INSURANCE LAW

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CONTENTS

INTRODUCTION 1055
I. *BP AIR*—CLARIFICATION OF "ADDITIONAL INSURED" AND PRIORITY OF COVERAGE ISSUES 1056
II. *GENERAL ELECTRIC*—SINGLE VS. MULTIPLE "OCCURRENCES" ...1060
III. *BENESOWITZ*—INSURANCE LAW § 3234 ONLY TOLLS THE PAYMENT OF DISABILITY INSURANCE..1065
IV. *NYACK HOSPITAL*—THE PRIORITY-OF-PAYMENT NO-FAULT REGULATION...1068
V. *GUISHARD*—LIABILITY INSURER FAILS TO ESTABLISH AUTO EXCLUSION 1071
VI. *FOSTER WHEELER*—CHOICE OF LAW..1072
CONCLUSION...1072

INTRODUCTION

Due to unforeseen circumstances beyond this author's control, this year's *Survey* article will address exclusively the insurance coverage decisions of the New York Court of Appeals. The number of coverage cases decided by the Court of Appeals continues to decline, from fifteen two years ago, to seven last year, to only six discussed in this *Survey* article. Moreover, there were no dissents in any of the Court's coverage decisions this year, and policyholders and insurers split the decisions, with each side winning three cases.

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I. *BP AIR* – CLARIFICATION OF "ADDITIONAL INSURED" AND PRIORITY OF COVERAGE ISSUES

In *BP Air Conditioning Corp. v. One Beacon Ins. Group*,[1] the Court addressed two significant issues of coverage law in New York: (1) the standard for determining when an insurer has a duty to defend and indemnify an additional named insured in an underlying action; and (2) a determination as to the priority of coverage among several different insurance policies.

The case arose in the common context of a construction project and an ensuing personal injury action brought by a worker injured at the job site.[2] The plaintiff, BP Air Conditioning Corp. ("BP"), was a subcontractor who had an agreement with its subcontractor, Alfa, to be named as an additional insured on a commercial liability ("CGL") policy.[3] Pursuant to the contract, Alfa obtained coverage for BP as an additional insured under its policy issued by One Beacon.[4] Both BP and Alfa were named in the injured worker's lawsuit.[5] Although hardly clear, the pleadings suggested that the worker was injured by a condition created by Alfa's operations.[6] The pleadings clearly presented a fact question as to which of the subcontractors or perhaps other parties would be liable for the condition that allegedly caused the injury.[7]

One Beacon agreed to defend Alfa, but declined to defend BP.[8] One Beacon contended that BP's tender of its defense was premature because "'a condition precedent to the triggering of additional insured coverage'" was not met because its "additional insured" endorsement was not triggered by the mere possibility that the accident arose out of Alfa's operations, but rather only when such liability was firmly established.[9] The relevant language in the additional insured endorsement of the One Beacon policy provided that a "'person or organization is an additional insured only with respect to liability arising out of your ongoing operations performed for

1. 8 N.Y.3d 708, 711, 871 N.E.2d 1128, 1129, 840 N.Y.S.2d 302, 303 (2007).
2. *Id.* at 712, 871 N.E.2d at 1130, 840 N.Y.S.2d at 304.
3. *Id.* at 711-12, 871 N.E.2d at 1129-30, 840 N.Y.S.2d at 303-04.
4. *Id.* at 712, 871 N.E.2d at 1130, 840 N.Y.S.2d at 304.
5. *Id.*
6. *BP Air Conditioning Corp.,* 8 N.Y.3d at 712, 871 N.E.2d at 1130, 840 N.Y.S.2d at 304.
7. *Id.* at 713, 871 N.E.2d at 1130-31, 840 N.Y.S.2d at 304-05.
8. *Id.* at 712, 871 N.E.2d at 1130, 840 N.Y.S.2d at 304.
9. *Id.* at 713, 871 N.E.2d at 1131, 840 N.Y.S.2d at 305 (quoting BP Air Conditioning Corp. v. One Beacon Ins. Group, 33 A.D.3d 116, 133, 821 N.Y.S.2d 1, 13 (1st Dep't 2006) (Sullivan, J., dissenting).

that insured.'"[10]

BP sued for a declaration that One Beacon was required to defend it in the underlying personal injury action and for reimbursement of its past defense costs.[11] BP obtained partial summary judgment from the Supreme Court, which was affirmed in a three-to-two decision in the Appellate Division, First Department.[12] The First Department held not only that BP's "additional insured" coverage was triggered and that One Beacon must defend BP, but also that the One Beacon policy was "primary" to BP's own CGL policy without reference to the "other insurance" clause in either policy.[13]

On the latter issue, the Court of Appeals applied its widely discussed 2003 decision in *Pecker Iron Works of N.Y., Inc. v. Traveler's Ins. Co.*[14] Briefly stated, in *Pecker* the Court of Appeals held that "additional insured" coverage in a CGL policy issued by Travelers to a contractor, Upfront, provided primary coverage to Pecker without any analysis of the other insurance clauses in either policy.[15] The Travelers policy contained a blanket additional insured endorsement naming as an additional insured any entity Upfront so designated in a written contract, but the policy provided that coverage to the additional insured would be "excess" unless it was agreed in the contract that the coverage would be primary.[16] The contract was silent on the issue.[17] The Court of Appeals held that the term "additional insured" as used in construction contracts means additional insured on a primary basis.[18] Without analyzing the "other insurance" provisions contained in either policy, the Court held that "Upfront's carrier—not Pecker's—would provide Pecker with primary coverage on the risk."[19]

The Appellate Division quoted *Pecker* in ruling that co-insurance was not available.[20] Specifically, the court held that

> [t]his statement that Pecker's primary coverage for the relevant risk was

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10. *Id.* at 712, 871 N.E.2d at 1130, 840 N.Y.S.2d at 304.
11. *BP Air Conditioning Corp.,* 8 N.Y.3d at 713, 871 N.E.2d at 1130, 840 N.Y.S.2d at 304.
12. *Id.* at 713, 871 N.E.2d at 1131, 840 N.Y.S.2d at 305.
13. *Id.*
14. *Id.* at 715, 871 N.E.2d at 1132, 840 N.Y.S.2d at 306 (citing *Pecker*, 99 N.Y.2d 391, 393, 786 N.E.2d 863, 864, 756 N.Y.S.2d 822, 823 (2003)).
15. *Pecker*, 99 N.Y.2d at 392, 786 N.E.2d at 863, 756 N.Y.S.2d at 822.
16. *Id.* at 392-93, 786 N.E.2d at 863, 756 N.Y.S.2d at 822.
17. *Id.* at 393, 786 N.E.2d at 864, 756 N.Y.S.2d at 823.
18. *Id.*
19. *Id.* at 394, 786 N.E.2d at 864, 756 N.Y.S.2d at 823.
20. *B.P. Air Conditioning Corp.*, 33 A.D.3d at 117, 821 N.Y.S.2d at 2 (1st Dept. 2006).

> its additional insured coverage under Upfront's policy, rather than the coverage under its own policy, is controlling here. . . . Thus, as between BP's coverage as an additional insured under Alfa's policy and BP's coverage as a named insured under its own policy, the additional insured coverage is primary.[21]

In a unanimous opinion by Judge Ciparick, the Court of Appeals modified the Appellate Division's Order.[22] The Court held that One Beacon's obligation to defend BP as an additional insured was not contingent on a determination in the personal injury action that the named insured, Alfa, was liable for the condition that caused the accident.[23] The Court also held, contrary to the Appellate Division, that co-insurance between One Beacon and BP's CGL carrier was still available.[24]

With respect to the "trigger" of One Beacon's duty to defend BP, the Court reaffirmed the principle that the duty to defend is very broad and therefore a defense must be provided whenever the complaint suggests a "'reasonable possibility of coverage.'"[25] If any of the claims alleged in the complaint against the insured fall within the risk of loss insured against, coverage will lie.[26] The Court also reiterated that the "merits of the complaint are irrelevant" to the duty to defend as opposed to the duty to indemnify because CGL coverage is "litigation insurance" under which the insurer is liable for the cost of defense even when it may not ultimately be obligated to indemnify the insured for the loss.[27]

The Court flatly rejected One Beacon's attempt to create a different standard for determining whether an additional insured is entitled to coverage and a defense.[28] To do so, said the Court, would defy the well-understood meaning of the term '"additional insured'" as "'an entity

21. *Id.* at 130, 821 N.Y.S.2d at 11. The Court continued, in a footnote, to point out that before *Pecker*, the question of other insurance would have perhaps been decided differently: "We observe that pre-*Pecker* case law from the Court of Appeals arguably would have supported deeming BP's own carrier and a carrier affording BP additional insured coverage to be primary coinsurers." *Id*. at 130 n.7, 821 N.Y.S.2d at 11 n.7. In that situation, a court would have looked to the "method of sharing" provisions contained in "other insurance" sections of the policies.

22. *BP Air Conditioning Corp.*, 8 N.Y.3d at 711, 716, 871 N.E.2d at 1128, 1133, 840 N.Y.S.2d at 303, 307.

23. *Id.* at 716, 871 N.E.2d at 1133, 840 N.Y.S.2d at 307.

24. *Id.*

25. *Id.* at 714, 871 N.E.2d at 1131, 840 N.Y.S.2d at 305 (quoting Auto. Ins. Co. of Hartford v. Cook, 7 N.Y.3d 131, 137, 850 N.E.2d 1152, 1155 (2006)).

26. *BP Air Conditioning Corp.*, 8 N.Y.3d at 714, 871 N.E.2d at 1131, 840 N.Y.S.2d at 305.

27. *Id.* at 714, 871 N.E.2d at 1131-32, 840 N.Y.S.2d at 305-06.

28. *Id.* at 714, 871 N.E.2d at 1132, 840 N.Y.S.2d at 306.

enjoying the same protection as the named insured.'"[29] The Court therefore held that "the standard for determining whether an additional named insured is entitled to a defense is the same standard that is used to determine if a named insured is entitled to a defense."[30] Applying that test, it was clear that the allegations in the worker's suit form a "'factual [and] legal basis on which [One Beacon] might eventually be held to be obligated to indemnify [BP] under any provision of the insurance policy,'" thus bringing "this claim within the ambit of the protection purchased."[31] "Since there [was] a possibility that [the worker's] injuries 'ar[ose] out of [Alfa's] ongoing operations performed for [BP]'"—the language of the additional insured endorsement—"One Beacon's obligation to provide BP with a defense [was] triggered."[32]

The Court rejected the view of the dissenters at the Appellate Division, who found that this language in One Beacon's endorsement would trigger coverage only upon a determination that Alfa was liable for the accident and the worker's injury.[33] The Court found that there is no such condition precedent to coverage, stating that

> when considering this policy language in light of an insurer's broad obligation to defend an insured, it does not affect the standard under which a duty to defend is determined. When the duty to defend is at issue, a liability alleged to arise out of Alfa's ongoing operations is one "arising out of" such operations within the meaning of the policy.[34]

Turning to the much anticipated issue of the priority of coverage, and the application of *Pecker* to the facts of this case, the Court resolved the issue quickly with no definitive ruling. The Court simply wrote:

> [W]e conclude that the Appellate Division erred in finding that One Beacon's coverage is primary and BP's coverage under its own policy is excess. In order to determine the priority of coverage among different policies, a court must review and consider all of the relevant policies at issue. Here, Supreme Court correctly concluded that because none of the other insurance carriers are parties to this declaratory judgment action and no other relevant policies have been submitted, the priority of

29. *Id.* at 714-15, 871 N.E.2d at 1132, 840 N.Y.S.2d at 306 (quoting *Pecker*, 99 N.Y.2d at 393, 786 N.E.2d at 864, 756 N.Y.S.2d at 823).

30. *Id.* at 715, 871 N.E.2d at 1132, 840 N.Y.S.2d at 306.

31. *BP Air Conditioning Corp.*, 8 N.Y.3d at 715, 871 N.E.2d at 1132, 840 N.Y.S.2d at 306 (alterations in original).

32. *Id.*

33. *Id.*

34. *Id.*

coverage cannot be determined.[35]

However, many insurance coverage practitioners interpret the Court's modification of the Appellate Division's order as a return to the pre-*Pecker* law that the priority of coverage is to be decided by reviewing the policy language of any triggered policy. In other words, additional insured coverage will not automatically be primary without reference to the other insurance clauses in the relevant policies. Since those other insurers were not a party to the declaratory judgment litigation and their policies were not before the Court in the case, the Court could not determine who was primary and who was excess. Thus, One Beacon will still be able to seek contribution (co-insurance) from all applicable policies, including the CGL policy covering BP as a named insured.

II. *GENERAL ELECTRIC*—SINGLE VS. MULTIPLE "OCCURRENCES"

In *Appalachian Ins. Co. v. Gen. Elec. Co.*,[36] the Court of Appeals again addressed what constitutes a single "occurrence" versus multiple "occurrences." The Court held that the incidents of asbestos exposure underlying personal injury actions against GE were not a "single unfortunate event," but instead constituted multiple "occurrences" under the language of the operative primary general liability insurance policies at issue.[37]

GE was a defendant or third-party defendant in numerous personal injury actions by persons who, between 1966 and 1986, were exposed to asbestos from insulation in custom steam turbines that GE had designed, manufactured, and in some cases installed at more than 22,000 sites throughout the United States.[38] GE did not produce any asbestos-related products, but the custom turbines were insulated with asbestos-containing products manufactured by others.[39] "In the typical personal injury case, a plaintiff sued GE on the theory that, with knowledge of the dangers of exposure to asbestos-containing products, it designed, manufactured, sold, installed and/or serviced turbines insulated with asbestos, without warning individuals working near its turbines of those dangers."[40] The number of claims made against GE was large—as of 2002 over 400,000 such claims had been filed—but because GE often was only one of many defendants, its

35. *Id.* at 716, 871 N.E.2d at 1133, 840 N.Y.S.2d at 307 (citation omitted).

36. *BP Air Conditioning Corp.*, 8 N.Y.3d at 162, 166, 863 N.E.2d 994, 995, 831 N.Y.S.2d 742, 743 (2007).

37. *Id.* at 174, 863 N.E.2d at 1001, 831 N.Y.S.2d at 749.

38. *Id.* at 166, 863 N.E.2d at 995, 831 N.Y.S.2d at 743.

39. *Id.*

40. *Id.* at 166-67, 863 N.E.2d at 995, 831 N.Y.S.2d at 743.

share of any individual settlement or judgment generally was small—$1,500 on average.[41]

During that time, GE maintained primary general liability insurance with the Electric Mutual Liability Insurance Co. ("EMLICO").[42] The EMLICO policies generally contained a five million dollar per-occurrence limit, but did not incorporate an aggregate liability limit capping the amount of coverage available.[43] GE also maintained excess liability insurance that supplied additional layers of coverage beyond the EMLICO limits, but the excess coverage was only triggered only when an "occurrence" exceeded the five million dollar per-occurrence limit in the underlying EMLICO primary policies.[44] Notably, EMLICO was partially owned by GE and its employees, and GE's annual premium payments "were calculated through a complicated formula that provided for retrospective payment by GE of a sum that was largely based on prior years' losses."[45] In effect, GE reimbursed EMLICO for claims it paid on GE's behalf.[46]

"The EMLICO policies define[d] an occurrence as 'an accident, event, happening or continuous or repeated exposure to conditions which unintentionally results in injury or damage during the policy period.'"[47] Prior to 1992, EMLICO had treated each personal injury claim as a separate occurrence.[48] "The number of asbestos-related claims substantially increased in 1991, [however,] causing GE to object to EMLICO's practice of treating each individual claim as a distinct 'occurrence.' After negotiation, and without the participation of any . . . excess insurers, GE and EMLICO entered into a 'Claims Handling Agreement,'" pursuant to which EMLICO treated all asbestos-related claims from turbines as a single occurrence for purposes of determining when the five million dollar annual limit was reached.[49] Not surprisingly, the excess carriers objected to this change in practice and commenced this action.[50]

41. *BP Air Conditioning Corp.*, 8 N.Y.3d at 167, 863 N.E.2d at 995-96, 831 N.Y.S.2d at 743-44.
42. *Id.* at 167, 863 N.E.2d at 996, 831 N.Y.S.2d at 744.
43. *Id.*
44. *Id.* at 167-68, 863 N.E.2d at 996, 831 N.Y.S.2d at 744.
45. *BP Air Conditioning Corp.*, 8 N.Y.3d at 167, 863 N.E.2d at 996, 831 N.Y.S.2d at 744
46. *Id.*
47. *Id.* at 168, 863 N.E.2d at 996, 831 N.Y.S.2d at 744.
48. *Id.*
49. *Id.* at 168, 863 N.E.2d at 996-97, 831 N.Y.S.2d at 744-45.
50. *BP Air Conditioning Corp.*, 8 N.Y.3d at 168-69, 863 N.E.2d at 997, 831 N.Y.S.2d

> After extensive discovery, . . . [the] excess insurers moved for summary judgment requesting a declaration that GE's primary policies had not been exhausted by the payment of the asbestos claims . . . . GE opposed the motion and cross-moved for summary judgment and a judicial declaration that the asbestos litigation arising from GE's turbine business was a single occurrence under each policy because all the claims could be traced to a single act of negligence—GE's failure to warn of the dangers of exposure to asbestos insulation in its turbines.[51]

The Supreme Court granted the excess insurers' motion for summary judgment and denied GE's cross-motion, and declared that GE's primary policies had not been exhausted by the payment of the asbestos claims because each claim by an injured plaintiff represented a separate occurrence for purposes of the EMLICO policies.[52]

> [T]he court held that the focus should be on the event for which the insured [was] being held liable, not a point further back in the causal chain. Applying the "unfortunate-event" test to the asbestos exposure claims, the court noted that the turbines were custom-designed based on the specific needs of GE customers, with little or no uniformity in the amounts or types of asbestos insulation incorporated in the design. Moreover, the exposure of the individual plaintiffs varied in duration and intensity and occurred over decades at . . . work sites throughout the nation.[53]

In affirming, the Appellate Division, "reason[ed] that the operative occurrence under the definition in the EMLICO policies was the 'last link in the causal chain leading to liability, i.e., the exposure of each individual claimant to asbestos contained in the turbines manufactured by the insured, rather than earlier events creating the potential for future injury.'"[54]

The Court of Appeals granted GE leave to appeal, but affirmed in a unanimous decision written by Judge Graffeo, with Judges Read and Jones taking no part.[55] The Court observed that "GE [was] entitled to [excess] coverage only if the $5 million per-occurrence policy limit in the underlying EMLICO [primary] policies [was] exceeded," which "turn[ed] on the meaning of the term 'occurrence' in the EMLICO policies."[56] The Court noted that it had "previously addressed the standard to be applied in

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at 745.

51. *Id.* at 169, 863 N.E.2d at 997, 831 N.Y.S.2d at 745.

52. *Id.*

53. *Id.* at 169, 863 N.E.2d at 997, 831 N.Y.S.2d at 745.

54. *Id*. at 170, 863 N.E.2d at 998, 831 N.Y.S.2d at 746.

55. *BP Air Conditioning Corp.*, 8 N.Y.3d at at 166, 170, 175, 863 N.E.2d at 995, 998, 1001, 831 N.Y.S.2d at 743, 746, 749.

56. *Id.* at 170, 863 N.E.2d at 998, 831 N.Y.S.2d at 746.

resolving whether a set of circumstances amounts to one accident or occurrence, or multiple accidents or occurrences . . . ."[57] In *Arthur A. Johnson Corp. v. Indem. Ins. Co. of N. Am.*,[58] the Court adopted the "unfortunate-event" test of the three approaches used by courts to determine whether a set of circumstances is a single "occurrence" or "accident": the sole-proximate-cause approach, the one-accident-per-person approach, or the unfortunate-event approach.[59] In *Hartford Accident & Indem. Co. v. Wesolowski*,[60] the Court applied this test to resolve the extent of coverage under a policy with a "per occurrence" limit "'[w]here the insured's automobile struck one oncoming vehicle, ricocheted off and struck a second more than 100 feet away . . . .'"[61] The Court "held that the three-car collision amounted to a single occurrence because 'the two collisions had occurred but an instant apart' and '[t]he continuum between the two impacts was unbroken, with no intervening agent or operative factor.'"[62]

The Court noted that the policies it interpreted in *Johnson* and *Wesolowski* did not specifically define the terms "accident" or "occurrence," and that "these sophisticated parties could have chosen to define occurrence in a manner that grouped incidents based on [one of] the approaches rejected in *Johnson* (such as the sole-proximate-cause model . . .) . . . But they did not do so."[63] As a result, said the Court, "the unfortunate-event standard governs the outcome of this appeal."[64]

Applying that test and the factors discussed in these prior cases, the Court found that "the asbestos exposure claims GE seeks to group as one occurrence (per policy period) represent multiple occurrences."[65] Using the definition of "occurrence" adopted by GE and EMLICO in the primary policies, the Court wrote that "the incident that gave rise to liability was each individual plaintiff's 'continuous or repeated exposure' to asbestos."[66] GE focused on the common causation of the incidents, specifically its

57. *Id.*
58. 7 N.Y.2d 222, 227-30 164 N.E.2d 704, 706-08, 196 N.Y.S.2d 678,682-84 (1959).
59. *Appalachian Ins. Co.*, 8 N.Y.3d at 170-71, 863 N.E.2d at 998, 831 N.Y.S.2d at 746.
60. 33 N.Y.2d 169, 170, 305 N.E.2d 907,908, 350 N.Y.S.2d 895, 897 (1973).
61. *Appalachian Ins. Co.*, 8 N.Y.3d at 171, 863 N.E.2d at 999, 831 N.Y.S.2d at 747 (quoting *Wesolowski*, 33 N.Y.2d at 170, 305 N.E.2d at 908, 350 N.Y.S.2d at 897).
62. *Id.* at 171, 863 N.E.2d at 999, 831 N.Y.S.2d at 747 (quoting *Wesolowski*, 33 N.Y.2d at 173-74, 305 N.E.2d at 910, 350 N.Y.S.2d at 900-01).
63. *Id.* at 173, 863 N.E.2d at 1000, 831 N.Y.S.2d at 748.
64. *Id.*
65. *Id.*
66. *Appalachian Ins. Co.*, 8 N.Y. at 173, 863 N.E.2d at 1000, 831 N.Y.S.2d at 748.

failure to warn, which it characterized as a single act of negligence.[67] But, the Court explained, the "fulcrum of our analysis" is the incident itself, and "the cause should not be conflated with the incident."[68] Notably, the Court stated that "[i]f [it] were to focus only on discerning the common originating cause of multiple events as GE urges, [it] would not be applying the unfortunate-event test but rather the sole-proximate-cause test that [it] explicitly rejected in *Johnson*."[69]

"Having determined that there were numerous exposure incidents, [the Court then analyzed] the temporal and spatial relationships between the incidents and the extent to which they were part of an undisrupted continuum to determine whether they can, nonetheless, be viewed as a single unfortunate event—a single occurrence."[70] It determined that, "[e]ven if [it] were to assume that the continuum element was met . . . because the exposures share[d] a common cause (as GE had urge[d]), the scenarios presented . . . faile[d] the ["unfortunate-event"] test because of the lack of any spatial or temporal relationship."[71]

The Court observed that

> it appear[ed] that the incidents share few, if any, commonalities, differing in terms of when and where exposure occurred, whether the exposure was prolonged and for how long, and whether one or more GE turbine sites was involved. Under the circumstances, there were unquestionably multiple occurrences and the excess insurers were entitled to a declaration to that effect.[72]

Finally, the Court noted that contrary to GE's argument, the unfortunate-event test is not "the equivalent of a one-occurrence-per-injured-party approach"; the Court noted that "the [*Johnson*] standard can lead to the grouping of claims as occurred in *Wesolowski*."[73] More importantly, the Court specifically declined to rule that the unfortunate-event test would

> necessarily bar excess coverage in multi-plaintiff mass tort contexts. Each mass tort scenario must be examined separately under the *Johnson* rule. There will undoubtedly be unfortunate occasions, such as a series of explosions, the accidental release of a hazardous substance or some

67. *Id.* at 169, 863 N.E.2d at 997, 831 N.Y.S.2d at 745.
68. *Id.* at 172, 863 N.E.2d at 999, 831 N.Y.S.2d at 747.
69. *Id.* at 172 n.2, 863 N.E.2d at 999 n.2, 831 N.Y.S.2d at 747 n.2.
70. *Appalachian Ins. Co.*, 8 N.Y. at 174, 863 N.E.2d at 1000-01, 831 N.Y.S.2d at 748-49.
71. *Id.* at 174, 863 N.E.2d at 1001, 831 N.Y.S.2d at 749.
72. *Id.*
73. *Id.*

> other calamity, that will result in numerous injuries or losses. In those situations, the *Johnson* test may well allow the grouping of some or all of the claims for purposes of satisfying the per-occurrence limit, thereby triggering excess coverage.[74]

III. *BENESOWITZ*—INSURANCE LAW § 3234 ONLY TOLLS THE PAYMENT OF DISABILITY INSURANCE

In *Benesowitz v. Metropolitan Life Ins. Co.*,[75] the Court of Appeals answered questions certified to it by the U.S. Court of Appeals for the Second Circuit on "how Insurance Law § 3234(a)(2) affects an employee's eligibility to receive benefits under the employer's group disability plan when the disability is caused by a preexisting medical condition."[76] The Court held that "the statute allows insurers to toll benefits during the first [twelve] months of coverage, but does not permit them to impose an absolute bar to coverage for disabilities stemming from preexisting conditions and arising during that [twelve]-month period."[77]

The plaintiff started a new job with Honeywell International, Inc. in April 2002 and was immediately covered under Honeywell's short- and long-term group disability insurance plans administered by MetLife.[78] In the three months preceding his Honeywell employment, the plaintiff had been treated for kidney disease.[79] After working at Honeywell for several months, he apparently decided that he could no longer work and applied for, and received, short-term disability benefits.[80] But the plan administrator denied his application for long-term disability benefits under its pre-existing condition exclusion, which provided as follows:

> Benefits will not be paid for any period of Disability caused or contributed to by, or resulting from, a Pre-[E]xisting Condition. A 'Pre-Existing Condition' means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within three months before the most recent effective date of your coverage.

The Pre-Existing Condition limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of

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74. *Id*.
75. 8 N.Y.3d 661, 664, 870 N.E.2d 1136, 1137, 839 N.Y.S.2d 706, 707 (2007).
76. *See* N.Y. INS. LAW § 3234(a)(2) (McKinney 2006).
77. *Benesowitz*, 8 N.Y.3d at 664, 870 N.E.2d at 1137-38, 839 N.Y.S.2d at 707-08.
78. *Id*. at 665, 870 N.E.2d at 1138, 839 N.Y.S.2d at 708.
79. *Id.*
80. *Id*.

Disability that begins after you are covered for at least [twelve] months after the most recent effective date of your coverage, or the effective date of any added or increased benefits.[81]

The plaintiff argued that this exclusion "conflict[s] with Insurance Law § 3234(a)(2), which provides that '[n]o pre-existing condition provision shall exclude coverage for a period in excess of twelve months following the effective date of coverage for the covered person.'"[82] After exhausting his administrative remedies, the plaintiff brought this action in federal court.[83] Eastern District Judge Platt granted MetLife's motion for summary judgment.[84] On appeal, the Second Circuit noted that it could find no New York case settling whether the twelve-month period in the statute "'means that (1) a policy may impose a twelve-month waiting period during which no benefits will be paid [and after which payment must be made] or (2) a policy may lawfully include a permanent absolute bar to coverage of disabilities resulting from pre-existing conditions that trigger disability within the first twelve months of the employee's coverage.'"[85] Moreover, the Second Circuit noted that in *Pulvers v. First UNUM Life Ins. Co.*,[86] it had found, in *dicta*, that the statute was ambiguous.[87]

The unanimous decision of the Court of Appeals, in an opinion by Judge Graffeo, upheld the plaintiff's interpretation of the statute, which was supported by New York State's Insurance Superintendent through an amicus curiae appearance in the case by the New York State Solicitor General.[88] The Court acknowledged that section 3234(a)(2) is "not a model of clarity."[89] The Court stated, however, that "[i]n discerning the legislative intent underlying section 3234(a)(2), it is instructive to examine Insurance Law § 3232 . . ."[90] The Court noted that "section 3234 tracks the language of section 3232, which was added a year earlier and places similar limitations on preexisting condition provisions in health insurance

81. *Id.* at 665, 870 N.E.2d at 1138, 839 N.Y.S.2d at 708.

82. *Benesowitz*, 8 N.Y. at 665, 870 N.E.2d at 1138, 839 N.Y.S.2d at 708 (quoting N.Y. INS. LAW § 3234(a)(2)).

83. *Id.* at 665, 870 N.E.2d at 1138, 839 N.Y.S.2d at 708.

84. *Id*. at 665-66, 870 N.E.2d at 1138, 839 N.Y.S.2d at 708.

85. *Id.* at 666, 870 N.E.2d at 1138, 839 N.Y.S.2d at 708 (quoting Benesowitz v. Metro. Life Ins. Co., 471 F.3d 348, 353 (2d Cir. 2006)).

86. 210 F.3d 89, 95 (2d Cir. 2000).

87. *Benesowitz*, 471 F.3d at 351-52.

88. *Benesowitz*, 8 N.Y.3d at 664, 666, 870 N.E.2d at 1137, 1139, 839 N.Y.S.2d at 707, 709.

89. *Id.* at 666, 870 N.E.2d at 1139, 839 N.Y.S.2d at 709.

90. *Id.* at 667, 870 N.E.2d at 1139, 839 N.Y.S.2d at 709. *See* N.Y. INS. LAW § 3232 (McKinney 2006).

policies."[91] According to the Court, "[b]oth statutes contain a portability provision requiring insurers to credit the time a person previously was covered under a comparable plan for purposes of determining the applicability of a preexisting condition provision."[92] "This portability feature," wrote the Court, "was designed to enable individuals to change jobs or insurance plans without fear of having to wait for coverage to take effect" and significantly "both statutes also prescribe a [twelve]-month maximum time frame for preexisting condition provisions."[93]

The Court noted that "[t]he parties agree[d] that under section 3232(b), although insurers may limit or preclude coverage for medical claims stemming from preexisting conditions during the first [twelve] months (assuming there is no portability of coverage), the insurers must cover such claims thereafter."[94] The Court wrote that "Section 3232(b) therefore functions as a tolling or waiting period because it mandates full health coverage—even for pre-existing medical conditions—once the [twelve]-month period expires. Insurers are not permitted to bar health coverage completely under section 3232(b)."[95]

The Court then ruled that "[i]f insurers may exclude health coverage for up to [twelve] months under section 3232 but must pay benefits for medical claims related to preexisting conditions after that time period, the statute should operate the same way for group disability plans under section 3234(a)(2)."[96] According to the Court, by using "the same 'for a period in excess of twelve months' language in [both statutes], the Legislature sought to create a similar tolling provision for preexisting conditions in group disability policies," and that the legislative history "buttresses our conclusion."[97] In fact, it cited Insurance Law section 3216(d)(1)(B)(ii) as an example of a statute where the Legislature used different language—"'commencing after two years'"—to create a permanent bar to coverage for disabilities arising from a preexisting condition.[98]

Accordingly, the Court held that Insurance Law section 3234(a)(2)

91. *Benesowitz,* 8 N.Y.3d at 667, 870 N.E.2d at 1139, 839 N.Y.S.2d at 709. *See* N.Y. INS. LAW §§ 3232, 3234.

92. *Benesowitz,* 8 N.Y.3d at 667, 870 N.E.2d at 1139, 839 N.Y.S.2d at 709 (citing N.Y. INS. LAW §§ 3232(a), 3234(a)(1)).

93. *Id.* at 667-68, 870 N.E.2d at 1139, 839 N.Y.S.2d at 709 (citing N.Y. INS. LAW §§ 3232(b), 3234(a)(2)).

94. *Id.* at 668, 870 N.E.2d at 1140, 839 N.Y.S.2d at 710.

95. *Id*.

96. *Benesowitz*, 8 N.Y.3d at 668, 870 N.E.2d at 1140, 839 N.Y.S.2d at 710.

97. *Id.*

98. *Id.* at 669, 870 N.E.2d at 1140, 839 N.Y.S.2d at 710 (quoting N.Y. INS. LAW § 3216(d)(1)(B)(ii) (McKinney 2006 & Supp. 2008)).

"means that a policy may impose a [twelve]-month waiting period during which no benefits will be paid for a disability stemming from a preexisting condition and arising in the first [twelve] months of coverage" and answered the certified questions accordingly.[99] Thereafter, the Second Circuit vacated the district court's judgment because it was premised on a conclusion that a permanent bar could be imposed and remanded for further proceedings.[100]

IV. *NYACK HOSPITAL*—THE PRIORITY-OF-PAYMENT NO-FAULT REGULATION

No-fault insurance has been one of the most active areas of insurance litigation in recent years and the Court of Appeals has often provided guidance to the lower courts in New York to assist them in resolving the voluminous cases that arise. In *Nyack Hosp. v. Gen. Motors Acceptance Corp.*,[101] the Court held that "an insurer that is waiting for information to verify a pending claim that causes aggregate claims to exceed $50,000 is [not] prohibited by the priority-of-payment regulation from paying already verified claims in the meantime."[102]

Nyack Hospital treated an individual who was injured in an automobile accident and who was covered under an automobile insurance policy that contained "the mandatory no-fault endorsement, providing coverage for basic economic loss up to $50,000 per person/per accident, with additional coverage for optional basic economic loss . . . of $25,000 per person."[103] "The hospital, as the patient's assignee, completed and sent the insurer the proper forms for claiming no-fault benefits [in the amount of $74,489.28] for medical services rendered to the patient during his hospital stay."[104] The insurer received the forms on August 20, 2003, and then sought additional verification of the claim in the form of the patient's complete inpatient hospital records "'[i]n order to determine whether the bill should be paid or denied and to properly assess the medical necessity of the services rendered.'"[105] In the meantime, "the insurer paid [other]

99. *Benesowitz*, 8 N.Y.3d at 670, 870 N.E.2d at 1141, 839 N.Y.S.2d at 711.

100. *See* Benesowitz v. Metro. Life Ins. Co., 514 F.3d 174, 176 (2d Cir. 2007). The Court of Appeals stated that on remand the district court should also determine whether the plaintiff is entitled to attorney's fees and pre-judgment interest. *Id.*

101. 8 N.Y.3d 294, 864 N.E.2d 1279, 832 N.Y.S.2d 880 (2007).

102. *Id.* at 295-96, 864 N.E.2d at 1280, 832 N.Y.S.2d at 881 (citing N.Y. COMP. CODES R. & REGS. tit. 11, § 65-3.15 (2007)).

103. *Id.* at 296, 864 N.E.2d at 1280, 832 N.Y.S.2d at 881.

104. *Id.*

105. *Id.* at 296-97, 864 N.E.2d at 1280, 832 N.Y.S.2d at 881 (quoting N.Y. COMP. CODES R. & REGS. tit. 11, § 65-3.5(b) (alteration in original)).

claims for the patient's lost earnings, and claims from other health service providers . . . so that only about $20,188.88 of the $50,000 basic economic loss coverage remained" available to be paid to the hospital once the insurer received the verification it had requested from the hospital and other forms necessary to make payment.[106] The insurer paid this amount to the hospital and advised it that all of the "personal injury protection and medical benefits under the policy had been exhausted by these payments."[107]

"The hospital commenced this action . . . , alleging that the insurer had not paid or denied its $74,489.28 claim within [thirty] days as required by Insurance Law § 5106(a)," and that it had "violated [the] no-fault regulation governing priority of payment when it paid health service providers who submitted their claims after August 20, 2003 before paying the hospital's claim."[108] The "priority of payment" regulation provides:

> When claims aggregate to more than $50,000, payments for basic economic loss shall be made to the applicant and/or an assignee in the order in which each service was rendered or each expense was incurred, provided claims therefor were made to the insurer prior to the exhaustion of the $50,000. If the insurer pays the $50,000 before receiving claims for services rendered prior in time to those which were paid, the insurer will not be liable to pay such late claims. If the insurer receives claims of a number of providers of services, at the same time, the payments shall be made in the order of rendition of services.[109]

The "Supreme Court denied the hospital's motion [for summary judgment] and granted the insurer's cross motion to dismiss the complaint."[110] "[T]he Appellate Division affirmed, holding that 'under the circumstances presented, the insurer did not violate 11 NYCRR 65-3.15, as the [hospital's] initial claim was premature when submitted [on August 20, 2003], and was not complete until the insurer received additional verification of the claim [on October 20, 2003].'"[111] In addition, the Appellate Division determined that the insurer timely acted on the claim because "the applicable limitation period for the insurer to pay or deny the hospital's claim did not start to run until November 24, 2003, when the

106. *Nyack Hospital,* 8 N.Y.3d at 297, 864 N.E.2d at 1280-81, 832 N.Y.S.2d at 881-82.

107. *Id.* at 298, 864 N.E.2d at 1281, 832 N.Y.S.2d at 882.

108. *Id. See* N.Y. INSURANCE LAW § 5106(a) (McKinney 2000 & Supp. 2008).

109. 11 N.Y. COMP. CODES R. & REGS. 65-3.15.

110. *Nyack Hospital,* 8 N.Y.3d at 298, 864 N.E.2d at 1282, 832 N.Y.S.2d at 883.

111. *Id.* (quoting Nyack Hospital v. Gen. Motors Acceptance Corp., 27 A.D.3d 96, 97, 808 N.Y.S.2d 399, 400 (2d Dep't 2005)).

insurer received the patient's completed . . . election form."[112]

In a unanimous opinion written by Judge Read, the Court rejected the hospital's argument that "once it submitted the requisite forms to make a claim that caused aggregate claims to exceed $50,000, the insurer had a duty under . . . the priority-of-payment regulation 'to keep the money that was due the [hospital] in reserve (up to the policy limits)' of $50,000."[113] As the Court noted, "[t]he no-fault regulations provide that '. . . benefits are overdue if not paid within [thirty] calendar days after the insurer receives proof of claim, which . . . include[s] verification of all of the relevant information requested pursuant to [the regulations].'"[114] Thus, an insurer must pay or deny only a claim that has been verified in compliance with the applicable regulations within thirty calendar days of receipt.[115] Conversely, an insurer is not obligated to pay any claim until it has been properly verified.[116]

The Court wrote that "[t]o adopt the priority-of-payment regime advocated by the hospital, we would have to interpret 'claims' in section 65-3.15 [the priority-of-payment regulation] to encompass claims that ha[d] not been verified in accordance with section 65-3.5."[117] "This approach," the Court stated, "runs counter to the no-fault regulatory scheme, which is designed to promote prompt payment of legitimate claims."[118] "[U]nder the hospital's theory, [for example,] the insurer in this case could not have paid any verified claims submitted after August 20, 2003, by other health service providers or the patient even though the regulations clearly required the insurer to pay these claims within [thirty] calendar days after receipt."[119] The hospital's interpretation of the regulation would also have the unintended consequence of allowing a health service provider of submitting a "bare-bones" claim exceeding the policy limits and blocking other payments, which would provide far less incentive for the provider to supply its verification information in a timely manner.[120]

In conclusion, the Court found that "the priority-of-payment regulation came into play . . . when the insurer received the requested

112. *Id.* at 298-99, 864 N.E.2d at 1282, 832 N.Y.S.2d at 883.

113. *Id.* at 299, 301, 864 N.E.2d at 1282, 11284, 832 N.Y.S.2d at 883, 885 (alterations in original).

114. *Id.* at 299, 864 N.E.2d at 1282, 832 N.Y.S.2d at 883 (quoting 11 N.Y. COMP. CODE R. & REGS. 65-3.8(b)(3)).

115. *Nyack Hospital,* 8 N.Y.3d at 299, 864 N.E.2d at 1282, 832 N.Y.S.2d at 883.

116. *Id.*

117. *Id.* at 300, 864 N.E.2d at 1282-83, 832 N.Y.S.2d at 883-84.

118. *Id.* at 300, 864 N.E.2d at 1283, 832 N.Y.S.2d at 884.

119. *Id.*

120. *Nyack Hospital,* 8 N.Y.3d at 300, 864 N.E.2d at 1283, 832 N.Y.S.2d at 884.

inpatient hospital records, which established verified claims aggregating more than $50,000."[121] It was only at that point that the hospital was entitled to be paid ahead of any other unpaid verified claims for services rendered or expenses incurred later than the services billed by the hospital, up to the policy's limits.[122]

V. *GUISHARD*—LIABILITY INSURER FAILS TO ESTABLISH AUTO EXCLUSION

In *Guishard v. Gen. Sec. Ins. Co.*,[123] the insureds sought a judgment declaring that the insurer was obligated to defend them in an underlying personal injury action brought against them by a plaintiff who was struck by a rivet from a rivet gun while converting a van owned by the plaintiffs into an ice cream vending truck. The insurer moved for summary judgment declaring that there was no coverage under its general liability policy based on an exclusion for bodily injury "'arising out of the ownership, maintenance, use or entrustment to others of any . . . 'auto' . . . owned or operated by or rented or loaned to any insured.'"[124] The Supreme Court granted summary judgment to the insureds and held that the insurer was obligated to defend and indemnify them.[125] The Appellate Division affirmed on the grounds that because the insurer "had not submitted the policy schedule defining the term 'auto,' it had not demonstrated that the van fell within the relied-upon exclusion."[126]

The Court of Appeals affirmed, "but for a different reason," in a Memorandum without oral argument.[127] The Court found that "[t]he work performed by the injured plaintiff did not constitute 'maintenance' of an auto . . . [because] as . . . used in an insurance policy, [that term] means performance of work on 'an intrinsic part of the mechanism of the car and its overall function.'"[128] According to the Court, "[r]iveting metal to a van in furtherance of its conversion to an ice cream truck aids in transforming the auto's function, an activity distinct from 'maintenance.'"[129]

121. *Id*. at 301, 864 N.E.2d at 1283, 832 N.Y.S.2d at 884.
122. *Id.*
123. 9 N.Y.3d 900, 901, 875 N.E.2d 881, 881, 844 N.Y.S.2d 163, 163 (2007).
124. *Id.* at 902, 875 N.E.2d at 881, 844 N.Y.S.2d at 163 (omissions in original).
125. *Id.*
126. *Id.* at 902, 875 N.E.2d at 881-82, 844 N.Y.S.2d at 163-64 (citing Guishard v. Gen. Sec. Ins. Co., 32 A.D.3d 538, 820 N.Y.S.2d 645 (2d Dep't 2006)).
127. *Id.* at 902, 875 N.E.2d at 882, 844 N.Y.S.2d at 164.
128. *Id.* (quoting Farmers Fire Ins. Co. v. Kingsbury, 105 A.D.2d 519, 520, 481 N.Y.S.2d 469, 471 (3d Dep't 1984)).
129. *Id.*

VI. *FOSTER WHEELER*—CHOICE OF LAW

In *Certain Underwriters at Lloyd's, London v. Foster Wheeler Corp.*,[130] the Court of Appeals affirmed the decision of the Appellate Division, First Department which held that New Jersey, rather than New York, law should apply to determine the amount of excess insurance coverage available for the defense and indemnity of asbestos-related personal injury claims. The First Department so held on the grounds that the state of the policyholder's "principal place of business takes precedence over the state of incorporation . . . ."[131] The Court of Appeals affirmed "for the reasons stated by Justice David Friedman at the Appellate Division."[132] As a result, Foster Wheeler, which has faced hundreds of thousands of lawsuits for manufacturing asbestos-contaminated boilers, will gain millions of dollars in possible insurance coverage, and approximately thirty excess insurers who sold Foster Wheeler polices from 1970 to 1982 will provide substantially more coverage than if New York law was applied.[133]

CONCLUSION

The Court of Appeals decided only six insurance coverage cases this *Survey* year, far fewer than in years past. Nonetheless, the decisions discussed herein were all significant and resolved, in many cases, issues of first impression in New York. We already know there will be significant decisions to report on next year.[134]

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130. 9 N.Y.3d 928, 930, 876 N.E.2d 500, 500, 844 N.Y.S.2d 773, 773 (2007), *aff'g* Certain Underwriters at Lloyd's, London v. Foster Wheeler Corp., 36 A.D.3d 17, 18-19 822 N.Y.S.2d 30, 31 (1st Dept. 2006).

131. *Foster Wheeler*, 36 A.D.3d at 25, 822 N.Y.S.2d at 36.

132. *Foster Wheeler*, 9 N.Y.3d at 930, 876 N.E.2d at 500, 844 N.Y.S.2d at 773.

133. *Foster Wheeler*, 36 A.D.3d at 19-20, 822 N.Y.S.2d at 32. The First Department's decision was discussed in detail in last year's *Survey* article. *See* Alan J. Pierce, *Insurance Law*, 57 SYRACUSE L. REV. 1281, 1302-1307 (2007).

134. We already know in early 2008 of three significant decisions from the Court of Appeals. *See* Bi-Economy Market, Inc. v. Harleysville Ins. Co. of New York, 37 A.D.3d 1184, 829 N.Y.S.2d 795 (4th Dep't 2007), *leave granted*, No. (1596/06) CA 06-00847, 2007 N.Y. App. Div. LEXIS 5036 (4th Dep't Apr. 20, 2007), *rev'd*, 10 N.Y3d 187, ___ N.E.2d ___ (2008); Panasia Estates, Inc. v. Hudson Ins. Co., 39 A.D.3d 343, 835 N.Y.S.2d 49 (1st Dep't 2007), *leave granted*, No. M-2940 2007 N.Y. App. Div. LEXIS 9193 (1st Dep't Aug. 16, 2007), *aff'd*, 10 N.Y.3d 200, ___ N.E.2d ___ (2008); Vigilant Ins. Co. v. Bear Stearns Cos., Inc., 2006 N.Y. Misc. LEXIS 63 (Sup. Ct. N.Y. County Jan. 11, 2006), *aff'd*, 34 A.D.3d 300, 824 N.Y.S.2d 91 (1st Dep't 2006), *rev'd*, 10 N.Y.3d 170 (2008).

We can also anticipate decisions from the Court of Appeals on the following cases, which are already before the Court at this time: Fair Price Med. Supply Corp. v. Travelers Indem. Co., 42 A.D.3d 277, 837 N.Y.S.2d 350 (2d Dep't 2007); Gaston v. Am. Transit Ins. Co., 40 A.D.3d 578, 835 N.Y.S.2d 369 (2d Dep't 2007), *leave granted*, 9 N.Y.3d 804, 872 N.E.2d 877, 840 N.Y.S.2d 764 (2007); Preserver Ins. Co. v. Ryba, 37 A.D.3d 574, 829

N.Y.S.2d 664 (2d Dep't 2007), *leave granted*, 9 N.Y.3d 811, 877 N.E.2d 651, 846 N.Y.S.2d 601 (2007).