



September 14, 2009

S.6068 (Sampson) / A.9052 (Hoyt) / S.52205 (Rules)

AN ACT to amend the insurance law, in relation to municipal cooperative health benefit plans, a study of community rating and the provision of claims experience to a municipality (Part A); to amend the general municipal law and the highway law, in relation to mutual aid (Part B); to amend the public health law, in relation to the composition of county and part-county boards of health (Part C); to amend the general municipal law, in relation to purchasing requirements (Part D); to amend the public authorities law and the local finance law, in relation to authorizing certain bonds to be issued or purchased by the municipal bond bank agency (Part E); and to amend the civil practice law and rules, in relation to treating public and private defendants equally when considering the impact of collateral source payments in tort claims for personal injury, property damage or wrongful death; to amend the general obligations law, in relation to protecting parties to the settlement of a tort claim from certain unwarranted lien, reimbursement and subrogation claims; and to repeal certain provisions of the civil practice law and rules relating to collateral source payments (Part F)

The New York State Trial Lawyers Association (NYSTLA) supports this bill, and Part F in particular, the enactment of new General Obligation Law section 5-335, which seeks to correct significant problems that have arisen in the litigation and settlement of personal injury and wrongful death actions. This portion of the bill aims to restore the important public policy goals of ensuring that personal injury victims obtain full and fair compensation and of promoting the settlement of tort actions by preventing benefit providers from making unwarranted reimbursement claims against plaintiffs and defendants alike.

In recent years, the Court of Appeals decisions in *Teichman v. Community Hosp. Of Western Suffolk*, 87 N.Y.2d 514 (1996), and *Fasso v. Doerr*, 12 N.Y.3d 80 (Feb. 24, 2009), have incorrectly opened the door to benefits providers, such as health insurers, to inject themselves into personal injury lawsuits by asserting claims of subrogation and rights of reimbursement, and by attempting to intervene in such lawsuits to assert those rights. There is currently no statute that addresses or limits the extent to which a benefit provider can claim a right of reimbursement or subrogation with respect to funds that it paid pursuant to an insurance contract or other agreement.

Part F would enact a new section of the General Obligations Law - § 5-335 - resulting in several important changes. First, it would create the conclusive presumption that, except with respect to payments made by a benefit provider for which there is a statutory right of reimbursement, the money paid in settlement of any personal injury or wrongful death action did not include compensation for the losses or expenses that were or will be paid by benefit providers. Second, a plaintiff in a personal injury or wrongful death action who settles with one or more of the defendants in the action could henceforth not be charged with thereby violating any non-statutory right of a benefit provider or the provisions of any contract between the plaintiff and a benefit provider. Third,

except for those payments made by a benefit provider for which there is a statutory right of reimbursement, no party that enters into such a settlement can thereafter be subject to any benefit provider's claim for reimbursement or subrogation.

Part F would also amend several sections of the Civil Practice Laws and Rules. It would amend CPLR § 4213 to be consistent with the 2003 amendments of CPLR Article 50-A. It would also repeal subdivision (b) of CPLR § 4545. This statute, which partially abolishes the common law "collateral source rule" in most tort cases, provides, in general, that a plaintiff who has a personal injury, wrongful death or property damage action cannot recover damages for any expense or loss that was or will be covered by a collateral source. The statute exempts those collateral sources that are entitled by law to liens against the plaintiffs' recovery (e.g., workers' compensation, Medicaid or Medicare payments). Further, under subdivision (b), a public employer is not entitled to any collateral source offset against future economic damages awarded to its employees in tort actions.

In addition to these principal changes, the bill would also amend CPLR § 4545 by codifying the case law permitting the plaintiff to prove his or her full damages at the trial, this because the presence or absence of substantial medical or other expenses may constitute telling circumstantial proof as to the nature or severity of the injury for which compensation is sought.

WHY PART F IS NECESSARY

Part F is needed because the proliferation of claims of subrogation and rights of recovery being asserted by health insurers in recent years has created significant difficulties for litigating and resolving personal injury cases. Two decisions by the Court of Appeals have facilitated this troubling trend.

Teichman v. Community Hosp. Of Western Suffolk, 87 N.Y.2d 514 (1996) was a medical malpractice action on behalf of an infant plaintiff. The health insurance plan that covered the child's mother contained a reimbursement provision in the event that she is repaid any medical expenses from another source. The case was settled before trial for \$4,500,000. Thereafter, plaintiff's counsel, who had received notice from the insurer that it was asserting a lien, wrote the insurer, informing it that the case was settled. Before a compromise order was signed, the plaintiffs moved to vacate the insurer's claims for reimbursement, and the insurer cross-moved for permission to intervene and a declaration that it was entitled to the approximate \$170,000 it had expended, plus all payments for future medical expenses. Before the Court of Appeals, the insurer sought either full reimbursement or a hearing to determine the amount of covered expenses included in the settlement. The Court held that the plan's language did not give rise to a lien, but that "intervention was proper to permit the insurer to establish its contractual right to reimbursement of any medical expenses actually included in the settlement." This decision ushered in a wave of health insurers asserting claims in personal injury actions, and often moving to intervene in the actions. Many courts have since denied intervention on the ground that it would create a conflict between the plaintiff and the insurer and would impede settlements; however, some courts have permitted such intervention.

These problems will invariably be exacerbated by the recent Court of Appeals decision in another malpractice case, *Fasso v. Doerr*, 12 N.Y.3d 80 (Feb. 24, 2009). In *Fasso*, the plaintiff's health insurer was granted permission to intervene to assert an equitable subrogation claim against the defendant for reimbursement of the payments made on the plaintiff's behalf, which totaled approximately \$780,000. The plaintiffs subsequently moved for summary judgment to dismiss the health insurer's complaint for equitable subrogation, arguing that it could not expect to receive

reimbursement from the defendant because the plaintiff's damages exceeded his malpractice coverage, and that the plaintiff could not be made whole in light of the coverage limits. The motion was denied, and the case settled for \$900,000, which was \$1.1 million less than the \$2 million in insurance coverage. By the terms of the settlement, the defendant admitted no wrongdoing, and the health insurer's subrogation claim was to be dismissed on the ground that the plaintiff was not made whole because the settlement payment was less than her actual damages. The trial court approved the settlement over the health insurer's objection, and the Appellate Division affirmed. But, the Court of Appeals reversed, holding that the insurer had a right of equitable subrogation, and that "the wrongdoer and the insured cannot agree to terminate the insurer's claim without its consent and such an agreement cannot be asserted as a defense to the insurer's cause of action." The Court found that while an insurer's subrogation rights are limited by the rule that a plaintiff must be "made whole" for her losses, this only applied where the recovery plaintiff receives is greater than the defendant's assets and available insurance coverage, leaving nothing for the insurer to execute its subrogation rights against. Only in that situation does the "made whole" rule prevent the insurer from sharing in the recovery. Since the insurance coverage was not exhausted, the "made whole" rule did not prevent the insurer from recovering pursuant to its right of subrogation. The Court concluded that the provision of the settlement that purported to bar the insurer's equitable subrogation claim was unenforceable, and could not prevent the insurer from obtaining reimbursement from the defendant. Thus, the defendant's liability did not end, as it thought it did, with the settlement of plaintiff's action.

The impact of the *Fasso* decision is that benefits providers asserting rights of subrogation can effectively hold up settlements between plaintiffs and defendants in personal injury actions, unless they get the amount they demand in satisfaction of their claims. This poses a significant threat to the rights of personal injury litigants on both sides, as well as to the court system generally, by stymieing settlements in such cases. Where a defendant is willing to settle, but wants to pay less than the full amount of the coverage, and a plaintiff is willing to accept such an offer to avoid the risk of proceeding to trial, the health insurer will be able to thwart the settlement unless its claim is paid. In fact, by the *Fasso* Court's reasoning, even if the full amount of the liability insurance coverage is offered in settlement, the insurer may be able to recover if the defendant retains assets. These insurers are in a position to demand full satisfaction of their claims, even if the injured plaintiffs are not made whole for their injuries.

The Court of Appeals' decisions in *Teichman* and *Fasso* have opened the floodgates to ever increasing claims of reimbursement and subrogation being made by health insurers in personal injury actions. These claims are in direct contravention of the sound public policy of this State to enable personal injury victims to obtain full and fair compensation, and to encourage settlements in personal injury cases. The proposed bill would further these important public policies and effectively address the problems identified above by preventing benefit providers from overreaching, be it in seeking to recover from plaintiff benefits that were surely not included in a settlement or by pursuing claims of subrogation against a settling defendant.

OTHER PROVISIONS OF PART F

NYSTLA also supports the provision of this bill that amends CPLR § 4213 to make it consistent with the 2003 revisions to §§ 4111(d) and 50-A. The new form of verdicts necessary to affect the new form of structured judgments under the 2003 legislation was not made applicable to bench trials under CPLR § 4213; this bill corrects that omission.

Historically, NYSTLA has opposed the repeal of subdivision (b) of CPLR § 4545, which denies a public employer the benefit of any collateral source offset against future economic damages awarded to its employee in a tort action. The City of New York argues that by reason of this exception, City employees are able to obtain certain benefits from the City and then receive similar compensation from it through litigation. However, there is little evidence that this in fact frequently occurs. Rather, current law serves to aid in obtaining a fair resolution of tort claims brought by firefighters and other municipal employees against their employer. Thus, NYSTLA would prefer for this bill not to include the repeal of CPLR § 4545 (b). We are at least encouraged by the fact that the bill provides for the repeal of this provision to apply only to cases filed on or after the effective date. To have the repeal also apply to pending cases would have unjust and egregious consequences; especially for the thousands of heroic firefighters and other first responders at Ground Zero who currently have actions pending against the City of New York for its failure to provide proper protective equipment resulting in debilitating respiratory illnesses. In 2003 the federal government granted the City \$1 billion to cover all 9/11 claims, and, according to the City's own attorneys, the City's liability is limited to \$1 billion for all such claims. If those funds are used for their stated purpose, these first responders will get the compensation they deserve, and, by its own admission, at no cost to the City.

Notwithstanding our serious concerns with the repeal of subdivision (b) of CPLR § 4545 which we believe to be unwarranted, given its prospective-only application and the paramount importance of enacting § 5-335 of the General Obligations Law for the reasons set forth above, NYSTLA supports this bill and urges the Legislature to promptly pass this bill.

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