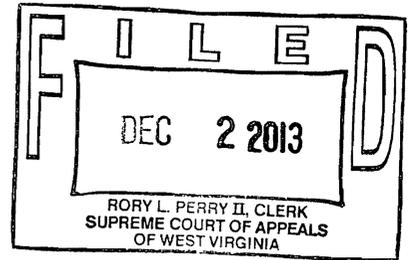


IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

\_\_\_\_\_  
No. 13-0692  
\_\_\_\_\_



WEST VIRGINIA MUTUAL INSURANCE COMPANY, INC.

Defendant Below, Petitioner

v.

BETTY J. ADKINS, RAYETTA D. BAUMGARDNER, DIANA L. BOERKE, LATHA A. BOLEN, CHARLOTTE L. DEAL, CONSTANCE L. DEVORE, TERESSA D. HAGER, LORENNA D. 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 PETIT, KIMBERLY A. ROE, JANICE ROUSH, REBECCA SMITH, BEULAH STEPHENS, and DEBRA L. WISE,

Plaintiffs Below, Respondents

\_\_\_\_\_  
**RESPONDENTS' BRIEF**  
\_\_\_\_\_

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## I. INTRODUCTION

This case is an appeal by an insurance company regarding the amount of insurance coverage under a claims-made insurance policy. Both parties stipulated the policy provisions are clear and unambiguous. The circuit court correctly applied the rules of construction, to a specific claims-made policy, and determined the plain meaning affords \$6 million in coverage.

The law regarding the construction of an insurance policy has been well-settled for decades in West Virginia. Simply stated, the law in West Virginia is that, in the absence of ambiguity, the provisions of an insurance policy “are not subject to judicial construction or interpretation, but full effect will be given to the plain meaning intended.” *Keffer v. Prudential Ins. Co.*, 153 W.Va. 813, 172 S.E.2d 714, Syl. (1970).

The insurance company does not challenge the plain meaning of the policy. Rather, the insurance company seeks to overturn the *Keffer* decision and permit the introduction of extrinsic evidence to interpret the policy provisions and equitably reform the amount of policy coverage.

The appellees contend the circuit court correctly applied West Virginia law to resolve the coverage dispute. The *Final Order* sets forth undisputed findings of fact which dictate fundamental conclusions of law. Affirming the *Final Order* is consistent with the *Keffer* decision and its progeny. There is no “butterfly-effect” to affirming the *Final Order*. Nonetheless, the appellees contend the extrinsic evidence does not mandate a different outcome. The facts of this unique insurance coverage dispute are not an appropriate vehicle to modify 40+ years of West Virginia law. Equity demands the affirmation of the *Final Order*.

## II. STATEMENT OF THE CASE

Some twenty-three (23) medical malpractice victims (the “Mesh Plaintiffs”) filed a declaratory judgment action to resolve a dispute regarding the limits of insurance coverage under West Virginia Mutual Insurance Company (“WVMIC”) Policy No. PL100133 (the “Policy”). The Mesh Plaintiffs contend there is a total of \$9 million in coverage available. WVMIC contends there is only \$3 million in coverage available. The circuit court ruled in favor of the Mesh Plaintiffs. WVMIC brings this instant appeal asserting seven (7) assignments of error.

The Mesh Plaintiffs are former patients of Mitchell Nutt, M.D. who underwent treatment for pelvic organ prolapse and were surgically implanted with transvaginal mesh. The Mesh Plaintiffs filed medical malpractice claims against Dr. Nutt and vicarious liability claims against his employer, United Health Professionals, Inc. (“UHP”), under the theory of *respondeat superior*. Both Nutt and UHP were insured under the Policy at the time the medical incidents occurred. The medical incidents occurred over a span of two (2) different policy periods. Nutt relocated his practice after the medical incidents occurred,<sup>1</sup> and he was canceled as an insured under the Policy. UHP paid a separate premium to purchase “tail coverage” for Nutt through an amendatory endorsement. The tail coverage afforded different limits of coverage than the Policy. All of the Mesh Plaintiffs’ claims against Nutt fall under the tail coverage. All of the Mesh Plaintiffs’ claims fall under the Policy.

The Mesh Plaintiffs, Dr. Nutt, UHP and WVMIC reached a global settlement agreement to end the tort litigation and resolve a dispute regarding insurance policy limits through a declaratory judgment action. The agreement entailed a dismissal of Nutt and UHP from further legal proceedings. The Mesh Plaintiffs and WVMIC agreed to submit the coverage dispute to the

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<sup>1</sup> There is no allegation, nor indication in the record below, that Nutt and/or UHP were aware of impending transvaginal mesh claims at the time Nutt relocated his practice out-of-state.

court for a declaration of coverage pursuant to the West Virginia UNIFORM DECLARATORY JUDGMENTS ACT, W. Va. Code, § 55-13-1, *et seq.* [1941]. The parties agreed to be bound by the declaration of coverage by the court. The Circuit Court of Kanawha County, the Honorable Jennifer F. Bailey presiding, determined there is \$3 million in coverage under a “tail” provision for Dr. Nutt and \$6 million in coverage for UHP under the Policy. WVMIC agrees there is \$3 million under the tail provision for Dr. Nutt and previously paid the same. WVMIC challenges the court’s finding that there is \$6 million in additional coverage for UHP.

### **III. SUMMARY OF ARGUMENT**

The circuit court entered a comprehensive order with detailed findings of facts and conclusions of law. The circuit court made the legal determination, to which WVMIC concedes and no error is assigned, that the Policy provisions are clear and unambiguous. *Riffe v. Home Finders Associates, Inc.*, 205 W.Va. 216, 517 S.E.2d 313, Syl. Pt. 2 (1999). The pertinent findings of fact are summarized below.

Nutt and UHP are insured under the Policy. (*Final Order*, ¶2). The Policy is a “claims-made” policy originally purchased by UHP from WVMIC on January 1, 2005, with a retroactive date of 2002. (*Final Order*, ¶10). All of the “medical incidents” occurred during the 2006 and 2007 policy periods. (*Final Order*, ¶3). Nutt left the employment of UHP and was canceled as an insured under the Policy by way of an amendatory endorsement, effective March 14, 2008. (*Final Order*, ¶12). UHP purchased from WVMIC an *Extended Reporting Endorsement* (“tail coverage”) for all claims filed against Nutt after the termination date. (*Final Order*, ¶12). All of the Mesh Plaintiffs’ claims filed against Nutt fall under the *Extended Reporting Endorsement*. (*Final Order*, ¶4). The *Extended Reporting Endorsement* has a self-contained aggregate policy

limit of \$3 million. (*Final Order*, ¶6). WVMIC previously paid aggregate policy limits of \$3 million for the claims against Nutt under the *Extended Reporting Endorsement*. (*Final Order*, ¶13).

The Mesh Plaintiffs filed claims against UHP under the Policy during the 2010 policy period. (*Final Order*, ¶5). The Mesh Plaintiffs' claims against UHP are covered under the 2010 Policy insuring agreement. (*Final Order*, ¶33). UHP has coverage for the Mesh Plaintiffs' claims under the 2010 Policy. (*Final Order*, ¶33). The aggregate limits for coverage are defined in the Policy. (*Final Order*, ¶35).

The crux of this dispute is whether UHP and Nutt share policy limits under the tail coverage. The circuit court determined UHP and Nutt do not share policy limits. (*Final Order*, ¶¶43-56). The court then determined that the Policy calculates aggregate limits for UHP by the year in which the medical incident occurs. (*Final Order*, ¶¶34-42). WVMIC asserts error in both conclusions of law.

#### **IV. STATEMENT REGARDING ORAL ARGUMENT AND DECISION**

WVMIC has requested oral argument, pursuant to Rule 18(a). The Mesh Plaintiffs respectfully submit that oral argument is not necessary because the dispositive issues have been authoritatively decided in a thorough *Final Order* setting forth detailed findings of fact and conclusions of law. Both Petitioner and Respondents are represented by competent counsel. It is anticipated that the facts and legal arguments are adequately presented in the briefs and record on appeal. To the extent this Court deems oral argument would significantly aid the decisional process, the Mesh Plaintiffs would be honored to appear and defend the issuance of the *Final Order* by the circuit court.

## V. ARGUMENT

The Mesh Plaintiffs respectfully submit the *Final Order* sets forth undisputed findings of fact and sound legal reasoning in its conclusions of law. The *Final Order* defines the insuring agreement (§§21-33) and correctly concludes that UHP is insured under the Policy (§33). Next, the *Final Order* concludes that UHP and Nutt do not share policy limits (§§43-56). Finally, the *Final Order* concludes that the WVMIC Policy affords UHP \$6 million in insurance coverage for the Mesh Plaintiffs' claims. (§§34-42).

WVMIC asserts seven (7) assignments of error. In a reversal of typical litigant roles, the insurance company is attempting to hide from the plain meaning of its own insurance policy. The terms of the insurance policy were written by WVMIC and filed with the West Virginia Insurance Commission. WVMIC petitions the West Virginia Supreme Court to modify the *Keffer* decision, reverse multiple findings of fact in the *Final Order*, and equitably reform the terms of its insurance policy in a variety of ways over different policy periods. The Mesh Plaintiffs contend the assignments of error conflict with the undisputed, and unchallenged, findings of fact, as well as the plain meaning of the terms of the Policy.

**Assignment of Error #1: WVMIC asserts the circuit court erred in failing to find that the Respondents stood in the shoes of United Health Professionals as an assignee. The Mesh Plaintiffs respond that this issue is irrelevant.**

First, and foremost, there is no dispute that the Mesh Plaintiffs have standing under West Virginia law to prosecute this declaratory judgment action. *Christian v. Sizemore*, 181 W.Va. 628, 383 S.E.2d 810, Syl. Pt. 3 (1989) (“An injured plaintiff may bring a declaratory judgment action against the defendant's insurance carrier to determine if there is policy coverage before obtaining a judgment against the defendant in the personal injury action where the defendant's insurer has denied coverage.”). Nor does this declaratory judgment action invoke the

complexities of a consent judgment. See, Strahin v. Sullivan, 220 W.Va. 329, 647 S.E.2d 765 (2007). Both WVMIC and the Mesh Plaintiffs agreed to be bound by the determination of coverage by the court.

WVMIC's first assignment of error does not challenge the existence of standing but, rather, attempts to re-define the nature of the relationship between the litigants. WVMIC seeks a declaration from the Court that UHP has *de facto* assigned its contractual interests to the Mesh Plaintiffs (*Brief of the Petitioner*, pp. 17-19) which enables WVMIC the ability to assert traditional contract defenses and equitable remedies to avoid coverage and protect its coffers.

The Mesh Plaintiffs respectfully submit this assignment of error is not necessary for the resolution of this appeal. The West Virginia UNIFORM DECLARATORY JUDGMENTS ACT, W. Va. Code § 55-13-2, states:

Any person interested under a deed, will, written contract, or other writings constituting a contract, or whose rights, status or other legal relations are affected by a statute, municipal ordinance, contract or franchise, may have determined any question of construction or validity arising under the instrument, statute, ordinance, contract or franchise and obtain a declaration of rights, status or other legal relations thereunder.

The purpose of the UNIFORM DECLARATORY JUDGMENTS ACT is set forth in W.Va. Code § 55-13-12:

This article is declared to be remedial; its purpose is to settle and to afford relief from uncertainty and insecurity with respect to rights, status and other legal relations; and is to be liberally construed and administered.

*Christian v. Sizemore*, 181 W.Va. 628, 383 S.E.2d 810, Syl. Pt. 2 (1989). The Mesh Plaintiffs are unaware of any limitation set forth in W. Va. Code § 55-13-2, or any precedent set forth in West Virginia jurisprudence, which prohibits the assertion of affirmative defenses under the UDJA.

WVMIC was not prevented from asserting its contractual defenses by the underlying circuit court. Rather, the circuit court, for reasons stated below, concluded that the affirmative defenses were not dispositive of the legal controversy. Nonetheless, if the Court deems it wise to issue a new syllabus point creating the *de facto* assignment of first-party contractual rights in the context of this declaratory judgment action, then the Mesh Plaintiffs submit such assignment includes, *sine qua non*, the assignment of UHP's first-party statutory and common law bad faith rights such as *Hayseeds* damages. See, *Hayseeds, Inc. v. State Farm Fire & Cas.*, 352 S.E.2d 73 (W.Va. 1986). The "goose-gander" rule has potentially far-reaching public policy ramifications if plaintiffs are *de facto* assignees in third-party insurance coverage disputes.

**Assignment of Error #2: WVMIC asserts the circuit court erred in finding that coverage existed under multiple policy periods. The Mesh Plaintiffs respond that the 2010 Policy expressly calculates aggregate limits by the year in which the medical incident occurs rather than the year in which the claim is filed.**

The second assignment of error relates to the calculation of aggregate limits under the 2010 Policy. (*Brief of the Petitioner*, pp. 19-23). WVMIC concedes, for the purpose of this assignment of error, the following findings of fact in the *Final Order*: UHP is insured under the Policy (*Final Order*, ¶26); the medical incidents occurred during the 2006 and 2007 policy periods (*Final Order*, ¶3); the claims against UHP were filed during the 2010 policy period (*Final Order*, ¶5); and the 2010 Policy contains the controlling language which defines the aggregate limit of insurance available to the Mesh Plaintiffs (*Final Order*, ¶35).

The circuit court declared, to which no assignment of error is asserted, that the Policy provisions are clear and unambiguous. (*Final Order*, ¶17); *Riffe v. Home Finders Associates, Inc.*, 205 W.Va. 216, 517 S.E.2d 313, Syl. Pt. 2 (1999) ("The interpretation of an insurance contract, including the question of whether the contract is ambiguous, is a legal determination

[...].”). The rules of construction for a clear, and unambiguous, insurance policy are well settled under West Virginia law:

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.

(*Final Order*, ¶¶17-20); *Mylan Labs, Inc. v. Am. Motorists Ins. Co.*, 226 W.Va. 307, 700 S.E.2d 518, Syl. Pt. 2 (2010); *Keffer v. Prudential Ins. Co.*, 153 W.Va. 813, 172 S.E.2d 714, Syl. (1970).

Given the policy is not ambiguous, the rules of construction state that the terms of the Policy will not be rewritten; instead, the Court will enforce the Policy as written without reference to extrinsic evidence. *Payne v. Weston*, 195 W.Va. 502, 507, 466 S.E.2d 161, 166 (1995) (Cleckley, J.) (“It is only when the document has been found to be ambiguous that the determination of intent through extrinsic evidence becomes a question of fact.”).

The 2010 policy language governing the aggregation of policy limits states:

**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.**

(*Final Order*, ¶35); (App. 319) (Exhibit K-9). The circuit court determined that aggregate limits are calculated by the year(s) in which the medical incident(s)<sup>2</sup> occur. WVMIC contends the aggregate limits should be calculated by the year in which the claims<sup>3</sup> are filed.

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<sup>2</sup> The Policy defines a *medical incident* as “any act, series of acts, failure to act, or series of failures to act arising out of the rendering of, or failure to render, professional services, to any one person by an insured or any person not otherwise excluded for whose acts or omissions an insured is legally responsible which results in damages, claim or suit.” (*Final Order*, ¶29); (2005 Policy – Exhibit L-13); (2006 Policy – Exhibit M-13); (2007 Policy – Exhibit N-14); (2008 Policy – Exhibit I-12); (2009 Policy - Exhibit J-12); (2010 Policy - Exhibit K-12).

<sup>3</sup> The Policy defines a *claim* as “a written demand for money or services arising out of medical incident.” (2005 Policy – Exhibit L-11); (2006 Policy – Exhibit M-11); (2007 Policy – Exhibit N-12); (2008 Policy – Exhibit I-10); (2009 Policy - Exhibit J-10); (2010 Policy - Exhibit K-10).

The 2010 Policy clearly states that “aggregate limit” for UHP is “the total limit of [WVMIC’s] liability for damages for that insured resulting from all covered *medical incident(s)* during the policy period.” The circuit court was well within the boundaries of intellectual honesty when it declared that annual aggregates shall be calculated by the policy period in which the medical incident occurs. It should be noted that the Policy provision does not mention the term *claim*; nor is there any reasonable implication that annual aggregates are calculated by the year in which claims are filed.

As noted by the circuit court, WVMIC “could have, but chose not to, calculate the aggregate limit by the year in which the claims were filed.” (*Final Order*, ¶39). For instance, WVMIC previously calculated aggregate policy limits by the year in which a claim is filed. The Policy language in 2005, 2006 and 2007, states as follows:

The Limit of Insurance specified in the Policy Declarations for each insured as the “annual aggregate” is the total limit of our liability for damages for that insured resulting from any and all medical incident(s) *which are first reported* during the policy period.

(*Final Order*, ¶39); (2005 Policy - APP. 343 - Exhibit L-10) (2006 Policy - APP. 361 - Exhibit M-10) (2007 Policy - App. 386 - Exhibit N-11). *The emphasized language was purposefully deleted from the 2008, 2009 and 2010 policies.* (2008 Policy - APP. 273 - Exhibit I-9); (2009 Policy - APP. 296 - Exhibit J-9); (2010 Policy - APP. 319 - Exhibit K-9). Notably, WVMIC omits any reference to the deletion of the phrase “which are first reported” in its Brief. No explanation is offered why the express terms of the Policy were amended. Nor does WVMIC attempt to reconcile the conflicting provisions.

Rather, WVMIC asks this Court to hold, as a matter of law, that “a claimant is bound by the insured’s applicable policy limits in the year that they make their claim.” (*Brief of the*

*Petitioner*, pp. 20-21). WVMIC cites no authority for this legal conclusion. The Mesh Plaintiffs posit that no statute, insurance regulation nor any case precedent supports WVMIC's position.

There is no logical inconsistency in calculating annual aggregate limits in a claims-made policy by the year in which a medical incident occurs. As long as a claim is filed during an active policy period, with a medical incident occurring after the retroactive date, WVMIC provides insurance coverage for an insured. For insureds such as UHP, which has been providing gynecology and obstetrical health care services in Cabell County for decades, liability exposure can extend far into the future. For instance, a UHP doctor may deliver 10 babies in a given year, but liability claims may be filed during 10 different policy periods in the future (as long as the policy remains active). WVMIC can calculate aggregate limits by the year in which the medical incidents occur; thereby subjecting all 10 babies to a single aggregate limit. Or, as in previous years, WVMIC could calculate aggregate limits by the year in which the claims are filed; thereby subjecting WVMIC to 10 separate aggregate limits for each of the 10 baby claims.

Beginning in 2008, WVMIC purposefully decided to limit its exposure by calculating annual aggregate limits by the year(s) in which a medical incident(s) occur rather than face exposure premised upon the year(s) in which the claim(s) are filed.

Finally, WVMIC attempts to draw attention to the word "**covered**" in the phrase "**covered medical incident**" to support its argument. However, WVMIC neglectfully fails to mention that it adopted a very different position in the record on appeal. The Mesh Plaintiffs served discovery (APP. 64-65) requesting that WVMIC identify the dates of each "covered medical incident." WVMIC responded (APP. 67) by specifically listing the dates of each "covered medical incident." The list sets forth "covered medical incident(s)" which span multiple policy periods.

WVMIC finds itself in the unusual position of obfuscating the meaning of its own policy in order to protect its coffers. In order to interpret the policy provision as suggested by WVMIC -- rather than apply its plain meaning -- WVMIC must prevail upon the Court to conclude that the definition of “aggregate limits” is ambiguous as a matter of law, despite failing to assert the same in the proceedings below. Nonetheless, convincing this Court that the Policy provision is ambiguous creates a secondary dilemma. *Boggs v. Camden-Clark Memorial Hosp. Corp.*, 225 W.Va. 300, 305, 693 S.E.2d 53, 58 (2010) (“Where a provision of an insurance policy is ambiguous, it is construed against the drafter, especially when dealing with exceptions and words of limitation.”). Consequently, if the annual aggregate provision is ambiguous, then it must be construed against the drafter (i.e., WVMIC).

Such a ruling is not in WVMIC’s best interests. For instance, the Mesh Plaintiffs can benefit from a construction of the ambiguity one way, and some other plaintiff in the future could benefit from a construction of the ambiguity some other way. Both constructions would be consistent with the rule that ambiguities are construed against the drafter.

WVMIC’s second assignment of error is rather simple. WVMIC wishes this Court to calculate the aggregate limits for UHP by the year in which the claims are filed, because, all the UHP claims were filed in 2010. WVMIC does not want the Court to calculate the aggregate limits for UHP by the year in which the medical incidents occurred, because, the medical incidents span two different policy periods.

Applying common sense and the well-established rules of construction, the plain meaning of the Policy calculates aggregate limits by the year in which the covered medical incident occurs. (*Final Order*, ¶37). The medical incidents occurred over the span of two policy periods. (*Final Order*, ¶¶ 3, 37). Therefore, aggregate limits for the medical incidents which occurred in 2006

are \$3 million, and the aggregate limits for the medical incidents which occurred in 2007 are \$3 million. (*Final Order*, ¶37). The circuit court correctly determined, applying the rules of construction, that there is a total of \$6 million in coverage for claims made against UHP.

**Assignment of Error #3: WVMIC asserts the circuit court erred in finding that separate coverage existed for the Respondents' claims against United Health Professionals. The Mesh Plaintiffs respond that the 2008 endorsement does not apply to the 2010 claims, and UHP has separate coverage in 2010 from the tail coverage purchased for Nutt.**

WVMIC's third assignment of error relates to the *Shared Limit Endorsement* (APP. 313) in the 2010 Policy. (*Brief of the Petitioner*, pp. 23-35). WVMIC concedes, for the purpose of this assignment of error, that UHP is insured under the Policy (*Final Order*, ¶26). However, WVMIC argues that the *Shared Limit Endorsement* requires UHP to share limits with Nutt under the tail coverage (APP. 313). WVMIC attempts to contort the plain meaning of the *Shared Limit Endorsement*, by reference to extrinsic evidence, to force a result wherein UHP shares in the \$3 million limits already paid to the Mesh Plaintiffs under the tail policy.

First, the *Shared Limit Endorsement* is an amendatory endorsement to the Policy which attempts to limit the scope of coverage. Under West Virginia law, “[w]here the policy language involved is exclusionary, it will be strictly construed against the insurer in order that the purpose of providing indemnity not be defeated.” *Cherrington v. Erie Ins. Property and Cas. Co.*, \_\_\_ W. Va. \_\_\_, 745 S.E.2d 508, Syl. Pt. 11 (2013).

Second, it is undisputed that the Policy is clear and unambiguous. (*Final Order*, ¶17). As such, the Policy is to be enforced without reference to extrinsic evidence. (*Final Order*, ¶19) (citing *Payne v. Weston*, 195 W.Va. 502, 507, 466 S.E.2d 161, 166 (1995) (Cleckley, J.) (“It is only when the document has been found to be ambiguous that the determination of intent through extrinsic evidence becomes a question of fact.”) (*Final Order*, ¶53) (citing *Blake v. State Farm*

*Mut. Auto. Ins. Co.*, 224 W.Va. 317, 323, 685 S.E.2d 895, 901 (2009) (“It is only when the document has been found to be ambiguous that the determination of intent through extrinsic evidence becomes a question of fact.”). It should be noted that WVMIC’s heavy reliance on extrinsic evidence is indicative of the strength of the circuit court’s construction of the *Shared Limit Endorsement*.

Nonetheless, this Honorable Court need not weigh competing extrinsic facts to interpret the meaning of the *Shared Limit Endorsement* because... **it does not apply**. The 2010 Policy *Shared Limit Endorsement* (APP. 313) reads:

This Endorsement is attached to and made a part of the policy.

Insured paramedical employees shall not have separate limits of liability, but shall share in the limits of liability of each insured(s). Any damages covered by the policy and paid on behalf of an insured paramedical employee shall be applied against the limits of liability applicable to the insured(s), in such order and manner as we deem appropriate.

If damages covered by the policy are awarded, or a settlement is made with our consent, against one or more insured paramedical employees and one or more insured(s), the total limit of liability available to the insured paramedical employees and such insured(s) shall not exceed the limit of liability then available under the policy to such insured(s). If damages covered by the policy are awarded, or a settlement is made with our consent, against one or more insured paramedical employees, but not against any insured(s), the limit of liability available to the insured paramedical employees shall equal the average of the limits of liability then available under all policy(ies) issued by us and providing coverage to such insured(s) but in no event will the limit be greater than the limit carried by the individual insured(s).

As noted by the court, and conspicuously ignored by the Petitioner, the *Shared Limit Endorsement* is not applicable to the Mesh Plaintiffs’ claims because: (1) Nutt is not an insured under the 2010 Policy (*Final Order*, ¶51); (2) UHP is not a paramedical employee under the

2010 Policy (*Final Order*, ¶47); and (3) the “tail” insurance amendatory endorsement provides its own, mutually exclusive “limit of insurance” provision (*Final Order*, ¶51).

WVMIC ignores these stubborn facts and sets forth a convoluted argument which attempts to piece together several unrelated historical events to protect its coffers. By way of background, and briefly, UHP purchased the WVMIC Policy in 2005 with a retroactive date of 2002. During the initial policy periods, UHP and the nursing staff “shared” policy limits with the physicians. In other words, if a doctor and a nurse mid-wife were named as co-defendants in a 2005 lawsuit, then both would share the same policy limit of \$1 million. So, too, would the corporation if also named as a co-defendant. In 2008, however, UHP changed its corporate limits from “shared” to “separate” by way of an amendatory endorsement (APP. 232). The 2008 amendatory endorsement (APP. 232) was “issued” on January 30, 2008, with an “effective” date of January 1, 2008.

WVMIC attempts to bootstrap the 2008 amendatory endorsement to the 2010 Policy. The Mesh Plaintiffs’ claims were all filed in 2010. The amendatory endorsement is not contained in the 2010 Policy (APP. 311-333). The third assignment of error is moot because the 2010 Policy renewal application, signed on December 1, 2009, specifically requests separate corporate limits for UHP with a retroactive date of January 1, 2002. (App. 402-403).

Simply stated, UHP is and always has been an insured under the Policy. WVMIC attempts to exclude coverage for UHP under the Policy premised upon the 2008 *Shared Limit Endorsement* (APP. 232). The endorsement is not contained in the 2010 Policy. The endorsement is rendered moot by the 2010 renewal application which directly contradicts the position taken by WVMIC. The endorsement does not apply because Nutt was no longer an insured when the claims were filed; therefore, there is no one with whom UHP must share limits.

Nutt was covered under separate limits found in the tail coverage. Nutt's tail coverage does not expressly share limits with named insureds (e.g., UHP) under the Policy; nor does the Policy state that named insureds share limits with Nutt under the tail coverage.

**Assignment of Error #4: WVMIC asserts the circuit court failed to consider extrinsic evidence when considering whether UHP and Nutt shared limits. The Mesh Plaintiffs respond that the best extrinsic evidence is the 2010 renewal application (App. 402-403) which specifically provides separate corporate limits and a 2002 retroactive date for 2010 claims against UHP.**

WVMIC's fourth assignment of error is a corollary of the preceding third assignment of error. WVMIC argues the court should have considered extrinsic evidence when constructing the plain meaning of the 2010 Policy. The Mesh Plaintiffs are not "ducking" the extrinsic evidence. In fact, the Mesh Plaintiffs requested the opportunity to conduct discovery if extrinsic evidence was relevant to the court's inquiry. As stated above, the court determined that extrinsic evidence was not necessary to resolve the matter because (1) the 2010 Policy is clear and unambiguous and (2) the extrinsic evidence proffered by WVMIC did not apply to the 2010 Policy (for reasons stated above).

To be clear, the most important piece of extrinsic evidence is the 2010 insurance renewal application (APP. 402). The renewal application specifically requests corporate coverage for UHP with "separate" limits with a retroactive date of January 1, 2002. The coverage requested by UHP in the renewal application directly contradicts the argument proffered by WVMIC and is irreconcilable with its interpretation of the *Shared Limit Endorsement*. From a public policy standpoint, the Mesh Plaintiffs take no position on the expansion of West Virginia precedent with regard to extrinsic evidence. The Mesh Plaintiffs assert the extrinsic evidence supports its position.

**Assignment of Error #5: WVMIC asserts the circuit court erred in failing to apply the doctrine of mutual mistake to equitably reform the 2010 policy to conform to the 2008 intent of the parties. The Mesh Plaintiffs respond that the 2010 renewal application (App. 402-403) best sets forth the intent for 2010 claims against UHP.**

WVMIC's fifth assignment of error requests this Honorable Court to equitably reform the 2010 Policy due to a mutual mistake which occurred in 2008. (*Brief of the Petitioner*, pp. 35-40). Again, WVMIC ignores the 2010 insurance renewal application (APP. 402). Any mutual mistake that occurred in 2008 regarding the change of corporate limits from shared to separate was cured by 2010. The 2010 renewal application specifically requests corporate coverage for UHP with "separate" limits with a retroactive date of January 1, 2002.

**Assignment of Error #6: WVMIC asserts the circuit court's ruling results in unjust enrichment. The Mesh Plaintiffs respond that equity resides in the compensation of some 23 victims of medical malpractice.**

WVMIC's sixth assignment of error argues that applying the plain meaning of the 2010 Policy unjustly enriches the Mesh Plaintiffs. (*Brief of the Petitioner*, pp. 41-42). Dr. Nutt, while employed by UHP, inserted polypropylene mesh into the vagina of at least 23 West Virginia women with utterly devastating results. Nutt blames the manufacturer; the manufacturer blames Nutt. Regardless of the finger pointing, the brutal truth is that 23 women are forever harmed in a way that no man can understand. Some urinate out their anuses. Others defecate out their vaginas. None maintain proper sexual function. WVMIC's argument that these ladies will be unjustly enriched is ignorant, insulting and absurd.

WVMIC argues that UHP paid a premium of \$42,847 but should have paid \$209,793 for the coverage provided. The purported underwriting mistake cost WVMIC \$166,946 in lost premiums. Rather than sue UHP for getting more insurance than it paid for, WVMIC demands this Honorable Court reform the policy to protect its coffers.

As stated in its 2012 Annual Report, WVMIC is the premier and preeminent medical liability insurer in West Virginia with \$183 million in cash, investments and other assets. WVMIC owns 55% of the medical malpractice market in West Virginia. It earned \$35 million in premiums in 2011 while paying only \$11 million in incurred losses, according to the West Virginia Insurance Commissioner's annual report. It is the most profitable insurance company in the State of West Virginia. It can afford to honor its insurance policy as written.

**Assignment of Error #7: WVMIC asserts the circuit court erred by refusing discovery on extrinsic evidence. The Mesh Plaintiffs respond that extrinsic evidence is not permitted under West Virginia law, and the extrinsic evidence relied upon by WVMIC is irrelevant and not dispositive of the controversy.**

Finally, WVMIC's seventh assignment of error repeats its arguments related to the exclusion of intrinsic evidence by the court. Again, the circuit court correctly determined that the Policy was clear and unambiguous. West Virginia law prohibits consideration of extrinsic evidence in such circumstances. Moreover, the extrinsic evidence relied upon by WVMIC is not dispositive of the findings and facts and conclusions of law recited in the *Final Order*. The circuit court correctly determined that UHP was insured under the 2010 Policy; the 2010 *Shared Limits Endorsement* does not apply to Nutt nor UHP; and the 2010 Policy expressly calculates the annual aggregate limit by the year in which the medical incident occurs.

The extrinsic facts which occurred in 2008 could arguably be germane to claims filed against UHP in 2008. However, WVMIC concedes, and the court made a finding of fact to which no assignment of error is asserted, that the 2010 Policy is the controlling policy for purposes of the Mesh Plaintiffs' claims. Discovery related to the 2008 Policy is not helpful to determine coverage under the 2010 Policy. To render the 2008 extrinsic evidence relevant, this Court will need to engage in legal gymnastics to piece together snippets of policy provisions and endorsements over a span of several policy periods.

The Mesh Plaintiffs purposefully considered the scope of coverage under the rules of construction dictated by the West Virginia Supreme Court when reaching the settlement agreement with WVMIC. The Mesh Plaintiffs explained their position to WVMIC in great detail. WVMIC entered into the settlement with eyes wide open and insisted that its interpretation of the 2010 Policy would prevail. WVMIC is mistaken in its position and takes unreasonable liberty with its policy terms. The Mesh Plaintiffs respectfully request this Honorable Court to apply the seasoned rules of insurance policy construction and affirm the ruling by the circuit court.

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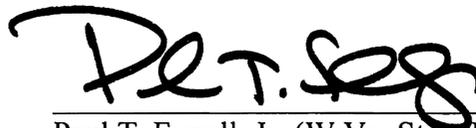
**CERTIFICATE OF SERVICE**

I, Paul T. Farrell, Jr., do hereby certify that I have hand-delivered the original and ten (10) copies of the **RESPONDENTS' BRIEF** this day to the Clerk of the West Virginia Supreme Court and have served a copy of said brief upon counsel of record by mailing a true copy thereof this 2nd day of December, 2013, to the following:

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