STATE OF NEW YORK

6813--A

2021-2022 Regular Sessions

IN SENATE

May 18, 2021

Introduced by Sens. RAMOS, GAUGHRAN, KRUEGER, RIVERA, SALAZAR, STAVISKY -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance -- recommitted to the Committee on Insurance in accordance with Senate Rule 6, sec. 8 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law, in relation to unfair claim settlement practices

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The insurance law is amended by adding a new section 2601-a to read as follows:

§ 2601-a. Unfair claim settlement practices; civil remedy. (a) The holder of a policy issued or renewed pursuant to article thirty-four of this chapter or injured person shall have a private right of action against any insurer doing business in this state for damages as provided in this section upon proof by a preponderance of the evidence that such insurer's refusal to pay or unreasonably delay payment to the policyholder or injured person of amounts claimed to be due under a policy is not reasonably justified. An insurer is not reasonably justified in refusing to pay or is unreasonably delaying payment when the insurer:

(1) fails to provide the policyholder with accurate information concerning policy provisions relating to the coverage at issue;

(2) fails to effectuate a prompt and fair settlement of a claim or any portion thereof, in that the insurer (i) fails to reasonably accord at least equal or more favorable consideration to its insured's interests as it did to its own interests, and thereby exposes the insured to a judgment in excess of the policy limits, or (ii) refuses to settle in response to a fair and reasonable settlement offer within the policy limits from an injured party;

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [-] is old law to be omitted.

LBD11091-05-2

(3) fails to provide a timely written denial of a policyholder's claim with a full and complete explanation of such denial, including references to specific policy provisions wherever possible;

(4) fails to make a final determination and notify the policyholder in writing of its position on both liability for and the insurer's valuation of a claim within a reasonable time not to exceed six months of the date on which it received actual or constructive notice of the loss upon which the claim is based;

(5) fails to act in good faith by compelling a policyholder to institute suit or compel appraisal to recover amounts due under its policy by offering substantially less than the amounts ultimately recovered in suit or by appraisal;

(6) fails to advise a policyholder that a claim may exceed policy limits, that counsel assigned by the insurer may be subject to a conflict of interest, or that the policyholder may retain independent counsel;

(7) fails to provide, on request of the policyholder or their representative, all reports, letters or other documentation arising from the investigation of a claim and evaluating liability for or valuation of such claim;

(8) refuses to pay a claim without conducting a reasonable investigation;

(9) negotiates or settles a claim directly with a policyholder known to be represented by an attorney without the attorney's knowledge or consent. The provisions of this paragraph shall not be deemed to prohibit routine inquiries to a policyholder to obtain details concerning the claim;

(10) negotiates or settles a claim directly with a policyholder known to be represented by a licensed public adjuster;

(11) negotiates or settles a claim directly with a contractor or unlicensed public adjuster;

(12) requires a policyholder to submit duplicative or repetitive information already submitted by a policyholder or an injured party; or

(13) acts in violation of section two thousand six hundred one of this article or any regulation promulgated pursuant thereto.

(b) Any policyholder who establishes liability pursuant to subsection (a) of this section shall be entitled to recover, in addition to amounts due under the policy, costs and disbursements, consequential damages, reasonable attorneys' fees incurred by the policyholder, interest from the date of the loss, and punitive damages as determined by the finder of fact.

(c) Any policyholder may recover damages from an insurer doing business in this state pursuant to this section either as part of an action to recover under the terms of an insurance policy or in a separate action.

(d) In any trial of a cause of action asserted against an insurer pursuant to this section, evidence of settlement discussions written and verbal offers to compromise and other evidence relating to the claims process shall be admissible. If causes of action relating to liability of the insurer under the policy and under this section are alleged in the same action, the court may bifurcate the trial of issues so as to avoid prejudice to the insurer on the issue of liability under the policy and facilitate admissibility of evidence on the causes of action asserted pursuant to this section.

(e) All amounts recovered from an insurer as damages and reasonable attorneys' fees in any action authorized in this section shall be

excluded by the insurer in its determinations of the premiums it will charge all policyholders on all policies issued by it.

(f) An action may also be maintained by any injured person or representative thereof including, but not limited to, a guardian, administrator, executor, individual with a power of attorney or any other personal representative against an insurer to recover damages including costs and disbursements, consequential damages, reasonable attorney's fees, interest from the time of failure to offer a fair and reasonable settlement in accordance with this section, and punitive damages as determined by the finder of fact or court, not limited to the policy limits, where a preponderance of the evidence establishes that the insurer fails to effectuate a prompt and fair settlement of a claim or any portion thereof, in that under the totality of the facts and circumstances related to the claim, the insurer fails to reasonably accord at least equal or more favorable consideration to its insured's interests as it did to its own interests.

(g) At least thirty days prior to the filing of any action pursuant to this section, a written demand for relief, identifying the claimant and reasonably describing the unfair claim settlement act or practice and the injury suffered, shall be mailed or delivered to any insurer doing business in this state. Any insurer doing business in this state receiving such a demand for relief who, within thirty days of the mailing or delivery of the demand for relief, makes a written tender of settlement which is rejected by the claimant may, in any subsequent action, file the written tender and an affidavit concerning its rejection and thereby limit any recovery to the relief tendered if the finder of fact finds that the relief tendered was reasonable in relation to the injury actually suffered by the claimant. In all other cases, if the finder of fact finds for the claimant, recovery shall be in the amount of actual damages; or up to three but not less than two times such amount if the finder of fact finds that the unfair claim settlement act or practice was a willful or knowing violation of subsection (a) or (f) of this section or that the refusal to grant relief upon demand was not reasonably justified with knowledge or reason to know that the act or practice complained of violated subsection (a) or (f) of this section. For the purposes of this chapter, the amount of actual damages to be multiplied by the finder of fact shall be the amount of the damages as determined by the finder of fact on all claims arising out of the same and underlying transaction or occurrence, regardless of the existence or nonexistence of insurance coverage available in payment of the claim. In addition, the court shall award such other equitable relief, including an injunction, as it deems to be necessary and proper. The demand requirements of this subsection shall not apply if the claim is asserted by way of counterclaim or cross-claim.

(h) The rights enumerated in this section are not the exclusive remedies available to the policyholder or injured person or representative thereof including, but not limited to, a guardian, administrator, executor, individual with power of attorney or any other personal representative and do not preclude any common law claims or other statutory claims that may exist or arise.

(i) Upon demand of a claimant policyholder or injured person pursuant to this section, an insurer shall make available to the claimant or injured person the entire claim file within thirty days.

(j) A policyholder or injured person shall have the right to a trial by jury. No mandatory arbitration agreement within or part of any writ-

ten contract for insurance shall prohibit an action pursuant to this section.

§ 2. Section 3425 of the insurance law is amended by adding a new subsection (t) to read as follows:

(t) No insurer shall refuse to issue or renew a covered policy solely on the grounds that the policyholder has brought an action pursuant to section two thousand six hundred one-a of this chapter.

§ 3. Paragraph 4 of subsection (a) of section 2601 of the insurance law, as amended by chapter 547 of the laws of 1997, is amended to read as follows:

(4) [~~not attempting in good faith~~] where the insurer fails to effectuate a prompt[~~,~~] and fair [~~and equitable settlements~~] settlement of [~~claims submitted in which liability has become reasonably clear~~] a claim or any portion thereof, in that the insurer fails to reasonably accord at least equal or more favorable consideration to its insured's interests as it did to its own interests, and thereby exposes the insured to a judgment in excess of the policy limits, except where there is a reasonable basis supported by specific information available for review by the department that the claimant has caused the loss to occur by arson. After receiving a properly executed proof of loss, the insurer shall advise the claimant of acceptance or denial of the claim within thirty working days;

§ 4. This act shall take effect on the first of January next succeeding the date on which it shall have become a law and shall apply to all acts and omissions by insurers occurring on or after such effective date.