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NEW YORK INSURANCE DEPARTMENT REGULATORY ACTIONS

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PARTIAL REGULATION OF CREDIT DEFAULT SWAPS SUSPENDED IN LIGHT OF FEDERAL PROGRESS ON COMPREHENSIVE APPROACH

As previously reported in our Fall 2008 *Insurance Regulatory Observer,* the New York Insurance Department (the "Department") announced that it intended to regulate certain types of credit default swap ("CDS") contracts beginning January 1, 2009.[1] In light of the progress being made on the federal level to create central counterparties and oversight for CDS contracts, New York Insurance Superintendent Eric Dinallo announced on November 20, 2008, during testimony to the House Agriculture Committee, that New York will hold off on its implementation of CDS regulations.

Superintendent Dinallo's comments are in response to initiatives undertaken by the President's Working Group on Financial Markets, the Federal Reserve Board of Governors, the U.S. Securities and Exchange Commission, and the Commodity Futures Trading Commission to, *inter alia,* establish central counterparties for CDS contracts and to improve information sharing and regulatory oversight of credit default swap issues.

Although, according to Dinallo, New York stepped in to regulate certain CDS contracts because of the "total lack of regulation of credit default swaps," he also stated that "the best solution for a healthy market is credit defaults in a single market." As a result, Superintendent Dinallo announced that New York will delay indefinitely its plan for partial regulatory oversight of CDS contracts.

While Superintendent Dinallo's comments indicate that New York will initially yield to federal initiatives to regulate CDS, Dinallo did offer the following guidelines for the effective regulation of CDS contracts:

> Effective regulation of credit default swaps should include the following provisions:
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> - All sellers must maintain adequate capital and post sufficient trading margins to minimize counterparty risk.
> - A guaranty fund should be created that ensures that a failure of one seller will not create a cascade of failures in the market.
> - There must be clear and inclusive mechanisms for dispute resolution and determining events of default.
> - To ensure transparency and permit monitoring, comprehensive market data should be collected and made available to regulatory authorities.
> - The market must have comprehensive regulatory oversight, and regulation cannot be voluntary.

GUIDELINES SET FOR IMPLEMENTATION OF CHANGE IN LATE NOTICE PROVISIONS

In Circular Letter No. 26 (2008), issued November 18, 2008, the Department reminded all property/casualty insurers that issue liability policies, including insurers issuing liability policies in the excess line market, of the necessity of revising their policy forms to comply with the new language of New York Insurance Law Section 3420(a).

The amendments to Section 3420(a) are based on the fundamental change in New York law, enacted under Chapter 388 of the Laws of 2008, requiring that the liability insurer establish that it has been prejudiced by a late notice of claim made within two years after the time set by the policy for

1. Please refer to our Fall 2008 *Insurance Regulatory Observer*, available at: http://www.cozen.com/admin/files/publications/InsRegObsFall08.pdf for a more in depth discussion of CDS contracts

providing notice of a claim. Under New York case law annulled by Chapter 388, an insurer could deny coverage on the ground of a late notice of claim without demonstrating prejudice. Chapter 388 enacted New York Insurance Law Section 3420(c)(2), providing that:

> (A)In any action in which an insurer alleges that it was prejudiced as a result of a failure to provide timely notice, the burden of proof shall be on: (i) the insurer to prove that it has been prejudiced, if the notice was provided within two years of the time required under the policy; or (ii) the insured, injured person or other claimant to prove that the insurer has not been prejudiced, if the notice was provided more than two years after the time required under the policy.
>
> (B) Notwithstanding subparagraph (a) of this paragraph, an irrebuttable presumption of prejudice shall apply if, prior to notice, the insured's liability has been determined by a court of competent jurisdiction or by binding arbitration; or if the insured has resolved the claim or suit by settlement or other compromise.
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> (C) The insurer's rights shall not be deemed prejudiced unless the failure to timely provide notice materially impairs the ability of the insurer to investigate or defend the claim.

Under subsection (A) of this new subsection, a notice of claim can be up to two years late and still be valid if the insurer cannot prove prejudice. For lateness exceeding two years, the burden is on the insured to prove lack of prejudice. Subsection (B) describes situations that amount to an irrebuttable presumption of prejudice and subsection (C) sets a material impairment standard to define prejudice.

The amendments to Section 3420(a) apply only to policies issued or delivered on or after January 17, 2009, according to the Department. Circular Letter 26 provides that any liability policy issued or delivered in New York on or after that date without the required new provisions will be enforceable as if it contained the required new provisions. The other major changes to Section 3420(a) are as follows.

Effective January 17, 2009, under Section 3420(a)(4), all liability policies are to contain:

> A provision that failure to give any notice required to be given by such policy within the time prescribed therein shall not invalidate any claim made by the insured, an injured person or any other claimant if it shall be shown not to have been reasonably possible to give such notice within the prescribed time and that notice was given as soon as was reasonably possible thereafter.

The amendment to this subsection adds "an injured person" and the word "thereafter" to this subsection.

Under Section 3420(a)(5), all liability policies insuring against liability for injury to person are also to contain:

> A provision that failure to give any notice required to be given by such policy within the time prescribed therein shall not invalidate any claim made by the insured, injured person or other claimant, unless the failure to provide timely notice has prejudiced the insurer.

Section 3420(a)(5) is new. It codifies the requirement of Chapter 388 that for a late claim to be invalidated, prejudice must be shown.

The new subsection 3420(a)(5) also provides that:

> With respect to a claims-made policy, however, the policy may provide that the claim shall be made during the policy period, any renewal thereof, or any extended reporting period, except as provided in paragraph four of this subsection. As used in this paragraph, the terms "claims-made policy" and "extended reporting period" shall have their respective meanings as provided in a regulation promulgated by the superintendent.

This new language clarifies how the new late notice standards are to be applied to a claims-made policy, while stressing that late notice alone will not invalidate a claim.

Another new subsection, Section 3420(a)(6) requires, in all liability policies:

> A provision that, with respect to a claim arising out of death or personal injury of any person, if the insurer disclaims liability or denies coverage based upon the failure to provide timely notice, then the injured person or other claimant may maintain an action directly against such insurer, in which the sole question is the insurer's disclaimer or denial based on the failure to provide timely notice, unless within sixty days following such disclaimer or denial, the insured or the insurer: (a) initiates an action to declare the rights of the parties under the insurance policy; and (b) names the injured person or other claimant as a party to the action.

This subsection authorizes a declaratory judgment action by a claimant directly against an insurer and preserves the right of both an insured and an insurer to seek a declaratory judgment.

CAUTION ADVISED AGAINST MID-TERM CANCELLATION OF HOMEOWNERS' POLICIES BASED ON A RESIDENCE BECOMING UNOCCUPIED

In Circular Letter No. 23 (2008), issued November 19, 2008, the Department reported that it had received numerous complaints from consumers whose homeowners' policies were cancelled on the ground that their homes had become unoccupied. Citing the case of a couple who suffered cancellation of their homeowners' policy while they were in a nursing home, the Department points out that mid-term cancellations are permitted only if there has been a physical change in the property that results in the property becoming uninsurable. Noting that a physical change occurs only when the dwelling has been altered or changed in some manner, the Department rejected lack of occupancy as a ground for a finding of a physical change. In addition, the Department states that lack of occupancy, standing alone, is not among the "willful or reckless acts or omissions increasing the hazard insured against," another ground for mid-term cancellation. Finally, the Department notes that the existence of a foreclosure action cannot be used as a basis for cancellation of a homeowners' policy.

INSURANCE BENEFITS MUST BE PROVIDED ON EQUAL BASIS TO SAME-SEX AND OPPOSITE-SEX SPOUSES

Following the February 1, 2008 decision in *Martinez v. Monroe Community College*[2] in which the Supreme Court of the State of New York, Appellate Division, held that a Canadian woman's marriage to her same-sex partner is entitled to recognition in New York State, and that her spouse in entitled to employer-provided healthcare benefits offered to the opposite-sex spouses of other employees, the Department has issued Circular Letter No. 27 (2008) stating its expectation that all licensees will recognize the marriages of same-sex couples legally performed in other jurisdictions, and that licensees provide all legally married couples with the same rights and benefits, regardless of the sex of the spouses.

Circular Letter No. 27, issued November 21, 2008, explains that following the *Martinez* decision, the Department received requests for guidance as to how insurers should, for insurance purposes, treat same-sex couples married outside of New York State. In response to such inquiries, the Department's Office of the General Counsel (the "OGC") provided in an opinion that, in light of *Martinez* and other controlling decisions, same-sex spouses in marriages legally performed outside of New York must be treated as spouses for purposes of the New York Insurance Law, including all provisions governing health insurance.

According to the Department, the OGC opinion provided that where an employer offers insurance[3] to employees and their spouses, the same-sex spouse of a New York employee who enters into a marriage legally performed outside the State is entitled to health insurance coverage to the same extent as any opposite-sex spouse.

With the issuance of Circular Letter No. 27, the Department makes it clear that it expects all licensees to comply with *Martinez* and the OGC opinion as stated above. Furthermore, the Department explains that refusal by an insurer to extend insurance benefits on an equal basis to same-sex and opposite-sex spouses may constitute an unfair act or practice and/or unfair discrimination under the New York Insurance and Executive Laws. Last, the Department states in the Circular Letter that, to the extent necessary, licensees will be expected to file new policy forms or policy form amendments with the Department to ensure compliance with the law.

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2. 50 A.D.3d 189, 850 N.Y.S.2d 740 (4th Dept), lv. to appeal denied, 10 N.Y.3d 856 (2008).

3. While the OGC opinion letter specifically refers to group health insurance, the opinion provides that its conclusions are applicable to other kinds of insurance as well.