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QUARTERLY INSURANCE COVERAGE NEWSLETTER: NEW YORK

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FEATURED DECISION:

On February 19, 2008, the New York Court of Appeals held, in a strongly contested decision (5 to 2), that an insured was permitted to seek consequential damages against its insurer under a breach of covenant of good faith and fair dealing claim. **Bi-Economy Mkt., Inc. v. Harleysville Ins. Co. of New York,** 2008 WL 423451 (Court of Appeals, February 19, 2008) (We note that the Court also rendered a parallel decision that same day in **Panasia Estates, Inc. v. Hudson Ins. Co.,** 2008 WL 420014, relying upon its analysis in Bi-Economy. The Panasia Estates case is discussed further below.)

In Bi-Economy, the insured, Bi-Economy Market, Inc. ("Bi-Economy"), commenced an action against Harleysville Insurance Company of New York ("Harleysville"), which issued a "Deluxe Business Owner's policy", asserting "bad faith claims handling, tortious interference with business relations and breach of contract," and seeking consequential damages above and beyond the policy's limits for the "complete demise of its business operation in an amount to be proved a trial." In sum, Bi-Economy alleged that Harleysville improperly delayed payment for its building and contents damage which was caused by a major fire and failed to timely pay the full amount of its lost business income claim, causing Bi-Economy's business to collapse, for which is sought recovery. In response, Harleysville argued that its policy excluded coverage for consequential damages and, in support, cited several contractual provisions excluding coverage for "consequential loss." The majority, rejecting Harleysville's arguments, held that Bi-Economy was permitted to seek such consequential damages.

According to the dissent, the majority sought to abandon the rule set forth in Rocanova v. Equitable Life Assur. Soc'y of U.S., 83 N.Y.2d 603 (1994) and New York Univ. v. Cont'l Ins. Co., 87 N.Y.2d 308 (1995), which rejected the argument that a bad faith failure by an insurer to pay a claim could, without more, justify a punitive damages award. The dissent claimed that the majority was "simply changing labels: punitive damages are now called 'consequential' damages and bad faith failure to pay a claim is called a 'breach of covenant of good faith and fair dealing.'"

The majority opinion contended, however, that the dissent "blurs the significant distinction between consequential and punitive damages." According to the majority, consequential damages are designed to compensate a party for reasonably foreseeable damages, must be proximately caused by the breach and must be proven by the party seeking them. In contrast, punitive damages, are assessed by way of punishment and, unlike consequential damages, are "unquantifiable." According to the majority, "[l]imiting an insured's damages to the amount of the policy, *i.e.*, money which should have been paid by the insurer in the first place, plus interest, does not place the insured in the position it would have been in had the contract been performed."

In addition, the majority stated: "[C]ontrary to the dissents view, the purpose of the contract was not just to receive money, but to receive it promptly so that in the aftermath of a calamitous event…the business could avoid collapse and get back on its feet as soon as possible. Thus, the insurance contract included an additional performance based component: the insurer agreed to evaluate the claim, and to do so honestly, adequately, and most importantly-promptly…When an insured…suffers additional damages as a result of an insurer's excessive delay or improper denial, the insurance company should

PENDING BILLS OF INTEREST IN THE NEW YORK LEGISLATURE:

FEATURED BILLS:

NOTICE:

A9059: Proposes that an insurer shall not deny coverage for a claim based on the failure of an insured to give timely notice unless the insurer can demonstrate that it has suffered substantial prejudice as a result of the delay. This legislation purports to ensure that the consumer can seek the benefits of an insurance policy for which they paid regardless of the time frame for filing a notice of claim.

A9188: Requires insurers to show prejudice resulting from the failure of the insured to provide notice within the prescribed time frame in the policy in order to invalidate coverage. Prejudice shall be found where: (a) late notice prevents an insurer from determining whether an affirmative defense is available; (b) delayed notice prevents the insurer from pursuing claims against third parties; (c) the insured admits liability prior to giving notice; (d) the insured consents to a judgment prior to giving notice; or (e) the insured makes a damaging statement prior to giving notice.

A486: Proposes to require notice of cancellation and non-renewal of insurance policies to be sent by registered mail.

A6208: Proposes to determines workers' compensation rates based upon number of hours worked for an employer; provides that workers' compensation insurance premiums for construction trades be based on hours worked rather than wages paid to the employees. The reasoning behind the bill is that utilization of the salaries of employees serves as a competitive disadvantage to those employers who choose to compensate their workers at a higher wage level. In a "low bid" environment, this formula unfairly acts against union contractors who have negotiated terms and conditions favorable to the bargaining unit employees. Calculation of rates based on hours worked would be a

stand liable for these damages. This is not to punish the insurer, but to give the insured its bargained-for-benefit."

The majority did not read the contractual liability exclusions for certain consequential "losses" as demonstrating that the parties contemplated, and rejected, the recoverability of consequential "damages". According to the majority, consequential "losses" refer to delay caused by third-party actors or by the "suspension, lapse or cancellation of any license, lease or contract," and consequential "damages" are in addition to those losses caused by a calamitous event, and include additional damages caused by a carrier's injurious conduct – in this case, the insurer's failure to timely investigate, adjust and pay the claim.

Panasia Estates, Inc. v. Hudson Ins. Co., 2008 WL 420014 (Court of Appeals, February 19, 2008) Relying upon its reasoning in BI-Economy (above), the Court again held that a claim for consequential damages resulting from a breach of the covenant of good faith and fair dealing may be asserted against an insurer, so long as the damages were "within the contemplation of the parties as the probable result of a breach at the time of or prior to contracting."

NOTICE:

Briggs Avenue L.L.C. v. Ins. Co. of Hannover, 516 F.3d 42 (2d Cir., February 15, 2008) The United States Court of Appeals for the Second Circuit has certified the following question to the New York Court of Appeals: When an injured party begins its suit against an insured by serving process on the Secretary of State, who, under New York law, is the insured's agent for service, does this service suffice to trigger the provisions in the relevant insurance policy that require the insured to inform its insurer in a timely manner that such a suit has been brought, where: (i) the insurance policy does not expressly refer to notice by an insured's "representative" rather than the insured itself, and (ii) the insured plausibly argues that – due to its failure to update its address with the Secretary of State – it had not received actual notice that the suit had been brought?

York Specialty Food, Inc. v. Tower Ins. Co., 47 A.D.3d 589 (1st Dep't, January 31, 2008) The Appellate Division, First Department, found that notice was not provided within a reasonable time where the plaintiff-insured became aware of a claimant's accident after three days, but did not notify the defendant-insurer of the possibility of a claim until eight months later. Although a good-faith belief in non-liability may excuse the failure to give timely notice, there was no indication that the insured took any action to ascertain its potential liability for the claimant's accident.

U.S. Underwriters Ins. Co. v. Carson, 2008 WL 740337 (3rd Dep't, March 20, 2008) An injured party has an independent right to give notice to an insurer so as to preserve his or her ability to proceed against the insurer to collect upon an unsatisfied judgment pursuant to Insurance Law §3420(d)(2). The notice required of an injured party to an insurer is measured less rigidly than the notice required of an insured, "since what is reasonably possible for the insured may not be reasonably practical for the injured person."

Donovan v. Empire Ins. Group, 2008 WL 669906 (2d Dep't, March 11, 2008) Insured's delay in providing notice of occurrence to insurer for nineteen (19) months after receipt of a claim letter from the injured party's attorney was in violation of the policy conditions, and the insurer was, therefore, under no obligation to provide coverage.

City of New York v. Welsbach Elec. Corp., 852 N.Y.S.2d 134 (1st Dep't, March 11, 2008) Where the named insured and additional insured were adverse parties in an underlying action, the additional insured had an independent obligation to provide timely written notice of the claim to the insurer.

more accurate measure of actual risk on the job while eliminating the completive disadvantage.

A1956: Proposes to authorize the Insurance Department to more aggressively police Insurance Law prohibitions on unfair claim practices by eliminating the requirement that insurers engage in such acts as a "general business practice." Under current law, before the Insurance Department will take enforcement action and impose penalties for violations of the unfair claim settlement practices statute, insurers must perform unfair claim settlement practices with excessive frequency, meaning in ten (10) to twenty (20) percent of the claims files examined in market conduct studies.

A02859: Prohibits discrimination in the issuance of homeowner's insurance policies based upon the property's location or age of structure. In addition, it also carries various provisions clarifying prohibition on refusal to issue or renew certain policies including homeowner's fire and extended coverage based solely on geographical location.

A07595: Provides that with respect to a serious personal injury action permissible under the no-fault insurance system, the award or decision of an arbitrator rendered in a no-fault arbitration will not constitute collateral estoppel of the issues arbitrated, but such an award or decision may be admissible as relevant evidence by a party to an action.

S194: Provides for a reduction in workers' compensation and employers' liability insurance rates for certain work subject to Sections 240 or 241 of the Labor Law and for introduction of comparative negligence in those suits. It also provides for an additional supplemental workers' compensation benefit for disability or death in such cases.

S635: Provides that upon divorce, annulment or dissolution of a marriage, the designation of a former spouse as beneficiary of a group life insurance policy is revoked, unless subsequently provided by a court order or by completion of a new designation document.

S1833: Seeks to enact the "New York State Catastrophe Fund Authority Act" for the purpose of facilitating the creation of innovative solutions to property insurance crises and to ensure the viability of insurance carriers in the state; will appropriate $10,000,000 to initiate such fund.

DISCLAIMER OF COVERAGE:

Sirus Am. Ins. Co. v. Vigo Constr. Corp., 48 A.D.3d 450 (2d Dep't, February 5, 2008) The Appellate Division, Second Department, found that an insurer's written disclaimer sent thirty-four (34) days after it knew or should have known of the basis for denying coverage was unreasonable as a matter of law and thus ineffective.

CHOICE OF LAW:

Tradin Organics USA, Inc., v. Maryland Cas. Co., 2008 WL 241081 (S.D.N.Y., January 29, 2008) Pursuant to a choice of law analysis, the Southern District applied New Hampshire law when interpreting an insurance policy based upon the following: (i) the policy was issued to a New Hampshire agent on behalf of the insured; (ii) the insured was a New Hampshire corporation; (iii) the parties offered no evidence about where the insured's agent signed the policy; and, (iv) New Hampshire was the insured's only place of business and, therefore, the only place where the premiums could have been paid.

SUBROGATION:

State Farm Fire & Cas. Co. v. Whistle Clean By Warren Services, Inc., 47 A.D.3d 918 (2d Dep't, January 29, 2008) Plaintiff-insurer brought a subrogation action against defendant-contractor that had been hired by plaintiff's insured to remove standing water and ceiling tile debris from the insured's home after a basement flood. The insurer sought to recover those sums it paid to remediate mold and mildew growth. The Appellate Division, Second Department, reversing the decision of the trial court below, granted the defendant-contractor's Motion for Summary Judgment, holding that the sole evidence proffered by State Farm, an affidavit from an expert industrial hygienist, failed to raise a triable issue of fact because it did not demonstrate that the defendant-contractor was retained by the insured to prevent the development of mold, or for any other action rather than the removal of the standing water and tile debris. Moreover, the court noted that the agreement between the insured and the defendant-contractor did not create a relationship for which the defendant owed a duty to the insured separate from its contractual obligations.

Liberty Mut. Ins. Co. v. N. Picco & Sons Contracting Co., Inc., 2008 WL 190310 (S.D.N.Y., January 16, 2008) The Southern District held, *inter alia*, that an insurer did not act as a volunteer and was not prohibited in seeking subrogation for amounts it expended to remediate certain water damage. Under New York law, a surety that answers for the default of its principal may be subrogated to any claims of the obgliee as well as any claims the defaulting principal might have had against third-parties whose wrongful conduct allegedly caused the default. This "equitable subrogation" is the principle by which an insurer, having paid losses, is placed in the same position of its insured so that it may recover from the third-party legally responsible for the loss. As such, Liberty Mutual was permitted to seek the contract balance and remediation costs as subrogee against other third-parties to the extent its principal and/or the owner/obligee, had valid claims against them. The court stated that to hold that the insurer merely "volunteered" to fix the damage would encourage a future party similarly situated to Liberty Mutual to turn a blind eye to apparent health hazards. Future parties would also be less likely to undertake this necessary remediation work if they knew that they would be barred from seeking subrogation.

Kumar v. Am. Transit Ins. Co., 2008 WL 748098 (4th Dep't, March 21, 2008) A subrogation claim will not be barred simply because the insurer has not yet paid the loss of its insured.

S2520: Creates a natural disaster reinsurance fund financed through voluntary participation by insurers in the state to provide additional protection in the case of catastrophic events; exempts any amounts deposited into the fund from taxation by the state, county, municipality or local taxing authority; prohibits participating insurers from increasing premiums based upon payments to such fund.

ANTI-SUBROGATION:

The Home Ins. Co. in Liquidation v. The Travelers Indem. Co., 2008 WL 331365 (S.D.N.Y., February 4, 2008) The Southern District held that the anti-subrogation rule prohibited the continuation of a claim by the named insured against the additional insured based upon the fact that they were covered under the same policy.

APPLICABILITY OF EXCLUSIONS:

Superior Contracting & Restoration, Inc. v. United States Liab. Ins. Co., 2008 WL 170690 (E.D.N.Y., January 17, 2008) Insured filed suit seeking a defense and indemnification for a claim arising from an injury sustained to its employee in the course of employment. The Eastern District found that the "Exclusion of Injury to Employees, Contractors and Employees of Contractors Endorsement" (which does not contain an "insured contract" exception) unambiguously excludes from coverage any claim for indemnification or contribution for injury to an employee during the course of employment with the insured.

Dream Spa, Inc. v. Fireman's Fund Ins., 2008 WL 355458 (S.D.N.Y., February 6, 2008) In a dispute between an insurer and an insured with respect to the applicability of coverage, the insured has the initial burden of demonstrating there is coverage for the subject loss. An insurer arguing for the applicability of an exclusion to coverage must establish that the exclusion is stated in clear and unmistakable language, is subject to no other reasonable interpretation, and applies in the particular case. If the language of the policy is doubtful or uncertain in this meaning, any ambiguity must be resolved in favor of the insured and against the insurer.

LaBoutique NY, Inc. v. Utica Ins. Co., 18 Misc.3d 1132(A) (N.Y. Sup. Richmond County, February 15, 2008) The Supreme Court of Richmond County found that the insurer's Contractual Liability Exclusion was inconsistent with the grant of coverage in the Additional Insured Endorsement, since the former purported to apply "to all liability Coverages," and would therefore render the terms of the Additional Insured Endorsement meaningless. Accordingly, it was held that the Contractual Liability Exclusion could not be applied to defeat any right to coverage which might have existed under the terms of the Additional Insured Endorsement.

PRIORITY OF COVERAGE:

Wausau Underwriters Ins. Co. v. QBE Ins. Corp., 533 F.Supp.2d 389 (S.D.N.Y., January 31, 2008) The Southern District explained that its prior determination that QBE's policy provided primary coverage, and not excess, was limited in scope, and did not include the determination that QBE's primary coverage was the *only* applicable primary coverage.

PERSONAL AND ADVERTING INJURY:

Accessories Biz, Inc. v. Linda and Jay Keane, Inc., 533 F.Supp.2d 381 (S.D.N.Y., January 31, 2008) The Southern District was called upon to evaluate, *inter alia*, the applicability of the "misappropriation of advertising ideas or style of doing business" provision found in the definition of "personal and advertising injury" in older ISO Commercial General Liability policy forms. In light of the fact that the policy did not define "advertising idea" or "style of doing business," the court indicated that it was appropriate to define the terms as they ordinarily would be understood by laypersons. Thus, the phrase "advertising idea" was found to relate to the manner in which one advertises its goods, and the phrase "style of doing business" refers to the manner or method in which a company operates. "The purpose is to define what promotional conduct is insured, not to provide products liability insurance."

AUTO COVERAGE:

RLI Ins. Co. v. Premier Coach, Inc., 2008 WL 282126 (S.D.N.Y., January 25, 2008) The Southern District found that an insurer had no obligation to provide an insured with coverage under a Business Auto policy where the incident (a physical altercation between an employee driver and third-party) did not involve an "accident" nor did it "result from the ownership, maintenance or use of a covered auto," as required by the terms of the policy. The court noted that "[w]here the operation or driving function of an automobile or the condition of the vehicle itself is not the proximate cause of the injury, the occurrence does not arise out of its use or operation."

Empire Fire and Marine Ins. Co. v. Eveready Ins. Co., 48 A.D.3d 406 (2d Dep't, February 5, 2008) The auto policy issued by the defendant covered damages for which an "insured" became liable as a result of an automobile accident. Although "any person using your covered auto" was an "insured" within the meaning of the policy, the Appellate Division, Second Department, held that the automobile at issue was not the policyholder's "covered auto" since it was not owned by the policyholder and was not a "temporary substitute" auto within the meaning of the policy.

ADDITIONAL INSURED COVERAGE:

Nicotra Group, LLC v. Am. Safety Indemnity Co., 48 A.D.3d 253 (1st Dep't, February 7, 2008) Plaintiff-owner was not afforded additional insured status under the defendant-insurers' policies because there was no written contract with the named insured construction manager (or any other entity) requiring that the plaintiff be provided with such coverage. The only document relating to the work to be performed by the construction manager was a letter proposal, which was never signed by the plaintiff, and therefore did not qualify as a "written contract" that was "executed" prior to the "bodily injury," within the meaning of the policies, which defined an "additional insured" as an organization whom the named insured agreed, pursuant to a written contract, to name as an additional insured.

DISABILITY COVERAGE:

Benesowitz v. Metropolitan Life Ins. Co., 514 F.3d 174 (2d Cir., December 27, 2007) The Second Circuit certified the following question to the New York Court of Appeals: "Whether Insurance Law § 3234(a)(2) means that (i) a policy may impose a twelve-month waiting period during which no benefits will be paid for disability stemming from a pre-existing condition and arising in the first twelve months of coverage or (ii) a policy may lawfully include a permanent absolute bar to coverage of disabilities resulting from pre-existing conditions that trigger disability within the first twelve months of the employee's coverage." In response, the New York Court of Appeals held (839 N.Y.S.2d at 706, 707-08) that the statute was properly interpreted to allow "insurers to toll benefits during the first [twelve] months of coverage, but does not permit them to impose an absolute bar to coverage for disabilities stemming from preexisting conditions and arising during that [twelve]-month period."

POLICY RESCISSION:

Nat'l Specialty Ins. Co. v. 218 Lafayette St. Corp., LLC, 2008 WL 629994 (S.D.N.Y., March 10, 2008) N.Y. Ins. Law § 3105 provides that if an insurance policy is issued in reliance on a material misrepresentation, an insurer may avoid the policy from its inception. A misrepresentation is "material" if knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to make such a contract. Ordinarily, materiality is a question of fact that should be submitted to a jury, but where the evidence as a whole can only lead to the conclusion that the insurance policy would not have been issued

had the true state of affairs been known, a court may rule on the issue of materiality as a matter of law. However, a conclusory statement that underwriting guidelines prohibited the issuance of a particular policy is insufficient to meet this burden without additional evidence.

MISCELLANEOUS ISSUES:

Patenuade v. Empire Contracting and Sales Co., Inc., 47 A.D.3d 1006 (3rd Dep't, January 3, 2008) The Appellate Division, Third Department, affirmed the denial of defense counsel's motion to withdraw as counsel, apparently based upon the insurer's denial of coverage, considering that the record contained no proof that the insured/client was provided with notice of the subject motion. "A motion to withdraw as counsel is a poor vehicle to test an insurer's right to disclaim liability or deny coverage."

Staats v. Wegmans Food Markets, Inc., 849 N.Y.S.2d 870 (4th Dep't, February 1, 2008) Plaintiff, an employee of a contractor hired by an owner to perform certain portions of a construction project, brought suit against the owner after having been injured during the course of his employment. The contractor moved to assume the defense of the owner based upon an indemnification agreement whereby the contractor agreed to indemnify the owner for all liability arising out of the work performed, with the exception of liability arising from the owner's own negligence. The court denied the contractor's motion, finding that "[a]s a general rule, a liability insurer has a right to control the defense of underlying litigation against its insured based on the right of the insurer to protect its financial interests." Since the owner was not the insured, the contractor and its insurer had no right to control the defense.

Cendant Car Rental Group, et al. v. Liberty Mut. Ins. Co., 48 A.D.3d 397 (2d Dep't, February 5, 2008) The Appellate Division, Second Department, held that a Certificate of Insurance is insufficient to support a claim of additional insured status, especially when the face of the certificate indicates that it is "issued as a matter of information only and confers no rights upon the certificate holder…"

Guayara v. Hudson Ins. Co., 48 A.D.3d 628 (2d Dep't, February 19, 2008) Plaintiff failed to comply with the service requirement of Insurance Law § 3420 (a)(2), which allows a direct action by a claimant against a tortfeasor's insurer to collect upon an unsatisfied judgment, by sending a letter to the broker of the insured, rather than to the insurer itself. The service was deemed insufficient despite the fact that the letter and the judgment were forwarded by the broker to the insurer. The plaintiff's contention that the broker would not cooperate with her in identifying the insurer, standing alone, did not demonstrate that it was impossible for her to learn the insurer's identity and directly serve it with the judgment and notice of entry in proper form.

LBC&C's INSURANCE INDUSTRY PRACTICE GROUP

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Should you have any comments, questions or suggestions in connection with the information provided in this newsletter please contact Richard P. Byrne, Esq., John D. McKenna, Esq. or Jillian Menna, Esq. at (516)-294-8844. You may also wish to visit the Firm's website at lbcclaw.com