# INSURANCE LAW

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## INTRODUCTION

For students of insurance law, we offer our annual contribution to legal scholarship. Often wondering about the breadth of its readership, we are occasionally heartened by an inquiry or comment about a case or theme that had tickled someone's interest. We offer an array of topics in this year's issue, from anti-subrogation to additional insured coverage to discovery to bad faith, noting trends as we see them developing. We offer a quiet salute to those who, as we do, love the study and understanding of insurance law, and hope this submission provides a good and useful summary of the case law during the *Survey* period.

## I. THE MYTH OF INSURANCE IN TORT LITIGATION

In tort litigation in New York and in most other states, the asset of insurance is largely a myth— that is, jurors do not hear about the existence or quantum of liability insurance coverage during trial, lest the existence of the policy impact on the jury's award. The wealth of the defendant, particularly if that solvency is supported by an insurer, could lead to a plaintiff's verdict (or perhaps, one higher than that which would be considered full and fair compensation). The mere mention of insurance by an injured plaintiff to the jury may ring a bell that cannot be un-rung, serving as grounds for a mistrial.

But what if the tortfeasor brings up the subject? That is exactly what transpired in *Gbadehan v. Williams et al*.[1]

Adedute Gbadehan filed suit after sustaining injuries in an auto accident with an SUV driven by the defendant, Jazmin Williams.[2] At trial, Gbadehan testified without objection during both direct and cross-examination that she contacted her insurance company immediately after the accident.[3] In addition, Williams testified on cross-examination that she asked for the co-defendant's insurance information immediately after the accident, which prompted co-defendant's counsel to move to strike the response from the record.[4] Thereafter, on re-direct, Williams testified that she thought she had sent everything to her insurer.[5] After a verdict in Gbadehan's favor, Williams successfully moved to set aside the verdict and Gbadehan appealed.[6]

New York's First Department Appellate Division agreed that Williams' motion was timely, but ultimately reversed on the merits. Although "[e]vidence that a defendant carries liability insurance is generally inadmissible due to its potential for prejudice, as a jury's awareness of insurance coverage might make it easier for it to render an adverse verdict against the defendant," mere "passing reference to insurance . . . does not necessarily warrant reversal."[7] Here, it was clear that Gbadehan had only mentioned insurance unintentionally, without objection, and, in fact, "[t]wo of the insurance references at issue were elicited by defense counsel, from his own client . . . ."[8] Under these circumstances, the court was unable to find a reason to set aside the jury verdict.[9]

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1. Gbadehan v. Williams et al., 172 N.Y.S.3d 432 (App. Div. 1st Dep't 2022) (This case should also serve as a reminder that the failure to object may serve to waive the objection entirely).

2. *Id.* at 433.

3. *Id.*

4. *Id.*

5. *Id.*

6. *Gbadehan*, 172 N.Y.S.3d at 433.

7. *Id.* (citing Salm v Moses, 918 N.E.2d 897, 898 (N.Y. 2009); Smith v Vohrer, 880 N.Y.S.2d 16, 18 (App. Div. 1st Dep't 2009)).

8. *Id.* (citing Kowalski v Loblaws, Inc., 402 N.Y.S.2d 681, 683 (App. Div. 4th Dep't 1978)).

9. *Id.* (citing Siegfried v Siegfried, 507 N.Y.S.2d 20, 21-22 (App. Div. 2d Dep't 1986)); Did we just suggest that insurance is a myth? Well, that may very

Surely, if defense counsel did not want insurance before the jury, better witness counseling would or could have avoided it.

## II. COVID-19 BUSINESS INTERRUPTION

During this *Survey* period, the door all but closed on insured's attempts at convincing New York courts that COVID-19 business closings were compensable under Business Interruption policies claims pending before New York courts. Recall that during the last survey period, New York's First Department Appellate Division in *Consolidated Restaurant Operations, Inc. v. Westport Ins. Corp.* upheld longstanding New York caselaw in finding that "direct physical loss of or damage to property" requires actual, discernable, quantifiable change constituting "physical" difference to property from what it was before exposure to the coronavirus.[10] Unsurprisingly, that trend continued.[11]

Although New York courts have, to date, uniformly dismissed these COVID-19 Business Interruption claims, policyholders have not given up hope just yet. Specifically, during the *Survey* period, the New York Court of Appeals granted leave to Consolidated

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well be the case for a jury trial under normal circumstances. However, it is beyond dispute that the mere existence of liability insurance drives most tort litigation. As but one illustrative example, see Federal Ins. Co. v Lester Schwab Katz & Dwyer, LLP, 181 N.Y.S.3d 52 (App. Div. 1st Dep't 2022). Therein, the First Department denied a motion to dismiss a legal malpractice action filed by an insurer against the law firm it had assigned to defend its insured in underlying litigation, where the insurer plausibly alleged facts supporting a reasonable inference that "but for [the firm's] alleged negligence in conducting the insureds' defense in the underlying action, [the] insurer would have achieved a better result in that litigation than the $4 million settlement to which it ultimately agreed." *Id.* This action essentially seeks to shift a portion of the insurer's settlement contribution to the law firm's errors and omissions carrier, on the basis that the law firm had failed to do right by the insured during its representation (and, *ipso facto*, the insurer who paid the settlement on the insured's behalf). *Id.*

10. Consol. Rest. Operations, Inc. v. Westport Ins. Corp., 167 N.Y.S.3d 15, 18 (App. Div. 1st Dep't 2022).

11. *See, e.g.*, 147 First Realty LLC v. Aspen Am. Ins. Co., 2023 U.S. App. LEXIS 9407, *4 (2d Cir. 2023); Madison Square Garden Sports Corp. v. Factory Mut. Ins. Co., 181 N.Y.S.3d 887, 887 (App. Div. 1st Dep't 2023); Buffalo Xerographix, Inc. v. Sentinel Ins. Co., Ltd., 2022 U.S. App. LEXIS 25857 (2d Cir. 2022).

Restaurant Operations, Inc. to appeal the First Department's dismissal of its action.[12] Resolution of the matter, once and for all, will have to wait until next year.[13]

## III. PRIORITY OF COVERAGE

Sometimes, when tort responsibility is attributable to multiple individuals or entities, it is not enough to establish merely the existence and extent of insurance coverage owed by one or more insurers. Rather, the next step is to determine the order that coverage is owed by and between these insurers. To answer this question, courts have historically reviewed what is referred to as the "other insurance" provisions of the insurance policies at issue.[14] However, this *Survey* period saw the continuation of a recent trend that resorts to assessment of the underlying trade contract in the name of judicial economy. That was the case in *Scottsdale Insurance Company v. Mt. Hawley Ins. Co.*[15]

For the insurance practitioner, it is the battle between horizontal exhaustion and vertical exhaustion.

In this action, Scottsdale Insurance Company, as excess insurer for a general contractor, Dome, sought reimbursement from Mt. Hawley Insurance Company and Certain Underwriters at Lloyd's, London, as primary and excess insurers for a property owner, 175 Broadway Hospitality, relative to Scottsdale's $2,000,000

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12. Consol. Rest. Operations, Inc. v. Westport Ins. Corp., 198 N.E.3d 788 (N.Y. 2022) (granting leave to appeal in part, while dismissing the appeal only insofar as it asserted "that such portion of the order does not finally determine the action within the meaning of the Constitution")

13. Notably, the First Department found Consolidated Restaurant's allegations of the presence of the virus and its impact to covered property both vague and conclusory, such that they were not afforded a presumption of truth on a threshold motion to dismiss. *See, Consolidated*, 167 N.Y.S.3d at 21. If affirmed, the Court of Appeals may do so merely by deeming these particular, conclusory allegations insufficient under New York's pleading standard. However, the Court of Appeals might instead find that the presence of Coronavirus cannot cause direct physical loss of or damage to property as a matter of law. These are two very different conclusions.

14. *See*, *e.g.*, State Farm Fire & Cas. Co. v. LiMauro, 482 N.E.2d 13, 16–17 (N.Y. 1985).

15. Scottsdale Ins. Co. v. Mt. Hawley Ins. Co., 183 N.Y.S.3d 83 (App. Div. 1st Dep't 2023).

contribution to an underlying settlement.[16] In finding that Scottsdale was not entitled to reimbursement, the First Department noted that "[w]hile New York's horizontal exhaustion rule mandates that all primary policies be exhausted before excess coverage is triggered,"[17] under the circumstances, "the rules governing priority of coverage are inapplicable here."[18] Specifically, the First Department found because 175 Broadway was entitled to a complete contractual pass-through of liability from Dome, it followed that "the excess policy issued to Dome must respond before the primary and excess policies issued to 175 Broadway Hospitality."[19]

The insurance "purist," your authors suggest, follows the doctrine of horizontal exhaustion. Under that approach, a court looks first at the insurance coverage availability for an insured defendant before addressing the risk transfer created by indemnity agreements. An example of that approach can be found in a 2007 Fourth Department decision in *Harleysville Insurance Company v. Travelers Insurance Company* where the court considered all of the coverage available to the general contractor, primary and excess, before it considered the impact of an indemnity agreement to shift ultimate liability.[20]

The decision in *Scottsdale v. Mt. Hawley*, using a vertical exhaustion approach, bypassed a strict policy analysis and looked to the intent of the parties to determine the ultimate coverage outcome. The Second Circuit, on the other hand, held tight to horizontal in *Amerisure Ins. Co. v. Selective Ins. Grp.*[21]

The owners of a theatre undergoing construction retained Eilerson Development Corporation (EDC) as general contractor for the

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16. *Id.* at 84.

17. *Id.* (citing see Tishman Const. Corp. of N.Y. v. Great Am. Ins. Co., 861 N.Y.S.2d 38 (App. Div. 1st Dep't 2008); Bovis Lend Lease LMB, Inc. v. Great Am. Ins. Co., 855 N.Y.S.2d 459 (App. Div. 1st Dep't 2008)).

18. *Id.*

19. *Id.* (citing see Arch Ins. Co. v. Nationwide Prop. & Cas. Ins. Co., 108 N.Y.S.3d 124 (App. Div. 1st Dep't 2019); Indemnity Ins. Co. of N. Am. v. St. Paul Mercury Ins. Co., 900 N.Y.S.2d 24 (App. Div. 1st Dep't 2010)).

20. Harleysville Ins. Co. v. Travelers Ins. Co., 831 N.Y.S.2d 625, 627 (App. Div. 4th Dep't 2007).

21. Amerisure Ins. Co. v. Selective Ins. Grp., Inc., No. 21-1516, 2023 U.S. App. LEXIS 11332 (2d Cir. May 9, 2023).

project.[22] EDC subcontracted masonry work to C&D Laface Construction, Inc. (C&D).[23] EDC and C&D were each required to obtain insurance, with EDC required to name the owners as additional insureds.[24] However, C&D was only required to name EDC as an additional insured on a policy that would be "primary and non-contributing so that [EDC's] policy [would] not respond until the limits under [C&D's] policy [were] exhausted." [25] C&D was also required to procure umbrella insurance "for at least $1,000,000 [that] shall be as broad as the primary General Liability . . . ."[26] EDC procured Commercial General Liability (CGL) and umbrella coverage from Amerisure Insurance Company and C&D procured the same from Selective Insurance Group, Inc.[27]

During the project, an accident occurred involving a forklift operated by a C&D foreperson at a construction site, which seriously injured another C&D employee.[28] The injured worker and his wife sued EDC and the owners.[29] Selective defended EDC as an additional insured under its primary policy, but asserted that the Selective umbrella policy was excess over the Amerisure primary policy issued to EDC. During settlement, Amerisure and Selective each reserved their rights to determine the coverage issues.[30]

Agreeing with Selective and finding that all primary policies were required to exhaust first, the Second Circuit first noted that the policies' respective other insurance clauses easily supported the conclusion that Amerisure's primary policy was primary to the Selective umbrella policy.[31] However, among other things, Amerisure argued "that C&D's agreement to indemnify EDC . . . should be transferred to Selective (as C&D's insurer), which would effectively require the

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22. *Id.* at *1–2.
23. *Id.* at *2.
24. *Id.*
25. *Id.*
26. Amerisure Ins. Co. v. Selective Ins. Grp., Inc., No. 21-1516, 2023 U.S. App. LEXIS 11332, at *2–3 (2d Cir. May 9, 2023).
27. *Id.*
28. *Id.*
29. *Id.*
30. Amerisure Ins. Co. v. Selective Ins. Grp., Inc., No. 21-1516, 2023 U.S. App. LEXIS 11332, at *2 (2d Cir. May 9, 2023).
31. *Id.* at *13.

Selective umbrella policy to provide coverage prior to that in the Amerisure CGL policy."[32]

In making this argument, Amerisure primarily relied upon a recent Second Circuit decision, *Century Surety Company v. Metropolitan Transit Authority*, in which a different judicial panel, applying New York law, concluded that "an indemnity agreement in a trade contract between insureds could override the terms of an insurance policy concerning priority of coverage."[33] Finding that decision distinguishable on its facts for two reasons, the Second Circuit astutely advised that "[t]he animating principle in *Century Surety*, and the cases on which it relied, is judicial economy — that is, that an indemnitee's insurer should not have to bring a separate suit to enforce an indemnity agreement that would nullify the court's earlier decision regarding priority of coverage."[34]

In finding this animating principle inapplicable here, the Second Circuit first found that Amerisure did not raise the indemnity argument before the district court and that, although "EDC's third-party complaint against C&D did assert indemnity-related claims against C&D," EDC and Amerisure subsequently stipulated to discontinue all claims against C&D.[35] Amerisure's attempt to resurrect abandoned indemnity-related claims "underscore[d] why judicial economy — the principle animating *Century Surety* — undercuts Amerisure's position here."[36] Next, the Second Circuit found that "the [underlying] court affirmatively held that the [relevant]

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32. *Id.* at *15. The Second Circuit also dispelled two additional arguments made by Amerisure, including that the relevant other insurance provision in the Amerisure CGL policy had been "deleted and replaced," and also that because the Subcontract required C&D's CGL coverage to be "primary and non-contributing" to any insurance procured by EDC and "also required that C&D procure umbrella insurance 'as broad as the primary General Liability' insurance," it followed that Selective's "umbrella policy must also be primary and non-contributing."

33. *Id.* at *16 (citing Century Surety Co. v. Metro. Transit Auth., No. 20-1474-CV, 2021 WL 4538633, at *3 (2d Cir. Oct. 5, 2021) (citing Indem. Ins. Co. of N. Am. v. St. Paul Mercury Ins. Co., 900 N.Y.S.2d 24 (App. Div. 1st Dep't 2010); Arch Ins. Co. v. Nationwide Prop. & Cas. Ins. Co., 108 N.Y.S.3d 124 (App. Div. 1st Dep't 2019))

34. *Id.*

35. Amerisure Ins. Co. v. Selective Ins. Grp. No. 21-1516, 2023 U.S. App. LEXIS, at *16 (2d Cir. May 9, 2023)

36. *Id.* at *17.

indemnity provision is void under Virginia law."[37] Amerisure's suggestion "that it [was] not bound by the [underlying] court's determination regarding the validity of the indemnity provision because it was not a party to that litigation," was unsupported and Amerisure failed to offer any "credible reason why we would reach a different conclusion . . . if we were to assess the validity of the indemnity provision anew."[38]

Accordingly, the Second Circuit found its traditional priority of coverage analysis was undisturbed and plainly established that the Amerisure CGL policy was primary to the Selective umbrella policy, affirming the district court.[39]

## IV. NOTICE OF POLICY FORMS

There is also a trend brewing relative to prior notice of a policy exclusion that formed the basis for an insurer's disclaimer of coverage.[40] Specifically, policyholders are contending that absent prior

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37. *Id.*

38. *Id.*

39. *Id.* at *18. The Second Circuit essentially provides a gloss on the holding in *Century Surety*, which relied upon Indem. Ins. Co. of N. Am. v. St. Paul Mercury Ins. Co., 900 N.Y.S.2d 24 (App. Div. 1st Dep't 2010) and Arch Ins. Co. v. Nationwide Prop. & Cas. Ins. Co., 108 N.Y.S.3d 124 (App. Div. 1st Dep't 2019) in predicting that the New York Court of Appeals would find "that an indemnity agreement in the underlying trade contract between insureds governs over the terms of an insurance policy concerning priority of coverage." The Second Circuit's gloss frames *Century Surety* as a decision predicated upon "judicial economy". Under *Amerisure*, where it was found that contractual indemnity claims had been entirely foreclosed by stipulation and an underlying decision, it would appear that *Century Surety* stands for the proposition that a court can determine the issue of contractual indemnification in a coverage action in the name of judicial economy, where sufficient facts exist to decide that issue on the record before it, so as to avoid the need for the filing of a separate lawsuit to decide that issue.

Between *Century Surety* and *Amerisure*, there stands any number of factual circumstances where judicial economy may not best be served by deciding contractual indemnification issues in a coverage action. For example, judicial economy is best served by allowing ongoing, third-party litigation between the contracting parties to serve as the vehicle for a determination on contractual indemnification issues, so as to avoid not only the necessity for duplicative discovery, but also duplicative verdicts that are potentially inconsistent with one another.

40. *See* Mallek v. Allstate Ins. Co., No. 22-86, 2023 U.S. App. LEXIS 12203 (2d Cir. May 18, 2023).

notice that an exclusion appeared within their policy, an insurance company is unable to rely upon that exclusion when disclaiming coverage. That was the case in *Mallek v. Allstate Insurance Company* before the Second Circuit Court of Appeals.[41]

Eva Mallek sued Allstate Insurance Company for refusing to pay an insurance claim following a house fire. Allstate denied the claim because, among other reasons, Mallek did not reside at the house as required.[42]

As part of discovery, Mallek testified "that Allstate did not provide her a copy of the Standard Homeowners Policy (containing the residency requirement) before the fire," and this unrebutted testimony served as the basis for Mallek's argument for coverage.[43] In response, Allstate did not proffer evidence establishing delivery of the policy, choosing instead to "raise the new legal argument that . . . the policy's incorporation by reference in renewal declarations mailed to Mallek was sufficient to bind her to the policy's terms without actual delivery of the policy."[44] The district court rejected this new argument as waived and awarded coverage to Mallek.[45]

On appeal, Allstate made two substantive arguments. First, it argued that the 2015, renewal mailing incorporated the Standard Homeowners Policy by reference, and that was sufficient under New York law to bind Mallek to the policy's terms.[46] Second, Allstate argued that it presented an issue of fact as to whether it notified Mallek of the residency requirement before her loss.[47] The Second Circuit disagreed on both counts.

As to the first, Allstate did not raise an incorporation by reference argument on summary judgment.[48] "By raising this argument for the first time in its response to [an] order to show cause, Allstate effectively sought reconsideration of the denial of its own summary judgment motion" and "[b]ecause a new argument may not be raised

41. *Id*.
42. *Id.* at *1-2.
43. *Id.* at *2.
44. *Id.* at *3.
45. *Mallek*, 2023 U.S. App. LEXIS 12203, at *3.
46. *Id.* at *5.
47. *Id.*
48. *Id.*

in a motion for reconsideration" before the district court, that argument was not properly before the Second Circuit.[49]

As to the second, "Allstate did not submit any evidence on summary judgment to rebut Mallek's sworn testimony that Allstate did not provide her a copy of the Standard Homeowners Policy prior to her loss."[50] Even considering Allstate's attempted reconsideration, "it still did not submit any evidence to establish a genuine dispute of material fact."[51] Merely asserting that it "anticipated that one of its employees would testify at trial that, according to Allstate's business records, the Standard Homeowners Policy was mailed to Mallek in 1996," was insufficient, since "Allstate [simply] did not submit an affidavit from its employee to support that assertion . . . ."[52] Allstate submitted a declarations statement for Mallek's 1996 renewal, but that only stated "that Mallek's policy was subject to the Standard Homeowners Policy; it did not establish that the Standard Homeowners Policy was mailed to her with the declarations statement."[53]

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49. *Id.* at *5-6. The incorporation by reference argument is an interesting one that we wish the Second Circuit would have sunk its teeth into on the merits. However, per footnote 1 of the decision, although the Second Circuit has "discretion to consider arguments that were waived below," Allstate provided no persuasive reason why the Second Circuit should exercise its discretion in this case. *Id.* Waiver simply was not addressed by Allstate on appeal and "[b]ecause we conclude that Allstate waived its incorporation-by-reference argument, we need not and do not express any view as to the merits of the argument." *Id.* Still, there is a body of caselaw in New York standing for the proposition that an insured "cannot seek the benefit of the coverage provided by [an] endorsement without being subject to the limitations of that coverage." Hirshfeld v. Maryland Cas. Co., 671 N.Y.S.2d 100 (App. Div. 2d Dep't 1998) (citing cases). Under the circumstances here, the argument would go that Mallek cannot derive benefit from the coverage afforded by the Standard Homeowners Policy form—which she claims was never mailed to her—without also being subjected to the limitations contained within that coverage form, including the relevant exclusion. Absent consideration of the Standard Homeowners Policy form itself, and its insuring agreement and coverage trigger contained therein, Mallek would not be able to meet her threshold burden as an insured to establish the existence of coverage to begin with. *See*, *e.g.*, Consolidated Edison Co. of New York, Inc. v. Allstate Ins. Co., 774 N.E.2d 687, 690 (N.Y. 2002) ("Generally, it is for the insured to establish coverage and for the insurer to prove that an exclusion in the policy applies to defeat coverage.").

50. *Mallek*, 2023 U.S. App. LEXIS 12203, at *6.

51. *Id.*

52. *Id.* at *7-8.

53. *Id.* at *7.

Ultimately, the Second Circuit vacated judgment solely as to the amount of damages, affirmed the district court's denial of summary judgment, and remanded for further proceedings consistent with its decision.[54]

New York's Fourth Department also had an opportunity to address this issue in *Walker v. Erie Insurance Company* last November.[55]

This was a direct action filed by the injured claimant, Juanita Walker, against Erie Insurance Company following an incident involving contraction of Methicillin-resistant Staphylococcus aureus (MRSA) during a pedicure at a nail salon insured by Erie.[56] Erie denied coverage and did not defend its insured on account of a professional liability exclusion that precluded coverage for the cosmetic services.[57] A judgment was ultimately entered against the insured in the underlying action and Walker then commenced this action against Erie to recover damages pursuant to the terms of the insurance policy.[58]

Erie successfully argued that the professional liability exclusion was unambiguous and precluded coverage for "plaintiff's injuries inasmuch as the evidence establishes that plaintiff contracted MRSA due to the rendering of a cosmetic service or treatment, namely, the professional pedicure performed by the insured."[59] The professional liability exclusion stated in clear and unmistakable language that the insured's policy "does not apply to 'bodily injury' . . . due to . … [t]he rendering of or failure to render cosmetic . . . services or treatments."[60] And as was

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54. *Id.* at *1. Allstate correctly argued that it was error to award "Mallek the face value of her insurance policy (i.e., $358,000) when she proffered no evidence in support of her damages." *Mallek*, 2023 U.S. App. LEXIS 12203, at *7. "[U]nder the policy renewal declarations (which Mallek indisputably received), the $358,000 face value of the policy was merely a limit of liability, and Mallek has not submitted evidence with respect to the cost of rebuilding or replacing her destroyed home." *Id.*

55. Walker v. Erie Ins. Co., 178 N.Y.S.3d 650 (App. Div. 4th Dep't 2022).

56. *Id.*

57. *Id.*

58. *Id.*

59. *Id.*

60. *Walker*, 178 N.Y.S.3d at 650. Plaintiff insisted on a different reading, "i.e., that the policy excludes only 'injuries due to the manner in which the cosmetic

> clear from the allegations of negligence for which the insured was found liable, plaintiff's injury was not caused by the insured's mere failure to sanitize the pedicure equipment—i.e., plaintiff was not infected simply by her presence among unsanitary instruments at the nail salon—but rather was caused by the insured's *use* of that contaminated equipment while *performing* the professional pedicure on plaintiff's feet and toenails.[61]

Despite finding the exclusion applicable on its merits, Walker raised a secondary argument that Erie did not establish that its insured had notice of the exclusion, which ultimately created an issue of fact.[62] Specifically, Walker "alleged in her verified complaint in the present action that, upon information and belief, the policy provided by defendant to the insured omitted numerous pages and forms, including the professional liability exclusion," such that "the exclusion could not form the basis for defendant's denial of coverage."[63] On remand, Erie must establish "that the exclusion was actually mailed to the insured" or "otherwise attempt to show that the exclusion was sent to the insured pursuant to office practice."[64]

## V. EXCLUSIONS

During the *Survey* period, we had an opportunity to review various decisions involving the potential application of exclusions, including commonly asserted ones and those a little less than ordinary.[65] But make no mistake: common exclusions can result in

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service is performed' such that 'the manner in which the pedicure was performed must be the cause of the injury,' which would not include preparatory tasks undertaken before a customer arrives for cosmetic treatment." *Id.* The court rejected that argument. *Id.*

61. *Id.*

62. *Id.*

63. *Walker*, 178 N.Y.S.3d at 650.

64. *Id.*

65. A few that we will not discuss in detail here include Transel Elevator & Elec., Inc. v. First Specialty Ins. Co., 185 N.Y.S.3d 139 (App. Div. 1st Dep't 2023) (auto exclusion); S. W. Marine & Gen. Ins. Co. v. Falls Lake Nat'l. Ins. Co., 179 N.Y.S.3d 559 (App. Div. 1st Dep't 2022) (employee exclusion); Gem-Quality Corp. v. Colony Ins. Co.,177 N.Y.S.3d 133 (App. Div. 2d Dep't 2022) (employee exclusion).

interesting results sometimes under New York law. That was the case in *City University of New York v. Utica First Ins. Co.*[66]

The City University of New York (CUNY) was sued by an injured employee of AIM Builders Corp., following a workplace accident.[67] CUNY sought a declaration that Utica First, AIM's insurer, "was required to defend and indemnify [it] as additional insureds on AIM's policy."[68] "Travelers Indemnity Company . . . [had] originally tendered coverage to Utica in December 2015, but Utica denied coverage in March 2016 citing, among other things, an employee exclusion contained in AIM's policy."[69] Due to this apparent delay, CUNY contended "that Utica's denial of coverage based on its employee exclusion was untimely" under Insurance Law Section 3420(d)(2) and thus void.[70]

Despite a delay of approximately three months in disclaiming coverage, the First Department found a question of fact as to whether the disclaimer was late.[71] In doing so, the court agreed with Utica that it was not readily apparent upon first notice that the employee exclusion applied, even though Travelers alleged employment in its original tender.[72] Absent a complaint filed and provided to Utica for review or any other evidence substantiating that his alleged employment led to injury, application of Utica's employee exclusion was not readily apparent.[73]

Still, off-beat exclusions are usually more interesting reads. For example, in *Skanska USA Building Inc. v. Harleysville Insurance Company of New York*, the First Department found that a wrap-up exclusion in an insurance policy issued by Harleysville Insurance Company applied to preclude coverage to an additional insured

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66. City Univ. of N.Y. v. Utica First Ins. Co., 181 N.Y.S.3d 525 (App. Div. 1st Dep't 2022).

67. *Id.* at 526.

68. *Id.* at 525–26.

69. *Id.* at 526.

70. *City Univ. of N.Y.*, 181 N.Y.S.3d at 526.

71. *Id.*

72. *Id.*

73. *Id.* This is a case to keep in mind the next time an additional insured tender is received pre-suit. Absent evidence substantiating pertinent facts alleged in the tender, an insurer is entitled to a reasonable time to investigate the factual scenario confronted.

where the exclusion did not require actual enrollment in the wrap-up policy that was issued for a relevant insurance project.[74]

Specifically, the exclusion in *Skanska* provided that coverage "does not apply to 'bodily injury' . . . arising out of . . . your ongoing operations . . . when a consolidated (wrap-up) insurance program has been provided by the prime contractor/project manager or owner of the construction project in which you are involved," with "you" and "your" defined as "the Named Insured shown in the Declarations, and any other person or organization qualifying as a Named Insured under this policy."[75]

Since Fred Geller Electrical, Inc. was the named insured on the policy, the underlying accident plainly arose out of its ongoing operations, and it was undisputed that a wrap-up insurance program had been provided for the construction project, the wrap-up exclusion was triggered, precluding coverage.[76] Despite argument to the contrary, Geller need not have actually enrolled in the wrap-up insurance program in order for the exclusion to apply.[77]

Another example is the Second Circuit's decision in *N. River Ins. Co. v. Leifer*.[78] That case concerned insurance coverage for a legal malpractice lawsuit.[79] Max D. Leifer and the Law Offices of Max D. Leifer, P.C. were named in an underlying malpractice lawsuit brought by a former client, Andy Lee, after Leifer failed to interpose a timely answer on Lee's behalf in yet another underlying lawsuit naming Lee as a defendant.[80] A default judgment was subsequently entered against Lee after Leifer failed to cure the default.[81]

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74. Skanska USA Bldg. Inc v. Harleysville Ins. Co. of N.Y., 186 N.Y.S.3d 639, 640 (App. Div. 1st Dep't 2023).

75. *Id.*

76. *Id.*

77. *Id.* Despite this, the First Department found an issue of fact relative to timeliness under Insurance Law §3420(d)(2), resulting in a remand on that issue.

78. N. River Ins. Co. v. Leifer, No. 22-1009, 2023 U.S. App. LEXIS 9158,*1 (2d Cir. April 18, 2023) (Summary Order).

79. *Id.*

80. *Id.*

81. *Id.* An interesting practice tip for federal court is articulated by the Second Circuit in footnote 1 of the decision, where the court notes that

> Although Leifer's answer inexplicably denies the assertion that the state court entered default judgment against Lee, we may still

In September 2019, Leifer applied for professional-liability insurance with The North River Insurance Company, who approved his application and issued a claims-made insurance policy to Leifer.[82] The Policy excluded "claims based upon 'facts or circumstances of which [Leifer] had knowledge as of the effective date of [the Policy] and which could reasonably have been expected to give rise to a Claim' (the 'Prior Knowledge Exclusion').'"[83]

The Second Circuit identified that the Prior Knowledge Exclusion required it to analyze "subjective knowledge of the insured and then the objective understanding of a reasonable attorney with that knowledge."[84] In applying this standard, the court found that:

> Leifer's own pleadings leave no doubt that, at the time of the Policy's effective date, (1) Leifer had knowledge of the facts and circumstances giving rise to Lee's malpractice claim, and (2) a reasonable attorney would have understood that Leifer's conduct could reasonably have been expected to give rise to a malpractice claim.[85]

Specifically,

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> take judicial notice of the fact that the court did enter such a judgment. See Simmons v. Trans Express Inc., 16 F.4th 357, 360 (2d Cir. 2021) (noting that courts may take judicial notice of state-court judgments and filings); see also Staehr v. Hartford Fin. Servs. Grp., Inc., 547 F.3d 406, 426 (2d Cir. 2008) (holding that matters judicially noticed by a court "are not considered matters outside the pleadings"); Hirsch v. Arthur Andersen & Co., 72 F.3d 1085, 1095 (2d Cir. 1995) (recognizing that a court need not accept factual allegations that conflict judicially noticed records).

The takeaway is that litigants are not required to accept the conclusory assertions of opponents at face value under the federal pleading standard, and, more importantly, that this is especially true where prior court proceedings entirely contradict such assertions. As third-party liability coverage actions routinely involve prior and/or contemporaneous proceedings, it is crucial to understand the positions that have been taken by your opponents before other courts and whether such positions contradict the positions taken in the coverage action itself.

82. *Id.* at *2.

83. *N. River Ins. Co,* 2023 U.S. App. LEXIS 9158 at *2.

84. *Id.*

85. *Id.* at *3 (citing Liberty Ins. Underwriters, Inc. v. Corpina Piergrossi Overzat & Klar LLP, 913 N.Y.S.2d 31, 33 (App. Div. 1st Dep't 2010).

> Leifer admitted that he advised Lee not to file an answer in a state-court action in which Lee was named as a defendant, and later sought leave to interpose a late pleading after the plaintiff moved for a default judgment. But the state court denied Leifer's request and ultimately entered a default judgment against Lee, citing (among other reasons) Leifer's failure to file an affidavit from his client, as required under New York's Civil Practice Law and Rules. Based on these undisputed facts, which were known to Leifer before the effective date of the Policy, a reasonable attorney would have appreciated that Leifer's conduct in Lee's case might have exposed him to a claim for malpractice.[86]

The Second Circuit went on to dispel Leifer's arguments to the contrary, one at a time. First, the court noted that although Leifer argued "that he advised Lee to file an answer, but that Lee never retained him to do so," this was "contradicted by Leifer's answer in this case, in which he admitted that he 'took the position of not entering an Answer.'"[87] Second, Leifer argued "that his decision not to file an answer was justified because Lee had no meritorious defenses," but this was again "contradicted by Leifer's own affirmation in opposition to the motion for default judgment in the state-court action against Lee, in which Leifer affirmatively stated that Lee did in fact have a 'meritorious defense.'"[88] Finally, Leifer argued "that he had no reason to anticipate the malpractice suit since Lee had thanked him for his services," but the court aptly noted that "[t]he relevant question, however, is not whether Leifer believed that Lee would bring a malpractice claim, *but whether a reasonable attorney, based on the facts known to Leifer at the time, could have expected one.*"[89]

Accordingly, the Prior Knowledge Exclusion applied to preclude coverage.

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86. *Id.* at *3-4 (citing Baldwin v. Mateogarcia, 869 N.Y.S.2d 217, 218 (App. Div. 2d Dep't 2008); Shapiro v. Butler, 709 N.Y.S.2d 687, 689 (App. Div. 3d Dep't 2000); Brodeur v. Hayes, 795 N.Y.S.2d 761, 762 (App. Div. 3d Dep't 2005)).

87. *Id* at *4.

88. *Id* at *5.

89. *Id.* at *6 (emphasis added).

## VI. COLLUSIVE JUDGMENTS

Another issue that the Courts had an opportunity to discuss this *Survey* period was the impact of potentially collusive judgments on the availability of insurance for a direct action under Insurance Law Section 3420(d)(2). An example of that was the Third Department's decision in *Bahnuk v. Countryway Insurance Company*.[90]

An EMT was responding to an emergency call at a residence when he allegedly fell and suffered injuries.[91] The EMT sued Pauline Williams, the property owner, and notified Countryway Insurance Company, her homeowners carrier.[92] Countryway disclaimed coverage to Williams and refused to defend her because the property was not a "residence premises" or "insured location," relying upon the policy's insured location and business pursuits exclusions.[93]

"Williams proceeded with her own attorney [and] [d]uring the course of the [underlying] litigation," Williams signed a "confession of judgment for $100,000—the limit of Williams' policy with [Countryway]"—allowing the EMT to pursue a claim against Countryway under New York's direct action statute, Insurance Law Section 3420(a)(2).[94] In turn, the EMT commenced this action against Countryway, "seeking satisfaction of the $100,000 judgment."[95]

Although the Third Department found that Countryway had failed to abide by the high specificity requirements relative to the grounds for disclaimer under Insurance Law Section 3420(d)(2),[96] invalidating Countryway's disclaimer of coverage, the court found "a

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90. Bahnuk v. Countryway Ins. Co., 186 N.Y.S.3d 412 (App. Div. 3d Dep't 2023).

91. *Id.* at 413.

92. *Id.* at 413.

93. *Id.*

94. *Id.* at 413-14.

95. *Id.* at 414.

96 *Bahnuk*, 186 N.Y.S.3d at 414. The court notes that when an insurer disclaims coverage for bodily injury arising out of an accident, it must provide written notice of the grounds with "a high degree of specificity." *Bahnuk*, 186 N.Y.S.3d at 414. (citing Ability Transmission, Inc. v. John's Transmission, Inc., N.Y.S.3d 367 (App. Div. 2d Dept. 2017), quoting General Acc. Ins. Grp. v. Cirucci, 387 N.E.2d 223 (N.Y. 1979)). Although Countryway provided a detailed explanation to Williams as to its grounds for disclaiming coverage, no such detail was provided to Bahnuk, the injured party.

triable issue of fact as to whether the [confession of judgment] was the product of collusion between [the EMT] and Williams."[97]

The court rejected the EMT's argument that Countryway was "required to bring a plenary action or vacatur motion in order to attack the validity of the underlying judgment . . . ."[98] "'[A] valid and enforceable judgment is a condition precedent to maintaining an action pursuant to Insurance Law Section 3420 (a) (2) . . . [and a] judgment entered through fraud, misrepresentation, or other misconduct practiced on the court is a nullity and is subject to collateral attack.'"[99] However, "a question remain[ed] as to whether the negotiations between the injured EMT and Williams in the underlying litigation amounted to such misconduct."[100]

> On the one hand, it is true that, as defendant argues, Williams sought to avoid risk by agreeing to a confession of judgment in the precise amount of her insurance policy limit in exchange for an assurance that [Bahnuk] would not seek to enforce the judgment against her, and this resolution occurred without any meaningful discovery having been undertaken. On the other hand, however, an agreement to cap damages in the amount of a policy limit is not unheard of in personal injury matters and does not necessarily mean that something untoward took place in the negotiations. Further, recognizing that [Bahnuk], as a consequence of his injuries, underwent a surgery and multiple hospitalizations and missed approximately 30 weeks of work, incurring a Workers' Compensation lien in excess of $60,000, it cannot be said that the agreed-upon amount of $100,000 was per se unreasonable. In addition, it is noted that the resolution was apparently negotiated by the lawyers for [Bahnuk] and Williams and discussed with Supreme Court. Finally, unlike the cases relied upon by defendant, there is no indication, for example, that [Bahnuk] and Williams were related to each . . . . or that Williams was promised a portion of [Bahnuk's] potential recovery against defendant . . . , circumstances that have led to findings that an agreement between the insured and the

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97. *Id.*

98. *Id.*

99. *Id.* (quoting Hernandez v. Am. Transit Ins. Co., 768 N.Y.S.2d 362, 363 (App. Div. 2d Dep't 2003)).

100. *Id.* at 415.

injured party was offensive to a "sense of justice and propriety."[101]

## VII. ANTI-SUBROGATION

Sometimes, the very purpose of insurance can be undermined if parties and courts are not careful. New York's anti-subrogation rule stands for this principle and protects against an insurer's attempt to recover amounts paid on behalf of one insured from that insured or any other insured. This *Survey* period saw at least two examples of this principle in action.

The key when applying the anti-subrogation rule in most cases is identifying that one insured party is attempting to recover from another insured under the same policy. This proved true in *Catlin Insurance Company, Inc. v. Falco Construction Corp.*, where the Second Department found the anti-subrogation rule inapplicable to the facts before it.[102]

Catlin Insurance Company, Inc., as subrogee of LRC Construction, LLC sued Falco Construction Corp. to recover amounts it

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101. *Bahnuk*, 186 N.Y.S.3d at 415 (citations omitted). We also note the use of this seldom used "confession of judgment" procedural device within the underlying lawsuit at issue in *Walker v. Erie Ins. Co*, *supra.* Although not directly at issue, the *Walker* case concerned a direct action filed by an injured claimant to recover damages following a confession of judgment by its insured that just so happened to lead to a money judgment in the amount of the available insurance policy limits ($1,000,000). *Id.* The use of a confession of judgment to recover insurance proceeds is potentially problematic when an insurer declines to provide a defense to an insured due to applicable coverage defenses. Although an insurer is entitled to deny a defense entirely where coverage is excluded, the safer strategy generally is to provide a courtesy defense to the insured and file a declaratory judgment action to confirm the denial of coverage. *See* Lang v. Hanover Ins. Co., 820 N.E.2d 855, 858-59 (N.Y. 2004) ("[A]n insurance company that disclaims in a situation where coverage may be arguable is well advised to seek a declaratory judgment concerning the duty to defend or indemnify the purported insured. If it disclaims and declines to defend in the underlying lawsuit without doing so, it takes the risk that the injured party will obtain a judgment against the purported insured and then seek payment pursuant to Insurance Law § 3420. Under those circumstances, having chosen not to participate in the underlying lawsuit, the insurance carrier may litigate only the validity of its disclaimer and cannot challenge the liability or damages determination underlying the judgment.").

102. Catlin Ins. Co., Inc. v. Falco Constr. Corp., 188 N.Y.S.3d 625, 627 (App. Div. 2d Dep't 2023).

paid to repair "property damage that occurred during a construction project."[103] During the project, "[LRC] was the construction manager and Falco performed excavation [and] installation work."[104] Falco filed third-party claims against LRC for indemnification and contribution.[105]

Catlin moved to dismiss the third-party complaint on behalf of LRC, asserting that it was, in essence, a subrogation action on behalf of Falco's insurer that was barred by the anti-subrogation rule.[106] Specifically, Catlin argued that pursuant to the contract between LRC and Falco, LRC was to be named as an additional insured under the insurance policy issued to Falco, making them each insureds under Falco's insurance policy.[107] And in opposition, Falco submitted its insurance policy listing LRC as an additional insured, "but only with respect to operations performed by or on behalf of Falco."[108]

> "Under the antisubrogation rule, an insurer has no right of subrogation against its own insured for a claim arising from the very risk for which the insured was covered."[109] Importantly, "the party to which the insurer seeks to subrogate [must be] covered by the relevant insurance policy."[110]

Denying Catlin's threshold motion, the Second Department found that Catlin failed to "demonstrate that the loss was related to operations performed by or on behalf of Falco," which was necessary to establish that LRC was covered as an additional insured under the terms of Falco's insurance policy.[111]

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103. *Id.* at 626.
104. *Id.* at 626-27.
105. *Id.* at 627.
106. *Id.*
107. *Catlin*, 188 N.Y.S.3d. at 627.
108. *Id.*
109. *Id.* (citing Wausau Underwriters Ins. Co. v. Gamma USA, Inc., 89 N.Y.S.3d 186 (App. Div. 2d Dep't 2023); ELRAC, Inc. v. Ward, 748 N.E.2d 1 (N.Y. 2001)).
110. *Id.* (citing Millennium Holdings LLC v. Glidden Co., 53 N.E.3d 723 (N.Y. 2016).
111. *Id.* Although the motion was denied, there is no reason to believe that Catlin cannot meet its burden on summary judgment at a later date.

In *Starr Indemnity & Liability. Co. et al. v. Zurich American Insurance Company et al.*, the First Department addressed the anti-subrogation rule relative to follow form excess policies.[112]

BDG Gotham Residential, LLC (as owner) and ZDG, LLC (as construction manager) contracted to construct a mixed-use building.[113] The contract required ZDG to obtain a wrap-up policy under the contract, and also required all contractors and subcontractors to be enrolled for coverage thereunder.[114]

Zurich American Insurance Company issued a general liability insurance policy (the primary policy) to ZDG and "all contractors of any tier to whom ZDG LLC contracts to furnish insurance under the [CCIP], enroll in the program and who perform operations at a designated project site."[115] Gotham was also listed as an additional insured.[116] Above the primary policy, ZDG obtained several excess liability policies, including policies from Starr Indemnity & Liab. Co. and Navigators Insurance Co.[117]

Western Waterproofing Company, Inc. subcontracted with ZDG to install a curtainwall façade for the project and an underlying lawsuit alleges that two Western employees were injured on the job.[118]

The primary policy's contractual liability and employer's liability exclusions contained an exception for damages "[a]ssumed in a contract or agreement that is an 'insured contract.'"[119] As Western is a named insured under the primary policy, and agreed to indemnify ZDG and others, claims on behalf of Gotham and ZDG under the primary policy against Western are barred by the anti-subrogation rule.[120] Since the excess policies contained follow form clauses, they were equally required to adhere to this exception and, accordingly,

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112. Starr Indem. & Liab. Co. v. Zurich Am. Ins. Co., 181 N.Y.S.3d 239 (App. Div. 1st Dep't 2023).

113. *Id.*

114. *Id.*

115. *Id at 240.*

116. *Starr*, 181 N.Y.S.3d at 240.

117. *Id.*

118. *Id.*

119. *Id.*

120. *Id.*

could not recover from one insureds amounts paid on another's behalf.[121]

## VIII. RECOVERY OF LEGAL FEES

At least two New York appellate courts had occasion this *Survey* period to affirm existing rules regarding the inability of certain parties to recover legal fees while prosecuting an action against an insurer.

In *Hershfeld v. JM Woodworth Risk Retention Group, Inc.*, the Second Department upheld New York's well-established rule under *Mighty Midgets v. Centennial Ins. Co.*, which limits recovery of legal fees to those actions which place an insured in a defensive posture alone.[122]

Two individuals filed a medical malpractice action against a doctor and his medical office, who were insured by JM Woodworth Risk Retention Group (JMW).[123] Although JMW originally provided a defense, it subsequently withdrew the defense on non-cooperation grounds.[124] Thereafter, the insureds filed this declaratory judgment action against JMW seeking defense and indemnification, as well as fees associated with the prosecution of their declaratory judgment action.[125]

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121. *Starr*, 181 N.Y.S.3d at 240.

122. Hershfeld v. JM Woodworth Risk Retention Grp., Inc., 181 N.Y.S.3d 667, 668 (App. Div. 2d Dep't 2023) (citing Mighty Midgets v. Centennial Ins. Co., 389 N.E.2d 1080 (N.Y. 1979))

123. *Id.*

124. *Id.* at 669. As an interesting aside relative to this case, under *Brothers v. Burt*, 265 N.E.2d 922 (N.Y. 1970), the New York Court of Appeals recognized that a motion to withdraw as counsel is a "poor vehicle" to test the propriety of a disclaimer, such that courts frequently deny counsel the ability to withdraw under the circumstances outlined here. However, where an independent basis exists for counsel to withdraw that does not necessarily bear upon an insurance coverage issue—e.g., a non-cooperative client or other conflict in the representation itself—courts do, in fact, allow for the withdrawal of counsel. *See, e.g.,* Dillon v. Otis Elevator Co., 800 N.Y.S.2d 385 (App. Div. 1st Dep't 2005). Whether an insurer who originally provided a defense to an insured (but changed its mind) is required to affirmatively assign new counsel after such an independent withdrawal appears to be an open issue under New York law.

125. *Id.*

Identifying correctly that *Mighty Midgets controlled*, the Second Department declined to award attorney's fees associated with the insured's prosecution of the declaratory judgment action.[126] Since the insured's first and second causes of action asserted against their insurer sought declaratory relief and amounted to an affirmative action by the insureds to settle their rights, rather than legal steps by an insurer to free itself from its policy obligations, the insureds were not entitled to an award of legal fees.[127]

The First Department also tackled a similar issue in *Greenway Mews Realty, LLC v. Liberty Ins. Underwriters, Inc.*, relative to a direct action under Insurance Law Section 3420(a)(2).[128] Therein, Greenway Mews Realty, L.L.C. obtained a $1,350,000 indemnity judgment against UAD Group.[129] Greenway and its insurer, Seneca Insurance Company, both commenced the instant action against UAD's insurer, Liberty Insurance Underwriters Inc., seeking to directly recover the judgment against UAD under the Liberty insurance policy.[130] Agreeing with the lower court, the First Department provided "that Greenway and Seneca were not entitled to attorneys' fees, as they were the prevailing parties in this action brought by themselves to enforce the UAD judgment."[131] Although it was argued that UAD had agreed in the relevant trade contract to indemnify attorneys' fees incurred in connection with claims arising out of UAD's work, the court found that Liberty was not bound by that agreement.[132]

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126. *Id.* at 670.

127. *Id.*

128. Greenway Mews Realty, LLC v. Liberty Ins. Underwriters, Inc., 185 N.Y.S.3d 58 (App. Div. 1st Dep't 2023).

129. *Id.*

130 *Id.*

131. *Id.* at 60 (citing U.S. Underwriters Ins. Co. v. City Club Hotel, LLC, 822 N.E.2d 777, 779 (N.Y. 2004); Sukup v. State of New York, 227 N.E.2d 842 (N.Y. 1967)).

132. *Id.* This case also addresses a rather nuanced issue involving potential recovery for pre-judgment interest. *Greenway*, 185 N.Y.S.3d at 60. The First Department noted that although Liberty agreed that it owed post-judgment interest, Greenway/Seneca were not entitled to seek interest on this acknowledged post-judgment interest since interest, on interest, would amount to a double recovery that is prohibited by New York law. *Id.* The pre-judgment interest claim was also rejected since the action was brought statutorily under Insurance Law 3420(a)(2). *Id.* Even were the action for breach of contract, however, the record

## IX. WHO IS AN INSURED, EXACTLY?

Among the threshold coverage issues, for which insureds carry the burden of proof, before any coverage obligation is owed by an insurance company, a purported insured is required to establish that they do, in fact, qualify as an insured under the terms of an insurance policy.[133] Below, we address various ways in which this question was raised resolved during the *Survey* period.

A common theme litigated in New York is whether a certain individual is entitled to insured status under a policy as a relative residing within the named insured's household. An interesting spin on that age-old question was addressed by the First Department in *Integon National Insurance Company v. Zhou*.[134]

Integon National Insurance Company issued a dwelling policy for a residence co-owned by Dong Dong Zhou and Chao Wei Gao.[135] Jing Yi Lin was injured while working at this residence and sued Zhou and Gao.[136] According to the policy's terms, the policy covered Zhou as the sole named insured, as well as her spouse and relatives residing in her household.[137] Gao was a stranger to the policy, and at the time of the accident, was merely Zhou's domestic partner or fiancé.[138]

Agreeing with Integon, the First Department found that Gao was neither a named insured nor a relative of Zhou at the time of the accident.[139] Although "relative" was left undefined in the policy, "Gao does not qualify as Zhou's relative under the ordinary

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was devoid of any proof that Liberty actually breached its agreement, since Liberty "was not refusing to satisfy the UAD judgment, but rather, was withholding payment pending resolution of the competing claims to the funds between Seneca and Federal Insurance Company, Greenway's excess liability insurer." *Id.*

133. *See, e.g.,* Moleon v. Kreisler Borg Florman General Const. Co., Inc.*,* 758 N.Y.S.2d 621 (App. Div.1st Depot. 2003); *see also* Consol. Edison Co. of N.Y., Inc. v. Allstate Ins. Co.,774 N.E.2d 687 (N.Y. 2002).

134. Integon Nat'l. Ins. Co. v. Dong Dong Zhou, 186 N.Y.S.3d 216, 216 (App. Div. 1st Dep't 2023).

135. *Id.* at 555 – 556.

136. *Id.* at 556.

137. *Id.*

138. *Id.*

139. 186 N.Y.S.3d at 216.

definition of that term."[140] No amount of further discovery would have changed this fact, entitling Integon to summary judgment.[141]

Likely the most commonly litigated issue pertaining to insured status is what is referred to as additional insured coverage. Contractual partners in various contexts, such as construction projects and property leases, usually require that one party—a downstream lessee or subcontractor—must name the other party—an upstream property owner or general contract—as an additional insured on their insurance policies.[142] Although the concept is rather simple, it is often difficult to discern whether an entity claiming additional insured status is entitled to such coverage under the particular circumstances of a claim.

Among the easier issues to determine is whether an underlying contract required a party to be named as an additional insured in the first instance—that is, when the parties agree to what was included in an underlying trade contract.

In *Arch Specialty Ins. Co. v. Nautilus Ins. Co.*, the First Department noted that:

> The additional insured endorsement of the Nautilus policy, issued to its named insured nonparty GSC Services Corporation (GSC), stated that additional insured coverage would be provided only to "any person(s) or organization(s) when you [GSC] and such person(s) or organization(s) have agreed in a written contract or written agreement that such person(s) or organizations(s) be added as an additional insured on your policy."[143]

Although the insurance policy's additional insured requirements were clear, the underlying subcontract was not, as "[i]ssues [remained] as to whether the signed two-page subcontract between GSC and Bordone incorporated an 'invoice requirements' page and

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140. *Id.* (citing BLACK'S LAW DICTIONARY (11th ed. 2019), relative ("(a) person connected with another by blood or affinity"); relative by affinity ("(s)omeone who is related solely as the result of a marriage and not by blood or adoption")).

141. *Id.*

142. *See*, e.g., Burlington Ins. Co. v. NYC Transit Auth., 79 N.E.3d 477 (N.Y. 2017).

143. Arch Specialty Ins. Co. v. Nautilus Ins. Co., 181 N.Y.S.3d 463, 463 (App. Div. 1st Dep't 2023).

whether that page sufficiently required GSC to procure additional insured coverage for Bordone."[144]

Another example of this principle is the Second Department's decision in *Arch Specialty Insurance Co. v. RLI Insurance Co.*, where it was determined that a tenant cannot be an additional insured under an endorsement that merely scheduled "[o]wners where required by written contract, signed prior to the loss."[145] That is because a tenant is a tenant under a lease, rather than an owner entitled to coverage under the policy.[146]

Another, more thorough example of this type of issue is the First Department's handling of *Wesco Insurance Company v. Fulmont Mutual Ins. Co.*, where it was found that although an insurance policy clearly listed one entity as an additional insured instead of another, the parties' intent was to provide coverage for the latter.[147]

Beyond 501 West SPE, LLC ("Beyond") was owner of a premises located at 501 West 173rd Street at the time of an accident resulting in injury and an underlying lawsuit.[148] Pursuant to the terms of an existing commercial lease, its tenant added the building and its then-owners, SC2284 LLC and EFE Realty LLC (SC2284 LLC), as additional insureds on an insurance policy issued by Fulmont Mutual Insurance Company.[149] Well before Beyond, SC2284 LLC had sold the premises to 501 West 173 Street, LLC ("501 West"), and the Fulmont insurance policy was updated merely to replace SC2284 LLC with 501 West.[150] Adding to the confusion, 501 West again sold the property to Beyond on January 7, 2016.[151] The additional insured endorsement in the Fulmont policy, however, was never updated and 501 West remained listed on the policy.[152]

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144. *Id.*at 463-64.

145. Arch Specialty Ins. Co. v. RLI Ins. *Co*, 175 N.Y.S.3d 739, 740 (App. Div. 2d Dep't 2022).

146. *Id.* at 741.

147. Wesco Ins. Co. v. Fulmont Mut. Ins. Co., 188 N.Y.S.3d 468, 469-70 (App. Div. 1st Dep't 2023).

148. *Id.* at 469.

149. *Id.*

150. *Id.*

151. *Id.*

152. *Wesco Ins. Co.*, 188 N.Y.S.3d at 470.

On October 2, 2019, Beyond's insurer, Wesco Insurance Company, tendered its defense and indemnification to Fulmont.[153] Fulmont disclaimed coverage to Beyond, in part, because Beyond was not "an insured or additional insured under the above referenced policy."[154]

Wesco argued that 501 West was misidentified on the Fulmont policy, contending that the failure to update the owner's name to Beyond was the result of an innocent mistake, and that, as such, the policy should be reformed to substitute Beyond for 501 West.[155] The First Department agreed and reformed the Fulmont policy to reflect the intention of the parties.[156]

Since the Fulmont policy always extended coverage to the building and its owner as additional insureds, the tenant's failure to notify Fulmont of a mere change in ownership was of no moment.[157] The court found that the name of the insured in the policy is not dispositive if the intent to cover the risk, as here, is clear.[158]

Although Wesco successfully argued for reformation above, the answer for similar questions often falls the opposite way, as was the case in *Zurich American Ins. Co. v. ACE American Ins. Co.*[159] In that case, an employee of B&R Rebar Consultants/Rebar Steel Corp., A Joint Venture (RJV) was allegedly injured while unloading a trailer. RJV was the rebar contractor on site.[160]

B&R Rebar Consultants, one of RJV's joint venturers, obtained auto coverage for itself and RJV through Zurich American Ins. Co. and after the accident, Zurich turned to Utica National Insurance Company of Texas to shoulder some of the load.[161] Prior to the

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153. *Id.*
154. *Id.*
155. *Id.*
156. *Id.*
157. *Wesco Ins. Co.*, 188 N.Y.S.3d at 470.
158. *Id.* (citing Anand v. GA Ins. Co., 643 N.Y.S.2d 661, 663 (App. Div. 2d Dep't 1996); Ebasco Constructors, Inc. v. Aetna Ins. Co., 692 N.Y.S.2d 295, 298 (App. Div. 1st Dep't 1999)).
159. Zurich Am. Ins. Co. v. ACE Am. Ins. Co., 175 N.Y.S.3d 526, 528 (App. Div. 1st Dep't 2022). To be clear, this is not an additional insured case, but does concern the appropriate standard for interpreting the scheduling and/or naming of insureds for coverage on policies, generally.
160. *Id.*
161. *Id.*

accident, Utica had issued an insurance policy to another one of RJV's joint venturers, Rebar Steel Corp., but "that policy did not name, describe, or otherwise refer to RJV itself as an insured in the policy."[162] Unlike *Wesco v. Fulmont* above, where the First Department inferred an intent to provide coverage for an unnamed party, "Utica's policy contain[ed] an extension that precludes coverage with respect to conduct of any joint venture not shown in the declarations of named insureds in Utica's policy, and RJV is not listed in the declarations."[163] This was enough to foreclose any coverage obligation owed by Utica to RJV.[164]

Once we overcome the threshold question of who might be a named or additional insured under the policy, the next logical questions asked are what coverage is to be afforded, when, where, and why under the terms of such coverage. One particularly interesting area under these latter questions involves coverage for landlords on policies issued to their tenants.[165]

For example, during the *Survey* period, the Second Department found in *1416 Coney Island Realty, LLC v. Wesco Insurance Company* that a landlord was entitled to additional insured coverage under a tenant's insurance policy for a passing wayfarer injured on the sidewalk abutting the leased premises.[166] [167]

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162. *Id.*

163. *Id.*

164. *Zurich Am. Ins. Co.*, 175 N.Y.S.3d at 528.

165. *See, e.g.*, Wesco Ins. Co. v. Fulmont Mut. Ins. Co., 188 N.Y.S.3d 468, 469-70 (App. Div. 1st Dep't 2023). (mentioning, but not addressing an argument raised by Fulmont, that "it cannot be determined that the alleged accident occurred within the demised premises or from the use of, maintenance of, or the direct operation of our insured," which are limitations placed upon the scope of additional insured coverage available).

166. 1416 Coney Island Realty, LLC v. Wesco Ins. Co., 191 N.Y.S.3d 462, 465 (App. Div. 2d Dep't 2023).

167. The authors tip their hats to Judge Benjamin Cardozo, who, when a judge on the Court of Appeals, in the iconic case of Messersmith v. Am. Fid. Co., 133 N.E. 432, 433 (N.Y. 1921), spoke eloquently about the term "accident" for the purposes of an insurance policy, and introduced us to the "passing wayfarer". His oft-cited opinion focused on the intention of the tortfeasor to cause damage, as compared to the intention to commit an act: *"The occupant of a dwelling leaves a flower pot upon the window-sill, and the pot, dislodged by wind, falls upon a passing wayfarer (N. Y. City Ordinances, § 250). The position of the flower pot is intended, but not the ensuing impact. The character of the liability is not to be*

Wesco Insurance Company insured 1416 Coney Island Realty, LLC ("Coney Island"), the tenant of a leased premises. The owners of the leased premises were listed as additional insureds on the Wesco policy, but only for liability "aris[ing] out of the[] ownership, maintenance, or use of the leased premises."[168] The Second Department found that these limitations to the owners additional insured coverage were met, since "[t]he owners' potential liability in the underlying action arose out of the 'use of the leased premises, as the sidewalk was necessarily used for access in and out of the leased premises.'"[169] The court was equally unpersuaded by Wesco's contention "that the sidewalk was specifically excluded from coverage under the policy, pursuant to a provision excluding coverage as to the additional insureds for liability arising from injury not sustained within the leased premises."[170]

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*determined by analyzing the constituent acts which, in combination, make up the transaction, and viewing them distributively. It is determined by the quality and purpose of the transaction as a whole."*

168. *1416 Coney Island Realty, LLC*, 191 N.Y.S.3d at 465.

169. *Id.* (citing ZKZ Assocs. LP v. CNA Ins. Co., 679 N.E.2d 629, 630 (N.Y. 1997)); Isidore Margel Trust Mitzi Zank Tr. v. Mt. Hawley Ins. Co., 145 N.Y.S.3d 817, 817 (App. Dive. 2d Dep't 2021); Frank v. Cont'l Cas. Co., 999 N.Y.S.2d 836, 838 (App. Div. 2d Dep't 2014). The *ZKZ Assocs.* case and its progeny have created the bulk of controlling caselaw in this area, although the results have been mixed. *Compare*, e.g., Tech. Ins. Co., Inc. v. Main St. Am. Assurance Co., 162 N.Y.S.3d 638 (App. Div. 4th Dep't 2022); Jones Mem'l Hosp. v. Main St. Am. Assurance Co., 159 N.Y.S.3d 311 (App. Div. 4th Dep't 2021); *with* Atl. Ave. Sixteen AD, Inc. v. Valley Forge Ins. Co., 56 N.Y.S.3d 207 (App. Div. 2d Dep't 2017); Chappaqua Cent. Sch. Dist. v. Phila. Indem. Ins. Co., 48 N.Y.S.3d 784 (App. Div. 2d Dep't 2017), *lv denied* 29 N.Y.S.3d 913, 2017 WL 2743272 (2017); Christ the King Reg'l High Sch. v. Zurich Ins. Co. of N. Am., 91 937 N.Y.S.2d 290 (App. Div. 2d Dep't 2012)). It is one thing for an individual to fall while entering or exiting the leased premises. However, it may be an entirely different question where the fall involved an individual without intending to enter the leased space or in an area geographically removed from the threshold entrance of the leased space. In other words, a fall on an abutting sidewalk does little to resolve whether the fall is encompassed within the risk intended to be insured.

170. *Id.* The court does not provide much detail on this issue. However, various courts have addressed contractual requirements, such as the inclusion of maintenance obligations owed by tenants, which may potentially extend the "leased premises" beyond its four walls by implication. *See*, *e.g.*, *Tech. Ins. Co*., 202 162 N.Y.S.3d at 639. ("[P]laintiffs established from the lease agreement that the use of the driveway was included in the scope of the leased premises," as well as the

There is also an abundance of additional insured caselaw derived from construction accident litigation. The Second Department's decision in *Meadowbrook Pointe Develop. Corp. v. F & G Concrete* is just such a case [171]

Following an accident that occurred at a condominium complex, F & G Concrete, a mason and concrete subcontractor, was brought into lawsuits along with its insurer, Merchants Mutual Insurance Co.[172] The complaints blamed F & G for negligent construction of a concrete slab alleged to have proximately caused the underlying injuries, and sought additional insured coverage for the property owner, Meadowbrook Pointe Development Corp., as well as the general contractor, Beechwood Contracting, LLC, and property manager, Total Community Management Corp. pursuant to a contractual agreement between Meadowbrook, Beechwood, and F & G.[173]

The Merchants insurance policy required privity of contract between F & G and any purported additional insured.[174] Although Merchants demonstrated that the property manager was not an additional insured absent privity of contract between it and F & G, others were afforded coverage.[175] Specifically, Merchants failed to demonstrate that Meadowbrook, Beechwood, and the relevant homeowners association were not additional insureds under the liability policy it issued to F & G, or that the alleged accident at issue in the underlying action was not proximately caused by negligent construction of the garage concrete slab by F & G.[176] Rather, Meadowbrook and Beechwood met their prima facie burden and were granted a defense from Merchants on their cross-motion, as required by the underlying trade contract and the insurance policy.[177]

In another Merchants case, *Main Street America Assurance Co. v. Merchants Mut. Ins. Co.*, New York's Appellate Division,

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existence of an obligation to remove snow and ice therefrom"); Pixley Dev. Corp. v. Erie Ins. Co., 108 N.Y.S.3d 76, 78 (App. Div. 4th Dep't 2019).

171. Meadowbrook Pointe Develop. Corp. v. F & G Concrete & Brick Indus., Inc., 187 N.Y.S.3d 242 (App. Div. 2d Dep't 2023).

172. *Id.* at 246.

173. *Id.*

174. *Id.* at 248-49.

175. *Id.* at 248.

176. *Meadowbrook*, 187 N.Y.S. at 248.

177 *Id.* at 249.

Fourth Department addressed a similar issue.[178] There, Main Street America Assurance Company (MSAAC) and its insured, XL Construction Services, LLC ("XL Construction"), sought additional insured coverage from Merchants for XL Construction, in an underlying personal injury action.[179]

Timothy J. O'Connor sued XL Construction seeking damages for injuries sustained during his work as a self-employed subcontractor on a construction project.[180] XL Construction had subcontracted drywall work to O'Connor and, as part of the subcontract, O'Connor was obligated to obtain insurance for the benefit of XL Construction.[181] O'Connor was insured by Merchants under a policy that provided additional insured coverage "where required by a written agreement, but 'only with respect to liability for "bodily injury" . . . caused, in whole or in part, by . . . [O'Connor's] acts or omissions.'"[182]

Finding additional insured coverage owed for O'Connor's injuries, the Fourth Department noted that there is "a reasonable possibility that O'Connor's own negligence was a proximate cause of his injuries."[183]

## X. COLLATERAL ESTOPPEL EFFECT OF UNDERLYING ACTION

In New York, the decision of an insurance company to disclaim coverage without providing a defense to an insured can result in an inability to contest liability determinations made in an underlying tort action or the damage amounts that result.[184] That is, however,

178. Main St. Am. Assurance Co. v. Merchants Mut. Ins. Co., 175 N.Y.S.3d 660 (App. Div. 4th Dep't 2022).

179. *Id.* at 661.

180. *Id.*

181 *Id.*

182. *Main St. Am. Assurance Co.,* 175 N.Y.S.3d at 661.

183. *Id.* As recognized by the Fourth Department here, "the endorsement language utilized here only 'applies to injury proximately caused by the named insured.'" *Id.* (citing Burlington Ins. Co. v NYC Tr. Auth., 79 N.E.3d 477, 478 (N.Y. 2017)).

184. *See* Lang v. Hanover Ins. Co., 820 N.E.2d 855, 858-59 (N.Y. 2004) ("Finally, we note that an insurance company that disclaims in a situation where coverage may be arguable is well advised to seek a declaratory judgment concerning the duty to defend or indemnify the purported insured. If it disclaims and declines to defend in the underlying lawsuit without doing so, it takes the risk that the injured

limited to those issues actually determined.[185] A case decided by the Second Department during the *Survey* period, *Mapfre Insurance Company of New York v. Ferrall*, provided a thorough discussion of this principle under New York law.[186]

Ryan Groskopf and Edward Ferrall were involved in an altercation outside a bar, at which time Ferral struck Groskopf in the head with a baton, causing injuries.[187] Groskopf sued Ferral and his parents, alleging both negligence and recklessness.[188]

Shortly thereafter, Mapfre Insurance Company of New York filed this declaratory judgment action against Groskopf and Ferrall.[189] Mapfre contends that coverage is only provided for the happening of an "occurrence," defined by its policy, in pertinent part, as "an accident."[190] And "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."[191]

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party will obtain a judgment against the purported insured and then seek payment pursuant to Insurance Law § 3420. Under those circumstances, having chosen not to participate in the underlying lawsuit, the insurance carrier may litigate only the validity of its disclaimer and cannot challenge the liability or damages determination underlying the judgment.") (in dicta); *see also*, K2 Inv. Grp., LLC v. Am. Guarantee & Liability Ins. Co., 6 N.E.3d 1117, 1120 (N.Y. 2014) (reaffirming that the advice provided by the Court of Appeals in *Lang* "continues to be sound advice").

185. Servidone Constr. Corp. v. Security Ins. Co. of Hartford, 477 N.E.2d 441, 444–45 (N.Y. 1985) (finding that although an insurer owed a defense to an insured based upon the alleged facts in the complaint, there had been no factual determination as to liability prior to an underlying settlement, leaving that issue subject to challenge by an insurer on the grounds that the factual basis for damages fell outside of coverage); *see also*, *K2 Inv. Grp*., 6 N.E.2d at 1119-20 (reaffirming *Servidone* as distinguishable from *Lang*).

186. Mapfre Ins. Co. of N.Y. v. Ferrall, 185 N.Y.S.3d 201, 205 (App. Div. 2d Dep't 2023).

187. *Id.* at 203.

188. *Id.*

189. *Id.* at 202.

190. *Id.* at 203. This particular issue involves an insured's "burden to establish coverage" in the first instance. *Id.* (citing Consol. Edison Co. of N.Y. v. Allstate Ins. Co., 774 N.E.2d 687, 688 (N.Y. 2002); Stout v. 1 E. 66th St. Corp., 935 N.Y.S.2d 49, 54 (App. Div. 2d Dep't 2011)).

191. *Mapfre*, 185 N.Y.S.3d at 203. (citing Agoado Realty Corp. v. United Int'l Ins. Co., 733 N.E.2d 213, 215 (N.Y. 2000)). This question is largely a factual

On motion, Groskopf and Ferrall submitted their deposition transcripts from the underlying action and Groskopf's sworn statement relative to criminal proceedings taken against Ferrall, which provided a rather thorough, albeit incomplete factual backdrop for the court:

> In his statement, dated September 30, 2017, Groskopf averred that earlier that morning, after 2:00 a.m., he was walking from his apartment to get pizza when he saw his friends involved in a verbal altercation with "some guys." He attempted to "diffuse" the situation. He was pushed by an "unknown person," and he pushed the person back. He "then saw a baton get whipped out and expanded." Upon seeing the baton, he said, "Woah, Woah," and backed up. He then "got struck on the head, fell on the ground, lost consciousness momentarily, then got up and attempted to chase the male down." At the scene, Groskopf identified the person who struck him with the baton, i.e., Edward, and requested "prosecution to the fullest extent" of the law.
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> During his deposition in the underlying action, Groskopf testified that the person who had pushed him was not the same person who struck him with the baton, i.e., Edward. Upon seeing the baton, Groskopf testified that he "t[ook] a step back." Edward was not "being aggressive with" the baton. However, when Groskopf's friend "Chris" lunged toward Edward in an aggressive manner, Groskopf was struck in head with the baton. Groskopf did not see Edward indicate any sign of aggression directed specifically at him.
>
> In his deposition in the underlying action, Edward testified that during the commotion, a group of five men, all of whom were taller than him, were yelling and cursing at him "as though maybe [he] was part of the commotion." Edward "backed up" and "pulled out the stick to wave them off to scare them away." According to Edward, he "didn't intentionally mean to hit anyone but create like a circle of just waving it to get them away." Edward did not recall how the five men reacted when he started swinging the baton. At some point, Edward struck one of the

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issue, which is problematic on summary judgment because a court may very well find support on both sides of the matter.

> five individuals who were aggressively coming at him. In a criminal proceeding arising from the incident, Edward entered a plea of guilty to (1) assault in the third degree, admitting that he "recklessly" caused physical injury to another person, and (2) criminal possession of a weapon in the fourth degree, admitting that he knowingly possessed a weapon, i.e., the baton.[192]

Finding outstanding issues of fact, the Second Department noted support for construing the relevant conduct as either accidental or intentional.[193] Specifically,

> [a]t their depositions . . . Groskopf, and [Ferrall] both gave versions of the incident characterizing [Ferrall's] act in striking Groskopf in the head with an illegal baton as being unintentional, varying inferences regarding [Ferrall's] intent may nonetheless be drawn from the circumstances described where the incident occurred during a heated altercation between two groups of men in the early morning hours. Moreover, in Groskopf's sworn statement in support of the criminal proceedings against [Ferrall], Groskopf did not suggest that [Ferrall's] conduct in striking him was accidental, and, in fact, requested that [Ferrall] be prosecuted "to the fullest extent" of the law.[194]

Further, "[s]ince Mapfre was not a party in the underlying action, it did not have an opportunity to participate in the depositions or otherwise litigate the issue of [Farrell's] intent in the underlying action."[195] Mapfre's defense of Ferrall "under a reservation of its right to disclaim coverage does not put it in privity with the Ferrall defendants."[196] Thus, "any determination in the underlying action regarding [Ferrall's] intent is not binding upon Mapfre," which was

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192. *Id.* at 204–05.

193. *Id.* at 205.

194. *Id.*

195. *Id.* at 205 (citing First State Ins. Co. v. J & S United Amusement Corp., 495 N.E.2d 351, 352 (N.Y. 1986)).

196. *Mapfre*, 185 N.Y.S.3d at 205 (citing *First State Ins. Co.*, 495 N.E.2d at 352). The court also noted the importance of the tripartite relationship of insurer, insured, and assigned defense counsel, advising that " the attorneys representing [Ferrall] . . . , although paid by [Mapfre] . . . , are obligated to act in the interest of [Ferrall]." *Id.* (quoting *First State Ins. Co.*, 495 N.E.2d at 352).

free to resolve that factual issue at a trial of the insurance coverage action.[197]

## XI. COMMON LAW ESTOPPEL

Although we will not dive into detail on this topic, we note that New York insureds frequently argue that their insurers should be estopped from denying coverage for one reason or another. Under New York law, an insurance company may certainly be estopped from denying coverage where an insured justifiably relied upon an insurer's words or actions, resulting in prejudice.[198] However, absent the required justifiable reliance,[199] or resulting prejudice,[200] an insurer is entitled to disclaim coverage upon the terms of its policy following a valid reservation of the right to do so.

## XII. EXAMINATION UNDER OATH AND OTHER COOPERATION ISSUES

It is common industry practice for insurance coverage under an insurance policy to be conditioned upon an insured's cooperation in the insurance company's investigation of any claim, including the disclosure of requested documents and submission to an examination under oath regarding the facts and circumstances involved. The First Department's decision in *MDRN Intelligence Living Wolfhome v. Hartford Fin. Servs.* showcases the ramifications for non-compliance.[201]

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197. *Id.* at 205. (citing *First State Ins. Co.*, 495 N.E.2d at 352; Dreyer v. New York Cent. Mut. Fire Ins., 964 N.Y.S.2d 251, 254 (App. Div. 2d Dep't 2013); Failla v. Nationwide Ins. Co., 701 N.Y.S.2d 161, 163 (App. Div. 3d Dep't 1999). Importantly, the court also recognized that "in the underlying action, it was in the mutual best interests of Groskopf and [Ferrall] to characterize [Ferrall's] conduct as accidental and, hence, within the coverage of the policy." *Id.* (citing *Failla*, 701 N.Y.S.2d at 163).

198. *See* Wesco Ins. Co. v. Salvo, 174 N.Y.S.3d 850, 850 (App. Div. 1st Dep't 2022); Jing Yu v. Allstate Ins. Co., 174 N.Y.S.3d 711, 712 (App. Div., 2d Dep't 2022).

199. *Jing Yu*, 174 N.Y.S.3d at 712.

200. *Wesco Ins. Co.*, 174 N.Y.S.3d at 850.

201. MDRN Intel. Living Wolfhome v. Hartford Fin. Servs. Grp. Inc., 189 N.Y.S.3d 89, 90 (App. Div. 1st Dep't 2023).

Intelligence Living Wolfhome filed suit against its insurer, Hartford Financial Services Group, Inc., challenging its declination of coverage on non-cooperation grounds.[202] Finding for Hartford, the First Department reminded the parties that "[w]here an insured brings an action on a policy of insurance without complying with conditions precedent, the failure to appear for examination under oath (EUO) is an 'absolute defense.'"[203] Here,

> [d]espite plaintiff MDRN's contention that they substantially complied with Twin's City requests for information, the failure to provide repeated requests for documents, to return a signed written transcript of the manager's EUO, to complete the manager's EUO, and to produce the insured's principal for an EUO, despite Twin City's continued warning that the failure to cooperate could result in the declination of coverage, constituted a material breach of the policy precluding recovery by plaintiff.[204]

*MDRN Intelligence* is not the only decision during the *Survey* period to touch on this issue. In *Burke Physical Therapy, PC v. State Farm Mut. Auto. Ins. Co.*, the Supreme Court, Appellate Term for the Second Department found that an insured's refusal to permit copying of documents requested to be brought to an EUO constituted a material lack of cooperation relative to the required disclosure of such documents, supporting a denial of coverage.[205]

## XIII. DISCOVERY

Speaking of the required disclosure of documents, a hot-button topic in the insurance world is the scope of permissible discovery from insurance claims files. This is largely dependent upon who is making the request and for what purpose.

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202. *Id.*

203. *Id.* (citing Lentini Bros. Moving & Storage Co., v. N.Y. Prop. Ins. Underwriting Ass'n., 428 N.Y.S.2d 684 (App. Div. 1st Dep't 1980), *affd*, 422 N.E.2d 819 (N.Y. 1981)).

204. *Id.* (citing Evans v. Int'l Ins. Co., 562 N.Y.S.2d 692, 694 (App. Div. 1st Dep't. 1990)).

205. Burke Physical Therapy, PC v. State Farm Mut. Auto. Ins. Co., 178 N.Y.S.3d 375, 375 (App. Div. 2d Dep't. 2022).

For example, in *Springer v. Tishman Speyer Properties, L.P.*, New York's First Department recognized that an insurer's claim file relative to ongoing tort litigation is conditionally privileged from disclosure as "material prepared in contemplation of litigation."[206] On this basis, the court concluded that a tort plaintiff was unable to obtain "an insured's statement to a liability insurer" and "[p]re-litigation communications between an insurer and its insured."[207] The court also rejected a "request for deposition testimony as to communications between [the insureds] and their insurers [as] improper because the information is confidential."[208]

A similar, albeit separate issue often arises in the insurance declaratory judgment context, where parties interested in establishing a right to coverage attempt to obtain an insurance company's post-disclaimer mental impressions and diary entries. The decision by the Fourth Department in *Merchants Preferred Insurance Company v. Campbell* serves as an example of this issue.[209]

Rose Charleus was injured in an automobile accident with another vehicle insured by Merchants Preferred Insurance Company. After Charleus sued Merchants, the insured failed to cooperate with Merchants in its investigation and defense and Merchants disclaimed

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206. Springer v. Tishman Speyer Props., L.P., 178 N.Y.S.3d 450, 451 (App. Div. 1st Dep't 2022); *see also* N.Y. C.P.L.R. 3101(d)(2) ("[M]aterials otherwise discoverable under subdivision (a) of this section and prepared in anticipation of litigation or for trial by or for another party, or by or for that other party's representative (including an attorney, consultant, surety, indemnitor, insurer or agent), may be obtained only upon a showing that the party seeking discovery has substantial need of the materials in the preparation of the case and is unable without undue hardship to obtain the substantial equivalent of the materials by other means. In ordering discovery of the materials when the required showing has been made, the court shall protect against disclosure of the mental impressions, conclusions, opinions or legal theories of an attorney or other representative of a party concerning the litigation."). In other words, the injured claimant is supposed to do his own investigation and is not entitled to rely upon the materials obtained by an insured's insurance company while investigating and defending a claim.

207. *Springer*, 178 N.Y.S.3d. at 451 (citing Recant v. Harwood, 635 N.Y.S.2d 231, 232 (App. Div. 1st Dep't. 1995)).

208. *Id.* (citing Grotallio v. Soft Drink Leasing Corp., 468 N.Y.S.2d 4, 5 (App. Div. 1st Dep't. 1983) ("[t]he contents of an insurer's claim file which have been prepared for litigation against its insured are immune from disclosure . . . .")).

209. Merchants Preferred Ins. Co. v. Campbell, 178 N.Y.S.3d 850, 851 (App. Div. 4th Dep't 2022).

coverage on that basis.[210] Charleus issued discovery demands and, in response, Merchants disclosed certain materials but withheld portions of its insurance claim file relating to the personal injury action on the ground that the documents were material prepared in anticipation of litigation, were protected by attorney client privilege, and were otherwise not relevant to the action to disclaim coverage.[211] After an in camera review of the withheld claims file materials, the motion judge ordered their disclosure.[212]

New York's Fourth Department, Appellate Division disagreed noting again that an insurer's claim file is conditionally exempt from disclosure as material prepared in anticipation of litigation unless "a party [demonstrates] that he or she is in substantial need of the material and is unable to obtain the substantial equivalent of the material by other means without undue hardship."[213] Finding instead for Merchants, the Fourth Department noted that the materials initially ordered to be disclosed were, in fact, "material prepared in anticipation of litigation and were prepared at a time after plaintiff had already determined to reject and defend against the claim made by Charleus."[214]

## XIV. SETTLEMENT AND RELEASE

A major touchpoint in any tort litigation involving insurance is finality for both the insured and insurer alike. Resolution of an underlying tort lawsuit may or may not draw an outstanding coverage issue to conclusion, unless closing documents are carefully constructed to reflect that intent. Problems arise absent consideration of these issues ahead of time.

This was a lesson learned the hard way in *Lancer Indem. Co. v Peerless Ins. Co.* Lancer Indemnity Company sued Peerless Insurance Company to recover costs incurred by Lancer in defending and

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210. *Id.*

211. *Id.*

212. *Id.*

213. *Id.* (citing Teran v. Ast, 84 N.Y.S.3d 504, 506 (App. Div. 2d Dep't 2018)).

214. *Merchants Preferred Ins. Co.,* 178 N.Y.S.3d at 851 (citing Lamberson v. Vill. of Allegany, 551 N.Y.S.2d 104, 105 (App. Div. 4th Dep't 1990); Advanced Chimney, Inc. v Graziano, 60 N.Y.S.3d 210, 213 (App. Div. 2d Dep't 2017)).

indemnifying its insured, TPJ Enterprises, LLC, including a $500,000 settlement of a lawsuit commenced by Heidi and Carl Siciliano.[215] The Sicilianos sued TPJ and Ace Hardware, which was insured by Peerless.[216]

The $500,000 settlement was obtained at a mediation where the attorneys provided by Lancer and Peerless to their respective insureds agreed to fund a $500,000 equally between such insureds.[217] Notably, both Lancer and Peerless were represented by counsel at mediation, actively participating in the settlement.[218]

Finding for Peerless, the Second Department noted that at the time of settlement, "Lancer did not reserve its right to commence an action to recover its defense and indemnity costs against Peerless in the settlement of the underlying negligence action," resulting in an estoppel from doing so.[219]

But it is not just insurance companies and their insureds that need to approach closing documentation carefully. Take for example the issue confronted by New York's First Department in *Guice v. PPC Residential, LLC*, where it was determined that "[a] binding settlement agreement existed between plaintiff and defendants when plaintiff's counsel responded, 'Confirmed. Thank you' to RB N.Y. Enterprises Inc.'s insurance carrier's email stating 'This email is to confirm we are settled at $85,000.'"[220] The court noted that "Plaintiff's counsel had authority to accept the settlement; the confirmation came from counsel's email account; the parties reached an agreement as to the settlement amount; no conditions were attached to the confirmation; the parties prepared the release documents; and plaintiff's

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215. Lancer Indem. Co. v. Peerless Ins**.** *Co***,** 172 N.Y.S.3d 643, 644 (App. Div. 2d Dep't 2022).

216. *Id.*

217. *Id.*

218. *Id.*

219. *Id.* Insurers in New York and elsewhere routinely pursue what is known as a "pay-and-chase" settlement strategy, where they agree to settle—protecting their insured—while reserving the right to pursue another carrier for amounts incurred. The lesson here is to make certain that the expectation of the chase is retained in the settlement agreement. Silence may very well end up being a fatal flaw to recovery.

220. Guice v. PPC Residential LLC, 182 N.Y.S.3d 94, 95 (App. Div. 1st Dep't 2023) (citing Phila. Ins. Indem. Co. v. Kendall, 151 N.Y.S.3d 392, 396 (App. Div. 1st Dep't 2021)).

counsel forwarded the releases to plaintiff for signature."[221] With an agreement in hand, additional emails concerning medical lien amounts were unable to vitiate the meeting of the minds "and plaintiff's failure to sign the release documents amounted to no more than a ministerial condition precedent to payment under these facts."[222]

In sum, global resolution of both an underlying tort action and any related insurance disputes is certainly within reach at the time of most settlements. The moral of the story, in simple terms, is that you get what you ask for at the time of settlement. No more. No less.[223]

## XV. RESCISSION

New York law relative to insurance policy rescissions is rather robust and this *Survey* period saw New York's appellate courts remind insurers of several requirements.

For example, New York's Second Department reminded us in *Rodriguez v. Mercury Cas. Co.* that:

> the insurer must present documentation concerning its underwriting practices, such as underwriting manuals, bulletins, or rules pertaining to similar risks, that show that it would not have issued the same policy if the correct information had been disclosed in the application must be submitted to establish a right to rescind.[224]

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221. *Id.*

222. *Id.* (citing Rawald v. Dormitory Auth. of the State of N.Y., 156 N.Y.S.3d 201 (App. Div. 1st Dept. 2021); *Kendall*., 151 N.Y.S.3d at 398).

223. *Compare* Burlington Ins. Co. v. Kookmin Best Ins. Co., Ltd., 177 N.Y.S.3d 884 (App. Div. 1st Dep't 2022) (finding that a failure to include third-party claims for indemnification and contribution in a stipulation of discontinuance permitted further pursuit of such claims by a party's insurer post-settlement), *with* Putnam v. Kibler, 178 N.Y.S.3d 851, 857 (App. Div. 4th Dep't 2022) (finding that a general release of claims for "bodily injury" encompassed a lawsuit seeking personal injury damages).

224. Rodriguez v. Mercury Cas. Co., 170 N.Y.S.3d 501, 502 (App. Div. 2d Dep't 2022) (citing Thandi v. Otsego Mut. Fire Ins. Co., 157 N.Y.S.3d 516, 518 (App. Div. 2d Dep't 2021); Caldara v. Utica Mut. Ins. Co., 15 N.Y.S.3d 346, 348 (App. Div. 2d Dep't 2015); Friedman v. Otsego Mut. Fire Ins. Co., 114 N.Y.S.3d 686, 687-88 (App. Div. 2d Dep't 2020); N.Y. Insurance Law §3105 McKinney 2011).

Thus, "[a]lthough Mercury submitted an affidavit of an underwriting supervisor who stated that it would have issued the plaintiff a different policy with a higher premium had the plaintiff disclosed her Brooklyn address," the underwriting documentation submitted failed to support this statement.[225]

In related fashion with the above, another frequent pitfall for insurers attempting to establish a right to rescind an insurance policy is New York's materiality requirement relative to an insured's misrepresentation of the risk insured. Courts often find that underwriting policies and procedures do not address the exact issue confronted by the court, or how an insurer would have acted differently if presented with the "truth," whatever that may be. That component was highlighted by the Second Department in *Union Mut. Fire Insurance Co. v. CMN Prop., LLC*, where the court, presented with what it described as "conclusory" statements of Union Mutual's chief underwriter, was unable to determine "whether the [insured's] admitted misrepresentation regarding tenants in arrears constituted a material misrepresentation such that the plaintiff would not have issued the same policy if the correct information had been disclosed in the application."[226] The Second Department was not alone in finding issues of fact relative to materiality, as the First Department found the same in *Liberty Mut. Insurance Co. v. Valera*.[227]

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225. *Rodriguez*, 170 N.Y.S.3d at 502 (citing Thandi v. Otsego Mut. Fire Ins., 157 N.Y.S.3d 516, 518 (App. Div. 2d Dep't 2021); Parmar v. Hermitage Ins., 800 N.Y.S.2d 726, 727 (App. Div. 2d Dep't 2005); Di Pippo v. Prudential Ins. Co., 450 N.Y.S.2d 237, 238 (App. Div. 2d Dep't 1982)). *See also*, American Empire Surplus Lines Ins. Co. v. ZNKO Constr. Inc., 186 N.Y.S.3d 69, 71 (App. Div. 2d Dep't 2023) ("[C]onclusory statements by insurance company employees, unsupported by documentary evidence, are insufficient to establish materiality as a matter of law.").

226 Union Mut. Fire Ins. Co. v. CMN Props., LLC 188 N.Y.S.3d 711 (App. Div. 2d Dep't 2023); *See also American Surplus Lines Ins.*, 186 N.Y.S.3d at 71 ("Triable issues of fact exist, inter alia, as to whether the alleged misrepresentations were material."): Concord Direct, Inc. v. Ameriprise Ins. Co., 179 N.Y.S.3d 515 (finding that an insurer failed to "demonstrate that the purported misrepresentation was material, as the underwriting eligibility guidelines included with its motion papers fail to show that defendant 'would not have issued the same policy if the correct information had been disclosed.'"

227 Liberty Mut. Ins. Co. v. Valera, 176 N.Y.S.3d 10, 11 (App. Div. 1st Dep't 2022)

Even more fundamentally, in order to establish the existence of a material misrepresentation, an insurer must establish that a representation was made at all. That simple—albeit crucial—issue was litigated in *Scottsdale Ins. Co. v. Casino Dev. Grp.*, where New York's First Department found that an unsigned application for insurance that formed the basis of an insurer's rescission was hearsay, and thus inadmissible.[228] Scottsdale Insurance Company offered no evidence that its insured, Casino Development Group, was the source of the information contained in the application, such that it could be considered under New York's business record exception to hearsay.[229]

Even where an insurer establishes that it once had the right to rescind, evidence tending to establish that an insurer acted in contravention to an intent to rescind may constitute a waiver of the right to rescind. That much was highlighted by the Second Department during the *Survey* period in both *American Empire Surplus Lines Ins. Co. v. ZNKO Construction* and *Sabharwal v. Hyundai Mar. & Fire Ins. Co*.[230] In both those decisions, the court noted that an insurer may waive the right to rescind if it renews an insurance policy or accepts premium payments after discovering the grounds for rescission.[231]

## XVI. ASSAULT AND BATTERY

Among the more interesting issues to litigate under New York insurance law is coverage (or lack thereof) for an alleged assault and battery. New York public policy favors insurers on this issue, since insurance is meant for the happening of a fortuitous, unintentional event—of which the intentional torts of assault and battery are not. Still, there are nuanced issues involved in assessing the availability of coverage where such torts are alleged.

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228. Scottsdale Ins. Co. v. Casino Dev. Grp., Inc., 190 N.Y.S.3d 28, 30 (App. Div. 1st Dep't 2023).

229. *Id.*

230. *American Empire Surplus Lines Ins. Co.,* 186 N.Y.S.3d at 71; Sabharwal v. Hyundai Mar. & Fire Ins. Co. Ltd., 189 N.Y.S.3d 660, 663-64 (App. Div. 2d Dep't 2023).

231. *American Empire Surplus Lines Ins. Co.,* 186 N.Y.S.3d at 71; *Sabharwal*, 189 N.Y.S.3d at 663–64.

Take for example the Third Department's handling of *Vermont Mutual Ins. Group v. LePore* during the *Survey* period.[232] There, a school staff member was injured breaking up a fight between students.[233] One of the students involved, Sheri Lepore, held a homeowners insurance policy with Vermont Mutual Insurance Group, but Vermont disclaimed coverage for the incident, contending that the assault was intentional and did not constitute an "occurrence" as required for coverage.[234] Vermont filed suit to verify that disclaimer was appropriate.[235]

Finding a duty to defend, the Third Department noted that:

> [t]he bill of particulars alleged that LePore "negligently and carelessly struck [Cole] in the back causing [Cole] to fall into a cement wall" while Cole was trying to stop an altercation involving LePore. It also alleged that LePore did not intend to injure Cole but accidently struck Cole while trying to hit the other student and that LePore "committed culpable conduct when she chose to ignore a command by [Cole] ... to stop her involvement in an altercation."[236]

Given these alleged facts, the court found that although the record contained indicia of intentional conduct, there was a "possibility that Cole's injuries could have resulted from unintentional conduct by LePore," and thus a duty to defend.[237]

Given the limitations of relying upon the lack of an "occurrence" relative to claims for assault and battery, which were on display in *LePore*, many insurers include provisions expressly limiting or excluding coverage for claims of assault and battery altogether.

In *Swan USA, Inc., v. Wesco Insurance Co.*, New York's Second Department found that an insurance policy's assault and battery exclusion unambiguously precluded coverage for injuries arising out of an alleged assault and battery, regardless of whether the insured

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232. *See* Vermont Mutual Ins. Grp. v. LePore, 179 N.Y.S.3d 479 (App. Div. 3d Dep't 2022).

233. *Id.* at 480.

234. *Id.* The policy defined "occurrence" in relevant part as "an accident."

235. *Id.*

236. *Id.* at 480–81.

237. *Vermont Mutual Ins. Grp.,* 179 N.Y.S.3d at 481.

perpetrated the assault in question.[238] Claims that an insured had negligently served the belligerent party with alcohol and failed to prevent an assault thereafter were plainly excluded as claims that "arise out of the assault and, thus, fall within the exclusion under the subject policy."[239]

A more interesting example of this latter line of cases is *Great Am. E&S Ins. Co. v. Commack Hotel, LLC*, wherein the Second Department was confronted with an assault and battery endorsement that provided limited coverage for damages available for such claims.[240] Following a fatal stabbing at a hotel during a party, the decedent's estate filed suit and alleged that the hotel was negligent relative to preventing the incident.[241] Finding that the assault and battery limitation capped the limits of liability at $25,000 for such claims, the Second Department relied upon caselaw involving assault and battery exclusions, indicating that "[a]n exclusion for assault and/or battery applies if no cause of action would exist 'but for' the assault and/or battery."[242] Since no negligence claim would exist but for the stabbing, it follows that coverage for such event is limited to $25,000.[243]

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238. Swan USA, Inc. v. Wesco Ins. Co., 191 N.Y.S.3d 723, 723 (App. Div. 2d Dep't 2023).

239. *Id.* at 724 (citing *Swan USA,* 191 N.Y.S.3d at 723; Parler v. North Sea Ins. Co., 11 N.Y.S.3d 659, 660 (App. Div. 2nd Dep't 2015); WSTC Corp. v. Nat'l Specialty Ins. Co., 888 N.Y.S.2d 602, 603 (App. Div. 2nd Dep't 2009); Marina Grand, Inc. v. Tower Ins. Co. of N.Y., 882 N.Y.S.2d 435, 437 (App. Div. 2nd Dep't 2009); Mark McNichol Enters. v. First Fin. Ins. Co., 726 N.Y.S.2d 828, 828–29 (App. Div. 2nd Dep't 2001).)

240 Great Am. E&S Ins. Co. v. Commack Hotel, LLC, 179 N.Y.S.3d 336, 338 (App. Div. 2d Dep't 2022).

241. *Id.* at 337.

242. *Id.* at 338 (citations omitted).

243. *Id.* Left unsaid was the argument made in contrast. Essentially, the hotel had argued, incorrectly, that where claims of intentional assault were limited by way of the endorsement at issue, claims of negligence should be covered to the full limit of liability as covered "occurrences," under reasoning similar to the *Vermont* case discussed. *See generally* Vermont Mutual Ins. Grp. v. LePore, 179 N.Y.S.3d 479, 481 (App. Div. 3d Dep't 2022) (showing that if the plaintiff fails to show "that the intentional act exclusion in the policy applied as a matter of law" then the plaintiff will not succeed on a motion for summary judgement).

## XVII. SUM

Although we will not spend too much energy on addressing Uninsured Motorist and Supplementary Uninsured/Underinsured Motorist (UM/SUM) Coverage claims during the *Survey* period, this year saw various decisions that remind us of the fundamental issues involved.

In *The Matter of USAA General Indemnity Co. v. McQueen*, New York's Second Department reminded us, following a framed issue hearing that upon identification of a properly insured hit-and-run vehicle, a claim for uninsured motorist coverage becomes premature.[244] In other words, absent an uninsured (or underinsured) motor vehicle, a necessary condition precedent to UM/SUM Coverage has not yet been met. The First Department also identified the same prerequisite in *Nakamura v Motor Veh. Acc. Indem. Corp.*[245] More fundamentally, we were also reminded that in order for a hit-and-run vehicle to exist at all, an insured must set forth facts establishing a "hit"—i.e., physical contact—had actually occurred in the first instance.[246]

In a Fourth Department decision, *D'Angelo v. Philadelphia Indemnity Insurance Company*, the court acknowledged that SUM Coverage is only available for those vehicles and individuals actually insured for SUM Coverage.[247] While New York Insurance Law Section 3420(d)(2) might invalidate a disclaimer of coverage due to an exclusion, it cannot create coverage where it did not already otherwise exist.[248] A similar issue was confronted in the First Department, where the court in *Travelers Home and Marine Insurance Company v. Barowitz* found an issue of fact as to whether an individual claiming to reside within the named insured's household was entitled to

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244. USAA Gen. Indem. Co. v. McQueen, 172 N.Y.S.3d 93, 95 (App. Div. 2d Dep't 2022). That was not the only chance New York's Second Department had to assess this particular issue. *See also* Melville v. Motor Vehicle Accident Indem. Corp., 178 N.Y.S.3d 151, 152 (App. Div. 2d Dep't 2022).

245. Nakamura v. Motor Veh. Acc. Indem. Corp., 175 N.Y.S.3d 209, 209 (App. Div. 1st Dep't 2022).

246. *See* Gov't Empls. Ins. Co. v. Siouni, 176 N.Y.S.3d 733, 734–35 (App. Div. 2d Dep't 2022).

247. D'Angelo v. Phila. Indem. Ins. Co., 172 N.Y.S.3d 315, 316 (App. Div. 4th Dep't 2022).

248. *D'Angelo*, 172 N.Y.S.3d at 316.

SUM Coverage under the named insured's auto policy.[249] That court indicated that an insurance policy's SUM Coverage "conditions the status of an insured relative on whether the relative resides with the named insured," but found that "a hearing is required to determine the question of fact as to whether Elliott is covered as a resident family member."[250]

A critical, yet all too common misstep from the insured's perspective was outlined by the Second Department during the *Survey* period in *Soshnick v. GEICO Gen. Ins. Co.*, where it was determined in a short decision that the decision of an insured to settle an underlying personal injury action without consent of its auto insurer prohibited any future right to pursue a claim for SUM Coverage against that insurer.[251]

Finally, in *All American Insurance Company v. Wilson*, the Fourth Department also provided insurers with a lesson regarding a trap for the unwary.[252] Specifically, when filing a petition to stay arbitration, the Fourth Department advised that a failure to provide a certified or otherwise authenticated insurance policy in support of a petition to stay arbitration was a fatal flaw, since it resulted in a complete lack of evidentiary basis supporting the stay.[253] Stay vigilant, always, when it comes to providing proof in admissible form.

## XVIII. FIRST PARTY – REPLACEMENT COSTS

As distinguished from third-party liability insurance, first-party property insurance carries unique challenges under New York law. This *Survey* period, we will focus on a few decisions addressing claims made for replacement cost coverage.

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249. Travelers Home & Mar. Ins. Co. v. Barowitz, 174 N.Y.S.3d 375, 377 (App. Div. 1st Dep't 2022).

250. *Id*.

251. Soshnick v. GEICO Gen. Ins. Co., 182 N.Y.S.3d 654, 655 (App. Div. 2d Dep't 2023).

252. All Am. Ins. Co. v. Wilson, 171 N.Y.S.3d 707, 708 (App. Div. 4th Dep't 2022).

253. *Id.* Specifically, compounding the issue, the insurer's attempt to cure this defect on reply was rejected, because the certified policy affixed thereto was different than the original policy submitted in support of the petition.

The Fourth Department in *Hall v. New York Central Mutual Ins. Co.* dealt with questions involving replacement cost payments.[254] The dispute in *Hall* arose when an insured sought release of certain replacement cost funds relative to repairs that had not yet been made.[255] New York Central Mutual Insurance Company (NYCM), not surprisingly, refused to extend its replacement cost holdback for these portions of the claim, while also contesting coverage for costs to upgrade insulation and partially finish a basement that was unimproved at the time of the loss.[256]

In affirming NYCM's position, the Appellate Division noted that an insured is only entitled to "actual cash value until such repairs or replacements were complete."[257] In addition, the Court referenced the long-accepted rule that an insured is only entitled replacements of "like kind and qualify for like use."[258] To trigger replacement cost coverage, the insured must show both replacement and costs.[259] Here, since the insured had incurred no "costs" prior to the request for recoverable depreciation (i.e., the difference between the replacement cost and actual cash value estimates), NYCM's refusal to extend the benefit was justified. [260]

The Second Department in *Apergis v. Narragansett Bay Ins. Co.* handled a similar issue, ultimately concluding that replacement of allegedly damaged property was not appropriate where the items were able to be cleaned or restored.[261] Specifically, in *Apergis*, the insured sustained damage to his personal property after a boiler malfunctioned and created a "puff back."[262] The insurer issued undisputed payments for structural damage, damage to flooring, and damage to personal property, but refused to provide certain replacement costs sought by the insured.[263] Agreeing with the insurance company,

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254. Hall v. New York Cent. Mut. Fire Ins. Co., 180 N.Y.S.3d 441, 442 (App. Div. 4th Dep't 2022).

255. *Id.*

256. *Id.*

257. *Id.*

258. *Id.* at 443.

259. Hall, 180 N.Y.S.3d at 443.

260. *Id.*

261. Apergis v. Narragansett Bay Ins. Co., 188 N.Y.S.3d 621, 622 (App. Div. 2d Dep't 2023).

262. *Id.* at 621.

263. *Id.*

Narragansett Bay Ins. Co., the court noted that it had "submitted evidence, including the reports of two claims investigators and an expert in garment cleaning and fabric restoration, that the clothes at issue were not in need of replacement and that the subject wood floors did not require replacement."[264]

Finally, the Third Department also considered replacement cost coverage in *Lorens v. New York Central Mut. Ins. Co.*, concluding that for a replacement cost enhancement endorsement, the claimed "value" of an insured's dwelling was not the same as its replacement cost.[265]

At the time of a fire that damaged an insured's dwelling, an insurance policy issued by New York Central Mutual Insurance Company (NYCM) included a coverage enhancement elevating the replacement cost limit to 125% of the stated limit after an alteration increasing the "replacement cost of the dwelling" by 5% or more.[266] The insured was obligated to notify the carrier of any such alterations taking place during the policy period.[267]

Following the fire, the insured submitted a replacement cost estimate amount to the 125% enhanced limit, and, at least initially, NYCM advised that coverage was available up to that amount.[268] However, the insured eventually advised of certain unspecified alterations which increased the "value" of the home from $200,000 to $275,000.[269] Relying on this concession, NYCM advised that it was never notified of the alteration—a condition precedent to coverage—and withdrew its offer of the enhanced limit in favor of another offer of the standard policy limit.[270]

On appeal, the Appellate Division noted that NYCM presented no evidence that there were, in fact, alterations which raised the replacement cost by more than 5%.[271] Further, the court noted that plaintiff's reference to alterations raising the value by $75,000

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264. *Id.* at 622.

265. *Lorens v. N.Y. Cent. Mut. Ins. Co.*,182 N.Y.S.3d 317, 319 (App. Div. 3d Dep't 2023).

266. *Id.* at 318.

267. *Id.* at 319.

268. *Id.*

269. *Id.*

270. *Lorens,* 182 N.Y.S.3d at 319.

271. *Id.* at 320.

did not speak to replacement cost.[272] Rather, at best, plaintiff's statement could only be used to infer that the actual cash value (i.e., the value of the property on the date of the loss) was raised.[273] Since actual cash value and replacement cost valuations are entirely different, the Court ruled that changes as to actual cash value did not automatically include changes to the replacement cost amount.[274]

## XIX. PROCEDURAL ISSUES FOR INSURANCE DISPUTES

Each and every year, insurance disputes weave interesting procedural issues for courts to untangle. This *Survey* period was no different.

Sometimes the issues involved who can sue or be sued and how. Take for instance *Sakandar v. American Transit Ins. Co.*, where the Second Department addressed a motion to disqualify a no-fault claimant's attorney from representing him in the dispute against his insurance carrier.[275] Agreeing that the attorney should be disqualified, the Second Department noted that American Transit Insurance Company had:

> [e]stablished that counsel for the plaintiff had a prior attorney-client relationship with [American Transit], that the issues involved in his prior representation of [American Transit] were substantially related to the issues involved in his firm's current representation of the plaintiff, and that the interests of the [insured] and [American Transit] were materially adverse.[276]

In another procedural decision, *Liberty Mut. Ins. Co. v. Bonilla*, this time regarding who should be included (or rather consolidated), the Fourth Department found that the lower court had erred in denying an insurer's motion to consolidate multiple actions related by an insured's failure to cooperate in appearing for

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272. *Id.*

273. *Id.*

274. *Id.*

275. Sakandar v. Am. Transit Ins. Co., 191 N.Y.S.3d 742, 743 (App. Div. 2d Dep't 2023).

276. *Id.* Specifically, it appears that American Transit's motion advised that the insured's counsel "had previously represented [American Transit] in hundreds of no-fault actions."

examinations under oath relative to various no-fault claims.[277] Specifically, "[a]fter th[is] action was commenced, two of [the insured's] medical providers, Bay Ridge Chiropractic PC and Hudson Valley Chiro & Rehab PC, both of which are defendants in this action, brought eight actions, all in Richmond County Civil Court, seeking payment" from Liberty Mutual Insurance Company.[278] Finding error in the lower court's reasoning, the Fourth Department noted that:

> [t]he issue of whether [the insured] failed to submit to the EUO, and whether such failure entitles Liberty to disclaim coverage for his alleged injuries and treatment, would affect the outcome of each of the cases, and Liberty would risk inconsistent verdicts and multiple trials if the Civil Court actions are not consolidated with this one.[279]

Another component of insurance litigation is where it is permitted to take place. In *Travelers Cas. & Sur. Co. v. Vale Can. Ltd*., where New York's First Department confronted arguments involving *forum non conveniens*, concluding that New York was an appropriate venue for an insurance dispute involving environmental remediation coverage for "remediation of environmental damage at or near its mines located throughout Canada and in Wales, Indonesia, Japan, and New Jersey."[280] Specifically, weighing various factors, the lower court had "properly determined that there is a substantial nexus between this litigation and New York, as the bulk of the policies were either issued, brokered, or negotiated here."[281] The court found that the insureds had "failed to establish that the transactions giving rise to the causes of action arose primarily in Ontario, as this coverage dispute involves many different policies issued in the United States, and concerns potential liability related to mines located throughout Canada and in Wales, Japan, Indonesia, and New Jersey."[282] And if an analysis of *forum non conveniens* were not interesting enough on

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277. Liberty Mut. Ins. Co. v Bonilla, 181 N.Y.S.3d 886 (App. Div. 1st Dep't 2023).

278. *Id.*

279. *Id.* (citing Phoenix Garden Rest. v. Chu, 608 N.Y.S.2d 205, 206 (App. Div. 1st Dep't. 1994).

280. Travelers Cas. & Sur. Co. v. Vale Can. Ltd., 186 N.Y.S.3d 199, 200 (App. Div. 1st Dep't. 2023).

281. *Id.* at 201.

282. *Id.*

its own, the First Department also found that there was no basis for dismissal under CPLR 3211(a)(4) because "This action was filed prior to the Ontario proceedings, and the New York court was the first to take jurisdiction,"[283] and also that other insurers named as defendants "were [appropriately] included as necessary parties that might be inequitably affected by a judgment in Travelers's favor."[284]

Situations often arise relative to which court, state or federal, should decide which issues. In *Admiral Insurance Co. v. Niagara Transformer Corp.*, the Second Circuit agreed that the Southern District of New York had appropriately found the absence of any justiciablity over an insurer's duty to indemnify under the particular facts presented, but partially remanded the declaratory judgment action to the district court relative to assessing the justiciability of the insurer's duty to defend its insured.[285]

> In this declaratory-judgment action, Admiral Insurance Co. ("Admiral") [sought] a declaration that it need not defend or indemnify its historical insured, Niagara Transformer Corp. ("Niagara"), in potential litigation between Niagara and nonparties Monsanto Co., Pharmacia LLC, and Solutia Inc. (collectively, "Monsanto") over harms caused by polychlorinated biphenyls ("PCBs") that Monsanto had sold to Niagara in the 1960s and 1970s.[286]

Admiral appealed from a Southern District of New York order that had dismissed its action for lack of a justiciable "case of actual controversy" within the meaning of the Declaratory Judgment Act (DJA), 28 U.S.C. § 2201(a).[287] In reaching this jurisdictional ruling, the district court relied principally on "(1) the fact that Monsanto has not commenced or explicitly threatened formal litigation

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283. *Id.* at 202. (citing GE Oil & Gas, Inc. v. Turbine Generation Servs., L.L.C., 35 N.Y.S.3d 311 (App. Div. 1st Dep't. 2016).

284. *Id.* (citing N.Y. C.P.L.R. 1001).

285. *See* Admiral Ins. Co. v. Niagara Transformer Corp., 57 F.4th 85, 100 (2d Cir. 2023). We anecdotally note that there appears to have been an uptick recently relative to federal district courts applying the federal abstention doctrine relative to insurance disputes. This is certainly worth reviewing when choosing whether to venue a declaratory judgment action in federal court.

286. *Id.* at 89.

287. *Id.*

against Niagara, and (2) its assessment that Monsanto would not be likely to prevail in such litigation."[288]

The Second Circuit held that:

> [w]hile the district court properly concluded that it lacked jurisdiction to declare Admiral's duty to indemnify Niagara, it did not adequately distinguish between that duty, (triggered by a determination of the insured's liability to an injured third party), and the insurer's separate duty to defend an insured, (triggered by the third party's filing suit against the insured). Because a declaratory judgment action concerning either duty becomes justiciable upon a "practical likelihood" that the duty will be triggered,… the justiciability of Admiral's duty-to-defend [turned] on the practical likelihood that Monsanto [would sue] Niagara – not whether Monsanto has already in fact done so or explicitly threatened to do so.[289]

The Second Circuit noted that it had previously held "that a district court *must* exercise jurisdiction if the issuance of a declaratory judgment would serve a useful purpose in settling the legal relations in issue or afford relief from the uncertainty giving rise to the proceeding."[290] However, the Second Circuit clarified that subsequent caselaw "has treated the factors established . . . as only two among other factors that district courts should balance in determining whether to exercise jurisdiction under the DJA."[291] As such, the Court wrote, "our caselaw suggests, and we now clarify, that district courts have discretion to decline jurisdiction upon the application of an open-ended, multi-factor balancing test in which no one factor necessarily mandates the exercise of jurisdiction."[292]Setting forth the appropriate standard upon remand, the Second Circuit notes that:

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288. *Id.*

289. *Id.* at 89.

290. *Admiral Ins. Co.,* 57 F.4th at 89-90. (citing Cont'l Cas. Co. v. Coastal Sav. Bank, 977 F.2d 734, 737 (2d Cir. 1992) (citing Broadview Chem. Corp. v. Loctite Corp., 417 F.2d 998, 1001 (2d Cir. 1969))).

291. *Id.* at 90. The Second Circuit went as far as to say that after the Supreme Court's decision in Wilton v. Seven Falls Co., 515 U.S. 277, 287 (1995), the Second Circuit's guidance "has been less than a model of clarity in its treatment of the Broadview/Continental Casualty factors." *Id.* (citing various cases and noting that "Not surprisingly, this lack of clear guidance has resulted in a significant split of authority among the district courts of our Circuit.") *Id.*

292. *Id.*

> [C]onsistent with our post-*Wilton* decisions, we now clarify that even in circumstances "when [a declaratory] judgment [would] serve a useful purpose in clarifying and settling the legal relations in issue" or "terminate and afford relief from the uncertainty, insecurity, and controversy giving rise to the proceeding," [citation omitted], district courts retain "broad discretion" to decline jurisdiction under the DJA, [citation omitted]. We further clarify that the following considerations, "to the extent they are relevant" in a particular case, [citation omitted], should inform a district court's exercise of such discretion: (1) "whether the [declaratory] judgment [sought] will serve a useful purpose in clarifying or settling the legal issues involved"; (2) "whether [such] a judgment would finalize the controversy and offer relief from uncertainty"; (3) "whether the proposed remedy is being used merely for procedural fencing or a race to res judicata"; (4) "whether the use of a declaratory judgment would increase friction between sovereign legal systems or improperly encroach on the domain of a state or foreign court"; (5) "whether there is a better or more effective remedy," [citation omitted]; and (6) whether concerns for "judicial efficiency" and "judicial economy" favor declining to exercise jurisdiction, [citation omitted].[293]

Absent addressing the above factors relative to Admiral Insurance Company's duty to defend its insured in the underlying litigation, the Second Circuit remanded to allow the Southern District of New York "to determine (1) whether there is a justiciable 'case of actual controversy,' . . . over Admiral's duty to defend Niagara, and (2) if so, whether to exercise its discretion—as guided by the framework clarified above—to decline jurisdiction."[294]

Having talked about who can sue and be sued about what, where, and why, we finally turn to when such litigation may ensue; at least under very particular circumstances. Specifically, in *Morales v. American United Transportation, Inc.*, the First Department considered an odd procedural posture involving an insurer liquidation, concluding that actions against the policyholders of liquidated insurers under an Order of Ancillary Receivership are stayed.[295] Although

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293. *Id.* at 99-100.

294. *Id.* at 101.

295. Morales v. American United Transp., Inc., 183 N.Y.S.3d 301, 302 (App. Div. 1st Dep't 2023).

this is an infrequent occurrence, it is important to understand how to navigate insurer liquidation, which could mean the difference between some recovery and no recovery.

## XX. REFORMATION

Whether an insurance policy ultimately reflects the intention of both the insured and insurer at the time of issuance is a common claim asserted in New York and elsewhere. Indeed, such claims for reformation are litigated often in this state. For example, the Third Department addressed such a claim in *Hilgreen v. Pollard Excavating, Inc.*, finding that an insured had adequately pled a claim for reformation due to an alleged mutual mistake as to who was intended to be insured relative to a claim for consequential damages.[296]

However, it is not every day that New York's high court touches on the issue of reformation. Specifically, New York's Court of Appeals considered an insurance policy reformation issue during the *Survey* period, concluding in *34-06 73, LLC v. Seneca Ins. Co.* that a claim for reformation does not relate back to the time that an initial complaint was filed asserting breach of contract.[297] There, an insured sued its insurer, Seneca Insurance Company after sustaining a fire loss at one of its insured premises.[298] Seneca denied the claim, contending that the plaintiff failed to maintain an active sprinkler system or other safeguards, in violation of a Protective Safeguard Endorsement found on the policy.[299]

At trial, testimony from a Seneca underwriter indicated that the inclusion of the Protective Safeguard Endorsement in the policy might have been a mistake.[300] Further, the plaintiff's own principal testified that he instructed the broker to not procure a policy with a sprinkler requirement.[301] At the completion of trial testimony, the

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296. Hilgreen v. Pollard Excavating, Inc., 179 N.Y.S.3d 405, 410 (App. Div. 3d Dep't 2022).

297 34-06 73, LLC v. Seneca Ins. Co. 198 N.E.3d 1282, 1289 (N.Y. 2022).

298 *Id.* at 1284.

299 *Id.*

300 *Id.* at 1285.

301 *Id.* at 1288.

insured moved to amend its Complaint to assert a claim for reformation.[302] Seneca opposed the claim as time-barred.[303]

The Court of Appeals recognized that a reformation claim was time-barred if it did not relate back to the original complaint. Core to its finding that reformation was time-barred, the Court of Appeals noted that "relation back" only applies where the initial pleading gives some notice of the "transactions, occurrences or series of transactions or occurrences, to be proved pursuant to the amended pleading."[304] Under this construct, the Court noted that only a review of the initiating complaint was relevant for determining if the newly proposed claim relates to the original pleading.[305] As a result, the status of discovery or trial testimony should not have factored into the lower courts decisions, rendering those courts' reasoning relying upon those items incorrect.[306]

Here, the complaint not only alleged the existence of a valid policy, but further alleged that the insured fully complied with all of the terms and conditions thereof.[307] With no alternative theory advanced in the complaint, the insured could not claim that Seneca had notice that, potentially, the contract should be reformed due to a mutual mistake in underwriting.[308]

The Court further noted the insured's proffered explanation for the delay was insufficient to overcome the vacuum of any mention of reformation in the Complaint.[309] The insured, in fact, submitted testimony from its principal that he advised the broker the policy should not be written with a Protective Safeguard Endorsement—all of which would have occurred prior to policy issuance.[310] As such, if reformation was a real issue at the time of the pleading, it not only could have, but should have been asserted in the initial complaint.[311]

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302. *Seneca Inc. Co.*, 198 N.E.3d at 1283.
303. *Id.* at 1286.
304. *Id;* N.Y. C.P.L.R. 203 (McKinney 2023).
305. *Seneca Ins. Co.*, 198 N.E.3d at 1286.
306. *Id.*
307. *Id.* at 1287-88.
308. *Id.* at 1288.
309. *Id.* at 1288.
310. *Seneca Ins. Co.*, 198 N.E.3d at 1289.
311. *Id.*

## XXI. NO-FAULT

It's not every year the New York Court of Appeals weighs in on New York's no-fault statutory scheme. This *Survey* period was the exception. In *Lemieux v. Horn,* the Court of Appeals redressed a split decision from the Third Department by finding that an injured plaintiff had failed to demonstrate that the exacerbation of significant pre-existing injuries qualified as a "serious injury," and thus could not maintain a viable personal injury lawsuit arising from an auto accident under Insurance Law Section 5104(a).[312]

Following a 2016 rear-end accident, David Lemieux filed suit against Alton Horn seeking to recover for his injuries, claiming a serious injury under New York's no fault law.[313] Lemieux claimed that he had sustained a serious injury to his lumbar spine in the November 2016 accident, but Horn established that degenerative changes to Lemieux's lumbar spine were diagnosed in 2002 and further that he had long complained of lower back pain and radiculopathy that required medical treatment.[314] In fact, Lemieux was undergoing treatment at the time of the November 2016 accident for "debilitating" and "severe" back and radiating leg pain that arose from a May 2016 golf injury.[315] Horn's medical experts showed that no "significant change" in his condition nor "any new or exacerbated injury to his lumbar spine" established that "the subject accident did not cause or exacerbate [p]laintiff's pre-existing low back conditions."[316]

Lemieux proffered testimony as to how his daily activities were impaired after the November 2016 accident and relied upon medical records reflecting post-accident medical treatment, including decompression surgery on his lumbar spine.[317] Lemieux's medical expert "opined, in conclusory fashion, that [Lemieux's] preexisting conditions were 'pushed . . . over the edge' by the accident and necessitated the surgery." [318]

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312. *See* Lemieux v. Horn, 207 N.E.3d 565, 565 (N.Y. 2023); *see also* Lemieux v. Horn, 176 N.Y.S.3d 737, 741 (App. Div. 3d Dep't 2022).

313. *Lemieux*, 176 N.Y.S.3d at 738.

314. *Id.* at 739.

315. *Id.* at 740.

316. *Id.*

317. *Id.*

318. Lemieux v. Horn*,* 176 N.Y.S.3d 737, 740 (App. Div. 3d Dep't 2022).

The majority at the Third Department found that Lemieux had failed to provide "*objective medical evidence distinguishing his preexisting back condition from its purported exacerbation in the November 2016 accident.*"[319] The dissent, on the other hand, would have found that Horn had failed to carry his burden to establish the lack of a serious injury. Specifically, the dissent primarily took issue with Hunt's expert affidavit, in that it used terms "substantially the same" and "no significant change[s]" without defining the terms "significant" or "substantial."[320]

The Court of Appeals agreed with the Third Department's majority opinion, finding that "[t]he Appellate Division correctly concluded that [Hunt] established prima facie entitlement to summary judgment and [Lemieux] failed to raise a triable issue of fact whether he suffered a serious injury within the meaning of Insurance Law § 5102 (d) as a result of the accident."[321]

## XXII. BAD FAITH AND OTHER CLAIMS OF MALFEASANCE

Although bad faith claims handling and other such malfeasance are frequently asserted against insurers in New York State, appellate decisions affirming any such finding have been little to nonexistent for decades, due to the heavy burden an insured must carry. This year was no different.

For example, in *N.Y. Marine & Gen. Ins. Co. v. Wesco Ins. Co.*, New York's First Department addressed a claim that an insurer that had served as a claims administrator, AmTrust of North America, Inc., had breached a fiduciary duty owed to an excess insurer, New York Marine & General Company.[322] The court found that even liberally construed, New York Marine had failed to plead sufficient facts to support a claim that AmTrust owed it a fiduciary duty.[323] This was for several reasons:

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319. *Id.* (citing Falkner v. Hand, 876 N.Y.S.2d 747, 748 (App. Div. 3d Dep't. 2009).

320. *Id.* at 742.

321. Lemieux v. Horn, 207 N.E.3d 565, 565 (N.Y. 2023) (citing Pommells v. Perez, 830 N.E.2d 278, 281-83 (N.Y. 2005)).

322. N,Y. Marine & Gen. Ins. Co. v. Wesco Ins. Co., 184 N.Y.S.3d 306, 307 (App. Div. 1st Dep't 2023).

323. *Id.* at 308.

> AmTrust was not a party to the policies at issue in the underlying lawsuits, and indeed had no contractual relationship with [New York Marine], the excess insurer. While [New York Marine] alleges that AmTrust was the authorized claims administrator for codefendant primary insurers Wesco Company and Technology Insurance Company at all relevant times, and "exercised direct and exclusive control over the claims and defense handling, the policies underwritten by [defendant insurers], and the coverages provided to the insureds," [New York Marine] alleges no facts giving rise to an inference of a special or confidential relationship between it and AmTrust.[324]

This alleged breach of fiduciary duty owed by one insurer to another was rather unique but claims of bad faith claims handling are not. This *Survey* period saw various spins on the age-old issues confronted by New York State courts.

In *Brown v. Erie Ins. Co.*, the Fourth Department thoroughly dispatched the matter due to a common issue with the claims—i.e., duplication of an existing breach of contract claim.[325] The court noted that although a bad faith cause of action "is not necessarily duplicative of a cause of action alleging breach of contract,"[326] "the allegations [of bad faith here] are predicated solely upon the claim that defendant failed or refused to pay her the full amount of SUM coverage under the insurance policy, i.e., that defendant had breached the terms of the policy."[327] Accordingly, these allegations were duplicative and dismissed under CPLR 3211(a)(7) as they failed to state a cause of action.[328]

Last, but not least, we note the First Department's decision in *Zurich Am. Ins. Co. v. The Ins. Co. of the State of Pa.*, wherein two other common results in these bad faith claims occurred.[329]

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324. *Id.* (citing Riggs v. Brooklyn Hosp. Ctr., 172 N.Y.S.3d 430, 432 (App. Div. 1st Dep't 2022)).

325. Brown v. Erie Ins. Co., 172 N.Y.S.3d 299, 302 (App. Div. 4th Dep't 2022).

326. *Id.* at 301. (citing Gutierrez v. Gov't Empls. Ins. Co., 25 N.Y.S.3d 625, 627 (App. Div. 2d Dep't 2016)).

327. *Id.* at 302.

328. *Id.* (citing Sue/Perior Concrete & Paving, Inc. v. Lewiston Golf Course Corp., 968 N.Y.S.2d 271, 279 (App. Div. 4th Dep't 2013); *aff'd*, 25 N.E.3d 15, (N.Y. 2014)).

329. Zurich Am. Ins. Co. v. Ins. Co. of the State of Pa., 175 N.Y.S.3d 220, 221 (App. Div. 1st Dep't 2022).

Specifically, the First Department found that no bad faith claim was viable under the circumstances, where the primary insurer, The Insurance Company of the State of PA, attempted to resolve the case within limits and no party expected an excess verdict to result.[330] The court found that under New York's well established "*Pavia* framework, the motion court properly determined that defendant primary insurer did not grossly disregard plaintiff excess insurer's interests in defending against and attempting to settle the underlying action."[331] Prior to the verdict, there were:

> [s]ignificant questions relating to causation and damages, [and] the record shows that the excess verdict was objectively improbable, a conclusion that is bolstered by the fact that no one—including plaintiff—expected the verdict to exceed the primary policy limit. Regardless, [the primary insurer] worked consistently to settle the case in a reasonable manner, making a total of six settlement offers, including four during the trial. Defendant was under no obligation to accept the $900,000 offer despite the fact that it fell within the policy limits, as an insurer cannot be compelled to settle a questionable claim simply because an opportunity to do so presents itself.[332]

We note that New York's current legislators have recently put forth bad faith legislation with increasing regularity and the rarity of these findings may very well change were new statutory provisions to be enacted. Thus, although the legal landscape on this issue has changed very little over the past few decades, change may be afoot and, if it occurs, we anticipate seeing those changes in an upcoming edition of this *Survey*.

## CONCLUSION

As we look back on the eleven previous *Survey* articles, and consider the cases included in this offering, we do, indeed, see courts wrestling with challenging issues in this area of law. We are purists at heart and suggest that courts do a much better job of getting it "right" if they focus on policy language and precedent, rather than

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330. *Id.*

331. *Id.* (citing Pavia v State Farm Mut. Auto. Ins. Co., 626 N.E.2d 24, 27 (N.Y. 1993)).

332. *Id.* (citing *Pavia*, 626 N.E.2d at 28).

trying to envision or recreate the parties' perceived intentions. Once courts look outside of insurance policies to answer insurance policy questions, particularly if policy language is clear, they run the risk of forging paths that lead to destinations unknown and unintended in the cases that follow. Insurance policies are contracts, and their terms demand both respect and honor.