IN THE SUPERIOR COURT OF THE STATE OF DELAWARE
IN AND FOR NEW CASTLE COUNTY

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY, et al.,	)	
Plaintiffs,	)	
v.	)	C.A. No.: N10C-11-219 FSS CCLD
CERTAIN UNDERWRITERS AT LLOYD'S OF LONDON SUBSCRIBING TO BOND NOS. B0391/FD020720G AND B0391/ FD020730G, et al.,	)	
Defendants.	)	

Submitted: March 20, 2014
Decided: June 6, 2014

ORDER

Upon Defendants' Motion to Dismiss – GRANTED
Upon Defendants' Motion for Partial Summary Judgment – DENIED

After paying a fortune in claims stemming from Bernie Madoff's Ponzi scheme, Plaintiffs demanded coverage from their fidelity and crime insurance tower. Now, the court is focused on whether Plaintiffs' recently added, good-faith/fair dealing claims "relate-back," whether the court has jurisdiction over a Massachusetts statutory fraud claim, and whether Plaintiffs' settlements with the underlying insurers in their tower satisfy the excess policy's exhaustion clause.

I.

The multi-billion dollar, Madoff fraud was widely covered by the media and it took the nation's breath away. For this case's purposes, investors purchased ownership interests in the Rye Funds Plaintiffs. Through Plaintiff Tremont Partners, Inc., these ownership interests were invested using dozens of investment managers and advisors, including Madoff. Hundreds of millions of dollars entrusted to Madoff's "investment" company were lost.

After Madoff's fraud was uncovered, many lawsuits were filed against Plaintiffs, generally alleging misrepresentation, breach of fiduciary duty, mismanagement, and failure to supervise. In turn, Plaintiffs, which are Delaware corporations: Massachusetts Mutual Life Insurance Company and its subsidiaries, sought coverage from Defendants, their D&O and financial institution bond insurers. Plaintiffs annually had purchased a fidelity and crime insurance tower covering losses up to $100 million per loss with a $200 million aggregate limit. Eleven insurers contributed to the tower's six tiers.

Initially, Defendants denied coverage and Plaintiffs defended themselves, accruing billions of dollars in losses and defense costs in the underlying litigation against them. Plaintiffs then filed suit, first in Chancery court, then here, against Defendants for apportionment, breach of contract, and declaratory relief.

Over four years into the litigation, on September 4, 2013, Plaintiffs amended their complaint, adding claims for breach of the implied covenant of good faith and fair dealing, bad faith, and statutory consumer fraud. Plaintiffs settled with all but two Defendants – RLI and Great American. These remaining Defendants form the fifth excess layer, the top tier of the six tier tower.

Defendants filed motions to dismiss the counts added in the amended complaint, Counts V and VI, and to strike paragraphs 135 to 156 supporting those counts. Defendants also filed motions for partial summary judgment, alleging failure to exhaust underlying insurance because Plaintiffs settled for less than the underlying policies' limits. Briefing was completed December 20, 2013. Oral argument was January 6, 2014. The transcripts were filed March 20, 2014.

The court will first address the amended complaint's new claims and allegations, which turn on relation-back and subject matter jurisdiction. Then the court will discuss summary judgment on exhaustion, which turns on policy construction.

II.

Plaintiffs withdrew their bad faith claim, Count VII, in their Response to Defendants' Motion to Dismiss. Accordingly, oral argument clarified that there are two distinct bases for Counts V and VI of the amended complaint: 1) a statutory,

consumer fraud claim,[1] and 2) an alleged violation of the common law implied covenant of good faith and fair dealing. They must be kept separate, although they suffer from the same infirmities, particularly a statute of limitations problem.

A.

Defendants' motions to dismiss characterize both the implied covenant of good faith/fair dealing and the statutory claims as involving "bad faith," thus requiring heightened pleading.[2] Defendants argue Plaintiffs' allegations do not satisfy Rule 9(b) because they are not specific enough. And, the allegations are based on litigation conduct, which, as a matter of law, are subject to the absolute litigation privilege. Further, Defendants correctly assert Massachusetts's consumer fraud law only protects acts "primarily and substantially within the commonwealth," and here, Plaintiffs do not allege any conduct took place in Massachusetts.[3] Lastly, in their strongest argument, Defendants counter the statute of limitations bars the amended complaints' new counts and they do not relate-back. The statute of limitations problem is paramount because unlike a pleading problem that can be fixed, a statute of limitations violation is fatal.

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[1] Mass. Gen. Laws ch. 93A, § 11.

[2] Superior Court Civil Rule 9(b) ("In all averments of fraud, negligence or mistake, the circumstances constituting fraud, negligence or mistake shall be stated with particularity").

[3] Mass. Gen. Laws ch. 93A, § 11. *See also Makino, U.S.A., Inc. v. Metlife Capital Credit Corp.,* 518 N.E.2d 519, 522 (Mass. App. Ct.1988).

Plaintiffs first respond that a Massachusetts statutory fraud claim cannot generally be dismissed on the pleadings because the "primarily and substantially" standard requires fact-finding. Plaintiffs also assert that a good faith/fair dealing claim is not the same as a bad faith claim, although they concede that the claims commonly overlap. Finally, Plaintiffs acknowledge that the statute of limitations has run, but argue the new counts relate-back because they arise from previously pled facts.

B.

Specifically, as to the prime issue, Defendants argue the amended complaint adds new allegations and claims that are barred by the statute of limitations.[4] Statutes of limitations protect defendants from undue prejudice: "Thus, notice to the defendant of a plaintiff's cause of action is essential to ensure that a defendant is not prejudiced in preparing an adequate defense."[5] An amendment relates-back to the original complaint's date only when the new claim "arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading."[6] Accordingly, the new claim can "relate-back" to the original complaint only if Defendants originally had sufficient notice of the late-filed, new

[4] 10 *Del.C.* § 8106.

[5] *Chaplake Holdings, LTD. v. Chrysler Corp.*, 766 A.2d 1, 6 (Del. 2001).

[6] Superior Court Civil Rule 15(c)(2).

claim. Conversely, where a new claim "presents an independent theory of liability based on independent facts that were not set forth in the original complaint," it does not relate-back.[7]

Defendants rely on *Moore v. Emeigh*, an aircraft disaster case.[8] There, the initial complaint alleged an aircraft's owner was vicariously liable for a pilot's negligence. The new claim alleged the owner negligently failed to inspect the plane. The Supreme Court affirmed dismissal because "the new claim presents an independent theory of liability based on independent facts that were not set forth in the original complaint."[9] Defendants argue that like in *Moore*, the new claims here are independent because they rely on newly pled facts. Specifically, Defendants contend none of the original complaint's allegations "suggested that the defendants acted in bad faith ... because the mere denial of coverage, without more, does not establish bad faith."

As mentioned, Plaintiffs concede the amended complaint is untimely. Rather, Plaintiffs attempt to distinguish *Moore*, arguing their new claims are not independent, but arise from the same failure to provide coverage alleged originally. Plaintiffs argue that claims relate-back where "the factual situation upon which the

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[7] *Moore ex rel. Moore v. Emeigh*, 935 A.2d 256, *3 (Del. 2007)(TABLE).
[8] *Id.*
[9] *Id.*

action depends remains the same," even if the legal theory changes.[10] When they allude to the standard for relation-back, however, Plaintiffs attempt to substitute their broader term, "factual situation," for the Supreme Court's narrower standard, "independent facts." Under Plaintiffs' thinking, the dismissed claim in *Moore* should have related-back because it depended on and related to the same airplane crash.

In make-weight fashion, Plaintiffs bolster their argument by quoting several cases. But, Defendants correctly observe that none addresses the issue here. Only one discusses adding new claims or facts: *F.P. Woll & Co. V. Valiant Ins. Co.* conclusively allows the new claim to relate-back to the original complaint because "the original complaint clearly 'set forth' the details of [the] interaction."[11] Here, in contrast, the original complaint does not allege facts relating to Defendants' claims handling. As discussed next, forcing Defendants to reveal and justify their claims handling adds a whole new dimension to the litigation, a dimension that Defendants had little reason to foresee, much less expect.

The original complaint waives the tort and simply makes claims for breach of contract. The original complaint alleges Defendants "still have not agreed to an apportionment of defense costs ... and have not indemnified [Plaintiffs] for the losses covered under the Bond and Excess Bonds." The damages allegations were

[10] *Mullen v. Alarmguard of Delmarva, Inc.*, 625 A.2d 258, 264 (Del. 1993).

[11] 2001 U.S. Dist. LEXIS 24141, *7 (E.D. Pa 2001).

merely for declaratory judgment apportioning defense costs and liabilities, requiring payment by insurers, and appropriate costs and interest.

The core of the amendments, however, relates to Defendants' claims handling, specifically: stalling, dissembling, and failing to investigate. Those new allegations will necessarily require extensive, expensive, time-consuming discovery into areas heretofore unexplored. The gale has already begun.[12]

Beyond the new discovery into claims handling, Plaintiffs will now insist on discovery into the new damages metric associated with an alleged breach of good faith/fair dealing. Even if the new claims broadly stem from Defendant's failure to cover, they would turn this old case on its head.

Looking at it another way, the tort claims will be at least as difficult to prove as the original contract claims, probably harder. Why, therefore, do Plaintiffs want the additional, and seemingly unnecessary, burden four years into the litigation? The likely answer, pointed out by Defendants, is the tort and fraud claims potentially add damages to the case. The statutory damages are tripled. Viewed in context, therefore, adding tort and statutory claims to this contract case at this late date looks like only a diaphanous effort to inflate the damages and pressure Defendants. To achieve that end, however, Plaintiffs must move the litigation's focus from the

[12] Special Discovery Master's Decision, *Massachusetts Mut. Life Ins. Co. v. Certain Underwriters at Lloyd's of London,* C.A. No. N10C-11-219 (Del. Super. Dec. 23 2013).

underlying insurance policies, claims, and settlements, and onto Defendants' claims handling and tort damages. This underscores how allowing the tort and statutory claims to relate-back is uncalled for and unreasonable.

III.

Defendants also move for summary judgment, generally claiming underlying insurance has not been exhausted under the policy's terms,[13] precluding coverage. Essentially, the parties clash over whether *Zeig v. Mass. Bonding & Ins. Co*. controls.[14] In short, Defendants' best argument alleges the unambiguous policy language requires exhaustion through "actual payment" by the underlying insurers all the way up to the policy limits, and Plaintiffs' lower-tier settlements do not satisfy this condition precedent. Plaintiffs' strongest response is that the policy is ambiguous as to who must make the required payment. It does not matter whether Defendants' attachment point is reached solely with lower tier carriers' money or a combination of the carriers' and Plaintiffs' money, so long as the losses were actually paid.

Because the policy's exhaustion clause is ambiguous, summary judgment is inappropriate. After addressing the controlling law, the court will first focus on the core disputes over ambiguity and *Zeig*, then touch on the parties' other contentions.

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[13] "Coverage under this policy shall attach only after all of the Single Loss Limit(s) of Liability or Aggregate Limit(s) of Liability, as applicable, of the Underlying Insurance has been exhausted by the actual payment of losses."

[14] 23 F.2d 665 (2nd Cir. 1928).

A.

As an initial matter, the court must determine which law to apply. Here, the policy plainly designates Massachusetts law. Even so, Delaware law controls procedural matters, such as the standard of review.[15] Moreover, at oral argument the parties essentially conceded the substantive analysis would be identical under Massachusetts and Delaware law. Delaware and Massachusetts look at contracts the same way, and neither has decided whether *Zeig* is still good.

A foreign jurisdiction's law will not be applied where the result would be the same under Delaware law even where the parties agree the foreign law applies.[16] Where there is a "false conflict," a choice of law analysis should be avoided altogether.[17] Accordingly, because the parties agree it makes no difference, Delaware law will govern these motions when feasible for clarity and consistency.

B.

Summary judgment can be granted when there are no genuine material issues of fact and the moving party is entitled to judgment as a matter of law.[18] "If,

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[15] *E.g., Tumlinson v. Advanced Micro Devices, Inc.*, 2013 WL 4399144 (Del. 2013).

[16] *Deuley v. DynCorp Int'l, Inc.*, 8 A.3d 1156, 1160-61 (Del. 2010).

[17] *Id*; *see also Lagrone v. Am. Mortell Corp.*, 2008 WL 4152677 (Del. Super. 2008) ("[where] the end result is the same regardless of which State's law the Court applies here, ... the Court may resolve the dispute without a choice between the laws of the competing jurisdictions.").

[18] *E.I. du Pont de Nemours & Co. v. Stonewall Ins. Co.*, 2009 WL 1915212 (Del. Super. 2009); *see also Viking Pump, Inc. v. Century Indem. Co.*, 2 A.3d 76, 86 (Del. Ch. 2009).

however, there are material factual disputes, that is, if the parties are in disagreement concerning the factual predicate for the legal principles they advance, summary judgment is not warranted."[19] Summary judgment should also be denied where "it seems desirable to inquire more thoroughly into the facts ... to clarify the application of law to the circumstances."[20] The evidence must be viewed in the light most favorable to the non-moving party.[21] "This means it will accept as established all undisputed factual assertions, made by either party, and accept the non-movant's version of any disputed facts. From those accepted facts the court will draw all rational inferences which favor the non-moving party."[22]

In contract disputes, ambiguity is often a threshold challenge for summary judgment motions. If the contract is ambiguous, summary judgment is out of order.[23] Delaware follows the "objective" theory of contracts, meaning a contract is construed as understood by a reasonable third party.[24] When interpreting a contract, Delaware courts give priority to the parties' intentions as reflected within the four corners of the agreement.[25] A court must construe the agreement as a whole,

[19] *Merrill v. Crothall-Am., Inc.*, 606 A.2d 96, 99 (Del. 1992).

[20] *Gunzl v. Chadwick*, 2 A.3d 74 (Del. 2010).

[21] *Brzoska v. Olson*, 668 A.2D 1355, 1364 (Del. 1995) citing Super. Ct. Civ. R. 56(c).

[22] *Marro v. Gopez*, 1994 WL 45338 (Del. Super. 1994) citing *Merrill*, 606 A.2d at 99-100.

[23] *Nw. Nat. Ins. Co. v. Esmark, Inc.*, 672 A.2d 41, 43 (Del. 1996).

[24] *Osborn ,* 991 A.2d at 1159.

[25] *GMG Capital Investments, LLC v. Athenian Venture Partners I, L.P.*, 36 A.3d 776, 779 (Del. 2012).

giving each provision effect so as not to render any part of the contract meaningless, illusory, or superfluous.[26]

When the contract is unambiguous, the court enforces the plain meaning of its terms and provisions.[27] If a policy is clear, by definition it speaks for itself, so there is no reason to look for the parties' subjective expectations. If, however, there is more than one reasonable interpretation, a provision is ambiguous.[28] But, a provision is not ambiguous just because the parties disagree on its proper construction; nor are unreasonable interpretations considered.[29]

Extrinsic evidence cannot be introduced to create ambiguity.[30] Nor can ambiguity arise because of case law. *Qualcomm, Inc. v. Certain Underwriters At Lloyd's, London* refused to let the court's interpretations of policy language create ambiguity.[31] There, the plaintiff argued case law created a reasonable expectation of excess coverage. The court, however, found "an expectation of coverage cannot create an ambiguity; it is merely an interpretive tool used to resolve an ambiguity once it is found to exist."[32]

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[26] *Osborn*, 991 A.2d at 1160.
[27] *Id.*
[28] *AT&T Corp. v. Lillis*, 953 A.2d 241, 252 (Del. 2008).
[29] *Id.*
[30] *Eagle Indus., Inc. v. DeVilbiss Health Care, Inc.*, 702 A.2d 1228, 1232 (Del. 1997).
[31] 73 Cal.Rptr.3d 770 (2008).
[32] *Id.* at 777 (citing *Fire Ins. Exchange v. Superior Court*, 10 Cal.Rptr.3d 617 (2004)).

C.

As mentioned, ambiguity is the threshold issue here. Accordingly, Defendants bore into the policy, alleging it unambiguously requires exhaustion by each underlying insurer's paying its respective underlying limits. Specifically, the RLI policy attaches "only after all [Underlying limits] have been exhausted by the actual payment of loss." Defendants argue this language, paired with the policy's definition of Underlying Insurance, specifically meaning all policies identified in the policy's declarations, unambiguously requires full payment by the underlying insurers. In simplest terms, Defendants argue that even if, as is the case, their insureds suffered a catastrophic loss far exceeding all their insurance, Defendants still do not have to respond. That is because their insureds settled with lower tier insurers for less than the lower tier policies' face values. It does not matter that actual payment of all loss was made, despite the settlements.

Defendants also rely on "Section III.B Reduction/Exhaustion of Underlying Limit(s)," which provides payment of reduced underlying limits "solely as the result of actual payment of loss." This section describes only one exception to an underlying insurer's payment requirement: If an underlying insurer fails to pay due to "insolvency, bankruptcy, or liquidation," the insured is "deemed self-insured" for any unpaid amount. For Defendants, this sole carve-out, in effect, precludes

allowing Plaintiffs to self-insure under other circumstances. Self-insurance, however, is not defined anywhere in the policy.

Defendants view any lower-tier settlement shortfall as *de facto* self-insurance, which Section III.B impliedly prohibits. Reading the policy as a whole, Defendants allege "there is nothing in the Excess policy that remotely grants to Mass Mutual the right to be 'self-insured' for the gap in insurance in the case of a settlement." The carve-out specifically allows self-insurance in the named circumstances, but the policy does not actually say that the list is exhaustive. Defendants read that into the policy. For Defendants, because one exception is specifically described, no other exception is reasonable.

Defendants further argue that courts consistently interpret substantially similar exhaustion language as requiring actual payment by their respective underwriters. For example, *Intel Corp. v. Am. Guar. & Liab. Ins. Co.,* a Delaware case decided under California law, held a similar clause requiring exhaustion by payment of judgments or settlements "cannot be construed under California precedent to encompass an insured's own payment of defense costs."[33] Similarly, the Fifth Circuit affirmed, in *Citigroup Inc. v. Fed.Ins. Co.*, that settlement for less than policy limits did not trigger an excess policy requiring "exhaustion of all of the limit(s) of

[33] 51 A.3d 442, 449 (Del. 2012).

liability of such 'Underlying Insurance' solely as a result of payment of loss thereunder."[34] *Citigroup* held "coverage does not attach until the underlying insurer makes a payment equal to 'all' the underlying insurer's limits of liability."[35] As discussed below, Defendants also argue their position follows a string of cases.

Plaintiffs argue the policy is ambiguous. Plaintiffs concede the language requires "the actual payment of losses," but assert it is unclear as to who must pay, even considering Section III.B. Plaintiffs emphasize they covered losses due to the Madoff catastrophe by actually paying their clients. Thus Plaintiffs argue their actual payment of losses to third parties satisfies the exhaustion clause. While insurers have a valid reason to require actual payment, such as preventing settlement manipulation, they have no excuse for requiring payment only by the underlying insurers. As Plaintiffs explained at oral argument, with Plaintiffs' actual payment "[the excess] insurer has some comfort that somebody actually gambled and paid real money."

Plaintiffs also distinguish several of Defendants' cases, primarily observing they do not involve actual payments of losses by the insured. For example, *Intel*, discussed above, involved only the insured's defense costs, but no damages had been paid by anyone to third parties, in contrast to what Plaintiffs did here. Other cases held substantially similar policies were ambiguous. For example, the relevant

[34] 649 F.3d 367, 373 (5th Cir. 2011).
[35] *Id.*

language in *Ali v. Federal Ins. Co.* stated coverage "shall attach only after all ... 'Underlying Insurance' has been exhausted by payment of claim(s)."[36] *Ali* held payment was required to trigger an excess insurer's liability, but explained that it "did not specify which party was obligated to make the requisite payments."[37] *Ali* turned on whether money had been paid, not on by whom.

Plaintiffs' position that the excess policy is ambiguous is persuasive. Again, in the passive voice the exhaustion clause provides: "this policy shall attach only after all of the Single Loss Limit(s) of Liability or Aggregate Limit(s) of Liability, as applicable, of the Underlying Insurance has been exhausted by the actual payment of loss(es)." By agreeing to frame the clause as they did, the parties obscured who must pay. Both interpretations – requiring payment by the underlying insurers or only requiring actual payment by anyone – are reasonable. The excess carriers may only have been concerned that they would not have to respond unless the loss truly reached their attachment point. Actual payments would eliminate that concern. Or, as Defendants now contend, for some reason they may have been concerned whether the lower-tier carriers had decided they had no choice but to cover their insureds' losses with the carriers' own money. One justification offered by Defendants and discussed below is they wanted to be sure that the lower tier carriers,

[36] 719 F.3d 83, 91 (2nd Cir. 2013).

[37] *Id*. at 92.

rather than Defendants, had worked through all possible defenses to coverage, thus relieving Defendants of that expensive burden.

It bears emphasis that the policy language at issue here is substantially similar to the policy interpreted in *Ali*. There, the policy required exhaustion of underlying insurance "solely as a result of payment of losses thereunder." The Second Circuit commented that the policy, just like the one at issue here, "describ[ed] the exhaustion requirement in the passive voice and did not specify which party was obligated to make the requisite payments."[38] That language, which was like the policy language here, was found inherently ambiguous, as discussed above.

D.

Even if the policy were not ambiguous, which the court just determined it is, the case law supports Plaintiffs' position. Plaintiffs argue that were the policy unambiguous, *Zeig v. Mass. Bonding & Ins. Co.* controls. *Zeig* involved an insured settling his $15,000 primary policy for $6,000 and the excess insurer refusing to pay, claiming the primary was not exhausted.[39] *Zeig* held where the insured proves losses greater than the primary policy's limit, settlement with the primary does not foreclose indemnity by the excess. *Zeig* focused, first, on the policy's ambiguity. The policy did not discuss collecting the full primary insurance amount. Rather, it required only

[38] *Ali*, 719 F.3d at 92.

[39] 23 F.2d 665 (2nd Cir. 1928).

that the primary "be exhausted in the payment of claims to the full amount of the expressed limits."[40] *Zeig* found "claims are paid to the full amount of the policies, if they are settled and discharged."[41]

Plaintiffs argue *Zeig's* rationale perfectly comports with this case's facts. Plaintiffs cite to several cases following *Zeig*, holding that settlement exhausts underlying insurance.[42] For example, *Koppers Co., Inc. v. Aetna Cas. And Sur. Co.* holds "settlement with the primary insurer functionally 'exhausts' primary coverage and therefore triggers the excess."[43] *Koppers* found this encourages settlement and allows the insured to obtain the benefit of its bargain, while preventing double recovery.[44]

Beyond the policy language, *Zeig* turned heavily on the conclusion that an insurer has no rational interest in requiring full payment by underlying insurers. *Zeig* found "the defendant had no rational interest in whether the insured collected the full amount of the primary policies, so long as it was only called upon to pay ... in excess of the limits."[45] *Zeig* would not impose "a result harmful to the insured, and

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[40] *Id.* at 666.

[41] *Id.*

[42] *E.g.*, *Trinity Homes LLC v. Ohio Casualty Insurance Co.*, 629 .3d 653 (7th Cir. 2010); *Dunlap v. State Farm Fire & Cas. Co.*, 878 A.2d 434 (Del. 2005).

[43] *Koppers Co. v. Aetna Casualty & Surety Co.*, 98 F.3d 1440, 1454 (3rd Cir. 1996).

[44] *Id.*

[45] *Zeig*, 23 F.2d at 666.

of no rational advantage to the insurer."[46] Plaintiffs assert that, like the *Zeig* defendants, Defendants here gain nothing by limiting Plaintiffs' ability to settle even if Plaintiffs covered some of the loss by paying others themselves.

Plaintiffs also rely on *Dunlap v. State Farm Fire & Cas. Co.*[47] *Dunlap* is not factually on point, much less controlling. But, like here, the insured in *Dunlap* had losses clearly exceeding the underlying insurance. Accordingly, by refusing to consent to the settlement with the primary there, the excess insurer was "not advancing any interest of its own, and had become a secondary source of injury" to the insured.[48] Just as the court previously emphasized in a similar case,[49] it is not relying on *Dunlap* here. The point is that this case, like the earlier one, has *Dunlap's* flavor.

As to *Zeig*, Defendants tacitly concede they cannot win on summary judgment if *Zeig* is applied here. Defendants assert, however, that *Zeig* does not apply because *Zeig* turned on ambiguities absent here. For example, *Zeig* reasoned "payment of claims" required by the policy could refer to "satisfaction of a claim by compromise." Defendants emphasize the policy here requires "actual payment of losses."

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[46] *Id.*

[47] 878 A.2d 434 (Del. 2005).

[48] *Dunlap*, 878 A.2d at 445.

[49] *Mills Ltd. P'ship v. Liberty Mut. Ins. Co.*, 2010 WL 8250848 (Del. Super. 2010).

As mentioned above, Defendants cite nearly a dozen cases refusing to follow *Zeig*. For example, even in the Second Circuit where *Zeig* was decided, *Ali v. Federal Ins. Co.*, as discussed, distinguished *Zeig*, holding that defense and indemnity obligations alone are insufficient to reach the attachment point.[50] Defendants' bandwagon argument, as with many arguments to numbers, does not bear-well under close scrutiny.

Defendants overstate their cases' precedential value. Before a case is precedent in this case, it must, at a minimum, involve both a catastrophic loss exceeding policy limits and actual money paid to a third party that exceeds each lower tier policy's limits. Out of their dozen cases, less than half are factually similar. Even the few cases that are factually similar do not include identical language, each case turning on its specific policy. And, even those decisions do not focus on Plaintiffs' point here. In short, Defendants' string cite has little more than headnote value, if that.

Defendants further reply that their reliance on the exhaustion clause is not just an easy out. They contend that the settlements here expose them to risks neither contemplated nor bargained for: 1) liability for Plaintiffs' defense costs, and 2) their own costs if they challenge coverage. Essentially, Defendants allege, citing

[50] 719 F.3d 83 (2013).

U.S. Fire Ins. Co. v. Lay, higher level excess insurers, such as themselves, "rely upon the Underlying Underwriters 'to defend in good faith or to discharge [their] duty to represent the interest of the excess carrier.'"[51]

For example, Defendants argue that as the highest level excess insurer, their policy and low premium contemplate that "the underlying underwriters bear a heavier burden to investigate the claim of the insured, and, if there is litigation, to carry the heavier burden to defend the case if there are coverage issues." Defendants further contend the exhaustion clause assures them that all coverage issues will have been fully explored by the lower tier carriers, at those carriers' expense, before the higher tiers must decide whether to respond. Thus, Defendants' essentially allege that Plaintiffs are now shifting those costs onto them. That is a serious argument.

Though it exceeds the standard of review here, the court potentially agrees with Defendants' take on the exhaustion clause's ancillary purposes. The shortcoming in Defendants' position regarding the exhaustion clause's back story is simply that it begs the question. Defendants' assertions to the contrary notwithstanding, it can be said Defendants got exactly what they bargained for: At their expense, Plaintiffs and underlying insurers investigated the claims and calculated the risk posed by litigating coverage issues. That was the "due diligence"

[51] 577 F.2d 421, 423 (7th Cir. 1978).

on which Defendants expected to rely. Presumably, for present purposes, the settlements reflect the odds calculated by both parties at the lower exposure point that litigation would end with a finding of no coverage.

Defendants argue, essentially, that the moment Plaintiffs agreed at a lower tier to anything less than full payment, the entire tower collapsed. The subtext to that argument is the unreasonable notion, rejected in *Zeig*, that Plaintiffs had to insist on either 100% coverage or they had to risk the chance of no recovery by litigating. That is even if they had carefully calculated that their likelihood of success was high, but not a sure thing. Here, Defendants will not acknowledge meaningfully that Plaintiffs actually paid the difference their risk calculation left. Nor, as discussed next, do they acknowledge the benefit the lower tier settlements conferred on them.

In reality, as in *Zeig*, viewing the exhaustion clause less dogmatically and more practically works to everyone's advantage, insured and insurer alike. It does not improperly shift anything onto Defendants. As the higher tiers anticipated, the lower tiers paid to calculate their actual risk, ultimately reflected in their settlements. Then, the insureds made up the difference out of their pockets. Defendants may now rely on that to calculate their exposure. Thanks to the lower-tiers' effort, Defendants probably can now settle for less than full coverage, despite the actual loss's overwhelming enormity. Anyway, further litigation may prove

Defendants are receiving precisely the benefit they bargained for: the primary and lower-tier carriers' risk assessment, settlement negotiations, and cash payment to the full policy limits before triggering Defendants' policy.

E.

Defendants' last significant argument focuses on the fourth excess policy. Essentially, Defendants argue that policy, issued by Lloyd's, was never triggered, so their higher-tier policy cannot have been triggered either. The Lloyd's policy provides it will not attach unless "the Underwriters of the Underlying Policy(ies) shall have paid or have admitted liability or have been held liable to pay, the full amount of their indemnity." This trigger provision was not satisfied by the settlements, and Defendants argue their policies cannot attach as this condition precedent was not met. Plaintiffs did not respond to this argument.

It is undisputed that at least two of the underlying insurers never admitted liability, nor have they been held liable to pay the full amount. And, by virtue of the settlements, none has paid the full amount. Failing to meet this condition has been held to bar liability for failing to satisfy a condition precedent.[52] Accordingly, it is true that the Lloyd's policy would not be liable to pay, but Defendants overstate the importance of that as it applies to them.

[52] 947 N.Y.S.2d 17 (N.Y. App. Div. 2012) leave to appeal denied, 984 N.E.2d 325 (2013).

Defendants rely on *JP Morgan Chase & Co. v. Indian Harbor Ins. Co.*[53] to show that the limiting Lloyd's policy language forecloses coverage here. *JP Morgan* involved an eight-layer insurance tower. After bringing suit, the insured settled with the third and sixth layer excess insurers. All the excess insurers above the third layer moved for summary judgment. The fourth level excess insurer's policy included a "pay or be held liable" provision like the Lloyd's policy here. While *JP Morgan* held that none of the remaining insurers was required to indemnify, it reached that holding by examining each policy's attachment clause. *JP Morgan* explained each attachment clause at issue was analogous to similar clauses interpreted to "unambiguously require[] the insured to collect the full limits of the underlying policies before resorting to excess insurance."[54] *JP Morgan's* analyzing each higher level policy rather than merely relying on the fourth tier undercuts Defendants' position that it can disclaim coverage simply by relying on the lower-tier Lloyd's policy's failure to attach.

Here, Defendants' opportunistic argument that because it follows form, their policy adopts the Lloyd's language is similarly unpersuasive. Defendants' policy is a follow-form policy, but the policy it follows is not the Lloyd's policy. Defendants' follow-form clause states it shall "apply in conformance with ... the

[53] *Id.*

[54] *Id.* at 23.

Primary Policy." The follow-form clause does not adopt changes to the primary found in any excess policy. The Lloyd's condition at issue is not in the primary policy, so Defendants' follow-form clause does not embrace it.

Put even more simply, nothing in the follow form clause contemplates Defendants piggybacking on the fourth-tier carrier. Had they wanted, Defendants could have bargained for a follow-form clause incorporating all the lower tier policies rather than just the primary. In passing, the court finally observes that not only is Defendants' follow-form argument unpersuasive, Defendants' calling attention to the Lloyd's attachment clause further undermines, albeit slightly, Defendants' exhaustion clause argument.

Defendants also rely on a limitation clause providing, "In no event shall coverage under this policy be broader than coverage under any Underlying Insurance." This general clause is not a catch-all substitute for a more specific and less expansive follow-form clause.[55] Rather, this sort of clause limits the scope of excess coverage to conform to the underlying insurance.[56] Scope is not at issue here.

Defendants further argue that as Plaintiffs never answered these last contentions, any opposition is waived and the motion must be granted as a matter of

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[55] *Veto v. Am. Family Mut. Ins. Co.*, 815 N.W.2d 713, 717 (Wis. App. 2012) review granted, 822 N.W.2d 880 (2012), and review dismissed, 829 N.W.2d 752 (2013).

[56] *E.g. Lynch v. Spirit Rent-A Car, Inc.*, 965 A.2d 417, 428 (R.I. 2009) (Excess coverage no broader than primary did not include uninsured motorist coverage where primary did not).

law. Defendants are overreaching again. On any dispositive motion, the moving party bears the burden of proof, while the opponent only has a burden to rebut a *prima facie* showing. For example, where the moving party establishes no genuine material issue of fact in a summary judgment motion, the burden shifts to the non-moving party; if the non-moving party fails to respond, the motion should be granted.[57] Only if Defendants satisfy their burden in the first place does Plaintiffs' silence matter. While the court wonders how the argument escaped Plaintiffs, the court reads no fatal concession into the otherwise firm answering brief opposing the motion. Even accepting Defendants' factual claims as true because they are uncontested, the court nevertheless reaches its own legal conclusion.

F.

Although the above arguments are most on point, the court mentions the parties' remaining contentions. Defendants laboriously characterize settlement for less than policy limits as, in effect, requiring excess insurers to drop down, which the policy specifically prohibits. But, even if some of the loss was covered by Plaintiffs, all money was paid up to Defendants' attachment point. Thus, under any view of the undisputed facts, Defendants are not asked to cover any loss below their attachment point. Nevertheless, Defendants declare the settlements require drop down.

[57] *Hurtt v. Goleburn*, 330 A.2d 134, 135 (Del. 1974).

Defendants say, "By virtue of Mass Mutual's settlement with the Primary Policy ... without payment of the Court Costs and Attorneys' fees to which they were exposed ..., the attachment point of the Excess Policy ... would be at a point significantly lower than $85,500,000." That argument simply is an attenuated reargument of Defendants' exhaustion argument.

Courts have firmly held that excess policies cannot be required to drop down.[58] A policy "drops down" to fill a void left by uncollectable insurance, usually due to insolvency. "Drop down" specifically contemplates an insurance policy's responding to lower limits than the policy's attachment point.[59] Plaintiffs, however, specifically state they are only seeking indemnity for actual losses actually exceeding the $85.5 million underlying policy limits.

Although Defendants raise other concerns about unusual liability, including defense costs, those concerns, if valid, implicate neither the policy's drop down provision nor hornbook insurance law. Defendants' aggressively ignore the factual lynchpin of this case. Plaintiffs' worst nightmare came true. Madoff's crime caused damages dramatically exceeding policy limits and Plaintiffs paid those

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[58] *E.g., Allmerica Fin. Corp. v. Certain Underwriters at Lloyd's, London*, 871 N.E.2d 418 (Mass. 2007).

[59] *Vickodil v. Lexington Ins. Co.*, 587 N.E.2d 777, 778 (Mass. 1992) ("they seek a judgment declaring that the lower limit of Lexington's coverage 'dropped down' from ... in excess of $1,000,000 to coverage [above] the $399,900 underlying coverage that has already been paid").

damages out of pocket. Once $85.5 million had actually been paid to claimants, and only after that sum had been paid, did Plaintiffs seek coverage from Defendants. Hence, there is no drop down.

Finally, although the court is denying summary judgment, it is not adopting Plaintiffs' position whole cloth. For example, Plaintiffs allege that disputed facts and ambiguities preclude summary judgment. Plaintiffs list several disputes, including if and when certain provisions were in effect, how many losses occurred, and so on. These traditional summary judgment stoppers are less helpful here because, actually, the disputes are mostly legal, not factual. For example, the number of losses is largely a direct function of the definition of "loss." With the definitional dispute resolved, the parties would probably have no dispute about numbers.

IV.

For the foregoing reasons, Defendants' Motion to Dismiss Counts V and VI and Strike Paragraphs 135 through 156 is **GRANTED**. Defendants' Motion for Summary Judgment is **DENIED**.

IT IS SO ORDERED.

/s/ Fred S. Silverman
Judge

cc: Prothonotary (Civil Division)
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