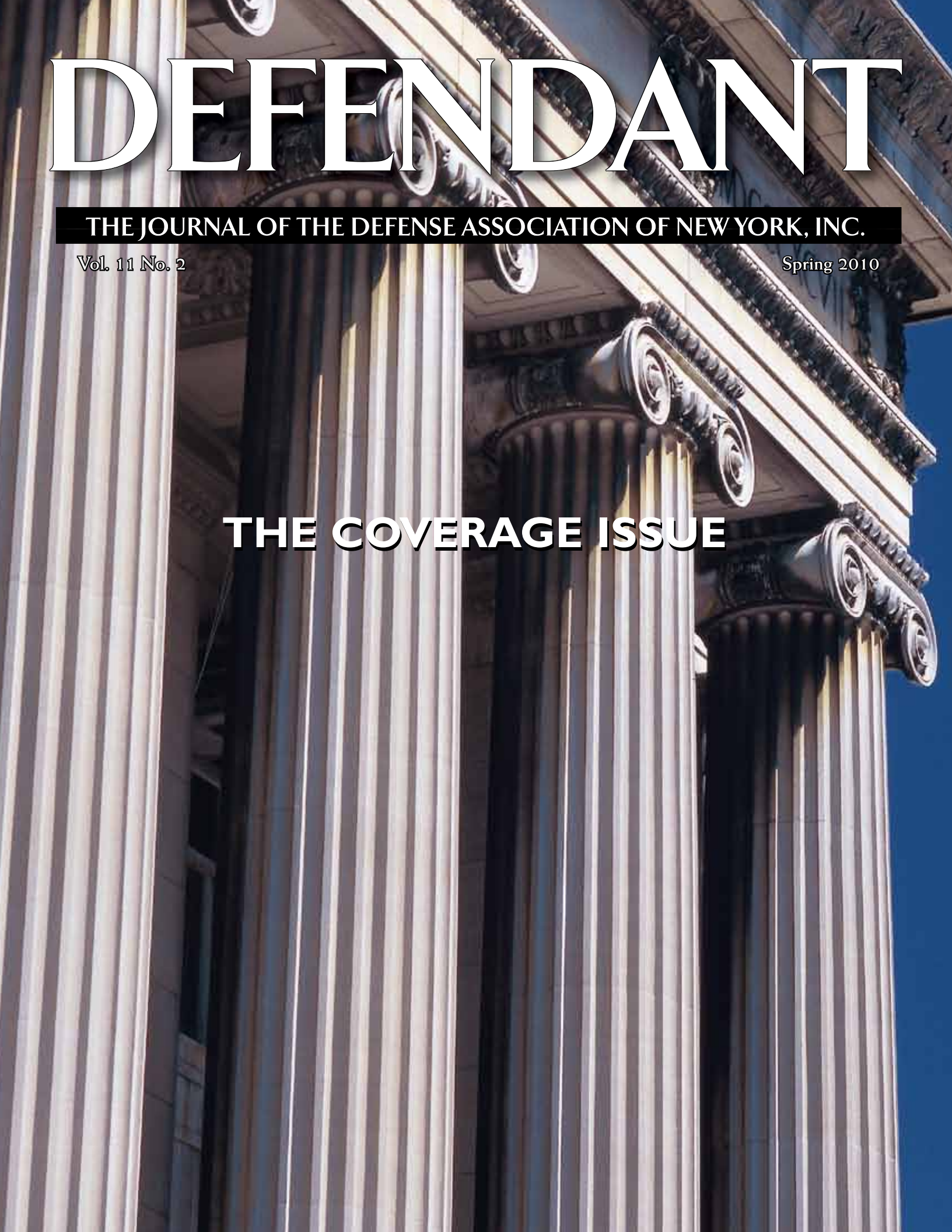

# DEFENDANT

THE JOURNAL OF THE DEFENSE ASSOCIATION OF NEW YORK, INC.

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## FEATURES



# President's Column

TIMOTHY J. KEANE ESQ.*

The officers and board of DANY are especially excited to be bringing you this exceptional issue of The Defendant. We are grateful for the authors and to Julian Ehrlich, the Chair of DANY's rapidly expanding Insurance Law Committee, whose tireless efforts brought about this wonderful tome addressing insurance coverage issues that every defense attorney needs to understand.

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** Timothy J. Keane is a partner at Quirk and Bakalor, P.C.*

# The Quadripartite Relationship: Remedies of The Excess Insurer

JOHN J. MCDONOUGH, ESQ.*

There has been significant judicial examination recently of the "tripartite relationship" and the various duties arising between an insurer, an insured and counsel appointed to represent the insured by its insurer. Missing from most of the discussion is any consideration of the rights of the excess insurer where there has been a breach of fiduciary duty by the primary to the excess carrier and possible malpractice by its appointed counsel. Does New York recognize any rights or remedies of the excess insurer in this quadripartite situation? The New York Court of Appeals has yet to rule on this issue, but based on the handful of cases that have considered this issue, New York is one of the few jurisdictions that has permitted a direct action by an excess insurer against a primary carrier rather than limiting it to only those rights available to the subrogee of the insured. Moreover, the First Department has recognized an excess insurer's right to maintain a claim on its own behalf against an insurer's attorneys for malpractice.

While the answer to the question of who is a lawyer's client in a situation where the attorney is appointed by the liability insurer of the insured to defend the insured in a tort action continues to evolve, it is clear the excess insurer is contractually bound only with the insured.[1] The excess insurer has a duty to indemnify the insured upon exhaustion of the primary layer by settlement or judgment but generally has no duty to defend. Consequently, the excess insurer relies on the primary insurer to select and hire defense counsel. Given the **lack of privity** between the excess carrier and appointed defense counsel there would appear to be no duty to be breached as none is owed.

In 1983, the Appellate Division, First Department reinstated an excess insurer's complaint against a primary insurer and a law firm in Hartford Accident and Indemnity v. Michigan Mutual Insurance Co., 93 A.D.2d 337, 462 N.Y.S.2d 175 (1st Dept. 1983), aff'd Hartford Accident and Indemnity Co. v. Michigan

*Continued on page 45*

** Mr. McDonough is a member of Cozen O'Connor where he is Vice Chair of the firm's General Litigation practice group.*

# What Every Insurance Defense Attorney and Their Client Need to Know about Coverage

COMPILED AND EDITED BY JULIAN D. EHRLICH *

## Introduction

Traditionally, many insurance defense attorneys have winced and recoiled at the mere mention of coverage. Early in their careers defense lawyers are taught that coverage can present dangerous conflicts that must be avoided and certain strict separating walls must be maintained. As a result, a deeply ingrained culture has evolved discouraging attorneys from understanding coverage issues which are actually essential to properly representing their clients.

Certainly, counsel must not act in a way that jeopardizes coverage for a client but emerging case law has made a head-in-the sand approach to coverage outdated and risky. Now, contrary to the traditional view, defense counsel who fail to understand coverage issues may actually be in a unique position to get blamed for unexpected and unpleasant results.

Whether counsel like it or not, from the onset through the resolution of tort claims assigned by carriers, coverage is unavoidably everywhere, and even conscientious lawyers can face a myriad of challenges.

For example, some carriers take the position that only the policyholder should tell counsel of the carrier's coverage position and thus, the carriers deliberately omit such information in suit assignment letters. Read on to see how that missing piece of information that can come back to haunt a defense attorney in very nasty ways.

Of course, it is standard practice for plaintiffs and codefendants to serve discovery demands on each other for all applicable insurance policies including declaration pages, certificates and endorsements and courts routinely will "so order" such exchanges at discovery conferences. Counsel will have to sign off on the response as to what policies actually are applicable.

When the time comes to discuss potential resolution or, even worse, after a verdict in excess of policy limits, too often counsel has to scramble to sort through issues like priority of coverage.

There is no question of the value that a skilled trial attorney brings. Nonetheless, many an experienced attorney has appeared in court to advise that they were there to try only the case on the calendar, not the related pending declaratory judgment action and that coverage is not their business. They are the *trial attorneys* – the *artistes* in the courtroom. Horizontal exhaustion has only vaguely erotic connotations that do not concern them. They are not to be bothered with this talk of coverage.

However, these are also the same lawyers who will live the nightmares when they have to explain, for example, how their failure to accomplish risk transfer triggered their client's endorsement that raised the deductible to the policy limits effectively eviscerating coverage or why their client's biggest customer is holding back contract payments due to unmet additional insured expectations or why no carrier will take their call for settlement authority because of a priority dispute.

Examples are legion and coverage can give rise to conflict issues at any time during the life of a case. While all of these issues are common in the construction accident claim setting, they can also arise in tort claims against commercial landlords and tenants and many other scenarios.

In this special dedicated issue of *The Defendant: The Journal of the Defense Association of New York*, a plethora of industry leading author "All Stars" each examine an aspect of coverage that insurance defense attorneys and their clients need to know, explaining the concept and why it is important. The result is a "greatest hits album" if you will on topics designed to help counsel and their clients avoid potential minefields, nightmare scenarios and red faced post mortems.

It may not be immodest to say that what follows qualifies as required reading.

*Continued on the next page then through page 46*

* *Julian D. Ehrlich is Senior Vice President Claims at Aon Construction Services Group, President-Elect of DANY and Chair of the DANY Insurance Committee.*

# Who Should Send the Tender Letter?

BY MICHAEL MAJEWSKI *

Contractual Risk Transfer is a frequently used tool to facilitate various commercial transactions. It transfers the risk or liability by means of a contract or agreement from one party to another.

This discussion will review some principles of the familiar two tracks of contractual risk transfer and then examine the often confusing issue of whether defense counsel, the carrier or the party itself should properly tender to start the process.

## Allocating Risk

There are many reasons why one party would agree to accept someone else's risk. Normally, it is a tool to facilitate a business relationship. It is also a sign of the relative bargaining power of the contracting parties. The party agreeing to accept the risk is normally in a lesser bargaining position than the party transferring the risk. It was the inequity of bargaining positions which first brought contractual indemnification agreements to the attention of the New York state legislature and the courts.

In two important commercial activities i.e., leasing property and construction of buildings, specific statutes were passed under the New York State General Obligations Law circumscribing the limits of possible indemnification parties and agreements. In all other contexts, however, as long as the indemnity agreement contains an unmistakable intent, one party may transfer it's negligence liability, complete or partial, to another agreeing party. However, as mentioned, the most frequent source of legal attention to contractual risk transfer takes place in reference to commercial leases and construction contracts.

There are two essential tools to contractual risk transfer. The first is by means of an indemnity agreement frequently found in leases and construction contracts. As noted, the indemnity agreement transfers the risk of liability from one party to another party.

The second tool is by means of an insurance procurement clause in a contract between the parties. This is an agreement to purchase additional insured coverage in favor of the party transferring the risk. The agreement is fulfilled by a procurement of additional insured coverage on a commercial general liability policy.

There are a wide variety of additional insured agreements. The two main varieties are a schedule endorsement on which the additional insured is specifically listed. The other additional insured endorsement is known as a blanket additional insured endorsement which normally provides additional insurance protection to any party that the named insured has agreed in a written contract to add as an additional insured. The later endorsement has the benefit of providing flexibility to the named insured to enter into contracts without the necessity of procuring separate additional insured endorsements.

There are compelling business reasons for contractual risk transfer. Contractual risk transfer can help identify, isolate and allocate risks. Such agreements identify responsible parties and obligate them to undertake certain actions in the event of loss. Such agreements may also help manage costs in that the party transferring the risk may be able to reduce the cost of it's overall insurance program including self-insured layers and deductibles. Another goal of contractual risk transfer is to reduce litigation between potentially responsible parties by having previously identified which party and which insurance policy would take the lead to adjust the consequences of any property damage or bodily injury sustained at a leased premises or a construction project.

## The Tender

The rights and benefits under a contractual risk transfer are activated in the event of loss or, where a claim or law suit is pursued against a potentially liable party. If that party has a risk transfer in its favor, that party seeks to "tender" the claim or lawsuit to the party that agreed to accept the transferred risk.

The tender may be based on both or either of the risk transfer mechanisms. Thus, a party may seek to establish it's status as an additional insured under another party's policy or, it may make a demand pursuant to the contractual indemnity in the contract.

The end result of a successful tender under either track may be the same, i.e. defense and indemnity. However, it is important to remember that the two tracks lead to different sources. Contractual indemnity runs to a downstream party while additional insured status runs to the downstream party's insurance carrier.

A carrier tender on behalf of its policyholder based on contractual indemnity grounds to a downstream party may be met with indifference. After all, the carrier was not a party to the contract and its policyholder, not the carrier, is owed the obligation.

Similarly, their conflicting authority on whether carrier-to-carrier tenders are recognized. [1]

Whichever the available track of risk transfer, there is typically a timeliness requirement. This makes the

question of precisely who should write the tender demand both urgent and susceptible to several answers as there are many interested parties in the contractual risk transfer scenario and the tracks lead to different places.

Carriers, defense counsel or parties themselves may tender. However, too often, these players assume another has tendered and as a result, nobody timely tenders.

Potential tendering individuals may also depend on the size of the tendering party's business.

For example, the party itself may have a risk control specialist – someone who knows the tendering party's own insurance policies, knows the contractual risk transfer in place with it's business partner and, just as importantly, knows the insurance coverage of it's business partners. All of these facts are necessary and essential for a timely and effective tender.

If the tendering party is smaller, it does not mean the information needs are less but it may mean that more work will fall on the insurance claim professional working on the investigation of the tendering party's insurance claim. In the case of such an investigation, it is customary for the claim professional to gather contracts, leases, insurance certificates, as well as actual policies of other involved parties.

In addition, defense counsel for the tendering party may, depending on circumstances such as limited to no liability exposure and adequate policy limits, not feel compelled to tender. Some interests of the client may not arise directly from the case – such as the potential impact on renewal rates due to loss experience under the tendering party's own policy. That matter can be extraordinarily complex, but typically there is no downside for defense counsel to actively seek as many tender targets as possible.

Indeed, recent case law tends to support the proposition that defense counsel has an obligation to seek additional coverages including excess policies.[2] Many defense counsel or specialized coverage counsel do normally have a compelling interest to secure as much insurance or indemnity protection for their client. The challenge for defense counsel is that additional protection may be available for business partners who are not parties to the suit. Therefore, defense counsel must closely coordinate with the client and claim representative to identify potential tender targets.

## Complications and Permutations

The contractual risk transfer is clearly facilitated by insurance and is almost, but not completely, dependent upon it's financial backing. The insurance tools are primarily the coverage for the contractual assumption of tort liability of another party – provided by the exception to the exclusion for contractual assumed liability in insured contracts found in the standard general liability policy. The second tool, different in scope and intent than contractual coverage, are additional insured endorsements, which come in a wide array of assortments.

Another question that arises is, with the clear commercial needs recognized and with products designed by the insurance companies to meet that commercial risk, why so many controversies involving contractual risk transfer and additional insurance arise. One of the sources of the problem is the ability or inability to determine if the insurance tools in the promissory insurance tool kit match the contractual obligations it has made to it's promissees.

These issues involve both the scope and enforceability of an indemnity agreement and the precise grant of coverage offered under specific additional insured endorsements. In both lease situations and construction contracts, there is the possibility of transferring all or some of the promisee's negligence liability to the promissor.

Recently, the Court of Appeals has construed the scope of permissible indemnity agreements between landlords and tenants within the context of GOL 5-321.[4] If the indemnity agreement presents unmistakable intent to assume the negligence liability of the landlord, and proper insurance protection has been procured, then a tenant can assume the tort liability occasioned by the landlord's negligence. It is also possible that this arrangement can work in reverse for leases involving tenants with very strong bargaining power.

The scope of that agreement is not mirrored in construction contracts where the Court of Appeals has held that promissors cannot assume the liability of the promissee if the promissee is actively at fault. The Court has created partial contractual indemnification to define the scope of permissible indemnification.[4] In either the lease or construction situation, the promissor's obligation can be transferred to it's insurance carrier under the contractual liability coverage.

Issues that may arise include whether the indemnification language does present an unmistakable attempt to indemnify or if it otherwise runs afoul of provisions of the General Obligations Law; whether the promissee qualifies for a defense under the supplementary payments coverage afforded under the promissor's general liability policy; and whether other parties involved in the enterprise may also afford indemnification.

Not all additional insured endorsements afford the

same extent of coverage to the additional insured. Some, as construed by Appellate courts, provide coverage for the additional insured's own negligence regardless of the named insured's role in the causing injury or damage. Other endorsements attempt to limit coverage to vicarious liability to which the additional insured is subject by reason of the action of the named insured. An evolving issue is the scope of the duty to defend the additional insured if the pleadings allege the named insured caused the injury, but strong factual arguments can be mounted that the named insured had no such role. Some contracts attempt to avoid such controversy by requiring the named insured to procure the very broadest additional insured endorsements available on the market.[5]

## Conclusion

As this examination has highlighted, tenders present in a plethora of variations and may create a host of associated issues. The law is evolving in real time. Nonetheless, the parties and their counsel must communicate clearly and early to ensure that the appropriate party tenders to the right place in a timely manner. It is certainly a safer practice for counsel and their clients to assume nobody else has tendered and tender themselves. A lack of proper tender can be a costly missed opportunity to avoid paying a claim but duplicative tenders do no harm.

* **Michael Majewski** is Claims Center General Counselor for Travelers Claim Legal Group.

1 See for example, *JT Magen v. Hartford Fire Ins. Co.,* 64 A.D.3d 266, 879 N.Y.S.2d 100 (1st Dept. 2009).

2 *Shaya B. Pacific, LLC v. Wilson, Elser, Moskowitz, Edelman & Dicker, LLP,* 38 A.D.3d 827 N.Y.S.2d 231 (2nd Dept. 2006).

3 *Great Northern Ins. Co. v. Interior Constr. Corp.,* 7 N.Y.3d 412, 823 N.Y.S.2d 765 (2006).

4 *Brooks v. Judlau Contracting, Inc.,* 11 N.Y.3d 204, 869 N.Y.S.2d 366 (2008).

5 See for example the ISO 20 10 11 85 additional insured endorsement.

# DJ Attorney and Underlying Attorney: More in Common Than You Might Think

BY GLENN DIENSTAG *

Too often the left hand does not know what the right is doing; that is the declaratory judgment (DJ) attorney and underlying attorney are not on the same page. This is true even where the DJ and underlying actions are being handled by the same firm.

Initially, when deciding to start a DJ and pursue additional insured coverage, the first question the decision maker should resolve is whether to split up the two tasks and assign the DJ to another firm. There are advantages and disadvantages to using two firms as opposed to one firm that will not be discussed here, but the strategies to effective contractual risk transfer remain the same.

The strategies are as follows:

### The attorneys should communicate with each other-

This point seems simple, but if the attorneys are not kept apprised of each others activities, it will only delay the ultimate objective of transferring risk. Timing is everything. Often times, the underlying attorney has no knowledge of the status of the DJ and visa versa. Underlying and DJ attorneys should exchange any substantive reports on case activity. The DJ could be used as leverage in resolving the underlying action. In addition, if the underlying suit is going to trial, and the DJ lags behind, it will not stop the progress of the underlying action and the parties may be forced to settle a case where they had viable risk transfer rights.

### In handling the underlying action, defense counsel should not defend in a vacuum-

It is important that if the underlying attorney is defending a GC, CM or owner that they are thinking from the onset about transferring the risk to the downstream contractor(s) and its carrier(s). This includes an early exchange of insurance policies in the underlying action. This often leads to early assessment of issues and a quicker resolution of the DJ. The underlying attorney should also ask contract and insurance related questions at contractor depositions in the underlying case and share the information with the DJ attorney. The underlying attorney should seek the assistance of the DJ attorney in scripting the questions. This can also lead to earlier resolution of DJ.

### Use of notices to admit may help avoid lengthy discovery and depositions–

For example, get the downstream party to admit to contractual terms, signatures, employment status, policies etc.. Pursuant to CPLR 3123, within 20 days prior to trial, one party can require another to admit stated facts, or the genuineness of a paper or document, or the correctness of photographs. The party receiving the notice has 20 days to respond and silence is deemed an admission. The notice to admit is an easy, inexpensive and underused way to expedite a DJ.

### Select a venue for the DJ that is advantageous to your position-

Depending on the circumstances, if you want the judge in the underlying action to preside over the DJ, you may want to file the DJ as a companion case to the underlying action. If you decide that you do not want the DJ to be part of the underlying action, then you may want to select a venue and court that is advantageous to your position and one that will move the DJ along.

### Prosecute the DJ; don't serve, file, ignore or worse forget-

Too often the DJ is filed and then ignored or abandoned. There is no follow up to determine if an answer to the DJ was even interposed. The DJ attorney should be aggressive. That means following for the answer. After pleadings are closed, the DJ attorney should consider a motion for summary judgment. Coverage or a defense obligation may be established early by aggressive motion practice and handling. Also, you should move the DJ forward so it is not pending in the event the underlying action goes to trial.

There are real limitations to DJ actions including the inability to recover attorney's fees but DJ's can be an effective tool to obtain risk transfer. Often, the mere act of serving the DJ complaint will prompt the defendant carrier to take a second look at their position before spending money to retain defense counsel. Sometimes, DJ's are necessary to resolve genuine and thoughtful differences in coverage positions. But never should they viewed with blinders to the underlying case.

* **Glenn Dienstag**, JD is Senior Vice President Claims at Old Republic Construction Program Group.

# Defense Counsel's Obligation After Shaya B. Pacific: Something Else To Lose Sleep Over

BY MICHAEL LENOFF *

Does counsel retained by an insurance carrier, whether staff legal or panel counsel, have any obligation to investigate the extent of their client's insurance coverage applicable for the case they are defending? If so, what is the scope of that obligation? The case of *Shaya B. Pacific, LLC v. Wilson, Elser, Moskowitz, Edelman & Dicker, LLP* [1] answers to the first question in the affirmative but unfortunately the answer to the second question remains vague.

*Shaya B.* arises out of an underlying personal injury action commenced by Kazimierz Golebiewski. Mr. Golebiewski was inured while performing demolition work at the premises of the Shaya B. Pacific LLC. In July 2008, Certain Underwriters at Lloyd's of London, (hereinafter Lloyd's), retained the firm of Wilson, Elser, Moskowitz, Edelman & Dicker, LLP, (hereinafter Wilson Elser), to defend Shaya B. in Mr. Golebiewski's personal injury action.

Lloyd's policy limit was $1,000,000. Mr. Golebiewski sought damages in excess of $52,000,000. Accordingly, on January 25, 2001 Lloyd's wrote to their insured Shaya B. Pacific, LLC stating in relevant part as follows:

> "As you know suit has been filed in this matter. We must advise you that the demand in the suit papers of $52,500,000.00 is in excess of your policy limits of $1,000,000.00 per occurrence. As such you may wish to engage counsel of your choice at your own expense to act on your behalf in regard to any potential excess judgments. **We can advise that we are continuing the defense of this matter on your behalf through the law offices of Wilson, Elser, Moskowitz, Edelman & Dicker.**
>
> Furthermore, you may wish to check with your insurance agent to determine if any excess coverage is in force. If so we would urge you to quickly notify any excess insurance carrier of the suit situation."

In February 2003, Golebiewski was granted summary judgment on his Labor Law § 240(1) claim. On or about April 24, 2003, just before commencement of the trial on damages, Wilson Elser on behalf of Shaya Pacific tendered the case to National Union Fire Insurance Company (hereinafter National Union), for further defense and for indemnification with respect to the excess claim. National Union had issued a commercial umbrella policy to Greendel Developers, Ltd. (hereinafter Greendel). Greendel was not a party to Golebiewski's personal injury action. (A review of the case and the underlying record fails to establish what if any relationship Greendel had to Shaya Pacific).

By letter dated May 14, 2003 National Union declined the tender and disclaimed coverage on grounds that it had not received timely notice and that National Union had no information to confirm that Shaya Pacific was an insured under the excess policy.

On October 22, 2003, Golebiewski and his wife obtained judgments against Shaya Pacific in the amounts of $5,694,320 and $795,000 respectively.

On March 8, 2004, Shaya Pacific commenced a legal malpractice action against Wilson Elser claiming that Wilson, Elser failed to timely notify National Union of the underlying action or, alternatively, that its failure to do so constituted a breach of contract.

Wilson Elser moved to dismiss the complaint arguing that the plaintiff failed to establish its status as an insured under the National Union policy and, therefore, could not establish causation. Wilson Elser also contended that any negligence on its part was not a proximate cause of the loss of excess coverage because the firm was retained more than three months after Shaya Pacific became aware of the need to notify any excess carrier and two months after Shaya Pacific became aware of the Golebiewski action. Most significantly, for purposes of this discussion the firm argued *in any event as defense counsel provided by the plaintiff's primary carrier, Wilson Elser had no duty to advise the plaintiff concerning coverage issues*.

The Supreme Court granted the motion and dismissed the complaint. On appeal, the Second Department framed central the issue as follows: "whether a law firm retained by a carrier has any duty to ascertain whether the insured it was hired to represent has available excess coverage, or to file a timely notice of excess claim on the insured's behalf."

The Court looked first at whether an attorney retained directly by a defendant in a personal injury action has any obligation to investigate the availability of insurance coverage for the client. The Court then considered whether such an obligation would also be imposed on an attorney retained to defend the personal injury action by the defendant's carrier rather than a defendant directly.

Wilson Elser contended that there was no authority in the state recognizing a theory of legal malpractice action against an attorney for failing to investigate insurance coverage. However, the majority disagreed with this contention.

The Court found that whether an attorney could be found negligent for failing to investigate the availability of coverage hinged primarily on the scope of the agreed representation and on whether, in light of all developments and circumstances, the attorney failed to exercise that degree of reasonable skill or knowledge, possessed by a member of the legal profession. According to the majority, these issues usually, posed questions of fact.

The Court held that it could not state as a matter of law that a legal malpractice action may never lie based upon a law firm's failure to investigate its client's insurance coverage or to notify its client's carrier of the claim. Furthermore, the Court saw no reason to differentiate counsel retained directly by a defendant in a personal injury action from counsel retained by the carrier.

The Appellate Division also rejected Wilson Elser's argument that imposing such an obligation created a conflict of interest. The Court noted that Lloyd's had no interest in whether there was excess coverage while the policyholder clearly did have such an interest. The Court noted that Wilson Elser eventually tendered the defense of Shaya Pacific to National Union which was inconsistent with Wilson Elser's position that it had no duty to investigate the possibility of excess coverage.

It is clear from the decision that the Second Department is willing to recognize that under certain circumstances, an attorney, whether retained directly by the insured or by the carrier, has an obligation to investigate the possibility of excess coverage. Whether such a duty exists depends on the scope of the representation.

Typically, however, when a carrier retains counsel, there is no "retainer" in the traditional sense. The only documentary evidence of the scope of Wilson Elser's representation was the letter from Lloyds dated January 25, 2001 advising Shaya Pacific "we are continuing the defense of this matter on your behalf through the law offices or Wilson, Elser, Moskowitz, Edelman & Dicker." The letter is silent as to what its representation of Shaya Pacific in the Golebiewski personal injury action involved.

Seldom is there any additional information available as to the scope of representation provided by insurance defense counsel. Perhaps expert testimony concerning the custom and practice in the industry will ultimately be necessary to establish whether defense counsel typically investigate information regarding excess coverage.

How does counsel discharge this undefined duty? Is a letter at the beginning of the case, requesting the information from the insured regarding potential excess coverage sufficient to discharge defense counsel's duty? If not, what additional efforts have to be made? At what point in the litigation does the duty originate? If a claim, in the opinion of defense counsel, is clearly worth less than the primary policy limit, is there any obligation to inquire regarding the availability of excess coverage? The decision leaves many questions unanswered.

Certainly, as a precautionary measure it would appear prudent to send an initial letter to the client

requesting the insured provide information regarding the excess coverage. Although, as Wilson Elser argued, as a practical matter the client and the carrier are usually in a position to know whether such coverage exists, the Court in *Shaya B.* did not find this to abrogate defense counsel's duty.

If there is excess coverage available, defense counsel must be mindful of timely notice requirements in insurance policies particularly for policies issued prior to January 2009 when Insurance Law § 3420 was amended.

Another option defense counsel may consider is to disclaim any obligation to investigate the availability of coverage in the initial assignment letter sent by the carrier to the insured and/or the initial acknowledgment letter to the client. Since *Shaya B.* holds defense counsel's duty is defined by the scope of representation, such a disclaimer would support an argument that there is no duty.

Most firms advising the client of representation include in their initial contact letter a request that the existence of excess coverage be disclosed to them by the insured. Such language, after this decision may be construed by the court as evidence that not only did counsel assume the duty but are also obligated to follow for the existence of such coverage and to timely notify the carrier as well.

Since *Shaya B.* provides little guidance as to what efforts are necessary to discharge a duty to discover the existence of coverage, failing to periodically follow with the insured for this information and, upon receiving it, timely notify the excess carrier, may serve as a factual predicate for a claim of legal malpractice.

## Conclusion

The holding in *Shaya B.* clearly recognizes that defense counsel whether retained directly by the insured, or through a carrier, may have a duty to investigate the potential existence of excess coverage. Whether the duty exists turns primarily on the scope of the agreed representation. Since the scope of insurance defense counsel's representation is seldom if ever particularized in writing, questions of fact will almost always exist as to whether the duty exists unless it is specifically disclaimed in writing to the insured.

Pending clarification in future case law, the courts have leeway to find questions of fact regarding whether insurance defense counsel assumed the obligation. These questions of fact will be resolved by looking at what insurance defense counsel did, custom and practice in the industry possibly elicited through expert testimony and whether counsel exercised reasonable skill or knowledge commonly possessed by a member of the profession.

Of all three parties to the tripartite relationship, defense counsel is often in the worst position to find out whether excess coverage is available. The policyholder should have knowledge of whether it purchased excess coverage or whether another party is contractually obligated to provide such coverage but may lack the sophistication to pursue available remedies. Further, the primary carrier may also be aware of whether excess coverage exists. From the standpoint of making sure all available coverage is in place, it certainly behooves both the insured and the primary carrier to make diligent efforts to put the excess carrier on notice of a potential claim but defense counsel is well advised not to rely on other parties to relieve its duties. In the absence of language disclaiming any duty to investigate coverage, it behooves defense counsel seeking to avoid a malpractice action to make diligent efforts to discover whether available excess coverage exists and if so put the carrier on notice.

* **Michael Lenoff** is Chief Trial Attorney for Cartafalsa, Slattery, Turpin & Lenoff in New York City.

[1] 38 A.D.3d 34, 827 N.Y.S.2d 231 (2nd Dept. 2006).

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# Unlimited 1b Coverage And The Grave Injury Defense: Avoiding Potential Conflicts

BY ANDREW ZAJAC AND DAWN C. DESIMONE *

Attorneys may face a conflict in representing employers in a third-party action. Typically, a third-party complaint against the employer contains claims for common-law contribution and indemnification, as well as contractual indemnification. Before we enter into a discussion of the conflicts that an attorney may face in these situations, it is helpful to analyze the typical claims in the third-party action, the grave injury requirement as set forth in Section 11 of the Workers' Compensation Law and insurance coverage issues.

## The Third-Party Pleadings: The Difference Between Contribution and Indemnification and the Distinction Between Common Law Claims and Claims Arising By Contrast

Contribution and indemnification are typically the two vehicles by which responsibility is sought to be shifted or apportioned as between defendants:

> Although the distinction is often critical, the proper characterization of third-party claims has often caused confusion . . .The parties' designation of the claim is not, of course, controlling . . . rather, '[w]hether apportionment or common-law indemnity should be applied in a given case * * * requires a careful analysis of the theory of recovery against each tort-feasor.'[1]

The Court of Appeals, New York's highest State Court, has addressed the distinction between contribution and common-law indemnification as follows:

> The conceptual distinction between contribution and common-law indemnification claims has often been discussed and is by now familiar to most practitioners. In the "classic indemnification case," the one seeking indemnity "had committed no wrong, but by virtue of some relationship with the tort-feasor or obligation imposed by law, was nevertheless held liable to the injured party." (D'Ambrosio v. City of New York, 55 N.Y.2d 454, 461, 450 N.Y.S.2d 149) . . . In other words, "where one is held liable solely on account of the negligence of another, indemnification, not contribution, principles apply to shift the entire liability to the one who was negligent . . . Conversely, where a party is held liable at least partially because of its own negligence, contribution against other culpable tort-feasors is the only available remedy..."[2]

Thus, contribution involves apportionment while indemnity, either based on common-law or contract, generally involves the total shifting of liability from one party to another.

For purposes of this discussion, it is also critical to keep in mind that claims for common law indemnity and contribution arise by operation of law, and claims based upon contractual indemnification are based upon express agreement between the parties.[3]

## The Added Twist: The Grave Injury Requirement

As we know, in New York, claims for common law indemnification or contribution against an employer cannot be maintained unless the third-party plaintiff shows that the injury sustained by the plaintiff-employee is a "grave injury" under the Workers' Compensation Law. A grave injury, as defined by § 11 of the Workers' Compensation Law "shall mean only one or more of the following: death, permanent and total loss of use or amputation of an arm, leg, hand, or foot, loss of multiple fingers, loss of multiple toes, paraplegia, or quadriplegia, total and permanent blindness, total and permanent deafness, loss of nose, loss of ear, permanent and severe facial disfigurement, loss of an index finger or an acquired injury to the brain caused by an external physical force resulting in permanent total disability."

Where the plaintiff has not sustained a grave injury, no claims for common law indemnity or contribution can be maintained against the third-party employer. Section 11 of the Workers' Compensation Law further provides that the grave injury bar does not apply to a claim for indemnity or contribution based upon a written contract entered into prior to the accident where the employer had expressly agreed to such indemnity or contribution.

So where is the potential conflict?

Understanding the claims that may be alleged in a third-party complaint as against the employer is one thing. To understand the potential conflict, the focus turns to what types of coverage are typically afforded for those claims.

## Employers' Liability Insurance (1B) v. General Liability Coverage

Where an employer elects to meet its obligation

by purchasing insurance pursuant to either Workers' Compensation Law § 50 (1) or (2), a standard "Workers' Compensation Insurance policy" is issued. Part One of such a policy requires coverage for an employer's obligation to pay statutory Workers' Compensation benefits. Part Two of the standard policy provides unlimited coverage for "Employer's Liability" (EL), i.e. liability for damages imposed on an employer by law, but excluding damages under the Workers' Compensation Law.[4] (Part Two of such a policy was formerly referred to as 1B coverage, which is a term that continues to be used today.)

Only claims for common-law contribution and indemnification are covered by the Employers' Liability Insurance. This insurance excludes coverage for liability assumed under a contract.[5]

A second type of coverage that the employer may have is general liability coverage. The contractual indemnification claims found in the third-party complaint are generally covered by general liability insurance. The policy typically provides that the insurance does not apply to injuries to an employee of the insured arising out of and in the course of employment by the insured unless the liability was assumed by the insured under an "insured" contract.

An insured contract is commonly defined within a general liability policy as:

> That part of any other contract or agreement pertaining to your business under which you assume the tort liability of another to pay damages because of "bodily injury" or "property damage" to a third person or organization, if the contract or agreement is made prior to the "bodily injury" or "property damage." Tort liability means liability that would be imposed by law in the absence of any contract or agreement.

Accordingly, claims for common law indemnity and contribution are typically covered under the unlimited 1B Employers' Liability (EL) policy. Contractual claims, on the other hand, are generally covered under the general liability insurance, and such policies always have a stated limit.

## The Conflict

Attorneys face a potential conflict in moving to dismiss common law claims asserted against the third-party employer on grave injury grounds inasmuch as they may lose for their client the unlimited coverage provided under the EL/1B policy. This could potentially result in a situation where the client is left with limited GL coverage, or no GL coverage at all where that carrier has disclaimed.

For example, in a case where no "grave injury" exists, the EL carrier would naturally want counsel for the third-party defendant-employer to make a motion to dismiss the common law claims so as to prevent the EL policy from paying indemnity. In such a situation, the question becomes whether counsel is obligated to move to dismiss the common law causes of action since, by eliminating those causes of action, the unlimited coverage provided by the EL would also be eliminated, thus leaving the insured with limited or perhaps no coverage available under its GL policy.

The conflict may arise when counsel for the employer is requested to make a motion to dismiss the common law causes of action by the EL carrier since a successful motion results in lost coverage.

The issue as to whether defense counsel can be compelled to make such a motion has been addressed, albeit in a factually distinguishable case, by the Appellate Division in the case of Nelson Electrical Contracting Corp. v. Transcontinental Ins. Company.[6] That case involved an insurance coverage dispute between a subcontractor, Nelson, and its insurer, Transcontinental. The facts as set forth by the court in that case were as follows:

> [Nelson] entered into a contract with Pyramid Company of Onondaga to provide electrical contracting services in connection with the construction of [a mall]. During construction of the mall, three workers, Richard Lovenduski, Barry Walsh and Joseph Bright, were injured at the work site. Each brought suit against Pyramid, which, in turn, cross-claimed or commenced a third-party action against [Nelson], seeking to recover on grounds of common-law and contractual indemnification and contribution. In addition, in the Lovenduski and Walsh actions, Pyramid in its third-party complaint, asserted a breach of contract claim against [Nelson] for failing to name Pyramid as an additional insured on the general liability policy, procured from [Transcontinental]. When Pyramid was denied leave to amend its cross-claim in the Bright litigation to add such a cause of action, it informed [Nelson] that it would continue to press the breach of contract claim in a separate lawsuit.[7]

The Appellate Division then went on to discuss insurance coverage issues pertaining to Pyramid's claims against Nelson and the conflict between Transcontinental and Nelson:

> It is undisputed that the indemnification and contribution claims asserted by Pyramid are covered under [Nelson's] liability policy and that the breach of contract claims are not. Hence, while it is in [Transcontinental's] interest to demonstrate that Pyramid is partially or entirely at fault for the accidents, and in so doing to limit Pyramid's recovery on the covered claims, this would increase the amount of damages for which [Nelson] might be held liable on the uncovered, breach

> of contract claim. Recognizing that the interests of its insureds are at odds with its own in this respect, [Transcontinental] permitted [Nelson] to select its own counsel to defend against Pyramid's allegations, at [Transcontinental's] expense.[8]

The Court then described a development in the litigation which brought the conflict between Nelson and Transcontinental to a head:

> Prior to trial, in the Bright action, Pyramid moved for summary judgment on its common-law and contractual indemnification claims against [Nelson]. [Nelson's] counsel, who was of the opinion that the best approach to defending the action would be for Pyramid and [Nelson] to work together to defeat the injured parties' claims, rather than trying to "point fingers" at each other (and in so doing, run the risk of indirectly providing the injured parties' case for them), determined that this goal would be best served by not opposing Pyramid's motion.
>
> Moreover, to defeat the motion, [Nelson] would have had to present evidence that Pyramid bore some of the liability for the accident. While this would have advanced [Transcontinental's] interests, by reducing or eliminating Pyramid's possible recovery on the covered claims, it would have done so at [Nelson's] expense, by shifting its potential liability to the uncovered breach of contract claim. Consequently, although he was urged to do otherwise by [Transcontinental], [Nelson's] counsel did not oppose Pyramid's motion and it was granted.
>
> [Transcontinental] thereafter disclaimed coverage, and advised that it would no longer pay for [Nelson's] defense in the Bright action, because [Nelson] had breached the policy conditions requiring that it cooperate in the defense of claims or lawsuits and refrain from assuming any obligation without [Transcontinental's] consent. [Nelson] then commenced this suit seeking a declaration that [Transcontinental] is obliged to defend and indemnify it in the underlying action.[9]

The issue before the Appellate Division was whether Nelson was entitled to summary judgment declaring that Transcontinental had a duty to defend and indemnify it in an underlying personal injury action. The Court discussed at length that a tactical decision of insured's counsel, without the liability insurer's consent, to not oppose co-defendant's motion for summary judgment on its indemnification claims against the insured did not breach the policy's requirement that the insured refrain from settling a claim or assuming any obligation without the insurer's consent, where the decision was part of reasonable litigation strategy intended to decrease the likelihood of the insured's liability.[10]

The Court in Nelson determined that where the interests of the insured were at odds with those of the insurer, the insured was entitled to select independent counsel to conduct the defense so that, inter alia, tactical decisions will "be in the hands of attorneys whose loyalty to the insured is unquestioned."[11] The Court went on to state that "though the insured is contractually precluded from settling their case, or otherwise assuming an obligation, without the consent of the insurance company, these limitations cannot be construed so broadly as to prohibit the insured's counsel from making tactical decisions, such as those at issue here, which are part of a reasonable litigation strategy intended to decrease the likelihood of liability on the part of the insured."[12] The Court added that the Code of Professional Responsibility requires an attorney to exercise professional judgment solely on behalf of the client, and it prohibits counsel from permitting an insurer from regulating his or her professional judgment.[13]

This decision makes clear that counsel for the third-party defendant-employer has an obligation to exercise his or her professional judgment and refrain from taking a position in the litigation that may jeopardize available insurance coverage. Thus, the attorney for the employer may refuse to make a motion based on grave injury because the making of the motion may result in the loss of the unlimited employers' liability coverage and would leave the insured with diminished coverage.[14]

## The Carrier's Options

Where counsel for the employer is faced with a conflict of interest and properly refuses to move to dismiss the third-party action based upon a lack of a grave injury, the insurer is not in privity with its insured and the insured's interests are then not properly being protected in the action.

The Appellate Division has held that where an insured and an insurer are not in privity, and thus their interests are adversarial, a finding in the bodily injury action does not collaterally estop the insurer.[15] The Appellate Division has also recognized that the existence of grave injury is a coverage issue as far as the EL carrier is concerned.[16]

Where the attorney for the employer refuses to make the motion to dismiss the common law claims citing an ethical conflict, the employers' liability insurer may attempt to obtain a de novo determination that no grave injury exists.[17] The carrier may seek to do this by intervening in the personal injury action[18] or by commencing a declaratory action.[19]

While the attorney representing the employer may properly refuse to assert the grave injury defense,

counsel should advise the employer that the EL carrier has the right to a separate determination on that issue. If the EL insurer is successful in that regard, then it will be entitled to a declaration that its policy owes no coverage to the employer.

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1 Glaser v. M. Fortunoff of Westbury Corp., 71 N.Y.2d 643, 529 N.Y.S.2d 59 (1988).

2 Glaser, 71 N.Y.2d at 646, 529 N.Y.S.2d at 61 (internal citations omitted).

3 Workers' Compensation Law §11.

4 Oneida Limited v. Utica Mutual Ins. Company, 263 A.D.2d 825, 694 N.Y.S.2d 221 (3d Dep't 1999).

5 See, Liberty Mutual Ins. Co. v. Insurance Co. of the State of PA, 43 A.D.3d 666, 668, 841 N.Y.S.2d 288, 290 (1st Dep't 2007) ("since the AIG policy afforded . . . coverage for common law liability only [excluding "liability assumed under a contract"], the determination of whether AIG is obligated . . . to reimburse Liberty for its settlement payment must await a finding on whether the employee suffered a grave injury").

6 231 A.D.2d 207, 660 N.Y.S.2d 220 (3d Dep't 1997).

7 Nelson, 231 A.D.2d at 208, 660 N.Y.S.2d at 221.

8 Nelson, 231 A.D.2d at 208-209, 660 N.Y.S.2d at 221.

9 Nelson, 231 A.D.2d at 209, 660 N.Y.S.2d at 222

10 Nelson, 231 A.D.2d at 209-210, 660 N.Y.S.2d at 222

11 Id.

12 Nelson, 231 A.D.2d at 210, 660 N.Y.S.2d at 222.

13 Id.

14 See, also, Commercial Ins. Co. of Newark, N.J. v. Popadich, 68 A.D.3d 401, 401-402, 890 N.Y.S.2d 36, 37 (1st Dep't 2009) (insurer cannot cause defense counsel to act in a manner which is not in best interests of insured).

15 Id.

16 Liberty Mutual Ins. Co. v. Insurance Co. of State of PA, supra.

17 Transcontinental Insurance Company v. State of New York, 22 A.D.3d 359, 802 N.Y.S.2d 643 (1st Dep't 2005).

18 Frost v. Monter, 202 A.D.2d 632, 609 N.Y.S.2d 308 (2d Dep't 1994).

19 Transcontinental Insurance Company v. State of New York, supra; Failla v. Nationwide Ins. Co., 267 A.D.2d 860, 701 N.Y.S.2d 161 (3d Dep't 1999).

# Why Counsel Needs To Understand Priority Of Coverage

BY OLIVIA M. GROSS *

You represent a general contractor facing a Labor Law claim with a potential $10,000,000 verdict and it will take at least $6,000,000 to settle the action. The injured worker's employer's primary policy of insurance with a limit of $1,000,000 for the occurrence under which your client is an additional insured has been authorized in its entirety to you for settlement. Your client is also an additional insured under several primary and excess policies of insurance purchased by other subcontractors who had a nexus to the accident and your client has its own primary and excess policies. You are proceeding comfortably, satisfied that there is more than enough insurance coverage to meet any obligation your client may have whether by settlement or judgment. However, suddenly, you find that no other insurer is willing to extend you settlement authority. Trial is imminent and you have no commitment from any insurer that it will be the next layer to satisfy the judgment.

Which policy do you turn to next? What do you tell your client?

Assume in this common scenario that your client entered into agreements with a subcontractor in which various subcontractors agreed to both defend and indemnify the owner and general contractor and to name them as additional insureds. The subcontractors also agreed to procure at least $5,000,000 in commercial general liability coverage on which the owner and general contractor were to be named as additional insureds. One subcontractor in turn subcontracted with plaintiff's employer. The employer agreed by contract to 1) indemnify and save harmless the owner, general contractor and the subcontractor which hired the employer and 2) name each of them as additional insureds on a commercial general liability insurance policy in an amount not less than $5,000,000. The first tier subcontractor and the employer, in order to satisfy the insurance procurement requirements of their respective contracts, each purchased a commercial general liability policy with a limit of $1,000,000 and an excess liability policy with a limit of $5,000,000, naming additional insureds as required by contract.

Inevitably, plaintiff is injured, commences suit against owner and general contractor and first tier subcontractor, as defendants, and all or some of the defendants implead the employer seeking contractual indemnity. All insurers agree the owner and the general contractor are entitled to a minimum of $5,000,000 additional insured coverage from the subcontractor's insurers and another $5,000,000 in additional insured

coverage from the employer's insurers affording your client $10,000,000 in additional insured coverage. The employer's primary carrier, recognizing the exposure is well beyond its policy limit, readily extends settlement authority of $1,000,000.

So far so good. Then, the bickering over priority of coverage begins.

No insurer, not the excess carrier for the employer, not the primary and excess carriers for the subcontractor, and not your own clients' insurers agree as to which policy pays next. Who do you turn to next for additional settlement authority, or, heaven forbid, to satisfy the judgment?

Assuming all parties to the contracts intended and understood that the contractor whose worker's presence posed the risk of loss would be the one affording insurance coverage, you turn next to the employer's excess or umbrella carrier. The excess carrier tells you its policy does not come into play until all primary policies are exhausted, including the subcontractor's policy and the owner and general contractor's own respective primary policies of insurance.

How could that be? The risk of the worker was occasioned by his employer's presence on site. The contracting parties all contemplated that the owner and general contractor's own policies would not be called upon to pay. Complicating matters further, the excess insurer states that once the primary policies are all exhausted, then it only shares a co-insurance obligation with the subcontractor's excess carrier and perhaps with the owner's as well as the general contractor's excess insurers as well.

You dutifully telephone your client, the general contractor, and you attempt to explain the scenario and the disagreement among the insurers. Your client wants to know the answer to one simple question: "What about our contracts?" The general contractor assures the owner that it continues to honor its indemnity obligation to the owner.

You, on the other hand, are not so certain you can avoid disclosing the owner's policies to the other interested insurers. Your clients are entitled to be saved harmless by contract and have $10,000,000 in additional insured coverage from two contractors' insurers, $1,000,000 each, and your clients each have their own coverage from their own carriers and layers of excess coverage from its own commercial excess carriers; yet no carrier is willing to pay next.

So which carrier is it that pays next?

## Horizontal Exhaustion

The rule generally speaking as to priority of coverage in New York under the current state of case law is horizontal exhaustion.

The rule is seemingly simple enough to state: "The rights and obligations of the insurers are governed by their respective insurance policies, not by the underlying trade contracts among the insureds."[1] Simply put, all primary policies that afford coverage to the insured, whether as a named insured or as an additional insured, must be exhausted before the insured may look to excess or umbrella policies.[2] In determining priority of coverage, the courts review and consider the provisions of all of the relevant policies, and particularly the "other insurance" provisions to determine the priority among them.[3]

In our scenario, assuming that all insurers accept that the general contractor is indemnifying the owner and accept its refusal to seek out the owner's insurance information, the three primary policies triggered by the loss, i.e. those of the general contractor, subcontractor, and employer pay before the excess and umbrella policies.

This, however, is an over simplification of the priority of coverage examination and does not answer the ultimate question of who pays the claim especially in light of the contractual indemnity agreement.

While the rule as set forth in two recent First Department cases, *Bovis v. Great American* and *Tishman v. Great American*, did seem to indicate an examination of the policy language and the comparison of the premiums paid for each policy (discussed further below), calls for exhaustion of all primary policies first, a closer reading of the decisions reflect that the true import of the decisions is that the insurance policy language controls.

The horizontal exhaustion rule can be avoided in underwriting insurance policies to an extent but only if subcontractors request the right language. Moreover, upstream owners and general contractors continue to be at the mercy of the downstream contractors policies to a large extent. Even if the contracts require the downstream contractors to procure policies with the requisite "other insurance" priority wording, there is little recourse to ensure the correct language is actually included when the policy is issued and little remedy for breach of contract to purchase insurance.

For example, if a trade contractors' excess or umbrella policy were specifically endorsed to state that the policy is intended to be primary to any insurance coverage held by the additional insureds, including their own primary and excess policies, the excess policy of a subcontractor or employer would drop down to be next in priority before the owner's and general contractor's own insurance policies.

Policy language controls. For instance, where the excess insurer issued a follow form policy which incorporated the terms and conditions of the

underlying commercial general liability policy, because the underlying commercial general liability policy provided it covered the additional insureds up to the lesser of the policy limits or the amount required by their trade contracts with the insured, the trade contract limitation was incorporated into the excess carrier's policy.[4]

## Priority v. Contractual Indemnity

Let us now return to the tension between priority of coverage and the separate but not mutually exclusive contractual indemnity obligation of the employer.

It is often useful to analyze indemnity and insurance procurement tracks of risk transfer separately. However, the two tracks can become intertwined before one gets the answer to the question of who pays the claim.

In the scenario used here for illustration purposes, the excess carrier for employer may well have to recognize that ultimately, contractual indemnification will cause its policy to be exhausted, or, alternatively, its evaluation of the case exposure is far in excess of $3,000,000 ($1,000,000 each from the three primary policies of insurance) so it must authorize its $1,000,000 towards the settlement.

But suppose the excess carrier for the employer does not authorize its $1,000,000 policy of insurance. Which of the three primary policies pays first?

Again, the language of the policies will determine priority say the courts.

Often, the policy will provide that additional insured coverage is provided as required by written contract and if the contract requires the named insured's (whether the subcontractor's or employer's) policy to be primary, then the policy will be rendered primary to other primary policies. In our scenario the subcontractor's and employer's policies will be primary to the policies of the owner and general contractor.

Your clients' question, "but what about our contracts?!" continues to reverberate in your ears.

While it may be inevitable that the owner and general contractor will be entitled to contractual indemnification from the first tier subcontractor as well as from the third-party defendant employer and that the subcontractor will similarly be entitled to contractual indemnification from the employer, the Court in *Bovis* held that "this scenario's playing out in the long run does not, however, have the effect, at this stage, of negating the priority of coverage among the applicable policies arising from the terms of those policies [citations omitted]."[5] An insurance policy, the Court in *Bovis* stated, is a contract between the insurer and the insured, thus the priority of coverage "is controlled by the relevant policy terms, not by the terms of the underlying trade contract that required the named insured to purchase coverage."[6]

Thus, you console your client, your contract will still have force and effect provided it has enforceable contractual indemnity language.[7]

However, parties and their representatives must be mindful of New York's anti-indemnity statute and anti-subrogation principles when considering contractual indemnity claims.

Pursuant to General Obligations Law 5-322.1, an owner or general contractor may not be indemnified for their own active negligence.[8]

In addition, pursuant to the anti-subrogation rule, an owner or general contractor provided additional insured status on the subcontractor's policy or tower of policies, are barred from asserting claims against the subcontractor to the limits of those policies.[9]

An emerging issue yet to be addressed by the courts is whether the anti-subrogation rule applies where downstream a contractors' excess carrier has acknowledged additional insured coverage but has taken a horizontal exhaustion priority position.

However, the *Tishman* decision may be a harbinger that the Courts may find priority trumps contractual indemnity in answering the ultimate question of who pays. While the question of priority of coverage arose in a declaratory judgment action in *Bovis* where the First Department specifically stated the contractual indemnity claims was not in front of the Court, in *Tishman* the First Department did have the contractual claim before it. However, in the last line of *Tishman*, the Court stated that in light of their horizontal exhaustion priority finding, they "need not reach the issue" of the anti-subrogation and the contractual claim.[10]

Here we see how the two tracks of risk transfer can get enmeshed.

As a practical matter, downstream excess carriers involved in these disputes often offer some settlement money if resolution is in hand or a verdict deemed an unacceptable risk. This approach preserves excess carriers' priority arguments for future cases as well.

## Priority Determined by Premiums Paid

The Court in *Bovis,* relied on the Court of Appeals decision in *State Farm Fire and Cas. Co. v. LiMauro*,[11] wherein the Court conducted a comparison of the premiums charged by the respective insurers as reflective of each insurer's expectation as to where it would stand in the hierarchy of priority of coverage. Reaffirming its earlier decision in *Bovis*, in *Tishman.*, the First Department stated:

> …in analyzing each policy to determine priority of coverage, a court is required to consider the intended purpose of each policy 'as evidenced by both its stated coverage and the premium paid for it, as well as upon the wording of its provision concerning excess insurance [citations omitted].[12]

Indeed, in *Tishman*, the court held that the existence of an excess clause in the primary policy did not transform the policy which, in the court's opinion, was clearly intended to be excess, as indicated by the comparatively small premium.[13]

However, the record, in each case, *Bovis* and *Tishman*, was devoid of any evidence as to how each policy's premium was calculated.

The analysis, in discerning the intent of the insurer as to priority of coverage based on the policy premium, this author submits, is severely flawed.

The Courts relying on a premium analysis as justification for priority of coverage do not consider that one contractor's excess policy premium could exceed a small company's primary policy's premium.

These Courts also fail to consider that premiums, at least in part, are based on the nature of the risk the work of the contractor itself presents. For instance, a contractor that performs excavation and/or sand blasting work may be charged a premium that contemplates that type of activity.

When conducting the premium analysis, the Courts also fail to account for the fact that a general contractor is likely exposed to more litigation and greater risk of loss by virtue of its role in overseeing all of the work of every contractor at a jobsite. By comparison, a masonry subcontractor's insurer calculates premiums and the potential risk factors and litigation that could arise solely from *that* contractor's own work.

These Courts also fail to consider the relative size of each company whose policies were being examined. For instance, a large developer or general contractor is likely to run a number of construction projects simultaneously during the policy period. The masonry contractor, on the other hand, may be been limited to one or two projects during the policy period.

Deductibles and self-insured retentions also affect premium calculations. This information was neither developed nor presented to the First Department in either *Bovis* or *Tishman*.

Another significant factor in underwriting and calculation of premiums is loss history. Different rates or multipliers were likely used to calculate the premiums of the various policies. While one company may pay $100,000 in premiums for an excess policy, another company may pay significantly less in premiums for the very same policy.

The policies of the respective insurers also were not identical in other meaningful respects. Each had different endorsements and did not afford identical coverage.

In sum, these Courts failed to consider or recognize the underwriting factors mentioned here and others. These Courts failed to make an apples-to-apples comparison, assuming that such a comparison is even possible. These Courts have also failed to consider that in the underwriting process, the insurers examined whether the named insured includes hold harmless and indemnification provisions and insurance procurement provisions in its contracts. Indeed, some policies are endorsed to vitiate coverage if the named insured hires a subcontractor without a contract containing such provisions.

## Conclusion

So, who do you call after the first primary policy is exhausted?

First, be mindful that there continues be tension between contractual indemnity and priority and open questions remain to be fully resolved in future decisions. Accordingly, be certain your client's contractual indemnity claims are litigated and determined before you negotiate your high exposure, multi-party case.

Second, examine the "other insurance" provisions of each applicable primary policy. Only consider the contractual provisions of the trade contract where the policy language allows the contract to vary the "other insurance" provision or "excess" provision of the policy.

Next, look to the excess and/or umbrella policies and examine their schedules of underlying insurance and their own other insurance or excess provisions. Again, only look to the trade contracts if the policy language calls for you to do so.

Only then will you be in a position to pick up the phone and convince the insurance representative to extend settlement authority or to pay the judgment entered against your client.

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1 *Bovis Lend Lease LMB Inc. v. Great American Insurance Co.*, 53 A.D.3d 140, 155, 855 N.Y.S.2d 459, 471 (1st Dept. 2008).

2 See also, *Tishman Construction v. Great American*, 53 A.D.3d 416, 861 N.Y.S.2d 38 (1st Dept. 2008).

3 *Village of Brewster v. Virginia Surety Co., Inc.*, 2010 N.Y. Slip Op 1411 (3d Dept. February 18, 2010), citing *BP A.C. Corp. v. 1 Beacon Ins. Group*, 8 N.Y.3d at 716 and *Bovis*, 53 A.D.3d 140, 147-148, 855 N.Y.S.2d 459 (2008).

4 See, for instance, *Metropolitan Transportation Authority v. Zurich American Ins. Co.*, 2009 N.Y. Slip Op 9517, 891 N.Y.S.2d 376 (1st Dept. 2009).

5 *Bovis*, 53 A.D.3d at 154-155, 855 N.Y.S.2d at 471.

6 *Bovis*, 53 A.D.3d at 145, 855 N.Y.S.2d at 464.

7 In order for an indemnity provision to be enforceable, it may not violate General Obligations Law § 5-322.1. A provision which allows for indemnity "to the extent permitted by law" (or such other similar language) and which does not purport to indemnify the indemnity for its own negligence, does not violate the General Obligations Law and generally is enforceable except to the extent of any degree of culpability or percentage of liability attributed to the indemnitee. *Brooks v. Judlau Contracting, Inc.*, 11 N.Y.3d 204, 869 N.Y.S.2d 366, 898 N.E.2d 549 (2008).

8 Unless the excess carrier's policy for the subcontractor or employer is endorsed to be primary to the general contractor's own policy(ies), a general contractor without an enforceable indemnity provision (or one which is itself negligent) will not be able to transfer the risk of loss through insurance as was contemplated by the Court of Appeals in *Kinney v. G.W. Lisk Co.*, 76 N.Y.2d 215 (1990) ("this particular distinction is what renders indemnification, but not insurance-procurement, agreements violative of the public policies underlying General Obligations Law § 5-322.1. While an agreement purporting to hold an owner or a general contractor free from liability for its own negligence undermines the strong public policy of placing and keeping responsibility for maintaining a safe workplace on those parties (see, e.g., Labor Law §§ 200, 240), the same cannot be said for an agreement which simply obligates one of the parties to a construction contract to obtain a liability policy insuring the other." *Kinney* at 218. "Where … a lessor and lessee freely enter into an indemnification agreement whereby they use insurance to allocate the risk of liability to third parties between themselves, General Obligations Law § 5-321 does not prohibit indemnity." *Great Northern Ins. Co. v. Interior Constr. Corp.,* 7 N.Y.3d 412, 419 (2006).

9 *See Northstar Reinsurance Corporation v. Continental Insurance Company*, 82 N.Y.2d 281, 604 N.Y.2d 510 (1993).

10 *Tishman*, 53 A.D.3d at 421.

11 65 N.Y.2d 369, 373, 492 N.Y.S.2d 534, 482 N.E.2d 13 (1985).

12 *Tishman*, 53 A.D.3d 416, 419, 861 N.Y.S.2d 38, 41 (1st Dept. 2008).

13 *Tishman*, 53 A.D.3d 420, 861 N.Y.S.2d at 42, *citing Cheektowaga Cent. School Dist. v. Burlington Co.,* 32 A.D.3d 1265, 822 N.Y.S.2d 216 (4thDept. 2006).



# Defending Under A Reservation of Rights: A Potential Minefield of Conflicts

BY JONATHAN A. JUDD *

A reservation of rights ("ROR") is a means by which an insurer agrees to defend an insured against a claim or suit while simultaneously retaining its ability to evaluate, or even disclaim, coverage for some or all of the claims alleged by the plaintiff.

This discussion will examine typical ROR scenarios and the minefield of challenges presented to defense counsel and clients in claims involving RORs.

Examples of common situations where insurers may issue RORs include the following: 1) some of the allegations in the complaint do not fall within the scope of the policy's coverage, 2) there is an applicable policy exclusion, 3) some of the damages are not covered by the policy, 4) the damages alleged exceed the policy limits, 5) the coverage has been exhausted under an "aggregate" limit of liability, and 6) the policyholder breached a condition of the policy.

ROR letters typically recite a laundry list of reasons the insurer could have for denying coverage and often frighten policyholders who had of course purchased policies thinking that they would be covered in the event of a loss. The insurer is obligated to notify the insured that it may not cover a particular claim, so as to enable the insured to prepare an adequate defense. The ROR letter must explain to the policyholder why a particular provision of the policy, as applied to the facts of the case, could result in the denial of coverage. The letter should quote the relevant policy language that is to be the basis of a possible future denial of coverage.

An insurer's indemnity obligation often cannot be determined until after a suit against the insured is concluded. For example, where the insured is charged with both negligent and intentional conduct, the insured may have coverage for the former but not the latter. Where the insurer's coverage obligations are unclear, it beneficial for the carrier to defend the insured subject to a ROR and, if appropriate, seek a declaratory judgment determining the obligations of the insurer.[1]

The issuance of a ROR allows the insurer the flexibility to fulfill its obligation under the policy to provide a defense while protecting itself by carrying on an investigation which could allow it to raise eventual defenses to coverage and, at the same, alerting the insured as to what actions it needs to take to protect its own interests.

Typically, when an insurer issues a ROR, it retains defense counsel for the insured while simultaneously monitoring the case and coverage issues related thereto either itself or with the help of coverage counsel. However, ROR's may also give rise to a

policyholder's right to independent counsel paid for at the carriers' expense.[2]

ROR letters should be sent as soon as questions of coverage are recognized. Pursuant to Insurance Law § 3420(d), an insurer wishing to disclaim coverage for death or bodily injury must give "written notice as soon as is reasonably possible." The Court of Appeals has held that a 48 day delay in disclaiming is unreasonable, late and renders the disclaimer void.[3] Recently, the Appellate Division recognized that the duty to timely disclaim extends to property damage claims as well.[4]

Such letters should contain, at a minimum:

- The relevant policy language.
- Every potential applicable defense to coverage; i.e., that claims for punitive damages are not covered; that intentional claims (fraud, assault, intentional infliction of emotional distress) are not covered; that a complaint seeking damages in excess of the policy limit is covered only to the limit of the policy.
- If further investigation is required to ascertain whether coverage is available, the Reservation of Rights Letter should state that the insurer reserves the right to disclaim coverage based upon further factual developments (and the investigation must in fact be promptly pursued).
- References to the allegations in underlying complaint.
- Identification of the claims that are covered and those which are not covered.
- Identification of each and every policy exclusion, coverage provision, general condition which may bar coverage.
- The insurer's position regarding coverage.
- Notification to the policyholder that it has the right to independent counsel in the underlying suit. (The value of advising the policyholder of this fact, of course, is if the insured raises a question as to the viability of the defense provided by the insurer at a later time.)
- An insurer will be estopped from raising any defenses known or which should have been known if not included in the letter.[5]
- If new grounds surface during discovery, the insurer should supplement the Reservation of Rights Letter as soon as it learns of the information.

Insurance defense attorneys must be extremely cautious because an insurance company's reservation of rights often presents a classic conflict of interest. Since the insurer may eventually prevail on a coverage issue, it could be perceived to have less initiative to defend a policyholder's claim. Since some of the claims asserted against the policyholder might be covered by insurance and others might not be, an insurer could appear to have more incentive to direct or steer counsel to more vigorously defend those claims not covered by the policy.

Since a defense attorney is often on a carrier's designated panel of litigation firms, and wants to remain there so as to obtain more business, there is a natural inclination for the attorney to want to satisfy the wishes of that insurer. In fact, the Eighth Circuit stated in United States Fidelity & Guar. Co. v. Louis A. Roser Co.,[6] that "the most optimistic view of human nature requires us to realize that an attorney employed by an insurance company will slant his efforts, perhaps unconsciously, in the interests of his real client -- the one who is paying his fee and from whom he hopes to receive future business -- the insurance company."

A Texas high court similarly stated, "[h]e who pays the piper, calls the tune."[7]

Whether a ROR is issued or not, defense counsel assigned by the insurer, of course, owes primary allegiance to the policyholder. Occasionally, however, a conflict may arise when an attorney finds himself caught in the financial and fiduciary tensions between him, his client, and the insurance company which hired him to represent his client.

These entities have what is known in industry parlance as a tripartite relationship, a creature unique to the insurance defense world, in which an insurer assigns counsel to a policyholder, and pays for the defense of that policyholder, although the interests of the policyholder and insurer could be divergent. Carriers who refer cases to defense counsel have an interest in controlling every aspect of the defense in order to minimize their costs and efforts by insurers to do so could interfere with an attorney's supreme duty to his client.

It is important to appreciate and avoid the potential ethical conflicts presented by this relationship in order to preserve the rights and interests of the client. An attorney who does not properly assess and address the ethical constraints of the tripartite relationship could be figuratively staring into the barrel of a gun, facing potential sanctions or even the loss of a client.

The most common scenario in which a defense attorney faces a potential conflict after a ROR is where he learns of information regarding potential coverage defenses.

For example, an attorney may learn that the insured acted intentionally or fraudulently, thereby vitiating coverage under its policy. Ethical opinions in New York provide that a lawyer retained by an

insurance company to represent an insured may not, unless the client consents, give the insurance company information the insurer can use to deny coverage to the client. Any request for information implicating coverage should be passed on to the client, with an explanation of the possible ramifications of responding to the request.

Under the recently enacted New York Rules of Professional Conduct, the requirement of the supreme allegiance to the insured client remains intact. Specifically, 22 NYCRR Part 1200, Rule 5.4 (c) states a "lawyer shall not permit a person who recommends, employs, or pays the lawyer to render legal service for another to direct or regulate the lawyer's professional judgment in rendering such legal services or to cause the lawyer to compromise the lawyer's duty to maintain confidential information of the client under Rule 1.6."

Based on an attorney's ethical obligations, he or she should not report matters that will harm the client by jeopardizing insurance coverage, and the insurer should not require such disclosures as a condition of representing the insured client. 22 NYCRR Part 1200, Rule 2.3 (b).

The attorney's duty to preserve the confidentiality of information under 22 NYCRR part 1200, Rule 1.6 requires the attorney to refuse to disclose certain information to the insurance company absent the policyholder's consent. If the insurer is entitled to obtain certain information, and the policyholder refuses to give counsel the consent to divulge the information, then defense counsel should consider recommending that the client retain separate conflicts counsel to protect the policyholder's rights in a potential coverage dispute with the insurance company.

An attorney who learns of his client's fraudulent acts that may impact coverage is not under a duty to inform the insurance company of the possibility of the fraudulent acts by the insured.[8]

In addition, because such information is learned by a lawyer in the course of his/her professional relationship with a client, such information is confidential and may not be disclosed to an insurance company, without the client's consent.[9]

Whenever conflicting interests exist, dual representation of an insured and an insurer cannot continue without each client's informed consent, and only if competent representation of both interests is possible. 22 NYCRR Part 1200, Rule 1.7(4). When an actual or potential conflict of interest exists, defense counsel must promptly, fairly and fully inform the insured of all the facts and legal consequences regarding the conflicts so the insured can make an intelligent, informed decision whether or not to consent to counsel's continued representation or to seek independent counsel.[10]

After a policyholder's consent to continue representation is obtained, defense counsel should undertake to communicate the nature and scope of the potential or actual conflict of interest to the insurer.[11] In communicating with the insurer, however, defense counsel must take care not to reveal the content of privileged communications with the policyholder. Disclosing such communications is a breach of counsel's duty of loyalty, and may also lead to the insurer being estopped from later denying coverage.[12]

In most circumstances, where consent has been obtained from both policyholder and insurer after full disclosure, defense counsel can continue dual representation of both clients. This may occur even where coverage is in dispute and a defense is provided subject to a ROR if: 1) counsel limits his or her involvement to the liability issues; and (2) avoids any involvement with coverage issues; and (3) the outcome of the subsequent coverage dispute will not depend upon the resolution of important factual issues in the underlying action. If liability of the insured in the underlying action will be resolved based upon factual issues important to the resolution of the coverage dispute, then an irreconcilable conflict of interest exists, and defense counsel must withdraw.[13]

Only after an actual conflict of interest exists can the policyholder demand independent counsel.[14] The most immediate problem arising once it is determined that a true conflict exists requiring the provision of independent counsel is whether the insurer or the policyholder is entitled to select independent counsel. The insurer, who will be funding the defense, will obviously seek to select counsel of its choosing, if for no other reason to assure that the counsel meets certain minimum qualifications. This raises the concern that counsel selected and funded by the insurer may favor the interests of the insurer to the detriment of the policyholder.

The majority of jurisdictions, including New York, grant the insured the right to choose independent counsel, whose reasonable fee is to be reimbursed by the insurer.[15]

## Conclusion

Counsel defending an insured under a ROR must be extremely vigilant to ensure that it maintains his supreme allegiance to his client, the policyholder. It is crucial for insurance defense attorneys to familiarize themselves with the new ethical rules and how they affect the obligations of counsel to their clients once a ROR is issued.

As a practical matter, counsel should also be aware that some carriers take the position that

only the policyholder should tell counsel of the carrier's coverage position and thus, the carriers deliberately omit such information in suit assignment letters. Accordingly, counsel should consider asking their clients from the onset of a case for any correspondence pertaining to the claim including correspondence from the carrier.

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1 See, Commercial Union Ins. Co. v. International Flavors & Fragrances, Inc., 822 F.2d 267, 274 (2d Cir. 1987).

2 Public Service Mut. Ins. Co. v. Goldfarb, 53 N.Y.2d 392 (1981).

3 First Fin. Inst. Co. v. Jetco Constr. Co., 1 N.Y.3d 64 (2003).

4 Village of Brewster v. Virginia Surety Company, Inc., 2010 WL 547082 (3d Dept. 2010).

5 See, Kokonis v. Hanover Ins. Co., 2001 WL 42958 (3d Dep't 2001); Macon v. Arnlie Realty Co., 207 A.D.2d 268, 615 N.Y.S.2d 28 (1st Dep't 1994).

6 585 F.2d 932, 938 n.5 (8th Cir. 1978).

7 State Farm Mut. Auto Ins. Co. v. Traver, 980 S.W.2d 625, 633 (Tex. 1998).

8 See, Opinions of the Committee on Professional Ethics, New York County Lawyers Association, No. 659, June 30, 1983.

9 See, Opinions of Committee on Professional Ethics, New York County Lawyers Association, No. 669 (89-2).

10 Eric M. Holmes, A Conflict Of Interest Road Map for Defense Counsel: Walking An Ethical Tightrope Without A Net, 26 Williamette L. Rev. 1, 61-62.

11 Id.

12 See, e.g., Parsons vs. Continental National American Group, 113 Ariz. 223, 550 P.2d 94 (1976); Employer Casualty Co. v. Tilley, 496 S.W.2d 552 (Tex. 1973).

13 See, Prashker vs. United States Guar. Co., 1 N.Y.2d 584, 154 N.Y.S.2d 910 (1956).

14 See, Public Serv. Mutual Ins. Co. v. Goldfarb, supra.

15 See, Public Service Mutual Ins. Co. v. Goldfarb, supra (when a conflict of interest is probable, selection of attorneys to represent the insured should be made by the insured rather than the insurance company, "whose reasonable fee is to be paid by the insurer.").

# Open Questions on the Duty to Advise of the Right to Select Independent Counsel

BY BARRY R. TEMKIN *

Much has been written about the tripartite relationship among insurance carriers, their policyholders, and insurance defense counsel appointed to represent the former's insureds. Most reported decisions on the topic, particularly in New York, arise in the context of coverage disputes between carriers and their policyholders. This article is not about, and does not purport to address, coverage disputes.

Rather, this discussion addresses the emerging issues presented to carriers and defense counsel on whether there is a duty to advise the policyholder client of the right to independent counsel, and given the current state of the law, what steps counsel can take to best protect their clients and themselves.

## Goldfarb Conflicts

As a matter of substantive law, a conflict may arise between an insurer and a policyholder when some of the claims in a case are covered by the policy, while others are not, and strategic decisions made by defense counsel may affect the insured's interests. In *Public Service Mut. Ins. Co. v. Goldfarb*,[1] a dentist was simultaneously accused of negligent malfeasance, which was covered by the insurance policy, and intentional sexual assault, which was not. The court wrote that:

> [I]nasmuch as the insurer's interest in defending the lawsuit is in conflict with the defendant's interest – the insurer being liable only upon some of the grounds for recovery asserted and not upon others – defendant Goldfarb is entitled to defense by an attorney of his own choosing, whose reasonable fee is to be paid by the insurer.[2]

Over the thirty years since it was decided, *Goldfarb* has begotten numerous progeny, not all of which are consistent. Still unsettled at this time is the issue of whether an insurance carrier is obligated to notify a policyholder of the latter's right to select conflict counsel at the carrier's expense.

In other words, must a carrier affirmatively give an insured the civil equivalent of a *Miranda* warning notifying the policyholder of its right to select independent counsel in the event of a conflict? *Compare Elacqua v. Physicians' Reciprocal Insurers*[3] (carrier must affirmatively and accurately notify insured of right to select *Goldfarb* counsel at carrier's expense), *with Sumo Container Station, Inc. v. Evans, Orr, Pacelli, Norton & Laffan*[4] (neither carrier nor appointed counsel has an affirmative duty to inform insured of its right to select its own counsel at the carrier's expense), *and Coregis Ins. Co. v. Lewis, Johs, Avallone, Aviles and Kaufman*[5] ("Defendants' position that Coregis was obligated to designate separate counsel once it realized that a coverage issue may exist is simply unsupported by New York law.").

## Ethical Duties Under Rules of Professional Conduct

There is little authority specifically addressing the duties of insurance defense counsel under the 2009 Rules of Professional Conduct. RPC 5.4(c) provides: "Unless authorized by law, a lawyer shall not permit a person who recommends, employs or pays the lawyer to render legal service for another to direct or regulate the lawyer's professional judgment in rendering such legal services or to cause the lawyer to compromise the lawyer's duty to maintain the confidential information of the client under Rule 1.6."[6] RPC 1.8(f)(2) similarly proscribes "interference with the lawyer's independent professional judgment" when someone other than the client is paying the fees.

What are a lawyer's duties when presented with a Goldfarb conflict? Should a lawyer retained and paid by the carrier be placed in a position to give the client advice which may be inimical to the interests of the carrier? Under some circumstances, the lawyer may have a longstanding and mutually dependent relationship with the carrier. And in the process of giving a so-called *"Goldfarb Miranda"* warning, a lawyer may, in effect, be advising the client of its right to fire existing counsel, i.e., the lawyer herself.

Thus, the lawyer may, in some circumstances, be conflicted from advising the client about choice of counsel because of a real and substantial conflict with the lawyer's own interests. RPC 1.7(a)(2) prohibits a lawyer, absent waiver, from representing a client where "there is a significant risk that the lawyer's professional judgment on behalf of a client will be adversely affected by the lawyer's own financial, business, property or other personal interests."[7]

But all is not lost. RPC 1.7(b) provides that, notwithstanding a concurrent conflict of interest,

a lawyer may still represent a client if all four of the following factors are met:

1. the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;
2. the representation is not prohibited by law;
3. the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and
4. each affected client gives informed consent, confirmed in writing.[8]

The New York City Bar, in an interesting and helpful ethics opinion, instructs that, under some circumstances, a law firm may limit the scope of its representation of a new client in order to avoid a conflict with an existing client.[9] By extension, a law firm with a direct financial stake in the outcome of a client's decision might be able to advise the client (in writing) to seek advice from another firm as to the existence, significance and waivability of the lawyer's conflict.

New York lawyers may take further guidance from California's experience in resolving what it refers to as *Cumis* conflicts, named after the landmark and legislatively-modified decision in *San Diego Navy Fed. Credit U. v. Cumis Ins. Co.*[10] The California Civil Code, while providing for choice of counsel by the insured in some instances, specifically gives clients the option of waiving that choice and opting for panel counsel selected by the carrier. In so doing, the California legislature has actually prescribed the language necessary to constitute such a waiver: "I have been advised and informed of my right to select independent counsel to represent me in this lawsuit. I have considered this matter fully and freely waive my right to select independent counsel at this time."[11] While the California language is useful, it does not resolve the question of under what circumstances a lawyer may ethically advise the client whether or not to waive its right to select independent counsel.

Of course, yet another option for defense counsel is to avoid giving any advice at all to the client. Many insurance defense counsel have traditionally interpreted their role as simply to defend the claim, and not venture into questions of coverage under any circumstances.

However, this approach worked out to the disadvantage of assigned defense counsel in *Shaya B. Pacific, LLC v. Wilson Elser Moskowitz Edelman & Dicker, LLP,*[12] which upheld the sufficiency of a legal malpractice complaint against a law firm for failing to investigate the existence of excess insurance or give notice to the client's excess carrier. The Appellate Division held that whether a retained insurance defense lawyer has a duty to ascertain excess coverage is a fact-specific determination, which "would turn primarily on the scope of the agreed representation – a question of fact . . .."[13] *Shaya B.* served as a wake-up call to the practitioners of the insurance defense bar, many of whom had assumed that their role was simply to defend – not to advise.

## Conclusion

Public policy behind the ethical rules and case law, in many respects, appears designed to protect policyholders. Moreover, until the many open questions examined in this discussion are resolved, counsel retained by insurance carriers to represent policyholders should keep in mind that their primary ethical duty is to their clients, even if somebody else is paying the lawyer's fees. Moreover, lawyers are

ethically obligated under RPC 1.4 to regularly consult with and inform their clients of the status of the representation. Under some circumstances, counsel may ethically seek to obtain informed consent and waiver for continued representation in a conflict situation, consistent with the Rules of Professional Conduct. Moreover, counsel should ensure that they are not conflicted even from giving advice about conflicts with the carrier.

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1 53 N.Y.2d 392 (1981).
2 *Id.* at 401 (citations omitted).
3 52 A.D.3d 886 (3d Dep't. 2008).
4 278 A.D.2d 169 (1st Dep't. 2000).
5 No. 01 CV 3844 (SJ), 2006 WL 2135782 (E.D.N.Y. July 28, 2006).
6 RPC 5.4(c) (22 NYCRR § 1200 *et seq.*).
7 RPC 1.7 (a) (2), 22 NYCRR Section 1200.0 et seq.
8 RPC 1.7 (b).
9 N.Y.C. Bar Op. 2001-3 (2001).
10 162 Cal. App. 3d 358, 208 Cal. Rptr. 494 (1985).
11 Cal. Civ. Code 2860.
12 38 A.D.3d 34 (2d Dept. 2006).
13 *Shaya B. Pacific,* 38 A.D.3d at 41.

# Additional Insureds – What Does *Pecker Iron Works* Mean to You?

BY GLENN A. KAMINSKA, ESQ.*

We've all heard it stated, an additional insured is "an entity enjoying the same protection as the named insured."[1] It is an important concept, but the statement is not nearly complete. In *Pecker Iron Works v. Traveler's Ins. Co.*,[2] the Court of Appeals reminded the bench and bar that "additional insured" had this "well-understood meaning." Almost four year later, in *B.P. Air Conditioning Corp. v. One Beacon Ins. Co.*,[3] the Court of Appeals ended the debate as to the interpretation of *Pecker*.

In *Pecker* the general contractor sought additional insured status under a policy issued to a subcontractor. Pursuant to contract, the subcontractor agreed to name the general contractor as an additional insured. The subcontractor's policy contained an additional insured endorsement. The endorsement contained a priority of coverage provision, which stated "[t]his insurance is excess over any valid and collectible insurance unless you [the subcontractor] have agreed in a written contract for this insurance to apply on a primary or contributory basis."[4]

The Court of Appeals determined that the general contractor was entitled to additional insured coverage on a primary basis. In doing so, the Court stated:

> When Pecker [the general contractor] engaged Upfront as a subcontractor and in writing provided that Upfront would name Pecker as an additional insured, Pecker signified, and Upfront agreed, that Upfront's carrier-not Pecker's-would provide Pecker with primary coverage on the risk.[5]

The Court's decision was premised upon the "policy provision at issue." Ultimately, the Court's decision resulted in the parties agreeing to co-insurance.[6]

While the effect of the Court of Appeals' decision was clear to the parties involved, the *Pecker* decision led to some confusion for the bench and bar. Following *Pecker,* some came to believe that additional insurance provided by a subcontractor for a general contractor was always to apply on a primary, non-contributory basis with regard to the general contractor's own policy.

Such a finding was made by the Appellate Division – First Department in *B.P Air Conditioning Corp. v. One Beacon Ins. Group.*[7] That Court determined that not only was the additional insured to be provided with a defense, but that "as between [the subcontractor's] policy and any policy covering BP as a named insured, any coverage [the subcontractor's] policy affords BP in the [underlying personal injury action] is primary."[8] It is interesting to note that not all of the policies involved were before the court.

The Court of Appeals put to rest the overly broad interpretation applied by the First Department and others. The Court found that "the Appellate Division erred in finding that One Beacon's coverage is primary and BP's coverage under its own policy is excess."[9] The Court reiterated the long standing principle that "a court must review and consider all of the relevant policies at issue" in order to determine priority of coverage.[10]

When one contracts to name another as an additional insured, they are agreeing to make them "an entity enjoying the same protection as the named insured." Coverage for an additional insured, however, is not necessarily primary and non-

contributory. One must still look to each policies' "other insurance" provisions to determine priority of coverage. While the contracts that one insured enters into with another can require that coverage be provided, it will be the policies of insurance that dictate the scope of such coverage.[11]

What does *Pecker* mean to defense counsel? It means that just because your client is named as an additional insured on another party's policy, does not necessarily mean that the client's own primary coverage will not be coinsurance. The policies involved and the language they employ will dictate coverage.

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1 *Pecker Iron Works v. Traveler's Ins. Co.*, 99 N.Y.2d 391 (2003).

2 *Id.*

3 8 N.Y.3d 708 (2007).

4 see *Pecker, supra.*

5 *Id* at 393-394.

6 see Stephen M. Lazare and Glenn A. Kaminska, *Dispelling the 'Pecker v. Travelers' Myth*, N.Y.L.J, March 14, 2007.

7 33 A.D.3d 116 (1st Dept. 2006).

8 *Id.* at 132.

9 8 N.Y. 3d at 716.

10 *Id.*

11 see Note 6.

# Triggering Unlimited "1B" Coverage in Non-Grave Injury Cases

BY GARY A. ROME *

When Workers Compensation Law § 11, the so called "Grave Injury" statute, became effective in September 1996, common law third party claims against injured workers' employers were barred absent an enumerated grave injury and unlimited "1B" coverage effectively was eliminated from most tort cases.[1] However, an emerging issue now ripe to be addressed by the courts is whether the "1B" coverage under the Workers Compensation policy can again be triggered by circumventing this statute with newly crafted contract language.

Due to the peculiarities of the statute, many kinds of career ending injuries can have huge values without qualifying as "grave injuries." Accordingly, triggering unlimited coverage in these cases is compelling for all sides. However, attempting to do so is not without risk.

Although not limited to the construction accident setting, this issue frequently presents in that scenario.

For example, prior to September, 1996, an owner, general contractor, or other higher tiered contractor found liable under the Labor Law would typically commence a third party action against the injured worker's employer under theories of contractual indemnity as well as common law contribution and indemnity.[2] The contractual claims would usually be covered by the employer's CGL (Commercial General Liability) policy and the common law claims would correspondingly trigger dovetailing unlimited coverage under the so called "1B" portion of the employer's Workers' Compensation policy.

Since enactment of the statute, most third party claims against an employer have been limited to arguments based on written indemnity or additional insured status under an insurance procurement clause. Both additional insured status and contractual indemnity claims were exempted from the grave injury requirement.[3] However, under either theory, such third party actions only triggered an employer's applicable CGL coverage.

In an effort to seek broader coverage for third party claims, a number of large general contractors have made recent attempts to trigger an employer's 1B coverage by revising the wording of certain written indemnification provisions to have employers waive grave injury defenses.

These contractors cite the following wording from the statute as support for their position: "for purposes of this section the terms 'indemnity' and 'contribution' shall not include a claim or cause of action for contribution or indemnification based upon a provision in a written contract entered into prior to the accident or occurrence by which the employer had expressly agreed to contribution to or indemnification of the claimant or person asserting the cause of action for the type of loss suffered."[4]

One example of such a contractual waiver provision reads as follows:

> Subcontractor also expressly agrees that the general contractor and owner, their trustees, officers, directors, members, agents, affiliates, and employees may pursue claims for contribution and indemnification against the subcontractor in connection with any claim brought against the general contractor or the owner in any form for injury and/or death to the subcontractor's

employees or special employees notwithstanding the provisions of § 11 of the Workers' Compensation Law limiting such claims for contribution and indemnification against employers or special employers and the subcontractor hereby agrees to waive the limitations on contribution and indemnity claims against employers or special employers provided in § 11 of the Workers' Compensation Law insofar as such claims are asserted by the general contractor and/or owner, their trustees, officers, directors, members, agents, affiliates, and employees against subcontractor.

Workers Compensation carriers have balked already and issued pre-emptive letters warning that they take the position that this language does not trigger coverage. When the issue is fully litigated, these carriers can be expected to argue that such waivers of the employer's grave injury defense are contractual in nature thus subject to the exclusion for contractual claims typically contained in such policies.

In response, the contractors and CGL carriers will argue that because the Grave Injury Statute abrogated a common law right to seek contribution or apportionment under an employer's 1B coverage, by satisfying the statutory exception for waiving a grave injury defense through an expressed agreement, the contract merely is the form which the statute prescribed for expressing such waivers and thus the waiver is not contractual in nature. In other words, the statute contemplated a return to the pre statute status quo provided an employer expressly waived its grave injury defense to claims for contribution in a written agreement.

The ability to trigger 1B coverage is an important consideration based upon the many pitfalls and difficulties which have arisen since the passage of the Grave Injury Statute in attempting to find coverage under an employer's CGL policy due to the ever changing decisional guidelines and policy language governing claims for additional insured status and contractual indemnity. In addition, even in such circumstances under which an owner, general contractor, or other higher tiered contractor successfully obtained coverage for contractual indemnity or were afforded additional insured status, in high exposure cases, an employer's CGL coverage has often been insufficient to satisfy exposure.

Clearly, one possibility that neither the general contractor nor the employer would want is a court finding that the waiver creates a viable but uninsurable common law claim.

Pending guidance from the courts, it would be prudent for general contractors, employers, and their representatives to consider potential ramifications to these contractual waiver clauses carefully. In an abundance of caution, the employer should notify both its Workers Compensation and CGL carriers for accidents involving an employee.

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1 N.Y. Work. Comp. Law § 11.

2 *See Hawthorne v. South Bronx Community Corp.*, 78 N.Y.2d 433 (1991).

3 N.Y. Work. Comp. Law § 11.

4 *Id.*

# Someone Failed to Procure Insurance - What Now?

BY JOHN V. FABIANI, JR. *

Numerous business relationships such as construction contracts and commercial and residential leases require one of the contracting parties to procure insurance protection for the other. Historically, the intent of the parties has been characterized as either cost allocation or risk allocation. In today's economic environment, it is apparent that the principal purpose is to shift the risk of loss from the party with the primary responsibility under the law, i.e., the owner or general contractor, to the party actually in control of the work or premises, i.e., the subcontractor or tenant. Risk allocation agreements such as this are regularly enforced by New York's courts.[1] The question is, however, what is the practical effect of the failure to comply with a contractual obligation to procure insurance for the benefit of another.

## Kinney Makes The Law Crystal Clear; Failure to Procure Calls For Full Indemnification

In 1990, New York's Court of Appeals decided Kinney v. G.W. Lisk Co.[2] as a result of which insurance practitioners felt comfortable that owners and contractors would be fully protected by the insurance policy purchased by a tenant or subcontractor regardless of whether that policy named the owner or contractor as an additional insured. The Kinney Court was presented with the question of whether an agreement to procure insurance contained in a construction subcontract ran afoul of New York's anti-indemnity statute, GOL § 322.1. The Court held

that because an agreement to procure insurance was not an agreement to indemnify and hold harmless, it did not fall within the scope of agreements barred by GOL § 322.1 and was enforceable as written. The Court of Appeals went on to conclude that because the subcontractor had not procured the insurance it had agreed to procure, it was liable for all of the damages assessed against the contractor.

In reaching this conclusion, the Kinney Court relied on a 1987 decision of the Third Department, Roblee v. Corning Comm. Coll.,[3] and a 1959 Second Circuit decision, Grant v. US.[4]

In Roblee, the contractor argued that the insurance procurement provision should be read to have required it to procure coverage that protected the owner only to the extent that the contractor was negligent. In rejecting this argument, the Third Department reasoned that had that been the intention, it could have been achieved simply by requiring the purchase of insurance coverage for the sole benefit of the contractor. Certainly, the requirement that the insurance protection be broader implied that it was intended to protect the owner in the event that it was negligent as well. Because the contractor breached its obligation to procure insurance for the benefit of the owner, it was obligated to indemnify the owner for its entire liability to the plaintiff, including the costs of defending itself.

Grant, on the other hand, was decided not on indemnity grounds but rather on the issue of whether the United States fit the definition of an insured under a policy procured by a contractor. Although the United States could not obtain indemnification from the contractor, because it fit the definition of an insured under that contractor's policy with Royal Insurance Company, the United States was entitled to be indemnified by Royal.

After Kinney, courts consistently held that a party that failed to procure insurance that it was required by contract to procure was liable for "all resulting damages".[5] Those damages included the damages assessed against the owner or contractor[6] and the costs of defense.[7] Many courts even held that because the obligation to procure insurance was independent of the obligation to indemnify, summary judgment could be awarded on the failure to procure claim even before it was determined whether the owner or contractor was liable to the plaintiff![8]

## Inchaustegui Makes the Law Crystal Clear; Kinney Didn't Mean What Everyone Thought It Meant

In 1996, in Mavashev v. Shalosh Realty,[9] the Second Department gave a preview of what was to come when it modified the Kinney rule, at least insofar as the landlord-tenant relationship was concerned.[10] The Court held that because the owner had procured its own insurance, the damages resulting from the tenant's failure to procure insurance were the costs incurred by the owner in procuring its own insurance.

Then, in 2001, the landscape changed dramatically with the Court of Appeals decision in Inchaustegui v. 666 5th Avenue Limited Partnership.[11] Statewide, no longer was the remedy complete indemnification but rather the remedy was reimbursement for the out-of-pockets costs.

An understanding of how the Court of Appeals came to a decision that appears diametrically opposed to its decision in Kinney starts with examination of Judge Saxe's majority opinion in the First Department in Inchaustegui. There, the Court commenced its analysis of the appropriate remedy by looking at a 1993 First Department decision, Wallen v. Polo Grounds Bar and Grill N.Y., Inc.[12]

In Wallen, the lease provision required the tenant to procure liability insurance and, in the event of the tenant's failure to procure, gave the landlord the option of buying the coverage and charging the tenant back for the cost. The landlord had its own policy. When someone was injured on the leased premises and sued the landlord, the landlord sought summary judgment based on the tenant's failure to procure insurance. The First Department reversed the trial court's award of summary judgment, finding that the landlord's purchase of insurance created a question of fact as to the extent of damages suffered by the landlord as the result of the breach.

Judge Saxe then went on to write that his reliance on the rationale in Wallen was buttressed by two other post-Kinney decisions, Wilson v Haagen Dazs Co.[13] and Noah v. 270 Lafayette Assocs.[14] Even though all of these cases involved leases where there was a right reserved to the landlord to buy the insurance and charge back the tenant, Judge Saxe went on to state that the rule should not be limited to such situation. Rather, because the action sounded in contract rather than tort, the landlord was obligated to mitigate its damages. Thus, if the landlord did, in fact mitigate its damages by purchasing its own insurance, then its remedy was the cost of mitigation, i.e., the cost of purchasing its own insurance and any related costs that were actually out-of-pocket to the landlord.

At the Court of Appeals in Inchaustegui, the respective parties both made compelling arguments. The landlord argued, in short, that the insurance procurement provision was not merely a method of allocating the cost of insurance but was part of a risk allocation scheme that would have been defeated

by limiting its recovery to the commercial remedy of "cover". The tenant argued principally that the landlord suffered no damage because the real party at interest was the landlord's own insurer which had received a premium for the risk that it was trying to pass on to the tenant.[15]

The Court of Appeals agreed with the Appellate Division majority and limited the measure of damages to the landlord's out-of-pocket damages caused by the tenant's breach. It explained away the apparent inconsistency with its decision in Kinney by pointing out that the parties in Kinney did not raise the issue of the insurance coverage available to the landlord, intimating that had the issue been raised, the decision might have been different. However, the Court then went on to point out that the landlord was "the only appellant before us" and was only entitled to be placed in the same position it would have been had the tenant not breached the agreement.

By taking pains to identify the landlord, as opposed to its insurer, as "the only appellant before us" was the Court of Appeals signaling that if the landlord's insurer were a party before it, the Court might be willing to consider the insurer's "out-of-pocket" damages separately from those of the landlord? One would think that in the ensuing ten years of jurisprudence some enterprising insurer would have taken the issue up but if one has, it has not resulted in a reported decision.

## Inchaustegui Is Extended Beyond The Landlord-Tenant Relationship

Although Kinney involved a construction contract, Inchaustegui arose out of the landlord-tenant relationship. Less then two months after Inchaustegui was decided, the First Department applied it to a construction contract in Trokie v. York Preparatory School, Inc.[16] The Court wrote:

> The proper measure of [the owner's] damages for [the contractor's] breach of the subject insurance procurement clause is the full cost of insurance to [the owner], i.e., the premiums it paid for its own insurance, any out-of pocket costs that may have been incurred incidental to the policy, and any increase in its future insurance premiums resulting from the liability claim.[17]

In Wong v. New York Times Company,[18] a compelling argument that mirrored the risk allocation argument made in Inchaustegui was rejected by the First Department and the application of the Inchaustegui rule to construction contracts was confirmed.[19]

From that point forward, the notion that Inchaustegui is all-encompassing appears to have gone without serious challenge and the vast majority of post-Inchaustegui reported decisions involve construction subcontractors having breached their contractual obligation to procure insurance for the benefit of the owner and general contractor.[20]

In Murray v. The New York City Transit Authority,[21] the Appellate Term held that because NYCTA was self-insured, it was entitled to recover all its out-of-pocket costs rather than simply the cost of procuring replacement insurance coverage. The Court rejected the argument of the subcontractor that NYCTA was obligated to look elsewhere for insurance, i.e., to the insurer of another contractor, before it could obtain complete recovery. Acknowledging NYCTA's obligation to mitigate its damages, one of the legal principles that served as the foundation of Judge Saxe's opinion in Inchaustegui, the Court held that requiring NYCTA to look elsewhere for insurance coverage would go beyond the "reasonable exertions"[22] called for by the mitigation principle.

## Who Pays The Bill?

Regardless of the measure of damages awarded for breaching the agreement to procure insurance, what party is responsible for paying those damages once they are awarded? Does the defaulting tenant or subcontractor have insurance coverage for those damages or must it pay out of its own pocket?

The typical general liability policy is triggered by an "occurrence" which is defined as an accident, event or continued repeated exposure that results in bodily injury or property damage.[23] It also contains an exclusion for liability assumed under contract unless that contract is an "insured contract". An "insured contract" is generally defined to include, *inter alia*, a lease and a contract where you assume the tort liability of another.

Surprisingly, there is a dearth of reported decisions in New York on the subject of whether damages awarded for breach of the obligation to procure insurance is covered under a general liability policy.

Guidance as to whether a defaulting tenant has coverage may be taken from the 2004 First Department decision in Hotel des Artistes, Inc. v. General Acc. Ins. Co. of America.[24] In rejecting an insurer's refusal to defend and indemnify its insured in a suit for damages for failing to repair a leased premises that had been damaged, the Court wrote:

> [s]ignificantly, nowhere in the policy's coverage provisions are there any restrictions on the source or theory of the insured's legal liability. For instance, nowhere is it said that the "insured's legal obligation to pay damages because of property damage" is limited to the insured's liability in tort. Nor is there any other language in the coverage provisions that could be interpreted to

> exclude liability that is derived from a contractual obligation. In short, nothing in the coverage terms of the policy even implies a distinction between liability acquired by contract or in tort.

This would seem to confirm that a tenant found liable to its landlord for breach of a lease obligation to procure insurance coverage would be insured under its general liability policy *to the extent that the damages assessed against it were for bodily injury or property damage*.

Prior to Inchaustegui, when the measure of damages for breach constituted the full personal injury or property damage awarded against the landlord, there would appear to have been little doubt that the tenant's general liability policy would have covered it for the loss. Since Inchaustegui, which made it clear that the measure of damages was not directly related to the underlying personal injury or property damage, it would appear that the tenant would not have coverage for any breach of contract damages awarded against it.

The exception would be if, similar to the situation in Murray, the owner is not fully insured, i.e., is a self-insured or has a deductible or self-insured retention. Then, in that case, the tenant should have coverage under its own general liability policy for that portion of any award against it that is for bodily injury or property damage but not any related breach of contract damages.

Whether a defaulting subcontractor is covered requires a different analysis. Under the standard ISO form Contractual Liability Exclusion wording,[25] contractual liability insurance applies only if the insured has assumed liability for damages in a contract or agreement and that contract or agreement falls within the definition of "insured contract".[26] As "necessary attorneys fees and litigation expenses" are included as part of bodily injury or property damage, if the contract to procure insurance is an "insured contract", the defaulting subcontractor could have broader protection than the defaulting tenant.

In sum, regardless of whether the defaulting party is a tenant or subcontractor, the determination of whether that party has coverage for its breach of the obligation to procure insurance will turn on two critical factors: the components of the damages award and the language of the insurance policy.

## Conclusion

Notwithstanding the fact that the procurement of insurance requirement in the commercial lease originated as a cost-sharing device whereas the procurement of insurance requirement in the typical construction contract is part of a pure risk-allocation scheme, the Courts of New York treat them the same for purposes of assessing the damages recoverable for breach of that obligation.

Thus, for the foreseeable future, the measure of damages recoverable for breach will be limited in all cases to the out-of-pocket loss suffered. Whether there is a realistic opportunity to recover those damages depends on the elements of the damages and either the resources available to the defaulting party or the terms of its general liability policy. The moral of the story is an ounce of prevention is worth a pound of cure; owners and contractors should make sure that their tenants and subcontractors have complied with their obligation to procure insurance and that the insurance that has been procured provides the coverage requested.

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1 *See, e.g.,* Hogeland v. Sibley, Lindsay & Curr Co., 42 N.Y.2d 153 (1977).

2 76 NY2d 215 (1990).

3 134 A.D.2d 803, *lv. den.,* 72 NY2d 803 (1987).

4 271 F.2d 651(1959).

5 Morel v. City of New York, 192 A.D. 2d 428 (1st Dep't 1993); Tkacs v. Dominion Constr. Corp., 278 A.D. 2d 486 (2d Dep't 2000).

6 Morel, *supra*; Spencer v. B. A. Painting Co., 224 AD 2d 307 (1st Dep't 1996);

7 Encarnacion v. Manhattan Powell, LP, 258 AD 2d 339 (1st Dept 1999); Darowski v. High Meadow Co-op No. 1, 239 A.D. 2d 541 (2d Dep't 1997); Ulrich v. Oneida Horizon Redevelopment Corp., 213 A.D. 2d 988 (4th Dep't 1995); DiMuro v. Town of Babylon, 210 A.D. 2d 373 (2d Dep't 1994).

8 McGill v. Polytechnic Inst., 235 A.D. 2d 400 (2d Dep't 1997); Spencer, *supra.*

9 233 A.D.2d 301, 649 N.Y.S.2d 718 (2d Dep't 1996).

10 In Tkacs v. Dominion Constr. Corp., *supra*, decided 4 years after Mavashev, the Second Department held that in a construction contract setting, the measure of damages required under Kinney was "all damages resulting from the breach, including a defense in the underlying personal injury action, indemnification for its liability to plaintiff, if any, and the costs it has incurred in defending the plaintiff's action."

11 96 N.Y.2d 111, 725 N.Y.S.2d 627 (2001).

12 198 A.D.2d 19 (1st Dep't 1993).

13 201 A.D. 2d 361 (1st Dep't 1994).

14 233 A.D. 2d 108 (1st Dep't 1996).

15 This raises the intriguing question of what if the landlord and its insurer were to put on evidence that when the insurer underwrote the landlord's policy, it based its premium calculations, in part, on the risk transfer scheme used by the landlord as part of its standard lease and that risk transfer scheme included contractual indemnification and procurement of insurance? As the real party in interest would the insurer also be entitled to recover the increased premium that it would have charged had it been aware that the risk transfer scheme did not include insurance procurement obligations on the part of the tenant?

16 284 A.D.2d 129 (1st Dep't 2001).

17 This begs the question of what the "appropriate remedy" would be if the cost of insurance exceeded the amount of the personal injury judgment.

[18] 297 A.D.2d 544 (1st Dep't 2002).

[19] The argument that the insurer's subrogation rights needed to be protected was made and apparently rejected by the Court in Wong. It is difficult to know what the result would have been had the insurer actually been a party.

[20] *E.g.*, Aragundi v. Tishman Realty & Const. Co., Inc., 68 A.D.3d 1027 (2d Dep't 2009); Quick v. City of New York, 24 Misc.3d 1210(A) (Sup. Ct. King County 2009); Bryde v. CVS Pharmacy, 61 A.D.3d 907 (2d Dep't 2009); Pepe v. Center for Jewish History, Inc., 19 Misc.3d 1130(A)(Sup. Ct. New York County 2008); Murray v. New York City Transit Authority, 20 Misc.3d 5 (Sup. Ct., App. Term, 2nd and 11th Judicial Districts 2008); Maternik v. Edgemere By the Sea Corp., 19 Misc.3d 1118(A) (Sup. Ct. Kings County 2008).

[21] 20 Misc.3d 5 (Sup. Ct., App. Term, 2nd and 11th Jud. Dist. 2008).

[22] Citing Holy Props. v. Cole Prods., 87 N.Y.2d 130, 132 (1995) and Janowitz Bros. Venture v. 25-30 120th St. Queens Corp., 75 A.D.2d 203 (1980).

[23] Because there are numerous policy forms used by insurance companies in the admitted and non-admitted market it is impossible to address all of them in this article.

[24] 9 A.D.3d 181 (1st Dep't 2004).

[25] There is no coverage for bodily injury or property damage in cases where the insured must pay damages based on assuming liability in a written contract or agreement. However, coverage does apply to liability for damages:

The insured would have had if there was no contract or agreement; or

That the insured assumed in an insured contract or agreement, subject to the bodily injury or property damage occurring after the contract or agreement was executed. This includes necessary attorney fees and litigation expenses incurred by or for a party other than the insured determined to be damages because of bodily injury or property damage, as long as: s

- The liability to the party for the cost of that party's defense is assumed in the same insured contract; and
- The attorney fees and litigation expenses are for the defense of that party against a civil or alternative dispute resolution proceeding in which damages covered by this insurance are alleged.

[26] That part of any other contract or agreement pertaining to your business (including an indemnification of a municipality in connection with work performed for a municipality) under which you assume the tort liability of another party to pay for "bodily injury" or "property damage" to a third person or organization. Tort liability means a liability that would be imposed by law in the absence of any contract or agreement.

# Taking Control of Priority of Coverage

BY LISA SHREIBER *

General contractors, construction managers and site owners (collectively "Owner") seeking to enforce priority of coverage requirements must make sure their subcontractors' policies contain language which incorporates these requirements. Contractual priority of coverage requirement will be rendered ineffective if contained solely in the trade contracts, and not incorporated by reference into the relevant policies.[1]

Most Owners require that subcontractors name them as an additional insured on both the subcontractor's commercial general liability ("CGL") and excess insurance policies. The subcontracts often contain a further requirement that the subcontractor's policies apply on a primary and non-contributory basis with the Owner's own policies.

The New York courts, however, have deemed such "contractual prioritization requirements" essentially meaningless in holding that a policy's priority vis-à-vis other policies is controlled solely "by the relevant policy terms, not by the terms of the underlying trade contract that required the named insured to purchase coverage." [2] This is commonly referred to as horizontal exhaustion.

However, there are steps the parties can take to avoid horizontal exhaustion and effectively imbue the "contractual prioritization requirements" to avoid the horizontal exhaustion rule.

Owners must require that subcontractors have their policies endorsed to incorporate the "contractual prioritization requirements" by reference. Endorsements which accomplish this goal are increasingly being offered as standard forms, and, of course, are always available as manuscript endorsements. Through the addition of these endorsements, insurers will be forced to acknowledge and honor the contracting parties' intentions regarding priority of coverage.

The most common form of additional insured endorsement in subcontractor-issued CGL policies are broad forms which incorporate as additional insureds any person or organization the named insured was "required to by written contract" to name as an additional insured. These broad form endorsements, by design, refer to the "written contract's" insurance procurement requirements in order to determine additional insured status. In order to set up priority of coverage, the endorsement must go a step further and state that coverage for an additional insured (i.e. Owner) will apply on a primary, noncontributory

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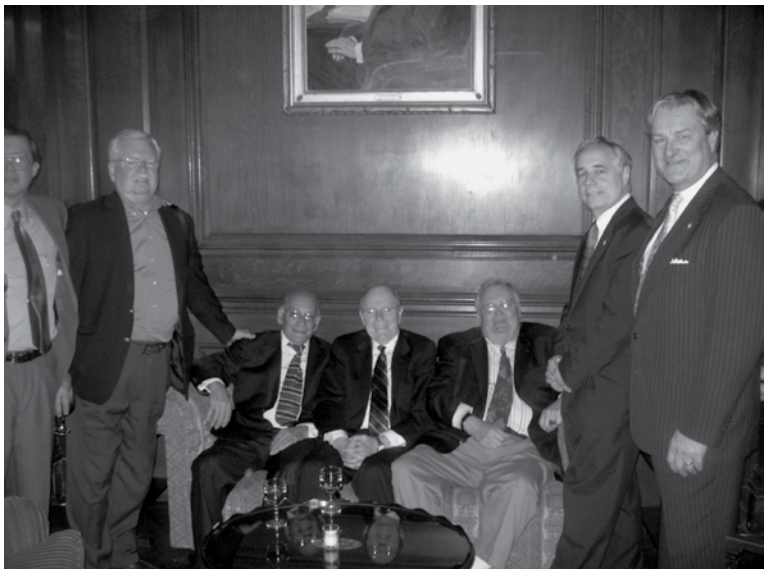
# Past Presidents' Dinner

Christopher Keane, Timothy Keane, and Thomas Keane

Speaker Richard Dawson, Past Presidents Robert Quirk and Anthony McNulty, and Board Member Teresa Klaum.



Past Presidents Andy Zajac, Kevin McCormick, Ralph Alio, John Moore, Roger McTiernan, Ed Hayes, and John McDonough

Speaker
Richard W. Dawson

# November 17, 2009

**Past Presidents Kevin McCormick, Robert Quirk, Ralph Alio, Roger McTiernan, Ed Hayes, President Timothy Keane, Past Presidents Kristin Shea, Anthony McNulty, Andy Zajac, Tom Maroney, and Kevin Kelly.**

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basis where the contract so requires. Hence, the endorsement will refer back to the contract not only for the parties' intentions regarding additional insured status, but also for priority of coverage.

Likewise, it is vital that the subcontractor's excess policy be endorsed to ensure that the Owner also gets primary and noncontributory coverage from that policy. This will ensure that the Owner's policies will not be called upon to pay a cent until the subcontractor's coverage is exhausted. Again, one way to accomplish this is to incorporate the "contractual prioritization requirements" into the subcontractor's excess policy by reference.

This is tricky with excess policies as they generally do not contain an additional insured endorsement which sets out the parameters of additional insured coverage. Instead, they define "insured" to include anyone qualifying as such under the Scheduled Underlying CGL Insurance policy and contain an "other insurance" provision that makes them excess to any other coverage available to the additional insured.

Based on their "other insurance" provision, most excess carriers will argue that their policies apply in excess of the Owner's CGL policy, and either on a coinsurance basis or in excess of the Owner's own excess policy, even where the Scheduled Underlying CGL Insurance contains "contract deferring priority language."

Therefore, to ensure priority of coverage, an Owner must be proactive. It must request that all subcontractors' excess policies be endorsed to include "contract deferring priority language" which states that the policy will apply after exhaustion of the Scheduled Underlying CGL Insurance, and before application of the additional insured's own coverage.

Without the inclusion of such "contract deferring priority language", the excess coverage afforded an additional insured will likely be found to apply after application of the Additional Insured Owner's own CGL coverage, and on a coinsurance basis with the Owner's own excess coverage.[3]

Thus, Owners who seek to effectively enforce the priority of coverage language included in their subcontracts, must address the issue proactively, before a project begins, and not after an accident occurs. The Owner should first advise subcontractors that they are required to endorse both their primary CGL and excess policies to include "contract deferring priority language", and provide them with the specific language to use. Second, the Owner should require that all subcontractors provide copies of the necessary policies prior to commencement of the project.

Finally, the Owner should review the policies prior to project commencement to ensure that the required "contract deferring priority language" has been included. By following these simple steps, an Owner can (1) effectuate the priority of coverage requirement contained in the trade contract, (2) protect its own insurance coverage limits for future use, and (3) stabilize or even reduce its insurance premiums.

* **Lisa Shreiber** is a member of Cozen O'Connor.

1 *Bovis Lend Lease LMB, Inc. v. Great American Insurance Company*, 53 A.D.3d 140, 855 N.Y.S.2d 459 (1st Dept 2008); *Tishman Const. Corp. of New York v. Great American Ins. Co* , 53 A.D.3d 416, 861 N.Y.S.2d 38 (1st Dept. 2008).

2 *Bovis Lend Lease LMB, Inc. v. Great American Insurance Company*, 53 A.D.3d 140, 855 N.Y.S.2d 459 (1st Dept 2008).

3 *Bovis Lend Lease LMB, Inc. v. Great American Insurance Company*, 53 A.D.3d 140, 855 N.Y.S.2d 459, (1st Dept 2008); *Tishman Const. Corp. of New York v. Great American Ins. Co.*, 861 N.Y.S.2d 38, 53 A.D.3d 416 (1st Dept. 2008).

# Spotting Illusory Downstream Coverage

BY WILLIAM G. KELLY *

In construction site litigation, the owner and general contractor for the project can be held statutorily liable under the Labor Law of the State of New York. It is imperative for the general contractor to be able to transfer this risk to the appropriate subcontractors. This can be accomplished through an appropriate contractual indemnification clause, common law indemnification or through the procurement of insurance by the subcontractor, which provides coverage for the owner and general contractor.

Certificates of Insurance are used in the construction industry in order to facilitate the actual commencement of the work. Too often, the owner and general contractor rely solely upon a Certificate of Insurance as proof that they are additional insureds under the subcontractor's policy.

The reliance on certificates by contractors is often to their detriment. Too many times contractors discover only after an accident occurs, that the certificate is quite worthless. Contractors find out that the coverage that was allegedly provided to them by a subcontractor is in fact illusory. The failure of

the contractor to make sure that his subcontractors have the appropriate insurance and the appropriate endorsements at the start of a job will result in the contractor's own insurance paying the loss with the resulting increase in premiums to the contractor.

A Certificate of Insurance is not an insurance policy but is merely evidence of a contract for insurance. It is not conclusive proof that the contract of insurance exists and is not in and of itself a contract to insure.[1] Moreover, most Certificates of Insurance contain a statement that the certificate is not an insurance policy and does not amend, extend or alter the coverage afforded by the policies listed.

Arguments have been made successfully in the Appellate Division of the Supreme Court, Third Department, that the issuance of a certificate by an insurance company[2] or by an agent[3] authorized to bind the insurance company may, in certain circumstances, create an estoppel. In order to proceed with this estoppel argument, you would need to subpoena the agency agreement for that agent to determine if it the agent had binding authority. However, if a policy has been cancelled, coverage cannot be created by estoppel.[4] This estoppel argument has not been adopted by any other Department of the Appellate Division.

Assuming that an insurance policy has been issued to a subcontractor, the owner and general contractor still need to know if in fact they were named as an additional insured and whether the policy is subject to any exclusions, which may negate that coverage.

At the present time, several insurance companies are issuing comprehensive general liability policies, which exclude coverage when one of their employees is involved in an accident. In effect, this makes their policy worthless in any construction setting accident involving their own employees. While the policy may provide coverage for claims brought by pedestrians, this employee exclusion leaves the policyholder with a significant gap in coverage.

In a common scenario, an owner and general contractor are sued under the Labor Law 240 statute after a subcontractor's employee has fallen off a ladder or a scaffold. The owner and general contractor are barred from commencing a common law indemnification or contribution claim against the subcontractor because the subcontractor's employee has not sustained a grave injury as defined by Worker's Compensation Law Section 11. The owner and general contractor then commence a contractual indemnification claim against the plaintiff's employer only to be met by a disclaimer of coverage by the subcontractor's CGL carrier as a result of an employee exclusion in the policy. The insurance carrier for the general contractor is then left paying for the claim with the resulting increase in premiums.

In an excellent discussion of this situation, Judge Victor of the Supreme Court, Bronx County in Fort Washington Ave. v. Utica First,, referred to these policies as misleading and worthless in the context of a construction site accident.[5] Judge Victor summarized the problem and noted that the owner and general contractor need to exercise due diligence at the start of a construction project in order to make sure that the applicable insurance policy is obtained by their subcontractor. Judge Victor stated:

> "while the insurance policy may have been misleading and rendered meaningless due to the exclusions, Fort Washington [owner] and DNA [general contractor] nevertheless had a duty to do a due diligence review of the policy presented by Rauman [subcontractor]. Had they read the policy when it was first presented, they may have observed the exclusion and rejected the policy as not in compliance with the construction contract requirements. Having failed to do so, they left themselves exposed and there is no public policy mandate, which the Court can utilize to rescue them or the injured worker if these entitles do not have sufficient coverage and/or the ability to pay a damage award. In that regard, the Court notes that because of the absence of any statutory mandate, Utica First, the defendant herein, has been repeatedly successful in having its insurance policy exclusions judicially upheld."

Judge Victor further wrote, "as stated above, the Court is sympathetic to the argument advanced by Fort Washington that the exclusions resulted in only an illusion of coverage. Unfortunately, this Court is constrained by the decision of the Court of Appeals in Slayko, supra,[6] to enforce the contract with its exclusions as written by defendant Utica First and accepted by the plaintiff."

In the Fort Washington case, the general contractor was not specifically challenging the exclusions as ambiguous and inapplicable but rather, arguing that the exclusions themselves are violative of public policy in that they create only an illusion of coverage in a construction site setting. Judge Victor held that these exclusions do not violate public policy.[5, 7]

The written decision by Judge Victor in the Fort Washington case should be required reading for anyone practicing in the field of construction site litigation. Judge Victor not only analyzes the issue but proposes his own solution. He proposes a standard policy, which would be a construction site policy that all parties to a construction site project could rely upon so that they could concentrate their expertise of performing construction work and not spend their time analyzing

the exclusions in a subcontractor's policy.

Examples of illusory downstream coverage abound. In addition, to complete employee exclusions that omit the usual give back for insured contracts, some carriers also issue "five borough exclusions" for work in New York City. Moreover, some carriers take the position that their policyholder down stream subcontractors have to satisfy the policy conditions as to a deductible or self insured retention before they recognize the additional insured status of the owner or general contractor. Also, some carriers are known to issue policies with minimal limits as low as $15,000.

The employee exclusions have been upheld [8] and do not violate public policy[9] even though as Judge Mazzarelli noted in a recent dissent the Court's interpretation of the employee exclusion in the particular case before her, "would defeat this purpose by depriving the insured of coverage for injuries to employees of subcontractors."[10] The other illusory or limited coverage policies may well be upheld in future decisions as well.

As noted above, owners and general contractors are now faced with the choice of accepting Certificates of Insurance and moving the project forward or actually reviewing their subcontractor's policies of insurance in order to make sure the coverage is not illusory. The first step for the general contractor is to understand that the Certificate of Insurance provided by the subcontractor does not mean that the subcontractor has the correct policy or that the general contractor has in fact been named as an additional insured on the policy. The next step is for the general contractor to understand that there are multiple forms of additional insured endorsements, some of which provide coverage, many of which don't.

In consultations with general contractors, they should be advised that if in fact they are an additional insured on the subcontractor's policy, an additional insured endorsement was added to the subcontractor's policy or the subcontractor has a blanket additional insured endorsement. In either case, preferably they should obtain a copy of the additional insured endorsement and read it.

In this age of computers, policies may be on line and all policies and endorsements can be scanned and forwarded to the general contractor, although even first tier carriers can be slow to issue policies. In fact, in recognition of systemic delays, the Insurance Department issued an advisory Circular Letter No. 20 on October 16, 2008 requiring carriers to promptly issue and deliver policies within 30 days from inception. Nonetheless, problems in persist for policyholders timely obtaining copies of their policies.

Moreover, a general contractor may have dozens of subcontractors, or more. Thus, there may well be issues of limited resources and time constraints to obtain all necessary policy information before work begins.

If a general contractor deals with a subcontractor on a regular basis, they may want to suggest that the subcontractor obtain a blanket additional insured endorsement with the appropriate language, which is triggered every time a purchase order or a contract is signed.

Lastly, a general contractor can rely upon the language in the written contract with the subcontractor with respect to the procurement of insurance but the contractor should be aware that the failure of the subcontractor to adhere to the terms of the contract with respect to the procurement of insurance will provide only limited relief in a breach of contract litigation.[11]

As highlighted above, the courts hands are tied to correct illusory policies. They simply cannot rewrite policies that have been issued before the claim arises. Accordingly, while there are practical realities of time constraints, limited resources and difficulties obtaining policies, owners and general contractors who don't know the terms of at least the subcontractors additional insured endorsements, may well find out the hard way that the subcontractors insurance procurement obligations have been unmet. Moreover, the remedy for the breach of contract to purchase is very limited and the owners and general contractors' only real remedy may well be limited to their own insurance which is neither the expected nor desired result.

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1 Horn v. Aetna, 255 A.D.2d 443 (1st Dept., 1996). American Ref-Fuel v. Resource, 248 A.D.2d 420 (2nd Dept., 1998); Gibbs v. East 34th Street, 16 Misc.3d 1135A (Supreme Court, Bronx County, 2007).

2 Bucon v. Pennsylvania, 151 A.D.2d 207 (3rd Dept., 1989).

3 Lenox v. Excelsior, 255 A.D.2d 644 (3rd Dept., 1998).

4 Wainwright v. Charlew, 302 A.D.2d 784 (3rd Dept., 2003).

5 720-730 26 Misc.3d 503 (Supreme Court, Bronx County, 2009).

7 Utica First v. Santagata, 66 A.D.3d 876 (2nd Dept., 2009).

8 Bassuk Brox. V. Utica First, 1 A.D.3d 470 (2nd Dept., 2003). Sixty Sutton v. Illinois Union, 34 A.D.3d 386 (1st Dept., 2006).

9 Moleon v. Kreisler, 304 A.D.2d 337 (1st Dept., 2003).

10 Nautilus v. Matthew, 893 N.Y.S.2d 522 (1st Dept., 2010).

11 Inchaustegui v. 666 5th Avenue, 96 N.Y.2d 111 (2001).

# Potential Ethical Dilemmas Facing Defense Counsel in the Tripartite Relationship

BY MELISSA WALTERS, ESQ. *

The relationship between an insurance company, its policyholder, and the defense attorney retained by the insurance company to represent the insured, is commonly referred to as the tripartite relationship. As the title implies, the relationship consists of three parts; the relationship between insurer and policyholder, the attorney and the policyholder and the attorney and the insurer.

This discussion will examine the nature of the tripartite relationship, common scenarios where conflicts and ethical dilemmas may arise and how those pitfalls may be avoided.

The relationship between the policyholder and the insurer is governed by the insurance contract. The insurance contract defines the responsibilities of each party. In the case of the policyholders, the obligations include prompt payment of premiums, timely notice and cooperation. In the case of the insurer, the responsibilities include providing the policyholder with a defense and indemnity against claims for covered losses. In conjunction with the obligation to defend, the insurance contract authorizes the insurer to retain defense counsel, to control the defense and to settle claims, commonly without the policyholder's consent.

The defense attorney is not a party to the insurance contract. Rather, the relationship between the attorney and the insured is governed by the laws of agency. The attorney's ethical obligations to the insured are dictated by model and/or state rules governing professional conduct.

The relationship between attorney and insurer is dictated by the retainer agreement. In the insurance defense situation, a retainer agreement often confers upon the insurer the status of client as opposed to third-party payor, which an insurer may prefer, as it allows the insurer to control the defense and to gain the benefit of evidentiary privileges.[1]

While the interests of both policyholder and insurer may initially be aligned (generally prompt and successful resolution of claims and litigation), potential conflicts can materialize into actual conflicts that raise ethical considerations for the defense attorney. The approach to resolving such conflicts begins with a basic understanding of who the client is and, in the case of a dual client scenario, to which does he owe a paramount duty of loyalty.

## One Client or Two?

Of the states that have addressed the issue of who an attorney's client is in the tripartite relationship, approximately twenty states have determined that the attorney has only one client, the policyholder, while approximately twenty-one states view the attorney as having two clients, the policyholder and the insurer. New York State has traditionally followed the former approach in viewing the tripartite relationship as involving one client, the insured. Therefore in New York, while a retainer agreement may impose upon the defense attorney a duty of loyalty to both the insurer that retained him and the insured, in the event a potential conflict materializes into actual conflict, the duty to the insured takes precedent.[2]

## The Defense Attorney's Approach to Resolving Actual Conflicts

The newly enacted New York Rules of Professional Conduct, modeled after the ABA Model Rules, maintain that a defense attorney may enter into a tripartite relationship despite the potential for numerous conflicts of interest that may arise.[3] However, once a conflict actually materializes, the attorney is ethically constrained from taking a position adverse to the policyholder, even if in the best interests of the insurer.

By way of illustration, what should a defense attorney do when a policyholder refuses to appear for deposition or to produce court ordered items of discovery and confides to the attorney that such disclosure will personally or professionally injure him? Unquestionably, the attorney owes a contractual duty of loyalty to the insurer to zealously defend the suit and to minimize loss.

However, simultaneously, he owes an ethical duty to the policyholder not to reveal confidences or to engage in other conduct harmful to the insured. Therefore, if the information revealed to the attorney was provided by the policyholder with an expectation of confidentiality, the attorney should refrain from divulging the policyholder's confidences to the insurer, explain to the policyholder that his testimony would minimize loss in the liability suit, and recommend that he consult with independent counsel (as the policyholder's decision not to cooperate could result in loss of coverage). Nonetheless, if the policyholder persists in his refusal, and the insurer

does not otherwise exercise its right to terminate the representation based on the insured's lack of cooperation, the defense attorney should withdraw.[4]

Another commonly encountered conflict is presented when an insurer wishes to settle a claim and the policyholder is opposed. If the policyholder stands fast in opposition, even at the expense of jeopardizing coverage, an attorney may believe he is ethically constrained from settling the matter and may seek to withdraw. This despite the fact that in New York, the Court of Appeals has recognized that when authorized to do so by the insurance contract, an insurer would not bear any liability to the insured for bad faith in settling a claim (within the policy limits) without the policyholder's consent.[5]

Yet another classic conflict of interest commonly encountered by the defense attorney arises when an insurer acknowledges its duty to defend a policyholder but issues a reservation of rights (the insurer reserves its right to disclaim its duty to defend and indemnify the policyholder). Such a scenario may create an actual conflict for the defense attorney from inception.

In New York, if a reservation of rights is based on issues independent of the facts to be determined in the underlying action (such as late notice), the defense attorney, in consenting to the tripartite relationship, does not run afoul of his ethical duties to the policyholder.[6] For example, no conflict would exist entitling both a motor vehicle lessee and operator to independent counsel in an underlying personal injury action where each share a common goal with the insurer to defeat liability and the issue of whether a rental agreement was breached was of no consequence to the defense of the underlying liability claim.[7]

By contrast, if a reservation of rights is issued as to certain claims asserted against the insured for which no coverage is afforded under the policy and the issue as to coverage is intertwined with the insured's liability (for example, whether the insured's conduct was negligent versus intentional), the New York State Court of Appeals has acknowledged a conflict compromising the defense attorney's loyalty.[8]

The Appellate Division, Fourth Department's holding in *State Farm Mutual Auto Insurance Company v. Van Dyke* is illustrative.[9] There, the Court determined that the defendants in a personal injury action, a motor vehicle owner and operator, were entitled to independent counsel to defend both claims of negligent and intentional conduct where the defendant operator had pled guilty to vehicular assault in a criminal action. In such a scenario, it is clear that insurance policy provisions would make it advantageous to the insurer to have the defense attorney tailor his defense to have any liability against the insureds hinge upon non-covered claims. Hence, the insurer's defense attorney is ethically constrained from representing the insured and the policyholder should have a right to select independent counsel.[10]

## Conclusion

This discussion addresses but just a few examples of conflicts that may arise for a defense attorney who consents to the tripartite relationship. When an actual conflict does arise, the defense attorney may resort to state specific case law, insurance law, rules and ethics opinions, the Restatement (Third) of the Laws Governing Lawyers as well as model and state specific rules of professional conduct for guidance as to appropriate conduct in response. However, as a general rule, in response to an actual conflict between insurer and insured, the New York defense attorney is reminded that the practice of law, while a business, is simultaneously a profession. As such, he must resist the tendency to favor the interests of the insurer and be prepared to honor the applicable rules governing professional responsibility.

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1 Charles Silver and Kent Syverud, *The Professional Responsibilities of Insurance Defense Lawyers*, 45 Duke L.J. 255, 278 (Nov. 1995).

2 *Feliberty v. Damon*, 72 N.Y.2d 112, 531 N.Y.S.2d 778 (1988); *Jackson v. Trapier*, 42 Misc.2d 139, 247 N.Y.S.2d 315 (Sup. Ct. Queens Cty. 1964).

3 New York Rules of Professional Conduct Rule 1.8(f) (2009).

4 Silver and Syverud, *supra*, 45 Duke L.J. at 360; New York Rules of Professional Conduct Rule 1.6 (2009).

5 *Feliberty v. Damon*, *supra*.

6 Warren Seifert, Jim Hogan, Douglas Hayden and Kenneth Brownlee, *Ethical Obligations and Prohibitions Facing Counsel*, NYSBA Torts, Insurance & Compensation Law Section Journal, Winter 2001, Volume 30, No. 1 53, 58.

7 *See ACP Services Corp. v. St. Paul Fire and Marine Insurance Company*, 224 A.D.2d 961, 637 N.Y.S.2d 566 (4th Dep't 1996).

8 *Public Service Mutual Insurance Company v. Goldfarb*, 53 N.Y.2d 392, 442 N.Y.S.2d 422 (1981).

9 247 A.D.2d 848, 668 N.Y.S.2d 821 (4th Dep't 1998).

10 *See Golotrade Shipping and Chartering Inc. v. Travelers Indemnity Company*, 706 F. Supp 214 (S.D.N.Y. 1989)(the right to select independent counsel is necessary where the question of insurance coverage is intertwined with the insured's liability and the defense attorney's duty to the insured would require that he defeat liability on any ground while his duty to the insurer would require that he defeat liability only upon grounds that would render the insurer liable).

# A Cautionary Tale: Tishman Construction Corp. of New York v. Great American Insurance Company

BY SCOTT E. MILLER * AND RICHARD C. IMBROGNO **

In 2008, the First Department rendered two decisions that reemphasized the importance of incorporating both additional insured and contractual indemnification clauses in construction contracts in order to obtain risk transfer.

First, in April 2008, the First Department decided *Bovis Lend Lease LMB, Inc. v. Great American Ins. Co.*,[1] holding that the provisions of the insurance policies governed priority and take precedence over the corresponding terms of trade contracts. There, the Court analyzed the specific provisions of the policies involved, including their respective premiums, to ascertain which policies were intended to provide true primary coverage and which policies were excess.[2]

More importantly, the Court recognized in *dicta* the argument that regardless of which policies were primary, and which were excess, the excess carrier may end up ultimately providing coverage that ultimately ends up paying a claim on the basis of contractual indemnification.[3] Specifically, the Court stated that the contractual indemnity "scenario's playing out in the long run does not have the effect of negating the priority of coverage among the applicable policies arising from the terms of those policies" at that stage.[4]

Accordingly, *Bovis,* which was a declaratory judgment action seeking only the order of the policies in question, did not resolve the tension between contractual indemnity and priority of coverage.

The Court subsequently faced similar issues in July 2008 in *Tishman Construction Corp. of New York v. Great American Insurance Company*,[5] a cautionary tale about ensuring that both additional insured status and contractual indemnification arguments are presented to, and addressed by, the court.

There, Tishman Construction Corp., ("Tishman"), was retained by Carnegie Hall as the General Contractor ("GC") for the construction of a new music hall. Tishman procured a general liability policy from National Union Fire Insurance Company ("NUFIC") with a $1 million limit per occurrence in accordance with its contract with Carnegie Hall and named Carnegie Hall as an additional insured.

Tishman then subcontracted the excavation, foundation, structural demolition, and structural steel and concrete work on the project to Schiavone Construction Company ("Schiavone"). Schiavone was obligated to add Tishman and Carnegie as additional insureds on its policy and to defend and indemnify for claims arising out of Schiavone's negligence in the performance of its contract with Tishman. Accordingly, Schiavone obtained a general liability policy with limits of $ 1 million per occurrence from NUFIC. Schiavone also acquired a "Protector Commercial Umbrella Coverage" policy from Great American with limits of $25 million, which named Tishman and Carnegie as additional insureds.

Subsequently, two Schiavone employees brought actions against Tishman, and Carnegie Hall after being injured on the construction site. Tishaman and Carnegie tendered their defense to Schiavone, which was accepted by Schiavone's primary carrier, NUFIC.

The first claim settled for $785,000, which NUFIC paid under its policy with Schiavone. The second resulted in a jury verdict of $2,324,146.

Subsequently, Tishman, Carnegie Hall and NUFIC commenced an action against Great American and Schiavone for a declaration that 1) Schiavone was responsible for paying whatever remained of the verdict for the second case after NUFIC paid the remainder of the proceeds of Schiavone's policy and 2) Great American should indemnify Tishman and Carnegie to the extent the verdict exceeded the NUFIC policy issued to Schiavone as additional insureds under Schiavone's Great American excess policy.

Essentially, Tishman, Carnegie Hall and NUFIC argued that in determining the priority of the insurance policies, Schiavone's policy with Great American should be applied first before Tishman's general liability policy, based on Tishman and Carnegie Hall's additional insured status with Great American as dictated by their agreement with Schiavone.

The First Department disagreed and cited to its prior decision in *Bovis*.[6]

It held in *Tishman* that a commercial umbrella policy issued to a subcontractor, which named the Owner and the GC as additional insureds, was an excess policy that would only apply after the exhaustion of the GC's commercial liability policy.[7] The Court found that the umbrella policy was meant to be a true excess policy despite the existence of an "other insurance" clause in the GC's policy stating it was excess over any other policies and a similar clause in the umbrella policy stating that it is excess policy unless other insurance is specifically written to be excess of it.[8]

Notably, the *Bovis* and *Tishman* holdings would

result, at least initially, in the "horizontal exhaustion" of *all* the primary policies providing coverage for Tishman and Carnegie.

The plaintiffs in *Tishman* attempted to argue in the lower court that Great American should satisfy the remainder of the verdict amount based on 1) Tishman and Carnegie Hall's additional insured status and 2) contractual indemnification. Nevertheless, the lower court only addressed the argument based on additional insured status, which the Appellate Division ultimately rejected.

Somewhat puzzling however, is that the Appellate Division found that in light of its priority holding, it did not need to reach the contractual indemnification argument.[9]

Was the Court signaling that contractual indemnity is irrelevant or trumped by priority of coverage?

There is, at present, a pending motion before the lower court regarding the contractual indemnification argument, which, if granted, should, as the *Bovis* court acknowledged, result in the excess carrier providing coverage toward paying the claim despite being last in priority.

No matter how this motion is decided, a return to the First Department seems inevitable.

Thus, securing additional insured coverage alone is not sufficient if the desired outcome is for the additional insured coverage to be exhausted first on the primary and horizontal excess level. A valid indemnification clause running in the favor of the additional insured must be coupled with the additional insured requirement to achieve a complete risk transfer to the indemnitor's insurer.

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1 *Bovis*, 53 A.D.3d 140 (1st Dept. 2008).

2 *Bovis*, 53 A.D.3d 140 (1st Dept. 2008).

3 *Id.*

4 *Bovis,* 53 A.D.3d 155 (1st Dept. 2008).

5 *Tishman*, 53 A.D.3d 416 (1st Dept. 2008).

6 *Bovis*, 53 A.D.3d 140 (1st Dept. 2008).

7 *Tishman*, 53 A.D.3d 416 (1st Dept. 2008).

8 *Tishman*, 53 A.D.3d 418 (1st Dept. 2008).

9 *Id.* at 421.

# CPLR 4545 Collateral Source Offsets: Special Rules for Public Employee Plaintiffs

BY LOUIS F. ECKERT *

Often plaintiffs will posture a case for settlement by claiming they will be able to blackboard large past and future medical specials and economic loss at trial when the reality is they will never be able to recover all those damages due to the collateral source statute's limit on double recovery. The law governing collateral source offsets is CPLR 4545 which is intended to prevent plaintiff's from recovering damages at trial that they would have paid regardless of the trial anyway from other sources, i.e. double recoveries.

However, one of the major hurdles confronting the defense attorney faced with an adverse jury verdict is actually proving the offsetting medical, dental, custodial, rehabilitative care, lost earnings, pension and other economic benefits plaintiff will be able to recover from collateral sources except for life insurance against the jury award.

Typically, the trial court will holding a collateral source hearing after trial and outside the presence of the jury to calculate the offset since by statute the plaintiff may prove his or her losses and expenses at the trial irrespective of whether such sums will later have to be deducted from the plaintiff's recovery

CPLR 4545(a) and (b) applies to all personal injury actions and essentially negates the common-law collateral source rule by allowing evidence to be admitted at the hearing for consideration in establishing that any past **or future** cost or expense (including loss of earnings) was or will be replaced from a collateral source.

Significantly, the statute requires that defendants prove that a plaintiff is legally entitled to continued receipt of such collateral source in order for the court to reduce the plaintiff's awarded for any future expenses.

This discussion will review the standard defendants face in establishing collateral source offsets with a special focus on the rules for public employees.

## Standard for the Applicability of Collateral Source Payments

In a post-trial collateral source hearing, there is an

increased burden of proof placed upon a defendant seeking to prove the availability of a collateral source of payments as the statute is a derogation of the common law and, as such, the statute has to be read narrowly to effect its meaning. Accordingly, the courts have required a higher standard, increasing the defendants burden of proof from a preponderance of the evidence to "reasonable certainty" that plaintiff will continue to receive the item claimed to be a collateral payment.

A moving defendant bears the burden of establishing an entitlement to a collateral source reduction of an award for past or future economic loss. The standard of proof, as set forth twice in the plain language of the statute, is that of "reasonable certainty". Reasonable certainty is understood as involving a quantum of proof that is greater than a preponderance of evidence but less than proof beyond a reasonable doubt. Each of the four judicial departments has interpreted "reasonable certainty" as akin to the clear and convincing evidence standard, that the result urged by the defendant be highly probable.

In deciding the question of entitlement to a collateral source reduction, the reasonable certainty test necessarily implicates a two-tiered evaluation of defendants' collateral source proof.

First, defendants must establish with reasonable certainty that the plaintiff has received, or will receive, payments from a collateral source. Such payments may illustratively include, but are not limited to, homeowner's insurance in property damage actions, and in actions involving personal injury or death, disability pension payments received in lieu of future lost pension benefits, disability retirement payments in lieu of lost future ordinary pension benefits, health insurance benefits not subject to any lien payable by the plaintiff, certain Social Security benefits, and workers' compensation benefits not subject to liens upon the plaintiff.

Reasonable certainty for future collateral source payments also requires an affirmative finding by the court that a contract or other enforceable agreement entitles the plaintiff to the ongoing receipt of such benefits, conditioned only upon the continued future payment of premiums and other financial obligations required by the agreement.

The second step of a defendant's proof under the reasonable certainty standard in seeking entitlement to a collateral source reduction is that collateral source payments which have been or will be received by the plaintiff must be shown to specifically correspond to particular items of economic loss awarded by the trier of fact. The match of an award for past or future economic loss on the one hand, and offsetting collateral source payments on the other, is consistent with the strict construction accorded to CPLR 4545, and assures that any reductions to an award for economic loss are limited to the prevention of "double recoveries" by plaintiffs as intended by the legislature.

The reasonable certainty standard of proof for entitlement to a collateral source reduction furthers the overall purpose and intent of CPLR 4545, by assuring that plaintiffs' awards for past and future economic loss not be reduced absent a highly probable evidentiary showing that the covered costs and expenses were, or will be, replaced or indemnified from collateral sources. Absent the reasonable certainty of collateral source reductions, the statute, to the extent it departs from common law, prefers double recoveries in favor of plaintiffs over the polar alternative of depriving plaintiffs of a compensatory award for economic losses to which the trier of fact found them entitled. See *Kihl v. Pfeffer*[1].

Problems arise when considering the type of proof that could potentially be placed before a jury with respect to a vocational rehabilitation expert. When plaintiffs are receiving a disability pension, by its terms, the monies paid to plaintiff only last the term of the disability. If plaintiffs are shown to be capable of work, they are not disabled and the payments would cease.[2]

An instructive case is *Ruby v. Budget Rent A Car*,[3] wherein the Court held that: [A]n N.Y. C.P.L.R. 4545(c) collateral source offset for future social security disability benefits should not have been granted where plaintiff's experts said that he was capable of working in the future in a reduced capacity amounting to $50,000 per year, and defendants' experts said that he was capable of working as he had before the accident such that he suffered no diminution of earning capacity whatsoever. Defendants did not meet their burden to show that it was "highly probable" that plaintiff would continue to be eligible for social security disability benefits.

Typically the proof submitted is on par with that in the *Ruby* case, i.e., experts designed to show that plaintiffs are not, or will not always be, disabled. It follows that the defendants, as in Ruby, would not then be able to prove, post trial, that plaintiff would be "reasonably certain" to continue to receive their 207-c disability payments.

It should be noted that the *Ruby* court also disallowed a collateral offset for future medical benefits where plaintiff was insured under his wife's insurance plan but testified that his marriage is strained. The court ruled that it is not certain that he would remain married and entitled to the coverage and disallowed the offset of future medical expenses

despite the fact that plaintiff was covered for them at the time of the verdict and post-trial motions.

Assume that plaintiff's economist puts forth a scenario where plaintiffs are disabled from ever working again (29 years of future work life, respectively) and the City, who cannot offset future lost wages under §4545(b), puts forth a vocational rehabilitation expert, along with video surveillance, that demonstrates plaintiff can return to work. Assuming a compromise verdict that finds that plaintiff's will suffer 5 years of future lost wages, there is a sound argument under *Ruby* that the defendant is not entitled to the offset at all given the lack of reasonable certainty that plaintiff will continue to receive a disability pension.

This not atypical scenario is cause for much strategic debate and deliberation.

## Special Rules for Public Employee Claimants

The issue presents itself in unique ways when considering a public employee who has instituted suit against a public employer. The distinction between the rules governing public employees and run of the mill plaintiffs is a key distinction that must be understood by practitioners so as to advise clients as to the availability and, ultimately, the applicability of collateral offsets. Employee benefits are specifically mentioned in the statute as a type of collateral source.

This section of the collateral source rules allows a public employer, who is being sued by its employee, to offset only past collateral source benefits. This limitation of the ability to offset collateral source benefits is established through the Court of Appeals holding in Iazzetti v. City of New York,[5] which determined that a public employer was not entitled to a reduction for collateral–source disability benefits under CPLR 4545(b) for future costs or expenses, owing to the limiting language located in the statute.

## A New Statute

A new law that may also reduce the ability of plaintiff's to posture the value of a case is the recently enacted GOL 5-335(a). This statute may well make settling cases easier by barring private HMOs and health insurers from enforcing liens (subrogating) in personal injury settlements. Previously, claimants with private medical insurance would have their doctors and hospital bills paid by those carriers and then posture in their personal injury claims for higher settlements arguing that they had to repay a substantial lien – which maybe they repaid and maybe often not resulting in a double recovery. Private insurance was entitled to enforce liens by interpleading into the lawsuit mucking up settlement agreements if the lien was bigger than the settlement value.

Two caveats: a) this new statute applies only to settlements, not judgments which private insurance can still lien against; and b) this statute does not apply to statutory liens such as Workers Comp or Medicare. Thus, there will be minimal effect on claims by injured workers.

However, for claimants with private insurance, carrier and defense counsel settlement evaluations should no longer include medical expenses.

## Conclusion

It almost goes without saying that defense counsel and carriers evaluating tort cases must be familiar with New York's statutes governing what plaintiff will really be able to ultimately recover. Clearly, there are practical challenges and hurdles for defendants to always maximize their reductions. The better understood, the earlier defense counsel can prepare and be effective.

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1 47 A.D.3d 154 (2nd Dept. 2007).

2 Under General Municipal Law §207(c), police officers are entitled to disability benefits for the period of time "until the disability arising therefrom has ceased…"

3 23 A.D.3d 257 (1st Dept. 2005).

4 94 N.Y.S.2d 183 (1999).

DEFENDANT

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# What Every Defense Attorney Needs to Know About the Antisubrogation Doctrine

BY TIMOTHY J. KEANE *

All defense attorneys know that there is something called "antisubrogation", that it may have an effect in many cases they are handling, and that it is, therefore, something they must understand. Although many defense attorneys cannot explain antisubrogation on the spot if asked to do so, with a little review they can master the doctrine if it becomes relevant in a matter they are handling.

Of course, it is relevant in many tort liability actions where there are multiple parties defendant, and it happens that attorneys sometimes misunderstand antisubrogation. Sometimes the doctrine, though applicable, is overlooked completely and sometimes, though inapplicable, the doctrine is successfully argued. This may occur because analysis of whether the antisubrogation doctrine applies and what effect the antisubrogation doctrine may have in any matter requires both an insurance coverage analysis and a tort liability defense analysis.

We are discussing the common law antisubrogation doctrine applicable in tort liability actions addressed by the Court of Appeals in *Pennsylvania General Insurance Co. v. Austin Powder Co.*[1] and *North Star Reinsurance Corp. v. Continental Insurance Co.*[2] We are not here discussing the 2009 statute limiting a motor vehicle insurer's ability to recover no fault benefits in subrogation and we are not discussing waiver of subrogation that arises from express provisions in insurers' policies. There are over 200 reported decisions addressing the antisubrogation doctrine in New York and there is a small degree of conflict in the authorities. As this note is, at most, a primer and not a treatise, we address here the substantial weight of the authorities.

## Subrogation

An understanding of the antisubrogation doctrine must begin with at least a rudimentary understanding of subrogation in the context of liability insurance. When an insured owes an obligation to one party (for instance, money damages due an injured plaintiff in a personal injury action) and a liability insurer satisfies its insured's obligation to that party (by paying the injured plaintiff), that liability insurer typically acquires its insured's right to recover the entire amount paid from any other party that is obligated to indemnify its insured (or to recover a portion of the amount paid from any party that owes its insured a portion in contribution).[3] It is frequently stated that subrogation permits an insurer to "stand in the shoes" of its insured:

> Subrogation, an equitable doctrine, entitles an insurer to "stand in the shoes" of its insured to seek indemnification from third parties whose wrongdoing has caused a loss for which the insurer is bound to reimburse (see, *Pennsylvania General*, 68 NY2d at 471; 16 Couch on Insurance 2d § 61:37 [rev ed]; Keeton and Widiss, Insurance Law § 3.10[a]). Subrogation allocates responsibility for the loss to the person who in equity and good conscience ought to pay it, in the interest of avoiding absolution of a wrongdoer from liability simply because the insured had the foresight to procure insurance coverage (see, 16 Couch on Insurance 2d § 61:18 [rev ed]). The right arises by operation of law when the insurer makes payment to the insured (see, 16 Couch on Insurance 2d §§ 61:4 [rev ed]).[4]

## The Antisubrogation Doctrine

Where an insurer is obligated to defend and/or indemnify two or more insureds pursuant to (a) the same policy ***or*** (b) a General Contractor's Liability (GCL) or Commercial General Liability (CGL) policy and an Owners and Contractors' Protective policy (OCP) purchased from the insurer by the same party, pursuant to the antisubrogation doctrine such an insurer (and only such an insurer) is precluded from becoming subrogated to the rights of any one of its insureds against any other insured the insurer is obligated to defend and/or indemnify pursuant to the same policy or combination of policies.

The antisubrogation doctrine was expressly adopted by the Court of Appeals in *Pennsylvania General* to preclude an insurer that had already paid an entire loss on behalf of one insured on a liability policy from seeking to recover the amount paid through prosecution of that insured's indemnity claim against another insured on the same liability policy. With the entire loss already paid by the sole primary insurer, neither the insured nor any excess insurer had a financial interest in the indemnity claim. Thus, prosecution of the indemnity claim was pursued for the sole benefit of the primary insurer that also insured the putative indemnitor.

The problem identified by the Court of Appeals is that in such an instance permitting the insurer to

prosecute, for its own financial benefit, an indemnity claim against another insured that the insurer was obligated to defend pursuant to the policy under which the insurer made its payment would allow the insurer to "*pass the incidence of loss*" back to its own insured, thereby breaching its obligation to defend one of its insureds even though the insurer accepted a premium to protect that insured against such a claim. The Court of Appeals wrote:

> The insurer's right of subrogation, long recognized as a matter of equity, has traditionally been applied to claims against third parties whose wrongdoing has caused a loss for which the insurer is bound to reimburse (citations omitted). A third party, by definition, is one to whom the insurer owes no duty under the insurance policy through which its loss was incurred (citations omitted). On the other hand, it has often been said that an insurer may not be subrogated to a claim against its own insured, at least when the claim arises from an incident for which the insurer's policy covers that insured (*see, e.g., Chrysler Leasing Corp. v. Public Administrator*, 85 A.D.2d 410, 448 N.Y.S.2d 181; *Beck v. Renahan*, 26 A.D.2d 990, 275 N.Y.S.2d 1010, *affg.* 46 Misc.2d 252, 259 N.Y.S.2d 768; 16 Couch, *op. cit.* §§ 61:133, 61:134; *see also, Hartford Acc. & Indem. Co. v. Michigan Mut. Ins. Co.*, 61 N.Y.2d 569, 475 N.Y.S.2d 267, 463 N.E.2d 608). The principal, although alluded to in our prior decisions (*Hartford Acc. & Indem. Co. v. Michigan Mut. Ins. Co., supra*, p. 573, 475 N.Y.S.2d 267, 463 N.E.2d 608), has never been formally addressed by this court. Having considered the relevant authorities, we now conclude that the rule is a sound one. To allow the insurer's subrogation right to extend beyond third parties and to reach its own insured would permit an insurer, in effect, "to pass the incidence of the loss * * * from itself to its own insured and thus avoid the coverage which its insured purchased" (*Home Ins. Co. v. Pinski Bros.*, 160 Mont. 219, 226, 500 P.2d 945, 949, *supra*).
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> The rule against allowing subrogation claims against an insured is based, in part, on the potential for conflict of interest that is inherent in these situations (*see, e.g., Chrysler Leasing Corp. v. Public Administrator, supra; Home Ins. Co. v. Pinski Bros., supra*, 500 P.2d p. 949). Here, for example, the interests of the insured indemnitor, Austin Powder, can only be fully protected through the vigorous defense of the indemnitee, Bison Ford. Yet, if indemnification from Austin Powder could be had for losses sustained on Bison Ford's behalf, Liberty Mutual would have less incentive to defend Bison Ford from claims made against it. As a consequence, allowing indemnification might sanction an indirect breach of the insured's obligation to defend its insured Austin Powder. Furthermore, it would sanction a direct breach of the primary obligation the insurer undertook-the obligation to indemnify Austin Powder from loss (*see, Home Ins. Co. v. Pinski Bros., supra*, p. 949.[5]

When an insurer's right to subrogation arises from an insurance policy that is separate from and unrelated to the insurance policy pursuant to which the insurer must defend an indemnitor, the common law antisubrogation doctrine has no application.

For instance, where the same insurer issues unrelated automobile liability policies to unrelated motorists whose cars just happen to collide, or where a building owner and a maintenance contractor place their general liability coverage separately, but coincidentally, with the same insurer, the antisubrogation doctrine will not preclude the insurer from standing in the shoes of an insured under one policy to enforce a right against someone who is an insured under an unrelated policy issued by the same insurer.[6]

However, where the same insurer issued a CGL to a contractor and an OCP or Railroad Protective policy purchased by that contractor for the protection of the owner, the Court of Appeals held that the antisubrogation doctrine precluded the mutual insurer from standing in the shoes of the owner (its insured under the OCP) to pursue the contractor (its insured under the CGL). The Court again held that, *"[p]ublic policy requires this exception to the general rule both to prevent the insurer from passing the incidence of loss to its own insured and to guard against the potential for conflict of interest that may affect the insurer's incentive to provide a vigorous defense for its insured"*, and extended the rule articulated in *Pennsylvania General:*

> The policy considerations underlying *Pennsylvania Gen.*, preventing the insurer from recouping the insurance proceeds from its insured, and avoiding the potential for conflict of interest when the parties' insurer is subrogated against an insured, are equally applicable herein. The OCP and GCL were purchased together as coverage against the same risk and paid for by the same party (citations omitted), and, as in *Pennsylvania Gen.*, the covered loss occurred. Application of *Pennsylvania Gen.* is warranted because the two policies are integrally related and indistinguishable from a single policy in any relevant way.[7]

## Is the Antisubrogation Doctrine Implicated?

Where (1) an insurer is obligated to defend two or more insureds on a single policy (or on related OCP or Railroad Protective and CGL policies), (2) two or more of those insureds are subject to liability, directly or indirectly, arising from the same injury or loss, and (3) one of those insureds has a right of indemnity or

contribution against another of those insureds, the antisubrogation doctrine will preclude such an insurer from becoming subrogated to the rights one of its insureds has against another of its insureds.

The first step is to determine whether any insurer has more than one insured subject to direct (to plaintiff) or indirect (indemnity or contribution) liability in a matter. The antisubrogation doctrine has potential application in any matter in which a single liability insurer has at least two insureds on a single policy or on a CGL and an OCP or Railroad Protective policy.

Such insureds may be "Named Insureds", "Additional Named Insureds", "Additional Insureds", expressly named, covered by virtue of the "*Who is an Insured*" provision, insured pursuant to a blanket additional insured endorsement, a "permissive user", or insured in any manner at all.[8] Matters in which at least two insureds on a single policy or in a CGL/OCP combination are frequently subject to exposure include, but are not limited to, construction accident litigation (owners, general contractors, and subcontractors), premises liability cases (landlords, tenants, and maintenance contractors), and motor vehicle accident litigation (owner, lessor, lessee, driver's employer, and/or driver). If there is not a single insurer with at least two insureds on a single policy (or on a CGL and an OCP), then there is no need for further consideration of the antisubrogation doctrine.

The second step is to determine whether any insurer with more than one insured subject to exposure in the matter owes a duty to defend both insureds. An insurer may have two insureds subject to liability, but if the insurer does not owe one of its insureds a duty to defend in the matter the antisubrogation doctrine does not preclude the insurer from standing in the shoes of another insured to proceed against that insured.[9]

In addressing the facts in the *North Star* case (one of three sets of facts the Court of Appeals addressed in the *North Star* decision), the Court of Appeals wrote, "*because exclusions in the GCL rendered that policy inapplicable to the loss, the anti-subrogation rule does not apply in that case.*"

This scenario presents itself in many different forms, including when the injured person is a contractor's employee and coverage for the named insured contractor is excluded under a standard CGL "employee injury exclusion" but available to the owner as an additional insured under the same CGL. The injured employee sues the owner, for whom there is additional insured coverage under the CGL issued to the contractor, and the CGL insurer defends the owner. Alleging that plaintiff's injuries are "grave", the owner seeks common law indemnity from the contractor (plaintiff's employer) and with coverage excluded under its CGL the contractor (plaintiff's employer) is defended only under its employer's liability policy.

It may seem peculiar that the CGL insurer – which issued the policy under which it is defending the owner not to the owner, but rather to the contractor – is permitted to stand in the owner's shoes and pursue the owner's common law indemnification claim against the contractor (who paid the insurer's premium), but the courts have consistently held that where the CGL insurer has no obligation to defend its named insured (the contractor) against liability arising from injuries to the contractor's own employees, there is no violation of the antisubrogation doctrine when the CGL insurer proceeds against its own insured standing in the shoes of the owner.[10]

It must be emphasized that in such an instance, due to the employee injury exclusion, the CGL insurer's policy places it under no obligation whatsoever to defend against the very claim it is prosecuting (a claim of injury to the contractor's employee), and thus, the CGL insurer is not, in such an instance, avoiding any coverage that the contractor purchased.[11]

The third step is to determine whether one of the insureds that the insurer is obligated to defend has a right of indemnity or contribution against another of the insureds that the insurer is also obligated to defend.

If one insurer is obligated to defend two or more insureds on a single policy (or on a CGL and OCP), two or more of those insureds are subject to liability directly or indirectly arising from the same injury or loss, and one of those insureds has a right of indemnity or contribution against another of those insureds, the antisubrogation doctrine is implicated and applies to preclude that insurer from becoming subrogated to the rights one of its insureds has against another of its insureds.

## Where the Antisubrogation Doctrine is Implicated, What is the Effect?

As discussed above, the antisubrogation doctrine precludes an insurer that has two insureds from becoming subrogated to the rights that one of its insureds has against another of its insureds. But what does this mean in any particular action?

One of the things that make it difficult to fully appreciate and understand the antisubrogation doctrine is that even after ascertaining that it is implicated, further analysis is required to determine whether it will have any effect, and if so, what effect, in a matter. Where it is implicated its ultimate effect

in a matter may be a bit different in almost every case depending upon a broad array of factors including, but not limited to, whether the extent of the loss is already fixed, the extent of the loss or exposure, the amount of insurance available to the indemnitee, the priority of insurance coverage and whether the indemnitee has exposed coinsurers and/or excess insurers, whether the indemnitee has uninsured exposure, whether the indemnitee has co-defendants also entitled to indemnity from the indemnitor, the existence of other indemnitors, whether indemnitee and indemnitor are co-defendants or third-party plaintiff and third-party defendant, whether employers' liability coverage is triggered by a "grave injury", and whether the claims that can be asserted in good faith are for only contribution and common law indemnity or include viable claims for contractual indemnity.

In some instances an insurer's preclusion from becoming subrogated to the rights that one of its insureds has against another of its insureds may have no effect on the ultimate outcome of the matter due to the existence of other insurers and/or other parties whose rights to proceed against all others are not precluded. When a judgment can be entered and enforced against two or more defendants and the antisubrogation doctrine precludes one insurer of only one defendant from proceeding against a third-party defendant, against which defendant(s) the judgment gets entered may be quite relevant.

Though the fact pattern permutations are seemingly endless, and changing one seemingly insignificant fact while keeping twenty-five other key facts the same can change the outcome substantially, understanding of what the antisubrogation doctrine is and is not allows proper application of the doctrine on a case by case basis, as is required.

Perhaps the most important thing to understand about the antisubrogation doctrine is that when an insurer is precluded from becoming subrogated to the rights of one of its insureds (i.e., when the doctrine is implicated), only the insurer that has an obligation to the putative indemnitor is precluded. The antisubrogation doctrine is an infirmity that only disqualifies an insurer from seeking to recover (or recovering) in subrogation against its own insured.[12] The antisubrogation doctrine does not eliminate one insured's right to recover in indemnity from another insured and does or curtail insurers that insure the indemnitee, but not the indemnitor, from becoming subrogated to the indemnitee's rights.[13]

## Examples

Assume a "grave injury" loss with projected maximum exposure of $5,000,000, a $1,000,000 primary CGL issued to a contractor, an unlimited employer's liability policy also issued to the contractor, another $1,000,000 primary CGL issued to an owner, and no excess insurance at all. Assume further that the $1,000,000 primary CGL issued to the contractor provides applicable coverage for both the contractor and the owner and that the CGL issued to the owner provides applicable coverage for only the owner. Plaintiff, an employee of the contractor, commences an action against only the owner and the owner commences a third-party action for common law and contractual indemnity against only the contractor. All agree that the owner will be held liable to plaintiff but that said liability will be only vicarious liability and that the owner will have a right of common law and contractual indemnity against the contractor.

The antisubrogation doctrine does not render such a third-party action dismissible.[14] Rather, the third-party action must be limited to preclude recovery to the extent that the loss is covered under the common insurance coverage, but allow recovery to the extent that the loss is not covered under the common insurance coverage. Since the amount of the loss is not yet fixed, it cannot be said that the contractor's CGL insurer is the only real party in interest, and thus, to uphold the owner's right to obtain indemnity from the contractor and the right of the insurer that issued the CGL to the owner to be subrogated to the owner's right, the third-party action must be permitted to proceed, subject only to the limitation that there can be no recovery to the extent that the loss is covered under the common insurance coverage.

Now assume, in the same hypothetical as above, that the insurer on the $1,000,000 primary CGL issued to the contractor settled with plaintiff, obtaining a complete release for the owner, for the sum of $950,000 with the entire amount paid by said insurer. Now, with the only recovery possible being for the benefit of the common insurer, the common insurer is the only real party in interest. Thus, in this hypothetical the third-party action (brought in the name of the owner but at this time continued only for the benefit of the common insurer) is subject to dismissal based upon the antisubrogation doctrine.

Now, change the hypothetical again to reflect that the insurer on the $1,000,000 primary CGL issued to the contractor and the insurer on the $1,000,000 primary CGL issued to the owner both had to exhaust their $1,000,000 limits, and in addition $500,000 was required from the owner's personal assets to settle the case with plaintiff, i.e., a gross settlement of $2,500,000.

Once again, the antisubrogation doctrine does not render such a third-party action dismissible. Again, the third-party action must be limited to allow recovery

to the extent that the loss is not covered under the common insurance coverage but to preclude recovery to the extent that the loss is covered under the common insurance coverage.

Because the owner and the insurer on the CGL issued to the owner paid $500,000 and $1,000,000 respectively, the contractor's CGL insurer is not, in this hypothetical, the only real party in interest. The owner and the insurer on the CGL issued to the owner can collectively recover $1,500,000 from the contractor, but due to the antisubrogation doctrine the insurer on the CGL issued to the contractor cannot be subrogated to the owner's right to recover from the contractor.

As mentioned above, there are scenarios in which the antisubrogation doctrine will have no effect on the amount the various insurers must ultimately pay. In the $2,500,000 settlement hypothetical, the contractor's $1,000,000 CGL limit was exhausted once it paid on behalf of the owner, but it would also have been exhausted had it remained available to satisfy the contractor's indemnity obligation to the owner, and thus, the antisubrogation doctrine did not alter the amounts that the contractor's CGL and employer liability insurers had to pay. However, in the $950,000 settlement hypothetical, the contractor's CGL insurer ultimately had to pay the entire loss.

Had antisubrogation not been an issue (for instance, as would have been the case if the insurer that issued the CGL to the owner been the sole primary insurer for the owner, i.e., obligated to exhaust without a right of contribution from the insurer that issued the CGL to the contractor), once the loss was passed through to the contractor on the basis of both common law and contractual indemnity the contractor's employer liability insurer would typically be responsible for at least half of the loss, or $475,000 in that hypothetical.

It has been recognized that application of the antisubrogation doctrine may result in what seems to be a windfall for employer liability and excess insurers. The Court of Appeals in *North Star* was aware that the rule it addressed did not concern an insurer's efforts to *"recoup[] the insurance proceeds from its insured"*, but rather concerned efforts to shift losses to employers' liability and excess insurers:

> As is apparent in the present cases, the mutual insurer, as subrogee of the owner, can fashion the litigation so as to minimize its liability under the GCL. By failing to assert a contractual indemnification claim on the owner's behalf, the insurer can trigger coverage under other insurance policies held by the contractor such as a workers' compensation or excess policy (see, *National Union*, 790 F Supp at 492; Covert, 117 Misc 2d at (1080).[15]

Against the background of the Court of Appeals' discussion of employers' liability and excess insurers, not surprisingly an insurer's preclusion under the antisubrogation doctrine against proceeding under a conflict of interest and seeking to recoup amounts from one's own insured has been understood to inure to the benefit of the putative indemnitor's other insurers.[16] This is not surprising when considered in light of the obligation of utmost good faith running from an insurer handling a mutual insured's defense to the insured's other insurers.[17]

Based, as it is in part, on the need for the insurer to avoid an inherent conflict of interest, an insurer is precluded from becoming subrogated to rights against its own insured as soon as the insurer becomes obligated to defend the putative indemnitor.[18] Regardless of whether the two insureds are co-defendants asserting cross-claims or third-party plaintiff and third-party defendant in a third-party action, the common insurer is precluded from becoming subrogated to one insured's claim against another insured under the same or a related policy.[19]

An insurer may be under an obligation to the insured indemnitee and/or one or more of the indemnitee's other insurers to, in the name of the insured indemnitee, commence a third-party action or assert a cross-claim against its own insured (the indemnitor). Although the antisubrogation doctrine precludes an insurer from commencing or maintaining a third-party action or asserting a cross-claim against its own insured for the insurer's own benefit, the antisubrogation doctrine does not preclude an insurer from commencing or maintaining a third-party action or asserting a cross-claim against its own insured when there is exposure to the insured indemnitee and/or one or more of the indemnitee's other insurers.

In such an instance the indemnity or contribution claim must be asserted, but the indemnity or contribution claim must be asserted for the benefit of the indemnitee and/or the indemnitee's other insurers who remain, under such circumstances, the real parties in interest.[20] Such a claim may not be asserted for the benefit of the common insurer as the antisubrogation doctrine precludes an insurer from prosecuting, for its own benefit, a claim against its own insured.[21]

The doctrine does not preclude an insurer from prosecuting, for the benefit of one insured or co-insurers, a claim against its own insured, and prosecuting such a claim is sometimes required, but an insurer cannot have a stake in the claim against its own insured. It cannot be a real party in interest vested against its own insured. The rule, when an

insurer must prosecute (for the benefit of one insured or co-insurers) a claim against its own insured the insurer cannot prosecute the claim for its own benefit, effectively removes the financial interest the insurer would otherwise have in seeing that the defense it affords the insured indemnitor is unsuccessful.

## How is Compliance with the Antisubrogation Doctrine Enforced?

In the first instance insurers enforce the antisubrogation doctrine by refraining from maintaining claims against their own insureds for their own financial benefit. Most insurers respect the mandate of the antisubrogation doctrine, do not knowingly violate the rule, and when called upon to come into conformance with the rule, do so.

When the antisubrogation doctrine is raised as a defense to an indemnity claim, the courts limit recovery on the indemnity claim in accordance with the antisubrogation doctrine to allow recovery to the extent that the loss is not covered under the common insurance coverage. For example, recovery on an indemnity claim may be, "*limited to an amount in excess of the applicable insurance policy limits, because indemnification is barred by the antisubrogation rule up to the amount of the applicable insurance policy limits*".[22]

Where the antisubrogation doctrine has not been addressed in underlying tort litigation, the courts will address the effect of the doctrine in a declaratory judgment action or a coverage action brought after judgment is entered in the underlying tort action or after the underlying tort action is settled with a reservation of rights.[23]

The New York State Superintendent of Insurance has jurisdiction to investigate violations of the antisubrogation doctrine and on at least one occasion the Attorney General of the State of New York has brought an action for "Violation of the Common Law Anti-Subrogation Rule".[24]

## Conclusion

If the antisubrogation doctrine is implicated it may have no effect whatsoever, but it may have a multimillion dollar effect on who ultimately must pay what amount in a matter. Proper analysis of whether the antisubrogation doctrine is implicated and what effect it may have requires both coverage analysis and liability defense analysis. Such analysis is particularly likely to be of value when any insurer in the matter has multiple insureds under one policy or related policies and where there are multiple parties defendant in high value tort litigation.

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1 *Pennsylvania General Insurance Co. v. Austin Powder Co.*, 68 N.Y.2d 465, 510 N.Y.S.2d 67 (1986).

2 *North Star Reinsurance Corp. v. Continental Insurance Co.*, 82 N.Y.2d 281, 604 N.Y.S.2d 510 (1993).

3 There are sometimes important distinctions between an insurer's right to equitable subrogation and an insurer's right to contractual subrogation, but in most cases the insurer's policy will afford it a broad right of contractual subrogation.

4 *North Star, supra.* This quote addresses equitable subrogation based upon a third-party's wrongdoing. An insurer's right of contractual subrogation typically does not require evidence of wrongdoing on the part of the third party against which the subrogee can proceed.

5 *Pennsylvania General, supra.*

6 *North Star, supra,* at Fn. 4; *see also Hartford Acc. and Indem. Co. v. Michigan Mut. Ins. Co.,* 61 N.Y.2d 569, 463 N.E.2d 608, 475 N.Y.S.2d 267 (1994).

7 *North Star, supra.*

8 *Jefferson Ins. Co. v. Travelers Indem. Co.,* 92 N.Y.2d 363, 681 N.Y.S.2d 208 (1998).

9 *Id.*

10 See, e.g., *Larson v. City of New York,* 214 A.D.2d 413, 625 N.Y.S.2d 898 (1st Dept. 1995).

11 Change the facts ever so slightly, by adding a claim for contractual indemnity and a CGL policy containing an "insured contract" exception to the employee injury exclusion, and the antisubrogation doctrine would preclude the CGL insurer from standing in the shoes of the owner.

12 The antisubrogation doctrine has also been applied to preclude a self-insured car rental company from obtaining indemnity from a car rental customer, though the self-insured car rental company was permitted to seek indemnity for amounts in excess of the statutory minimum insurance it was obligated to maintain for the customer. *See, ELRAC, Inc. v. Ward*, 96 N.Y.2d 58, 724 N.Y.S.2d 692 (2001).

13 *See, e.g., Flowers v. K.G. Land New York Corp.*, 219 A.D.2d 579, 631 N.Y.S.2d 177 (2d Dept. 1995); *see also, Aprea v. Willets Point Contracting Corp.*, 215 A.D.2d 708, 627 N.Y.S.2d 76 (2d Dept. 1995).

14 *Id.*

15 *North Star, supra.*

16 *See generally, National Union Fire Insurance Company of Pittsburgh, Pa. v. Hartford Insurance Company of the Midwest*, 248 A.D.2d 78, 677 N.Y.S.2d 105 (1st Dept. 1998).

17 *Hartford Acc. and Indem. Co. v. Michigan Mut. Ins. Co.*, 93 A.D.2d 337, 341 (1st Dept 1983), *aff'd*, 61 N.Y.2d 569 (1984).

18 *Cuzzi v. Brook Shopping Center, Inc.*, 287 A.D.2d 403, 731 N.Y.S.2d 717 (1st Dept. 2001).

19 *Pennsylvania General, supra; see also, Pitruzello v. Gelco Builders, Inc.*, 304 A.D.2d 302, 757 N.Y.S.2d 280 (1st Dept. 2003); *Cuzzi supra.*

20 See Note 12.

21 *Bruno v. Price Enterprises*, 299 A.D.2d 846, 848, 752 N.Y.S.2d 180, 182 (4th Dep't 2002); *Pennsylvania General, supra; North Star, supra.*

22 *Bruno, supra.*

23 *AIU Ins. Co. v. Nationwide Mutual Ins. Co.*, 62 A.D.3d 421, 878 N.Y.S.2d 52 (1st Dept. 2009); *Federal Insurance Company v. North American Specialty Ins. Co.,* 47 A.D.3d 52, 847 N.Y.S.2d 7 (1st Dept. 2007) (*Federal's claim that CUIC manifested a "conscious disregard" for Federal's rights [citation omitted] by allowing one of its insureds, the owners, to escape liability in violation*

*of the antisubrogation rule, thereby removing one of its policies [OCP] from the layer of coverage that had to be exhausted before triggering Federal's excess coverage, sufficiently states a cause of action for bad faith*); *Liberty Mutual Ins. Co. v. Aetna Cas. & Surety Co.,* 235 A.D.2d 523, 652 N.Y.S.2d 764 (2d Dept. 1997), (insurer unable to enforce a lower "*step down*" coverage limit applicable to putative indemnitor due to antisubrogation doctrine); *National Union Cas. Co. v. State Insurance Fund*, 227 A.D.2d 115, 641 N.Y.S.2d 665 (1st Dept. 1996); *Travelers Indemnity Co. v LLJV Dev. Corp.*, 227 A.D.2d 151, 643 N.Y.S.2d 520 (1st Dept. 1996).

[24] *State of New York v. Elrac, Inc., Snorac, Inc., and Enterprise Rent-a-Car Company, Inc., (N.Y. Sup. Ct., Index No. 402073/00).*

*Continued from page 1*

# The Quadripartite Relationship: Remedies of The Excess Insurer

Mutual Ins. Co., 61 N.Y.2d 269, 475 N.Y.S.2d 267 (1984). Hartford, excess carrier of the defendants in the underlying action, contended throughout the defense of the underlying personal injury action that the defendants, whose primary insurer Michigan Mutual appointed defense counsel for the defendants, should have commenced a third-party action against plaintiff's employer. Hartford alleged this was not done, which would have expanded the exposure of Michigan Mutual who was the Worker's Compensation insurer for the employer.

In its complaint, Hartford alleged breach of fiduciary duty by Michigan Mutual and malpractice by its appointed defense counsel. The lower court dismissed the complaint and the issue thus presented on appeal was whether Hartford has a cause of action in its own right, as opposed to acquiring such right through equitable subrogation from its insured, as against Michigan Mutual. In reinstating the complaint for breach of fiduciary duty the Court stated:

> It is well established that, as between an insurer and its assured, a fiduciary relationship does exist, requiring utmost good faith by the carrier in its dealings with its insured. In defending a claim, an insurer is obligated to act with undivided loyalty; it may not place its own interests above those of its assured. Similar, it has been recognized in this and other states as well as in the federal courts, that the primary carrier owes to the excess insurer the same fiduciary obligation which the primary insurer owes to its insured, namely, a duty to proceed in good faith and in the exercise of honest discretion, the violation of which exposes the primary carrier to the liability beyond its policy limits…

Id. at 341. The Court went on to find that Hartford could sue for a breach of the duty owed by the primary carrier. The Court stated that the primary insurer, acting as a fiduciary, "is held to an exacting standard of utmost good faith." Id.

Subsequent to the decision in Hartford, supra, Judge Spatt reiterated the rule regarding the duty owed by a primary insurer to an insured in New England Insurance Co. v Healthcare Underwriters Mutual Insurance. 146 F. Supp 2d 280 (E.D.N.Y. 2001). "Under New York Law, a primary insurer owes an excess insurer the same duty of good faith that it owes to its insured. Id. at 284.

In 2004, the First Department upheld the right of an excess insurer to pursue a malpractice claim against the primary appointed attorney in Allianz Underwriters Ins. Co. v. Landmark, 13 A.D.3d 172, 787 N.Y.S.2d 15 (1st Dept. 2004). In this matter, the excess insurer claimed that the defense counsel appointed by the primary insurer refused to implead plaintiff's employer to insulate the 1B portion of the employer's liability policy, which policy was also issued by the insurer who issued the primary policy. Allianz claimed this manipulation of coverage constituted a breach of the fiduciary duty owed to it by the law firm appointed by the primary insurer. Allianz claimed it was entitled to maintain an action against the law firm as the "equitable subrogee" of its insured and because it was in "near privity" with the primary appointed law firm.

Subrogation is the principle by which an insurer, having paid losses if its insured, is placed in the position of its insured so that it may recover from the third party legally responsible for the loss. It has also been held that "Subrogation is an equitable doctrine [that] entitles an insurer to stand in the shoes of its insured to seek indemnification from third parties whose wrongdoing has caused a loss for which the insurer is bound to reimburse." Federal Ins. Co. v. North American Specialty Ins. Co., 47 A.D.3d 52 at 62, quoting North Star Reins Corp. v. Continental Ins. Co. 82 N.Y.2d 281, 294, 604 N.Y.S.2d 510 (1993).

The law firm challenged Allianz's right to proceed against it as an equitable subrogee by asserting that Allianz had not yet paid anything on the underlying judgment. The Court rejected this contention by stating that "contingent claims by subrogees have been recognized especially where it would further judicial economy." Allianz, 13 A.D.3d at 175 (citations omitted).

Allianz also claimed that it could maintain an action against the law firm based on a 'near privity' relationship. The Court set forth a three prong test to determine whether an excess insurer could pursue a malpractice action against a law firm appointed by the primary insurer to defend its material insured. "In

order for a relationship to approach "near" privity's borders, for the purpose of maintaining a professional negligence claim, the professional must be aware that its services will be used for a specific purpose, the plaintiff must reply upon those services, and the processional must engage in some conduct evincing some understanding of the plaintiff's reliance. Allianz, 13 A.D.3d at 174. The First Department reinstated Allianz's complaint against the law firm.

Judge Robert Carter upheld the "equitable subrogee" theory of liability in deciding Harleysville Worcester Insurance Co. v. Hurwitz and Silverstein & Hurwitz, 2005 U.S. Dist. Lexis 5721 (S.D.N.Y. April 14, 2005):

> Moreover, since Federal courts apply New York law have held that excess insurers may bring malpractice claims against an insurer's counsel based on the doctrine of equitable subrogation, [citation omitted] the Court believes that an insurer may allege a claim for subrogation based on counsel's negligent representation of its insured.

Id. at 14.

With respect to the potential 'privity' problem facing an excess carrier due to the fact that the excess carrier generally does not have a duty to defend and thus does not usually appoint defense counsel, the First Department addressed that issue in Great Atlantic Insurance Co. v. Weinstein, 125 A.D.2d 214, 509 N.Y.S.2d 325 (1st Dept. 1986). In this matter, the Court reinstated an excess insurer's complaint alleging malpractice against defense counsel appointed by the primary insurer. In doing so, the Court found the complaint "legally sufficient" under CPLR §3211 in its allegations that defense counsel owed a duty not only to his client, the insured, but a similar duty to the excess carrier.

Judge Nina Gershon of the United States District Court for the Eastern District of New York was compelled to address New York law on the rights of an excess carrier as against a primary insurer and its assigned defense counsel in Allstate Insurance Co. v. American Transit Ins., 977 F.Supp 197 (E.D.N.Y. 1997). In this matter, American Transit Insurance Company was the primary insurer for the lessor, lessee and the driver of a truck that caused severe injuries to two plaintiffs in underlying personal injury actions. Federal Insurance Company was an excess insurer of the lessee and the driver of the truck, and Allstate was the excess insurer of the lessor of the truck. American Transit hired one defense firm to represent all three defendants. Allstate alleged that this representation involved conflicts and/or potential conflicts, of which none of the defendants were advised. Furthermore, Allstate alleged that neither American Transit, nor its assigned defense counsel provided proper notice of the state court action. Allstate and Federal each sought to recover the one million dollars each paid as part of a pre-trial settlement of the action by alleging that American Transit breached the fiduciary duties it owed to the excess insurers and by claiming the appointed defense counsel committed malpractice. In denying the defendants' F.R.C.P. 12 (b)(6) motion to dismiss, Judge Gershon stated:

> Moreover, as the Court of Appeals for the Second circuit has noted, New York is one of the few jurisdictions "that have permitted a direct action by an excess insurer against a primary carrier, rather than limited to only those rights available to a subrogee of the insured. (Citation omitted). By establishing direct fiduciary duties between excess insurers and primary insurers, New York has evidenced the strength of its concern that the parties responsible for defense of an underlying claim be held accountable to excess insurers for wrongdoing.

Id. at 201.

Clearly, it behooves counsel and claims professionals to be aware of the increasing significance of the quadripartite relationship and the duties and obligations flowing therefrom.

[1] See Restatement of the Law Governing Lawyers. American Law Institute Reporters Draft of Comment f to §215 of the Restatement.

# Conclusion

As this compendium has demonstrated, there may well be coverage disputes for which defense counsel has to sit on the sidelines but counsel is well advised to understand the coverage issues sufficiently to know their proper role in best protecting their client, themselves and the carrier.

While not exhaustive, the sections of this edition deal with real, not hypothetical, problems known or encountered first hand by the authors and should serve as fair warning that counsel cannot possibly advise their clients wisely without understanding the coverage implications of their case.

It is time to put the insurance back into insurance defense attorneys.

Finally, it should be noted that the cumulative efforts in this collaborative edition reflects the authors passion for their work, the depth and breadth of their exceptional expertise and the robust nature of the Defense Association of New York.

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# Worthy Of Note

VINCENT P. POZZUTO *

## 1. EVIDENCE

Court Affirms Defendant's Verdict and Finds Evidentiary Rulings Proper

Santos v. Ford Motor Company
2010 N.Y. Slip. Op. 402 (1st Dept. 2010)

The Court held that the preclusion of certain testimony about a predecessor model to the 1995 Ford Explore Model UN-105 was proper, and that the lower Court had the discretion to exclude it from an already lengthy trial. The Court further held that minor differences between two testing methods did not render plaintiff's test novel. However, the Court held that any error in precluding plaintiff's test was harmless because plaintiff's expert was allowed to testify extensively about the other testing method. The Court also held that the lower Court properly denied plaintiff's request for a missing document charge, as there was no evidence that Ford disposed of the data in anything other than the ordinary course of business. Finally, the Court held that the lower Court properly declined to charge the jury on the failure to warn claim as there was no evidence that Plaintiffs would have purchased a different vehicle or packed the car differently had Ford given a warning beyond those it already gave.

## 2. PRODUCTS LIABILITY

Court Dismisses Manufacturing Defect and Failure to Warn Claim; Finds an Issue of Fact on Design Defect Claim.

Cwiklinski v. Sears Roebach & Co.
2010 N.Y. Slip. Op. (4th Dept. 2010)

Plaintiff was using a table saw with a molding head cutter attachment. Plaintiff was making a "non-through" cut in a test piece of wood which required removal of the blade guard on the table saw. While making the cut, the saw began to "chatter." Plaintiff placed his left hand on the wood to steady it. The wood kicked back and plaintiff's left hand came in contact with the saw blade. The Court agreed that Defendants established that the molding head cutter had no manufacturing or assembly defect, and dismissed the manufacturing defect cause of action. On the failure to warn claim, the Court noted that Plaintiff admitted that he read the instruction manual, and it can only be concluded that the danger in placing his hands near an unguarded blade is open and obvious. Finally, the Court held that Plaintiff raised a triable issue of fact on the design defect claim by submitting the affidavit of an expert who stated that there were several appropriate workable guards on the market that could have been used with the mold head cutter, and could have prevented the accident.

## 3. PROCEDURE

Court Denies Leave to Amend; Dismisses Certain Affirmative Defenses.

Greco v. Christofferson
2010 N.Y. Slip. Op. 924 (2nd Dept. 2010)

In an action to recover damages for fraud, the Court reversed the lower Court's grant of leave to defendant to amend his answer to assert a counter-claim for abuse of process and malicious prosecution. The Court held that leave to amend shall not be given when the proposed amendment is devoid of merit. The Court stated that there was no evidence that plaintiff commenced the instant action with an intent to do harm without excuse or justification. The mere commencement of a lawsuit cannot serve as the basis for a cause of action alleging abuse of process. In addition, the commencement of the action did not give rise to a counter-claim alleging malicious prosecution since there was no interference with defendant's person or property. The Court held that the affirmative defense of unclean hands is an equitable defense that is unavailable in actions that are exclusively for damages. The Court further held that Plaintiff's complaint stated the circumstances constituting fraud with the requisite specificity.

## 4. PROCEDURE

Counsel for Non-Party Witnesses is Precluded From Objecting During Videotaped Deposition.

Thompson v. Mather
2010 N.Y. Slip. Op. 1239 (4th Dept. 2010)

In a medical malpractice action, plaintiff's counsel arranged for plaintiff's treating cardiologist, non-parties,

*Continued on page 50*

* *Vincent P. Pozzuto is a member in the Manhattan office of Cozen O'Connor.*


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to provide testimony in advance of trial that would be videotaped and presented at trial in accordance with 22 NYCRR 202.15. The physicians were accompanied at the scheduled videotaping by counsel retained by their insurance carrier. Counsel interposed objections to form and relevance. Plaintiff's counsel objected to such participation by counsel and the parties were unable to resolve the dispute. The lower Court directed that plaintiffs were to consider providing the physicians general releases, and then counsel for the non-party physicians would not be permitted to speak during depositions. The Appellate Division held that counsel for a non-party does not have a right to object during or otherwise participate in a pre-trial deposition under CPLR § 3113(c). Counsel for the non-party physicians argued that while they could not participate or object during trial, they were entitled to object during depositions. The Court held that there is no such distinction in the language of CPLR § 3113(c). The Court further noted that 22 NYCRR 202.15 refers only to objections by the parties (22 NYCRR 202.15(g)(1)(2) ).

## 5. FIREFIGHTER RULE

The Firefighter Rule Applied to Bar Police Officer's Common Law Negligence Claim.

David Wadler v. The City of New York
2010 N.Y. Slip. Op. 1373 (2010)

Plaintiff, the commanding officer of the Police Commissioner's Liaison Unit, was injured as he was driving into a secured parking lot of New York City Police Headquarter in Manhattan. A security barrier was accidentally raised while plaintiff was driving over it. The front of his car was lifted into the air, and he was injured. The Court of Appeals set forth the "Firefighter" rule, which holds that "where some act taken in furtherance of a specific policy or firefighting function exposed the officer to a heightened risk of sustaining injury, he or she may not recover damages. By contrast a common-law negligence claim may proceed where an officer is injured in the line of duty merely because he or she happened to be present in a given location, but was not engaged in any specific duty that increased the risk of receiving that injury." The Court then held that the rule applied to bar the action, because a high-security device protecting the police headquarters parking lot was plainly a risk associated with the particular dangers inherent in police work. The Court further found that the entry into the parking lot, which only plaintiff's police credentials allowed him to enter was an act taken in furtherance of a specific police function, and which exposed plaintiff to the risk of this injury. Judge Jones dissented, finding that plaintiff's injuries were completely unrelated to the assumed risks of police duty and that there were no actions taken by him that heightened his risk of injury.

## 6. NEGLIGENCE

Landowner Not Liable for Acts of Third Person

Ahlers v. Wildermuth
2010 N.Y. Slip. Op. 1039 (3rd Dept. 2010)

While breaking up a house party, police discovered several intoxicated and apparently unconscious individuals inside a home owned by defendant Harold Clement. Plaintiff, Angela Ahlers, a paramedic with a local rescue squad, arrived and found defendant Josh Wildermuth unconscious. Wildermuth regained consciousness after Ahlers cleared his airway and administered oxygen. Wildermuth became combative, grabbed and twisted Ahler's arm and repeatedly struck her in the head. Plaintiff commenced suit against, among others, Harold Clement, the property owner, and Tara Clement, the purported host of the party. The Court held that is well settled that landowners have a duty to control third persons only when they have the opportunity to control such persons and are reasonably aware of the need for such control. Harold Clement averred that he was out of town at the time of the party, that he did not give permission to his daughter to host a party and that there was no alcohol in the house when he left. Tara Clement averred that there was no alcohol in the house when her parents left, that she did not invite Wildermuth to the house that night and that she never saw him drinking or intoxicated. The Court held that such evidence was sufficient to discharge Defendant's initial burden on their motion for summary judgment. The Court further held that Plaintiff failed to raise an issue of fact to defeat the motion. An affidavit from an investigator suggesting that Wildermuth had "prior contact with the criminal justice system" fell short of establishing that Wildermuth had a reputation for violence and that Tara Clement was aware of it.

## 7. INSURANCE

Insured's Notice to Carrier was Untimely

Lehigh Construction Group v. Lexington Insurance Co.
2010 NY Slip Op 1234 (4th Dept. 2010)

Construction worker John Sherk was injured in January 2004 when he fell from a height while performing construction work on a church. Sherk's employer had been hired by plaintiff Lehigh Construction Group. Sherk commenced an underlying personal injury action and served Lehigh via the Secretary of State on January 12, 2007. Lehigh received notice of service on February 23, 2007. Lehigh had been named as an additional

*Continued on next page*

insured on a commercial general liability policy issued to Sherk's employer by Lexington. Lehigh did not notify Lexington of the underlying action until April 17, 2007. Lexington denied coverage to Lehigh based on late notice. Lehigh contended that the delay in notice was based upon a reasonable belief that it was only a "pass through" defendant with respect to the underlying action. In reversing the denial of Lexington's motion for summary judgment, the Court held that while belief in non liability may excuse a failure to provide timely notice of an occurrence, in the subject case Lehigh had failed to provide timely notice of the actual commencement of the underlying action.

## 8. LABOR LAW

Plaintiff was not Engaged in Protected Activity

Davis v. Wind-Sun Construction, Inc.

2010 N.Y. Slip. Op 1173 (4th Dept. 2010)

Plaintiff was injured while he was attempting to move the fabricated steel components of a pedestrian bridge into his employer's facility. The Defendant was the general contractor of the project to construct the pedestrian bridge, and had entered into a contract with plaintiff's employer to fabricate the steel bridge components. The Court held that the Supreme Court properly granted defendant summary judgment dismissing the Labor Law Section 241(6) cause of action as plaintiff was not engaged in "construction, excavation and demolition work" at the time of the accident. The Court noted that the accident did not even occur on the construction site. On the same grounds, the Court held that the Supreme Court properly denied plaintiff's action for leave to amend to assert an alleged violation of Labor Law Section 240.

## 9. NEGLIGENCE

Defendants Owed No Duty to Protect Plaintiff From Acts of Third Party

Raczka v. Ramirez

2010 N.Y. Slip Op. 1272 (4th Dept. 2010)

Plaintiff was among a group of picketers protesting the work of non-union employees at a job site. After a scuffle, Defendant Ramirez, without authority, drove a truck owned by Defendant Brind'Amour through the picket line. Ramirez was an employee of Defendant Elliott Creek. As Ramirez drove through, he struck plaintiff. The Court held that in cases arising out of injuries sustained on another's property, the scope of the duty owed by permittees on the property is defined by past experience and the likelihood of conduct on the part of third persons which is likely to endanger the safety of the visitor. The Court held that the unauthorized use by Ramirez of the truck owned by Brind'Amour and his reckless disregard of the risk of serious injury in driving through the picketers was not the foreseeable result of any alleged security breach. The Court further held that even assuming a duty, the injuries were caused by Ramirez's independent and intervening criminal actions. The Court further held that the "key in the ignition" statute (VTL Section 1210) which provides an exception to the common law rule that an owner of a stolen vehicle is not liable for the negligence of a thief, did not apply to Brind'Amour as the accident occurred on private property, and the exception applies only to vehicles on public highways, private roads open to public vehicle traffic and parking lots.

## 10. NEGLIGENCE

Jury Verdict Set Aside on Both Liability and Damages

Dessasore v. New York City Housing Authority

2010 N.Y. Slip Op. 896 (1st Dept. 2010)

Plaintiff claimed that he tripped over a handrail that had come loose from the wall and was resting of the top of the steps in Defendant's building. At trial, plaintiff conceded that he was looking straight ahead and had not reached for the hand rail before commencing his descent. There was evidence that plaintiff may have been talking on his cell phone. The jury found both plaintiff and defendant were negligent, but that plaintiff's negligence was not a substantial factor in causing his injuries. The jury awarded plaintiff $5 million for past pain and suffering and zero for future pain and suffering and future medical costs. The lower Court denied Defendant's motion to set aside the verdict on liability. The lower Court granted both parties' motion to set aside the verdict on damages. The Appellate Division held that given the extent of plaintiff's injuries and the evidence of permanence, the award of zero damages for future medical costs and future pain and suffering could not be explained rationally. As such, the lower Court properly directed a new trial on damages. The Court further held that because there was evidence that plaintiff was not looking down before he proceeded to descend the stairs that he was not paying attention to his surroundings and that he was talking on his cell phone just before he fell, it was logically impossible to find negligence without also finding proximate cause, and remanded for a new trial on liability.

## 11. VICARIOUS LIABILITY

Employee was not Acting Within Scope of Employment at Time of Accident.

Wu v. Ng

2010 N.Y. Slip Op 957 (2nd Dept. 2010)

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Defendant Ng and a co-worker Liang were driving to find a restaurant for lunch. They worked for appellant General Human Outreach, Inc. Ng and Liang were not paid for their lunch hours. Ng only sought reimbursement for the mileage made for an earlier trip made from Appellant's Brooklyn office to the Queen's office. Ng had stopped at a curb after the trip from Queens to Brooklyn to seek authority to go to lunch. Once authority was granted, she pulled away from the curb. The accident happened thereafter, when the vehicle struck plaintiff. The Court held that appellant was entitled to summary judgment as appellant submitted sufficient evidence to establish that Ng was driving her personal vehicle to engage in a personal venture, namely to pick up lunch during an unpaid lunch break, and that she was not acting within the scope of her employment at the time of the accident.

## 12. LABOR LAW

Court of Appeals Grants Summary Judgment to Plaintiff Under Labor Law Section 240

Gallagher v. The New York Post

2010 N.Y. Slip Op 1014(2010)

The Court held that liability under Labor Law Section 240 does not attach when the safety devices that plaintiff alleges were absent were readily available at the work site, albeit not in the immediate vicinity of the accident, and plaintiff knew he was expected to use them but for no good reason chose not to do so causing an accident. However, the Court held that in the subject case there was no evidence in the record that plaintiff knew where to find the safety devices that the owner argued were readily available or that he was expected to use them. While one witness testified that appropriate devices were available at the project site on the date of the accident, nowhere in his testimony did he state that plaintiff had been told to use such safety devices. In addition, while the witness referred to a "standing order" directing workers to have a harness and tie off, he could not say that the order had been conveyed to the workers.

## 13. PRODUCT LIABILITY

Summary Judgment Granted to Defendant on Failure to Warn and Design Defect Claims

Yun Tung Chow v. Reckitt & Colman, Inc.

2010 N.Y. Slip Op. 13 (1st Dept. 2010)

Plaintiff was injured while using a drain cleaner called "Lewis Red Devil Lye". Plaintiff was attempting to use the lye to unclog a floor drain in the kitchen of a restaurant where he worked. The warning printed on the label stated that the lye should be used only as directed, that users should keep their face away from the can and drain at all times and that misuse may result in backsplash. The directions also called for the insertion of only one teaspoon of lye directly into the drain. Plaintiff used three teaspoons mixed with water, did not wear eye protection (another precaution in the warnings) and bent over and poured the mixture directly into the drain. At that point, the caustic liquid splashed back into plaintiff's face, causing injury. The Court held that the failure to warn claim must be dismissed as plaintiff made no attempt to read or obtain assistance in reading the label.

As to the design claim, the Court held that plaintiff's expert's opinion that nothing plaintiff did caused his injury lacked probative value because it omitted critical discussion of plaintiff's use of more than one tablespoon of lye. The expert also left unexplained how he arrived at percentages of dilution which would purportedly make the product safer. Finally, the Court held that the expert's postulation that bottling the lye in a water based solution would not render it ineffective was unsupported.

## 14. EXCULPATORY CLAUSE

Exculpatory Clause was Enforceable – Summary Judgment Granted to Defendant

Brothers v. Tyco International Ltd.

2010 N.Y. Slip Op 464 (2nd Dept. 2010)

While installing a home security system, a worker employed by the defendant Tyco allegedly drilled a hole in a waste disposal pipe in plaintiff's home. This allegedly caused a slum leak that resulted in a moldy condition throughout parts of plaintiff's house. The Court held that defendant established their prima facie entitlement to judgment as a matter of law by submitting a contract between the plaintiffs and defendant ADT, which unequivocally provided that the defendants would not be liable to plaintiffs for losses due to water intrusion or mold resulting from the installation of the home security system. The Court held that plaintiffs did not demonstrate the existence of a compelling public policy consideration that would justify voiding the exculpatory provision in this instance.

## 15. TRIAL

Court Reverses dismissal of Case Pursuant to CPLR Section 4401(a) After Opening Statements

Beshay v. Eberhart L.P. #1

2010 N.Y. Slip Op 461 (2nd Dept. 2010)

Plaintiff was allegedly injured at a work site when a

*Continued on page 57*

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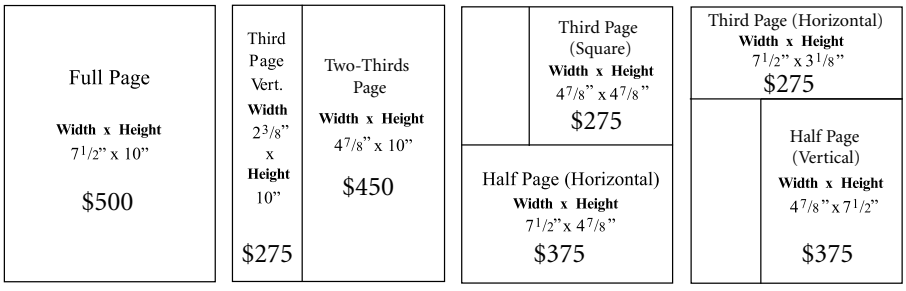

# President's Column

*Continued from page 1*

DANY is The New York Civil Defense Bar, and DANY remains vibrant. We were most fortunate to have thirteen past presidents at our *Past Presidents' Dinner* on November 17, 2009. (See the photographs inside!) And earlier this year, under the leadership of the Board of Directors, DANY came together in a campaign for donations for the Haitian people affected by the devastating earthquake.

Now, we look forward. We expect a great crowd at our ***Thirty-Fifth Annual Charles C. Pinckney Awards Dinner*** on Tuesday **April 20, 2010** at the New York Downtown Marriott Hotel at 85 West Street, New York, New York when DANY will honor **Robert S. Smith**, Associate Judge of the New York State Court of Appeals with the Charles C. Pinckney Award and honor **Stanley B. Green**, Justice of the Supreme Court of the State of New York, County of the Bronx, with the Distinguished Jurist Award.

As it always does, the Awards Dinner evening will start with an extraordinary CLE event at 5:30 pm. **Justice Allen Hurkin Torres** (Supreme Court, Kings), **Justice George J. Silver** (Supreme Court, New York), and **Shelley Rossoff Olsen**, Former Senior Court Mediator and Summary Jury Trial Judge (Supreme Court, New York) will present a panel discussion concerning, ***"What Defense Attorneys Should Know About How to Settle a Case***". These esteemed panelists have developed insights primarily from their vantage as neutral parties in settlement discussions, where most of us are typically partisans, and we are very interested in hearing from them.

More education? Yes! DANY will present, "***What You Need to Know About Medicare Set Asides***: *The Medicare Secondary Payer Statute, and The Medicare, Medicaid and SCHIP Extension Act*" from 5:30 pm until 7:30 pm on Thursday, April 29, 2010 at **The New York State Insurance Fund,** 199 Church Street, New York, NY 10007 –15h Floor. We have **Eric Berger** (Member, Cozen O'Connor) and **Brian Rayhill (**Managing Attorney, Epstein & Rayhill) to thank for this presentation.

Registration forms for the ***April 20, 2010 Awards Dinner*** and the ***April 29, 2010 Medicare Set Asides CLE*** can be found in this magazine and at our website, www.dany.cc, or contact Tony Celentano at 212.313.3618 for tickets to the Awards Dinner and to enroll for the CLE. Note also that it is not too early to contact Tony to reserve a foursome at ***DANY's Annual Meeting and Golf Outing***, which will be held on ***June 14, 2010*** at the beautiful Village Club of Sands Point, Sands Point, New York, convenient to New York City, Long Island, and Westchester!

Whether you are one of DANY's many new members, or whether you have been a member since before I was born, please share with me or any DANY officer any comments, concerns, questions, or suggestions concerning DANY and/or any of DANY's programs and member benefits.

# Worthy of Note

*Continued from page 52*

piece of flying debris struck him in the left eye. The debris was allegedly a piece of a circular saw blade. At the time, the saw was being operated by plaintiff's co-worker. After plaintiff's counsel made an opening statement at trial, both defendants made separate motions pursuant to CPLR Section 4401(a) for judgment as a matter of law. After plaintiff's counsel informed the lower Court that he would not change his opening statement if given a chance to "reopen", the Court granted both motions. On appeal, the Court held that a dismissal of the complaint after the opening statement of plaintiff's attorney is warranted only where (1) the complaint does not state a cause of action (2) that a cause of action that is otherwise stated is conclusively defeated by something interposed by a way of a defense and clearly admitted as fact; or (3) that counsel for the plaintiff in his or her opening statement, by some admission or statement of fact, so completely compromised his or her case that the court was justified in awarding judgment as a matter of law. The Court held that in his opening statement, plaintiff's counsel admitted that plaintiff was wearing protective eye gear just prior to the time of the accident, but chose to remove the gear in order to clean it. This admission required dismissal of the Labor Law Section 241(6) cause of action under Industrial Code Section 23-1.8(a). However, the Court held that the complaint stated viable causes of action under Labor Law Section 200 and strict products liability against defendant Bosch, and nothing in plaintiff's opening statement precluded the possibility of recovery under these theories.

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