EXHIBIT D

To commence the statutory time period for appeals as of right (CPLR 5513 [a]), you are advised to serve a copy of this order with notice of entry, upon all parties.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF DUTCHESS
HON. PAUL I. MARX, J.S.C.

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CHRISTINE STEELE,

Plaintiff,

-against-

HEALTHCARE PROFESSIONALS INSURANCE COMPANY and SPYROS PANOS, M.D.

Defendants.

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DECISION AND ORDER

Index No.: 2019-54012

The following papers, filed on NYSCEF, have been read and considered on Defendant Healthcare Professionals Insurance Company's ("HPIC") motion to dismiss Plaintiff's complaint pursuant to CPLR §3211, which the Court converted to a motion for summary judgment:

In support of the motion:	Doc ## 23 through 27;
In opposition to the motion:	Doc ## 30 through 38;
In reply:	Doc ## 39 through 40;
In further support of the motion:	Doc ## 42 through 46;
In further opposition to the motion:	Doc ##47 through 49; and
In further reply:	Doc # 50.

BACKGROUND

Plaintiff, Christine Steele ("Steele" or "Plaintiff"), is one of 255 individuals who previously brought suit against Defendant Spyros Panos, M.D. ("Panos"), an orthopedic surgeon, arising from medical treatment rendered by him during the period 2004 through 2011. Collectively, the actions against Panos came to be referred to as the "Panos Litigation."[1] Steele alleged that she suffered

[1] A list of the claims asserted is annexed to the Complaint as Exhibit I. NYSCEF Doc # 10. The Panos Litigation was overseen at its conclusion by the undersigned and the Hon. Lewis J. Lubell, J.S.C.

medical malpractice at the hands of Panos on February 23, 2010. As a result, she filed suit against Panos on November 16, 2011. (NYSCEF Doc # 1, Dutchess County Index # 1312/2011). Medical Liability Insurance Company ("MLMIC"), which provided Panos with the first layer of professional liability insurance, defended the action pursuant to a claims-made insurance policy which covered claims made in 2011.

After extensive discovery and delay caused by various factors, including the number of claims, Panos' incarceration and his refusal to consent to settle,[2] the claims proceeded to alternative dispute resolution pursuant to an Arbitration Agreement dated December 21, 2017 ("the Agreement"). All 255 plaintiffs, MLMIC and HPIC,[3] which provided Panos with the first layer of excess insurance coverage,[4] entered into the Agreement. The Agreement was subsequently So Ordered by the Court.

The Agreement and Judgments

The Agreement provided for all cases to be resolved by the chosen arbitrator, the Hon. Peter B. Skelos (Associate Justice, Appellate Division, Second Department, ret.). As prescribed by the Agreement, Justice Skelos applied a matrix under which he allotted points to each individual

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[2] Panos refused to consent to settlement of the claims as was his right under the insurance policies issued by MLMIC. In turn, MLMIC exercised its right to seek review of Panos' refusal by submitting the issue to a physician advisor appointed by the Medical Society of the State of New York, Stephanie E. Siegrist, M.D. ("Siegrist"). Panos challenged Siegrist's determination that the claims should be settled over his objection in an action entitled *Panos v MLMIC*, Putnam County Index #50013/2017. By Decision and Order dated February 20, 2018, this Court dismissed Panos' claims against MLMIC and Siegrist. The Court adhered to that determination on Panos' motion for re-argument/renewal in a Decision and Order dated June 22, 2018.

[3] Plaintiff's complaint alleges that HPIC is the successor to HANYS Member Hospitals Self Insurance Trust ("HANYS"). Complaint Doc # 1, ¶ 8. Plaintiff alleges that HANYS issued policies to Panos for the years 2004 through 2007 and that HPIC issued excess policies to Panos from 2007 through 2011. *Id.* ¶ 9-10. The parties agree that HANYS' obligations under the policies issued by it are now the obligations of HPIC. References herein will be to HPIC, regardless of which entity actually issued the policy.

[4] MLMIC also provided insurance coverage to Panos' medical group. That layer of insurance is excess to HPIC. The proceeds of that coverage have been paid into escrow by MLMIC, to be distributed after determination of this declaratory judgment action.

plaintiff, based on the nature, type and number of surgical procedures performed by Panos,[5] as well as the length of time each plaintiff had uninterrupted treatment.[6] Additional monies were awarded for medical bills/liens and lost wage claims. Wrongful death cases were valued under a slightly different model not relevant to this dispute. Each point carried a dollar value which, when multiplied by the number of points, yielded a monetary award to each plaintiff. Each party submitted a proposed point evaluation and was given the opportunity to argue the claims before Justice Skelos.

Each of the plaintiffs in the Panos Litigation was given the right to opt out of the Agreement and elect to proceed to trial. MLMIC reserved the right to withdraw from the Agreement if a large enough number of plaintiffs opted out, thereby negating the efficacy of the Agreement. Apparently recognizing that the amount of available insurance likely would be insufficient to compensate all plaintiffs fully and accepting that some measure of compensation was better than none, all plaintiffs ultimately accepted the Agreement. Thus, each plaintiff agreed to a *pro rata* share of all collectible insurance based on their awards.

All parties benefitted from the Agreement. Plaintiffs benefitted because both liability (malpractice) and causation were conceded. This eliminated the uncertainties of trying each individual case and the possibility of a finding that Panos did not depart from good and accepted practice in a particular case, or that the claimed damages were not caused by his malpractice. Panos benefitted, though he objected to the Agreement, by avoiding exposure to personal liability for judgments which exceeded the available insurance coverage. MLMIC benefitted by avoiding the immense costs associated with the continued defense and trial of the large number of cases and the possibility of leaving Panos uninsured for a significant number of claims. MLMIC also avoided potential claims of unfair practices or bad faith caused by elevating one claim above other claims,

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[5] Numerous plaintiffs had multiple surgeries performed by Panos. In some cases, Panos performed multiple surgeries on the same body part, in other cases he performed multiple surgeries on different body parts for the same plaintiff. Panos' malpractice was not limited to surgery. Some claims involved the failure to diagnose conditions while others involved the performance of surgeries which were not necessary.

[6] Defined in the Agreement as a period in which no more than 18 months elapsed between medical treatments.

paying an individual claimant before other claimants, or exhausting the available coverage inequitably. MLMIC further benefitted, as did HPIC, from the provision in the Agreement that interest on judgments against Panos would accrue only after this then anticipated declaratory judgment action was determined by the Court, rather than from the date of each entered judgment as provided for in CPLR §5003. In addition, plaintiffs agreed to reduce the amount of interest from the statutory 9% per year provided for in CPLR §5004 to 4% per year from the date of the Court's determination, until paid. The Agreement also provided that the interest rate increases to 6% per annum if HPIC appeals the determination of this action. Interest is to be paid on "any unpaid Judgment", subject to the terms of the insurance policies and irrespective of policy limits.[7] *Id.* at ¶¶ 52, 53, 54.

As part of the Agreement, HPIC preserved its right to challenge the applicability of its coverage, the issue at bar. The parties anticipated that HPIC might contest coverage based upon its previously articulated suggestions that its coverage was not implicated by the claims for various reasons. Thus, the Agreement contemplated the instant action.

The awards rendered by Justice Skelos were reduced to judgments in the total amount of $141,851,026. The awards covered alleged malpractice which occurred in the period 2004 through 2011, for which claims were asserted in the years spanning 2010 to 2014. The claims asserted in

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[7] HPIC contends that it has no obligation to pay interest. This position is incorrect. In the insurance policies issued by HPIC, it agreed to pay all sums to which Panos became liable "in excess of the limits of liability of the Underlying Policy as set forth in the Declarations, but only up to a total amount of the limits of liability provided herein, which the Named Insured shall become legally obligated to pay as damages because of injury to any one person, including death resulting therefrom, arising out of the rendering of or failure to render, during this excess coverage period, professional services ...". NYSCEF Doc # 3, Coverage Agreement at 3. While this language appears to limit HPIC's exposure to the face amount of its policies, the Agreement specifically stated that "interest would accrue on any unpaid Judgment, or portion thereof". Agreement ¶ 52. Finally, the parties clearly evidenced their intention as follows: "[i]t is intended that the interest to be paid by MLMIC and/or HPIC is irrespective of their policy limits". Agreement ¶ 54.

Statutory interest on the judgments is an amount for which Panos became obligated when the judgments were entered. CPLR §§5003, 5004. Thus, except for the fact that the parties contracted for a different inception date for interest to accrue and for rates different than set by statute, the judgments would earn interest at 9%. Having contracted to defer interest at a reduced rate and having agreed that interest was "irrespective of policy limits", HPIC is bound to pay interest on the unpaid portion of the judgments.

the MLMIC 2010 to 2011 policy year resulted in awards totaling $3,495,939. The claims asserted in the MLMIC 2011 to 2012 policy year resulted in awards totaling $78,896,834. The claims asserted in the MLMIC 2012 to 2013 policy year resulted in awards totaling $53,366,071. The claims asserted in the MLMIC 2013-2014 policy year resulted in awards totaling $6,092,183. NYSCEF Doc # 10.

MLMIC issued primary insurance policies to Panos on an annual basis from July 1, 2005 to July 1, 2011, with limits in the amounts of $1.3 million per person and $3.9 million in the aggregate for each policy period. The MLMIC policy periods were July 1, 2005 through July 1, 2006, July 1, 2006 through July 1, 2007, July 1, 2008 through July 1, 2009, July 1, 2009 through July 1, 2010, and July 1, 2010 through July 1, 2011. When MLMIC ceased issuing policies to Panos in 2011, he obtained coverage for subsequent years pursuant to extended reporting endorsements, colloquially known as "tails". Panos obtained tails for the periods July 1, 2011 through July 1, 2012, July 1, 2012 through July 1, 2013 and July 1, 2013 through July 1, 2014. NYSCEF Doc # 3.

HPIC (or its predecessor, HANYS) issued excess professional liability insurance policies to Panos for the periods July 1, 2005 to June 30, 2005, July 1, 2006 to June 30, 2007, July 1, 2007 to June 30, 2008, July 1, 2008 to June 30, 2009, July 1, 2009 to June 30, 2010 and July 1, 2010 to June 30, 2011. Each policy carried limits of $1 million per claim and $3 million in the aggregate. The parties dispute whether HANYS or HPIC issued a policy for July 1, 2004 to June 30, 2005. That issue is not presently before the Court.

The awards against Panos dwarfed the amount of coverage available through MLMIC. As noted above, MLMIC's primary policies provided insurance coverage of up to $1.3 million per claimant with an aggregate of $3.9 million in any given policy year. Because the awards exceeded $3.9 million in each policy year, except for 2010, MLMIC's policies were exhausted.

In only 5 of the 255 claims was the primary insurance adequate to pay the judgments. These 5 claims, made in 2010, were paid by MLMIC pursuant to the primary insurance policy issued by it for that policy year and are not before the Court at this time.

In the remaining 250 claims, the insurance available through the MLMIC primary policies was inadequate to fully satisfy the judgments. Consequently, on March 21, 2019, Steele's counsel, acting for Steele and the other plaintiffs, tendered the judgments to HPIC for compensation. NYSCEF Doc # 8. HPIC denied coverage despite tender of the judgments. Hence, the issues are ripe for determination.

HPIC's Disclaimer

By letter dated May 21, 2019,[8] HPIC's Executive Chairman of the Board, Mark Morris, denied coverage for all of the judgments, asserting:

> the total arbitration awards exceed the MLMIC $3.9 million aggregate limit in three tail periods, 2011-2012, 2012-2013, and 2013-2014. The HPIC policies were not in effect during these periods. NYSCEF Doc #12.

Morris continued:

> The only coverage period during which a HPIC policy was in effect and for which claims resulting in arbitration awards were made is the 2010-2011 period. The awards during that period total only about $3.5 million, an amount not sufficient to exhaust the MLMIC aggregate coverage, and no individual claim award exceeds $1.3 million. Similarly, the MLMIC policies underlying HPIC's policies for 2005-2006, 2006-2007, 2007-2008, 2008-2009 and 2009-2010 policy periods were not exhausted by the payment of claims. *Id.*

Consequently, the disclaimer by Morris asserted that:

> none of the six MLMIC policies underlying the six HPIC policies were exhausted. And only during one such policy, the 2010-2011 MLMIC policy, were claims even made. Under these circumstances, none of the six HPIC policies have been triggered, and the excess coverage cannot be made available to satisfy the arbitration awards. *Id.*

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[8] The disclaimer letter was directed to the undersigned and Justice Lubell because the Agreement was the product of negotiations which occurred with significant input from the court. A copy of the letter was provided to all plaintiffs' counsel in the Panos Litigation.

Simply stated, HPIC denied coverage under the excess policies because it contended that: (1) the policies issued by it were "not in effect" during 2011-2012, 2012-2013 and 2013-2014 when Panos's primary coverage was pursuant to a tail; (2) the judgments which arose from treatment rendered during the 2010-2011 policy were less than the aggregate coverage afforded to Panos under MLMIC's primary policy;[9] and (3) none of the primary claims-made policies issued by MLMIC for occurrence years 2004 through 2010 were exhausted. Affirmation of Tyler Lory, Esq., Doc # 24, ¶ 13. This suit followed.

The Instant Action

On February 8, 2019, Plaintiff received an arbitration award in the amount of $1,031,564.61. The award was reduced to a judgment signed by this Court on March 20, 2019. NYSCEF Doc # 16. The judgment was tendered, along with all other judgments entered against Panos, to MLMIC and HPIC on March 21, 2019. NYSCEF Doc # 8. MLMIC subsequently paid Plaintiff a portion of the judgment awarded to her, allocating all available insurance for the 2011 claim year amongst all plaintiffs who filed claims in that year. As a result of the allocation of the $3.9 million MLMIC policy limits, Steele received payment from MLMIC in the amount of $50,487.86, a small fraction of the $1,031,564.61 awarded to her.[10] NYSCEF Doc # 17.

Plaintiff alleges that HPIC issued excess insurance coverage to Panos on an occurrence basis during the years commencing July 2004 through July 2011, in the amount of $1 million per person and $3 million in the aggregate.[11] Plaintiff seeks a declaration that the excess policies issued

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[9] As noted above, there was no dispute regarding these 5 claims.

[10] Roughly 4.89% of the amount awarded.

[11] Plaintiff's complaint alleges that HANYS issued an excess policy of insurance to Panos for the year 2004 as well. Plaintiff asserts the policy number is "believed to be 0515400413 for the period July 1, 2004 through June 30, 2005". Complaint ¶ 8(a). HPIC denies the existence of such a policy, although for the purposes of its motion, asserted that "the issuance or non-issuance of HPIC excess coverage for the period beginning July 1, 2004 is not relevant." Given the determinations made herein, the issuance of a policy for that period is, in fact, relevant to claims asserted by other plaintiffs. Because Steele's claim did not arise during that policy period, the Court makes no determination in this action as to whether such policy exists.

by HPIC to Panos were triggered by the exhaustion of the primary claims-made policy for the year the claim was made, such that HIPC must pay the damages awarded pursuant to the judgments entered against Panos.[12] Thus, Plaintiff seeks a declaration that HPIC is required to pay up to its policy limits of $3,000,000 for malpractice which occurred in each of the policy years in which the MLMIC primary coverage was inadequate, a potential exposure by HPIC of $18,000,000, plus interest .[13]

As filed, Plaintiff's complaint set forth five causes of action. The first cause of action seeks a declaration that the claims-made MLMIC policy which responded to plaintiff's complaint constituted the requisite underlying policy to require HPIC's excess policies to answer for the awards entered against Panos. The second cause of action seeks a declaration that for those periods in which MLMIC provided coverage to Panos pursuant to an Optional Extended Reporting Period Endorsement ("tail"), the tail constituted the requisite underlying policy, the exhaustion of which required HPIC to answer for the damages. The third cause of action alleged that HPIC was estopped from disclaiming coverage because the disclaimer was untimely. The fourth cause of action asserted that HPIC acted in bad faith with respect to Plaintiff's claims (and all other claimants) against Panos by refusing to pay the judgments. The fifth cause of action contended

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[12] The determinations made herein are applicable to all other plaintiffs who, like Steele, were awarded damages in excess of the aggregate amount of insurance available to answer the awards from the MLMIC policies and who, but for the disclaimer, are entitled to be paid under the excess policies. Agreement ¶ 50. Pursuant to the Agreement, all plaintiffs agreed to share on a *pro rata* basis in any available and collectible insurance proceeds. Agreement, ¶¶ 49, 50. Had they not agreed to such a distribution, it was likely, assuming plaintiffs' verdicts, that the cases which were tried first would have exhausted all coverage, leaving no insurance money available to pay the remaining plaintiffs' damages. This would have visited a gross inequity on those plaintiffs whose cases were tried later.

[13] Plaintiff asserts that there are seven policy periods. As noted above, HPIC disputes issuing a policy that covers occurrences in 2004. The Court is aware that a second declaratory judgment action entitled, *Negri v HPIC and Panos*, has been filed. (Dutchess County Index # 2020-53051). One of the primary issues in that case is whether HANYS , in fact, issued a policy to Panos for 2004-2005 (which was assumed by HPIC) and/or whether HPIC should be estopped from denying the existence of coverage for that period. That action is in its infant stages.

that HPIC is liable to Plaintiff under General Business Law § 349 for alleged deceptive practices. The third, fourth and fifth causes of action have now been withdrawn.[14]

HPIC's Motion to Dismiss

HPIC moved to dismiss the action under CPLR §3211, in lieu of answering. Although HPIC did not specify under which sections of CPLR §3211 it sought relief, the affirmation submitted in support of the motion stated that the motion is predicated on CPLR §3211 (a)(1) and (a)(7). HPIC asserts that the insurance policies comprise documentary evidence which refutes Plaintiff's contention that excess insurance is available to respond to the judgments entered against Panos and that, as a result, Plaintiff's complaint fails. As to the first cause of action, HPIC submits that Plaintiff misconstrues the insurance policies to require only the exhaustion of the primary claims-made policy for the year in which her claim was asserted, 2010-2011. As to the second cause of action, HPIC contends that its policies are inapplicable because the requisite primary policies have not been exhausted and a tail cannot constitute an Underlying Policy within the meaning of HPIC's policy.

In making its motion, HPIC advances the coverage position espoused by Morris in his May 21, 2019 disclaimer letter. Essentially, HPIC asserts that its policies are not excess to the tail coverage and that unless the primary policy for the occurrence year was exhausted, it has no obligation to pay out. HPIC identifies, as the Underlying Policy, only the specific policy which is reflected on the Coverage Declaration Page of its policy. NYSCEF Doc # 3 un-numbered page 1.

Upon review of the papers submitted on HPIC's motion to dismiss, the Court notified the parties that it intended to treat the motion as a motion for summary judgment pursuant to CPLR §3211(c). Consequently, the Court invited additional briefing and submissions. Both parties submitted additional papers and, after some period of delay occasioned largely by the COVID-19

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[14] While this motion was *sub judice*, plaintiff's counsel informed the Court that the third, fourth and fifth causes of action were being voluntarily discontinued. Hence, this Decision and Order does not address that portion of the motion which sought to dismiss those claims. A So Ordered Stipulation of Discontinuance has been filed as NYSCEF Doc #53.

pandemic, the final briefs were submitted on July 8, 2020. Oral argument was held via Skype on August 18, 2020.[15] The Court addresses only the remaining causes of action which seek declarations as to the proper interpretation and application of HPIC's excess policies.

HPIC submitted additional evidence and an additional memorandum of law. The evidence submitted included (1) an affidavit from Morris;[16] (2) an affidavit from Gregory V. Serio, Esq., the Superintendent of the Department of Insurance for the State of New York from 2001 to 2005, ("Serio"); (3) a copy of Section 18 of the Laws of 1986, ch 266, §18 (1)(a)(4) ("Section 18 Program"); and (4) the 2012 Report on the Hospital Excess Liability Pool.

Serio provided his opinion of how the Section 18 Program from which the excess policies emanated was created and should, in his opinion, be interpreted. Among other opinions, Serio asserted that the funding of the Section 18 Program, which is discussed below, does not contemplate HPIC's policies being excess to tail coverage.

HPIC contends that the provisions of the insurance policies constitute documentary evidence which refute each and all of Plaintiff's claims such that the complaint should be dismissed. Alternatively, HPIC contends that Plaintiff's complaint fails to state a cause of action. HPIC submits that Plaintiff incorrectly interprets the language of HPIC's policies to find that excess coverage was triggered. Essentially, HPIC contends that because MLMIC's primary policies in effect *in the occurrence years* were not exhausted, excess coverage was not implicated. Parroting the disclaimer letter, HPIC asserts that:

> the only coverage period during which a HPIC policy was in effect and for which claims resulting in arbitration awards were made is the 2010-2011 policy period. The awards during that period totaled only about $3.5 million, an amount not sufficient to exhaust the MLMIC total $3.9 million limit. No individual claim

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[15] The Court delayed issuing this Decision and Order at the parties' request to allow settlement discussions to proceed.

[16] When submitted, Morris' affidavit was not notarized, although it was accompanied by a letter from counsel explaining that Morris was unable to obtain a notary because of COVID-19 related issues while he was in Florida. NYSCEF Doc # 42. HPIC was permitted to submit a notarized affidavit after oral argument. NYSCEF Doc # 52.

> award, moreover, exceeded the MLMIC $1.3 million each person limit, and the Plaintiff does not claim otherwise. In addition, and as evident, the MLMIC policies underlying HPIC's policies for the 2005-2009 policy years were not affected by the claims asserted against Dr. Panos. Thus, MLMIC paid no claims paid [sic] for the policies in effect for those years. Affirmation of Tyler J. Lory, Esq. in support of Motion to Dismiss, NYSCEF Doc # 24, ¶ 14.

HPIC argues further that:

> As a result, none of the six MLMIC policies underlying the six HPIC policies were exhausted. And only during one such policy, the 2010-2011 MLMIC policy, were claims even made. Under these circumstances, none of the six HPIC policies have been triggered, and the excess coverage cannot be made available to satisfy the arbitration awards. *Id.* ¶ 15.

HPIC contends that Plaintiff has incorrectly identified the underlying policies which were required to be exhausted in order to trigger the excess policies. HPIC argues that the relevant claims-made policy was the one in effect during the year of the occurrence. It asserts that "the declaration page of each policy expressly references MLMIC as the underlying carrier for each policy year." *Id.* ¶ 21. HPIC submits that

> the coverage form attached to the declaration page for each policy period expressly describes the underlying MLMIC coverage that must be maintained as a condition of the HPIC excess coverage. (*See* Complaint Exhibit B, Part IV of each coverage form.) The requirement that the specified underlying coverage be maintained for each policy period is reinforced by the following language that appears on page 9 of each coverage form:
>
> Continuous maintenance of an Underlying Primary Policy or policies as set forth in the Declarations is ***required as a condition of this policy and this excess policy shall be deemed concurrently cancelled*** on the date of the failure to maintain the required Underlying Primary Policy. *Id.* (Emphasis in original)

Consequently, HPIC contends that "Count [sic] 1 should be dismissed because the relief sought contradicts the terms of the HPIC policies attached to the Complaint as Exhibit B."

Affirmation of Tyler J. Lory, Esq. at ¶ 24, NYSCEF Doc # 24. HPIC adds that "Count [sic] II should be dismissed "for the same reasons as Count [sic] 1." *Id.* ¶ 27. Succinctly stated, HPIC contends that its coverage was not triggered because the requisite underlying policy, which it asserts was the claims-made policy in effect in the year of the occurrence (not the year of the claim) was not exhausted.

Plaintiff's Opposition

Plaintiff opposed HPIC's motion, asserting that HPIC's interpretation of the insurance policies is "directly contrary to the plain meaning of their policy language and directly contrary to HPIC's prior business practices. Nowhere in HPIC's policy does language exist that supports the argument they have made herein." Affirmation of Nancy McGee, Esq., dated January 31, 2020, at 2, NYSEC Doc # 30. Plaintiff contends that HPIC's argument is "totally illogical" as it would require the exhaustion of "**nine** separate primary policy periods totaling $35,100,000." *Id.* (Emphasis in original).

Plaintiff contends that the policy language is clear and unequivocal and that application of the verbiage employed in the policy requires a declaration that the exhaustion of the MLMIC policies in each of the years in which the claims were made, not the years of the occurrences, is sufficient to implicate the excess coverage provided by HPIC. In addition, plaintiff asserts that exhaustion of the claims-made primary policy in each of the tail years similarly implicates the excess coverage for each occurrence year.

Plaintiff notes that in the underlying malpractice action, HPIC confirmed that its excess occurrence policy was excess to the claims-made MLMIC primary policy for the claim year. In this regard, Plaintiff notes that the insurance disclosure made pursuant to CPLR §3101(2)(f) by Panos' defense counsel indicated that the excess policy HPIC issued for the year of Plaintiff's surgery (2009-2010) was excess to the MLMIC 2011 claims-made policy, the year in which Plaintiff made her claim. NYSCEF Doc # 33. The insurance disclosure recites that Panos had (1) primary insurance afforded to him by MLMIC pursuant to a tail appended to MLMIC policy #3232329 for the policy year August 30, 2011 through August 30, 2012; and (2) occurrence based excess insurance through HPIC pursuant to policy number 1015400413 for the period July 1, 2009

through June 30, 2010. That this is so, Plaintiff submits, is reinforced by a letter sent by HPIC's Vice President of Claims, Grace Morgan, Esq., on January 20, 2012, to Panos in which she disclaimed coverage to Panos' professional corporation, which was also named as a defendant in Plaintiff's medical malpractice complaint against Panos. In disclaiming coverage to the professional corporation, Morgan explicitly stated that excess coverage was provided to Panos based on the claim which was made in 2009-2010. The letter specifically recited that HPIC "provides excess professional liability coverage of $1 million per claim/$3 million per aggregate *to you* for the period 7/1/09 - 6/30/10" but does not provide coverage for Panos' professional corporation. NYSCEF Doc # 32 (emphasis in original).

In addition, Plaintiff submitted evidence that on prior occasions, HPIC applied a different interpretation of its policies than it urges here. Plaintiff submits evidence of three (3) other claims in which HPIC provided excess coverage to its insured upon the exhaustion of a primary claims-made insurance policy issued by MLMIC. Thus, Plaintiff contends, HPIC cannot now offer a different interpretation of its policies.

Plaintiff urges that public policy requires the Court to reject HPIC's "tortured interpretation of their excess professional liability insurance policy." This latter assertion is predicated on Plaintiff's claim that the issuance of an excess policy on an occurrence basis which requires the exhaustion of a claims-made policy for the same coverage period renders the actual application of excess insurance "nearly impossible." To benefit from an excess policy issued on an occurrence basis which requires the exhaustion of a claims-made primary policy in the manner HPIC suggests would require a plaintiff to "recognize that they were malpracticed [sic], hire an attorney, who would have to have the case reviewed and put into suit, all within whatever time was left on HPIC's occurrence based policy period. Not only is that nearly impossible to do, but it is effectively shortening plaintiff's statute of limitations to less than a year." Thus, Plaintiff continues, "[i]f this Court accepts HPIC's coverage position, they [sic] are condoning HPIC's sale of insurance policies that could never be utilized by their insureds." McGee Affirmation at 18, NYSCEF Doc # 30.

Plaintiff alleges that HPIC has misconstrued its own policies by requiring the claims-made policy in effect during the year of the occurrence to be exhausted as a condition of HPIC's coverage. Plaintiff contends that because the underlying policy issued by MLMIC was a claims-made policy, it is the primary policy in the claim year that must be exhausted to trigger excess coverage in the occurrence year. Plaintiff asserts that, under HPIC's interpretation, excess coverage would be limited to those cases where either (1) the claim was made in the occurrence year; or (2) the claim was made outside of the occurrence year and the exhaustion of *two* primary policies was required. Thus, in the latter situation, Plaintiff contends that HPIC's interpretation would require both the exhaustion of the primary policy in the year the malpractice occurred and in the year the claim was made before excess coverage would be triggered. This requirement, which Plaintiff refers to as a "double trigger", is not stated in HPIC's policy.

HPIC's Reply

In reply, HPIC argues that "Plaintiff's arguments ... do nothing to create a fact issue that would prevent the granting of judgment in favor of HPIC." Defendant's Supplemental Reply Memorandum in Support of Motion to Dismiss/Summary Judgment. NYSCEF Doc # 50 at 2. HPIC re-asserts its contention that Plaintiff fails to understand the mechanics of the occurrence policy. HPIC contends that Plaintiff incorrectly argues that excess coverage is determined by the year of the claim rather than the year of the occurrence. HPIC argues that, to the contrary, it is the claims-made policy in effect in the year of the occurrence which is identified as the "Underlying Policy" and, therefore, it is that policy which must be exhausted to activate excess coverage.

HPIC contends that Plaintiff has conceded that "HPIC's policy language is unambiguous". Thus, "the Court need look no further than the policy itself to determine HPIC's excess coverage obligations." HPIC Brief Supplemental Reply Memorandum at 3, *citing R/S Associates v New York Job Development Authority*, 98 NY2d 29, 32 [2002], NYSCEF Doc # 50. As such, HPIC urges the Court to adopt an interpretation which would hold that "the Underlying Policy remained the same, namely, the policy shown in the Declarations for each year and issued for the same coverage period as the HPIC policy." Thus, it submits that "there is no dispute as to the fact that the coverage limits of the MLMIC policies designated as Underlying Policies for Dr. Panos – *i.e.*, the MLMIC

policies issued for the years beginning July 1 of 2005 through 2010 – were never exhausted. Consequently, no coverage obligation under the corresponding HPIC policies was ever triggered." Defendant's Supplemental Reply Memorandum in Support of Motion to Dismiss/Summary Judgment at 4, NYSCEF Doc # 50.

In his affidavit, Morris contested the years for which HPIC issued policies to Panos, asserting that no policy was issued for occurrence year 2004. Morris also addressed the three cases cited by Plaintiff in which HPIC contributed to settlement of claims without requiring the exhaustion of the primary policy. These, he explained, were "accommodations" to HPIC's insureds, none of whom had the loss experience that Panos created. He asserts that such accommodations do not bind HPIC here.

DISCUSSION

The Undisputed Facts

While the parties contest coverage in this case of first impression, certain facts are not in dispute. These include the fact that Panos obtained primary claims-made policies from MLMIC; that claims were asserted against Panos by the 255 claimants; that those claims alleged medical malpractice committed by Panos in the years 2004 through and including 2011; that the claims were resolved pursuant to the Arbitration Agreement; that the total awards rendered and judgments entered were in the amount of $141,851,026; and that the insurance provided by MLMIC was inadequate to pay 250 of the judgments entered.

Principal Issue Presented

The principal issue presented in this action can be summarized as follows:

Where an occurrence based excess liability policy is issued following an underlying claims-made liability policy, is coverage under the excess policy triggered by exhaustion of the primary policy in the claim year, or in the occurrence year, or by exhaustion of primary policies in both the claim year and the occurrence year?

As a corollary to the principal issue, where a claim is made during a primary policy's tail period, is coverage under the excess policy triggered by exhaustion of the primary policy in the tail period?

Insurance Policies

The issues presented here necessarily require an understanding of the interplay between claims-made and occurrence policies. Therefore, the Court begins its analysis with a discussion of the differences between the two types of policies.

Terms pertaining to insurance policies are standardized by the Rules and Regulations of the Insurance Department of the State of New York in the New York Code Rules and Regulations ("NYCRR"). The applicable definitions are set forth in 11 NYCRR 73.1. Section 73.1(a) defines a claims-made policy as:

> an insurance policy that covers liability for injury or damage that the insured is legally obligated to pay (including injury or damage occurring prior to the effective date of the policy, but subsequent to the retroactive date, if any), arising out of incidents, acts or omissions, as long as the claim is first made during the policy period or any extended reporting period.

Under claims-made policies, the occurrence or date(s) on which it is alleged that the physician committed malpractice does not determine coverage under the policy. The only date which determines coverage is the date on which the claim was interposed. Thus, under a claims-made policy, the policy that was in effect in the year in which the claim was asserted responds to the claim. Consequently, MLMIC responded to each of the plaintiffs' claims pursuant to the policy it issued in the year in which the claim was made.

Panos also opted to insure himself against losses that might exceed the coverage provided by MLMIC. Panos obtained excess insurance policies from HPIC for the years 2005 through

2011.[17] These policies were obtained pursuant to the Hospital Excess Liability Pool (the "Excess Pool") established by Section 18. As described in the Report on the Excess Pool:

> The Excess Pool was intended to help solve a medical malpractice insurance affordability crisis - a crisis that the Legislature characterized as a danger to public health because it discouraged doctors from practicing in New York State and contributed to the high cost of health care for consumers. Section 18 sought to contain these costs and keep doctors practicing in New York State, in part by providing a way to fund a secondary layer of medical malpractice insurance, known as "excess coverage," for eligible doctors at no cost to them.
>
> The law requires the Superintendent of Insurance (now the Superintendent of Financial Services) (the "Superintendent"), in conjunction with the Commissioner of Health (the "Commissioner"), to purchase medical malpractice policies for physicians and dentists (collectively, "doctors") to cover liabilities in excess of their usual policy limits (known as their "primary" layer of insurance) of $1.3 million for each incident and $3.9 million for all incidents in a year. Report on the Hospital Excess Liability Pool, December 2012, NYSCEF Doc # 45.

As with the MLMIC policies, the HPIC policies commenced on July 1 of each year and continued through July 1 of each ensuing year. However, unlike the MLMIC policies, the HPIC policies were occurrence policies. Occurrence policies are defined by 11 NYCRR §73.1(j) as:

> Occurrence policy means an insurance policy that covers liability for injury or damage that the insured is legally obligated to pay arising out of incidents, acts or omissions that occurred during the policy period, and *where a claim may be made during or subsequent to the policy period.* (Emphasis added).

Thus, under an occurrence policy, the year in which the claim is made does not determine coverage. Rather, the year in which the claim arose, *i.e.*, the year in which the malpractice is alleged to have occurred, determines which policy period is implicated. Stated differently, as long

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[17] Counsel for both sides refer to Panos having "purchased" the excess coverage from HPIC. That reference, given the provisions of Section 18 under which the policies are purchased by the Superintendent of Financial Services, is incorrect.

as treatment occurs during the policy period, if the damages awarded exceed the coverage provided by the primary policy, the excess policy is implicated.

Where the occurrence policy supplies excess insurance, there must be a primary or underlying policy with specified limits in place as a condition to coverage under the excess policy. Where the excess policy is an occurrence policy, coverage under the policy is triggered not by an occurrence, in the first instance, but by exhaustion of the underlying policy. The underlying policy may be an occurrence policy or a claims-made policy. Where the underlying policy is a claims-made policy and the excess policy is an occurrence policy, however, determining whether excess coverage is triggered depends upon identifying which claims-made policy was required to be exhausted. The mis-match of policy types creates a coverage issue where the claim under the primary claims-made policy is interposed in a different year than the year when the malpractice occurred, as invariably happens. Once the correct underlying policy is identified and exhaustion of that policy is confirmed, thereby triggering the excess occurrence policy, the question of which excess policy provides coverage is determined by the date of the malpractice. This is so regardless of the year when the claim was made pursuant to the primary claims-made policy.

Relevant Provisions of the HPIC Policies

All of the HPIC policies, which are annexed to the Complaint as Exhibit B, contain the following provisions of relevance to the determination of this motion:

1. A cover page entitled "Coverage Declaration Page – First Layer of Excess Liability Coverage".

The Coverage Declaration Page provides relevant information concerning the insurance contract, including the Policy Number (Item #1), Named Insured and Address (Item #2), Policy Period (Item #3), Identity of Underlying Carrier (Item #4), Limits of Underlying Coverage and Limits of Excess Coverage (Item #5). HPIC Excess Insurance Policy, Un-Numbered Declarations Page at 2, NYSCEF Doc # 3.[18]

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[18] Some of the pages of the HPIC policies are not numbered. Where a page is un-numbered it is referred to as such. Where pages are numbered, the page number will be indicated. Capitalized terms are as they appear in the policy.

2. A preamble section entitled "OCCURRENCE POLICY FORM – NOTICE OF EXCESS COVERAGE".

This section includes a Notice which reads as follows:

> This is an occurrence policy. It covers you only for Claims brought against you because of Professional Services which you provided (or should have provided) in the course of your medical or surgical practice. As long as you provided (or failed to provide) those Professional Services during the Policy Period *a related Claim is covered no matter when it is brought against you. Id,* Un-Numbered Notice of Excess Insurance Page, NYSCEF Doc # 3 at 3(Emphasis added).

Item 1 of the Occurrence Policy Form provides:

> This is an excess policy only. The HANYS Member Hospitals Self-Insurance Trust hereinafter referred to as the Company, shall not provide coverage under this policy for sums which do not exceed the limits of liability of the Underlying Policy except when the aggregate limits of the Underlying Policy have been exhausted by payment of claims, notwithstanding any other circumstances that exist (including but not limited to the insolvency of the underlying insurer). HPIC Excess Insurance Policy at 2, NYSCEF Doc # 3.

Item 2 of the Occurrence Policy Form states that "[i]t is a condition of this policy that the Named Insured maintain at all times in full force and effect the underlying insurance and underlying limits specified in the Declarations." *Id.*

Item 3 of the Occurrence Policy Form provides:

> This policy is issued on an occurrence basis, and only affords coverage for those damages which the Named Insured shall become legally obligated to pay because of injury or death resulting from rendering or failing to render, DURING THE POLICY PERIOD, professional services by the Named Insured, or by any person for whose acts or omissions the Named Insured is legally responsible, performed in the practice of the Named Insured's profession described in the Declarations. If the underlying insurance specified in the Declaration and required to be maintained by the Named Insured as a condition of this policy is issued on a claims-made basis, coverage by the Company will be effective only if the Underlying Policy, *a renewal thereof or tail coverage* is in effect when the claim is made AND the injury or death giving rise to the claim arose out of the

rendering of or failure to render, DURING THIS POLICY PERIOD, professional services by the Named Insured, or by any person for whose acts or omissions the Named Insured is legally responsible, performed in the practice of the Named Insured's profession. *Id.* (Emphasis added).

The policies describe the terms and conditions in paragraphs identified by Roman Numerals. Roman Numeral I describes the Coverage Agreement and recites that the insurer agrees to pay:

> ... on behalf of the Named Insured all the sums in excess of the limits of liability of the Underlying Policy as set forth in the Declarations, but only up to a total amount of the limits of liability provided herein, which the Named Insured shall become legally obligated to pay as damages because of injury to any one person, including death resulting therefrom, *arising out of the rendering of or failure to render, during this excess coverage period*, professional services by the Named Insured to any one person, or by any person for whose acts or omissions the Named Insured is legally responsible ... HPIC Excess Insurance Policy at 3, NYSCEF Doc # 3 (emphasis added).

Roman Numeral IV dictates that the coverage is predicated on the maintenance by the insured of an Underlying Policy with specified limits of $1 million for each claimant and $3 million in the aggregate. The amounts obtained by Panos from MLMIC, $1.3 million per person and $3.9 million in the aggregate, exceeded these required limits. This section provides that:

> Maintenance of Underlying Insurance
>
> It is a condition of this policy, and the Named Insured warrants, that the Underlying Policy as set forth in the Declarations shall be maintained by the Named Insured in full force and effect at all times. The Underlying Policy must provide limits of not less than One Million Dollars ($1,000,000) for each claimant and Three Million Dollars ($3,000,000) for all claimants. In the event of the failure to continuously maintain at all times a primary policy of $1 million for each claimant and $3 million for all claimants from a New York licensed company pursuant to Chapter 208 of the Laws of 1987 and pursuant to the Declarations during this policy period, this policy shall be deemed canceled and terminated by the Company on the date of cancellation or termination of the Underlying primary policy whether by the issuer thereof or the Named Insured unless replaced immediately by a primary policy of $1million/$3 million pursuant

> to law. An Underlying Policy must be continuously maintained without reduction of limits of liability, except for the reduction of aggregate limits caused by the payment of claims or losses under the Underlying Policy. If an Underlying Policy is issued on a claims-made basis, any failure by the Named Insured to maintain continuous primary coverage or to obtain a fully paid tail coverage upon its termination, will result in no coverage being provided under this policy for any and all claims reported to the Company following the termination date of the underlying claims-made policy. HPIC Excess Insurance Policy at 4, NYSCEF Doc # 3.

Roman Numeral V defines various terms. As defined there, the term "Underlying Policy" means:

> the primary policy of Professional Liability Insurance which is listed in the Declarations of this policy and which is required to be maintained by the Named Insured as a condition of this coverage. *Id.*

It is the meaning of the term "Underlying Policy" from which the parties' primary disagreement arises. HPIC contends, based on the inclusion of a reference to a single MLMIC policy on each Declaration page, that the term Underlying Policy means only the MLMIC policy issued in the same year as the excess policy. Plaintiff urges that the term Underlying Policy is whatever policy or tail answers the claim when it is made, provided the limits of the policy conform to the required coverage described on the Coverage Declaration Page.

In interpreting contracts, the Court is required to give meaning to all terms and conditions consistent with the parties' intent. The Appellate Division, Second Department has instructed:

> The fundamental, neutral precept of contract interpretation is that agreements are construed in accord with the parties' intent. [A] written agreement that is complete, clear and unambiguous on its face must be enforced according to the plain meaning of its terms. To determine whether a writing is unambiguous, language should not be read in isolation because the contract must be considered as a whole. If the language of the contract is susceptible of more than one reasonable interpretation, the contract will be considered ambiguous.

NRT New York, LLC v Harding, 131 AD3d 952, 953-54 [2nd Dept 2015] (internal quotations and citations omitted). The court continued:

> [W]hen interpreting a contract, the court should arrive at a construction which will give fair meaning to all of the language employed by the parties to reach a practical interpretation of the expressions of the parties so that their reasonable expectations will be realized. Extrinsic and parol evidence of the parties' intent may not be admitted to create ambiguity in a contract that is unambiguous on its face, but such evidence may be considered where a contract is determined to be ambiguous. *Id.* (internal quotations and citations omitted).

The Court of Appeals has held that this rule of interpretation is equally applicable to insurance policies. *In re Viking Pump, Inc.*, 27 NY3d 244 [2016]. "When construing insurance policies ... we must construe the policy in a way that affords a fair meaning to all of the language employed by the parties in the contract and leaves no provision without force and effect." *Id.* at 257 (internal quotations and citations omitted).

This Court must first determine if the insurance contract is ambiguous. "The threshold question of whether a contract is unambiguous, and the subsequent construction and interpretation of an unambiguous contract, are issues of law within the province of the court." *NRT New York, supra* at 954 (citations omitted).

Here, both parties asserted that the policies are unambiguous. Each, however, has their differing interpretation of the verbiage of the contract. The fact that the parties disagree in their respective interpretations does not render the contract ambiguous. Indeed, the Court finds that the policies are not ambiguous. "[A] contract is not ambiguous 'if the language it uses has a definite and precise meaning, unattended by danger of misconception in the purport of the [agreement] itself, and concerning which there is no reasonable basis for a difference of opinion". *In re Viking Pump, supra* at 258 (quoting *Selective Ins. Co. of Am. v County of Rensselaer*, 26 NY3d 649, 655 [2016] (internal quotation marks and citation omitted)). Hence, although both sides submitted extrinsic evidence in support of their positions, the Court need not consult it to reach a proper determination of the instant dispute. Rather, the Court looks to the language of the policies to ascertain their meaning and intent. *Cohen & Slamowitz, LLP v Zurich American Insurance Company,* 168 AD3d 905 [2nd Dept 2019].

In *Cohen, supra*, the court clearly enunciated the law surrounding interpretation of insurance policies as follows:

> In construing policy provisions defining the scope of coverage pursuant to a policy of insurance, courts first look to the language of the policy. The policy is read in light of common speech and the reasonable expectations of a businessperson and in a manner that leaves no provision without force and effect. The unambiguous terms of an insurance contract must be given their plain and ordinary meaning, and the interpretation of such terms is a question of law for the court. The mere assertion by one that contract language means something different to him or her, where it is otherwise clear, unequivocal and understandable when read in connection with the whole contract, is not in and of itself enough to raise a triable issue of fact. However, if the terms of the policy are ambiguous, any ambiguity must be construed in favor of the insured and against the insurer. (*Id.* at 905-906 (internal quotations and citations omitted)).

When all policy terms are read in conjunction with each other in such a way as to give meaning to all of the terms as required by law, the conclusion is obvious – HPIC's policies were triggered upon exhaustion of the MLMIC primary policies in the claim year. In fact, the clear language of the HPIC policies provides that the coverage supplied to Panos is excess to a policy issued to him by MLMIC, so long as that policy provided primary coverage in the requisite amounts. Significantly, the Declaration Page does not identify the Underlying Policy by a specific policy term or a specific policy number. This is because the HPIC policy contemplates claims being made well after the occurrence year, with such claims outside the occurrence year nonetheless being covered by HPIC's policy. Reinforcing this determination is the fact that the policy states that it will answer a claim "*no matter when it is brought against you*". *See* NYSCEF Doc #3, Notice of Excess Coverage at 3. In addition, the regulatory definition of an occurrence policy states that such policies will answer claims which "*may be made during or subsequent to the policy period*". 11 NYCRR §73.1(j).

As previously stated, HIPC contends that its policy is not implicated because the primary layer of insurance issued by MLMIC to Panos in the occurrence year has not been exhausted. HPIC's interpretation ignores, and renders extraneous, the language of both its policy and the applicable regulation. HPIC's position fails to appreciate that coverage under a claims-made policy

is not determined by the date of an occurrence. By requiring exhaustion of the Underlying Policy in effect during the occurrence year, HPIC effectively seeks to convert its policies to claims-made policies in the occurrence year or to require exhaustion of TWO Underlying Policies. Oddly, HPIC fails to realize that its interpretation would have this effect.

As Plaintiff argues, this constitutes a double trigger, a requirement not stated in the policy. Conspicuous by its absence from the policy is any language that would incorporate a requirement for the exhaustion of two primary insurance policies in order for the excess policy to be implicated. Yet, HPIC offered this interpretation. Under HPIC's analysis, in order for there to be coverage for Panos' malpractice, both the primary claims-made policy in the claim year and the primary claims-made policy in the occurrence year would have to be exhausted. This position does not square with HPIC's own argument that the applicable Underlying Policy is referenced on its Declaration Page, as there is only one Underlying Policy referenced on its Declaration Page. To be sure, HPIC's strained and convoluted construction of its policy is inconsistent with the underpinnings of Section 18 and the statutory definitions set forth in the applicable regulations.

As a matter of statutory definition, an occurrence policy applies to occurrences, irrespective of when the claim is interposed. Indeed, as quoted above, 11 NYCRR 73.1(j) clearly states that an occurrence policy covers "incidents, acts or omissions that occurred during the policy period" and, significantly, "where a claim may be made during or subsequent to the policy period." To assert otherwise negates the inclusion of such language in the regulation. Moreover, the very definition of "occurrence policy" under 11 NYCRR § 73.1(j) plainly sets forth the interaction between an occurrence based policy and a claims-made policy by stating that an occurrence policy is determined by the date of the incident even "*where a claim may be made during or subsequent to the policy period.*" (Emphasis added). Simply put, inherent in the definition of an occurrence policy is the fact that a claim against such policy may be made during or after the policy year of the occurrence.

The Tail Coverage

HPIC builds on its unsubstantiated argument regarding claims-made policies, further asserting, based on Morris' statement, that the policies "were not in effect during [the] periods (2011-2012, 2012-2013 and 2013-2014)" when Panos had tail coverage. Morris' statement, and HPIC's reliance on it, is blind to the language of its policies which explicitly refer to tail coverage and it reflects no understanding of how an occurrence policy interacts with a tail.

As stated above, after MLMIC declined to renew Panos' primary insurance policies following the 2010-2011 policy year, Panos opted to continue coverage by availing himself of extended claims reporting coverage. Extended reporting period or tail coverage is defined by 11 NYCRR §73.1(d) as:

> Extended reporting period coverage, tail or tail coverage means coverage for that period of time specified in the policy wherein claims first made after termination of coverage under the policy, for injury or damage that occurs during the policy term, or that occurs on or after the retroactive date, if any, will be considered made during the policy term.

HPIC contends that its policies are not excess to tails, stating, using Morris' verbiage, that its policies "were not in effect" when the primary coverage was pursuant to the tails. This position is wholly without merit. The fact that primary coverage emanated from a tail as opposed to a separate policy is of no consequence. HPIC's policies clearly contemplated that an Underlying Policy may operate in conjunction with tail coverage. This is plainly stated in Item 3 of the Occurrence Policy Form:

> If the underlying insurance specified in the Declaration and required to be maintained by the Named Insured as a condition of this policy is issued on a claims-made basis, coverage by the Company will be effective only if the Underlying Policy, *a renewal thereof or tail coverage* is in effect when the claim is made AND the injury or death giving rise to the claim arose out of the rendering of or failure to render, DURING THIS POLICY PERIOD ... . (Emphasis in italics added).

It is again plainly stated in Roman Numeral I, where the insurer agrees to pay

> on behalf of the Named Insured all the sums in excess of the limits of liability of the Underlying Policy as set forth in the Declarations, but only up to a total amount of the limits of liability provided herein, which the Named Insured shall become legally obligated to pay as damages because of injury to any one person, including death resulting therefrom, *arising out of the rendering of or failure to render, during this excess coverage period*, professional services by the Named Insured to any one person, or by any person for whose acts or omissions the Named Insured is legally responsible ... . HPIC Excess Insurance Policy at 3, NYSCEF Doc #3 (emphasis added).

Moreover, 11 NYCRR §73.1(d) provides that a claim asserted during tail coverage is to be treated "*as if made during a policy term.*" This language clearly demonstrates that the regulatory intent of tail coverage is to treat claims which arise during a tail as if they arose during the policy term. Given that HPIC's policies are excess for claims asserted during the primary policy period, so, too, they are excess to claims asserted during tail coverage.

It is beyond cavil that by allowing the Underlying Policy to include coverage afforded pursuant to a claims-made policy, HPIC cannot plausibly argue that its policies did not include coverage provided pursuant to a tail. That this is so is compelled by the definition of a claims-made policy provided by 11 NYCRR 73.1(a), which states that a claims-made policy includes coverage "as long as the claim is first made during the policy period *or any extended reporting period.*" (Emphasis added). As such, the conclusion is inescapable that coverage pursuant to the tail of a claims-made policy is the same as coverage pursuant to the claims-made policy itself. The tail merely extends the policy coverage period, as clearly indicated by its name "extended reporting period".

To reiterate the Court of Appeals' directive, "[w]hen construing insurance policies ... the language of the contracts must be interpreted according to common speech and consistent with the reasonable expectation of the average insured. Furthermore, we must construe the policy in a way that affords a fair meaning to all of the language employed by the parties in the contract and leaves

no provision without force and effect. Significantly, surplusage [is] a result to be avoided." *In re Viking Pump, Inc., supra* at 257–58 (internal quotations and citations omitted).

HPIC's construction of its policy ignores the provision which states that the policy provides excess coverage where the "Underlying Policy, a *renewal thereof or tail of coverage is in effect when the claim is made*" as stated in Item 3 of Occurrence Policy Form. HPIC's construction also ignores the applicable regulations. HPIC's interpretation would render the inclusion of the words "tail of coverage in effect", which is stated in the policy, and "extended reporting period", which is stated in the regulation, to be surplusage. Therefore, HPIC's improper construction is hereby rejected.

CONCLUSION

Plaintiff is entitled to summary judgment declaring that HPIC's excess policy was triggered when the individual or aggregate limits of MLMIC's primary policy was exhausted for the year that a claim was made. Further, in the years in which the primary coverage was pursuant to a tail, when the tail coverage was exhausted for the year the claim was made, excess coverage was similarly triggered. Because the excess policy was an occurrence policy, coverage under that policy was necessarily determined by the year in which the malpractice incident occurred. There is no requirement anywhere in HPIC's policy that the occurrence year must be the same as the claim year. Moreover, there is no requirement that two claims-made policies must be exhausted, the one in effect in the occurrence year and the one in effect in the claim year, in order to trigger excess coverage. There is no exclusion of tail coverage from HPIC's policy; to the contrary, it is expressly included.

On searching the record, the Court awards summary declaratory judgment to Plaintiff on the first and second causes of action. Succinctly stated, the Court holds that the exhaustion of a claims-made policy in the year in which a claim was made invokes the coverage afforded by the excess occurrence policy for the occurrence year. Furthermore, where the claim was made in a tail period, exhaustion of the coverage provided by the tail triggers the excess coverage in the same manner.

SUMMARY

It is ORDERED, ADJUDGED AND DECREED that the exhaustion of the claims-made policy applicable to the year in which each claim was made invoked and triggered the occurrence based policy issued by HPIC for the year of the alleged malpractice; and it is further

ORDERED, ADJUDGED AND DECREED that for those claims which were asserted in years in which primary coverage was afforded to Panos pursuant to a tail, exhaustion of the tail coverage for the claims made during the tail period invoked the excess coverage for the year in which the malpractice occurred.

Plaintiff shall have Judgment accordingly.

The foregoing constitutes the Decision and Order of the Court.

Dated: October 13, 2020
New City, NY

HON. PAUL I. MARX, J.S.C.

Appearances

For Plaintiff:

Nancy M. McGee, Esq.
Wissell and McGee, LLP
80-02 Kew Gardens Road, Suite 307
Kew Gardens, NY 11415

For Defendant HPIC:

Christopher Massaroni, Esq.
Hodgson Russ, LLP
677 Broadway, Suite 301
Albany, NY 12207

John P. DeFillipis, Esq.
Clausen Miller, PC
28 Liberty Street, 39th floor
New York, NY 10005

For Defendant Spyros Panos, M.D.:

No appearance either self-represented or through counsel