UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISI ON

In re:	)	Case No. 04-25167
	)	
KISMET PRODUCTS, INC.,	)	Chapter 11
	)	
Debtor.	)	Judge Pat E. Morgenstern-Clarren
	)	
	)	
KISMET PRODUCTS, INC.,	)	Adversary Proceeding No. 05-1465
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
HCC BENEFITS CORPORATION, et al.,	)	
	)	
Defendants.	)	

PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW REGARDING CROSS MOTIONS FOR SUMMARY JUDGMENT – RECOMMENDING THAT THE DISTRICT COURT GRANT HCC'S MOTION FOR SUMMARY JUDGMENT AND DENY THE PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

Plaintiff chapter 11 debtor Kismet Products, Inc. (Kismet) asks for a declaratory judgment that defendants HCC Life Insurance Corporation (HCCL) and HCC Benefits Corporation (HCCB) (collectively, HCC) are required to defend, indemnify, and reimburse Kismet with respect to employee medical benefit claims filed in Kismet's bankruptcy case.[1] Each party moved for summary judgment,[2] and the court held an oral argument regarding the cross motions on August 22, 2007.[3]

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[1] Kismet's claims against HCC are set forth in count three of the complaint. In addition to declaratory relief, Kismet asks for money damages and legal fees. (Docket 1).

[2] Docket 86, 89, 91, 96, 99, 100, 101, 102, 108, 110, 111, 115, 116, and 117. Additionally, HCC moved for judgment on the pleadings under rule 12(c) of the federal rules of civil procedure (made applicable by rule 7012(b) of the federal rules of bankruptcy procedure). (Docket 58). The court bases its decision on the motions for summary judgment, rendering the motion for judgment on the pleadings moot.

[3] Docket 108.

This is a non-core, related proceeding and HCC did not consent to entry of a final judgment by this court.[4] The court, therefore, submits these proposed findings of fact and conclusions of law to the district court with a recommendation that the district court enter summary judgment for HCC and deny Kismet's motion for summary judgment. *See* 28 U.S.C. § 157(c); FED. R. BANKR. P. 9033.

I. SUMMARY JUDGMENT STANDARD

Summary judgment is appropriate only where there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. *See* FED. R. CIV. P. 56(c) (made applicable by FED. R. BANKR. P. 7056); *see also Celotex Corp. v. Catrett*, 477 U.S. 317 (1986); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986); *Matsushita Elec. Indus. Co. v. Zenith Radio Corp*., 475 U.S. 574 (1986). The movant must initially demonstrate the absence of a genuine issue of material fact. *Celotex Corp.*, 477 U.S. at 323. The burden is then on the non-moving party to show the existence of a material fact which must be tried. *Id.* The non-moving party may oppose a proper summary judgment motion "by any of the kinds of evidentiary materials listed in Rule 56(c), except the mere pleadings themselves . . . ." *Id.* at 324. All reasonable inferences drawn from the evidence must be viewed in the light most favorable to the party opposing the motion. *Hanover Ins. Co. v. Am. Eng'g Co.*, 33 F.3d 727, 730 (6th Cir. 1994). Summary judgment may be granted when "the record taken as a whole could not lead a rational trier of fact to find for the non-moving party." *Northland Ins. Co. v. Guardsman Prods., Inc.*, 141 F.3d 612, 616 (6th Cir. 1998) (internal citations and quotation marks omitted).

Where multiple parties file summary judgment motions, the court must evaluate each on its merits and "draw all reasonable inferences against the party whose motion is under consideration." *Lansing Dairy, Inc. v. Espy*, 39 F.3d 1339, 1347 (6th Cir. 1994) (internal citations and quotation marks omitted). Because neither party identifies a dispositive issue of

[4] *See* memorandum of opinion and order at docket 52, 53 (determining that this adversary proceeding is not a core proceeding).

material fact, the question here becomes whether either party is "entitled to a judgment as a matter of law." FED. R. CIV. P. 56(c).

II. FACTS

A. The Kismet Health Care Benefit Plan

The parties agree that the material facts are not disputed.[5]

Kismet filed its chapter 11 case on November 30, 2004. Kismet, which has now sold substantially all of its assets with court approval, remains in chapter 11 to pursue this litigation. Kismet recently filed a plan of liquidation that has not been confirmed.

Kismet maintained a Health Care Benefit Plan (the plan) for its employees and their dependents and served as the plan administrator and fiduciary. The self-insured plan provided benefits under the Employee Retirement Income Security Act of 1974 (ERISA).[6] Kismet and the qualifying employees shared the plan costs, with the employee contributions withheld from their pay. North American Benefits Network, Inc. (NABN) administered the plan. Plan participants and providers submitted claims to NABN for audit and processing. NABN would approve and summarize the reimbursable claims, Kismet would issue a check to NABN, and NABN would then pay the reimbursable amounts to either the providers or the participants.

During the period from October 1, 2003 through September 30, 2004, Kismet withheld employee contributions from each participating employee's paycheck, but failed to use those funds properly to fund the plan. Kismet also failed to reimburse plan participants during this period and approximately 90 proofs of claim have been filed by plan participants seeking unreimbursed medical expenses.[7]

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[5] The parties did not expressly stipulate to any facts. The court draws the undisputed facts from the joint pretrial statement, admissions in the briefs, evidence submitted with the motions, and statements at oral argument.

[6] 29 U.S.C. § 1001 *et seq.*

[7] Docket 1.

B. The Excess Reimbursement Insurance Policy

In addition to the plan, Kismet maintained an Excess Reimbursement Policy[8] (the policy) with HCCL.[9] In brief, the policy provided that HCCL would reimburse Kismet (through NABN) after Kismet paid out expenses above a designated amount to plan participants. Under the terms of the policy, the policy became effective on October 1, 2003 and expired on September 30, 2004 unless terminated by other means as provided in the policy. During the policy period, premiums were paid by Kismet to HCCL in the amount of $233,021.48 and claims paid by Kismet were reimbursed by HCCL in the amount of $23,845.63.[10] Kismet admitted that it did not pay its September 2004 premium.[11]

HCC's primary duties appear in Article III, § A,[12] which states: "Subject to the terms, conditions and limitations of this Policy, [HCCL] will reimburse [Kismet] for Plan Benefits Paid in excess of the Individual (or Family) Specific Deductible."[13] The policy defines "Deductible" as "[t]he amount of Covered Expenses [Kismet] must pay before Aggregate Excess Loss Insurance and/or Individual Excess Loss Insurance benefits become reimbursable,"[14] and sets the individual specific deductible at $35,000.00 per person.[15] The "Plan" which the policy refers to

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[8] References to the policy will be cited as "Policy." (Docket 10, 11, 86, 89).

[9] At the time the policy was issued, HCCL and HCCB were separate but affiliated entities. Since the filing of the complaint, HCCB was consolidated with HCCL. (Docket 89, at 1, n.1). Any issues regarding HCCB's privity with Kismet are moot.

[10] Affidavit of Dennis Lawrence, attached to Kismet's motion for summary judgment. (Docket 86, exh. 3, ¶¶ 16, 18).

[11] Docket 110.

[12] Article II concerns the Aggregate Excess Loss Insurance, and Article III concerns the Individual Excess Loss Insurance. While the provisions of both articles are similar, except with respect to scope of coverage, the court will focus its analysis on Article III, as that seems to be the focus of the parties' contentions.

[13] Policy, at 7.

[14] Policy, at 4.

[15] Policy, attachment 1, at 2.

is the same plan described above between Kismet and its employees.[16] The "Plan Benefits" include, with exceptions, "[t]he total amount of medical expense benefits to which Covered Persons become entitled under the Plan during the Policy Year . . . which are: (1) Incurred after the Effective Date of this Policy . . .; (2) Incurred while this Policy is in force; and (3) Paid during the Policy Year . . . ."[17] Further, the policy defines "Covered Persons" in such a manner as to include Kismet's employees covered in the plan (i.e., the plan participants), and "Covered Expenses" in part as "[e]xpenses incurred by a Covered Person . . . [f]or which benefits are paid by [Kismet] under the Plan . . . ."[18] Finally, the policy provides a definition of "paid":

> PAY, PAID, PAYMENT. Charges that are covered and payable under [Kismet's plan], adjudicated, and approved, check or draft issued and deposited in the U.S. Mail, other similar conveyance, or otherwise delivered to the payee, with adequate funds on deposit at time of presentation for payment. [HCCL's] reimbursements will not be made until all conditions are satisfied.[19]

The policy has these additional relevant terms and limitations:

(1) Article IV provides: "This Policy is between [Kismet] and [HCCL]. No other party has any rights under this Policy."[20]

(2) Article V specifies in part that "[HCCL] will not reimburse [Kismet] for: . . . (7.) Costs of the administration of claims, expenses of litigation or other adjudicatory process including, but not limited to, costs of defense, fees, interest and liability for punitive or exemplary or extra-contractual damages."[21]

(3) Article VI has these three provisions: "[a]ll insurance provided hereunder to [Kismet] will automatically terminate: (a) At the beginning of any Contract Month for which any premium for either Individual or Aggregate Excess Loss Insurance has not been paid by the end of the [thirty-one day] grace period; [or] (b) On the date [Kismet] fail[s] to pay claims promptly or make funds

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[16] Policy, at 5.

[17] Policy, at 5.

[18] Policy, at 3–4.

[19] Policy, at 5.

[20] Policy, at 7.

[21] Policy, at 7–8.

> available to pay claims promptly as required by this Policy . . . ."[22] Second, the policy qualifies that "[HCCL] act[s] only as an insurer to [Kismet]. [HCCL is] not a fiduciary or party in interest to the Plan or any Plan participant."[23] And third, with respect to the possibility of Kismet's insolvency, the policy states:
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> INSOLVENCY: In the event of [Kismet's] insolvency or bankruptcy, and upon receipt of Proof of Loss, [HCCL] may pay to [Kismet's] receiver, trustee, liquidator or legal successor amounts otherwise payable under this Policy had [Kismet] first Paid the covered Plan Benefits. [HCCL] will make such payments only if [Kismet has] Paid all required premiums and [has] complied with [its] obligations under this Policy. Nothing in this section shall increase [HCCL's] liability beyond that which would have existed had [Kismet] not become insolvent or bankrupt.[24]

III. THE POSITIONS OF THE PARTIES

HCC argues that Kismet was required to pay claims to plan participants as a condition precedent to HCC's duties under the policy. Because Kismet failed to pay those claims, HCC is under no obligation to "reimburse" Kismet under the terms of the policy. HCC also requests summary judgment on the theory that Kismet cannot prove damages for the breach of contract claim because Kismet failed to produce a deposition witness who could testify on the issue of damages.

Kismet contends that, as a debtor in possession, it has a duty to bring these claims against HCC for the benefit of the plan participants. The proofs of claim filed by the plan participants against Kismet constitute a claim against the bankruptcy estate, which is now the owner of the policy. These claims, Kismet continues, require HCC to fulfill its obligations under the policy, irrespective of Kismet's inability to pay the plan participants' claims or even the individual specific deductibles. In the alternative, Kismet seeks reimbursement of the policy premiums paid, arguing that the policy automatically terminated before September 30, 2004 because Kismet did not pay the premiums on time as required by the policy.

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[22] Policy, at 9.

[23] Policy, at 11.

[24] Policy, at 12.

IV. DISCUSSION

A. Ohio Insurance Law

The interpretation of an insurance policy is an issue of law. *See Golden v. Kelsey-Hayes Co.*, 73 F.3d 648, 653 (6th Cir. 1996) (stating that "[q]uestions of contract interpretation are generally considered questions of law"); *see also* 11 JAMES WM. MOORE, et al., MOORE'S FEDERAL PRACTICE - CIVIL § 56.31[2] (3d ed. 1997) (noting that a contract case which turns on the interpretation of a document as a question of law is particularly suited to determination on summary judgment). This policy is governed by Ohio law.[25]

The Ohio Supreme Court has consistently held that "insurance contracts must be construed in accordance with the same rules as other written contracts." *Hybud Equip. Corp. v. Sphere Drake Ins. Co.*, 597 N.E.2d 1096, 1102 (Ohio 1992). "In construing any written instrument, the primary and paramount objective is to ascertain the intent of the parties." *Aultman Hosp. Ass'n v. Cmty. Mut. Ins. Co.*, 544 N.E.2d 920, 923 (Ohio 1989). The court should then construe the contract so as to give effect to the intent of the parties. *Id.* Moreover, the intent of the parties is presumed to reside in the language they chose to use in the agreement. *Foster Wheeler Enviresponse, Inc. v. Franklin County Convention Facilities Auth.*, 678 N.E.2d 519, 526 (Ohio 1997). "If a contract is clear and unambiguous, then its interpretation is a matter of law and there is no issue of fact to be determined." *Ohio ex rel. Parsons v. Fleming*, 628 N.E.2d 1377, 1379 (Ohio 1994) (per curiam).

When determining whether a contract is clear and unambiguous, "words appearing in a written instrument are to be given their plain and ordinary meaning unless manifest absurdity results or unless some other meaning is clearly intended from the face or overall contents of the instrument." *Alexander v. Buckeye Pipe Line Co.*, 374 N.E.2d 146, 150 (Ohio 1978). "A contract or its terms will be viewed as ambiguous only in the event that the rights and duties imposed upon the parties thereto are reasonably subject to conflicting interpretations." *Kern v. Clear Creek Oil Co.*, 778 N.E.2d 115, 119 (Ohio Ct. App. 2002). "If the words and terms of the

[25] Policy, at 1.

contract are plain and clear, there is neither room nor right for any court to attempt construction." *First Nat'l Bank of Van Wert v. Houtzer*, 117 N.E. 383, 384 (Ohio 1917). Furthermore, a contract will not become ambiguous by the mere fact that its operation will work a hardship upon one of the parties. *Aultman Hosp. Ass'n*, 544 N.E.2d at 924. It is not the operation or function of the court to rewrite the parties' contract so as to enlarge or extend its scope beyond the parties' intent. *See Foster Wheeler Enviresponse, Inc.*, 678 N.E.2d at 526; *Stickel v. Excess Ins. Co. of Am.*, 23 N.E.2d 839, 841 (Ohio 1939). If language in an insurance contract is ambiguous, however, it will be construed in favor of the insured. *Nationwide Mut. Fire Ins. Co. v. Wittekind*, 730 N.E.2d 1054, 1057 (Ohio Ct. App. 1999).

The parties' intent also controls whether a provision in a contract is a condition precedent. *Kern*, 778 N.E.2d at 119. A condition precedent is a condition "that is to be performed before the agreement becomes effective. It calls for the happening of some event, or the performance of some act, after the terms of the contract have been agreed on, before the contract shall be binding on the parties." *Mumaw v. W. & S. Life Ins. Co.*, 119 N.E. 132, 135 (Ohio 1917); *see also Sweeney v. Grange Mut. Cas. Co.*, 766 N.E.2d 212, 216 (Ohio Ct. App. 2001). If the condition is not fulfilled, the parties are excused from performing. *Kern*, 778 N.E.2d at 119. When determining whether a provision is a condition precedent, the entire contract, not merely the language of the particular provision, must be considered. *Kaufman v. Byers*, 823 N.E.2d 530, 537 (Ohio Ct. App. 2004). As a general rule, the court should not construe a provision in a contract as a condition precedent, "unless such construction is required by clear, unambiguous language; and particularly so where a forfeiture would be involved or inequitable consequences would result." *Id.* (quotation marks and citations omitted).

B. Kismet Failed to Satisfy a Condition Precedent to HCC's Obligation

The language used in the policy is clear and unambiguous as to whether payment of claims by Kismet was a condition precedent to HCC's obligations under the policy. The policy specifies that HCCL "will reimburse [Kismet] for Plan Benefits Paid in excess of the Individual

(or Family) Specific Deductible."[26] The policy sets the relevant deductible at $35,000.00 per person, and defines "Paid" as to require that Kismet actually send a draft or check with adequate funds to clear the bank.[27] The only relevant word not defined is "reimburse," but "[t]he mere absence of a definition in an insurance contract does not make the meaning of the term ambiguous." *Nationwide Mut. Fire Ins. Co. v. Guman Bros. Farm*, 652 N.E.2d 684, 686 (Ohio 1995). If a term is not defined, the court will give the term its ordinary and plain meaning, unless manifest absurdity results or some other meaning is clearly intended by the contract. *Alexander*, 374 N.E.2d at 150. Here, the word "reimburse" is not a technical term and means "to pay back (an equivalent for something taken, lost, or expended) to someone." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY OF THE ENGLISH LANGUAGE 1914 (unabr. 1993); *see also* BLACK'S LAW DICTIONARY 1287 (6th ed. 1990) (defining "reimburse" as "[t]o pay back, to make restoration, to repay that expended; to indemnify, or make whole"). Accordingly, the intent of the parties is clear and unambiguous: HCCL agreed to pay back to Kismet expenses it incurred as part of the plan that exceeded $35,000.00 per person. Manifest absurdity does not result from the use of this definition, and no other meaning is contemplated by the policy.

Looking at the policy as a whole, the policy is consistent in its use of terms and consistently refers to Kismet's duty to pay out claims before HCCL is obligated to reimburse Kismet. For example, the policy defines "Covered Expenses" in part as "[e]xpenses incurred by a Covered Person . . . [f]or which benefits are paid by [Kismet] under the Plan . . . ."[28] Also Article VI, § B states: "REIMBURSEMENT OF CLAIMS: Prior to making any reimbursement, [HCCL] ha[s] the right to review each claim submitted to [HCCL] to determine if [Kismet is] entitled to a reimbursement. . . . [Kismet] warrant[s] that [it] *ha[s] paid* the providers of services and supplies for which reimbursement is sought."[29] Based on the consistent use of the past tense

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[26] Policy, at 7.

[27] Policy, at 4–5; attachment 1, at 2.

[28] Policy, at 3.

[29] Policy, at 10 (emphasis added).

throughout the policy and the definitions of key terms, it is clear that Kismet was to pay out claims before HCCL's duty to reimburse arose. Nowhere in the policy is a contrary intent expressed. The policy as a whole, therefore, supports the conclusion that Kismet's actual payment was a condition precedent to HCCL's obligations under the policy.

Kismet does not argue that the policy is ambiguous as to this point. Indeed, Kismet concedes in its complaint that "[t]he Excess Loss Policy provided by HCCL was a so-called 'reimbursement policy'. In other words, HCCL was required to reimburse Kismet (through NABN) *after Kismet paid* the Participants the amounts of the excess claims."[30] Kismet further acknowledges that it did not pay the claims of plan participants and was "delinquent in its remittance of the administrative costs of the Plan as well as the claim reimbursement amounts."[31] In other words, Kismet does not seek a declaratory judgment that it is entitled to recover funds it actually paid to plan participants in excess of the policy deductible, but rather Kismet seeks a declaratory judgment that it is entitled to recover funds it did not pay to plan participants for which these individuals have filed proofs of claim in Kismet's bankruptcy case.[32] As actual payment of claims by Kismet to plan participants was a condition precedent, which Kismet did not satisfy, Kismet is not entitled to reimbursement under the terms of the policy. The remaining issue is whether Kismet's insolvency excused this condition.

C. Kismet's Insolvency Does Not Excuse this Condition

HCC argues that Kismet's insolvency does not change the relationship between the parties as the policy contained an insolvency clause stating that HCCL's liability would not increase if Kismet were to become insolvent or bankrupt. Kismet does not argue that any part of the insolvency clause is ambiguous, but merely noted at oral argument that the insolvency clause

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[30] Docket 1, ¶ 17 (emphasis added).

[31] Docket 1, ¶ 11. *See also* the affidavit of Dennis Lawrence, attached to Kismet's motion for summary judgment, stating that Kismet failed to use the employee contributions to properly fund the plan obligations. (Docket 86, exh. 3, ¶ 26).

[32] Docket 1, ¶¶ 34–38.

does not decrease HCCL's liability if Kismet were to become insolvent or bankrupt. Regardless, this particular part of the policy is not in effect under the circumstances of this case. The insolvency clause states in part that "[HCCL] will make such payments only if [Kismet has] Paid all required premiums and [has] complied with [its] obligations under this Policy."[33] The parties agree that Kismet did not pay its September premium. Notwithstanding Kismet's other failures to comply with its obligations under the policy, with Kismet's failure to pay all the required premiums, HCC is not obligated to pay Kismet's claims.

Kismet asks the court to look beyond the terms of the policy and find that HCC is obligated to pay the claims of plan participants regardless of Kismet's inability to satisfy the condition precedent to that obligation because Kismet is in bankruptcy. Kismet's argument, however, relies on non-authoritative case law, decided under non-analogous state law, interpreting dissimilar insurance policies, in distinguishable factual situations.

Kismet bases its legal argument on *Home Insurance Company of Illinois v. Hooper*, 691 N.E.2d 65 (Ill. App. Ct. 1998), which held that a policy provision requiring the insured debtor to pay the self-insured retention as a condition precedent to the insurer's obligation under the policy was against public policy. *Id.* at 70. That public policy was based on an Illinois statute intended to "prevent insurers from using the insured's bankrupt condition and resulting inability to make actual payment to satisfy a judgment or any portion thereof as grounds to avoid payment on a policy." *Id.* at 69–70 (citing 215 ILL. COMP. STAT. 5/388 (1994)).

Home Insurance is distinct from the case at hand. First, *Home Insurance* is not controlling authority in this jurisdiction. Second, the decision in *Home Insurance* is primarily based on the application of Illinois insurance law and there is no comparable provision in Ohio law. Third, the Illinois law on which *Home Insurance* is based applies to liability and indemnity insurance and appears to be meant to protect third party tort victims from losing their rights to recover from the insured for injuries for which the insured is liable. By the terms of the policy,

[33] Policy, at 12.

however, HCCL is not indemnifying Kismet for claims made against it under the plan, but rather reimbursing Kismet for claims it pays according to the plan. The particular statute on which *Home Insurance* relied, therefore, is not applicable to these facts, and Kismet cites no precedent applying this statute to stop loss or excess loss insurance. *Cf. Premcor USA, Inc. v. Am. Home Assurance Co.*, No. 03-C-7377, 2004 WL 1152847, at *8 (N.D. Ill. May 21, 2004) (holding that *Home Insurance* did not compel an excess insurer's coverage to "drop down" and cover the primary insurer's liability when the primary insurer was insolvent and the condition precedent triggering the excess insurer's liability had not occurred), *aff'd*, 400 F.3d 523 (7th Cir. 2005). As *Home Insurance* does not apply to this case and because the policy specifies that HCCL's liability will not increase because of Kismet's insolvency or bankruptcy, there are no grounds to excuse the condition precedent in the policy. *See Pak-Mor Mfg. Co. v. Royal Surplus Lines Ins. Co.*, No. SA-05-CA-135-RF, 2005 WL 3487723, at *6 (W.D. Tex. Nov. 3, 2005).

Kismet does cite cases from outside Illinois applying *Home Insurance* in the bankruptcy context, but these cases are equally unavailing. For instance, Kismet cites *In re OES Environmental, Inc.*, 319 B.R. 266 (Bankr. M.D. Fla. 2004), where the court held that a creditor was entitled to relief from stay to bring its negligence tort claim against the debtor as long as the creditor waived its claim against the debtor's estate and sought recovery solely from the debtor's liability insurance policy. The court in *In re OES Environmental, Inc.* cited *Home Insurance* when ruling that the insurer was obligated to defend and indemnify the debtor for any amount exceeding the self-insured retention, irrespective of the debtor's ability to pay the self-insured retention. *Id.* at 269. The *OES* court, however, only reached this analysis after concluding that under the policy, the self-insured retention was required to be "borne by" the debtor, not "exhausted" by the debtor before the insurer became obliged to defend and indemnify against claims. *Id.* at 268. The court contrasted that policy with policies in two similar cases where each court held that under the plain terms of those policies, the debtors were required to exhaust the self-insured retention before the insurer's obligation to defend arose. *Id.* (discussing *T.Y. Lin*

Int'l v. Hyundai Marine & Fire Ins. Co., No. C-97-1693, 1997 WL 703778 (N.D. Cal. Oct. 27, 1997); *Fid. & Guar. Ins. Co. v. Employers Ins. of Wausau (In re Apache Prods. Co.)*, 311 B.R. 288 (Bankr. M.D. Fla. 2004)). This case is similarly distinguishable because under the policy, HCCL was required to reimburse Kismet only after Kismet actually paid the claims of the plan participants.

Kismet also cites *American Safety Indemnity Co. v. Vanderveer Estates Holdings, LLC (In re Vanderveer Estates Holdings, LLC)*, 328 B.R. 18 (Bankr. E.D.N.Y. 2005). That court held that based on *Home Insurance*, the excess liability insurer must provide coverage against certain personal injury actions brought against the insured debtor despite the debtor's inability to pay the self-insured retention. However, the *Vanderveer* court applied *Home Insurance* because the policy in question was governed by Illinois law. *Id.* at 21. Kismet also quotes a paragraph of dicta from the *Vanderveer* case, in which the court explains "case law interpreting § 365 of the Bankruptcy Code makes it clear that even in the absence of an applicable statutory provision . . . , the failure of a bankrupt insured to fund a self-insured retention does not relieve the insurer of the obligation to pay claims under the policy." *Id.* at 25. This dicta is inapplicable as the *Vanderveer* court discussed a distinguishable factual situation where, in the context of liability insurance, an insurer that chooses to defend and indemnify a claim against the insured, despite the insured's inability to cover the deductible, cannot fully recover the deductible from the debtor's bankruptcy estate if the insurance policy is not an executory contract. *Id.* at 25–26 (following *E. Retailers Serv. Corp. v. Argonaut Ins. Co. (In re Ames Dep't Stores, Inc.)*, No. 93 CIV. 4014, 1995 U.S. Dist. LEXIS 6704 (S.D.N.Y. May 18, 1995)). Furthermore, other courts have held that, if the contract so provides, the insurer's obligation to perform can be limited by the insured debtor's payment of a self-insured retention. *See, e.g.*, *Pak-Mor Mfg. Co.*, 2005 WL 3487723, at *6; *In re Apache Prods. Co.*, 311 B.R. at 297.

The remainder of Kismet's argument is premised on the theory that because of its status as a debtor in possession, the proofs of claim filed by the plan participants satisfy the condition

precedent. Kismet relies on *Amatex Corp. v. Aetna Casualty & Surety Co. (In re Amatex Corp.)*, 107 B.R. 856 (E.D. Penn. 1989), which held, in essence, that a proof of claim filed against the debtor by personal injury and wrongful death tort claimants was equivalent to filing a suit against the debtor, which gave rise to the insurer's contractual duty to defend. *Id.* at 871. The insurance policy in *Amatex* specified that the insurer had a duty to defend against "every claim made, suit brought, or proceedings instituted" against the debtor which may result in liability that the insurer was required to indemnify. *Id.* at 869. In contrast, the policy between Kismet and HCCL does not indemnify Kismet for any claims brought by plan participants, nor does it provide for any duty to defend against claims. The *Amatex* case is, therefore, not applicable to the case at hand because it concerns a contractual duty to defend against tort claims, not a duty to reimburse excess loss.

Similarly, the additional cases cited by Kismet are inapplicable. For example, Kismet cites *Pak-Mor Mfg. Co.*, 2005 WL 3487723, at *6–7, which held that the debtor could satisfy the self-insured retention by payment in any form, including a non-dischargeable promissory note to the judgment creditor, and *In re Keck, Mahin & Cate*, 241 B.R. 583, 596 (Bankr. N.D. Ill. 1999), which held that the debtor could satisfy its self-insured retention through treatment in the plan of reorganization. The policies in both *Pak-Mor* and *In re Keck, Mahin & Cate* are distinguishable from the case at hand in that neither policy defined the method by which the self-insured retention was to be paid, which in turn led to ambiguity. *Pak-Mor Mfg. Co.*, 2005 WL 3487723, at *6–7; *In re Keck, Mahin & Cate*, 241 B.R. at 596. The policy between Kismet and HCCL, however, is clear as to how payment of claims is to be made. Specifically, the policy requires that payment take the form of a check or draft, delivered to the payee, "with adequate funds on deposit at time of presentation for payment."[34] At oral argument, Kismet acknowledged that this definition of "pay" is not fulfilled by allowing the proofs of claim and then assigning to the employees the proceeds of this law suit. Further, Kismet could not identify a legal theory that

[34] Policy, at 5.

permits the court to override the policy's definition of "pay" and allow the proofs of claim to satisfy the condition precedent. The condition precedent cannot, therefore, be satisfied by the proofs of claim.

D. Remaining Arguments

HCC also requests summary judgment on the theory that Kismet cannot prove damages for the breach of contract claim. Part of Kismet's complaint, however, was for a declaratory judgment that the policy applied to this situation, while a second part was for damages. At oral argument, HCC agreed that the court could issue an order granting Kismet's declaratory relief without also granting a damage award. Therefore, regardless of Kismet's ability or inability to prove damages in this case, it would still be possible for Kismet to obtain declaratory relief.

Kismet argued alternatively that it is entitled to reimbursement of the policy premiums because the policy automatically terminated when Kismet failed to pay the premiums on time. Essentially, Kismet argues that it is entitled to equitable relief because it breached its contract with HCC. This argument is unavailing for multiple reasons. First, Kismet did not state this alternative theory of relief in its complaint. Rule 56(a) states that a "[p]arty seeking to recover upon a claim . . . or to obtain a declaratory judgment may . . . move . . . for a summary judgment in the party's favor upon all or any part thereof." FED. R. CIV. P. 56(a). Rule 56(a) does not permit a claimant to move for summary judgment on a claim not made or a declaratory judgment not sought, and a brief in support of or in opposition to a motion for summary judgment is not the proper place to amend the complaint. *See Tucker v. Union of Needletrades, Indus., & Textile Employees,* 407 F.3d 784, 788 (6th Cir. 2005); *Shanahan v. City of Chicago*, 82 F.3d 776, 781 (7th Cir. 1996). Moreover, Kismet's alternative theory is not within the substance of the allegations that HCC breached its duty to reimburse Kismet. *Cf. Minger v. Green*, 239 F.3d 793, 799–800 (6th Cir. 2001) (holding that courts should examine the substance of the complaint and not mere labels when ruling on a motion to dismiss).

Second, Kismet did not state any legal principle that would entitle it to relief under this alternative theory. In one of its briefs, Kismet argued that the theory is supported by the equitable concept of unjust enrichment.[35] The thrust of this argument is that HCC accepted premiums from Kismet despite being "fully aware of Kismets [sic] inability to properly fund the claims under this excess loss policy."[36] Kismet's only argument that it would be unconscionable for HCC to retain the premiums is the conclusory statement that such an outcome would be "highly unjust and inequitable."[37] Under these circumstances, it is not equitable for an insurance company to retain a profit procured lawfully. *See Chesnut v. Progressive Cas. Ins. Co.*, 850 N.E.2d 751, 759 (Ohio Ct. App. 2006). Kismet is not, therefore, entitled to summary judgment on this theory.

E. The Summary Judgment Motions

After examining the undisputed evidence submitted by the parties and considering the parties's opposing legal theories, the court concludes that HCC is entitled to judgment as a matter of law. Kismet is not entitled to summary judgment under its primary theory because Kismet's insolvency does not circumvent the terms of the policy in a way that requires HCC to "reimburse" Kismet for claims that it did not pay. Further, Kismet is not entitled to summary

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[35] In Ohio courts,

> unjust enrichment of a person occurs when he has and retains money or benefits which in justice and equity belong to another. To establish unjust enrichment, a plaintiff must show the following: (1) a benefit conferred upon defendant by plaintiff, (2) knowledge by defendant of the benefit, and (3) the acceptance or retention by defendant of the benefit under circumstances that make it inequitable for defendant to retain the benefit without payment of its value.

Chesnut v. Progressive Cas. Ins. Co., 850 N.E.2d 751, 758 (Ohio Ct. App. 2006) (internal quotation marks and citations omitted).

[36] Docket 110, at 5.

[37] Docket 110, at 5.

judgment under its alternative theory of relief because Kismet's arguments are procedurally and substantively insufficient to support a judgment.

HCC, on the other hand, is entitled to summary judgment on its primary argument because there is no dispute that Kismet failed to satisfy a condition precedent under the policy. Kismet did not come forward with any affirmative evidence showing the existence of a genuine issue of material fact regarding this failure, and Kismet's theory that it is entitled to declaratory relief regardless of this failure is unavailing. As a rational trier of fact could not find in favor of Kismet, HCC is entitled to judgment as a matter of law.[38]

CONCLUSION

For the reasons stated, this court recommends that the district court (1) deny plaintiff Kismet's motion for summary judgment; and (2) grant defendant HCC's motion and enter summary judgment for HCC on count three of the complaint.

Pat E. Morgenstern-Clarren
United States Bankruptcy Judge

[38] This decision makes it unnecessary to decide HCC's motions for sanctions and to strike Kismet's affidavits. (Docket 85, 93).