[4] in which it held that the sudden and accidental discharge exception to the pollution exclusion clause is unambiguous and that both contingencies included in the exception have to be satisfied for it to apply. Here, the Court reiterated that the term sudden is not ambiguous but has a temporal quality, as a discharge of the pollutant abruptly, precipitantly or brought about in a short time.

This interpretation, the Court stated, conformed to the commonsense meaning of the term as well as the reasonable expectations of a business person because the exception exists in the context of an insurance contract that is universally recognized as intended to exclude damage from persistent pollution from the policy's expansive basic coverage. The Court then concluded that it is the policyholder's burden to prove that a discharge was sudden as contemplated by the exception.

This decision could have a great deal of practical importance because it is likely to make it easier for carriers to be awarded summary judgment on the issue of their duty to defend plaintiffs in pollution cases. Indeed, the Court upheld the lower court's decision in this case that the insurance carriers were not obligated to defend or indemnify against the liability of the plaintiff for the discharges at issue.

Construction Coverage

The Court of Appeals had not recently addressed a construction coverage issue, a fertile ground for litigation in other states.[5] In May, though, the Court decided a construction coverage issue when it issued a memorandum decision in a case relating to the work product exclusion.[6]

In this case, the Court unanimously ruled that a developer's comprehensive liability carrier was not obligated to defend the developer in an action alleging that the developer failed to build homes in a workmanlike manner because they did not have a safe water supply. The Court relied on the work product exclusion, which excludes coverage for property damage arising out of [the insured's] products [or] out of the work performed by or on behalf of the named insured. In the Court's view, the builder's site choice, a choice that necessarily includes consideration of its access to a water supply, is clearly part of that work product.

The extent to which litigation will continue to develop in New York involving construction coverage issues bears watching.

No-Fault Matters

There may be no area of insurance law more ripe for legislative reform than the no-fault law. This is particularly important given the extensive number of claims that arise, and that frequently are litigated, under this law. Consider the Court's decisions this past term in **Presbyterian Hospital in the City of New York v. Maryland Casualty Co.**[7] and **Central General Hospital v. Chubb Group of Ins. Co.**[8]

Presbyterian Hospital involved a lawsuit brought by Presbyterian Hospital against the Maryland Casualty Company to recover no-fault medical payments for services and treatments the hospital provided to a Maryland policyholder who was injured in a single-car accident when the automobile she was driving hit a utility pole. Maryland disclaimed coverage on the ground that its policyholder had been intoxicated at the time of the accident. Presbyterian argued that the carrier was precluded from raising the intoxication defense because it had not denied the claim within 30 days as required by regulations of the Superintendent of Insurance[9] and Insurance Law 5106(a).

Maryland asserted that preclusion of an exclusion defense is an unavailable remedy under both the Insurance Law and Insurance Department regulations. It argued that the common law does not preclude defenses, neither the Insurance Law nor the Superintendent's regulations expressly provided for such preclusion, and the Legislature's prescribed penalties for overdue payments (namely, statutory interest and attorney's fees) are exclusive remedies that impliedly reject the sanction of ultimate preclusion.

Four of the Court's judges concluded that Maryland could be precluded from interposing a statutory exclusion defense for failure to deny a claim within 30 days. They reasoned that the Court has precluded carriers from disclaiming or denying liability after untimely notification of denials in cases involving liability coverage under Insurance Law 3420(d) even though that section of the law does not expressly authorize the preclusion remedy. It then stated that unless and until the Legislature clearly declares

otherwise, this preclusion analysis should be applied with respect to the 30-day requirement in the no-fault context.

Although the no-fault law was enacted to provide prompt and uncontested first-party insurance benefits, one wonders whether it is appropriate as a matter of public policy to preclude a carrier from raising an intoxication defense merely for failing to deny a claim or take other appropriate action within 30 days - especially when other sanctions are and could be imposed. The Court's decision created coverage for an accident that appeared to be alcohol-related solely because of the carrier's apparent lack of promptness.

The peculiarity of the ruling is compounded when taken together with the other no-fault decision it issued that day in **Central General.**

This second case also involved a hospital's attempts to recover no-fault benefits from an insurance carrier for medical services rendered to a person allegedly injured in an automobile accident. The issue here, though, was whether the carrier's untimely disclaimer should preclude it from denying liability on a strict lack of coverage ground. The Court unanimously ruled that a carrier, despite its failure to reject a claim within the applicable 30-day period, may assert a lack of coverage defense premised on the fact or its belief that the alleged injury did not arise out of an insured accident.

Significantly, Judge Wesley issued a concurring opinion, joined by Judges Titone and Levine, that agreed with the majority's position on the lack of coverage defense but that also stated that a carrier that misses the 30-day deadline should not be precluded from asserting the defense that the medical treatment rendered by the hospital was excessive; the majority specifically indicated that it did not agree with this sentiment.

Perhaps as a result of these two rulings the Legislature will study the no-fault laws and regulations and remedy what the Court itself referred to as a Rube Goldberg-like maze through which carriers must attempt to travel.[10]

No Prejudice

The Court's decision in **American Home Assurance Co. v. International Ins. Co.**[11] addressed the rule in New York that relieves the burden on an insurance carrier to prove that it was prejudiced by a policyholder's failure to provide timely notice. The question before the Court was whether this no prejudice rule applies to excess insurance carriers.

New York courts have long concluded that, as between a primary insurance carrier and its policyholder, compliance with a notice provision in an insurance policy is a condition precedent to a carrier's duty to defend or indemnify the policyholder and that a policyholder's failure to provide timely notice vitiates coverage - even if the carrier can show no prejudice.[12]

Several years ago, however, the Court of Appeals held that a reinsurer could not disclaim coverage following breach of a prompt-notice provision in a reinsurance policy unless it could prove that it actually was prejudiced by the delay.[13]

In **American Home,** the Court made it clear that any limitations to the no prejudice rule should occur only in a situation involving reinsurers. The Court emphasized the importance of prompt notice to excess carriers, explained that excess carriers have much in common with primary carriers but few of the same interests as reinsurers, and refused to impose any limitation on the no prejudice rule in an excess carrier

case. Thus, the law is now clear in New York that failure to provide appropriate notice of a claim or lawsuit to a primary carrier or to an excess carrier can vitiate coverage without the carrier having to prove that the lack of notice caused it harm.[14]

Agent Liability

Finally, the Court decided an interesting case that should provide some comfort to insurance agents and brokers across the state.[15]

The case involved a suit against an insurance agent for tortious misrepresentation and breach of implied contract based on the agent's failure to advise a policyholder as to possible additional automobile insurance coverage that the policyholder could purchase. The plaintiffs argued that the agent could be held liable to them because of the long, continuing course of business between the plaintiffs and the agent.

In a unanimous decision, the Court ruled that the suit should be dismissed because there was no special relationship between the parties. It found that the record did not support the plaintiffs' efforts to shift to defendant insurance agent the customer's personal responsibility for initiating, seeking and obtaining appropriate coverage, without something more than is presented here. Although the basis for the Court's ruling suggests that agents under certain extreme circumstances could be held liable for failing to recommend coverage to a policyholder, as a practical matter such a result is likely to occur very rarely.

1. 89 NY2d 293 (1996).

2. 89 NY2d 308 (1996).

3. 89 NY2d 621 (1997).

4. 74 NY2d 66 (1989).

5. See, e.g., **Commerce Ins. Co. v. Betty Caplette Builders, Inc.,** 420 Mass. 87 (1995).

6. **Basil Development Corp. v. General Accident Ins. Co.,** 1997 WL 224815 (May 6, 1997).

7. 1997 WL 310455 (June 10, 1997).

8. 1997 WL 310457 (June 10, 1997).

9. See 11 NYCRR 65.15(g)(3).

10. This past term the Court also issued an important decision involving uninsured motorist coverage. That case arose out of a dispute concerning uninsured motorist insurance coverage for injuries suffered by a woman in a traffic accident. The Court unanimously held that an insurance company/party loses its opportunity for appellate review of the denial of an application to stay arbitration under CPLR Article 75 when it participates in an arbitration without seeking an interim stay from the Appellate Division of the order, even if it believed that its request for such an interim stay would result in summary denial. **Commerce and Industry Ins. Co. v. Nester,** 1997 WL 336305 (June 16, 1997).

11. 1997 WL 336262 (June 17, 1997).

12. See, e.g., **Security Mutual Ins. Co. v. Acker-Fitzsimons Corp.,** 31 NY2d 436 (1972).

13. **Unigard Security Ins. Co., Inc. v. North River Ins. Co.,** 79 NY2d 576 (1992).

14. The Court issued another decision this term involving relationships between insurance carriers. In **Michigan National Bank-Oakland v. American Centennial Ins. Co.,** 89 NY2d 94 (1996), the Court found that an insurance company's insolvency is a material fact that must be disclosed to a potential reinsurer and that the reinsured's failure to do so supported the voiding of reinsurance treaties as against both the liquidator of the insolvent insurance company and the beneficiary of a bond issued by the insolvent carrier.

15. **Murphy v. Kuhn,** 1997 WL 354936 (June 27, 1997).

Load-Date: August 5, 2011

End of Document

MANY IMPORTANT ISSUES CONSIDERED; Special Pullout Section; Court Of Appeals; Insurance Law

New York Law Journal

October 5, 1998 Monday

New York Law Journal

Section: Pg. 25, (col. 1); Vol. 220

Length: 2619 words

Byline: Evan H. **Krinick**

Body

Special Pullout Section

Court Of Appeals

Insurance Law

OVER THE PAST term, the Court of Appeals continued its recent trend of considering and deciding a significant number of cases involving important insurance law issues.

In **Royal Bank & Trust Co. v. Superintendent of Ins.**,[1] the Court held that the New York Property/Casualty Insurance Security Fund, from which claims against insolvent insurance carriers are paid, could be held responsible for interest on claims and attorney fees to claimants.

On the same day, the Court rendered a decision in an insurance bad faith case, **Smith v. General Accident Ins. Co.**,[2] that ended insurance carriers' long winning streak in this area.[3]

The Court also decided three significant coverage cases. The first, **Panepinto v. New York Life Ins. Co.**,[4] involved disability income policies. Tanzer v. Health Ins. Plan of Greater New York[5] stemmed from differing interpretations of a provision in a health insurance policy. The third ruling, Frontier Insulation Contractors, Inc. v. Merchants Mutual Ins. Co.,[6] settled a dispute over the product hazards exclusion in a comprehensive general liability insurance (CGL) policy.

Finally, the Court demonstrated its willingness to decide insurance law cases that reach it from outside the state court system: It accepted certification from the Second U.S. Circuit Court of Appeals in two cases that will be argued and decided next term. Of particular interest will be the Court's decision in one of those cases, **Great Northern Ins. Co. v. Mount Vernon Fire Ins. Co.**,[7] involving interpretation of the other insurance provision in CGL policies.[8]

Security Fund

The Court's **Royal Bank** ruling was by far the longest insurance law decision of the past term. It also was the only one with a dissent (by Judge Levine) as well as a decision concurring in part and dissenting in part (by Chief Judge Kaye).

The facts of the case were summarized by Judge Bellacosa in his decision for the Court. In 1983, the Union Indemnity Insurance Company of New York issued financial guaranty surety bonds to the Royal Bank & Trust Company to secure the payment of promissory notes signed by 55 investors in a limited partnership. After the partnership and most of the individual investors had defaulted, Royal demanded payment from Union under the bonds. In 1985, after making partial payment, Union was placed into liquidation and the Superintendent of Insurance was named liquidator.

The following year, Royal filed 55 separate proofs of claim in Union's liquidation proceeding, demanding indemnification and payment from the Security Fund. Each claim had three components: principal; pre- and post-liquidation interest; and attorney fees.

The Superintendent argued that Insurance Law Sec. 7434(b), which states that [n]o creditor shall be entitled to interest on any dividend by reason of delay in payment of such dividend, prohibited payment of post-liquidation interest out of the Security Fund. The Superintendent also contended that Insurance Law Sec. 7608(c) barred pre-liquidation interest and attorney fees.

The Court first found that the limitation in Sec. 7434(b) does not apply to claims against the Security Fund but only to claims against the estates of insolvent insurers. It noted that distributions to claimants from the Security Fund are consistently referred to as payments in the Insurance Law.[9] On the other hand, the Court pointed out, the Insurance Law treats distributions from insolvent estates as dividends.[10]

The Court recognized that the common law prohibits liquidators from paying interest on claims unless all claims first are paid in full. The purpose of that rule was to satisfy all creditors equally and to preserve the limited funds of an insolvent insurer's estate, the Court said.

It declared, however, that the Security Fund serves a fundamentally different purpose -- to protect New York insureds -- and found no compelling reason to carry that rule over to the statutory Security Fund.

The Court also rejected the Superintendent's arguments that payment of pre-liquidation interest and attorney fees would result in a total payment over the limit of liability of the underlying bonds and violate Sec. 7608(c), which prohibits the Superintendent from making payments that exceed the limit of liability provided for in the insurance policy or surety bond.

The Court first determined, based on a review of the legislative history, that the reference to surety bond did not refer to the bonds guaranteed by the Security Fund in this case but related to automobile insurance. The Court rejected the Superintendent's contention that the limit of liability of a bond was the principal amount of the bond, emphasizing that the financial guaranty bonds that Union had issued expressly provided for the payment of interest and attorney fees.

Judge Levine dissented, arguing that the Court should have deferred to the Superintendent's interpretation of the law. He emphasized that the procedures for liquidating an insolvent insurer's estate and for claims against the Security Fund were part of an intricate interlocking statutory framework.

In her opinion concurring in part and dissenting in part, Chief Judge Kaye referred to the significant financial impact of the majority's decision -- the Court's ruling meant that in this case Royal Bank would

receive post-liquidation interest amounting to $6,632,450 (as of September 29, 1997) -- and suggested that the Legislature might wish to revisit the pertinent statutes to determine if the Court's construction was the intended one.[11]

The **Smith** case stemmed from a jury verdict on liability finding David Smith, who had been injured in an accident, and Jay Brody, the holder of a policy (with $500,000 limits) issued by the General Accident Insurance Company, each 50 percent at fault for injuries suffered by Smith. When General Accident did not reach a settlement agreement with Smith, the damages phase of the trial was conducted and the jury returned a verdict of $1.1 million.

Brody assigned to Smith any rights Brody may have had to bring an insurance bad faith suit against General Accident, and Smith filed such a suit. In part, Smith contended that General Accident should be held liable for bad faith because it had not informed Brody of its settlement negotiations with Smith, including an offer by Smith to settle for the policy limits.

Joining the national trend, and referring to New York Pattern Jury Instruction 4:67, the Court upheld the trial court's charge to the jury that, in determining whether General Accident had acted in bad faith, the jury could consider whether [General Accident] had informed Jay Brody of the amount for which David Smith was prepared to settle his claim and of course the negotiations with David Smith.

The ultimate impact of the ruling remains to be seen because the Court repeatedly emphasized that its decision was a narrow one based on the specific facts of the case. For example, Smith had based his argument in part on a provision of General Accident's claims manual that required General Accident to keep policyholders informed of settlement negotiations; however, that usually is the responsibility of the attorneys hired by carriers to represent policyholders.

Additionally, no one raised the issue of whether Brody would have taken advantage of the settlement offer had he known of it, although this undoubtedly will be raised in future bad faith cases involving similar issues and may doom bad faith claims where it can be shown that the policyholder would not have acted.

Moreover, General Accident's failure to keep Brody informed was only one of eight factors that the trial court instructed the jury that it could consider in assessing General Accident's bad faith. Although such evidence may persuade a jury to rule one way or the other, its ultimate impact probably will depend on the cumulative evidence introduced by each party at the bad faith trial.

Coverage Issues

The **Panepinto** case involved two disability income policies issued by the New York Life Insurance Company to Maria Panepinto. On January 20, 1984, Panepinto had filed a notice of claim for total disability and provided proof of loss to New York Life. The carrier made monthly payments of $2,000 to her for three years. On October 28, 1986, however, New York Life notified her that it was terminating her disability payments.

Panepinto brought suit on June 28, 1990, approxitmately 3-1/2 years after the notice of termination. New York Life argued that the action was time-barred by the three-year limitations period included in the insurance policies.

Paragraph 17 of the policies linked the commencement of the limitations period to the date Panepinto had to submit proof of loss. Specifically, it provided that no action could be brought after the expiration of

three years from the time written proof of loss is required to be furnished. Paragraph 9 stated that proof of loss must be furnished within ninety days after termination of any period of disability for which the Company is liable.[12]

The Court emphasized the insurer's practical construction of the policies in making continuous disability payments for an initial period of three years without ever requiring Panepinto to file written proofs of loss on a monthly basis. It then adopted Panepinto's position (which also has been adopted by most other courts across the country that have faced the issue) and held that proof of loss requirements, and, by extension, the three-year limitations period in the policies, commenced on the termination of the disability as an objective, medical fact.

Because there was an issue of fact as to whether Panepinto's total disability continued or terminated in 1986 as New York Life asserted, the Court concluded that summary judgment based on the untimeliness of Panepinto's claims was precluded.

The Court conceded that its decision could postpone the commencement of the limitations period indefinitely for a policyholder who was continuously disabled, but declared that this would not open the floodgates to stale claims. As a practical matter, the Court said, an insured is not likely to wait years before filing proof of loss because the insured would want to receive benefits as soon as possible.

Tanzer involved a claim seeking coverage for the cost of surgery-related anesthesiologists' services. The carrier contended that such costs were not recoverable because the parties' insurance contract, which covered the cost of certain medical and surgical care, contained a specific exclusion for anesthesia.

In a strict reading of the provision, the Court ruled in favor of the patient, finding that the exclusion did not unambiguously apply to the medical services associated with the administration of anesthetic agents and could just as readily be construed to exclude only the cost of those agents themselves.

As a result, the Court concluded, it could not find that the carrier had satisfied its burden of demonstrating that the proposed exclusion for anesthesiologists' services was stated in clear and unmistakable language, subject to no other reasonable interpretation, and applicable in this case.

The third coverage case, **Frontier**, was a declaratory judgment action brought by Frontier Insulation Contractors, a Buffalo-based industrial and commercial insulation contractor engaged in the business of installing and applying asbestos insulation on plumbing, ductwork, boilers and other equipment. Frontier had been named a defendant in a number of lawsuits alleging bodily injury and resulting damages caused by asbestos exposure at various locations.

Its CGL carriers disclaimed coverage, contending that the claims in the underlying complaints fell within the policies' exclusions for product hazards because they all alleged that bodily injuries resulted from exposure to Frontier's asbestos products.

The Court concluded that the focus in determining whether a product-hazard exclusion applied was not whether a policyholder's product caused the loss at issue but rather was dependent on the location of the accident and the possession of the product. The product hazards exclusion, the Court stated, exempted from coverage only those bodily injuries arising out of the named insured's products that occurred away from premises owned by or rented to the named insured and after physical possession of such products has been relinquished to others.[13]

After noting some question as to whether the asbestos involved in the underlying claims even was Frontier's product, the Court determined that the exclusions did not apply. It said that none of the underlying complaints specified that the plaintiffs' personal injuries had occurred only after Frontier had completed installation and departed from the covered premises. In the Court's view, there was a reasonable possibility that any liability attributed to Frontier would stem from injuries that occurred during ongoing operations -- which, the Court pointed out, were covered events.

It should be emphasized that the Court rejected Frontier's request for a determination that its carriers had a duty to indemnify it in all of the underlying actions. Distinguishing once again between the duty to defend and the duty to indemnify, the Court refused to pass on the question of the carriers' duty to indemnify at this early juncture.

Setting The Stage

When the Court agreed to accept certification in **Great Northern**, it set the stage for a decision next term on an important subject: The proper interpretation under New York law of a provision in the other insurance clause of a CGL insurance policy. The issue may be of greater interest to insurance carriers than to policyholders because the other insurance clause is intended to deal with situations in which multiple policies cover a single loss by specifying when their coverage is primary as opposed to excess with respect to other applicable coverages.

Under New York law, if two policies are excess to one another, the two other insurance clauses cancel each other out and the companies must apportion the costs of defending and indemnifying a policyholder on a pro rata basis. By contrast, if one policy is primary with respect to another, then the primary carrier must pay up to the limits of its policy before coverage under the excess carrier's policy is triggered.

1. 1998 WL 305441 (June 11, 1998).

2. 1998 WL 305443 (June 11, 1998).

3. See, e.g., New York University v. Continental Ins. Co., 87 N.Y.2d 308 (1995), Soto v. State Farm Ins. Co., 83 N.Y.2d 718 (1994), Rocanova v. Equitable Life Assur. Soc., 83 N.Y.2d 603 (1994), and Pavia v. State Farm Mutual Automobile Ins. Co., 82 N.Y.2d 445 (1993).

4. 90 N.Y.2d 717 (1997).

5. 91 N.Y.2d 850 (1997).

6. 91 N.Y.2d 169 (1997).

7. 1998 WL 297804 (June 9, 1998).

8. The other case is Royal Indemnity Co. v. Providence Washington Ins. Co., 91 N.Y.2d 955 (1998).

9. See, e.g., Insurance Law Secs. 7603(a)(1); 7603(a)(2); 7603(c)(1); 7608(a); 7608(b)(1); 7608(c).

10. See, e.g., Insurance Law Secs. 7434(b); 7434(c).

11. Although the bonds issued to Royal Bank were covered by the Security Fund at the time of Union's insolvency, financial guaranty insurance was removed from the protection of the Security Fund by the

1989 enactment of Article 69 of the Insurance Law. See 1989 McKinney's Session Laws of NY, at 2057, 2389. The Court's rationale, however, should apply to other kinds of claims against the Security Fund.

12. This section is mandated, albeit in somewhat different words, in disability income policies issued in New York State by Insurance Law Sec. 3216(d)(1)(G), (K).

13. In its decision, the Court distinguished product hazards coverage from premises-operations coverage and completed-operations insurance.

Load-Date: August 5, 2011

End of Document

PERVASIVE SOCIETAL ROLE OF INSURANCE SHOWN; Court Of Appeals: The Year In Review; Insurance Law

New York Law Journal

October 4, 1999 Monday

New York Law Journal

Section: Pg. 38, (col. 4); Vol. 222

Length: 2364 words

Byline: Evan H. **Krinick**

Body

Court Of Appeals: The Year In Review

Insurance Law

INSURANCE ISSUES permeate many areas of New York commerce, and as a result, often are at the center of a wide variety of lawsuits. The Court of Appeals' past term's rulings reflect both the practical significance of insurance and the diverse factual situations in which insurance disputes now arise. Interestingly, the Court also continued its recent trend of issuing decisions on insurance issues without dissent.

Certified Questions

Three of the Court's decisions resolved insurance coverage issues that had been certified by the U.S. Court of Appeals for the Second Circuit.[1]

Last December, in **Royal Indemnity Co. v. Providence Washington Ins. Co.**[2] the Court ruled that a non-trucking-use exclusion in an insurance policy obtained by the owner of a commercial vehicle was unenforceable.

The case arose after John Van Dorp leased a tractor-trailer to Deliverance Road Transport Inc. Providence Washington Insurance Company issued a non-trucking-use policy to Mr. Van Dorp that was intended to cover all instances when the truck was not being use for business purposes. This exclusion created a gap in policy coverage for any loss incurred when the truck was being used in business. The gap was filled when the Royal Indemnity Insurance Company issued a truckers liability insurance policy to Deliverance that covered accidents that took place when the truck was being used in Deliverance's business.

Scott Bodine was driving the tractor-trailer for Deliverance when it struck and severely injured a bicyclist. After Royal paid $929,163 to settle the lawsuit brought by the bicyclist's guardian ad litem, it filed suit in

a federal district court seeking a judgment declaring that Providence was obligated to indemnify Royal for one-half of the $929,163. Royal argued that the non-trucking-use exclusion was void because it could by its terms apply even if the truck was not covered by insurance that met New York's minimum standards. Providence contended that the exclusion was valid because under Providence's standard underwriting procedure, it would not issue a non-trucking-use policy until the vehicle's owner provided proof that the lessee had truckers liability insurance.

The Court stated that New York law[3] requires that all insurance policies contain a provision guaranteeing indemnity against liability arising from permissive operation of the owner's vehicle, without reference to any carrier's practices with respect to the issuance of insurance policies. Because the exclusion in Providence's policy did not expressly provide that it was only operative if the lessee has business use liability coverage in effect for the accident in question, the Court ruled that the exclusion was void.

The Court's second coverage decision in response to a certified question from the **Second Circuit was Great Northern Ins. Co. v. Mount Vernon Fire Ins. Co.**[4]

This case began when Great Northern Insurance Company and its policyholder, Linn Howard Selby, filed a federal lawsuit against Mount Vernon Fire Insurance Company to determine Great Northern's responsibility for defense and indemnification of Ms. Selby in a personal injury action brought by a carpenter who was injured while doing work at her cooperative apartment.

Great Northern had issued Ms. Selby a standard homeowner's policy. Mount Vernon had issued a commercial general liability policy to Ms. Selby's general contractor. Both policies provided for the defense and indemnification of Ms. Selby with respect to the carpenter's claims against her and both had other insurance clauses dealing with situations in which multiple policies covered a single loss. The Great Northern policy clearly was excess with respect to the Mount Vernon policy; the issue was whether Mount Vernon's coverage was primary or excess to Great Northern's. The parties focused on the phrase in the Mount Vernon policy providing that it was excess over other insurance [t]hat is Fire, Extended Coverage, Builder's Risk, Installation Risk or similar coverage for your work.

In its decision, the Court distinguished between first-party coverage (pertaining to loss or damage sustained by a policyholder to its property) and third-party coverage (where a carrier's duty to pay runs to a third-party claimant). The Court said that in analyzing the other insurance clause it was a mistake[] to sever the similar coverage for your work phrase from the unambiguous antecedent enumerated coverages. When considered in context, the Court found, the provision protected only Ms. Selby's property interests and had to be categorized as first-party insurance. Thus, the Court continued, the phrase similar coverage for your work meant first-party property coverage.

The Court then concluded that because the carpenter's claim was not a first-party claim, Mount Vernon's coverage was primary with respect to Great Northern's, and Mount Vernon had to pay up to the limits of its policy before Great Northern could be obligated to indemnify under its policy. This decision is in accord with decisions from other states.[5]

The Court's third decision responding to certified questions from the Second Circuit was **Argentina v. Emery World Wide Delivery Corp**.[6]

In that case, the Court first found that loading and unloading a truck constitutes use or operation of the truck for purposes of Vehicle and Traffic Law Section 388(1). The Court then analyzed whether a truck's

owner may be held liable under Section 388(1) for injuries suffered by a person while unloading the truck, when the truck was not itself a proximate cause of the injuries.

The Court stated that the touchstone of Section 388(1) was injury resulting from negligence in the use or operation of a vehicle. Here, the Court continued, it was uncontroverted that the truck was negligently loaded, a use contemplated by the Legislature. In the Court's view, to read an additional limitation into Section 388(1) and require that the vehicle itself be the instrumentality or a proximate cause of a plaintiff's injury would tend to circumvent the statute's negligence requirement and unduly limit its intended beneficial purpose. Therefore, the Court found that there was no proximate cause requirement under Section 388(1).

Coverage Issues

The Court also decided three other important cases dealing with insurance coverage issues this past term.

In **New England Mutual Life Ins. Co. v. Doe**,[7] the Court considered whether an insurance carrier may disclaim coverage for a claim made after the expiration of the two-year incontestability period in a disability policy on the basis that the disabling condition had manifested itself before the effective date of the policy. This issue has divided courts across the country, with some ruling that an insurance carrier in this situation may not disclaim coverage, and others concluding that an incontestability clause does not preclude a carrier from denying benefits where the policyholder knew, before the policy was issued, of any symptom or condition related to the eventual cause of the disability and did not disclose it. The California Supreme Court currently is considering this issue.[8]

The New York Court of Appeals joined those courts that have concluded that once the incontestability period is over, a carrier may not deny coverage by claiming that the applicant knew (by manifestation) of any symptom or condition related to the eventual cause of the disability. Carriers justifiably may be concerned that this decision will open the floodgates to fraudulent claims.[9]

On June 8, the Court issued a combined opinion in two different cases dealing with notice of claim requirements for underinsurance coverage under automobile insurance policies.

In **Matter of Metropolitan Property and Casualty Ins. Co. v. Mancuso**,[10] the Court recognized that in theory most automobile accidents carry a potential claim for underinsurance benefits, but stated that it takes time, investigation and analysis to determine whether one actually will result. The Court then found that the phrase as soon as practicable[11] in the underinsurance context requires that a policyholder give notice with reasonable promptness after the policyholder knew or reasonably should have known that the tortfeasor was underinsured.[12]

Interestingly, when the Court applied this standard, it refused to overturn the trial court's decision in one of the two combined cases that the policyholder had not given timely notice. In that case, the policyholder had been injured in an accident on Dec. 21, 1994, had filed suit Jan. 15, 1996, and had given notice about 10 months later when he came to learn of the limits of the tortfeasor's policy in connection with a settlement offer.

The policy in the second case considered by the Court required notice [w]ithin 90 days or as soon as practicable, but did not say 90 days from when. The Court found this clause to be ambiguous, and construed it in favor of the policyholder to allow him to file a claim 90 days or as soon as practicable

(whichever is longer) from the date that he knew or should reasonably have known that the tortfeasor was underinsured.

Again, however, in applying the test, the Court found that the policyholder's notice-filed 14 months after he began his personal injury action and three years after the accident-was too late. It remains to be seen what message lower courts will take from this opinion.

The Court issued a one-sentence ruling affirming **Crouse West Holding Corp. v. Sphere Drake Ins. Co. PLC**,[13] for the reasons stated in the Appellate Division's memorandum decision. That the Court of Appeals' decision is so short should not necessarily reflect on its ultimate significance.

In this case, a carrier had issued a single insurance binder for two policies-a commercial general liability policy and a liquor liability policy-but only had noted an assault and battery exclusion for the commercial general liability coverage. The policyholder was named as a defendant in a personal injury action arising from a fight at its pub, and the carrier disclaimed coverage.

A sharply divided Fourth Department found that by issuing a binder that specifically noted the exclusion with respect to one coverage but not the other, the carrier had created confusion regarding the exclusion's application to both coverages. The discrepancy had to be resolved in the policyholder's favor, the court found, concluding that the policyholder was entitled to coverage under the liquor liability policy. Despite the Court of Appeals' strong views on the assault and battery exclusion,[14] it affirmed this decision.

Receiving Payments

Finally, the Court issued two decisions that should serve to remind policyholders-and their beneficiaries and creditors-of the importance of knowing how carriers determine to whom they should make payments under various policies.

In **Badillo v. Tower Ins. Co**.,[15] the Court found that landlords who had a properly perfected security interest in their tenant's property could not bring a claim against the tenant's insurance carrier after a fire destroyed the tenant's store and the carrier paid the loss proceeds directly to the tenant. The Court emphasized that, despite the landlords' UCC-1 filing, the carrier had no actual notice of the landlords' lien. A creditor with a lien on a debtor's property that is covered by insurance should make certain that it is named as the sole loss payee to avoid this problem.

In the other case, **McCarthy v. Aetna Life Ins. Co.**,[16] the court ruled that a policyholder could not effect a change of the designation of beneficiary on a life insurance policy by means of a testamentary disposition when the policy set out another procedure for changing beneficiaries. The Court conceded that there may be situations when something other than a direct notice to the carrier will be required. But just as secured creditors should learn a lesson from **Badillo**, holders of life insurance policies should learn a lesson from **McCarthy**: to change the beneficiary of a policy, inform the insurance carrier directly, as provided in the policy itself.

(1) See Section 500.17 of the Rules of Practice of the New York State Court of Appeals.

(2) 92 N.Y.2d 653 (1998).

(3) See Vehicle and Traffic Law Section 388(1); Insurance Law Section 3420(e); 11 NYCRR 60-1.1(c)(2).

(4) 92 NY2d 682 (1999).

(5) See, e.g., Gerrish Corp. v. Aetna Cas. & Sur. Co., 949 F.Supp. 236 (D.Vt. 1996); Gabe's Constr. Co. v. United Capitol Ins. Co., 539 N.W.2d 144 (Iowa 1995).

(6) 1999 WL 444345 (N.Y. July 1, 1999).

(7) 93 NY2d 122 (1999).

(8) **Galanty v. Paul Revere Life Insurance Co**., 79 Cal.Rptr.2d 671 (1998). It should be noted that the author and his firm represent American Council of Life Insurance, as amicus curiae, in both **New England Mutual Life v. Doe** and in **Galanty v. Paul Revere Life Insurance Co.**

(9) The Court based its ruling on the legislative intent behind requiring incontestability clauses in disability and life insurance policies: to encourage insurance buyers to purchase insurance with confidence that after the contestable period has passed they are assured of receiving benefits if they are disabled. The Court might very well reach a different result in cases where applicants fraudulently acquire insurance policies not for the policies' benefits but for their resale value.

(10) 1999 WL 372553 (N.Y. June 8, 1999).

(11) This is the language used by the New York Insurance Department in its standard form of endorsement, 11 NYCRR 60-2.3, set forth in Regulation 35-D, see 11 NYCRR subpart 60-2 et seq.

(12) It should be noted that Insurance Law Section 3420(f)(2)(A) now requires carriers to disclose insurance policy coverage limits within 45 days after a written request by any person seeking damages who also is covered by his or her own underinsurance insurance. In addition, that section tolls the time for an insured to make a claim for underinsurance benefits during the period the insurer of any other owner or operator of another motor vehicle that may be liable for damages to the insured, fails to so disclose its coverage.

(13) 92 NY2d 1017 (1998).

(14) See, e.g., **U.S. Underwriters Ins. Co. v. Val-Blue Corp.**, 85 NY2d 821 (1995).

(15) 92 NY2d 790 (1999).

Load-Date: August 5, 2011

End of Document

INSURANCE CARRIERS ARE DEALT DEFEATS; Court Of Appeals: The Year In Review; Insurance Law

New York Law Journal

October 2, 2000 Monday

New York Law Journal

Section: Pg. 33, (col. 4); Vol. 224

Length: 2612 words

Byline: Evan H. **Krinick**

Body

Court Of Appeals: The Year In Review

Insurance Law

IT WAS A DIFFICULT YEAR for insurance companies before the New York Court of Appeals. Although the Court ruled in favor of an insurance carrier in deciding that a life insurance policy's two-year incontestability period began to run from the start date of the policy rather than from the date of issuance of the binder,[1] it rejected insurance carrier arguments under General Business Law 349 in vanishing premium litigation,[2] and in coverage cases stemming from a dispute under a construction contract,[3] an automobile accident that raised an important underinsurance coverage issue[4] and an intentional assault.[5]

Indeed, the Court, in **The Guardian Life Ins. Co. v. Chemical Bank**,[6] also ruled against an insurance company that had sued a bank under the Uniform Commercial Code. In an opinion by Judge Howard A. Levine, the Court unanimously held that the insurer should bear the losses resulting from a fraudulent scheme perpetrated by an independent insurance broker, finding that the broker was an agent for the insurer for purposes of the fictitious payee[7] exception to the UCC's forged indorsement rule.[8]

Incontestability Period

For the second consecutive term, the Court issued a decision in a dispute over the running of an incontestability period. Last term, the case was **New England Mutual Life Ins. Co. v. Doe**.[9] The case this term, **Springer v. Allstate Life Ins. Co. of New York**, required the Court to determine the starting point for the two-year period in which a life insurance carrier could deny coverage as a result of a policyholder's death by suicide when the policyholder had purchased a binder prior to issuance of the policy. The suicide was more than two years after the binder had been issued, but under two years from the date of the policy's issuance.

The beneficiary filed suit against the carrier and the trial court concluded that the different effective dates for the binder and the policy created at best an ambiguity that had to be construed against the insurer. Thus, the court determined that the incontestability clause precluded the carrier from disputing coverage. The Appellate Division unanimously affirmed, but the Court of Appeals reversed.

Judge Richard C. Wesley, writing for a unanimous Court, said that an insurance binder provides interim insurance, usually effective as of the date of application, that terminates when a policy is either issued or refused. A binder does not constitute part of a policy or create any rights for the insured other than during its effective period, Judge Wesley continued. Because a binder and policy are two distinct contracts, each with separate specified start and end dates, there also was no ambiguity, Judge Wesley concluded.

It should be noted that the policy as issued did not have the binder attached to it, and thus the binder was not part of the policy under Insurance Law 3204(a)(1). Insurers should make certain not to attach binders to policies if they do not want them to become part of the policies.

Vanishing Premiums

It is no surprise that litigation involving so-called vanishing premium life insurance has reached the Court of Appeals, given that these lawsuits have been prevalent in courts across the country. What is at least somewhat surprising, though, is that the Court used the opportunity to rule, for the first time, that General Business Law 349 could be applied to an insurance carrier's actions.[10] Section 349 is a consumer protection statute modeled after the Federal Trade Commission Act that provides private parties with a cause of action for injuries resulting from deceptive acts or practices. In fact, the Court's ruling, in **Gaidon v. The Guardian Life Ins. Co. of America**, appears broad enough to lead to new 349 claims against insurance carriers and other corporate defendants in New York courts.

The vanishing premium litigation before the Court of Appeals had been filed by policyholders who alleged, in essence, that they had purchased insurance policies in the mid-1980s based on false representations by insurance company sales agents that their out-of-pocket premium payments would vanish within a stated period of time. When interest rates fell sharply, the economics of the policies changed and accumulated cash values became insufficient to pay expected future insurance and administrative costs. Some consumers who had purchased vanishing premium policies were told that they would have to continue out-of-pocket payments to keep their policies in force. Lawsuits followed.

One of the plaintiffs' claims was that the insurance carriers violated 349 by engaging in deceptive marketing and sales practices. They contended, in essence, that the insurance companies' sales agents lured them into purchasing policies by using illustrations that created unrealistic expectations as to the prospects of premium disappearance on a strategically chosen vanishing date. This date, the plaintiffs alleged, was misleading, as based on the premise that interest rates would continue at a high, unprecedented rate for, in some cases, 20 or more years: a premise that the insurance companies allegedly knew to be unlikely.

For their part, the insurance companies asserted, in substance, that the illustrated vanishing dates were not deceptive. They pointed out that the policies had merger clauses, which sought to confine representations to the four corners of the policies. They also relied on disclaimer language stating that the illustrated dividend/interest rates were neither guarantees nor estimates of future results and that such rates could be higher or lower ... depending on the company's actual future experience.

The Court, in an opinion by Judge Albert M. Rosenblatt, declared that the merger provisions were not determinative of the plaintiffs' 349 claims because those claims were based on deceptive business practices, not on deceptive contracts. Moreover, the Court continued, the disclaimers, although more particularized than the merger provisions, did not speak to the true, unrevealed relationship between dividend/interest rates and the vanishing dates as represented. The Court said that the issue was not whether, as a matter of law, reasonable consumers would be misled in a material way, but whether that prospect was enough to permit the complaints to go forward. It concluded, with Judge Joseph W. Bellacosa dissenting in part, that it was.[11]

The Court's decision may have broad ramifications. As noted by Judge Bellacosa, no actions allegedly taken by the insurance company defendants amounted to a misrepresentation of fact that would have misled a reasonable consumer, acting reasonably, into buying a policy, given the disclaimers, policy provisions, and common sense. The alleged misrepresentations made by the defendants were not likely to mislead a reasonable consumer acting reasonably, which was the test that the Court itself set forth for liability under 349 only five years ago,[12] and which it has subsequently reapplied.[13] The ultimate reach of this decision will be of great interest to many.

Coverage Cases

The Court also issued three unanimous coverage decisions this past term.

The first, **Charles F. Evans Co., Inc. v. Zurich Ins. Co.**, arose after the Damon G. Douglas Company, a general contractor, subcontracted with the Charles F. Evans Company to do roofing work for a building constructed for BASF Corporation. Douglas sued BASF, claiming the remaining amounts due under the construction contract. BASF, in turn, counterclaimed against Douglas, alleging that the roofing around the skylights in the new building had been improperly installed and leaked. BASF's counterclaim in the underlying action sought damages for breach of the construction contract, in part incurred because of bodily injury. Specifically, BASF alleged that due to the leaking roof, its employees slipped and fell in puddles ... and were injured, and [a]s a result thereof, BASF has been forced to incur expenses, in the form of lost-time and workers' compensation claims, and has thereby been damaged.

Douglas then brought a third-party action against Evans. When its carrier declined coverage, Evans filed a declaratory judgment action seeking an order that it was entitled to a defense.

In a memorandum decision, the Court pointed out that the policy provided coverage for those sums that the insured becomes legally obligated to pay as damages because of bodily injury. Without extensive analysis, the Court ruled that BASF's claims arising from slip-and-fall injuries alleged facts or grounds that brought the action within the policy, and triggered the carrier's duty to defend Evans.

The underinsurance case, **In the Matter of Worcester Insurance Company v. Bettenhauser**, was the Court's second venture into this area in two years.[14] The case stemmed from a two-car automobile accident in which Thomas Bettenhauser was seriously injured. The other driver's insurance policy had a $10,000 limit, and the policy Mr. Bettenhauser had for his car, which he had been driving, did not include underinsurance coverage. Mr. Bettenhauser, who lived with his parents at the time of the accident, filed an underinsurance claim under their policy.

Over the next several months, Mr. Bettenhauser responded to the carrier's demands for discovery and for a medical examination. After settlement negotiations on the underinsurance claim stalled, he served the

carrier with a demand for arbitration. The carrier thereafter filed an action to permanently stay arbitration, urging that there was no coverage for Mr. Bettenhauser's claim for underinsured motorist benefits in that he was operating his own vehicle at the time of the accident rather than one owned by his parents, who were the policyholders.

The parents' policy provided that it would pay damages that a family member was entitled to recover from the owner or operator of an underinsured motor vehicle because of bodily injury sustained by the family member and caused by an accident. An exclusion provided that there was no coverage for bodily injury sustained by any person while occupying ... any motor vehicle owned by ... any family member which is not insured for this coverage under this policy.

The carrier contended that the policy indicated lack of coverage where, as here, a family member was involved in an accident while driving his own car that was not insured under the policy. Consequently, the carrier maintained that it had no duty whatever with respect to Mr. Bettenhauser's claim. Mr. Bettenhauser, on the other hand, argued that the carrier waived its right to invoke the policy exclusion by failing to timely deny coverage under Insurance Law 3420(d). The Court, in an opinion by Chief Judge Judith S. Kaye, agreed with Mr. Bettenhauser.

The Court relied on familiar law[15] and stated that disclaimer under 3420(d) was unnecessary when a claim fell outside the scope of a policy's coverage provisions. Under those circumstances, it continued, the policy does not contemplate coverage in the first instance, and requiring payment of a claim on failure to timely disclaim would create coverage where it never existed.

By contrast, the Court declared, disclaimer under 3420(d) was necessary when denial of coverage was based on a policy exclusion without which the claim would be covered. In this case, the Court found, timely disclaimer was required because Mr. Bettenhauser's claim fell squarely within the policy's coverage provisions; the insurer's denial of coverage was predicated on one of the designated exclusions.

Certainly it is difficult at times to draw the line between a lack of coverage by failing to be included in the insuring agreement (requiring no disclaimer) and a lack of coverage based on an exclusion (requiring timely disclaimer). Carriers and policyholders, to be sure, will continue to litigate this important issue.

Intentional Assault

The third coverage case, **Agoado Realty Corp. v. United International Ins. Co.**, began when a tenant was intentionally assaulted by an unknown assailant and the tenant's estate filed a lawsuit against the landlord. The landlord's insurance carrier declined to provide coverage, arguing that there was no occurrence because the claim was based on an intentional assault and that, in any event, it fell within an exclusion for expected or intended injuries.

The Court, in an opinion by Judge Wesley, rejected these arguments. The Court first concluded that the assault constituted an accident, observing that the estate's action against the landlord set forth a claim of negligent security, demonstrating that the incident was unexpected, unusual and unforeseeable from the [landlord's] standpoint. The Court also said that the policy exclusion did not apply because it could not be argued that the assault was intended from the landlord's standpoint.

Admittedly, the policy contained no assault and battery exclusion, which clearly would have barred coverage.[16] It should be pointed out, however, that this is the second consecutive term in which the Court has permitted coverage for an intentional assault to move forward.[17]

Even more curious is that the Court apparently relied on the negligent security claim to find coverage. New York law had seemed rather clear that in negligent hiring, supervision and retention cases, it is the nature of the underlying acts, rather than artful pleading, that determines whether there is coverage.[18] It remains to be seen whether the Court's ruling here is signaling a reversal in this area of insurance coverage law.

1. **Springer v. Allstate Life Ins. Co. of New York**, May 9, 2000.

2. **Gaidon v. The Guardian Life Ins. Co. of America**, 94 NY2d 330 (1999).

3. **Charles F. Evans Co., Inc. v. Zurich Ins. Co.**, May 11, 2000.

4. **In the Matter of Worcester Insurance Company v. Bettenhauser**, June 20, 2000.

5. **Agoado Realty Corp. v. United International Ins. Co.**, June 20, 2000.

6. Feb. 22, 2000.

7. UCC 3-405(1)(c).

8. UCC 3-404(1).

9. 93 N.Y.2d 122 (1999).

10. Cf. **New York University v. Continental Ins. Co.**, 83 NY2d 308 (1995) (policyholder may not rely on 349 to complain about a carrier's allegedly unfair claims settlement practices).

11. The Court also ruled that the plaintiffs' fraudulent inducement claims could not go forward, finding that the disclaimers were sufficient to absolve the insurance companies of fraud.

12. **Oswego Laborers' Local 214 Pension Fund v. Marine Midland Bank N.A.**, 85 NY2d 20, 26 (1995).

13. See, e.g., **Small v. Lorillard Tobacco Co.**, 94 NY2d 43 (1999); **Karlin v. IVF America, Inc.**, 93 NY2d 282 (1997).

14. See **Matter of Metropolitan Property and Casualty Ins. Co. v. Mancuso**, 93 NY2d 487 (1999).

15. **Handelsman v. Sea Ins. Co.**, 85 NY2d 96 (1994); **Zappone v. Home Ins. Co.**, 55 NY2d 131 (1982).

16. See, e.g., **U.S. Underwriters Ins. Co. v. Val-Blue Corp.**, 85 N.Y.2d 821 (1995).

17. See **Crouse West Holding Corp. v. Sphere Drake Ins. Co., PLC**, 92 NY2d 1017 (1998).

18. See, e.g., **Sweet Home Central School District of Amherst and Tonawanda v. Aetna Commercial Ins. Co.**, 695 NYS2d 445 (4th Dept. 1999), appeal withdrawn, 94 NY2d 915 (2000); **Public Serv. Mut. Ins. Co. v. Camp Raleigh, Inc.**, 650 NYS2d 136 (1st Dept. 1996), appeal denied, 90 NY2d 801 (1997); **First Finan. Ins. Co. v. XLNT Recovery Specialist, Inc.**, 2000 U.S. Dist. Lexis 9452 (S.D.N.Y. July 7, 2000). For a further discussion of this issue, see Michael A. Sirignano, Although Some Courts Have Ruled Differently, The Better View Is That A Commercial General Liability Policy Does Not Afford Coverage To Employers For Negligent Hiring, Training, Supervision, Or Retention Claims Stemming From An Employee's Intentional Acts, Mealey's Emerging Insurance Disputes, Sept. 13, 2000.

Load-Date: August 5, 2011

End of Document

INSURERS RECEIVED MIXED RESULTS; Court of Appeals; Insurance Law

New York Law Journal

October 1, 2001 Monday

New York Law Journal

Section: Pg. 25, (col. 2); Vol. 226

Length: 2520 words

Byline: Evan H. **Krinick**

Body

Court of Appeals

Insurance Law

INSURANCE CARRIERS obtained mixed results from the Court of Appeals this past term, when it again issued a large number of unanimous insurance decisions.

Auto Policies

Insurance carriers and rental car companies have been sparring over the past few years regarding a rental company's right to seek indemnity from its renter (and the renter's insurer). The issue reached the Court this past term. In **ELRAC, Inc. v. Ward**,[1] the Court, in a unanimous opinion by Chief Judge Judith S. Kaye, ruled that a rental car company could not enforce an indemnification clause to the extent that personal injuries suffered by a third party were less than the minimum insurance that the company was required to provide the renter under 370 of the Vehicle and Traffic Law.

Further, because 370 contains no minimum insurance requirement for property damage, the Court ruled that indemnification is appropriate for property damage awards.

Section 370 requires that common carriers, including rental car companies, obtain insurance for their vehicles that inures to the benefit of any permissive user of the vehicle, such as a renter. Finding 370's language to be plain and precise, the Court held that it clearly requires the rental company to provide the renter with this minimum level of coverage. This rationale even applied to self-insured rental car companies because they must provide the same minimum coverage as companies that purchase insurance policies, the Court said.[2]

About two months after **ELRAC, Inc. v. Ward,** the Court decided another case involving 370, **ELRAC, Inc. v. Masara**.[3]

The case arose when Amnodia Masara rented a car from Enterprise Rent-A-Car and promised to indemnify it for any damage caused by her use of the vehicle. The rental agreement did not permit Ms. Masara to allow anyone else to drive the car.

While being driven by Ms. Masara's father, Rafael Masara, the car was involved in an accident, causing property damage to three other vehicles. Enterprise settled the property damage claims and sought indemnification against the Masaras under the rental agreement.

The Court held that Enterprise was entitled to indemnification. It emphasized that Rafael Masara was not a permissive user of the rental car because the rental agreement did not allow him to drive it. Accordingly, the Court said, the insurance coverage required by 370 did not inure to his benefit.

Further, the Court added, although 370 requires that rental companies obtain a minimum amount of coverage for bodily injury and death, the statute contains no minimum insurance requirement for property damage. Thus, in accord with **ELRAC, Inc. v. Ward,** Enterprise could seek indemnification from the Masaras for property damage awards to the extent otherwise legally permissible, the Court concluded.[4]

No-Fault

Since it was enacted nearly 30 years ago, the No-Fault Law has rarely been addressed by the Court of Appeals, although the Appellate Divisions frequently face questions involving this statute. In **Oberly v. Bangs Ambulance Inc.**,[5] the Court, in an opinion by Judge George Bundy Smith, examined a portion of the No-Fault Law which had never before been squarely before it. That section, formally known as Insurance Law 5102(d), provides that a party injured in an automobile accident may bring a plenary action in tort to recover for noneconomic loss, pain and suffering only if he or she has suffered a serious injury.

The plaintiff was a dentist whose arm had been injured while he was being transported in an ambulance. After the accident, he said his arm pain limited his ability to practice as a dentist. He then filed an action against the ambulance company, alleging that the limitation on the use of his arm amounted to one of the kinds of injuries that qualified as a serious injury under 5102(d), i.e., a permanent loss of use of a body organ, member, function or system.

The Court ruled that only a total loss of use is compensable as a permanent loss of use. Because the dentist had not established total loss of use, the Court said, he failed to establish a serious injury within the meaning of the No-Fault Law. The Court's decision will provide helpful guidance to the Appellate Divisions regarding the meaning of this aspect of the No-Fault Law.

Questions of Coverage

The Court issued three important decisions on insurance coverage questions, resolving disputes against the carriers in all three cases.

Harvey v. Members Employees Trust for Retail Outlets[6] was an action against a self-insured health benefit plan that had denied coverage for the hospitalization and medical care of an insured with a history of illnesses caused by alcohol abuse, including cirrhosis of the liver, on the ground that it did not provide benefits for illnesses arising from the use of alcohol. The insurer argued that its exclusion for alcohol-related illnesses was authorized by Insurance Law 3221(l)(6)(A) and 11 NYCRR 52.16(c).

Judge Howard A. Levine, writing for the Court, disagreed with the insurer's analysis. According to the Court, insurers must make available to proposed insureds the option to purchase certain additional coverage for the diagnosis and treatment of alcoholism. In the Court's view, however, the regulatory bar against excluding coverage by type of illness[7] applied to illnesses arising from the use of alcohol. Because the insured suffered from illnesses arising from his use of alcohol, the insurer could not exclude coverage by type of illness, and the exception for coverage for alcoholism did not apply. Thus, the Court ruled that the insurer could not exclude coverage for the insured's alcohol-related illnesses.[8]

The issue in another coverage case, **Lane v. Security Mutual Ins. Co.**,[9] was whether a fire insurance policy that excluded coverage for an intentional fire set by an insured violated Insurance Law 3404 when applied to exclude coverage to an innocent insured.

The case arose under a homeowner's insurance policy that provided coverage against loss by fire but that excluded coverage for loss resulting from intentional acts by an insured, defined as you and, if residents of your household, your relatives. When Joretta Lane's 17-year-old, live-at-home son intentionally set fire to her home, Ms. Lane's insurer disclaimed liability based on the policy exclusion.

The Court, in an opinion by Judge Smith, held that the exclusion impermissibly restricted the coverage mandated by 3404 for an innocent insured. Under 3404, the Court noted, any policy that insures against the peril of fire must incorporate terms and provisions no less favorable to the insured than those contained in the standard policy. The standard policy exclusion states that damages will be disclaimed for loss occurring ... while the hazard is increased by any means within the control or knowledge of the insured.

The Court said that through use of the language the insured in the standard policy, the statute delineated independent liabilities and obligations as to each insured to refrain from incendiary acts. Accordingly, the Court concluded, to the extent that the Intentional Acts exclusion in the policy created joint liability and barred coverage to Ms. Lane, whom the court referred to as an innocent insured not implicated in her son's incendiary act, the exclusion was unenforceable under 3404.[10]

A third coverage case, **Westview Associates v. Guaranty National Ins. Co.**,[11] was brought by a New York City apartment building owner seeking a declaration that its insurer had to defend it in an action claiming injuries caused by the ingestion of lead-based paint.

Two insurance policies were at issue: a commercial general liability (CGL) insurance policy that contained a specific exclusion for injuries caused by lead-based paint, and an umbrella policy with two types of coverage, Coverage A and Coverage B. Coverage A provided excess coverage for damages exceeding the policy limits of the CGL policy and specifically incorporated the coverage provisions of the CGL policy. Coverage B provided additional primary coverage for certain claims not already covered by the CGL policy; it did not contain an incorporation clause. In addition, the umbrella policy contained a clause specifically excluding coverage for injuries caused by pollution.

The Court, in another opinion by Judge Smith, focused on the umbrella policy and found that the incorporation clause in Coverage A also incorporated the exclusions in the CGL policy. However, the Court added, because there was no incorporation clause in Coverage B, there was no exclusion for lead-based paint in Coverage B.

Importantly, the Court also found that the pollution exclusion clause of the umbrella policy did not exclude coverage for lead paint poisoning, primarily because, the Court said, the insurer had failed to meet its burden of showing that lead paint came within the definition of pollutants.

Statutes of Limitations

Several of the Court's insurance decisions this past term stemmed from disputes over applicable statutes of limitations.

The question at the heart of **Chase Scientific Research, Inc. v. NIA Group, Inc.**,[12] was whether the three-year statute of limitations applicable in nonmedical malpractice actions under CPLR 214(6) governed a suit against an insurance broker or agent. In a comprehensive opinion by Chief Judge Kaye carefully limited to its facts, the Court held that insurance brokers and agents are not professionals subject to malpractice actions, and that CPLR 214(6) therefore did not apply. These actions nevertheless still may be governed by a three-year limitations period if they contain negligence claims[13] but they also may face the six-year period for breach of contract actions.[14] How this decision will affect suits against other professionals, such as pharmacists and social workers, remains to be seen.

In December 1999, the Court issued its decision in **Gaidon v. Guardian Life Ins. Co.**,[15] finding for the first time that General Business Law 349 applied to an insurance carrier's actions. The case, involving claims of deceptive marketing and sales practices in connection with the promotion of sales of so-called vanishing premium life insurance, reached the Court of Appeals again this term.[16]

In **Gaidon II**, Judge Levine first decided that the three-year statute of limitations in CPLR 214(2) for statutory causes of action, rather than the six-year limitations period of CPLR 213(8) for fraud, applies to a cause of action brought under 349. It then addressed whether the plaintiffs' actions accrued when they purchased and received their policies, or when the defendant life insurers demanded additional premium payments beyond the dates by which they led the plaintiffs to believe that premium payments would vanish.

The Court explained that accrual of a private right of action under 349 occurs when the plaintiff has been injured by a deceptive act or practice violating that law. According to the Court, the essence of the plaintiffs' 349 claims was that the insurers' deceptive practices induced unrealistic expectations of the continuing interest or dividend rate performance to fully offset premiums at the projected date. Thus, the Court said, the plaintiffs suffered no measurable damage until the time when those expectations were not met, and they were then called upon either to pay additional premiums or lose coverage and forfeit the premiums they previously had paid. The Court therefore held that the date when those additional premiums were demanded triggered the statute of limitations, and actions commenced within three years of those dates were timely.

Effective Date of Policy

Another question of statutory interpretation was at issue in **Rosner v. Metropolitan Property and Liability Ins. Co.**,[17] a case decided on the last day of the Court's term on certification from the U.S. Court of Appeals for the Second Circuit. At issue was whether the phrase the date as of which a covered policy is first issued as used in Insurance Law 3425(a)(7), governing personal lines insurance policies, refers to the date of execution of a policy, a policy's effective date, or another date. The Court, in an opinion by Judge Victoria Graffeo, held that the statutory language refers to the effective date of a policy.

In the Court's view, this result avoided problems that could arise where a policy's effective date did not coincide with issuance or delivery of the policy. The Court also said that its decision provides certainty with respect to policy coverage periods for both insureds and insurance companies.

Damages

Finally, the Court issued two interesting insurance-related decisions in which insurance companies were not direct participants.

Inchaustegui v. 666 5th Avenue Limited Partnership[18] involved the remedy for a tenant's breach of an agreement to obtain liability insurance for the landlord's benefit.

The landlord had been sued by an employee of the tenant who had been injured on the premises. In its suit against the tenant, the landlord sought to recover the full amount of the settlement and defense costs in the underlying tort claim even though it had its own insurance. Judge Albert Rosenblatt, writing for the Court, held that the landlord's recovery should be limited to out-of-pocket damages caused by the tenant's breach. Thus, because the landlord had obtained its own insurance and therefore sustained no loss beyond its out-of-pocket costs, it could not look to the tenant for the full amount of the settlement and defense costs in the underlying tort claim.

In **Darby & Darby, P.C., v. VSI Int'l, Inc.**,[19] the Court, in an opinion by Judge Carmen Beauchamp Ciparick, ruled that a New York law firm retained to defend a corporate client in a Florida patent infringement litigation did not have a duty to advise the client about possible insurance coverage for the costs of the litigation. This decision did not specifically address whether such a duty may exist in other circumstances, and undoubtedly will lead to further litigation in New York courts.

(1) 96 NY2d 58.

(2) See **Allstate Ins. Co. v. Shaw,** 52 NY2d 818.

(3) No. 115 (June 14). The author's firm represents ELRAC, Inc., generally, but did not represent it in the two cases discussed in this article.

(4) See, also, **Morris v. Snappy Car Rental,** 84 NY2d 21 (indemnification clause, if otherwise valid, is enforceable for amounts exceeding the statutory minimum liability requirements).

(5) 96 NY2d 295 (May 3).

(6) 96 NY2d 99.

(7) 11 NYCRR 52.16(c)(2).

(8) The Court also held that ERISA did not pre-empt the application of 3221(l)(6)(A) and 11 NYCRR 52.16(c) in this case.

(9) 96 NY2d 1.

(10) The Court specifically limited its holding to cases involving fire insurance where 3404 is implicated. Thus, **Allstate Ins. Co. v. Mugavero,** 79 NY2d 153, a case involving alleged sexual abuse and a policy exclusion for bodily injury intentionally caused by an insured (rather than caused by the insured) is not affected by this decision.

(11) 95 NY2d 334.

(12) 96 NY2d 20.

(13) CPLR 214(4).

(14) CPLR 213(2).

(15) 94 NY2d 330.

(16) 96 NY2d 201 (May 8).

(17) 96 NY2d 475 (July 10, 2001).

(18) 96 NY2d111 (April 26, 2001).

(19) 95 NY2d 308.

Load-Date: August 5, 2011

End of Document

INSURANCE CASES DECIDED UNANIMOUSLY; News

New York Law Journal

October 7, 2002 Monday

New York Law Journal

Section: Pg. 22, (col. 5); Vol. 228

Length: 2565 words

Byline: Evan H. **Krinick**

Body

News

THIS PAST TERM, the Court of Appeals once again considered and decided - all without a single dissent - a significant number of cases involving important insurance law issues.

Environmental claims were at the heart of the Court's decisions in Consolidated Edison Co. of New York, Inc. v. Allstate Ins. Co.[1] and Travelers Casualty and Surety Co. v. Certain Underwriters at Lloyd's of London.[2] For the second consecutive term, the Court issued a ruling interpreting the serious injury threshold under the No-Fault Law.[3] In Goshen v. The Mutual Life Ins. Co. of New York,[4] the Court addressed vanishing premium policies for the third consecutive term. The Court also settled questions involving an exclusion under a homeowner's policy in Slayko v. Security Mutual Ins. Co.[5] and timely notice under auto policies in Matter of Brandon v. Nationwide Mutual Ins. Co.[6]

Environmental Damage Claims

The Consolidated case arose when Con Ed filed an action against 24 insurers that had issued it general liability policies between 1938 and 1986, seeking indemnification for costs related to its agreement to clean up property in Tarrytown, N.Y.

The policies at issue spoke of damages caused by or arising from either an accident or an occurrence. Con Ed contended that those terms had the effect of excluding coverage for intended and expected harms, and therefore once it proved property damage during the policy period, the insurers should have the burden of proving that the property damage was intended or expected.

The Court was not persuaded by Con Ed's arguments. In an opinion by Chief Judge Judith Kaye, the Court held that the requirement of a fortuitous loss is a necessary element of insurance policies based on either an accident or occurrence and the insured therefore has the initial burden of proving that the damage was the result of an accident or occurrence to establish coverage.

Notably, the Court's ruling rejects the decision by the U.S. Court of Appeals for the Second Circuit to the opposite effect in Stonewall Ins. Co. v. Asbestos Claims Management Corp.[7]

Also at issue in Consolidated was an allocation issue of great practical importance: where an alleged continuous harm spans many years and implicates several successive insurance policies, is each policy liable for the entire loss or only for a portion of the loss?

Con Ed urged that it should be permitted to collect its total liability - all sums - under any policy in effect during the 50 years or so that the property damage had occurred, up to that policy's limit. In a subsequent action, it added, the indemnifying insurer could then seek contribution from the other insurers that also provided coverage during the relevant period. This legal concept is known as joint and several allocation.

The insurers, by contrast, argued that each insurer's liability was limited to all sums incurred by the insured during the policy period. Pursuant to this legal concept, known as pro-rata allocation, the liability is spread among the policies. The Court agreed with the insurers, finding that joint and several allocation was inconsistent with the unambiguous language of the policies because the policies provided indemnification for liability incurred as a result of an accident or occurrence during the policy period, not outside that period. In the Court's view, Con Ed's focus on all sums would read this important qualification out of the policies.

Allocation was at issue in the Travelers case, albeit under somewhat different circumstances than in Consolidated.[8] The issue here was whether losses from environmental injury claims involving decades of commercial activities at numerous industrial and waste disposal sites properly could be aggregated as a single disaster and/or casualty under certain reinsurance treaties.

Judge Victoria Graffeo, writing for the Court, concluded that such an allocation was not covered under the definition of loss in the reinsurance treaties because the treaties sought to allow aggregation only where the losses were linked spatially or temporally and shared a common origin. Indeed, the Court observed, the reinsurance treaties did not intend for the reinsured carrier to simply group together all other losses. Because the separate treatment of each site failed to pierce any of the retention levels of the reinsurance treaties, the Court determined that the trial court had properly granted summary judgment to the reinsurers.

Significantly, the Court rejected the argument that the follow the fortunes clauses found in the reinsurance treaties mandated that the reinsurers reimburse the reinsured for losses it allocated to them reasonably and in good faith. The Court opined that such a clause does not alter the terms or override the language of reinsurance policies.

Serious Injury

The Court held last term in Oberly v. Bangs Ambulance, Inc.[9] that only a total loss of use is compensable as a permanent loss of use under the serious injury provisions of the No-Fault Law.[10] This past term, in Toure, the Court focused on the nature and extent of the qualitative, objective medical proof necessary for a plaintiff to meet the serious injury threshold under the No-Fault Law under different factual circumstances.

Judge Graffeo, writing for the Court, first set forth the standard: To prove the extent or degree of physical limitation, an expert's qualitative assessment of a plaintiff's condition may suffice, provided that the evaluation has an objective basis and compares the plaintiff's limitations to the normal function, purpose

and use of the affected body organ, member, function or system. Judge Graffeo then applied that standard to three different situations.

In the first, the plaintiff submitted an affirmation from his neurosurgeon that was supported by objective medical evidence, including MRI and CT scan tests and reports, paired with the doctor's observations of muscle spasms during his physical examination of the plaintiff. The Court found this evidence sufficient to defeat the defendants' motion for summary judgment.

In the second, an orthopedic surgeon had diagnosed the plaintiff as having a cervical and lumbosacral sprain and referred her for an MRI scan of her cervical and lumbosacral spine. Based on his review of the MRI films, which were admitted into evidence, the surgeon concluded that the plaintiff suffered two herniated discs in her cervical spine. He further opined that this injury was consistent with the plaintiff's complaints regarding the physical limitations of her neck and back and that the injury was permanent, a conclusion founded on the plaintiff's history, physical examination, [and] the review of the MRI scan. The Court found this evidence, too, sufficient to defeat a defense motion for summary judgment.

The Court reached a different result in the third case. Here, the plaintiff contended that the testimony of her chiropractor regarding his detection of a back spasm and his review of an MRI report, together with his testimony regarding the limited range of motion in her neck and spine, were sufficient to support the jury's finding that she had suffered a serious injury.

The Court pointed out that although medical testimony concerning observations of a spasm can constitute objective evidence in support of a serious injury, the spasm must be objectively ascertained. In this case, the Court stated, the plaintiff's expert did not indicate what test, if any, he had performed to induce the spasm and thus there was no objective support for the conclusion. The Court also noted that the tests administered by the chiropractor to reach his conclusion regarding plaintiff's limitation of motion were subjective in nature because they relied on the plaintiff's complaints of pain.

Finally, the Court declared that although an expert's conclusion based on a review of MRI films and reports can provide objective evidence of a serious injury, in this case, the witness merely mentioned an MRI report without testifying as to the findings in the report and the MRI report itself had not been introduced into evidence, thus foreclosing cross-examination. Accordingly, the Court ruled that the plaintiff had not demonstrated serious injury within the meaning of No-Fault Law.

Vanishing Premium Policies

After rendering decisions in each of the last two terms expanding the ability of plaintiffs in vanishing premium cases to bring suit against insurance carriers[11] under General Business Law 349, the Court has limited the scope of that right.[12]

Plaintiff Paul A. Goshen, a Florida resident, received information about vanishing premium policies in Florida and purchased a policy and paid premiums in Florida, through a Florida insurance agent. The Court found that he was unable to bring a 349 claim in a New York court based on these facts, concluding that the statute requires that the transaction in which a consumer is deceived must occur in New York.

The Court, in an opinion by Judge Carmen Ciparick, first looked to the statutory language in support of its conclusion. The reference in 349(a) to deceptive practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state, the Court stated, unambiguously evinces a legislative intent to address commercial misconduct occurring within New York. The legislative history

also supported this reading of the statute as it referred to the law as adding significant new protection to consumers in this state.[13] Under the Court's analysis, non-New York residents may be able to rely on 349, but only for transactions that take place in New York state.

Criminal Activity Exclusion

Is the criminal activity exclusion in a homeowner's general liability insurance policy unenforceable as a matter of public policy? In Slayko, the Court decided that the exclusion is enforceable.

The case arose after a person picked up a shotgun, pointed it at his friend, with whom he had been fooling around, and shot him. The shooter subsequently pled guilty to the felony of assault, second degree, admitting that he recklessly caused serious physical injury by means of a deadly weapon. At about the same time, the victim sued the shooter for negligence. The shooter's insurance carrier disclaimed coverage, relying on an exclusion in the policy for liability arising directly or indirectly out of instances, occurrences or allegations of criminal activity by the insured. The victim did not dispute that the shooter's conduct fell within the broad sweep of the exclusionary language; rather, he argued that the language was too broad.

Each side relied on public policy arguments before the Court. For the insurer, the overriding policy concern was the interest law-abiding homeowners have in low premiums, an interest best served if such homeowners are not compelled to pool risk with convicted felons. Additionally, the insurer relied on the settled principle that no one shall be permitted to take advantage of his own wrong. The victim countered that accident victims should as a matter of public policy have recourse to financially responsible defendants.

Chief Judge Kaye's decision for the Court pointed out that the cases from which the victim had culled his public policy argument related specifically to automobile accidents and insurance. The Court noted that cases involving auto insurance coverage - an area in which the contractual relationship and many of its terms are prescribed by law - provide a weak basis for generalization about the constraints public policy places upon other insurance contracts.

In upholding the exclusion, Chief Judge Kaye observed that the Insurance Law explicitly permits carriers of personal lines insurance, which includes homeowner's insurance, to cancel policies if the insured is convicted of a crime arising out of acts increasing the hazard insured against.[14] Thus, the Court concluded, to the extent that the Legislature has expressed a public policy about coverage for persons who perform criminal acts, that policy is to facilitate rather than hinder insurers' efforts to remove such persons and their property from the general risk pool.

Timely Notice

In many contexts, an insured's failure to furnish timely notice of a claim vitiates an insurance contract, and the insurer may rely on this defense regardless of whether it can demonstrate that the insured's failure operated to its prejudice. Insurance policies providing Supplementary Uninsured Motorists (SUM) coverage typically require the insured not only to submit a notice of claim but also to transmit promptly to the insurer the summons and complaint in any action the insured brings against a tortfeasor.

In Matter of Brandon, Chief Judge Kaye, again writing for the Court, rejected an insurer's argument that a policyholder's failure to timely submit a summons and complaint vitiated the policy without its need to demonstrate that it had been prejudiced by the delay.

The Court determined that the factors that supported the no prejudice rule when an insured fails to furnish timely notice of a claim did not apply when an insured provides late notice of legal action. The Court conceded that immediate notice of legal action may indeed help SUM insurers protect themselves against fraud, set reserves, and monitor and perhaps settle the tort action, but it stated that the notice of claim requirement also serves this purpose.

It concluded by noting that unlike most notices of claim - which must be submitted promptly after the accident, while an insurance carrier's investigation has the greatest potential to curb fraud - notices of legal action become due at a moment that cannot be fixed relative to any other key event, such as the injury, the discovery of the tortfeasor's insurance limits, or the resolution of the underlying tort claim. The Court also concluded that under these circumstances, and given the protection SUM insurers already enjoy by virtue of the notice of claim requirement and the clauses governing settlement, insurers relying on the late notice of legal action defense should be required to demonstrate prejudice.

The Court's distinctions between timely notice of claim and notice of suit suggest it continues to recognize the need for the no prejudice rule in the timely notice of claim situation, but it remains to be seen whether the adoption of a prejudice rule in the limited late notice context will lead to its adoption in other contexts. Indeed, a footnote noted that New York remained among the minority of states that generally maintain a no prejudice position and that a shift to a prejudice requirement often begins in the uninsured motorist context. In the terms to come, this issue is sure to be revisited by the Court.

FN[1] 2002 N.Y. Lexis 1041.

FN[2] 96 N.Y.2d 583.

FN[3] Toure v. Avis Rent A Car Systems, Inc., 2002 N.Y. Lexis 1994.

FN[4] 2002 N.Y. Lexis 1900.

FN[5] 2002 N.Y. Lexis 1902.

FN[6] 97 N.Y.2d 491.

FN[7] 73 F.3d 1178 (2d Cir. 1995).

FN[8] The author's firm submitted an amicus curiae brief on behalf of the American Insurance Association in Travelers.

FN[9] 96 N.Y.2d 295.

FN[10] Insurance Law 5102(d).

FN[11] Gaidon v. Guardian Life Ins. Co. of America, 96 N.Y.2d 201, 94 N.Y.2d 330.

FN[12] Goshen, supra.

FN[13] Gov Bill Jacket, L. 1980, c 346.

FN[14] See Insurance Law 3425(c)(2)(B).

Evan H. Krinick is a partner in Uniondale's Rivkin Radler LLP.

Load-Date: August 6, 2011

End of Document

NEW ISSUES AND RARE DISSENT HIGHLIGHT TERM; News

New York Law Journal

September 2, 2003 Tuesday

New York Law Journal

Section: Pg. 17, (col. 3); Vol. 230

Length: 2509 words

Byline: Evan H. **Krinick**

Body

News

IN RECENT YEARS, the Court of Appeals' insurance law decisions typically have been unanimous, and often have involved issues that seemed to reappear from time to time in one form or another. For example, the Court addressed vanishing premium policies in three consecutive terms, beginning in September 1999. It also interpreted the serious injury threshold under the No-Fault Law in its 2000-2001 term as well as in its 2001-2002 term.

This past term's decisions were somewhat different. In Belt Painting Corp. v. TIG Ins. Co.,[1] the Court examined a pollution exclusion endorsement for the first time in nearly three years. In Town of Massena v. Healthcare Underwriters Mutual Ins. Co.,[2] the Court analyzed the duty of insurance carriers to defend defamation claims. The common law rule that cancellation of an insurance contract becomes effective when it is received by the insurance carrier was at the heart of Crump v. Unigard Ins. Co.[3] Continental Ins. Co. v. State of New York[4] resolved an insurance question under the Workers' Compensation Law.

The Court's ruling in Pierre v. Providence Washington Ins. Co.[5] stands alone for a number of reasons, including that it was not a unanimous decision, but rather was a rare 4-3 vote.

Certainly, not all was new (or even relatively new) this past year. The Court continued at least one of its regular practices when it accepted certified questions from the U.S. Court of Appeals for the Second Circuit in First Financial Ins. Co. v. Jetco Contracting Corp.[6]

Pollution Exclusion

A decade ago, in Continental Cas. Co. v. Rapid-Am. Corp.,[7] the Court analyzed whether a pollution exclusion clause precluded coverage for claims for asbestos exposure injuries. The Court reasoned that, although asbestos may be an irritant, contaminant or pollutant under the exclusion, the clause was ambiguous with regard to whether the asbestos fibers had been discharged into the atmosphere as contemplated by the exclusion. Three years ago, in Westview Assocs. v. Guaranty Natl. Ins. Co.,[8] the

Court concluded that the insurer failed to meet its heavy burden of showing that lead paint was unambiguously included within the exclusion's definition of pollutant.

The underlying plaintiff in this term's Belt Painting case alleged that he had been injured as a result of inhaling paint or solvent fumes in an office building. The insurer declined to cover the claim, pointing out that the definition of pollutant in the exclusion included fumes and contending that the absence of the language into or upon the land, the atmosphere or any water course or body of water in the exclusion indicated an intent to extend the exclusion to indoor, as well as outdoor, pollution.

The Court, in a unanimous opinion by Chief Judge Judith S. Kaye, observed that the exclusion referred to the discharge, dispersal, seepage, migration, release or escape of pollutants. The Court declared that those terms were terms of art in environmental law used with reference to damage or injury caused by disposal or containment of hazardous waste. The Court found that reasonable minds could disagree as to whether the exclusion applied and it was thus ambiguous. The Court then reached the same result as it had in Continental Casualty and Westview, and rejected the insurer's efforts to apply the pollution exclusion.

Defamation

As explained in Judge George Bundy Smith's opinion for a unanimous Court,[9] the Town of Massena case arose when Dr. Olof Franzon brought suit against Massena Memorial Hospital alleging that the hospital had defamed him for advocating nurse-midwifery services. The hospital argued that a Personal Injury Liability policy, which covered all personal injury damages arising out of various offenses, including the publication or utterance of a libel or slander or of other defamatory or disparaging material, obligated the insurer, Healthcare Underwriters Mutual Insurance Company, to provide it with a defense.

The Court rejected Healthcare's attempt to apply the exclusion for defamatory statements made within a business enterprise with knowledge of their falsity. The Court reasoned that even if the allegedly defamatory statements concerned the business enterprise of Dr. Franzon's practice of medicine and even if the statements were intentionally and maliciously made, there was no allegation that the statements were made with knowledge of their falsity. The Court also addressed the public policy that conduct engaged in with the intent to cause injury is not covered by insurance. Coverage was required, the Court found, because Dr. Franzon, as a limited public figure, could recover on his defamation claim if he established that defamatory statements were made with reckless disregard of their truth.

Cancellation of a Policy

The Crump case stemmed from the issuance in March 1996 by Unigard Insurance Company of an insurance policy to Prosper's Trucking, Inc., and the trucking company's decision to enter into a premium finance agreement with AFCO Credit Corporation. Under that agreement, AFCO had the authority to cancel Unigard's policy if Prosper's failed to pay a premium installment.

After Prosper's apparently failed to make a premium payment, AFCO sent Prosper's and Unigard a notice of cancellation that indicated that the policy would be canceled as of Nov. 25, 1996. On Nov. 29, a Prosper's driver was involved in an accident in which Thomas Crump died. Prosper's did not receive the cancellation notice until after Nov. 29, and Unigard did not receive the cancellation notice until Dec. 6.

Winnie Crump filed a wrongful death action against Prosper's, which sought a defense from Unigard. In response, Unigard asserted that the policy had been canceled as of Nov. 25. Crump filed suit.

When the case reached the Court, the issue was whether a 1978 amendment to Banking Law 576, which sets forth the procedures a premium finance agency must follow to effect a cancellation of an insurance contract, abrogated the common law rule requiring that the insurer had receipt of the cancellation notice in order for the cancellation to be effective.

Judge Smith, writing for the Court, concluded that the plain language of the statute -- which provides that the insurance contract shall be canceled as if such notice of cancellation had been submitted by the insured himself -- did not indicate an intent to abrogate the common law rule that extends the period of coverage until the insurer receives the notice of cancellation. Moreover, Judge Smith pointed out, nothing in the legislative history revealed an intent to abrogate the common law rule. To the contrary, Judge Smith stated, the express intent of the 1978 amendment was to give notice to the defaulting insured of its opportunity to cure the default so as to prevent coverage gaps. [T]hat would be undermined if the statute were interpreted to abrogate the common law rule, Judge Smith concluded.[10]

Workers' Compensation

The Continental Insurance case involved T&T Murray Company, Inc., owned by brothers Thomas and Timothy Murray, who served as the only corporate officers. T&T purchased a Workers' Compensation and Employers' Liability policy from the State Insurance Fund and elected to exclude the Murrays, as executive officers, pursuant to Workers' Compensation Law 54(6).

Concept Construction Corp. hired T&T as a roofing subcontractor on a job, and Thomas Murray was injured. He sued Concept under Labor Law 240(1). Ultimately, Thomas Murray recovered almost $6 million from Continental Insurance Co., Concept's liability carrier. In turn, Concept was awarded a judgment against T&T based on common law indemnification.

After the State Fund denied coverage based upon T&T's previous election to exclude the Murray brothers under the policy, Continental, as equitable subrogee to Concept's rights against the State Fund, brought suit against the State Fund. Continental argued that the statutory election contained in 54(6) was limited in application to workers' compensation coverage. The Court disagreed with Continental, finding that employers' liability insurance is inextricably linked to workers' compensation coverage. Once T&T elected to have Timothy and Thomas Murray excluded from coverage of this chapter, they were no longer employees, the Court explained. Therefore, it concluded, T&T's Employers' Liability Insurance -- insuring only against liability for injuries to or death of employees -- did not extend to the injury suffered by Thomas Murray, a non-employee executive officer when the injury occurred.[11]

A Case With a Rare Split Court

It has been a handful of years since a Court of Appeals judge filed a dissent in an insurance case,[12] and about seven years since the Court was split 4-3 in an insurance case.[13] The Court's decision this term in Pierre was a 4-3 vote.

The case arose after Steve Pierre was injured when his vehicle was struck by a tractor-trailer driven by Steve Harris. Mr. Harris' employer, Preston Conquest, owned the tractor cab but the trailer was owned by Blue Hen Lines, a federally registered motor carrier. Conquest had leased the tractor to Blue Hen and agreed to provide Blue Hen with a driver. In turn, the lease obligated Blue Hen to obtain liability insurance coverage. The liability policy Blue Hen obtained from Providence Washington Insurance

Company contained a notice of accident provision requiring that the insured promptly notify the insurance carrier of any accident arising from operation of the vehicle.

Mr. Pierre sued Mr. Harris and Conquest and obtained a default judgment. After Mr. Pierre learned that Blue Hen owned the trailer and that Providence had issued it a liability policy, Mr. Pierre forwarded the judgment to Providence and requested payment under Blue Hen's policy. Providence disclaimed coverage on the ground that Mr. Harris and Conquest had failed to timely inform Providence of the accident.

Mr. Pierre brought suit against Providence. He argued that a federally mandated policy endorsement, known as the MCS 90, obviated the effect of the policy's notice condition. The endorsement provides that the insurance carrier agrees to pay any final judgment recovered against the insured despite the insured's failure to comply with policy conditions.

Mr. Pierre argued that because the term insured was not defined in the endorsement, the Court had to look to the definition of that term in the body of the policy. Because Mr. Harris and Conquest fell within the policy definition of insured, Mr. Pierre contended that the final judgment against them constituted the requisite final judgment recovered against the insured referenced in the MCS 90 endorsement. For its part, Providence argued that the endorsement had to be viewed as distinct from the underlying policy and that its enhanced protections were triggered only if the injured party obtained a judgment against the named insured who had purchased the policy, in this case Blue Hen. The majority of the Court agreed with Mr. Pierre.

As Judge Victoria A. Graffeo explained, under the MCS 90 endorsement, the motor carrier who purchased the insurance -- the so-called named insured -- need not have been negligent; all that was required was that the accident resulted from negligence and that a judgment was entered implicating the coverage provisions of the policy and endorsement. Accordingly, the majority held, because Providence was obligated under the endorsement to pay any final judgment recovered against the insured, Mr. Pierre was entitled to judgment directing Providence to pay the judgment against Mr. Harris and Conquest, its insureds.

Judge Richard C. Wesley dissented in an opinion in which Judges Smith and Howard A. Levine concurred. In their view, the term the insured in the endorsement could only mean the named insured to whom the underlying policy was issued -- that is, the motor carrier, Blue Hen. The majority's view, Judge Wesley wrote, creates absolute liability against the insurer for anyone injured by a vehicle operating under the registration of the motor carrier who obtains a judgment against only the operator. Judge Wesley concluded that had Congress intended such a result, it could have required that the provisions of the MCS 90 apply to a judgment not just against the insured, but against any insured as defined in the liability policy.

It remains to be seen whether further litigation in other cases will challenge the Court's interpretation of the MCS 90 endorsement, perhaps on the ground that the Department of Transportation's form of the endorsement goes beyond the statutory authority granted by Congress.

Next Term

Important insurance law cases are on the immediate horizon. In one of the first arguments scheduled in its new term, the Court will determine, in Medical Society of the State of New York v. Serio,[14] the constitutionality of amendments to the no-fault regulations. In October, the Court is scheduled to hear

argument in First Financial on notice questions certified to it by the Second Circuit. In particular, the Court has agreed to decide whether an insurer that has discovered grounds for denying coverage can wait to notify the insured of denial of coverage until after the insurer has conducted an investigation into alternate, third-party sources of insurance benefiting the insured. If the Court decides that an investigation into alternate sources of insurance is not a proper basis for delayed notification, it has agreed to decide whether an unexcused delay in notification of 48 days is unreasonable as a matter of law under Insurance Law 3420(d). The Court's decisions on these questions are likely to have important practical ramifications.

1. No. 86 (July 1, 2003).

2. 98 N.Y.2d 435.

3. 100 N.Y.2d 12.

4. 99 N.Y.2d 196.

5. 99 N.Y.2d 222.

6. 2003 WL 1818133. See, also, Mark A. Varrichio and Associates v. Chicago Ins. Co., 99 N.Y.2d 545 (certification accepted), 2003 WL 1989280 (certified question marked withdrawn).

7. 80 N.Y.2d 640.

8. 95 N.Y.2d 334.

9. Chief Judge Judith S. Kaye took no part in the decision.

10. The Court also addressed a notice issue in Matter of Merchants Mutual Ins. Co. v. Falisi, 99 N.Y.2d 568. In reversing the Appellate Division, Second Department, the Court found that a form the insureds provided to their insurer 11 days after an accident was sufficient notice of a claim for uninsured motorist coverage.

11. In another construction-related insurance dispute, the Court held, in Pecker Iron Works of New York, Inc. v. Traveler's Ins. Co., 99 N.Y.2d 391, that a subcontractor's insurance policy, naming the contractor as an additional insured, provided primary coverage and not excess coverage.

12. Gaidon v. The Guardian Life Ins. Co. of America, 94 N.Y.2d 330 (Judge Joseph W. Bellacosa dissenting in part); Royal Bank & Trust Co. v. Superintendent of Ins., 1998 WL 305441 (dissent by Judge Levine and decision concurring in part and dissenting in part by Chief Judge Kaye).

13. Incorporated Village of Cedarhurst v. Hanover Ins. Co., 89 N.Y.2d 293.

14. 298 A.D.2d 255.

Evan H. Krinick is a partner with Uniondale's Rivkin Radler.

Load-Date: August 6, 2011

End of Document

SIGNIFICANT RULINGS ON NOTICE AND COVERAGE; News

New York Law Journal

September 7, 2004 Tuesday

New York Law Journal

Section: Pg. 23, (col. 1); Vol. 231

Length: 2837 words

Byline: Evan H. **Krinick**

Body

News

THIS PAST TERM, the Court of Appeals continued its recent trend of deciding a broad range of insurance law questions. The Court issued two significant notice rulings, two important coverage decisions, and two noteworthy opinions in cases involving the Superintendent of Insurance. Once again, the Court's insurance law cases typically were decided without dissent. The Court also continued what has become a regular practice of accepting and deciding certified questions on insurance law matters from the U.S. Court of Appeals for the Second Circuit.

In fact, in anticipating the 2004-2005 term's insurance law decisions, on May 11, the Court accepted certification in USCOA v. City Club Hotel, LLC,1 involving the payment of a defendant's attorney fees in a declaratory judgment action brought by an insurance company. Then, on June 18, the Second Circuit certified a question under New York's no-fault automobile insurance law to the Court; a decision whether to accept certification is expected shortly.2 Next term's insurance law decisions also will include three cases where argument is calendared for the opening weeks of the term: Miceli v. State Farm Mutual Automobile Ins. Co.,3 Lang v. Hanover Ins. Co.,4 and Excess Ins. Co. Ltd. v. Factory Mutual Ins. Co.5

Notice

The Court's decision last November in First Financial Ins. Co. v. Jetco Contracting Corp.6 responded to two certified questions from the Second Circuit.

The case arose on July 9, 1998, when an employee of Jetco Contracting Corp.'s scaffolding subcontractor was injured. The employee brought suit on Jan. 6, 1999, and Jetco's commercial general liability insurer, First Financial Insurance Company, did not learn of the accident until Feb. 23, 1999. On March 30, 1999, First Financial confirmed that Jetco's president had known of the accident since the day it had occurred. But it was not until May 17, 1999 -- 48 days later -- that First Financial notified Jetco that it was denying coverage.

A federal district court found that the insurer had not violated its obligation to give written notice of the denial of coverage as soon as is reasonably possible, observing that during the 48-day delay, First Financial was investigating potential alternative sources of insurance. Jetco appealed to the Second Circuit, which led to the New York Court of Appeals' decision following certification.

Chief Judge Judith S. Kaye acknowledged in her opinion for the Court that investigation into issues affecting an insurer's decision whether to disclaim coverage may excuse delay in notifying the policyholder of a disclaimer. However, she wrote, delay simply to explore other sources of insurance for the policyholder is an excuse unrelated to the insurer's own decision to disclaim and therefore is not an acceptable reason for delayed disclaimer.

It is important to emphasize that Chief Judge Kaye also stated that investigation into issues affecting an insurer's decision whether to disclaim coverage obviously may excuse delay in notifying the policyholder of a disclaimer, citing Appellate Division decisions that found delay to be reasonable because of the insurer's (i) need to conduct a prompt, diligent and good faith investigation of the claim,7 (ii) need to review a 500-page file and conduct legal research,8 and (iii) difficulty gathering evidence because all those involved in the accident had been killed.9 Indeed, last October, in Peters v. State Farm Fire and Casualty Co.,10 the Court issued a memorandum decision finding that an insurer who learned of a claim in January 1992, issued reservation of rights letters in February, and later concluded its investigation, had timely disclaimed coverage in April -- more than two months later.

The Jetco Court then addressed the Second Circuit's second certified question and held that an unexcused delay (or, more precisely, a delay based on an unsatisfactory explanation) of 48 days is unreasonable as a matter of law. Unfortunately, this holding does little more than resolve that a 48-day unexcused delay is unreasonable as a matter of law. The Legislature has avoided imposing a fixed time period in the Insurance Law, and the Appellate Divisions continue to grapple with determining how much of a delay is reasonable as a matter of law.11

Condition Precedent

The Court's decision in American Transit Ins. Co. v. Sartor12 also involved a question of notice. The particular issue in this case was whether Vehicle and Traffic Law 370 obligates the insurance carrier of a taxicab to satisfy a default judgment entered against its insureds where the carrier was never notified, as required by the terms of its commercial liability policy, that legal proceedings had been commenced by the injured party.

Writing for the Court, Judge Victoria A. Graffeo stated that the insurer's receipt of such notice was a condition precedent to its liability under the policy, and that the failure to satisfy this requirement allowed the insurer to disclaim its duty to provide coverage. The Court ruled that there was nothing in the text of 370(4) of the Vehicle and Traffic Law, which specifically addresses taxicabs and other vehicles that transport passengers for hire, that indicated that the Legislature had intended to alter the long-standing insurance industry practice with regard to notice.

It should be pointed out that the Court's decision does not necessarily put a claimant injured by a vehicle for hire at risk; he or she can safeguard the ability to seek enforcement of a judgment against the insurer by exercising the independent notice right provided by the Legislature in Insurance Law 3420(a)(3). Concomitantly, in that situation, the insurer will have an opportunity to challenge or settle claims against its insured.

Sexual Assault

The Court's April 1 decision in RJC Realty Holding Corp. v. Republic Franklin Ins. Co.13 resolved a coverage issue that, although limited to its facts, raised significantly broader issues. The narrow question was whether a liability insurer was obligated to defend and indemnify its insured, a beauty salon and health spa, in an action brought against the insured based on an alleged sexual assault by the insured's employee, a masseur. The broader issue concerned whether a sexual assault could ever be deemed to be an occurrence as defined in a general liability insurance policy.

The Court was faced with two different lines of cases. One, exemplified by Allstate Ins. Co. v. Mugavero,14 bars insurance coverage under general liability insurance policies for sexual abuse or sexual assault because these acts cannot be seen to be anything other than intentional. Mugavero involved the alleged sexual abuse of children, but the Court's rationale has been applied since then to numerous other cases of alleged sexual assault.15

The other line of cases is illustrated by the Court's 2000 decision in Agoado Realty Corp. v. United Int'l Ins. Co.,16 where the issue was whether the insurer was required to indemnify its insureds, the landlords of a building, against a claim brought by the estate of a tenant who had been murdered in the building by an unknown assailant. There, the Court declared that, in deciding whether a loss is the result of an accident, it must be determined, from the point of view of the insured, whether the loss was unexpected, unusual and unforeseen. Because the landlords in Agoado obviously did not expect or intend the tenant's murder, the Court held that it was an accident from their point of view. The Agoado Court also held that the murder was not within the policy exclusion for conduct expected or intended from the standpoint of the landlords.

With the Agoado decision in mind, the RJC Court, in an opinion by Judge Robert S. Smith, decided that the alleged sexual assault was an accident within the meaning of the policy, and that the policy's exclusion for injuries expected or intended from the standpoint of the insured did not apply. The Court was not persuaded that there should be a different result because the perpetrator in Agoado was a stranger and the alleged perpetrator in RJC was the insured's employee. The Court found that it could not attribute the masseur's expectation and intention in committing the alleged sexual assault to his employer, and it therefore concluded that the insurer was obligated to defend and indemnify.

The failure of the RJC Court to even cite the Mugavero ruling or its progeny leads one to wonder about the continued viability of those decisions, which rested to a large extent on the public policy barring insurance coverage of sexual assaults under New York law.

Mental Disabilities

In Matter of Polan v. State of New York Insurance Department,17 the Court was asked to decide whether a long-term disability plan violated Insurance Law 4224(b)(2) by failing to afford equivalent coverage for mental and physical disabilities. The policy at issue provided coverage for physical disabilities until the disabled employee reached age 65 or the disability ceased, while coverage for disabilities caused by mental and nervous disorders or diseases generally was limited to 24 months.

As the Court explained in its July 1 ruling, in an opinion by Judge Susan Phillips Read, the insurer did not adopt the 24-month limitation solely because of the petitioner's mental disability; the limitation preceded her disability. Nor was the petitioner otherwise discriminated against, the Court continued. Rather, she

was eligible for the same long-term disability coverage at the same premium as were all other employees participating in her employer's group plan. So long as the insurer offered the petitioner the same policy it offered everyone else, the insurer did not violated the anti-discrimination statute, the Court concluded.

The Court's decision seems quite correct. The New York statute is similar to the anti-discrimination statutes of several other states, including Maine and Texas, and courts have generally declined to interpret these statutes to require equivalent coverages for mental and physical disabilities.18

Regulatory Rulings

In 1995, the Legislature enacted new subsections (g) through (j) to Insurance Law 4308, dubbed the file and use provisions. Under the file and use methodology, insurers seeking to increase or decrease premiums may submit a rate filing or application to the Superintendent, which shall be deemed approved, provided that the anticipated incurred loss ratio for the contract form falls within prescribed minimum and maximum loss ratios as certified by an actuary.

Thereafter, Excellus Health Plan, Inc., which provides health care coverage in 45 upstate New York counties, submitted its rate filing for new premium rates, accompanied by the required actuarial certifications. The Superintendent subsequently notified Excellus that he was modifying some of the rates by reducing increases.

Excellus challenged the Superintendent's action in court, arguing that it ran afoul of the file and use statutory scheme by improperly conditioning a premium rate change on the Superintendent's review and approval. In Matter of Excellus Health Plan, Inc. v. Serio,19 the Court agreed with Excellus. Judge Read's majority opinion observed that the clear wording of 4308(g)(1) unambiguously states that a rate filing or application submitted to the Superintendent 'shall be deemed approved,' provided that it is accompanied by an actuarial document certifying that the anticipated loss ratios fall within the statutorily prescribed range. Thus, the Court ruled, once the Superintendent receives a new premium rate filing, accompanied by the requisite actuarial certification, the rates specified in the filing are approved by operation of law. Judge Graffeo dissented on this issue.

It should be noted that even after Excellus, the Superintendent may act to ensure that initial contract terms and premiums are not excessive, inadequate or unfairly discriminatory under subsections (a) and (b) of 4308, and may review rates pursuant to the excessive management salary provision of subsection (b) or the audit provisions of subsections (d) through (f). The Superintendent also may ensure that the file and use actuarial certifications are correct, and may issue regulations regarding how loss ratio certifications are to be prepared. After the Excellus decision, though, the Superintendent simply may not exercise traditional rate review powers with respect to premium rates deemed approved.

No-Fault

The Superintendent of Insurance also was a party in Matter of Medical Society of the State of New York v. Serio,20 a significant case that involved a challenge to new regulations issued by the Superintendent in an effort to combat automobile insurance fraud. The new regulations, applicable in no-fault cases, required an accident victim to submit a notice of claim to the insurer within 30 days rather than 90 days of the accident, as had been the case under older regulations, and required that proof of medical expenses for which compensation is sought be submitted within 45 days rather than the older regulations' 180-day period.

The Superintendent enacted these new regulations in an effort to reduce suspected automobile insurance fraud, primarily in no-fault insurance cases. In the Superintendent's view, one of the most common ways such fraud was perpetrated consisted of exploiting the time lag between the alleged loss and the deadline for submitting proof of the loss. Specifically, ringleaders would purchase minimum automobile insurance, perhaps under a fraudulent name, on wrecked or salvaged vehicles and would recruit others to fill up the vehicles and participate in staged accidents. These purported victims were then steered to corrupt medical clinics, called medical mills, where they feigned aches, pains and soft tissue injuries. The medical mills then would generate stacks of medical bills for each passenger, detailing treatments and tests that were unnecessary or never performed.

Around 90 days after the staged accident, the insurer would be notified of the claim, but not of the large number of bills to follow. Later, just before expiration of the 180-day period for submitting proof of loss, the medical mills would submit stacks of false bills generated over six months, often reaching the statutory no-fault cap of $50,000 for each passenger. By the time the insurer received the bills and attempted to investigate, the passenger would be pronounced cured, thus frustrating the insurer's ability to perform its own independent medical examination in a timely fashion and forcing the insurer to choose between undertaking largely ineffective investigations and paying questionable claims.

Shortly before the revised regulations were scheduled to take effect, the Medical Society of the State of New York and other petitioners challenged them in court. Supreme Court, New York County, rejected the challenge, the Appellate Division affirmed, and the case reached the Court of Appeals.

The Court affirmed, in another insurance law opinion by Chief Judge Kaye. Given that the Superintendent had determined that the revised regulations were the most effective means of advancing the legislative intent of providing prompt payment of benefits as the loss was incurred, while reducing rampant abuse, the Court declared that it would not substitute its judgment for that of the superintendent. Concluding that the superintendent acted within the scope of his lawfully delegated authority, and that his determination was neither irrational nor unreasonable, and neither arbitrary nor capricious, the Court determined that the regulations should be upheld.

1. 2004 N.Y. Lexis 1026.

2. State Farm Mutual Automobile Ins. Co. v. Mallela, 2004 U.S. App. Lexis 12034. (The author and his firm represent the insurance carrier in this matter.)

3. 1 N.Y.3d 503. (The author and his firm also represent the insurance carrier in this matter.)

4. 1 N.Y.3d 508.

5. 2004 N.Y. App. Div. Lexis 2108.

6. 1 N.Y.3d 64.

7. 2540 Assocs. Inc. v. Assicurazioni Generali, 271 A.D.2d 282.

8. DeSantis Bros. v. Allstate Ins. Co., 244 A.D.2d 183.

9. Aetna Cas. & Sur. Co. v. Brice, 72 A.D.2d 927.

10. 100 N.Y.2d 634.

11. See, e.g., New York Central Mut. Fire Ins. Co. v. Majid, 5 A.D.3d 447 (31 days reasonable); West 16th Street Tenants Corp. v. Public Service Mut. Ins. Co., 290 A.D.2d 278 (30 days unreasonable);

12. 2004 N.Y. Lexis 1611.

13. 2 N.Y.3d 158.

14. 79 N.Y.2d 153.

15. See, e.g., Sormani v. Orange Co. Comm. College, 263 A.D.2d 511 (allegations of sexual abuse, sexual harassment); Tasso v. Aetna Ins. Co., 247 A.D.2d 376 (allegations of rape); Public Service Mutual Ins. Co. v. Camp Raleigh, Inc., 233 A.D.2d 273 (allegations of sexual molestation); Board of Ed. v. Continental Ins. Co., 198 A.D.2d 816 (allegations of sexual harassment).

16. 95 N.Y.2d 141.

17. 2004 N.Y. Lexis 1608.

18. See e.g. McNeil v. Time Ins. Co., 205 F.3d 179; El-Hajj v. Fortis Benefits Ins. Co., 156 F.Supp.2d 27.

19. 2 N.Y.3d 166.

20. 100 N.Y.2d 854.

Evan H. Krinick is a partner with Rivkin Radler in Uniondale.

Load-Date: August 6, 2011

End of Document

PERSONAL INJURY IS THE THEME IN MAJOR RULINGS; News

New York Law Journal

September 12, 2005 Monday

New York Law Journal

Section: Pg. 3, (col. 1); Vol. 234

Length: 3039 words

Byline: Evan H. **Krinick**

Body

News

Serious Injury

Notice

Direct Actions

Attorney's Fees

Fraudulent Incorporations

The Future

IN RECENT TERMS, the Court of Appeals has decided a broad range of insurance law questions under a wide variety of insurance contracts and policy provisions. For example, the application of a pollution exclusion endorsement was at issue in the Court's July 1, 2003, decision in **Belt Painting Corp. v. TIG Ins. Co.**[1] A decision later that year, **First Financial Ins. Co. v. Jetco Contracting Corp.**,[2] involved a dispute over notice under a commercial general liability insurance policy. Then, last summer, the Court analyzed coverage under a long-term disability plan, in **Matter of Polan v. State of New York Insurance Department**.[3]

By contrast, the significant insurance law decisions issued by the Court this past term have one underlying theme in common: they all arose out of different aspects of personal injury claims by individuals. As a result, their impact is likely to be widely felt by individuals, corporate policyholders, and insurers throughout the state for many years to come.

A portion of the no-fault law was at issue in the three cases decided as **Pommells v. Perez**.[4] More precisely, the serious injury provisions of the law were at issue in these cases. (The author and his firm represented one of the defendants.)[5] Under the statute, only in the event of serious injury can a person

initiate suit against a car owner or driver for damages caused by an accident.[6] In the context of soft-tissue injuries involving complaints of pain that may be difficult to observe or quantify, deciding what is a serious injury can be particularly vexing.

The plaintiffs in these three cases all claimed to have suffered soft-tissue injuries--herniated discs--caused by car accidents. Even where there is objective medical proof of injury, the Court ruled, when additional contributory factors interrupt the chain of causation between the accident and claimed injury--such as a gap in treatment, an intervening medical problem, or a pre-existing condition--summary dismissal of the complaint may be appropriate.

Thus, the Court found with respect to plaintiff Anthony Pommells, that he had ended his physical therapy six months after an auto accident and that he had sought no other treatment until years later, when he visited a physician in connection with his lawsuit. The Court declared that although a cessation of treatment is not dispositive--it stated that the law does not require a record of needless treatment in order to survive summary judgment--a plaintiff who terminates therapeutic measures following the accident, while claiming serious injury, must offer some reasonable explanation for having done so. Here, the Court found, the plaintiff provided no explanation as to why he failed to pursue any treatment for his injuries after the initial six-month period, nor did his doctors. Accordingly, the Court ruled, the defendants' motion for summary judgment dismissing the complaint had been correctly granted.

Gap in treatment has become a prominent factor in summary judgment motions in recent no-fault cases. Certainly a plaintiff might be able to adequately explain a gap in treatment where his or her injuries received no outside attention, such as if a physician determined that further medical therapy would have been unhelpful. However, the Court's decision in **Pommells** emphasizing the significance of treatment gaps is likely to provide trial and appellate courts with a valuable road map for deciding whether plaintiff has satisfied the serious injury threshold.

For years the rule in New York has been that where a contract of primary insurance requires notice as soon as practicable after an occurrence, claim, or lawsuit, the absence of timely notice of an occurrence, claim, or lawsuit is a failure to comply with a condition precedent that, as a matter of law, vitiates the contract--and no showing of prejudice suffered by the carrier by the late notice is required.[7]

The Court has applied the no-prejudice rule in various contexts in recent years.[8] Three years ago, however, in **Matter of Brandon**, it held that an insurance carrier must show prejudice before disclaiming based on late notice of a lawsuit in the context of supplementary underinsured motorist insurance (SUM).[9]

Some suggested that the **Brandon** ruling presaged an end to the no-prejudice rule generally. In three cases this past term, the Court was presented with an opportunity to reaffirm, change, or otherwise modify the no-prejudice rule. The Court issued a decision in **Rekemeyer v. State Farm Mutual Automobile Ins. Co.**, a case in which the author and his firm submitted an amicus brief on behalf of the Complex Insurance Claims Litigation Association in support of the insurance carrier. The decision once again required a carrier to demonstrate prejudice arising from late notice of a suit in a SUM case--at least where the policyholder gave timely notice of the accident and made a claim for no-fault benefits soon thereafter.[10]

Rekemeyer arose on May 8, 1998, when plaintiff Cynthia Rekemeyer's vehicle allegedly was rear-ended while she was driving it. Shortly after the accident occurred, she notified her auto insurer and made a claim for no-fault benefits. On April 27, 1999, the plaintiff filed suit against the driver of the other car. By

letter dated July 21, 1999, the plaintiff notified her auto insurer of the lawsuit. In September 1999, the plaintiff learned that the defendant's maximum liability coverage was $50,000. The following March, the plaintiff notified her insurer that she would pursue Supplementary Uninsured/Underinsured Motorist (SUM) coverage under her own policy. After the insurance carrier disclaimed coverage based upon the plaintiff's failure to notify it of the SUM claim as soon as practicable and because of failure to notify it immediately of the lawsuit, the plaintiff brought suit.

The Court ruled that the facts of the case warranted a showing of prejudice by the plaintiff's insurance carrier. Here, it noted, the plaintiff gave timely notice of the accident and made a claim for no-fault benefits soon thereafter. In the Court's view, that notice was sufficient to promote the policy objective of curbing fraud or collusion. Moreover, it continued, the record indicated that the insurer undertook an investigation of the accident, requiring the plaintiff to undergo medical exams in December 1998 and February 2000. Under these circumstances, the Court held that where an insured previously gives timely notice of the accident, the carrier must establish that it is prejudiced by a late notice of SUM claim before it may properly disclaim coverage.

The Court reached a different result in a memorandum decision in **Great Canal Realty Corp. v. Seneca Ins. Co., Inc.**,[11] and in **The Argo Corp. v. Greater New York Mutual Insurance Co.**[12]**Argo**, a case in which the author and his firm submitted an amicus brief in support of the insurance carrier on behalf of the Complex Insurance Claims Litigation Association, arose on Jan. 2, 1997, when Igo Maidenek slipped and fell on ice on the sidewalk adjacent to a building in Kew Gardens, New York. On Feb. 23, 2000, Igo Maidenek brought suit against Argo Corporation, the property manager, for personal injuries. On Nov. 10, 2000, Argo was served with a default judgment. On Feb. 13, 2001, Argo received a notice of entry of the default judgment and of the scheduling of a hearing on that judgment.

Argo notified Greater New York Mutual Insurance Company (GNY), its commercial liability insurance carrier, on May 2, 2001. Soon thereafter, GNY disclaimed coverage because of the late notice of the occurrence and lawsuit.

Argo brought a declaratory judgment action against GNY challenging its disclaimer. The trial court granted judgment to the insurance carrier. The judgment was affirmed by the Appellate Division and then the Court of Appeals. The Court reasoned that a liability insurer requires timely notice of lawsuit to take an active, early role in the litigation process and in any settlement discussions and to set adequate reserves. It then stated that late notice of lawsuit in the liability insurance context is so likely to be prejudicial to these concerns as to justify the application of the no prejudice rule. In the Court's view, Argo's delay was unreasonable as a matter of law and thus its failure to timely notify GNY vitiated the insurance contract. GNY was not required to show prejudice before declining coverage for late notice of the lawsuit, the Court concluded.

Insurance Law 3420 grants an injured plaintiff the right to sue a tortfeasor's insurance company to satisfy a judgment obtained against the tortfeasor. The issue presented in **Lang v. Hanover Insurance Co.**[13] was whether an injured party may bring a declaratory judgment action against an insurance company before securing a judgment against a tortfeasor. The question arose after plaintiff David Lang was injured when he was struck in the eye while playing paintball at the home of John and Elizabeth Durbin. The paintball shot was fired by Richard Bachman, a houseguest of the Durbins. When notified of the incident, Hanover Insurance Company, the homeowners' liability insurance carrier, promptly disclaimed coverage for Mr. Bachman's acts on the ground that Mr. Bachman was not an insured party under the terms of the policy.

After the plaintiff filed a personal injury action against Mr. Bachman seeking damages for his allegedly negligent conduct, he learned that Mr. Bachman had filed a Chapter 7 bankruptcy petition. While the personal injury case was pending, plaintiff also initiated a declaratory judgment action against Hanover challenging the disclaimer of coverage and seeking a declaration that Mr. Bachman was an insured under the Durbin policy and that Hanover therefore was obligated to compensate Mr. Lang for the injuries Mr. Bachman allegedly had caused. Among other arguments, Hanover asserted that the plaintiff lacked standing to sue Hanover directly because he had not yet obtained a judgment against Mr. Bachman. The Court agreed with Hanover.

As the Court explained, Insurance Law 3420 grants an injured party a right to sue the tortfeasor's insurer, but only under limited circumstances-- the injured party must first obtain a judgment against the tortfeasor, serve the insurance company with a copy of the judgment and await payment for 30 days. Compliance with these requirements is a condition precedent to a direct action against the insurance company, the Court found. Once the statutory prerequisites are met, the injured party steps into the shoes of the tortfeasor and can assert any right of the tortfeasor-insured against the insurance company.

Because the plaintiff in this case had not obtained a judgment against Mr. Bachman, the alleged tortfeasor, he could not pursue a direct action against Hanover pursuant to Insurance Law 3420. Moreover, the Court rejected plaintiff's reliance on CPLR 3001, the statute that governs declaratory judgment actions, finding that nothing in CPLR 3001 alters the requirement regarding the injured party's standing to sue a tortfeasor's insurer.

The Court resolved an interesting attorney fee issue in **U.S. Underwriters Insurance Co. v. City Club Hotel, LLC**,[14] another case that reached the Court via certification from the Second Circuit.

The plaintiff here, U.S. Underwriters Insurance Company, issued a commercial general liability policy to City Club Hotel, LLC, and Shelby Realty, LLC, as named insureds, in connection with renovation work City Club was to perform on Shelby's property. While performing the renovation work, Marek Szpakowski, a construction worker employed by City Club, fell from a scaffold and sustained serious injuries. U.S. Underwriters received notice of Marek Szpakowski's claim, disclaimed coverage (but nonetheless provided Shelby a defense), and sought a declaratory judgment that it had no duty to defend or indemnify City Club or Shelby.

The district court found the disclaimer of coverage untimely as a matter of law, but it denied the defendants' motion to recover attorney's fees incurred in successfully defending the declaratory judgment action, ruling that attorney's fees were not warranted because U.S. Underwriters had not breached the duty to defend.

The Court ruled that an insured who prevails in an action brought by an insurer seeking a declaratory judgment that it had no duty to defend or indemnify the insured may recover attorney's fees expended in defending against the declaratory judgment action regardless of whether the insurer provided a defense to the insured.

The Court reasoned that Shelby, a named insured under the policy, was cast in a defensive posture by U.S. Underwriters in their dispute over whether the insurer had a duty to defend and indemnify Shelby in the underlying personal injury action. Further, it noted, Shelby had successfully defended against the insurer's summary judgment motion and thereby had prevailed in the matter. As a result, the Court ruled, Shelby

was entitled to recover attorney's fees. Simply put, Shelby's recovery of attorney's fees was incidental to its insurer's contractual duty to defend.

State Farm Mutual Automobile Insurance Co. v. Mallela[15] began when State Farm, represented by the author and his firm, filed a complaint in the U.S. District Court for the Eastern District of New York seeking a judgment declaring that it need not reimburse the defendants--which it alleged were fraudulently incorporated medical corporations--for assigned claims submitted under the no-fault insurance laws.[16] State Farm contended, in essence, that to obtain payments from an insurance carrier under the requirements of no-fault insurance, the defendants had willfully evaded various New York laws prohibiting non-physicians from having any ownership interests in medical corporations.[17]

According to the complaint, the unlicensed defendants had paid physicians to use their names on paperwork filed with the state to establish medical corporations. Once the medical corporations were established, the non-physicians actually operated the companies. To maintain the appearance that the physicians owned the entities, the non-physicians caused the corporations to hire management companies owned by the non-physicians, which billed the medical corporations inflated rates for routine services. In this manner, State Farm alleged, the actual profits did not go to the nominal owners but were channeled to the non-physicians who owned the management companies.

The Court of Appeals unanimously held that a fraudulently incorporated medical corporation is not entitled to be reimbursed by insurers for medical services rendered by licensed medical practitioners. The Court rejected the defendants' argument that they were entitled to reimbursement even if they were fraudulently incorporated because the actual care that patients received was within the scope of the licenses of those who treated the patients. The Court explained that the reimbursement goes to the medical service corporation that exists to receive payment only because of its willfully and materially false filings with state regulators. It then concluded that insurance carriers may look beyond the face of licensing documents to identify willful and material failure to abide by state and local law.

Fraud in the no-fault regime has been identified as correlative with the corporate practice of medicine by non-physicians. The Court's decision should help combat the rapidly growing incidences of such fraud, to the benefit of consumers and taxpayers alike.

The Court also issued other personal injury related decisions of note this past term, including **Raymond Corp. v. National Union Fire Ins. Co.**,[18] where a divided Court held that a vendor's endorsement in a commercial general liability policy did not cover personal injury claims allegedly caused by the vendor's independent acts of negligence but that it only covered claims stemming from a defective product.

An appeal that the Court will decide in its upcoming term also stems from personal injury claims. In **Maroney v. N.Y. Cent. Mut. Fire Ins. Co.**,[19] the Court will examine the applicability of uninsured premises and business pursuits exclusions in a policy issued to a home-based day care center in a case seeking damages for personal injuries allegedly suffered by a child at the center. The Court's ruling in this case, as its decisions this past term, should help to clarify important insurance law issues that frequently arise in practice.

1. No. 86 (July 1, 2003).

2. 1 N.Y.3d 64.

3. 2004 N.Y. Lexis 1608.

4. 2005 N.Y. Lexis 1041.

5. See Insurance Law 5102(d).

6. Insurance Law 5104(a).

7. See, e.g., Security Mut. Ins. Co. of NY v. Acker-Fitzsimons Corp., 31 N.Y.2d 436.

8. See, e.g., Matter of Metropolitan Prop. & Cas. Ins. Co. v. Mancuso, 93 N.Y.2d 487 (supplementary underinsured motorist insurance); American Home Assur. Co. v. International Ins. Co., 90 N.Y.2d 433 (excess insurance).

9. Matter of Brandon (Nationwide Mut. Ins. Co.), 97 N.Y.2d 491.

10. 4 N.Y.3d 468.

11. See, also, Great Canal Realty Corp. v. Seneca Ins. Co., Inc., 2005 N.Y. Slip. Op. 05115 (reaffirming that a carrier need not show prejudice before disclaiming based on the insured's failure to timely notify it of an occurrence).

12. 4 N.Y.3d 332.

13. 3 N.Y.3d 350.

14. 3 N.Y.3d 592.

15. 4 N.Y.3d 313.

16. See Insurance Law 5101, et seq.

17. See e.g. Business Corporations Law 1507 (A professional service corporation may issue shares only to individuals who are authorized by law to practice in this state a profession which such corporation is authorized to practice.).

18. 2005 N.Y. Lexis 1462.

19. 2005 N.Y. Lexis 62.

Evan H. Krinickis a partner with Uniondale's Rivkin Radler. He and his firm represented one of the defendants in 'Pommells v. Perez' and State Farm in 'State Farm Mutual Automobile Insurance Co. v. Mallela.' The cases are discussed in this article. Mr. Krinick and his firm also submitted amicus briefs on behalf of the Complex Insurance Claims Litigation Association in the cases 'Rekemeyer v. State Farm Mutual Automobile Ins. Co.' and 'The Argo Corp. v. Greater New York Mutual Insurance Co.,' also discussed in this article.

Load-Date: August 7, 2011

End of Document

GRAPPLING WITH POLICY SCOPE AND EXCLUSIONS; Court Of Appeals: Year In Review; A New York Law Journal Special Section; Insurance Law

New York Law Journal

September 11, 2006 Monday

New York Law Journal

Section: Pg. 33, (col. 1); Vol. 236

Length: 2669 words

Byline: Evan H. **Krinick**

Body

Court Of Appeals: Year In Review

A New York Law Journal Special Section

Insurance Law

THE WIDE RANGE of insurance law issues resolved by the Court of Appeals this past term arose under homeowner's and automobile liability insurance policies and included a class action against insurers and an important lead paint litigation matter. In a break from recent tradition, the Court did not accept or decide any significant certified question on insurance law from the U.S. Court of Appeals for the Second Circuit. Interestingly, rather than the unanimous insurance law decisions so often rendered by the Court in recent terms, this past term also featured dissents in two key rulings. More importantly, both carriers and policyholders emerged with favorable rulings.[1]

Arising Out Of

Maroney v. New York Central Mutual Fire Ins. Co.[2] involved a horse stable located on property owned by Deborah Morris across the road from her home. Before she established the business, the property had been insured as part of a homeowner's policy issued by the New York Central Mutual Fire Insurance Company (NYCM). Once Ms. Morris began boarding horses for a fee, the policy was amended to remove coverage for the property where the stable was located, and Ms. Morris obtained a separate policy from another insurer for the business.

In the summer of 1997, Ms. Morris' 14-year-old daughter agreed to care for a 6-year-old boy. One morning, Ms. Morris took the boy across the road to the stable, where she proceeded to feed and turn out two boarded horses. As she was leading one of the horses to pasture, the horse kicked the boy in the forehead, causing serious injury.

Ms. Morris notified NYCM. The insurer disclaimed coverage based on, among other things, the policy's uninsured premises exclusion, which provided that coverage for personal liability did not apply to bodily injury or property damagearising out of a premisesowned by an insuredthat is not an insured location. The boy's mother filed suit against NYCM, seeking a declaration that the company had a duty to defend and indemnify Ms. Morris in a personal injury action for damages for the boy's injuries. The carrier counterclaimed and commenced a third-party action against Ms. Morris, also seeking a declaration of its obligations under the policy.

Supreme Court, Otsego County, ordered NYCM to defend and indemnify Ms. Morris, but a divided Appellate Division reversed. It found that the injury arose out of the uninsured premises and, therefore, the exclusion was applicable.

On appeal, the boy's mother contended that the exclusion was inapplicable because the allegedly negligent conduct of Ms. Morris, not the physical condition of the premises, caused the boy's injuries. For its part, the insurance carrier argued that the term arising out of pertained to both the physical condition of the premises and to conduct related to the use of the uninsured premises that was causally connected to the injury. The Court, in a decision by Judge Carmen Beauchamp Ciparick, agreed with the carrier.[3]

The Court explained that the phrase arising out of requires only that there be some causal relationship between the injury and the risk for which coverage is provided. The Court declared that, when reviewing the allegedly injurious conduct and its causal relationship to the premises in this case, it was clear that the boy's injury, the consequence of a horse's kick, was causally related to the purpose for which the uninsured property was being used: the care and boarding of horses. Specifically finding that the policy language was not ambiguous,[4] the Court concluded that because there existed a sufficient causal connection between the injury to the child and the purpose for which the premises was used, the injury arose out of such premises, and the uninsured premises exclusion precluded coverage.

It remains to be seen whether the Court's expansive interpretation of arising out of in the exclusion in the NYCM policy will affect its interpretation of that clause in a policy's insuring agreement or in other exclusions.

A homeowner's insurance policy also was at the heart of the decision by the Court in **Automobile Ins. Co. of Hartford v. Cook**.[5] This case arose after Alfred Cook shot and killed Richard Barber. Witnesses testified that Mr. Barber had burst into Mr. Cook's home and menacingly started advancing toward Mr. Cook, who warned him that he would shoot if he came any closer. There was further testimony that Mr. Cook aimed his gun toward the lowest part of Mr. Barber's body that was not obscured by the pool table at which he was standing and that when Mr. Barber was about one step away from the barrel of the gun, Mr. Cook fired a shot into his abdomen; Mr. Barber died later that day at a hospital.

A jury acquitted Mr. Cook, who raised a justification defense, of intentional and depraved indifference murder and of the lesser included offenses of manslaughter in the first and second degrees. The administrator of Mr. Barber's estate then commenced a wrongful death action against Mr. Cook alleging, among other things, that injury to the decedent and the decedent's death were caused by [Mr. Cook's] negligence.

Mr. Cook sought coverage from his homeowner's insurer, which disclaimed coverage on the ground that the incident was not an occurrence within the meaning of the insuring agreement of the policy and

furthermore that the injury inflicted upon Mr. Barber fell within a policy exclusion for bodily injury which is expected or intended by any insured. The insurer commenced an action seeking a declaration that it was not obligated to defend or indemnify Mr. Cook in the wrongful death action.

Supreme Court, Albany County, found that the insurer had a duty to provide a defense, but the Appellate Division reversed, concluding that because Mr. Cook had intentionally shot Mr. Barber, his actions could not be considered an accident or occurrence and, thus, were not covered by the policy. The appellate court also found that the acts came within the policy exclusion for bodily injury expected or intended by the insured.

On appeal, the Court stressed that the complaint alleged that Mr. Cook had negligently caused Mr. Barber's death. It then ruled that, if such allegations could be proven, they would fall within the scope of the policy as a covered occurrence. The Court said that the policy defined an occurrence as an accident, and that, 30 years ago, it had defined the term accident to pertain not only to an unintentional or unexpected event which, if it occurred, would foreseeably bring on death, but equally to an intentional or expected event which unintentionally or unexpectedly has that result.[6] Thus, the Court found, if Mr. Cook had accidentally or negligently caused Mr. Barber's death, such event could be considered an occurrence within the meaning of the policy and coverage would apply.

The Court similarly rejected the insurer's reliance on the expected or intended exclusion. It stated that because an allegation of negligence implied an unintentional or unexpected event, the insurer necessarily has failed to demonstrate that the allegations of the complaint are subject to no other interpretation than that Cook 'expected or intended the harm to Barber. The Court therefore concluded that the insurer was required to defend Mr. Cook in the underlying wrongful death action.

Without deciding whether the insurer will ultimately be required to indemnify Mr. Cook, the Court reaffirmed its expansive view of the duty to defend and further isolates its ruling in **Allstate Ins. Co. v. Mugavero**,[7] which found no duty to defend in a suit for sexual abuse or sexual assault. The Court also left unresolved whether acts of self defense are intentional acts precluding coverage under a homeowner's policy, an issue it no doubt will have to face in the future.

Notice on Coverage

Three years ago, in **First Financial Ins. Co. v. Jetco Contracting Corp.**,[8] the Court decided that an insurer's unexcused 48-day delay in notifying an insured of denial of coverage was unreasonable as a matter of law. Last term's decision in **Matter of New York Central Mutual Fire Ins. Co. v. Aguirre**[9] can be seen as a straightforward application of **Jetco** or, as suggested in a dissent by Judge Robert S. Smith, in which Judge Susan Phillips Read concurred, a ruling that places an unreasonable and unnecessary burden on the insurance company.

Three people allegedly were injured while sitting in a car that was hit by an unidentified hit-and-run driver. The insurance policy that had been issued to the car owner included Supplementary Uninsured/Underinsured Motorists (SUM) coverage that required that, [a]s soon as practicable after our written request, the insured or other person making claim shall give us written proof of claim upon forms we furnish.

On Aug. 15, 2002, an attorney representing the three injured people sent a letter to the insurer to make a claim under the policy's SUM provisions. On Sept. 3, 2002, the insurer sent a letter to the attorney acknowledging the three claims and stating that it required the immediate completion and return of the enclosed Notice of Intention to Make Claim forms, which asked for information about the accident and claimants' injuries. The letter also stated that failure to cooperate will jeopardize any rights which you may have under this policy for us to make Supplementary Uninsured Motorists payments, but did not include a precise deadline.

The three claimants never filled out and returned the forms. The insurer did not disclaim coverage until it sought to stay the claimants' request for uninsured motorist arbitration. The Court of Appeals held the disclaimer to be untimely. It pointed out that Insurance Law 3420(d) requires insurers to disclaim liability as soon as reasonably possible. In this case, it continued, the insurer's Sept. 3, 2002, letter directed the immediate completion and return of the notice of claim forms yet the insurer did not seek to deny coverage until June 19, 2003. Because that delay was not as soon as reasonably possible, the Court ruled that the insurer had not met its 3420(d) obligations.

In Judge Smith's view, the insurer acted reasonably here. It demanded, as was its right, a proof of claim form and then waited to see when and if the claimants sent in the form. Judge Smith stated that the insurer no doubt assumed, quite appropriately, that until the form arrived it was in no position to judge whether the claimants had submitted the form as soon as practicable, as required by the SUM endorsement. Moreover, Judge Smith declared, the carrier also could reasonably assume that, if it never received the form, it could forget about the claim. Judge Smith was concerned that the Court's decision, permitting claimants who have never submitted proof of their claim to recover, would open the door to claims that are spurious or fraudulent.

To limit their exposure, it is likely that, as the Court pointed out, insurers in the future will set a firm deadline for return of a proof of claim form and promptly disclaim after the expiration of the deadline if the requested information is not received.

The C.O.D. Option

Life insurers typically provide their new policyholders with two options for payment: they can pay at the time they submit their application and receive temporary coverage until the delivery of the policy, or they can pay at the time their policy is delivered and have coverage become effective upon receipt of the first initial premium and delivery of the policy. This second option is known as the cash on delivery (C.O.D.) option.

The plaintiffs in **Goldman v. Metropolitan Life Ins. Co.**[10] all chose the C.O.D. option and then brought class actions arguing that there is a breach of an insurance contract when a policy date is set prior to an effective date and the insured, in the first year of the policy, pays for days that are not covered.

The Court unanimously rejected all of the claims and affirmed dismissal of the complaint on a pre-answer motion. With respect to the plaintiffs' breach of contract claims, the Court pointed out that the applications clearly stated the terms and conditions of the insurance policies and when coverage would begin. It found nothing in the policies suggesting that coverage would start from the policy date without the payment of a premium.

The Court also rejected the plaintiffs' claims for unjust enrichment, simply finding that the theory of unjust enrichment lies as a quasi-contract claim and there could be no unjust enrichment because the matter was controlled by contract.

Finally, the Court also rejected an assertion that there was a breach of General Business Law 349, which makes unlawful deceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state. The Court concluded that the plaintiffs had not properly alleged any deceptive practices.

Non-Cumulation Clauses

The insurance carrier in **Hiraldo v. Allstate Ins. Co**.[11] issued a $300,000 liability policy for a term of one year to the owners of a building in Brooklyn. Upon its expiration, the policy was renewed for another year, and then again for a third. The plaintiff child allegedly was exposed to lead paint continuously during the terms of all three policies and was awarded $700,000 in damages. The question before the Court was whether the available insurance coverage was $300,000 or $900,000.

The Court based its decision on the fact that each policy contained a non-cumulation clause. As the Court explained, each non-cumulation clause stated that regardless of the number ofpolicies involved, [Allstate's] total liability under Business Liability Protection coverage for damages resulting from one loss will not exceed the limit of liabilityshown on the declarations page. That limit was $300,000, and thus Allstate was liable for no more, the Court concluded.

Next Term

The Court already has agreed to hear two insurance law cases of note in its upcoming term. In **Appalachian Ins. Co. v. General Electric Co.**,[12] the Court again will explore the definition of occurrence, this time in the context of the availability of excess coverage. In **Great Northern Ins. Co. v. Interior Construction Corp.**,[13] the Court will review a First Department decision regarding insurance coverage in light of the general rule that lease provisions purporting to exempt a commercial lessor from liability for its own negligence are void as against public policy.

1. In another interesting decision from this term, **Hoffend & Sons, Inc. v. Rose & Kiernan, Inc.**, 2006 N.Y. Lexis 1398, the Court reaffirmed the rule of **Murphy v. Kuhn**, 90 N.Y.2d 266, limiting the potential liability of insurance brokers to their customers, but did not address the significance, if any, of a policyholder receiving a policy, having the opportunity to read it, but requesting no changes to it.

2. 5 N.Y.3d 467.

3. Interestingly, in a footnote, the Court avoided the issue it resolved last term in **Lang v. Hanover Ins. Co.**, 3 N.Y.3d 350, finding that Insurance Law 3420 bars an injured party from bringing a declaratory judgment action against an insurance company before securing a judgment against the tortfeasor, by emphasizing that NYCM had joined Ms. Morris in seeking a declaration of its rights.

4. Judge Albert M. Rosenblatt, in dissent, found an ambiguity in the phrase arising out of a premises, declaring that it did not, without strain, refer to the conduct of the insured but was more easily read to refer to injuries causally connected to a dangerous condition of the premises.

5. 2006 N.Y. Lexis 1400.

6. **Miller v. Cont. Ins. Co.**, 40 N.Y.2d 675, 678.

7. 79 N.Y.2d 153.

8. 1 N.Y.3d 64.

9. 2006 N.Y. Lexis 1484.

10. 5 N.Y.3d 561.

11. 5 N.Y.3d 508.

12. 6 N.Y.3d 741.

13. 6 N.Y.3d 705.

Evan H. Krinick is a partner with Uniondale's Rivkin Radler. He and his firm filed an amicus brief on behalf of the Property Casualty Insurers Association of America in Hiraldo v. Allstate Ins. Co., discussed in this article.

Load-Date: August 7, 2011

End of Document

Coverage Issues Result in Unanimous Rulings; News

New York Law Journal

September 10, 2007 Monday

New York Law Journal

Section: Pg. p. S9, col. 1; Vol. 238; No. 49

Length: 2413 words

Byline: Evan H. **Krinick**

Body

IN THIS PAST TERM, the New York Court of Appeals issued a series of unanimous rulings on a variety of insurance law topics. The cases included a constitutional challenge to a health insurance statute, a ruling on additional insured coverage under a comprehensive general liability (CGL) insurance policy, the interpretation of a no-fault regulation and an Insurance Law statute governing disability insurance, and an examination of 'occurrence' in liability policies.

Coverage for Contraception

It is not often that federal and state constitutional provisions protecting religious freedom are at issue in insurance law cases. *Catholic Charities of the Diocese of Albany v. Serio*[1] was such a case. *Catholic Charities* was an action against the Superintendent of Insurance challenging provisions of the state's Women's Health and Wellness Act (WHWA) requiring health insurance policies that provide coverage for prescription drugs to include coverage for contraception.[2] The plaintiffs, 10 faith-based social service organizations that objected to the contraceptive coverage mandated in the WHWA, contended that the statute's exemption for "religious employers," pursuant to which an employer could request an insurance contract "without coverage for...contraceptive methods that are contrary to the religious employer's religious tenets,"[3] was unconstitutionally narrow and that they were entitled to be exempt from the provisions of the WHWA providing for coverage of contraceptives. In an opinion by Judge Robert S. Smith, the Court unanimously rejected their arguments.

The Court first found that the plaintiffs' federal free exercise claim was barred by the U.S. Supreme Court's decision in *Empl. Div. v Smith*,[4] which held that the right of free exercise does not relieve an individual of the obligation to comply with a "valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes)." Here, the Court found, the burden on the plaintiffs' religious exercise was the incidental result of a "neutral law of general applicability," one requiring health insurance policies that included coverage for prescription drugs to include coverage for contraception.

It next observed that, under the state constitution's free exercise provision,[5] when the state imposes "an incidental burden" on the right to free exercise of religion, courts had to consider the interest advanced by the legislation that imposed the burden, and that the respective interests had to be balanced to determine whether the incidental burdening was justified. That balancing, the Court ruled for the first time, required that "substantial deference" be given to the legislature, and that the party claiming an exemption had the burden of showing that the challenged legislation, as applied to that party, was an unreasonable interference with religious freedom. Applying this test, the Court found that the choice the Legislature made was not an unreasonable interference with the plaintiffs' exercise of their religion, and that the WHWA therefore was not unconstitutional.

Additional Insured

The Appellate Divisions have issued conflicting decisions about additional insured coverage under CGL policies. *BP Air Conditioning Corp. v. One Beacon Insurance Group*[6] addresses some of the issues in the duty to defend context. The plaintiff, BP, was a subcontractor whose agreement with another subcontractor, Alfa, required BP to be named as an additional insured on a CGL policy. After an employee of another subcontractor allegedly was injured and brought suit, BP tendered its defense in that action to Alfa's insurer. The insurer declined to defend BP, although it defended Alfa in the underlying action. The insurer contended that under the language of the additional insured endorsement, BP was not an additional insured under its policy until it was determined that the employee's alleged injury arose out of its insured's activities.

In an opinion by Judge Carmen Beauchamp Ciparick, a unanimous Court first found that the standard for determining whether an entity is an additional insured entitled to a defense is no different than the usual inquiry to determine if a named insured is entitled to a defense. Noting that a duty to defend is triggered by the allegations contained in the underlying complaint, the Court pointed out that, in this case, the employee alleged that Alfa, BP's subcontractor, had been engaged in construction work at the work site where he was injured, that Alfa had breached its duty to keep the work site safe, and that Alfa's breach had caused his injuries.

These allegations, the Court ruled, formed a factual and legal basis on which the insurer "might eventually be held to be obligated to indemnify [BP] under any provision of the insurance policy" and "certainly" brought the claim "within the ambit of the protection purchased." Simply put, because there was a possibility that the employee's injuries arose out of Alfa's ongoing operations performed for BP, the insurer's obligation to provide BP with a defense was triggered.[7]

Priority of Payment

No-fault insurance is one of the most active and growing areas of insurance litigation. One such case reached the Court of Appeals this term. In *Nyack Hospital v. General Motors Acceptance Corp.*,[8] the Court interpreted the priority-of-payment regulation[9] in a no-fault insurance context. The issue arose after an individual who was injured in an automobile accident was treated by Nyack Hospital for his injuries. The injured person was covered under an automobile insurance policy that contained the mandatory no-fault endorsement, providing coverage for basic economic loss up to $50,000 per person/per accident, with additional coverage for optional basic economic loss of $25,000 per person.

The hospital, as the patient's assignee, completed and sent the insurer the proper forms for claiming no-fault benefits for medical services rendered to the patient during his hospital stay. The insurer received

these forms on Aug. 20, 2003; the hospital's claim totaled $74,489.28. The insurer then sought additional verification of the claim in the form of the patient's complete inpatient hospital records. Meanwhile, the insurer paid other claims for the patient's lost earnings and from other health service providers so that only about $19,325.67 of the $50,000 basic economic loss coverage was available to be paid to the hospital; all the personal injury protection and medical benefits under the policy also were exhausted by the time the insurer received the verification it had requested from the hospital.

The hospital brought suit, alleging that the insurer had violated the no-fault regulation governing priority of payment when it paid health service providers who submitted their claims after Aug. 20, 2003, before paying the hospital's claim. The hospital argued that once it submitted the requisite forms to make a claim that caused aggregate claims to exceed $50,000, the insurer had a duty under the priority-of-payment regulation "to keep the money that was due [the hospital] in reserve (up to the policy limits)" of $50,000. The Court disagreed with the hospital in a unanimous opinion by Judge Susan P. Read.

As the Court noted, the no-fault regulations contemplate that an insurer must pay or deny only a verified claim - that is, a claim that has been verified to the extent compliance with the applicable regulations dictate in the particular case - within 30 calendar days of receipt, and conversely, is not obligated to pay any claim until it has been so verified. It then declared that to adopt the priority-of-payment regime advocated by the hospital, it would have to interpret "claims" in the priority-of-payment regulation to encompass claims that had not been appropriately verified. This approach, the Court stated, ran counter to the no-fault regulatory scheme, which was designed to promote prompt payment of legitimate claims. For example, under the hospital's theory, the insurer in this case could not have paid any verified claims submitted after Aug. 20, 2003, by other health service providers even though the regulations clearly required the insurer to pay these claims within 30 calendar days after receipt.

In conclusion, the Court found that the priority-of-payment regulation came into play only when the insurer received the requested inpatient hospital records from the hospital, which established verified claims aggregating more than $50,000. At that point, the hospital was entitled to be paid ahead of any other unpaid verified claims for services rendered or expenses incurred later than the services billed by the hospital, up to the policy's limits.

Portability Provision

On the same day the Court decided *BP Air Conditioning*, it decided *Benesowitz v. Metropolitan Life Ins. Co.*,[10] a case in which the U.S. Court of Appeals for the Second Circuit asked the Court to decide how Insurance Law 3234(a)(2) affects an employee's eligibility to receive benefits under the employer's group disability plan when the disability is caused by a pre-existing medical condition.

This case arose when the plaintiff began a new job with Honeywell International, Inc., and was immediately covered under Honeywell's short- and long-term group disability insurance plans. In the three months preceding his Honeywell employment, the plaintiff had been treated for kidney disease. After working at Honeywell for several months, he apparently decided that he could no longer work and applied for, and received, short-term disability benefits.

The plan administrator denied the plaintiff's request for long-term disability benefits based on the plan's "pre-existing condition" provision. The plaintiff argued that that provision conflicted with Insurance Law 3234(a)(2), which provides that "no pre-existing condition provision shall exclude coverage for a period in excess of twelve months following the effective date of coverage for the covered person." The question

certified to the Court by the Second Circuit was whether that section means that (1) a policy may impose a 12-month waiting period during which no benefits will be paid for disability stemming from a pre-existing condition and arising in the first 12 months of coverage or (2) a policy may lawfully include a permanent absolute bar to coverage of disabilities resulting from pre-existing conditions that trigger disability within the first 12 months of the employee's coverage.

The unanimous opinion by Judge Victoria A. Graffeo stated that it was instructive to examine 3232, a health insurance statute that also places limitations on pre-existing condition provisions in health insurance policies. The Court observed that both statutes contain a portability provision requiring insurers to credit the time a person previously was covered under a comparable plan for purposes of determining the applicability of a pre-existing condition provision. In particular, both statutes prescribe a 12-month maximum time frame for pre-existing condition provisions.

The Court noted that under 3232(b), the health insurance provision, although insurers may limit or preclude coverage for medical claims stemming from pre-existing conditions during the first 12 months (assuming there is no portability of coverage), the insurers must cover such claims thereafter. Section 3232(b) therefore functions as a tolling or waiting period because it mandates full health coverage - even for pre-existing medical conditions - once the 12-month period expires. "Insurers are not permitted to bar health coverage completely" under 3232(b).

The Court then ruled that, if insurers may exclude health coverage for up to 12 months under 3232 but must pay benefits for medical claims related to pre-existing conditions after that time period, the statute "should operate the same way for group disability plans" under 3234(a)(2). Accordingly, it held that Insurance Law 3234(a)(2) means that a policy may impose a 12-month waiting period during which no benefits will be paid for a disability stemming from a pre-existing condition and arising in the first 12 months of coverage.

'Occurrence'

Another unanimous opinion by Judge Graffeo considered the definition of 'occurrence' in liability policies issued to General Electric for asbestos-related personal injuries. In *Appalachian Ins. Co. v. General Electric Co.*,[11] the excess insurers argued that each claim by an injured plaintiff represented a separate occurrence. General Electric, which sought to combine claims to reach the $5 million per-occurrence policy limit in the underlying policies, contended that all litigation arising from a single product was a single occurrence because each claim could be traced to a single act of negligence. (One of the excess insurers was represented by the author's firm.)

The Court ruled in favor of the excess insurers, relying on and reaffirming the various factors to be applied to distinguish a single occurrence from multiple occurrences: whether there is a close temporal and spatial relationship between the incidents giving rise to injury, and whether the incidents can be viewed as part of the same causal continuum. Applying these factors, the Court found these were "unquestionably" multiple occurrences.

1. 7 NY3d 510 (2006).

2. Insurance Law 3221(l)(16), 4303 (cc).

3. Insurance Law 3221(l)(16)(A); 4303 (cc)(1).

4. 494 U.S. 872 (1990).

5. Article I, 3.

6. No. 93 (June 27, 2007).

7. The Court rejected the lower court's conclusion that the insurer's coverage was primary and BP's coverage under its own policy was excess, finding that to determine the priority of coverage among different policies, a court must review and consider all of the relevant policies at issue. Here, however, because none of the other insurance carriers were parties to the action and no other relevant policies had been submitted, the priority of coverage could not be determined. Significantly, the Court declined to consider the priority of coverage issue based on the agreements between the contractor and the subcontractors, finding that the insurance policies themselves had to be examined.

8. 8 NY3d 294 (2007).

9. 11 NYCRR 65-3.15.

10. No. 92 (June 27, 2007).

11. 8 NY3d 162 (2007).

Evan H. Krinick, a partner with Uniondale's Rivkin Radler, regularly represents insurance companies and other clients in appeals in state and federal court. He can be reached at evan.krinick@rivkin.com

Load-Date: August 7, 2011

From Damages Claims to No Fault, Opinions Covered Wide Territory

New York Law Journal (Online)

September 2, 2008 Tuesday

New York Law Journal

Length: 2986 words

Byline: Evan H. **Krinick**,, web-editor@nylj.com, , Special to the new york law journal

Body

If one had to summarize the past term's insurance law decisions in one word, it might be "diverse." The Court of Appeals explored a wide range of issues involving different types of insurance products; ruled in some instances for insurance companies and in others for policyholders; was mostly unanimous but had a number of dissents; affirmed and reversed the Appellate Division equally; had more judges write more significant insurance law opinions than any term in recent memory; and decided an important case, **Certain Underwriters at Lloyd's, London v. Foster Wheeler Corp.**,[1] an action that resolved the apportionment of responsibility for the defense and indemnity costs of hundreds of thousands of asbestos-related personal injury claims by a thorough choice of law analysis, by adopting the decision of the Appellate Division, First Department, authored by Justice David Friedman.

2

The Court's opinions that are likely to have the most widespread impact in the future resolved disputes involving coverage for additional insureds, policyholders' settlement obligations to insurers under professional liability policies, insurers' liability for consequential damages, and the interpretation of various regulations in the no fault arena. They are discussed below.

Additional Insureds

Worth Construction Co. Inc. v. Admiral Ins. Co.[3] returned the Court to the additional insured coverage area following last year's significant decision in **BP Air Conditioning Corp. v. One Beacon Insurance Group**.[4] The **Worth Construction** case arose when the owner of real property in White Plains retained Worth Construction Co. Inc., as general contractor for the construction of an apartment complex. Pacific Steel Inc., a subcontractor, provided commercial general liability insurance through Farm Family Casualty Insurance Company, which covered Worth and the property owner as additional insureds.

Pacific was to construct the staircase and then, after walls were erected around the stairs, it was to affix the handrails to the walls. After the stairs had been installed but before the walls had been raised, an iron worker allegedly was injured when he slipped on fireproofing that had been applied to the stairs by another subcontractor. The iron worker brought suit against the property owner and Worth. Because the complaint alleged that the iron worker was injured on the staircase, Worth forwarded a copy of the complaint to Farm Family. Worth subsequently brought suit against Farm Family, seeking defense and indemnification in the iron worker's action.

The Court, in a unanimous opinion by Judge Eugene F. Pigott Jr., noted that the policy's additional insured endorsement stated that Worth was an additional insured "only with respect to liability arising out of [Pacific's] operations." The Court noted that although the general nature of Pacific's operations involved the installation of a staircase and handrails, an entirely separate company was responsible for applying the fireproofing material on which the iron worker allegedly had slipped. Moreover, the Court continued, at the time of the accident, Pacific was not even on the job site, having completed construction of the stairs and waiting to return to affix the handrails.

In the underlying tort action, Worth had conceded that it had no viable negligence claims against Pacific and all claims against Pacific had been dismissed. Given this, the Court ruled, the staircase was merely the situs of the accident and there was no connection between the accident and the risk for which coverage was intended; it did not "arise out of" Pacific's operations. Accordingly, the Court held, Farm Family was not required to defend or indemnify Worth.

Settling Claims

Professional liability and similar insurance policies (such as directors' and officers' policies) are an extremely important insurance product in today's financial markets. Despite its importance and prevalence, litigation regarding the terms and conditions is relatively infrequent. In contrast to commercial general liability policies and automobile policies, which grant the insurer the right to control settlement, a key provision in such policies often prohibits policyholders from settling claims, or claims in excess of certain thresholds, without their insurance company's consent. Such a provision was at issue in **Vigilant Ins. Co. v. The Bear Stearns Companies Inc**.[5]

Bear Stearns had been issued a primary professional liability insurance policy by Vigilant Insurance Company that provided coverage for losses resulting from claims against Bear Stearns. The policy afforded $10 million in coverage after Bear Stearns exhausted a $10 million self-insured retention. Other insurers provided Bear Stearns with an additional $40 million in coverage under follow-form excess liability policies. Pursuant to the terms of these insurance contracts, Bear Stearns agreed not to settle any claim in excess of $5 million without first obtaining the consent of its insurers.

In early 2002, the U.S. Securities and Exchange Commission (SEC), National Association of Securities Dealers (NASD) and New York Stock Exchange (NYSE), along with state Attorneys General, initiated a joint investigation of practices at Bear Stearns and other institutions. Later that year, Bear Stearns signed a

settlement-in-principle document, and the following April it executed a consent agreement in which it acceded to the entry of a final judgment against it in an SEC lawsuit and agreed to pay a total of $80 million, including a $25 million penalty. Bear Stearns explicitly agreed not to seek insurance coverage for the penalty.

Several days after it executed the consent agreement, Bear Stearns sent letters to its insurers requesting their consent to the settlement. The insurers disclaimed coverage and brought an action seeking a declaration that the $45 million sought by Bear Stearns (after depletion of the $10 million self-insured retention) was not covered by the policies.

The Court, in a unanimous opinion by Judge Victoria A. Graffeo, agreed with the insurance carriers. The Court ruled that Bear Stearns had breached the policy provision obligating it to obtain the insurers' consent prior to settling claims when it executed the consent agreement before notifying the insurers or obtaining their approval. The Court was not persuaded by Bear Stearns' contention that a triable issue of fact existed because the district court had not approved the settlement until it entered a final judgment in October 2003, which was after Bear Stearns had requested the insurers' consent to the settlement. The Court pointed out that the consent agreement contained no provision that made it subject to the insurers' approval and concluded that, because Bear Stearns had elected to finalize all outstanding settlement issues and had executed the consent agreement before informing its carriers of the terms of the settlement, it could not recover the settlement proceeds from its insurers.

Consequential Damages

The principal issue in **Bi-Economy Market Inc. v. Harleysville Ins. Co. of New York**[6] was whether a policyholder could assert a claim for consequential damages against an insurer for its breach of the insurance policy. For the first time, the Court ruled that, under the circumstances of this case, the insured could assert such a claim and seek recovery of damages beyond the policy limits.

The case arose after a fire at the Bi-Economy Market in Rochester. At the time, Bi-Economy was insured by Harleysville Insurance Company under a policy that provided replacement cost coverage on its building as well as business property or "contents" loss coverage. The policy also provided coverage for lost business income, commonly referred to as "business interruption insurance," for up to one year from the date of the fire.

Following the fire, Bi-Economy submitted a claim to Harleysville for actual damages and for lost business income. It later brought suit against Harleysville, alleging that Harleysville had improperly delayed payment for its building and contents damage and, in bad faith, had failed to timely pay the full amount of its lost business income claim. As a result, Bi-Economy argued that Harleysville should be required to pay consequential damages beyond the limits of the policy.

In a decision written by Judge Pigott, the Court explained that, in breach of contract actions, "[t]he party breaching the contract is liable for those risks foreseen or which should have been foreseen at the time the contract was made."[7] To determine whether consequential damages were reasonably contemplated by the

parties, courts look to, among other things, the nature, purpose and particular circumstances of the contract known by the parties. Here, the Court noted, the purpose served by the business interruption coverage was to "ensure that Bi-Economy had the financial support necessary to sustain its business operation in the event disaster occurred." Accordingly, the Court found, the payment of money that should have been paid by the insurer to Bi-Economy in the first place, plus interest, would not place Bi-Economy in the position it would have been in had the contract been performed.

Therefore, the Court held, in light of the nature and purpose of the Harleysville insurance contract and Bi-Economy's allegations that Harleysville had breached its duty to act in good faith, Bi-Economy's claim for consequential damages for the demise of its business was reasonably foreseeable and contemplated by the parties, and thus could not be dismissed on a motion for summary judgment.

The scope of the Court's ruling, and whether it might ever extend beyond business interruption insurance in the limited context in which it arose in **Bi-Economy**, remains to be seen. Interestingly, on the same day it issued its decision in **Bi-Economy**, the Court, in **Panasia Estates Inc. v. Hudson Ins. Co.**,[8] ordered Supreme Court, New York County, to determine whether consequential damages were foreseeable damages as the result of a breach of a commercial property insurance policy that included "Builders Risk Coverage." If that case reaches the Court again, it will give the Court the opportunity to further discuss when consequential damages might, or might not, be payable for a bad faith breach of an insurance contract.[9]

No Fault

No fault litigation continues to overwhelm the dockets of the lower courts, and numerous issues of law are making their way to the Court of Appeals. Last November, in **Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co.**,[10] Judge Graffeo, writing for the Court, discussed New York's no fault automobile insurance system[11] and restated the oft repeated purposes of the system: to ensure prompt compensation for losses incurred by accident victims without regard to fault or negligence, to reduce the burden on the courts, and to provide substantial premium savings to New York motorists.

The Court described the basic no fault regime and explained that an insurance company generally must pay or deny a claim within 30 calendar days after receipt of the proof of claim[12] or generally be precluded from asserting certain defenses against payment of the claim. The Court held that this preclusion remedy applied to a defense asserted in a subsequent litigation that the medical provider did not have an assignment of the claim from its patient and thus lacked standing.[13]

Then, on June 5, in **Fair Price Medical Supply Corp. v. Travelers Indemnity Co.**,[14] the Court once again addressed an important no fault issue. The **Fair Price** case arose on May 8, 2001, after Cesar Nivelo allegedly was injured in a car accident. The following day, a chiropractor prescribed certain equipment and orthotic appliances and, on June 18, a physiatrist prescribed additional devices and equipment.

The Fair Price Medical Supply Corporation claimed to have furnished all these items, and Mr. Nivelo executed "Assignment of Benefits" forms to transfer to Fair Price his right to recover the cost of these medical supplies. Fair Price asked for payment of Mr. Nivelo's no fault benefits from the Travelers Indemnity Company, his no fault insurance carrier. Travelers informed Fair Price that it was "unable to process" the claims "[p]ending verification of the facts of the loss including statements from all parties involved" and letters "of medical necessity."

Fair Price mailed Travelers the requested letters of medical necessity, but Travelers did not pay the claims and it did not deny them until nearly two years after they were first submitted. Travelers' denial was based on an item in a questionnaire titled "No Fault Statement" that asked "What medical supplies did you receive?" In response, the word "none" was handwritten; according to Travelers, this information was given by Mr. Nivelo to Travelers' investigator and was signed by Mr. Nivelo, a witness and a Spanish translator.

Fair Price brought suit against Travelers to recover the cost of the medical supplies it claimed to have provided. Fair Price moved for summary judgment, and Travelers took the position that, at a minimum, the "No Fault Statement" created a triable issue of fact as to whether Mr. Nivelo had ever received the prescribed medical supplies. Travelers maintained that fraudulent claims, such as medical supplies that were never actually delivered, were not subject to the 30-day preclusion remedy.

The Court, in a decision by Judge Susan Phillips Read, explained that the key issue in this case was whether the facts fit within the no-coverage exception to the preclusion rule. The Court reasoned that it had to decide whether Travelers' argument was more like a "normal" exception from coverage (e.g., a policy exclusion), or a lack of coverage in the first instance (i.e., a defense "implicat[ing] a coverage matter"). In the Court's view, a defense that the billed-for services were never rendered was "more akin to the former." Here, the Court observed, "there was an actual accident and actual injuries" and "coverage legitimately came into existence," thus removing this fact pattern "from the realm of cases" where preclusion would "create coverage where it never existed." In a dissent, Judge Robert S. Smith (joined by Judge Pigott, who also had dissented in **Hospital for Joint Diseases**), argued that if the basis for Fair Price's claims were non-existent, those claims were outside the coverage of the policy.

Fair Price is a significant victory for medical providers who can seek recovery of no fault bills from insurers that violate the 30-day rule even if the bills result from non-existent or fraudulent services.

Conclusion

Certainly, there were other notable decisions on insurance disputes this past term, such as **White v. Continental Casualty Co.**,[15] where Judge Pigott, writing for a unanimous Court, found that the definition of "total disability" in a disability income policy was clear and unambiguous and that the plaintiff had failed to establish his entitlement to benefits under a disability policy as a matter of law; **Preserver Ins. Co. v. Ryba**,[16] where a unanimous Court, in an opinion by Chief Judge Judith S. Kaye, found that, in a

dispute between two insurers in a case where a construction worker allegedly suffered a job site injury, that the employers' liability insurance coverage was limited to $100,000, as specified in the policy; **Raffellini v. State Farm Mutual Automobile Ins. Co.**,[17] (in which the author and his firm represented the insurance carrier) where Judge Graffeo, writing for a unanimous Court, found that a "serious injury" exclusion in a supplementary uninsured/underinsured motorist endorsement to an automobile liability policy was enforceable; and **Friedman v. Connecticut General Life Ins. Co.**,[18] (in which the author and his firm represented the insurance carrier) where Judge Read found a retention of earnings clause in a disability policy to be enforceable.

The Court's rulings in all of its insurance law cases this past term reflect the ubiquity and importance of insurance coverage to businesses and individuals in New York, and it seems clear that insurance cases will continue to reach the Court in large numbers for years to come.

Evan H. Krinick, a partner with Uniondale's Rivkin Radler, regularly represents insurance companies and other clients in appeals in state and federal court. He can be reached at .

Endnotes:

1. 9 NY3d 928 (2007).

2. 36 AD3d 17 (1st Dept. 2006).

3. 10 NY3d 411 (2008).

4. 8 NY3d 703 (2007).

5. 10 NY3d 170 (2008).

6. 10 NY3d 187 (2008). The author and his firm submitted an amicus brief in this case on behalf of the New York Insurance Association Inc., National Association of Mutual Insurance Companies, American Insurance Association and Property Casualty Insurers Association of America.

7. **Ashland Mgt. v. Janien**, 82 NY2d 395, 403 (1993).

8. 10 NY3d 200 (2008).

9. Judge Robert S. Smith dissented in **Bi-Economy** and in **Panasia Estates** and was joined by Judge Susan Phillips Read. In Judge Smith's view, the whole idea of "consequential damages" permitted by the majority was disguised punitive damages, which was out of place in a suit against an insurer that had failed to pay a claim, or in any case where the obligation breached was merely to pay money.

10. 9 NY3d 312 (2007). The author and his firm submitted an amicus brief in this case on behalf of the New York Insurance Association Inc.

11. Insurance Law Article 51.

12. See Insurance Law 5106(a); 11 NYCRR 65-3.8(c).

13. Judge Pigott authored a dissenting opinion, arguing that standing in a lawsuit was a threshold determination that should not be precluded.

14. 2008 N.Y. Lexis 1471 (June 5, 2008). The author and his firm submitted an amicus brief in this case on behalf of the New York Insurance Association Inc.

15. 9 NY3d 264 (2007).

16. 2008 N.Y. Lexis 1483 (June 10, 2008).

17. 9 NY3d 196 (2007).

18. 9 NY3d 105 (2007).

Load-Date: January 6, 2012

End of Document

Rulings Hold Practical Importance for Carriers and Policyholders

New York Law Journal (Online)

August 31, 2009 Monday

New York Law Journal

Length: 3161 words

Byline: Evan H. **Krinick**,, web-editor@nylj.com, , Special to the new york law journal

Body

The past term's insurance law decisions can be divided into two general categories: one group of cases resolving notice and disclaimer disputes, and another involving a wide range of issues under different insurance policies. Interestingly, each present member of the Court authored at least one of the decisions,[1] with Judge Robert S. Smith authoring three. There was a dissent in only one of the Court's major insurance rulings, but all of the cases will likely have a great deal of practical importance for both insurance carriers and policyholders.

The Insured's Address

The Court did not have to engage in excessive analysis to resolve three notice and disclaimer cases. On Nov. 20, the Court decided Briggs Avenue LLC v. Ins. Corp. of Hannover,[2] in which the corporate owner of a building in the Bronx was named a defendant in a personal injury action but did not learn of the suit--and did not notify its liability insurance carrier--until after the plaintiff moved for a default judgment.

The plaintiff apparently had served a summons and complaint on the Secretary of State,[3] but the Secretary of State did not have a current address for the building owner because it had not updated its address after moving. In an opinion by Judge Smith, the Court found that the insured's own error in failing to update its address with the Secretary of State caused it to breach the policy's timely notice requirement. Accordingly, the Court ruled that the insurer had properly disclaimed coverage for breach of the timely notice condition of the policy.[4]

Timeliness of Insurer's Disclaimer

About one week later, Judge Carmen Beauchamp Ciparick authored the Court's unanimous opinion in Continental Cas. Co. v. Stradford.[5] This case presented a clash of two well-settled principles of insurance law. On one hand, an insurer must disclaim coverage as soon as reasonably practicable after it learns of a ground for disclaimer. On the other hand, in order to validly disclaim for lack of cooperation, a

carrier must meet a heavy burden of establishing its efforts to elicit the policyholder's cooperation. Here, the parties agreed that the insurer was entitled to disclaim coverage under a professional liability insurance policy due to the failure of the insured dentist to "fully cooperate" in two malpractice actions brought against him. The issue was whether the disclaimer the insurer had issued after investigating the insured's noncooperation was timely--approximately two months to analyze a pattern of obstructive conduct in the six-year relationship between the insurer and the insured.

Judge Ciparick explained that the timeliness of a disclaimer almost always presents a factual question that requires an assessment of all relevant circumstances surrounding a particular disclaimer--and that cases in which the reasonableness of an insurer's delay may be decided as a matter of law are "exceptional and present extreme circumstances." Moreover, Judge Ciparick continued, insurers "must be encouraged to disclaim for noncooperation only after it is clear that further reasonable attempts to elicit their insured's cooperation will be futile." Thus, fixing the time from which an insurer's obligation to disclaim for lack of cooperation is difficult.

The Court then declared that where an insured has punctuated periods of noncompliance with sporadic cooperation or promises to cooperate, as apparently took place here, some "reasonably longer period for analysis may be warranted." Accordingly, the unanimous Court concluded that there was a question of fact as to the reasonableness of the approximately two months the insurer took to analyze the pattern of conduct that permeated the relationship.

Notice

The Court's brief memorandum opinion in Sorbara Constr. Corp. v. AIU Ins. Co.[6] determined important issues relating to a policyholder's notice obligations. The Court rejected the insured's contention that it had provided notice to its liability insurance carrier "as soon as practicable" because it had given notice under a Workers' Compensation policy at the time of the alleged incident. The Court ruled that that notice did not constitute notice under the insured's liability policy "even though both policies were written by the same carrier." The Court explained that each policy imposed upon the insured "a separate, contractual duty to provide notice."

Similarly, the Court declared, an additional insured's notice to the insurance carrier under a different policy did not excuse the insured's obligation to provide timely notice under its policy. The Court concluded that the insured's failure to provide the required notice therefore relieved the insurer of its obligation to defend or indemnify the insured.

Health Insurance

Fasso v. Doerr[7] involved important issues under a health insurance policy, which may become all the more significant depending on the scope of the health reform legislation coming out of Washington.

The plaintiff in this case received medical services from her physician, developed complications, and required two liver transplants, which were paid for by her health insurance carrier. After the plaintiff brought a medical malpractice suit against her doctor, the plaintiff's health insurance carrier intervened

(without objection from the defendant or doctor) to assert an equitable subrogation claim against the doctor for reimbursement of the payments it had made on the plaintiff's behalf.

The plaintiff and the doctor reached a settlement under which the plaintiff would receive $900,000, the physician would not admit wrongdoing and the health insurer's equitable subrogation claim would be dismissed on the basis that the plaintiff had not been "made whole" because the settlement payment was less than her actual damages. The health insurer objected to the dismissal of its equitable subrogation claim because, after the $900,000 settlement, there remained $1.1 million in potential malpractice insurance coverage--an amount greater than the sum it sought in subrogation.

In a unanimous decision by Judge Victoria A. Graffeo (with Chief Judge Jonathan Lippman taking no part), the Court explained that under the so-called "made whole" rule, an insurer may seek subrogation against only those funds and assets that remain after the insured has been compensated. The Court rejected the argument by the plaintiff and the physician that the "made whole" rule precluded the health insurer from pursuing equitable subrogation against the doctor in this case because the plaintiff settled for less than the total damages caused by the physician's alleged negligence. Instead, it held that the made whole doctrine did not present an obstacle to the health insurer's right to seek recoupment from the physician because the settlement left a potential source of recovery--$1.1 million in remaining insurance coverage.[8] Accordingly, the Court concluded that the provision of the settlement that purported to bar the health insurer's equitable subrogation claim could not prevent the health insurer from seeking reimbursement from the physician for the payments it made for the plaintiff's medical expenses.[9]

Life Insurance

The $500,000 life insurance policy issued on Dec. 3, 2001, that was at issue in Green v. William Penn Life Ins. Co. of New York[10] contained a provision that stated that if the insured "dies by suicide within two years" from the date the policy was issued, the only death benefit would be the premiums paid. After the insured died on Feb. 20, 2002, his widow made a claim for the face amount of the policy. The life insurer rejected the claim on the ground that the insured had died by suicide, and the insured's widow brought suit.

After a non-jury trial, Supreme Court, New York County, found that the insured had committed suicide, and it dismissed the complaint. The Appellate Division, First Department, with two justices dissenting, reversed and directed the entry of judgment for plaintiff. In reversing, the Appellate Division did not exercise its factual review power, but held that "the evidence failed as a matter of law to overcome the presumption against suicide." It reasoned that because there were other reasonable conclusions that could be drawn from the evidence, aside from suicide, the application of the law regarding the "presumption against suicide" necessitated a directed verdict in this case.

The Court of Appeals, in an opinion by Judge Smith, unanimously reversed. The Court acknowledged that a presumption against suicide is applicable in litigation under life insurance policies. However, it added, it had never held that the presumption against suicide required rejection of a claim of suicide as a matter of law. Indeed, the Court stated, "[e]xcept in rare cases, a claim of suicide presents a factual issue, not a legal one." The Court remitted the case to the First Department, concluding that because there was legally

sufficient evidence to support the trial court's decision, the First Department had to exercise its weight of the evidence review power.

Commercial Insurance

The plaintiff in Pioneer Tower Owners Ass'n v. State Farm Fire & Casualty Co.[11] submitted a claim to its insurance company for damage to the condominium apartment building it owned that resulted from an excavation on an adjacent lot. The insurer contended that there was no coverage, relying on the policy's "earth movement" and "settling [or] cracking" exclusions. The author and his firm represented the insurance carrier in this case.

The insurer's argument was that earth movement exclusion applied because the loss was caused by the movement of earth, and specifically by its "sinking" and "shifting" beneath the plaintiff's building. The settling or cracking exclusion also applied because the loss consisted of cracking that was directly and immediately caused by the settling of the building. Indeed, the insurer pointed out, the plaintiff's own engineer's report stated "that the left wing of the building had settled as evidenced by the cracking and lateral displacement of the structure."

The plaintiff argued that a literal reading of the words did not give the meaning that an ordinary reader would assign to these exclusionary clauses. As to the earth movement exclusion, the plaintiff stressed the examples of earth movement given in the policy--"earthquake, landslide, erosion and subsidence." The plaintiff argued that an excavation was a different kind of event from an earthquake and the other examples given; the plaintiff suggested that, when specific examples were mentioned, those not mentioned should be understood to be things of the same kind. Similarly, the plaintiff argued that the settling or cracking exclusion would not be thought, by an ordinary reader, to apply to settling or cracking that was the immediate and obvious result of some other event, such as the intentional removal of earth in the vicinity of the building.

In another unanimous ruling, again by Judge Smith, the Court found that the case was "a close one" and that both the plaintiff's and the defendant's readings of the clauses were "reasonable." However, the Court continued, it could not say that the event that caused the plaintiff's loss "was unambiguously excluded" from the coverage of the policy. Its precedents required that it adopt the readings that narrowed the exclusions, resulting in coverage, the Court concluded.

No Fault

LMK Psychological Services, P.C. v. State Farm Mutual Automobile Ins. Co.[12] reached the Court after the plaintiffs, two medical providers that treated various automobile accident victims, were granted summary judgment against the no-fault insurer on benefit claims that had been assigned to them and were awarded attorney's fees and interest. The attorney's fees were calculated on each bill submitted for each insured, but the insurer sought a calculation of attorney's fees on a per insured basis. In addition, the interest was awarded at the statutory rate of 2 percent per month without any tolling, but the insurer contended that the tolling provision set forth in the Insurance Law regulations should apply. The author and his firm represented the insurance carrier in the appeals.

In a unanimous decision written by Judge Eugene F. Pigott Jr. (with Chief Judge Lippman taking no part), the Court explained that in a regulation[13] and opinion letter,[14] the Superintendent of Insurance has interpreted a claim to be the total medical expenses sought by a medical provider on behalf of a single insured, and not each separate medical bill submitted by the provider. The Court added that because this interpretation was neither irrational nor unreasonable, and did not run counter to the clear wording of Insurance Law 5106, it was entitled to deference. Thus, the Court accepted the Insurance Department's interpretation of its own regulation and directed Supreme Court, Greene County, to calculate attorney's fees based on the aggregate of all bills for each insured.

The Court also explained that pursuant to Insurance Law 5106(a), interest accrues on overdue no-fault insurance claims at a rate of 2 percent per month, and that another Insurance Department regulation[15] tolls the accumulation of interest on overdue no-fault insurance claims if the claimant "does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." Moreover, the Court continued, the Superintendent has interpreted this provision to mandate that the accrual of interest is tolled, regardless of whether the particular denial at issue was timely. Finding that that interpretation was similarly entitled to deference given that it was "not irrational or unreasonable," the Court directed the Supreme Court to calculate appropriate interest on each claim, taking into consideration the tolling provision of 5106 (a) as interpreted by the Superintendent of Insurance.

SUM Trigger

Finally, on June 4, the Court issued its decision (authored by Judge Theodore T. Jones) in Matter of Allstate Ins. Co. v. Rivera[16]--the one major insurance law decision from this past term with a dissent (by Judge Ciparick, with Chief Judge Lippman concurring).

The issue here was whether supplementary uninsured/underinsured motorists (SUM) coverage had been triggered, and the Court ruled that it had not been. One of the policyholders had been issued an automobile insurance policy by Allstate Insurance Company that provided bodily injury liability and SUM coverage of $25,000 per person/$50,000 per accident. While the Allstate policy was in effect, the insured and five passengers in her car were injured when they were struck by another vehicle insured by GMAC Insurance Company, which provided the same bodily injury liability coverage as the Allstate policy.

GMAC tendered its coverage limit of $50,000, paying $25,000 to the driver insured by Allstate and $5,000 to each of her five passengers. Subsequently, the five passengers sought SUM benefits under the Allstate policy. Allstate denied SUM coverage, stating that because GMAC's $50,000 liability was an offset to Allstate's SUM coverage, Allstate would not be able to honor any claims for SUM coverage under its policy.

The majority of the Court agreed with Allstate, rejecting the argument that each co-occupant in the covered vehicles should be allowed to deduct the payments made to other co-occupants, thereby reducing the tortfeasor's bodily injury liability coverage to an amount less than the coverage limits on their vehicle, triggering SUM coverage. The Court rejected the SUM claimants' contention that their co-occupants constituted "other persons" under the endorsement even though they were insureds under the policy.

Simply put, the Court held that the "payments to other persons" that may be deducted from the tortfeasor's coverage limits for purposes of rendering the tortfeasor "uninsured" under a SUM endorsement "do not encompass payments made to anyone who is an insured under the endorsement."

Stated otherwise, the Court held that insureds are able to reduce the coverage limits of the tortfeasor's policy only when payments made under the tortfeasor's policy are to individuals--such as occupants of the tortfeasor's vehicle, injured pedestrians or those operating a third vehicle--not covered under the SUM endorsement. "This guarantees that those who have purchased SUM coverage will receive the same recovery they have made available to third parties they injure--but no more," the Court concluded.

Evan H. Krinickis a partner with Uniondale's Rivkin Radler and can be reached at evan.krinick@rivkin.com. He and his firm represented the insurance carrier in 'Pioneer Tower Owners Ass'n v. State Farm Fire & Casualty Co.' and 'LMK Psychological Services, P.C. v. State Farm Mutual Automobile Ins. Co.'

Endnotes:

1. On June 25, Chief Judge Jonathan Lippman wrote his insurance law decision for the Court, in Kassis v. Ohio Cas. Ins. Co., 2009 N.Y. Slip Op. 05207 (Ct. App. June 25, 2009). There, the Court found that a landlord was an additional insured under a tenant's commercial general liability insurance policy.

2. 11 N.Y.3d 377 (2008).

3. See Limited Liability Company Law 301.

4. The Court applied the common law no prejudice rule to this case; the recently amended Insurance Law 3420 applies to policies issued on or after Jan. 17, 2009.

5. 11 N.Y.3d 443 (2008).

6. 11 N.Y.3d 805 (2008).

7. 12 N.Y.3d 80 (2009).

8. The Court noted that New York courts have disagreed on the issue of whether it is permissible to grant intervention to health insurers of injured parties in tort cases, pointing out that allowing an insurer to intervene "inevitably complicates settlement negotiations over the tortfeasor's insurance coverage." The issue was not implicated here because no party objected to the health insurer's motion to intervene. Recognizing the issue, however, the Court invited the Legislature to reexamine the concept of permissible intervention under CPLR 1013 as it applies to personal injury actions involving a health insurer's claim of equitable subrogation.

9. Subrogation also was at issue in Matter of Central Mutual Ins. Co. v. Bemiss, 2009 N.Y. Slip Op. 5206 (June 25, 2009), where the Court, in a unanimous decision by Judge Susan Phillips Read, found that the policyholder had improperly settled with the tortfeasor for less than the maximum available policy

limits without the written consent of the insurance carrier that had issued the supplementary uninsured/underinsured (SUM) endorsement in the policyholder's automobile liability insurance policy.

10. 12 N.Y.3d 342 (2009).

11. 12 N.Y.3d 302 (2009).

12. 12 N.Y.3d 217 (2009).

13. 11 NYCRR 65-4.6.

14. Ops Gen Counsel NY Ins Dept., No. 03-10-04 (October 2003).

15. 11 NYCRR 65-3.9(c).

16. 2009 N.Y. Slip Op. 4300 (June 4, 2009). The author and his firm submitted an amicus brief in this case on behalf of the New York Insurance Association Inc.

Load-Date: September 19, 2011

End of Document

13 N.Y.3d 313, 919 N.E.2d 172, 891 N.Y.S.2d 1, 2009 N.Y. Slip Op. 07453
Court of Appeals of New York

Executive Risk Indemnity Inc., Appellant
v
Pepper Hamilton LLP et al., Respondents. Pepper Hamilton LLP et al., Third-Party Plaintiffs-Respondents, v Continental Casualty Company et al., Third-Party Defendants-Appellants.

CITE TITLE AS: Executive Risk Indem. Inc. v Pepper Hamilton LLP

130
Argued September 9, 2009
Decided October 20, 2009

Appeal, by permission of the Appellate Division of the Supreme Court in the First Judicial Department, from an order of that Court, entered September 23, 2008. The Appellate Division (1) reversed, on the law, an order of the Supreme Court, New York County (Karla Moskowitz, J.), which had (a) granted a motion by plaintiff for summary judgment on the complaint and a motion by third-party defendant Twin City Fire Insurance Company for summary judgment on its counterclaims to the extent that they were entitled to a declaratory judgment that, based upon a prior knowledge exclusion, plaintiff and third-party defendant Twin City Fire Insurance Company had no obligation to indemnify defendants Pepper Hamilton LLP or W. Roderick Gagné under certain excess insurance policies for any claim made as a result of certain underlying actions; (b) granted a cross motion for summary judgment by third-party defendant Continental Casualty Company on its counterclaims to the extent that it was entitled to a declaratory judgment that two of its excess policies were rescinded and a third excess policy did not cover or respond to the underlying actions; (c) dismissed the counterclaims of defendants Pepper Hamilton LLP and W. Roderick Gagné; (d) dismissed the third-party complaint; and (e) severed and continued the cross claim of defendants Pepper Hamilton LLP and W. Roderick Gagné against defendant Westport Insurance Corporation; and (2) denied the motions and cross motion for summary judgment. The following question was certified by the Appellate Division: "Was the order of this Court, which reversed the order of the Supreme Court, properly made?"

Executive Risk Indem. Inc. v Pepper Hamilton LLP, 56 AD3d 196, modified.

Click here to return to the List of Indices

15 N.Y.3d 34, 930 N.E.2d 259, 904 N.Y.S.2d 338, 2010 N.Y. Slip Op. 04661
Court of Appeals of New York

Regal Construction Corporation et al., Appellants
v
National Union Fire Insurance Company of Pittsburgh, PA, Respondent, et al., Defendant.

CITE TITLE AS: Regal Constr. Corp. v National Union Fire Ins. Co. of Pittsburgh, PA

Argued May 5, 2010
Decided June 3, 2010

Appeal from an order of the Appellate Division of the Supreme Court in the First Judicial Department, entered July 14, 2009. The Appellate Division, with two Justices dissenting, affirmed an order of the Supreme Court, New York County (Debra A. James, J.; op 19 Misc 3d 1122[A], 2008 NY Slip Op 50816 [U]), which had (1) denied plaintiffs' motion for summary judgment; (2) granted defendants' cross motion for summary judgment; and (3) declared that plaintiff Insurance Corporation of New York was obligated to provide defense and indemnification to defendant URS Corporation in an underlying personal injury action.

Regal Constr. Corp. v National Union Fire Ins. Co. of Pittsburgh, Pa., 64 AD3d 461, affirmed.

Click here to return to the List of Indices

Decisions Reflect Significance of Insurance Law Across New York

New York Law Journal (Online)

August 22, 2011 Monday

New York Law Journal

Length: 2521 words

Byline: Evan H. **Krinick**,, web-editor@nylj.com, , Special to the new york law journal

Body

The New York Court of Appeals' nine significant insurance law rulings last term displayed no discernible theme, evidenced no apparent trend, and reflected no obvious insurance law philosophy. Policyholders were victorious in some of the cases and insurance companies in others ;and creditors in another.

The principal cases involved statutory construction,[1] policy construction,[2] and common law issues,[3] as well as procedural matters such as collateral estoppel[4] and choice of law.[5] The majority opinions were written by four different members of the Court: Chief Judge Jonathan Lippman (3),[6] Judge Carmen Beauchamp Ciparick (3),[7] Judge Robert S. Smith (2),[8] and Judge Theodore T. Jones (1).[9] Five cases were unanimous.[10] Judge Smith wrote two dissenting opinions,[11] and Judge Susan Phillips Read[12] and Judge Eugene F. Pigott Jr., wrote one each.[13]

The diversity of the underlying facts, legal issues, and insurance policies in these cases may be the one feature that unifies them. In essence, the very breadth and scope of the Court's insurance law cases illustrate the importance of insurance and insurance law to a growing swath of businesses and individuals across New York.

Life Insurance

Following certification from the U.S. Court of Appeals for the Second Circuit, the Court held in Kramer v. Phoenix Life Ins. Co.that New York law permits a person to obtain an insurance policy on his or her own life and immediately transfer it to one without an insurable interest in that life, even where the policy was obtained for just such a purpose.

The Court found "no support" in Insurance Law 3205(b) for the proposition that a policy obtained by an insured with the intent of immediate assignment to a stranger was invalid, explaining that the statute contained no intent requirement and did not attempt to prescribe the insured's motivations. Indeed, the Court pointed out, 3205(b)(1) explicitly allowed for "immediate transfer or assignment," at least where the insured's decision was free of what the Court characterized as "nefarious influence or coercion."

The Court's ruling gave a boost to the so-called "stranger-owned life insurance" market, although it should be noted that provisions added to the Insurance Law by the Legislature in 2009, which were not applicable

to this case because they went into effect on May 18, 2010, prohibit anyone from entering a valid life settlement contract[14] for two years following the issuance of a policy, with some exceptions,[15] and prohibit stranger-originated life insurance.[16]

Broker Incentives

When Governor Andrew Cuomo was still Attorney General Cuomo, he brought an action against an insurance brokerage firm now known as Wells Fargo Insurance Services Inc., alleging that the firm had engaged in "repeated fraudulent or illegal acts" in violation of Executive Law 63(12), was unjustly enriched, committed common law fraud, and breached its fiduciary duties. The complaint alleged that Wells Fargo acted as an agent for organizations and individuals seeking to purchase insurance, dealt with insurance companies on those customers' behalf, obtained quotes from insurers and presented them to customers, and offered customers recommendations about what coverage would best suit their needs.

The complaint also alleged that Wells Fargo entered into a number of "incentive" arrangements with insurance companies in which the companies financially rewarded Wells Fargo for bringing them business. It alleged that, as a result of the incentive programs, Wells Fargo "steered" its customers to particular insurance companies and away from others that did not participate in the programs, and that the incentive payments were not disclosed to Wells Fargo customers.

In its decision, the Court pointed out that there were no allegations that Wells Fargo had made any affirmative misrepresentations, that any customer had suffered demonstrable harm from the incentive arrangements, or that any customer had been persuaded to buy inferior or overpriced insurance to help Wells Fargo earn its incentives. The Court explained that a broker had a "dual agency status" as an agent of the insured who customarily looked for compensation to the insurer. The Court then held that an insurance broker did not have a common law fiduciary duty to disclose to its customers "incentive" arrangements that the broker had entered into with insurance companies, and it affirmed dismissal of the complaint.[17]

'Other Insurance'

In Fieldston Property Owners Assoc. Inc. v. Hermitage Ins. Co. Inc., Hermitage Insurance Company issued a commercial general liability (CGL) policy to Fieldston Property Owners Association Inc., for the period July 5, 2000, to July 5, 2001. Federal Insurance Company issued an "Association Directors and Officers Liability" (D&O) policy covering the period from Feb. 13, 1999 to Feb. 13, 2002. Two lawsuits asserting a variety of claims, including "injurious falsehood," were filed against Fieldston and the Court had to decide which insurance carrier had the primary duty to defend given that both had "other insurance" provisions.

The Court pointed out that the parties had conceded at least the possibility that both Hermitage's CGL and Federal's D&O policies covered the injurious falsehood claims in the two underlying actions. Then, based on the policies' "other insurance" clauses, the Court found that Hermitage's CGL policy was primary to Federal's D&O policy as they related to defense costs. The Court held that the Hermitage policy's primacy on the injurious falsehood claim triggered a primary duty to defend against the remaining causes of action in the two complaints, thus preempting any defense obligation by Federal. The Court reached the conclusion that Hermitage had the full obligation to defend its insured notwithstanding that Federal apparently had an obligation to indemnify Fieldston for a greater proportion of the causes of action, if successfully prosecuted.

Interestingly, the Court acknowledged that the result reached by the Appellate Division, which permitted Hermitage to recover from Federal its equitable share of defense, except to the extent that those costs related to the injurious falsehood claims, had "much equitable appeal." It added, however, given the policies' provisions, that it could "not judicially rewrite the language of the policies" to reach that result.

What Is an Accident?

State Farm Mut. Auto. Ins. Co. v. Langanreached the Court after a driver intentionally drove his vehicle into pedestrians in Manhattan, injuring many of them, including Neil Spicehandler, who required surgery and died from complications after the operation. The driver later pleaded guilty to second degree murder and admitted that he had intended to cause the decedent's death.

The decedent was an insured under an automobile liability policy purchased by Robert Langan. As the administrator of the decedent's estate, Mr. Langan made a claim seeking to recover benefits under the policy's uninsured/underinsured motorist endorsement (UM endorsement), mandatory personal injury protection endorsement (PIP endorsement) and death, dismemberment and loss of sight endorsement (Coverage S).

The insurer commenced a declaratory judgment action seeking a declaration that it was not obligated to provide benefits in connection with the decedent's death on the ground that the decedent was not injured as the result of an accident. The summary judgment motion by the insurer, which at this point was represented by the author and his firm, was granted by the Supreme Court, Nassau County; a divided Appellate Division, Second Department, modified, and the case reached the Court of Appeals.

The Court found that, viewed from the insured decedent's perspective, the occurrence was an unexpected or unintended event and therefore an "accident," even though the driver admittedly had intended to strike the decedent with the vehicle. According to the Court, consistent with what it stated was the purpose of the UM endorsement (to provide coverage against damage caused by uninsured motorists) and the national trend toward allowing innocent insureds to recover uninsured motorist benefits when injured through the intentional conduct of another, the intentional assault of an innocent insured was an accident from the insured's point of view. Accordingly, Mr. Langan was entitled to benefits under the UM endorsement.

Moreover, the Court ruled that Mr. Langan also was entitled to coverage under the PIP endorsement and Coverage S. It reasoned that the average insured's understanding of the term "accident" was unlikely to vary from endorsement to endorsement within the same policy. The occurrence, from the insured's perspective, "was certainly unexpected and unforeseen and should be considered an accident subject to coverage," the Court concluded. The Court further noted that it did not perceive any danger that this result will frustrate efforts to fight fraud, as there was no allegation of fraud in this case.

Creditor Rights

The dispute in ABN AMRO Bank, N.V. v. MBIA Inc. between MBIA Insurance Corporation, a monoline insurer that exclusively wrote financial guarantee insurance, and certain of its policyholders arose following the 2009 restructuring of MBIA Insurance and its related subsidiaries and affiliates that had been authorized by the New York State Insurance Superintendent. The restructuring segregated MBIA Insurance's municipal bond policy portfolio from its structured-finance policy portfolio.

The plaintiff policyholders alleged that the restructuring had fraudulently stripped approximately $5 billion in cash and securities out of MBIA Insurance and that MBIA Insurance had received no consideration for the assets it transferred. They further alleged that the transaction exposed them to potentially billions of dollars in losses because MBIA Insurance was undercapitalized and insolvent.

The Court decided that the superintendent's approval of the restructuring pursuant to its authority under the Insurance Law did not bar policyholders from asserting claims against MBIA Insurance under the New York Debtor and Creditor Law and the common law. In reaching that result, the Court rejected arguments that the plaintiffs' claims under the Debtor and Creditor Law and the common law constituted "impermissible collateral attacks" on the superintendent's approval of the transaction, or that the Insurance Law vested the superintendent with "exclusive original jurisdiction" to adjudicate the plaintiffs' claims, subject only to potential Article 78 relief. In the Court's view, the superintendent's exclusive original jurisdiction to approve the transaction under the Insurance Law did not mean that he also was the exclusive arbiter of all private claims that might arise in connection with the transaction, including claims that the restructuring rendered MBIA Insurance insolvent and was unfair to its policyholders. Simply put, the Court found no indication from the statutory language and structure of the Insurance Law or its legislative history that the Legislature intended to give the superintendent the power to extinguish the rights of policyholders to attack fraudulent transactions under the Debtor and Creditor Law or the common law.

Other Rulings

The Court's other insurance law decisions included rulings on a homeowner's insurance policy exclusion (Cragg v. Allstate Indem. Corp.), a choice-of-law dispute between policyholders and the New York State Liquidation Bureau stemming from an insurance company's insolvency (Matter of the Liquidation of Midland Ins. Co.), an excess liability insurance policy covering asbestos claims (Union Carbide Corp. v. Affiliated FM Ins. Co.), and a dispute over arbitration of an uninsured motorist benefits award (Matter of Arbitration Between Falzone and New York Central Mut. Fire Ins. Co.). In addition, the Court already has agreed to hear four insurance law cases next term, involving alleged bad faith failure to settle,[18] no-fault medical benefits,[19] a fiduciary liability policy,[20] and a professional liability insurance policy,[21] that further demonstrate the broad range of insurance law disputes facing the courts today.

Evan H. Krinick*is a partner with Uniondale's Rivkin Radler and can be reached at evan.krinick@rivkin.com*

Endnotes:

1. Kramer v. Phoenix Life Ins. Co., 15 N.Y.3d 539 (Nov. 17, 2010); ABN AMRO Bank, N.V. v. MBIA Inc., 2011 N.Y. Slip Op. 5542 (June 28, 2011).

2. Union Carbide Corp. v. Affiliated FM Ins. Co., 16 N.Y.3d 419 (Feb. 22, 2011); Fieldston Prop. Owners Assoc. Inc. v. Hermitage Ins. Co. Inc., 16 N.Y.3d 257 (Feb. 24, 2011); State Farm Mut. Auto. Ins. Co. v. Langan, 16 N.Y.3d 349 (March 29, 2011) (the author and his firm represented the insurance carrier in this case); Cragg v. Allstate Indemnity Corp., 2011 N.Y. Slip Op. 4767 (June 9, 2011).

3. State v. Wells Fargo Ins. Services Inc., 16 N.Y.3d 166 (Feb. 17, 2011).

4. Matter of Arbitration Between Falzone and New York Central Mut. Fire Ins. Co., 15 N.Y.3d 530 (Oct. 21, 2010).

5. Matter of the Liquidation of Midland Ins. Co., 16 N.Y.3d 536 (April 5, 2011).

6. Kramer; Langan; Cragg.

7. Fieldston; Midland; ABN AMRO.

8. Wells Fargo; Union Carbide.

9. Falzone.

10. Wells Fargo (with Judge Victoria A. Graffeo taking no part); Union Carbide; Fieldston; Midland; Cragg.

11. Kramer (in which Judge Pigott concurred); Langan (in which Judge Reed concurred).

12. ABN AMRO (in which Judge Graffeo concurred).

13. Falzone.

14. Insurance Law 7802(k) defines life settlement contracts as agreements by which compensation is paid for "the assignment, transfer, sale, release, devise or bequest of any portion of: (A) the death benefit; (B) the ownership of the policy; or (C) any beneficial interest in the policy, or in a trust that owns the policy."

15. See Insurance Law 7813(j)(1).

16. Insurance Law 7815 defines stranger-originated life insurance as "any act, practice or arrangement, at or prior to policy issuance, to initiate or facilitate the issuance of a policy for the intended benefit of a person who, at the time of policy origination, has no insurable interest in the life of the insured under the laws of this state."

17. The Court acknowledged, without going into detail, that there may be exceptions where disclosure would be required, but pointed out that the complaint did not allege that anything Wells Fargo did was contrary to industry custom. It should be noted that a regulation, 11 NYCRR 30.3(a)(2), effective Jan. 1, 2011, and thus not applicable to this case, requires disclosure to a purchaser of insurance if a broker "will receive compensation from the selling insurer based in whole or in part on the insurance contract" that the broker sells.

18. Doherty v. Merchants Mut. Ins. Co., 74 A.D.3d 1870 (4th Dept. 2010).

19. Wyckoff Heights Med. Ctr. v. Country-Wide Ins. Co., 71 A.D.3d 1009 (2d Dept. 2010), appeal granted, 15 N.Y.3d 709 (2010).

20. Federal Ins. Co. v. International Bus. Mach. Corp., 78 A.D.3d 763 (2d Dept. 2010), appeal granted, 16 N.Y.3d 706 (2011).

21. McCabe v. St. Paul Fire & Marine Ins. Co., 79 A.D.3d 1612 (4th Dept. 2010), appeal granted, 16 N.Y.3d 711 (2011).

Load-Date: August 19, 2011

End of Document

Unanimity, for the Most Part, In Broad Variety of Insurance Rulings
August 27, 2012 | Appeals | Insurance Coverage
The past term's insurance law decisions by the Court of Appeals generally did not involve the rather traditional slew of insurance coverage, insurance bad faith, and insurance fraud rulings that usually comprise the Court's insurance law docket. The opinions, however, are by no means any less significant, or less interesting. Mostly rendered by a unanimous Court, the key insurance law cases it decided resolved a range of issues, from automobile insurance questions to the applicability of the statute of limitations to claims for retrospective premiums. In these rulings, the Court affirmed the Appellate Division in three cases, reversed in three, and, in one, affirmed in part and reversed in part.
No-Fault Decisions
The Court issued two decisions regarding different aspects of the No-Fault Law this past term. In October, Associate Judge Theodore T. Jones wrote the unanimous opinion for the Court in *New York and Presbyterian Hospital v. Country Wide Ins. Co*.[1]
The case arose after an insured was injured in a traffic accident and treated in a hospital. When the insured was discharged, he assigned his right to receive no-fault benefits to the hospital. The hospital subsequently billed the insurer and submitted a number of documents to it, including a form notifying the insurer of the accident.
The insurance carrier received these documents 40 days after the accident and denied the hospital's claim on the ground it had not received timely notice of the accident as provided by insurance regulations that require an "eligible insured person" to give written notice to the insurer "in no event more than 30 days after the date of the accident."[2] I
In response, the hospital argued that it had met the regulations' requirement that it submit written proof of claim no later than 45 days after the date health care services were rendered, and that that submission also met the notice requirement.
The Court rejected the hospital's argument, ruling that a health care services provider, as assignee of a person injured in a motor vehicle accident, could not recover no-fault benefits by timely submitting the required proof of claim after the 30 day period had expired for providing written notice of the accident. The Court found that the "notice of accident" and "proof of claim" requirements were "independent conditions precedent" to a no-fault insurer's liability.
About one month after the *Country Wide* decision, Associate Judge Robert S. Smith wrote the opinion for a unanimous Court in the term's second no-fault case: *Perl v. Meher*.[3]
Under the No-Fault Law, to bring a personal injury action against a tortfeasor arising out of an automobile accident, a plaintiff must suffer a "serious injury" as defined in the Insurance Law. That issue has been addressed often by the Court[4] and has continued to inundate the Appellate Division.
Here, the Court reviewed three cases in which the Appellate Division had rejected allegations of "serious injury" as a matter of law. Although the Court acknowledged that "serious injury" claims were "still a source of significant abuse," and that courts – including the Court of Appeals – approached claims that soft-tissue injuries satisfy the "serious injury" threshold with "well-deserved skepticism," it reversed two of the cases and affirmed the third.
The Court gave great weight to a physician's specific, numerical range of motion measurements about the plaintiffs in the two cases it reversed – even though those measurements had been made well after the accidents. Indeed, the Court specifically refused to find "contemporaneous" quantitative measurements a prerequisite to recovery, declaring that such a rule "could have perverse results."

Even though the plaintiffs will still need to prove their entitlement to recovery before a jury, the inability of the courts to grant summary judgment under the facts presented will likely provide an impetus to plaintiffs to bring more cases alleging that they have suffered "serious injury." Such a result defeats the litigation-limiting purpose of no-fault insurance. If that were to occur, the legislature may need to address the definition of "serious injury" in order for its legislative goals to be satisfied.

Uninsured Motorist Benefits

The unanimous opinion in the Court's third automobile insurance case, *Matter of Elrac, Inc. v. Exum*,[5] also was written by Judge Smith.

The case arose when an employee of Elrac, Inc., a subsidiary of Enterprise Rent-A-Car Company, was driving a car owned by Elrac in the course of his employment and was involved in an accident with another car, which was driven by a person without liability insurance. Elrac was self-insured and thus had not obtained an insurance policy to cover the car its employee was driving. The employee sought uninsured motorist benefits from Elrac. Elrac contended that the employee was barred from recovering those benefits by the exclusivity provision of the Workers' Compensation Law.[6]

The Court rejected Elrac's argument, holding that a self-insured employer whose employee was involved in an automobile accident could be liable to that employee for uninsured motorist benefits, notwithstanding that exclusivity provision. The Court found that the Workers' Compensation statute could not be read to bar all suits to enforce contractual liabilities. It reasoned that if an employer agreed, as part of a contract with an employee, to provide life insurance or medical insurance, and if the employer breached that contract, an action to recover damages for the breach would not be barred. By the same token, the contractual claim for uninsured motorist benefits also was not barred.

Exclusions Applied

The court issued two decisions that were noteworthy because they found each of the exclusions at issue to be unambiguous and that there was no coverage.

The issue in *Federal Ins. Co. v. International Business Machines Corp*.[7]was whether language in an excess insurance policy extended coverage to alleged violations of the Employee Retirement Income Security Act of 1974 ("ERISA") by the insureds, International Business Machines Corporation and the IBM Personal Pension Plan (collectively, "IBM"), acting in their capacity as the settlor of their employee benefit plans.

The case began when a class action was filed against IBM, alleging that certain amendments to benefit plans had violated ERISA provisions pertaining to age discrimination. The parties reached a settlement, which included amounts designated to cover plaintiffs' attorneys' fees. IBM made those payments and then sought reimbursement from its excess insurer, maintaining that the limits of the underlying policy had been exhausted.

In a unanimous opinion, by Chief Judge Jonathan Lippman, the Court explained that the policy covered violations of ERISA by an insured acting in its capacity as an ERISA fiduciary. In this case, the Court found, even if IBM were a fiduciary and even if the actions were alleged to have violated certain provisions of ERISA, IBM was not acting as an ERISA fiduciary when it took the actions that gave rise to the allegations in the underlying lawsuit. Rather, the Court concluded, it was acting as a plan settlor when it made the changes to the benefit plans that allegedly violated ERISA. The Court concluded that the policy language was not ambiguous, and it held that the insurer was entitled to summary judgment and a declaration that it was not required to indemnify IBM.

On occasion, the Court decides a case by relying on the opinion of the Appellate Division. Less frequently, it decides a case by relying on a *dissenting* opinion from the Appellate Division. In both situations, it is as if the Court wrote the opinion itself, and it is equivalent to a decision by the Court.

In *Dzielski v. Essex Ins. Co.*,[8] the Court reversed the majority decision by the Appellate Division, Fourth Department, "for the reasons stated in the dissenting memorandum at the Appellate Division."[9]

Here, the plaintiff allegedly fell from a loading dock after exiting the rear door of a nightclub. He had provided sound equipment for a band that performed at the nightclub. The nightclub's insurer disclaimed coverage based on a "stage hand" exclusion in the policy's "Restaurant, Bar, Tavern, Night Clubs, Fraternal and Social Clubs Endorsement." In the Fourth Department, a three-justice majority determined that the exclusion was ambiguous and found coverage.

The dissenting opinion – which the Court of Appeals later adopted – found the exclusion to be "clear and unmistakable" and that it applied where two conditions were met: (1) the injured party was an entertainer, stage hand, crew member, independent contractor, spectator, patron, or customer who "participates in or is a part of" an athletic event, demonstration, show, competition, or contest; and (2) the injury "arises out of" such participation.

The dissent concluded that the language "participates in or is a part of" a show was not ambiguous, and that the plaintiff fell squarely within that language. Moreover, it also found, the plaintiff's injury arose out of his participation in the show within the meaning of the exclusion, noting that, in the insurance context, the phrase "arising out of" has been broadly interpreted to mean "originating from, incident to, or having connection with."

Additional Insured

Admiral Ins. Co. v. Joy Contractors, Inc.,[10] stemmed from the collapse of a tower crane during construction of a luxury high-rise condominium in Manhattan.Here, the excess insurer sought, among other things, to rescind the policy with respect to the coverage claims of additional insureds based on the named insured's alleged misrepresentations in its underwriting submission. The lower courts rejected the excess insurer's arguments, but the Court did not.

Associate Judge Susan Phillips Read, writing for a unanimous Court, accepted the excess insurer's contentions that the lower courts' decisions dismissing their cause of action seeking rescission of the policy as against all defendants except the named insured illogically left in place the excess policy to be enforced by the other parties even if the policy were ultimately rescinded. In effect, these other parties would be permitted to rely on the terms of a policy that might be deemed never to have existed to create coverage in the first place. The Court made clear that "additional" insureds must exist in addition to *something*; namely, the named insureds in a valid existing policy.

Dissent

The one insurance case that divided the Court was *Hahn Automotive Warehouse, Inc. v. American Zurich Ins. Co.*,[11] a 4-3 decision.

The policyholder, an auto parts distributor with operations in multiple states, secured general liability, automotive liability, and Workers' Compensation policies from the defendant insurers for annual coverage periods between September 1992 and September 2003. The policies provided for the regular adjustment of premiums based on actual claims experience.

Although the contractual relationship between the parties began in the early 1990s, it was not until 2005 and 2006 when the insurers discovered that they had not billed the policyholder for

the additional premiums to which they believed they were entitled. The policyholder did not pay the amounts requested, and the dispute reached the Court.

The insurers argued that their claims seeking all of the amounts billed were timely because the six year statute of limitations did not begin to run until 2005 and 2006, when they demanded payment and the policyholder refused to pay. The policyholder countered that the statute had begun to run much earlier, when the insurers possessed the right to demand payment for the various amounts owed, such that any debts that arose before May 2000 (six years prior to the commencement of the lawsuit) were untimely.

The majority opinion, by Associate Judge Victoria A. Graffeo, relied on Appellate Division cases that have held that, where a claim was for payment of a sum of money allegedly owed pursuant to a contract, the cause of action accrued when the party making the claim possessed the legal right to demand payment. Put simply, the majority continued, the statute of limitations in these cases was triggered when the party that was owed money had the right to demand payment, not when it actually made the demand.

The majority then agreed with the policyholder that it was reasonable to apply this accrual principle to its insurance contracts. Accordingly, the majority concluded that the statute of limitations on the insurers' claims began to run when they acquired the right to demand payment of the various amounts owed under the policies. Hence, the majority concluded, any debts for which the insurers had the legal right to demand payment prior to May 2000, i.e., more than six years before the commencement of the litigation, were time-barred.

Judge Read wrote the dissenting opinion, declaring that courts have "uniformly concluded" that the statute of limitations for a claim for unpaid premiums calculated on the basis of claims history did not accrue until the insured refused payment after demand had been made by the insurer. Whether the majority's decision changes what has been New York law or puts New York in an outlier position depends, perhaps, on one's point of view. Certainly, however, the decision is noteworthy for both insurers and policyholders involved in policies that provide for premium adjustments based on claims history.

---

[1] 17 N.Y.3d 586 (2011).
[2] *See*, 11 NYCRR 65-1.1.
[3] 18 N.Y.3d 208 (2011).
[4] *See, e.g., Pommells v. Perez*, 4 N.Y.3d 566 (2005); *Toure v. Avis Rent A Car Sys*., 98 N.Y.2d 345 (2002).
[5] 18 N.Y.3d 325 (2011).
[6] *See*, Workers' Compensation Law § 11.
[7] 18 N.Y.3d 642 (2012).
[8] 19 N.Y.3d 871 (2012).
[9] 90 A.D.3d 1493, 1495-1497 (4th Dep't 2011).
[10] No. 93 (June 12, 2012).
[11] 18 N.Y.3d 765 (2012).

Breach of Duty to Defend Stands Out Among Noteworthy Issues
August 26, 2013 | Appeals | Insurance Coverage
The past term's significant insurance law decisions by the New York Court of Appeals resolved a variety of issues that will alter the practice of insurance law in important ways. Among the most notable of these decisions was *K2 Investment Group, LLC v. American Guarantee & Liability Ins. Co*.,[1] where the court evaluated the consequences to an insurance carrier of its breach of the duty to defend its insured. Decided at the end of the term, and discussed at the end of this article, the decision is surely one of the most widely discussed and debated insurance law decisions rendered by the court in recent years.
Judge Robert S. Smith wrote three opinions for the court, including the opinion in *K2 Investment*; all of Smith's opinions were unanimous. Judge Carmen Beauchamp Ciparick, now retired, wrote two majority opinions. Judge Victoria A. Graffeo wrote one unanimous opinion,[2] while Judge Jenny Rivera, whom the New York State Senate confirmed on Feb. 11, wrote one opinion for a divided court. The court affirmed three Appellate Division decisions, reversed three, and modified one.
Homeowner's Insurance
Residency. *Dean v. Tower Ins. Co. of New York*[3] arose after a couple purchased a home, discovered extensive termite damage, and began to repair and renovate it. Before they could complete the work and move in, their home was destroyed by fire.
The couple notified their homeowner's insurer, which disclaimed coverage on the ground that "the dwelling was unoccupied at the time of the loss" and, therefore, did not qualify as a "residence premises." They sued.
The majority decision, by Judge Ciparick, held that residency required at least some degree of permanence and intent to remain. The court found there were issues of fact that made summary judgment inappropriate, including whether the husband's regular presence in the house to renovate it, coupled with his intent to eventually move in with his family, was sufficient to satisfy the policy's "residence premises" requirement. More significantly, the court found that because the term "reside" was not defined in the policy, the term "residence premises" was ambiguous, and it ruled that it was "arguable that the reasonable expectation of an average insured" was that "occupancy," a lesser standard than residence, would satisfy the policy's requirements.
Earth Movement Exclusion
In 2009, in *Pioneer Tower Owners Assn. v. State Farm Fire & Cas. Co*.,[4] the court held that an "earth movement" exclusion in an insurance policy did not unambiguously apply to excavation, *i.e*., the "intentional removal of earth by humans." This past October, in *Bentoria Holdings, Inc. v. Travelers Indemnity Co*.,[5] a case in which a building allegedly suffered cracks as a result of an excavation being conducted on the lot next door to it, the court was faced with a policy exclusion similar to the exclusion in *Pioneer Tower* except that the exclusion was expressly made applicable to "man made" movement of earth.
Smith held that this added language eliminated the ambiguity the court had found in *Pioneer Tower*, and that, therefore, the loss allegedly caused by the excavation was excluded from the policy. The court reasoned that by expressly excluding earth movement "due to man made or artificial causes," the policy contradicted the idea that "the intentional removal of earth by humans" was not an excluded event.
Broker Liability

Ciparick's second majority opinion came on Nov. 19, in *American Building Supply Corp. v. Petrocelli Group, Inc*.[6]

In this case, a company that subleased a building in the Bronx sued its insurance broker for failing to obtain adequate insurance coverage. The court found that issues of fact existed as to whether the company had requested specific coverage that was not provided, as required to set forth a case for negligence or breach of contract against an insurance broker.[7]

Significantly, the court resolved an issue that it had left open in 2006 in *Hoffend & Sons, Inc. v. Rose & Kiernan, Inc*.[8]: whether a policyholder who had received an insurance policy and had had an opportunity to read it but had not requested any changes was barred from suing his or her broker. The court acknowledged that it was "certainly the better practice for an insured to read its policy," but it held that the failure to read a policy, "at most, may give rise to a defense of comparative negligence but should not bar, altogether, an action against a broker."[9]

Asbestos Claims

Smith's second unanimous opinion for the court came in February, in *U.S. Fidelity & Guaranty Co. v. American Re-Ins. Co*.,[10] a case in which an insurance company, United States Fidelity & Guaranty Company ("USF&G"), having settled asbestos claims for nearly $1 billion, sought to recover a share of its settlement payment – about $391 million – from its reinsurers.

The court explained that the reinsurance contracts contained a "follow the fortunes" or "follow the settlements" clause, which ordinarily barred challenge by a reinsurer to the decision of a party in USF&G's position (the "cedent") to settle a case for a particular amount. The court then specifically decided that a "follow the settlements" clause required "deference" to a cedent's decisions on allocation.

The court added, however, that a cedent's allocation decisions were not "immune from scrutiny." It decided that "objective reasonableness" ordinarily should determine the validity of an allocation, meaning that the reinsured's allocation must be one that the parties to the settlement of the underlying insurance claims might reasonably have arrived at in arm's length negotiations if the reinsurance did not exist. The court then held that there were issues of fact in the particular allocation in this case.

Occurrences

On May 7, the court decided *Roman Catholic Diocese of Brooklyn v. National Union Fire Ins. Co. of Pittsburgh, PA*.[11] The case was unusual in that it was heard by only five judges, and because it resulted in three separate decisions. Rivera's first insurance law decision for the court was joined by Judges Susan Phillips Read and Eugene F. Pigott, Jr.; Smith concurred in the result, while Graffeo concurred in part and dissented in part. Chief Judge Jonathan Lippman took no part in the case; Judge Sheila Abdus-Salaam, who was confirmed by the Senate on May 6, also did not participate.

The dispute involved the apportionment of liability for a settlement between the Roman Catholic Diocese of Brooklyn and a minor plaintiff in an underlying civil action charging sexual molestation by a priest. The insurance carrier contended that alleged incidents of sexual abuse constituted a separate occurrence in each of the seven implicated policy periods, and required the exhaustion of a separate $250,000 self-insured retention ("SIR") for each occurrence covered under any policy from which the Diocese sought coverage. For its part, the Diocese argued that the alleged sexual abuse constituted a single occurrence requiring the exhaustion of only one SIR.

Addressing for the first time the meaning of "occurrence" in the context of claims based on numerous incidents of alleged sexual abuse of a minor by a priest spanning several years and

several policy periods, the court held that they constituted multiple occurrences. Rivera's plurality opinion found that each alleged incident involved a "distinct act of sexual abuse perpetrated in unique locations and interspersed over an extended period of time," and that they should not be grouped into one occurrence. Both Smith and Graffeo concluded that there was only one occurrence.

All five Judges, however, agreed it was appropriate to have a *pro rata* allocation of the loss across all seven of the insurance policies that were in effect when the alleged abuse had occurred. All five judges rejected the Diocese's argument that the allocation of liability should be pursuant to a joint and several allocation method, under which the entire settlement amount could be paid for with two particular policies of its choosing.

Finally, the court decided*K2 Investment Group, LLC v. American Guarantee & Liability Ins. Co*.,[12] one of the most controversial insurance law decisions issued by the court in recent memory.

The facts were fairly simple. A lawyer was sued for malpractice and his malpractice carrier disclaimed coverage and refused to provide a defense. The plaintiffs obtained a default judgment against the lawyer, which they sought to recover from his insurance company pursuant to Insurance Law § 3420. The insurer moved for summary judgment, claiming that two policy exclusions established that it had no obligation to provide indemnity to its insured. After the Supreme Court ruled in favor of the plaintiffs, a divided Appellate Division affirmed, and the case reached the court.

The court, in a decision by Smith, affirmed. The Court held that when a liability insurer breached its duty to defend its insured, the insurer could not later rely on policy exclusions to deny its obligation to indemnify its insured for a judgment. The court found that the insurer in this case had breached its duty to defend the lawyer, and concluded that, as a consequence, it had "lost its right" to rely on the policy's exclusions in litigation over its indemnity obligation to the insured.

Controversy over this decision stems both from its holding – expanding the consequences for a breach of a duty to defend – and from its reasoning. Almost 30 years ago, in *Servidone Construction Corp. v. Security Ins. Co. of Hartford*,[13] the court held that an insurer's breach of its duty to defend did not create coverage and that there could be no duty to indemnify unless there was a covered loss. The decision in *K2 Investment* is plainly inconsistent with *Servidone*, at least so far as indemnity defenses based on exclusions are concerned. Yet, there was no mention of *Servidone* in *K2 Investment*. Even more curious, the authority relied on by the court for its ruling, *Lang v. Hanover Ins. Co*.[14] involved a wholly discrete issue and only touched on this issue in *dicta*, also without mentioning *Servidone*.

The long term impact of *K2 Investment* remains to be seen. There undoubtedly will be opportunities for the court itself, and for lower courts, to provide further guidance as to the holding's applicability to different circumstances. In the short term, the most immediate result will be an increase in declaratory judgment actions brought by insurance carriers to adjudicate their obligations to provide a defense while, concomitantly, they actually provide a defense. In that scenario, insurers will be able to preserve their ability to resolve their indemnity obligations on the merits, although policyholders will be required to engage in litigation on multiple fronts, and courts will be forced to resolve multiple actions.

---

[1] No. 106 (N.Y. June 11, 2013).

[2] *J.P. Morgan Securities Inc. v. Vigilant Ins. Co*., No. 113 (N.Y. June 11, 2013) (reinstating complaint on "limited record" available at the motion-to-dismiss stage).
[3] 19 N.Y.3d 704 (2012).
[4] 12 N.Y.3d 302 (2009). The author and his firm represented the insurer in this case.
[5] 20 N.Y.3d 65 (2012).
[6] 19 N.Y.3d 730 (2012).
[7] *See Murphy v. Kuhn*, 90 N.Y.2d 266 (1997).
[8] 7 N.Y.3d 152 (2006).
[9] In a dissent in which Judge Graffeo concurred, Judge Pigott wrote that it seemed "elementary" that before a person could "complain about the contents of any contract," he or she "should at least have read it."
[10] 20 N.Y.3d 407 (2012).
[11] 21 N.Y.3d 139 (2013).
[12] No. 106 (N.Y. June 11, 2013).
[13] 64 N.Y.2d 419 (1985).
[14] 3 N.Y.3d 350 (2004).

Among Significant Decisions, Court Vacates Prior Breach of Duty to Defend Ruling

New York Law Journal (Online)

August 25, 2014 Monday

New York Law Journal

Length: 2434 words

Byline: Evan H. **Krinick**

Body

Insurance law is surely an area of the civil law that occupies more than its fair share of the docket of the New York Court of Appeals. This past term, the court issued nine significant insurance law decisions, including one for which it heard reargument and vacated a unanimous-and highly controversial-ruling that it had issued near the end of its 2012-2013 term. In these rulings, almost every judge wrote either a majority or dissenting opinion and the nine cases generated 14 separate opinions, including an unusual number of dissenting opinions. Certain of the decisions were clear victories for insurance companies, while others favored policyholders.

Unlike the divisions among the U.S. Supreme Court justices on so very many issues, there does not appear to be any predictable division among the New York Court of Appeals judges as to the likelihood of a particular judge ruling in favor of policyholders or insurance carriers. In fact, examination of the five insurance law cases that divided the court this term revealed that each judge on the court voted in favor of the policyholder and the carrier in at least one instance. Rather than relying on philosophical underpinnings, the court seems to address each insurance law issue individually based on precedent and public policy. With New York's longstanding and continuing role as a leader in insurance jurisprudence, the court is likely to continue facing difficult insurance law issues for quite some time to come.

Exclusions

On June 11, 2013, the court issued its first decision in K2 Investment Group v. American Guarantee & Liability Ins. This case arose when a lawyer was sued for malpractice but his insurance carrier disclaimed coverage and refused to provide a defense. The plaintiffs obtained a default judgment against the lawyer, which they sought to recover from his insurance company pursuant to Insurance Law §3420. The insurer claimed that two policy exclusions established that it had no obligation to provide indemnity to its insured.

In its June 11, 2013 decision, the court held that the insurer had wrongly breached its duty to defend the lawyer and concluded that, as a consequence, it had "lost its right" to rely on the policy's exclusions in litigation over its indemnity obligation to the insured.

Early in this current term, the court granted reargument. On February 18, it vacated its June 11 decision and issued a new one.[1] The court decided that it had erred in its earlier ruling by failing to take account of a controlling precedent, Servidone Const. v. Security Ins. of Hartford,[2] in which the court held that when an insurer breached a contractual duty to defend its insured in a personal injury action, and the insured thereafter concluded a reasonable settlement with the injured party, the insurer was not liable to indemnify the insured even if coverage was disputed. The court recognized that Servidone and its June 11 holding in K2 could not be reconciled, and it specifically refused to overrule Servidone. In language certainly comforting to carriers and policyholders alike, the court stated: "When our Court decides a question of insurance law, insurers and insureds alike should ordinarily be entitled to assume that the decision will remain unchanged... ." Thus, in its decision in K2 on reargument, it held that the insurer was not barred from relying on policy exclusions as a defense to the lawsuit against it.

Notice

The issue in KeySpan Gas East v. Munich Reinsurance America,[3] was whether Insurance Law §3420(d)(2), which requires that insurance carriers disclaim coverage based on late notice "as soon as reasonably possible after first learning of the ... grounds for disclaimer," applied in this case, and the court ruled that it did not.

The court said that §3420(d)(2) applies only in a particular context: insurance cases involving death and bodily injury claims arising out of a New York accident and brought under a New York liability policy. Because the underlying claim in this case did not arise out of an accident involving bodily injury or death, the notice of disclaimer provisions set forth in §3420(d)(2) were "inapplicable." Rather, the court concluded, in this case the insurance carrier could not be barred from disclaiming coverage "simply as a result of the passage of time," and its delay in giving notice of disclaimer had to be considered under "common-law waiver and/or estoppel principles."

Country-Wide Ins. v. Preferred Trucking Services also involved a question of notice.[4] In this case, §3420(d)(2) did apply, and the issue was whether the insurance company had issued a timely disclaimer based on the insured's failure to cooperate in the defense of the action.

The court ruled that it had done so, even though the personal injury lawsuit against the insured company had been filed in March 2007 and the insurer had not disclaimed until Nov. 6, 2008-about 20 months later.

The court explained that the policyholder in this case had not cooperated with the insurer in the defense of the suit. The court acknowledged that the insurer knew or should have known in July 2008 that the president of the insured would not cooperate, but it also found that the insurer was not in a position to know that the driver of the vehicle involved in the alleged accident underlying the personal injury lawsuit would not cooperate until Oct. 13, 2008, when he told the insurance company's investigator that he did not care about attending a deposition and, thereafter, gave no further response.

Given that the driver "punctuated periods of noncompliance with sporadic cooperation or promises to cooperate," the court concluded that the insurance carrier had established as a matter of law that its disclaimer had been made in a reasonable time. The court distinguished other bases for disclaimer where the facts supporting the disclaimer were immediately apparent.

Brokers

Under well-established New York law, insurance brokers have a common law duty to obtain requested coverage for their clients within a reasonable time or inform their clients of their inability to do so. Brokers, however, typically have no continuing duty to advise, guide, or direct a client to obtain additional coverage. Thus, in the ordinary broker-client situation, a client may prevail in a negligence action only where it can establish that it made a particular request to the broker and the requested coverage was not procured.

The situation is somewhat different where a "special relationship" exists between a broker and client. In that case, a broker may be liable, even in the absence of a specific request, for failing to advise or direct the client to obtain additional coverage.

In Voss v. Netherlands Ins.[5] the client argued that the broker should have advised about a higher level of business interruption coverage. A divided court determined that the client's complaint should not have been dismissed on the basis that no special relationship arose between the parties, concluding that the broker had not satisfied its burden of establishing the absence of a material issue of fact as to the existence of a special relationship.

It should be noted that the majority opinion specifically reiterated that special relationships in the insurance brokerage context "are the exception, not the norm." Still, as the dissent observed, a consequence of the majority decision may result in brokers becoming "a kind of back-up insurer."

Indeed, when this decision is considered with the court's 2012 ruling in American Building Supply v. Petrocelli Group,[6] holding that an insured's failure to read did not bar its lawsuit against its broker, it appears that the court may be cutting back on protections for brokers. This certainly bears watching.

Disclaimers

In February, the court issued an important memorandum decision in QBE Ins. v. Jinx-Proof .[7]

The case arose when a patron of a bar owned by Jinx-Proof sued Jinx-Proof, alleging that she had been injured when one of its employees threw a glass at her face. The bar's insurance carrier wrote it two letters that stated, among other things, that Jinx-Proof had no coverage for the assault and battery claims. Jinx-Proof argued that the disclaimers were ineffective. A divided court ruled otherwise.

Over the dissent of two judges, the majority said that although the letters contained some "contradictory and confusing language" and although the letters also contained "reservation of rights" language, the letters "specifically and consistently stated" that Jinx-Proof's insurance policy excluded coverage for assault and battery claims. According to the court, these statements "were sufficient to apprise Jinx-Proof that [its insurer] was disclaiming coverage on the ground of the exclusion for assault and battery."

Vandalism Coverage

As the court has done a number of times in recent years, this past term it answered questions of insurance law certified to it by the U.S. Court of Appeals for the Second Circuit. In Georgitsi Realty v. Penn-Star Ins.,[8] the Second Circuit first asked the court if, for purposes of construing a property insurance policy covering acts of vandalism, malicious damage could be found to result from an act not directed specifically at the covered property. Then, the circuit court asked, if so, what state of mind was required?

In its first decision ever to address the meaning of the term "vandalism" in an insurance policy, the court ruled that malicious damage within the coverage of a property insurance policy "may be found to result from acts not directed specifically at the covered property." The court reasoned that there was "no reason" that the term "vandalism" should be limited to acts "directed specifically at the covered property," or that an act of vandalism had to bring the vandals in direct contact with the covered property. "Where damage naturally and foreseeably results from an act of vandalism, a vandalism clause in an insurance policy should cover it."

In response to the second certified question, the court ruled that, to obtain coverage under a property insurance policy, the insured must show "malice," which it defined as "such a conscious and deliberate disregard of the interests of others that the conduct in question may be called willful or wanton." In the court's view, this test would "serve to distinguish between acts that may fairly be called vandalism and ordinary tortious conduct."

Three Cases

Of the last three cases, two were unanimous. In Executive Plaza v. Peerless Ins.,[9] Judge Robert S. Smith wrote the opinion for the court (also in answer to a question certified by the Second Circuit).

Here, a fire insurance policy limited the time in which the insured could bring suit against its insurer under the policy to two years. The policy also provided that the insured could recover the cost of replacing destroyed property-but only after the property already had been replaced. The court decided that the two year contractual limitations period was unreasonable and unenforceable where the property could not reasonably be replaced in two years.

The issue in Ragins v. Hospitals Ins.,[10] was whether excess insurers had to pay interest on a $1,100,000 medical malpractice judgment against the insured where the liquidator of the insured's insolvent primary professional liability insurer had paid the $1,000,000 per occurrence liability limit of that policy.

The court, in a unanimous memorandum decision, concluded that, given the policies' language, the liquidator's payment of the primary policy's $1,000,000 liability limit triggered the excess insurers' duty to pay all remaining amounts in connection with the judgment, including interest. It reached this conclusion, it said, in the absence of a provision in the primary policy expressly covering interest above the policy's liability limit, regulations mandating that the primary insurer cover additional damages or interest beyond the primary policy's limit, or regulations exempting the excess carriers from the responsibility to pay all amounts in excess of the primary policy's limit.

Finally, in Matter of Beth V. v. New York State Office of Children & Family Services,[11] the court found that a workers' compensation carrier could take a credit under §29(4) of the Workers' Compensation Law against the settlement proceeds of a civil rights lawsuit brought by a recipient of worker's compensation benefits against her employer and co-employees for injuries arising from the same incident for which she was receiving benefits. The court disregarded the form of the settlement (which, it said, may have been structured to afford the claimant a presumed tax advantage), and concluded that the settlement agreement indicated that the settlement proceeds were intended to compensate the workers' compensation claimant for the same personal physical and mental injuries for which she had been awarded compensation benefits.

Endnotes:

1. K2 Investment Group v. American Guarantee & Liability Ins., 22 N.Y.3d 578 (2014), reargument denied, Motion No.: 2014-315 (N.Y. May 6, 2014). Judge Robert S. Smith wrote the majority opinion, in which Chief Judge Jonathan Lippman and Judges Susan P. Read and Jenny Rivera concurred. Judge Victoria A. Graffeo dissented in an opinion in which Judge Eugene F. Pigott concurred. Judge Sheila Abdus-Salaam took no part in the case.

2. 64 N.Y.2d 419 (1985). See Evan H. Krinick, "Breach of Duty to Defend Stands Out Among Noteworthy Issues," NYLJ, Aug. 26, 2013.

3. 2014 N.Y. Slip Op. 4113 (June 10, 2014). Judge Abdus-Salaam wrote the opinion for a unanimous court; Chief Judge Lippman and Judge Rivera took no part in the case.

4. 22 N.Y.3d 571 (2014). Judge Pigott wrote the opinion for a unanimous court; Judge Abdus-Salaam took no part in the case.

5. 22 N.Y.3d 728 (2014). Judge Graffeo wrote the decision for the court, in which Chief Judge Lippman and Judges Rivera and Abdus-Salaam concurred. Judge Smith dissented in an opinion in which Judges Read and Pigott concurred.

6. 19 N.Y.3d 730 (2012).

7. 22 N.Y.3d 1105 (2014). Judges Graffeo, Read, Smith, Rivera, and Abdus-Salaam concurred. Judge Pigott dissented in an opinion in which Chief Judge Lippman concurred.

8. 21 N.Y.3d 606 (2013). Judge Smith wrote the majority opinion, in which Chief Judge Lippman and Judges Graffeo, Read, Pigott, and Rivera concurred. Judge Abdus-Salaam dissented in part in an opinion.

9. 22 N.Y.3d 511 (2014).

10. 22 N.Y.3d 1019 (2013).

11. 22 N.Y.3d 80 (2013). Judge Read wrote the majority decision, with Judge Rivera dissenting.

Load-Date: August 25, 2014

End of Document

Dissenting Opinions Highlight Split Among Exiting Judges

New York Law Journal (Online)

August 24, 2015 Monday

New York Law Journal

Length: 2836 words

Byline: Evan H. **Krinick**

Body

The Court of Appeals issued seven principal insurance law decisions this past term.[1] Four decisions affirmed the rulings below, two reversed, and one modified. Five were in favor of insurance companies and two in favor of policyholders. Two of the seven were unanimous, one was decided by a vote of four-to-one, and four had at least two dissenting judges.

Looking at the four cases that divided the Court with at least two dissenting judges, one sees that the individual judges voted as follows:

· Judge Sheila Abdus Salaam: three (pro-insurer); one (pro-policyholder)

· Judge Susan P. Read: three (pro-insurer); one (pro-policyholder)

· Judge Leslie Stein: two (pro-insurer); zero (pro-policyholder)

· Judge Jenny Rivera: one (pro-insurer); one (pro-policyholder)

· Judge Victoria A. Graffeo: two (pro-insurer); zero (pro-policyholder)

· Jude Robert S. Smith: two (pro-insurer); zero (pro-policyholder)

· Judge Eugene F. Pigott: one (pro-insurer); three (pro-policyholder)

· Judge Eugene M. Fahey: zero (pro-insurer); two (pro-policyholder)

· Chief Judge Jonathan Lippman: zero (pro-insurer); four (pro-policyholder)

Although this is a relatively small sample, one thing stands out with respect to Chief Judge Lippman and Judge Read, both of whom will be leaving the Court: Chief Judge Lippman ruled in favor of policyholders

in every one of these four cases and Judge Read ruled in favor of insurance companies in three of these four cases (all of which will be discussed in more detail below).

The tendency of Chief Judge Lippman and Judge Read to rule in favor of policyholders or insurance companies, respectively, is further seen from their votes in the six insurance law cases that divided the Court (i.e., with at least two judges dissenting) during the 2012-2014 terms: Chief Judge Lippman voted in favor of insurers one time and in favor of policyholders five times, while Judge Read was just the opposite, with five votes in favor of insurers and one in favor of policyholders.[2]

In fact, during the past four years in insurance law cases that divided the Court, Chief Judge Lippman was the judge who most voted in favor of policyholders (nine out of 10 cases) while Judge Read was the judge who most voted in favor of insurers (eight out of nine decisions in which she participated).[3]

The balance of this column will discuss the four insurance law cases that divided the Court this past term.

'Strauss Painting'

The first of the four cases chronologically, Strauss Painting v. Mt. Hawley Ins., arose after Strauss Painting/Creative Finishes contracted with the Metropolitan Opera Association to strip and repaint the rooftop steel carriage track for the opera house's automated window-washing equipment.

A Creative employee who allegedly was injured while working at the site sued the Met. In subsequent litigation among Strauss, Mt. Hawley Insurance, and the Met, the Met sought a declaration that it was an additional insured on the commercial general liability (CGL) insurance policy issued by Mt. Hawley to Strauss, thereby requiring Mt. Hawley to defend and indemnify it in the lawsuit brought by the Creative employee.

In a per curiam decision, the Court decided that the Met was not an additional insured under the Mt. Hawley policy. It explained that, under the additional insured endorsement of the Mt. Hawley policy, whether the Met was an additional insured hinged on whether Strauss and the Met had "agreed in writing in a contract or agreement that [the Met] be added as an additional insured on [Strauss'] policy." In connection with that requirement, the parties focused on the provision in the contract between Strauss/Creative and the Met that stated:

b. Owners and contractors protective liability insurance with a combined single limit of $5,000,000.00. Liability should add the Metropolitan Opera Association as an additional insured and should include contractual liability and completed operations coverage.

The Court found that the second sentence of this provision referred only to owners and contractors protective (OCP) liability insurance and not to Strauss' CGL policy.

Interestingly, the two judges who dissented in this case were Judge Read and Chief Judge Lippman. They agreed that this provision should be read in favor of the Met, asserting that the second sentence did not only refer to OCP insurance but "clearly obligate[d] Strauss" to have in place a CGL policy protecting the Met as an additional insured.

'Nesmith'

Chief Judge Lippman and Judge Read were on opposite sides of the next three cases, beginning with Nesmith v. Allstate Ins., decided the day after Strauss Painting.

In September 1991, Allstate Insurance issued a liability insurance policy to the landlord of a two-family house in Rochester that contained a "non-cumulation clause" limiting Allstate's total liability to one policy limit.[4] The policy was renewed annually in September 1992 and September 1993.

Felicia Young and her children lived in one of the two apartments in the house from November 1992 until September 1993. In July 1993, the Department of Health (DOH) notified the landlord that one of the children had an elevated blood lead level and that several areas in the apartment were in violation of state regulations governing lead paint. The DOH listed the violations, the landlord made some repairs, and the DOH advised him in August 1993 that the violations had "been corrected."

After the Young family moved out of the apartment in September 1993, Lorenzo Patterson, Sr., and Qyashitee Davis moved in with their two children. Again a child was found to have an elevated blood lead level, and the DOH sent another letter saying that violations had been found and instructing the landlord to correct them.

Young, on behalf of her children, and Jannie Nesmith, on behalf of the Patterson children (her grandchildren), brought two separate actions against the landlord for personal injuries allegedly caused by lead paint exposure. Young's action was settled for $350,000, which Allstate paid. Nesmith then settled her claim pursuant to a stipulation that reserved the issue of the applicable policy limit for future litigation. Allstate paid the $150,000 that it claimed was the remaining coverage and Nesmith sued Allstate, asserting that a separate $500,000 limit applied to each family's claim and that her grandchildren, therefore, could recover up to an additional $350,000 from Allstate.

In a majority opinion by Judge Smith, the Court ruled in favor of Allstate. The majority rejected the argument that the alleged injuries to Young's children and Nesmith's grandchildren were separate losses. The majority reasoned that Young's children and Nesmith's grandchildren had been exposed "to the same hazard, lead paint, in the same apartment." According to the majority, there was no basis for inferring that a new lead paint hazard had been introduced into the apartment after the landlord's remedial efforts. The "only possible conclusion," according to the majority, was that the landlord's remedial efforts had not been wholly successful, and that the same general conditions continued to exist. The Court concluded that because Young's children and Nesmith's grandchildren allegedly had been injured by exposure to the same general conditions, their injuries were part of a single "accidental loss," and only one policy limit was available to the two families.

Judge Pigott, in a dissent joined by Chief Judge Lippman, interpreted the non-cumulation clause to provide that the policy limit-$500,000 limit for "each occurrence"-applied to limit the liability for lead exposure of children in one family during the course of that family's tenancy. Because the Nesmith children had moved into the apartment during the second renewal period and had lived in the apartment

from September 1993 to September 1994, they were entitled to recover up to the full policy limits, the dissenting judges contended. Otherwise, they reasoned, when the landlord renewed his policy and paid his premium, "he procured less protection with respect to lead paint claims." They concluded that if the insured knew that his later policies would not cover lead paint injuries occurring after his remediation efforts, "he surely would not have continued purchasing the insurance at essentially the same premium from the same insurer."

'Viviane Etienne Medical Care'

Viviane Etienne Medical Care v. Country-Wide Ins., arose when Alem Cardenas was treated at the office of Viviane Etienne Medical Care (VEMC) after an automobile accident. Cardenas, who was insured by Country-Wide Insurance Company, assigned his right to receive no-fault benefits to VEMC.

VEMC submitted eight verification of treatment forms to Country-Wide; the insurer denied payment on one claim in the amount of $139 but did not respond to any of the other claims.

VEMC sued Country-Wide to recover the no-fault insurance benefits it claimed it was owed. VEMC moved for summary judgment, arguing that it had met its prima facie burden of showing the fact and amount of loss sustained and that the payment of the benefits was overdue. As support, VEMC submitted the eight verification of treatment forms as proof of claim, along with seven mailing ledgers stamped by the U.S. Postal Service indicating the date the forms were mailed, and the denial of claim form. Additionally, VEMC submitted an affidavit of the president of a third-party billing company hired by VEMC that explained his procedures for billing insurers on behalf of VEMC.

The majority opinion, by Judge Abdus-Salaam, explained that where an insurer failed to pay or deny a claim within 30 days following its receipt of the claim, the insurer was precluded-on the basis of decisions by the Court itself-"from asserting a defense against payment of the claim" except where the insurer raised lack of coverage as a defense.

The majority then held that a summary judgment motion in a no-fault insurance case where benefits were overdue only required "proof that the statutory claim forms were mailed to and received by the insurer." The majority concluded that VEMC had met this standard.

Judge Stein's dissent, in which Judge Read joined, disagreed with the majority's decision that a medical provider in a no-fault case established prima facie entitlement to summary judgment by demonstrating that the insurer was billed and failed to timely deny or pay the billed claim. The dissent argued that nothing in the statutory and regulatory no-fault scheme or in the Court-created preclusion doctrine obviated a medical provider's burden to demonstrate its prima facie entitlement to benefits sought, as compared to only proof of billing and non-payment.

The dissent pointed out that although proof of billing and the absence of timely denial or payment may be required in order to invoke the preclusion rule, the Court had never held that such proof constituted a prima facie showing of entitlement to judgment in a no-fault plaintiff's favor. The dissent warned that the practical effect of the majority's holding was that courts lacked authority to verify that a no-fault plaintiff

had established the basic facts supporting a claim prior to awarding judgment-increasing the risk that insurers will be required to pay out fraudulent claims.

'State Farm'

The issue in the final case, State Farm Mutual Automobile Ins. v. Fitzgerald,[5] was whether a police car was a "motor vehicle" for purposes of the New York insurance law provision requiring that all motor vehicle insurance policies must contain uninsured motorist coverage.

In this case, Police Officer Patrick Fitzgerald alleged that he was injured when he was riding in a police vehicle driven by Police Officer Michael Knauss that was struck by an intoxicated driver of an underinsured vehicle. At the time, Knauss maintained an automobile liability insurance policy issued by State Farm Mutual Automobile Insurance Company that included a supplementary uninsured/underinsured motorist (SUM) endorsement. In addition to covering Knauss as the named insured and his family, the SUM endorsement insured against injuries to "any other person while occupying" Knauss' personal vehicle or "any other motor vehicle while being operated by [the named insured] or [the named insured's] spouse."

State Farm rejected Fitzgerald's demand for underinsured motorist arbitration under the SUM endorsement of Knauss' policy on the ground that he had occupied a police vehicle, which was not a covered "motor vehicle" within the meaning of the endorsement.

The majority, in a decision by Judge Abdus-Salaam, held that a SUM endorsement prescribed by Insurance Law §3420(f)(2)(A) exempted police vehicles from its definition of the term "motor vehicle" absent a specific provision to the contrary in a given SUM endorsement. Because there was no contrary provision in the State Farm SUM endorsement, the majority held that it did not cover liability for injuries arising from the use of a police vehicle of the sort occupied by Fitzgerald during his accident.

Judge Pigott's dissent, in which Chief Judge Lippman and Judge Fahey concurred, asserted that Fitzgerald was entitled to coverage under Knauss' SUM endorsement. The dissent's view was that the legislature had intended to make compensation available in cases in which insured persons suffered automobile accident injuries at the hands of financially irresponsible motorists. Judge Pigott concluded that the legislature had "specifically declared its grave concern that motorists who use the public highways be financially responsible to ensure that innocent victims of motor vehicle accidents be recompensed for their injuries and losses," warning that under the majority holding, Fitzgerald was left "without uninsured motorist coverage altogether."

Conclusion

Of course, it is difficult to predict how individual judges will decide particular cases. Moreover, most of the insurance cases resolved by the Court are decided by unanimous or near unanimous rulings. Nevertheless, for those cases in which the Court is divided, insurers and policyholders may want to pay

particular attention to the replacements for Chief Judge Lippman and Judge Read, as the new judges could affect their interests in future cases before the Court.

Endnotes:

1. Sierra v. 4401 Sunset Park, 24 N.Y.3d 514 (2014); Nesmith v. Allstate Ins., 24 N.Y.3d 520 (2014) (the author and his firm represented Allstate Insurance in this case); Strauss Painting v. Mt. Hawley Ins., 24 N.Y.3d 578 (2014); Platek v. Town of Hamburg, 24 N.Y.3d 688 (2015); Viviane Etienne Medical Care v. Country-Wide Ins., No. 75 (N.Y. June 10, 2015); Universal American v. National Union Fire Ins. of Pittsburgh, PA., No. 95 (N.Y. June 25, 2015); and Matter of State Farm Mutual Automobile Ins. v. Fitzgerald, No. 119 (N.Y. July 1, 2015) (the author and his firm represented State Farm Mutual Automobile Insurance in this case).

2. Hahn Automotive Warehouse v. American Zurich Ins., 18 N.Y.3d 765 (2012) (Judges Read, Smith, and Pigott dissent from pro-policyholder decision); Dean v. Tower Ins. of N.Y., 19 N.Y.3d 704 (2012) (Judges Jones, Read, and Smith dissent from pro-policyholder decision); American Building Supply v. Petrocelli Group, 19 N.Y.3d 730 (2012) (Judges Pigott and Graffeo dissent from ruling against insurance broker); K2 Investment Group v. American Guaranty & Liability Ins., 22 N.Y.3d 578 (2014) (Judges Graffeo and Pigott dissent from pro-insurer ruling); Voss v. Netherlands Ins., 22 N.Y.3d 728 (2014) (Judges Smith, Read, and Pigott dissent from ruling against insurance broker); and QBE Ins. v. Jinx-Proof, 22 N.Y.3d 1105 (2014) (Judge Pigott and Chief Judge Lippman dissent from pro-insurer decision).

3. The combined tally for the other judges is as follows:

· Judge Smith: five (insurer); one (policyholder)

· Judge Abdus Salaam: four (insurer); two (policyholder)

· Judge Stein: two (insurer); zero (policyholder)

· Judge Graffeo: four (insurer); four (policyholder)

· Judge Rivera: three (insurer); two (policyholder)

· Judge Pigott: four (insurer); six (policyholder)

· Judge Fahey: zero (insurer); two (policyholder)

4. The policy's noncumulation clause provided:

Regardless of the number of insured persons, injured persons, claims, claimants or policies involved, our total liability under the Family Liability Protection coverage for damages resulting from one accidental loss will not exceed the limit shown on the declarations page. All bodily injury and property damage resulting from one accidental loss or from continuous or repeated exposure to the same general conditions is considered the result of one accidental loss.

5. The Court ordered reargument in this case, Matter of State Farm Mutual Automobile Ins. v. Fitzgerald, 2015 N.Y. Slip Op. 02673 (March 31, 2015), and issued its decision on July 1 with Judge Rivera taking no part and with Presiding Justice Luis A. Gonzalez of the Appellate Division, First Department, participating.

Load-Date: August 21, 2015

End of Document

Six Rulings Range From Asbestos Claims to No-Fault Reimbursement; Court of Appeals: Insurance Law

New York Law Journal

August 22, 2016 Monday

New York Law Journal

Section: COURT OF APPEALS AND APPELLATE PRACTICE; Pg. S6; Vol. 256; No. 36

Length: 2241 words

Byline: EVAN H. **KRINICK**

Body

The six significant insurance law decisions issued this past term by the New York Court of Appeals covered a wide range of issues. Five of the cases were decided by a unanimous Court, with a dissent (by Judge Eugene M. Fahey) occurring only in one.[1] Four different judges wrote an opinion for the Court (Judge Leslie E. Stein wrote two; one case was decided in a memorandum decision). Neither of the two newest members of the Court (Chief Judge Janet DiFiore and Judge Michael J. Garcia) wrote an opinion, but they concurred with the majority in every case in which they participated.

Two decisions were pro-insurance carrier[2] and two were pro-policyholder.[3] In one case,[4] the Court decided one issue in favor of insurance companies and a second issue in favor of insureds. In the final case,[5] the Court ruled in favor of an automobile insurer and against a health insurer.

Facility Fees

New York's no-fault law requires that automobile insurers must provide up to $50,000 of coverage for an insured's "basic economic loss." The law authorizes the chair of the state's Workers' Compensation Board

---

[1] Aetna Health Plans v. Hanover Ins. Co., 2016 N.Y. Slip Op. 04658 (N.Y. June 14, 2016) (the author and his firm represented the automobile insurance company in this case).

[2] Government Employees Ins. Co. (GEICO) v. Avanguard Medical Group, 27 N.Y.3d 22 (2016) (the author and his firm represented the insurance company in this case); Matter of Monarch Consulting v. National Union Fire Ins. Co. of Pittsburgh, PA, 26 N.Y.3d 659 (2016).

[3] Matter of Viking Pump, 27 N.Y.3d 244 (2016); Spoleta Construction v. Aspen Ins. UK Limited, 27 N.Y.3d 933 (2016).

[4] Selective Ins. Co. of America v. County of Rensselaer, 26 N.Y.3d 649 (2016).

[5] Aetna Health Plans, 2016 N.Y. Slip Op. 04658.

and the superintendent of the Department of Financial Services (DFS) to adopt fee schedules for basic economic loss and provides that basic economic loss service charges generally may not exceed the charges permissible under that schedule. A health care provider may not "demand or request any payment in addition to the charges authorized" under the fee schedules.

The schedules include facility fees for hospitals and ambulatory surgery centers (ASC) for the use of their physical locations and related support services.

The GEICO case involved a limited liability company accredited under New York's Public Health Law as a facility for the provision of office-based surgery (OBS) services. Its owner, a medical doctor who conducts OBS procedures on patients covered by New York's no-fault law, billed GEICO for his professional services and separately billed for facility fees-totaling more than $1.3 million-associated with his OBS services.

The Court, in an opinion by Judge Jenny Rivera, ruled that OBS centers may not collect facility fees because they are not expressly permitted or authorized by the no-fault law or the payment schedules. To conclude otherwise, the Court said, would undermine the "obvious legislative purpose" of containing costs. Moreover, the Court declared that the legislature or the DFS is the appropriate body to make the policy determination as to whether to include OBS facility fees in the fee schedule. The Court's conclusion means that millions of dollars of OBS facility fee claims that were pending against GEICO and other New York automobile insurers at the time of the Court's decision will not have to be paid.

Asbestos Claims

Viking Pump reached the Court on certification from the Delaware Supreme Court, which asked New York's highest court to determine how to allocate primary and excess liability insurance coverage for two companies that had acquired pump manufacturing businesses in the 1980s that subjected them to significant potential liability in connection with asbestos exposure claims.

In particular, the Court first had to decide whether "all sums"[6] or "pro rata"[7] allocation applied where an excess insurance policy contained or was governed by a "non-cumulation" provision.[8] Then, the Court had to determine whether "horizontal" or "vertical" exhaustion[9] was required before certain upper level excess policies attached.

---

[6] An "all sums" (or "joint and several") approach permits an insured to collect under any policy in effect during the periods that the damage occurred, up to the policy limits.

[7] Under the "pro rata" method, an insurer's liability is limited to sums incurred by the insured during the policy period; in other words, each insurance policy is allocated a "pro rata" share of the total loss representing the portion of the loss that occurred during the policy period.

[8] A "non-cumulation" clause generally prevents "stacking," which occurs when a policyholder facing a loss that occurred over time while insured by different policies seeks to recover the maximum limits under all of them.

[9] Under "horizontal" exhaustion, all triggered primary and excess liability policies have to be exhausted before insureds may look to any additional excess policies. "Vertical" exhaustion allows insureds to access each excess policy once the immediately underlying policies' limits are depleted, even if other lower-level policies during different policy periods remain unexhausted.

The Court concluded, in a decision by Judge Stein, that all sums allocation and vertical exhaustion applied in this case based on the policies' language.

In a prior opinion, Consolidated Edison Co. of N.Y. v. Allstate Ins.,[10] the Court applied pro rata allocation to claims involving environmental contamination over a number of years. In this case, the Court explained that the Con Ed decision was based solely on the language of the particular policies in issue in that case. Here, the Court reasoned that it was the "very essence of pro rata allocation" that an insurance policy limited indemnification to losses and occurrences during the policy period-meaning that no two insurance policies, unless containing overlapping or concurrent policy periods, would indemnify the same loss or occurrence. A non-cumulation clause, the Court continued, negated that premise by presupposing that two policies could be called on to indemnify the insured for the same loss or occurrence. In other words, it declared, non-cumulation clauses could "not logically be applied in a pro rata allocation." Based on the contract language in this case, all sums allocation was the appropriate methodology.

Next, the Court observed that all of the excess policies involved in this case primarily hinged their attachment on the exhaustion of underlying policies that covered the same policy period as the overlying excess policy. The Court reasoned that vertical exhaustion was more consistent than horizontal exhaustion with this language tying attachment of the excess policies specifically to identified policies that spanned the same policy period. It also decided that vertical exhaustion was conceptually consistent with an all sums allocation, permitting the insureds to seek coverage through the layers of insurance available for a specific year.[11]

Arbitration

Judge Stein also wrote the Court's opinion in Monarch Consulting, which involved a challenge to the validity of certain "payment agreements" entered into by an insurance company with three different California-based employers to which it had issued workers' compensation insurance policies. The payment agreements contained arbitration clauses requiring that disputes arising out of the agreements, if not resolved internally, had to be submitted to arbitration.

After disputes arose between the insurer and the insureds and court proceedings were initiated in New York, the insurer sought to compel arbitration under the Federal Arbitration Act (FAA).

The employers challenged the arbitration provisions in the payment agreements on the ground that the insurer had not filed them with the Workers' Compensation Insurance Rating Bureau of California (WCIRB) in accordance with California Insurance Code §11658. In their view, the failure to file meant that the payment agreements were not enforceable under §11658. They also argued that the federal McCarran-Ferguson Act-which generally provides for the primacy of state regulation of insurance-exempted §11658 from the FAA.

---

[10] Consolidated Edison Co. of N.Y. v. Allstate Ins., 98 N.Y.2d 208 (2002).

[11] In Spoleta, the Court's other pro-policyholder ruling, the Court ruled in a memorandum decision that an insurer's motion to dismiss a declaratory judgment action commenced by a policyholder had been properly denied. The Court reasoned that the documentary evidence did not conclusively establish that a letter to an insurer sent on behalf of an additional insured that sought defense and indemnity with respect to an alleged occurrence was not timely and sufficient notice under the policy.

The Appellate Division, First Department, agreed with the employers and decided that it would not enforce the arbitration provisions in the agreements, but the Court of Appeals reversed.

The Court observed that McCarran-Ferguson preempts laws that "invalidate, impair, or supersede" state insurance laws, but found that the FAA did not invalidate, impair, or supersede §11658 given that California law did not limit the use of arbitration clauses in insurance policies. The Court concluded that whether the insurer's failure to file the agreements rendered the arbitration clauses unenforceable had to be determined by the arbitrators pursuant to the FAA and the parties' agreements to arbitrate arbitrability.

Deductibles and Fees

The Selective Insurance case arose when Rensselaer County was sued in a class action after it implemented a policy of stripsearching all people who were admitted into its jail, regardless of the type of crime the person was alleged to have committed. The county sought coverage for the claims from its insurance company, Selective Insurance Company of America, which agreed to defend the county subject to the limits of the insurance policies it had issued to the county over a number of years and to the policies' deductible.

The court approved a settlement that provided for a $5,000 payment to the named plaintiff and a $1,000 payment to the approximately 800 other class members. The settlement also set the plaintiffs' attorney fees at $442,702.

The county argued that it only was obligated for a single $10,000 deductible payment, and that the legal fees generated in the action should be allocated to only one policy. For its part, the insurer argued that each class member was subject to a separate deductible and that the attorney fees should be calculated by allocating the settled amount of fees ratably to each "occurrence."

In a decision by Judge Sheila Abdus-Salaam, the Court first agreed with Selective and held that the improper strip searches of the arrestees over the four-year period that was the subject of the class action constituted separate occurrences under the policies, and that each was subject to a single deductible payment.

The Court then agreed with the county with respect to the allocation of the attorney fees. It found that the county's assertion about the fees-because there was one defense team for all class members, they should be attributed only to the named plaintiff-was reasonable. The Court reasoned that the policies were silent as to how attorney fees would be allocated in class actions and ruled, therefore, that they were ambiguous on that point. The Court concluded that the policy language should be interpreted in favor of the insured county, and that the attorney fees were properly charged to the named plaintiff.

Reimbursement Claims

The issue in Hanover was whether a health insurer that paid for medical treatment that arguably should have been covered by the insured's no-fault automobile insurance carrier could maintain a reimbursement claim against the no-fault insurer within the framework of the New York no-fault law. The Court, in an opinion by Judge Eugene F. Pigott Jr., ruled that the health insurer could not maintain such a claim.

The Court reasoned that the no-fault law and governing regulations provide that reimbursement can be made to a health care provider, but do not contemplate any such reimbursement to a health insurer.

Moreover, the Court decided, the insured's putative assignment of her no-fault benefits to the health insurer did not help the health insurer because the insured previously had assigned her no-fault benefits to her health care provider, which left the insured with no rights to assign to the health insurer. The Court also pointed out that the no-fault regulations permit only the insured-or providers of health care services by an assignment from the insured-to receive direct no-fault benefits. Because a health insurer is not a "provider of health care services" and does not fall under the term "health care provider," the insured could not assign her rights to it, the Court concluded.[12]

Evan H. Krinick, managing partner of Uniondale's Rivkin Radler, can be reached at evan.krinick@rivkin.com

Load-Date: August 22, 2016

End of Document

[12] Judge Stein concurred in the majority in an opinion that also expressly found that equitable subrogation was not an appropriate claim in this case. In a dissent joined by Judge Rivera, Judge Fahey reasoned that the health insurer should have been permitted to pursue a cause of action sounding in equitable subrogation.

In Term of Transition, Court Sides With Insurers; Court of Appeals: Insurance Law

New York Law Journal (Online)

August 21, 2017 Monday

New York Law Journal

Length: 1841 words

Byline: Evan H. **Krinick**

Body

It was a term of transition for the New York Court of Appeals, with Associate Judge Eugene Pigott Jr., retiring at the end of 2016, Associate Judge Rowan Wilson joining the Court in February 2017, Associate Judge Sheila Abdus-Salaam's death in April 2017, and Associate Judge Paul Feinman joining the Court at the end of June 2017. The recent changes in the composition of the Court and the fact that the most tenured judge (Associate Judge Jenny Rivera) has been on the Court for only four years make it difficult to predict how insurance law cases will be decided in the future. The one thing that can be said about the most significant insurance law cases decided by the Court this past term: They all were decided in favor of the insurance carriers.

'Burlington'

The decision with the most important practical implications for insurance companies and policyholders, Burlington Ins. Co. v. New York City Transit Authority, 2017 N.Y. Slip Op. 04384, came down on June 6, 2017. Judge Rivera wrote the majority decision, in which Chief Judge Janet DiFiore and Judges Michael Garcia and Wilson concurred. Judge Eugene Fahey dissented, in an opinion in which Judge Leslie Stein concurred.

The case arose after an employee of the New York City Transit Authority (NYCTA) fell off an elevated platform at an excavation site as he tried to avoid an explosion that occurred after a Breaking Solutions, Inc. (BSI) machine apparently touched a live electrical cable buried in concrete. The employee and his spouse brought an action against New York City and BSI in federal court, asserting Labor Law claims, negligence, and loss of consortium.

The city tendered its defense in the federal action to The Burlington Insurance Company, which had issued an insurance policy to BSI with an endorsement listing the NYCTA and MTA New York City Transit as "additional insureds."

The city impleaded the NYCTA and MTA and asserted third-party claims for indemnification and contribution, based on a lease between the NYCTA and the city as a property owner of certain transit facilities. Under the lease, the NYCTA had agreed to indemnify the city for liability "arising out of or in connection with the operation, management[,] and control by the [NYCTA]" of the leased property.

The NYCTA tendered its defense of these claims to Burlington, also as an additional insured under the BSI policy. Burlington accepted the defense, subject to the reservation that the NYCTA qualify as an additional insured under the additional insured endorsement to the policy.

Discovery in the employee's federal lawsuit revealed that the NYCTA had failed to identify, mark, or protect the electric cable, and that it also had failed to turn off the cable power. Documents further established that the BSI machine operator could not have known about the location of the cable or the fact that it was electrified. Based on these revelations, Burlington disclaimed coverage of the NYCTA and MTA, asserting that BSI had not been at fault for the injuries and, therefore, that NYCTA and MTA were not additional insureds under the policy.

The district court dismissed the employee's claims against BSI with prejudice and the city's third-party claims against NYCTA without prejudice. Burlington subsequently settled the lawsuit for $950,000 and paid the city's defense costs.

Then, Burlington filed its own action, in a state court in New York, seeking a declaratory judgment that it did not owe NYCTA and MTA coverage as additional insureds under the additional insured endorsement to BSI's insurance policy.

The Supreme Court, New York County, granted summary judgment in favor of Burlington, concluding that the NYCTA and MTA were not additional insureds because the endorsement limited liability to instances where BSI, as the named insured, was negligent.

The Appellate Division, First Department, reversed. It ruled that the NYCTA and MTA were entitled to coverage as additional insureds under the Burlington policy. The First Department concluded that although BSI had not been negligent, the "act of triggering the explosion ... was a cause of [the employee's] injury" within the meaning of the policy sufficient to afford additional insured coverage to the NYCTA and MTA.

The Court of Appeals granted Burlington leave to appeal. Burlington argued that under the plain meaning of the additional insured endorsement, the NYCTA and MTA were not additional insureds because the acts or omissions of the named insured, BSI, were not a proximate cause of the injury.

For their part, the NYCTA and MTA claimed that by its express terms the endorsement applied to any act or omission by BSI that resulted in injury, regardless of negligence on the part of an additional insured. They further argued that the First Department had properly concluded that BSI's operation of its excavation machine had provided the requisite causal nexus between injury and act to trigger coverage under the policy.

The Court reversed the First Department, concluding that there was no coverage because, by its terms, the policy endorsement was limited to those injuries proximately caused by BSI.

In its decision, the Court explained that the endorsement stated that an entity was an additional insured "only with respect to liability for 'bodily injury' caused, in whole or in part, by [BSI's] acts or omissions." The Court then rejected the argument put forth by the NYCTA and MTA that the endorsement did not limit liability to cases in which an insured's acts or omissions were negligent or otherwise legally actionable but, rather, that the phrase "caused, in whole or in part" meant "but for" causation. According to the Court, the NYCTA and MTA were "incorrect" when they argued that all that was necessary for an additional insured to be covered was that the insured's conduct "be a causal link to the injury."

Instead, the Court held, this policy language described "proximate causation" and legal liability "based on the insured's negligence or other actionable deed."

Among other things, the Court reasoned that the endorsement's reference to "liability" caused by BSI's acts or omissions confirmed that coverage for additional insureds was limited to situations where the insured was the proximate cause of the injury. According to the Court, the fact that the policy extended coverage to an additional insured "only with respect to liability" established that the "caused, in whole or in part, by" language limited coverage for damages resulting from BSI's negligence or some other actionable "act or omission."

The Court observed that BSI had not been at fault, and that the employee's injury was due to the NYCTA's sole negligence in failing to identify, mark, or de-energize the cable. Although "but for" BSI's machine coming into contact with the live cable, the explosion would not have occurred and the employee would not have fallen or been injured, that triggering act "was not the proximate cause of the employee's injuries," the Court ruled, because BSI was not at fault in operating the machine in the manner that led it to touch the live cable.

The Court was not persuaded by the dissent's contention that the majority's decision might have a "destructive" impact on liability insurance coverage in New York. The Court reasoned that to the extent additional insured coverage in this case would allow the NYCTA to compel a subcontractor to pay for injuries to its employee that the NYCTA had proximately caused, it was an outcome "not intended by the parties and contrary to the plain language of the endorsement."

The Court's decision restricts additional insured coverage in construction injury cases involving additional insureds in those situations where there is no liability on the part of the named insured. Had the Court decided the case in favor of the NYCTA and MTA and ruled that only a "but for" connection was necessary for additional insured coverage, untold numbers of entities might have received an unexpected- and unintended-windfall.

The Crane Case

On Feb. 14, 2017, the Court issued its decision in Lend Lease (US) Constr. LMB v. Zurich Am. Ins. Co., 28 N.Y.3d 675 (2017), which involved a dispute over insurance coverage for a tower crane damaged in

October 2012 by Superstorm Sandy. The crane had been installed on a reinforced slab on the 20th floor of a building being constructed on West 57th Street in Manhattan.

The question before the Court was whether the contractor's tools exclusion to the builder's risk insurance program excluded coverage for the crane. The Court, in a decision by Judge Fahey, in which Chief Judge DiFiore and Judges Rivera, Abdus-Salaam, Stein, and Garcia concurred, with Judge Wilson taking no part, ruled that the exclusion precluded coverage for damage to the crane.

Construing various provisions of the insurance policy, which it found unambiguous, the Court ultimately reasoned that the exclusion precluded coverage for tools, equipment, and machinery, and that the crane fell "squarely" within the definition of machinery as something "mechanically, electrically, or electronically operated device for performing a task." The Court added that, assuming that the policy contained coverage for the crane in the first instance, the fact that the exclusion defeated that coverage did not render the coverage afforded under the policy illusory.

Memorandum Decisions

There were several notable memorandum decisions issued by the Court this past term. For example, in Estee Lauder v. OneBeacon Ins. Group, 28 N.Y.3d 960 (2016), the Court held, without dissent, that an insurance carrier that had identified a "late notice" defense in early communications with a policyholder but had not specifically identified late notice in its disclaimer letters had not waived the right to assert the defense as a matter of law. Rather, under common law principles of waiver, triable issues of fact existed as to whether there was an intent to abandon the defense.

Finally, in Town of Amherst v. Granite State Ins. Co., 29 N.Y.3d 1016 (2017), a memorandum decision in which Chief Judge DiFiore and Judges Rivera, Garcia and Wilson concurred (and in which Judge Fahey took no part), the Court decided that, given the terms of the parties' insurance policy, which incorporated the rules of the American Arbitration Association, the issue of whether a later agreement between the parties affected the arbitrability of their dispute had to be resolved by the arbitrator.

Judge Stein dissented, concluding that the arbitration clause should be interpreted narrowly and that the determination of the arbitrability of the parties' dispute should be made by the courts.

Conclusion

Judge Feinman joined the Court after it had issued all of its insurance decisions for the term, and Judge Wilson concurred, without writing a decision of his own, in the few insurance cases in which he participated after he joined the Court. It will be interesting to see the positions these two new judges take in the insurance cases that come to the Court next term, and in future years.

Load-Date: August 19, 2017

End of Document

So Far, No Consistent Lineup of Judges For Carriers or Policyholders; Court of Appeals: Insurance Law

New York Law Journal

August 20, 2018 Monday

New York Law Journal

Section: COURT OF APPEALS AND APPELLATE PRACTICE; Pg. S10; Vol. 260; No. 35

Length: 1916 words

Byline: EVAN H. **KRINICK**

Body

A fter a term of transition for the New York Court of Appeals-with Associate Judge Eugene F. Pigott, Jr., retiring at the end of 2016, Associate Judge Rowan D. Wilson joining in February 2017, Associate Judge Sheila Abdus-Salaam's death in April 2017, and Associate Judge Paul G. Feinman joining at the end of June 2017-the 2017-2018 term was stable, and productive. The court decided seven significant insurance cases. In four, the court was unanimous. In two of the other cases, the court sided with insurers, while it gave policyholders a win in the remaining case. The court voted to affirm in three cases, reversed in three, and answered a certified question in the other. At this early stage in this court's history, there does not yet seem to be a consistent lineup of judges on the carrier or the policyholder side.

"Excess Line"

On Oct. 19, the court decided its first insurance case of the term, Excess Line Association of N.Y. v. Waldorf & Associates, 30 N.Y.3d 119 (2017), a unanimous decision by Judge Leslie E. Stein. The issue here was rather straightforward: Did the Excess Line Association of New York (ELANY)-a legislatively created advisory association under the supervision of the New York State Department of Financial Services (DFS)-have the capacity to sue its members to recover fees that it was statutorily authorized to receive and to compel an accounting to determine amounts allegedly owed.

The court held that it did not, ruling that ELANY's enabling statute did not expressly authorize ELANY to sue for that relief. Instead, the court said, the legislature intended that the DFS would be the primary enforcer of the Insurance Law and corresponding regulations. The statutorily enumerated powers of ELANY related to recordkeeping and education, rather than regulatory enforcement, the court concluded.

"American Economy"

The court's next insurance decision, American Economy Ins. Co. v. State of New York, 30 N.Y.3d 136 (2017), came down several days after Excess Lines, on Oct. 24. A unanimous decision by Judge Eugene M. Fahey, the case arose in the heavily regulated area of workers' compensation insurance.

The particular issue involved the Legislature's 2013 amendment to Workers' Compensation Law §25-a, which closed the Special Fund for Reopened Cases to new applications. The fund had been established in 1933 to ensure that injured workers with "closed" cases that unexpectedly "reopened" after many years would continue to receive necessary benefits even if the insurance carrier had become insolvent-and to protect insurance carriers and employers from uncertain future liability costs they might incur in these "stale" cases. The fund was financed by assessments on carriers, which passed them on to their insureds through policyholder surcharges.

Insurers challenged the amendment, asserting that it operated retroactively to the extent that it imposed unfunded liability on insurers in connection with future reopened claims made on policies finalized before the amendment's effective date. The court rejected that position, ruling that even assuming that the amendment had retroactive impact to the extent it imposed unfunded liability costs on insurers under policies finalized before the amendment's effective date, it was constitutionally permissible. The court reasoned that the closure of the fund did not impair any terms of the insurers' contracts with their insureds. In the court's view, the amendment "merely altered the allocation of costs" of reopened cases by removing an avenue for carriers to transfer those cases to the fund and then to pass assessments for the costs of those cases to their insureds.

At most, the court concluded, the insurers' contracts with their insureds became "less profitable."

"Global Reinsurance"

The court issued its third unanimous insurance decision on Dec. 14, in response to a question certified to it by the U.S. Court of Appeals for the Second Circuit. Global Reinsurance Corp. of America v. Century Indemnity Co., 30 N.Y.3d 508 (2017), was the first insurance decision by Judge Feinman since he joined the court.

In this case, the Second Circuit asked whether, under the court's decision in Excess Insurance Co. v. Factory Mutual Insurance, 3 N.Y.3d 577 (2004), a per occurrence liability cap in a reinsurance contract limited the total reinsurance available under the contract to the amount of the cap regardless of whether the underlying policy covered the reinsured's expenses such as defense costs.

The court answered the certified question in the negative. It explained that reinsurance contracts were governed by the same principles that governed contracts generally and it held that New York law does not impose either a rule, or a presumption, that a limitation on liability clause necessarily caps all obligations owed by a reinsurer without regard for the specific language employed therein. Quoting from Knight-Ridder Broadcasting v. Greenberg, 70 N.Y.2d 151, 160 (1987), the court said that, despite language to the

contrary in Essex, that decision was not controlling under the important appellate doctrine that principles of law "are not established by what was said, but by what was decided, and what was said is not evidence of what was decided, unless it relates directly to the question presented for decision."

"Keyspan"

On March 27, the court issued its fourth unanimous insurance law decision, another by Judge Stein. KeySpan Gas East Corp. v. Munich Reinsurance America, Inc., 31 N.Y.3d 51 (2018), involved so called "long-tail" insurance claims, stemming from environmental contamination caused by manufactured gas plants owned and operated by the Long Island Lighting Company beginning in the late 1880s and early 1990s. LILCO's successor, KeySpan Gas East Corporation, sought coverage for the costs of remediating the contamination under insurance policies that had been issued between 1953 and 1969.

The insurer sought a declaration that it was not responsible for any portion of the property damage at the sites that had occurred outside of its policy periods, and that the costs should be allocated pro rata over the entire period during which property damage at each site had occurred. For its part, KeySpan argued that the insurer's pro rata share should not be reduced by factoring in the years in which pollution property damage liability insurance was unavailable-namely, before 1925-and after a "sudden and accidental pollution exclusion" was generally adopted by the insurance industry in or after October 1970.

The court agreed with the insurer and rejected the proposed "unavailability rule." The court pointed out that the insurer's policies limited the insurer's liability to losses and occurrences happening "during the policy period." It reasoned that applying the unavailability rule to insurance policies that directed pro rata allocation would effectively provide insurance coverage to policyholders for years in which no premiums had been paid and in which insurers had made the choice not to assume or accept premiums for those risks. The court concluded that the average insured would not expect to receive coverage without regard to the number of years for which it had purchased applicable insurance.

Pro-Insurers

The two cases that divided the court, with the majority ruling in favor of insurers, were Gilbane Building Co./TDX Construction v. St. Paul Fire and Marine Ins., 31 N.Y.3d 131 (2018), decided on March 27 (5-2) and Contact Chiropractic v. New York City Transit Authority, 31 N.Y.3d 187 (2018), decided on May 1 (4-3).

Gilbane arose after the construction manager for a New York City project was sued and sought "additional insured" coverage under an insurance policy issued to the project's general contractor. The policy afforded additional insured coverage to any organization "with whom" the general contractor "agreed to add as an additional insured by written contract."

The majority of the court, in an opinion by Judge Wilson, ruled that the construction manager was not entitled to additional insured coverage under the policy because there was no contract between the construction manager and the general contractor that required that the general contractor obtain insurance

naming the construction manager as an additional insured. According to the majority, the endorsement was clear and unambiguous and consideration of extrinsic evidence was not appropriate.

The dissent, by Judge Stein in an opinion in which Chief Judge Janet DiFiore concurred, argued that the policy language was ambiguous and that the construction manager was entitled to additional insured coverage under the policy because there was a contract-albeit not between the construction manager and general contractor-that required that the construction manager be named an additional insured under the general contractor's insurance policy.

Judge Fahey wrote the majority opinion in Contact Chiropractic, concluding that the three-year statute of limitations set forth in CPLR 214(2), which applies to actions to recover on a liability created or imposed by statute, applied to a claim for no-fault benefits against a self-insurer. The majority reasoned that the disputed no-fault benefits were not provided by a contract with a private insurer but, rather, that the source of the claim was "wholly statutory."

Judge Garcia, in a dissenting opinion in which Judges Rivera and Wilson concurred, would have held that an action to recover no-fault benefits-whether from insurers or self-insurers-was subject to a six-year statute of limitations.

Judge Stein concurred with the majority in a brief opinion explaining that the court had not resolved whether no-fault insurers themselves were subject to a threeor sixyear statute of limitations.

Pro-Policyholder

Judge Fahey took no part in Carlson v. American International Group, Inc., 30 N.Y.3d 288 (2017), and the remaining six members of the court were equally divided. Judge Wilson wrote the majority opinion (which was his first insurance decision since joining the court), in which Judges Rivera and Feinman concurred, while Judge Garcia wrote the dissent, in which Chief Judge DiFiore and Judge Stein concurred. The court vouched in Appellate Division Justice Randall T. Eng under the procedure in Article VI, Section 2, of the New York State Constitution-and the justice's vote essentially was determinative.

The majority and dissenting opinions disagreed about, among other things, the application of Insurance Law §3420(a), which allows a limited cause of action on behalf of injured parties directly against insurers of policies "issued or delivered in this state." Insurance Law §3420 does not define the term "issued or delivered in this state," and the majority gave it an expansive reading, holding that it encompassed situations where both insureds and risks were located in New York. The minority, concerned that the majority had misinterpreted Section 3420(a) "in a manner that enacts sweeping change across the Insurance Law," rejected its conclusion. The minority reasoned that the excess insurance policy that was the subject of the case, which had been issued by an insurer from New Jersey and delivered to the insured in Washington and then in Florida, had not been "issued or delivered" in New York as that phrase was ordinarily understood. The implications of the majority's decision remain to be seen.

Evan H. Krinick, managing partner of Uniondale's Rivkin Radler, can be reached at evan.krinick@rivkin.com

Load-Date: August 20, 2018

End of Document

Court Issues Three Major Insurance Rulings, Sets the Stage for Next Term

New York Law Journal

August 19, 2019 Monday

New York Law Journal

Section: COURT OF APPEALS: INSURANCE LAW; Pg. S6; Vol. 262; No. 35

Length: 1912 words

Byline: EVAN H. **KRINICK**

Body

T he New York Court of Appeals decided three important insurance cases in its 2018-2019 term. Judge Rowan D. Wilson was the sole dissenter in the first two, with the Court reaching a unanimous decision in the third, and most significant, of the trio. The Court also began to arrange its insurance caseload for next term by accepting a certified question from the U.S. Court of Appeals for the Second Circuit and by granting leave to appeal in another case.

Additional Compensation

In December, the Court decided Matter of Mancini v. Office of Children and Family Services, 32 N.Y.3d 521 (2018), which involved Workers' Compensation Law (WCL) §15(3)(v) (Paragraph V), which permits certain permanently partially disabled workers who have exhausted their schedule awards to apply for "additional compensation."

The case arose in 2008, when Steven Mancini was injured while working as an aide at a facility run by the Office of Children & Family Services (OCFS). A workers' compensation law judge (WCLJ) found that Mancini had suffered a 50% loss of use of his left arm and, therefore, that he was entitled to a 156-week "schedule loss of use" award pursuant to WCL §15(3)(a)-(u), the statutory schedule providing wage-based compensation for permanent partial disability arising from injury to certain body parts and for serious facial or head disfigurement.

When Mancini's schedule loss of use award was exhausted, he applied for and was awarded additional compensation under Paragraph V. Paragraph V incorporates by reference WCL §15(3)(w) (Paragraph W), stating that additional compensation under Paragraph V "shall be determined in accordance with [P] aragraph [W]."

At the hearing on Mancini's application, an issue arose regarding which portions of Paragraph W's framework for calculating benefits applied to an additional compensation award under Paragraph V.

The WCLJ determined that Paragraph V incorporated only the Paragraph W formula for determining the sum of each weekly payment and not the portion of Paragraph W stating the number of weeks the benefits were to be awarded.

The workers' compensation board rejected that interpretation, however, and concluded that Paragraph W's durational limits applied to additional compensation awards under Paragraph V. After further proceedings, the board ultimately determined that Mancini lost 37.5% of his wage-earning capacity and was entitled, based on the Paragraph W calculation, to 275 weeks of additional compensation under Paragraph V due to the injury to his arm.

The Appellate Division, Third Department, affirmed, and the case reached the Court of Appeals. There, Mancini argued that Paragraph V incorporated only Paragraph W's formula for calculating the weekly payment amount and not Paragraph W's durational component setting forth the number of weeks that sum was paid. The board countered that Paragraph V incorporated by reference the entirety of Paragraph W's framework for calculating benefits, including its durational limits.

The Court, in a decision by Chief Judge Janet DiFiore, agreed with the board. The Court found that the "plain text" of Paragraph V adopted, without qualification, Paragraph W's process for determining the size and scope of a disability award and incorporated the "entirety" of Paragraph W's framework for calculating benefits, including both the Paragraph W formula "for determining a weekly benefit payment" and the portion of that provision "setting the maximum number of weeks" the sum was to be paid.

Accordingly, the Court concluded that the board had properly computed the additional compensation benefits payable to Mancini.

Judge Wilson dissented, explaining that in his view the durational provision of Paragraph W did not apply to the calculation of additional compensation under Paragraph V.

Risk Retention Groups

On June 11, the Court decided Nadkos, Inc. v. Preferred Contractors. Ins. Co. Risk Retention Group LLC, No. 37 (N.Y. June 11, 2019), which involved an insurance coverage dispute between Nadkos, Inc., a general contractor sued by an employee of a Nadkos subcontractor, and the subcontractor's general liability insurer, a risk retention group (RRG) chartered in Montana and doing business in New York. An RRG is an issuer of insurance owned and operated by insureds that work in the same industry and that are exposed to similar liability risks.

Here, Nadkos sought additional insured coverage of the subcontractor's employee's lawsuit under the policy that the RRG had issued to the subcontractor.

After the RRG disclaimed coverage based on certain exclusions in the policy, Nadkos sought a declaratory judgment that the policy obligated the RRG to defend and indemnify Nadkos. Nadkos also

maintained, without objection from the RRG, that the RRG's disclaimer was untimely. As a result, Nadkos argued, the disclaimer was void under Insurance Law §3420(d)(2), which provides that if "an insurer shall disclaim liability or deny coverage ... it shall give written notice as soon as is reasonably possible."

The Supreme Court, New York County, granted summary judgment in favor of the RRG, the Appellate Division, First Department, affirmed, and the case reached the Court of Appeals.

The Court, in an opinion by Justice Jenny Rivera, affirmed. It held that foreign RRGs are not subject to §3420(d)(2) and its requirement that insurers "disclaim" liability as soon as is reasonably possible.

The Court reasoned that §3420(d)(2) does not apply to RRGs because it does not involve a failure to promptly "disclose" coverage within the meaning of Insurance Law §2601(a) (6), the statutory provision applicable to foreign RRGs.

Therefore, the Court concluded, the RRG was not barred from asserting coverage defenses as applied to Nadkos.

Justice Wilson once again dissented, declaring that §3420(d)(2) by its terms applied "to all liability insurers operating in this state," including foreign RRGs and the policy the RRG had issued to Nadkos' subcontractor.

Non-Physician-Owned Medical Providers

Also on June 11, the Court issued its decision in Andrew Carothers, M.D., P.C. v. Progressive Ins. Co., No. 39 (N.Y. June 11, 2019), the insurance decision with the most significant practical implications from this past term because it strengthened the ability of insurers to refuse to pay claims submitted by medical providers secretly owned by non-physicians in violation of New York's prohibition of the corporate practice of medicine.

The case involved Andrew Carothers, M.D., P.C., a professional service corporation formed in 2004 by Andrew Carothers, M.D., a radiologist. The PC provided magnetic resonance imaging services to patients, including those allegedly injured in motor vehicle accidents. The patients assigned their rights to receive first-party no-fault insurance benefits to the PC, which billed insurance companies to recover payment on the assigned claims.

Insurance companies stopped paying the PC's no-fault claims in 2006 and the PC sued. The insurers asserted that, under State Farm Mutual Automobile Ins. Co. v. Mallela, 4 N.Y.3d 313 (2005) (a case in which my firm and I were co-counsel for State Farm), and 11 N.Y.C.R.R §65-3.16(a)(12), the PC was not eligible to seek reimbursement of the insurance benefits because Carothers was merely a nominal owner of the PC and the PC actually was owned and controlled by individuals who were not physicians.

The PC asserted that Mallela allowed insurers to withhold payments under 11 NYCRR 65-3.16(a)(12) only where the professional corporation's ostensible or real managers had engaged in conduct "tantamount to fraud," which it claimed the insurers had not demonstrated.

A jury found that the insurers had proved that the PC was "fraudulently incorporated," and, accordingly, not entitled to recover the payment it sought from the insurers. The case reached the Court of Appeals.

The Court, in a unanimous decision by Judge Eugene M. Fahey, upheld the decision in favor of the insurance companies. It ruled that Mallela does not require a finding of fraud for an insurer to withhold payments to a medical service corporation improperly controlled by non-physicians.

In particular, the Court ruled that, under Mallela and 11 NYCRR 65-3.16(a)(12), an insurance carrier need not demonstrate that a professional service corporation or its managers engaged in common law fraud in order to deny payment of no-fault benefits. Rather, the Court stated, a corporate practice that shows "willful and material failure to abide by" licensing and incorporation statutes may support a finding that the provider is not an eligible recipient of reimbursement under the no-fault rules.

The Court concluded that the jury's finding that the PC was in material breach of the "foundational rule" for professional corporation licensure-that it violated the principle of control by licensed professionals-was enough to render the PC ineligible for reimbursement.

And for Next Term ...

As noted above, the Court already has agreed to decide two insurance-related cases next term.

In March, in Haar v. Nationwide Mutual Fire Ins. Co., No. 48 (N.Y. March 21, 2019), the Court accepted a certified question from the Second Circuit in a case that began when an orthopedic surgeon sued an insurance company, alleging that the insurer had submitted a report about him in bad faith to the New York State Office of Professional Medical Conduct (OPMC). The surgeon asserted a cause of action for damages pursuant to Public Health Law §230(11)(b).

The U.S. District Court for the Southern District of New York dismissed the cause of action asserted by the surgeon under §230(11)(b), holding that the New York Court of Appeals, were it faced with the question, would find that the statute did not create a private right of action. Section 230(11)(b) states that "[a]ny person, organization, institution, insurance company, osteopathic or medical society who reports or provides information to the [state board for professional misconduct] in good faith, and without malice shall not be subject to an action for civil damages or other relief as the result of such report."

The surgeon appealed, arguing that there was an implied cause of action under the statute for complaints made in bad faith to the OPMC. The Appellate Division, Second Department, has determined that there is no private right of action, while the Appellate Division, First Department, has reached the opposite result.

The Second Circuit asked the Court of Appeals to decide whether §230(11)(b) creates a private right of action for bad faith and malicious reporting to the OPMC.

Excess Insurance

Finally, in June, the Court granted the plaintiff leave to appeal in Chen v. Insurance Company of Pennsylvania, No. 2019-337 (N.Y. June 11, 2019).

In this case, the Court will consider questions related to the obligations of an excess carrier for interest on a judgment based on an excess policy that "follows form" to the underlying policy.

Conclusion

The Court's decisions this past term on issues relating to workers' compensation payments, risk retention groups, and no-fault insurance claims reflects the Court's continuing interest in a wide range of insurancerelated questions. That will continue next term, with the Court already having agreed to decide two cases involving other important insurance subjects.

Evan H. Krinick, managing partner of Rivkin Radler, is the Insurance Fraud columnist for the New York Law Journal. Mr. Krinick can be reached at evan.krinick@rivkin.com

Load-Date: August 20, 2019

Court Covers Broad Range of Topics in Insurance Rulings

New York Law Journal

August 27, 2020 Thursday

Section: INSURANCE LAW
Byline: EVAN H. KRINICK

Body

As unique as the past term of the New York Court of Appeals was – taking place in the midst of the COVID-19 pandemic, which led the Court to eliminate oral arguments in March, April, and May and to hear oral arguments in June via videoconferencing – there were some important similarities to prior terms.

Continuing its trend, the Court issued decisions in a wide variety of insurance cases; three of the Court's four significant insurance rulings were unanimous; and two of those four reached the Court by certification from federal circuit courts (as did an increasing number of other non-insurance cases).

Moreover, the observation I made two years ago in this column – that there does not yet seem to be a consistent lineup of judges on the carrier or the policyholder side – still holds true.

Arbitration

Many insurance disputes between carriers have long been resolved by arbitrators rather than by courts. In some cases, insurance policies themselves contain arbitration clauses, as did the policies in *American International Specialty Lines Ins. Co. v. Allied Capital Corp.*, No. 23 (N.Y. April 30, 2020). The Court, in an opinion by Judge Leslie Stein, unanimously upheld a determination by an arbitration panel to reconsider a partial final award.

Insurance Fraud

Perhaps none of the Court's insurance decisions from this past term will have as important a practical impact as its ruling in *Haar v. Nationwide Mutual Fire Ins. Co.*, 34 N.Y.3d 224 (2019).

Click here to return to the List of Indices

The case arose when a surgeon, Dr. Robert Haar, treated four patients who had been injured in automobile accidents and who were insured by Nationwide Mutual Fire Insurance Company. Haar submitted claims to Nationwide, which the insurer either fully or partially denied.

Thereafter, Nationwide filed complaints with the Office of Professional Medical Conduct (OPMC) alleging insurance fraud. After an investigation, the OPMC declined to impose any discipline against Haar. He then sued Nationwide, asserting that the insurer's complaints to the OPMC lacked a good faith basis in violation of Public Health Law § 230(11)(b). Section 230(11)(b) states that "[a]ny person, organization, institution, insurance company, osteopathic or medical society who reports or provides information to the [OPMC] in good faith, and without malice shall not be subject to an action for civil damages or other relief as the result of such report."

Nationwide argued that Section 230(11)(b) did not provide Haar with the right to assert a bad faith claim. The case reached the U.S. Court of Appeals for the Second Circuit, which certified the following question to the Court: Does New York Public Health Law Section 230(11)(b) create a private right of action for bad faith and malicious reporting to the OPMC?

The Court, in a unanimous decision by Judge Stein (with Judge Michael Garcia taking no part), answered the certified question in the negative, finding "no indication that the legislature intended to create a private right of action" in Section 230(11)(b). The Court stated that the text and legislative history of Section 230(11)(b) establish that, to encourage increased reporting of unprofessional conduct, "the legislature specifically sought to *shield complainants* from liability by imparting a limited immunity from civil actions commenced by regulated entities."

The Court's decision has important ramifications for all those who file reports with the OPMC, including insurance companies. Insurers are required by New York's no-fault law and implementing regulations to report "patterns of overcharging, excessive treatment or other improper actions by a health provider." Had the Court authorized bad faith lawsuits against insurers that file these reports, carriers

Click here to return to the List of Indices

likely would have faced a blizzard of lawsuits by physicians who are the subjects of these reports. The Court's decision avoids that result, and allows the statutory procedures to work as the legislature intended.

General Business Law §§ 349, 350

Judge Stein was the author of yet another unanimous insurance decision: *Plavin v. Group Health Inc.*, 35 N.Y.3d 1 (2020). This case reached the Court after the U.S. Court of Appeals for the Third Circuit asked it to decide whether the plaintiff, a retired New York City police officer, had sufficiently alleged consumer-oriented conduct to assert claims under General Business Law (GBL) Sections 349 and 350 for damages allegedly incurred due to materially misleading representations an insurance company allegedly made to New York City employees and retirees about the terms of its insurance plan to induce them to select it from among 11 health insurance plans.

GBL Section 349 makes unlawful any "[d]eceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state." Similarly, GBL Section 350 makes "[f]alse advertising in the conduct of any business, trade or commerce or in the furnishing of any service in this state" unlawful. To state a claim under these sections, a plaintiff must allege, among other things, that a defendant had engaged in "consumer-oriented conduct."

In *Plavin*, the Court observed that, by providing a choice of 11 options, the city created a health insurance marketplace for its employees and retirees, and the insurer's summary materials "contained the only information" provided to city employees and retirees when determining whether to select the insurer's plan. Under these circumstances, the Court held, the complaint "adequately alleged consumer-oriented conduct."

It remains to be seen if the Court's decision in *Plavin* will help clarify the "consumer-oriented conduct" requirement or will help trial and appellate courts that continue to struggle with the standard. Consider that, just about one week after *Plavin*, the Court issued a memorandum opinion in *Collazo v. Netherland Property Assets LLC*, No. 5 (N.Y. April 2, 2020), reaching a different result than it reached in *Plavin*. The Court in *Collazo* upheld the dismissal of a GBL Section 349 claim, finding that the plaintiffs

Click here to return to the List of Indices

failed to allege more than "bare legal conclusions" regarding the existence of consumer-oriented, deceptive acts. Neither the Court's memorandum decision, nor the partial dissent by Judge Jenny Rivera, cited *Plavin*.

New York has no bad faith statute providing a private right of action. In its stead, GBL Section 349 has been utilized and continues to be a source of litigation as to its scope and applicability.

Unemployment Insurance

The Court decided an interesting workplace-related insurance case this past term, involving the question of deference to an administrative agency.

The issue before the Court in *Matter of Vega*, No. 13 (N.Y. March 26, 2020), was whether there was substantial evidence supporting the decision of the Unemployment Insurance Appeals Board that Luis Vega, a former courier for the delivery business Postmates, Inc., and others similarly-situated were employees for whom Postmates was required to make contributions to the unemployment insurance fund.

The New York State Department of Labor initially determined that Vega was an employee of Postmates, requiring that Postmates pay unemployment insurance contributions on Vega's earnings as well as on the earnings of "all other persons similarly employed." An administrative law judge sustained Postmates' objection, concluding that Vega was an independent contractor and reasoning that Postmates had not exercised sufficient supervision, direction, and control over Vega to establish an employer-employee relationship.

The board reversed, overruled Postmates' objection, and sustained the department's initial determination that Vega was an employee.

Postmates appealed to the Appellate Division, Third Department, which reversed the board's determination. The Third Department concluded that "[w]hile proof was submitted with respect to Postmates' incidental control over the couriers," the proof "d[id] not constitute substantial evidence of an employer-employee relationship to the extent that it fail[ed] to provide sufficient indicia of Postmates' control over the means by which these couriers perform their work." Two dissenting justices would have

Click here to return to the List of Indices

confirmed the board decision, concluding that there was substantial evidence supporting its determination that Vega was an employee of Postmates.

The Court, in an opinion by Chief Judge Janet DiFiore, in which Judges Stein, Eugene M. Fahey, and Paul G. Feinman concurred, explained that the board traditionally considers a number of factors in determining whether a worker is an employee or an independent contractor, but that the "touchstone of the analysis" is whether the employer exercised control over the results produced by the worker or the means used to achieve the results.

The Court noted that a determination by the board, "if supported by substantial evidence on the record as a whole," was beyond further judicial review even though there might be evidence in the record supporting a contrary conclusion. Moreover, the Court added, substantial evidence was a "minimal standard" requiring "less than a preponderance of the evidence."

The Court rejected the contention put forth by Judge Rivera in a separate opinion concurring in the result and by Judge Rowan D. Wilson in a dissenting opinion, in which Judge Garcia concurred, that the Court should devise a different test for analyzing whether a worker is an employee or independent contractor. Among other things, the Court said that whether a different definition or test should apply to employees generally, or to couriers in particular, was a policy question for the legislature.

The Court then found that the board's determination that the couriers were employees was supported by "substantial evidence" in the record. Accordingly, the Court reversed the Third Department and reinstated the board's decision.

Setting the Stage

Finally, the Court already has agreed to hear two important insurance coverage cases in its next term.

At the end of March, the Court again agreed to hear an appeal in *J.P. Morgan Securities, Inc. v. Vigilant Ins. Co.*, 166 A.D.3d 1 (1st Dep't 2018). This is the second time the case has reached the Court. *J.P. Morgan Securities, Inc. v. Vigilant Ins. Co.*, 21 N.Y.3d 324 (2013).

Click here to return to the List of Indices

The dispute arose out of the insured's settlement of a Securities and Exchange Commission (SEC) proceeding and related private litigation predicated on the insured's alleged violations of federal securities laws. The Appellate Division, First Department, concluded that the insurers did not have to cover the $140 million portion of the SEC settlement that amounted to "disgorging" allegedly improper profits acquired by third-party hedge fund customers. (The insured did not seek coverage for the $20 million portion representing its own allegedly ill-gotten gains.) The First Department held that the SEC disgorgement was an "uninsurable penalty" and not a "loss" covered by the insured's policies – which now is an issue squarely before the Court.

Then, in early May, the Court accepted certification from the Second Circuit in *Brooklyn Center for Psychotherapy, Inc. v. Philadelphia Indemnity Ins. Co.*, 955 F.3d 305 (2d Cir. 2020), involving a dispute over the scope of a commercial general liability insurance policy.

In this case, a hearing impaired woman sued Brooklyn Center for Psychotherapy, Inc., for allegedly failing to accommodate her disability. Brooklyn Center sought defense costs for that lawsuit from its insurer. The insurer denied coverage and Brooklyn Center sued.

The case reached the Second Circuit, which explained that the question it had to decide was whether Brooklyn Center's alleged failure to accommodate the woman's disability constituted an "occurrence" under Brooklyn Center's insurance policy. Finding that the New York Court of Appeals had not directly addressed that subject, it certified the following question to the Court:

> Must a general liability insurance carrier defend an insured in an action alleging discrimination under a failure-to-accommodate theory?

Conclusion

Click here to return to the List of Indices

Just days ago, the Court changed argument dates for its September and October sessions and released its calendar of sessions for 2021. All members of the bench and bar are hopeful that the next term of the Court will see a return to its normal practices.

Click here to return to the List of Indices