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NO. 68478-7

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION I

QUELLOS GROUP LLC, *Appellant/Cross-Respondent*,

v.

FEDERAL INSURANCE COMPANY and INDIAN HARBOR
INSURANCE COMPANY, *Respondents/Cross-Appellants*.

**BRIEF OF APPELLANT/CROSS RESPONDENT IN REPLY TO
BRIEF OF RESPONDENT AND CROSS-APPELLANT INDIAN
HARBOR INSURANCE COMPANY**

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TABLE OF CONTENTS

	<u>Page</u>
SUMMARY OF ARGUMENT	1
ARGUMENT	3
I. THE AISLIC SETTLEMENT DOES NOT ELIMINATE COVERAGE.....	3
A. The Attachment Point Provisions Are Conditions To Coverage.....	3
B. The Excess Carriers’ Contrary Arguments Lack Merit.....	5
C. The Excess Carriers Waived Any Right To Demand Compliance With The Attachment Point Conditions.....	11
D. The Excess Carriers Failed To Meet Their Burden Of Proving That Quellos’ Claimed Breach Was Material And Prejudicial.....	13
II. THE TRIAL COURT ERRED IN ACCEPTING THE EXCESS CARRIERS’ LITERAL INTERPRETATION.....	17
A. This Literal Interpretation Impermissibly Nullifies Coverage.....	17
B. The Excess Carriers’ Literal Interpretation Also Contravenes Paramount Principles Favoring Settlement.....	19
III. THE POLICIES WERE NOT NEGOTIATED.....	23
CONCLUSION.....	25

TABLE OF AUTHORITIES

Cases

<i>Allmerica Fin. Corp. v. Certain Underwriters at Lloyd's, London,</i> 871 N.E.2d 418 (Mass. 2007)	16
<i>Allstate Ins. Co. v. Dana Corp.,</i> 759 N.E.2d 1049 (Ind. 2001)	16
<i>Allstate Ins. Co. v. Raynor,</i> 93 Wn. App. 484, 969 P.2d 510 (1999)	20
<i>Allstate Ins. Co. v. Riverside Ins. of Am.,</i> 509 F. Supp. 43 (E.D. Mich. 1981).....	17, 22
<i>Am. Home Assurance Co. v. Cohen,</i> 124 Wn.2d 865, 881 P.2d 1001 (1994).....	20
<i>Am. Nat'l. Fire Ins. Co. v. B & L Trucking & Constr. Co.,</i> 134 Wn.2d 413, 951 P.2d 250 (1998).....	10
<i>Am. Safety Ins. Co. v. City of Olympia,</i> 162 Wn.2d 762, 174 P.3d 54 (2007).....	21
<i>Boeing Co. v. Aetna Cas. & Sur. Co.,</i> 113 Wn.2d 869, 784 P.2d 507 (1990).....	24
<i>Canon, Inc., v. Fed. Ins. Co.,</i> 82 Wn. App. 480, 918 P.2d 937 (1996)	14
<i>Citigroup, Inc. v. Fed. Ins. Co.,</i> 649 F.3d 367 (5th Cir. 2011)	25
<i>City of Seattle v. Blume,</i> 134 Wn.2d 243, 947 P.2d 223 (1997).....	21
<i>Comerica, Inc. v. Zurich Am. Ins. Co.,</i> 498 F. Supp. 2d 1019 (E.D. Mich. 2007).....	5
<i>D & S Realty, Inc. v. Markel Ins. Co.,</i> 789 N.W.2d 1 (Neb. 2010).....	10

<i>Devese v. Transguard Ins. Co.</i> , 798 N.W.2d 614 (Neb. 2011).....	10
<i>Drake v. Ryan</i> , 514 N.W.2d 785 (Minn. 1994).....	17, 22
<i>Elliott Co. v. Liberty Mut. Ins. Co.</i> , 434 F. Supp. 2d 483 (N.D. Ohio 2006).....	17, 22
<i>Federal Ins. Co. v. Pacific Sheet Metal, Inc.</i> , 54 Wn. App. 514, 774 P.2d 538 (1989).....	7
<i>Fremont Indem. Co. v. New England Reinsurance Co.</i> , 815 P.2d 403 (Ariz. 1991).....	10
<i>Goodyear Tire & Rubber Co. v. Nat'l Union Ins. Co. of Pittsburgh</i> , 2011 WL 5024823 (N.D. Ohio Sept. 19, 2011).....	5, 24
<i>Griffin v. Allstate Ins.</i> , 108 Wn. App. 133, 29 P.3d 777 (2001).....	9
<i>Haller v. Wallis</i> , 89 Wn.2d 539, 573 P.2d 1302 (1978).....	21
<i>HLTH Corp. v. Agricultural Excess & Surplus Ins. Co.</i> , 2008 WL 3413327 (Del. Sup. Ct. July 31, 2008).....	22
<i>Home Ins. Co. v. St. Paul Fire & Marine Ins. Co.</i> , 229 F.3d 56 (1st Cir. 2000).....	10
<i>JP Morgan Chase & Co. v. Indian Harbor Ins. Co.</i> , 98 A.D.3d 18 (N.Y. App. Div. Dep't 1 2012).....	5, 24
<i>Kalama Chem., Inc. v. Allianz Ins. Co.</i> , 1995 WL 17015061 (Wash. Super. Ct. Aug. 14, 1995).....	16, 22
<i>Keystone Shipping Co. v. Home Ins. Co.</i> , 840 F.2d 181 (3rd Cir. 1988).....	16
<i>Koppers Co., Inc. v. Aetna Cas. & Surety Co.</i> , 98 F.3d 1440 (3d Cir. 1996).....	22

<i>Med. Mut. Ins. Co. of NC v. Am. Cas. Co. of Reading, PA</i> , 721 F.Supp.2d 447 (E.D.N.C. 2010).....	10
<i>Moeller v. Farmers Ins. Co. of Wash.</i> , 155 Wn. App. 133, 229 P.3d 857 (2010).....	11
<i>Morgan v. Prudential Ins. Co. of Am.</i> , 86 Wn.2d 432, 545 P.2d 1193 (1976).....	17
<i>Mut. of Enumclaw Ins. Co. v. USF Ins. Co.</i> , 164 Wn.2d 413, 191 P.3d 866 (2008).....	16
<i>National Sur. Corp. v. Immunex Corp.</i> , 162 Wn. App. 762, 256 P.3d 439 (2011).....	9
<i>Nw. Steel Rolling Mills, Inc. v. Fireman’s Fund Ins. Co.</i> , No. C86-376WD (W.D. Wash. Jan. 16, 1991)	16, 17, 22
<i>Oregon Auto. Ins. Co. v. Salzberg</i> , 85 Wn.2d 372, 535 P.2d 816 (1975).....	5, 13, 17
<i>Pereira v. National Union Fire Insurance Co. of Pittsburgh, Pa</i> , 2006 WL 1982789 (SDNY 2006).....	22
<i>Pub. Util. Dist. No. 1 of Klickitat County v. Int’l Ins. Co.</i> , 124 Wn.2d 789, 881 P.2d 1020 (1994).....	4, 5, 10, 13
<i>Qualcomm, Inc. v. Certain Underwriters at Lloyd’s London</i> , 161 Cal. App. 4th 184 (2008)	5
<i>Rees v. King Insurance Co.</i> , 77 Wn. App 716, 892 P.2d 1128 (1995).....	6
<i>Reliance Ins. Co. v. Transamerica Ins. Co.</i> , 826 So. 2d 998 (Fla. Dist. Ct. App. 2001)	17, 22
<i>Ross v. Harding</i> , 64 Wn.2d 231, 391 P.2d 526 (1964).....	5, 10
<i>Royal Indem. Co. v. C.H. Robinson Worldwide, Inc.</i> , 2009 WL 2149637 (Minn. App. 2009).....	25

<i>Safeco Title Ins. Co. v. Gannon</i> , 54 Wn. App. 330, 774 P.2d 30 (1989)	8
<i>Seafirst Ctr. Ltd. P'ship v. Erickson</i> , 127 Wn.2d 355, 898 P.2d 299 (1995)	21, 22
<i>Seaway Port Authority of Duluth v. Midland Ins. Co.</i> , 430 N.W.2d 242 (Minn. Ct. App. 1988)	7
<i>Siligato v. Welch</i> , 607 F. Supp. 743 (D. Conn. 1985)	17, 22
<i>Simms v. Allstate Ins. Co.</i> , 27 Wn. App. 872, 621 P.2d 155 (1991)	9
<i>Stargatt v. Fid. & Cas. of N.Y.</i> , 67 F.R.D. 689 (D. Del. 1975)	17, 22
<i>State Farm Fire & Cas. Co. v. Nationwide Mut. Ins. Co.</i> , 596 F. Supp. 2d 940 (E.D. Va. 2009)	19
<i>Teigen v. Jelco of Wis. Inc.</i> , 367 N.W.2d 806 (Wis. 1985)	17, 22
<i>Trinity Homes LLC v. Ohio Cas. Ins. Co.</i> , 629 F.3d 653 (7th Cir. 2010)	17, 22
<i>Truck Ins. Exch. v. VanPort Homes, Inc.</i> , 147 Wn.2d 751, 58 P.3d 276 (2002)	12
<i>Universal Holdings II Ltd. Partnership v. Overlake Christian Church</i> , 115 Wn. App. 59, 60 P.3d 1254 (2003)	9
<i>Vision One, LLC v. Philadelphia Indemnity Insurance Co.</i> , 158 Wn. App. 91, 241 P.3d 429 (2010)	11, 12, 13
<i>Zeig v. Mass. Bonding & Ins. Co.</i> , 23 F.2d 665 (2d Cir. 1928)	17, 22
Other Authorities	
13 Lee R. Russ, <i>Couch on Insurance</i> , §§ 195:41, 195:57	12
13 Richard A. Lord, <i>Williston on Contracts</i> § 38.1 (4th ed. 2000)	4

2 Allan D. Windt, *Insurance Claims & Disputes* § 6:35 (2007)..... 13
2 Allan D. Windt, *Insurance Claims & Disputes* § 6:45 7, 19
Franklin D. Cordell, 3 *New Appleman On Insurance Law* § 20 (2011) 4
RCW Ch. 7.07..... 21

SUMMARY OF ARGUMENT

In their response brief (“R.B.”), Federal Insurance Company and Indian Harbor Insurance Company (the “Excess Carriers”) adamantly insist that the attachment point provisions in their policies should be read to nullify \$30 million in excess insurance simply because Quellos Group, LLC (“Quellos”) failed to collect full policy limits from its primary insurer (“AISLIC”). Endeavoring to create the illusion that this interpretation is permissible, the Excess Carriers repeatedly characterize Quellos as a “sophisticated commercial” insured, and misleadingly suggest that the exhaustion requirements at issue are specialized terms the parties negotiated. But the record evidence indisputably establishes that these requirements are standardized terms drafted by the insurance industry. Washington’s settled principles of policy interpretation govern construction of such standardized terms for individuals and small and big businesses alike, and call for rejection of the Excess Carriers’ quest to reap a \$30 million windfall from the policies sold to Quellos.

Contrary to the Excess Carriers’ contentions, the exhaustion requirements are conditions to coverage, not coverage-granting terms, that they cannot now invoke to avoid coverage. Controlling Washington precedent and much other authority dictates that these provisions are conditions because they impose a procedural requirement as to how the

underlying policy limits are exhausted once the policyholder suffers a loss within the scope of coverage.

The Excess Carriers cannot now demand compliance with this procedural condition because they waived that right by categorically denying coverage four years before Quellos settled with AISLIC for less than full policy limits. While the Excess Carriers retort that they reserved this right when they denied coverage, they waived this procedural condition and all others by denying coverage, and not because of any deficiency in their purported reservation of rights.

The Excess Carriers also are precluded from invoking the exhaustion requirement now because they failed to prove that Quellos' noncompliance constituted a substantial and material breach of their policies. While claiming to have lost the right, purportedly factored into their premiums, to rely on AISLIC to determine underlying coverage for the POINT losses, they submitted no evidence showing that this was a factor in calculating premiums. Contrary to their unsubstantiated claims of reliance, the Excess Carriers denied coverage when Quellos' POINT losses already far exceeded AISLIC's policy limits, and their counsel, who became actively involved in this coverage dispute three years before Quellos' settlement with AISLIC, are presently contesting whether even the payments AISLIC did make for the POINT claims were for covered

losses. There is no basis on this record for concluding that AISLIC's absence from this litigation is either material or substantially prejudicial.

Washington law also calls for reversal of the trial court's decision because the Excess Carriers' literal reading of the attachment point provisions produces an absurd and unfair windfall and frustrates Washington's strong public policy favoring settlement by compelling policyholders to litigate coverage disputes to judgment. The Excess Carriers argue that the Court is powerless to act, but Washington law plainly confers the authority to enforce this public policy here.

ARGUMENT

I. THE AISLIC SETTLEMENT DOES NOT ELIMINATE COVERAGE.

A. The Attachment Point Provisions Are Conditions To Coverage.

In its opening appellate brief ("O. B."), *Quellos* demonstrated that the coverage-granting provisions of the Excess Carriers' policies consist of those defining the type of liabilities that are covered and the amount of underlying loss that must be incurred before excess coverage will attach. (O.B. 17-18). *Quellos* also demonstrated that the exhaustion requirements at issue are conditions because they impose ancillary procedural requirements for perfecting the right to coverage established by the coverage-granting terms of these policies.

Quellos relied on Washington Supreme Court precedent

establishing that, unlike coverage-granting provisions, conditions “designate the manner in which claims covered by the policy are to be handled once a claim has been made or events giving rise to a claim have occurred.” *Pub. Util. Dist. No. 1 of Klickitat Cnty. v. Int’l Ins. Co.* (“*Klickitat County*”), 124 Wn.2d 789, 803, 881 P.2d 1020 (1994) (*en banc*). Quellos also relied on preeminent treatises likewise recognizing that conditions specify procedural steps a policyholder is to undertake to perfect the right to coverage defined by the coverage granting terms and exclusions. *See* Franklin D. Cordell, 3 *New Appleman On Insurance Law* § 20 (2011) (conditions do not “define the scope of coverage,” but instead “impose ‘procedural’ duties on the contracting parties”); 13 Richard A. Lord, *Williston on Contracts* § 38.1 (4th ed. 2000) (contract conditions limit or modify rights instead of creating them). The provisions invoked by the Excess Carriers impose just such procedural requirements by specifying how primary policy limits are to be exhausted once the policyholder incurs a loss falling within the scope of excess coverage and in an amount exceeding underlying policy limits.

Quellos also showed that the terms of these policy provisions, which purport to prescribe that the Excess Carriers will pay “only after” and “in the event” of collection of the underlying policy limits, reconfirm

that these provisions are conditions. CP 99, § I (Ex. D)¹, CP 110, § I (Ex. E); *see Ross v. Harding*, 64 Wn.2d 231, 237, 391 P.2d 526 (1964). As the Washington Supreme Court has instructed, contractual conditions typically employ phrases and words such as “after” to convey that they impose procedural requirements for performance. *Ross*, 64 Wn.2d at 237. Indeed, although inconsistent with Washington law in other material respects, even out-of-state cases cited by the Excess Carriers hold that functionally identical language, including language contained in the insuring agreement of a policy, is a condition precedent to coverage.²

B. The Excess Carriers’ Contrary Arguments Lack Merit.

The Excess Carriers studiously avoid discussion of any of the precedent relied on by Quellos in arguing that the exhaustion requirements are coverage-granting terms supposedly establishing the “key defining feature” of excess coverage. R.B. 19, 22. As the only bases for this

¹ Citations to Exhibits (“Ex. ___”) denote exhibits appended to Quellos’ opening brief.

² *See, e.g., JP Morgan Chase & Co. v. Indian Harbor Ins. Co.*, 98 A.D.3d 18 (N.Y. App. Div. Dep’t 1 2012); *Comerica, Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019, 1022, 1028 (E.D. Mich. 2007); *Goodyear Tire & Rubber Co. v. Nat’l Union Ins. Co. of Pittsburgh*, 2011 WL 5024823, at *1, 3 (N.D. Ohio Sept. 19, 2011); *Qualcomm, Inc. v. Certain Underwriters at Lloyd’s London*, 161 Cal. App. 4th 184 (2008). *JP Morgan, Comerica*, and *Qualcomm* conflict with Washington’s rule that the insurer cannot avoid coverage based on noncompliance with any condition absent a showing of material prejudice. *See Klickitat*, 124 Wn.2d at 803-804; *Oregon Auto. Ins. Co. v. Salzberg*, 85 Wn.2d 372, 377, 535 P.2d 816 (1975). While the Ohio court in *Goodyear Tire* did rule that a showing of prejudice was required for breach of a virtually identical requirement in a policy’s insuring agreement, its decision that a less-than-limits settlement with a primary insurer is prejudicial is contrary to Washington law as discussed in § I(C) *infra*.

erroneous contention, the Excess Carriers invoke *Rees v. King Insurance Co.*, 77 Wn. App. 716, 892 P.2d 1128 (1995), and a few cases addressing the scope of coverage afforded by claims-made policies, along with the fact that the exhaustion requirements appear in (among others) the insuring agreements of their policies. Neither this case law nor the location of the exhaustion requirements supports the Excess Carriers' characterization of these requirements as coverage-granting terms.

Rees did not even consider exhaustion requirements of the sort contained in the Excess Carriers' policies. At issue in *Rees* was an "artifice" by which the policyholder, primary carrier, and claimant colluded to trigger excess coverage by (1) stipulating that the total loss was \$600,000 and thus exceeded the \$500,000 primary limits, and (2) releasing the policyholder and primary carrier from liability for a settlement of only \$421,000. The court held (correctly) that the excess policy was never triggered because the release was an "artifice" designed to make the excess insurer "drop down" and pay losses below its attachment point. *Id.* at 719. No such "artifice" exists here because Quellos paid the difference between the AISLIC settlement and primary limit, and the Excess Carriers are not being asked to drop down.

Rather than supporting the Excess Carriers' position, *Rees* is consistent with the Washington "drop-down" cases discussed in Quellos'

opening brief. (O.B. 18-19). These drop-down cases show that what defines the scope of excess coverage is the amount of the loss that must be incurred, not whether the underlying insurer or policyholder pays this loss.

Because payment of the full underlying amount is essential to establishing excess coverage, an excess carrier has no duty to “drop down” and pay losses below its attachment point even if an underlying carrier is insolvent and cannot pay the specified amount. *Fed. Ins. Co. v. Pac. Sheet Metal, Inc.*, 54 Wn. App. 514, 520-21, 774 P.2d 538 (1989); *Seaway Port Auth. of Duluth v. Midland Ins. Co.*, 430 N.W.2d 242, 247-48 (Minn. App. 1988); 2 Allan D. Windt, *Insurance Claims & Disputes* § 6:45, at 6-359 (5th ed. 2007). Conversely, and also because the critical consideration is whether the underlying limit has been paid, the excess carrier must pay losses exceeding the attachment point even when the underlying carrier is unable to pay and the limit must be paid by the policyholder instead. *See* 2 Allan D. Windt, *Insurance Claims & Disputes* § 6:45, at 109 (5th ed. 2012 Supp.) Given that the availability of excess coverage does not depend on whether the primary carrier actually pays any of the underlying limit, a provision requiring full payment by the primary carrier plainly cannot be “the defining feature of excess coverage.” R.B. 19, 22.

The Excess Carriers’ reliance on the cases construing the scope of coverage afforded by claims-made policies is equally misplaced. These

cases distinguish between occurrence-based policies, which afford coverage whenever a covered injury occurs during the policy period, and claims-made policies, which expressly limit coverage to claims reported during the policy period. Because claims-made policies “are essentially *reporting* policies” designed “to define the risk so that it is ascertainable at the end of the policy period,” these cases hold that “no liability attaches” when “the claim is not reported during the policy period.” *Safeco Title Ins. Co. v. Gannon*, 54 Wn. App. 330, 337, 338, 774 P.2d 30 (1989) (emphasis in original). In contrast to “occurrence policies, where the insurer contracts to cover risk that is by its very nature open-ended,” the showing of prejudice is not required for the breach of a notice requirement in a claims-made policy because this requirement decreases the carrier’s risk by narrowing the length of exposure for a commensurately lower premium. *Id.* The rationale in these cases is thus the same as in “drop down” cases; namely, that “allow[ing] an extension of reporting time after the end of the policy period” would entail “an extension of coverage to the insured gratis, something for which the insurer has not bargained.” *Id.*

Unlike the situation presented in such claims-made and “drop-down” cases, *Quellos* is not seeking to expand the bargained for excess coverage but only to recover for POINT losses that exceed underlying policy limits. The Excess Carriers’ coverage obligations are the same

whether the AISLIC primary policy limit is paid fully by AISLIC or is paid in part by AISLIC and in part by Quellos (as happened here).

The rule applicable in this situation is the same one Washington courts apply when a carrier challenges a policyholder's breach of a notice requirement in an occurrence-based policy. Notwithstanding that notice is "a condition precedent" to coverage under an occurrence-based policy, Washington courts require "a showing of actual and substantial prejudice ... before an insured's breach will release" the insurer from its coverage obligations. *Nat'l Sur. Corp. v. Immunex Corp.*, 162 Wn. App. 762, 788, 256 P.3d 439 (2011); see *Universal Holdings II Ltd. P'ship v. Overlake Christian Church*, 115 Wn. App. 59, 60 P.3d 1254 (2003); *Griffin v. Allstate Ins.*, 108 Wn. App. 133, 140, 29 P.3d 777 (2001).³ As with the notice requirement in occurrence-based policies, the exhaustion requirement in the Excess Carriers' policies is a condition to coverage, and as with such conditions, Washington law requires a showing that the claimed breach was both material and substantially prejudicial.

³ *Simms v. Allstate Ins. Co.*, 27 Wn. App. 872, 876-77, 621 P.2d 155 (1991), which the Excess Carriers cite in passing (R.B. 20 n.5), provides no support for their position. The *Simms* court enforced a policy's one-year limitations period, and its holding that the carrier need not make a showing of prejudice in this context is completely inapposite. Indeed, the court explained that RCW 48.18.200 expressly authorizes policy provisions limiting a policyholder's right of action to a period of one year or more from the date of loss. *Id.* Furthermore, the court confirmed that the prejudice requirement still applies to policy conditions because their purpose is to avoid prejudice while the purpose of a contractual limitations period, in contrast, is to affect "a contractual modification of the statute of limitations." *Id.* at 876-77 (citations and internal quotation marks omitted).

That the attachment point language appears in the insuring agreements, as well as other sections of the Excess Policies, also provides no support for their contention that the exhaustion requirements are coverage-granting provisions. In advancing that contention (R.B. 21), the Excess Carriers ignore the settled principle that the function of a particular policy provision, and not where it is placed in the policy, determines the proper construction.⁴ As demonstrated above, the provisions at issue function as conditions because they impose procedural requirements as to how exhaustion is to be accomplished “in the event” that Quellos incurs a loss. *Ross*, 64 Wn.2d at 237; *Klickitat County*, 124 Wn.2d at 803.

The Excess Carriers also offer no meritorious response to Quellos’ showing that it is reasonable to construe the exhaustion requirements as conditions to coverage. The reasonableness of this reading is underscored by the Washington Supreme Court’s decisions in *Klickitat* and *Ross*, as well as, among others, the cases relied upon by the Excess Carriers that hold that the very same provisions at issue here constitute conditions precedent to coverage. Because Quellos’ reading is reasonable, Washington law mandates that this reading controls, even if the Excess

⁴ *E.g.*, *Am. Nat’l. Fire Ins. Co., v. B & L Trucking & Constr. Co.*, 134 Wn.2d 413, 427-28, 951 P.2d 250 (1998); *Home Ins. Co. v. St. Paul Fire & Marine Ins. Co.*, 229 F.3d 56, 62-63 (1st Cir. 2000); *Med. Mut. Ins. Co. of NC v. Am. Cas. Co. of Reading, PA*, 721 F. Supp. 2d 447, 459 n. 3 (E.D.N.C. 2010); *Devese v. Transguard Ins. Co.*, 798 N.W.2d 614, 619 (Neb. 2011); *D & S Realty, Inc. v. Markel Ins. Co.*, 789 N.W.2d 1, 13 (Neb. 2010); *Fremont Indem. Co. v. New England Reins. Co.*, 815 P.2d 403, 406 (Ariz. 1991).

Carriers' contrary reading also were reasonable. *Moeller v. Farmers Ins. Co. of Wash.*, 155 Wn. App. 133, 140, 229 P.3d 857 (2010).

C. The Excess Carriers Waived Any Right To Demand Compliance With The Attachment Point Conditions.

A carrier that denies coverage and abandons a policyholder waives the right to invoke subsequent noncompliance with policy conditions as a justification for repudiating coverage. *E.g., Vision One, LLC v. Phila. Indem. Ins. Co.*, 158 Wn. App. 91, 241 P.3d 429 (2010). As a matter of law, this precedent mandates that, by denying coverage and abandoning Quellos in 2007, at a time when Quellos' POINT losses already exceeded underlying policy limits, the Excess Carriers waived the right later to insist that Quellos comply with the attachment point conditions when it settled with AISLIC in 2011. CP 211-12, ¶¶16-17, 19 (Ex. B).

The Excess Carriers argue this Court should affirm the trial court's contrary ruling on the ground that "nothing about [their] prior denials fairly can be characterized as a waiver of the exhaustion requirement" R.B. 23. But it is irrelevant what contractual rights the Excess Carriers sought to reserve when they categorically denied coverage for Quellos' POINT losses. As this Court has unequivocally instructed, Washington law does not "allow[]" an insurer "to deny liability," while also "insist[ing] that the insured honor all his contractual commitments."

Vision One, 158 Wn. App. at 101; *see also Truck Ins. Exch. v. VanPort Homes, Inc.*, 147 Wn.2d 751, 761, 58 P.3d 276 (2002) (insurer preserves defenses by accepting defense of underlying suit *and* issuing reservation of rights). As this Court further instructed, and courts across the country have recognized, “the rationale” for adopting “this particular waiver theory” is that the denial is a breach on the part of the insurer that should, by rights, relieve the insured of the punitive effects of his failure to comply with policy conditions. *Vision One*, 158 Wn. App. at 101; *accord* 13 Lee R. Russ, *Couch on Insurance*, §§ 195:41, 195:57 (3rd ed. 2005) (collecting numerous cases holding that insurer’s denial of coverage waives right to demand compliance with policy conditions).

The Excess Carriers attempt to sidestep *Vision One* on the ground that the policy condition at issue there required the carrier’s consent to settle with the underlying plaintiff. R.B. 24. Nothing in *Vision One* suggests that the waiver doctrine being discussed applies only to consent-to-settlement conditions, and this Court’s reasoning in approving this waiver doctrine applies forcefully here. Regardless of whether the abandoned policyholder settles with the underlying plaintiff or its primary insurer, the excess carrier waives the right to claim that the policyholder’s noncompliance with a policy condition forfeits coverage by denying coverage. *See Vision One*, 158 Wn. App. at 101 (the insured should not be

required to comply with policy conditions “when he has already been told, in essence, that the insurer is not concerned, and he is to go his way”).

The Excess Carriers also claim that waiver here would improperly create coverage where none exists. R.B. at 25. But excess coverage exists when Quellos’ liability exceeds the underlying limits and involves claims covered by the Excess Policies. The exhaustion requirements only purport to condition the Excess Carriers’ obligation to pay such covered loss on Quellos’ collection of underlying limits. As one treatise explains, the doctrine of waiver “properly applies to [such] conditions to coverage because it serves to preserve, and not create coverage, by prevent[ing] an insurer from exercise[ing] rights it might otherwise have had under the policy.” 2 Allan D. Windt, *Insurance Claims & Disputes* § 6:35 (5th ed. 2007); accord *Vision One*, 158 Wn. App. at 101.

D. The Excess Carriers Failed To Meet Their Burden Of Proving That Quellos’ Claimed Breach Was Material And Prejudicial.

Because the attachment point provisions are conditions, controlling Washington precedent required the Excess Carriers to prove Quellos’ claimed breach was material and substantially prejudicial even if they had not waived the right to invoke these conditions by denying coverage. *E.g.*, *Klickitat Country*, 124 Wn.2d at 803-04; *Salzberg*, 85 Wn.2d at 377; see also *Canron, Inc., v. Fed. Ins. Co.*, 82 Wn. App. 480, 485, 918 P.2d 937

(1996). The Excess Carriers failed to produce any evidence of either materiality or substantial prejudice at summary judgment.

Although they argue that the AISLIC settlement ostensibly deprived them of a contractual right, purportedly factored into their premiums, “to be relieved of the burden of litigating whether Quellos incurred covered loss beneath the attachment point of the Excess Policies” (R.B. 37), the Excess Carriers did not submit any evidence showing either that they relied on AISLIC to make these coverage determinations or factored AISLIC’s performance of this role into the calculation of their excess premiums. RP 37:5-39:22, 44:4-45:5. Their conduct in connection with the instant coverage dispute, moreover, cannot be squared with their unsubstantiated claims of reliance. Contrary to those claims, the Excess Carriers’ own coverage counsel (including lawyers representing them on this appeal) have been actively involved since the early stages of the underlying proceedings on the POINT Claims, and denied any obligation to cover Quellos’ POINT losses years before Quellos and AISLIC settled their coverage dispute, and at a time when those losses far exceeded primary policy limits. CP 211, ¶12, 14 (Ex. B.); CP 144, ¶5. Because Quellos was forced to sue the Excess Carriers in an effort to secure coverage for the POINT losses, the supposed benefit of being relieved of having to litigate whether Quellos has incurred losses covered by the

AISLIC policy, which the Excess Carriers claim to have lost, has no value.

It also bears emphasizing that the Excess Carriers have argued both in the trial court and on appeal that the conduct exclusions contained in AISLIC's policy preclude coverage for even the \$4.9 million in POINT losses that AISLIC agreed to pay. *See* CP 1236; Brief of Cross-Appellant Federal 35-36 (both arguing that amount of insured POINT losses is \$1.27 million at most and thus does not exceed attachment points of Excess Policies). *See also* Quellos' Response to Federal's Brief §1.A.2. (demonstrating the fallacy of this argument). As the Excess Carriers themselves argue, the coverage issues thus "remain exactly the same with AISLIC dismissed from the case," and "Quellos must litigate the *same* POINT-related coverage issues" to recover from the Excess Policies. R.B. 37 (emphasis in original). The situation would be no different if AISLIC had settled with Quellos for full policy limits because the Excess Carriers would still be contesting whether Quellos' insured POINT losses actually exceed underlying policy limits.

The Excess Carriers cannot have it both ways. Because they have not agreed to be bound by AISLIC's coverage determinations, and would remain free to contest coverage even if AISLIC had paid its full policy

limit,⁵ the Excess Carriers cannot make the requisite showing that Quellos' failure to collect full policy limits had any "identifiable and material detrimental effect on [their] interests." *Mut. of Enumclaw Ins. Co. v. USF Ins. Co.*, 164 Wn.2d 413, 191 P.3d 866 (2008).

The Excess Carriers certainly have not shown, moreover, that the \$30 million windfall they secured from the trial court is warranted in these circumstances. As Washington courts have recognized, the excess carrier suffers no material "prejudice" in any case in which the insured "pays an amount equivalent to the retained limit." *Kalama Chem., Inc. v. Allianz Ins. Co.*, 1995 WL 17015061, at *5 (Wash. Sup. Ct. Aug 14, 1995); *see also Nw. Steel Rolling Mills, Inc. v. Fireman's Fund Ins. Co.*, No. C86-376WD, Order at 2:11-15 (W.D. Wash. Jan. 16, 1991). As scores of cases similarly have held, the excess carrier simply has "no rational interest in whether the insured collected the full amount of the primary policies, so long as it was only called upon to pay such portion of the loss as was in

⁵ Consistent with the Excess Carriers' conduct in the instant coverage litigation, excess insurers routinely contend that they are not bound by the primary insurer's coverage determinations, and have secured numerous decisions accepting that contention. *See, e.g., Allmerica Fin. Corp. v. Certain Underwriters at Lloyd's, London*, 871 N.E.2d 418, 429 (Mass. 2007) (excess carrier not bound by primary carrier's coverage determination and settlement even though excess policy followed form to primary policy); *Keystone Shipping Co. v. Home Ins. Co.*, 840 F.2d 181, 182-83 (3rd Cir. 1988) (same); *see also Allstate Ins. Co. v. Dana Corp.*, 759 N.E.2d 1049, 1060 (Ind. 2001) (primary carrier's interpretation of primary policy not binding on following-form excess carrier).

excess of the limits of those policies.”⁶

II. THE TRIAL COURT ERRED IN ACCEPTING THE EXCESS CARRIERS’ LITERAL INTERPRETATION.

A. This Literal Interpretation Impermissibly Nullifies Coverage.

In arguing that Quellos forfeited excess insurance merely because AISLIC refused to pay 100 percent of its limits for the POINT losses, the Excess Carriers urge a literal reading of the attachment point provisions that produces an absurd result nullifying excess coverage any time a policyholder settles with a primary carrier for even a cent less than full policy limits. *See Morgan v. Prudential Ins. Co. of Am.*, 86 Wn.2d 432, 434-35, 545 P.2d 1193 (1976); *see also* 2 Allan D. Windt, *Insurance Claims & Disputes* § 6:45, at 109 (5th ed. 2012 Supp.). Washington law forbids such readings that render coverage “ineffective” because insurance policies “serve essential, protective risk-spreading functions, unlike ordinary contracts.” *Salzberg*, 85 Wn.2d at 376-77; *see Morgan*, 86 Wn.2d at 435.⁷

⁶ *Zeig v. Mass. Bonding & Ins. Co.*, 23 F.2d 665, 666 (2d Cir. 1928). *See also, e.g.*, *Stargatt v. Fid. & Cas. Co. of N.Y.*, 67 F.R.D. 689, 691 (D. Del. 1975); *Reliance Ins. Co. v. Transamerica Ins. Co.*, 826 So. 2d 998, 999 (Fla. Dist. Ct. App. 2001); *Elliott Co. v. Liberty Mut. Ins. Co.*, 434 F. Supp. 2d 483, 500 (N.D. Ohio 2006); *Siligato v. Welch*, 607 F. Supp. 743, 747 (D. Conn. 1985); *Teigen v. Jelco of Wis. Inc.*, 367 N.W.2d 806, 809-10 (Wis. 1985); *Trinity Homes LLC v. Ohio Cas. Ins. Co.*, 629 F.3d 653, 659 (7th Cir. 2010); *Allstate Ins. Co. v. Riverside Ins. Co. of Am.*, 509 F. Supp. 43, 47 (E.D. Mich. 1981); *Nw. Steel Rolling Mills, Inc. v. Fireman’s Fund Ins. Co.*, No. C86-376WD, Order at 2:11-15 (W.D. Wash. Jan. 16, 1991); *Drake v. Ryan*, 514 N.W.2d 785 (Minn. 1994).

⁷ The Excess Carriers’ assertion that this statement applies only to auto insurance is wholly without merit. *See* R.B. 39. The *Salzberg* court broadly held that noncompliance

The Excess Carriers make light of the holding in *Morgan* by mischaracterizing it as merely construing ambiguous policy language in favor of the policyholder. R.B. 39-40. But the majority in *Morgan* reversed this Court’s decision based on the “plain and ordinary meaning” of the policy terms at issue because the “literal interpretation” of the phrase granting coverage for “loss by severance of both hands at or above the wrists” would produce the absurd result of allowing coverage “only in those cases where there has been a severance of the entire hand in the most precise anatomical sense” *Id.* at 435. One justice, in turn, dissented precisely because the majority had declined to apply the “plain” and unambiguous “language” of the policy. *Id.* at 438 (Wright, J. dissenting).

The Excess Carriers seek to discount the absurd results produced by their interpretation by claiming that Quellos “freely contracted” with them and that the policy language is “not ‘standardized.’” R.B. 41-42. As discussed below, however, there is not a scintilla of evidence that Quellos negotiated this policy language (*see infra* § III), and the Excess Carriers cannot deny that these policy terms are standardized and appear in policies sold to big and small companies alike. *See infra*, § III.

with a condition forfeits coverage only when the carrier suffers prejudice because liability policies “abound with public policy considerations, one of which is that the risk-spreading theory of such policies should operate to afford to affected members of the public-frequently innocent third persons-the maximum protection consonant with fairness to the insurer.” *Id.* at 376-77.

The Excess Carriers also baldly assert that the absurd results flowing from the interpretation that *Quellos* has enumerated “bear no relation to the facts of this case.” R.B. 41.⁸ But they simply ignore the overarching flaw in that interpretation, which is that it deprives the policyholder of excess coverage in precisely the situation most needed, for catastrophic losses far exceeding primary policy limits. There is no legitimate justification for accepting their interpretation when the underlying limits have been paid, and the policy holder is only seeking payment of covered losses exceeding the specified attachment points.

B. The Excess Carriers’ Literal Interpretation Also Contravenes Paramount Principles Favoring Settlement.

The Excess Carriers do not even attempt to reconcile their interpretation of the attachment point provisions with Washington’s strong public policy favoring settlement. They studiously avoid this point because their interpretation plainly frustrates this public policy by forcing

⁸ In contending that their policies require *Quellos* to maintain primary insurance (R.B. 41), the Excess Carriers quibble with *Quellos*’ showing that their interpretation produces the further absurd result of rendering *Quellos* worse off for having purchased a primary policy than if none had been obtained. That contention ignores the well-settled principle that a breach of this requirement does not forfeit coverage, but instead merely requires a credit to the excess carrier for the amount of primary limits the policyholder failed to maintain. *State Farm Fire & Cas. Co. v. Nationwide Mut. Ins. Co.*, 596 F. Supp. 2d 940, 947-48 (E.D. Va. 2009); 2 Allan D. Windt, *supra*, § 6:45, at 6-365. The Indian Harbor Policy incorporates this principle. CP 111, § 4 (Ex. E). It is absurd to construe the attachment point language as precluding excess insurance when *Quellos* *did* purchase a primary policy. The Excess Carriers avoid the numerous other situations in which a policyholder may be unable to obtain primary policy limits. *See* R.B. at 40-41. That the policyholder loses excess coverage in these situations is also absurd, particularly since the excess carrier is only asked to pay losses exceeding its attachment point.

an insured to prosecute until final judgment claims against every underlying carrier that will not agree to pay every cent of its policy limits.

The Excess Carriers also concede (R.B. 44) that Washington courts decline to “enforce limitations in insurance contracts that are contrary to public policy” *Allstate Ins. Co. v. Raynor*, 93 Wn. App. 484, 499, 969 P.2d 510 (1999). They erroneously contend, however, that the attachment point provisions could be invalidated on public policy grounds only if there were statutes that specifically (1) require “companies to purchase D&O insurance for the benefit of potential fraud victims,” or (2) preclude “excess D&O insurers from limiting the scope of coverage provided to their corporate insureds.” R.B. 44. As made clear by *American Home Assurance Co. v. Cohen*, 124 Wn.2d 865, 875, 881 P.2d 1001 (1994), a case the Excess Carriers cite, the Court’s authority is not nearly so limited.

Far from restricting judicial authority to enforce public policy only to instances in which a policy provision contravenes a policy directly expressed in a statute, the *Cohen* court recognized that public policy may be expressed in “the Legislature or prior court decisions” and broadly considered whether the provision at issue ran afoul of any “concern” expressed in legislation, regulations, or court opinions. *Id.* at 875-76. Here, the strong public policy favoring settlement is expressed in myriad

court opinions⁹ and the Uniform Mediation Act, the prefatory notes of which extoll the societal benefits of settlement and proclaim the strong public policy of encouraging settlement. *See* RCW Ch. 7.07. The Court is thus well within its authority to find that the attachment point provisions are contrary to public policy.

The Excess Carriers seek to discount *Seafirst*, 127 Wn.2d at 366, on the ground that it invalidated a common law principle rather than an insurance provision. R.B. 44. But the considerations the Washington Supreme Court invoked in abrogating the “rule of discharge” based on the public policy favoring settlements apply with equal force here. The *Seafirst* court abrogated this rule because it released all joint obligors when a settlement was reached with any joint obligor and because “allowing the obligee to accept partial satisfaction promotes settlement, which the law strongly favors.” *Id.* at 365. The Court also noted that “if [the opposing] view is correct, one recalcitrant obligor could force a trial regardless of the desires of the other parties.” *Id.*

So too here, the Excess Carriers’ interpretation allows a recalcitrant excess insurer to force a policyholder to go to trial any time

⁹ *E.g. Am. Safety Ins. Co. v. City of Olympia*, 162 Wn.2d 762, 772, 174 P.3d 54 (2007) *City of Seattle v. Blume*, 134 Wn.2d 243, 258, 947 P.2d 223 (1997); *Seafirst Ctr. Ltd. P’ship v. Erickson*, 127 Wn.2d 355, 366, 898 P.2d 299 (1995); *Haller v. Wallis*, 89 Wn.2d 539, 545, 573 P.2d 1302 (1978).

the underlying insurer refuses to pay 100 percent of its limits, even though the policyholder and underlying insurer both desire to settle their dispute. For this reason, and as mandated by *Seafirst*, Washington courts have invoked public policy favoring settlement in holding that a policyholder should be permitted to settle for less than limits with its primary carrier.¹⁰

The Excess Carriers cavalierly dismiss the great weight of authority from other jurisdictions recognizing that their position is contrary to public policy favoring settlement of coverage disputes on the ground that these cases did not consider exhaustion requirements, such as those at issue, that “impose[d] . . . a condition precedent to liability on the policy.” R.B. 32.¹¹ The public policy concern is no less applicable here, and the deleterious impact of the Excess Carriers’ interpretation underscores why they should not be permitted to repudiate coverage when

¹⁰ *E.g.*, *Nw. Steel Rolling Mills*, No. C86-376WD, at 2:16-3:3 (citing favorably to *Zeig v. Mass. Bonding & Ins. Co.*, 23 F.2d 665 (2d Cir. 1928); *Stargatt*, 67 F.R.D. 689; *see also Kalama*, 1995 WL 17015061, at *3 & n.5 (explaining why less-than-limits settlement with primary insurer does not eliminate excess coverage).

¹¹ *E.g.*, *HLTH Corp. v. Agric. Excess & Surplus Ins. Co.*, 2008 WL 3413327 (Del. Sup. Ct. July 31, 2008); *Pereira v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa.*, 2006 WL 1982789 (SDNY 2006); *Koppers Co., Inc. v. Aetna Cas. & Sur. Co.*, 98 F.3d 1440 (3d Cir. 1996); *see also Zeig*, 23 F.2d at 666; *Reliance Ins. Co.*, 826 So. 2d at 999; *Teigen*, 367 N.W.2d at 809-810; *Drake*, 514 N.W.2d at 789; *Elliott Co.*, 434 F. Supp. 2d at 500; *Siligato*, 607 F. Supp. at 747; *Allstate Ins. Co.*, 509 F. Supp. at 48; *Trinity Homes*, 629 F.3d at 659. The Excess Carriers claim incorrectly that the discussion in *HLTH* was *dicta* because the court found that the underlying insurers had paid their full policy limits. Rather than deciding that issue, the court ruled that the excess insurer must pay for any covered loss that exceeds the excess policy’s attachment point because the underlying policies are exhausted as a matter of law regardless of “any loss [the policyholders] may have imposed on themselves by accepting settlements with underlying insurers for less than the policy limit.” *HLTH Corp.*, 2008 WL 3413327, at *14-15.

Quellos' claimed breach was neither material nor substantially prejudicial.

III. THE POLICIES WERE NOT NEGOTIATED.

While purporting to disclaim any argument that this Court should uphold the forfeiture of coverage because Quellos can be viewed as a “sophisticated” insured, the Excess Carriers’ response brief abounds with assertions about Quellos’ “sophisticated commercial” status, and its supposed ability to negotiate less restrictive exhaustion language. R.B. 42; *see* R.B. 20, 41, 45, 46, 50. The Excess Carriers aver that Quellos could have purchased an endorsement to amend § III(C) of Indian Harbor’s policy and allow Quellos to “fill the gap left by an insolvent insurer (or for other reasons).” R.B. 45. There is no evidence that Federal even offered such an endorsement, and the record evidence shows that Quellos was not informed of such an endorsement when it purchased the Excess Policies. CP 300-01, ¶3 (Ex. F).¹² Moreover, the endorsement would not have even provided “gap-filling coverage” because it would have modified only the exhaustion requirement stated in § III of the Indian Harbor policy, while leaving intact the exhaustion requirement in § I.

When, as here, “the specific language in question was not

¹² The Excess Carriers also aver that “since 2004, this kind of ‘gap filling’ endorsement has become widely available in the marketplace.” R.B. 45. Coverage offered by carriers after Quellos purchased the Excess Policies in 2004 is entirely irrelevant. In addition, the Excess Carriers rely solely on an Internet blogger’s hearsay comment that excess carriers are more receptive “in recent years” to offering such coverage.

negotiated,” standard rules of policy construction govern even if (unlike Quellos) “the insured is itself a corporate giant,” including rules that govern application of policy conditions and that preclude interpretations producing absurd results nullifying coverage. *Boeing Co. v. Aetna Cas. & Sur. Co.*, 113 Wn.2d 869, 883, 784 P.2d 507 (1990). “The critical” considerations in such cases are, as here, that “the policy in question is a standard form policy prepared by the Company’s experts, with language selected by the insurer,” and that, “once the court construes the standard form coverage clause . . . the Court’s construction will bind policyholders throughout the state regardless of the size.” *Id.*

The Excess Carriers also misleadingly imply that the attachment provisions at issue are “not standardized” terms drafted by the insurance industry. Quite to the contrary, this exhaustion language appears in preprinted forms, with form numbers, including the date the form was prepared by the issuing insurer. *See* CP 99 (Form 14-02-2272 (Ed. 5/97)) (Ex. D), CP 110 (Form EX 71 01 09 99) (Ex. E), CP 210-11, ¶¶9, 11 (Ex. B). Further underscoring the standardized nature of this exhaustion language is the Excess Carriers’ citation of cases from jurisdictions throughout the U.S. that have considered the same or functionally identical policy language. *See, e.g., JP Morgan Chase & Co.*, 98 A.D.3d at 20; *Goodyear Tire & Rubber Co.* 2011 WL 5024823, at *1; *Citigroup, Inc. v.*

Fed. Ins. Co., 649 F.3d 367, 372 (5th Cir. 2011). This standard-form language is also utilized by a wide variety of excess insurers to cover small and large businesses alike.¹³

CONCLUSION

For the reasons discussed herein and in its opening brief, Quellos respectfully requests that the Court reverse the trial court's February 20, 2012 Order Granting Defendants' Motions for Summary Judgment (CP 322-26), vacate the entry of judgment in favor of the Excess Carriers, direct the trial court to grant Quellos' motion for summary judgment instead, and award Quellos reasonable attorneys' fees and costs.

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¹³ See, e.g., *RLI Excess Policy Specimen*, Irmi.com, <http://www.irmi.com/online/dno/cos/rli/excess/prior-editions/rli-excess-policy-09-98.pdf>; *CNA Excess Insurance Policy, Form No. G-22075-B*, Irmi.com, <http://www.irmi.com/online/dno/cos/cna/excess/cna-excess-insurance-policy-10-95.pdf>; *Chicago Old Republic Excess DIC Endorsement* (modifying the exhaustion language), Irmi.com, <http://www.irmi.com/online/dno/cos/chicago-underwriting/excess/chicago-old-republic-excess-limiting-endt-excess-dic-endorsement-04-08.pdf>; *Darwin Excess Insurance Policy Specimen*, Irmi.com, <http://www.irmi.com/online/dno/cos/darwin/excess/darwin-excess-insurance-policy-06-04.pdf>; *Royal Indem. Co. v. C.H. Robinson Worldwide, Inc.*, 2009 WL 2149637 (Minn. App. 2009).

CERTIFICATE OF SERVICE

I hereby certify that on September 10, 2012, I filed with the Court of Appeals of the State of Washington, Division 1, the foregoing, **Brief of Appellant/Cross-Respondent in Reply to Brief of Respondent and Cross-Appellant Indian Harbor Insurance Company**, and served a copy on the following counsel of record:

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NO. 68478-7

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION I

QUELLOS GROUP LLC, *Appellant/Cross-Respondent*,

v.

FEDERAL INSURANCE COMPANY and INDIAN HARBOR
INSURANCE COMPANY, *Respondents/Cross-Appellants*

**UNPUBLISHED CASES CITED IN
BRIEF OF APPELLANT/CROSS-RESPONDENT IN REPLY TO
BRIEF OF RESPONDENT/CROSS-APPELLANT INDIAN
HARBOR INSURANCE COMPANY**

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ORIGINAL

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(Cite as: 2009 WL 2149637 (Minn.App.))



Only the Westlaw citation is currently available.

NOTICE: THIS OPINION IS DESIGNATED AS UNPUBLISHED AND MAY NOT BE CITED EXCEPT AS PROVIDED BY MINN. ST. SEC. 480A.08(3).

Court of Appeals of Minnesota.
ROYAL INDEMNITY COMPANY, successor in interest to Royal Insurance Company of America, Appellant,
v.
C.H. ROBINSON WORLDWIDE, INC., Respondent.

No. A08-0996.
July 21, 2009.
Review Denied Sept. 29, 2009.

West KeySummaryInsurance 217 ↔2319

217 Insurance
217XVII Coverage--Liability Insurance
217XVII(B) Coverage for Particular Liabilities
217k2317 Employers' Liabilities
217k2319 k. Scope of coverage. Most Cited Cases

A district court properly determined that severance payments were covered losses under an insured's insurance policy. A severance agreement, by itself, would not necessarily be a wrongful employment act under the terms of the policy. However, the severance agreements at issue were part of a settlement agreement between the insured and employees concerning the employees' claims for hostile work environment. The settlement agreement was the result of covered claims for wrongful employment acts, and therefore the insured became legally obligated to make the severance payments when it entered into the settlement agreement.

Hennepin County District Court, File No.

27-CV-06-19200.

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Considered and decided by PETERSON, Presiding Judge; CONNOLLY, Judge; and JOHNSON, Judge.

UNPUBLISHED OPINION

PETERSON, Judge.

*1 This appeal is from a grant of summary judgment in favor of a second excess insurer, appellant Royal Indemnity Company, in an insurance-coverage declaratory-judgment action against its insured, respondent C.H. Robinson Worldwide, Inc. (CHRW). CHRW filed a notice of review. We affirm in part, reverse in part, and remand.

FACTS

CHRW had a primary policy for employment-practices liability insurance from Gulf Underwriters Insurance Co. that contains a \$10 million limit of liability and a duty to defend. CHRW also had excess-liability coverage. The first layer of CHRW's excess-liability coverage was provided by a Nutmeg Insurance Co. policy with a \$10 million limit of liability, which follows form to the underlying Gulf policy, except as to the duty to defend. The second layer of excess-liability coverage was provided by Royal's policy, which has a \$10 million limit of liability and also follows form to the underlying policies.

In 2002, current and former CHRW employees brought a nationwide class-action lawsuit against CHRW in federal district court (*Carlson* Litigation), alleging gender-discrimination, hostile-work-environment, compensation, and promotion

Not Reported in N.W.2d, 2009 WL 2149637 (Minn.App.)
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claims. CHRW tendered defense and indemnification to Gulf, Nutmeg, and Royal. The insurers accepted, subject to reservations of their rights.

In 2005, the federal district court granted class certification for the compensation and promotion claims, but denied certification for other claims. Following this order, individuals with claims outside the scope of the certified classes filed administrative charges with the Equal Employment Opportunity Commission (EEOC), and some of these individuals commenced lawsuits (EEOC lawsuits).

As litigation progressed, Gulf, Nutmeg, and Royal questioned the necessity and reasonableness of the defense costs submitted, as well as the sufficiency of defense counsel's billing practices, but the billing disputes were not resolved. Defense costs exhausted the \$10 million liability limit of Gulf's primary policy.

One week before trial was scheduled to begin, CHRW demanded authorization for a settlement offer of up to \$15 million, which was within its remaining insurance limits with Nutmeg and Royal. CHRW threatened to sue for excess/uninsured exposure if the insurers refused to pursue the settlement in good faith. Nutmeg and Royal consented to the settlement offer, but Royal expressly reserved its rights to continue to dispute coverage and to seek reimbursement for uncovered claims included in the settlement and to recoup improperly paid defense costs. CHRW settled for \$15 million. Nutmeg paid \$8.5 million toward the settlement, with the remainder of its \$10 million limit going toward defense costs, and Royal contributed \$6.5 million. The settlement agreement included the creation of a Qualified Settlement Fund to be administered by trustees for the purpose of distributing the settlement funds.

Royal then commenced this declaratory-judgment action against CHRW to pursue its coverage and defense-costs challenges. In several orders, the district court granted summary judgment in favor of CHRW, concluding that (1) Royal had no inde-

pendent cause of action against CHRW to challenge whether the underlying insurers paid for non-covered claims that did not properly exhaust their respective liability limits; (2) taxes and severance payments were covered losses under the policy; and (3) the EEOC lawsuits were sufficiently related to the class-action lawsuit to be covered, except as to one plaintiff. The district court referred the defense-costs issue to a special master, and the parties ultimately stipulated to accept the findings by the special master as to the reasonableness of the defense costs.

*2 After judgment was entered, Royal filed this appeal. CHRW filed a notice of review.

DECISION

On appeal from summary judgment, a reviewing court must determine whether there are any genuine issues of material fact and whether the district court erred in its application of the law. *State by Cooper v. French*, 460 N.W.2d 2, 4 (Minn.1990). The reviewing court views the evidence in the light most favorable to the nonmovant. *Fabio v. Bellomo*, 504 N.W.2d 758, 761 (Minn.1993). "Insurance coverage issues and the interpretation of insurance contract language are questions of law," which will be reviewed de novo. *Jenoff, Inc. v. N.H. Ins. Co.*, 558 N.W.2d 260, 262 (Minn.1997).

A court will interpret insurance policies pursuant to the general principles of contract law. *Thommes v. Milwaukee Ins. Co.*, 641 N.W.2d 877, 879 (Minn.2002). "In interpreting insurance contracts, we must ascertain and give effect to the intentions of the parties as reflected in the terms of the insuring contract." *Jenoff*, 558 N.W.2d at 262. The insured bears the burden of demonstrating coverage under an insurance policy *Travelers Indem. Co. v. Bloomington Steel & Supply Co.*, 718 N.W.2d 888, 894 (Minn.2006). If this burden is met, the insurer must then establish the applicability of exclusions, which will be "construed narrowly and strictly against the insurer." *Id.*

I.

Not Reported in N.W.2d, 2009 WL 2149637 (Minn.App.)
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The district court concluded that Royal “has no independent cause of action as against [CHRW] to challenge amounts paid to exhaust the policy limits of the underlying insurers Gulf and Nutmeg, or for recoupment of defense costs paid under CHRW’s policies with the two prior insurers.” In its memorandum, the court explained:

Royal’s right to challenge amounts paid or owing only applies to amounts owed by Royal, through its contribution to the settlement and defense costs submitted to Royal by CHRW. Royal has no right, through contract or subrogation, to an *ex post facto* challenge of amounts paid by Gulf or Nutmeg after exhaustion of those underlying policies.

The court further explained that “Royal can cite to no Minnesota authority that allows an excess carrier to challenge the amounts paid by other carriers, not paid under the terms of the excess carrier’s own contract, let alone recoup amounts that may have been wrongfully paid out by others.”

It appears that in reaching its conclusion, the district court misunderstood Royal’s claim. As we understand the claim, Royal is challenging the amounts that it paid through its contribution to the settlement, alleging that under the terms of its own policy, it was not obligated to pay the full amount that it contributed. Royal’s argument is based on provisions in its policy that state that Royal’s “[l]iability for any covered Loss ... shall attach ... only after the insurers of the Underlying Policies shall have paid in legal currency the full amount of the Underlying Limit” and that “[i]n the event ... of the ... exhaustion of the Underlying Limit by reason of the insurers of the Underlying Policies paying in legal currency Loss, this policy shall ... continue in force as primary insurance.” (Emphasis added.) In other words, Royal’s liability as an excess insurer attaches when the liability limits of the underlying policies have been exhausted because the underlying insurers have made payments for loss. Royal claims that because the underlying Gulf policy specifically defines “Loss,” it is not sufficient under

Royal’s policy for CHRW to show only that the underlying insurers made payments in the amount of the underlying liability limits; it is also necessary for CHRW to show that the payments that were made fit within the policy definition of “Loss.” Therefore, if Gulf and Nutmeg made payments that did not fit within the policy definition of “Loss,” CHRW cannot rely on those payments to establish that the underlying policies have been exhausted.

*3 The primary Gulf policy, to which the Royal policy follows form, defines “Loss” to mean,

1. any amount which an Insured becomes legally obligated to pay as the result of a covered Claim or Claims ... for Wrongful Employment Acts, including but not limited to damages (including back pay and front pay), judgments (including an award of pre-judgment and post-judgment interest) and settlements; and
2. Defense Costs.

The policy defines “Defense Costs” to mean “that part of Loss consisting of the reasonable costs, charges and expenses (including but not limited to attorney fees) incurred in defending or investigating Claims, including appeals therefrom.” Royal’s claim is that CHRW cannot rely on payments for claims that are not covered or defense costs that are not reasonable to establish that the underlying policies have been exhausted.

We disagree with the district court that Royal cannot assert this claim against CHRW. The claim may appear to be an *ex post facto* challenge to the amounts that Gulf and Nutmeg paid under their policies because the district court considered it after the settlement occurred and the insurers made their contributions to the settlement. But Royal’s policy was in effect when the payments were made, and Royal had previously asserted to CHRW that its coverage did not include certain claims. And in response to CHRW’s settlement demand, Royal stated that to the extent the settlement included uncovered claims, it would require-and it received-CHRW’s

Not Reported in N.W.2d, 2009 WL 2149637 (Minn.App.)
(Cite as: 2009 WL 2149637 (Minn.App.))

written acknowledgement that Royal “reserved its right to continue to dispute coverage for the uncovered claims, and to seek reimbursement for any amounts attributable to such claims.” Royal also reserved its right to be reimbursed by CHRW “for any defense costs paid by the insurance tower, including all underlying insurers, which were not covered or which were otherwise not reasonable and/or necessary to the defense of coverage litigation and claims.”

Furthermore, an insurer “owes its insured a duty of good faith in deciding whether to accept or reject a settlement.” *Cont'l Cas. Co. v. Reserve Ins. Co.*, 307 Minn. 5, 8, 238 N.W.2d 862, 864 (1976). If the settlement offer had collapsed because Royal wanted to resolve whether its liability attached because the underlying coverage was properly exhausted, Royal could be liable for a bad-faith, failure-to-settle claim, which CHRW in fact threatened. *See, e.g.*, 1 Allan A. Windt, *Insurance Claims & Disputes*, § 2:1, at 55-56 (4th ed.2001) (discussing similar situation).

Consequently, we conclude that Royal may assert its claim that under the terms of the Royal policy, if Gulf and Nutmeg made payments that did not fit within the policy definition of “Loss,” CHRW cannot rely on those payments to establish that the underlying policies have been exhausted. This policy-interpretation issue is properly raised in a declaratory-judgment action,

II.

As we have already discussed, the Gulf policy defines “Loss.” In addition to the portion of the definition quoted above, the policy states that “Loss does not, however, include ... taxes or fines or penalties imposed by law.” Based on this exclusion from the definition of “Loss,” Royal sought a declaration that it is entitled to reimbursement or credit for the amounts paid into the settlement that are designated for taxes. The district court ruled that the policy provision is ambiguous with regard to the question of the person upon whom a tax obligation must be imposed to be excluded from the

definition of “Loss” and, construing the exclusion narrowly against the drafter, the district court found that amounts paid into the settlement and designated for taxes were not excluded from coverage.

*4 Royal argues that the district court erred because the policy contains no language that suggests that coverage for taxes depends upon a determination that the taxes were imposed on the insured. We disagree. An insurance “policy must be construed as a whole, and unambiguous language must be given its plain and ordinary meaning.” *Henning Nelson Constr. Co. v. Fireman's Fund Am. Life Ins. Co.*, 383 N.W.2d 645, 652 (Minn.1986). Language in a policy is ambiguous if it is susceptible to two or more reasonable interpretations. *Medica, Inc. v. Atl. Mut. Ins. Co.*, 566 N.W.2d 74, 77 (Minn.1997).

The Gulf policy defines “Loss” as “any amount which an Insured becomes legally obligated to pay as the result of a covered Claim or Claims ... for Wrongful Employment Acts.” The policy defines “Claim” to include, among other things, “a civil proceeding commenced by the service of a complaint or similar pleading” and “a formal administrative or regulatory proceeding commenced by the filing of a notice of charges, formal investigative order or similar document” if either of these proceedings “is brought and maintained by or on behalf of any past, present or prospective Employee of the Insured Company.”

Reading the exclusion for taxes imposed by law in light of the definition of claim, the exclusion refers only to taxes imposed on the insured company because taxes, fines, or penalties would be a possible outcome of a formal administrative or regulatory proceeding against the company but the imposition of taxes, fines, or penalties would not ordinarily be expected to be the outcome of a civil proceeding commenced by an employee. Also, a tax, fine, or penalty imposed on a party other than the insured company would not ordinarily be paid by the company, and there would be no reason to exclude from coverage amounts that the company would not pay.

Not Reported in N.W.2d, 2009 WL 2149637 (Minn.App.)
 (Cite as: 2009 WL 2149637 (Minn.App.))

In this case, amounts paid into the Qualified Settlement Fund will be used, in part, to pay taxes that are imposed on employees due to payments that the employees receive from the fund. The taxes are not imposed on CHRW, and the payments from the fund produce the same net result as making larger payments to employees and having them pay their own taxes. The district court did not err in interpreting the taxes exclusion as not applying to taxes owed by settling employees in the underlying litigation.

III.

Royal asserts that because certain “severance payments” made to three named plaintiffs do not qualify as “Loss” under the policy, it is entitled to reimbursement and/or credit from CHRW for the amounts used to make the payments.

The Gulf policy defines “Loss” as “any amount which an Insured becomes legally obligated to pay as the result of a covered Claim or Claims ... for Wrongful Employment Acts.” The policy defines “Wrongful Employment Act” as “any act, error or omission committed or attempted, or allegedly committed or attempted ... in connection with any actual or alleged wrongful dismissal, discharge or termination of employment, ... [or] violation of employment discrimination laws.” Royal argues that the severance payments were not a covered loss because the payments were made solely in exchange for the employees’ voluntary agreements to sever their employment and were not amounts that CHRW became legally obligated to pay as the result of a claim for a wrongful employment act.

*5 The three named plaintiffs had class claims and asserted individual non-class claims for hostile work environment. When approving the settlement agreement, the federal district court stated:

Named Plaintiffs will be treated the same as other class members with respect to the settlement of the Class Claims. To the extent that they are entitled to receive additional settlement monies outside of the claims process, they are required to

give additional consideration—that is, a broader release of claims than the release to be signed by other class members, including the relinquishment of their individual appellate rights, and, in three instances, the voluntary termination of their employment with [CHRW].

Even though a severance agreement, by itself, would not necessarily be a wrongful employment act under the policy, the three severance agreements at issue here are part of the settlement agreement. The settlement agreement is the result of covered claims for wrongful employment acts, and CHRW became legally obligated to make the severance payments when it entered into the settlement agreement. It is simply implausible to suggest that the severance agreements are not the result of the covered claims that were settled in the settlement agreement. The district court was correct in ruling that the severance payments are covered losses.

IV.

The next issue concerns the district court ruling that claims for the EEOC lawsuits, which were denied class certification and were filed after the expiration of the Royal policy period, were covered under the Royal policy as “related claims.”

The Gulf policy provides wrongful-employment-act coverage for “any Claim first made against the Insureds during the Policy Period .” The policy states:

All Loss based upon or arising out of the same Wrongful Employment Act or Related Wrongful Employment Acts of one or more of the Insureds shall be considered a single Loss incurred as a result of a single Claim, which Claim shall be deemed to have been made on the date the first Claim for such Wrongful Employment Act or for one or more of such Related Wrongful Employment Acts is made against any of the Insureds, whether such date is before or after the Policy Inception Date. The retention shall apply only once to each such Claim.

Not Reported in N.W.2d, 2009 WL 2149637 (Minn.App.)
(Cite as: 2009 WL 2149637 (Minn.App.))

“Related Wrongful Employment Act” is defined as “Wrongful Employment Acts that arise out of, are based on, relate to or are in consequence of the same facts, circumstances or situations.”

Royal contends that because the federal district court concluded that the EEOC claims did not satisfy the commonality test under Fed.R.Civ.P. 23(a)(2), they cannot satisfy the “related claims” provisions of the policy. We disagree, because class certification is separate and distinct from the policy language governing whether claims are “related” for coverage purposes. As the district court ruled, the policy definition of “Related Wrongful Employment Act” is broader than the commonality test.

*6 “[T]he common understanding of the word ‘related’ covers a very broad range of connections, both logical and causal.” *Am. Commerce Ins. Brokers, Inc. v. Minn. Mut. Fire & Cas. Co.*, 551 N.W.2d 224, 228 (Minn.1996) (addressing whether employee’s acts of embezzlement were related for coverage purposes). Under the policy, related wrongful acts are those “that arise out of, are based on, relate to or are in consequence of the same facts, circumstances or situations.” As the district court determined, each of the EEOC lawsuits arose out of the wrongful employment acts alleged in the class action, were specific in number and readily identifiable, and were filed as a direct result of being excluded from the class action. As the district court further explained, but for these plaintiffs being dismissed from the class-action suit, no individual claims would have been filed. Under the related-wrongful-acts provision of its policy, Royal must indemnify for the EEOC lawsuits.

CHRW contends in its notice of review that the district court erred in ruling that another individual lawsuit was not a related case. Because this suit raised age-discrimination and retaliation claims, was not originally contemplated to be part of the class action, and was a “subsequently filed” case, it is not a related wrongful act. As stated by the district court, to hold that this claim is covered under the Royal policy would impermissibly extend the

Royal coverage beyond the reasonable expectations of the parties when they negotiated and drafted the policy.

V.

CHRW challenges the district court’s adoption of the special master’s finding that, as a matter of law, Royal cannot be liable for the portions of the defense-cost invoices that were not paid by the underlying carriers. CHRW contends that the special master did not have authority to make this legal conclusion. But we need not reach this issue, because we are reviewing the district court’s decision, not the special master’s decision.

The district court ruled that Royal had no obligation to pay the remaining balances of the defense-cost invoices that Gulf and Nutmeg did not pay, explicitly applying the same logic that it applied in its ruling that Royal could not challenge whether the underlying policies were prematurely exhausted. As Royal concedes, because we reverse the district court’s decision as to Royal, we reverse its decision as to CHRW and hold that just as Royal may assert claims that Gulf and Nutmeg paid defense costs that were not reasonable, CHRW may assert claims that Gulf and Nutmeg refused to pay defense costs that were reasonable.

Under Royal’s excess policy, liability for covered losses, which include covered claims and defense costs, attaches when the liability limits of the underlying policies have been exhausted. Royal asserts that it only has an obligation to pay reasonable defense costs and that it should have the opportunity to review the unpaid invoices for a determination of reasonableness. Royal asserts that it has a right to a jury trial as to all fact questions, including reasonableness. Because the district court ruled that Royal could not assert its claim regarding the reasonableness of defense costs, it has not considered whether Royal has a right to a jury trial. We will not consider the issue for the first time on appeal. *See Thiele v. Stich*, 425 N.W.2d 580, 582 (Minn.1988) (reviewing court will not consider issue not decided by district court).

Not Reported in N.W.2d, 2009 WL 2149637 (Minn.App.)
(Cite as: 2009 WL 2149637 (Minn.App.))

VI.

*7 CHRW argues that the district court erred in adopting the special master's determination of the reasonableness of defense fees. CHRW contends that the special master's analysis of the reasonableness of attorney fees is not consistent with Minnesota law. But the judgment for attorney fees was entered in accordance with the parties' stipulation and order for entry of final judgment, in which the parties agreed "to accept as the findings of the fact finder in this action the Special Master's findings and recommendations as to the reasonableness of defense costs incurred by CHRW in the *Carlson* Litigation and for those EEOC claims determined by this Court to be covered under the Royal Excess Policy." CHRW has not addressed why this stipulation is not valid and binding. Consequently, we will not review its claim that the special master did not apply the correct legal analysis.

VII.

Finally, CHRW argues that the district court erred when it ruled that the Royal policy was merely a "defense reimbursement policy" and did not impose a duty to defend CHRW. The district court ruled that because the Royal policy followed form to the Nutmeg policy, which specifically excluded a duty to defend, Royal did not have a duty to defend.

CHRW argues that because Royal's "follow form" policy fails to distinguish its coverage of defense costs from the primary layer's "duty to defend," Royal's policy should also provide "duty to defend within its limits" coverage. CHRW cites *In re Silicone Implant Ins. Coverage Litig.*, 652 N.W.2d 46, 64-68 (Minn.App.2002), *rev'd in part on other grounds*, 667 N.W.2d 405 (Minn.2003). In that case, excess insurers sought to be relieved of any obligation to pay defense costs in excess of their policy limits. *Silicone Implant Ins. Coverage Litig.*, 652 N.W.2d at 63. This court held "that unless there is a specific exclusion, policies that follow form to the underlying policy and do not limit defense costs ... obligate the insurer to pay defense

costs in addition to policy limits." *Id.* at 66-67. CHRW argues that because the excess policies do not expressly limit the defense obligation to "defense reimbursement coverage," Royal is obligated to provide duty-to-defend coverage to CHRW. Because the Nutmeg policy repeatedly and explicitly excludes the duty to defend, we disagree. The district court correctly ruled that Royal had no duty to defend.

Affirmed in part, reversed in part, and remanded.

Minn.App.,2009.

Royal Indem. Co. v. C.H. Robinson Worldwide, Inc.

Not Reported in N.W.2d, 2009 WL 2149637 (Minn.App.)

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That the attachment point language appears in the insuring agreements, as well as other sections of the Excess Policies, also provides no support for their contention that the exhaustion requirements are coverage-granting provisions. In advancing that contention (R.B. 21), the Excess Carriers ignore the settled principle that the function of a particular policy provision, and not where it is placed in the policy, determines the proper construction.⁴ As demonstrated above, the provisions at issue function as conditions because they impose procedural requirements as to how exhaustion is to be accomplished “in the event” that Quellos incurs a loss. *Ross*, 64 Wn.2d at 237; *Klickitat County*, 124 Wn.2d at 803.

The Excess Carriers also offer no meritorious response to Quellos’ showing that it is reasonable to construe the exhaustion requirements as conditions to coverage. The reasonableness of this reading is underscored by the Washington Supreme Court’s decisions in *Klickitat* and *Ross*, as well as, among others, the cases relied upon by the Excess Carriers that hold that the very same provisions at issue here constitute conditions precedent to coverage. Because Quellos’ reading is reasonable, Washington law mandates that this reading controls, even if the Excess

⁴ *E.g.*, *Am. Nat’l. Fire Ins. Co., v. B & L Trucking & Constr. Co.*, 134 Wn.2d 413, 427-28, 951 P.2d 250 (1998); *Home Ins. Co. v. St. Paul Fire & Marine Ins. Co.*, 229 F.3d 56, 62-63 (1st Cir. 2000); *Med. Mut. Ins. Co. of NC v. Am. Cas. Co. of Reading, PA*, 721 F. Supp. 2d 447, 459 n. 3 (E.D.N.C. 2010); *Devese v. Transguard Ins. Co.*, 798 N.W.2d 614, 619 (Neb. 2011); *D & S Realty, Inc. v. Markel Ins. Co.*, 789 N.W.2d 1, 13 (Neb. 2010); *Fremont Indem. Co. v. New England Reins. Co.*, 815 P.2d 403, 406 (Ariz. 1991).