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INSURER'S FAILURE TO TIMELY SEEK VERIFICATION OF ACCIDENT VICTIM'S ASSIGNMENT OF CLAIM TO HOSPITAL BARS INSURER FROM CONTESTING ASSIGNMENT

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Please call me to discuss any legal issues or for a clarification of current law.

NEW YORK

INSURER'S FAILURE TO TIMELY SEEK VERIFICATION OF ACCIDENT VICTIM'S ASSIGNMENT OF CLAIM TO HOSPITAL BARS INSURER FROM CONTESTING ASSIGNMENT

Hospital for Joint Diseases v. Travelers Property Cas. Ins. Co.
9 N.Y.3d 312 (2007)

In this action, a hospital sought to recover no-fault insurance benefits for services rendered to a patient injured in a motor vehicle accident. The issue was whether an insurance company would be barred from contesting the validity of an assignment of a patient's claim to a hospital when the insurance company failed to respond to the claim in a timely manner as prescribed by law. The Court of Appeals of New York affirmed the lower court's decision and held that the insurance company's delay barred it from challenging the validity of the assignment.

The plaintiff, New York and Presbyterian Hospital (hospital), treated patient Browne for injuries he sustained from an automobile accident. Browne had an insurance policy with defendant Travelers Property Casualty Insurance Company (Travelers) which afforded him no-fault coverage. The hospital sought payment of $24,344.96 from Travelers for services provided to Browne. The assignment portions of the forms sent to Travelers indicated that Browne's signature was "on file," but was not on the actual forms sent to Travelers. Travelers did not reject the forms or request verification of the assignment. Travelers failed to pay or deny the claim within 30 days of receiving it, and the hospital commenced this action against Travelers.

New York's no-fault automobile insurance system is designed to "ensure prompt compensation for losses incurred by accident victims without regard to fault or negligence, to reduce the burden on the courts, and to provide substantial premium savings to New York motorists." *Matter of Med. Soc'y v. Serio*, 100 NY2d 854 (2003). To promote these goals, circumscribed time frames for claim procedures have been created.

When an assignment is made, the insurer is entitled to proof of it. The facility (hospital in this case) has 45 days from the rendition of services to submit the proof to the insurer in verification forms. The insurer then has 30 days from the receipt of the verification forms to either pay or deny the claim. If the insurer then request additional verification of the assignment, it has 15 business days from the receipt of the verification forms to do so, and the 30-day period to pay or deny the claim is tolled until the additional verification is received. An insurer that fails to deny a claim within the 30-day period is generally precluded from asserting a defense against payment of a claim. An exception to this preclusion exists where the insurance company raises a defense of "lack of coverage." *see Central Gen. Hosp. v. Chubb Group of Ins. Cos.*, 90 NY2d 195 (1997).

In this case, Travelers had neither paid nor denied the claim within 30 days of receipt of the hospital's proof of claim, and did not elect to request for additional verification of the assignment. The Court of Appeals ruled that Travelers was barred from raising a defense that the assignment forms were inadequate because they were not signed by Browne. Travelers argued that the preclusive effect of the 30-day rule would not apply because a failure to provide a validly executed assignment would equate to a "lack of coverage," and would therefore be exempt from the 30-day rule. The Court of Appeals disagreed, stating that the "lack of coverage" exception did not apply to this case.

Browne's policy was in effect at the time of the car accident, and the policy covered the accident. The Court's view was that any defect or deficiency in the assignment between Browne and the hospital does not implicate a "lack of coverage" warranting an exemption from the 30-day preclusion rule. The Court used the facts in *Chubb* to describe a situation where the "lack of coverage" exception would apply. In *Chubb*, after the 30-day period had lapsed, the insurer asserted as a defense that the claimant's injuries arose out of a prior work-related accident rather than a car accident. The Court held that insured was not barred from arguing the injuries were unrelated to the accident because, if true, the treatment would not have been covered by the automobile liability policy in the first instance.

Travelers was therefore unable to assert the defense that the assignment claims were inadequate, and the assignment of Browne's claim was held valid by the Court of Appeals.

NEW JERSEY

IF ALL SETTLEMENT AND COSTS ARE PAID BY ONE INSURER, THEN INSURED CANNOT SUE A SECOND INSURER FOR COVERAGE

Marshall v. Raritan Valley Disposal
Superior Court of New Jersey, Appellate Division
398 N.J. Super. 168 (2008)

In this case, the issue was whether an insured, when covered under two insurance policies, can sue the second insurer for coverage of costs once the first insurer paid all the defense and settlement costs for the insured.

Raritan Valley Disposal contracted with the Township of West Amwell (Township) to provide a garbage truck at the municipal transfer station for residents to dispose of their trash. Raritan named the Township as an additional insured under its insurance policy, which was issued by Illinois National Insurance Company (Illinois National). The Township also had its own general liability insurance policy, the Public Alliance Insurance Coverage Fund (PAIC).

Greta Schmidt was fatally injured when she was disposing her trash at the Township's transfer station. Her estate brought a survivorship and wrongful death action against the Township, and PAIC undertook the Township's defense. While the lawsuit was pending, the Township filed a third-party complaint against Illinois National for coverage under the insurance policy issued to Raritan Valley. PAIC reached a settlement with Schmidt's estate for $1.85 million, yet the Township continued to pursue insurance coverage from Illinois National. The trial court awarded the Township $1 million, which was the full amount under Illinois National's policy, plus defense costs and prejudgment interest. Illinois National appealed, claiming that the Township lacked standing[1] to maintain a coverage action once the original claim was settled by PAIC.

The Appellate Division reversed the trial court's decision. It held that where all costs of defense and settlement of a claim have been paid by one insurer (PAIC), the insured (Township) lacks standing to pursue a coverage action against another insurer (Illinois National) for those same costs. The Appellate Division also held that PAIC still had a claim for contribution[2] against Illinois National, but it would have to pursue the claim in its own name.

On the issue of standing, the Appellate Division referenced case law stating that "a financial interest in the outcome of litigation is ordinarily sufficient to confer standing." Case law states that a party who claims to be an insured has sufficient financial interest to seek a declaration of coverage, even if the party also has other coverage and the other insurer has undertaken its defense. This is because coverage under one policy may be insufficient to protect the insured from its full exposure to liability. Here, when Township filed its third-party complaint against Illinois National, it had sufficient interest because there was a possibility that the claim by Schmidt's estate exceeded the coverage provided by PAIC's policy. The Appellate Division held that once PAIC had settled the Schmidt action, paying the Township's defense costs and the full amount of the settlement, the Township had lost its standing to pursue its coverage against Illinois National. It concluded that the Township no longer had the financial interest necessary to maintain its coverage action against Illinois National.

The Appellate Division concluded that a PAIC coverage claim against Illinois National survived the settlement because PAIC had paid for all the costs, and Illinois National could be obligated to contribute to these costs depending on the terms of their insurance policies. The last issue decided was whether the Township's claim against Illinois National would have to be dismissed for lack of standing, or whether PAIC could be substituted for the Township as a third-party plaintiff under Rule 4:34-3. The Appellate Division concluded that based on the substantial amount of time and resources that had been invested and the flexibility of Rule 4:34-3, "the interests of efficient judicial administration would be served" by permitting PAIC to substitute for the Township as a third-party plaintiff in an action against Illinois National.

[1]**Standing** - the right to file a lawsuit or file a petition under the circumstances.

[2]**Contribution** - the sharing of a loss by each of several persons who may have been jointly responsible for injury to a third party. Quite often this arises when one responsible party pays more than his share and then demands contribution from the others in proportion to their share of the obligation.

Brief Latin: *"de novo"*

from Latin for "anew," which means starting over, as in trial de novo. For example, a decision in a small claims case may be appealed to a local trial court, which may try the case again, de novo.

- Black's Law Dictionary

Maybe we will se you at the NASP litigation conference in Las Vegas at the end of this month. We will be there. We hope to see you there as well.