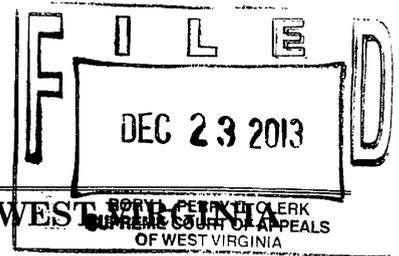


No. 13-0692



IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA
At Charleston

WEST VIRGINIA MUTUAL INSURANCE COMPANY, INC.

Petitioner,

v.

BETTY J. ADKINS, RAYETTA D. BAUMGARDNER, DIANA L. BOERKE,
LATHA A. BOLEN, CHARLOTTE L. DEAL, CONSTANCE L. DEVORE,
TERESSA D. HAGER, LORENN A. HANKINS, TAMMY H. CLARK,
PAMELA K. HATFIELD, MARCIE J. HOLTON, LINDA L. JONES, PATTY S.
LEWIS, TERESA LOVINS, MARTHA J. MARTIN, LOUELLA PERRY,
SHERRY L. PERRY, JANICE PETTIT, KIMBERLY A. ROE, JANICE
ROUSH, REBECCA SMITH, BEULAH STEPHENS, AND DEBRA L. WISE

Respondents.

REPLY BRIEF OF THE PETITIONER,
WEST VIRGINIA MUTUAL INSURANCE COMPANY, INC.

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Petitioner, West Virginia Mutual Insurance Company (“WVMIC”) respectfully submits this reply brief, seeking reversal of the Kanawha Circuit Court’s judgment in favor of the Respondents.

ARGUMENT

I. Introduction

In an eighteen-page response brief, the Respondents ignore clear and well-established principles of West Virginia insurance law and attempt to confuse the Court as to which policies and language are at issue. The Respondents further cite to information that is neither part of the record nor relevant to the issues raised in WVMIC’s assignments of error. The Respondents go so far as to argue that because WVMIC is a successful business it should be forced to inequitably disgorge profits to benefit a group of claimants that are part of the one of the largest collections of cases involved in multi-district litigation pending in the federal court system in the United States. The Respondents’ overreaching is the simple product of the fact that WVMIC’s legal and equitable arguments are overwhelmingly in favor of reversal of the Kanawha Circuit Court’s judgment and the award of judgment in favor of the Petitioners.

What is clear from the record of this case, as evidenced by the affidavits of representatives for WVMIC (the insurer), United Health Professionals (the insured) (“UHP”) and the West Virginia Medical Insurance Agency (the insurance agency) is

that WVMIC did not intend to issue and UHP did not intend to purchase the insurance coverage the Respondents claim exists. The Respondents attempt to evade the clear intentions of the parties to the insurance agreement by making arguments and assertions which are either irrelevant to the issues in this case, unsupported by the record or contrary to existing law.

II. The Respondents Can't Escape the Reality that Whatever Rights They Possess in the 2010 Policy, They Are Derivative of UHP's Right to Coverage

The Respondents attempt to escape the reality that their rights, if any, to recover damages under the 2010 Policy¹ are derivative of UHP's right to receive coverage. They claim that this issue is irrelevant. This issue is not only relevant, it is dispositive of this case. Whether couched in terms of a *de facto* assignee or otherwise, it is simply indisputable that the Respondents are not entitled to receive coverage any broader (or any narrower) than that to which UHP is entitled. Any standing the Respondents have to assert claims against the 2010 Policy are purely derivative of UHP's right to receive coverage. Thus, the Respondents must stand in the shoes of UHP and must prove that UHP is entitled to coverage in order to have any claim that they are entitled to the proceeds of the 2010 Policy.

It is obvious why the Respondents are trying to avoid standing in UHP's shoes. The evidence in the record supports WVMIC's position that there was a

¹ All parties concede that the only policy at issue is the 2010 Policy.

defect in the formation of the 2010 Policy. The record is clear from the affidavits of Tamara Lively-Huffman, Executive Vice President and Chief Operating Officer for WVMIC, Alan Chamberlain, M.D., President and Chief Executive Office of UHP, and Steve Brown, Agency Manager for the West Virginia Medical Insurance Agency, that neither WVMIC nor UHP intended there to be any additional coverage for UHP beyond UHP sharing in the limits of insurance for the individually named physicians employed by UHP for claims made between January 1, 2002 to January 1, 2008. See Appendix, pgs. 222-224, 167-169, and 407-408 (respectively).

Ms. Lively-Huffman, Dr. Chamberlain and Mr. Brown all support WVMIC's position that WVMIC and UHP did not intend to issue a policy in 2008, 2009 or 2010 that binds coverage for UHP for separate limits of insurance with a retroactive date of January 1, 2002. Instead, what is abundantly clear from the record, is that UHP and WVMIC intended the 2008, 2009 and 2010 policies to bind coverage for UHP with separate limits of insurance with a retroactive date of January 1, 2008 and to retain the coverage previously bound for shared limits of insurance with a retroactive date of January 1, 2002. The 2010 application for insurance submitted by UHP, which was prepared by the West Virginia Medical Insurance Agency, clearly failed to comport with the intent of both WVMIC and UHP. See Appendix, pgs. 222-224, 167-169, and 407-408.

To construe the 2010 Policy otherwise is clearly in contravention of the clear and unambiguous intent of the parties. In light of the fact that no party to the 2010 Policy intended the coverage that the Kanawha Circuit Court found existed, there is clearly a failure of the resultant insurance policy to reflect the intent of the parties. This Court's precedent clearly favors application of the doctrine of mutual mistake and an order reforming the 2010 Policy to conform to the intent of the parties is clearly warranted. *See Am. Emp. Ins. Co. v. St. Paul Fire & Marine Ins. Co. Ltd.*, 594 F.2d 973, 977 (4th Cir. 1979 (*cited by Ohio Farmers Ins. Co. v. Video Bank, Inc.*, 200 W. Va. 39, 488 S.E.2d 39 (1997)). A reformed instrument that reflects the intent of the parties precludes a finding of coverage for the Respondents' claims and therefore they are not entitled to recover anything under the 2010 Policy.

III. The Aggregate Insurance Coverage Available Under 2010 Policy is Limited to Three Million Dollars (\$3,000,000)

The 2010 Policy is a claims-made and reported policy. Despite the Respondents' assertions to the contrary, both the West Virginia Supreme Court of Appeals and the West Virginia Legislature have defined a claims-made policy. *See Auber v. Jellen*, 196 W. Va. 168, 174, 469 S.E.2d 104, 110 (1996); *Lindsay v. Attorneys Liab. Prot. Soc., Inc.*, 11-1651, 2013 WL 1776465 (W. Va. Apr. 25, 2013) (FN 2), W. Va. Code § 11-13T-2², W. Va. Code § 33-20D-2³. Both *Auber* and

² W. Va. Code § 11-13T-2 states in pertinent part:

(b) Terms defined. --(1) "Claims made malpractice insurance policy" means a medical malpractice liability insurance policy that covers claims which:(A) Are reported during the

Lindsay stand for the proposition that a claims-made policy provides coverage based on when a claim is made as opposed to when the circumstances giving rise to the claim came into existence. Furthermore, claims-made policies have a finite policy period⁴ in which claims can be reported. Upon expiration of a claims-made policy, the insured may purchase a renewal policy, purchase “tail-coverage” or allow the policy to lapse. Irrespective of an insured’s insurance coverage decision, the prior policy is expired and the limits of insurance available thereunder cease to exist.

Notwithstanding the foregoing, the Kanawha Circuit Court and the Respondents fail to grasp the difference between a claims-made insurance coverage from occurrence insurance coverage. The 2010 Policy clearly binds claims-made coverage and the aggregate limits of insurance under this policy are clearly limited to three million dollars (\$3,000,000). This is supported by the policy declarations, the schedule of insureds and the plain language of the policy. *See* Appendix, pg. 311-333. The Respondents cite a provision contained in the 2005, 2006 and 2007 policies that defined the annual aggregate limits of insurance. While WVMIC acknowledges that its policy language changed over time, this fact is not relevant to

policy period,(B) Meet the provisions specified by the policy, and(C) Are for an incident which occurred during the policy period, or occurred prior to the policy period, as is specified by the policy.

³ W.Va. Code § 33-20D-2(b) states: “Claims made malpractice insurance policy” means a policy which covers claims which are reported during the policy period, meet the provisions specified by the policy, and are for an incident which occurred during the policy period, or occurred prior to the policy period, as is specified by the policy.

⁴ Defined by the 2010 Policy to mean: “Policy period means the period specified as such in the policy declarations.” *See* Appendix, pg. 322.

the calculation of the aggregate limits of insurance available under the 2010 Policy, especially in light of the Respondents' repeated assertions throughout their brief that the only policy relevant to the disposition of this action is the 2010 Policy.

The analysis of the 2010 Policy language clearly supports a determination that the applicable limits of insurance are limited to three-million dollars (\$3,000,000) in aggregate coverage. The applicable provision of the 2010 Policy states:

A. The limit of insurance specified in the **policy declarations** and **schedule of insureds** for each **insured** for "each **medical incident**" is the total of **the Company's** liability for **damages** for that **insured** resulting from any one **medical incident** during the **policy period**. The limit of insurance specified in the **policy declarations** for each **insured** as the "annual aggregate" is the total limit of **the Company's** liability for **damages** for that **insured** resulting from all covered **medical incident(s)** during the **policy period**. ...

See Appendix pg. 319, 2010 Policy (emphasis in the original). The limit of insurance is expressly limited to "damages for that insured resulting from all covered medical incidents during the policy period." The key phrase in this provision is "covered medical incident(s)." In order to determine whether a medical incident is a "covered medical incident," one must look at the insuring agreement to see if the medical incident is covered. The insuring agreement states in pertinent part:

The company will pay those sums that the **insured** becomes legally obligated to pay as **damages** because of a **claim** that is a result of a **medical incident** which occurs on or after the **retroactive date** applicable to such insured and which is first reported by the insured during the **policy period**....

See Appendix pg. 217, 2010 Policy (emphasis in the original). A medical incident is a “covered medical incident” only if it meets to two conditions. First, the medical incident must occur on or after the retroactive date. Second, the medical incident must be reported as a claim for damages by the insured during the policy period. The “claim” is a condition precedent for a determination that a medical incident is a “covered medical incident.” Pursuant to the plain language of the 2010 Policy, the applicable limits of insurance are those specified in the policy declarations for the policy period in which there is a covered medical incident.

The Respondents attempt to mislead the Court by asserting that the applicable policy period is the year the medical incident occurred. However, the Respondents conveniently omit from their analysis the fact that a claim must first be made in order to convert a medical incident to a “covered medical incident.” Pursuant to the plain language of the 2010 Policy, only damages arising from “covered medical incidents” are compensable and the insurance coverage for “covered medical incidents: is defined by the policy declarations of the policy in effect at the time the claim is made.

The Respondents acknowledge and the Kanawha Circuit Court correctly found that all claims were made during the 2010 Policy period. Accordingly, any

coverage that exists is limited to the policy declarations of the 2010 Policy, which is three million dollars in aggregate. See Appendix, pg. 312.⁵

The Respondents' arguments concerning the potential inequities that claims-made policies create are highly irrelevant. West Virginia law permits claims-made policies to be issued and they are, in fact, the predominate type of coverage issued to medical providers practicing in West Virginia. The Respondents also reference WVMIC's discovery responses stating that they requested WVMIC to identify dates of each "covered medical incident." WVMIC submits that these dates are not dispositive of when a medical incident becomes a "covered medical incident" under the 2010 Policy. Furthermore, the Kanawha Circuit Court found, and the Respondents agreed, that all claims were made during the 2010 Policy. Accordingly all of the medical incidents, giving rise to these claims became "covered medical incidents" during the 2010 policy period and are subject to coverage solely under the aggregate limits of insurance 2010, which is strictly limited to three million (\$3,000,000).

IV. UHP Shares Coverage with Dr. Nutt's Tail Policy/Extended Reporting Endorsement

The Respondents' assertion that Dr. Nutt's Tail Policy/Extended Reporting Endorsement is not part of the 2010 Policy is nonsensical, particularly in light of

⁵ WVMIC denies that there is any coverage for the Respondents' claims. However, should this Court affirm the Kanawha Circuit Court's judgment, any award should be limited to three million dollars (\$3,000,000).

the purpose of such coverage. Medical professionals insured under a claims-made policy may have a change of circumstances (e.g. retirement, change of employment, death, etc.) such that they no longer need to continue their claims-made insurance coverage. In these instances they often purchase “tail coverage” or an “extended reporting endorsement” for purposes of having liability insurance coverage for claims/lawsuits that are made after the change in circumstance. Rather than continue to purchase claims-made coverage, the tail policy provides an indefinite policy period beginning on the day of termination of the underlying claims-made coverage to cover claims that are brought after the termination date. Individual professionals and their employers often purchase these policies to insure the potential risks that may be posed by unknown claims that have yet to be made. The individual’s interest in purchasing this coverage is to avoid potential personal liability and the employer’s interest in procuring coverage is to avoid vicarious liability for the acts or omissions of the departing professional agent/employee.

The Respondents invite the Court to take an overly myopic and hyper-technical reading of the 2010 Policy such that their claims of vicarious liability against UHP for the alleged acts and omissions of Dr. Nutt are miraculously afforded separate coverage. For reasons that the WVMIC has argued at length, the Respondents’ claims are entitled to only shared coverage. Furthermore, they share coverage in this instance with the extended reporting endorsement purchased for claims that might arise against Dr. Nutt.

The inequities of the Respondents' position are obvious. Had the Respondents' made their claims against UHP and Dr. Nutt while Dr. Nutt was still employed by UHP, their claim to the proceeds of the policy would be strictly limited to the limits of insurance applicable for Dr. Nutt.⁶ However, the Respondents argue that by the fortuitous timing their claims, they are suddenly entitled to a separate limit of insurance for UHP that would not have existed had they asserted claims against UHP at the same time they asserted claims against Dr. Nutt.⁷ WVMIC submits that principles of equity and fair play as well as public policy militate against permitting such an arbitrary and unfair result.

While Dr. Nutt's extended reporting endorsement was not incorporated on the face of the 2010 Policy, it does not bar WVMIC from treating the Respondents' claims against UHP as sharing in Dr. Nutt's limits of insurance under the extended reporting endorsement. First and foremost, UHP is the holder of the extended reporting endorsement, not Dr. Nutt. *See* Appendix, pg. 144. It would be illogical for UHP to purchase an insurance policy to which it is not entitled to coverage or derive any benefits from the policy. Second, the extended reporting endorsement has the same policy number that is recited by the 2010 Policy. *See* Appendix, pg. 114 and pg. 311. Finally and most importantly, the extended reporting

⁶ WVMIC assumes the Court recognizes the validity of their argument that the Respondents' claims against UHP are limited to shared coverage.

⁷ Arguably, UHP was an indispensable party at the time the Respondents filed suit or made claims against Dr. Nutt under Rule 19 of the West Virginia Rules of Civil Procedure, because a finding against Dr. Nutt could be potentially used as collateral estoppel against UHP in a subsequent suit for vicarious liability.

endorsement does not have an expiration date, instead it continues in perpetuity so long as the conditions precedent for its continuance are met by the holder. *See* Appendix, pg. 114-115. Thus, while not referenced on the face of the claims made policy for 2010, the extended reporting endorsement was in effect at the time the Respondents made their claims against UHP and was part of the policy as it clearly bears the same policy number.

The language of the Dr. Nutt's extended reporting endorsement identifies Dr. Nutt as an insured. *See* Appendix, pg. 144. The pertinent language regarding sharing insurance coverage in the 2010 Policy, is found in "IV. Limit of Insurance":

C. Except as may otherwise be provided by endorsement to this **policy**, each **insured** for which no other separate limit of insurance is stated in the **policy declarations**, shall share the limit of insurance stated in the **policy declarations**; except that no **insured** may share in more than one limit of insurance under this policy.

(emphasis in the original). *See* Appendix, pg. 319. UHP is a sharing insured with regard to the Respondents' claims. Since Dr. Nutt is an **insured** under the 2010 Policy by virtue of the continued existence of the extended reporting endorsement and the fact that the document bears the same policy number, WVMIC is correct in its contention that UHP shares in the limits of insurance of Dr. Nutt's extended reporting endorsement for the Respondents' claims. Because Dr. Nutt's limits have been exhausted and because under the plain language of the 2010 Policy UHP cannot share in more than one limit of insurance, UHP has no additional coverage for the Respondents' claims. For this Court to hold otherwise, would create an

inequitable result and would only serve to promote personal injury claimants to attempt to artfully time their claims in hopes of triggering additional coverage.

V. The Respondents and UHP Will Be Unjustly Enriched if the Judgment of the Kanawha Circuit Court Is Upheld

Rather than addressing the merits of WVMIC's arguments that UHP and the Respondents will be unjustly enriched if the judgment of the Kanawha Circuit Court is upheld, the Respondents reference their own physical conditions, the fact that WVMIC has not sued UHP to recover unpaid premiums, and argue that WVMIC is a successful and profitable insurance company as a basis for not finding that they were unjustly enriched. While WVMIC is sympathetic to the plight of the Respondents, the nature or extent of their injuries are not in any way relevant to WVMIC's claim that they will be unjustly enriched. Instead of making legal arguments on the merits of WVMIC's claim of unjust enrichment, counsel for the Respondents attacks and chides WVMIC for asserting a valid affirmative defense to the Respondents' claims. The Respondents' physical conditions are simply not germane to any issue in this case.

The Respondents further cite WVMIC's failure to sue UHP to collect a premium that would entitle UHP to separate coverage with a retroactive date of January 1, 2002. Despite ignoring a central fact in this case that neither WVMIC and UHP intended coverage on a separate limits of insurance basis prior to January 1, 2008, the Respondents' position presupposes the existence of the very coverage that the Respondents are seeking to gain and the Petitioner is contesting. It would

defy the most basic premise of insurance for an insurance company to allow an insured to pay or to collect a premium for a risk that has already been realized. That is not the purpose of insurance.

Finally the Respondents cite the financial success of WVMIC in support of their argument that they would not be unjustly enriched if the Court adopts their position regarding coverage. The Respondents' citation to WVMIC's financial status is wholly irrelevant to the determination of any issue involved in this case. WVMIC could just as easily cite to the fact that all (or most) of the Respondents named in this action are parties to the multi-district mesh product liability litigation pending in the United States District Court, Southern District of West Virginia, seeking damages against the manufacture of the particular mesh product that was used in their surgeries. There has been at least one jury trial thus far in the multi-district litigation resulting in a plaintiff's verdict in the amount of two millions dollars. In addition, there have been verdicts in other jurisdictions of \$5.5 million and \$11 million dollars in favor of individuals asserting products liability claims against mesh manufacturers. While the Respondents may have additional avenues in which to address their claims for damages, this is likewise irrelevant to the issues in this case. The Court should decide this case on the merits of the parties' legal arguments and not on irrelevant facts that are not part of the record.

CONCLUSION

For all of the foregoing reasons stated above as well as those reasons set forth in its Petitioner's Brief, the West Virginia Mutual Insurance Company, Inc., respectfully prays that this Honorable Court reverse the order by the Kanawha Circuit Court granting judgment in favor of the Respondents based upon the clear errors of law made by the Kanawha Circuit Court that resulted in a windfall judgment of six million dollars (\$6,000,000.00) that was neither bargained for nor intended by the parties to the subject insuring agreements. In the alternative, West Virginia Mutual Insurance Company respectfully prays that this Honorable Court rule that the amount of coverage available to the Respondents on their claims is three million dollars (\$3,000,000.00), not six million dollars (\$6,000,000.00) and remand the case to the Circuit Court of Kanawha County directing and judgment be entered in the Respondents' favor in the reduced amount.

RESPECTFULLY SUBMITTED



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Respondents.

CERTIFICATE OF SERVICE

I, D.C. Offutt, Jr., hereby certify that I have this day served a copy of "**Reply Brief of The Petitioner, West Virginia Mutual Insurance Company, Inc.**" upon all parties to this matter by depositing a true copy of the same in the U.S. Mail, postage prepaid, this 23rd day of December, 2013, to the following:

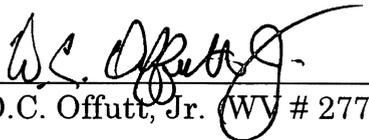
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