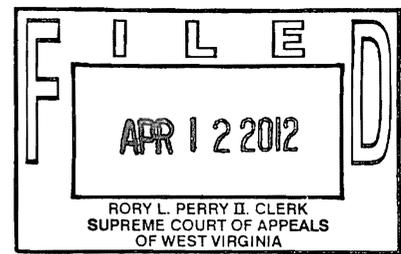


BRIEF FILED
WITH MOTION



No. 11-1651

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

**RICHARD D. LINDSAY and
PAMELA LINDSAY d/b/a
TABOR LINDSAY & ASSOCIATES,**

**Defendants/Third-Party
Plaintiffs Below, Petitioners,**

v.

**ATTORNEYS LIABILITY
PROTECTION SOCIETY, INC., et al.,**

**Third-Party Defendants
Below, Respondents.**

***AMICUS CURIAE* BRIEF ON BEHALF OF
WEST VIRGINIA MUTUAL INSURANCE COMPANY**

COMES NOW, the West Virginia Mutual Insurance Company (“Mutual”), by and through counsel, and pursuant to Rule 30 of the West Virginia Rules of Appellate Procedure, hereby submits its brief *amicus curiae* in the above-referenced matter.

INTRODUCTION AND INTEREST OF *AMICUS*

The Mutual is a West Virginia, domestic, private, non-stock, non-profit, member-owned medical professional liability insurance company providing professional liability insurance to physicians in West Virginia.¹ Citing the shortage of medical liability carriers in the state, which in turn threatened the ability of qualified physicians to stay in West Virginia, the Legislature by

¹ Pursuant to the disclosure requirements of Rule 30(e)(5), please be advised that the undersigned authored this brief in its entirety. No party has made a monetary contribution intended to fund the preparation or submission of this brief.

statute provided for the formation of the Mutual in 2004 to make available a means for West Virginia physicians to obtain affordable medical liability insurance. *See* W.Va. Code § 33-20F-1, *et seq.* The Mutual currently insures approximately 1,450 physicians and provides them with continuing education through more than fifty seminars and more than 250 office visits each year. The Mutual’s mission is to improve public health in West Virginia by providing affordable malpractice insurance, thereby keeping doctors in the state, and by encouraging the best practices among physicians through its robust risk management program.

This case turns on the determination of the proper coverage of an insurance contract, namely a claims-made-and-reported insurance policy of the type previously sanctioned by this Court and issued by most professional liability insurers, including the Mutual. Petitioner, however, urges this Court to disregard its own precedent and impose upon such insurers an extra-contractual obligation to demonstrate “prejudice” caused by Petitioner’s failure to comply with the unambiguous notice requirements of its claims-made-and-reported policy. Because such a requirement would result in the unbargained-for expansion of coverage and have far-reaching implications on professional liability insurance in West Virginia, the Mutual and its members have a significant interest in upholding West Virginia’s continued recognition of claims-made policies, and thereby preserving access to affordable professional liability insurance to physicians across the State (along with the attendant economic and societal benefits resulting therefrom).

DISCUSSION OF LAW

The professional liability policy at issue is a claims-made-and-reported policy. As the name would suggest, such policies cover those “claims” that are first “made” against the insured and then “reported” to the insurer within the operative policy term. *See* Bob Works, *Excusing*

Nonoccurrence of Insurance Policy Conditions in Order to Avoid Disproportionate Forfeiture: Claims-Made Formats as a Test Case, 5 Conn. Ins. L.J. 505, 525 (1999) (noting that a claims-made-and-reported policy “require[s] that at least two things must happen during a particular policy period in order to trigger the policy: . . . the injured party must assert a claim against the insured during the policy period, and the insured must report that claim to the insurer during the policy period”). Claims-made policies were developed as an alternative to so-called “occurrence” policies (that provide coverage for defined incidents that “occur” during a policy period) and were designed to cover claims made against a policyholder and reported to the insurer during the policy period. *Id.* at 516-17. By limiting an insurer’s exposure in this manner, such policies prevent policyholders from reporting claims long after a policy has expired. As a result, insurers are able to pass along this decreased risk in the form of reduced premiums to insureds. *Id.* Given the nature of the professional liability insurance market, where an “occurrence” might not give rise to injury until years later – and therefore “claims” are typically asserted long after the expiration of a particular policy – claims-made policies largely have become the norm. *Id.* at 508 (noting the advantages of claims-made policies in professional and commercial liability markets).

As the Circuit Court of Kanawha County observed below, claims-made insurance policies have been accepted and enforced by this Court. *See Soliva v. Shand, Morahan & Co., Inc.*, 176 W.Va. 430, 433, 345 S.E.2d 33, 35 (1986) (concluding that an insurance policy limiting coverage to “claims that are first made . . . during the policy period” was unambiguous and should be enforced); *see also Auber v. Jellen*, 196 W.Va. 168, 174, 469 S.E.2d 104, 110 (1996) (recognizing that a claims-made policy protects the insured “only against claims made during the life of the policy”). Similarly, the additional requirement imposed in the policy at issue, that the

claim also be “first reported” within the policy period, is a common and generally enforced feature of claims-made coverage. See No. 08-C-75, Order Granting Motion for Summary Judgment at p. 9, ¶ 9 (citing *Gargano v. Liberty Intern. Underwriters, Inc.*, 572 F.3d 45, 49 (1st Cir. 2009); *Employers Reins. Corp. v. Sarris*, 746 F. Supp. 560, 563 (E.D. Pa. 1990)).

Despite its failure to comply with the unambiguous notice provisions of its professional liability policy, Petitioner insists that the insurer should provide coverage because this failure has not “prejudiced” the insurer. In support of this argument, Petitioner turns to a “minority of courts” that have held that an “insurer must demonstrate prejudice to relieve itself of coverage pursuant to a notice provision in a policy of insurance.” Specifically, Petitioner cites *Coop. Fire Ins. Ass’n. of Vermont v. White Caps, Inc.*, 694 A.2d 34 (Vt. 1997), where the Supreme Court of Vermont held that, despite a policy-holder’s breach of its policy’s notice requirement, the insurance carrier must nevertheless demonstrate that the breach resulted in substantial prejudice to its position. *Id.* at 39.

Critically, however, the *White Caps* decision involved a different type of insurance policy (a premises liability occurrence policy) that contained a different reporting requirement (obligating the insured to provide “prompt written notice” of any claim). 694 A.2d at 35. By contrast, when presented with a claims-made-and-reported professional liability policy, the Supreme Court of Vermont does not appear to have adopted any “prejudice” requirement, opting instead to apply the unambiguous terms of the policy itself. See *McAlister v. Vermont Property and Casualty Ins. Guaranty Assoc.*, 908 A.2d 455, 460 (Vt. 2006) (concluding that a medical liability insurer “was obligated to cover a claim only if damages were caused by a medical incident that occurred during the claims-made policy period *and* if the claim was reported to the company while the claims-made policy was in effect”).

Likewise, Petitioner's reliance on this Court's decision in *State Automobile Mutual Insurance Co. v. Youler*, 183 W.Va. 556, 396 S.E.2d 737 (1990), is similarly misplaced. The policy in *Youler* was an automobile insurance policy also containing a similar "prompt" notice provision. *Id.* While conceding "that there are differences between automobile policies of insurance and the claims-made-claims-reported policy at issue in this litigation[,]" Petitioner refuses to accept the impact that these differences have on the determination of coverage. Principal among these differences is that claims-made-and-reported policies, by definition, explicitly describe an insured's reporting obligation. As a result, the obligation to "report" a claim during the policy period is generally considered to be a condition precedent to coverage and enforceable irrespective of any prejudice to the insurer. *See Esmailzadeh v. Johnson and Speakman*, 869 F.2d 422, 424 (8th Cir. 1989) ("Because the reporting requirement helps to define the scope of coverage under a claims-made policy, several courts have held that excusing a delay in notice beyond the policy period would alter a basic term of the insurance contract"); *City of Harrisburg v. International Surplus Lines Ins. Co.*, 596 F.Supp. 954, 960 (M.D. Pa. 1984) ("[W]e reject plaintiffs' contention that . . . [there is a] duty upon the insurer in this case to show prejudice from the late notice before coverage can be denied"); *Zuckerman v. National Union Fire Ins. Co.*, 495 A.2d 395, 405-06 (N.J. 1985) (dismissing the contention that the court should require the insurance company to prove "appreciable prejudice" in order to avoid coverage in a case where a claim has not been reported until after the expiration of the policy); *Gulf Ins. Co. v. Dolan, Fertig & Curtis*, 433 So.2d 512, 515 (Fla. 1983) ("Coverage depends on the claim being made and reported to the insurer during the policy period. . . . If a court were to allow an extension of reporting time after the end of the policy period, such is tantamount to an *extension of coverage* to the insured gratis, something for which the insurer has not bargained").

Indeed, the rationale behind Petitioner’s “prejudice” argument appears to conflict with fundamental principles of West Virginia insurance law, namely this Court’s stated preference for enforcing and applying unambiguous policy terms. In *Soliva*, for instance, this Court rejected a similar type of strained, extra-contractual reasoning. There, the plaintiff alleged that his “reasonable expectation” of coverage should have been given effect despite plain policy language limiting coverage to claims made during the policy period. The Court dismissed this argument, concluding that where the policy clearly and unambiguously limited coverage in such a fashion, “a man could not, having read this provision, reasonably expect the contract to provide such coverage.” *Soliva*, 176 W.Va. at 433, 345 S.E.2d at 36.² Similarly, where a policy unambiguously limits coverage to claims *made and reported* during the policy period, no reasonable person could expect coverage to be available when notice is provided *over two years later*.

Moreover, as this Court recognized in *Keffer v. Prudential Insurance Co.*, 153 W.Va. 813, 815-16, 172 S.E.2d 714, 715 (1970), “where the provisions of an insurance policy contract are clear and unambiguous they are not subject to judicial construction or interpretation, but full effect will be given to the plain meaning intended.” Thus, while a policy requiring “prompt,” “immediate,” or “reasonable” notice may lend itself to interpretation, the unequivocal notice conditions in a claims-made-and-reported policy cannot be subject to similar judicial construction. *See Payne v. Weston*, 195 W.Va. 502, 507, 466 S.E.2d 161, 166 (1995) (“We recognize the well-settled principle of law that this Court will apply, and not interpret, the plain

² The *Soliva* decision also quickly disposes of Petitioner’s argument that West Virginia Code § 33-6-14 precludes the strict application of the “claims-made and reported” provisions of the ALPS insurance policy. In *Soliva*, the insured similarly claimed the policy violated West Virginia Code § 33-6-14’s prohibition of insurance policies without tail provisions of at least two years. Drawing a distinction between a “claim” and an “action,” this Court held that the claims-made provision of the policy did not limit the time in which to bring an “action” under the policy, and therefore did not violate the code. 176 W.Va. at 434, 345 S.E.2d at 36.

and ordinary meaning of an insurance contract in the absence of ambiguity or some other compelling reason”). To do otherwise would “extend insurance coverage beyond the terms of an insurance contract.” Syl. pt. 5, *Potesta v. U.S. Fidelity & Guaranty Co.*, 202 W.Va. 308, 310, 504 S.E.2d 135, 137 (1998). Simply put, an insurer cannot be compelled to pay for a loss for which it has neither bargained for nor charged a premium.

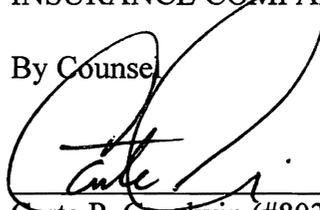
CONCLUSION

The Circuit Court of Kanawha County rightfully rejected Petitioner’s attempt to impose extra-contractual elements into this coverage dispute and instead applied the plain and unambiguous language of the claims-made-and-reported policy. West Virginia Mutual Insurance Company, as *amicus curiae*, respectfully requests this Court to carefully consider the points raised herein, and affirm the decision of the Circuit Court.

Respectfully submitted,

WEST VIRGINIA MUTUAL
INSURANCE COMPANY

By Counsel



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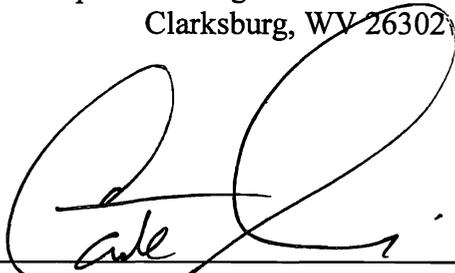
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CERTIFICATE OF SERVICE

I, Carte P. Goodwin, hereby certify that service of the foregoing *Amicus Curiae* Brief on Behalf of the West Virginia Mutual Insurance Company, has been made upon the following counsel of record via United States Mail, first class, postage prepaid, on this 12th day of April, 2012, addressed as follows:

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