IN THE SUPERIOR COURT OF THE STATE OF DELWARE

IN AND FOR KENT COUNTY

DELAWARE INSURANCE GUARANTY ASSOCIATION and ROBERT JAMES, .M.D.,	)	C.A. No. 03C-05-023 (JTV)
Plaintiffs,	)	
v.	)	
THE MEDICAL PROTECTIVE COMPANY,	)	
Defendant.	)	

Submitted: April 15, 2005
Decided: July 29, 2005

Michael L. Sensor, Esq., Perry & Sensor, Wilmington, Delaware. Attorney for Plaintiffs.

Anne L. Naczi, Esq., Griffin & Hackett, Georgetown, Delaware. Attorney for Defendant.

Upon Consideration of Cross Motions for Summary Judgment
Plaintiff's Motion DENIED
Defendant's Motion DENIED

VAUGHN, President Judge

Delaware Insurance Guaranty v. Medical Protective Company
C.A. No. 03C-05-023 (JTV)
July 29, 2005

OPINION

This is a declaratory judgment action arising out of an insurance coverage dispute between the Delaware Insurance Guaranty Association ("DIGA") and The Medical Protective Company ("Medical Protective"). The parties seek a determination of their rights and obligations with respect to payment of defense costs, indemnification, and settlement amounts in connection with a claim asserted against Dr. Robert James. The underlying action is a medical negligence lawsuit filed by Kenneth Xiques against Dr. James, *et al* ("the *Xiques* case"). The parties have reached a settlement in that action. DIGA and Medical Protective have filed cross motions for summary judgment and now seek a determination from the record as a matter of law. They both agree there are no factual disputes.

FACTS

The following are the stipulated facts:

Dr. Robert James was employed by The Center for Neurology ("the Center") from August of 1999 until August of 2000. On January 7, 2000, Kenneth Xiques was admitted to Bayhealth Medical Center for treatment following an automobile accident (the term "Center" hereinafter refers to The Center for Neurology, not Bayhealth Medical Center). He was treated by Dr. James and Dr. Edward Alexander. On December 12, 2001, Xiques filed a medical negligence lawsuit naming Dr. James, Dr. Alexander, Diane Rinehart, R.N., and Bayhealth as parties. The Center was joined as a third-party defendant on August 26, 2003.

The Center was insured by PHICO on a claims-made policy of professional liability insurance with effective dates of December 31, 1999 to December 31, 2000.

Dr. James was added to the "Schedule of Physicians" on the PHICO policy on August 23, 1999.[1] He continued to appear on the "Schedule of Physicians" until he left the center on August 1, 2000. Dr. James then purchased Extended Reporting Period Coverage ("ERP coverage") from PHICO with an initial effective date of August 1, 2000. On December 31, 2000, the Center terminated liability coverage with PHICO and began coverage with The Medical Protective Company which issued a claims-made policy with a retroactive date of January 1, 1992. Medical Protective defended the Center in the *Xiques* case.

PHICO was declared insolvent on February 2, 2002 and, pursuant to the Delaware Insurance Guaranty Association Act ("the Guaranty Act"),[2] DIGA assumed responsibility for claims arising in the State of Delaware under Delaware issued PHICO policies. DIGA defended Dr. James and Dr. Alexander in the *Xiques* case.

On July 30, 2004, the parties reached a settlement in the *Xiques* case. DIGA contributed $150,000 on behalf of Dr. James and $150,000 on behalf of Dr. Alexander. Medical Protective contributed a total of $682,500. In accordance with the terms of the settlement agreement, liability was apportioned by the Court.[3] The settlement agreement further provided that the parties would litigate unresolved issues in the Delaware courts. DIGA then initiated this declaratory judgment action

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[1] PHICO also insured Dr. Alexander's practice, Dover Surgical Associates, P.A., which listed Dr. Alexander as the only physician in the "Schedule of Physicians."

[2] 19 *Del. C.* §§ 4201-4223.

[3] *Xiques v. James*, Del. Super., C.A. No. 01C-12-031, Ridgely, J. (Aug. 26, 2004)(ORDER)(65% apportioned to Dr. Alexander and 35% apportioned to Dr. James).

on May 19, 2003. The parties thereafter filed cross motions of summary judgment.

ISSUES

The following questions are presented by the parties for a determination by the Court:

1- Whether the claim in the *Xiques* case against Dr. James was covered under the Medical Protective policy, thus entitling DIGA to be reimbursed pursuant to 18 *Del. C.* § 4212(a) for the amounts it paid to settle the *Xiques* case and defend Dr. James?

2- Whether DIGA's obligation under the Guaranty Act was satisfied when it paid $150,000 on behalf of Dr. James?

In its brief in support of its motion for summary judgment, DIGA raised an additional issue.

3- Whether the defendant, Medical Protective, lacks standing to assert a claim against DIGA?

For the reasons discussed below, I find that Dr. James was not covered under the Medical Protective policy and DIGA is not entitled to reimbursement from Medical Protective for amounts it paid to settle and defend the claim against Dr. James arising from the *Xiques* case. I also find that Medical Protective is not entitled to seek any payment from DIGA because it does not fit within the definition of a "claimant" under the Guaranty Act and it does not have a valid covered claim. Because I find that Medical Protective does not have a valid covered claim, it is not necessary to address the question of DIGA's statutory financial obligation to the settlement.

STANDARD OF REVIEW

Summary judgment should be rendered if the record shows that there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law.[4] The facts must be viewed in the light most favorable to the non-moving party.[5] Summary judgment may not be granted if the record indicates that a material fact is in dispute, or if it seems desirable to inquire more thoroughly into the facts in order to clarify the application of the law to the circumstances.[6] However, when the facts permit a reasonable person to draw but one inference, the question becomes one for decision as a matter of law.[7] When parties file cross motions for summary judgment, they are acknowledging the record is sufficient to support their respective motions and implicitly conceding that there are no material facts in dispute.[8]

CONTENTIONS THE PARTIES

Medical Protective contends that Dr. James does not qualify as an insured under the policy issued by Medical Protective and, consequently, it has no duty to defend or indemnify Dr. James in the *Xiques* case. It further argues that DIGA's

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[4] Superior Court Civil Rule 56(c).

[5] *Guy v. Judicial Nominating Comm'n*, 659 A.2d 777, 780 (Del. Super. Ct. 1995); *Figgs v. Bellevue Holding Co.,* 652 A.2d 1084, 1087 (Del. Super. Ct. 1994).

[6] *Ebersole v. Lowengrub*, 180 A.2d 467, 470 (Del. 1962).

[7] *Wooten v. Kiger*, 226 A.2d 238, 239 (Del. 1967).

[8] *Browning-Ferris, Inc., v. Rockford Enters., Inc.,* 642 A.2d 820 (Del. Super. Ct. 1993).

contribution for the settlement of claims against Dr. James should have been $300,000 and its contribution for the settlement of claims against Dr. Alexander should have been $300,000 (rather than $150,0000 each or $300,000 combined). Medical Protective maintains that DIGA is responsible for $300,000 per policy because that is the full statutory cap owed for Dr. James' ERP policy and for Dr. Alexander's policy. Thus, in the present action, it seeks an additional $150,000 of contribution from DIGA for Dr. James' liability.

DIGA argues that the policy issued by Medical Protective to the Center provides coverage for Dr. James as well as the Center. It argues that Medical Protective was obligated to defend and indemnify Dr. James because all other insurance was secondary to the PHICO policy and DIGA is statutorily barred from paying a claim to the extent there exists other insurance.[9] DIGA seeks reimbursement from Medical Protective for the amount it paid to resolve Dr. James' claim and for costs incurred defending Dr. James. DIGA argues that Medical Protective does not have standing ("a covered claim") under the statute and cannot seek additional contributions from DIGA. Even if it is found that Medial Protective has a covered claim, DIGA maintains that its $300,000 payout to the settlement was proper as the Guaranty Act limits its contribution to $300,000 per claimant and in this action there is only one claimant, Xiques.

DISCUSSION

I. Does the Medical Protective policy insure Dr. James?

[9] 18 *Del. C.* § 4212.

When resolving questions of insurance contract coverage, Delaware courts will first attempt to determine contractual intent from the language of the insurance contract itself.[10] "Clear and unambiguous policy language in an insurance contract should be given its ordinary and usual meaning" and "where the language of a policy is clear and unequivocal, the parties are to be bound by its plain meaning."[11] "[A]mbiguity in policy language will not be found to exist merely because two conflicting interpretations may be suggested."[12]

The parties do not dispute that the Medical Protective policy was the effective policy for the time of the *Xiques* claim. The parties also do not dispute that Dr. James was an employee of the Center when he administered the treatment which gave rise to the *Xiques* case. The question to be resolved is whether Dr. James was a named insured under the Medical Protective policy, thus requiring Medial Protective to defend and indemnify Dr. James in connection with the *Xiques* claim.

This dispute, presented by the parties as a matter of first question, can be resolved by a plain reading of the language of the policy issued by Medical Protective. The relevant policy language reads:

> . . . the company hereby agrees to DEFEND and PAY DAMAGES, in the name and on behalf of the Insured,

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[10] *E. I. du Pont de Nemours & Co. v. Allstate Ins. Co.*, 686 A.2d 152, 155-156 (Del. 1996)(citing
Aetna Cas. and Sur. Co. v. Kenner, 570 A.2d 1172 (Del. 1990).

[11] *O'Brien v. Progressive N. Ins. Co.*, 785 A.2d 281, 288 (Del. 2001).

[12] *E. I. Du Pont de Nemours,* 686 A.2d at 156.

> A. IN ANY CLAIM FOR DAMAGES, FIRST FILED DURING THE TERM OF THIS POLICY, BASED ON PROFESSIONAL SERVICES RENDERED OR WHICH SHOULD HAVE BEEN RENDERED AFTER THE RETROACTIVE DATE, BY THE INSURED OR ANY OTHER PERSON FOR WHOSE ACTS OR OMISSIONS THE INSURED IS LEGALLY RESPONSIBLE, IN THE PRACTICE OF THE INSURED'S PROFESSION AS HEREINAFTER LIMITED AND DEFINED.
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> The policy lists only "The Center for Neurology" as the insured.

DIGA argues that because the language includes "any other person for whose acts or omissions the insured is legally responsible," and the Center was legally responsible for Dr. James, Medical Protective must defend and indemnify Dr. James. According to DIGA, "Dr. James falls within the insuring agreement under the policy, since the Center would be vicariously liable for his acts and defendant was responsible for paying claims arising out of his acts. . . ." Medical Protective argues that the insurance contract obligates it to defend and indemnify the Center for its vicarious liability for Dr. James' acts or omissions, but that it is under no duty to defend or indemnify Dr. James for his individual liability. It directs the Court to the policy language which states a duty to defend or indemnify the named insured, which in this policy is the "The Center for Neurology."

Medical Protective's argument on this point is more persuasive because it follows the plain language of the contract. Dr. James does not fall within the insuring agreement himself. The "acts or omissions" of Dr. James while working for the Center fall within the insuring agreement. Medical Protective has an obligation to defend or indemnify the Center for any liability the Center incurs based on Dr. James

"acts or omissions" but does not have an obligation to defend or indemnify Dr. James in the suit against him individually. Dr. James was not named as an insured in the policy and there is no coverage for the defense and indemnification of persons who are not named as an insured. The Court will not read beyond the clear and unambiguous language in the policy.

Although there is no Delaware authority interpreting this policy language, the Court's decision is supported by precedent from other jurisdictions. In both *Miller v. Marrocco*[13] and *National Union v. Medical Protective*,[14] the respective Courts examined identical or nearly identical policy language, found no ambiguities, and refused to go beyond the plain language of the contract.

In *Miller*, the Supreme Court of Ohio interpreted identical policy language to determine whether the insurance policy in question provided coverage to the defendant physician. The physician had been issued an individual insurance policy from Medical Protective, while his professional corporation had been issued a separate insurance policy also from Medical Protective. Medical Protective agreed to insure the physician under his individual policy up to his policy limits, but it maintained he was not entitled to additional coverage under the policy issued to his professional corporation. The policy issued to the professional corporation limited coverage to actions "in the name and on behalf of the insured" and then listed the

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[13] 504 N.E. 2d 67 (Ohio 1986).

[14] 446 N.Y.S.2d 480 (N.Y. App. Div. 1981).

insured as the professional corporation.[15] In a declaratory judgment action, the Court determined that the policy provided coverage to the professional corporation for any liability incurred on behalf of the physician, but not for the physician's individual liability.

DIGA distinguishes *Miller* by pointing out that the Court noted only the physician was named as a defendant and his professional corporation was never joined as a party. The Court did make note of this fact, but it did not rely upon it in reaching its conclusions. Even taking into consideration that the professional corporation was a party in the instant action and not in *Miller,* the outcome does not change. Had the corporation been joined in *Miller*, the corporation's policy would have been responsible for liability the corporation incurred due to the physician's negligence, but it would not have changed the fact that the physician was only covered under his individual policy for his direct liability. DIGA further attempts to distinguish *Miller* based on the dissenting opinion in the case. The Court, however, agrees with the majority opinion and finds its analysis more persuasive.

In *National Union*, a physician and his nurse were sued for malpractice. The physician had been issued a policy requiring the insurer:

> To pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of injury or death resulting from rendering or failing to render, during the policy period, professional services by the insured, or by any person for whose acts or omissions the insured is legally responsible, performed in the practice

[15] *Miller*, 504 N.E.2d at 69.

of the insured's profession.[16]

The policy also provided that the insurer would defend any suit or claim against the insurer, it then defined the insured as "the licensed physician or surgeon named in the declarations."[17]

This policy language is almost identical to the language in the Medical Protective policy issued to the Center. The primary difference is the insured is listed as the licensed physician whereas in the disputed policy in this case the insured is listed as the Center. The defendant nurse in *National Union* sought coverage for her liability under the physician's policy based on this language. The Court found that the policy only provided coverage for the defense and indemnification of the physician for liability he incurred based on his actions or the actions of his employees. "Nowhere in the policy does it provide for the defense and indemnification of an employee."[18] Similarly, in this case the policy issued by Medical Protective naming the Center as the insured provides coverage for the defense and indemnification of the Center for liability incurred due to Dr. James' negligence but not for Dr. James himself.

DIGA relies heavily on the case of *Zavota v. Ocean Accident & Guarantee Corp.*[19] In *Zavota*, a truck driver was injured by a crane and sued both the operator

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[16] *National Union*, 446 N.Y.2d at 481.

[17] *Id.*

[18] *Id.* at 482.

[19] 408 F.2d 940 (1st Cir. 1969).

of the crane and the Zavota Bros., the corporation that owned the crane. The crane operator, Louis Zavota, also happened to be a corporate officer of the corporation. One policy implicated in the case was a general liability policy of the corporation referred to as the manufacturers' and contractors' or M & C policy. The policy listed the named insured as the Zavota Bros. The question for the court was whether the M & C policy also covered Louis Zavota. It found that it did relying on the following language in the policy:

> With respect to the insurance under coverages A, B, and D the unqualified word 'insured' includes the named insured and also includes any executive officer, director or stockholder thereof while acting within the scope of his duties as such.[20]

The policy in question in *Zavota* specifically extended the definition of insured to include persons others than the corporation itself. We do not have a similar extended definition in the policy issued by Medical Protective. The policy clearly lists the insured as "The Center for Neurology" and no provision of the policy purports to include physicians as insureds.

Zavota is materially distinguishable from the instant action as the Court in *Zavota* had an additional definition of insured to rely upon. DIGA relies on the absence of an additional definition to argue that the policy is ambiguous. The more logical view is that Medial Protective did not further define "insured" because it intended the insured to be limited to the Center. Regardless, the Court cannot rely on

[20] *Id*. at 942.

the absence of words to create an ambiguity when the language of the contract is plain.

Medical Protective puts forth an additional argument which lends support to its position. The policy issued by Medical Protective contains a "Shared Limit Additional Endorsement" which extends coverage to the following persons:

> Allied Health Care Professionals, other than physicians or dentists, as Additional Insureds for claims arising from professional services rendered or which should have been rendered while acting within the scope of their duties in rendering health care services on behalf of the **Named Insured** . . . .

DIGA points out that application of this portion of the insurance agreement is not determinative in this dispute because DIGA is not arguing that Dr. James is entitled to coverage under this portion of the policy. But it is noteworthy insofar as the endorsement specifically declines to extend coverage to physicians. The endorsement provides further support for the conclusion that Medical Protective never intended to provide coverage for physicians and is consistent with the decision reached by the Court today, that Dr. James is not an insured under the policy.

II. Did DIGA satisfy its obligation when it contributed $150,000 to the settlement, on behalf of Dr. James?

A. Covered Claim

Medical Protective asks the Court to determine whether DIGA has satisfied its statutory financial obligation to afford coverage for Dr. James. Before turning to this question, the Court must address a preliminary issue raised by DIGA. In DIGA's

opening brief, it argues that the defendant lacks standing to seek additional funds from DIGA in connection with Dr. James' ERP coverage. In the context of the Guaranty Act, the question is more appropriately framed as whether Medical Protective has a covered claim, as defined by the statute, permitting it to seek reimbursement from DIGA. Section 4208 of the Guaranty Act provides that DIGA is only required to pay valid covered claims. A covered claim is specifically defined in the Guaranty Act at § 4205(6)(a):

> an unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage, and subject to the applicable limits, of an insurance policy to which the chapter applies, issued by an insurer, if such insurer becomes an insolvent insurer after July 5, 1991.

Section 4205(6)(b) then goes on specifically to exclude certain amounts from the definition of covered claim. Subsection 3 reads as follows:

> "Covered Claim" shall in no event include:
>
> 3. Any amount due any re-insurer, insurer, insurance pool or underwriting association as subrogation moneys or otherwise. No such claim for any amount due any reinsurer, insurer, insurance pool or underwriting association may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent such claim exceeds the association obligation limits set forth in § 4208 of this title.

This exclusion is consistent with the purpose of the statute. The Guaranty Act was drafted for the protection of claimants and policyholders. Should an insurer

become insolvent, the Guaranty Act provides statutory safeguards to those claimants and policyholders who have valid covered claims, so as to avoid financial loss.[21] The statute does not provide protections for other insurers. Indeed, amounts due insurers are specifically excluded from the definition of covered claim.

Medical Protective makes much of the argument that it preserved its right to litigate this question in the settlement agreement and DIGA cannot now argue that Medical Protective has no standing to argue the issue. An agreement by the parties to pursue further legal proceedings through a declaratory judgment action does not mean that either party has waived a right to assert any defenses. DIGA has a valid defense in that Medical Protective does not have a covered claim as defined by the statute. By agreeing, as part of the settlement, to preserve certain issues and litigate those issues in this Court, DIGA did not waive its right to defend on the ground that Medical Protective does not have a valid covered claim.

Turning to whether Medical Protective has a covered claim, under the language of the Guaranty Act, it does not. Section 4205(6)(b)(3) excludes any amount due any insurer as subrogation moneys or otherwise from the definition of covered claim. Medical Protective, as the insured for the Center, now seeks to recover from DIGA based on a subrogation claim. The statute does not provide Medical Protective with the authority to do this.

The decision cited by DIGA, *Pie Mutual Ins. Co. v. The Ohio Ins. Guarantee*

[21] 18 *Del C.* § 4202.

Assoc.,[22] is on point. In *Pie Mutual*, two insurance carriers, PICO and Pie Mutual, argued that the Ohio Insurance Guaranty Association ("OIGA") was required to reimburse them for a share of amounts the insurers paid to settle a medical malpractice action. The Ohio Guaranty Act contained language for the definition of a "covered claim" similar to the language found in the Delaware Guaranty Act. The statute excluded from the definition amounts "due any reinsurer, insurer, insurance pool, or underwriting association through subrogation."[23]

The lower court, in *Pie Mutual,* found that the insurance companies were precluded from pursuing recovery against OIGA on two independent grounds: (1) neither insurance carrier's claim was an "unpaid claim"; and (2) an insurance company's subrogation claims could not be asserted against OIGA.[24] The lower court could find no support for the contention that a covered claim could include an amount due any insurer through subrogation.[25] The Ohio Supreme Court affirmed on appeal and held that "an insurance carrier which has settled an action with the insured or third-party claimant is not entitled to seek payment from OIGA for a pro-rata share of the settlement amount on the basis of commonlaw subrogation principles."[26] Medical Protective attempts to do the same here and the Court finds no authority in

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[22] 611 N.E.2d 313 (Ohio 1993), *aff'g* 1991 Ohio App. LEXIS 4760 (1991).

[23] *Id*. at 315.

[24] 1991 Ohio App. LEXIS 4760 *at 7.

[25] *Id*. at 8.

[26] *Pie Mutual*, 611 N.E.2d at 316.

the Delaware Guaranty Act for such a claim.

Additional support for the Court's conclusion is found in the Guaranty Act's definition of "claimant." Pursuant to § 4205(6)(a), a covered claim must be submitted by a claimant. Section 4205(3) defines claimant as "any insured making a first-party claim or any person instituting a liability claim." In the present action, the insured is Dr. James and the person instituting the liability claim is *Xiques*. Medical Protective is neither an insured making a first-party claim nor a person instituting a liability claim. It does not fall within the definition of a claimant and, because a covered claim must be submitted by a claimant, Medical Protective cannot have a valid covered claim.

Having determined that Medical Protective does not fit the definition of a claimant and that its claim has been specifically excluded from the Guaranty Act's definition of a covered claim, Medical Protective cannot seek reimbursement from DIGA for amounts it contributed to the settlement agreement. It is, therefore, not necessary for the Court to address the remaining question of whether DIGA was required to pay out it statutory limits for each physician's policy or whether it was properly considered one medical incident entitled to only one payout.

/s/ James T. Vaughn, Jr.
President Judge Vaughn

oc: Prothonotary
cc: Order Distribution
File

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