

68478-7

68478-7

No. 68478-7

COURT OF APPEALS, DIVISION I
STATE OF WASHINGTON

QUELLOS GROUP, LLC, Appellant/Cross Respondent,

v.

FEDERAL INSURANCE COMPANY; INDIAN HARBOR
INSURANCE COMPANY, Respondents/Cross Appellants,

and

NUTMEG INSURANCE COMPANY,

Defendant.

BRIEF OF RESPONDENT AND CROSS-APPELLANT
INDIAN HARBOR INSURANCE COMPANY

Jerret E. Sale, WSBA #14101
Deborah Carstens, WSBA #17494
BULLIVANT HOUSER BAILEY PC
1601 Fifth Avenue, Suite 2300
Seattle, Washington 98101-1618
Telephone: 206.292.8930
Facsimile: 206.386.5130

Leslie S. Ahari (*pro hac vice*)
Gabriela Richeimer (*pro hac vice*)
TROUTMAN SANDERS LLP
401 Ninth Street NW, Suite 1000
Washington, DC 20004
Telephone: 202.274.2950
Facsimile: 202.274.2994

Counsel for Respondent and Cross-Appellant Indian Harbor Insurance
Company and Cross-Appellant
Indian Harbor Insurance Company

COURT OF APPEALS
STATE OF WASHINGTON
FILED
1/14/15
COURT OF APPEALS
STATE OF WASHINGTON
FILED
1/14/15

ORIGINAL

TABLE OF CONTENTS

	Page
I. INTRODUCTION	1
II. ASSIGNMENTS OF ERROR	2
III. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR	3
IV. STATEMENT OF THE CASE	4
A. The Investment Management Insurance Policies	4
B. The POINT Claims	7
C. The AISLIC Settlement And Release Agreement	8
D. The Decision Below.....	9
V. SUMMARY OF ARGUMENT	11
VI. ARGUMENT.....	13
A. Legal Standard.	13
B. The Trial Court Correctly Enforced the Plain Language of the Excess Insuring Agreements.....	14
1. Quellos Did Not Meet Its Burden to Prove Coverage Under the Excess Insuring Agreements	14
2. Quellos Cannot Shift the Burden of Proof Under the Excess Insuring Agreements to the Insurers By Arguing That Exhaustion Is a Mere Condition of Excess Coverage.....	18
3. Quellos Cannot Invoke the Doctrines of Waiver or Estoppel to Create Coverage Under the Excess Insuring Agreements.....	23

4. Numerous Courts Have Enforced Similar Requirements in Excess Policies	25
C. The Trial Court Properly Found in the Alternative that the Insurers Established Material and Substantial Prejudice from Quellos’ Below-Limits Settlement with AISLIC.....	33
D. Enforcing the Plain Meaning of the Excess Insuring Agreements Is Not “Absurd,” Nor Does Public Policy Displace the Parties’ Freedom of Contract	38
1. Quellos’ Subjective Expectations Regarding the Excess Coverage Cannot Supplant the Plain Contract Language	38
2. No Washington Public Policy Precludes Excess Insurers From Limiting the Scope of Excess Coverage By Requiring Complete Exhaustion of Underlying Insurance	42
VII. CONCLUSION	50

TABLE OF AUTHORITIES

	Page
CASES	
<i>Allstate Ins. Co. v. Raynor</i> , 93 Wn. App. 484, 969 P.2d 510 (1999).....	43
<i>Allstate Ins. Co. v. Riverside Ins. Co. of Am.</i> , 509 F. Supp. 43 (E.D. Mich. 1981).....	32
<i>Am. Home Assur. Co. v. Cohen</i> , 124 Wn.2d 865, 881 P.2d 1001 (1994).....	42, 43
<i>Am. Safety Cas. Ins. Co. v. Olympia</i> , 162 Wn.2d 762, 174 P.3d 54 (2007).....	44
<i>Anderson v. Kemper Ins. Co.</i> , 128 Mich. App. 249, 340 N.W.2d 87 (1983).....	27
<i>Belz v. Clarendon Am. Ins. Co.</i> , 158 Cal. App. 4th 615, 69 Cal. Rptr. 3d 864 (2007).....	27
<i>Boeing Co. v. Aetna Cas. & Sur. Co.</i> , No. C86-352WD, 1990 U.S. Dist. LEXIS 20231 (W.D. Wash. Apr. 17, 1990).....	25
<i>Certain Underwriters at Lloyd’s, London v. The Travelers Prop. & Cas. Co. of Am.</i> , 161 Wn. App. 265, 256 P.3d 368 (2011).....	14, 38
<i>Citigroup, Inc. v. Fed. Ins. Co.</i> , 649 F.3d 367 (5th Cir. 2011).....	26, 28-29, 30
<i>City of Seattle v. Blume</i> , 134 Wn.2d 243, 947 P.2d 223 (1997).....	44
<i>Clements v. Travelers Indem. Co.</i> , 121 Wn.2d 243, 850 P.2d 1298 (1993).....	13
<i>Comerica Inc. v. Zurich Am. Ins. Co.</i> , 498 F. Supp. 2d 1019 (E.D. Mich. 2007).....	26-27, 30, 33-34, 49

<i>Crocker v. Nat'l Union Fire Ins. Co.</i> , No. SA-04-CA-0389-RF, 2005 U.S. Dist. LEXIS 9377 (W.D. Tex. May 12, 2005).....	28
<i>Daley v. Allstate Ins. Co.</i> , 135 Wn.2d 777, 958 P.2d 990 (1998).....	42-43
<i>Danbeck v. Am. Fam. Mut. Ins. Co.</i> , 245 Wis.2d 186, 629 N.W.2d 150 (2001).....	15
<i>Defrain v. State Farm Mut. Auto. Ins. Co.</i> , No. 294505, 2011 Mich. App. LEXIS 453 (Mich. Ct. App. March 10, 2011).....	28
<i>Drake v. Ryan</i> , 514 N.W.2d 785 (Minn. 1994).....	32
<i>Elliot Co. v. Liberty Mut. Ins. Co.</i> , 434 F. Supp. 2d 483 (N.D. Ohio 2006).....	32
<i>Gaston v. Allstate Ins. Co.</i> , No. 4:08-cv-0749, 2008 U.S. Dist. LEXIS 107996 (N.D. Ohio July 31, 2008).....	27-28
<i>Goodyear Tire & Rubber Co. v. Nat'l Union Ins. Co.</i> , No. 5:08-cv-1789, 2011 U.S. Dist. LEXIS 121866 (N.D. Ohio, Sept. 19, 2011), appeal do cketed, Case No. 11-4145 (6 th Cir.)	26, 34
<i>Great Am. Ins. Co. v. Bally Total Fitness Holding Corp.</i> , No. 06-4554, 2010 U.S. Dist. LEXIS 61553 (N.D. Ill. June 22, 2010)	26, 27
<i>Haller v. Wallis</i> , 89 Wn.2d 539, 573 P.2d 1306 (1978).....	44
<i>Hernandez v. Gulf Group Lloyds</i> , 875 S.W.2d 691 (Tex. 1994).....	28
<i>HLTH Corp. v. Agric. Excess & Surplus Ins. Co.</i> , No. 07C-09-102 RRC, 2008 Del. Super. LEXIS 280 (Del. Super. Ct. July 31, 2008)	47-48

<i>Ind. Gas. Co. v. Aetna Cas. & Sur. Co.</i> , 951 F. Supp. 811 (N.D. Ind. 1996), <i>rev'd on other grounds</i> , 141 F.3d 314 (7th Cir. 1998)	34
<i>JP Morgan Chase & Co. v. Indian Harbor Ins. Co.</i> , No. 6461-6462-6463-603766/08.....	26, 27, 29-30, 41
<i>Kalama Chem., Inc. v. Allianz Ins. Co.</i> , No. 90-2-05011-4, 1995 WL 17015061 (Wash. Super. Ct. Aug. 14, 1995)	15, 31
<i>Ledcor Indus. (USA), Inc. v. Mut. of Enumclaw Ins. Co.</i> , 150 Wn. App. 1, 206 P.3d 1255 (Wash. Ct. App. 2009)	25
<i>McDonald v. State Farm Fire & Cas. Co.</i> , 119 Wn.2d 724, 837 P.2d 1000 (1992).....	15
<i>Moeller v. Farmers Ins. Co.</i> , 155 Wn. App. 133, 229 P.3d 857 (2010).....	49
<i>Moody v. Am. Guar. & Liab. Ins. Co.</i> , No. C10-01102-RSM, 2011 U.S. Dist. LEXIS 38024 (W.D. Wash. Apr. 7, 2011).....	19
<i>Morgan v. Prudential Insurance Company of America</i> , 86 Wn.2d 432, 545 P.2d 1193 (1976).....	39-40
<i>Northwest Airlines v. Hughes Air Corp.</i> , 37 Wn. App. 344, 679 P.2d 968 (1984).....	46
<i>Northwest Steel Rolling Mills, Inc. v. Fireman's Fund Insurance Co.</i> , No. C86-376WD, 1991 U.S. Dist. LEXIS 20984 (W.D. Wash. Jan. 16, 1991).....	31
<i>Northwestern Title Sec. Co. v. Flack</i> , 6 Cal. App. 3d 134, 85 Cal. Rptr. 693 (1970).....	28
<i>Oregon Automobile Insurance Co. v. Salzburg</i> , 85 Wn.2d 372, 535 P.2d 816 (1975).....	27, 39
<i>Overton v. Consol. Ins. Co.</i> , 145 Wn.2d 417, 38 P.3d 322 (2002).....	15

<i>Pereira v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA</i> , No. 04-Civ-1134 LTS, 2006 U.S. Dist. LEXIS 49263 (S.D.N.Y. July 12, 2006)	47, 49
<i>Piser v. State Farm Mut. Auto Ins. Co.</i> , 405 Ill. App. 3d 341, 938 N.E.2d 640 (2010)	27
<i>Pittway Corp. v. Am. Motorists Ins. Co.</i> , 56 Ill. App. 3d 338, 70 N.E.2d 1271 (1977)	28
<i>Polygon Nw. Co. v. Am. Nat'l Fire Ins. Co.</i> , 143 Wn. App. 753, 189 P.3d 777 (2008)	14, 37
<i>Prodigy Commc'n Corp. v. Agric. Excess & Surplus Ins. Co.</i> , 288 S.W.3d 374 (Tex. 2009)	28
<i>Public Utility District No. 1 of Klickikat County v. International Insurance Co.</i> , 124 Wn. 2d 789, 881 P.2d 1020 (1994)	27
<i>Quadrant Corp. v. Am. States Ins. Co.</i> , 154 Wn.2d 165, 110 P.3d 731 (2005)	13-14, 22-23, 38, 39
<i>Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London</i> , 161 Cal. App. 4th 184, 73 Cal. Rptr. 3d 770 (2008)	26, 30, 49
<i>Rees v. Viking Ins. Co.</i> , 77 Wn. App. 716, 892 P.2d 1128 (1995)	15, 16, 21, 31
<i>Reliance Ins. Co. v. Transamerica Ins. Co.</i> , 826 So. 2d 998 (Fla. Dist. Ct. App. 2001)	32
<i>Safeco Title Ins. Co. v. Gannon</i> , 54 Wn. App. 330, 774 P.2d 30, rev. denied, 113 Wn. 2d 1026, 782 P.2d 1069 (1989)	19-20
<i>Seafirst Ltd. P'ship v. Erickson</i> , 127 Wn.2d 355, 898 P.2d 299 (1995)	44
<i>Siligato v. Welch</i> , 607 F. Supp. 743 (D. Conn. 1985)	32

<i>Simms v. Allstate Ins. Co.</i> , 27 Wn. App. 872, 621 P.2d 155 (1981).....	20
<i>Stargatt v. Fid. & Cas. Co. of N.Y.</i> , 67 F.R.D. 689 (D. Del. 1975)	31-32
<i>State Farm Gen. Ins. Co. v. Emerson</i> , 102 Wn. 2d 477, 687 P.2d 1139 (1984).....	43
<i>Teigen v. Jelco of Wisc., Inc.</i> , 367 N.W.2d 806 (Wis. 1985).....	32
<i>Trinity Homes LLC v. Ohio Cas. Ins. Co.</i> , 629 F.3d 653 (7th Cir. 2010)	32
<i>Vision One, LLC v. Phila. Indem. Ins. Co.</i> , 158 Wn. App. 91, 241 P.2d 429 (2010).....	24
<i>Westport Ins. Co. v. Markham Group, Inc.</i> , 403 Fed. App'x 264 (9th Cir. Nov. 17, 2010).....	19
<i>Zeig v. Massachusetts Bonding & Insurance Co.</i> , 23 F.2d 665 (2d Cir. 1928).....	31, 32
STATUTES	
RCW 46.29	43
RCW 48.22.030	43
OTHER AUTHORITIES	
Kevin LaCroix, <i>The D&O Diary</i>	45-46

I. INTRODUCTION

In this appeal, Quellos Group, LLC (“Quellos”) asks the Court to re-write two unambiguous insurance policies under the guise of contract interpretation. Quellos purchased excess directors and officers (“D&O”) liability insurance from Federal Insurance Company and Indian Harbor Insurance Company (together, the “Insurers”). Both Insurers issued insurance policies to Quellos specifically defining the scope of excess coverage (the “Excess Policies”). In this regard, both Insurers’ excess insuring agreements require that the underlying primary insurer must pay the primary policy limit *in full* in order to trigger the excess coverage.

This unambiguous contract language leaves no room for the result Quellos urges here – that the excess insuring agreements should be deemed to contain *no* specific requirements for exhausting the primary coverage, and that the *insured* should be permitted to dictate when the Insurers’ coverage obligations are triggered. No principle of Washington law or public policy supports this result. Indeed, in Washington, as elsewhere, the insured’s failure to exhaust its primary coverage as required by the plain terms of the excess policies is an absolute bar to coverage.

Yet, despite the clear limitations of the excess insuring agreements, Quellos voluntarily released the primary insurer, American International Specialty Liability Corporation (“AISLIC”), without obtaining full payment of the primary policy limit. Quellos initially sued AISLIC along with the Insurers and others, asserting breach of contract claims for the

insurers' failure to pay for defense costs and other losses arising from a fraudulent investment strategy called "POINT." Rather than litigate against AISLIC, however, Quellos settled. As a result, AISLIC has paid less than half of its \$10 million limit of liability.

Because Quellos chose to release its primary insurance carrier for less than the primary policy limits, Quellos cannot establish exhaustion under the excess insuring agreements as a matter of law, just as the trial court concluded. Absent exhaustion as defined in the Excess Policies, Quellos' claims for coverage of the POINT claims properly were dismissed as a matter of undisputed fact and law.

II. ASSIGNMENTS OF ERROR

Quellos is appealing the trial court's Order granting summary judgment to the Insurers based on Quellos' failure to establish a prima facie case for coverage under the insuring agreements of the Excess Policies. CP 322-26. Indian Harbor Insurance Company ("Indian Harbor") does not assign any error to the trial court's decision in this regard.

In addition, Indian Harbor joins in and incorporates by reference the Assignments of Error on cross-review identified in the brief of co-respondent and cross-appellant Federal Insurance Company ("Federal").

III. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

With respect to Quellos' statement of the issues relevant to its appeal, Indian Harbor respectfully provides the following counter-statement of issues:

- (1) Did the trial court correctly hold Quellos to its burden of establishing coverage under the plain and unambiguous language in the insuring agreements of the Excess Policies?
- (2) Did the trial court properly reject Quellos' argument that the excess insuring agreements state mere "conditions" of coverage and do not specify the fundamental terms defining the scope of coverage?
- (3) Under Washington law, can a policyholder invoke the doctrine of "waiver" to create coverage under the insuring agreement of an excess policy?
- (4) Should the trial court have placed the burden of proof on the Insurers to show that Quellos' failure to establish coverage under the excess insuring agreements was a "material" breach and "substantially prejudicial" to the Insurers?
- (5) Did the trial court properly find in the alternative that Quellos' failure to meet the basic terms of the excess insuring agreements was a material and substantially prejudicial breach of the policies as a matter of law?
- (6) Was it absurd for the trial court to require Quellos to satisfy all requirements to coverage stated unambiguously in the excess insuring agreements?
- (7) Does Washington public policy override the parties' freedom of contract where, as here, no statute or regulation prohibits excess insurers from limiting the scope of excess coverage?

In addition, Indian Harbor incorporates by reference and adopts the statement of issues on cross-review contained in Federal's separately filed brief.

IV. STATEMENT OF THE CASE

A. The Investment Management Insurance Policies

This is a case about excess D&O liability insurance coverage issued to Quellos for the policy period from September 21, 2004 to September 21, 2005. In this period, AISLIC issued the primary policy to Quellos, No. 885-37-42 (the "Primary Policy"), with a \$10 million limit of liability and subject to a \$2.5 million self-insured retention. *See* CP 47-95 (Declarations). This policy obligated AISLIC to pay on behalf of the Insured (or Executive Insured) all sums which the Insured shall become legally obligated to pay as damages resulting from any claim or claims first made against the Insured and reported in writing to the Company during the Policy Period or the Extended Reporting Period (if applicable) for any Wrongful Act of the Insured or of any person for whose Wrongful Act the Insured is legally responsible. CP 50-51 (Insuring Agreements, Section I(A),(B),(C), (D)). "Wrongful Act" is defined by the Primary Policy as "any breach of duty, neglect, error, misstatement, misleading statement, omission or other act wrongfully done or attempted by the Insured." CP 53 (Definitions (i)).

The Primary Policy also obligated AISLIC to pay Defense Costs as part of and subject to the applicable limit of liability. CP 51 (Insuring

Agreements, Section II). “Defense Costs” are defined as “reasonable and necessary fees, costs and expenses . . . incurred by the Company or by the Insured with written consent of the Company, and resulting solely from the investigation, adjustment, defense and appeal of any claim against the Insured . . .” CP 52 (Definitions (a)).

In this same policy period, Federal issued a first-layer excess policy to Quellos, Policy No. 7023-2408 (the “Federal Excess Policy”), with a \$10 million layer of liability. *See* CP 97 (Declarations). The Federal Excess Policy attaches upon exhaustion of the underlying Primary Policy. In this regard, the Federal policy states in the Insuring Clause:

The Company shall provide the Insureds with insurance during the Policy Period excess of the Underlying Limit. Coverage hereunder shall attach only after *the insurers of the Underlying Insurance shall have paid in legal currency the full amount of the Underlying Limit* for such Policy Period. Coverage hereunder shall then apply in conformance with the terms and conditions of the Primary Policy as amended by any more restrictive terms and conditions of any other policy designated in Item 4(B) of the Declarations, except as otherwise provided herein.

See CP 99.

Indian Harbor issued the next excess policy to Quellos, Policy No. ELU087006-04 (the “Indian Harbor Excess Policy”). *See* CP 110-12. The Indian Harbor Excess Policy has an aggregate limit of \$20 million in excess of (i) the \$10 million limit provided by the Federal Excess Policy, (ii) the \$10 million limit provided by the AISLIC Primary Policy, and (iii) Quellos’ \$2.5 million self-insured retention. *Id.* Together, the AISLIC Primary Policy and Federal Excess Policy are “Underlying

Insurance” to the Indian Harbor Excess Policy. CP 110 (Definitions, Section II (D)).

Like the Federal Excess Policy, the Indian Harbor Excess Policy does not attach until the Underlying Insurance exhausts as set forth in the policy. Specifically, the Insuring Agreement states:

The coverage hereunder will attach *only* after *all* of the Underlying Insurance has been exhausted by the *actual payment of loss by the applicable insurers thereunder* and in no event will the coverage under this Policy be broader than the coverage under any Underlying Insurance.

CP 110 (Insuring Agreement, Section I) (emphasis added).

The Indian Harbor Excess Policy further specifies the circumstances when it will continue as excess insurance or primary insurance upon depletion of the underlying limits:

(A) This Policy, subject to the terms, conditions, limitations, and endorsements of this Policy and the Underlying Insurance, will continue to apply to loss as excess insurance remaining under such Underlying Insurance, in the event of the reduction or exhaustion of the limits of liability of the Underlying Insurance *solely* as the result of the *actual payment of loss by the applicable insurer thereunder*.

(B) This Policy, subject to the terms, conditions, limitations and endorsements of this Policy and the Underlying Insurance, will continue for subsequent claims or loss as primary insurance in the event of the exhaustion of all of the limits of liability of such Underlying insurance *solely* as the result of *the actual payment of loss by the applicable insurer thereunder*.

CP 110 (Section III) (emphasis added).¹

¹ The Federal Excess Policy similarly provides that it “shall continue in force as primary insurance,” but “[o]nly in the event of exhaustion of the Underlying Limit by reason of the insurers of the Underlying Insurance, or the Insureds in the event of financial impairment or insolvency of an insurer of the Underlying Insurance, paying in legal

shelter, allowing high net worth individuals to offset huge capital gains with fictitious paper losses that Quellos created through synthetic investments in overseas entities. *See id.* at 15-18.

Quellos claims that it has paid tens of millions of dollars in legal fees defending itself and its directors and/or officers in federal and state investigations and prosecutions regarding the POINT transactions, as well as several pre-suit demands by Quellos' POINT investors. *See* Quellos' Response to Interrogatory No. 1 CP 1270-92. Quellos also has paid confidential settlements to the POINT investors to resolve their pre-suit demands. *See id.*

Quellos tendered the POINT Claims to its insurers in the 2004-2005 policy period. *See id.* In July of 2009, AISLIC agreed to pay certain POINT-related losses under its Primary Policy, totaling \$4,982,973.58. CP 1285. This amount was paid in August 2009. *See id.* Since then, however, AISLIC has not paid another penny under the Primary Policy for POINT.

C. The AISLIC Settlement And Release Agreement

Quellos initially sued AISLIC along with numerous excess insurers in connection with the POINT Claims. After filing the lawsuit below, however, Quellos settled its disputes with AISLIC in a Confidential Settlement and Release Agreement dated June 27, 2011 between Quellos and AISLIC's affiliated company, Chartis (the "Settlement"). In the

Settlement, Quellos agreed to release *all* remaining coverage under the Primary Policy without further payment by Chartis/AISLIC for POINT Claims. *See* CP 22-37 (releasing any and all “claims, demands, suits, obligations, costs, damages, losses, claims for sums of money, controversies, judgments, liabilities, rights, action and causes of action of any nature, known or unknown, suspected or unsuspected, fixed or contingent in law or equity”).

Although Chartis paid a significant amount to resolve coverage issues under policies issued to Quellos in other periods for other claims, it paid *no* new money in the Settlement for POINT. *See* CP 29 (expressly allocating portions of the settlement payment to a 2000-2004 policy and to the 2006 policy – but zero to the 2004-2005 policy period applicable to POINT). With AISLIC dismissed from the lawsuit, the Insurers, Federal and Indian Harbor, were left to litigate the POINT-related coverage issues under the AISLIC Primary Policy, to which the Excess Policies follow form.

D. The Decision Below

Quellos and the Insurers cross-moved for summary judgment as to whether Quellos could trigger coverage under the excess insuring agreements without first exhausting the AISLIC Primary Policy. As here, Quellos urged the court below to ignore the excess insuring agreements and to substitute “public policy” for the parties’ chosen contract terms.

The Insurers, for their part, contended that the coverage limitations contained in the excess insuring agreements were unambiguous and should be enforced as written.

The trial court agreed with the Insurers and granted summary judgment on the exhaustion issue. The court's principal holding was that the policy language was unambiguous: "It seems to me that these two policies are crystal clear that the underlying limit has to be paid by the underlying insurers." RP 103:12-14. As a result, "the court will give effect to the policy language that the parties entered into." RP 100:17-18.

The trial court went on to address (and dismiss) Quellos' various arguments attempting to avoid this "crystal clear" policy language. To begin with, the court found no waiver or estoppel to prevent the Insurers from raising the exhaustion language after they previously denied coverage for the underlying claims. As the court explained, the Insurers' position in the coverage litigation was fully consistent with their prior denials of coverage. *See* RP 104:6-16.

The court also rejected Quellos' argument that the excess policy language should be disregarded unless the Insurers can plead and prove "prejudice" from Quellos' failure to establish payment of the full underlying limits by the underlying primary insurer. According to the court, "there is a substantial difference between a grant of coverage and conditions to that coverage itself." RP 105:4-6. "[T]he Washington courts as well as other courts have long held and have consistently held

that as to [a] specific grant of coverage . . . , that is not defined by the prejudice analysis.” RP 105:10-14. Where, as here, the exhaustion language is the “essential characteristic” or “defining characteristic” of the “excess insurance policy,” then “it is not a mere condition to coverage that is susceptible to the prejudice analysis.” RP 105:18-25; 106:1-5.

In the alternative, the trial court found that the Insurers did show that the exhaustion language was a “material condition” to the Excess Policies, and that the Insurers suffered prejudice as a matter of law “by the failure of the primary carrier to pay \$10 million dollars of *covered* losses.” RP 107:7-9 (emphasis added). The Court emphasized that the Excess Policies required payment of covered losses as the trigger of coverage. Here, however, instead of an underlying insurer making the determination as to what losses were covered (and then paying those losses), the policyholder took the underlying insurer out of the picture by accepting a partial payment of the primary limit. Given the unambiguous policy language, the court found it reasonable for the excess insurer to count on the presence of a primary carrier to make the determination about coverage, and that the Insurers were prejudiced when the policyholder assumed that role for itself. RP 107:10-21.

V. SUMMARY OF ARGUMENT

The trial court correctly granted summary judgment to the Insurers. Applying straightforward principles of contract interpretation, the court

held that Quellos did not meet its threshold burden to establish coverage under the plain terms of the insuring agreements in the Excess Policies. In this regard, the insuring agreements are unequivocal and unambiguous in requiring the full payment of the underlying limits of insurance coverage by the underlying insurers. Here, however, it is undisputed that the primary carrier, AISLIC, paid less than half of its \$10 million policy limit before being released by Quellos. Under Washington law, this means that coverage never attached under the excess insuring agreements.

Contrary to Quellos' assertions, Washington law does not require the Insurers to demonstrate prejudice in order to enforce the clear terms of the excess insuring agreements. Quellos cites Washington cases requiring an insurer to show prejudice when invoking certain policy conditions, such as the insured's duty to cooperate. Where, however, a policy term forms an essential part of the bargain between the insurer and policyholder, Washington courts enforce that limitation strictly, as written, without imposing an extra-textual prejudice requirement. Likewise, Quellos cannot invoke doctrines of "waiver" or "estoppel" to create coverage under the Excess Policies, when this coverage never attached according to the unambiguous terms of the excess insuring agreements. In any event, even though the trial court was not required to reach the prejudice issue, it correctly held in the alternative that the Insurers would be prejudiced if forced to insure a risk not contemplated by the policy and to continue litigating the coverage issues with Quellos.

Quellos also is wrong to argue that the trial court's decision enforcing the unambiguous exhaustion requirements in the excess insuring agreements was "absurd" and against public policy. Put simply, no principle of Washington law precludes an excess insurer from limiting the scope of its coverage obligations, and insurers are free to limit the coverage they write so long as it does not violate public policy as expressed by the Legislature. In areas where, as here, the Legislature has not mandated insurance coverage, Washington courts have declined to invalidate unambiguous coverage limitations and instead have upheld the parties' freedom of contract.

VI. ARGUMENT

A. Legal Standard.

An order granting summary judgment is reviewed *de novo*, with the reviewing court engaging in the same inquiry as the trial court. *See Clements v. Travelers Indem. Co.*, 121 Wn.2d 243, 249, 850 P.2d 1298 (1993). As such, a summary judgment should be upheld under Washington law where "there is no genuine issue as to any material fact and [] the moving party is entitled to judgment as a matter of law." CR 56(c).

Furthermore, in Washington, "[t]he criteria for interpreting insurance contracts in Washington are well settled. We construe insurance policies as contracts." *Quadrant Corp. v. Am. States Ins. Co.*, 154 Wn.2d 165, 171, 110 P.3d 731 (2005) (citing *Weyerhaeuser Co. v.*

Commercial Union Ins. Co., 142 Wn.2d 654, 665, 15 P.3d 115 (2000)).
See also *Certain Underwriters at Lloyd's, London v. The Travelers Prop. & Cas. Co. of Am.*, 161 Wn. App. 265, 277, 256 P.3d 368 (2011) (same).
Because insurance policies are contracts, the “touchstone” of the Court’s analysis is the parties’ mutual intent objectively manifested in the policy language; one party’s unexpressed subjective intent is irrelevant. See *Certain Underwriters*, 161 Wn. App. at 278. Thus, insurance policies, as contracts, should be enforced as written based “only [on] what the parties wrote, giving words in a contract their ordinary, usual, and popular meaning unless the agreement as a whole clearly demonstrates a contrary intent.” *Id.* at 277-78; see also *Polygon Nw. Co. v. Am. Nat’l Fire Ins. Co.*, 143 Wn. App. 753, 785, 189 P.3d 777 (2008) (“we must examine the entire policy as a whole and give effect to every clause contained therein”) (citing *Tyrrell v. Farmers Ins. Co. of Wash.*, 140 Wn.2d 129, 133, 994 P.2d 833 (2000)).

B. The Trial Court Correctly Enforced the Plain Language of the Excess Insuring Agreements

1. Quellos Did Not Meet Its Burden to Prove Coverage Under the Excess Insuring Agreements

Applying these well-settled standards for interpreting contracts, the trial court correctly enforced the plain and unambiguous terms of the Excess Policies and rejected Quellos’ pleas to re-write the excess insuring agreements to provide broader coverage.

To begin with, Quellos as the insured has the burden to prove that its loss falls within the scope of the insuring agreement. *See Overton v. Consol. Ins. Co.*, 145 Wn.2d 417, 431, 38 P.3d 322 (2002) (“The burden first falls on the insured to show its loss is within the scope of the policy’s insured losses.”); *accord McDonald v. State Farm Fire & Cas. Co.*, 119 Wn.2d 724, 731, 837 P.2d 1000 (1992).

In the context of *excess* insurance coverage, this means that Quellos, as the insured, has the burden to prove exhaustion of underlying insurance coverage as defined in the excess policy itself. In Washington, an excess carrier’s obligation to pay “begins when, and only when, the limits of the primary insurance policy are exhausted.” *Rees v. Viking Ins. Co.*, 77 Wn. App. 716, 719, 892 P.2d 1128 (1995) (citing *Truck Ins. Exch. v. Century Indem. Co.*, 76 Wn. App. 527, 531, 887 P.2d 455 (1995)). And the question of *how* an underlying policy can be exhausted – and the excess coverage triggered – is a function of the specific policy language. *See Kalama Chem., Inc. v. Allianz Ins. Co.*, No. 90-2-05011-4, 1995 WL 17015061, at *2 (Wash. Super. Ct. Aug. 14, 1995) (“How a[n] [underlying] policy can be exhausted requires interpretation and construction of the [excess] language and therefore is a question of law”) (cited throughout Quellos’ brief at 26); *see also Danbeck v. Am. Fam. Mut. Ins. Co.*, 245 Wis.2d 186, 195, 629 N.W.2d 150 (2001) (holding that, where an excess policy “specifies that only one manner

of exhaustion will trigger the obligation to pay,” another manner of exhaustion does not trigger coverage).

In *Rees*, for example, the plaintiffs were injured in an automobile accident and ultimately settled with the tortfeasors and the tortfeasors’ primary insurer for a stated amount ostensibly exceeding the primary coverage, while accepting a payment from the primary carrier of an amount less than the \$500,000 available under the primary policy. The plaintiffs then demanded payment of the \$50,000 excess coverage from the excess insurer, Viking Insurance Company. Viking rejected the demand, and the Division Three of the Washington Court of Appeals agreed. According to the Court, the plaintiffs agreed to settle their claim “with full knowledge of the consequences” for a sum less than the available primary limits. Having done so, they could not sustain their burden to establish exhaustion under the excess policy. *See Rees*, 77 Wn. App. at 720, 892 P.2d at 1130.

That is exactly what happened here. It is undisputed that the limits of the underlying insurance have not been exhausted through payments by the underlying insurers, AISLIC and Federal. AISLIC, of course, was released from all liability in the Settlement with Quellos without paying the full primary limit. Indeed, AISLIC did not pay anything for the POINT Claims beyond approximately \$5 million paid long before the Settlement. Because the AISLIC Policy is not

exhausted, Quellos has not reached – let alone exhausted – the \$10 million limit of the underlying Federal Excess Policy. *See* Federal Excess Policy, Insuring Clause (“Coverage hereunder shall attach only after the insurers of the Underlying Insurance *shall have paid in legal currency the full amount of the Underlying Limit* for such Policy Period”); CP 99 (emphasis added). Likewise, the Indian Harbor Excess Policy does not attach and begin paying claims without “actual payment” of “all” underlying limits “by the applicable insurers.” *See* Indian Harbor Excess Policy, Insuring Agreement, Section I (“[C]overage hereunder will attach *only* after *all* of the Underlying Insurance has been exhausted by the *actual payment of loss by the applicable insurers thereunder*”); CP 110 (emphasis added). This language appears first in the insuring agreements of the Excess Policies and is reinforced throughout to ensure complete clarity about the Insurers’ obligations.

Interpreting the grant of coverage made in each of the Excess Policies together with the contracts as a whole, the trial court correctly held that the Excess Policies require complete exhaustion of the underlying insurance with actual payments of loss by the underlying insurers. In fact, the Excess Policies expressly preclude the result Quellos urges here – that Quellos as the policyholder should be able to step into the role of the primary carrier and fill any difference between the settlement amount and the Primary Policy limit. The Excess

Policies specify with undeniable clarity *how much* needs to be paid – the “full amount” (Federal) or “all” (Indian Harbor) – *by whom* – the underlying insurer – and further provide that the excess coverage will in no other circumstances drop down. As the policies state, this is the “only” way for an insured to establish coverage under the excess insuring agreements. And yet, just as in *Rees*, Quellos voluntarily settled with its primary insurer, AISLIC, with full knowledge of the excess coverage grant, and released AISLIC in exchange for an amount well below the limits of the Primary Policy.

As a consequence of the unambiguous policy language and its own conduct, Quellos cannot show exhaustion as required in the Insuring Agreement of the Indian Harbor Excess Policy. Without that threshold showing, Quellos cannot meet its burden to establish coverage for the POINT Claims under the Indian Harbor Excess Policy, and the trial court’s judgment should be affirmed.

2. Quellos Cannot Shift the Burden of Proof Under the Excess Insuring Agreements to the Insurers By Arguing That Exhaustion Is a Mere Condition of Excess Coverage

Because Quellos cannot establish exhaustion by the terms of the Excess Policies, it seeks to shift the burden of proof to the Insurers by relegating the exhaustion requirement from the insuring agreement to the status of a mere policy condition. As such, according to Quellos, an excess insurer ostensibly waives the right to rely on its insuring agreement

when it denies coverage; and an insured should be relieved of its burden to prove exhaustion within the meaning of the insuring agreement so long as the insurer is not “prejudiced.” The trial court correctly rejected these arguments as a matter of law.

Where, as here, a policy term defines the scope of coverage, Washington courts do not treat such terms as mere conditions to coverage. For example, notice of a claim is a condition precedent to coverage in a “claims made” policy (which is a policy covering claims made during the policy period, as opposed to accidents or occurrences). Nevertheless, Washington courts allow claims-made insurers to deny coverage for late notice of claims without showing prejudice, because notice is a key defining feature of the coverage. *See Moody v. Am. Guar. & Liab. Ins. Co.*, No. C10-01102-RSM, 2011 U.S. Dist. LEXIS 38024, at *4-*5 (W.D. Wash. Apr. 7, 2011) (citing the seminal decision in *Safeco Title Ins. Co. v. Gannon*, 54 Wn. App. 330, 338, 774 P.2d 30, *rev. denied*, 113 Wn. 2d 1026, 782 P.2d 1069 (1989)); *see also Westport Ins. Co. v. Markham Group, Inc.*, 403 Fed. App’x 264, 266 (9th Cir. Nov. 17, 2010) (noting that claims made policies “by their very nature” require reporting during the policy period in order to trigger coverage) (citing *Schwindt v. Commonwealth Ins. Co.*, 140 Wn.2d 348, 352, 997 P.2d 353 (Wash. 2000)). As the Court explained in *Gannon*:

The notice is critical to the insurer in the type of coverage provided here because the policy is structured to allow the insurer to assess its risk. Unlike occurrence policies, where the insurer contracts to

cover risk that is by its very nature open-ended, claims-made policies attempt to define the risk so that it is ascertainable at the end of the policy period.

Gannon, 54 Wn. App. at 337.

The Court in *Gannon* went on to explain that claims made policies “are essentially reporting policies. If the claim is reported to the insurer during the policy period, then the carrier is legally obligated to pay; if the claim is not reported during the policy period, no liability attaches.” *Id.* at 338 (internal emphasis omitted). As such, notice of the claim is “so very different from a *mere condition* of the policy,” that requiring an insurer to show prejudice “in effect rewrites the contract between the two parties.” *Id.* (emphasis added). Indeed, it would offend public policy to require insurers to show prejudice “because to do so would be to provide coverage the insurer did not intend to provide and the insured did not contract to receive.” *Id.* at 339 (citations omitted).²

Here, too, the specific – not standardized, as *Quellos* contends – exhaustion language is “so very different from a mere condition of

² Washington courts permit insurers to enforce certain other policy conditions without requiring a showing of prejudice, such as specific time limitations for suing an insurance company. See *Simms v. Allstate Ins. Co.*, 27 Wn. App. 872, 876-77, 621 P.2d 155 (1981) (1981) (citing *Brandywine One Hundred Corp. v. Hartford Fire Ins. Co.*, 405 F. Supp. 147, 151 (D. Del. 1975), *aff'd mem.*, 588 F.2d 819 (3d Cir. 1978)). In *Simms*, the court specifically declined to require the insurer prove prejudice in order to deny coverage after the policyholder filed a lawsuit or claim outside the contractual limitations period. See *id.*, at 877. Accordingly, it is simply not true, as *Quellos* contends, that all conditions in an insurance policy must be deemed to include a prejudice requirement.

the policy,” yet Quellos asks this Court to rewrite the essential nature of the contract between the insured and the Excess Carriers and to provide *gratis* additional coverage Quellos did not purchase. Just as notice defines the scope of coverage in a claims made policy, exhaustion of the underlying insurance triggers an insurer’s coverage obligations under an excess policy. *See Rees*, 77 Wn. App. at 719 (“Viking [the excess insurer] had no obligation to defend unless, and until, Transamerica’s policy limits were fully exhausted. Those policy limits were never exhausted; therefore, the duty to defend or indemnify never arose”). Under Washington law, therefore, *no liability arises* under the Excess Policies unless and until the underlying insurance is exhausted in accordance with policy terms.

Quellos, on the other hand, views the Excess Policies as little more than slips of paper lacking their own coverage terms, with liability arising as soon as Quellos claims to have suffered a loss in excess of the underlying limits. *See Br.* at 18-19 (“Quellos . . . seeks to obtain payment for losses at the level at which the Excess Carriers contracted to begin payment”). This view cannot be squared with the excess policy language. In both Excess Policies, the specific exhaustion language appears first as part of the basic insuring agreement and is repeated and reinforced throughout the contract,

appearing no fewer than three times in the Federal policy (Sections 1, 2 and 3) and four times in the Indian Harbor policy (Section I, Section II(A), (B) and (C)). These policies contain precious few other terms – further highlighting the importance of the exhaustion requirements. Reading the policy as a whole, which Quellos concedes is the correct inquiry (Br. at 19), leads to only one reasonable construction: the Insurers specifically made complete exhaustion of underlying insurance by the underlying insurers *the* key defining feature of the excess coverage. And that is precisely what the trial court determined. RP 105:15-22 (“the attachment point . . . is the essential characteristic of an excess policy.”)

Almost as an afterthought, Quellos meekly suggests (Br. at 21-22) that its proposed reading of the excess insuring agreements as mere conditions is reasonable and renders the insuring agreements ambiguous. Nonsense. Under Washington law, the fact that the insured offers a contrary interpretation does not render the contract language ambiguous. As the Washington Supreme Court has stated: “*Most importantly*, if the policy language is clear and unambiguous, we must enforce it as written; we may not modify it or create ambiguity where none exists.” *Quadrant Corp.*, 154 Wn.2d at 171

(2005) (emphasis added). Furthermore, “the expectations of the insured cannot override the plain language of the contract.” *Id.* at 172.

The undisputed fact is that Quellos purchased excess insurance from Indian Harbor and Federal on their excess forms, with the scope of excess coverage specifically delineated in the insuring agreements. Quellos now cannot wriggle out of this bargain and secure broader coverage by re-casting the core coverage grant as a condition to coverage.

3. Quellos Cannot Invoke the Doctrines of Waiver or Estoppel to Create Coverage Under the Excess Insuring Agreements

Quellos’ argument that the Insurers have waived the right to rely on their excess insuring agreements to deny coverage lacks any basis in fact or law. The trial court’s decision to reject this argument, therefore, should be affirmed.

According to Quellos, after the Insurers denied coverage for one of the POINT Claims back in 2007, Quellos was free to release AISLIC and tap the excess carriers for the amount of loss ostensibly exceeding the primary limit. Quellos offers no evidence, however, that the Insurers did not properly identify the exhaustion requirements in the Excess Policies and reserve all of their rights under these provisions. Thus, as the trial court correctly recognized, nothing

about the Insurers' prior denials fairly can be construed as a waiver of the exhaustion requirements in the Excess Policies.

Nor does Quellos' argument find support in Washington law. In Washington, "when an insurer denies liability and the insured settles with the tort [claimant], the insurer is estopped from claiming that the insured breached the policy by impairing the insurer's recovery rights." *Vision One, LLC v. Phila. Indem. Ins. Co.*, 158 Wn. App. 91, 100-01, 241 P.2d 429 (2010). In other words, under *Vision One*, Quellos was free to settle with the *tort claimant* once Federal and Indian Harbor denied coverage without obtaining the Excess Insurers' consent to settle. But nothing in *Vision One* purports to give Quellos the right to seek coverage under the Excess Policies without satisfying the most basic terms of the excess insuring agreements. As such, the trial court was exactly right when it declined to apply *Vision One* to the facts here.

Finally, even if the Insurers somehow could be deemed to have waived the exhaustion requirement in the Excess Policies, Washington courts uniformly hold that "waiver or estoppel cannot operate to extend coverage or restrictions on coverage. These doctrines, in other words, waiver and estoppel, cannot create coverage where none was provided by the contract in the first place. They cannot operate to

write coverage for the insured that the insured never purchased from the carrier.” *Boeing Co. v. Aetna Cas. & Sur. Co.*, No. C86-352WD, 1990 U.S. Dist. LEXIS 20231, at * 16 (W.D. Wash. Apr. 17, 1990). *See also Ledcor Indus. (USA), Inc. v. Mut. of Enumclaw Ins. Co.*, 150 Wn. App. 1, 11, 206 P.3d 1255 (Wash. Ct. App. 2009) (“estoppel does not operate to create coverage”). Yet this is precisely what Quellos asks this Court to do – to create coverage under the excess insuring agreements ostensibly because the Insurers denied coverage.

Here, because coverage under the excess policies has not attached, and cannot attach unless and until AISLIC pays the full limit of its liability, it is irrelevant that Federal and Indian Harbor denied coverage for one of the POINT Claims back in 2007. This fact does not permit the Court to rewrite the insuring agreement between Quellos and its excess carriers.

4. Numerous Courts Have Enforced Similar Requirements in Excess Policies

Not only did the trial court’s decision comport fully with Washington law, but it also fits neatly into the mainstream of recent coverage decisions involving similarly worded exhaustion requirements in excess D&O or other professional liability policies.

The overwhelming majority of courts construing policies nearly identical to the Excess Policies have enforced the exhaustion requirement

strictly, as written, to be an unambiguous limitation of coverage. See *Citigroup, Inc. v. Fed. Ins. Co.*, 649 F.3d 367, 372 (5th Cir. 2011) (“If Federal’s coverage attached with a settlement for less than the underlying insurer’s limits of liability, as Citigroup contends, then the phrase ‘full amount’ would be innocuous.”); *JP Morgan Chase & Co. v. Indian Harbor Ins. Co.*, No. 6461-6462-6463-603766/08, 6466, 2012 N.Y. App. Div. LEXIS 4627, at *6 (N.Y. App. Div. June 12, 2012) (no coverage under excess policy that attached only after underlying insurers “shall have duly admitted liability and shall have paid the full amount of their respective liability”); *Goodyear Tire & Rubber Co. v. Nat’l Union Ins. Co.*, No. 5:08-cv-1789, 2011 U.S. Dist. LEXIS 121866, at *10-*12 (N.D. Ohio, Sept. 19, 2011) (same result analyzing same Federal policy language at issue here), appeal docketed, Case No. 11-4145 (6th Cir.); *Great Am. Ins. Co. v. Bally Total Fitness Holding Corp.*, No. 06-4554, 2010 U.S. Dist. LEXIS 61553, at *7 (N.D. Ill. June 22, 2010) (excess insurance applies only after “insurers of the Underlying Policies shall have paid, in the applicable legal currency, the full amount of the Underlying Limit”); *Qualcomm, Inc. v. Certain Underwriters at Lloyd’s, London*, 161 Cal. App. 4th 184, 189, 73 Cal. Rptr. 3d 770 (2008) (excess insurer liable only after underlying insurers “have paid . . . the full amount of the Underlying Limit of Liability”); *Comerica Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019, 1022 (E.D. Mich. 2007) (underlying insurance must be

exhausted by “actual payment of loss thereunder by the applicable insurers”).

Notably, these courts all applied state insurance law that, like Washington’s, requires an insurer to show prejudice to enforce some conditions precedent to coverage. In this regard, the Washington decisions featured so prominently in Quellos’ brief, including *Oregon Automobile Insurance Co. v. Salzburg*, 85 Wn.2d 372, 535 P.2d 816 (1975), and *Public Utility District No. 1 of Klickitat County v. International Insurance Co.*, 124 Wn. 2d 789, 881 P.2d 1020 (1994), do not establish any rule unique to Washington requiring insurer prejudice to enforce the duty to cooperate. In fact, each state’s laws at issue in the pertinent cases – *Citigroup* (Texas), *Goodyear* (Ohio), *Qualcomm* (California), *Comerica* (Michigan), *JP Morgan* (Illinois) and *Bally Total Fitness* (Illinois) – require an insurer to show material, actual and/or substantial prejudice to deny coverage based on an insured’s failure to cooperate. See, e.g., *Belz v. Clarendon Am. Ins. Co.*, 158 Cal. App. 4th 615, 625, 69 Cal. Rptr. 3d 864 (2007) (under California law, an insured’s breach of a cooperation clause does not excuse the insurer’s performance unless the insurer can show that it suffered prejudice); *Piser v. State Farm Mut. Auto Ins. Co.*, 405 Ill. App. 3d 341, 347, 938 N.E.2d 640, 648 (2010) (same under Illinois law); *Anderson v. Kemper Ins. Co.*, 128 Mich. App. 249, 253-54, 340 N.W.2d 87, 90 (1983) (same under Michigan law); *Gaston v. Allstate Ins. Co.*, No. 4:08-cv-0749, 2008 U.S. Dist. LEXIS

107996, at *7 (N.D. Ohio July 31, 2008) (same under Ohio law); *Crocker v. Nat'l Union Fire Ins. Co.*, No. SA-04-CA-0389-RF, 2005 U.S. Dist. LEXIS 9377, at *10-*12 (W.D. Tex. May 12, 2005) (same under Texas law).³ Nevertheless, the courts did not require an excess insurer to establish prejudice in order to enforce clear and unambiguous exhaustion requirements.

In *Citigroup*, for example, the insured sought coverage for a \$240 million settlement of certain class action lawsuits from its lender liability insurers (which had issued a total of \$200 million in coverage). *Citigroup*, 649 F.3d at 370. The insured, however, like *Quellos* here, settled with the primary insurer for less than the full limits of the primary policy. *See id.* Applying Texas law, the Fifth Circuit enforced the strict exhaustion language in each of the excess policies at issue. *Id.* at 372. For example, one of the excess policies in *Citigroup* – much like the Federal and Indian Harbor policies – provided that coverage attached “in the event of the exhaustion of all of the limit(s) of liability of such ‘Underlying Insurance’ solely as a result of payment of loss thereunder.” *Id.* at 373.

³ These states require actual prejudice when an insured breaches other policy conditions as well, such as late notice in an occurrence-based policy and some claims-made policies, breach of a voluntary payments provision or breach of a consent to settle provision. *See, e.g., Northwestern Title Sec. Co. v. Flack*, 6 Cal. App. 3d 134, 140-41, 85 Cal. Rptr. 693 (1970) (late notice); *Pittway Corp. v. Am. Motorists Ins. Co.*, 56 Ill. App. 3d 338, 346, 70 N.E.2d 1271, 1277 (1977) (breach of voluntary payments provision); *Prodigy Commc'n Corp. v. Agric. Excess & Surplus Ins. Co.*, 288 S.W.3d 374, 382 (Tex. 2009) (late notice); *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691, 693 (Tex. 1994) (failure to obtain insurer's consent to settle); *Defrain v. State Farm Mut. Auto. Ins. Co.*, No. 294505, 2011 Mich. App. LEXIS 453, at *1-2 (Mich. Ct. App. March 10, 2011) (late notice).

The Fifth Circuit held that this language unequivocally required that “all of the underlying insurer’s limits of liability be exhausted before coverage attaches.” *Id.* Because the insured had settled with the primary carrier for less than its full policy limit, none of the excess policies could be triggered, and the excess carriers were not obligated to provide coverage to the insured. *Id.*

Most recently, a New York appellate court reached the same result in *JP Morgan*, where the insured had purchased \$175 million in bankers professional liability insurance and had settled with the primary and certain excess carriers without obtaining the full policy limits. 2012 N.Y. App. Div. 4627, at *3-*5. Applying Illinois law, the court enforced the exhaustion requirements in several different excess policies, which by their terms provided coverage: (1) “only after all applicable Underlying Insurance with respect to an Insurance Product has been exhausted by actual payment under such Underlying Insurance”; (2) “only . . . after the total amount of the Underlying Limit of Liability has been paid in legal currency by the insurers of the Underlying Insurance as covered loss thereunder”; (3) “only after exhaustion of the Underlying Limit solely as a result of actual payment under the Underlying Insurance”; and (4) “only when the Underlying Insurer(s) shall have paid or have been held liable to pay, the full amount of the Underlying Limit(s).” *Id.* at *7-*8. Following *Citigroup*, the court in *JP Morgan* held that each of these provisions was unambiguous and precluded the insured from seeking coverage under the

excess policies without fully exhausting the underlying insurance coverage. *Id.* at 6-7.

Likewise, the courts in *Qualcomm* and *Comerica* rejected the insureds' attempts to cast aside clear exhaustion requirements as insignificant procedural hurdles. In *Qualcomm*, the policyholder and the primary D&O carrier settled with each other for less than the \$20 million primary policy limit, and the insured funded the difference between the primary insurer's payment and the excess attachment point. 161 Cal. App. 4th at 190. The court dismissed the insured's suit against the excess carrier based on the language in the excess policy, which provided that the excess insurer "shall be liable to pay only after the insurers under each of the Underlying Policies have paid . . . the full amount of the Underlying Limit of Liability." *Id.* at 189. Finding this provision unambiguous, the court held that the policy "cannot have any other reasonable meaning than actual payment of no less than the \$20 million underlying limit." *Id.* at 195; *see also Comerica*, 498 F. Supp. 2d at 1032 (finding that the excess policy unambiguously "require[d] that the primary insurance be exhausted or depleted by the actual payment of losses by the underlying insurer. Payments by the insured to fill the gap, settlements that extinguish liability up to the primary insurer's limits, and agreements to give the excess insurer 'credit' against a judgment or settlement up to the primary insurer's liability limit are not the same as actual payment.").

These cases are fully consistent with Division Three’s decision in *Rees* and with trial court decisions applying Washington law in *Kalama, supra*, and *Northwest Steel Rolling Mills, Inc. v. Fireman’s Fund Insurance Co.*, No. C86-376WD, 1991 U.S. Dist. LEXIS 20984 (W.D. Wash. Jan. 16, 1991). As discussed above, *Rees* held that an excess carrier’s obligation to pay “begins when, and only when, the limits of the primary insurance policy are exhausted,” 77 Wn. App. at 719; and *Kalama* made clear that “[h]ow a policy can be exhausted requires interpretation and construction of the language” at issue. 1995 WL 17015061, at *2-*5 (emphasis added). In *Kalama* and *Northwest Steel*, however, the policies did not contain *any* specific exhaustion language, leading the courts to deem the policies ambiguous as to whether the underlying insurer was required to pay the full policy limit. See *Kalama*, 1995 WL 17015061, at *4-*5 (finding that “no insurance policy provision [in the excess policy] . . . require[d] that only the *underlying insurer* pay the full limits as a condition precedent to reach the excess coverage”) (emphasis in original); *id.* at *4 (noting that, in *Northwest Steel*, “where the policy did not define ‘exhaustion,’ any ambiguity is not associated with the word itself, but rather with how exhaustion can be achieved”).⁴ Of course, an altogether different result is warranted here, where no such ambiguity exists.

⁴ This same ambiguity appears in the “scores” of cases cited in Quellos’ brief (at p. 33-34 and n.6), including *Zeig v. Massachusetts Bonding & Insurance Co.*, 23 F.2d 665 (2d Cir. 1928), and its progeny. See *Stargatt v. Fid. & Cas. Co. of N.Y.*, 67 F.R.D. 689, 690-91 (D. Del. 1975) (following *Zeig* where excess policy stated that it attached ““only when the primary policy . . . has been exhausted,”” and the term exhausted was not further

In short, no principle of Washington law prevents excess insurers from writing more restrictive excess coverage with the reasonable expectation that clear exhaustion requirements will be enforced in the courts. The cases cited by Quellos only reinforce this conclusion. *See Zeig*, 23 F.2d at 666 (recognizing that “parties could impose such a condition precedent to liability upon the policy, if they chose to do so”); *Trinity Homes LLC v. Ohio Cas. Ins. Co.*, 629 F.3d 653, 658-59 (7th Cir. 2010) (following *Zeig* in a case where excess policy “d[id] not clearly provide that the full limit must be paid out by the [primary] insurer alone” and noting that the insurer “could have used similarly clear language in its policy” like the insurers in *Qualcomm* and *Comerica*).

For these additional reasons, the trial court’s decision should be affirmed.

defined or explained); *Reliance Ins. Co. v. Transamerica Ins. Co.*, 826 So. 2d 998, 999 (Fla. Dist. Ct. App. 2001) (similar); *Elliot Co. v. Liberty Mut. Ins. Co.*, 434 F. Supp. 2d 483, 500 (N.D. Ohio 2006) (analogizing to *Zeig* where another insured, as opposed to an excess carrier, contested exhaustion of multiple primary policies through payments that would exceed the policy limits); *Teigen v. Jelco of Wisc., Inc.*, 367 N.W.2d 806, 809 (Wis. 1985) (allowing claimant injured in motorcycle accident to proceed against defendant’s excess insurer after settling with the primary carrier without mentioning, let alone analyzing, the excess language). Indeed, some of these cases did not involve true excess policies at all. *See Drake v. Ryan*, 514 N.W.2d 785, 789 (Minn. 1994) (allowing insured to settle with one primary carrier and proceed against second, which was a “standard automobile policy”); *Siligato v. Welch*, 607 F. Supp. 743, 747 (D. Conn. 1985) (allowing injured claimant to proceed against second automobile carrier after settling with another automobile carrier for less than its limit; second policy was not a true umbrella or excess policy); *Allstate Ins. Co. v. Riverside Ins. Co. of Am.*, 509 F. Supp. 43, 48 (E.D. Mich. 1981) (similar).

C. **The Trial Court Properly Found in the Alternative that the Insurers Established Material and Substantial Prejudice from Quellos' Below-Limits Settlement with AISLIC**

Quellos challenges the trial court's alternative finding that the exhaustion requirements were material, and that Quellos' below-limits settlement with AISLIC caused the Insurers actual and substantial prejudice. Although this Court is not required to reach the issue – because prejudice is irrelevant when an insured fails to establish coverage under the insuring agreement – the trial court's ruling should be affirmed on this alternative basis as well.

To begin with, the exhaustion requirements in the Excess Policies are material to the Insurers, for the reasons stated in the preceding sections. Indeed, the court in *Comerica, supra*, rejected the assertion now made by Quellos that an excess insurer has no material interest in whether the underlying insurer pays the full amount of its policy limits or the policyholder pays that amount, as long as the excess insurer's obligations attach at the same point. As explained in *Comerica*:

Comerica [the insured] had a fundamental disagreement with its primary insurer as to whether Federal [the primary carrier] was liable for *any* amount of the settlement. . . . Comerica could have litigated its dispute with Federal, which of course would have involved the risk of losing all coverage for the securities liability; but it also could have resulted in a finding that Federal was liable for the entire \$20 million, i[n] which case Zurich's [the excess] coverage would have been triggered. Comerica seeks the certainty that its settlement brought and the benefit of coverage from its excess carrier as if

it had won its dispute with the primary insurer, despite language in the excess policy to the contrary. No public policy argument says that Comerica may have its cake and eat it too.

Comerica, 498 F. Supp. 2d at 1032; *see also Ind. Gas. Co. v. Aetna Cas. & Sur. Co.*, 951 F. Supp. 811, 814 (N.D. Ind. 1996) (“a settlement for less than the primary limit that imposed liability on the excess carrier would remove the incentive of the primary insurer to defend in good faith”) (citation omitted), *rev'd on other grounds*, 141 F.3d 314 (7th Cir. 1998).⁵

Furthermore, the Insurers have suffered prejudice in fact from Quellos' unilateral decision to release AISLIC without payment of the primary policy limit. As the court in *Goodyear* recognized, excess carriers agree to insure only those risks set forth in the insuring agreement of the excess policy and price their premiums accordingly. As such, “the potential exposure of an excess insurance provider and the triggering point of that exposure inform the calculus used in setting the premiums the insured will be charged. . . . Here, Federal's expectation was a triggering point of \$15 million plus the \$5 million self-insured retention. Federal based the premium it charged Goodyear on that expectation, not some lesser amount. Therefore, Federal has suffered real prejudice.” *Goodyear*, 2011 U.S. Dist. LEXIS 121866, at *11.

⁵ Of the supposedly “scores” of cases contrary to this point (Quellos Br. at 33-34 & n.6), not one involved specific exhaustion language such as that appearing in the Excess Policies. *See supra note 4*, at pp. 31-32. Evidently, actual exhaustion by the underlying insurers was not material to those insurers because they did not choose to make it part of the basic insuring agreement. The same cannot be said of the Insurers here.

In fact, the premiums paid here for the Excess Policies underscore the limited nature of the excess coverage and the far greater risks assumed by the primary carrier and typically maintained until exhaustion. Whereas Quellos paid \$1.2 million for AISLIC's \$10 million primary limit, it paid just half that (\$600,000) for the additional \$10 million provided in Federal's first-layer excess policy. *See* CP 210-11. Then, for \$950,000, Quellos secured twice as much excess coverage – \$20 million – from Indian Harbor. CP 211.

This reduced premium reflects the fact that Indian Harbor and Federal, as excess carriers, pay only when the insured's *covered* losses exceed the underlying limits. Generally speaking, a primary insurer will pay its full policy limit only if it determines that the insured actually incurred covered losses in that amount as a result of a judgment or settlement. On the other hand, the primary insurer's determination that it should *not* pay its full limit implies that the insured, in fact, has not incurred covered loss equal to that limit. Enforcing the strict exhaustion provisions in the excess policies shields Indian Harbor and Federal from coverage disputes that should not trigger the excess coverage, and also prevents the insured (and primary carrier) from shifting risk to the excess carriers that properly should be borne by the primary carrier.

Applying these general principles here, the settlement between Quellos and AISLIC for less than half the Primary Policy limit indicates that AISLIC did not believe that Quellos' *covered* losses

actually exceeded \$12.5 million (the \$2.5 million self-insured retention plus the \$10 million Primary Policy limit). To the Excess Carriers, it is important who determines that the covered losses exceed \$12.5 million, *i.e.*, it matters that AISLIC as the primary carrier – as opposed to Quellos as the insured – makes this critical, coverage-triggering decision. As such, the excess carriers contracted with Quellos for the primary carrier to pay its full policy limit before the excess coverage can be reached. This requirement has nothing to do with securing a windfall for the Insurers and everything to do with ensuring that, as a prerequisite to excess coverage, Quellos has incurred covered loss that exhausts the retention and the AISLIC Primary Policy limit.

The attachment point language in the excess policies takes on particular significance where, as here, all of the insurance carriers disputed whether Quellos' POINT losses are covered. Quellos asserts that the Insurers are no worse off because they are not required to drop down and fill the gap left between the AISLIC settlement and the policy limit. *See* Br. at 19. But this argument ignores the fact that the below-limits settlement means that Quellos and AISLIC could not agree that Quellos suffered covered loss up to the amount of the Primary Policy limit. Indeed, AISLIC paid *no* additional money in the settlement beyond the amount it paid long before this coverage lawsuit was filed. Quellos cannot now “fill the gap” with non-covered loss.

Quellos may argue that its settlement with AISLIC should not be viewed as an admission; regardless, both the Indian Harbor and Federal Excess Policies plainly require actual payment of the entire \$10 million AISLIC Primary Policy limit. The excess coverage attaches *only* after the underlying insurance has been paid by the underlying insurers. Pursuant to the insuring agreement and related exhaustion provisions in the Excess Policies, Indian Harbor and Federal contracted for the right to be relieved of the burden of litigating whether Quellos incurred covered loss beneath the attachment point of the Excess Policies. *Cf. Polygon*, 143 Wn. App. at 775 (“Washington law does not, in fact, force insurers to pay for losses that they have not contracted to insure”).

Finally, Quellos’ “no prejudice” argument also ignores the fact that its settlement with AISLIC has not resolved any issues in the coverage litigation. Having settled with AISLIC, Quellos must litigate the *same* POINT-related coverage issues with the excess carriers. *See* Federal’s brief (raising various provisions in the AISLIC Primary Policy that preclude coverage for the POINT Claims). While the defendants are one fewer in number, the coverage issues remain exactly the same, even with AISLIC dismissed from the case. As such, invalidating the attachment point and exhaustion language in the excess policies would require the Insurers to litigate coverage issues that otherwise would be advanced by AISLIC as the primary carrier.

Because the Insurers suffered actual prejudice when Quellos released AISLIC without exhausting the Primary Policy limit, the trial court's decision should be affirmed on its alternative basis.

D. Enforcing the Plain Meaning of the Excess Insuring Agreements Is Not “Absurd,” Nor Does Public Policy Displace the Parties’ Freedom of Contract

1. Quellos’ Subjective Expectations Regarding the Excess Coverage Cannot Supplant the Plain Contract Language

Quellos insists that the trial court ignored “special considerations” for interpreting insurance policies when it enforced *all* of the policy terms, including the unambiguous exhaustion requirements in the excess insuring agreements. *See* Br. at 36. Because enforcing unambiguous contract language is the court’s principal task when interpreting insurance policies, the trial court’s decision works neither a forfeiture nor an injustice to Quellos. Any perceived injustice instead flows from Quellos’ informed decision to settle with its primary carrier for less than its full limit.

As discussed above (at 13-14), Washington courts enforce insurance policies as contracts, meaning that the court will give effect to the parties’ mutual intent as objectively manifested in the policy language. *See Quadrant*, 154 Wn.2d at 171; *Certain Underwriters*, 161 Wn. App. at 278. The insured’s subjective, unilateral intent is

irrelevant and “cannot override the plain language of the contract.” *Quadrant*, 154 Wn.2d at 172. As such, Quellos’ subjective views about the “purpose” of excess coverage (*see* Br. at 36-37) cannot displace the actual contract terms employed in the Excess Policies, including the excess insuring agreements.

Contrary to Quellos’ contention (Br. at 36), the Washington Supreme Court’s decision in *Oregon Automobile Insurance Co. v. Salzberg*, 85 Wn. 2d 372, 535 P.2d 816 (1975), does not undermine these bedrock legal principles. Rather, in *Salzberg*, the court followed many other states in abolishing the formal distinction between “conditions precedent” and mere “covenants” and holding that an insurer must show prejudice before denying coverage for breach of the cooperation condition. *Id.* at 376-77. The court’s discussion of the supposed “risk spreading theory” of insurance was appropriate for the automobile policy at issue there – which the Legislature makes mandatory to protect the public – but does not in any way suggest that this Court should alter the plain terms of contracts entered into freely by a sophisticated commercial entity like Quellos.

Quellos also relies on *Morgan v. Prudential Insurance Company of America*, 86 Wn.2d 432, 545 P.2d 1193 (1976), but this case actually supports the trial court’s decision below. In *Morgan*, the

Washington Supreme Court interpreted a life insurance policy providing benefits for the insured's "loss by severance of both hands at or above the wrists." The insurance company denied coverage for a claim where the insured permanently severed several fingers on each hand and a significant portion of each thumb, resulting in complete loss of use of both hands. *Id.* at 433-34. According to the court, the policy *by its terms* did not require complete anatomical severance of the hands, as distinct from a severance of a substantial part of the hands resulting in loss of use. Rather, coverage under the policy depended on (1) severance of the hands "at or above the wrists," and (2) "loss of both hands," at least in function. *Id.* at 437. As such, the policy language in *Morgan* supported the result urged by the insured without contorting the plain meaning or reading certain provisions out of the policy.

Put differently, the insurer in *Morgan* was asking the court to read additional terms into the insuring agreement requiring complete anatomical severance of the insured's hands, whereas the court was constrained to apply just the language appearing in the policy. This is no different from what the trial court did here, where the Insurers were unmistakably clear in specifying in the insuring agreement (1) the one and "*only*" way excess coverage may attach, (2) *how much* of the

underlying insurance needs to be paid first (all of it), and (3) *by whom* the coverage-triggering losses must be paid (the underlying insurer).

Quellos also is wrong to suggest that construing the Indian Harbor Excess Policy or Federal Excess Policy as a whole renders the exhaustion provisions absurd or nonsensical. Although Quellos contends that it simply could have foregone purchasing primary coverage altogether and self-insured for the \$10 million in primary coverage (Br. at 39), there is not a shred of evidence to suggest that Federal or Indian Harbor would have issued excess coverage without the protections of an underlying primary carrier. Furthermore, nothing in the “maintenance of underlying insurance” provisions purports to give the insured the right to let the primary policy lapse, or otherwise change the basic requirement in the insuring agreement that all underlying insurance limits must be paid in full. *See JP Morgan*, 2011 N.Y. Misc. LEXIS 2767, at *11 (rejecting similar argument by insured and noting that this “excess insurance language . . . pertains to the solvency of the underlying insurer, a circumstance that is not at issue here”) (internal citations omitted).

The point is that Quellos’ hypothetical arguments for absurdity bear no relation to the facts of this case. Here, Quellos freely contracted with Federal and Indian Harbor for excess coverage with

highly specific – not “standardized” – attachment point language, and just as freely settled with AISLIC while understanding the risk of not fully exhausting the primary coverage. There is nothing absurd or unfair about reaching the result spelled out in the Excess Policies and finding that these policies do not attach under the facts of this case.

2. No Washington Public Policy Precludes Excess Insurers From Limiting the Scope of Excess Coverage By Requiring Complete Exhaustion of Underlying Insurance

Quellos argues that Washington’s public policy favoring settlement trumps the unambiguous policy language requiring exhaustion by full payment by the underlying insurers. This suggests that sophisticated commercial entities like Quellos and the Insurers *never* could contract for excess coverage triggered only by the underlying insurer’s actual payment of its full limit of liability. There is not a shred of law or logic to support this result.

In declining to recognize a public policy exception in this context, the trial court followed black letter Washington law. Absent a legislative statement of public policy, Washington courts strictly enforce unambiguous coverage limitations. *See Am. Home Assur. Co. v. Cohen*, 124 Wn.2d 865, 875, 881 P.2d 1001 (1994) (“Because public policy is generally determined by the Legislature and expressed through statutory provisions, the proper starting place for a public policy analysis is in applicable legislation”); *Daley v. Allstate Ins. Co.*, 135 Wn.2d 777, 790,

958 P.2d 990 (1998) (“Public policy, as a rule, is recognized by the courts of this state when the Legislature has acted, and not before”) (emphasis omitted). For this reason, Washington courts have only invoked public policy to invalidate clear contract terms in two well defined areas where the court “found a legislative expression favoring financial compensation for injuries suffered by innocent victims of automobile accidents,” namely, uninsured motorist insurance (UIM) coverage authorized under RCW 48.22.030 and the Financial Responsibility Act, RCW ch. 46.29. *Cohen*, 124 Wn.2d at 874 (citations omitted). The courts’ hesitation to recognize public policy limitations beyond these two limited areas has held true “even though [the contract] terms may be harsh and [their] necessity doubtful.” *See State Farm Gen. Ins. Co. v. Emerson*, 102 Wn. 2d 477, 483, 687 P.2d 1139 (1984); *accord Allstate Ins. Co. v. Raynor*, 93 Wn. App. 484, 499, 969 P.2d 510 (1999) (“Although the Washington Supreme Court has occasionally questioned the wisdom of certain exclusionary clauses, ‘it has rarely invoked public policy to limit or void express terms in an insurance contract even when those terms seem unnecessary or harsh in their effect’”) (citing *Cary v. Allstate Ins. Co.*, 130 Wn.2d 335, 340, 922 P.2d 1335 (1996)).

These considerations are dispositive here, where Quellos is not claiming that the Legislature requires companies to purchase excess D&O insurance for the benefit of potential fraud victims, or that the

Legislature otherwise has acted to preclude excess D&O insurers from limiting the scope of coverage provided to their corporate insureds. Instead, Quellos is relying on the Washington Supreme Court's general observations about public policy and settlements in an attempt to circumvent the plain language of the Excess Policies.

Even if this Court were to look beyond the lack of legislative action in this context, Quellos cannot prevail. None of the Washington cases cited in Quellos' brief (at 36-41) purport to re-write the parties' contracts or otherwise invalidate clear language limiting the risk assumed in an insuring agreement. It is not difficult to see why the Washington Supreme Court would invoke public policy to limit a *common law* principle that no longer serves a useful purpose in today's commercial setting. See *Seafirst Ltd. P'ship v. Erickson*, 127 Wn.2d 355, 364, 898 P.2d 299 (1995) (abrogating the "ancient rule of discharge" in settlements involving joint contractual obligations).⁶ But no Washington case has cited a supposed public policy favoring settlement as a reason to reform an unambiguous contract, like the

⁶ See also *City of Seattle v. Blume*, 134 Wn.2d 243, 258-60, 947 P.2d 223, 230-31 (1997) (abrogating "independent business judgment rule," which recognizes failure to exhaust administrative remedies as a bar to tort claims, because the rule tends to chill mitigation and settlement); *Am. Safety Cas. Ins. Co. v. Olympia*, 162 Wn.2d 762, 772, 174 P.3d 54, 59 (2007) (rejecting argument that City impliedly waived contractual rights by participating in settlement negotiations); *Haller v. Wallis*, 89 Wn.2d 539, 545, 573 P.2d 1306 (1978) (upholding guardian's settlement on behalf of ward in part because "the law favors amicable settlement of disputes and is inclined to clothe them with finality").

excess policies here, freely entered into between sophisticated business entities.

Quellos' resort to public policy arguments is particularly dubious here, where the market has addressed the very issues Quellos raises. Quellos certainly could have purchased excess coverage allowing it to fill the gap left by a below-limits settlement, as was done here. For example, in 2004, Indian Harbor offered in the market an endorsement to amend Section III(C) of the Indian Harbor Excess Policy to allow the insured to fill the gap left by an insolvent insurer (or for other reasons). *See* CP 216-18 (emphasis added). If Quellos was not familiar with this type of "gap filling" endorsement, then it could have asked its national insurance broker, Frank Crystal & Co., about the available coverage. *See* CP 48. Moreover, in the years since 2004, this kind of "gap filling" endorsement has become widely available in the marketplace. *See* Kevin LaCroix, *The D&O Diary*, June 14, 2012 ("In recent years, and in large part as a reaction to these cases, excess carriers increasingly have been willing to provide language that allows the excess carriers' payment obligations to be triggered regardless whether the underlying amounts were paid by the underlying insurer or by the insured"), available at <http://www.dandodiary.com/2012/06/articles/d-o-insurance/ny->

appellate-court-excess-insurers-off-the-hook-where-it-cant-be-determined-if-underlying-insurance-exhausted/.

With a vibrant insurance market inhabited by sophisticated insurers, policyholders and brokers, there is simply no reason for the Court to invoke public policy to supplant the plain contract language. The point – recognized by the trial court – is *not* that the Excess Policies are entitled to different treatment than other insurance policies because they were negotiated by sophisticated parties. The point is simply that Quellos is asking this Court to wield its equitable powers to invalidate clear contract language and to re-write the parties' contract based on public policy. Certainly, the Court is entitled to consider the market realities when determining whether to step in and act when the Legislature has not done so. *Cf. Northwest Airlines v. Hughes Air Corp.*, 37 Wn. App. 344, 348-49, 679 P.2d 968 (1984) (holding that public policy considerations did not override freedom of contract principles where the parties “stand upon equal terms and the indemnification provision relates exclusively to their private affairs without affecting the [public]”).

Last, Quellos attempts to argue (again) that the trial court ignored the “overwhelming” majority of cases nationwide on the exhaustion issue. As shown above (at 31-32), this argument cannot

stand when, in fact, these cases involved different policy language that did not define the manner in which the primary coverage must be exhausted. As the trial court recognized, the clarity of the excess policy language – and not public policy considerations – is the real point of distinction between *Zeig* and its progeny, cited extensively in Quellos’ brief, and the recent cases addressing the underlying exhaustion issue with excess policies like the ones here. *See supra* at 25-28.

Although Quellos makes passing reference to these cases in its brief, it does not fairly confront their holdings. As discussed in detail above, these holdings fit neatly with Washington law and the facts of this case. In contrast, the two cases cited in Quellos’ brief are distinguishable both procedurally and substantively. *See Pereira v. Nat’l Union Fire Ins. Co. of Pittsburgh, PA*, No. 04-Civ-1134 LTS, 2006 U.S. Dist. LEXIS 49263 (S.D.N.Y. July 12, 2006); *HLTH Corp. v. Agric. Excess & Surplus Ins. Co.*, No. 07C-09-102 RRC, 2008 Del. Super. LEXIS 280 (Del. Super. Ct. July 31, 2008). Moreover, neither case allowed the policyholder to fill a gap left by its voluntary, below-limits settlement with the primary carrier.

In *HLTH Corp. v. Agricultural Excess & Surplus Insurance Company*, the underlying insurers, in fact, had paid their full limits,

and therefore any discussion of the excess policy language ultimately was *dicta*. 2008 Del. Super. LEXIS 280 (Del. Super. Ct. July 31, 2008). In that case, Federal issued a policy excess of a \$10 million primary policy issued by National Union and a \$10 million first-excess policy issued by Great American. The plaintiffs sought partial summary judgment ordering Federal to advance defense costs while the underlying action was ongoing. In response, Federal argued that fact issues precluded summary judgment because the plaintiffs had not shown the underlying policies were exhausted. *Id.* at *23-*24. The plaintiffs later disclosed, however, that *both* underlying insurers had paid their *full* limits of liability. *Id.* at *14-*15. Thus, the exhaustion issue was moot. Furthermore, when Federal raised the exhaustion issue, it raised no other coverage issues other than allocation. In other words, Federal did not dispute coverage for at least some of the insured's claimed losses. In these circumstances, the court deemed it "unfair[]" to allow the excess insurers "to avoid payment on an otherwise *undisputedly* legitimate claim" because of an exhaustion provision. *Id.* at *47 (emphasis added); *see also id.* at *38-*39 ("all three towers of insurance have some amount of contractually viable claims that have triggered them"). Here, on the other hand, the insurers vigorously dispute coverage. *See generally* Federal's

separate brief. Where, as here, coverage is hotly disputed, it is unfair to say that an excess insurer's only motivation for insisting on compliance with its exhaustion provision is to deter settlement between the primary carrier and the insured. *Comerica*, 498 F. Supp. 2d at 1032.

In the second case, *Pereira v. National Union Fire Insurance Company of Pittsburgh, PA*, the first layer excess carrier was in liquidation and unable to pay. 2006 U.S. Dist. LEXIS 49263, at *24. Without analyzing the excess policy language, the court in *Pereira* followed the *Zeig* result of allowing the insured to make up the difference left by the insolvent underlying insurer. *See id.* at *25-*26. Here, of course, Quellos released a fully solvent carrier, AISLIC, from its alleged coverage obligations.

In any event, these two cases, *Pereira* and *HLTH*, are contrary to Washington law, which enforces "clear and unambiguous language . . . as written." *Moeller v. Farmers Ins. Co.*, 155 Wn. App. 133, 141, 229 P.3d 857 (2010); *accord Qualcomm*, 161 Cal. App. 4th at 200 ("Because we are bound by the policy language before us, Qualcomm's citation to the numerous authorities for their results as opposed to their analysis is unpersuasive."). Here, both Excess Policies similarly are unambiguous in stating that the underlying

insurers must pay their total limits in order for the excess policies to attach. Quellos therefore should not be permitted under supposed principles of public policy to “fill the gap” in an attempt to trigger the Excess Policy.

In short, public policy does not support altering the terms of an unambiguous excess insurance policy to suit the interests of an insured who cannot convince its primary carrier to pay its full policy limits. Quellos, in fact, had plenty of options. It could have negotiated a different excess policy in the first place, one which was less restrictive about exhausting the underlying insurance. It could have continued to litigate the coverage issues with the primary carrier together with the excess insurers. Or it could have attempted to negotiate a global settlement with all the carriers. However, under the Excess Policies it purchased, Quellos did not have the option to take less than the full policy limit from the primary carrier if it wanted also to access the excess coverage.

VII. CONCLUSION

For the reasons set forth above, Indian Harbor respectfully requests that this Court AFFIRM the trial court’s dismissal of Quellos’ claims against the Insurers on summary judgment.

DATED this 3rd day of August, 2012.

BULLIVANT HOUSER BAILEY PC

By 
Jerret E. Sale, WSBA #14101
Deborah L. Carstens, WSBA #17494

Attorney for Respondent and Cross-Appellant
Indian Harbor Insurance Company

TROUTMAN SANDERS LLP

By 
Leslie S. Ahari (*pro hac vice*)
Gabriela Richeimer (*pro hac vice*)

Attorney for Respondent and Cross-Appellant
Indian Harbor Insurance Company

CERTIFICATE OF SERVICE

The undersigned certifies that on this 3rd day of August, 2012, I caused the foregoing to be served to:

Paul E. Fogarty
Dearmin Fogarty, PLLC
600 Stewart Street, Ste. 1200
Seattle, WA 98101
**Attorney for Plaintiff
Quellos Group**

via hand delivery.
 via first class mail.
 via e-mail.
pfogarty@dearminfogarty.com

Barry J. Fleishman
Helen K. Michael
Eric M. Gold
Kilpatrick Townsend &
Stockton LLP
607 14th St., NW
Ste. 900
Washington DC 20005
**Pro Hac Attorneys for
Plaintiff Quellos Group**

via hand delivery.
 via first class mail.
 via e-mail.
Bfleishman@kilpatricktownsend.com
Hmichael@kilpatrickstockton.com
Egold@kilpatricktownsend.com

Mark T. McMaster
Kilpatrick Townsend &
Stockton LLP
1420 Fifth Ave.
Suite 4400
Seattle, WA 98101
**Attorneys for Plaintiff
Quellos Group**

via hand delivery.
 via first class mail.
 via e-mail.
mmcmaster@kilpatricktownsend.com

FILED
COURT OF APPEALS DIV 1
STATE OF WASHINGTON
2012 AUG -3 PM 4:46

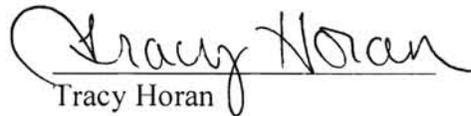
John D. Wilson Jr.
Wilson Smith Cochran
Dickerson
901 Fifth Ave., Ste. 1700
Seattle, WA 98164
**Attorneys for Defendant
Federal Ins. Co.**

via hand delivery.
 via first class mail.
 via e-mail.
wilson@wscd.com

Daniel J. Standish
Gary P. Seligman
Wiley Rein LLP
1776 K St. NW
Washington DC 20006
**Pro Hac Attorneys for
Defendant Federal Ins. Co.**

via hand delivery.
 via first class mail.
 via e-mail.
dstandish@wileyrein.com
gseligman@wileyrein.com

I declare under penalty of perjury under the laws of the
state of Washington this 3rd day of August, 2012, at Seattle,
Washington.


Tracy Horan

13838602.1

No. 68478-7

COURT OF APPEALS, DIVISION I
STATE OF WASHINGTON

QUELLOS GROUP, LLC, Appellant/Cross Respondent,

v.

FEDERAL INSURANCE COMPANY; INDIAN HARBOR
INSURANCE COMPANY, Respondents/Cross Appellants,

and

NUTMEG INSURANCE COMPANY,

Defendant.

APPENDIX TO BRIEF OF RESPONDENT AND
CROSS-APPELLANT INDIAN HARBOR
INSURANCE COMPANY

Jerret E. Sale, WSBA #14101
Deborah Carstens, WSBA #17494
BULLIVANT HOUSER BAILEY PC
1601 Fifth Avenue, Suite 2300
Seattle, Washington 98101-1618
Telephone: 206.292.8930
Facsimile: 206.386.5130

Leslie S. Ahari (*pro hac vice*)
Gabriela Richeimer (*pro hac vice*)
TROUTMAN SANDERS LLP
401 Ninth Street NW, Suite 1000
Washington, DC 20004
Telephone: 202.274.2950
Facsimile: 202.274.2994

Counsel for Respondent and Cross-Appellant Indian Harbor Insurance
Company and Cross-Appellant
Indian Harbor Insurance Company

2012 MAR -3 PM 4:56
COURT OF APPEALS
STATE OF WASHINGTON


ORIGINAL

TABLE OF OUT OF STATE CASES

	Tab
<i>Boeing Co. v. Aetna Cas. & Sur. Co.</i> , No. C86-352WD, 1990 U.S. Dist. LEXIS 20231 (W.D. Wash. Apr. 17, 1990)	A
<i>Crocker v. Nat'l Union Fire Ins. Co.</i> , No. SA-04-CA-0389-RF, 2005 U.S. Dist. LEXIS 9377 (W.D. Tex. May 12, 2005)	B
<i>Defrain v. State Farm Mut. Auto. Ins. Co.</i> , No. 294505, 2011 Mich. App. LEXIS 453 (Mich. Ct. App. March 10, 2011)	C
<i>Gaston v. Allstate Ins. Co.</i> , No. 4:08-cv-0749, 2008 U.S. Dist. LEXIS 107996 (N.D. Ohio July 31, 2008)	D
<i>Goodyear Tire & Rubber Co. v. Nat'l Union Ins. Co.</i> , No. 5:08-cv-1789, 2011 U.S. Dist. LEXIS 121866 (N.D. Ohio, Sept. 19, 2011), appeal docketed, Case No. 11-4145 (6 th Cir.)	E
<i>Great Am. Ins. Co. v. Bally Total Fitness Holding Corp.</i> , No. 06-4554, 2010 U.S. Dist. LEXIS 61553 (N.D. Ill. June 22, 2010)	F
<i>HLTH Corp. v. Agric. Excess & Surplus Ins. Co.</i> , No. 07C-09-102 RRC, 2008 Del. Super. LEXIS 280 (Del. Super. Ct. July 31, 2008)	G
<i>JP Morgan Chase & Co. v. Indian Harbor Ins. Co.</i> , No. 6461-6462-6463-603766/08	H
<i>Kalama Chem., Inc. v. Allianz Ins. Co.</i> , No. 90-2-05011-4, 1995 WL 17015061 (Wash. Super. Ct. Aug. 14, 1995)	I
<i>Moody v. Am. Guar. & Liab. Ins. Co.</i> , No. C10-01102-RSM, 2011 U.S. Dist. LEXIS 38024 (W.D. Wash. Apr. 7, 2011)	J

- Northwest Steel Rolling Mills, Inc. v. Fireman's Fund Ins. Co.*,
No. C86-376WD, 1991 U.S. Dist. LEXIS 20984 (W.D. Wash.
Jan. 16, 1991) K
- Pereira v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*,
No. 04-Civ-1134 LTS, 2006 U.S. Dist. LEXIS 49263
(S.D.N.Y. July 12, 2006) L
- Westport Ins. Co. v. Markham Group, Inc.*,
403 Fed. App'x 264 (9th Cir. Nov. 17, 2010) M
- Kevin LaCroix, *The D&O Diary*,
June 14, 2012, available at
<http://www.dandodiary.com/2012/06/articles/d-o-insurance/ny-appellate-court-excess-insurers-off-the-hook-where-it-cant-be-determined-if-underlying-insurance-exhausted/> N

CERTIFICATE OF SERVICE

The undersigned certifies that on this 3rd day of August, 2012, I

caused the foregoing to be served to:

Paul E. Fogarty
Mary Przekop
Dearmin Fogarty, PLLC
600 Stewart Street, Ste.
1200
Seattle, WA 98101
**Attorney for Quellos
Group**

via hand delivery.
 via first class mail.
 via e-mail.
pfogarty@dearminfogarty.com
mprzekop@dearminfogarty.com

Barry J. Fleishman
Helen K. Michael
Eric M. Gold
Kilpatrick Townsend.
607 14th St., NW
Ste. 900
Washington DC 20005
**Attorneys for Quellos
Group, admitted pro
hac vice**

via hand delivery.
 via first class mail.
 via e-mail.
Bfleishman@kilpatricktownsend.com
Hmichael@kilpatrickstockton.com
Egold@kilpatricktownsend.com

Mark T. McMaster
Kilpatrick Townsend
1420 Fifth Ave.
Suite 4400
Seattle, WA 98101
**Attorneys for Quellos
Group**

via hand delivery.
 via first class mail.
 via e-mail.
mmcmaster@kilpatricktownsend.com

Brian Epps
Kilpatrick Townsend
690 Broad St., Ste. 1400
Wells Fargo Bank Bldg.
Augusta, GA 30901
**Attorneys for Quellos
Group, admitted pro
hac vice**

via hand delivery.
 via first class mail.
 via e-mail.
bepps@kilpatricktownsend.com

Alfred E. Donohue
John D. Wilson, Jr.
Wilson Smith, et al.
901 Fifth Ave.
Ste. 1700
Seattle, WA 98164
**Attorneys for Federal
Ins. Co.**

via hand delivery.
 via first class mail.
 via e-mail.
donohue@wscd.com
wilson@wscd.com

Gary P. Seligman
Wiley Rein LLP
1776 K St. NW
Washington, DC 20006
**Attorneys for Federal
Ins. Co., admitted pro
hac vice**

via hand delivery.
 via first class mail.
 via e-mail.
gseligman@wileyrein.com

I declare under penalty of perjury under the laws of the state of
Washington this 3rd day of August, 2012, at Seattle, Washington.


Tracy Horan

13838719.1



THE BOEING COMPANY, Plaintiff, v. AETNA CASUALTY & SURETY COMPANY, et al., Defendants.

No. C86-352WD

UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF WASHINGTON, AT SEATTLE

1990 U.S. Dist. LEXIS 20231

April 17, 1990, Filed

JUDGES: [*1] DWYER

OPINION BY: WILLIAM L. DWYER

OPINION

COURT'S ORAL DECISION on motions for summary judgment in the above-entitled and -numbered cause, by the Honorable William L. Dwyer, Judge of the United States District Court for the Western District of Washington, at 3 o'clock p.m., April 16, 1990.

THE COURT: I am about to give the oral decision that was promised last week. There is a large roomful of people here and there are also counsel on the telephone. If anybody in the room begins to find anything I am saying hard to hear, please raise your hand and I will keep an eye out for you. And if counsel on the telephone have any difficulty hearing, please speak up.

Now, in this case the Boeing Company seeks indemnification from its liability insurance carriers for environmental cleanup costs it has paid or will pay under the federal statute that is referred to as CERCLA. There are two toxic waste disposal sites involved, the Queen City Farms site and the Western Processing site. It is estimated that Boeing deposited about 24 million gallons of toxic wastes into pits on these two sites, that figure being the total for the two, over a period of about twenty years. It is claimed that property damage occurred [*2] in the form of contamination when toxic wastes leached into the soil and ground water.

There are many policies and insureds involved in Boeing's liability coverage over the span of years covered by the evidence in this case. Most of the questions that have been raised are common to all the policies and

all the time periods. Another common feature is that the law of the state of Washington, the forum state, applies to the questions to be decided today.

One question has been answered by the Washington Supreme Court, that is, whether these cleanup costs constitute damages within the meaning of the insurance policies. That question was certified by this Court to the Washington Supreme Court because of the basic importance of the question to this case and numerous other cases, and because of the lack at that time of an answer to the question in the published reports of the Washington court system.

The Supreme Court in January of this year by a vote of seven to two held that these costs do constitute damages within the meaning of the liability policies.

Now we have a series of motions for summary judgment that are ready for decision. This oral decision will constitute the Court's [*3] order on these motions. A summary judgment, if granted, means that the case or part of it is decided without a trial. The rules governing whether or not summary judgment can be ordered are very familiar to all counsel, but I will state them briefly.

Summary judgment can be rendered only where the record shows there is no genuine issue of material fact for trial and the moving party is entitled to judgment as a matter of law. In deciding the motion, the Court must view the evidence in the light most favorable to the non-moving party, that is, the party against whom the motion for summary judgment is made, and the Court must draw all reasonable inferences from the evidence in favor of the non-moving party.

Now to the first motion. There is a joint motion by the defendants, that is, the insurance carriers, for sum-

mary judgment in regard to the word "occurrence" in the policies. The motion is for summary judgment in their favor on the basis that the record shows without any issue of fact being present for trial that there was no occurrence within the meaning of these insurance policies.

Nearly all the policies in question provide coverage for damages sustained by reason of an [*4] occurrence. The wording varies a little from one policy to another, but not in a way that is material enough to affect the outcome of this motion, and a typical definition in these policies reads like this:

"'Occurrence' means an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured."

The question is, therefore, whether this property damage, the contamination of the soil and ground water, was expected or intended by Boeing. It is important to remember that this is not the trial. The evidence cannot be weighed at this point to see whose evidence is more persuasive. The question rather for today is this: Was the property damage expected or intended by Boeing so clearly that that result must be reached even when the evidence of record is viewed in the light most favorable to Boeing and all reasonable inferences are drawn in Boeing's favor? That is the test that must be applied in determining whether a party can be deprived of a trial.

Applying that standard here, I find that there is a genuine issue of material fact for trial as to whether Boeing expected [*5] the property damage to result from its acts and, if it did, as to when that expectation on its part existed, whether at the beginning or only commencing at some later time.

A party's state of mind is very often an issue that is not well suited for summary judgment, and in this instance I find that the insurers' motions for summary judgment on that issue must be denied and the issue will be decided at the trial.

Now, there is an alternative motion by the insurers which forms part of this motion for summary judgment in regard to the alleged absence of an occurrence, and that is this: The insurers ask that an order be issued stating that the definitions of "occurrence" in the policies are unambiguous as a matter of law and that parol evidence, that is, evidence outside the four corners of the policies, will not be considered as to their meaning, and that any remaining fact issues will be decided at trial. That alternative motion is granted. The definitions in the policies are not ambiguous - the definitions, that is, of the word "occurrence." "Occurrence" has a well-established meaning under Washington law and under the majority rule of the appellate courts in the United States. [*6]

There is no need for parol evidence to provide that meaning.

Now, turning specifically to the "expected or intended" language. What does the policy language mean when it says that the resulting damage is to have been neither expected nor intended from the standpoint of the insured in order for coverage to exist?

"Intended" means that the insured wanted the damage to result from its act. "Expected" means that the insured knew that there was a high degree of probability or a substantial certainty that damage would result from its act. Now, this test that I have just summarized may be re-worded when the instructions for the jury are written. It is enough today to give the essence of it. What I have just stated is the essence of it under Washington law and under the majority rule in the United States.

There is an important related point. If the jury finds that Boeing expected some property damage in the form of contamination of soil and ground water to occur, that will defeat coverage even if the actual damage later proved to be greater, more widespread or more serious than the damage Boeing expected. Under Washington law, once it is found that the insured intended or expected [*7] that its acts would cause damage, it makes no difference that the damage actually caused was of, to use a phrase that the courts of Washington have used, "a different character or magnitude" from what was expected or intended.

Another important related point is this: Who has the burden of proof as to whether there was an occurrence within the policy definition? The answer is that the insured does - in this case, Boeing. The burden will be on Boeing at trial to prove that the property damage was neither expected nor intended from its standpoint. Whether or not it can satisfy that burden of proof will be for the jury to decide.

There is a separate motion by INA, one of the carriers, for summary judgment very closely related to the "occurrence" motion that I have just described. INA's motion is for summary judgment on the basis that there was no "accident" within the meaning of its policy. Its policy requires that property damage be "caused by an accident." The wording here is different from the occurrence wording but under the clear rule in the state of Washington, that difference in wording, "occurrence" in one policy and "accident" in another, makes no difference as to the [*8] outcome. The ruling as to the INA motion will therefore be the same.

So to summarize, the motions of the carriers for summary judgment on the basis that there was no occurrence or accident are denied and the jury will decide that

at trial. The alternative motion of the carriers for a ruling that these policy words are not ambiguous is granted.

Next are the cross-motions for partial summary judgment based on the pollution exclusion. Boeing requests a determination that this exclusion does not bar coverage except where damage was expected or intended from the standpoint of the insured. The insurers ask for summary judgment to the effect that the policy exclusion, the pollution exclusion, precludes coverage in this instance. These policies contain a provision which is common to liability insurance policies throughout the United States and is often called the qualified pollution exclusion. It provides that the insurance does not apply to, and I quote, "property damage arising out of the discharge, dispersal, release or escape of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste materials or other irritants, contaminations or pollutants, into or [*9] upon land, the atmosphere or any watercourse or body of water; but this exclusion does not apply if such discharge, dispersal, release or escape is sudden and accidental." In other words, if the discharge, dispersal, release or escape is sudden and accidental, then there would be coverage.

Here again the decisional law of the state of Washington must be followed by this Court in deciding this motion. There are two Washington cases that particularly control. They are the *Van's Westlake* case, 34 Wn. App. 708 (1983) and the *Anderson and Middleton* case, 53 Wn. 2d. 404 (1959).

On first reading the policy language that I have just read, one might readily believe that the language providing coverage only for pollution resulting from a sudden dispersal or escape would necessarily exclude coverage for property damage resulting from pollution that occurred gradually and over a long period of time. However, the Washington cases have construed the policy language otherwise in deciding what the word "sudden" means in this context.

In the *Anderson* case one party contended that sudden should mean instantaneous, or at least something [*10] along the line of instantaneous. The Supreme Court of Washington rejected that argument and it said, and I quote, "We do not so construe the word 'sudden' when its primary meaning in common usage, is not 'instantaneous' but rather 'unforeseen and unexpected.'" That was in 1959 - over thirty years ago.

In 1983 in the *Van's Westlake* case the Washington Court of Appeals held that the pollution exclusion applies only to active polluters and does not apply where the property damage was neither expected nor intended by the insured.

Now these cases have been criticized. They have been criticized as assertedly taking the pollution exclusion out of the policy. But this policy language must be given the meaning, the established meaning that it has under Washington law. It appears that the policy language has not been changed or amended by the carriers in the years that have gone by since the Washington appellate courts announced the rulings that I have just summarized. Under those rulings, "sudden" is practically synonymous with unforeseen and unexpected. "Accidental" has its usual meaning. These terms are not ambiguous. They have a settled meaning under Washington law. The carriers' [*11] motion for summary judgment under the pollution exclusion must be denied, and here again it will be for the jury to decide, based on the evidence and the instructions, whether there is or is not coverage in light of that policy exclusion.

Boeing in its motion on this subject asks for a determination, in effect, that the policy exclusion really adds nothing to the "neither expected nor intended" language in the definition of occurrence. That will be a matter for instructions to the jury at the trial and it will be decided at the trial. I am not going to make that ruling now. So Boeing's motion will be denied, and, to summarize, both sides' motions as to the pollution exclusion are denied and the issue will be decided at the trial by the jury under appropriate instructions.

The next motion is called the trigger of coverage motion. Boeing brings this motion against four of its primary insurers, INA, Hartford, Continental and Aetna. It asks for a ruling that as a matter of law each primary policy in effect during the period beginning when hazardous waste was first released at the two sites until the date that the contamination was remediated - and for students of English, I hasten [*12] to add that is a term of art in the pollution cleanup industry - remediated - this motion asks that the Court issue an order to the effect that all those carriers have a joint and several liability to indemnify Boeing, absent of course any other valid coverage defenses.

To summarize it in fewer words, the motion asks that each of those four primary carriers be held jointly and severally liable for the whole loss, if any is liable at all for the loss. This motion has to do with the time at which coverage becomes applicable and the time at which coverage ceases to be applicable.

The policies issued by Hartford, Continental and Aetna are occurrence policies while the INA policy is an accident policy, but as stated a moment ago, in Washington that makes no practical difference. The terms "accident" and "occurrence" are synonymous. The term "trigger of coverage" refers to the event that triggers liability on the part of an insurer to indemnify the insured.

The time of an occurrence, the time of such an event, in other words, for insurance coverage purposes is determined by when the damages or injuries took place.

Damage of a continuing nature was addressed by the Washington Court [*13] of Appeals in *Gruol Construction Company v. INA*, 11 Wn. App. 632 (1974). In that case, damage to a building from dry rot could be traced to defective back-filling during construction, but the damage was not discovered until five years later at which time a claim was filed. The insurance policy at issue there, as in this case, defined "occurrence" to include continuous or repeated exposure to conditions. The Court found that the resulting damage was continuous and that coverage was properly found with respect to insurers whose policies were in effect during the progress of the dry rot, even though the initial negligent act took place during the coverage period of an earlier policy.

The *Gruol* case is good law for purposes of this case but there are issues for trial. When did the property damage begin? Did the damage continue to occur during each policy period? Can the damage be allocated among policy periods? In that regard, if there is coverage and if there is no way to allocate the damage, in other words, no way to tell how much occurred during each policy period, then each carrier ordinarily would be jointly and severally liable for the whole [*14] damage, if liable for any part of it. The burden of proof in that regard is on the insurers to make the allocation.

This, as I say, involves issues for trial, and the motions for summary judgment holding the companies jointly and severally liable without a trial is denied.

Next is the late notice motion. This is a motion by the defendants Smith & Companies, North River Insurance Company, INSCO, Limited, Aetna Casualty & Surety Company, Highlands Insurance Company and Puritan Insurance Company for summary judgment dismissing claims against them on the ground that timely notice was not provided by the insured. All the policies require timely notice to the carrier by the insured. The wording varies a little, but here is a typical provision.

"The assured, upon knowledge of any accident or occurrence likely to give rise to a claim hereunder, shall give immediate written advice thereof to [a broker named in the policy]."

The argument is that Boeing failed to do this, failed to give notice as required, and that the insurers were prejudiced by the lack of a timely notice because they were denied a chance to make a contemporaneous investigation of what was happening and were denied [*15] a chance to consider whether to cease insuring these risks.

On this ground they ask for summary judgment of dismissal.

This motion also goes to the question of Boeing's knowledge, what Boeing knew and when. There is enough in the record to create an issue of fact as to whether or not Boeing complied with the notice requirement. An important point to note in that regard is this: Notice is due under the policy if the insured knew that what it had done was likely to give rise to a claim, not necessarily a CERCLA claim. In other words, the policies did not require Boeing to be prescient or omniscient in foreseeing that there would be a CERCLA statute and that a claim would be asserted under that statute, but if the facts were such as to call for notice of a claim under whatever body of law, then that duty on the part of the insured would arise.

I mentioned a moment ago that there is an issue of fact as to whether Boeing complied with the notice requirement. There is also an issue of fact as to whether the carriers were actually prejudiced if it failed to give a timely notice. Actual prejudice ordinarily would be required.

The motion for summary judgment in regard to notice is [*16] denied. That issue may very well be bifurcated for a separate trial. That is a matter that I will come back to in talking with counsel in a few minutes.

Next is the waiver and estoppel motion. Boeing has moved for a determination that the defendants Continental, Hartford, and Aetna, and the London Market defendants, have waived or are estopped to assert certain policy defenses.

Now, there is a threshold rule of law here that is important. In Washington, waiver or estoppel cannot operate to extend coverage or restrictions on coverage. These doctrines, in other words, waiver and estoppel, cannot create coverage where none was provided by the contract in the first place. They cannot operate to write coverage for the insured that the insured never purchased from the carrier. I will mention three cases in that regard. The *Carew* case, 189 Wn. 329 at 336; the *Fuller* case, 10 Wn. App. 824 at 826; the *Saunders* case, 113 Wn. 2d. 330 at 335-36.

Now, in a different category are such matters as failure to pay a premium on time, failure to cooperate with the carrier as to a claim, failure to [*17] give timely notice of a claim, and so on. Defenses of that nature can be lost, depending upon the facts, through waiver or estoppel.

On the record here, Boeing's motion for summary judgment as to waiver and estoppel must be denied.

The carriers have not filed a counter-motion on the subject, but they have suggested a ruling in their favor on summary judgment, and the Court may enter an order on summary judgment in response to one party's motion, even where the other party has not explicitly moved for summary judgment in its favor. Summary judgment will be granted to the carriers in this instance as to any contentions by Boeing that coverage was expanded by waiver or estoppel beyond what it would have been under the contracts as written. As to other matters such as notice, and that is the one that leaps out from this record, there may be an issue for trial. As to notice, I find it is an issue for trial and that will be, of course, for the jury at the trial. That issue, too, I think, probably should be bifurcated, and I will get back to that in a moment.

Next is the motion of certain excess carriers for summary judgment. The moving parties here are the carriers with excess policies [*18] overlying Unigard policy No. BC 01-2210. Unigard, the primary carrier, has not been sued in this case by Boeing. The apparent reason is that Unigard, had it been included as a defendant, would have defeated diversity jurisdiction and this whole matter would be in state court rather than federal court. Boeing, of course, has the right to leave out a non-diverse defendant in order to have diversity jurisdiction.

The excess policies generally provide that there will be no liability until the underlying carrier has paid or has been held liable to pay the full amount of its coverage. The excess carriers seek summary judgment dismissing the claims against them, with prejudice and without costs.

Boeing argues that it is only seeking a declaratory judgment as to the excess carriers, not an award of damages. Boeing does, however, seek indemnification, in other words, damages, from the other defendants. A declaratory judgment as to these excess carriers would accomplish very little. There still would have to be adjudicated the question of Unigard's liability or nonliability to Boeing. That apparently would have to be done in state court. The excess carriers over Unigard's [*19] limits could not be obligated under their contracts until and unless Unigard were found liable to the full extent of its coverage. The liability of the excess carriers cannot be decided prior to the liability of the underlying carrier. For that reason, the absence of a declaratory judgment will not have any immediate and practical effect on Boeing. In other words, if Boeing were to prevail in this case and win a declaratory judgment against these excess carriers, it would have accomplished very little because that judgment would still have zero effect until and unless the liability of Unigard were established, and Unigard, according to an affidavit which is part of this record, denies liability to Boeing.

The motion must therefore be granted as to the excess carriers and policy members listed in the motion. This will apply to those carriers whether or not their policy includes that express clause saying that their liability would not occur until and unless the primary carrier is held liable, because in an excess policy that follows in any event.

In granting this motion, however, the dismissal will be without prejudice. Boeing's right to sue these excess carriers over Unigard's [*20] policy at the appropriate time and in the appropriate forum is preserved.

There is a motion by Boeing to strike certain parts of the carriers' submissions on this Unigard excess motion and the motion to strike is denied.

Next is the motion of Defendant Puritan Excess and Surplus Lines Insurance Company for summary judgment. The ground of this motion is that the wrong party was named as a defendant. The policy was actually issued not by Puritan Excess, as it can be called for short, but by Puritan Insurance Company. Puritan Excess, a phrase which almost sounds like an oxymoron, is a wholly owned subsidiary of Puritan Insurance Company and the two entities have the same CEO, Chairman of the Board, and the same general counsel. The defendant that was sued begins its answer by stating, "Comes now the defendant Puritan Excess and Surplus Lines, whose true and accurate name is Puritan Insurance Company." The true defendant, I find, was on notice. The true defendant would not be prejudiced by an amendment, and in fact the defendant has consistently acted as though it were the true defendant until the present motion was filed. The test for allowing leave to amend to substitute a new [*21] party comes to this: Whether the proper party had notice of the bringing of the action so that it will not suffer prejudice by the substitution, and whether the proper party knew or should have known that but for a mistake in identity, it would have been a party to the action.

That test is easily passed here. The defendant behaved as though it wrote the insurance policy at issue or was acting for the writer of the policy. The Court has discretion to allow leave to amend the complaint to substitute a proper party. For the reasons I have just summarized, the motion of Puritan Excess for summary judgment of dismissal under Rule 56 is denied and plaintiff Boeing is granted leave to amend by substituting the name of the correct defendant, Puritan Insurance Company. That amendment may be filed within one week from today. It will not contain any other changes in the complaint. If Puritan Insurance Company so elects, the answer already on file may be deemed the answer to the complaint as amended.

Next are the cross-motions by Boeing on the one hand and Defendant Aetna on the other regarding the

duty to defend. Boeing asks for summary judgment against Aetna, Hartford, Continental [*22] and INA to the effect that each of them as primary carrier was obligated by its insurance contract to defend Boeing in the underlying case. Aetna has moved for summary judgment to the effect that it had no duty to defend, and in its motion, Hartford, Continental and INA have concurred.

Liability policies such as these include a duty to defend the insured against a suit. That duty to defend is a separate covenant. It is a distinct duty from the duty to indemnify as to a covered loss, and the duty to defend is broader than the duty to indemnify.

Before giving the ruling on this motion or on these cross-motions, it is necessary to give a bit of background. On May 19, 1983, Boeing received a letter from the Environmental Protection Agency, the EPA, informing Boeing that the EPA had started action at the Western Processing facility to investigate and control releases of hazardous substances. The letter said, "Responsible parties may be liable for all monies expended by the government to take necessary corrective action at the site, including investigation, planning and cleanup of the site." The letter identified Boeing as a potentially responsible party, or PRP for short.

The letter [*23] also said, "If sufficient response by responsible parties is not forthcoming and EPA is required to use public funds to accomplish the necessary response activities, your company/organization may be held liable for the costs incurred by the agency in its activities on this site."

On July 17, 1984, EPA filed a second amended complaint in this district naming Boeing as a defendant and alleging that Boeing deposited waste at Western Processing; that the waste had contaminated water and soil and damaged natural resources; and that the EPA sought to recover response costs and to direct Boeing to remedy conditions at the site.

Boeing later, on August 28, 1984, entered into a partial consent decree, and on April 13, 1987, entered into a full consent decree. Under these agreements, Boeing has expended and continues to expend money for cleanup.

On September 13, 1985, Boeing received a PRP letter as to the Queen City Farms site. In October of that year Boeing entered into a consent decree governing initial measures to remedy the situation. In February 1988, Boeing entered into a consent order governing further expenses.

The insurance companies refused Boeing's tender of defense for these [*24] actions, and in doing so they relied on these propositions: First, that the PRP letter was not a suit and therefore did not trigger the duty to defend. Second, that even if the PRP letter were deemed a suit,

the allegations in it were so vague that the insurers had a right to rely on their conclusion that no coverage existed based on their own investigation, rather than acting on the allegations which, according to this argument, were too vague to be acted upon, and it follows, according to this argument, that the duty to defend could not be determined until liability is decided at the trial. Finally, it is argued that even if the insurers had a duty to defend, they would be liable only for the defense of covered claims.

Now as to the first point, whether a PRP letter is a "suit" for purposes of invoking a duty to defend. The courts around the country are split on that proposition. There is not yet a square holding in the state of Washington, so the job now is to figure out how the Washington Supreme Court would decide the issue.

There is a strong policy in Washington, reflected in many decisions, to the effect that where terms in an insurance contract are susceptible of more [*25] than one meaning, they are construed in favor of the insured. The word "suit" is defined in Webster's Third New World International Dictionary, 1976, as "the attempt to gain an end by legal process." There are other definitions as well, but that one seems the most cogent for present purposes.

Given the way that the Washington court construed "damages" when that question was certified to it in this case, and the way it has read the word "sudden," which I covered a few minutes ago, for purposes of insurance coverage, it seems most likely that in Washington the appellate courts would consider the PRP letter to be a suit.

There is a trial court decision by Judge Shellan, a renowned King County Superior Court judge, who has since left the bench but at the time was the chief judge in King County, and in this quite recent decision in *Queen City Farms, Inc. v. Aetna*, King County Superior Court No. 86-2-06236-0, Judge Shellan said, among other things, the following: "The property owner does not have to wait for a lawsuit to be filed against it by DOE, EPA or any other person or authority before the property owner is entitled to insurance coverage if coverage is otherwise afforded under [*26] the insurance policies at issue." That tends to suggest a duty to defend in Washington starting with the PRP letter.

There is also the public policy argument. If the insured cannot cooperate with the EPA under a PRP letter and still be defended by its insurer, there would be some disincentive to voluntary cooperation, and voluntary cooperation is a strong public policy under CERCLA.

The insurers also argue that their investigation of the underlying facts led them to conclude that there was no coverage. However, it is the allegations of the complaint or the claim letter that ordinarily determine the duty to

defend. To put it another way, the duty of an insurer to defend an action against the insured arises where the allegations could, if proven, impose liability within the coverage of the policy. If there is a potential for covered claims, the insurer must defend.

The conclusion I reach here is that the primary carriers did have a duty to defend in this instance.

The defendants also argue that their duty is to defend only covered claims, not non-covered claims, but that again is determined by the allegations of the complaint or suit. Here the allegations were such that the

[*27] duty to defend must be deemed applicable to the EPA's claim as a whole.

The insurers may eventually win this case as to coverage, but the duty to defend is a separate matter, and even if they do win as to coverage, they will not be entitled to a refund as to the costs of defense paid, if any, or to a finding of non-liability to pay the costs of defense.

So for the reasons stated, as to the duty to defend, the motion of Boeing is granted and the motion of the insurance carriers is denied.



**BEATRICE CROCKER, Plaintiff, v. NATIONAL UNION FIRE INSURANCE
COMPANY OF PITTSBURGH, PA, Defendant.**

No. SA-04-CA-0389-RF

**UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF
TEXAS, SAN ANTONIO DIVISION**

2005 U.S. Dist. LEXIS 9377

May 12, 2005, Decided

PRIOR HISTORY: *Crocker v. Nat'l Union Fire Ins. Co.*, 2005 U.S. Dist. LEXIS 2806 (W.D. Tex., Feb. 15, 2005)

CASE SUMMARY:

PROCEDURAL POSTURE: Plaintiff nursing home resident sued defendant insurer, seeking benefits under a liability policy based upon a default judgment against an insured. The court granted the resident's summary judgment motion and granted in part and denied in part the insurer's cross-motion for summary judgment, awarding the resident \$ 1 million. The insurer moved for reconsideration. The resident moved for attorney's fees.

OVERVIEW: The resident was injured by a nursing home employee and obtained a default judgment of \$ 1 million against the employee, who failed to defend the suit because the employee did not know that the nursing home owner's insurance policy covered him. As a judgment creditor and third-party beneficiary of the policy, the resident argued that the insurer breached its duty to defend the employee and was liable to the resident in the amount of the default judgment. The court determined that Texas insurance law governed the policy under Tex. Ins. Code Ann. § 21.42 (1981) and Tex. Ins. Code Ann. § 101.051 because the policy covered the Texas nursing home. Therefore, the policy was subject to the Texas common-law prejudice rule, which required the insurer to show prejudice to avoid liability. The court determined that the insurer failed to show prejudice from the employee's failure to forward suit papers and request a defense, because the insurer had actual knowledge of the underlying suit. In addition, the insurer was bound by the

default judgment against the employee because, inter alia, there was a full adversarial trial on the merits against the nursing home owner in the underlying suit.

OUTCOME: The court denied the insurer's motion for reconsideration and denied the resident's motion for attorney's fees.

LexisNexis(R) Headnotes

Civil Procedure > Judgments > Relief From Judgment > Motions to Alter & Amend

[HN1] The Federal Rules do not recognize a motion for reconsideration in haec verba. Courts in the United States Court of Appeals for the Fifth Circuit treat so-called motions to reconsider either as motions to alter or amend under *Fed. R. Civ. P. 59* or as motions for relief from judgment under *Fed. R. Civ. P. 60*. *Fed. R. Civ. P. 59(e)* provides that a party may move the court to amend its judgment within 10 days of entry. *Fed. R. Civ. P. 59(e)*.

Insurance Law > Industry Regulation > General Overview

Public Health & Welfare Law > Healthcare > Services for Disabled & Elderly Persons > Care Facilities > Nursing Facilities

[HN2] Any insurance company doing business in Texas is subject to Texas laws governing insurance. Tex. Ins. Code Ann. § 21.42 (1981). Tex. Ins. Code Ann. § 101.051 provides that an insurer engages in the business of insurance in Texas when it provides liability insurance for a facility located in Texas. Tex. Ins. Code Ann. §

101.051(b)(6)(D). Further, the United States Court of Appeals for the Fifth Circuit has found that Texas law governs any insurance policy payable to any citizen or inhabitant of this State.

Insurance Law > Industry Regulation > General Overview

[HN3] See Tex. Ins. Code Ann. § 21.42 (1981).

Civil Procedure > Federal & State Interrelationships > Erie Doctrine

Insurance Law > Industry Regulation > General Overview

[HN4] The United States District Court for the Western District of Texas's role, sitting as an Erie court, is to rule the way it believes the Texas Supreme Court would rule. The United States Court of Appeals for the Fifth Circuit has held that all policies issued to Texas residents are subject to Texas law and the rules of construction followed by the Texas Courts.

Insurance Law > Claims & Contracts > Notice to Insurers > Prejudice to Insurer

Insurance Law > General Liability Insurance > Obligations > Defense

[HN5] The Prejudice Rule is the common law of Texas and precludes an insurer from being able to escape liability from breach by an insured, unless the breach is material.

Insurance Law > Claims & Contracts > Notice to Insurers > Prejudice to Insurer

Insurance Law > General Liability Insurance > Obligations > Defense

[HN6] Under Texas law, an insurer who is not prejudiced by the breach may not deny coverage. If anything, the failure to give notice of a claim poses a smaller risk of prejudice than failure to obtain consent to a settlement. In many instances of untimely notice of a claim, the insurer is not prejudiced at all, and ultimately may not face any coverage obligation.

Insurance Law > Claims & Contracts > Notice to Insurers > General Overview

[HN7] Texas courts hold that evidence of actual knowledge of a lawsuit against an insured negates the prejudice suffered by an insurer. Even where insureds fail to forward suit papers and specifically request a defense, Texas courts find that this failure does not result in pre-

judice when the insurers had actual knowledge of the suit.

Contracts Law > Third Parties > Beneficiaries > Claims & Enforcement

[HN8] The Texas Supreme Court has held that to recover on a claim as a third-party beneficiary, the plaintiff must show that the insured complied with the conditions precedent, including the "actual trial" requirement. The Texas Supreme Court has stated that an "actual trial" contemplates a genuine contest of issues. The key for the Texas court then is that there be a genuine contest of the issues in order for a third-party beneficiary claim to be appropriate.

Civil Procedure > Pretrial Judgments > Default > Default Judgments

Contracts Law > Third Parties > Beneficiaries > Claims & Enforcement

Insurance Law > General Liability Insurance > Obligations > General Overview

[HN9] The Texas court of appeals has stated that generally, direct actions by an injured third-party against a tortfeasor's insurance company are prohibited until it has been established by judgment or agreement that the insured has a legal obligation to pay damages to the injured party.

Civil Procedure > Pretrial Judgments > Default > Default Judgments

Insurance Law > Motor Vehicle Insurance > Obligations > Defense

Insurance Law > Motor Vehicle Insurance > Vehicle Use > Permissive Users > Third Parties

[HN10] Texas judges have allowed injured third-party beneficiaries to sue on default judgments in Texas state courts.

Civil Procedure > Pretrial Judgments > Default > Default Judgments

Contracts Law > Third Parties > Beneficiaries > Claims & Enforcement

Insurance Law > General Liability Insurance > Obligations > Defense

[HN11] The Texas court of appeals has held that an insurer who refuses to defend its insured cannot thereafter insist on compliance with the insurance contract. The Texas court of appeals thus has allowed a third-party beneficiary to enforce a default judgment against an insurer.

Civil Procedure > Pretrial Judgments > Default > Default Judgments

Contracts Law > Third Parties > Beneficiaries > Claims & Enforcement

Insurance Law > General Liability Insurance > Coverage > General Overview

[HN12] Texas courts allow third-party beneficiaries to sue insurers on default judgments entered in underlying cases.

Civil Procedure > Remedies > Costs & Attorney Fees > General Overview

[HN13] U.S. Dist. Ct., W.D. Tex., R. CV-7(j) requires that a motion for attorney's fees be filed within 14 days of entry of the judgment.

COUNSEL: [*1] For DEAN KILGORE, neutral: Dean Kilgore, Attorney-Mediator, Austin, TX.

For BEATRICE CROCKER, plaintiff: William Schmidt, Law Offices of William Schmidt, Austin, TX; Thomas J. O'Meara, Jr., Attorney at Law, Austin, TX.

For NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA, defendant: Harrison H. Yoss, Thompson, Coe, Cousins & Irons, LLP, Dallas, TX.

JUDGES: ROYAL FURGESON, UNITED STATES DISTRICT JUDGE.

OPINION BY: ROYAL FURGESON

OPINION

ORDER DENYING DEFENDANT'S MOTION FOR RECONSIDERATION AND DENYING PLAINTIFF'S MOTION FOR ATTORNEY'S FEES

BEFORE THE COURT is Defendant's Motion for Reconsideration (Docket No. 36), filed on March 2, 2005, along with Plaintiff's Response. Also before the Court is Plaintiff's Motion for Attorney's Fees (Docket No. 39), filed on March 15, 2005, and Defendant's Response and objections. The Court granted Defendant's request for argument and held a hearing on March 31, 2005. On April 11, the Court granted Plaintiff's request for leave to submit additional briefing and Plaintiff's supplemental brief was entered on April 12, 2005. (Docket No. 44). After careful consideration of these arguments, the briefing, and the applicable law, the Court is of [*2] the opinion that Defendant's Motion for Reconsideration (Docket No. 36) must be DENIED and

Plaintiff's Motion for Attorney's Fees (Docket No. 39) must be DENIED.

FACTUAL AND PROCEDURAL BACKGROUND

The instant case involves an insurance dispute over an earlier personal injury action against a nursing home filed in state court by a resident who was injured by a nursing home employee. The resident -- and Plaintiff here -- sued the nursing home's owner and the employee, obtaining a default judgment of \$ 1,000,000 against the employee, who failed to defend the suit.

On April 5, 2004, Plaintiff Beatrice Crocker filed the instant suit against National Union as judgment creditor and third-party beneficiary of a liability policy written by Defendant National Union and covering the nursing home's corporate owner ("Emeritus") and the employee Morris. Plaintiff contended that Morris was entitled to coverage under the National Union policy and that Defendant breached its policy by failing to defend its insured, Morris, against Crocker's claims in the underlying suit. Since Defendant breached this duty, Plaintiff argued, Defendant is liable to Plaintiff in the amount of the state court default [*3] judgment: \$ 1,000,000.

Defendant and Plaintiff filed cross motions for summary judgment, agreeing that there were no genuine issues of material fact to preclude judgment as a matter of law. On February 15, 2005, the Court granted Plaintiff's motion for summary judgment and granted in part and denied in part Defendant's cross motion for summary judgment (Docket No. 34), awarding Plaintiff final judgment here in the amount of \$ 1,000,000.

On March 2, 2005, Defendant filed the instant motion for reconsideration, arguing that the Court's resolution of the issues before it on summary judgment was erroneous and contrary to law. Defendant also sought oral argument on the motion to reconsider. Plaintiff responded to Defendant's motion on March 14 and filed its own motion for attorney's fees on March 15, 2005. The Court addresses both of these motions here.

DISCUSSION

I. Motion for Reconsideration

At the outset, the Court notes that [HN1] the Federal Rules "do not recognize a motion for reconsideration *in haec verba*." ¹ Courts in the Fifth Circuit treat so-called motions to reconsider either as motions to alter or amend under *Rule 59* or as motions for relief from judgment [*4] under *Rule 60*. ² Here, Defendant's motion invokes *Rule 59(e)*, which provides that a party may move the court to amend its judgment within ten days of entry. ³ Defendant timely filed its motion to reconsider on March 2, 2005.

1 *Lavespere v. Niagara Mach. & Tool Works. Inc.*, 910 F.2d 167, 173 (5th Cir. 1990).

2 *Id.*

3 *FED. R. CIV. P. 59(e)*.

A. Application of the Prejudice Rule

Defendant argues that the Court's previous ruling was erroneous because the Court misapplied Texas insurance law. Specifically, Defendant asserts that the Court's application of Texas Board of Insurance Order 23080 was in error, arguing that the Board Order does not apply because the policy at issue here was not issued in Texas.⁴ Instead, Defendant argues that the policy was issued and delivered to Emeritus in the State of Florida. Further, Defendant argues that Emeritus is incorporated in Washington and has its headquarters there. Defendant argues that the [*5] policy in question was not "issued or delivered" in the State of Texas and, thus, that Board Order 23080 does not apply to the policy here.

4 The Amendatory Endorsement created by Order 23080 applies to "all General Liability policies issued or delivered in Texas" and requires that an insurer show prejudice to avoid liability.

Defendant argues that, if Order 23080 does not apply, then there is no duty on the part of Defendant National Union to defend Morris absent a specific request and forwarding of suit papers by the additional insured. Since it is undisputed that Morris did not forward the suit papers or request a defense from National Union in the underlying suit, Defendant argues that this Court should have entered summary judgment for it instead of for Plaintiff. Defendant moves on these grounds for reconsideration of the February 15, 2005 Order granting summary judgment to Plaintiff in this cause.

Defendant National Union argues in the alternative that it is entitled to reconsideration of the February [*6] 15 order granting summary judgment for Plaintiff because National Union was not bound by the default judgment because Morris failed to defend himself and this failure precluded a fully adversarial trial below. Defendant states that a judgment for a plaintiff against a defendant, rendered without a fully adversarial trial, is never binding on the defendant's insurer, citing the Texas Supreme Court decision in *Gandy*.⁵ Since a judgment is not binding on the insurer, National Union argues that it is not liable to a judgment creditor like Plaintiff Crocker.⁶ Defendant concludes that a fully adversarial trial is a condition precedent to an insurer's liability to a judgment creditor and argues that the Court must reconsider its February 15 order.

5 *State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696, 714, 39 Tex. Sup. Ct. J. 965 (Tex. 1996).

6 *Id.*

Plaintiff responds, arguing that the "Prejudice Rule" is alive and well in Texas and applied to the National Union insurance policy, as found by this Court in its [*7] February 15 order. She states that National Union's arguments as to why its policy is not governed by Order 23080 are erroneous. Specifically, Plaintiff states that the terms "issued or delivered" as set forth in Order 23080 are terms of art and that the order applies to all policies covering property located in Texas. If the property is located in Texas, Plaintiff argues, the insurance policy -- and the Texas Insurance Board's amendatory endorsement requiring a showing of prejudice to avoid liability -- has been issued and delivered in Texas.

[HN2] Any insurance company doing business in Texas is subject to Texas laws governing insurance.⁷ The Texas Insurance Code, *section 101.051*, provides that an insurer engages in the business of insurance in Texas when it provides liability insurance for a facility located in Texas.⁸ Further, the Fifth Circuit has found that "Texas law governs any insurance policy payable to any citizen or inhabitant of this State."⁹ National Union has conceded herein that it is authorized to engage in the insurance business in Texas.¹⁰ Therefore, the Court finds that the National Union policy written to Emeritus and covering [*8] the nursing home in the underlying dispute is governed by Texas law, including Board Order 23080.

7 *TEX. INS. CODE ANN. § 21.42* (West 1981) [HN3] ("Any contract of insurance payable to any citizen or inhabitant of this State by any insurance company or corporation doing business within this State shall be held to be a contract made and entered into under and by virtue of the laws of this State relating to insurance, and governed thereby, notwithstanding such policy or contract of insurance may provide that the contract was executed and the premiums and policy (in case it becomes a demand) should be payable without this State, or at the home office of the company or corporation issuing the same.")

8 *TEX. INS. CODE ANN. § 101.051(b)(6)(1)*.

9 *Hanson Production Co. v. Americas Ins. Co.*, 108 F.3d 627, 629 (5th Cir. 1997).

10 See Defendant's Response to Request for Admission No. 2 (Ex. H); Defendant's First Amended Answer to Plaintiff's Original Petition for Damages (Ex. I).

[*9] Further, even if the Court found that Defendant's argument that its policy was not affected by Order

23080 because the policy was not "issued or delivered" in Texas was meritorious, the Court would find nonetheless that the policy at issue was subject to the prejudice rule and that National Union would have to show prejudice to avoid the judgment entered below against Morris. [HN4] The Court's role, sitting as an *Erie* court, is to rule the way it believes the Texas Supreme Court would rule.¹¹ The Fifth Circuit, acting in this same role in similar cases, has held that "all policies issued to Texas residents are subject to Texas law and the rules of construction followed by the Texas Courts."¹²

11 *Browning Seed, Inc. v. Bayles*, 812 F.2d 999, 1002 (5th Cir. 1987).

12 *Hanson*, 108 F.3d at 630.

The Fifth Circuit in *Hanson* reasoned that the Texas Supreme Court would have followed the overwhelming national trend and required a showing of prejudice even in the close cases. [*10]¹³ The Fifth Circuit applied the doctrine of "immaterial breach" to the so-called policy defenses -- such as the failure to notify, failure forward suit papers, and similar defenses -- determining that the insurer would have to prove the breach (such as failure to notify the insurer of suit) was material in order to avoid liability.¹⁴ Further, as laid out by the Texas Supreme Court in *Hernandez*, [HN5] the Prejudice Rule is the common law of Texas and precludes an insurer from being able to escape liability from breach by an insured, unless the breach is material.¹⁵

13 *Id.* at 631 ("Most other jurisdictions presented with this issue have likewise imposed a prejudice requirement, primarily on public policy grounds. See *Thompson v. American States Ins. Co.*, 687 F.Supp. 559, 564 (M.D.Ala. 1988); *Shelter Mut. Ins. Co. v. Bough*, 310 Ark. 21, 834 S.W.2d 637, 640 (1992); *Rafferty v. Progressive American Ins.*, 558 So.2d 432, 433 (Fla.App. 1990); *Marsh v. Prestige Ins. Group*, 58 Ill. App. 3d 894, 374 N.E.2d 1268, 1270, 16 Ill. Dec. 390 (1978); *Kapadia v. Preferred Risk Mut. Ins. Co.*, 418 N.W.2d 848, 852 (Iowa 1988); *MacInnis v. Aetna Life & Casualty Co.*, 403 Mass. 220, 526 N.E.2d 1255, 1257-58 (1988); *Silvers v. Horace Mann Ins. Co.*, 324 N.C. 289, 378 S.E.2d 21, 27 (1989); *Wheeler v. Nationwide Mut. Ins. Co.*, 749 F.Supp. 660, 663 (E.D.Penn.1990)).

[*11]

14 *Id.* [HN6] ("An insurer who is not prejudiced by [the breach] may not deny coverage. . . . If anything, we believe that the failure to give notice of a claim poses a smaller risk of prejudice than failure to obtain consent to a settlement. In many instances of untimely notice of a claim, the insurer is not prejudiced at all, and ultimately

may not face any coverage obligation.")(citing *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691, 37 Tex. Sup. Ct. J. 731 (Tex. 1994)).

15 *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d at 694.

The Court is also confident in applying the Prejudice Rule and requiring that National Union show prejudice to avoid liability for the default judgment entered against it because both Florida and Washington -- the other two jurisdictions in which Emeritus is located and thus the other two jurisdictions where the policy at issue could be considered to be in effect -- both apply the Prejudice Rule in situations such as this.¹⁶ Thus, whether the Court determined that National Union was a company operating in the business of insurance in Texas, Washington, [*12] or Florida, the Court would appropriately apply the Prejudice Rule and require National Union to show that it was prejudiced by Morris's failure to forward the suit papers and specifically request a defense in the underlying suit to avoid liability here. For this reason, the Court declines to reconsider the application of the Prejudice Rule to Defendant National Union.

16 *Tiedtke v. Fidelity & Cas. Co.*, 222 So.2d 206, 209 (Fla. 1969); *Liberty Mutual Ins. Group v. Cifuentes*, 760 So.2d 230, 231 (Fla. App. 2000); *Oregon Auto Ins. Co. v. Salzberg*, 85 Wn.2d 372, 535 P.2d 816, 819 (Wash. 1975) ("For the foregoing reasons, we are convinced that sound public policy requires that an alleged breach of a cooperation clause may be considered substantial and material, and may effect a release of an insurer from its responsibilities Only if the insurer was actually Prejudiced by the insured's actions or conduct. The requirement of a showing of prejudice would pertain irrespective of whether the cooperation clause could be said to be a covenant or an express condition precedent and, in this regard, the burden of proof is upon the insurer."); *Kaplan v. Northwestern Mut. Life Ins. Co.*, 990 P.2d 991, 996, 100 Wn. App. 571 (Wash. App. 2000).

[*13] B. Defendant Failed to Show Prejudice

The Court has held, and has upon reconsideration has concluded again, that under Texas insurance law, National Union must show prejudice to avoid liability to Plaintiff. National Union has asserted that, even if the Court requires a showing of prejudice, it can show prejudice from Morris's failure to forward suit papers and request a defense. The main thrust of this argument is that National Union was not aware that Morris had been served. However, counsel for Plaintiff informed the carrier in writing that Morris had been served.¹⁷ Documents

uncovered in discovery also indicate that National Union knew that Morris had been served, knew that the insurer was required to defend him, and even provided that the counsel designated to defend Emeritus would represent Morris as well. ¹⁸ In light of these facts and other evidence submitted by Plaintiff, the Court concludes that National Union had actual knowledge of the suit against Morris.

17 Plf.'s Mot. for Summ. J. at App. 3.

18 *Id.* at App. 1, Ex. D-5.

[*14] [HN7] Texas courts also hold that evidence of actual knowledge of a lawsuit against an insured negates the prejudice suffered by an insurer. ¹⁹ Even where insureds fail to forward suit papers and specifically request a defense, Texas courts find that this failure does not result in prejudice when the insurers had actual knowledge of the suit. ²⁰ Based on the clear precedent from Texas courts rejecting the prejudice argument when insureds fail to forward suit papers and request a defense and the insurer had actual knowledge of the suit, this Court finds that National Union was not prejudiced by Morris's failure to forward suit papers and specifically request a defense when National Union had actual knowledge that Morris had been served in the underlying suit.

19 *Liberty Mut. Ins. Co. v. Cruz*, 883 S.W.2d 164, 165, 37 Tex. Sup. Ct. J. 276 (Tex. 1993).

20 *Id.*; *Struna v. Concord Ins. Servs., Inc.*, 11 S.W.3d 355, 359 (Tex. App.-Houston [1st Dist.] 2000, no pet.); *Allstate Ins. Co. v. Pare*, 688 S.W.2d 680, 682 (Tex. App.-Beaumont 1985, writ *ref'd n.r.e.*)

[*15] C. National Union Is Bound by Default Judgment

At the March 31, 2005 hearing on this issue, counsel for Defendant National Union focused on the argument that National Union is not bound by the default judgment because it was not reached after a fully adversarial trial. National Union argues specifically that, because the court below did not reach a decision on Plaintiff's damages following a full hearing or trial on the merits, it was not bound by the \$ 1,000,000 default judgment taken against Morris.

Defendant cites a number of Texas cases in support of its claim that it is not bound by the default judgment entered against Morris. Defendant argues that the policy held by Emeritus and covering the nursing home facility owned by it where Plaintiff was injured required that Morris's liability be determined by a trial before it would be obligated to pay on his behalf. The National Union policy, attached to Plaintiff's summary judgment motion,

provides that third parties could sue the insurer only after the insured's liability has been determined "by a trial, after which a final judgment has been entered." ²¹

21 Plf.'s Mot. Ex. B.

[*16] In *State Farm Lloyds Ins. Co. v. Maldonado*, [HN8] the Texas Supreme Court held that to recover on a claim as a third-party beneficiary, the plaintiff must show that the insured complied with the conditions precedent, including the "actual trial" requirement. ²² The Texas Supreme Court stated in *Maldonado* that

An "actual trial" contemplates a genuine contest of issues. . . Although Maldonado presented evidence to a judge who later made findings of fact and conclusions of law, this evidence was uncontested. Robert did not appear at trial. His attorney did not cross-examine any witnesses or put on any of his own. [Counsel] made no argument to the court contesting liability or damages and at one point even referred to the trial as a "hearing." In sum, there was no real contest of issues. ²³

22 *State Farm Lloyds Ins. Co. v. Maldonado*, 963 S.W.2d 38, 40, 41 Tex. Sup. Ct. J. 443 (Tex. 1998).

23 *Id.*

The key for the Texas court in *Maldonado* then was that there be a genuine contest of the [*17] issues in order for a third-party beneficiary claim to be appropriate.

After carefully reviewing the facts before it, the Court finds that the situation confronting the Texas Supreme Court markedly different from that before this Court. Here, there was a full trial on the merits, defended by counsel retained by Defendant on behalf of Emeritus, Jonathan LaMendola. While LaMendola was not representing Morris individually, "the case against Morris and Emeritus was tried together and LaMendola, on behalf of Emeritus, had the opportunity to challenge evidence, make objections, and cross-examine witnesses. Here, there was an actual trial, involving a real contest of the issues. Thus, the Court finds the holding in *Maldonado* inapplicable because there was a genuine contest of the issues and Emeritus failed to comply with its duty to defend Morris.

Defendant also cites the unpublished Fifth Circuit decision in *Ace Property & Casualty Ins. Co. v. Doris-*

mund, which it argues supports its point that a default judgment does not constitute a fully adversarial trial.²⁴ In *Dorismund*, the plaintiff sued now-defunct retailer Service Merchandise in a suit filed two months after the retailer [*18] filed for bankruptcy.²⁵ The retailer notified its liability insurance provider, Ace Property and Casualty Co. ("Ace"), that it did not intend to defend itself in the suit brought by the plaintiff. Neither Ace nor Service Merchandise entered an appearance in the matter and the Texas trial court entered a default judgment for plaintiff Dorismund in the amount of \$ 421,516.39.

24 See *Ace Prop. & Cas. Ins. Co. v. Dorismund*, 88 Fed.Appx. 695, 2004 WL 256557 (5th Cir. 2004).

25 *Id.* at **1.

Upon motion by Ace, the trial court entered a declaratory judgment, finding that Service Merchandise had breached notice provisions in the insurance policy and an implied duty to defend itself and to mitigate its damages and that Ace was not liable as a result.²⁶ However, the Fifth Circuit, upon reviewing the insurance contract, found that Ace had no duty to defend Service Merchandise and that it had expressly written the duty to defend out of the contract.²⁷ Concluding its holding, the Fifth Circuit [*19] wrote that

Service deliberately decided not to take any action, as shown in its August 2, 2002, letter to ACE. Service's inaction provides an egregious example of avoiding "a fully adversarial trial" or even some sort of aggressive settlement negotiation. Such inaction constitutes a breach of Service's duty to its insurer.²⁸

26 *Id.*

27 *Id.*

28 *Id.* at **2.

In the situation before the Court, the facts are different. As set forth in the Court's February 15 order, the summary judgment evidence is clear that Morris did not know that Emeritus's insurance policy covered him as an additional insured and that he was entitled to a defense for claims covered by the policy. In the case below, Morris did not make the same decision that Service Merchandise made in *Dorismund*: not to defend the suit because the plaintiff had waived any right to a distribution by Service Merchandise. Rather, the former nursing home employee failed to appear at the trial because he could not afford counsel [*20] and did not know of

National Union's duty to defend him. As a result, the Court finds the Fifth Circuit's holding in *Dorismund* inapplicable to the determination before it: whether National Union is bound by the default judgment entered against Morris.

Finally, Defendant cites to *State Farm Fire Ins. Co. v. Gandy*, for the proposition that a judgment rendered without a fully adversarial trial is never binding on the defendant's insurer.²⁹ However, *Gandy* involved an assignment of choses in action and stated that the issue before the court was whether an insured could assign his claims against an insurance company for breach of its duty to defend.³⁰ The *Gandy* court limited its discussion to situations involving assignments of claims and did not purport to extend its ruling beyond that limited factual scenario. This limits the applicability of the holding in *Gandy* and precludes it from creating controlling precedent for this Court in deciding whether National Union is bound by the judgment taken against Morris, since there was no assignment of claims here.

29 *State Farm Fire Ins. Co. v. Gandy*, 925 S.W.2d 696, 714, 39 Tex. Sup. Ct. J. 965 (Tex. 1996).

[*21]

30 *Id.* at 719.

Further, even taking Defendant's quoted statement from the court in *Gandy* at face value, the Court has already noted that there was a trial in this case and that the claims against Morris were severed from the suit against Emeritus after the close of evidence. Emeritus and National Union had the chance to rebut all of Plaintiff's evidence in the trial below. Indeed, as a co-defendant, Emeritus had an incentive to challenge all of the evidence submitted by Plaintiff and vigorously defend the claims brought against it. This incentive existed whether or not National Union fulfilled its duty to defend Morris. Thus, the Court finds that there was a fully adversarial trial on the merits below, with competent counsel representing plaintiff and defendant Emeritus. Additionally, there was no assignment of claims and *Gandy*'s holding is inapplicable for this reason.

Other cases decided by Texas courts and cited by Plaintiff uphold default judgments in insurance cases.³¹ In *Struna*, [HN9] the Texas court of appeals stated that generally, "direct actions by an injured [*22] third-party against a tortfeasor's insurance company are prohibited until it has been established by judgment or agreement that the insured has a legal obligation to pay damages to the injured party."³² Like Defendant National Union, the insurer in *Struna* focused on the actual trial requirement and argued that there had not been an actual trial establishing the insured's liability to the *Struna* plaintiff and that there could be no liability on the part of the insurer

for the default judgment taken against its insured.³³ In that case, there had not been an actual trial, but the trial court entered judgment after a hearing on the issue of the plaintiff's damages. The Texas court of appeals held that this hearing satisfied the actual trial requirement and reversed the trial court's decision to grant summary judgment to the insurer trying to avoid its liability for the default judgment.³⁴

31 See *Struna v. Concord Ins. Services, Inc.*, 11 S.W.3d 355 (Tex. App.-Houston [1 Dist.] 2000); *Ohio Casualty Group v. Risinger*, 960 S.W.2d 708 (Tex. Civ. App. Tyler 1997, reh'g overruled); *Allstate Ins. Co. v. Pare*, 688 S.W.2d 680, 680 (Tex. App.-Beaumont 1985, writ ref'd n.r.e.).

[*23]

32 11 S.W.3d at 359 (citing *State Farm County Mut. Ins. Co. v. Ollis*, 768 S.W.2d 722, 723, 32 Tex. Sup. Ct. J. 168 (Tex. 1989); *Great Am. Ins. Co. v. Murray*, 437 S.W.2d 264, 265, 12 Tex. Sup. Ct. J. 225 (Tex. 1969)).

33 *Id.*

34 *Id.* at 358-59.

In *Risinger*, another Texas appellate court addressed a suit against an insurer to collect on a default judgment. The insureds in the underlying case did not notify in the insurer Ohio Casualty that they had been served with citation and the Ohio Casualty argued that the insureds' failure to notify prejudiced it and precluded its liability for the default judgment. The court determined that the holder of the default judgment could overcome the insurer's affirmative defense of prejudice due to lack of notice by the insured by proving that Ohio Casualty had actual knowledge of the suit and was not prejudiced. The Court finds this case analogous and finds on these facts that National Union can and is bound by the default judgment taken against Morris in the underlying suit.

As to the court's statements regarding prejudice [*24] to the insurer from the insureds' failure to notify the insurer of the claim, this Court notes that National Union does not rely upon prejudice from lack of notice. Further, National Union concedes that it knew of the lawsuit and knew that Morris was a party to it. National Union argues instead that it was prejudiced by Morris's failure to forward suit papers and specifically request a defense and that it should be able to avoid liability for the underlying default judgment as a result.

In fact, in cases going back for decades, [HN10] Texas judges have allowed injured third-party beneficiaries to sue on default judgments in Texas state courts. For example, Plaintiff cites to *Pioneer v. Jefferson*, a third-party beneficiary claim brought against an insurer under an automobile policy.³⁵ The *Pioneer* court addressed a situation not unlike that before this Court: an

insurer who refuses to defend the personal injury action then seeks to avoid liability for a subsequent default judgment. The defendant insurer in *Pioneer* also relied upon the actual trial requirement, protesting that the insured did not comply with the notice and cooperation provisions in its policy and that it could [*25] not be liable for the default judgment. Finding the insurer's argument disingenuous, [HN11] the Texas court of appeals held that an insurer who refuses to defend its insured cannot thereafter insist on compliance with the insurance contract.³⁶ The Texas court of appeals thus allowed the third-party beneficiary to enforce the default judgment against the insurer.

35 456 S.W.2d 410 (Tex. Civ. App.-14th Dist. 1970, writ ref'd, n.r.e.).

36 *Id.* at 413.

In numerous other cases, Texas courts have allowed third-party beneficiaries to sue insurance companies on default judgments taken against them and rejects the insurer's inevitable argument that they are not bound by these default judgments. On the basis of the cases cited to the Court by counsel for both parties, the Court finds that [HN12] Texas courts allow third-party beneficiaries to sue insurers on default judgments entered in underlying cases. The Court thus finds that it had more than adequate authority to support its *Erie* determination [*26] that Texas courts would allow the claim Plaintiff asserts against Defendant National Union here. As a result, the Court will deny Defendant's motion to reconsider.

II. Motion for Attorney's Fees

Also before the Court is Plaintiff's motion for attorney's fees (Docket No. 37), filed on March 2, 2005. The Court notes at the outset that Plaintiff's request was filed out of time. [HN13] Local Rule CV-7(j) requires that a motion for attorney's fees be filed within fourteen days of entry of the judgment. The instant request was filed fifteen days after entry of the judgment, rendering it untimely. Defendant asks that Plaintiff's motion be denied on this basis.

The Court declines to deny Plaintiff's request merely because of a procedural defect. However, considering the nature of the case and the posture in which it was decided, the Court has determined that an award of fees is not appropriate here. As a result, the Court will deny Plaintiff's request for attorney's fees.

CONCLUSION

For the foregoing reasons, it is hereby ORDERED that Defendant's Motion for Reconsideration (Docket No. 36) is DENIED.

2005 U.S. Dist. LEXIS 9377, *

It is further ORDERED that Plaintiff's Motion for Attorney's Fees (Docket [*27] No. 39) is hereby DENIED.

Signed this 12th day of May, 2005.

ROYAL FURGESON

UNITED STATES DISTRICT JUDGE



NANCY JANE DeFRAIN, Personal Representative of the ESTATE OF WILLIAM DEFRAIN, deceased, Plaintiff-Appellee, v STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, Defendant-Appellant.

No. 294505

COURT OF APPEALS OF MICHIGAN

291 Mich. App. 713; 809 N.W.2d 601; 2011 Mich. App. LEXIS 453

March 10, 2011, Decided

SUBSEQUENT HISTORY: Later proceeding at *DeFrain v. State Farm Mut. Auto. Ins. Co.*, 490 Mich. 870, 802 N.W.2d 615, 2011 Mich. LEXIS 1599 (2011)
Reversed by, Remanded by *DeFrain v. State Farm Mut. Auto. Ins. Co.*, 2012 Mich. LEXIS 764 (Mich., May 30, 2012)

PRIOR HISTORY: [***1]
Wayne Circuit Court. LC No. 08-125814-NF.

CASE SUMMARY:

PROCEDURAL POSTURE: Defendant insurer challenged a decision from the Wayne Circuit Court, Michigan, which denied its motion for summary disposition in an uninsured motorist coverage dispute involving plaintiff personal representative.

OVERVIEW: An insured was injured in a hit-and-run accident. He had uninsured motorist coverage through an insurance policy with the insurer. The insured failed to timely comply with a policy provision that required the reporting of a hit-and-run accident within 30 days. The insured later died as a result of his injuries. The insurer's motion for summary disposition was denied, and this appeal followed. In affirming, the appellate court determined that an insurer who sought to cut off responsibility on the ground that the insured did not comply with a contract provision requiring notice immediately or within a reasonable time had to establish actual prejudice to its position. This rule applied, even though the 30-day provision in this case did not require notice immediately or within a reasonable time. The prejudice standard was not met in this case.

OUTCOME: The decision was affirmed.

LexisNexis(R) Headnotes

Insurance Law > Claims & Contracts > Policy Interpretation > General Overview
Insurance Law > Motor Vehicle Insurance > Coverage > Uninsured Motorists > General Overview

[HN1] Because uninsured motorist benefits are not required by statute, interpretation of the policy dictates under what circumstances those benefits will be awarded.

Insurance Law > Claims & Contracts > Notice to Insurers > Prejudice to Insurer

[HN2] It is a well-established principle that an insurer who seeks to cut off responsibility on the ground that its insured did not comply with a contract provision requiring notice immediately or within a reasonable time must establish actual prejudice to its position.

Insurance Law > Claims & Contracts > Notice to Insurers > Prejudice to Insurer

[HN3] *Koski v Allstate Ins Co.* has carved out a narrow prejudice requirement relative to all insurance contracts, and *Rory v Continental Ins Co.* does not overrule the Michigan Supreme Court's earlier ruling in *Koski*, which is controlling.

JUDGES: Before: MURPHY, C.J., and STEPHENS and M.J. KELLY, JJ.

OPINION BY: MURPHY

OPINION

[**602] [*714] MURPHY, C.J.

Defendant, State Farm Mutual Automobile Insurance Company, appealed by leave granted the trial court's order denying its motion for summary disposition. This case arose out of a hit-and-run accident that resulted in the death of William DeFrain, who had uninsured motorist (UIM) coverage through an insurance policy with State Farm. The dispute before us concerns Mr. DeFrain's failure to timely comply with a provision in the policy that required an insured to report an accident involving a hit-and-run motor vehicle to State Farm within 30 days. In *Koski v Allstate Ins Co*, 456 Mich 439; 572 NW2d 636 (1998), our Supreme Court held that an insurer had to establish actual prejudice before it could be relieved from contractual liability under an insurance policy, when the insured had failed to timely comply with a notice provision contained in the policy that constituted a condition precedent to insurer liability. Because we conclude that *Koski* applies here, and because we agree with the trial court that State Farm failed to establish actual prejudice as a matter of law, we affirm [***2] the trial court's order denying State Farm's motion for summary disposition.

[*715] On May 31, 2008, Mr. DeFrain was a pedestrian when he was struck by a hit-and-run driver and sustained severe head injuries. He first notified State Farm of the accident on August 25, 2008. On November 11, 2008, Mr. DeFrain died as a result of his injuries. His State Farm policy had provided for UIM benefits.¹ Pursuant to the policy, a person making a claim for UIM benefits "must report an accident, involving a 'hit-and-run' motor vehicle to the police within 24 hours and to us within 30 days . . ." As indicated, Mr. DeFrain failed to timely comply with the 30-day notice provision.² The policy also had language requiring a claimant to notify State Farm of a UIM claim and to give it "all the details about the death, injury, treatment, and other information that [State Farm] may need as soon as reasonably possible after the injured insured is first examined or treated for the injury." (Emphasis in italics added.) The trial court denied State Farm's motion for summary disposition, noting the existence of an ambiguity when reading the 30-day notice provision in conjunction with the [***3] provision calling for a claimant to provide State Farm with notice of a claim and medical details as soon as reasonably possible.

1 There is no indication in the record that Mr. DeFrain had failed to pay his premiums on the policy that had provided the UIM coverage.

2 At oral argument, plaintiff's counsel indicated, without dispute from State Farm's counsel, that Mr. DeFrain underwent brain surgery after the accident and was in intensive care throughout the 30-day notice period. This fact does not play a role in our analysis and holding.

We find it unnecessary to decide the issue whether the trial court erred by finding an ambiguity, because the trial court also ruled that "I don't really see any real prejudice here, so I am accordingly going to deny State Farm's] motion for summary disposition and that's my decision." One of the arguments on appeal proffered by plaintiff in support of affirming the trial court's denial [*716] of State Farm's motion for summary disposition is that [**603] State Farm did not show any prejudice that resulted from the failure to comply with the 30-day notice provision. We agree. Indeed, State Farm makes no argument that it suffered any prejudice as a result of the delay.

In [***4] *Jackson v State Farm Mut Automobile Ins Co*, 472 Mich 942; 698 NW2d 400 (2005), our Supreme Court, in lieu of granting leave to appeal, vacated a judgment entered by this Court and reinstated an order of summary dismissal entered by the trial court "for the reasons stated in the Court of Appeals dissent." As revealed in this Court's opinion in *Jackson*, the injured insured failed to comply with a similar 30-day notice provision with respect to a claim for UIM benefits after being injured in a hit-and-run accident. *Jackson v State Farm Mut Auto Ins Co*, unpublished opinion per curiam of the Court of Appeals, issued October 5, 2004 (*Docket No. 246388*, 2004 Mich. App. LEXIS 2616). The majority found the existence of an ambiguity in the policy and held that the trial court erred by granting State Farm's motion for summary disposition. 2004 Mich. App. LEXIS 2616 at *1. In light of its holding, the Court found it unnecessary to address the plaintiff's argument that the notice provision was enforceable only if State Farm could prove prejudice. 2004 Mich. App. LEXIS 2616 at *9. The dissent, however, addressed the prejudice issue and rejected the argument that prejudice had to be established. The dissent found that *Wendel v Swanberg*, 384 Mich 468; 185 NW2d 348 (1971), [***5] which was cited by the plaintiff in support of the prejudice argument, was "distinguishable on the basis that it d[id] not involve a condition precedent to the filing of an action against an insurer, but, rather, when reasonable notice of a pending lawsuit is given to the insurance carrier." *Jackson*, unpub op at 4 (GRIFFEN, J., dissenting). The dissent also stated that "the present [*717] case d[id] not involve any sta-

291 Mich. App. 713, *; 809 N.W.2d 601, **;
2011 Mich. App. LEXIS 453, ***

tutory obligations; instead, it entail[ed] a matter of contractual interpretation." *Id.*

We initially note that [HN1] "because uninsured motorist benefits are not required by statute, interpretation of the policy dictates under what circumstances those benefits will be awarded." *Rohlman v Hawkeye-Security Ins Co*, 442 Mich 520, 525; 502 NW2d 310 (1993). Here, on the prejudice issue, plaintiff also cites *Wendel*, which was distinguished and rejected in the *Jackson* dissent adopted by the Supreme Court. However, plaintiff also cites *Koski*, 456 Mich 439; 572 N.W.2d 636, which concerned the interpretation and application of a homeowner's insurance policy. Under the policy, in the event of an accident or claim, the insured was required to immediately forward to Allstate any legal papers received by the insured concerning the accident [***6] or claim (the notice-of-suit provision). The Court stated, "plaintiff's duty to immediately forward any legal papers relating to a claim is a *condition precedent* to Allstate's liability under [the] policy." *Id.* at 444 (emphasis added). Thus, the two grounds cited by the dissent in *Jackson* for distinguishing *Wendel* and rejecting application of a prejudice requirement, i.e., the 30-day hit-and-run notice provision was a condition precedent to liability and the provision entailed a matter of contractual interpretation and not statutory obligations, were both present in *Koski*, i.e., the notice-of-suit provision was a condition precedent to liability and the provision entailed a matter of contractual interpretation and not statutory obligations. Therefore, *Jackson* squarely stands in direct conflict with *Koski*. The *Koski* Court ruled that [HN2] "it is a well-established principle that an insurer who seeks to cut off responsibility on the ground that its insured did not comply with a contract provision requiring notice immediately or within a [**604] reasonable time *must establish actual prejudice to its position.*" *Koski*, 456 [**718] Mich at 444 (emphasis added). We find that *Jackson* is of questionable and limited value because it did not address *Koski*, [***7] which apparently was not argued there, and which constitutes binding precedent that we are not free to disregard.

The 30-day notice provision here did not require notice immediately or within a reasonable time, but there is no reason why the actual-prejudice requirement from *Koski* would not apply because of that distinction. The well-established prejudice principle from *Koski* is offended and essentially discarded by not applying it in the case at bar, and *Koski* is a fully developed and reasoned opinion on the subject of prejudice in the context of insurance law, whereas the Supreme Court's order in *Jackson* is merely a cursory order. The proposition that we should give more weight to a Supreme Court opinion than to a Supreme Court order, aside from being self-evident, is reflected in how the Supreme Court itself

has at times treated its own orders. For example, in *Mullins v St Joseph Mercy Hosp*, 271 Mich App 503; 722 NW2d 666 (2006), rev'd 480 Mich. 948, 741 N.W.2d 300 (2007), this Court ruled that a prior Supreme Court opinion had to be applied retroactively where "the Michigan Supreme Court ha[d] plainly and unambiguously expressed its intent that the decision . . . applie[d] retroactively" in *three consecutive orders*. [***8] However, the Supreme Court reversed this Court's ruling, holding that its earlier opinion was not fully retroactive despite the fact that it had issued three orders commanding retroactive application, and the Court did not even bother to discuss *stare decisis* in ignoring and essentially overruling its prior orders. 271 Mich. App. 503, 506, 722 N.W.2d 666.

Finally, we note this Court's decision in *Bradley v State Farm Mut Automobile Ins Co*, 290 Mich. App. 156; ___ NW2d ___, 2010 Mich. App. LEXIS 1809), wherein we applied the *Koski* prejudice [**719] requirement when the plaintiff failed to join State Farm and the tortfeasors in a suit as required by the UIM benefits provision of the insurance policy. We held that "because defendant suffered no prejudice from the failure to join, defendant should not be relieved of liability to provide uninsured-motorist benefits to plaintiff, who had paid premiums for that coverage." *Id.* at 160. The *Bradley* panel also discussed *Rory v Continental Ins Co*, 473 Mich. 457, 461; 703 N.W.2d 23 (2005), in which the Supreme Court held that an unambiguous provision in a UIM policy must be enforced as written regardless of the equities and the provision's reasonableness. The majority opinion in *Bradley* [***9] stated that [HN3] "*Koski* carved out a narrow prejudice requirement relative to all insurance contracts, and *Rory* did not overrule the Supreme Court's earlier ruling in *Koski*, which we find controlling." *Bradley*, 290 Mich App at 161, 2010 Mich. App. LEXIS 1809 at *6. The Court, *id.* at 161 n1, further observed:

The dissent disagrees that defendant should be required to show prejudice, asserting that *Rory* controls *Rory*, however, did not examine the prejudice principle discussed in *Koski*. Moreover, *Tenneco [v Amerisure Mut Ins Co]*, 281 Mich App 429; 761 NW2d 846 (2008)), which was decided in 2008 and after *Rory* was issued, and which constitutes binding precedent, acknowledged the continuing application of *Koski*. The *Tenneco* panel also cited additional, earlier Michigan Supreme Court precedent supporting imposition of a prejudice requirement. *Id.* at 448.

291 Mich. App. 713, *; 809 N.W.2d 601, **;
2011 Mich. App. LEXIS 453, ***

In sum, we hold that, regardless of the order in *Jackson, Koski* demands that we [**605] affirm the trial court's order denying State Farm's motion for summary disposition.

Affirmed. Plaintiff, as the prevailing party, is awarded costs pursuant to *MCR 7.219*.

/s/ William B. Murphy

/s/ Cynthia Diane Stephens

/s/ Michael J. Kelly



JOHN GASTON, Plaintiff, vs. ALLSTATE INSURANCE COMPANY, Defendant.

CASE NO. 4:08 cv 0749

**UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF
OHIO, EASTERN DIVISION**

2008 U.S. Dist. LEXIS 107996

July 31, 2008, Decided

CASE SUMMARY:

PROCEDURAL POSTURE: Plaintiff insured filed an action against defendant insurer alleging breach of contract and bad faith arising from the denial of a claim. The insurer sought summary judgment on the basis that the insured failed to cooperate with the claim investigation.

OVERVIEW: When the insured's truck was recovered completely burned, the insurer denied the claim. To investigate the possibility of arson, the insurer requested from the insured certain financial documents. The court concluded that the document requests were perfectly reasonable and relevant to the claim investigation and that the fact that the insured declared that he had a willingness to cooperate was beside the point. Thus, the court found that the insured failed to cooperate with the investigation as required by the policy and that this failure was a material and substantial breach of the insured's obligations under the policy. Because the insured reasonably suspected arson, the insurer's failure to produce the requested information resulted in material and substantial prejudice to the insurer as a matter of law. The insurer was precluded from determining the truth or falsity of the claim, which was materially prejudicial to its investigation. Having satisfied its burden of establishing the insured's noncompliance with the cooperation clause and the resulting prejudice, the insurer was entitled to summary judgment on the insured's claim for coverage under the policy.

OUTCOME: The court granted the insurer's motion for summary judgment and dismissed the insured's complaint.

LexisNexis(R) Headnotes

Civil Procedure > Summary Judgment > Standards > General Overview

[HN1] The function of summary judgment is to dispose of claims without trial when one party is unable to demonstrate the existence of a factual dispute which, if present, would require resolution by a jury or other trier of fact.

Civil Procedure > Summary Judgment > Standards > Appropriateness

[HN2] See *Fed. R. Civ. P. 56(c)*.

Civil Procedure > Summary Judgment > Standards > Appropriateness

Civil Procedure > Summary Judgment > Supporting Materials > Affidavits

[HN3] See *Fed. R. Civ. P. 56(e)*.

Civil Procedure > Summary Judgment > Burdens of Production & Proof > Absence of Essential Element of Claim

Civil Procedure > Summary Judgment > Burdens of Production & Proof > Movants

Civil Procedure > Summary Judgment > Supporting Materials > Affidavits

[HN4] In a summary judgment motion, the movant is not required to file affidavits or other similar materials negating a claim on which its opponent bears the burden of proof, so long as the movant relies upon the absence of

the essential element in the pleadings, depositions, answers to interrogatories, and admissions on file.

Civil Procedure > Summary Judgment > Standards > Appropriateness

Civil Procedure > Summary Judgment > Standards > Genuine Disputes

Civil Procedure > Summary Judgment > Standards > Materiality

Civil Procedure > Summary Judgment > Standards > Need for Trial

[HN5] In reviewing summary judgment motions, a court must view the evidence in a light most favorable to the non-moving party to determine whether a genuine issue of material fact exists. A fact is "material" only if its resolution will affect the outcome of the lawsuit. Determination of whether a factual issue is "genuine" requires consideration of the applicable evidentiary standards. Thus, in most civil cases the court must decide whether reasonable jurors could find by a preponderance of the evidence that the non-moving party is entitled to a verdict. There is no issue for trial unless there is sufficient evidence favoring the nonmoving party for a jury to return a verdict for that party. If the evidence is merely colorable, or is not significantly probative, summary judgment may be granted.

Civil Procedure > Summary Judgment > Burdens of Production & Proof > Absence of Essential Element of Claim

Civil Procedure > Summary Judgment > Burdens of Production & Proof > Nonmovants

Civil Procedure > Summary Judgment > Standards > Appropriateness

[HN6] Summary judgment is appropriate whenever the non-moving party fails to make a showing sufficient to establish the existence of an element essential to that party's case and on which that party will bear the burden of proof at trial. Moreover, the trial court no longer has a duty to search the entire record to establish that it is bereft of a genuine issue of material fact. Rather, the non-moving party is under an affirmative duty to point out specific facts in the record as it has been established which create a genuine issue of material fact. The non-movant must show more than a scintilla of evidence to overcome summary judgment; it is not enough for the non-moving party to show that there is some metaphysical doubt as to material facts.

Contracts Law > Types of Contracts > General Overview

Insurance Law > Claims & Contracts > Policy Interpretation > Questions of Law

[HN7] Under Ohio law, an insurance policy is a contract, the interpretation of which is a matter of law.

Contracts Law > Contract Interpretation > General Overview

Insurance Law > Claims & Contracts > Policy Interpretation > Plain Language

[HN8] Where the contract language is clear and unambiguous, courts must enforce the contract as written and give the words their plain and ordinary meaning.

Insurance Law > General Liability Insurance > Obligations > Cooperation

[HN9] When cooperation is a policy condition, and an insured fails to comply, the insurer may be relieved of further obligation with respect to a claim with which the insured did not cooperate.

Insurance Law > Claims & Contracts > Disclosure Obligations > General Overview

[HN10] When an insurance company demands information, the policyholder is required to make a fair and frank disclosure of information demanded by the company.

Insurance Law > General Liability Insurance > Obligations > Cooperation

[HN11] To avoid liability to a policyholder, the insurer must establish that the failure to cooperate was material and substantial, and resulted in prejudice to the insurer's rights.

Civil Procedure > Pleading & Practice > Defenses, Demurrers & Objections > Affirmative Defenses > General Overview

Evidence > Procedural Considerations > Burdens of Proof > Allocation

Insurance Law > General Liability Insurance > Obligations > General Overview

[HN12] Failure to comply with policy conditions is an affirmative defense, on which the insurer bears the burden of proof.

Insurance Law > General Liability Insurance > Obligations > Cooperation

[HN13] Whether an insured violated a cooperation clause is determined in light of the facts and circum-

tances of the case, but may be decided by the court as a matter of law when the case presents undisputed facts.

Insurance Law > Claims & Contracts > Disclosure Obligations > General Overview

Insurance Law > Property Insurance > Coverage > Arson & Intentional Loss > Evidence of Arson

[HN14] An insured's financial position is relevant to establishing motive for arson.

Insurance Law > Claims & Contracts > Disclosure Obligations > General Overview

Insurance Law > Property Insurance > Coverage > Arson & Intentional Loss > Evidence of Arson

[HN15] Income tax records are relevant to an arson defense.

Insurance Law > General Liability Insurance > Obligations > Cooperation

[HN16] Simply signing a release is not sufficient to withstand summary judgment on the issue of compliance with a cooperation clause in an insurance contract where the insurer has made specific document requests.

Insurance Law > General Liability Insurance > Obligations > Cooperation

[HN17] Failure to produce requested documents such as tax returns and other financial information constitutes a substantial and material breach of the cooperation clause in an insurance policy.

Insurance Law > General Liability Insurance > Obligations > Cooperation

[HN18] In a case of noncompliance with a cooperation clause, prejudice involves material injury to the insurer's ability to contest the merits of the case, or serious impairment in investigating the claim or defending the merits of the case.

Insurance Law > Bad Faith & Extracontractual Liability > Payment Delays & Denials

[HN19] In Ohio, an insurer has a duty to act in good faith in the processing and payment of the claims of its insured. An insurer fails to exercise good faith in the processing of a claim of its insured where its refusal to pay the claim is not predicated upon circumstances that furnish reasonable justification therefor.

COUNSEL: [*1] For John Gaston, Plaintiff: Jeffrey V. Goodman, LEAD ATTORNEY, Warren, OH; John E. Fowler, II, LEAD ATTORNEY, Fowler Law Office, Warren, OH.

For Allstate Insurance Company, Defendant: Margo Stoffel Meola, LEAD ATTORNEY, David Cooper Comstock, Jr., Comstock, Springer & Wilson, Youngstown, OH.

JUDGES: HONORABLE SARA LIOI, UNITED STATES DISTRICT JUDGE.

OPINION BY: SARA LIOI

OPINION

MEMORANDUM OPINION AND ORDER

This case is before the Court on the motion for summary judgment filed by Defendant Allstate Insurance Company ("Allstate" or "Defendant"). Plaintiff filed a response to the motion, and Defendant replied. The motion is ripe for resolution.

I. Factual and Procedural Background

Plaintiff John Gaston ("Gaston" or "Plaintiff"), a resident of Warren, Ohio, purchased an automobile insurance policy for his 1998 Ford F150 pickup truck from Defendant. (Compl. PP 1-3.) Plaintiff's truck allegedly was stolen, and on November 21, 2006, Plaintiff filed a notice of claim and sworn proof of loss with Defendant based upon the loss occasioned by the purported theft. (*Id.* P 5.) On November 27, 2006, the truck was recovered in Mecca, Ohio. It had been burned completely. (*Id.* P 6.) On October 31, 2007, Allstate issued a letter to Plaintiff [*2] denying his claim. (*Id.* P 8.)

Plaintiff filed suit against Defendant in state court alleging breach of contract and bad faith. Defendant removed the case to this Court on the basis of diversity jurisdiction. ¹ Defendant thereafter filed the instant motion seeking summary judgment on the basis that Plaintiff failed to cooperate with the claim investigation as he was required to do under the terms of the policy. Plaintiff opposed the motion, claiming that he did cooperate fully with Defendant's investigation or, alternatively, genuine issues of material fact exist as to Plaintiff's compliance.

¹ It is undisputed that, for purposes of diversity jurisdiction, Defendant is a citizen of Illinois. (See Def.'s Answer, Doc. No. 4, P 1.)

II. Law and Analysis

A. Standard of Review

[HN1] The function of summary judgment is to dispose of claims without trial when one party is unable to demonstrate the existence of a factual dispute which, if present, would require resolution by a jury or other trier of fact. *Schultz v. Newsweek, Inc.*, 668 F.2d 911, 918 (6th Cir. 1982). *Fed. R. Civ. P. 56(c)* governs summary judgment motions and provides:

[HN2] The judgment sought shall be rendered forthwith if the pleadings, depositions, [*3] answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law [. . .].

Rule 56(e) specifies the materials properly submitted in connection with a motion for summary judgment:

[HN3] Supporting and opposing affidavits shall be made on personal knowledge, shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein [. . .]. The court may permit affidavits to be supplemented or opposed by depositions, answers to interrogatories, or further affidavits. When a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denial of the adverse party's pleading, but the adverse party's response, by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial. If the adverse party does not so respond, summary judgment, if appropriate, shall be entered against the adverse party.

However, [HN4] the movant is not required [*4] to file affidavits or other similar materials negating a claim on which its opponent bears the burden of proof, so long as the movant relies upon the absence of the essential element in the pleadings, depositions, answers to interrogatories, and admissions on file. *Celotex Corp. v. Catrett*, 477 U.S. 317, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986).

[HN5] In reviewing summary judgment motions, this Court must view the evidence in a light most favora-

ble to the non-moving party to determine whether a genuine issue of material fact exists. *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 90 S. Ct. 1598, 26 L. Ed. 2d 142 (1970); *White v. Turfway Park Racing Ass'n*, 909 F.2d 941, 943-44 (6th Cir. 1990). A fact is "material" only if its resolution will affect the outcome of the lawsuit. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986). Determination of whether a factual issue is "genuine" requires consideration of the applicable evidentiary standards. Thus, in most civil cases the Court must decide "whether reasonable jurors could find by a preponderance of the evidence that the [non-moving party] is entitled to a verdict." *Id.* at 252. "[T]here is no issue for trial unless there is sufficient evidence favoring the nonmoving party for a jury to return a verdict for [*5] that party. If the evidence is merely colorable, or is not significantly probative, summary judgment may be granted." *Id.* at 249-50 (citations omitted).

[HN6] Summary judgment is appropriate whenever the non-moving party fails to make a showing sufficient to establish the existence of an element essential to that party's case and on which that party will bear the burden of proof at trial. *Celotex*, 477 U.S. at 322. Moreover, "the trial court no longer has a duty to search the entire record to establish that it is bereft of a genuine issue of material fact." *Street v. J.C. Bradford & Co.*, 886 F.2d 1472, 1479-80 (6th Cir. 1989) (citing *Frito-Lay, Inc. v. Wiloughby*, 274 U.S. App. D.C. 340, 863 F.2d 1029, 1034 (D.C. Cir. 1988)). Rather, the non-moving party is under an affirmative duty to point out specific facts in the record as it has been established which create a genuine issue of material fact. *In re Morris*, 260 F.3d 654, 665 (6th Cir. 2001). The non-movant must show more than a scintilla of evidence to overcome summary judgment. *Street*, 886 F.2d at 1477; it is not enough for the non-moving party to show that there is some metaphysical doubt as to material facts. See *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 106 S. Ct. 1348, 89 L. Ed. 2d 538 (1986).

B. [*6] Breach of Contract -- Insurance Coverage

The policy was issued in Ohio to an Ohio resident, so its interpretation is governed by Ohio law. *Bank of N.Y. v. Janowick*, 470 F.3d 264, 271 (6th Cir. 2006). [HN7] Under Ohio law, an insurance policy is a contract, the interpretation of which is a matter of law. *Alexander v. Buckeye Pipe Line Co.*, 53 Ohio St. 2d 241, 374 N.E.2d 146 (1978). [HN8] Where the contract language is clear and unambiguous, courts must enforce the contract as written and give the words their plain and ordinary meaning. *Cincinnati Indem. Co. v. Martin*, 85 Ohio St. 3d 604, 1999 Ohio 322, 710 N.E.2d 677 (1999).

Allstate asserts that it has no obligation to pay Plaintiff's claim under the terms of the policy because Plaintiff failed to produce certain documents requested by Allstate during its investigation into Plaintiff's claim. Allstate contends that by failing to produce the requested documents, Plaintiff violated the policy provision requiring that he "cooperate with [Allstate] in the investigation, settlement and defense of any claim or lawsuit." (Def.'s Mot. for Summ. J., Ex. A, at 5.) The terms of the policy expressly preclude Plaintiff from bringing suit "unless [*7] there has been full compliance with all policy terms and conditions." (*Id.* at 6.) Allstate contends that Plaintiff's breach was material, thus relieving Allstate of its obligations under the policy.

[HN9] "When [. . .] cooperation is a policy condition, and an insured fails to comply, the insurer may be relieved of further obligation with respect to a claim with which the insured did not cooperate." *Gabor v. State Farm Mut. Auto. Ins. Co.*, 66 Ohio App. 3d 141, 143, 583 N.E.2d 1041 (8th Dist. 1990) (citations omitted). [HN10] "When an insurance company demands information, the policyholder is 'required to make a fair and frank disclosure of information demanded by the company.'" *Id.* (quoting *Luntz v. Stern*, 135 Ohio St. 225, 231, 20 N.E.2d 241 (1939)). [HN11] To avoid liability to the policyholder, the insurer must establish that the failure to cooperate was material and substantial, and resulted in prejudice to the insurer's rights. *Templin v. Grange Mut. Cas. Co.*, 81 Ohio App. 3d 572, 576, 611 N.E.2d 944 (2d Dist. 1992) (citing *State Farm Mut. Auto Ins. Co. v. Holcomb*, 9 Ohio App. 3d 79, 81-82, 9 Ohio B. 99, 458 N.E.2d 441 (9th Dist. 1983)). [HN12] Failure to comply with policy conditions is an affirmative defense, on which the insurer bears the burden of proof. *Ermakora v. Daillakis*, 90 Ohio App. 453, 463, 62 Ohio Law Abs. 307, 107 N.E.2d 392 (8th Dist. 1951). [*8] [HN13] Whether an insured violated the cooperation clause is determined in light of the facts and circumstances of the case, but may be decided by the court as a matter of law when the case presents undisputed facts. *Weller v. Farris*, 125 Ohio App. 3d 270, 274, 708 N.E.2d 271 (2d Dist. 1998).

Because the recovered vehicle exhibited evidence of fire damage, Allstate commissioned a report on the cause and origin of the fire. (Affidavit of Lynn Bostrom, Doc. No. 9-4, P 7.) Forensic mechanic Mark Sargent issued a report indicating that the fire was incendiary in nature, i.e., it bore indicia of arson. (Affidavit of Mark Sargent, Doc. No. 9-3, P 17.) To investigate the possibility of arson, Allstate requested from Plaintiff certain financial documents. Allstate's document requests were very specific; it asked for Plaintiff's (1) income tax returns; (2) bank records for November and December 2006 and January 2007; (3) cellular phone records for November 2006; and (4) estimates to support Plaintiff's damage

claim. (Bostrom Aff., P 11.) Allstate reiterated these requests several times. (*Id.*, PP 10, 12, 14, 16-17.) Plaintiff never complied. (*Id.*, PP 10, 13, 18.) It is undisputed that Plaintiff never provided documents [*9] to satisfy any of Allstate's four specific requests.

In opposing summary judgment, Plaintiff argues ² that he "was willing and able to cooperate with the investigation of the insurance claim." This is beside the point. The plain language of the policy required Plaintiff actually to cooperate, not merely to have a willingness to do so. Thus, it is Plaintiff's actions, not his after-the-fact declaration that he was willing and able to act, by which the Court must judge Plaintiff's compliance with the policy. Allstate requested documents from Plaintiff on numerous occasions. The document requests were perfectly reasonable and relevant to the claim investigation. See *Templin*, 81 Ohio App. 3d at X ([HN14] insured's financial position is relevant to establishing motive for arson); *Moore v. State Farm Fire & Cas. Co.*, 1985 Ohio App. LEXIS 9595, 1985 WL 62876, at *3 (Ohio App. 2d Dist. Dec. 3, 1985) ([HN15] income tax records relevant to arson defense). Allstate set a reasonable deadline for compliance with its requests, provided Plaintiff ample opportunity to respond, and yet received nothing.

2 Much of the argument in Plaintiff's opposition to summary judgment misses the mark entirely. Plaintiff devotes a large portion of his brief [*10] to arguing that he provided "prompt notice" of the claim to Allstate. Allstate, however, acknowledges that it received prompt notice of Plaintiff's claim. Its summary judgment argument is premised solely upon Plaintiff's failure to cooperate with the claim investigation, which has nothing to do with the promptness of the claim notice.

Plaintiff's only contention that he in fact complied with his duty to cooperate is premised upon his signing of a waiver authorizing Allstate to obtain any information it desired. ³ (Affidavit of John Gaston, Doc. No. 12-4, P 3.) However, [HN16] simply signing a release is not sufficient to withstand summary judgment on the issue of compliance with the cooperation clause in an insurance contract where the insurer has made specific document requests. *Great Am. Ins. Co. of N.Y. v. Brock Constr. Co., Inc.*, 2007 U.S. Dist. LEXIS 74807, 2007 WL 2844945, at *5 (E.D. Ky. Sept. 28, 2007) ("authorizing a broad release of documents is not sufficient cooperation where specific documents are requested that are easily capable of being produced by their holder."); see also *Doerr v. Allstate Ins. Co.*, 121 F. App'x 638, 640 (6th Cir. 2005) ("compliance with some of the policy's conditions precedent does [*11] not excuse failure to comply with all of the conditions precedent.")

3 In his affidavit, Plaintiff vaguely asserts that he "has provided to Defendants [. . .] all the requested and required information [. . .]." (Gaston Aff., P 2.) However, nowhere in his opposition to the motion does Gaston claim that he provided the requested tax returns, bank records, phone records, or claim estimates. There is no evidence in the record to suggest that Plaintiff actually provided this specific information, and considerable evidence supplied by Allstate indicates that he did not. The Court finds that no reasonable jury could conclude, based upon the evidence submitted, that Gaston provided the requested documents.

Under the circumstances established by the undisputed facts, the Court finds that Plaintiff failed to cooperate with the investigation as required by the policy. The Court further finds that this failure was a material and substantial breach of Plaintiff's obligations under the policy. Courts have held consistently that [HN17] failure to produce requested documents such as tax returns and other financial information constitutes a substantial and material breach of the cooperation clause in an insurance [*12] policy. *Gabor*, 66 Ohio App. 3d at 145; *Ameduri v. Buckeye Union Ins. Co.*, 1989 Ohio App. LEXIS 1672, 1989 WL 49500, at *6 (Ohio App. 7th Dist. Apr. 28, 1989); *Moore*, 1985 Ohio App. LEXIS 9595, 1985 WL 62876, at *4.

To avoid its obligations under the policy, Allstate also must establish that its ability to defend the claim was prejudiced by Plaintiff's noncompliance. In such cases, [HN18] prejudice involves "material injury to the insurer's ability to contest the merits of the case, or serious impairment in investigating the claim or defending the merits of the case." *Weller*, 125 Ohio App. 3d at 276. Because Allstate reasonably suspected arson, Plaintiff's failure to produce the requested information resulted in material and substantial prejudice to Allstate as a matter of law. *Doerr*, 121 F.App'x at 641-42; see also *Mobley v. Philadelphia Indem. Ins. Co.*, 218 F. App'x 456, 463 (6th Cir. 2007). As in *Doerr*, Plaintiff's refusal to provide documents prevented Allstate from any assessing any

aspect of Plaintiff's involvement in the vehicle fire, including any motive Plaintiff may have had to commit arson. Allstate was precluded from determining the truth or falsity of the claim. This was materially prejudicial to Allstate's investigation.

Consequently, [*13] having satisfied its burden of establishing Plaintiff's noncompliance with the cooperation clause and prejudice resulting therefrom, Allstate is entitled to summary judgment on Plaintiff's claim for coverage under the policy.

C. Bad Faith

[HN19] In Ohio, "an insurer has a duty to act in good faith in the processing and payment of the claims of its insured." *Staff Builders, Inc. v. Armstrong*, 37 Ohio St. 3d 298, 302, 525 N.E.2d 783 (1988). "[A]n insurer fails to exercise good faith in the processing of a claim of its insured where its refusal to pay the claim is not predicated upon circumstances that furnish reasonable justification therefor." *Zoppo v. Homestead Ins. Co.*, 71 Ohio St. 3d 552, 554, 1994 Ohio 461, 644 N.E.2d 397 (1994). In this case, Allstate was justified in denying Plaintiff's claim because, as explained previously, Plaintiff materially breached his obligations under the policy by failing to cooperate with Allstate's investigation. Accordingly, Allstate is entitled to summary judgment on Plaintiff's bad faith claim.

III. Conclusion

For the foregoing reasons, Allstate's motion for summary judgment is **GRANTED**. Plaintiff's complaint is **DISMISSED**. The Court will enter judgment contemporaneously with this memorandum opinion and [*14] order in favor of Allstate.

IT IS SO ORDERED.

Dated: July 31, 2008

/s/ Sara Lioi

HONORABLE SARA LIOI

UNITED STATES DISTRICT JUDGE



THE GOODYEAR TIRE & RUBBER COMPANY, Plaintiff, vs. NATIONAL UNION INSURANCE COMPANY OF PITTSBURGH, et al., Defendants.

CASE NO. 5:08CV1789

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OHIO, EASTERN DIVISION

2011 U.S. Dist. LEXIS 121866

**September 19, 2011, Decided
September 19, 2011, Filed**

PRIOR HISTORY: *Goodyear Tire & Rubber Co. v. Nat'l Union Ins. Co.*, 2009 U.S. Dist. LEXIS 99233 (N.D. Ohio, Oct. 23, 2009)

CASE SUMMARY:

OVERVIEW: Coverage under defendant excess insurer's insurance policy did not attach because the excess insurer's policy coverage attached only after the insurers of the underlying insurance paid in legal currency the full amount of the underlying limit for such policy period, and defendant underlying insurer did not pay, in legal currency, the full amount of its policy limit.

OUTCOME: Motion granted.

LexisNexis(R) Headnotes

Civil Procedure > Summary Judgment > Standards > General Overview

[HN1] A summary judgment shall be granted only if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law. *Fed. R. Civ. P. 56(a)*.

Civil Procedure > Summary Judgment > Burdens of Production & Proof > Movants

[HN2] On a motion for summary judgment, the burden is on the moving party to conclusively show no genuine issue of material fact exists. The moving party must do

so by either pointing to particular parts of materials in the record, including depositions, documents, electronically stored information, affidavits or declarations, stipulations, admissions, interrogatory answers, or other materials or by showing that the materials cited (by the adverse party) do not establish the absence or presence of a genuine dispute, or that an adverse party cannot produce admissible evidence to support the fact. *Fed. R. Civ. P. 56(c)(1)(A), (B)*.

Civil Procedure > Summary Judgment > Standards > Appropriateness

[HN3] A court considering a motion for summary judgment must view the facts and all inferences in the light most favorable to the nonmoving party.

Civil Procedure > Summary Judgment > Burdens of Production & Proof > Nonmovants

[HN4] On a motion for summary judgment, once the movant presents evidence to meet its burden, the nonmoving party may not rest on its pleadings, but must come forward with some significant probative evidence to support its claim.

Civil Procedure > Summary Judgment > Standards > Appropriateness

[HN5] Whether summary judgment is appropriate depends upon whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law.

Civil Procedure > Federal & State Interrelationships > Erie Doctrine

[HN6] A federal court sitting in diversity must apply the substantive law of the forum state.

Contracts Law > Contract Interpretation > General Overview

Contracts Law > Contract Interpretation > Intent Insurance Law > Claims & Contracts > Policy Interpretation > General Overview

Insurance Law > Claims & Contracts > Policy Interpretation > Ordinary & Usual Meanings

[HN7] The Supreme Court of Ohio has instructed that insurance contracts must be construed in accordance with the same rules as other written contracts. Furthermore, words and phrases used in an insurance policy must be given their natural and commonly accepted meaning to the end that a reasonable interpretation of the insurance contract consistent with the apparent object and plain intent of the parties may be determined.

Contracts Law > Contract Interpretation > General Overview

Contracts Law > Contract Interpretation > Intent

[HN8] In Ohio, a court must interpret a contract as a whole. If the language used by the parties in a contract is plain, complete, and unambiguous, the intention of the parties must be gathered from that language, and from that language alone. When the terms of the contract are clear and unambiguous, courts will not in effect create a new contract by finding an intent not expressed in the clear language employed by the parties. In a fully integrated agreement, intentions not expressed in the writing are deemed to have no existence.

COUNSEL: [*1] For Goodyear Tire & Rubber Company, Plaintiff: Steven E. Sigalow, LEAD ATTORNEY, Mark J. Andreini, Sarah F. Suma, Jones Day - Cleveland, Cleveland, OH.

For National Union Fire Insurance Company of Pittsburgh, PA, erroneously named in the Complaint as National Union Insurance Company of Pittsburgh, PA, Defendant: Jeffrey D. Roush, LEAD ATTORNEY, Wilmer, Cutler, Pickering, Hale & Dorr - Dayton, Dayton, OH; Steven G. Janik, LEAD ATTORNEY, Crystal L. Maluchnik, Janik - Cleveland, Cleveland, OH; Kelly H. Rogers, Janik, Cleveland, OH.

For Federal Insurance Company, Defendant: Cara Tseng Duffield, Daniel J. Standish, Wiley Rein, Washington,

DC; Michele L. Jakubs, Patrick M. Watts, Zashin & Rich - Cleveland, Cleveland, OH.

JUDGES: CHRISTOPHER A. BOYKO, United States District Judge.

OPINION BY: CHRISTOPHER A. BOYKO

OPINION

OPINION AND ORDER

CHRISTOPHER A. BOYKO, J.:

This matter comes before the Court upon the Motion (ECF DKT #103) of Defendant Federal Insurance Company ("Federal") for Summary Judgment. For the following reasons, the Motion is granted.

I. FACTUAL BACKGROUND

The Goodyear Tire & Rubber Company ("Goodyear") instituted this lawsuit in July of 2008, and filed its Amended Complaint on March 23, 2009. Count I alleges [*2] breach of directors and officers ("D & O") liability policies issued by National Union Insurance Company of Pittsburgh ("National Union") and Federal; and seeks reimbursement of Goodyear's legal and accounting costs, amounting to approximately \$30 million, incurred in defending numerous securities class action and derivative lawsuits and an SEC investigation. Count II, which sought a declaratory judgment, pursuant to the Declaratory Judgment Act, 28 U.S.C. § 2201, against Federal only, was dismissed by the Court's Opinion and Order issued on October 23, 2009. (ECF DKT #37).

Subject to its terms, conditions and limitations, the National Union Policy has an aggregate limit of liability of \$15 million, and a \$5 million retention for Securities Claims. The Federal Policy has an aggregate limit of liability of \$10 million, that is excess of the National Union Policy limit of liability and applicable retention.

The insuring agreement of the Federal Policy recites:

The Company shall provide the Insureds with insurance during the Policy Period excess of the Underlying Limit. Coverage hereunder *shall attach only after the insurers of the Underlying Insurance shall have paid in legal currency the* [*3] *full amount of the Underlying Limit* for such Policy Period. (Emphasis added).

At Section 3, the Federal Policy further provides:

Only in the event of exhaustion of the Underlying Limit by reason of the insurers of the Underlying Insurance, or the Insureds in the event of financial impairment or insolvency of an insurer of the Underlying Insurance, paying in legal currency loss which, except for the amount thereof, would have been covered hereunder, this policy shall continue in force as primary insurance, subject to its terms and conditions and any retention applicable to the Primary Policy, which retention shall be applied to any subsequent loss in the same manner as specified in the Primary Policy.

In the course of this litigation, on July 16, 2010, Goodyear informed Federal and the Court that it had entered into a settlement with National Union, for \$10 million and some non-monetary considerations.

Following that, the Court overruled as moot all of the parties' pending motions, and granted leave until September 7, 2010 to file renewed dispositive motions, including arguments and applicable law on settlement and exhaustion. (ECF DKT #102). Those motions have been filed and fully briefed. [*4] Federal argues: (1) The Federal Policy does not attach because the National Union Policy was not fully exhausted; (2) The disputed fees did not "result solely" from a "claim" against an insured; (3) The "related claims" provision does not create coverage for Goodyear's internal investigation or the SEC investigation; (4) Goodyear did not seek or obtain Federal's consent to incur the disputed fees; and (5) The disputed fees incurred for Goodyear's overseas internal investigation were not reasonable and necessary to the defense of the litigation or SEC investigation. Goodyear counters: (1) Under Ohio law, a policy condition requiring exhaustion of the limits of another policy before the insurer pays cannot result in a forfeiture of coverage, at least where the insurer has not been prejudiced by the other policy's failure to pay limits; (2) It is uncontested that the disputed defense costs resulted solely from the investigation and defense of a claim; (3) By treating all related claims as having been made at the same time, National Union's clause 7(B) is designed to avoid any issue of "pre-claim" expenses or allocation of defense costs incurred in the defense of the same wrongful act; [*5] (4) Federal has no basis to assert consent as a defense; and (5) Examination of overseas accounting irregularities was necessary to the SEC investigation, and Federal's unsupported assertion to the contrary raises at most a question of fact for the jury.

II. LAW AND ANALYSIS

Civil Rule 56 Standard

[HN1] A summary judgment shall be granted only if "the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." *Fed.R.Civ.P. 56(a)*. [HN2] The burden is on the moving party to conclusively show no genuine issue of material fact exists, *Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986); *Lansing Dairy, Inc. v. Espy*, 39 F.3d 1339, 1347 (6th Cir.1994). The moving party must do so by either pointing to "particular parts of materials in the record, including depositions, documents, electronically stored information, affidavits or declarations, stipulations, admissions, interrogatory answers, or other materials" or by "showing that the materials cited (by the adverse party) do not establish the absence or presence of a genuine dispute, or that an adverse party cannot produce admissible evidence to support the fact." *Fed.R.Civ.P. 56(c)(1)(A)*, [*6] (B). [HN3] A court considering a motion for summary judgment must view the facts and all inferences in the light most favorable to the nonmoving party. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587, 106 S. Ct. 1348, 89 L. Ed. 2d 538 (1986). [HN4] Once the movant presents evidence to meet its burden, the nonmoving party may not rest on its pleadings, but must come forward with some significant probative evidence to support its claim. *Celotex*, 477 U.S. at 324; *Lansing Dairy*, 39 F.3d at 1347. [HN5] Whether summary judgment is appropriate depends upon "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." *Amway Distributors Benefits Ass'n v. Northfield Ins. Co.*, 323 F.3d 386, 390 (6th Cir.2003)(quoting *Anderson*, 477 U.S. at 251-52).

Applicable law

[HN6] A federal court sitting in diversity must apply the substantive law of the forum state. *Erie R.R. Co. v. Tompkins*, 304 U.S. 64, 58 S. Ct. 817, 82 L. Ed. 1188 (1938); *Talley v. State Farm Fire & Cas. Co.*, 223 F.3d 323, 326 (6th Cir.2000). In this case, Ohio law governs.

Contract Interpretation

[HN7] The Supreme Court of Ohio has instructed that "insurance contracts must be construed in accordance with [*7] the same rules as other written contracts." *Hybud Equip. Corp. v. Sphere Drake Ins. Co.*, 64 Ohio St.3d 657, 597 N.E.2d 1096, 1102 (1992), cert. denied, 507 U.S. 987, 113 S. Ct. 1585, 123 L. Ed. 2d 152 (1993). Furthermore, "words and phrases used in an in-

insurance policy must be given their natural and commonly accepted meaning *** to the end that a reasonable interpretation of the insurance contract consistent with the apparent object and plain intent of the parties may be determined." *Gomolka v. State Auto. Mut. Ins. Co.*, 70 Ohio St.2d 166, 436 N.E.2d 1347, 1348 (1982).

[HN8] The Court must interpret the contract as a whole. *Westfield Ins. Co. v. Galatis*, 100 Ohio St.3d 216, 219, 2003 Ohio 5849, 797 N.E.2d 1256 (2003). "If the language used by the parties [in a contract] is plain, complete, and unambiguous, the intention of the parties must be gathered from that language, and from that language alone." Williston on Contracts § 31:4. "When the terms of the contract are clear and unambiguous, courts will not in effect create a new contract by finding an intent not expressed in the clear language employed by the parties." *Shifrin v. Forest City Enterprises, Inc.*, 64 Ohio St.3d 635, 638, 1992 Ohio 28, 597 N.E.2d 499 (1992). In a fully integrated agreement, intentions [*8] not expressed in the writing are deemed to have no existence. *Construction Interior Systems, Inc. v. Marriott Family Restaurants, Inc.*, 984 F.2d 749, 754 (6th Cir. 1993) (quoting *Aultman Hosp. Ass'n v. Community Mut. Ins. Co.*, 46 Ohio St.3d 51, 544 N.E.2d 920 (1989)) (interior citations omitted).

To reiterate, the Federal Policy coverage attaches "only after the insurers of the underlying insurance shall have paid in legal currency the full amount of the underlying limit for such policy period." The parties do not dispute that the underlying insurer, National Union, paid Goodyear \$10 million in settlement; while its policy limit for the relevant coverage period was \$15 million, with a \$5 million self-insured retention.

Goodyear insists that Federal's exhaustion provision is unenforceable, because the interest in enforcing it is outweighed by the strong Ohio public policy favoring settlements. An Ohio appellate panel addressed this principle of public policy, and cited the Ohio Supreme Court's decision in *Bogan v. Progressive Casualty Insurance Co.*, 36 Ohio St.3d 22, 521 N.E.2d 447 (1988), saying:

It is uncontroverted that public policy favors settlement. When parties agree to settle cases, litigation is avoided, costs [*9] of litigation are contained, and the legal system is relieved of the burden of resolving the dispute with the resulting effect of alleviating an already overcrowded docket. When the amount of settlement is less than the policy limits, the unpaid amount may represent a significant savings cost since litigation was avoided or curtailed . . . Thus, separate from the

contract of insurance, considerations of public policy generally favor settlements. *Triplett v. Rosen*, Nos. 92AP-816 & 92AP-817, 1992 Ohio App. LEXIS 6787, 1992 WL 394867, at *18-19 (10th Dist. Dec. 29, 1992).

The Court recognizes this compelling public policy and the line of Ohio cases espousing it; yet, will not go so far as to find Federal's contract provision unenforceable. The Court agrees, first, with Federal's position that this Ohio precedent almost exclusively arose in the context of uninsured/underinsured motorist litigation. The language of those types of policies is clearly distinguishable from the language of the D & O policy before us. Moreover, Ohio state law mandates uninsured/underinsured coverage; thus motivating courts to find coverage wherever possible. There is no similar statutory mandate with regard to business and commercial excess [*10] liability coverage. Thus, although there is a substantial public interest in encouraging settlements, the Court finds an equally potent interest in fostering freedom of contract and holding parties to the agreements they make.

Goodyear further argues that settlement for an amount less than the full limits of the underlying limits is a failure of a condition precedent, which can result in the forfeiture of coverage *only* where the excess insurer is prejudiced. Goodyear contends that Federal is not prejudiced. Goodyear intends to prove it suffered losses exceeding the limits of the underlying National Union Policy; and thus, Federal would only ever have to pay the amount it agreed to pay. The Court does not agree. Federal is indeed prejudiced. It has been required to litigate since the inception of this suit in state court in 2008. Approximately two years ago, Federal briefed, and successfully obtained, dismissal of Count II of the Complaint for Declaratory Judgment on the exhaustion provision. Federal, National Union and Goodyear attempted mediation, pursued vigorous discovery, and briefed summary judgment. Then, following the settlement with National Union, the summary judgment briefing [*11] was repeated, leading the Court to this stage. Would these significant litigation efforts have been necessary *but for* Goodyear's insistence that the underlying policy limits were exhausted by a less-than-the-limits settlement?

Placing itself in the shoes of an insurer for a moment, the Court recognizes the realities of defining the scope of coverages and setting premiums accordingly. Certainly, the potential exposure of an excess insurance provider and the triggering point of that exposure inform the calculus used in setting the premiums the insured will be charged. Will coverage be triggered by losses

amounting to \$20 million ... \$15 million ... or \$10 million? An excess insurer, in the Court's opinion, is entitled to at least that degree of certainty. Here, Federal's expectation was a triggering point of \$15 million plus the \$5 million self-insured retention. Federal based the premium it charged Goodyear on that expectation, not some lesser amount. Therefore, Federal has suffered real prejudice.

Goodyear and Federal are commercial enterprises of such size and quality as to presumably possess a high degree of sophistication in matters of contract. Each has the ability to retain highly [*12] competent counsel, skilled in negotiating and/or drafting insurance contract terms and advising on the impact of inserting or deleting coverage provisions. Additionally, in this free market society, Goodyear could have "shopped around" to other excess insurance providers for a different, broader exhaustion clause.

Finally, in the Court's view, the plain language of the Federal Policy's insuring clause ? "the full amount of the underlying limit" -- does not mean "some lesser amount" or "partial amount," nor does it contemplate the insured "filling the gap" or "crediting the difference."

III. CONCLUSION

Therefore, the Court finds, as a matter of law, that coverage under the Federal Policy does not attach because the underlying insurer, National Union, did not pay, in legal currency, the full amount of its Policy limit. Since the clear and plain language of the Federal Policy's insuring clause drives this Court's conclusion, the Court need not address any other issues, including claims or related claims, consent, and reasonable and necessary expenses and costs. The Motion (ECF DKT #103) of

Defendant Federal Insurance Company for Summary Judgment is granted. The Amended Complaint of Plaintiff [*13] Goodyear Tire & Rubber Company is dismissed. The Motion (ECF DKT #108) of Plaintiff Goodyear Tire & Rubber Company for Partial Summary Judgment is denied. The Motion (ECF DKT #123) of Defendant Federal Insurance Company to Strike the Expert Report and Exclude the Testimony of Tom Baker is denied as moot.

IT IS SO ORDERED.

DATE: September 19, 2011

/s/ Christopher A. Boyko

CHRISTOPHER A. BOYKO

United States District Judge

JUDGMENT

The Court has filed its OPINION AND ORDER in the above-captioned matter, granting the Motion of Defendant Federal Insurance Company for Summary Judgment and dismissing the Amended Complaint of Plaintiff Goodyear Tire & Rubber Company. Accordingly, this action is terminated pursuant to *Federal Rule of Civil Procedure 58*.

IT IS SO ORDERED.

DATE: 9/19/11

/s/ Christopher A. Boyko

HONORABLE CHRISTOPHER A. BOYKO

UNITED STATES DISTRICT JUDGE



2 of 13 DOCUMENTS

GREAT AMERICAN INSURANCE COMPANY, an Ohio Corporation, Plaintiff, v. BALLY TOTAL FITNESS HOLDING CORPORATION, Defendant and Third-Party Plaintiff, v. RLI INSURANCE COMPANY; TRAVELERS INDEMNITY COMPANY (as successor-in-interest by merger to Gulf Insurance Company); FIREMAN'S FUND INSURANCE COMPANY; and ACE AMERICAN INSURANCE COMPANY, Third-Party Defendants. ACE AMERICAN INSURANCE COMPANY, Third-Party Defendant and Counterclaimant, v. GEORGE N. ARONOFF; PAUL TOBACK; JOHN H. DWYER; LEE S. HILLMAN; STEPHEN C. SWID; JAMES McANALLY; J. KENNETH LOOLOIAN; LIZA M. WALSH; ANNIE P. LEWIS, as Executor of the Estate of AUBREY C. LEWIS, Deceased; THEODORE NONCEK; GEOFF SCHEITLIN; JOHN H. WILDMAN; JOHN W. ROGERS, JR.; and MARTIN E. FRANKLIN, Additional Defendants on Counterclaim.

No. 06 C 4554

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

2010 U.S. Dist. LEXIS 61553

**June 22, 2010, Decided
June 22, 2010, Filed**

COUNSEL: [*1] For Great American Insurance Company, an Ohio Corporation, Plaintiff: Robert Bruce Baker, LEAD ATTORNEY, Leonard Steven Surdyk, Surdyk & Baker, Chicago, IL.

For Bally Total Fitness Holding Corporation, a Delaware Corporation, Defendant: Norman T. Finkel, LEAD ATTORNEY, William R. Klein, Schoenberg, Finkel, Newman & Rosenberg, LLC, Chicago, IL; Steven Ross Gilford, LEAD ATTORNEY, Sheri D. Davis, Proskauer Rose LLP (70W), Chicago, IL.

For Bally Total Fitness Holding Corporation, Third Party Plaintiff: Steven Ross Gilford, LEAD ATTORNEY, Sheri D. Davis, Proskauer Rose LLP (70W), Chicago, IL; Norman T. Finkel, Schoenberg, Finkel, Newman & Rosenberg, LLC, Chicago, IL.

For RLI Insurance Company, Third Party Defendant: David Michael Goldhaber, Sedgwick, Detert, Moran & Arnold, Chicago, IL; Michael R. Davison, Susan Koeh-

ler Sullivan, Sedgwick, Detert, Moran & Arnold, LLP, Los Angeles, CA.

For Travelers Indemnity Company, Third Party Defendant: Luke P. Sheridan, LEAD ATTORNEY, Kristine S Phillips, O'Hagan Spencer, L.L.C., Chicago, IL; Benjamin L. Schiffman, Gregg D. Minkin, James Walsh, London Fischer LLP, New York, NY; Elizabeth M Dillon, Kevin Michael O'Hagan, O'Hagan Spencer, LLC, Chicago, IL.

For [*2] Ace American Insurance Company, Third Party Defendant: Christopher A Wadley, Edward P. Gibbons, LEAD ATTORNEYS, Tiffany Suzan Saltzman-Jones, Neil E. Holmen, Walker, Wilcox, Matousek LLP, Chicago, IL.

For Fireman's Fund Insurance Co, Third Party Defendant: James Richard Murray, LEAD ATTORNEY, Tressler, Soderstrom, Maloney & Priess, Chicago, IL; Thomas Kevin Hanekamp, LEAD ATTORNEY, Tressler LLP, Chicago, IL.

For John H. Dwyer, Third Party Defendant: Jerold Sherwin Solovy, LEAD ATTORNEY, Christopher C. Dickinson, Howard Steven Suskin, William Denby Heinz, Jenner & Block LLP, Chicago, IL.

For George N Aronoff, Counter Defendant: Gregory A Markel, Cadwalader, Wickersham & Taft LLP, New York, NY.

For Paul Toback, Counter Defendant: Daniel A. Kaufman, LEAD ATTORNEY, Michael Best & Friedrich LLP (Illinois), Chicago, IL; Carrie A. Hall, Michael Best & Friedrich LLP, Chicago, IL.

For John H. Dwyer, Counter Defendant: Jerold Sherwin Solovy, LEAD ATTORNEY, Christopher C. Dickinson, Howard Steven Suskin, William Denby Heinz, Jenner & Block LLP, Chicago, IL.

For Lee S Hillman, Counter Defendant: Gregory A Markel, PRO HAC VICE, Mollie E O'Rourke, PRO HAC VICE, Cadwalader, Wickersham & Taft LLP, New York, [*3] NY; Howard Steven Suskin, Jenner & Block LLP, Chicago, IL.

For Stephen C Swid, Counter Defendant: William Timothy Pruitt, Kirkland & Ellis, LLP, Chicago, IL.

For James McAnally, John W Rogers, Jr., Counter Defendants: Kevin Bernard Dreher, LEAD ATTORNEY, Morgan, Lewis & Bockius LLP, Chicago, IL; Dawn S Pittman, PRO HAC VICE, Morgan Lewis & Bockius LLP, San Francisco, CA.

Theodore Noncek, Counter Defendant, Pro se, Evanston, IL.

For Geoff Scheitlin, Counter Defendant: Phillip Leon Stern, LEAD ATTORNEY, Heather Leigh Freiburger, Neal, Gerber & Eisenberg, Chicago, IL.

For Martin E Franklin, Counter Defendant: Kevin Bernard Dreher, LEAD ATTORNEY, Morgan, Lewis & Bockius LLP, Chicago, IL.

For Ace American Insurance Company, Counter Defendant: Christopher A Wadley, Edward P. Gibbons, LEAD ATTORNEYS, Tiffany Suzan Saltzman-Jones, Neil E. Holmen, Walker, Wilcox, Matousek LLP, Chicago, IL.

For Fireman's Fund Insurance Co., Counter Defendant: James Richard Murray, LEAD ATTORNEY, Tressler, Soderstrom, Maloney & Priess, Chicago, IL; Thomas

Kevin Hanekamp, LEAD ATTORNEY, Tressler LLP, Chicago, IL.

For Bally Total Fitness Holding Corporation, a Delaware Corporation, Counter Claimant: Steven Ross Gilford, [*4] LEAD ATTORNEY, Sheri D. Davis, Proskauer Rose LLP (70W), Chicago, IL.

For Great American Insurance Company, an Ohio Corporation, Counter Defendant: Robert Bruce Baker, LEAD ATTORNEY, Leonard Steven Surdyk, Surdyk & Baker, Chicago, IL.

For Ace American Insurance Company, Counter Claimant: Christopher A Wadley, Edward P. Gibbons, LEAD ATTORNEYS, Tiffany Suzan Saltzman-Jones, Neil E. Holmen, Walker, Wilcox, Matousek LLP, Chicago, IL.

For Travelers Indemnity Company, Counter Claimant: Luke P. Sheridan, LEAD ATTORNEY, Kristine S Phillips, O'Hagan Spencer, L.L.C., Chicago, IL; Benjamin L. Schiffman, James Walsh, London Fischer LLP, New York, NY; Kevin Michael O'Hagan, O'Hagan Spencer, LLC, Chicago, IL.

For Bally Total Fitness Holding Corporation, a Delaware Corporation, Counter Defendant: Steven Ross Gilford, LEAD ATTORNEY, Sheri D. Davis, Proskauer Rose LLP (70W), Chicago, IL.

For RLI Insurance Company, Counter Claimant: David Michael Goldhaber, Sedgwick, Detert, Moran & Arnold, Chicago, IL; Michael R. Davisson, Susan Koehler Sullivan, Sedgwick, Detert, Moran & Arnold, LLP, Los Angeles, CA.

For Fireman's Fund Insurance Co, Counter Claimant: James Richard Murray, LEAD ATTORNEY, Tressler, Soderstrom, [*5] Maloney & Priess, Chicago, IL; Thomas Kevin Hanekamp, LEAD ATTORNEY, Tressler LLP, Chicago, IL.

For Great American Insurance Company, an Ohio Corporation, Cross Claimant: Robert Bruce Baker, LEAD ATTORNEY, Leonard Steven Surdyk, Surdyk & Baker, Chicago, IL.

For Paul Toback, Cross Defendant: Daniel A. Kaufman, LEAD ATTORNEY, Michael Best & Friedrich LLP (Illinois), Chicago, IL; Carrie A. Hall, Michael Best & Friedrich LLP, Chicago, IL; William Timothy Pruitt, Kirkland & Ellis, LLP, Chicago, IL.

For John H. Dwyer, Cross Defendant: Jerold Sherwin Solovy, LEAD ATTORNEY, Christopher C. Dickinson, Howard Steven Suskin, William Denby Heinz, Jenner & Block LLP, Chicago, IL; William Timothy Pruitt, Kirkland & Ellis, LLP, Chicago, IL.

For Lee S Hillman, Cross Defendant: Gregory A Markel, PRO HAC VICE, Mollie E O'Rourke, PRO HAC VICE, Cadwalader, Wickersham & Taft LLP, New York, NY; Howard Steven Suskin, Jenner & Block LLP, Chicago, IL.

For Stephen C Swid, Theodore Noncek, Cross Defendants: William Timothy Pruitt, Kirkland & Ellis, LLP, Chicago, IL.

For James McAnally, John W Rogers, Jr., Cross Defendants: Kevin Bernard Dreher, LEAD ATTORNEY, Morgan, Lewis & Bockius LLP, Chicago, IL; Dawn S Pittman, [*6] PRO HAC VICE, Morgan Lewis & Bockius LLP, San Francisco, CA.

Theodore Noncek, Cross Defendant, Pro se, Evanston, IL.

For Geoff Scheitlin, Cross Defendant: Phillip Leon Stern, LEAD ATTORNEY, Heather Leigh Freiburger, Neal, Gerber & Eisenberg, Chicago, IL; William Timothy Pruitt, Kirkland & Ellis, LLP, Chicago, IL.

For Martin E Franklin, Cross Defendant: Kevin Bernard Dreher, LEAD ATTORNEY, Morgan, Lewis & Bockius LLP, Chicago, IL.

JUDGES: Wayne R. Andersen, United States District Judge.

OPINION BY: Wayne R. Andersen

OPINION

MEMORANDUM OPINION and ORDER

This matter is before the Court on cross motions for summary judgment [224, 234, 235]. Pursuant to 28 U.S.C. § 2201, both parties seek a judicial declaration regarding the contractual interpretation of certain excess insurance policies and the conditions precedent to coverage defined within those policies. Specifically, Defendants Bally Total Fitness Holding Corp. ("Bally"), Lee Hillman, Paul Toback, and John Dwyer (collectively referred to herein as "Insureds") seek a judicial declaration "confirming their entitlement to coverage under two policies of excess directors' and officers' liability insurance, issued by Third Party Defendants ACE American Insurance Company and [*7] Fireman's Fund Insurance

Company, for the array of claims asserted against them and others alleging violations of securities law stemming from Bally's financial restatements." Docket No. 224. In opposition, Third Party Defendants ACE and Fireman's Fund seek a judicial declaration that Insureds' below policy limits settlement with certain other excess insurance carriers, no longer parties to this case, does not satisfy the conditions precedent to coverage defined within the excess insurance policies issued by Third Party Defendants. Docket Nos. 234, 235.

The following clause from the excess insurance policy issued by ACE ("Third Layer Excess Carrier") defines conditions precedent to coverage:

It is expressly agreed that liability for any covered Loss shall attach to the Insurer only after the insurers of the Underlying Policies shall have paid, in the applicable legal currency, the full amount of the Underlying Limit and the Insureds shall have paid the full amount of the uninsured retention, if any, applicable to the primary Underlying Policy.

Similarly, the excess insurance policy issued by Fireman's Fund ("Fourth Layer Excess Carrier") contains the following clause defining conditions [*8] precedent to coverage:

The insurance coverage afforded by the Policy shall apply (1) only in excess of all Underlying Insurance and (2) only after all Underlying Insurance has been exhausted by payment of the total underlying limit of insurance and (3) only if each and every Underlying Insurance Policy has responded by payment of loss as a result of any wrongful act.

Additionally, the policy clarifies "Exhaustion Of Underlying Insurance" as follows:

In the event of exhaustion of all of the limits of insurance of the Underlying Insurance solely as a result of actual payment of loss or losses thereunder, this Policy shall, subject to the Limit of Insurance, terms and conditions of this Policy, apply as Primary Insurance subject to any retention specified in the Primary Policy.

For the following reasons, the Court denies Insureds' motion for summary judgment and grants Third Party Defendants' motion for summary judgment.

BACKGROUND

Bally is a Delaware Corporation with its principal place of business in Chicago, Illinois and operates fitness centers throughout the United States. Lee Hillman and Paul Toback are Bally's former Chief Executive Officers. John Dwyer is Bally's former Chief Financial [*9] Officer.

Insureds have allegedly incurred \$ 33 million in legal costs defending suits arising from Bally's past financial restatements. To cover the alleged legal costs, Insureds sought coverage from their primary directors' and officers' insurance carrier and four excess insurance carriers.

Great American Insurance Company ("Primary Carrier") issued the Primary Policy with a policy limit of \$ 10 million. RLI ("First Layer Excess Carrier") issued the first layer excess directors' and officers' liability insurance policy ("First Layer Excess Policy") with a policy limit of \$ 10 million for claims in excess of \$ 10 million. In other words, the First Layer Excess Carrier is responsible for covered claims between \$ 10 million and \$ 20 million. Gulf ("Second Layer Excess Carrier") issued the second layer excess directors' and officers' liability insurance policy ("Second Layer Excess Policy") with a policy limit of \$ 10 million for claims in excess of \$ 20 million. Third Party Defendant ACE ("Third Layer Excess Carrier") issued the third layer excess directors' and officers' liability insurance policy ("Third Layer Excess Policy") with a policy limit of \$ 10 million for claims in excess of [*10] \$ 30 million. Finally, Third Party Defendant Fireman's Fund Insurance Company ("Fourth Layer Excess Carrier") issued the fourth layer excess directors' and officers' liability insurance policy ("Fourth Layer Excess Policy") with a policy limit of \$ 10 million for claims in excess of \$ 40 million.

After initially filing this suit to invalidate coverage, the Primary Carrier and the First and Second Layer Excess Carriers agreed to contribute \$ 19.5 million towards Insureds' alleged legal costs ("The Settlement"). Most notably, the First Layer Excess Carrier settled with Insureds for \$ 8 million, \$ 2 million less than the policy limit of the First Layer Excess Policy. The Second Layer Excess Carrier settled with Insureds for \$ 1.5 million, \$ 8.5 million less than the policy limit of the Second Layer Excess Policy. In accordance with The Settlement's Voluntary Stipulation of Partial Dismissal, this Court dismissed with prejudice the claims and counterclaims between Insureds and the Primary Carrier and First and Second Layer Excess Carriers. Additionally, The Settle-

ment released the Primary Carrier and the First and Second Layer Excess Carriers from any further coverage obligations.

The Third [*11] and Fourth Layer Excess Carriers refused to settle and contribute anything towards Insureds' alleged legal costs. These carriers claim that they are only liable for coverage after the First and Second Layer Excess Carriers have made payment of covered claims equal to the policy limits of the First and Second Layer Excess Policies. Insureds, on the other hand, claim the Third and Fourth Layer Excess Carriers contracted with the Insureds to cover claims above \$ 30 million irrespective of who makes payment for claims below \$ 30 million. Thus, Insureds claim the Third and Fourth Layer Excess Carriers are still liable for coverage above \$ 30 million.

In response to this disagreement, the Court ordered the parties to brief the following single issue: Does The Settlement preclude Insureds from accessing coverage under the Third and Fourth Layer Excess Policies? Docket No. 229. Each party submitted briefs requesting declaratory judgment clarifying the parties' contractual rights with regards to this issue. Docket Nos. 224, 234, 235. This Court will treat each party's request for judgment as a motion for summary judgment despite not being explicitly titled as such.

For the reasons stated below, [*12] this Court agrees with the Third and Fourth Layer Excess Carriers. The plain language of the Third and Fourth Layer Excess Policies requires that the First and Second Layer Excess Carriers make actual payments of \$ 10 million each in covered claims before Insureds can access coverage provided by the Third and Fourth Layer Excess Policies.

LEGAL STANDARD

Under 28 U.S.C. § 2201, this Court has the authority to "declare the rights and other legal relations of any interested party" who presents "a case of actual controversy." The issues presented in the Defendants' motion for a declaratory judgment are all questions regarding the parties' contractual rights and therefore, can be addressed in a declaratory judgment. In addition, summary judgment is appropriate when, as in this case, there are no disputed issues of material fact and judgment may be entered as a matter of law. See *Fed. R. Civ. P. 56*. The interpretation of an insurance contract is a question of law to be decided by the court. *Zurich Ins. Co. v. Heil Co.*, 815 F.2d 1122 (7th Cir. 1987).

DISCUSSION

Illinois law of contract interpretation provides that the words of an insurance policy should be "given their plain and ordinary meaning." [*13] *Hudson Insurance*

Company, v. Gelman Sciences, Inc., 921 F.2d 92, 94 (7th Cir. 1990). When interpreting an insurance contract, a court must read all of the provisions together, as opposed to reading them in isolation, to determine whether an ambiguity exists. *Id.* A provision is ambiguous if it is subject to more than one reasonable interpretation and in such instances, the provision is interpreted in favor of the insured and against the insurer. *United States Fire Insurance Company v. Schnackenberg et al.*, 88 Ill. 2d 1, 429 N.E.2d 1203, 1205, 57 Ill. Dec. 840 (Ill. 1981). "However, if the provisions of the insurance policy are clear and unambiguous there is no need for construction and the provisions will be applied as written." *Id.*

Insureds insist the Third and Fourth Layer Excess Policies are ambiguous as to whether the First and Second Layer Excess Carriers must make actual payments of \$ 10 million each in covered claims prior to Insureds accessing coverage under the Third and Fourth Layer Excess Policies. Insureds claim the Third and Fourth Layer Excess Carriers contracted with the Insureds to cover claims in excess of \$ 30 million and the risk insured by the Third and Fourth Excess Policies is the same regardless [*14] of who makes payment for covered claims under \$ 30 million. Thus, Insureds maintain this Court should declare that Insureds can still access coverage under the Third and Fourth Layer Excess Policies.

Insureds base their argument on *Zeig v. Mass. Bonding & Ins. Co.*, 23 F.2d 665 (2d Cir. 1928) and subsequent case law. In *Zeig*, plaintiff sought coverage under plaintiff's primary and excess insurance policies for an array of unspecified claims. *Id.* Plaintiff settled with the primary carriers for \$ 6,000, \$ 7,000 less than the policy limit. *Id.* Plaintiff then brought suit against the excess carrier, the defendant, seeking coverage for claims in excess of \$ 15,000. *Id.* The plaintiff's excess insurance policy contained the following clause:

[This] policy is issued and accepted:
As excess and not contributing insurance,
and shall apply and cover only after all
other insurance herein referred to shall
have been exhausted in payment of claims
to the full amount of the expressed limits
of such other insurance.

The defendant claimed the above clause required the primary insurance carriers to make actual payments equal to the full policy limits of the primary insurance policies prior to the plaintiff [*15] seeking coverage under the excess insurance policy. *Id.* at 666. However, the Second Circuit found the phrase "payment of claims to the full amount of the expressed limits" ambiguous.

Id. "[P]ayment", according to the Second Circuit, could refer to actual payment or "satisfaction of a claim by compromise, or in other ways." *Id.* Additionally, the Second Circuit was troubled by the policy's failure to mention "'collection' of the full amount of the primary insurance." *Id.* Thus, the Second Circuit found the clause quoted above ambiguous and held that plaintiff's excess insurance carrier was still liable for coverage despite plaintiff's settlement with the underlying insurance carriers. *Id.*

Cases following *Zeig's* line of reasoning typically examine whether an excess insurance policy clearly defines how the underlying policies must be exhausted. See *Comerica v. Zurich American Ins. Co.*, 498 F.Supp.2d 1019, 1030 (E.D. Mich. 2007) (listing the various cases following *Zeig's* line of reasoning). Generally, an excess insurance policy defines exhaustion of an underlying policy by declaring the conditions precedent to coverage that must be satisfied prior to liability for covered claims passing from [*16] an underlying insurance policy to an excess insurance policy. *Id.* Once liability has passed to the excess policy and the underlying policies no longer have any obligations to make payment for covered claims, the underlying policies are considered exhausted. *Id.*

If an excess insurance policy ambiguously defines exhaustion, as in *Zeig*, courts generally find that settlement with an underlying insurer exhausts the underlying policies. *Id.* However, in cases when the policy language clearly defines exhaustion, the courts tend to enforce the policy as written. *Id.* Even the Second Circuit in *Zeig* noted that parties are free to clearly define how an underlying policy must be exhausted and can preclude settlement as a method of exhaustion. 23 F.2d at 666.

In this case, the Third Layer Excess Policy clearly defines how the underlining insurance must be exhausted prior to Insureds accessing coverage under the Third Layer Excess Policy. The policy defines the method of exhaustion as actual payment by the "insurers of the Underlying Policies." The policy defines the "Underlying Policies" as the Primary Policy and the First and Second Layer Excess Policies. The payment amount is "the full amount of [*17] the Underlying Limit" and is specifically defined as the combined aggregate of the underlying policy limits (i.e. \$ 30 million). Unlike the policy language in *Zeig*, the Third Layer Excess Policy's plain language is not ambiguous regarding the manner in which the underlying insurance policies must be exhausted. Thus, this Court, in accordance with well-established Illinois law, must enforce the plain language as written. *Hudson Insurance Co.*, 921 F.2d at 94.

Similarly, the Fourth Layer Excess Policy contains clear language specifying how the First, Second, and

Third Layer Excess Policies must be exhausted prior to Insureds accessing coverage under the Fourth Layer Excess Policy. Again, the policy defines the method of exhaustion as the "actual payment of loss or losses thereunder" by "all Underlying Insurance." The policy defines "Underlying Insurance" explicitly as the Primary Policy and the First, Second, and Third Layer Excess Policies. The payment amount is the "total underlying limit of insurance" and is explicitly defined as the combined aggregate policy limits of the Primary Policy plus the First, Second, and Third Excess Layer Policies (i.e. \$ 40 million). Again, unlike the policy [*18] language in *Zeig*, the Fourth Layer Excess Policy's plain language is not ambiguous regarding the manner in which the underlying insurance policies must be exhausted. Thus, this court must enforce the policy as written. *Hudson Insurance Co.*, 921 F.2d at 94.

DECLARATION

This Court holds that the Third Layer Excess Policy requires that the Primary Carrier and the First and Second Layer Excess Carriers themselves must make actual payment of \$ 10 million each for covered claims, pursuant to the Primary Policy and the First and Second

Layer Excess Policies, prior to Insureds accessing coverage provided by the Third Layer Excess Policy.

Also, this Court holds that the Fourth Layer Excess Policy requires that the Primary Carrier and the First, Second, and Third Layer Excess Carriers themselves must make actual payment of \$ 10 million each for covered claims, pursuant to the Primary Policy and the First, Second, and Third Excess Layer Policies, prior to Insureds accessing coverage provided by the Fourth Layer Excess Policy.

CONCLUSION

For all the foregoing reasons, the Insureds' motion for summary judgment is denied [224] and the Third Party Defendants' motion for summary judgment is granted [234, [*19] 235].

It is so ordered.

/s/ Wayne R. Andersen

Wayne R. Andersen

United States District Judge

Dated: June 22, 2010



**HLTH CORPORATION and EMDEON PRACTICE SERVICES, INC., Plaintiffs,
v. AGRICULTURAL EXCESS AND SURPLUS INSURANCE COMPANY; CER-
TAIN UNDERWRITERS AT LLOYD'S, LONDON; CLARENDON NATIONAL
INSURANCE COMPANY; FEDERAL INSURANCE COMPANY; GREAT
AMERICAN INSURANCE COMPANY; GULF INSURANCE COMPANY N/K/A
THE TRAVELERS INDEMNITY COMPANY; NEW HAMPSHIRE INSURANCE
COMPANY; OLD REPUBLIC INSURANCE COMPANY SAFECO INSURANCE
COMPANY OF AMERICA; ZURICH AMERICAN INSURANCE COMPANY,
Defendants.**

C.A. No. 07C-09-102 RRC

SUPERIOR COURT OF DELAWARE, NEW CASTLE

2008 Del. Super. LEXIS 280

May 5, 2008, Submitted

July 31, 2008, Decided

SUBSEQUENT HISTORY: Motion granted by *HLTH Corp. v. Axis Reinsurance Co.*, 2009 Del. Super. LEXIS 99 (Del. Super. Ct., Mar. 23, 2009)

DISPOSITION: [*1] On Defendant Federal Insurance Company's "Motion for Partial Summary Judgment on Allocation." DENIED. On Plaintiffs' "Motion for Partial Summary Judgment to Enforce [Certain Defendant Insurance Companies'] Duty to Advance and Reimburse Defense Costs." GRANTED.

CASE SUMMARY:

PROCEDURAL POSTURE: Plaintiff insureds filed an action against defendant insurers for declaratory relief and breach of contract. The insureds filed a motion for partial summary judgment to enforce the insurers' duties to advance and reimburse defense costs. The insurers filed a cross-motion for partial summary judgment, arguing that the law required an allocation between the insurance coverage of the costs of defending covered and uncovered matters.

OVERVIEW: A corporation was acquired by another company, which was acquired by the insureds. Each company had a tower of insurance. A grand jury returned an indictment against former directors and officers of the corporation. The insureds indemnified the officers for

their costs in defending the indictment. They argued that the insurers had a duty to advance defense costs. The superior court held that allocation of defense costs prior to the final disposition of the underlying claim was not required in the absence of contract language requiring it. The insureds purchased additional "run-off reporting coverage," and all towers of coverage had been triggered. Therefore, they could elect to collect payments in advance from any tower. Because the towers of coverage had been triggered, the insurers could not demonstrate that all of the allegations in the indictment fell outside of the coverage periods of their respective towers, and they had to advance defense costs. To the extent that the insureds' defense costs exceeded any loss they could have imposed on themselves by accepting settlements with underlying insurers for less than the policy limit, those underlying policies had been exhausted.

OUTCOME: The superior court denied the insurers' motion for partial summary judgment on allocation and granted the insureds' motion for partial summary judgment to enforce the insurers' duty to advance and reimburse defense costs.

LexisNexis(R) Headnotes

Civil Procedure > Summary Judgment > Motions for Summary Judgment > Cross-Motions

Civil Procedure > Summary Judgment > Standards > General Overview

[HN1] Upon cross motions for summary judgment, a court will grant summary judgment to one of the moving parties. No genuine issues of material fact exist as a matter of law where opposing parties have each sought summary judgment. Del. Super. Ct. R. Civ. P. 56(h).

Civil Procedure > Summary Judgment > Motions for Summary Judgment > Cross-Motions

[HN2] See Del. Super. Ct. R. Civ. P. 56(h).

Civil Procedure > Federal & State Interrelationships > Choice of Law > General Overview

[HN3] Absent any conflict, a court may apply general principles that are consistent with the law of either jurisdiction.

Insurance Law > Claims & Contracts > Costs & Attorney Fees > General Overview

[HN4] In the absence of contract language that would require it, allocation of defense costs prior to the final disposition of an underlying claim is not required.

COUNSEL: David J. Baldwin, Esquire and Jennifer C. Wasson, Esquire, Potter Anderson Corroon LLP, Wilmington, Delaware; William G. Passannante, Esquire, Anderson, Kill and Olick, P.C., New York, New York; James J. Fournier, Esquire, Anderson, Kill and Olick, P.C., Washington, D.C., Attorneys for Plaintiffs HLTH Corporation and Emdeon Practice Services, Inc.

Timothy J. Houseal, Esquire and Martin S. Lessner, Esquire, Young Conaway Stargatt & Taylor, LLP, Wilmington, Delaware; Joseph G. Finnerty, III, Esquire, Megan K. Vesely, Esquire and Eric S. Connuck, Esquire, DLA Piper US LLP, New York, New York, Attorneys for Defendant Federal Insurance Company.

James W. Semple, Esquire, Matthew F. Lintner, Esquire and Jason C. Jowers, Esquire, Morris James LLP, Wilmington, Delaware; Edward J. Kirk, Esquire and J. Gregory Lahr, Esquire, Sedgwick, Detert, Moran & [*2] Arnold LLP, New York, New York, Attorneys for Defendant Certain Underwriters at Lloyd's, London.

Kevin F. Brady, Esquire, Connolly Bove Lodge & Hutz LLP, Wilmington, Delaware; Gary V. Dixon, Esquire, John W. Duchelle, Esquire and Meredith E. Werner, Esquire, Ross, Dixon & Bell LLP, Washington, D.C., At-

torneys for Defendant Clarendon National Insurance Company.

David P. Primack, Esquire and Janet R. McFadden, Esquire, Drinker Biddle & Reath LLP, Wilmington, Delaware, Attorneys for Defendant Gulf Insurance Company n/k/a The Travelers Indemnity Company.

John D. Balaguer, Esquire, White and Williams LLP, Wilmington, Delaware; Michael S. Loeffler, Esquire, Loeffler Thomas Touzalin LLP, Northbrook, Illinois, Attorneys for Defendant New Hampshire Insurance Company.

Neal J. Levitsky, Esquire and Seth A. Niederman, Esquire, Fox Rothschild LLP, Wilmington, Delaware; Michael Goodstein, Esquire and Matthew J. Burkhart, Esquire, Bailey Cavaliere LLC, Columbus, Ohio, Attorneys for Defendant Old Republic Insurance Company.

J. Scott Shannon, Esquire, Marshall, Dennehey, Warner, Coleman & Goggin, Wilmington, Delaware; Robert W. Jozwik, Esquire, Marshall, Dennehey, Warner, Coleman & Goggin, Philadelphia, [*3] Pennsylvania, Attorneys for Defendant Safeco Insurance Company of America.

JUDGES: Richard R. Cooch, J.

OPINION BY: Richard R. Cooch

OPINION

MEMORANDUM OPINION

COOCH, J.

I. INTRODUCTION

This Court is called upon to address Plaintiffs' and Defendants' cross motions for partial summary judgment in this insurance coverage case. The parties agree that there are no genuine issues of material fact in dispute. The issue in this case is whether the Court must allocate the defense costs of Plaintiffs' former directors and officers, while a criminal case against them is ongoing, across the multiple towers of directors' and officers' liability insurance purchased by Plaintiffs and in the absence of contract language that would require it. The issue at hand is not where the defense costs will ultimately lie but rather is which company or companies contracted to be exposed to the present risk of funding the Plaintiffs' directors' and officers' defenses during litigation that implicates coverage.

Given the complexity of the underlying facts of this case and the resulting latticework of issues of law which they create, neither the Court nor the parties have identi-

fied any precedent from any jurisdiction that squarely answers the questions [*4] raised. Defendants argue that New Jersey law, by purportedly requiring allocation at this juncture, resolves this issue in their favor, but the Court concludes that there is no true conflict between the law of Delaware and that of New Jersey with respect to this issue.

Therefore, and for reasons discussed below, having duly considered the applicable contract language, case law, public policy and the parties' respective arguments, the Court **DENIES** Defendant Federal Insurance Company's "Motion for Partial Summary Judgment on Allocation" and **GRANTS** Plaintiffs' "Motion for Partial Summary Judgment to Enforce [Certain Defendant Insurance Companies'] Duty to Advance and Reimburse Defense Costs."

II. BACKGROUND

A. FACTS'

1 The factual background of the case (including footnotes) has been taken in its entirety and nearly verbatim from the "Joint Statement of Undisputed Facts" submitted at the request of the Court by Plaintiffs and Defendants on May 30, 2008. Docket 70.

Also on that day, Plaintiffs filed an additional document: "Plaintiffs' Statement of Uncontroverted Facts Not Stipulated to by Defendants." This pleading, unsolicited by the Court, has not been considered in the Court's decision [*5] and is not a part of the factual background provided here. Docket 71.

The following defendant insurance companies joined in Federal's Motion for Partial Summary Judgment on Allocation ("Federal's Motion"): Travelers, Clarendon, Lloyd's, Old Republic and Safeco.

HLTH's Motion for Partial Summary Judgment on the Defendant Insurance Companies Duty to Advance Defense Costs is directed to Defendants Federal, Travelers, Clarendon, Lloyd's and New Hampshire. A slightly different set of defendant insurance companies joined in Federal's Opposition to Plaintiffs' Motion for Partial Summary Judgment on the Defendant Insurance Companies' Duty to Advance Defense Costs ("Opposition"): New Hampshire, Travelers, Clarendon and Lloyd's. Old Republic and Safeco did not join in Federal's Opposition. New Hampshire did not join in Federal's Motion.

The defendant insurance companies are collectively referred to as "Federal" or the "defendant insurance companies." The insurance policy that Federal sold to Plaintiffs for which Plaintiffs seek insurance coverage is referred to as the "Federal Policy."

1. Medical Manager Corporation ("MMC") was formed in July 1996 and, prior to July 23, 1999, was an independent, [*6] publicly-traded company. MMC's primary business was the development and sales of computer software to assist healthcare providers in managing their healthcare practices.

2. On July 23, 1999, MMC was acquired by Syntec, Inc. ("Syntec"), which assumed the name Medical Manager Corporation ("New MMC") and changed the name of its wholly-owned subsidiary MMC to Medical Manager Health Systems, Inc. The following year, on September 12, 2000, Syntec/New MMC was acquired by Healtheon WebMD Corporation, which was subsequently renamed Emdeon Corporation ("Emdeon") and most recently changed its name to HLTH Corporation.

3. Each of the companies, MMC, Syntec and Emdeon, had its own program of D&O insurance, referred to here as a "tower." The tower of insurance maintained by MMC, as a stand-alone company, is referred to herein as the "MMC Tower." The tower of insurance maintained by Syntec is referred to herein as the "Syntec Tower." The tower of insurance maintained by Emdeon is referred to herein as the "Emdeon Tower."

4. The MMC Tower provides a total of \$ 20 million in coverage.

5. The MMC policies state:

If during the Policy Period (i) the Parent Company [MMC] is acquired by merger into or consolidation [*7] with another entity, or (ii) another entity, or person or group of entities and/or persons acting in concert acquires securities or voting rights which result in ownership or voting control by the other entity(ies) or person(s) of more than 50% of the outstanding securities representing the present right to vote for the election of directors of the Parent Company, then coverage under this Policy shall continue until termination of the Policy Period, but only with respect to Claims for Wrongful Acts taking place prior to such merger, consolidation or acquisition.

Syntec's acquisition of MMC occurred on July 23, 1999.

6. Federal did not participate in the MMC Tower.

7. The Synetic Tower provides a total of \$ 100 million in coverage.

8. The Synetic policies state:

In all events, coverage as is afforded under this policy with respect to any Claim made against a Subsidiary or any Director or Officer thereof shall only apply for Wrongful Acts committed or allegedly committed after the effective time that such Subsidiary became a Subsidiary and prior to the time that such Subsidiary ceased to be a Subsidiary.

MMC became a Subsidiary, as that term is defined in the Synetic policies on July 23, [*8] 1999.

9. The Synetic policies also state:

[If Synetic] (a)...shall consolidate with or merge into, or sell all or substantially all of its assets to any other person or entity, or group of persons and/or entities acting in concert...herein referred to as the Transaction...then this policy shall continue in full force and effect as to Wrongful Acts occurring prior to the effective time of the Transaction, but there shall be no coverage afforded by any provision of this policy for any actual or alleged Wrongful Act occurring after the effective time of the Transaction.

Synetic was acquired by Emdeon on September 12, 2000.

10. The period during which claims may be reported under the Synetic Tower commenced on December 14, 1997 and initially ended on December 14, 2000, but HLTH purchased an endorsement to the Synetic policies when it acquired Synetic (and MMC) that extends the period during which claims may be reported for a period of six years following the merger until September 12, 2006. The endorsement states in part:

RUN-OFF ENDORSEMENT (SELLER/BUYER MERGER)

In consideration of the additional premium of \$ 241,552 it is hereby understood and agreed that as of the time and date designated as the [*9] effective time of the merger or acquisition (herei-

nafter the "Effective Time") in the merger agreement or plan of merger or similarly titled contract executed by and between MEDICAL MANAGER CORPORATION f/k/a SYNETIC, INC. and HEALTHEON WebMD CORPORATION, dated as of September 12, 2000 including any amendments or revisions thereto, (hereinafter the "Merger Agreement") the following provisions shall apply and be added to the policy:

RUN-OFF COVERAGE CLAUSE

The Named Corporation shall have the right to a period of time Six (6) years commencing on the Effective Time (herein referred to as the Discovery Period or Run-off Coverage) in which to give written notice to the Insurer of any Claim(s) first made against any Insured(s) during said Run-off Coverage for any Wrongful Act(s) occurring on or prior to the Effective Time and otherwise covered by this policy.

11. The Synetic policies define "Wrongful Act" as the following:

[A]ny breach of duty, neglect, error, misstatement, misleading statement, omission or act by the Directors or Officers of the Company in their respective capacities as such, or any matter claimed against them solely by reason of their status as Directors or Officers [*10] of the Company.

12. The Synetic policies also state:

[E]xcept as hereinafter stated, the Insurer shall advance, at the written request of the Insured, Defense Costs prior to the final disposition of a Claim. Such advanced payments by the Insurer shall be repaid to the Insurer by the Insureds or the Company severally according to their respective interests, in the event and to the extent that the Insured or the Company shall not be entitled under the terms and conditions of this policy to payment of such Loss.

13. The Emdeon Tower provides a total of \$ 70 million in coverage.

14. The Emdeon policies state:

In all events, coverage is afforded under this policy with respect to a Claim made against any Organization and/or any Insured Person thereof shall only apply for Wrongful Acts committed or allegedly committed after the effective time such Organization became an Organization and such Insured Person became an Insured Person, and prior to the effective time that such Organization ceases to be an Organization or such Insured Person ceases to be an Insured Person.

Emdeon acquired Synetic on September 12, 2000.

15. On December 15, 2005, a federal grand jury returned a first superseding indictment [*11] against ten former MMC directors and officers for allegedly participating in a conspiracy to inflate fraudulently MMC's earnings between 1997 and 2001 and for money laundering.

16. On February 27, 2007, the grand jury returned a Second Superseding Indictment, which omitted one defendant, Maxie L. Juzang (the "Indictment"). The Indictment includes many of the same substantive facts and charges as the first superseding indictment, including allegations of a conspiracy to commit securities, mail, and wire fraud between February 1997 and at least 2003 (Count 1) and a money laundering conspiracy between 1997 and at least 2004 (Count 2).

17. The Indictment names nine defendants all of whom were directors or officers of MMC (Maxie Juzang was dismissed from the case) and contains seven counts. Count One alleges that the defendants conspired to commit wire fraud, mail fraud and securities fraud, in violation of 18 U.S.C. § 371, by fraudulently inflating the earnings of MMC and WebMD and concealing their fraudulent conduct by making false statements in public filings and to auditors. Count Two alleges a money laundering conspiracy, 18 U.S.C. § 1956(h), in that the defendants agreed to engage in [*12] monetary transactions with proceeds from sales of MMC stock made at fraudulently inflated prices. Counts Three through Seven allege substantive money laundering crimes, in violation of 18 U.S.C. § 1957. All nine defendants are charged in the first two counts, and only defendant John Sessions is charged in the five substantive money laundering counts.

There is also a forfeiture allegation against all nine defendants, which seeks disgorgement of \$ 34,346,974 "representing the total proceeds from the conspiracy...alleged in Count 1."

18. The Indictment remains pending and counsel for the indicted former officers and directors of MMC recently has informed the parties that a trial date of February 2, 2009 has been set. Each of the MMC officers has expressly denied any wrongdoing and has entered a plea of "Not Guilty" with respect to each and every count of the Superseding Indictment and the Second Superseding Indictment. There has been no adjudication of any wrongdoing alleged in the Indictment.

19. HLTH is indemnifying each of the MMC officers for their costs in defending the Indictment. The Wrongful Acts alleged in the Indictment implicate the MMC Tower, the Synetic Tower and the Emdeon Tower, [*13] and HLTH has provided notice to the insurers under each of these three towers. In this litigation, HLTH asserts claims for coverage only under the MMC Tower and the Synetic Tower and has not asserted claims in this action for reimbursement under the Emdeon Tower, which contains a \$ 10 million deductible. HLTH has reserved its rights under the Emdeon Tower. The limits of the policies in the MMC Tower are no longer available as a result of (a) payment of the \$ 5 million in limits under the primary policy issued by Rock River Insurance Company in the MMC Tower; (b) payment of the \$ 5 million in limits under the first layer excess policy issued by TIG Insurance Company in the MMC Tower; (c) a settlement by HLTH with Zurich, the carrier providing the third layer of \$ 5 million in coverage in the MMC Tower; and (d) a settlement by HLTH with Agricultural Excess & Surplus Insurance Company ("AESIC"), the carrier providing the top layer of \$ 5 million in coverage in the MMC Tower. HLTH's remaining claims in this action are directed only against the insurers in the Synetic Tower.

20. The policy that Federal issued to Synetic states:

Only in the event of exhaustion of the Underlying Limit by reason [*14] of the insurers of the Underlying Insurance, or the insureds in the event of financial impairment or insolvency of an insurer of the Underlying Insurance, paying in legal currency loss which, except for the amount thereof, would have been covered hereunder, this policy shall continue in force as primary insurance, subject to its terms and conditions and any retention applicable to the Primary Policy, which retention shall be applied to any subsequent loss in the same manner as specified

in the Primary Policy. The risk of uncollectability of any Underlying Insurance, whether because of financial impairment of insolvency of art underlying insurer other reason, is expressly retained by the Insureds and is not in any way insured or assumed by the Company.

"Underlying Insurance" is defined in Item 4 of the Declarations of the Federal Policy to mean the \$ 10 million primary policy issued to Synetic by National Union Fire Insurance Company of Pittsburgh, Pa. ("National Union") and the \$ 10 million policy issued to Synetic by Great American. National Union paid the full limits of liability of its insurance policies in the Synetic Tower by paying such amount in legal currency on account of Loss [*15] as defined in the policy.

21. On January 11, 2008, HLTH entered into a settlement agreement with AESIC and a settlement agreement with Great American.

22. Under the terms of the settlement agreement with AESIC, AESIC paid less than \$ 5 million.

23. Under the terms of the settlement agreement with Great American, Great American paid \$ 10 million.

24. On January 11, 2008, AESIC and Great American were and are affiliated companies. Both AESIC and Great American were represented by the same counsel in this action.

25. The defense costs incurred to date in defending the Indictment exceed the limits of the insurance purchased in the MMC Tower.

26. Old Republic's Excess Directors and Officers Liability and Reimbursement Coverage Policy Number CUG 25835 (the "Old Republic Policy"), which is one of the Synetic policies, contains a provision titled "Allocation," which provides:

...[I]f a Claim against the Insured Persons includes both covered and uncovered matters, the Insured Persons, the Company and the Insurer shall use their best efforts to agree upon a fair and proper allocation of any costs, charges, expenses, settlement, judgment or other loss on account of such Claim between covered Loss reasonably [*16] attributable to the Claim against the Insured Persons and uncovered loss. Such allocation between Insured Persons and others shall be based upon the relative exposure of the parties to such Claim, without regard to whether

the liability of any such party is independent of, concurrent with or duplicated by the liability of any other party to such Claim. Such relative exposure shall be determined based upon each party's proportionate liability exposure and other relevant factors.

If the allocation of loss under the Underlying Policies is different than the allocation of loss pursuant to this policy, the allocation of loss under the Underlying Policies shall apply to determine the Insurer's liability attachment under this policy and the allocation of loss pursuant to this policy shall apply to determine the amount of covered Loss excess of the insurer's liability attachment under this policy.

B. PROCEDURAL BACKGROUND

2

2 The procedural background of the case (including footnotes) has been taken in its entirety and nearly verbatim from the "Joint Statement of Procedural History" submitted, at the request of the Court, by Plaintiffs and Defendants on May 28, 2008. Docket 68.

1. On July 25, 2007, [*17] Plaintiffs filed a complaint for declaratory relief and breach of contract in this matter in the Court of Chancery of the State of Delaware (the "Complaint").

2. The Complaint named Agricultural Excess and Surplus Insurance Company n/k/a Great American E&S Insurance Company ("AESIC"), Lloyd's, Clarendon, Federal, Great American Insurance Company ("Great American"), Travelers, Old Republic, Safeco and Zurich American Insurance Company ("Zurich") as defendants.

3. On August 17, 2007, Plaintiffs filed in the Court of Chancery their motion for partial summary judgment against Defendant Zurich, AESIC and Great American to enforce their duties to advance and reimburse defense costs.

4. By stipulation and Order of the Court of Chancery, the matter was transferred to this Court on September 12, 2007.

5. On October 4, 2007, Defendants filed answers to the Complaint, asserting various counterclaims and cross-claims. The counterclaims generally seek declara-

tory judgments to establish the extent, if any, to which Defendants' policies cover the defense costs requested by Plaintiffs. AESIC and Great American asserted cross-claims against the other Defendants, sought rescission of their policies and [*18] filed a third-party complaint against National Union Fire Insurance Company ("National Union").³

3 On October 23, 2007, Travelers filed its answer to AESIC's and Great American's cross-claims. Clarendon, Safeco and Lloyd's filed their answers to these cross-claims on October 24, 2007. On November 13, 2007, Zurich and Old Republic filed answers to the cross-claims.

6. By letter dated December 11, 2007, counsel for Plaintiffs informed the Court that Plaintiffs had reached settlements in principle with the three defendants named in Plaintiffs' motion for partial summary judgment, Zurich, AESIC and Great American.

7. On January 3, 2008, this Court granted Plaintiff's motion for leave to file an amended complaint ("Amended Complaint") in order to join New Hampshire Insurance Company ("New Hampshire") as a defendant. Apart from the addition of New Hampshire as a defendant, the allegations in the Amended Complaint are identical to the allegations in the original Complaint.

8. On January 14, 2008, Federal filed its Motion for Partial Summary Judgment on Allocation. Various defendants joined in Federal's Motion.⁴

4 Clarendon, Travelers, Safeco, Lloyd's and Old Republic joined Federal's Motion. New [*19] Hampshire did not join Federal's Motion.

9. By letter dated January 29, 2008, counsel for Plaintiffs informed the Court that Plaintiffs had executed settlement agreements with Zurich, AESIC, and Great American, thereby rendering moot the Motion for Partial Summary Judgment filed by Plaintiffs on August 17, 2007.

10. On February 29, 2008, Plaintiffs filed a Motion for Partial Summary Judgment to enforce certain defendants' duties to advance and reimburse defense costs.⁵ The Motion names Federal, Travelers, Clarendon, Lloyd's and New Hampshire.

5 New Hampshire, Travelers, Clarendon and Lloyd's joined in Federal's opposition to HLTH's Motion. Old Republic and Safeco did not join in the opposition.

11. On March 31, 2008, New Hampshire answered the Amended Complaint and counterclaimed for declaratory relief. The other defendants remaining in the case

have not responded to the Amended Complaint, and Plaintiffs have not responded to any of Defendants' counterclaims. The parties agreed to file a separate stipulation whereby Defendants' answers, defenses and counterclaims to the Complaint shall be deemed to respond to the Amended Complaint. In addition, the parties agreed that Plaintiffs would [*20] file any reply to Defendants' counterclaims within seven days following the filing of the aforementioned stipulation.

12. On March 31, 2008, Plaintiffs and Zurich filed a Stipulation to (1) dismiss with prejudice Plaintiffs' claims against Zurich American Insurance Policy No. DOC 2156347 02 (policy period January 30, 1999 to January 30, 2000) and Zurich American Insurance Policy No. DOC 2156347 03 (which replaced Policy No. DOC 2156347 02 and was effective for the policy period of July 23, 1999 to July 23, 2005) and (2) dismiss without prejudice Plaintiff's claims against Zurich with respect to Zurich American Insurance Policy No. DOC 3561126 00 (policy period September 12, 2000 to September 12, 2006). SO ORDERED by this Court on April 1, 2008.

13. On May 2, 2008, Plaintiffs and AESIC filed a stipulation to (1) dismiss with prejudice Plaintiffs' claims against AESIC with respect to Great American E&S Insurance Policy No. NSX2422079 (policy period of January 30, 1999 to January 30, 2000) and (2) dismiss with prejudice AESIC's counterclaim against Plaintiffs. SO ORDERED by this Court on May 5, 2008.

14. Also on May 2, 2008, Plaintiffs and Great American filed a stipulation to (1) dismiss [*21] with prejudice Plaintiffs' claims against Great American with respect to Great American Insurance Policy No. DFX0009292 (policy period December 14, 1997 to September 12, 2000, with an extended reporting period to September 12, 2006 for "Wrongful Acts" that occurred prior to September 12, 2000) and (2) dismiss with prejudice Great American's counterclaims against Plaintiffs. SO ORDERED by this Court on May 5, 2008.

15. On May 2, 2008, AESIC and Great American filed a Notice and Order of Dismissal of Crossclaims and Third-Party Complaint without prejudice. SO ORDERED by this Court on May 6, 2008.

16. As a result of the stipulations referenced above in paragraphs 12 through 15, Zurich, AESIC, Great American and National Union are no longer parties to this action.

17. This Court heard oral argument on Plaintiffs' and Defendants' Motions for Partial Summary Judgment on May 5, 2008.

III. THE PARTIES' CONTENTIONS

A. Allocation of Plaintiffs' Directors' and Officers' Defense Costs before Final Disposition of their Criminal Charges

In their Motion for Partial Summary Judgment, Defendants contend that the law governing the contract requires "an allocation [between the three towers of Plaintiffs' insurance [*22] coverage] of the costs of defending covered and uncovered matters." ⁶ As the MMC, Synthetic and Emdeon towers of coverage all "expressly cover[] wrongful acts committed within a distinct period of time," Defendants argue that a proper allocation at this time will allocate defense costs to the appropriate tower of coverage based on "the timing of the wrongful acts alleged in the [i]ndictment." ⁷ Defendants proposed allocation scheme, based on the dates of the alleged overt acts in the indictment, would allocate Plaintiffs' defense costs as follows: 63% to the MMC tower, 23% to the Synthetic tower and 14% to the Emdeon tower. ⁸ In support of their proposed allocation scheme, Defendants assert that Plaintiffs "acquired an entity [i.e. Synthetic f/k/a MMC] that was underinsured" and "may not lawfully shift this uninsured liability to other insurance towers" because the applicable tower of coverage has been exhausted. ⁹

6 Defs. Mot. for Partial Summ. J., at 9.

7 *Id.* at 10, 11.

8 *Id.* at 13.

9 *Id.* at 14.

Plaintiffs contend, with respect to allocation among the three towers, that Defendants have put forth an "arbitrary scheme" that incorrectly equates "the [*23] definition of 'overt act' under conspiracy law principles" with "'Wrongful Act' in the Federal Policy." ¹⁰ Moreover, Plaintiffs argue that allocation based on overt acts alleged in an indictment is unrealistic because "conspiracy is a single crime, and it must be defended as such." ¹¹ Finally, Plaintiffs contend that the absence of "any language in the Federal Policy supporting its allocation theory" bars Defendants from "unilaterally assert[ing] -- after a Claim is made -- an allocation scheme which alters the coverage." ¹²

10 Pls. Opp'n to Defs. Mot. for Partial Summ. J., at 10, 12.

11 *Id.* at 17.

12 *Id.* at 18, 21.

B. Exhaustion of Underlying Policy Limits

As a supplementary argument, Defendants contend that since the "Federal [Policy] provides that coverage does not apply until the full amounts of liability on the two underlying policies have been 'paid in legal currency' by the underlying insurers," Plaintiffs have "failed to

demonstrate that this simple condition to coverage...has been satisfied." ¹³ In reference to Plaintiffs' settlements with some of its carriers, Defendants argue that Plaintiffs are "expressly required by Federal's excess policy" to "demonstrate the exhaustion of th[e] [*24] underlying coverage." ¹⁴ Defendants contend that this type of provision is permissible and enforceable "in order to prevent settlements between an insured and an underlying insurer that attempt to shift risk to higher level insurers that received less premium to cover risk at a higher attachment point." ¹⁵

13 Defs. Opp'n to Pls. Mot. for Partial Summ. J., at 14.

14 *Id.* at 17.

15 *Id.*

Plaintiffs respond that the underlying policies are in fact exhausted by payment in legal currency up to the full policy limits as required by the contract. ¹⁶ In the alternative, Plaintiffs contend that "an excess policy is triggered once the underlying policy is 'functionally exhausted' by settlement[] and the loss exceeds the limits of th[e] underlying policy." ¹⁷ Plaintiffs argue that New Jersey and Delaware courts have held that a strict interpretation of this contract provision, i.e., to require full payment of underlying policies before excess coverage is triggered, is both against public policy as "the law favors settlement" and irrelevant because "Federal would not be required to pay one penny more in insurance than it would have if the underlying insurance company paid its limits in full." ¹⁸

16 Pls. Reply [*25] to Defs. Opp'n to Pls. Mot. for Partial Summ. J., at 9-10.

17 *Id.* at 11.

18 *Id.* at 12, 13.

C. Advancement of Defense Costs

In their Motion for Partial Summary Judgment, Plaintiffs contend that Defendants have a duty to advance defense costs "if any allegation in the underlying case is potentially or possibly covered under the insurance policy." ¹⁹ With respect to the timing of such payments, Plaintiffs assert that "[u]nder the Defendant Insurance Companies' policies, there is no duty to defend but, rather, there is an obligation to pay defense costs as those costs are incurred." ²⁰ Plaintiffs' main focus with respect to the language in the insurance contract executed by Plaintiffs and Defendants is that "the Defendant Insurance Companies 'shall advance' defense costs 'prior to the final disposition of a claim'" and that "to the extent that it is *finally established* that any such Defense Costs are not covered...the Insureds...hereby agree to repay the Insurer such non-covered Defense Costs." ²¹

Lastly, and in conjunction with their other contentions concerning advancement and amount of payment, Plaintiffs argue that "an insurance company must pay costs incurred to defend uncovered claims if [*26] the defense of those claims is 'reasonably related' to the defense of covered claims."²² In sum, Plaintiffs contend that each of the defendants is under a duty to defend, up to their respective policy limits, the entirety of the criminal conspiracy alleged against Plaintiffs' former directors and officers and to do so as defense costs accrue.

19 Pls. Mot. for Partial Summ. J., at 17.

20 *Id.* at 19.

21 *Id.* at 23 (emphasis in original).

22 *Id.* at 25.

In response, Defendants argue that, prior to advancing potentially uncovered defense costs to Plaintiffs, the Court must first substantively address and resolve the question of allocation among the three towers, and further assert that, under supposedly applicable New Jersey law, "the allocation of defense costs need not be established with 'scientific certainty' and that if the insurer and insured [can]not reach [an] agreement as to the apportionment of costs, the court should then make the determination."²³ Defendants propose an allocation of defense costs among the three towers of coverage according to the "timing of the wrongful acts alleged in the [i]ndictment."²⁴ Moreover, Defendants argue that the pertinent contract language "require[s] [*27] only the indemnification or reimbursement of reasonable defense costs" rather than the total advancement of costs asserted by Plaintiffs.²⁵ Defendants thus contend that "the Court first must address the issue of allocation -- which establishes if and to what extent coverage exists -- before it may order the insurers to advance defense costs."²⁶

23 Defs. Opp'n to Pls. Mot. for Partial Summ. J., at 8.

24 Defs. Mot. for Partial Summ. J., at 11.

25 Defs. Opp'n to Pls. Mot. for Partial Summ. J., at 9 (emphasis in original).

26 *Id.* at 13.

IV. STANDARD OF REVIEW

[HN1] "Upon cross motions for summary judgment, this Court will grant summary judgment to one of the moving parties."²⁷ No genuine issues of material fact exist as a matter of law where opposing parties have each sought summary judgment.²⁸ Superior Court Civil Rule 56(h) provides:

[HN2] Where the parties have filed cross motions for summary judgment and have not presented argument to the Court

that there is an issue of fact material to the disposition of either motion, the Court shall deem the motions to be the equivalent of a stipulation for decision on the merits based on the record submitted with the motions.

The questions before this Court are questions [*28] of law, and the parties by filing cross motions for summary judgment have in effect stipulated that the issues raised by the motions are ripe for a decision on the merits.

27 *Scottsdale Ins. Co. v. Lankford*, 2007 Del. Super. LEXIS 338, *11

28 Super. Ct. Civ. R. 56(h).

V. DISCUSSION

A. Allocation of Liability Is Not Required Prior to Final Disposition of the Claim²⁹

29 Defendants have raised the threshold question of choice of law as to whether New Jersey or Delaware law should apply as to court-administered allocation. The Court does not believe that there is a conflict of law on the precise questions at issue under the particular facts of the instant case. Delaware law is that [HN3] "absent any conflict, the Court may apply general principles that are consistent with the law of either jurisdiction." *Sun-Times Media Group, Inc. v. Royal & SunAlliance Ins. Co. of Canada*, 2007 Del. Super. LEXIS 402, 2007 WL 1811266, *9-10 (Del. Super. June 20, 2007). Any conflict that Defendants may have identified between New Jersey and Delaware law does not come to bear on the ultimate issue, i.e., whether any allocation of liability is required prior to the final disposition of an underlying claim, of this case. Therefore, this Court will [*29] follow its holding in *Sun-Times* and apply consistent rules from both jurisdictions in its decision.

The Synthetic policies contain the following provision:

[E]xcept as hereinafter stated, the Insurer shall advance, at the written request of the Insured, Defense Costs prior to the final disposition of a Claim. Such advanced payments by the Insurer shall be repaid to the Insurer by the Insureds or the Company severally according to their respective interests, in the event and to the extent that the Insured or the Company

shall not be entitled under the terms and conditions of this policy to payment of such Loss.³⁰

30 See *supra* at 7.

This contract language allows for other portions of the contract to alter Defendants' general duty of advancing defense costs by the phrase "except as hereinafter stated." With respect to these exceptions that could deflect Defendants' baseline duty of advancement of defense costs, Defendants rely on the two provisions of the contracts in the Synetic tower and their analog in the Emdeon tower concerning when coverage begins and ends under each tower, i.e., after the company was acquired/merged and before it was sold/merged. The relevant provisions are reproduced [*30] below (the first two were included in the Synetic tower contracts and the last was included in the Emdeon tower contracts):

In all events, coverage as is afforded under this policy with respect to any Claim made against a Subsidiary or any Director or Officer thereof shall only apply for Wrongful Acts committed or allegedly committed after the effective time that such Subsidiary became a Subsidiary and prior to the time that such Subsidiary ceased to be a Subsidiary.³¹

[If Synetic] (a)...shall consolidate with or merge into, or sell all or substantially all of its assets to any other person or entity, or group of persons and/or entities acting in concert...herein referred to as the Transaction...then this policy shall continue in full force and effect as to Wrongful Acts occurring prior to the effective time of the Transaction, but there shall be no coverage afforded by any provision of this policy for any actual or alleged Wrongful Act occurring after the effective time of the Transaction.³²

In all events, coverage is afforded under this policy with respect to a Claim made against any Organization and/or any Insured Person thereof shall only apply for Wrongful Acts committed or allegedly [*31] committed after the effective time such Organization became an Organization and such Insured Person became an Insured Person, and prior to the effective time that such Organization ceases to be

an Organization or such Insured Person ceases to be an Insured Person.³³

The reasoning behind these clauses and the interest they protect for Defendants, Defendants argue, is that "when a company is overtaken, is absorbed, merged into, or taken over by someone else, that risk has shifted so dramatically, that underwriters foresee that they cannot have calculated what could be the appropriate premium."³⁴

31 See *supra* at 6.

32 See *supra* at 6.

33 See *supra* at 7.

34 Tr. of Oral Argument at 36 (May 5, 2008).

With respect to Defendants' allocation scheme that is based on the above clauses in the contract, the Court finds their proposal unpersuasive. Under Defendants' proposal, defense costs would be allocated according to the alleged overt acts in the federal indictment, and each tower's allocation would be as follows: 63% to the MMC tower, 23% to the Synetic tower and 14% to the Emdeon tower.³⁵ Defendants arrive at these percentages by allocating the alleged overt acts, according to the alleged dates of [*32] their occurrences as set forth in the indictment, to each tower's coverage period and then dividing by the total. For example, the 274 overt acts alleged to have occurred during the MMC tower's coverage period divided by the 437 total alleged overt acts roughly equals 63%. Defendants concede that each tower of coverage has been triggered by the underlying claim. However, in their allocation scheme as to the extent to which their policies have been triggered, Defendants ask the Court to take at least two leaps in logic: 1) to equate "overt acts" listed in the indictment to "wrongful acts" as described in the insurance contract and 2) to assume that all "overt acts" would require essentially the same amount of defense work. Defendants' proposed allocation scheme is unfair to Plaintiffs, especially considering the inability of Defendants to direct the Court to any contract provision or case that would specifically require it. Plaintiffs are presently expending large sums of money to pay for the defense costs of their former directors and officers in the underlying litigation.

35 See *supra* at 14.

However, Defendants cite several New Jersey cases (no Delaware cases are to be found), which [*33] mandate court-administered "apportionment" after the underlying claim has been resolved even in the absence of contract language to that effect. In *SL Industries, Inc. v. American Motorists Insurance Co.*,³⁶ the New Jersey Supreme Court found that a defendant insurer had wrongfully refused to defend a plaintiff insured against

an age discrimination claim brought by a former employee. The *SL Industries* Court held that the defendant insurer's duty to reimburse was limited to covered claims and thereby required that an apportionment be performed between covered and non-covered claims.³⁷ This case set out a rule, as further elucidated in *Hebela v. Healthcare Insurance Co.*,³⁸ which separates New Jersey law from Delaware on this issue in that, in New Jersey, apportionment between covered and non-covered claims is apparently to be performed by the court no matter how difficult the process may be. However, as *SL Industries* dealt with apportionment only after the underlying claim had been resolved, the Court is not persuaded that the rule set forth there should apply in the instant case.

36 *SL Industries, Inc. v. American Motorists Ins. Co.*, 128 N.J. 188, 607 A.2d 1266 (N.J. 1992).

37 *Id.* at 1280.

38 *Hebela v. Healthcare Ins. Co.*, 370 N.J. Super. 260, 851 A.2d 75 (N.J. Super. Ct. App. Div. 2004).

In [*34] *Hebela*, the former Chief Financial Officer of a hospital initiated a wrongful termination claim against his former employer, which was met with a counterclaim from the hospital alleging plaintiff insured's negligence in his duties as CFO. The plaintiff insured was denied coverage initially under a directors' and officers' liability policy issued by defendant insurer and sought to recover his defense costs. The *Hebela* Court held that *SL Industries*, while seemingly allowing for the possibility of an instance where apportionment will not be possible, had "essentially foreclosed the idea that there will be cases in which defense costs cannot be fairly apportioned" and required that case to undergo apportionment even though it would be difficult.³⁹ As *Hebela* only stands as a practical clarification of the holding in *SL Industries*, it is not helpful.

39 *Id.* at 83-84.

In *L.C.S., Inc. v. Lexington Insurance Co.*, a New Jersey court required apportionment of the defense costs of a plaintiff insured between negligence (covered) and intentional tort (uncovered) claims after the insured had settled with an injured bar patron and its insurer had refused to defend during the litigation.⁴⁰ *L.C.S., Inc.*, similarly, only stands for a rule recognizing apportionment between covered and uncovered claims after the underlying claim has been resolved.

40 *L.C.S., Inc. v. Lexington Ins. Co.*, 371 N.J. Super. 482, 853 A.2d 974, 984-985 (N.J. Super. Ct. App. Div. 2004).

Finally, in *Morgan, Lewis & Bockius LLP v. Hanover Insurance Co.*,⁴¹ plaintiff, as assignee of the insured, sought to collect its defense costs from the insured who had refused to defend against, *inter alia*, claims of trademark infringement. The *Morgan, Lewis & Bockius* court, following the logic as set out in *SL Industries, Inc.* and *Hebela*, proceeded to apportion defense costs between covered and uncovered claims.⁴² Again, this case follows the logic of the previous three cases cited by Defendants and likewise says nothing about requiring apportionment before the resolution of the underlying claim in the absence of contractual language regarding the same.

41 *Morgan, Lewis & Bockius LLP v. Hanover Ins. Co.*, 929 F.Supp. 764 (D.N.J. 1996).

42 *Id.* at 769-73.

Defendants' reliance on the holdings in *SL Industries, Inc.* and its progeny is misplaced in the instant case. The court in *SL Industries, Inc.* stated a rule requiring "apportion[ment] between covered [*36] and non-covered claims [of a single insurer]" so that the insurer would pay "only those defense costs reasonably associated with claims covered under the policy" and how "the lack of scientific certainty [in performing such an apportionment] does not justify imposing all the costs on the insurer by default."⁴³ Defendants ask the Court to extrapolate the *SL Industries* Court's rule requiring apportionment between covered/uncovered claims after the resolution of the underlying case to a new rule requiring allocation of defense costs across multiple insurers before the resolution of the underlying case. The *SL Industries* Court does not suggest its endorsement of such a rule.

43 See *SL Indus., Inc.*, 607 A.2d at 1280.

Moreover, none of the above cases required allocation to be performed *before* the claim was finally decided, nor did they involve insurance packages as complex and multi-faceted as the one presented in the present case. Indeed, a requirement to allocate insurance liability before a triggering claim has been finally decided actually could create more, rather than less, uncertainty about ultimate proportionate liability for insurance coverage between two or more insurance companies. [*37] This Court's concern about judicial economy seems confirmed by the Court's being furnished a copy of a letter by Plaintiffs from the U.S. Department of Justice to Plaintiffs' former directors' and officers' defense counsel.⁴⁴ In this letter of May 30, 2008, the U.S. attorney noted several "amendments to the government's acquisition chart," which may change the number of overt acts in the underlying indictment. If, through this letter or through the return of another superseding indictment by the

South Carolina grand jury, the number of alleged overt acts were to change, this would negate this Court's allocation of costs among Defendants, assuming this Court were to accept Defendants' proposed 63%--23%--14% allocation scheme.⁴⁵ This letter demonstrates the Court's concern about redundant and wasteful litigation when asked to allocate the defense costs of an underlying complex criminal case, yet to be concluded, based on the United States Government's identification of 437 overt acts over an eight-year period.

44 Letter of May 30, 2008 from Acting U.S. Att'y for the District of South Carolina Kevin F. McDonald to Pls. Directors' and Officers' Att'ys. Docket 76.

45 *Id.*

Also, Defendants could [*38] have explicitly included an allocation requirement in their contracts that would require the very allocation that they now ask this Court to order, but they did not.⁴⁶ Therefore, [HN4] in the absence of contract language that would require it, the Court finds that allocation of defense costs prior to the final disposition of an underlying claim is not required.

46 Pls. Opp'n to Defs Mot.s for Partial Summ. J., at 19, n.14.

Defendants' related argument that Plaintiffs may not "choose in [their] sole discretion to call upon any of the three towers of insurance to pay defense costs" is linked to their request for allocation and requires the explicit contract provisions cutting off the coverage of the insured company in the event of purchase/merger, analyzed *supra* at 20-21, to trump their duty to advance defense costs, analyzed *supra* at 20.⁴⁷ Importantly, Defendants do not dispute that the claim stemming from Plaintiffs' former directors' and officers' criminal defense implicates all three towers of coverage; they only dispute the *extent* to which their coverage is implicated. Indeed, Defendants acknowledge, simply from the nature of their request for allocation, that all three towers of insurance [*39] have some amount of contractually viable claims that have triggered them.

47 Defs. Mot. for Partial Summ. J., at 10.

Perhaps the closest precedent available (though admittedly still quite different from the facts of the present case in that the coverage-triggering event had been resolved prior to the court's apportionment), *Hebela v. Healthcare Insurance Co.* addressed a dispute as to coverage under a directors' and officers' liability policy, which, when the plaintiff insured claimed the triggering of the policy, the defendant insurer refused to defend due to the claim's overlap with an uncovered but intimately

related matter.⁴⁸ The *Hebela* Court's approach coincides with that of this Court:

[The insured] was entitled to the full benefit of the duty to defend which [the insurer] owed him, and to limit the value of that benefit by reducing the amount which was actually expended in defending the counterclaim [which was covered by insurance], because it overlapped the steps taken in prosecuting the complaint [which was uncovered], would deprive plaintiff of that full benefit.⁴⁹

If the instant case had but one tower of insurance with the claim being concededly both covered and uncovered in [*40] some proportion, a rule of law like that established in *Hebela* might apply. Therefore, the Court holds that Plaintiffs, having purchased additional "run-off reporting coverage" for a valuable consideration, see *supra* 6-7, and with the concession by Defendants that all three towers of coverage have been triggered, may elect to collect payments in advance from any tower with which it currently holds coverage. To hold otherwise would be tantamount to requiring that an allocation be performed at this preliminary stage, which the Court declines to do. This Court expresses no view as to whether allocation will be required at some future time.

48 *Hebela*, 851 A.2d at 85.

49 *Id.*

Delaware law is similar to New Jersey law on this issue. In *Sun-Times Media Group, Inc. v. Royal & SunAlliance Insurance Company of Canada*, this Court held, when presented with "advancement of defense costs" contract language substantially similar to that in the instant case, that "the personal exclusions [in the contract] do not override a present contractual duty to advance defense costs unless the Defendants can unequivocally now show that all of the allegations in the [underlying] complaint fall within the...exclusions." [*41]⁵⁰ In *Sun-Times*, the defendant insurer argued that the plaintiff insured was not entitled to defense costs because the plaintiff's receipt of the payments was "precluded under two exclusions in the applicable policies."⁵¹ While the instant case does not raise issues of personal conduct exclusions, *Sun-Times* applies here in that, since Defendants have conceded that their respective towers of coverage have all been triggered, Defendants now cannot demonstrate that all of the allegations in the indictment fall outside of the coverage periods of their respective towers and therefore must advance defense costs.

50 *Sun-Times Media Group, Inc. v. Royal & SunAlliance Ins. Co. of Canada*, 2007 Del. Super. LEXIS 402, 2007 WL 1811266, *11 (Del. Super. June 20, 2007).

51 2007 Del. Super. LEXIS 402, [WL] at *8.

Interestingly, a New York court in the very recent case of *The Trustees of Princeton University v. National Union Fire Insurance Co. of Pittsburgh, Pa.*⁵² faced a similar dispute in which the insured plaintiff sought advancement of defense funds for an underlying claim that was still pending from the defendant insurer. In *Trustees of Princeton University*, the court held on appeal, with respect to the request for allocation of defense costs prior to [*42] the resolution of the underlying claim, that:

As the policy obligates [the insurer] to advance all defense costs as they are incurred, subject to a right of recoupment of payment for noncovered costs after the underlying litigation is completed, the court had no obligation at this juncture to rule on the allocation of defense expenses.⁵³

Admittedly, important differences exist between this case and the instant case in that there were not multiple insurance policies from which to collect nor was the insurer's refusal to advance defense costs based on contract provisions concerning termination of coverage in the event of merger/sale. Nevertheless, this Court finds *Trustees of Princeton University* to be analogous and similarly finds no obligation presently to engage in the allocation of defense expenses.

52 *The Trustees of Princeton University v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 52 A.D.3d 247, 859 N.Y.S.2d 174, 2008 WL 2277830 (N.Y. App. Div. 1st Dept. 2008).

53 *Id.*

B. The Underlying Policies are Exhausted as a Matter of Law

On the supplementary argument put forward by Defendants of the necessity of Plaintiffs' demonstration of exhaustion of the underlying policies before Defendants can be compelled [*43] to pay costs, Defendants rely on a provision in the contract, which provides the following:

Only in the event of exhaustion of the Underlying Limit by reason of the insurers of the Underlying Insurance, or the insureds in the event of financial impair-

ment or insolvency of an insurer of the Underlying Insurance, paying in legal currency loss which, except for the amount thereof, would have been covered hereunder, this policy shall continue in force as primary insurance, subject to its terms and conditions and any retention applicable to the Primary Policy, which retention shall be applied to any subsequent loss in the same manner as specified in the Primary Policy. The risk of uncollectability of any Underlying Insurance, whether because of financial impairment of insolvency of art underlying insurer other reason, is expressly retained by the Insureds and is not in any way insured or assumed by the Company.⁵⁴

54 See *supra* at 9.

Plaintiffs and Defendants have stipulated that Plaintiffs have reached settlement agreements with two of the underlying insurers.⁵⁵ In *Stargatt v. Fidelity and Casualty Company of New York* where the sole issue was whether an excess insurance policy may be reached [*44] by an insured when the primary policy has been settled for less than its limit, the United States District Court for the District of Delaware held that "[t]he excess insurers will be liable only for covered losses in excess of [the primary policy limit plus the deductible on the excess insurance policy]."⁵⁶ The *Stargatt* Court continued, "I believe the reasoning of the *Zeig* case is correct, and I am confident that the Delaware courts would reach the same result."⁵⁷ Indeed, Delaware courts have followed this reasoning.⁵⁸

55 See *supra* at 9-10, 12.

56 *Stargatt v. Fidelity and Cas. Co. of New York*, 67 F.R.D. 689 (D.Del. 1975), *aff'd* 578 F.2d 1375 (3d. Cir. 1978)

57 *Id.*

58 See *Tenneco Automotive Inc. v. El Paso Corp.*, 2001 Del. Ch. LEXIS 147, 2001 WL 1641744, *9-10 (Del. Ch. Nov. 29, 2001) (rejecting argument that policyholder could not settle its claims with its insurer for less than its policy limit as "inconsistent with our general policies favoring and encouraging settlement.")

New Jersey law is in accord with Delaware law on this issue. In *Westinghouse Electric Corporation v. American Home Assurance Company*,⁵⁹ thousands of liability claims had been made against the plaintiff in-

sured company for injury to people [*45] who had used its products. While the insured reached settlements with some of its underlying insurers, the defendant insurers were excess insurance companies who had not joined in the settlements and who refused to cover the insured's claims by arguing, *inter alia*, that the underlying policy limits had not been exhausted as their contracts had required. *The Westinghouse* Court reasoned that the excess policy was triggered when the underlying policy limit was reached by the total costs incurred by the insured, regardless of whether the total payments to the insured reached those limits, because the excess insurance company could not possibly claim to have a stake in whether the insured actually received all of the underlying insurance limits.⁶⁰ The Court believes that the reasoning in *Westinghouse* and *Stargatt* applies equally here.

59 *Westinghouse Electric Corp. v. American Home Assurance Co.*, 2004 WL 1878764 (N.J. Super. Ct. Jul. 8, 2004). See also *Zeig v. Massachusetts Bonding & Ins. Co.*, 23 F.2d 665 (2d Cir. 1928).

60 *Id.* at *6. See also *UMC/Stamford, Inc. v. Allianz Underwriters Ins. Co.*, 276 N.J. Super. 52, 647 A.2d 182, 190 (N.J. Super.Ct. App. Div. 1994) ("If there is any dollar difference between [*46] the primary layer of coverage and the amount of the settlement, plaintiffs will have to pay that difference before expecting to obtain any reimbursement from excess insurance companies...It is therefore irrelevant what the exact dollar figure was in the settlement.").

Defendants cite two cases from California and Michigan, which either distinguish or decline to follow the reasoning in *Stargatt*. However, the decisions in New Jersey and Delaware are clear on the issue of exhaustion of underlying policy limits' position, i.e., that Defen-

dants' liability is completely unchanged whether Plaintiffs have received all of the underlying payments or not. The Court thus declines to accept the reasoning set forth in *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*, 161 Cal. App. 4th 184, 73 Cal. Rptr. 3d 770, 2008 WL 763483 (Cal. App. 2008) or in *Comerica Inc. v. Zurich American Insurance Co.*, 498 F.Supp.2d 1019 (E.D. Mich. 2007) as the opinions in both of these cases are contrary to that of *Zeig* and its progeny, including *Stargatt*, and are therefore contrary to the established case law of New Jersey and Delaware.

Settlements avoid costly and needless delays and are desirable alternatives to litigation where both parties can [*47] agree to payment and leave other separately underwritten risks unchanged. The Court sees unfairness in allowing the excess insurance companies in the instant case to avoid payment on an otherwise undisputedly legitimate claim. Therefore, to the extent that Plaintiffs' defense costs exceed any loss they may have imposed on themselves by accepting settlements with underlying insurers for less than the policy limit, the Court holds that those underlying policies have been exhausted as a matter of law.

VI. CONCLUSION

For the foregoing reasons, Defendant Federal Insurance Company's "Motion for Partial Summary Judgment on Allocation" is **DENIED** and Plaintiffs' "Motion for Partial Summary Judgment to Enforce [Certain Defendant Insurance Companies'] Duty to Advance and Reimburse Defense Costs" is **GRANTED**.

IT IS SO ORDERED.

Richard R. Cooch, J.



[***] **JP Morgan Chase & Co., et al., Plaintiffs-Appellants, v Indian Harbor Insurance Company, et al., Defendants, Arch Insurance Company, et al., Defendants-Respondents. JP Morgan Chase & Co., et al., Plaintiffs-Respondents, Indian Harbor Insurance Company, et al., Defendants-Appellants, Arch Insurance Company, et al., Defendants.**

6461-6462-6463-603766/08, 6466

SUPREME COURT OF NEW YORK, APPELLATE DIVISION, FIRST DEPARTMENT

947 N.Y.S.2d 17; 2012 N.Y. App. Div. LEXIS 4627; 2012 NY Slip Op 4702

June 12, 2012, Decided

June 12, 2012, Entered

NOTICE:

THE LEXIS PAGINATION OF THIS DOCUMENT IS SUBJECT TO CHANGE PENDING RELEASE OF THE FINAL PUBLISHED VERSION. THIS OPINION IS UNCORRECTED AND SUBJECT TO REVISION BEFORE PUBLICATION IN THE OFFICIAL REPORTS.

PRIOR HISTORY: *JPMorgan Chase & Co. v. Indian Harbor Ins. Co.*, 31 Misc. 3d 1240A, 930 N.Y.S.2d 175, 2011 N.Y. Misc. LEXIS 2767 (2011)

CASE SUMMARY:

PROCEDURAL POSTURE: Plaintiff insured sued defendant insurers, alleging breach of obligations to provide indemnification under excess insurance policies. The Supreme Court, New York County (New York), granted the motions of the insurers for summary judgment dismissing the complaint as against them and denied a motion by certain of the insurers to compel production of certain documents. The insured appealed.

OVERVIEW: The insured's predecessor bought "claims made" professional liability insurance and securities action claim coverage, and the insured sought coverage under these policies. The appellate court found that by the plain language of a provision in the policy issued by one of the insurers, the underlying insurance carriers' admission of liability and the payment of the full amount

of their liability were conditions precedent to liability under its policy. The first condition was not met because the insurance carrier directly beneath the insurer in the tower of follow-the-form coverage did not admit liability when it settled with the insured. Moreover, there was no way to determine that the insurance carrier paid the full amount of its liability under its tower policy because the settlement provided for no allocation of the payment. Further, conditions precedent to liability under other insurers' excess policies had not been met, either. Summary judgment was properly granted because the combination of the insured's settlements with other insurance carriers precluded any determination of whether the policy limits were reached as required by the policies at issue.

OUTCOME: The order which granted the insurers' motions for summary judgment dismissing the amended complaint as against them with prejudice was affirmed. The order which denied the motion to compel production of certain documents was also affirmed.

LexisNexis(R) Headnotes

Contracts Law > Contract Interpretation > General Overview

Insurance Law > Claims & Contracts > Policy Interpretation > General Overview

[HN1] Under the law of Illinois, the construction of an insurance policy is a question of law that requires a court to ascertain the intent of the parties to the contract. Accordingly, insurance policies are construed like any other contract.

Contracts Law > Contract Conditions & Provisions > Conditions Precedent

[HN2] A condition precedent is defined as an event which must occur or an act which must be performed by one party to an existing contract before the other party is required to perform.

Insurance Law > Claims & Contracts > Policy Interpretation > General Overview

Insurance Law > Claims & Contracts > Policy Interpretation > Ordinary & Usual Meanings

Insurance Law > Claims & Contracts > Policy Interpretation > Plain Language

[HN3] If the words in an insurance policy are unambiguous, a court must afford them their plain, ordinary and popular meaning.

Insurance Law > Claims & Contracts > General Overview

Insurance Law > Claims & Contracts > Policy Interpretation > General Overview

[HN4] Parties are free to impose any condition precedent to liability upon a policy as they choose.

Insurance Law > Claims & Contracts > Secondary Insurance

Insurance Law > Excess Insurance > General Overview

Insurance Law > Excess Insurance > Obligations > General Overview

[HN5] The Supreme Court of New York, Appellate Division, First Department, rejects the notion that when an insured settles with its primary insurer for an amount below the primary policy limits but absorbs the resulting gap between the settlement amount and the primary policy limit, primary coverage should be deemed exhausted and excess coverage triggered, obligating the excess insurer to provide coverage under its policy.

Civil Procedure > Federal & State Interrelationships > Choice of Law > General Overview

Civil Procedure > Discovery > Privileged Matters > General Overview

Evidence > Privileges > General Overview

[HN6] The law of the place where the evidence in question will be introduced at trial or the location of the discovery proceeding, is applied when deciding privilege issues.

COUNSEL: [**1] Proskauer Rose LLP, New York (John H. Gross, Steven E. Obus, Seth B. Schafler, Francis D. Landrey, Michelle R. Migdon, and Lauren J. Rabinowitz of counsel), for JP Morgan Chase & Co., JP Morgan Chase Bank, N.A., and J.P. Morgan Securities, Inc., appellants/ respondents.

Troutman Sanders LLP, New York (Matthew J. Aaronson of counsel), Troutman Sanders LLP, Washington, DC (John R. Gerstein, of the bar of the District of Columbia and the State of Maryland, admitted pro hac vice, of counsel), and Troutman Sanders LLP, Chicago, IL (David F. Cutter, of the bar of the States of Illinois and Maryland and the District of Columbia, admitted pro hac vice, of counsel), for Indian Harbor Insurance Company, appellant.

Melito & Adolfsen PC, New York (S. Dwight Stephens of counsel), for Houston Casualty Company, appellant.

Kaufman Borgeest & Ryan LLP, Valhalla (Scott A. Schechter of counsel), for Travelers Indemnity Company, appellant, and for Arch Insurance Company and St. Paul Mercury Insurance Company, respondents.

Akin Gump Strauss Hauer & Feld LLP, New York (Mitchell P. Hurley, Elizabeth J. Young, and Isabelle R. Liberman of counsel), for Twin City Fire Insurance Company, respondent.

Lewis Brisbois [**2] Bisgaard & Smith, LLP, New York (Stephanie A. Nashban of counsel), for Lumbermens Mutual Casualty Company, respondent.

Caughlin Duffy LLP, New York (Robert J. Kelly of counsel), for Swiss Re International SE, respondent.

JUDGES: Luis A. Gonzalez, P.J., Richard T. Andrias, Leland G. DeGrasse, Rosalyn H. Richter, Sheila Abdus-Salaam, JJ. Opinion by DeGrasse, J. All concur.

OPINION BY: Leland G. DeGrasse

OPINION

[EDITOR'S NOTE: The following court-provided text does not appear at this cite in N.Y.S.2d.]

[*none] Appeals from orders of the Supreme Court, New York County (Barbara R. Kapnick, J.), entered May 31, 2011, which [***2] granted the motions

947 N.Y.S.2d 17, *; 2012 N.Y. App. Div. LEXIS 4627, **;
2012 NY Slip Op 4702, ***

by Arch Insurance Company, St. Paul Mercury Insurance Company, Twin City Fire Insurance Company, Lumbermens Mutual Casualty Company and Swiss Re International SE for summary judgment dismissing the amended complaint as against them with prejudice, and from an order, same court and Justice, entered on or about May 31, 2011, which denied the motion by Indian Harbor Insurance Company, Houston Casualty Company and Travelers Indemnity Company to compel production of certain documents.

[***3] [*19] DEGRASSE, J.

Plaintiff alleges that defendants breached their contractual obligations to provide indemnification under excess insurance policies they issued. Plaintiff's predecessor, Bank One Corporation, [**3] purchased \$175

million in "claims made" bankers professional liability insurance and securities action claim coverage for the period October 1, 2002 to October 1, 2003. Bank One's insurance program was structured as a tower of follow-the-form coverage in excess of a self-insured retention. Defendant Indian Harbor Insurance Company was the primary carrier while defendants Houston Casualty Company, Arch Insurance Company, St. Paul Mercury Insurance Company, Twin City Fire Insurance Company, Lumbermens Mutual Insurance Company, Swiss Re International SE and nonparties Federal Insurance Company, American Zurich Insurance Company and Gulf Insurance Company provided excess coverage. The carriers and the tiers of coverage they provided are listed in descending order as follows:

Tier/ Insurance Company	Coverage Limits
Seventh Excess-Swiss Re	\$50 million in excess of \$150 million
Sixth Excess-Federal	\$10 million in excess of \$140 million
Fifth Excess-Lumbermens, St. Paul and Arch	\$30 million in excess of \$110 million, with a "quota share" apportionment of \$10 million among the three carriers
Fourth Excess-Twin City	\$15 million in excess of \$95 million
Third Excess-Zurich	\$15 million in excess of \$80 million
Second Excess-Gulf	\$15 million in excess of \$65 million
First Excess-Houston	\$15 million in excess of \$50 million
Primary-Indian Harbor	50% of loss up to \$50 million subject to a maximum coverage limit of \$25 million

In [**4] November 2002, actions were brought against Bank One and some of its affiliates in connection with their roles as indenture trustee and otherwise with regard to certain notes issued by NPF XII, Inc. and NPF VI, Inc. Plaintiff's entities (the JP Morgan entities) were defendants in some of the actions as well as other related actions in which the Bank One entities were not defendants. Between July and November 2004, while the NPF litigation [*20] was still pending, the Bank One entities were merged into the JP Morgan entities. Between February 2006 and March 2008, plaintiff settled six actions that were part of the NPF litigation for an aggregate of \$718 [***4] million. Plaintiff's theory of recovery in this action is that the portion of the settlement attributable to claims made against the heritage Bank One entities, as opposed to claims based on the conduct of the premerger JP Morgan entities, exceeded the combined limits of the policies in the Bank One tower of insurance.

Before bringing this action, plaintiff settled with Federal for the sum of \$17 million. That settlement agreement covered Federal's liability under the Bank One

program as well as claims under separate policies issued by Federal's [**5] affiliate, Executive Risk Indemnity, Inc., under a different insurance program. The agreement provided for no allocation of the settlement as between plaintiff's claims against Federal and those against Executive Risk. As shown above, Swiss Re is the only carrier that was higher than Federal in the Bank One tower.

After commencing this action, plaintiff entered into another \$17 million settlement, this time with Zurich and its affiliate, Steadfast Insurance Company. This settlement covered plaintiff's \$15 million claim under Zurich's policy in the Bank One tower as well as a \$13.4 million claim against Steadfast under separate insurance covering unrelated litigation. After that settlement, plaintiff amended the complaint so as to drop Zurich as a defendant.

Twin City moved for summary judgment, asserting that plaintiff could not establish the occurrence of express conditions precedent to coverage under Twin City's policy. Invoking their own policy provisions, Swiss Re, Lumbermens, St. Paul and Arch also moved for sum-

mary judgment on similar grounds. The motion court granted all of the motions for summary judgment on the basis of its construction of the various policies. We affirm.

The [**6] parties agree that Illinois law governs the disposition of the motions for summary judgment. [HN1] Under the law of that state, the construction of an insurance policy is a question of law that requires a court to ascertain the intent of the parties to the contract (*Outboard Marine Corp. v Liberty Mut. Ins. Co.*, 154 Ill. 2d 90, 108, 607 NE2d 1204, 1212, 180 Ill. Dec. 691 [1992]). Accordingly, insurance policies are construed like any other contract (*Putzbach v Allstate Ins. Co.*, 143 Ill App 3d 1077, 1082, 494 NE2d 192, 196, 98 Ill. Dec. 265 [1986]).

The Twin City policy provided "that liability for any loss shall attach to [Twin City] only after the Primary and Underlying Excess Insurers shall have duly admitted liability and shall have paid the full amount of their respective liability."

Hence, by the plain language of this attachment provision, the underlying insurers' admission of liability and the payment of the full amount of their liability were conditions precedent to Twin City's liability under its policy. [HN2] "A condition precedent is defined as an event which must occur or an act which must be performed by one party to an existing contract before the other party is required to perform" (*Vuagniaux v Korte*, 273 Ill App 3d 305, 309, 652 N.E.2d 840, 210 Ill. Dec. 38 [1995] [**7] [internal quotation marks omitted]).

The first condition was not met because Zurich, the insurer directly beneath Twin City in the Bank One tower, did not admit liability when it settled with plaintiff. In fact, the settlement agreement between Zurich and plaintiff provided that "the negotiation, execution and [*21] performance of this Agreement shall not constitute, or be construed as, an admission of liability or infirmity of any defense or claim whatsoever by any Party." Moreover, there is no way to determine that Zurich paid the full amount of its liability under its Bank One tower policy [***5] because the settlement provided for no allocation of the \$17 million payment between Zurich and Steadfast. Therefore, the second condition set forth in Twin City's attachment provision was not met either. For reasons that follow, conditions precedent to liability under the remaining movants' excess policies have not been met either.

Lumbermens' policy provided that the insurance afforded thereunder "shall apply only after all applicable Underlying Insurance with respect to an Insurance Product has been exhausted by actual payment under such Underlying Insurance . . ." St. Paul's policy provided that "[St. [**8] Paul] shall only be liable to make payment

under this policy after the total amount of the Underlying Limit of Liability has been paid in legal currency by the insurers of the Underlying Insurance as covered loss thereunder." Similarly, the insurance coverage afforded by Arch's policy applied "only after exhaustion of the Underlying Limit solely as a result of actual payment under the Underlying Insurance in connection with Claim(s) and after the Insureds shall have paid the full amount of any applicable deductible or self insured retentions" (emphasis omitted). Swiss Re's liability under its policy attached "only when the Underlying Insurer(s) shall have paid or have been held liable to pay, the full amount of the Underlying Limit(s) . . ."

The foregoing attachment provisions are analogous to two attachment provisions that were at issue in *Great American Ins. Co. v Bally Total Fitness Holding Corp.* (US Dist Ct, ND Ill, 06 Civ 4554, 2010 U.S. Dist. LEXIS 61553 *Andersen, J.*, 2010). Under one such provision in *Great American*, excess coverage became applicable "only after all Underlying Insurance has been exhausted by payment of the total underlying limit of insurance" (2010 U.S. Dist. LEXIS 61553, [WL] at *1). Pursuant to the other excess policy [**9] before the *Great American* court, liability for covered losses attached "only after the insurers of the Underlying Policies shall have paid, in the applicable legal currency, the full amount of the Underlying Limit and the insureds shall have paid the full amount of the uninsured retention, if any, applicable to the primary Underlying Policy" (*id.*). We are persuaded by *Great American's* holding that the excess policies before the court unambiguously required the insured to collect the full limits of the underlying policies before resorting to excess insurance (2010 U.S. Dist. LEXIS 61553, [WL] at 5).

We are also persuaded by the Fifth Circuit's reasoning in *Citigroup Inc. v Federal Ins. Co.* (649 F3d 367 [2011]) in which it was held that under Texas law "settlement for less than the underlying insurer's limits of liability does not exhaust the underlying policy" (*id.* at 373). In this case, summary judgment was properly granted because the aforementioned combination of plaintiff's settlements with Zurich and Steadfast preclude any determination of whether Zurich's policy limits were reached as required by the policies issued by Twin City, Lumbermens, St. Paul, Arch and Swiss Re. Plaintiff's pre-action settlement with [**10] Federal and Executive Risk had the same effect on Swiss Re's liability because there was no allocation of the settlement between the two underlying carriers.

Plaintiff seeks refuge in language in a maintenance provision of Twin City's policy which provided that the insured's failure to maintain all of the underlying policies in full effect would not invalidate the policy. [HN3] "If the words in the policy are [*22] unambiguous, a

947 N.Y.S.2d 17, *; 2012 N.Y. App. Div. LEXIS 4627, **;
2012 NY Slip Op 4702, ***

court must afford them their *plain, ordinary and popular meaning* (*Outdoor Marine Corp.*, 154 Ill. 2d at 108). Guided by *Outdoor Marine Corp.*, we reject plaintiff's argument that its settlement with Zurich can be construed as a failure to maintain the underlying policies within the contemplation of the [***6] maintenance provision. In addition, Twin City does not challenge the validity of its policy. It simply maintains that conditions precedent to coverage were not met. As stated above, its premise is that conditions precedent to its liability have not been met. Therefore, the maintenance provision is irrelevant to Twin City's motion.

Plaintiff also relies on *Zeig v Massachusetts Bonding & Ins. Co.* (23 F2d 665 [2d Cir 1928]). In *Zeig*, an insured who settled with his primary carriers [**11] for less than their policy limits, sued his excess carrier, seeking indemnification for the amount of his loss exceeding the underlying policy limits (*id.* at 665). The policy in *Zeig* provided that the excess insurance thereunder "shall apply and cover only after all other insurance herein referred to shall have been exhausted in the payment of claims to the full amount of the expressed limits of such other insurance" (*id.*). The Second Circuit found this provision ambiguous, reasoning that "payment" as used therein could refer to "the satisfaction of a claim by compromise, or in other ways" in addition to "payment in cash" (*id.* at 666). The *Zeig* court, nevertheless, recognized that [HN4] parties are free to impose any condition precedent to liability upon a policy as they choose (*id.*). Here, Twin City's attachment provision stands apart from the one before the court in *Zeig* because of its exacting requirement that the underlying carriers shall have admitted and paid the full amounts of their respective liabilities. For reasons already stated, the attachment provisions of the other policies before this Court are also distinguishable from the one before the *Zeig* court. Like the court in *Great Am. Ins. Co. v Bally Total Fitness Holding Corp.* (US Dist Ct., ND Ill, 06 Civ 4554, 2010 U.S. Dist. LEXIS 61553, *Andersen, Jr.*, 2010, *supra*) [**12], we find no ambiguity in any of the policies that would make *Zeig* controlling (2010 U.S. Dist. LEXIS 61553, [WL] at *5). We further note that the United States District Court for the Northern District of Illinois, interpreting Illinois law, found *Zeig* to be contrary to Seventh Circuit precedent insofar as it stands for the proposition that "exhaustion" of the primary policies' payments does not require collection of the primary policies as a condition precedent to the right to recover excess insurance" (*see Premcor USA, Inc. v Am. Home Assur. Co.*, 2004 US Dist LEXIS 9275, *22, 2004 WL 1152847, *8 [ND Ill 2004], *affd* 400 F3d 523 [7th Cir 2005]). Plaintiff's reliance on *Hasemann v White* 177 Ill. 2d 414, 686 N.E.2d 571, 226 Ill. Dec. 788 [1997]) is misplaced because that case involved the interpretation

of a statutory provision as opposed to an insurance policy.

By its own terms, the attachment provision of Swiss Re's policy was subject to Condition 3 of the policy, which provided that

"[i]n the event of erosion or exhaustion of the aggregate limit of liability on the Underlying Insurer(s) policy by reason of loss(es), this Policy shall

(a) if erosion [**13] be partial, pay the excess of the reduced Underlying Limit(s) of the Policy(ies) of the Underlying Insurer(s), or

(b) if exhaustion be complete, continue in force in place of such Policy(ies) of the Underlying Insurer(s)."

In *Qualcomm, Inc. v Certain Underwriters at Lloyd's, London* (161 Cal App 4th 184, 73 Cal. Rptr. 3d 770 [***7] [2008]) the [*23] court distinguished *Zeig* and held that a "paid or have been held liable to pay" provision required primary insurance to be exhausted or depleted by actual payment of losses by the underlying insurer (*id.* at 195, 198-200). Like the *Qualcomm* court, [HN5] we reject the notion that "when an insured settles with its primary insurer for an amount below the primary policy limits but absorbs the resulting gap between the settlement amount and the primary policy limit, primary coverage should be deemed exhausted and excess coverage triggered, obligating the excess insurer to provide coverage under its policy" (*id.* at 188). Accordingly, we are still not persuaded by plaintiff's argument that there was an exhaustion under the Swiss Re policy.

The motion court correctly applied New York law in deciding the discovery motion. [HN6] The law of the place where the evidence in question will be introduced [**14] at trial or the location of the discovery proceeding, is applied when deciding privilege issues (*People v Greenberg*, 50 AD3d 195, 198, 851 N.Y.S.2d 196 [2008], *lv dismissed* 10 N.Y.3d 894, 891 N.E.2d 299, 861 N.Y.S.2d 266 [2008]). As the motion court found, the cooperation clauses in the insurance policies did not operate as waivers of plaintiff's attorney-client and work-product privileges (*see Gulf Ins. Co. v Transatlantic Reins. Co.*, 13 AD3d 278, 279-280, 788 N.Y.S.2d 44 [2004]). We have considered the appealing parties' remaining contentions for affirmative relief and find them unavailing.

947 N.Y.S.2d 17, *; 2012 N.Y. App. Div. LEXIS 4627, **;
2012 NY Slip Op 4702, ***

Accordingly the orders of the Supreme Court, New York County (Barbara R. Kapnick, J.), entered May 31, 2011, which granted the motions by Arch, St. Paul, Twin City, Lumbermens and Swiss Re for summary judgment dismissing the amended complaint as against them with prejudice, should be affirmed, with costs. The order of the same court and Justice, entered on or about May 31, 2011, which denied the motion by Indian Harbor, Houston and Travelers to compel production of certain documents, should be affirmed, with costs.

ALL Concur.

Orders, Supreme Court, New York County (Barbara R. Kapnick, J.), entered May 31, 2011, affirmed, with costs. Order, same court and Justice, entered [**15] on or about May 31, 2011, affirmed, with costs.

Opinion by DeGrasse, J. All concur.

Gonzalez, P.J., Andrias, DeGrasse, Richter, Abdus-Salaam, JJ.

THIS CONSTITUTES THE DECISION AND ORDER OF THE SUPREME COURT, APPELLATE DIVISION, FIRST DEPARTMENT.

ENTERED: JUNE 12, 2012

Not Reported in P.2d, 1995 WL 17015061 (Wash.Super.)
(Cite as: 1995 WL 17015061 (Wash.Super.))

H

Only the Westlaw citation is currently available.

Superior Court of Washington.
KALAMA CHEMICAL, INC., A Washington Corporation, Plaintiff,
v.
ALLIANZ INSURANCE CO., et al., Defendants.

No. 90-2-05011-4.
Aug. 14, 1995.

MEMORANDUM OF DECISION ON DEFENDANT'S AND PLAINTIFF'S MOTIONS FOR SUMMARY JUDGMENT RE: EXHAUSTION AS TO PASCO SITE (# 7, # 8), DUTY TO DEFEND (# 1), MOTIONS FOR REVISION (# 27 & 29), AND II'S MOTION FOR DISMISSAL OF CROSS-MOTION (# 30)

FLECK, J.

INDUSTRIAL INDEMNITY'S AND KALAMA'S MOTIONS FOR REVISION RE: EXHAUSTION (# 27, # 29)

*1 Industrial Indemnity (hereafter II) initially moved for summary judgment of dismissal as to the Pasco Site on the basis of lack of justiciability (Motion # 8); II now moves for revision (Motion # 27) of Judge Bridge's prior order dated January 5, 1995, regarding exhaustion, pursuant to *Rees v. Viking*, infra. Kalama initially moved for summary judgment to establish indemnity coverage at the Pasco Site (Motion # 7); by cross-motion (Motion # 29), Kalama now moves for revision of Judge Bridge's January 5, 1995 order. II further moves (Motion # 30) for dismissal of Kalama's Motion # 29 on the grounds that Kalama has presented no new authority for its position.

Preliminarily the issue of exhaustion must be addressed. Initially, II asserted that Judge Bridge has determined that exhaustion is a question of fact, and it must therefore be decided by the fact finder. Further, II asserted that her decision is the "law of the case."^{FNI} Kalama takes an opposing position, stating that Judge Bridge did not hear or determine the issue of how Kalama could exhaust the underlying insurance. Kalama asserts that that issue is now before me in a

number of motions. After initial briefing on the Duty to Defend and Pasco Site motions, II has now brought a motion under CR 54(b) seeking revision of Judge Bridge's denial of II's motions heard in late 1994 based on the recent decision in *Rees v. Viking Ins. Co.*, 77 Wash.App. 716, 892 P.2d 1128 (1995), which was issued after her ruling.

^{FNI} II asked that I read the pleadings associated with its motions on the exhaustion issue. I did so, and note II's citation to authority in its reply brief at p. 7, 787 P.2d 1385 on the issue of "law of the case" for the proposition that in Washington, the principle of "law of the case" applies to "parties who raise identical issues on successive appeals of the same case. *MGIC* presents no relevant authority for extending the doctrine to apply to motions raised several times at the trial court level. We see no reason to extend the doctrine here." *MGIC Financial Corp. v. H.A. Briggs Co.*, 24 Wash.App. 8, 600 P.2d 573 (1979). II also cited out of state authority as follows. "The law of the case doctrine does not apply to pretrial rulings such as motions for summary judgment." *Shouse v. Ljunggren*, 792 F.2d 902, 904 (9th Cir.1986). II stated at page 7 of its reply brief: "Thus, this court is free to, and should, weigh the arguments and come to whatever conclusion it feels is right, just and fair[.]" and cited the following from *Robinson v. Parrish*, 720 F.2d 1548, 1550 (11th Cir.1983) (accord, *Whirlpool Corp. v. U.M.C.O. International Corp.*, 748 F.Supp. 1557, 1560-61 (S.D.Fla.1990): "To hold that a [trial] court must rigidly adhere to its own rulings in an earlier stage of a case would actually thwart the purpose of the [law of the case] doctrine. New developments or further research often will convince a [trial] court that it erred in an earlier ruling, or the court may simply change its mind." In Washington, even in appeals, the law of the case doctrine is discretionary. *Coffell v. Clallam County*, 58 Wash.App. 517, 794 P.2d 513 (1990). On the other hand, Kalama cites in its prior Response to II's motion at p. 1, fn. 2, 794 P.2d 513, out of

Not Reported in P.2d, 1995 WL 17015061 (Wash.Super.)
(Cite as: 1995 WL 17015061 (Wash.Super.))

state authority to the contrary. (Emphasis added.)

Judge Bridge ruled on two motions brought by II ^{FN2} in which she determined that the plaintiff was not required to prove total horizontal and vertical exhaustion, but rather only vertical exhaustion in the year of the II policy and that the liability of II, if found, would not be limited to the "time on the risk." She also stated that Kalama's motions were not properly before her. She said Kalama's burden under this policy is to prove: 1) that its ultimate net loss was in excess of the retained limit in II's policy, and 2) that it has exhausted the limits of the Schedule A policy (Allianz) and other insurance collectible by the insured for policies maintained by Kalama on the sites during the term of the II policy (and none are known).

FN2. II's motions specifically were a request that the court "dismiss this action against II because Kalama failed to exhaust the limits of all other applicable insurance .. In the alternative, II seeks a ruling that it is not obligated to indemnify Kalama for any alleged property damage at the Kalama or Pasco site occurring outside the effective dates of the II policy [time on the risk]...."

Judge Bridge stated that "summary judgment *at this juncture* is premature because of this outstanding material question of fact" regarding the issue of exhaustion.^{FN3} She offered her own concerns about Kalama's ability to show exhaustion, given its settlement with Allianz (a company which insured Kalama in various time periods including this one) without allocating amounts to specific policy periods at the time of the settlement. In her explanation, Judge Bridge also stated that settlement for less than policy limits is not exhaustion. There was no motion specifically addressed to the issue of how underlying policies can be exhausted. (Although Kalama filed its motion for reconsideration, which included arguments contained in current motions in apparent response to some of Judge Bridge's comments or explanations, Kalama's original motions were not timely and neither Kalama's motions nor its motion for reconsideration were argued.) These latter statements were not holdings; even if they were, they are subject under the rules to being revisited by her or by a subsequent judge as described below.

FN3. The June 13, 1995 Clarified memorandum of Opinion contained a typographical error at line 7; it should have read "page 3, lines 12-14 are deleted" rather than lines 12-16.

*2 I discussed with counsel informally on June 9 and then addressed briefly in the memorandum decision on Allocation, issues which arise with multiple judges/multiple decision making as well as legal standards applied under Civil Rule 56. For purposes of this decision, the applicable rules are as follows. Unless summary judgment is granted in toto, it is not a final order for purposes of CR 54(b). It is an interlocutory order and not appealable by right, unless the trial court enters a written finding that there is no just cause for delay. The denial of a motion for summary judgment is not a final judgment, and is thus interlocutory. Likewise, an order under CR 56(d) which specifies facts which are not in dispute is not a final order, and is therefore interlocutory. Moreover, a CR 56(d) order is not actually a judgment, although it is frequently called a "partial summary judgment." See 10 Wright & Miller, Federal Practice and Procedure, Civil, § 2737 (1983). The court retains jurisdiction to modify an order at any time before final judgment. After the Allocation decision, I reviewed the briefing on II's motions on exhaustion, and additional authority *cited by II* at page 7 of its reply brief supports this interpretation as well. Judge Bridge's discussion of the reasons for her ruling were not intended by her to be the "law of the case," ^{FN4} nor does the Washington authority support this notion regarding summary judgment motions.

FN4. I have also previously indicated to you that the revision of language in her ruling dated January 25, 1995 was to make absolutely clear her decision that Kalama must only exhaust insurance "vertically" and that the repetition of other words in that paragraph was not intended to infer anything regarding the exhaustion issue.

The issue of exhaustion can involve both questions of law and questions of fact. How a policy can be exhausted requires interpretation and construction of the language and therefore is a question of law. Whether a policy has been exhausted may involve questions of fact if genuine issues regarding whether the policy is exhausted are raised when considered in

Not Reported in P.2d, 1995 WL 17015061 (Wash.Super.)
(Cite as: 1995 WL 17015061 (Wash.Super.))

light of the interpretation of the term; otherwise, it may be decided upon the record presented.

The issue of exhaustion involves consideration of the, "coverage," "retained limit," "ultimate net loss," "underlying insurance" and "loss payable," policy provisions. These provisions state:

I. COVERAGE

The Company [II] agrees to pay the ultimate net loss in excess of the retained limit ... which the insured [Kalama] may sustain by reason of the liability imposed upon the insured by law arising out of an occurrence ... for ... (b) Property Damage Liability....

V. RETAINED LIMIT-

LIMIT OF LIABILITY

With respect to Coverage I(a),I(b) or I(c), or any combination thereof, the company's liability shall be only for the ultimate net loss In excess of the insured's retained limit defined as the greater of:

(a) the total of the applicable limits of the underlying policies listed in Schedule A hereof, and the applicable limits of any other insurance collectible by the insured; or....

CONDITIONS

G. *Loss Payable.* Liability of the company with respect to any one occurrence shall not attach unless and until the insured, the company in behalf of the insured, or the insured's underlying insurer, has paid the amount of retained limit.

*3 ...

J. *Underlying Insurance.* If underlying insurance is exhausted by any occurrence, the company shall be obligated to assume charge of the settlement or defense of any claim or proceeding against the insured resulting from the same occurrence, but only where this policy applies immediately in excess of such underlying Insurance, without the intervention of excess Insurance of another carrier.

It is undisputed that the retained limit in this policy is one million dollars, that is, that II agreed to pay all sums Kalama is legally obligated to pay above one million dollars for occurrences during its policy period, up to the limits of this excess policy. There remains an issue regarding how and when the "aggregate" provision applies.

In a letter responding to my request that counsel analyze the exhaustion issue in light of or by analogy to the floating layer theory of underinsured motorist coverage found in *Elovich v. Nationwide Insurance Co.*, 104 Wash.2d 543, 707 P.2d 1819 (1985), II cited the new case of *Rees v. Viking Insurance.* *supra*, as addressing the exhaustion issue directly. Kalama has responded, again in letter form; subsequently, II filed its motion under CR 54(b) in which it asks me to dismiss Kalama's action in light of *Rees*, and Kalama filed its cross-motion.

Rees is distinguishable. The *Rees* case involved automobile coverage for an accident by a permissive driver which was secondary to the insurance held by the owner of the vehicle. The Injured party settled with the primary insurer for an amount under the primary policy limits, sought a finding by the court approving the settlement but also determining that the value of the injury was in excess of the primary limits and then sought coverage from the driver's policy. Division Three recognized the procedure as an "artifice," noting the lack of contract relationship between the party seeking coverage and the insurer as well as the lack of public policy involved in this fact pattern (unlike the situation involved in UIM coverage in which public policy is reflected in a statute). Here, of course, there is a contractual relationship between II and Kalama; this is a critical distinction. Here, Kalama asserts that it has paid the entire retained limits in up to three ways and is still liable to the "injured party" (the government), whereas in *Rees*, the insured's carrier paid a sum less than the policy limits in order to obtain a release from the injured party. In addition, public policy favors settlements generally according to various authority cited by counsel and in environmental cases in particular, as can be seen at a minimum from Insurance Commissioner Senn's regulations with their statement of public policy in favor of such settlements.^{ES2} As long as the excess carrier receives full credit for whatever the retained limits are, it has received the benefit of its bargain, and it is consistent with the public policies of early settlements and effi-

Not Reported in P.2d, 1995 WL 17015061 (Wash.Super.)
 (Cite as: 1995 WL 17015061 (Wash.Super.))

cient use of judicial resources. II has not cited any public policy which is contrary.^{FN6} In oral argument, Mr. Spoonemore asserted that the excess carrier would not receive a part of its bargain (the primary carrier's duty to defend), unless the primary itself was required to pay in order to exhaust (as opposed to the insured paying some or all of the retained limit). Mr. Spoonemore asserted that this would fundamentally change the policy from an excess insurance policy to a primary policy with a large deductible. Who pays the retained limits and the duty to defend are not, however, that intimately connected. Mr. Spoonemore conceded that the primary insurer's obligations including the duty to defend are extinguished when the primary's indemnity limits are paid in full.^{FN7} For example, the primary insurer is not limited in its business decision making from paying its limits at the outset of a claim, thereby not implicating its duty to defend which would then shift to any excess carrier on the claim.^{FN8} This interpretation is consistent with the insurance policy the parties entered into: II would insure for damages in excess of one million dollars up to twenty million dollars. As long as II is given credit for the one million dollars underlying its coverage, its position is fully protected and it is not prejudiced. The applicable terms of the policy are consistent with this interpretation. In the Retained Limits provision, the II policy is triggered when Kalama's ultimate net loss exceeds the underlying limits. Under the Loss Payable provision, the underlying limits can be paid by the primary insurer, the insured or by both. *This very policy section* was cited by II at p. 5, fn. 4, 892 P.2d 1128 of its Brief in Response to Kalama's Motion for Clarification and/or Reconsideration [of Judge Bridge's memorandum of decision on II's motions]:

^{FN5}. The Kalama/II fact pattern involves Kalama's assertion that it has paid, not part, but all of the retained limits of II's policy in up to three different ways. The issue here, then, is whether the insured can pay retained limits in lieu of the primary insurer actually paying the retained limits. The fact pattern is similar to, but not the same as that involved in Judge Dwyer's case of *Northwest Steel Rolling Mills* in which the insured paid a small portion of the retained limits after settlement with the primary insurer. The result was an application of the floating layer concept of insurance authorized under Washington law in UIM coverage. Examples provide some insight regarding why it is also an

appropriate and supportable concept in excess coverage environmental cases regardless of whether the insured pays some or pays all of the retained limits. It would be a waste of judicial resources and an unnecessary risk to the insured to expose itself to the unknowns of a trial, if the insured were required, for example, to go to trial in order to access its excess coverage, even if it had an offer to settle for one penny or one dollar short of full primary limits. Likewise, if the damages were ten million dollars, the primary limits were \$100,000 and the excess limits were twenty million, it might be a good business decision to forego the expense associated with pursuing the primary carrier altogether. Similarly, it may be economically sound for the insured to take a percentage of its primary insurance, pay the difference itself to the retained limit of its excess carrier and then proceed under its excess. Finally, if the insured had a small primary policy, it may be economically sensible to pay the primary limits and then proceed under the excess. This in fact is what the II policy authorizes.

^{FN6}. I am aware of II's citation to authority including the *American Home Assurance Co. v. Cohen*, decision at 124 Wash.2d 865, 881 P.2d 1001 (1994) regarding the starting place for public policy analysis being in applicable legislation. Regulations by the state insurance Commissioner are similar.

^{FN7}. See e.g. Mr. Spoonemore's citation to Appleman's concern about shifting liability to the excess carrier before the primary insurer "has paid its limits and has bought the claim and fulfilled its obligations." See also various arguments and authority cited in the motion re: Duty to Defend and the policy language.

^{FN8}. There was some oral argument regarding an ongoing duty to defend despite settlement. The cases cited are distinguishable for a variety of reasons, including a fact pattern of primary co-insurers, "settlement" without payment, settlement late and then an effort to pro rate defense costs, etc. Where

Not Reported in P.2d, 1995 WL 17015061 (Wash.Super.)
(Cite as: 1995 WL 17015061 (Wash.Super.))

excess insurers' retained limits are exhausted by payment, the primary's duty to defend terminates and the excess carrier assumes the obligation.

*4 Key policy language makes clear that exhaustion of underlying limits is a condition precedent to coverage under the II excess policy. For instance, condition G of the policy states that II's liability shall not attach unless and *until the insured*, the company on behalf of the insured, or the insured's underlying insurer *has paid the amount of the retained limit...* (Emphasis added.)

At footnote 5 on page 7 of the same brief, II cites additional authority as follows:

See also *Span Inc. v. Associated International Insurance Co.*, 277 Cal.Rptr. 828, 835, 227 Cal.App.3d 463, 475 (Cal.App.1991) (declaring that the policy's "in the event of reduction or exhaustion" language unambiguously contemplates "exhaustion" of the underlying insurance only by *payment of the underlying limits, either by the insured or its primary carrier.*) (Emphasis added.)

There is no insurance policy provision that requires that only the *underlying insurer* pay the full policy limits as a condition precedent to reach the excess coverage; rather, the policy specifically authorizes payment by the insured and uses the term "exhaustion" without specifying how exhaustion is to occur. As stated in *Boeing v. Aetna*, 113 Wash.2d 869, 784 P.2d 507 (1990), "[t]he undefined term 'as damages' does not stand exclusionary guard for the industry and represent a vast exclusion from coverage. The term damages is to be given its plain ordinary meaning and not the technical meaning advocated by insurers." Similarly, the term "exhaustion" is undefined. If the insurer wanted to require that full policy limits be paid *by the underlying insurer only*, it could have written such a provision. However, instead, the term employed is "exhaustion." There is no reason in the policy or in terms of public policy why the manner in which a primary policy is exhausted could matter from the excess insurer's standpoint. No argument has been offered that full payment of the policy limits by the primary carrier only is a factor in terms of setting the rate. In addition, there is no public policy that would suggest such an interpretation; contrary public policy is noted above. Finally, the policy provision itself identifies the insured as a potential payor of the re-

tained limit, which then triggers the excess insurer's liability.

As Judge Dwyer, I believe, noted in one of his decisions cited where the policy did not define "exhaustion," any ambiguity is not associated with the word itself, but rather with how exhaustion can be achieved. See also *Brown v. Lumbermens Mutual Casualty Co.*, 326 N.C. 387, 390 S.E.2d 150, 154 (N.C.1990) In addition, in *Northwest Steel Rolling Mills, Inc. v. Fireman's Fund Insurance Co.*, No. C86-376C, Oral Decision (W.D.Wash. Feb. 25, 1991), Judge Dwyer noted in his *Order on Plaintiff's Motion for Determination that Proposed Settlement Exhausts Policies of Defendant Fireman's Fund* that there is no prejudice to the insurer in finding exhaustion as long as the full amount of the retained limits is credited against the insured, and also noted the additional considerations of "the desirability of settlement (which would be made more difficult by a contrary holding), and the construction of insurance policy provisions, if ambiguous, in favor of the insured," citing to *Britton v. Safeco Insurance Co.*, 104 Wash.2d 518, 528, 707 P.2d 125, 132 (1985).

*5 Applying the principles of contract interpretation and construction identified in the "Owned Property" and "Pollution Exclusion" decisions, there is no evidence that the provisions of the policy which implicate exhaustion were negotiated by the parties, nor is there extrinsic evidence regarding the parties' mutually manifested intent on the issue of exhaustion. Reading the policy as a whole, including the loss payable provision with its specific language regarding the ability of the insured to pay the retained limits as one of the triggers to the excess carrier's liability, there is no ambiguity regarding exhaustion. II's liability is not implicated until the primary policy is "exhausted;" it is exhausted when the retained limits have been paid by the primary insurer, by the insured, or by the company on behalf of the insured. Even if the undefined term is ambiguous, the sound reasoning in Judge Dwyer's *Northwest Steel Rolling Mills* Order on this issue should be applied here to resolve the issue of "how" the underlying policy may be exhausted. The answer is that it may be exhausted by a method other than the underlying insurer paying the full amount up to II's retained limits. This policy, apparently consistent with others, does require payment in order to trigger the excess carrier's liability; as long as the insured or primary carrier pays an amount equivalent

Not Reported in P.2d, 1995 WL 17015061 (Wash.Super.)
(Cite as: 1995 WL 17015061 (Wash.Super.))

to the retained limit, then II is not prejudiced based on the policy it sold.

It appears undisputed that allocation of settlement proceeds involving the primary carrier can constitute exhaustion (although the parties clearly dispute *when* such allocation should occur). II asserts that Kalama made a fatal mistake by not fully allocating at the time it settled with Allianz, and that any attempt at allocation after the fact should not be considered for purposes of determining the exhaustion issue. Kalama asserts that there is no requirement that it allocate at the time of settlement and acknowledges that delaying allocation until after settlement allows it the possibility of maximizing its recovery.

Kalama has allocated one million dollars of the Allianz settlement to the 1982/1983 II policy year according to the uncontroverted declaration of Mr. Macomber dated February 2, 1995. This constitutes either payment by the insured or payment by the underlying insurer, and triggers the excess coverage at least as to the Kalama site. The time of the allocation is not critical, as long as there remain funds from the Allianz settlement which have not previously been allocated to other claims and as long as there is not double recovery.^{FN9} There is nothing in II's policy which indicates when payment needs to occur, nor is there anything in the policy which provides that the insurer has the right to state how the insured's settlement with the underlying insurer should be allocated between sites or covered periods. In addition, there is no legal authority cited for this requirement of simultaneous allocation.^{FN10}

^{FN9} Similarly, in deciding Kalama's Motion regarding defense costs, Judge Bridge in her Order dated March 23, 1994, stated that the primary carrier had not offered any authority for its position that Kalama was required to allocate settlement proceeds from other insurers to defense costs and indemnification. She stated, "(p)laintiffs do not seek a double recovery, and moreover, public policy is contrary to Allianz's position because the necessity for allocation would have limited settlement, contrary to the policy of encouraging parties to settle early and rewarding those who do achieve early settlements."

At oral argument, II asserted that allowing

an insured to allocate after a settlement with an underlying insurer would facilitate the insured's manipulation of multiple insurers for settlement purposes as well as facilitate the allocation and "reallocation" of the same dollars, essentially in a dishonest manner. However, the public policy in favor of early settlements and the rule of interpretation that insurance contracts must be liberally construed in favor of the insured support not imposing a requirement of allocation at the time of settlement (when none is required by the terms of the policy), provided that there is no previous allocation which consumes all of the funds and provided that there is no double recovery.

^{FN10} Kalama has also paid more than two million dollars in response costs at the Kalama site; it is not clear however for what time period or property damage or particular damages this applies. In addition, there is also the payment associated with the Garfield site.

*6 The issue of interpretation and construction of the "aggregate" language must be addressed in order to resolve the Pasco Site and Duty to Defend issues. The policy between II and Kalama states in *Schedule A-Schedule of Underlying Policies* that the underlying bodily injury and property damage combined single limit CGL insurance with Allianz for the 1981/1982 policy period is one million dollars each occurrence and one million dollars aggregate when applicable. II asserts that in order to understand whether the policy between II and Kalama was aggregating or non-aggregating, we must turn to the Allianz policy because the printed portion of the II policy says "aggregate when applicable." II then reviews endorsement 4 to the Allianz policy which says under coverage for bodily injury liability and property damage liability, the limits of liability are one million dollars each occurrence and one million dollars aggregate. Under the narrative description, II argues that subparagraph (b) describes the only four instances where the aggregate applies (without so stating), in part because of the conjunctive "and" contained in the body of subparagraph (b).^{FN11} Kalama asserts that the language following the four subparts to subparagraph b ("Such aggregate limit shall apply separately: ...")

Not Reported in P.2d, 1995 WL 17015061 (Wash.Super.)
(Cite as: 1995 WL 17015061 (Wash.Super.))

means that the aggregate limit applies separately to whatever it is that is described in the four subparagraphs, that is, that this is an exception to the overall aggregate limit of one million for each year and that these are the only exceptions. Since it is possible to read the Allianz policy in this manner and since both sides concede that Kalama does not fall within any of the four subparts, then the one million dollar aggregate should apply, Kalama asserts.

FN11. "... commencing from its effective date and which is described in any of the numbered subparagraphs below .."

The task is to determine what the parties to *this* policy between II and Kalama intended in terms of the trigger for II's coverage. There is no extrinsic evidence that the parties negotiated this item. There is no extrinsic evidence about manifested mutual intent. The only documentary evidence is the representation in the II file from Kalama's agent that the Allianz policy was "\$1,000,000 each occurrence and aggregate" which serves as notice from Kalama to II of Kalama's understanding of its primary insurance policy. The language on Schedule A to II's own policy is that it is "\$1,000,000 occurrence" and "\$1,000,000 aggregate when applicable" with the numbers typewritten and the words in preprinted form. How could II intend something about which it was apparently completely unaware, that is, any particular language in the Allianz policy? II's proposed interpretation of its policy which imposes a significant limit on its coverage is certainly not clear from the language of its own policy, nor is it clear from reading the disputed language of the Allianz policy. In applying the rules of interpretation and construction set out in the Owned Property and Pollution Exclusion decisions, insurance contracts must be liberally construed in favor of the insured, the entire contract must be construed together to give effect to each clause, the policy should be given a fair, reasonable and sensible construction as would be given by the average person purchasing insurance even if the insured is a large corporation with company counsel. The interpretation must be reasonable and must take into account the purpose of the insurance at issue. If there are ambiguities which cannot be resolved, they must be resolved against the drafter-insurer and in favor of the insured. Looking at the II policy with these considerations in mind, if there is any ambiguity, it exists because of the preprinted words "when applicable" next to the word "aggregate." Applying the

principles of interpretation and construction noted above, the fair and reasonable construction as would be understood by the average person purchasing *this excess coverage policy* is that it was implicated when the one million dollars aggregate had been reached in the Allianz policy. The purpose of this coverage is to provide an umbrella or excess layer of insurance, once the underlying policy limits have been reached. If II had wanted to provide the very limited coverage for which it now argues, it could have clearly written its policy to so provide.^{FN12} However, it is not a reasonable interpretation of the II policy to have the pre-printed words "when applicable" with no other explanation or reference "stand exclusionary guard" for coverage here by requiring the average purchaser of this excess coverage to refer back to an endorsement on the primary policy and then to read subparagraph (b) contained there as providing, without clearly so stating, that under four rather esoteric circumstances, the policy will be an aggregate policy, but otherwise, the insured has broad per occurrence coverage (even though the middle separated section (not the "fine print") simply states under "limits of liability," "\$1,000,000 each occurrence \$1,000,000 aggregate"). Such an intention needs to be far more explicitly stated in the II policy.^{FN13} I interpret the II policy to be implicated when the insured has incurred damages as defined in II's policy of one million dollars, that is, that the policy is an aggregate policy.

FN12. Here II's position is that the words "when applicable" following the word "aggregate" operate (like an exclusion) to limit or exclude the coverage under its policy. In *Transcontinental Insurance v. Utility Systems*, 111 Wash.2d 452, 760 P.2d 337 (1988), in interpreting an exclusion the Supreme Court declined to give meaning to the words in the exclusion "subject to the terms" because they conflicted with coverage language and would render the declarations page and the endorsement meaningless.

FN13. II argues that the court should apply the rule of construction to the underlying Allianz policy, that ambiguous terms should be construed in favor of the insured or of coverage, thereby construing it as a per occurrence policy, thus providing greater coverage under *that policy*. The concurrent effect would of course be to find very limited cov-

Not Reported in P.2d, 1995 WL 17015061 (Wash.Super.)
(Cite as: 1995 WL 17015061 (Wash.Super.))

erage under the excess policy, which is the policy at issue before me. This result would turn the purpose of that particular rule of construction on its head. Whether it is by applying the language of *Berg* that the principles should not be applied as absolutes, but as suggestive working rules only, or whether it is simply by focusing on the II policy and its construction, I believe that the suggested application of that rule of construction is inappropriate. Moreover, no authority has been cited for its application in a similar situation.

*7 Based on the un rebutted record, I find that the only underlying policy, issued by Allianz, has been exhausted not only by Kalama's allocation of one million dollars from the Allianz settlement to the Kalama site, but also by the Garfield site settlement. This does not address whether the payment by Kalama of over two million dollars at the Kalama site (without indicating to which period or occurrences the payments applied) constitutes exhaustion.^{FN14}

FN14. II asserts that Kalama has not shown receipts, inferring that the Macomber declaration requires corroboration. There is also a dispute regarding whether the expenditures made thus far, which are largely for investigation, can be considered as applying to exhaust retained limits, or indemnity requirements, as opposed to being defense costs. Kalama asserts they can be both and that Judge Bridge has previously so found. II provides memoranda in which Kalama has previously taken the position that such costs are defense costs, and Kalama has provided additional materials disputing that characterization of its prior positions. Particularly in light of Judge Bridge's ruling that they can be both, Kalama's position may not be inconsistent. I don't believe it is necessary to reach this issue at this time.

II's MOTION FOR SUMMARY JUDGMENT RE:
PASCO SITE (# 8)

Defendant Industrial Insurance moves for summary judgment dismissing plaintiff's claims regarding the Pasco site. Defendant asserts that there is no justiciable dispute between the parties here with respect to the Pasco claims. Defendant asserts that plaintiff's

claims with respect to Pasco are premature and speculative, in that Kalama's contributive share of liability for damages has not been established at the Pasco site. II does not seek a determination or adjudication of the merits of Kalama's claim for coverage. II seeks a dismissal of Kalama's Pasco site claims, asserting that Kalama's present costs do not currently exceed one-million dollars and therefore II's coverage is not yet implicated, and further that future costs are speculative and unpredictable.

Kalama responds that II has misapplied the doctrine of justiciability, that the underlying primary policy has been exhausted, and that the Pasco site claim represents an actual dispute between the parties which is substantial and capable of a final judicial determination. Kalama asserts that cleanup at Pasco will probably exceed fifty million dollars, and that Kalama is jointly and severally liable as a "potentially liable party." Kalama asserts that it is liable for cleanup at Pasco pursuant to the Enforcement Order issued by the DOE on October 21, 1994, that site investigation continues and that interim and final remedial measures are being developed for submittal to the DOE for approval. Kalama asserts that II's policy provides coverage for claims that exceed one million dollars in the aggregate, that the Pasco site claim meets the requirements of justiciability and in addition, involves issues of overriding public concern. Kalama further asserts that the contingent events which II alleges must precede justiciability are inapplicable, in that the DOE has already determined Kalama's liability at Pasco.

II replies that the aggregate limits of the underlying Allianz policy do not apply to this situation, the underlying policy is not exhausted, Kalama's liability is based on speculation and conjecture, the controversy is not an issue of overriding public import, Kalama's judicial economy argument violates fundamental fairness, and II's policy covers only damages paid, not anticipated.

II's motion is based on the notion of lack of justiciability, which in turn, is based on its assertion that the Allianz policy is non aggregating except in a few circumstances which don't apply to the parties here. The rules to determine whether a controversy is justiciable have been cited by both sides. They are: 1) actual, present and existing dispute, or the mature seeds of one, as distinguished from a possible, dor-

Not Reported in P.2d, 1995 WL 17015061 (Wash.Super.)
(Cite as: 1995 WL 17015061 (Wash.Super.))

mant, hypothetical, speculative or moot disagreement, 2) between parties having genuine and opposing interests, 3) which involves interests that must be direct and substantial, rather than potential, theoretical, abstract or academic, and 4) a judicial determination of which will be final and conclusive. These elements must coalesce, otherwise the court steps into the prohibited area of advisory opinions. Diversified Industries Development Corp. v. Riplev, 82 Wash.2d 811, 814-15, 514 P.2d (1973); Walker v. Muir, 124 Wash.2d 402, 411, 8789 P.2d 920 (1994); Arnold v. Retirement Systems, 74 Wash.App. 654, 875 P.2d 665 (199). The Declaratory Judgment Act is remedial in nature, and is subject to liberal construction and administration. RCW 7.24.120; Clallam County Deputy Sheriff's Guild v. Board of Clallam County Commissioners, 92 Wash.2d 844, 601 P.2d 943, 945 (1979), and Arnold, supra. Although no Washington authority has been cited on the issue of justiciability between parties to an insurance contract, Kalama has cited the case of ACandS Inc. v. Aetna Casualty & Surety Co., 666 F.2d 819 (1981) for the following proposition:

*8 Declaratory suits to determine the scope of insurance coverage have often been brought independently of underlying claims, albeit the exact sums to which the insurer may be liable to indemnify depends upon the outcome of the underlying suits....The inescapable indication of the actuality of this controversy is that a liability insurer's indemnification agreement carries with it not only an obligation to pay judgments against the insured, but also in the real world to pay settlement amounts. Indeed, liability insurers owe fiduciary obligations to their insured with respect to the consideration of settlement offers and the conduct of settlement negotiations. It would turn the reality of the claims adjustments process on its head to hinge justiciability of an insurance agreement on the maturization of a suit to a judgment when the overwhelming number of disputes are resolved by settlements.

In Judge Bridge's earlier determination of this issue on April 13, 1993, in the Monroe site claims, she cited language from the Supreme Court in Maryland Casualty Co. v. Pacific Coal & Oil Co., 312 U.S. 270, 61 S.Ct. 510, 85 L.Ed. 826 as follows:

The difference between an abstract question and a "controversy" contemplated by the Declaratory Judgment Act is necessarily one of degree, and it

would be difficult, if it would be possible, to fashion a precise test for determining in every case whether there is such a controversy. Basically, the question in each case is whether the facts alleged, under all the circumstances, show that there is a substantial controversy, between the parties having adverse legal interests, of sufficient immediacy and reality to warrant the issuance of a declaratory judgment. [citing also to 10 Wright & Miller, Federal Practice and Procedure. Civil. § 2757 (2d ed.1983).

Judge Bridge further noted that the proper trigger of coverage is the "likelihood that limits of primary coverage will be exceeded, i .e., the reasonable probability that excess layers will be invaded by reason of damage sustained by this insured within the policy term(s) which exhausts primary coverage." She then reviewed the status of the pertinent sites: all but one had damages only in the tens of thousands of dollars. She determined that the most clear estimates on all sites showed that they were well below the one million dollar limit per occurrence of the Allianz policies (and they were also far less than one million dollars in the aggregate). The Monroe site claims were also at a later stage, either settled, old or dormant. Pasco, on the other hand, is a site on the National Priorities List, is the subject of an enforcement order against Kalama and other potentially liable parties who are jointly and severally liable for the response action at Pasco. Kalama's expert has given an opinion that "extensive and costly remedial measures will, more probably than not, be required at the Pasco site" and that the "cost of these remedial measures will likely exceed fifty million dollars." II's expert has given an opinion that no clean up would be an appropriate response, although he does not give an opinion that that will be the response of the regulators. ^{FN15} Kalama is jointly and severally liable at Pasco, but even if the standard is what is Kalama's likely share of the total liability, the evidence offered from Mr. Hale's declaration dated November 9, 1994, that he expects Kalama to pay a 2-5% share, or one million seventy hundred fifty thousand (\$1,750,000), (average of 3.5%) of Mr. Lang's estimate of fifty million dollars exceeds the retained limits (even if the policy was non-aggregating). I have found that the policy between II and Kalama is properly interpreted to mean that II will pay amounts Kalama is legally obligated to pay above the one million dollar retained limits of its policy. Kalama has allocated one million dollars to this policy year at the Kalama site (as well as has paid over two million dollars itself for response costs for

Not Reported in P.2d, 1995 WL 17015061 (Wash.Super.)
(Cite as: 1995 WL 17015061 (Wash.Super.))

some period of time), and has received over a million dollars (\$1.6 million) from II for the Garfield site. Mr. Lang's expert opinion regarding clean-up costs is sufficient to oppose II's motion for summary judgment of dismissal based on lack of justiciability. Kalama's liability at the Pasco site is not too speculative. The issue between Kalama and II is justiciable. II's motion to dismiss Kalama's claims is denied.

FN15. For example, at page 148, line 8 of Dr. Steiner's deposition: "Q: ... your opinion is not that it is not likely that the regulators will require ___ or no remediation it's simply that in your view it doesn't need it, is that correct? A: Yes, that's my opinion."

KALAMA'S MOTION FOR SUMMARY JUDGMENT RE: PASCO SITE (# 7)

***9** Plaintiff Kalama moves for summary judgment to establish Industrial Indemnity's indemnity coverage for Kalama's liability on the Pasco site claim under II's excess coverage policy. Kalama asserts that there is no dispute of material fact with respect to the elements necessary to require II to afford indemnity coverage to Kalama for the Pasco site claim.

Kalama asserts that the incidents in question were the release of hazardous chemicals from not later than 1974, proceeding through II's policy period and continuing to present. Kalama asserts that leakage from drums moved through the soil at Pasco, creating a single continuous occurrence, which nevertheless caused new damage each year from 1974 as the contamination moved through the soil as liquid or vapor into the groundwater. Kalama asserts that such groundwater contamination was first determined to exist in 1985 and that such leakage was not expected or intended.

Kalama's recital of the facts asserts that it shipped drummed waste containing toluene, benzene, benzoic acid, copper and phenol to the Pasco Municipal Landfill, which contaminants have been detected in the groundwater. In October of 1991, Kalama was advised by the Washington State Department of Ecology (hereinafter "DOE") that it was a potentially liable party (hereinafter "PLP") at the Pasco site. Notice of such potential liability was given to II on December 20, 1991. Phase I of the cleanup process has been approved and agreed to by all PLPs. The DOE ordered Kalama to participate in Phase II (Remedia-

tion Investigation and Feasibility Study) and notified Kalama in January, 1992, that it is subject to "generator liability" jointly and severally with the other PLPs. Kalama's expert estimates that the cost of remediation is likely to exceed fifty million dollars.

Kalama asserts that pursuant to the foregoing fact pattern, Kalama will incur and is legally obligated to pay damages for cleanup imposed by law, and that such cleanup costs constitute "damages" under the terms of CGL policies. Kalama further asserts that pursuant to Judge Bridge's prior order with respect to the Monroe site, Kalama does not have to "fingerprint" its waste as a cause of property damages. Kalama asserts that the pollution exclusion provision of II's policy does not preclude coverage, because discharge was "sudden and accidental."

II responds that Kalama's motion is premature and therefore unjusticiable because the investigation into the cause and extent of contamination at the Pasco site will not be completed for at least two years, and Kalama's assumptions regarding remediation (if any) and its share of attendant costs are speculative. II argues that II's policy is not triggered until Kalama exceeds onemillion dollars in expenses, and that Kalama has failed to establish such obligation has been incurred. II asserts that factual disputes which existed in late 1994 still exist, that a jury could conclude that contact with the soil at the dump was clearly expected and was not an occurrence, and that even if the groundwater is found to be contaminated, it is not an occurrence because the groundwater was not affected until after II's policy period had elapsed. II asserts in support of this contention that the Pasco landfill discontinued dumping of industrial waste in 1975, that no dioxin or organic contamination appeared in 1984 tests of the groundwater, and that the 1985 tests showed organic compounds normally associated with municipal landfills in 1984 tests of groundwater.

***10** Kalama replies that based on the language of the policy and uncontroverted facts, the elements for coverage are met. Kalama notes that the only elements that II disputes relate to the element of an "occurrence" and to the speculative nature of Kalama's liability, and that II reasserts arguments on exhaustion and justiciability.

The standards for summary judgment have been previously set forth in the memorandum of opinion on

Not Reported in P.2d, 1995 WL 17015061 (Wash.Super.)
(Cite as: 1995 WL 17015061 (Wash.Super.))

Kalama Site. The Washington courts have frequently cited the U.S. Supreme Court's decision in *Celotex v. Catrett*, 477 U.S. 319, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986), for the proposition that there must be genuine issues of material fact, not merely a "scintilla of evidence" in order to avoid summary judgment.

The earlier decisions relating to exhaustion and justiciability address some arguments presented here. Kalama is under an order as a potentially liable party on a site listed on the National Priorities List. Kalama is liable now pursuant to an agreement for Phase I of the clean-up process and is ordered by the DOE to participate in the remedial investigation and feasibility study. There is no requirement that Kalama's wastes cause particular damage; it is sufficient if Kalama sent waste to the site of a type which has been found to have caused property damage to that site. There is no requirement that groundwater contamination occur; since this is non-owned property, it is sufficient that the soil was damaged, a fact which is uncontroverted. The only disputes relate to whether the Pasco site pollution constitutes an occurrence (whether the property damage was expected and intended) and whether the damages for which Kalama is liable are speculative. The bulk of II's "expected and intended" argument has been that, based on Kalama's experiences with on-site, approved wastewater disposal at Beaufort and the accidents which had occurred at the Kalama site, the company must have known that property damage would occur at the Pasco site. II also cited to newspaper articles from 1979 through 1981 including references to drummed wastes at disposal sites in support of this position. Although this determination appears closer than in the determination with respect to the Kalama site, there nevertheless is a genuine issue of material fact with respect to whether the pollution was "unexpected and unintended," that is, whether Kalama "must have known" of the pollution during II's policy period.

The only other disputes relate to the argument regarding speculation: will Kalama be liable (which is determined by the exhaustion/aggregation and justiciability decisions) and the cost of cleanup. Because of the earlier decisions relating to exhaustion and aggregation, the amount of the costs is not an issue. As previously noted, Dr. Steiner's testimony does not controvert Mr. Lang's testimony regarding the government's requirement of cleanup (nor does it controvert his testimony regarding cost); rather, his tes-

timony is limited to the opinion that the site will clean itself up and does not address whether the DOE will require cleanup. While the actual extent of the damages and Kalama's share of such cost remain unresolved at this time, nevertheless on this record, the matter is justiciable.^{FN16}

^{FN16} The drummed waste was sent to Pasco in 1973 and 1974. At the outset of this process involving cleanup, Kalama apparently didn't believe it had even sent waste to Pasco. Kalama purchased Beaufort in 1976, the articles on waste sites were in 1979 through 1981 and the accidents and continuous and repeated exposure to conditions at Kalama range from 1977 to 1983.

*11 Because of the outstanding issues relating to whether the damage at Pasco was expected or intended, Kalama's motion for partial summary judgment to establish indemnity coverage at the Pasco site is denied.

KALAMA'S MOTION FOR SUMMARY JUDGMENT ON DUTY TO DEFEND (# 1)

Kalama moves for partial summary judgment against defendant Industrial Indemnity that II has a duty to defend Kalama under II's policy No. JU 839-7860. Kalama asserts that II's excess coverage policy covers two environmental claims:

1. The claim by the U.S. Environmental Protection Agency relating to the Kalama Washington facility;
2. The claim by the Washington State Department of Ecology relating to the Pasco Sanitary Landfill.

Kalama asserts its settlement on May 19, 1994 with Allianz Insurance, the issuer of a one million dollar underlying primary coverage policy, triggered II's excess coverage policy under II's exhaustion prong. Kalama further asserts that Allianz's duty to defend (determined by prior court order dated August 26, 1992) then passed to II and that the same principles which governed Allianz's duty to defend also apply to II's duty to defend. Plaintiff asserts that II has breached its duty to defend, and that II now owes to plaintiff all defense costs incurred by plaintiff since May 19, 1994, as well as all future defense costs relating to the Kalama and Pasco site claims. Kalama

Not Reported in P.2d, 1995 WL 17015061 (Wash.Super.)
(Cite as: 1995 WL 17015061 (Wash.Super.))

asserts that the II policy does not define "exhaustion" and that word must therefore be construed in the light most favorable to Kalama, that the DOE claim creates a potential for coverage at the Pasco site, that no genuine issue of material fact exists regarding exhaustion, and that II has breached its duty to defend Kalama with respect to the Pasco site. Kalama asserts that the investigation at the Pasco site is currently in Phase II, in which remediation measures will be developed for approval and proportionate liability will be assessed among the potentially liable parties, which Kalama asserts is a critical phase, during which II is obligated to defend Kalama's interest to minimize cleanup costs.

II responds that facts remain in dispute regarding whether the underlying primary insurance is exhausted, asserting that Judge Bridge's order of November 30, 1994, referred to outstanding material questions of fact regarding exhaustion. II further asserts that plaintiff did not notify it of the settlement with Allianz within thirty days of such settlement. II asserts that Allianz issued six consecutive policies and that Kalama did not exhaust all of Allianz's primary policies, citing to Judge Bridge's reference to "other insurance collectible by the insured."

Kalama replies that the present record is more complete than that on which Judge Bridge relied in November of 1994 and that II does not contest that facts exist which raise the potential for coverage. With respect to notice, Kalama asserts that II attended the settlement conference at which the settlement with Allianz was reached, and further, even assuming II's late notice claim was valid, II cannot prove it is prejudiced by such late notice. Kalama asserts that Judge Bridge rejected II's claim that other policies in other policy periods must be exhausted, and that the issue of whether this one underlying Allianz policy had been exhausted was not before Judge Bridge.

*12 "Insurers have a duty to defend any complaint alleging facts which, if proven, would render the insurer liable for indemnification of the Insured." *Viking Ins. Co. v. Hill*, 57 Wash.App. 341, 346, 787 P.2d 1385 (1990). The duty to defend here would arise if Kalama faces a "suit" arising out of alleged releases or continuing events during the 1982/1983 policy period which are potential occurrences giving rise to claims for damages potentially covered under the II policy. The excess coverage

policy in this case has several pertinent provisions relating to when II's duty to defend arises. They include Section II, Defense Settlement, which requires II to "defend any suit" which is not covered by the "underlying policies" (here, only Allianz) but which is covered by the terms and conditions of the II policy, even if the suit is "groundless, false or fraudulent." In Section V, Retained Limit, II agreed that if the underlying insurance (here, Allianz) was exhausted, then II's policy would "continue in force as underlying insurance." In addition, Condition E, Assistance and Cooperation, provides that if the aggregate limits of the underlying insurance are exhausted, II does not have to "assume charge of the settlement or the defense" unless it falls within Section II, Defense Settlement or Section V, Retained Limit. In paragraph J, regarding underlying insurance, II agreed to defend any claim or proceeding against Kalama arising from the same occurrence which exhausted the primary coverage. Kalama has exhausted the underlying policy as noted previously: (1) by its allocation of one million dollars of the Allianz settlement proceeds to the Kalama site; (2) by the Garfield site settlement; and potentially (3) by its payment of over two million dollars on this aggregating policy at Kalama for some period of time. (This payment includes investigative costs (which may be both defense and indemnity expenditures according to Judge Bridge's earlier order with another insurer) as well as interim corrective measures which are clearly indemnity payments.) The RCRA complaint by the U.S. Environmental Protection Agency for the Kalama site is a "suit." The pleadings, including the Order by the Washington State Department of Ecology for the Pasco site, likewise constitute a "suit." As has been found in earlier decisions, the releases during the policy period and the potential continuing property damage from earlier releases constitute potential occurrences at the Kalama site. The un rebutted continuing property damage (soil, as well as potentially groundwater) at Pasco constitutes a potential occurrence. The Kalama site RCRA claim and the Pasco site DOE claim are claims for damages and investigative expenses as well as interim corrective measures have been undertaken; at Pasco, the required corrective measures and investigation of the nature and extent of contamination arising out of releases there to determine corrective measures are sufficient to constitute potential damages. Because the underlying policy is an aggregating policy which is exhausted, and because there is the potential for coverage by II due to allegations of occurrences in the II policy year giving rise to an obligation by Kalama to

Not Reported in P.2d, 1995 WL 17015061 (Wash.Super.)
(Cite as: 1995 WL 17015061 (Wash.Super.))

pay damages, II has a duty to defend for both sites.^{FN17}

FN17. There is no duty for Kalama to exhaust all Allianz policies; rather there is only an obligation to exhaust the Allianz policy underlying II in this 1982/1983 policy year.

*13 II asserts that it has not received proper written notice of the exhaustion of the underlying policy, thus implicating coverage here. Mr. Thonn did acknowledge in oral argument that he “would assume that that could be cured but it hasn’t been cured to date.” Mr. Hale argues that he in fact gave actual notice to II’s attorneys, face to face, within minutes of settling with Allianz, and that pleadings constitute “written notice” if his contact with counsel is technically insufficient. Moreover, he argues that prejudice must be shown and none is argued. It appears that Kalama has substantially complied with the notice provision by giving almost simultaneous notification in person of the settlement; the pleadings also provide the writing. In any event, no prejudice has been asserted from the lack of some specific notification document.

The potential for coverage exists as to both sites and II’s duty to defend under its policy has arisen.

Wash.Super.,1995.
Kalama Chemical, Inc. v. Allianz Ins. Co.
Not Reported in P.2d, 1995 WL 17015061
(Wash.Super.)

END OF DOCUMENT



**RODNEY R. MOODY, Plaintiff, v. AMERICAN GUARANTEE AND LIABILITY
INSURANCE COMPANY, Defendant.**

CASE NO. C10-01102-RSM

**UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF
WASHINGTON**

804 F. Supp. 2d 1123; 2011 U.S. Dist. LEXIS 38024

**April 7, 2011, Decided
April 7, 2011, Filed**

COUNSEL: **[**1]** For Rodney R Moody, Plaintiff:
Mark Gregory Olson, LEAD ATTORNEY, EVERETT,
WA.

For American Guarantee and Liability Insurance Com-
pany, Defendant: Jacquelyn A Beatty, Robert Arnold
Radcliffe, LEAD ATTORNEYS, KARR TUTTLE
CAMPBELL, SEATTLE, WA.

JUDGES: RICARDO S. MARTINEZ, UNITED
STATES DISTRICT JUDGE.

OPINION BY: RICARDO S. MARTINEZ

OPINION

**[*1124] ORDER GRANTING DEFENDANT'S MO-
TION FOR SUMMARY JUDGMENT**

I. INTRODUCTION

This matter comes before the Court upon Defen-
dant's Motion for Summary Judgment. Dkt. #11. Defen-
dant argues that the "claims made and reported" policy
issued to the insured does not cover Plaintiff's claim be-
cause the claim was not reported to the insurer until after
the policy had already expired. For the reasons set forth
below, Defendant's motion is GRANTED.

II. BACKGROUND

At issue is a professional liability insurance policy
issued by Defendant American Guarantee and Liability
Insurance Company ("American") to attorney Leland
Ripley in 2008. The policy was issued on a "claims made

and reported" basis and was effective from November 1,
2007 to November 1, 2008. Dkt. #12, Ex. 1 at 6. The
insuring agreement provided that American would pay
damages and claim expenses for claims that were "*both
made and reported* to **[**2]** [American] during the Pol-
icy Period or any extended reporting period based on an
act or omission in the Insured's rendering or failing to
render Legal Services for others..." *Id.* at 7 (emphasis
added). Mr. Ripley did not purchase coverage for an ex-
tended reporting period. Dkt. #13, para. 2.

On October 31, 2008, one day before the American
Guarantee policy expired, Plaintiff Rodney Moody filed
an attorney malpractice action against Mr. Ripley. How-
ever, the summons and complaint were not served on Mr.
Ripley until November 15, 2008. Dkt. #14, Ex. 1 at 5. In
addition, Mr. Ripley never reported the claim to Defen-
dant American. In fact, American did not learn of the
lawsuit until April 30, 2009, when Plaintiff's counsel
called and spoke with Defendant's claims counsel. Dkt.
#12, para. 4.

Plaintiff Moody brings this suit against Defendant
American Guarantee and Liability Insurance Company
("American") as an assignee of Ripley. Mr. Ripley as-
signed his claim against Defendant American to Mr.
Moody as part of the settlement of the underlying attor-
ney malpractice dispute. Defendant American moves for
summary judgment.

III. DISCUSSION

A. Standard of Review

Summary judgment is appropriate where "the **[**3]**
pleadings, the discovery and disclosure materials on file,

and any affidavits show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law." *FRCP 56(c); Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986). The Court must draw all reasonable inferences in favor of the non-moving party. See *F.D.I.C. v. O'Melveny & Myers*, 969 F.2d 744, 747 (9th Cir. 1992), *rev'd on other grounds*, 512 U.S. 79, 114 S. Ct. 2048, 129 L. Ed. 2d 67 (1994). However, the non-moving party must make a "sufficient showing on an essential element of her case with respect to which she has the burden of proof" to survive summary judgment. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986). In ruling on summary judgment, a court does not weigh evidence to determine the truth of the matter, but "only determin[e] whether there is a genuine [*1125] issue for trial." *Crane v. Conoco, Inc.*, 41 F.3d 547, 549 (9th Cir. 1994) (citing *O'Melveny & Myers*, 969 F.2d at 747). Material facts are those which might affect the outcome of the suit under governing law. *Anderson*, 477 U.S. at 248.

B. "Claims Made and Reported" Policies

Defendant argues that summary judgment should be granted in its favor because [**4] Mr. Ripley's insurance policy required that American be notified of any claim for which Mr. Ripley was seeking coverage during the time period in which the policy was still in effect. Since American was not notified of Mr. Moody's malpractice claim against Mr. Ripley until well after the policy expired, it is not liable to pay the claim. The Court agrees.

The Court's "[i]nterpretation of insurance policies is a question of law, in which the policy is construed as a whole and each clause is given force and effect." *Overton v. Consolidated Ins. Co.*, 145 Wn.2d 417, 424, 38 P.3d 322, 324 (2002). Ambiguities in insurance policies are to be interpreted in favor of the insured, but clear and unambiguous language must be given effect according to its plain meaning and may not be construed by the courts. *McDonald Indus., Inc. v. Rollins Leasing Corp.*, 95 Wn.2d 909, 913, 631 P.2d 947 (1981); *Progressive Cas. Ins. Co. v. Jester*, 102 Wn.2d 78, 79-80, 683 P.2d 180 (1984). Here, the language of the American Guarantee policy unambiguously requires that the insured notify American of the claim during the policy period as a condition precedent for coverage. Further, Washington law requires that the [**5] notice requirement of "claims made and reported" policies be strictly construed. See *Safeco Title Ins. Co. v. Gannon*, 54 Wn. App. 330, 338, 774 P.2d 30, *review denied*, 113 Wn.2d 1026, 782 P.2d 1069 (1989) ("[C]laims-made policies require that the notice be given during the policy period itself. When an insured becomes aware of any event that could result in

liability, then it must give notice to the insurer, and that notice must be given "within a reasonable time" or "as soon as practicable"- at all times, however, during the policy period.")¹. Since the undisputed evidence demonstrates that Mr. Ripley did not report Mr. Moody's claim to American during the policy period, American is not liable for the claim amount.

1 Because the Washington State Supreme Court has not addressed the issue at hand, the Court may look to the Washington Court of Appeals decision as persuasive authority. See *West v. American Tel. & Tel. Co.*, 311 U.S. 223, 237-38, 61 S.Ct. 179, 85 L.Ed. 139 (1940).

C. The Notice/Prejudice Rule

Plaintiff contends that the notice/prejudice rule applies to the policy at issue. The notice/prejudice rule requires insurers to show actual prejudice when denying coverage for lack of timely notice. [**6] See *Gannon*, 54 Wn. App. at 336; see also *Oregon Auto Ins. Co. v. Salzberg*, 85 Wn.2d 372, 377, 535 P.2d 816 (1975). The court in *Gannon*, however, explicitly held that the notice/prejudice rule does not apply to "claims made" policies. 54 Wn. App. at 336. This is because, "[i]f a court were to allow an extension of reporting time after the end of the policy period, such is tantamount to an extension of coverage to the insured gratis, something for which the insurer has not bargained." *Id.* (quoting *Gulf Ins. Co. v. Dolan, Fertig & Curtis*, 433 So. 2d 512, 515-16 (Fla. 1983)). Therefore, since the policy at issue is a "claims made" policy, the notice/prejudice rule does not apply.

[*1126] IV. CONCLUSION

Mr. Ripley's malpractice insurance required that any claims be reported during the coverage period. It is undisputed that the claim associated with Mr. Moody's action against Mr. Ripley was not reported to American during the coverage period. Having thus concluded, the Court does not address Defendant's arguments in the alternative.

Having reviewed the relevant pleadings, the declarations and exhibits attached thereto, and the remainder of the record, the Court hereby finds and ORDERS:

(1) Defendant's [**7] Motion for Summary Judgment (Dkt # 11) is GRANTED.

(2) The Clerk is directed to send a copy of this order to all counsel of record.

Dated this 7th day of April 2011.

/s/ Ricardo S. Martinez

RICARDO S. MARTINEZ



**NORTHWEST STEEL ROLLING MILLS LIQUIDATING TRUST, Plaintiff, v.
FIREMAN'S FUND INSURANCE COMPANY, a foreign insurance company; et al.,
Defendants.**

No. C86-376WD

UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF
WASHINGTON, SEATTLE DIVISION

1991 U.S. Dist. LEXIS 20984

**December 5, 1991, Decided
December 9, 1991, Filed, Entered**

CASE SUMMARY:

PROCEDURAL POSTURE: Plaintiff insured and defendant insurer filed motions under *Fed. R. Civ. P. 59(e)* for orders amending a judgment in a pollution case.

OVERVIEW: In the insured's motion, the court denied the insured's request that the judgment should provide that insurance policies "drop down" to provide indemnification for a loss within the coverage limits of a primary insurer that had become insolvent. The insurer's policy limited the carrier's duty to indemnify to losses which exceeded a certain size. The court denied the insured's request that the court should order indemnification as to all policy years, despite the finding that after a certain date, the insured expected soil and ground-water pollution to occur as a result of its acts, and thus would have no coverage under the contracts. The court denied the insured's request that no damage should be allocated to the years 1981-84, because deliveries ceased in March 1981. The evidence showed that the flue dust piles continued to cause pollution through additional leaching during that time. The court granted the insurer's request to amend the judgment to reflect that it was not liable for defense costs of the underlying action because other available insurance had to be exhausted first. The court granted the insurer's request to limit its total obligation to the statutory amount.

OUTCOME: The court denied the insured's motion to amend the judgment as to indemnification and allocation of damages. It granted the insured's motion as to an

oversight in the findings. It granted the insurer's motion to amend the judgment regarding defense costs, maximum liability for indemnity and defense, and the insurer's overall liability limit. It denied the insurer's motion to delete any liability on its part for attorney fees and costs.

LexisNexis(R) Headnotes

Insurance Law > General Liability Insurance > Coverage > General Overview

[HN1] *Wash. Rev. Code § 48.32.060* provides that: The association shall be obligated to the extent of the covered claims, but such obligation shall include only that amount of each covered claim which is in excess of \$ 100 and is less than \$ 300,000. It shall be deemed the insurer to the extent of its obligation on the covered claims, pay covered claims to the extent of the association's obligation, and deny all other claims.

Insurance Law > Claims & Contracts > Premiums > Excess Premiums

Insurance Law > General Liability Insurance > Coverage > General Overview

Insurance Law > Industry Regulation > Insurer Insolvency > General Overview

[HN2] "Covered claim" is defined by *Wash. Rev. Code § 48.32.030(4)*: "Covered claim" means an unpaid claim, including one for unearned premiums, which arises out of and is within the coverage of an insurance policy to

which this chapter applies issued by an insurer, if such insurer becomes an insolvent insurer after the first day of April, 1971 and (a) the claimant or insured is a resident of this state at the time of the insured event; or (b) the property from which the claim arises is permanently located in this state.

Insurance Law > Claims & Contracts > Costs & Attorney Fees > General Overview

Insurance Law > Claims & Contracts > Good Faith & Fair Dealing > Duty to Defend

[HN3] An award of fees is required in any legal action where the insurer compels the insured to assume the burden of legal action, to obtain the full benefit of his insurance contract, regardless of whether the insurer's duty to defend is at issue.

JUDGES: [*1] Dwyer

OPINION BY: WILLIAM L. DWYER

OPINION

ORDER ON MOTIONS OF NORTHWEST STEEL AND WIGA TO ALTER OR AMEND JUDGMENT

Plaintiff Northwest Steel Rolling Mills Liquidating Trust ("Northwest"), and defendant Washington Insurance Guaranty Association ("WIGA"), have moved under *Fed. R. Civ. P. 59(e)* for orders amending the judgment entered on July 15, 1991. Having fully considered the materials submitted in support of or opposition to the motions, and having determined that oral argument is not necessary, the court now finds and rules as follows:

1. In one respect Northwest's motion is uncontested and concerns an oversight in the findings. Finding of Fact No. 8, and the judgment at paragraph 2, are hereby corrected to reflect that defendant Continental Casualty Insurance Company ("CNA") is liable as to damage that occurred in 1970 through 1972, and in the period from January 1, 1978, to January 27, 1978, in addition to the years 1973 through 1977 originally specified.

2. Northwest argues further that the judgment should provide that the 1978 and 1979 CNA policies "drop down" to provide indemnification for a loss within the coverage limits of a primary insurer that has become insolvent. However, as found in Finding [*2] of Fact No. 9, the CNA policies provide coverage only for losses "in excess of the applicable limits of liability of the underlying insurance." That is an unambiguous provision. It plainly limits the carrier's duty to indemnify to losses which exceed a certain size. The insuring agreement cannot be changed by the happenstance that a primary

carrier became insolvent. The plaintiff's motion to amend the judgment in this respect is therefore denied.

3. Northwest argues further that the court should refuse to allocate any of the damage by policy year, and thus should order indemnification as to all policy years, despite the finding that from and after May 22, 1981, Northwest expected soil and ground-water pollution to occur as a result of its acts, and thus would have no coverage under the contracts. As noted in Finding of Fact No. 5, if that argument were accepted the result would be to afford Northwest insurance coverage beyond what it purchased and contrary to the provisions of the policies. Under the findings, from and after May 22, 1981, Northwest expected pollution damage to occur as a result of its having deposited toxic waste materials at the Western Processing site; the piles [*3] of flue dust continued to exist and continued to cause damage by leaching. Even though Northwest made no further deliveries after that date, its position as to this additional damage is legally no different from that of a deliberate ongoing polluter. If a reasonable method of allocating the uninsured part of the damage to the policyholder, rather than to the insurers, exists under the evidence, it should be adopted. Precise allocation proof cannot be expected. The evidence as a whole was adequate to show, in satisfaction of the carriers' burden of proof, that the volume of flue dust delivered each year provided a rough quantification of the injury caused in that year. Moreover, Northwest's obligation to pay environmental cleanup costs to the third party claimants was computed on the basis of its percentage of the total weight of the contaminants shipped to the site by all depositors. Northwest contends that the migration of leachate from earlier years, and the annual rainfall, should have been considered; however, the evidence did not permit such factors to be embodied in a formula. *Aetna Casualty & Surety Co., Inc. v. Pintlar Corp.*, Nos. 89-35286, 89-35287, 1991 WL 225948 (9th [*4] Cir. Nov. 7, 1991), cited by Northwest in a supplemental brief, is consistent with this court's rulings as to scope of coverage, and does not reach the question of how the loss should be allocated if part of it was caused by the policyholder's uninsured conduct. The court adheres to the findings, and the motion in this regard is denied.

4. Northwest further contends that no damage should be allocated to the years 1981-84, since deliveries ceased in March 1981. The evidence showed, however, that the flue dust piles from Northwest continued to be stored at the site from March 1981 until November 1984; that they continued to cause pollution through additional leaching during that time; and that Northwest knew this. There is thus no coverage as to this damage under the policy provisions. The court has found that a reasonable yearly approximation, under the evidence, is computed on the

basis set out in Finding of Fact No. 7. Again, exact precision cannot be expected, and the only alternative would be to afford the policyholder "windfall" coverage for damage it expected or intended would result from its acts. Northwest's motion in this regard is denied.

5. WIGA moves for an order amending [*5] the judgment to reflect that it is not liable for defense costs of the underlying action because such liability is joint and several among carriers and, under *RCW 48.32.100(1)*, other available insurance must first be exhausted before any recovery may be had from WIGA. The obligation of insurance carriers to defend is joint and several under the circumstances of this case. WIGA's position is correct and the judgment will be amended accordingly.

6. WIGA further contends that its maximum liability for indemnity and defense combined cannot exceed \$ 299,900. [HN1] *RCW 48.32.060* provides that:

(1) The association shall:

(a) Be obligated to the extent of the covered claims . . . but such obligation shall include only that amount of each covered claim which is in excess of one hundred dollars and is less than three hundred thousand dollars. . . .

(b) Be deemed the insurer to the extent of its obligation on the covered claims

* * *

(d) . . . pay covered claims to the extent of the association's obligation and deny all other claims.

[HN2] "Covered claim" is defined by *RCW 48.32.030(4)*:

"Covered claim" means an unpaid claim, including one for unearned premiums, which arises out of and [*6] is within the coverage of an insurance policy to which this chapter applies issued by an insurer, if such insurer becomes an insolvent insurer after the first day of April, 1971 and (a) the claimant or insured is a resident of this state at the time of the insured event; or (b) the property from

which the claim arises is permanently located in this state.

WIGA's position is correct. A one hundred dollar deductible provision is involved. WIGA's total obligation, by statute, is thus limited to \$ 299,900. This limitation includes its obligation for attorney fees and costs herein.

7. WIGA also asks that the judgment be amended to delete any liability on its part for attorney fees and costs herein. In *Olympic Steamship Co. v. Centennial Ins. Co.*, 117 Wash. 2d 37, 53, 811 P.2d 673 (1991), the Washington Supreme Court held:

Upon reconsideration, however, we believe that [HN3] an award of fees is required in any legal action where the insurer compels the insured to assume the burden of legal action, to obtain the full benefit of his insurance contract, regardless of whether the insurer's duty to defend is at issue. We thus overrule *Farmers* to [*7] the extent that it is inconsistent with our holding today.

WIGA argues that because *Olympic Steamship* was not decided until after the evidence was presented in this case, and because it overruled prior law, its rule should not apply herein. No authority is cited for this proposition. *Olympic Steamship* became binding law in Washington before judgment was entered in this case. Its holding requires an award of attorney fees to Northwest herein, against both defendants. WIGA's motion in this regard is therefore denied. However, the judgment will be amended to reflect that WIGA's overall liability limit of \$ 299,900 includes this item.

8. An amended judgment will be entered to reflect the rulings made in paragraphs 1, 5, 6, and 7 of this order.

The clerk is directed to send copies of this order to all counsel of record.

Dated: December 5, 1991.

William L. Dwyer

United States District Judge



JOHN S. PEREIRA, Trustee of Trace International Holdings, Inc., in his capacity as judgment creditor in *Pereira v. Cogan, et al.*, 00 Civ. 619 (RWS), Plaintiff, -v- NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA., GULF INSURANCE COMPANY, and EXECUTIVE RISK INDEMNITY INC., Defendants.

No. 04 Civ. 1134 (LTS)

**UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF
NEW YORK**

2006 U.S. Dist. LEXIS 49263

**July 12, 2006, Decided
July 12, 2006, Filed**

SUBSEQUENT HISTORY: Summary judgment granted, in part, summary judgment denied, in part by *Pereira v. National Union Fire Ins. Co.*, 2007 U.S. Dist. LEXIS 65369 (S.D.N.Y., Sept. 5, 2007)

PRIOR HISTORY: *Pereira v. Farace*, 413 F.3d 330, 2005 U.S. App. LEXIS 13040 (2d Cir. N.Y., 2005)

DISPOSITION: The court granted the motion to dismiss to the extent that it sought to exclude coverage of the portion of the judgment representing monies wrongfully obtained by officers and directors and denied the motion to dismiss in all other respects. The court granted the executives' motion for intervention and denied the executives' motion for a preliminary injunction preventing the insurers from paying monies under the policies to the trustee.

CASE SUMMARY:

PROCEDURAL POSTURE: Plaintiff trustee for a debtor's estate filed an action against defendants, a primary insurer and two excess insurers, to collect insurance proceeds allegedly due by virtue of a judgment entered against the debtor's directors and officers for violating fiduciary duties. The insurers filed a *Fed. R. Civ. P. 12(b)(6)* motion to dismiss the complaint. Two of the debtor's executives filed a motion to intervene and requested a preliminary injunction.

OVERVIEW: The debtor purchased directors and officers liability insurance from the insurers. In the underlying action, the primary insurer advanced legal fees for the officers and directors. With respect to the executives who sought to intervene in the instant action, the judgment in the underlying action was vacated and the matter was remanded for a new trial. The underlying judgment exceeded the policy limits, and the trustee sought to recover the full extent of coverage under the policies. The court determined that the trustee could not seek coverage for the portions of the judgment representing the return of monies wrongfully obtained by officers and directors because, as a matter of public policy under New York law, an insurer could not insure against equitable judgments involving the restitution of ill-gotten gains. Because there were reasonable interpretations of the policies that would provide coverage, the court could not conclude as a matter of law that coverage was excluded under a personal profit exclusion or that the nonpayment of the first level of excess insurance due to the liquidation of an insurance company excused other excess insurers from providing coverage.

OUTCOME: The court granted the motion to dismiss to the extent that it sought to exclude coverage of the portion of the judgment representing monies wrongfully obtained by officers and directors and denied the motion to dismiss in all other respects. The court granted the executives' motion for intervention and denied the executives' motion for a preliminary injunction preventing

the insurers from paying monies under the policies to the trustee.

LexisNexis(R) Headnotes

Civil Procedure > Pleading & Practice > Defenses, Demurrers & Objections > Failures to State Claims

[HN1] In evaluating a motion to dismiss a complaint pursuant to *Fed. R. Civ. P. 12(b)(6)*, the court must take as true the facts alleged in the plaintiff's complaint and draw all reasonable inferences in his favor. The court must not dismiss a complaint unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief.

Civil Procedure > Pleading & Practice > Defenses, Demurrers & Objections > Motions to Dismiss

[HN2] On a motion to dismiss, the court may consider any written instrument attached to the complaint as an exhibit or incorporated in the complaint by reference, as well as documents upon which the complaint relies and which are integral to the complaint. This includes documents that the plaintiff either possessed or knew about and upon which it relied in bringing the suit.

Insurance Law > Business Insurance > Directors & Officers Liability Insurance > Coverage > Wrongful Acts

[HN3] Under New York law, as a matter of public policy, one may not insure against the orders of a court sitting in equity. The equitable judgments as to which insurance coverage is precluded are ones involving the restitution of ill-gotten gains or the return of property wrongfully in the possession of a defendant. An insurance company cannot insure against the risk of being ordered to return money or property that has been wrongfully acquired.

Civil Procedure > Federal & State Interrelationships > Choice of Law > Governmental Interests

[HN4] Under federal law, the substantive law of the jurisdiction having the greatest interest in the litigation will be applied.

Evidence > Procedural Considerations > Burdens of Proof > Allocation

Insurance Law > Claims & Contracts > Policy Interpretation > Exclusions

[HN5] Under New York law, exclusionary clauses in insurance contracts are construed strictly to give the interpretation most beneficial to the insured. An insurer claiming that a loss is excluded by a policy term has the burden of demonstrating that the term expressly excludes the loss--exclusions are not extended by interpretation or implication.

Insurance Law > Claims & Contracts > Policy Interpretation > Ambiguous Terms > Unambiguous Terms
Insurance Law > Claims & Contracts > Policy Interpretation > Plain Language

[HN6] Under New York law, an insurance contract is interpreted to give effect to the intent of the parties as expressed in the clear language of the contract. When a contract is not ambiguous, the court should assign the plain and ordinary meaning to each term and interpret the contract without the aid of extrinsic evidence.

Evidence > Procedural Considerations > Burdens of Proof > Allocation

Insurance Law > Claims & Contracts > Policy Interpretation > Exclusions

[HN7] In the context of insurance agreements, an insurer generally bears the burden of proving that the claim falls within the scope of an exclusion. To negate coverage by virtue of an exclusion, an insurer must establish that the exclusion is stated in clear and unmistakable language, is subject to no other reasonable interpretation, and applies in the particular case. The insurer may rely on the facts as alleged in the complaints to demonstrate that an exclusion applies.

Insurance Law > Claims & Contracts > Policy Interpretation > Exclusions

[HN8] In determining whether a prior litigation clause excludes coverage, courts have focused on whether there was a sufficient factual nexus between the two lawsuits. The coverage does not depend upon the pleader's art but rather upon underlying facts.

Insurance Law > Claims & Contracts > Cancellation & Nonrenewal > Material Misrepresentation

[HN9] Under New York law, an insured's policy is void if the insured made misrepresentations to the insurance company and this misrepresentation was material to the issuance of the policy. The failure to disclose is as much a misrepresentation as a false affirmative statement. Even if a misrepresentation was made innocently or without the intent to deceive, it is sufficient to void the policy if it is material. A misrepresentation is material if

the insurer can show that the misrepresentation induced it to accept an application that it might otherwise have refused. A material misrepresentation can void the policies of coinsured employees of a corporation whose president made the misrepresentation in the warranty.

Insurance Law > Claims & Contracts > Policy Interpretation > Exclusions

[HN10] To negate coverage by virtue of an exclusion, the exclusion must be stated in clear and unmistakable language.

Civil Procedure > Parties > Intervention > Right to Intervene

[HN11] *Fed. R. Civ. P. 24(a)* permits intervention as of right upon a timely application: (1) when a statute of the United States confers an unconditional right to intervene; or (2) when the applicant claims an interest relating to the property or transaction which is the subject of the action and the applicant is so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest, unless the applicant's interest is adequately represented by existing parties.

Civil Procedure > Parties > Intervention > Right to Intervene

[HN12] To succeed on a motion under *Fed. R. Civ. P. 24(a)(2)*, an intervenor must (1) timely file an application, (2) show an interest in the action, (3) demonstrate that the interest may be impaired by the disposition of the action, and (4) show that the interest is not protected adequately by the parties to the action.

Civil Procedure > Parties > Intervention > General Overview

[HN13] A proposed intervenor must show that he has a direct, substantial, and legally protectable interest in the action.

Civil Procedure > Parties > Intervention > General Overview

[HN14] Courts examine the totality of circumstances in making a determination of timeliness. Circumstances considered in this determination include: (1) how long an applicant had notice of the interest before he made the motion to intervene; (2) prejudice to the existing parties resulting from any delay; (3) prejudice to the applicant if the motion is denied; and (4) any unusual circumstances militating for or against a finding of timeliness.

Civil Procedure > Parties > Intervention > Permissive Interventions

[HN15] Under *Fed. R. Civ. P. 24(b)(2)*, a would-be party can be permitted to intervene when an applicant's claim or defense and the main action have a question of law or fact in common.

Civil Procedure > Remedies > Injunctions > Elements > General Overview

Civil Procedure > Remedies > Injunctions > Preliminary & Temporary Injunctions

[HN16] In the Second Circuit, the standard for preliminary injunctive relief ordinarily requires the moving party to show that: (1) it is likely to suffer irreparable injury; and (2) either (a) a likelihood of success on the merits of its case; or (b) sufficiently serious questions going to the merits to make them a fair ground for litigation and a balance of hardships tipping decidedly in its favor.

Civil Procedure > Remedies > Injunctions > Elements > Irreparable Harm

[HN17] Irreparable harm is an injury that is not remote or speculative but actual or imminent, and for which a monetary award cannot be adequate compensation.

Civil Procedure > Remedies > Injunctions > Mandatory Injunctions

Civil Procedure > Remedies > Injunctions > Preliminary & Temporary Injunctions

[HN18] Where a request for injunctive relief would amount to a mandatory injunction rather than a prohibitory injunction seeking to keep the status quo, the former requires an even greater showing of harm where extreme or very serious damage will result from a denial of preliminary relief.

COUNSEL: [*1] **LEBOEUF, LAMB, GREENE & MACRAE, LLP**, By: John P. Campo, Esq., New York, NY, Attorneys for Plaintiff.

D'AMATO & LYNCH, By: Ronald H. Alenstein, New York, NY, Attorneys for Defendant National Union Fire Insurance Company of Pittsburgh, PA.

DRINKER, BIDDLE & REATH, LLP, By: Kathleen A. Donohue, Esq., New York, NY, Attorneys for Defendant Gulf Insurance Company.

KORNSTEIN, VEISZ, WEXLER & POLLARD, LLP,
By: Marvin Wexler, New York, NY, Attorneys for Defendant Executive Risk Indemnity Inc.

JUDGES: LAURA TAYLOR SWAIN, United States District Judge.

OPINION BY: LAURA TAYLOR SWAIN

OPINION

OPINION AND ORDER

LAURA TAYLOR SWAIN, United States District Judge

Plaintiff John S. Pereira (the "Trustee"), as Trustee of Trace International Holdings, Inc. ("Trace"), brings this action to collect insurance proceeds allegedly due to him by virtue of a judgment entered against Defendants' insureds by this Court in *Pereira v. Cogan*, 00 Civ. 619 (RWS) (the "Underlying Action"). Defendant insurance companies National Union Fire Insurance Co. of Pittsburgh ("NUFIC"), Gulf Insurance Co. ("Gulf"), Executive Risk Indemnity, Inc. ("Executive"), (collectively "Defendants") move, on a number of grounds, to [*2] dismiss the Complaint pursuant to *Federal Rule of Civil Procedure 12(b)(6)*. Andrea Farace ("Farace") and Phillip Smith ("Smith") move to intervene in the action and for a preliminary injunction. The Court has jurisdiction of the instant action pursuant to 28 U.S.C. § 1334(b).

The Court has considered carefully the parties' oral and written arguments. For the following reasons, the Court grants in part and denies in part Gulf's and Executive's motion to dismiss, denies, in its entirety, NUFIC's motion to dismiss, and grants Farace's and Smith's motion for intervention but denies their application for a preliminary injunction.

BACKGROUND

The following facts alleged in the Complaint are taken as true for the purposes of the instant motions to dismiss the complaint for failure to state a claim. On or about July 21, 1999, Trace filed a petition for reorganization under Chapter 11 of the Bankruptcy Code in the United States Bankruptcy Court for the Southern District of New York. (Compl. P10.) As part of the bankruptcy case, an Official Committee of Unsecured Creditors (the "Creditors Committee") was formed. On or about [*3] October 18, 1999, the Creditors Committee, with per-

mission of the bankruptcy court, commenced the Underlying Action as an adversary proceeding on behalf of the Trace estate against current and former officers and directors of Trace. (Id. PP11-12.) In the adversary proceeding, the Creditors Committee alleged that the officers and directors had violated their fiduciary duties to Trace and sought monetary relief for those violations. (Id. P13.)

Trace had purchased and maintained directors and officers ("D & O") liability insurance from the Defendants and Reliance National Company ("Reliance").¹ (Id. P14.) The Defendants and Reliance provided D & O coverage to indemnify the directors and officers from liabilities and reasonable litigation expenses incurred in connection with the adversary proceeding in the following manner: NUFIC provided the primary layer up to \$ 10 million; Reliance provided the first excess layer above \$ 10 million and up to \$ 20 million; Gulf provided the second excess layer above \$ 20 million and up to \$ 30 million; Executive provided the third excess layer above \$ 30 million and up to \$ 40 million; Reliance provided a fourth and final excess layer above \$ 40 million [*4] and up to \$ 50 million. (Id. PP14-19.)

¹ Reliance is not named as a Defendant in this action because it is currently in liquidation. (Compl. P29.)

On the motion of certain Defendants, this Court (Sweet, J.) withdrew the reference of the Underlying Action from the bankruptcy court. (Id. PP20-21.) On or about January 24, 2000, the bankruptcy case was converted from a Chapter 11 reorganization to a liquidation under Chapter 7 of the Bankruptcy Code, and the Trustee was appointed as trustee for Trace's estate. (Id. P22.) The Trustee, after being substituted for the Creditors Committee as the plaintiff in the Underlying Action, amended the complaint and prosecuted the litigation through trial and judgment. (Id. P23.) In connection with the Underlying Action, NUFIC advanced some or all of the legal fees for the officers and directors. (Id. P24.) The Trustee is unaware of these amounts and whether they were reasonable or appropriate under the NUFIC D & O insurance policy. (Id.)

On June 25, 2003, after trial, this [*5] Court (Sweet, J.) entered judgment in the Underlying Action ("the Judgment") against the following directors and officers in the following amounts:

Marshall S. Cogan ("Cogan")	\$ 44,374,824.16
Andrea Farace ("Farace")	\$ 27,308,841.12

Frederick Marcus ("Marcus")	\$ 37,360,290.70
Robert H. Nelson ("Nelson")	\$ 38,321,643.30
Philip Smith ("Smith")	\$ 21,392,974.45
Karl Winters ("Winters")	² \$ 21,350,774.60

2

On June 30, 2005, the Judgment was vacated as against Frederick Marcus, Andrea Farace, and Philip Smith and the matter was remanded for a new trial as to those three defendants. See *Pereira v. Farace*, 413 F.3d 330 (2d Cir. 2005). In a letter dated July 20, 2005, Defendant Executive argues that, by virtue of this Second Circuit decision, the entire case is rendered moot. While the Second Circuit's decision moots the claims in this action for indemnity as to the now-vacated judgments against defendants Marcus, Farace and Smith, it does not affect the underlying judgment entered against the non-appealing and the settling defendants in the Underlying Action, and the case is not moot as to the Trustee's claims for payment of those elements of the Judgment.

(Id. P25.) The Judgment is exclusive of pre-judgment interest from June 15, 2003, through June 25, 2003, and post-judgment interest. (Id. P26.) On July 8, 2003, the Trustee served notice of the Judgment on Defendants and Reliance, pursuant to Section 3420(a)(2) of the New York Insurance Law. (Id. P27.) The Judgment exceeded the limits of each Defendant's respective insurance coverage. ³ (Id. P30.) At the time the Complaint was written, Defendants had not paid any portion of the Judgment. (Id. P28.)

[*6]

³ The Judgment exceeds Defendants' respective insurance coverage layers even after excluding the amounts assessed against Frederick Marcus, Andrea Farace, and Phillips Smith.

The Trustee alleges that he is entitled to recover the full extent of coverage under the insurance policies. (Id. P31.) As part of his claim for relief, the Trustee also seeks proof by NUFIC that its payment of defense costs to the Trace officers and directors in connection with the Underlying Action was appropriate and reasonable. (Id. P24.)

DISCUSSION

[HN1] In evaluating a motion to dismiss a complaint pursuant to *Rule 12(b)(6)*, the Court must take as true the facts alleged in the plaintiff's complaint and draw all reasonable inferences in his favor. *W. Mohegan Tribe &*

Nation v. Orange County, 395 F.3d 18, 20 (2d Cir. 2004); *Hernandez v. Coughlin*, 18 F.3d 133, 136 (2d Cir. 1994). The Court must not dismiss a complaint "unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Conley v. Gibson*, 355 U.S. 41, 45-46, 78 S. Ct. 99, 2 L. Ed. 2d 80 (1957). [*7]

[HN2] On a motion to dismiss, the court may consider "any written instrument attached to the complaint as an exhibit or incorporated in the complaint by reference, as well as documents upon which the complaint relies and which are integral to the complaint." *Subaru Distribs. Corp. v. Subaru of Am., Inc.*, 425 F.3d 119, 122 (2d Cir. 2005). This includes documents "that the plaintiff[] either possessed or knew about and upon which [it] relied in bringing the suit." *Rothman v. Gregor*, 220 F.3d 81, 88-89 (2d Cir. 2000). In his Complaint, the Trustee refers to the D & O liability insurance purchased from Defendants for the Trace officers and directors. (Compl. P14.) The Court finds that the relevant insurance policies of Defendants are integral to the Complaint and that Plaintiff knew about these policies and relied on them in bringing the instant action. The Court will therefore consider these policies in making its determination on the motions to dismiss. (See Lisa B. Lance Aff. in Supp. of Executive's Mot. to Dismiss, "Lance Aff.," Exs. A, "NUFIC Policy," C, "Gulf Policy," D, "Executive Policy.") The Court will also take judicial notice of the pleadings, [*8] orders, and judgments in prior litigation related to this instant case. See *Patrowicz v. Transamerica Homefirst, Inc.*, 359 F. Supp. 2d 140, 144 (2d Cir. 2005).

Motions to Dismiss

Defendants Gulf and Executive make their motion to dismiss on five grounds, each of which they contend applies equally to both insurers. Gulf's brief addresses two of the grounds and Executive's brief addresses the other three. Defendant NUFIC makes its own motion on independent grounds. The Court will first address Gulf's and Executive's motion to dismiss and then address NUFIC's motion to dismiss.

Gulf's/Executive's Motion to Dismiss

(1) Nature of Judgment Against Trace Officers and Directors

Gulf argues that the complaint should be dismissed, contending that the damages awarded against the Trace officers and directors in the prior litigation are not recoverable as a matter of law under its insurance policy because the underlying claims and judgment were equitable in nature. Gulf cites [HN3] the New York law⁴ principle that, as a matter of public policy, "[o]ne may not insure against . . . the orders of a court sitting in equity." (See Gulf's Reply in support of [*9] Mot. to Dismiss at 4 (citing, e.g., *Debruyne v. Clay*, 1999 U.S. Dist. LEXIS 15266, No. 94 Civ. 4704 (JSM), 1999 WL 782481 at *14 (S.D.N.Y. Oct. 1, 1999)). However, an examination of the relevant authorities (including those cited by Gulf) reveals that the cited principle does not preclude the claims asserted in this action. The "equitable" judgments as to which insurance coverage is precluded are ones involving the restitution of ill-gotten gains or the return of property wrongfully in the possession of the defendant. See *Reliance Group Holdings, Inc. v. Nat. Union Fire Ins. Co.*, 188 A.D.2d 47, 594 N.Y.S.2d 20 (N.Y. App. Div. 1993). *Reliance*, a decision upon which the Debruyne court relied, held that an insurance company could not insure "against the risk of being ordered to return money or property that has been wrongfully acquired." *Reliance Group Holdings Inc.*, 594 N.Y.S.2d at 24. In that case, the corporation which had bought the D & O insurance was also in possession of the proceeds of illegal activity and had benefitted from that activity and therefore could not recover its indemnification costs under the policy. *Id.* at 25. See also *Level 3 Communs., Inc. v. Fed. Ins. Co.*, 272 F.3d 908, 910 (7th Cir. 2001) [*10] (finding that an insurance company does not insure against the restoration of an ill-gotten gain).

4 New York substantive law applies as most of the parties have their principal place of business in New York and the prior litigation in this case involved events principally occurring in New York. See *Wells Fargo Asia Ltd. v. Citibank, N.A.*, 936 F.2d 723, 726 (2d Cir. 1991) (finding that, [HN4] under federal law, the substantive law of the jurisdiction having the greatest interest in the litigation will be applied). The parties also do not object to the application of New York law.

Here, while Judge Sweet found that the fiduciary claims against the officers and directors and the subsequent monetary relief were equitable in nature, he noted that only Cogan personally possessed any of the disputed funds. See *Pereira v. Cogan*, 294 B.R. 449, 544-46 (S.D.N.Y. 2003), vacated and remanded, 413 F.3d 330 (2d Cir. 2005).⁵ Because the Gulf and Executive policies do not [*11] specifically exclude "equitable" claims to any extent greater than would be the case under the general principles of New York law discussed above,⁶ the insurers' motion on this ground is granted only to the

extent the Trustee's claims seek coverage for the portions of the Judgment representing the return of monies wrongfully obtained by Cogan and Nelson. This result is, moreover, consistent with the Second Circuit's determination in *Pereira v. Farace*, 413 F.3d 330, 339 (2d Cir. 2005), on the appeal of Judge Sweet's decision, which rejected the notion that Plaintiff's fiduciary claims against the appealing defendants were equitable in nature.

5

Nelson personally received a small part of the monies upon which his liability under the Judgment is predicated, including loans from Trace in the amount of \$ 600,000. See *Cogan*, 294 B.R. at 494.

6

[HN5] Under New York law, "exclusionary clauses in insurance contracts are construed strictly to give the interpretation most beneficial to the insured.... An insurer claiming that a loss is excluded by a policy term has the burden of demonstrating that the term expressly excludes the loss--exclusions are not extended by interpretation or implication." *In re Donald Sheldon & Co., Inc.*, 186 B.R. 364, 369 (S.D.N.Y. 1995). Gulf's insurance policy incorporates the terms and conditions of the primary policy issued by NUFIC subject to any additional terms in its own policy. (See Lance Aff. Ex. C, § I A-C.) The NUFIC Policy provides that it will "pay the Loss of each and every Director or Officer of the Company arising from a Claim first made against the Directors or Officers." (*Id.*, Ex. A, § 1.) The policy defines "Loss" broadly to include "damages, judgments, settlements...." (*Id.*, Ex. A, § 2(g).) "Claim" is defined as "a written demand for monetary or non-monetary relief." (*Id.*, Ex. A, § 2(a).) Endorsement 7, which also deals with claims, defines "claim" as "a written demand for monetary damages or equitable relief." (*Id.*, Ex. A, Endorsement 7 at 2.) Executive's Policy also incorporates the definitions and claims of the underlying insurance, which would include the NUFIC policy (See Lance Aff. Ex. D, Item 4, "Schedule of Underlying Insurance," and § IV.)

[*12] (2) Exclusionary Argument based on "Prior and Pending Litigation" Clause of Policy

Gulf argues that its policy excludes coverage of the Judgment against the Trace directors and officers because of a prior litigation exclusionary clause.

In making its argument, Gulf relies on Endorsement No. 1 to its policy, which reads in its entirety,

In consideration of the payment of premium, it is hereby understood and agreed that the Insurer shall not be liable to make any payment for Loss in connection with any Claim made against any of the Insureds based upon, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving any Claim, demand, cause of action, legal or quasi-legal proceeding or administrative proceeding pending, or orders, decrees or judgments entered, against the Directors and Officers or the Insured Company on or prior to 07-06-1998, or any fact, circumstance or situation underlying or alleged therein.

(Lance Aff., Ex. C, Endorsement No. 1.)⁷

⁷ Executive's policy has a similar prior litigation exclusionary provision. (See Lance Aff. Ex. D, Endorsement No. 3.)

[*13] [HN6] Under New York law, "an insurance contract is interpreted to give effect to the intent of the parties as expressed in the clear language of the contract." *Vill. of Sylvan Beach v. Travelers Indem. Co.*, 55 F.3d 114, 115 (2d Cir. 1995). In this respect, "[w]hen a contract is not ambiguous, the court should assign the plain and ordinary meaning to each term and interpret the contract without the aid of extrinsic evidence." *Zunenshine v. Executive Risk Indem., Inc.*, 1998 U.S. Dist. LEXIS 12699, No. 97 Civ. 5525 (MBM), 1998 WL 483475, at *3 (S.D.N.Y. Aug. 17, 1998) (citations omitted). [HN7] In the context of insurance agreements, "the insurer generally bears the burden of proving that the claim falls within the scope of an exclusion.... To negate coverage by virtue of an exclusion, an insurer must establish that the exclusion is stated in clear and unmistakable language, is subject to no other reasonable interpretation, and applies in the particular case." *Vill. of Sylvan Beach*, 55 F.3d at 115 (citations omitted). The "insurer may rely on the facts as alleged in the complaints to demonstrate that an exclusion applies." *Zunenshine*, 1998 U.S. Dist. LEXIS 12699, 1998 WL 483475, at [*14] *4 (citations omitted). [HN8] In determining whether a prior litigation clause excludes coverage, courts "have focused on whether there was a sufficient factual nexus between the two lawsuits." *Id.* (citations omitted). "The coverage does not depend upon the pleader's art but rather upon 'underlying' facts. *Id.*

Gulf argues that the Judgment for which the Trustee here seeks coverage is excluded from the scope of the

insurance contracts by reason of the pendency of a civil complaint, captioned Anthony Barbuto v. Trace Int'l Holdings, Inc., No. 15175, ("Barbuto"), in the Court of Chancery, New Castle County, Delaware. (See Decl. of Blair Nespole in Supp. of Gulf's Mot. to Dismiss, "Nespole Decl.," Ex. G.), at the time the relevant insurance documents were issued.⁸ A review of the Barbuto complaint and comparison of it with the complaint and amended complaints in the Underlying Action reveals a substantial, but not perfect, overlap of specific fund claims of improper declaration and payment of dividends, excessive compensation, breach of fiduciary oversight duties and other matters. While it is clear that certain of the claims would be excluded under the plain language [*15] of the prior litigation provisions of the insurance contracts, it cannot, however, be said that there are no circumstances under which the Trustee would be able to prevail against a claim that all of the factual circumstances underlying the Judgment "ar[ose] out of, . . . in consequence of, or in any way involv[ed]" the factual circumstances underlying the claims asserted in Barbuto. Defendants' motion to dismiss the complaint is, accordingly denied insofar as it is premised on the prior litigation exclusion provisions of the insurance contracts.

8

The Court takes judicial notice of the Barbuto complaint as a fact "capable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned." *Fed. R. Evid. 201(b)(2)* (West 2005). See *Bensalem Township v. Int'l Surplus Lines Ins. Co.*, 1992 U.S. Dist. LEXIS 8243, No. 91 Civ. 5315, 1992 WL 142024, at *2 (E.D. Pa. June 15, 1992) (in context of prior litigation exclusion argument, court took judicial notice under *Federal Rule of Evidence 201(b)(2)* of state court complaint.), *rev'd* on other grounds, 38 F.3d 1303 (3d Cir. 1994). Furthermore, from his motion papers, it is clear that Plaintiff is aware of the this complaint and its content and does not appear to object to its consideration in the pending motion to dismiss. (See Pl's Mem. in Opp. to Mot. to Dismiss by Gulf and Executive, "Opp. to Gulf and Executive," at 20-22.)

[*16] (3) Representation Made in Application for Insurance Policies

Executive argues that its and Gulf's policies are void as matter of law as to all Trace officers and directors because Cogan, who was then the Chief Executive Officer of Trace, signed a false representation concerning potential liability claims against these officers and directors in connection with the issuance of the policies. [HN9] Under New York law, an insured's policy is void

if the insured made misrepresentations to the company and this misrepresentation was material to the issuance of the policy. See *Chicago Ins. Co. v. Kreitzer & Vogelman*, 265 F. Supp. 2d 335, 342-43 (S.D.N.Y. 2003). "The failure to disclose is as much a misrepresentation as a false affirmative statement." *Id.* at 343. Moreover, "[e]ven if a misrepresentation was made innocently or without the intent to deceive, it is sufficient to void the policy if it is material." *Id.* (citing *Kulikowski v. Roslyn Sav. Bank*, 121 A.D.2d 603, 503 N.Y.S.2d 863, 864 (N.Y. App. Div. 1986)). A misrepresentation is material if the insurer can show "that the misrepresentation induced it to accept an application that it might otherwise [*17] have refused." *Id.* at 343. Further, a material misrepresentation can void the policies of co-insured employees of a corporation whose president made the misrepresentation in the warranty. See *INA Underwriters Ins. Co. v. D.H. Forde & Co., P.C.*, 630 F. Supp. 76, 77 (W.D.N.Y. 1985).

Here, Cogan delivered representations, dated August 18, 1998, and August 7, 1998, to Gulf and Executive respectively, in connection with applications for excess insurance coverage. Both statements read, in pertinent part, "[t]his will confirm that we are not aware of any acts, errors or omissions which could give rise to a claim as respects the [relevant] layer of our Directors and Officers Liability program." (See *Lance Aff., Exs. C, G.*) Relying on Judge Sweet's determinations concerning longstanding breaches of fiduciary duty and excessive compensation dating back to 1993 as well as the pendency of the Barbuto action at the time, Executive contends that there can be no dispute that Cogan's representations concerning the possibility of claims that could give rise to liability under the policies were false when made. (See Executive's Mot. to Dismiss at 9-15.) However, [*18] at this early stage, there is a question of fact as to whether Cogan made a misrepresentation. Even under the policies' broad definition of "Claim" as any written demand for relief,⁹ the Court cannot conclude on the current record that Cogan was aware of the existence of any acts that would give rise to claims that would reach the excess coverage in the Gulf and Executive policies.¹⁰ The Barbuto complaint does not specify an amount of damages as part of its claim for relief.¹¹ So, even if the Court imputes knowledge of the Barbuto litigation to Cogan, it is possible that he may have believed that any judgment from that action could not have reached Gulf's or Executive's excess coverage. Further, any determination after the fact by Judge Sweet as to Cogan's breaches of fiduciary duty and excessive compensation is not dispositive of the question as to whether Cogan made a misrepresentation when he signed the statements in 1998.

9 See supra note 6.

10 It is important to note here that the language of the representations focuses on the signatory's state of mind ("we are not aware of any facts") rather than on the objective state of affairs (e.g. "There are no acts"). Compare with *Chicago Ins. Co.*, 265 F. Supp. 2d at 339 (policy simply asked whether any lawyer had been the subject of reprimand or disciplinary action not whether signatory was aware of such fact).

[*19]

11 Plaintiff contends that the litigation involved damages in the amount of \$ 1 million or \$ 2 million dollars at most. (See Oral Argument Tr. at 44.)

Even if it were indisputable that Cogan made a misrepresentation, there would also be a question of fact as to whether this misrepresentation was material. Executive recognizes that materiality is generally an issue of fact but argues that this case is an instance "where the facts misrepresented are so serious that one would know them to be of substantial concern to the insurers, [such that] they may be found to be material as a matter of law." (Executive's Mot. to Dismiss at 9, quoting *Ris v. Nat'l Union Fire Ins. Co.*, No. 86 Civ. 9718 (RO), 1989 WL 76199, at *2 (S.D.N.Y. July 6, 1989).) However, on the current record, the Court cannot conclude as a matter of law that the companies would not have provided coverage upon disclosure of this misrepresentation. Plaintiff argues that the Barbuto litigation was already a matter of public record prior to the policies being issued and that Gulf, specifically, was sent documents [*20] which disclosed the pendency of this action. (See Oral Argument Tr. at 38; Pl.'s Opp'n. to Gulf's and Executive's Mot. to Dismiss at 11.) It may be, then, that the companies decided to provide coverage despite the existence of that action. This scenario lends support to the hypothesis that the companies, already aware of the possible liabilities, would have provided coverage even if Cogan had not signed the representations. The motion to dismiss is denied insofar as it is premised on the alleged misrepresentation in Cogan's written statements.

(4) Personal Profit Exclusion

Executive argues that a personal profit exclusion in the NUFIC policy¹² excludes coverage of the money damages sought by Plaintiff. (Executive's Mot. to Dismiss at 19-21.) The language reads,

The Insurer shall not be liable to make any payment for Loss in connection with a Claim made against an Insured: (a) arising out of, based upon or attributable to the gaining in fact of any profit or advantage to which an Insured was not legally entitled. . . .

(Lance Aff. Ex. A, § 4(a).) ¹³ Executive argues that the quoted language precludes coverage of the Judgment as against Cogan as well as [*21] the other officers and directors. Plaintiff concedes that the exclusion may limit coverage attributable to Cogan because he personally profited from his ill gotten gain. Plaintiff contends, however, that the language does not bar coverage of the damages assessed against the other directors and officers. (See Pl.'s Opp'n. to Gulf's and Executive's Mot. to Dismiss at 14-16.)

12 Both the Gulf and Executive policies incorporate the terms of the NUFIC policy. See supra note 6.

13 "Insured" includes any director or officer of Trace. (See Lance Aff. Ex. A, § 2(e)(1).)

Executive argues that the plain meaning of the provision supports application of the exclusion to preclude coverage of all defendants because the language excludes any damages against "an" Insured (that is, any Trace director or officer) that arise out of or are attributable to "an" Insured's (that is, any Trace director's or officer's) ill-gotten gain. (See Executive's Mot. to Dismiss at 21.) In this instance, the bulk [*22] of the damages assessed against the non-Cogan defendants (the "Loss") did relate to the ill-gotten gain of an Insured, namely Cogan. ¹⁴ That said, when read in context with the other Section Four provisions, the Court cannot conclude as a matter of law that the language was intended to exclude coverage as to the non-Cogan defendants. Section 4(c) of the NUFIC policy provides that "The Wrongful Act of a Director or Officer shall not be imputed to any other Director or Officer for the purpose of determining the applicability of the foregoing exclusions 4(a) through 4(c)." (Lance Aff. Ex. A, § 4(c).) This appears to render the personal profit exclusion truly personal as to each officer. At the very least, it raises sufficient ambiguity to preclude a determination as a matter of law at this stage that there is no recovery to be derived from the coverage of those officers who did not profit personally. See *In re Donald Sheldon & Co.*, 186 B.R. 364, 369 (Bankr. S.D.N.Y. 1995) (on summary judgment motion, exclusion related to personal gain provision not conclusive because language susceptible to multiple interpretations), *aff'd*, 182 F.3d 899 (2d Cir. 1999); [*23] *Vill. of Sylvan Beach v. Travelers Indem. Co.*, 55 F.3d 114, 115 (2d Cir. 1995) ("[t]o [HN10] negate coverage by virtue of an exclusion," the exclusion must be stated in "clear and unmistakable language").

14

It is important to note here, however, that Judge Sweet did not impute Cogan's wrongdoing to the other officers and directors, but found, rather, that those individuals were liable for their own wrongdoing in allowing Cogan to take money and, in the process, damage Trace. See *Pereira v. Cogan*, 294 B.R. 449, 463 (S.D.N.Y. 2003).

(5) Exhaustion of Underlying Excess Layers of Coverage

Executive argues that it is not responsible for providing any coverage because the excess layers below have not and will not be exhausted. (Executive's Mot. to Dismiss at 22-24.) Executive points to language in its policy providing that it will supply coverage only after the underlying policies have been exhausted:

The Company shall provide the **Insured** with insurance excess of [*24] the **Underlying Insurance** . . . only after all **Underlying Insurance** has been exhausted by actual payment of claims or losses thereunder.

(Lance Aff. Ex. D, § I (emphasis in original).)

In the event of the depletion of the limits of liability of the **Underlying Insurance** solely as the result of actual payment of claims or losses thereunder by the applicable insurers, this policy shall . . . apply to claims or losses as excess insurance over the amount of insurance remaining under such **Underlying Insurance**.

(*Id.*, § IV (emphasis in original).) ¹⁵ Executive contends that the plain meaning of these provisions is that it does not have to provide any coverage unless and until the underlying insurance policies have been exhausted by actual payment. In this instance, the Complaint alleges that Reliance, the first layer of excess coverage, is in liquidation and therefore unable to pay. Executive argues that, consequently, neither Gulf nor Executive is under any obligation to pay and the Complaint should be dismissed as against them because Reliance's layer will never be exhausted by actual payment. (See Executive's Mot. to Dismiss at 22-23.) [*25]

15 Gulf's policy has a nearly identical provision. (See Lance Aff. Ex. C at 2.)

Though Executive's interpretation of the relevant provisions may be reasonable, the Court cannot conclude that it is the only reasonable interpretation. See *In re*

Donald Sheldon & Co., Inc., 186 B.R. at 369. In this connection, the Court notes that the Second Circuit has rejected a similar argument that an insurance policy provision required actual exhaustion of previous layers of insurance as a condition precedent for payment of the excess coverage. See *Zeig v. Mass. Bonding & Ins. Co.*, 23 F.2d 665 (2d Cir. 1928). In that case, the pertinent language of the provision read that excess coverage "shall apply and cover only after all other insurance herein referred to shall have been exhausted in the payment of claims to the full amount of the expressed limits of such other insurance." *Id.* at 665. In *Zeig*, the claims against the policies providing coverage below the excess [*26] policy floor had been settled for less than the face amount of those policies, and the claim at issue was asserted against the excess insurer only to the extent of the level of liability that was within the scope of that policy. The court found that interpreting this language to require that the underlying insurance had to be exhausted by actual collection was "harmful to the insured and of no rational advantage to the insurer [and] ought only to be reached when the terms of the contract demand it." *Id.* at 666. The Second Circuit concluded that it could "see nothing in the clause before [it] to require a construction so burdensome to the insured, and must accordingly reject such an interpretation." *Id.* This Court finds that the same reasoning is relevant to this case. Interpreting the policy to excuse the excess insurers from providing coverage within their respective layers on account of the unrelated insolvency of an intermediary insurer would work a similar hardship on the insureds, who have already been deprived of a layer of coverage by the insolvency, and provide a windfall to the excess insurers. Thus, it cannot be said that the excess insurers' interpretation [*27] of the policy is the only reasonable one and the motion to dismiss on this ground is denied.

NUFIC's Motion to Dismiss

NUFIC moves to the dismiss the complaint on the grounds that its \$ 10 million policy limit has already been exhausted by payment of attorney costs in connection with the Underlying Action. Under the terms of its policy, NUFIC's limit of liability is reduced by the amount incurred in legal fees. (See NUFIC Mot. to Dismiss at 8-9.) The policy provides that "[d]efense costs are part of Loss and as such are subject to the Limit of Liability for Loss." (See Lance Aff. Ex. A, § 5.) NUFIC submits an affidavit from Elizabeth Wacik, a coverage director for NUFIC, in which she states that the legal bills relating to the Underlying Action exceeded the \$ 10 million policy limit and that, as a result of these payments, the policy has been exhausted. (See Elizabeth Wacik Aff. in Supp. of NUFIC's Mot. to Dismiss.) However, the question of exhaustion is a factual issue that cannot be resolved at this stage. In this connection,

the Court notes that the Wacik affidavit is not properly before the Court on the instant motion to dismiss. Accordingly, the Court [*28] cannot conclude on the current record that there is no set of facts upon which Plaintiff would prevail against a claim that the NUFIC coverage layer has been exhausted.

NUFIC also moves to dismiss the portion of the Complaint that seeks proof that its advance of defense costs to the Trace officers and directors in connection with the Underlying Action was appropriate and reasonable. NUFIC argues that the terms of its policy do not give Plaintiff standing to object to the reasonableness of the defense costs. (See NUFIC Mot. to Dismiss at 4-8.) The Court disagrees. The relevant provision of the policy provides that "Defense Costs' means reasonable and necessary fees, costs and expenses consented to by the Insurer." (Lance Aff. Ex. A, § 2(d).) While this language may be read to indicate that the Insurer alone determines whether an expense is reasonable and necessary, and whether it will consent to the payment, this interpretation is not the only reasonable one. See *In re Donald Sheldon & Co.*, 186 B.R. 364, 369 (Bankr. S.D.N.Y. 1995). One could also reasonably interpret this language to read that the Insurer must consent to the payment and that it must be objectively [*29] reasonable. The Court therefore cannot conclude as a matter of law at this stage that the Trustee does not have standing to question the reasonableness of the payments of defense costs. Accordingly, the Court denies NUFIC's motion to dismiss the portion of the Complaint that seeks proof that the defense costs were reasonable and appropriate.

Motion for Intervention and Preliminary Injunction

Motion for Intervention

Farace and Smith ("the Intervenors") move to intervene in the instant action by right or, in the alternative, for permission to intervene.

[HN11] *Rule 24(a)* permits intervention as of right upon a timely application:

(1) when a statute of the United States confers an unconditional right to intervene; or

(2) when the applicant claims an interest relating to the property or transaction which is the subject of the action and the applicant is so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest, unless the applicant's interest is adequately represented by existing parties.

Fed. R. Civ. P. 24(a) (West 2006). The Intervenor [*30] do not contend that they have any statutory right to intervene. Instead, they argue that they should be allowed to intervene pursuant to *subsection (a)(2)*. [HN12] To succeed on a motion under *Rule 24(a)(2)*, an intervenor must "(1) timely file an application, (2) show an interest in the action, (3) demonstrate that the interest may be impaired by the disposition of the action, [and] (4) show that the interest is not protected adequately by the parties to the action." *Brennan v. N.Y.C. Board of Education*, 260 F.3d 123, 128 (2d Cir. 2001) (internal quotations and citation omitted). The Court finds that the Intervenor has met all of the requirements of *Rule 24(a)(2)*.

The Intervenor has an interest in the property which is the subject of the action. [HN13] A proposed intervenor must show that he has a "direct, substantial, and legally protectable" interest in the action. *Washington Electric Cooperative, Inc. v. Massachusetts Mun. Wholesale Electric Co.*, 922 F.2d 92, 97 (2d Cir. 1990). Here, the Intervenor has a direct interest in property that is the subject of the instant action--namely, the insurance proceeds being sought by Plaintiff under Defendants' policies [*31] in connection with a judgment against the Trace officer and directors. The Second Circuit vacated the Judgment as against the Intervenor and remanded their case for retrial. The Intervenor alleges that, as directors and officers of Trace, they are entitled to payment of their defense costs (both in connection with the first trial and the retrial) and indemnification from any judgment against them under Defendants' insurance policies ¹⁶ in connection with a retrial. (See Notice of Mot. for Intervention, Ex. A, "Proposed Intervention Complaint," PP10, 16.).

16 The costs and judgment would appear fall under the general category of "Loss" as contained in the policies. See *supra* note 6.

The Court also finds that disposition of the instant action may adversely affect the Intervenor's ability to secure insurance proceeds under Defendants' policies. A finding that Plaintiff is entitled to all remaining proceeds under Defendants' policies could prevent the Intervenor from receiving coverage of defense [*32] costs and future indemnification for any judgments against them. Similarly, a judgment in favor of Defendants that they do not have any further obligations under the policies would make it difficult for the Intervenor, as beneficiaries of these policies, to recover defense costs and any future indemnification.

The Court finds that the Intervenor's interests are not adequately protected by the current parties to the action. Defendants take the position that they have no further

obligations under the policies and Plaintiff only seeks monetary judgment for the estate. Thus, none of the parties advocates for the Intervenor's claims of a right to payment of defense costs and indemnification in connection with the retrial.

Finally, the Court finds that the application for intervention is timely. [HN14] Courts examine the totality of circumstances in making a determination of timeliness. See *D'Amato v. Deutsche Bank*, 236 F.3d 78, 84 (2d Cir. 2001). "Circumstances considered in this determination include: (1) how long the applicant had notice of the interest before [he] made the motion to intervene; (2) prejudice to the existing parties resulting from any delay; (3) prejudice [*33] to the applicant if the motion is denied; and (4) any unusual circumstances militating for or against a finding of timeliness." *Id.* (internal quotations omitted). The Court notes that the application for intervention was filed on January 23, 2006, nearly two years after the instant case was filed in this District on February 11, 2004. However, the Second Circuit decision reversing the judgment in the Underlying Action as to the Intervenor and remanding the case for a jury trial was not rendered until June 30, 2005. So, at least in connection with defense costs and any future indemnification associated with the retrial, the Intervenor was not aware until after this decision of their direct interest in seeking reimbursement for these costs under the policies. See, e.g., *Werbungs Und Commerz Union Austalt v. Collectors' Guild, Ltd.*, 782 F. Supp. 870, 874 (S.D.N.Y. 1991) (finding that application for intervention filed almost two years after notice of interest in case was timely because application filed shortly after interest became direct). In any event, the Court does not find that the delay between the filing of the instant action and the filing of the intervention [*34] application, when weighed with the other factors, warrants denial of intervention. See, e.g., *United States v. Pitney Bowes, Inc.*, 25 F.3d 66, ("[T]he time lapsed between notice of an interest in pending litigation and an application to intervene is only one of several factors a district court must weigh when deciding the issue of timeliness."). The Court notes in this connection that there is no prejudice to the existing parties as a result of this delay but that, as explained above, the Intervenor will be prejudiced if the application is denied.

In the alternative, the Court finds that permissive intervention is warranted under *Rule 24(b)(2)*. [HN15] Under this provision, a would-be party can be permitted to intervene "when an applicant's claim or defense and the main action have a question of law or fact in common." *Fed. R. Civ. P. 24(b)(2)* (West 2006). "In exercising its discretion the court shall consider whether the intervention will unduly delay or prejudice the adjudication of the rights of the original parties." *Id.* The Court

finds that there are common questions of law and fact, that no such undue delay or prejudice [*35] will result from intervention and that, for substantially the reasons stated in its analysis of intervention as of right, permissive intervention is appropriate.

Preliminary Injunction Motion

The Intervenor move for a preliminary injunction "preserving the status quo by preventing the defendants from paying any monies under the Policies to [Plaintiff] . . . and . . . directing that the defendants continue to advance 'defense costs' [to the Intervenor] for retrial of the Prior Action." (Mem. in Supp. of Mot. for Intervention at 13.) [HN16] In the Second Circuit, the standard for preliminary injunctive relief ordinarily requires the moving party to show that: (1) it is likely to suffer irreparable injury; and (2) either (a) a likelihood of success on the merits of its case; or (b) sufficiently serious questions going to the merits to make them a fair ground for litigation and a balance of hardships tipping decidedly in its favor. *Green Party of New York State v. New York State Bd. of Elections*, 389 F.3d 411, 418 (2d Cir. 2004). [HN17] "Irreparable harm is an injury that is not remote or speculative but actual or imminent, and for which a monetary award cannot be [*36] adequate compensation." *Tom Doherty Assocs. v. Saban Entertainment*, 60 F.3d 27, 37 (2d Cir. 1995) (internal quotations omitted).

The Court finds that a preliminary injunction is not warranted, as the Intervenor have not made a showing of irreparable harm.¹⁷ The Intervenor only allege monetary harm in that they may not receive all the insurance proceeds due to them. They do not even allege that they will be unable to mount their defense in the retrial without the insurance advances. Thus, the Intervenor have failed to demonstrate the requisite irreparable harm.

17

Defendants indicate that they have not advanced any defense costs to the Intervenor. To

the extent then that the Intervenor seek such costs, [HN18] their request for injunctive relief would amount to a mandatory injunction rather than the requested prohibitory injunction seeking to keep the status quo. See *Tom Doherty Assocs., Inc.*, 60 F.3d 27 at 33-4. The former requires an even greater showing of harm "where extreme or very serious damage will result from a denial of preliminary relief." *Id.* at 34 (internal quotations omitted). Because the Intervenor have not made a showing of irreparable harm for a prohibitory injunction, they have not, a fortiori, made a showing of the harm required for a mandatory injunction.

[*37] CONCLUSION

For the foregoing reasons, Gulf's and Executive's motion to dismiss the complaint is granted to the extent it seeks to exclude coverage of the portion of the Judgment representing monies wrongfully obtained by Cogan and Nelson and is denied in all other respects, NUFIC's motion to dismiss is denied in its entirety, and Farace's and Smith's motion for intervention is granted but their application for a preliminary injunction is denied.

The parties shall appear in Courtroom 17C, United States Courthouse, 500 Pearl Street, New York, NY 10007, for a pretrial conference on August 22, 2006 at 10:45 a.m. and shall file their Joint Preliminary Pretrial Statement (with a courtesy copy to chambers) by August 15, 2006.

SO ORDERED.

Dated: New York, New York

July 12, 2006

LAURA TAYLOR SWAIN

United States District Judge



WESTPORT INSURANCE CORPORATION, Plaintiff - Appellant, v. MARKHAM GROUP INC. PS; MARK KAMITOMO; RACHEL NAIDU, individually and as personal representative of the Estate of James L. Overcash, Defendants - Appellees.

No. 10-35075

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

403 Fed. Appx. 264; 2010 U.S. App. LEXIS 23683

November 3, 2010, Argued and Submitted, Seattle, Washington

November 17, 2010, Filed

NOTICE: PLEASE REFER TO *FEDERAL RULES OF APPELLATE PROCEDURE RULE 32.1* GOVERNING THE CITATION TO UNPUBLISHED OPINIONS.

PRIOR HISTORY: [**1]

Appeal from the United States District Court for the Eastern District of Washington. D.C. No. 2:08-CV-00221-RHW. Robert H. Whaley, Senior District Judge, Presiding.

Westport Ins. Corp. v. Markham Group, Inc., 2009 U.S. Dist. LEXIS 76877 (E.D. Wash., Aug. 26, 2009)

DISPOSITION: REVERSED and REMANDED.

COUNSEL: For WESTPORT INSURANCE CORPORATION, Plaintiff - Appellant: James B. King, Esquire, Attorney, Evans, Craven & Lackie, P.S., Spokane, WA; Robert Allen Chaney, Attorney, Jeffrey Alan Goldwater, Attorney, George J. Manos, Esquire, Attorney, Lewis Brisbois Bisgaard & Smith LLP, Chicago, IL; Robert Patrick Conlon, Attorney, Christopher Wadley, Walker Wilcox Matousek LLP, Chicago, IL.

For MARKHAM GROUP INC. PS, MARK KAMITOMO, Defendants - Appellees: Daniel Edward Huntington, Attorney, RICHTER WIMBERLEY, PS, Spokane, WA.

For RACHEL NAIDU, individually and as personal representative of the Estate of James L. Overcash, Defendant - Appellee: Richard B. Kilpatrick, Esquire, Attorney, Richard B. Kilpatrick, P.S., Bellevue, WA.

JUDGES: Before: B. FLETCHER, FERNANDEZ, and BYBEE, Circuit Judges.

OPINION

[*265] **MEMORANDUM***

* This disposition is not appropriate for publication and is not precedent except as provided by 9th Cir. R. 36-3.

Before: B. FLETCHER, FERNANDEZ, and BYBEE, Circuit Judges.

Westport Insurance Corporation appeals the district court's [**2] grant of summary judgment and attorney's fees against it and in favor of the Markham Group, Inc., P.S. law firm and one of its members, Mark Kamitomo (collectively "insureds") and one of their former clients, Rachel Naidu. We have jurisdiction¹ and we reverse and remand.

1 28 U.S.C. § 1291.

(1) Insureds had a claims made and reported policy (hereafter "claims made policy") with Westport effective July 1, 2007, which, inter alia, provided an exclusion for "any act, error, omission, circumstance or PERSONAL INJURY occurring prior to the effective date of this POLICY if any INSURED at the effective date knew or could have reasonably foreseen that such act, error, omission, circumstance or PERSONAL INJURY might be the basis of a CLAIM." Prior to that date, the insureds knew that, due to errors on their part, a client's case had been dismissed and could not be refiled.² Indeed, they had been sanctioned at that time for filing a baseless claim without proper investigation. They assert that the

exclusion does not apply because its language regarding reporting if their actions "might be the basis" of a claim was ambiguous. We disagree. Under the law of Washington, clear and unambiguous policy [**3] language is enforced as written, and a court "may not modify it or create ambiguity where none exists." *Am. Nat'l. Fire Ins. Co. v. B & L Trucking & Constr. Co., Inc.*, 134 Wn.2d 413, 951 P.2d 250, 256 (Wash. 1998); see also *Assurance Co. of Am. v. Wall & Assocs. LLC of Olympia*, 379 F.3d 557, 560 (9th Cir. 2004); *Greenfield v. W. Heritage Ins. Co.*, 154 Wn. App. 795, 226 P.3d 199, 202 (Wash. Ct. App. 2010). Here, any reasonable insured would have recognized that the errors in question "might" result in a claim. See *Tewell, Thorpe & Findlay, Inc., P.S. v. Cont'l Cas. Co.*, 64 Wn. App. 571, 825 P.2d 724, 726-28 (Wash. Ct. App. 1992); see also *Allstate Ins. Co. v. Peasley*, 131 Wn.2d 420, 932 P.2d 1244, 1249 (Wash. 1997). In short, the district court erred when it declared that the policy was ambiguous and, in effect, amended it to create coverage.

2 That is, it could not be refiled unless the trial court's judgment was overturned on appeal. It was not; in fact, the insureds were sanctioned for bringing a frivolous appeal.

(2) The insureds then assert that an earlier claims made policy, with an effective date of July 1, 2006, should provide coverage even though they violated its terms by not giving notice at the proper time. They argue that the notice-prejudice [**4] [*266] rule should

apply. However, while that rule is applied to occurrence policies, claims made policies are fundamentally different in character. See *Am. Cont'l Ins. Co. v. Steen*, 151 Wn.2d 512, 91 P.3d 864, 867 (Wash. 2004). They, by their very nature, require reporting "during the policy period." *Schwindt v. Commonwealth Ins. Co.*, 140 Wn.2d 348, 997 P.2d 353, 356 n.3 (Wash. 2000). As the Washington Court of Appeals has stated in rejecting application of the notice-prejudice rule to a claims made policy, its application "would . . . provide coverage the insurer did not intend to provide and the insured did not contract to receive." *Safeco Title Ins. Co. v. Gannon*, 54 Wn. App. 330, 774 P.2d 30, 35 (Wash. Ct. App. 1989). In fact, it "[would negate] the inherent difference between" occurrence and claims made policies, and would rewrite the insurance contract. *Id.*; see also *Manufactured Hous. Cmty. of Wash. v. St. Paul Mercury Ins. Co.*, 660 F. Supp. 2d 1208, 1214-15 (W.D. Wash. 2009). We are satisfied that the Washington Supreme Court would agree with that reasoning. Thus, again, we must disagree with the district court.³

3 Because of our resolution of the merits, the attorney's fee award against Westport must also fall. Cf. *Smith v. Ohio Cas. Ins. Co.*, 37 Wn. App. 71, 678 P.2d 829, 831 (Wash. Ct. App. 1984).

In [**5] short, judgment should have been and should now be entered in favor of Westport.

REVERSED and REMANDED.

PUBLISHED BY
Kevin M. LaCroix

THE D&O DIARY

The D & O Diary

Posted at 3:41 AM on June 14, 2012 by Kevin LaCroix

NY Appellate Court: Excess Insurers Off the Hook Where It Can't Be Determined if Underlying Insurance Exhausted



In the latest of what is now a lengthening line of cases, on June 12, 2012, the New York Supreme Court, Appellate Division, First Department, applying Illinois law, ruled in a coverage case brought by JPMorgan Chase that owing to settlements by underlying carriers in a professional liability insurance program, excess insurers in the program have no payment obligation because conditions precedent to coverage under the excess carriers' policies had not been met. As discussed below, this case presents an interesting twist on the usual set of circumstances involved in these kinds of coverage disputes. A copy of the June

12 opinion can be found [here](#).

Background

Though this coverage action was initiated by JP Morgan, the insurance coverage at issue was procured by Bank One, which later merged into JP Morgan. For the policy period October 1, 2002 through October 1, 2003, Bank One had procured a total of \$175 million of bankers' professional liability insurance and securities action claim coverage. The insurance was structured in a program of eight layers, consisting of a primary layer and seven excess layers.

In November 2002, actions were brought against Bank One and certain of its affiliates in connection with their roles as indenture trustees of certain notes issued by various NPF entities. After it acquired Bank One, JP Morgan settled the NPF actions for a total of \$718 million and sought coverage under the Bank One insurance program for a portion of the settlement amount.

Prior to initiating the coverage suit against the carriers in the Bank One insurance program, JP Morgan settled with the sixth level excess carrier for \$17 million. The sixth level excess carrier's policy provided excess insurance coverage of \$15 million in excess of \$140 million. However, the \$17 million insurance settlement with this sixth level excess carrier covered both the carrier's liability under the Bank One program and claims under a separate policy the same carrier's affiliate company issued under a different insurance program. There was no

allocation of the \$17 million insurance settlement among the carrier's various policies

After initiating the coverage lawsuit, JP Morgan entered a separate \$17 million settlement with the third level excess carrier. This separate insurance settlement covered both the third level excess carrier's liability under the Bank One program as well as a separate claim under a separate insurance policy the carrier had issued.

Following these developments, the excess carriers in the fourth, fifth, and seventh excess insurance layers moved for summary judgment in the coverage action, arguing that as a result of the settlement with the third level excess carrier (and in the case of the seventh level excess carrier, the settlement with the sixth level excess carrier), conditions precedent to coverage under their respective policies had not been fulfilled, particularly with respect to their policies' requirement that the underlying layers should be exhausted by payment of loss.

In a May 31, 2011 opinion, the New York (New York County) Supreme Court granted the excess carriers' motions for summary judgment. JP Morgan appealed.

The June 12 Opinion

A June 12, 2012 opinion written by Judge Leland DeGrasse for a five-judge panel off the New York Supreme Court, Appellate Division, First Department and applying Illinois law, affirmed the lower Court's summary judgment rulings.

Focusing first on the fourth level excess carrier's position, the appellate court noted that the carrier's excess policy provide that "liability for any Loss shall attach to [the carrier] only after the Primary and Underling Excess Insurers shall have duly admitted liability and shall have paid the full amount of their respective liability." The court noted that the "plain language of this attachment provision" requires both the underlying insurers' admission of liability and the payment of the full amount of their limits, as "conditions precedent" to the carrier's liability.

The appellate court agreed with the fourth level excess carrier that neither of conditions precedent had been met. The first condition was not met because the third level excess carrier's settlement agreement with JP Morgan specifically provided that the agreement "shall not constitute, or be construed as, an admission of liability." Moreover, the court noted, there is "no way to determine that [the third level excess carrier] paid the full amount" under its excess policy in the Bank One tower, because the settlement agreement "provided for no allocation" of the \$17 million insurance settlement payment between the two policies that the carrier had issued and that were part of the insurance settlement.

For similar reasons, the court further concluded that conditions precedent in the fifth and seventh level carriers'

policies had not been met either. Relying on the Northern District of Illinois's 2010 opinion in the *Bally Total Fitness Holding Corp.* case (about which refer [here](#)) and the Fifth Circuit's 2011 opinion in *Citigroup* case (about which refer [here](#)), the court concluded that the lower court had "properly granted summary judgment" because JP Morgan's settlements with the third and sixth level excess carriers "preclude any determination" whether the settling excess insurers' policy limits were exhausted as required by the excess policies of the carriers that had moved for summary judgment, "because there was there was no allocation of settlement between the two underlying carriers."

The appellate court also rejected JP Morgan's efforts to rely on the venerable second circuit opinion in *Zeig v. Massachusetts Bonding & Ins. Co.* The appellate court here said that the Second Circuit's unwillingness in *Zeig* to allow the excess carrier to evade payment when an underlying carrier had settled for less than full policy limits had been dependent on a finding of an ambiguity in the excess policy at issue in that case. The appellate court found no ambiguity in the excess policies of the carriers that had moved for summary judgment here, making the present case distinguishable from *Zeig*. The appellate court also questioned, in reliance on the *Bally Total Fitness* case, whether *Zeig* was contrary to applicable Illinois precedent.

Discussion

As I noted at the outset, this decision joins a growing list of cases that have found *Zeig* to be inapplicable and that have required as a trigger of coverage for excess insurance coverage that the limit of liability of the underlying insurance be exhausted by payment of loss. (A full list of the growing line of cases can be found in the Discussion section of my post pertaining to the Fifth Circuit's opinion in the *Citigroup* case, refer [here](#).)

An interesting complication in this case was the fact that the two excess carriers that had reached settlements with JP Morgan had in each case settled the insurance dispute with JP Morgan for payment of amounts that were actually *greater* than the amount of their respective excess layers in the Bank One insurance program. In each of the two settlements, the involved carrier's respective layers in the Bank One program were \$15 million, and the amount of each insurance settlement was \$17 million.

The complicating factor was that in each of these two settlements, the settlements had also involved the settlement of coverage under a second insurance policy, other than the carrier's policy in the Bank One program. Because of the involvement of these separate policies and because of the absence of any allocation between the policies in the respective insurance settlements, there was no way (the appellate court found) to determine whether or not the insurance settlements had exhausted the applicable excess policies in the Bank One program.

Although it may be twenty-twenty hind sight, you can certainly see in retrospect how these insurance settlements could have been structured to avert the outcome here. Just to put this into perspective, the policy limits of the excess carriers who prevailed on summary judgment in the lower court and on appeal totaled \$95 million.

It is probably worth adding that there is nothing that says that even if the excess carriers had not prevailed on this specific issue that there would have been coverage available under their respective excess policies. Indeed, it appears that, even though the various carriers on the third level through seventh level excess layers are now out of the case (either through settlement or through summary judgment), the carriers on the primary and first two excess layer levels all apparently remain in this case and all apparently are continuing to contest coverage.

While this list of case authority on the excess trigger issue is growing longer, it is important to keep in mind that the outcome of each of these cases was a direct reflection of the specific language of the excess policies at issue. These cases underscore the critical importance of the language describing the payment trigger in the excess policy. In recent years, and in large part as a reaction to these cases, excess carriers increasingly have been willing to provide language that allows the excess carriers' payment obligations to be triggered regardless whether the underlying amounts were paid by the underlying insurer or by the insured. This language was not generally available in 2002 when Bank One purchased the insurance that was at issue here.

Increasingly larger settlement amounts and increasingly higher defense expenses are increasingly driving claims losses into the excess layers, and as a result these issues pertaining to the excess policies' coverage triggers are also increasingly important. These cases underscore the critical importance of the specific wording used in the excess policies, which in turn highlights the need to have an experienced, knowledgeable insurance professional involved in the insurance placement process.

Trackbacks (0)

Comments (0)

Kevin M. LaCroix

2000 Auburn Drive, Suite 200, Beachwood, OH 44122, Phone: (216) 378-7817